Alternate Care Site Plan

Version 1.1

November 2013

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I. Supportive Legislation

A. Maryland currently has no legislation addressing the issue of licensing an Alternate Care Site to provide inpatient and outpatient health services. This issue is critical to receiving medical care reimbursement. However, there is an ACS legislative initiative to amend an existing statute in Public Safety, Title 14, Subtitle 3, Governor's Emergency Powers.

1. There is an It will add the definition of an "alternate care site" in the Subtitle's "Definitions" section (§14-301).

2. The legislative proposal states that the Governor may "authorize the use of alternate care sites by accredited health care facilities, as defined in Title 19, §19-114."

3. This wording is intentionally broad to allow for greater freedom in implementing ACS policies and regulations.

4. By "authorizing the use," the provision specifically contemplates an ACS without unnecessarily statutorily restricting or narrowing that use.

5. Policy guidelines or regulations, if needed, could be drafted later by the appropriate agency.

B. See Appendix A for a review of the framework of relevant laws that may apply during a public health emergency or other medical surge situations requiring the operation of an Alternate Care Site in the State of Maryland.

II. Uses and Triggers (opening and closing) for the Alternate Care Site

A. Best uses of an Alternate Care Site (ACS) would arise when an influenza pandemic is present (Gradual, Long-Term Impact Disaster):

B. Triggers for opening an ACS (all have been met):

1. Local hospital's daily ER visits are over_____.

2. Local Urgent Care facilities are each seeing _____ patients daily on a consistent basis.

4. Other counties in the region are experiencing the same level of surge.

5. Hospitals in the region have cancelled all elective surgeries and are no longer accepting noncritical admissions.

6. Hospitals in the region have identified inpatient individuals who are stable enough to be discharged or transferred to another suitable medical facility (lateral transfer regarding level of medical care).

7. Altered standard of care has been addressed, if applicable, regarding patient care and the use of scarce resources.

C. Best Uses of an ACS include:

1. Influenza Triage Site with limited supportive care.

Limited care to influenza patients who may require hydration, medication, and/or IV fluids. Patients who are only minimally ill who can be treated and sent home.

2. Ambulatory Care Center for patients not infected with influenza.

Provides care to those patients not infected with influenza who require basic ambulatory care and can be quickly discharge to their home following a regime of basic care.

3. Convalescent-Hospice Care Site for influenza patients.

These individuals require basic care but have no caregiver at home and are unable to care for themselves. They may recover or require palliative care until their death.

D. Medical gases would only be offered if the appropriate infrastructure is in place.

E. Prior to opening an Alternate Care Site, the local jurisdiction must establish what triggers should be present for its closure. These triggers should include regional healthcare activity.

F. Triggers for closing an ACS (all have been met):

1. Local hospitals are no longer seeing _____daily ER visits.

2. Local Urgent Care facilities are no longer seeing 300 patients daily on a consistent basis.

4. Other counties in the region are experiencing a decreased level of surge.

5. Hospitals in the region have begun accepting patients for elective surgeries and are now accepting noncritical admissions.

6. Hospitals in the region are no longer making lateral transfers to other facilities in order to treat a surge of critical care patients.

III. Command and Control

A. State Level

1. DHMH

a. Coordinate Maryland Professional Volunteer Corps and regional/state/federal health and medical resources.

b. Provide medical surveillance and public health situational updates to the local level

c. Implement regional or statewide communicable disease control strategies

d. Assist with ensuring food safety and environmental safety, sanitation, and managing animal control issues

e. Authorize use, in consultation with other partners, of the permanent ACS @ GBMC

f. Forward requests for; and provide notification of changes in laws and regulations related to public health and patient care

g. Provide local level health and medical updates to the state level

h. Provide media assistance and participate in Joint Information Center

2. OHCQ

a. Issue alternate care site licenses and establish approved levels of care at said sites

b. Coordinate with CMS and assist with necessary CMS waivers

c. Perform site visits throughout the activation of alternate care sites

d. Expedite approvals for hospitals to temporarily exceed bed capacities

3. MIEMSS

a. Coordinate with local jurisdictions regarding the establishment of alternate triage protocols and/or temporary patient triage locations

b. Coordinate patient movement via ambulance
c. Monitor bed availability and surge capabilities of healthcare entities

d. Work with unified/area commands and site incident commander to determine transfer requirements for each alternate care site location

B. Jurisdictional Level

The primary authority for expanding health and medical capabilities, including the activation of alternate care sites, would be at the jurisdictional level. If possible, the decision to expand the health and medical community, including opening an alternate care site should be made before the healthcare system is completely overwhelmed.

1. A Healthcare Incident Command Team should be established at the local Emergency Operations Center to begin planning for how to handle the impending patient surge.

   a. This team should include members from the local healthcare community, local health department, local EMS, emergency management agency, and state partners, as necessary.

   b. The Healthcare Incident Command Team responsibilities would include:

      i. Identifying available medical surge resources and determine utilization of those resources

      ii. Request regional, state, and/or federal resources, as necessary

      iii. Determine the need for activation of an alternate care site (utilizing defined triggers)

      iv. Maintain regular communication with the local EOC and DHMH

      v. Notify DHMH and OHCQ of decision to open an alternate care site

   c. It is recommended that the Healthcare Incident Command Team operate as long as the patient surge event continues, including through the demobilization of any alternate care sites.

   d. Specifically regarding alternate care sites, the Healthcare Incident Command Team will not only decide if an alternate care site or sites are needed, but also the type and level of care that is necessary and can reasonably be accomplished.

   e. If the Healthcare Incident Command Team determines an alternate care site or sites are needed, it is recommended that an Alternate Care Site Branch be

implemented. This Branch will coordinate activation and operations of all alternate care sites within the jurisdiction.

2. ACS Governance

   a. The local health department will have governance over sites that require low acuity care.
      - Examples include: public health intervention; medication distribution
      - Such sites will work under the medical license of the health department medical director

   b. The healthcare community will have governance over sites that require acuity above the capabilities available to the local health departments.

      - Examples include: ambulatory and/or palliative care
      - Such sites will work under the medical license of a physician or medical director of a healthcare entity.

   c. MIEMSS will have governance over sites designated for mass triage

   d. It is recommended that each jurisdiction have similar designations for governance to minimize confusion and increase uniformity throughout the state, although it is understood that this may not always be feasible.

C. Alternate Care Site Level

1. Each alternate care site location should be established using the National Incident Management System's Incident Command Structure with liaisons designated for continuous communication with the Alternate Care Site Branch at the jurisdictional level.

2 Additional recommendations include:

   a. All sites, regardless of patient care level, be assigned a Site Incident Commander/ACC Administrator- with a demonstrated knowledge of patient care operations

      i. Pre-designation of possible site incident commanders is preferred

   b. Regardless of what entity has governance, the Healthcare Incident Command Team will provide an overall medical surge plan and guidance on how the ACS will be utilized. See Attachment 1.

      i. This will include when to open and close the ACS.

      ii. What level of care will be provided.

      iii. How the ACS will be integrated into the overall medical surge event.

c. The ACS Branch will focus on the operational aspects of the ACS. See Attachment 2.

i. It will establish how the ACS will receive reimbursement for services, assist with resource challenges, security issues, liability and maintenance as well as other challenges which may arise with patient and facility care.

IV. Funding of the Alternate Care Site and Compensation for Patient Care

A. Normal Business Operation Funding

1. Hospital Reimbursement

In order to receive reimbursement from the Federal Healthcare Programs: Centers for Medicare and Medicaid Services (CMS -Medicare, Medical Assistance, Children's Health Insurance Program), and TRICARE- military personnel), healthcare providers must meet certain statutorily defined conditions of participation ("CoPs"). These include issues related to:

- Governance
- Quality assurance
- Professional staffing
- Record keeping
- Clinical services
- Utilization review
- Physical environment
- Infection control
- Patient health and safety
- Licensed by the state
- Personnel are licensed or meet other applicable state and local standards

a. Maryland's Office of Healthcare Quality performs CoPs surveys on behalf of CMS, the functions of which are collectively referred to as the "certification process."

b. After having met the criteria under the CoPs survey, a healthcare facility is eligible to receive reimbursement for inpatient and outpatient services.

2. Hospital ACS Reimbursement

a. Hospitals may establish an onsite (i.e., "hospital-based") ACS, to include facilities with shared licensing and accreditation.

i. Facilities certified for additional Medicare beds beyond their current available capacity may increase their numbers without review and approval.

ii. Main campus outpatient services may be expanded through the use of temporary medical tents, parked mobile units or permanent facility-based treatment areas, subject to compliance with state licensure rules and applicable CoPs.

b. Hospitals may establish an offsite ACS that provides inpatient and/or outpatient services under its existing provider agreement; however, the new location must meet all the CMS "provider-based" requirements (CoP compliance, shared licensure with the main facility, as well as clinically and financially integrated services.)

i. The provider-based location must be represented as part of the main provider.

ii. In an emergency or disaster, the hospital would be expected to file amended documents with its Medicare Administrative Contractor or legacy Fiscal Intermediary as soon as possible adding the new location.

iii. CMS requires a survey of CoP compliance at all new provider-based inpatient locations, but has indicated its "discretion to waive the onsite survey in this area."

c. Emergency medical services capacity may be increased at any department or facility of the hospital, regardless of location, if it meets the statutory definition of a "dedicated emergency department." EMTALA- Emergency Medical Treatment and Active Labor Act requires:

i. The location is licensed as an emergency room or department.

ii. Is "held out to the public" as providing care for "emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

B. Section 1135 Waiver Funding

1. <u>Non-hospital or provider-based ACS reimbursement</u>
Eligible for reimbursement following a Presidential declaration of an emergency or major disaster or Public Health Emergency declared by the Secretary of Health and Human Services (HHS)

a. A Section 1135 Waiver

i. May be issued by the Secretary of Health and Human Services

ii. "Temporarily waives or modifies the application of" a number of statutory and regulatory requirements. If a hospital is forced out of compliance with one or more of the CoPs may remain eligible for Federal Healthcare Program reimbursement.

iii. May be granted to individual and/or classes of healthcare providers retroactive to the beginning of the emergency.

iv. Waivers remain in effect for 60 days but may be renewed for additional periods of up to 60 days at the Secretary's discretion.

v. All waivers terminate upon the expiration of the emergency period.

vi. There are four categories of a Section 1135 Waiver. All or only some of these categories may be put into effect at the time the waiver is issued.

b. Categories of a Section 1135 Waiver:

i. Certain CoPs (e.g., state licensure requirements for professionals and facilities), certification requirements, program participation, or preapproval requirements.

ii. Sanctions under the EMTALA

iii. Medicare Advantage patients' use of out-of-network providers
iv. Sanctions under the Health Insurance Portability and Accountability Act (HIPAA)

c. Steps to take prior to opening a non-hospital or provider-based ACS:

i. Contact the Office of Health Care Quality to determine the ACS location.

ii. Request the Section 1135 Waiver

iii. Detail services to be provided

iv. Provide assurances regarding patient safety

d. The approval of an ACS is made on a case-by-case basis.

C. **FEMA reimbursement** will be limited to those eligible costs:

1. Associated with patient transportation, basic treatment, and monitoring:

a) Triage

b) Medically necessary testing and diagnosis
c) First aid
d) Prescription assistance
e) Durable medical equipment
f) Vaccinations
g) Mobile treatment facilities

2. Associated with hospital services provided at a congregate shelter (e.g., hotel, gymnasium, etc.)

   a) Includes services listed above
   b) Care for persons with chronic conditions
   c) Staffing
   d) Transportation to a medical facility

3. Medical costs incurred once a disaster victim has been admitted to a medical care facility on an inpatient basis are specifically excluded.

4. Eligible costs are limited to a 30-day period, post-emergency declaration.

5. Costs are not eligible for reimbursement unless no other forms of insurance are available (i.e., private insurance, Medicare, medical Assistance).

6. FEMA reimbursement is not timely and questions have been raised regarding allowable cost calculation.

7. Costs associated with providing hospital-level care (i.e., acute or intensive care services) in an ACS will not likely be reimbursed.

8. **FEMA reimbursement is uncertain and impractical and therefore reimbursement of ACS services should come from maintaining existing revenue streams via Federal Healthcare programs.**

V. Liability

A. During an emergency response, public and private sector representatives, officials, and entities – particularly health care providers and other responders -- may need to take actions that cause some individuals to feel that they have somehow been treated negligently or in an improper fashion

   1. While the actions taken by these public and private sector entities may be perfectly legal, it is possible that some individuals may still try to file civil law suits and hold these entities liable for their actions.

2. Health care providers and other response personnel may not always find it possible or practical to comply with all statutory, regulatory, and other legal requirements while operating under the extraordinary restraints on time and resources that are common during an emergency response.

B. Plaintiffs' claims for injuries or harm arising out of a medical emergency or public health emergency will most likely be filed as negligence claims.

1. Negligence is broadly defined as the failure to do what a person of ordinary prudence would have done under the circumstances of the situation, or doing what such a person, under such circumstances, would not have done. In Maryland, a successful claim for negligence must prove all of the following elements:

a. Duty: The plaintiff must prove that the defendant had a duty of care to the plaintiff imposed by statute, contract, or specific relationship or role.

b. Breach of Duty: The plaintiff must prove that the defendant failed to meet his duty according to the accepted standard of care.

c. Harm: The plaintiff must prove that he suffered harm.

d. Causation: The plaintiff must prove that his harm was directly or proximately caused by the defendant's breach of duty.

C. Standards of Care

1. **Maryland law does not officially legally recognize any altered standard of medical care that may be adopted during an emergency.** However, this standard may be interpreted in a way that should likely help to shield health care providers from liability for decisions made regarding care during an emergency.

a**.** Under Maryland law, the standard of medical care for all situations requires health care facilities and providers to:

i. Use the degree of care expected of a **reasonably competent practitioner**; under the **same or similar circumstances**, accounting for:

- advances in the profession;
- availability of specialized facilities and/or providers; and
- other relevant factors.

b. Standards of medical care could be interpreted to account for the circumstances of the emergency under which health care facilities and providers are forced to perform.

i. For example, to account for the same or similar circumstances prong of the medical standard of care, a court or jury hearing a malpractice

claim arising from care provided during an emergency or disaster situation would need to consider the exigencies of the situation when determining the appropriate standard of care to which the health provider should be held. As such, the fact that the providers were administering care during an emergency would need to be considered when determining if the defendant met the required standard of care, and this may result in the jury or court finding that the defendant was not, in fact, negligent in his or her conduct. Due to the legally-required consideration of the circumstances in which care was provided, a court or jury might find that care that ordinarily would be considered as negligence or malpractice meets the expected standard of care for a provider who is forced to operate under the emergency circumstances created by a medical surge or public health emergency.

D. Liability and Immunity of Health Care Providers and Other Responders

Some immunity protections are not in effect unless certain prerequisite conditions, such as a proclamation of a catastrophic health emergency, have occurred, and none of the immunity laws discussed herein apply to actions performed with willful misconduct or gross negligence.

1. Immunity Under the Catastrophic Health Emergencies Act (CHE Act)

   a. Applies to individuals and facilities

   b. Triggers/Limitations: Immunity only applies upon DHMH Secretary's proclamation of a catastrophic health emergency.

   c. A health care provider acting under a proclamation of a catastrophic health emergency is immune from civil or criminal liability if the health care provider acts in good faith.

   d. By definition under the Act, a health care provider includes:

      i. A health care facility as defined in § 19-114(e)(1) of the Health General Article of the Maryland Code.

      ii. A health care practitioner as defined in § 19-114(f) of the Health General Article of the Maryland Code

      iii. An individual licensed or certified as an emergency medical services provider under §13-516 of the Education Article of the Maryland Code.

2. Immunity for Vaccine Administration

   a. Applies to individuals

b. Triggers/Limitations: In order to receive immunity for participating in an "immunization project," the project must be officially certified by the Secretary of the Department of Health and Mental Hygiene.

c. Maryland law states that any person lawfully administering a drug or vaccine is immune from liability for injuries that vaccine may cause.

3. Immunity Under the Good Samaritan Act

a. Applies to individuals

b. Triggers/Limitations: Immunity does not apply if person assisting victim receives ANY form of compensation from the victim. The Act has different requirements for health care professionals and lay volunteers.

c. Health Care Professionals and Emergency Responders receive immunity from civil liability for any act or omission while providing assistance or medical care, provided that:

i. The act or omission is not one of gross negligence

ii. The assistance or medical care is provided without compensation of any form from the individual(s) being assisted.

iii. The "assistance or medical care is provided at the scene of an emergency, in transit to a medical facility, or through communications with personnel providing emergency assistance."

d. Lay Volunteers receive immunity from civil liability in certain situations when assistance or medical aid is provided to victims at the scene of an emergency and the following conditions are satisfied:

i. The assistance or aid must be reasonably and prudently provided

ii. The assistance or aid must be provided without receiving any form of compensation from the individual(s) being assisted.

iii. The lay volunteer must relinquish care when someone who is licensed or certified in the state to provide medical services becomes available to assist.

e. It is unclear whether the Act would offer immunity protections to individuals who assist with response activities during a proclaimed public health emergency.

4. Immunity Under the Maryland Tort Claims Act (MTCA)

a. Applies to individuals

b. Triggers/Limitations: For immunity provisions to apply to volunteers of state agencies, such volunteers must be formally recognized as volunteers before they perform actions on behalf of the State.

c. State personnel are immune from suit in courts of the State and from liability in tort for a tortious act or omission that is within the scope of the public duties of the State personnel and is made without malice or gross negligence and for...which immunity has been waived under Title 12, Subtitle 1 under the State Government Article.

   i. State personnel‖ is broadly defined in the MTCA and includes an individual who, without compensation, exercises a part of the sovereignty of the State. Generally, this definition includes any State employee paid by the Central Payroll Bureau in the Office of the Comptroller of the sovereignty of the State.

d. Additionally, the Maryland Tort Claims Act provides immunity for some individuals who volunteer for the State. Pursuant to Title 25, Subtitle 2, Chapter 1 of the Code of Maryland Regulations, a volunteer is an individual who:

   i. Is performing services to or for a unit of State government, the employees of which are considered State personnel.

   ii. Is engaged in the actual performance of the services at the time of the incident giving rise to a claim

   iii In the performance of services: is participating in a formal volunteer program, or before the beginning of those services, is formally recognized by the unit as a volunteer.

   iv. It is important to note that, by the COMAR definition's requirement of advance formal recognition of volunteers for state agencies, the MTCA likely provides no protection to spontaneous volunteers.

5. Immunity Under the Local Government Tort Claims Act (LGTCA)

   a. Applies to individuals

   b. Triggers/Limitations: Volunteers must be providing services at the request of the local government in order for immunity provisions to apply.

   c. Like the MTCA, the Local Government Tort Claims Act (LGTCA) provides immunity protections for local government employees who, in good faith, perform activities within the scope of their duties.

d. A person may not execute against an employee on a judgment rendered for tortious acts or omissions committed by the employee within the scope of employment with a local government, unless the employee is found to have acted with actual malice.

   i. In situations in which a local government employee is found to have acted with actual malice, the judgment may be executed against the employee and the local government may seek indemnification for any sums it is required to pay.

e. Pursuant to the LGTCA, a volunteer also meets the definition of employee for purposes of liability and immunity protections provided by the Act, as long as the volunteer is providing services or performing duties at the request of the local government at the time the allegedly tortious act or omission occurs.

6. Immunity Under the Maryland Volunteer Service Act

   a. Applies to individual volunteers performing service for a qualified "association or organization."

   b. Triggers/Limitations: Does not provide immunity from suit; merely limits defendant's liability in damages to the extent of his personal insurance.

   c. Does not provide immunity to individuals; rather, it limits the extent of possible damages that can be collected in a judgment against a defendant.

   d. Under the Act, a volunteer is not liable in damages beyond the limits of any personal insurance he may have in any suit that arises from the volunteer's act or omission in connection with any services provided or duties performed by the volunteer on behalf of the association or organization, unless an act or omission of the volunteer constitutes gross negligence, reckless, willful, or wanton misconduct, or intentionally tortious conduct.

   e. The Act defines a volunteer as any officer, director, trustee, or other person who provides services or performs duties for an association or organization without receiving compensation.

      i. While the Act's specific application to volunteers of an association or organization varies depending upon an organization's taxation status, an association or organization, as defined in the Act, generally would include a business league; a charitable organization; a civic league; a club; a labor, agricultural, or horticultural organization; or a local association of employees.

   f. The Act also contains exceptions from its liability protections for volunteers who somehow ratify the misconduct of others within the organization.

i. The Act states that its limitations on liability do not apply if a volunteer knew or should have known of an act or omission of a particular officer, director, employee, trustee, or another volunteer, and the volunteer authorizes, approves, or otherwise actively participates in that act or omission; or, after an act or omission...with full knowledge...ratifies it.

7. Immunity Under the Public Readiness and Emergency Preparedness Act (PREP Act)

   a. Applies to Individuals and Entities

   b. Triggers/Limitations: A PREP Act declaration must be issued by the Secretary of health and Human Services for the specific countermeasure in question.

   c. The Act authorizes the Secretary of Health and Human Services (HHS) to issue a declaration under the Act that provides immunity from tort liability for the administration or use of countermeasures to diseases or public health threats determined by the Secretary to pose a present or future risk of a public health emergency.

   d. The Secretary, within the declaration, can specify the conditions under which her declaration will apply, including effective dates and geographic areas.

8. Immunity Pursuant to Mutual Aid Agreements

   a. Applies to individuals

   b. Triggers/Limitations: Some mutual aid agreements depend upon the governor's proclamation of an emergency before their provisions apply.

   c. Emergency Management Assistance Compact (EMAC)

      i. EMAC is a mutual aid compact that has been adopted by all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. EMAC's application requires a governor-declared emergency; however, once that declaration is made, a state may make requests for additional resources, equipment, and personnel through the Compact.

      ii. Out-of-state personnel providing assistance pursuant to an EMAC request are eligible for the same limitations on liability and immunity protections as the state's own employees.

      iii. EMAC provides immunity from liability for any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith.

iv. Acts constituting willful misconduct, gross negligence, or recklessness would not be subject to the immunity protections available through EMAC.

d. Maryland Emergency Management Assistance Compact (MEMAC)

i. The Maryland Emergency Management Assistance Compact (MEMAC) is a statewide compact that provides for mutual aid assistance among Maryland jurisdictions to manage intrastate emergencies.

ii. Officers or emergency responders of a party jurisdiction rendering aid in another jurisdiction pursuant to this Compact shall be considered agents of the requesting jurisdiction for tort liability and immunity purposes.

iii. M E MAC provides that no party jurisdiction or its officers or emergency responders rendering aid pursuant to MEMAC can be held liable for any act or omission in good faith on the part of responding personnel.

iv. MEMAC does not provide immunity protection for acts or omissions that constitute willful misconduct, gross negligence, or recklessness.

e. National Capital Region Mutual Aid Agreements (NCR Agreements)

i. The National Capital Region includes the District of Columbia and several counties in Maryland and Virginia that surround the District.

ii. A responding party that renders aid or fails to render aid pursuant to an Agreement shall be liable on account of any act or omission of its officers or employees while so engaged, but only to the extent permitted under the laws and procedures of the State of the party rendering aid.

iii. NCR Agreements subject out-of-state responders only to the same liability and immunity protections that they would experience in their home state.

iv. NCR Agreements require that civil actions against an aid-rendering party must be brought only under the laws and procedures of the party rendering aid and only in the Federal or State courts located therein.

VI. Communication

A. Interoperable Communications

1. The communication pathway within _____County's public health and healthcare system (inside the hospital and between all healthcare agencies). See Attachment 3.

2. Communication devices that would be utilized include: phone, fax, HAM radio, satellite phone, local WebEOC, 800MHz radio, HC Standard, HAN, walkie-talkies and runners.

3. Contact numbers for all essential staff within the LHD are located in our automated web based system, Connect CTY as well as listed on an Excel spreadsheet. See All Hazard Plan – Communication Plan.

4. Contact numbers for essential emergency ESF-8 partners are located in our automated web based system, Connect CTY as well as listed on an Excel spreadsheet. See All Hazard Plan – Communication Plan.

5. EMS should be consulted regarding the best communication pathway for coordinating the transfer of patient to and from the ACS.

6. The ACS should have several work stations with access to computers and the internet.

7. The ACS should ideally have a webpage on the hospital's intranet, available only to employees and possibly password-protected, to provide information to employees regarding ACS staffing, policies, management, etc.

B. Risk Communication

1. _____ County will deliver consistent, accurate and relevant public health and medical information to:

   a. Clinicians- using Blast Faxes

   b. First Responders/ LHD staff- using _____ (Reverse 911) and Web EOC

   c. General Public- using media, websites, _____ (Reverse 911)

   d. Media- using our Joint Information Center

   e. Special Populations- using _____(Reverse 911)/ Blast Faxes

2. _____County will use the following methods for delivering public health and safety information to the public (shelter in place, evacuation plans, where to receive more information). See All Hazard Plan – Communication Plan.

   a. _____ (Reverse 911)- contacts every resident in the county and if appropriate, Emergency broadcast system (Highest priority)

   b. Websites (Second priority)

   c. Press Releases to radio/television/newspapers (Third priority)

3. The decision to publicize a low-acuity, non-primary treatment ACS opening is not generally recommended.

    a. Staff members' communications regarding the ACS should avoid identifying its exact location for both security and patient flow reasons, as non-triaged patients or worried well may self-present at an ACS, drawing valuable resources away from patients already under care, and potentially adding to a chaotic, stressful environment.

4. If the ACS is publicized or becomes known, clear consistent messaging about the ACS' services and resources may help limit the number of self-presenting patients, or inform those patients of procedures once arriving.

    a. However, even when not used for primary treatment, public awareness of the patient distribution process and the reasoning behind it can be of benefit to overall emergency health systems effectiveness.

    b. Regardless of the services offered, during a public health emergency, any healthcare site is likely to be overwhelmed.

5. A pre-planned communications structure should be in place before the activation of the ACS.

C. Call Center

1. Purpose- provide health information and to perform telephone triage.

2. Protocol for implementation- the Healthcare Incident Command Team will determine when the Call Center will be opened based on the needs of the community.

3. Location- local EOC

4. Staffing- a nurse will be present as a resource for the telephone operators (county employees)

5. Hours of operation- based on community need, but possibly from 7AM-11PM.

6. Hardware/equipment- EOC telephones

7. Phone number- (410-838-5800)

VII. Transportation

A. Designate parking areas for:

1. Ambulances
2. Staff members
3. Family members and visitors of patients (if visitors are permitted)
4. Taxis and private vehicles to pick up patients being discharged from the ACS
5. Police and law enforcement vehicles
6. Vehicles being used for resource transport.

B. Ambulance entrance designated for dropping and picking up patients should be:

1. Located near the Admissions and Registration section of the ACS.
2. Separate from the loading/unloading zone designated for deliveries of supplies and equipment.

C. Arrange for alternative transportation services, including private ambulance companies, to supplement EMS transport capabilities.

1. Consider using school buses or commuter buses to transport patients to and from the ACS to their homes, other healthcare facilities, or hospitals.

VIII. Security and Safety

A. The ACS should not be opened to patients until proper security personnel are present and ready to manage the facility. 127 As such, a security plan should be created to address the following issues:

1. Entry to and exit from the facility;
2. Restriction of movement between different areas of the ACS;
3. Securing patient areas and family/visitor areas (if provided);
4. Securing staff areas;
5. Securing access to controlled substances and other pharmaceutical supplies;
6. Securing access to facility grounds and parking lots;
7. Securing loading and unloading zones for ambulances, supply trucks, etc;
8. When necessary, securing access to public roads that serve the area around the facility

B. A perimeter may need to be secured around the entire ACS campus, including staging areas and loading/unloading zones.

1. Use of six-foot chain link fence has been successful in the past to secure the perimeter of an ACS.

C. In addition to this measure, security personnel need to be posted:

1. At all entry points to the ACS

2. At higher-risk areas (where pharmaceuticals are stored and dispensed; medical supply areas; and family/visitor areas (if they are established).

3. Consider posting armed guards near the pharmaceutical storage area and dispensary to prevent looting or theft of these materials.

D. Secure parking areas for staff, separate from patient and visitor parking.

1. Security escorts should be available to walk staff members to their cars at night, as well as to outdoor toilet facilities that may be set up for staff use, if requested

E. Verify the identification of staff members, patients, and family members or visitors who seek to enter the ACS facility.

1. Issue temporary identification to wear while in the ACS.

2. A system of temporary identification badges needs to be created for the ACS.

a. This may be something as simple as stick-on name tags, or as complex as temporary computer-generated photo IDs.

b. Wallet ID cards be issued in conjunction with temporary ID badges so that individuals within the ACS have a secondary source of identification for security to verify when necessary.

F. Security staff Shift rotations must be established.

G. Sources of potential security personnel must be identified.

1. Off-duty security personnel from area hospitals;

a. Private, contracted security officers;

b. Police officers (on-duty or off-duty) and other law enforcement personnel;

c. Activated members of the National Guard (depending upon the severity of the emergency), and even ROTC cadets.

H. The security team at the ACS should wear the same uniform, have common identification, and operate on the same radio frequencies operate on the same radio frequencies.

I. Finally, because circumstances of the emergency or disaster may create social disturbances, such as rioting or looting, ACS security personnel should be trained and prepared for instituting a lockdown of the ACS, if necessary.

1. The primary goal of an ACS lockdown is to isolate and control access to the Alternate Care Site facility while caring for the safety of patients, visitors, staff, and property.

2. Once a lockdown has been initiated and the ACS facility is secured, security personnel should notify local law enforcement, as well as notifying staff, vendors, and others who may need to enter the facility.

IX. Facility Maintenance

A. Principles of Standard (Universal) Precautions should be used throughout the ACS at all times.

B. Procedures should be implemented to provide for the routine care, cleaning, and disinfection of surfaces, patient beds, equipment, and any areas that receive high amounts of traffic from patients, staff, and/or visitors.

1. Regular cleaning supplies may be used for this purpose, and to enhance opportunities for quick cleaning of potentially-contaminated areas, the use of pre-treated, antibacterial wipes may be beneficial .

2. In the case of a public health emergency, certain pieces of equipment and patient areas may need to receive heightened disinfection measures to kill microorganisms capable of living for a longer time on inanimate objects and surfaces.

3. Cleaning supplies may include Cavicide, Clorox 409-R and Ethanol Alcohol.

C. Protocols should be followed to manage medical waste and infection control at the ACS.

1. Equipment that is soiled or contaminated (or which may be contaminated) with blood, bodily fluids, and other secretions should be handled in a manner that prevents exposure to an individual’s skin and mucous membranes, avoids contact with clothing, and minimizes the possibility of transfer of microorganisms.

2. If patient linens are not disposable, they should be handled, transported, and laundered to avoid microbial transfer to other patients, ACS personnel, and the facility.

3. Equipment that enters normally-sterile body tissues should be properly sterilized before reuse.

4. Contaminated medical waste should be sorted and discarded according to appropriate federal, state, and local regulations.

D. Medical staff should also take appropriate precautions when dealing with patients, particularly in the event of a public health emergency.

1. Healthcare staff should wear clean gloves when they are required to touch blood, bodily fluids, or items that are potentially contaminated with any of these substances.

2. Face masks and appropriate eye protection, such as goggles or face shields, should be worn to protect staff members' eyes, noses, and mouths while they are performing procedures that may cause blood or bodily fluids to splash.

3. Staff members should wear protective gowns while performing procedures and treatment care activities that may generate splashes of blood, bodily fluids, etc.

4. After procedures are completed, soiled gowns should be removed and promptly disposed of to avoid transfer of microorganisms.

5. Strict hand washing protocols should be implemented throughout the ACS. Staff should wash hands:

a. After contact with blood, bodily fluids, or contaminated items

b. After having direct contact with a patient or with items used by a patient

c. Between patients

d. Other times, as necessary, to prevent cross-contamination of surfaces and objects.

X. Procurement

A. The Logistics Section Chief should prepare for procuring supplies, equipment, and services in five main areas:

1. Materials and Supplies
2. Food Service
3. Resource Transportation
4. Housekeeping
5. Maintenance

B. It is important to note that, while the Logistics Section Chief may be responsible for ordering some medical equipment and supplies, due to the specialized procedures and enhanced need for controlled access surrounding the procurement of pharmaceuticals, designated medical or pharmacy personnel at the ACS should be responsible for procurement of these items.
See Appendix B for Accounting Form Templates.

C. During an emergency, depending upon the type, scope, magnitude, and duration of the event, normal hospital supply chains may be highly stressed or even non-operational. Therefore, the following medical supply caches should be requested:

1. Region III Health and Medical UASI Cache.
   See *Medical Surge Plan,* Attachment 7.

D. The following patient care supplies are generally recommended for inclusion in the ACS' supply cache (See Attachment 4):

1. Patient beds/cots (in multiples of 50), including appropriate linens
2. Patient ID wristbands or labels
3. Mobile supply, medical, and treatment carts
4. Wheelchairs and stretchers
5. IV poles
6. Wash basins
7. Patient commodes and/or bed pans
8. Walkers and canes
9. Pharmacy carts (that can be locked)
10. Personal Protective Equipment (PPE), including gloves, aprons, and masks

E. Administrative and non-medical supplies will also be needed for the ACS. These include:

1. Desks, chairs, and various workspaces
2. Status boards, white boards, and easels
3. Writing implements
4. Clipboards
5. Computers or laptops, fax machines, telephones, and other communications equipment
6. Solar charging stations for portable electronic devices, such as cell phones and radios
7. Copy machine
8. Calculators
9. Housekeeping cart and cleaning supplies
10. Wheeled carts for transportation of resources
11. Pallets and storage containers
12. Physical supports (i.e. back belts) for heavy lifting

F. The Logistics Section Chief should ensure that sufficient stores of pediatric supplies of medical equipment are ordered for use at the ACS, as children frequently require smaller equipment and smaller doses of medication than adults.

G. Ordering adequate supplies of extra scrubs in a variety of sizes is recommended to provide staff with an alternative source of clean scrubs during an emergency, when they may not have access to routine laundry service or time to obtain clean clothing from their homes.

H. To ensure the safety and integrity of resource supplies, a secure receiving and storage area should be created at the ACS, particularly for pharmaceuticals and other supplies, such as N-95 masks, that may be scarce or highly limited in supply during an emergency.

I. A Memorandum of Understanding (MOU) regarding the lending or donating of equipment may be utilized as it may be more feasible to borrow or accept donations of supplies from an area hospital or other medical facility than to attempt to procure it from a vendor. Health care providers should consult with their organization's appropriate legal counsel to delineate the specific terms of any MOU created for this purpose prior to lending, donating, or receiving any equipment.

1. Some diagnostic and monitoring equipment may be too expensive to pre-deploy to the ACS, but may be needed during certain types of emergencies. During these times, the following basic guidelines are recommended to govern the loan agreement:

    a. The facility that requests assistance through the lending of equipment or supplies should accept the requisition forms of the facility providing such equipment or supplies.

    b. The facility that receives loaned or donated resources should confirm the delivery and condition of such resources, as well as designating the parties responsible for such items.

    c. For loaned equipment, the facility that is lending equipment should confirm delivery and condition of such equipment upon its return.

    d. Legal responsibility for loaned or donated equipment and supplies shifts from the facility sending the equipment to the facility receiving the equipment upon delivery to each facility, respectively.

J. Pharmaceuticals

1. During an emergency, basic medications and other medical treatments will likely be required to manage a variety of medical conditions, including those used for:

    a. Acute respiratory therapy
    b. Acute hemodynamic support
    c. Pain control and anxiolysis
    d. Antibiotic support
    e. Behavioral health
    f. Chronic disease management

2. Because patients requiring medications for advanced cardiac life support and severe respiratory problems should generally be transferred to a hospital, if possible, rather than being treated at the ACS, these medications are generally not recommended to be ordered in any substantial amounts for the ACS.

3. While, in some situations, the Strategic National Stockpile (SNS) may be able to supply some types of necessary pharmaceuticals, the SNS supplies may not be available immediately.

4. The ACS should be prepared to be self-sufficient for up to 72 hrs. See Attachment 5.

5. Because supply chains of pharmaceuticals may also be interrupted or non-functional during a large-scale emergency, health care providers should identify multiple sources for obtaining the necessary medications for the ACS, including local pharmacies, other hospitals, and local businesses, and make agreements in advance regarding procurement and delivery of pharmaceuticals during an emergency. See Appendix C.

6. Due to the specialized procedures and need to control access to pharmaceuticals, the ordering and purchasing of medications and special medical equipment should be handled through a designated medical or pharmacy staff member with purchasing authority, rather than through the Logistics Section Chief.

7. To Minimize the need for face-to-face counseling regarding prescriptions, basic fact sheets should be created for the most widely-prescribed medications that will be used at the ACS so they can be distributed with each prescription.

8. Medication fact sheets should include information about the medication's use, potential drug interactions, potential side effects, contraindications, and warnings to ensure that patients are adequately informed.

9. The introduction of counterfeit drugs has become a significant concern during the last few years, largely because their safety and effectiveness cannot be appropriately verified, and therefore, they may pose significant health risks to patients who take them.

    a. During an emergency, particularly a public health emergency, the risk of counterfeit drugs finding their way into the supply chain increases, mainly due to the fact that such an event will probably involve a mass influx of patients seeking treatment, and supplies of needed medications may be limited.

    b. For each potential vendor of pharmaceuticals, the ACS' designated authority for procurement of pharmaceuticals should verify that:

        i. Each vendor is either an authorized distributor of record or manufacturer of record

        ii. Systems, such as due diligence mechanisms, are in place to ensure that pharmaceuticals are only ordered and received from authorized manufacturers and distributors

        iii. Procedures are in place to monitor for and remove counterfeit medications from their supplies.

K. Procurement of Services

1. The ACS Logistics Section Chief must also ensure that services for food, housekeeping, laundry, and infrastructure maintenance are provided at the facility.

    a. While the hospital using the facility, or other area hospitals, may be able to provide some of these services through normal channels, the Logistics Section Chief, in coordination with the Finance Section Chief, should also research the possibility of creating agreements with vendors who can provide these services to supplement the hospital's existing systems during an emergency requiring activation of the ACS.

    b. Food service, in particular, should be handled by an outside caterer, when possible, in order to ensure appropriate feeding of patients and staff without unnecessarily taxing the hospital's Food Service Department. Two primary options exist for food service at the ACS:

        i. Cater all meals (meals for both patients and staff) provided at the ACS by an outside vendor

        ii. Cater all meals that can be handled by an outside vendor, and have special dietary needs of both patients and staff handled by the hospital's Food Service Department.

    c. The Logistics Section Chief should ensure that caterers used for food service at the ACS are contracted to also provide a sufficient supply of plates and eating utensils for each meal .

    d. Proper refrigeration for food supplies, separate from refrigeration provided for medical specimens and medications, should also be available at the ACS. This may be supplied by either onsite refrigeration services or through temporary refrigeration containers.

2. The Logistics Section Chief may need to supplement services and make the ACS more self-sufficient by leasing portable units – including portable surgical, laboratory, pharmacy, bathroom, and kitchen units – from a variety of companies. Two companies that provide some of these services include:

    a. Johnson Portables _Metaspace (available at http://www.sjohnsonportables.com/metaspace-portable-building)

    b. MERK Rentals, which provides mobile emergency response kitchens (available at http://www.merkrentals.org).

3. The Logistics Section Chief should coordinate with these suppliers in advance of an emergency to negotiate for priority in repair and restoration of service during a disaster.

    a. This procedure should be done for vendors that provide:

        i. Electrical power and other power sources
        ii. Water
        iii. Wastewater disposal

iv. Solid waste transport and disposal
v. Air-handling/Processing of indoor air quality
vi. Fuel
vii. Communications (telephone, internet, wireless, etc)
viii. Transportation services
ix. Laundry services
x. Food delivery services
xi. Janitorial/housekeeping services

b. For an additional layer of protection, sufficient electrical production must be available through the use of backup generators to run the ACS if electrical service goes out during an emergency and all medical equipment and security equipment must have access to emergency power.

c. All electrical supplies for the ACS should also be surge-protected in order to protect electronic, medical, and computer equipment from potential damage.

L. Contracts and Memoranda of Understanding (MOUs) for Emergency Procurement of Goods and Services

1. Critical supplies and infrastructure, like electrical power, water, and telecommunications, be negotiated in advance of an emergency to ensure that these services will be repaired and restored as soon as possible, should disruptions occur.

2. Negotiate contracts for temporary personnel, pharmaceuticals, and other essential services. See Appendix D.

3. Review the agreements for a variety of items and discuss the contracts with vendors to address a number of areas, including:

a. Understanding the various options for delivery of supplies, pharmaceuticals, and equipment, and knowing to whom and to what location they will be delivered during an emergency

b. Verifying the estimated turnaround time‖ for delivery of critical supplies, pharmaceuticals, and equipment once they are ordered

c. Addressing alternate payment terms that may be available during or following an emergency.

d. Discussing the potential impact of a disaster or force majeure or ―Act of God clause on a vendor's obligation to provide supplies and services in the time specified.

e. Particularly in instances where the potential interruption or delay of services or resources is substantial, the Logistics Section Chief should seek out additional vendors for procurement of that specific good or service to minimize disruption to the ACS' functionality.

M. Ability to Modify or Nullify Contracts During an Emergency

1. During an emergency or disaster, both the vendor and the health care provider may be able to modify or nullify contracts for resources and services in certain situations.

2. Most commonly, the inclusion of a force majeure or Act of God clause may function as a vehicle for either contractual party to void its contractual duties without actually legally breaching the contract.

3. The Logistics Section Chief should review all contracts and ensure that he or she understands the impact of this type of clause, as well as how it may modify or nullify the contractual duties of both vendor and customer.

XI. Patient Management

A. Prior to opening an ACS the following guidelines should be established regarding patient care:

1. Process of triaging patients

2. Method used for tracking patients
3. How to manage uncooperative patients

4. Management of patients' families

5. Patient Care documentation forms

6. Train potential staff on the building facility and layout, command structure and organization.

7. Establish policies and procedures and review them with the OHCQ if possible.

8. Establish a clear command and decision-making structure

9. Establish a clear communication strategy with the public

B. Triage and Tracking.

1. Four-level prioritization schedule (detailed below from highest to lowest priority of service):

a. Red – the patient should be directed to the hospital for critical care. These patients receive critical care resource priority over all other patients.

b. Yellow – the patient should be directed to the hospital for critical care but are prioritized below red patients.

c. Gray – the patient is not expected to survive and/or palliative or observational care is recommended.

d. Green – Patient who can be discharge or reassessed as necessary.

2. Using the above prioritization schedule, patients are reassessed after 48 hours and 120 hours. Patients who improve are then relocated or discharged; patients who become more acute are relocated accordingly.

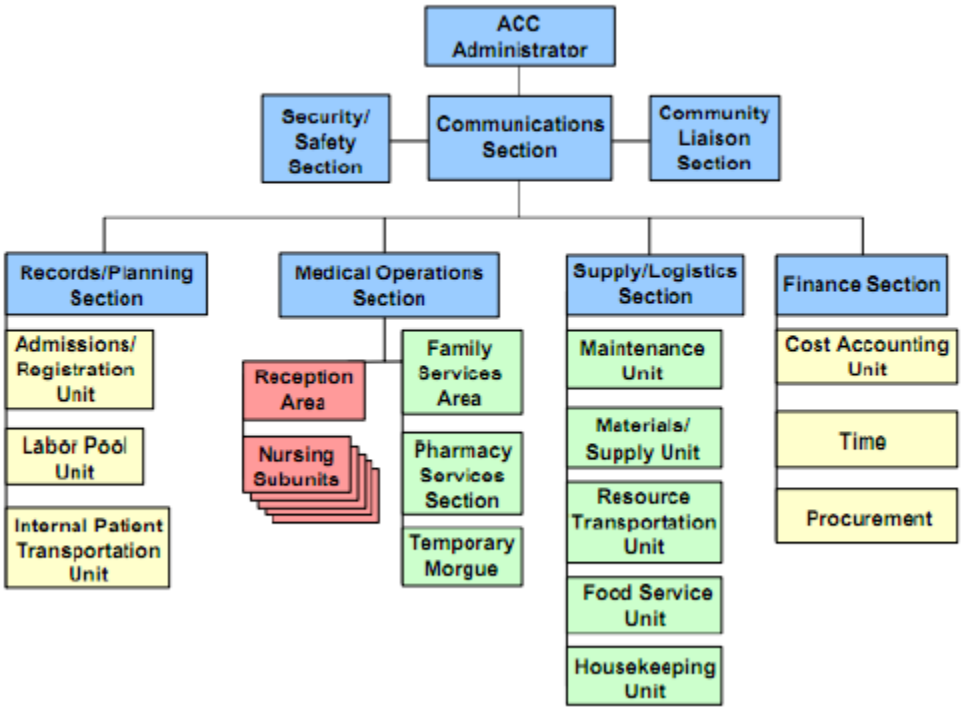
3. See Attachment 6 and Attachment 7 for the START and JumpSTART triage tools.

4. The ACS should have pre- established criteria to guide patient transfer and discharge decisions.

5. Triage tags, prioritization schedules and the use of the MIEMSS Patient tracking system can be used to maintain proper patient tracking as well as WASP bar code scanners and an Excel spreadsheet.

C. Staffing

1. The nationally-recognized Incident Command System (ICS) and the Hospital Incident Command System (HICS) can be used in an ACS for a command and control structure. One alternate care center (ACC) recommends adapting the ICS/H ICS structure in the following way, while noting that the type of agent used and resulting illness will determine the precise composition of the ACS.



a. The structure will provide administrative and functional oversight, and the staff's familiarity with ICS and HICS will make the command structure more efficient. Additionally, because the structure is scalable with clear chains of command, proper implementation will help limit inefficiencies and duplicative efforts, thereby helping conserve valuable resources.

b. This structure also allows an ACS to apply consistent and responsive approaches to care in a fast moving and constantly shifting environment.

c. See Attachment 8 for all HICS forms.

2. An essential part of resource allocation includes determining the minimum number of clinical staff needed for an ACS and identifying from where that staff will be selected. A common staffing formula recommends the following staffing minimums for a 12-hour shift:

Recommended ACS Staffing Chart				
	Total Beds			
Staff (type)	**10**	**20**	**50**	**100**

Physician	1	2	4	8
Physician Assistant or Nurse Practitioner	1	1	2	4
RN/LPN	1	2	4	10
Health Technician	1	2	4	8
Unit Secretary	1	1	2	3
Respiratory Therapist	1	1	2	3
Case Manager	1	1	2	3
Social Worker	1	1	2	3
Housekeeper	1	1	2	3
Lab	1	1	3	4
Medical Assistant/Phlebotomy	1	1	2	3
Food Services	1	1	3	4
Chaplain/Pastoral	as needed	as needed	as needed	as needed
Day Care/Pet Care	as needed	as needed	as needed	as needed
Engineering/Maintenance	as needed	as needed	as needed	as needed
Biomed	as needed	as needed	as needed	as needed
Security	3	4	6	8
Patient Transporter	1	1	2	3
Total Staffing per 12hr Shift	16	20	40	67

a. Under this model, total staffing (both clinical and non-clinical) is set at a minimum of 40. However, obtaining the medical staff necessary for an ACS during a public health emergency or medical surge may be more difficult than expected.

b. Local medical personnel inundated by patients in their health care facilities; may be unlikely to report in an outbreak or terrorist event because of fears for their own safety; or, depending on the event, medical staff may be physically unable to report to an ACS because it is inaccessible.

c. Similarly, in a pandemic flu surge that is nationwide, outside medical staffing will not likely be forthcoming.

3. Staffing Source

a. _____County Health Department has access to MD Responds, a state

network of volunteers that can respond to local emergencies and ongoing public health efforts.

i. MD Responds is the Medical Reserve Corps (MRC) for the State of Maryland. The MRC is a nation-wide network of volunteer programs. MD Responds, previously known as the Maryland Professional Volunteer Corps, is administered by the Maryland Department of Health and Mental Hygiene (DHMH), Office of Preparedness and Response (OPR).

http://mdr.dhmh.maryland.gov/SitePages/Home.aspx (Home Page)
https://mdresponds.dhmh.maryland.gov/ (Log-in Page)

ii. The MD Responds MRC consists of health care professionals and community members ready to assist with disaster and emergency response and recovery during a declared emergency. MD Responds coordinates the recruitment, training, activation, and retention of practicing and retired physicians, nurses and other health professionals, as well as citizens who are eager to address their community's ongoing public health needs and to help during large-scale emergencies.

iii. MD Responds volunteers may deliver a variety of necessary public health services during a crisis, including providing care directly to individuals seeking medical attention at state relief shelters. Volunteers may also serve a vital role by assisting their communities with ongoing public health needs (e.g., immunizations, screenings, health and nutrition education, volunteering in community health centers and local hospitals).

iv. Membership is open to anyone over 18 years of age. New volunteers are required to complete the MD Responds Volunteer Orientation Training and should be able and willing to assist in the event of an emergency, participate in annual exercises and drills, and support ongoing public health outreach projects.

b. Memoranda of Understanding (MOUs) or Mutual Aid Agreements for assistance during a surge event can provide medical staff, equipment, and other necessities that may be scarce at an ACS.

i. Regional Hospital Alliance with all hospitals in the Central Region of Maryland.

Central Maryland area hospitals have entered into an agreement to share resources during any type of man-made or natural disaster that may occur in the Baltimore region. The voluntary Baltimore Healthcare Facilities Regional Mutual Aid System’s Memorandum of Understanding (MOU) agreement has formalized the process of collaborating in the event that one hospital becomes overwhelmed during a disaster.

This agreement allows all participating hospitals to work together during an emergency to share staff, beds, equipment, and supplies. Hospitals within the Baltimore Metropolitan region, which includes Baltimore City, Anne Arundel, Baltimore, Carroll, Harford, and Howard counties, are part of the first region in Maryland to complete such an agreement. Additional hospitals from Montgomery and Prince George's counties have signed the MOU.

Maryland is susceptible to disasters, both natural and man-made, that could exceed the resources of an individual hospital facility. Additionally, the possibility of a terrorist act in the Baltimore Metropolitan area must be considered due to the geographic proximity to important government, military, and high profile public institutions. In the event of a local or regional disaster, the facilities will communicate with each other and offer assistance to the facility in need. This could include the transfer of patients between facilities in the event of an emergency evacuation of a hospital such as flooding during the hurricane season.

Partnerships with the Department of Health and Mental Hygiene (DHMH), Maryland Hospital Association (MHA), Maryland Emergency Management Agency (MEMA), Maryland Institute for Emergency Medical Services Systems (MIEMSS), and Baltimore Metropolitan Council (BMC) helped facilitate this accomplishment for the Region.

Participating hospitals include:
Anne Arundel Medical Center
Baltimore Washington Medical Center
Bon Secours Baltimore Health System
Carroll Hospital Center
MedStar Franklin Square Medical Center
MedStar Good Samaritan Hospital
Greater Baltimore Medical Center
MedStar Harbor Hospital
Harford Memorial Hospital
Johns Hopkins Bayview Medical Center
The Johns Hopkins Hospital and Health System
Howard County General Hospital
Kennedy Krieger Institute
Kernan Orthopedics and Rehabilitation Hospital
Maryland General Hospital
Mercy Medical Center
Mt. Washington Pediatric Hospital
Northwest Hospital
Sinai Hospital
St. Agnes Hospital
St. Joseph Medical Center
Sheppard Pratt Hospital
MedStar Union Memorial Hospital

University of Maryland Medical Center
Upper Chesapeake Medical Center

4. Staff Shift Change

   a. Effective knowledge transfer between shifts, especially between the first and second 12 hours of operation, will be critical. See Attachment 10 for ACS Job Action Sheets.

   b. Relief staff should arrive 30 minutes early in order for the transfer of information to take place between shift changes.

   c. Information exchange between shifts should include but is not limited to:

      i. Information on infectious agents or any other medical conditions present within the patient population.

      ii. Key available resources

      iii. Facility status.

      iv. Personal protective measures.

      v. Infection control measures

      vi. Standard operating procedures

      vii. Reporting procedures.

      viii. Review of Job Action Sheets, which will assign and identify roles and responsibilities for all personnel.

D. Medical Records

   a. Only modest means for patient care documentation should be expected.

   b. A medical record must be established for every individual treated at the Alternate Care Site.

   c. A simple paper-based charting system will be utilized.

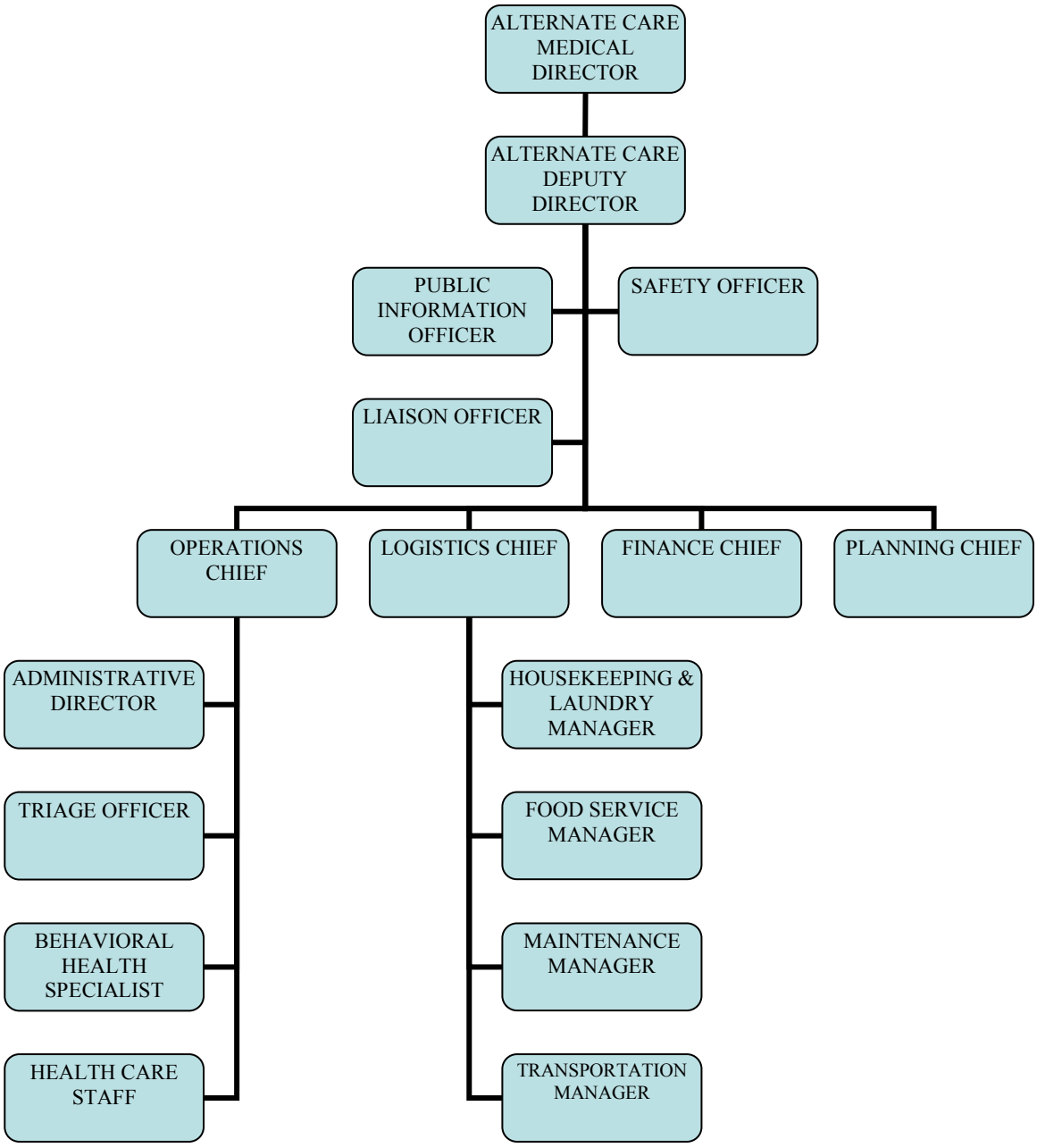
   d. The medical record should accompany the patient throughout their time at the Alternate Care Site and be available to medical staff for documenting treatment, response, and other important information.

   e. Forms for patient records have been prepared. See Attachment 11.

Attachment 2

Alternate Care Site
Organizational Chart

ORGANIZATIONAL CHART ALTERNATE CARE FACILITY



Attachment 4

Alternate Care Site
Equipment and Supplies

EQUIPMENT CONSIDERATIONS AND RECOMMENDED SUPPLIES

The list of equipment considerations and recommended consumables, below, is originally found in the *Advanced Practice Center Hospital Surge Capacity Toolkit*, created by Cameron Bruce Associates in consultation with the California Department of Public Health. The Toolkit is available at:
http://www.sccgov.org/sites/sccphd/en-us/HealthProviders/BePrepared/Pages/Hospital-Surge-Capacity-Toolkit.aspx

Please note that this list is designed for supplying a 10-bed unit, so quantities will need to be increased for the specific bed capacity of the ACS.

Table 2. Equipment (Recommended) Alternate Care Site: 10 Beds

Equipment Considerations for a 10-Bed Unit[170]			
Equipment	**Infectious**	**Non-Infectious**	**Quarantine**
Beds/Cots	11	11	11
Chairs (staff)	3	3	3
Desks	2	2	2
Fax Machine	1	1	0
Housekeeping Cart with Supplies	1	1	1
Internet email Access	1	1	1
IV Poles	11	11	0
Linens Sets (sheets/pillows/pillow cases/ towels)	20	20	20
Patient Commodes	1	1	1
Pharmacy Carts	1	1	0
Privacy Dividers	5	5	5
Refrigerators (foods/meds)	1	1	0
Stretchers	1	1	0

[170] Originally adapted from The Concept of Operations for Acute Care Center, the U.S. Army Soldier and Biological Chemical Command (SBCCOM), 2003, in press.
Modified by Cameron Bruce Associates from a 50-bed unit to a 10-bed unit.

Equipment Considerations for a 10-Bed Unit[170]			
Equipment	**Infectious**	**Non-Infectious**	**Quarantine**
Supply Carts	1	1	1
Telephones	1	1	1
Treatment Carts	1	1	0
Washing Machine	1	1	1
Wheelchairs	1	1	1

Table 3. Consumables (Recommended) Alternate Care Site: 10 Beds

Consumables – 10-Bed Unit[171]	
Product Name	**Consumption Rate per Week**
Patient Care-Related Consumables	
Alcohol Pads	120
Intermittent IV Access Devices	50
IV Catheters, 18g with Protectocath Guard	30
IV Catheters, 20g with Protectocath Guard	30
IV Catheters, 22g with Protectocath Guard	5
IV Catheters, 24g with Protectocath Guard	5
IV Fluid Bags, NS, 1000cc (required by 60% of pts)	65 L
IV Fluid Bags, D5, 1/2 NS, 1000cc (required by 40% of pts)	45 L
IV Start Kits	12
IV Tubing with Macrodrip Set for Adults	50
Needles, Butterfly, 23g	5
Needles, Butterfly, 25g	5
Needle, Sterile, 18g	150
Needle, Sterile, 21g	150
Needle, Sterile, 25g	150
Saline for Injection 10cc Bottle	70 bottles
ABD Bandage Pads, Sterile	75
Patient Care-Related Consumables (Continued)	
Band-Aids	75
Bedpans - Regular	15
Toilet Paper	35 rolls

[171] Rocky Mountain Regional Care Model for Bioterrorist Events, AHRQ No. 04-0075, July 2004.

Consumables – 10-Bed Unit[171]	
Product Name	**Consumption Rate per Week**
Blankets (changed daily)	70
Chux Protective Pads	1700
Cots (10 + 1 extra)	11
Curtains (wheeled)	5
Diapers - Adult	15
Gloves Non-Sterile (sm, med, lg) - Latex and Non-latex	400
Goggles/Face Shields (splash resistant, disposable)	400
Gown (splash resistant, disposable) - 3 per Staff/Shift	50
Gown, Patient	100
Mask, N-95 (for staff)	50
Mask, 3M (for patients)	210
Gauze Pads, Non-Sterile, 4”x4”	560
Hand Cleaner (waterless alcohol based)	6 bottles
Paper Towels	35 rolls
Medicine Cups (30 ml, plastic)	140
Pen Lights	2
Povidone-Iodine bottles, 12oz.	5 bottles
Sanitary Pads (OB pads)	5
Sharps Disposal Containers (2 gallon)	1 container
Sheets (disposable, paper) for Stretchers & Cots	100
Syringes (10cc) Luer Lock	80
Syringes (3cc) Luer Lock, w/ 21g 1.5" Needle	280
Syringes (60cc) Catheter Tip	5
Syringes, Insulin	6
Syringes, TB	20
Tape (2") - Silk	20 rolls
Tongue Depressor	200
Urinals	10 units
Washcloths (disposable) - 10 per Patient/Day	700
Water (bottled) - 1 Liter, for Mixing ORT	40 bottles
Water (container) - 1 Gallon Potable	25 bottles
Drinking Cups	250

Consumables – 10-Bed Unit[171]	
Product Name	**Consumption Rate per Week**
Diagnostic Consumables	
Glucometer	1 unit
Glucometer Test Strips	5 strips/vials
Probe Covers for Thermometers	100
Stethoscopes	3
Administrative Consumables	
Pens	40
Stapler and Staples	5 staplers/1000 staples
Tape (masking)	5 rolls
Paper, Notebooks	500 sheets
Paper Clips	100
Paper Punch (3- 5-hole)	2
Chart Holders/Clipboards	25
File Folders	100
Name Bands for ID and Allergies	50
Batteries (9V, AA, C)	25-50 pack

The list of medical supplies that may be necessary for an ACS, shown on the next two pages, is from: Susan Skidmore, et al., *Modular Emergency Medical System: Concept of Operations for the Acute Care Center (ACC)*, Appendix E (2003).

Item Description	Calculations of Quantities	Total Item Count	Unit Of Issue	Total UOIs Required
All supplies are based on the needs of one (1) 50 bed subunit; two, 12 hour shifts per 24-hour day and approximately 6 staff providing direct patient care per shift.				
IV Supplies (approximately 50% of 25 patients/day estimated to require IVs) 50 pts first day, then 10 new pts/day for 6 remaining days = approx. 110 different pts/wk (88 adults; 22 peds)				
Alcohol pads (multiple widespread use)	2-4 boxes per 24 hrs	14-28 boxes/week	Box	
Catheters, intraosseous module blue (pediatric use)	May use 1/day max.	6-7/wk of 1 standard size	Ea	7
Intermittent IV access device (lock)	50 pts initially (first day) then 10% turnover qday	250/wk	50/Box	5
IV catheters, 18g with protectocath guard	40% of pts req IVs	150/wk	50/Box	3
IV catheters, 20g with protectocath guard	40% of pts req IVs	150/wk	50/Box	3
IV catheters, 22g with protectocath guard	10% of pts req IVs	25/wk	50/Box	0.5
IV catheters, 24g with protectocath guard	10% of pts req IVs	25/wk	50/Box	0.5
IV fluid bags, NS, 1000cc (required by 60% of patients)	(50% of pts(25)/day x 3L/pt) x	315 L/wk	12/case	18 cases
IV fluid bags, D5 1/2NS, 1000cc (required by 40% of patients)]	(50% of pts(25)/day x 3L/pt) x	210 L/wk	12/case	18 cases
IV start kits	same # as intermittent access device	60	25/box	2.5 boxes
IV tubing w/ Buretrol drip set for peds	10% peds/wk	25/wk	20 per case	1.25 cases
IV tubing w/ standard macrodrip for adults	same # as intermittent access	250/wk	48/case	5 cases
Needles, Butterfly, 23g	10% peds/wk	25/wk	50/box	0.5 boxes
Needles, Butterfly, 25g	10% peds/wk	25/wk	50/box	0.5 boxes
Needles, sterile 18g	1 box/day	7 boxes/wk	100/box	7 boxes
Needles, sterile 21g	1 box/day	7 boxes/wk	100/box	7 boxes
Needles, sterile 25g	1 box/day	7 boxes/wk	100/box	7 boxes
Saline for injection 10cc bottle	50 bottles/day	350 bottles/wk	24/box	14.5 boxes
Patient Care Supplies				
ABD bandage pads, sterile	10%of pts/day =5 pads/day = 35 pads/wk	35 pads/wk	16/box	2 boxes
BandAids	1 box/day	7 boxes/wk	50/box	7 boxes
Basins, bath	20 pts/day	140/wk	100/case	1.5 cases
Bathing supply, prepackaged (e.g.Bath in a Bag (TM))	50 pts every day	350/wk		350
Bedpans - regular	40 pts/day initially then 10%	65/wk	50/case	1.25 cases
Blankets	50 pts/day; changed daily	50/day or 350/wk		

Item Description	Calculations of Quantities	Total Item Count	Unit Of Issue	Total UOIs Required
Carafes - 1 liter (for variety of uses)	30/day	210/wk		
Cart, supply	3/sub-unit (1 for IV's; 1 for Pt	3/sub-unit		
Chux protective pads (many uses)	3/pt q3hrs = 24 chux/pt/day x 50 pts = 1200/day	8400/wk	50/box	168 boxes
Cots (have extras available to replace broken equipment)	50/sub-unit plus 2 extra	52/sub-unit		
Curtains, privacy (wheeled)	1 between every bed = 25	25/sub-unit		
Diapers - adult	10/day	70/wk	72/case	1 case
Diapers - infant	8/day/infant x 5 infants/day =	280/wk	100/case	3 cases
Diapers - pediatric	5/day/ped x 5 peds/day = 25/day	175/wk	144/case	1.25 cases
Emesis basins	100/wk	100/wk	250/case	0.5 case
Facial tissue, individual patient box	1box/pt/day	350 boxes/wk	200 boxes/	1.75 cases
Feeding tubes, pediatric				
- 5 French	10/wk	10/wk	10/box	1 box
-8 French	10/wk	10/wk	10/box	1 box
Foley Catheters - 16F Kits (includes drainage bag)	>50% of pts/wk	100/wk	10/case	10 cases
Gloves**** non-sterile, large (non latex)	6 boxes/day	42 boxes/wk	100/ box	42 boxes
Gloves**** non-sterile, medium (non latex)	6 boxes/day	42 boxes/wk	100/box	42 boxes
Gloves**** non-sterile, small (non latex)	6 boxes/day	42 boxes/wk	100/box	42 boxes
Goggles, splash resistant, disposable	1 /staff + extras	12/sub-unit	10/box	1.2 boxes
Gown, splash resistant, disposable	3/staff/shift = 36/day	252/wk	Box	
Gown, patient	75/day	525/wk		
Guaze pads, non-sterile, 4x4 size, tube size	400/day	2800/wk	Roll	
Hand cleaner, waterless alcohol-based	1 per handwash station/day x 4	28/wk	25 bottles/case	1 case
Lubricant, Water soluble		1-2 boxes/wk	25 boxes/ca	0.5 cases
Medicine cups, 30ml, plastic	2/pt/day = 100/day	700/wk		
Morgue Kits	Tularemia: 15pt/day mortality;	300/wk		
Nasogastric tubes - 18F		25/wk	50/case	0.5 cases
OB Kits		1/wk		
Pen lights		12/unit	6/box	2 boxes/unit
Povidone-iodine bottles, 12 oz	2/day	14/wk	48 bottles/c	0.25 cases
Restraints, Extremity, soft - adult		25/wk	48/case	0.5 cases

Item Description	Calculations of Quantities	Total Item Count	Unit Of Issue	Total Units Required
Sanitary pads (OB pads)	2 women/wk; 10pads/day	20 pads/wk	12 pads/bo	2 boxes
Sharps disposal containers - 2 gallon	2-4 /wk/sub-unit	2-4/wk	20/case	0.25 cases
Sheets, disposable, paper, for stretchers & cots	100/day	700/wk		
Syringes, 10cc, luer lock	4 boxes/wk (100 ct box)	400/wk	100/box	4 boxes
Syringes, 3cc, luer lock, w/ 21g 1.5" needle	200/day	1400/wk	100/box	14 boxes
Syringes, catheter tip 60cc		25/wk	50/box	0.5 boxes
Syringes, insulin	4/day	28/wk	100/box	0.25 boxes
Syringes, TB	2/day	14/day	100/box	0.4 boxes
Tape, silk - 1 inch	12/day	96/wk	12rolls/box	8 boxes
Tape, silk - 2 inch	6/day	42/wk	12rolls/box	3.5 boxes
Toilet tissue	25 rolls/day	175 rolls/wk		175 rolls
Tongue depressor		2 boxes/wk	500/box	2 boxes
Tubex [TM] pre-filled syringe holders	1 per staff member plus extras	12/sub-unit	50/case	.25 cases
Urinals		50/wk	50/case	1 case
Washcloths, disposable	10/pt/day	3500/wk		3500
Water, bottled 1 liter (for mixing ORT)	1/patient	200/wk		
Water container, 1 gallon potable		125/wk		125
Diagnostic Supplies				
Glucometer		1per sub-unit	Ea	
Glucometer test strips		2 bottles/wk	50 strips/vil	2 viles
Probe covers for thermometers	4 boxes/day	28 boxes/wk	20/box	28 boxes
Protocol unit (or other brand), 02 sat monitor, thermometer, BP, HR		4 per sub-unit	Ea	
Protocol unit, disposable plastic BP covers	200/day	1400/wk		
Single Use Shielded Lancets	25/day	175/wk	200/box	1 box
Stethoscopes		12/sub-unit	Ea	12
Housekeeping and Misc. Supplies				
Backboard, plastic		1	Ea	1
Bleach	1 gal/day	7 gal/wk		7gallons
Microwave oven		1 per sub-unit		1
Refrigerator		3 per sub-unit		3
Stretcher, EMS (rolling)		2/sub-unit	Ea	2
Towels, paper	25 rolls/day	175 rolls/wk		175 rolls
Trash cans with pop lids (biologic), large		6 per sub-unit	Ea	6
Trash liners, red plastic (large)	6 changes/day x 6 trash cans	252/wk	100/roll	2.5 rolls
Wheelchair		10/sub-unit min	Ea	10

In addition to the items listed above, which only address medical supplies for one 50-bed nursing subunit, planners should also provide supplies and equipment for the other sections of the ACC. Those requirements are found in the description of each section (see Appendix B). General supplies common to all sections are not included in the lists but must be considered. Some of these common items include but are not limited to:

- Personal Protective Equipment (PPE) – The exact PPE requirements will be dependant upon the disease. Likely PPE will include:
  - Gloves
  - Surgical Masks
  - N95 Masks
  - Gowns
- Paper
- Pens/Pencils

Attachment 5

Alternate Care Site
Pharmaceutical Supplies

RECOMMENDED PHARMACEUTICAL SUPPLIES

The list of pharmaceutical supplies that may be necessary for an ACS, shown on the next two pages, is from: Susan Skidmore, et al., *Modular Emergency Medical System: Concept of Operations for the Acute Care Center (ACC)*, Appendix E (2003).

Pharmaceutical Supplies

1. Selected Pharmaceuticals. The list of stock medications that should be available in the ACC was determined by identifying the most likely symptoms the majority of patients would present with, regardless of the agent, as well as each drug's flexibility in action, treatment applications, and use across all age populations. An estimate was made regarding the percentage of patients on a 50-bed unit who might require that medication. Under most circumstances, the total quantity of medication required was based on the maximum allowable daily adult dosage. Pediatric dosing is provided where appropriate. All dosing is on an as-needed basis (PRN) except for antibiotics.

The chart below is calculated for one 50-bed subunit with 80 percent adults and 20 percent pediatrics at full capacity for one day and for one month.

(Note: A legend of all abbreviations used in the following table is included at the end of this document.)

Drugs	% of pts requiring drug	1 day	1 week
Antibiotic **CDC push pack**	**100%**	**50 daily doses** **medication for all 50 patients**	**350 daily doses**
Promethazine (Phenergan) Dosing: 12.5–25 mg q4–6hr (IV/IM/PR) Maximum dose: 200 mg/day Pediatrics: 0.25–0.5 mg/kg/dose q6h 25 mg/vial; 50 mg/suppository	**100%** **60%**	**320 vials** (8 vials/pt/day x 40 pts) **40 suppositories** (4 suppositories/day x 10 pts)	**2,240 vials** **210 suppositories**
Digoxin (Lanoxin) Maintenance dose: 0.25 mg/day Loading dose: 1 mg/day divided QID (assume 1 pt requires loading dose & 4 pts require maintenance dose per day) 0.25 mg/tablet	**10%**	**8 tablets** (1 loading dose of 4 tablets + 4 maintenance doses)	**56 tablets**
Furosemide (Lasix) (Assume 4 pts/day require maintenance dose of 40 mg PO BID & 1 pt/day requires acute therapy of 100 mg IV BID) 40 mg tablets 100 mg/vial	**20%**	**8 tablets** **2 vials**	**56 tablets** **14 vials**
Diphenhydramine (Benadryl) Dosing: 25–50 mg IV/IM/PO q6h Pediatrics: 1 mg/kg IV/IM/PO q6h 50 mg/vial 12.5 mg/5 cc	**75%**	**80 vials** (4 vials/pt/day x 20 pts) **400 cc or 14 fluid ounces** (80 cc/pt/day x 5 pts)	**560 vials** **100 fluid ounces**

Drugs	% of pts requiring drug	1 day	1 week
Lorazepam (Ativan) Dosing: 2 mg IV/IM q6hr Pediatrics: 0.05 mg/kg/dose q6h 2 mg/vial	**70%** **75% for all**	**48 vials** (4 vials/pt/day x 12 pts)	**336 vials**
Nitroglycerin SL 0.4 mg Dosing: 1 tab SL q5 min	**10%**	**1 bottle**	**1 bottle**
Insulin NPH & Reg Dosing: individualized (Assume 30 units/pt/day of NPH, 70/30 & Regular) 10 cc vials (100 units/cc)	**6%**	**1 vial of NPH & Regular**	**1 vial of NPH & Regular**
Albuterol MDI Dosing: 6 puffs QID with spacer Nebulizer: 1 u dose QID Multidose dispenser Unit dose for nebulizer	**40%**	**12 MDI**	**12 MDI**
Aspirin 325 mg Dosing: 325 mg/day for platelet inhibition (cardiac & TIA)	**10%**	**1 bottle**	**1 bottle**
Naloxone (Narcan) Dosing: 0.4 mg–2 mg IV/IM/SC q 3 min, PRN 1.0 mg/ml prefilled syringe (box of 10)	**1%**	**1 box**	**1 box**
Morphine Sulfate Dosing (titrate to effect): 5 mg IV/IM/SC q4h (0.1 mg/kg in 2-4 mg increments) Pediatrics: 0.1 mg/kg/dose 10 mg/vial	**50%**	**100 vials (4 mg or 10 mg)** (4 vials/pt/day x 25 pts)	**700 vials**
IV Fluids Dosing: 4 liters/pt/day Normal saline or D_5W .45% NS 1 liter bags Dump out half the IV bag for peds or use volutrols	**50%** **(assumes the other 50% would use oral rehydration therapy)**	**100 liter bags** **60 liters of NS** **40 liters of D5W.45%**	**700 liter bags** **(Assume 60% of pts are given NS and 40% of pts are given D_5W .45% NS; therefore, need 420 bags NS and 280 bags D_5W .45% NS)**
Acetaminophen Dosing: 1 g q4h Pediatric: 15 mg/kg q4h (elixir volume based on a 32 kg child) 500 mg/tablet 160 mg/5 cc	**100%**	**480 tablets** (12 tablets/pt/day x 40 pts) **60 ounces of elixir** (3 oz/day x 20 pts)	**3,360 tablets** **420 ounces of elixir**
Spacers for Albuterol MDI 1 per pt	**40%**	**12 spacers**	**84 spacers**
Oral rehydration packets Oral rehydration therapy (ORT) is a primary mode of treatment for dehydration in mass casualty situations. **One packet makes 1 liter**	**50%**	**100 packets** **(4 liters/pt/day x 25 pts)**	**700 packets**

Legend

BID	twice-a-day dosing
cc	cubic centimeters
d	day(s)
D_5W	5% dextrose and water
h	hour(s)
IM	intramuscular
IV	intravenous
g	gram(s)
kg	kilograms
mg	milligrams
mL	milliliters
MDI	metered dose inhaler
min	minute
NPH	isophane insulin
NS	normal saline
ORT	oral rehydration therapy
oz	ounce(s)
PCN	Penicillin
PO	per os (orally)
PR	per rectum
PRN	as necessary
pt (pts)	patient (patients)
q	every (e.g., q6h = every 6 hours)
QID	four times daily
Rx	treatment or prescription
SC	subcutaneous
SL	sublingual
TIA	transient ischemic attack
u	unit(s)

2. Rationale for Selected Drugs:

a. Promethazine (Phenergan): This drug is safe for both adults and pediatrics and has multiple uses in the clinical setting. It may be used as an anti-emetic, as an adjunct to narcotics to potentiate their effect and thus decrease the amount of narcotic used, and as a sedative to promote rest and calm agitated patients.

b. Digoxin (Lanoxin): Given the expected mass casualty situation, it is likely that many patients would present with comorbidities including cardiovascular disease. Digoxin is versatile enough to treat arrhythmias as well as heart failure.

c. Furosemide (Lasix): Most patients requiring diuresis respond to this diuretic or are on it for maintenance. It is stable, readily available, and inexpensive.

d. Diphenhydramine (Benadryl): A very versatile drug to have on hand to treat allergic (drug) reactions, nausea, and insomnia.

e. Lorazepam (Ativan): This drug provides effective treatment for both anxiety and insomnia. It is relatively safe with few side effects or contraindications and may be given IV or IM. Its rapid onset and short half-life make it a useful addition to the basic drug inventory.

f. Nitroglycerin Sublingual: Provides a safe and effective treatment for congestive heart failure (CHF) and anginal pain. Use of this drug combined with aspirin may stabilize a patient long enough for transfer to a hospital if bed space is available. This combination may also be used for advanced cardiac care, or it may prevent the patient from further suffering.

g. Insulin (Regular and NPH): Insulin was included in the basic drug inventory because approximately 6 percent of the general population are diabetic. In persons 65 years and older, the prevalence increases to more than 18 percent. Because the elderly are more susceptible to illness in general, it can be surmised that at any given time, the census of the ACC will lean towards more elderly than middle-aged patients and therefore a higher percentage of diabetics. Although regular insulin will be used more than NPH, some portion of the diabetic population will require both.

h. Albuterol Meter Dose Inhaler (MDI): Albuterol is the bronchodilator of choice, when combined with a spacer, because of its ease of administration and rapid onset of action. It is assumed that the need for bronchodilators will be widespread since the respiratory tract will be the primary site of infection.

i. Aspirin: This antiplatelet drug was included in the formulary to help treat cardiac or stroke (including transient ischemic attacks) comorbidity that may present to the ACC.

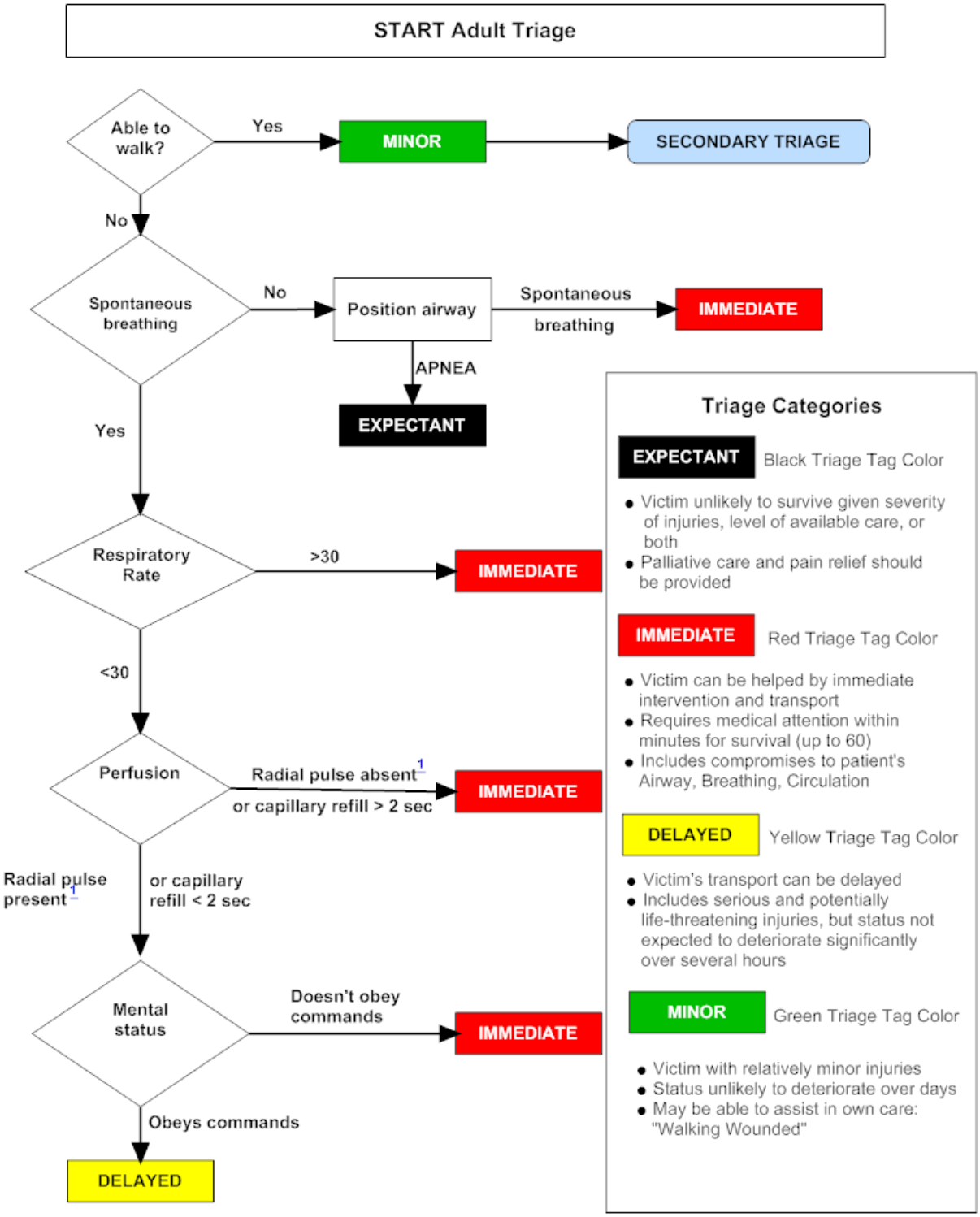
j. Naloxone (Narcan): This drug prevents or reverses the adverse effects of narcotics, including respiratory depression, hypotension, and sedation. Because many patients will presumably receive morphine for pain and respiratory distress, it is imperative to have Narcan to reverse accidental overdoses.

k. Morphine: Morphine is the preferred pain medicine because of its use in easing respiratory distress and decreasing cardiac oxygen consumption.

l. Oral Rehydration Therapy (ORT): Many patients suffering from the effects of bioterrorist agents will present with dehydration from fever, emesis, or diarrhea. Rehydration may be accomplished by either ORT or intravenous routes. ORT may be used safely for patients with altered mental status (especially pediatric) and may be administered by family members with minimal instruction. It is the mainstay of disaster/epidemic relief worldwide.

Attachment 6

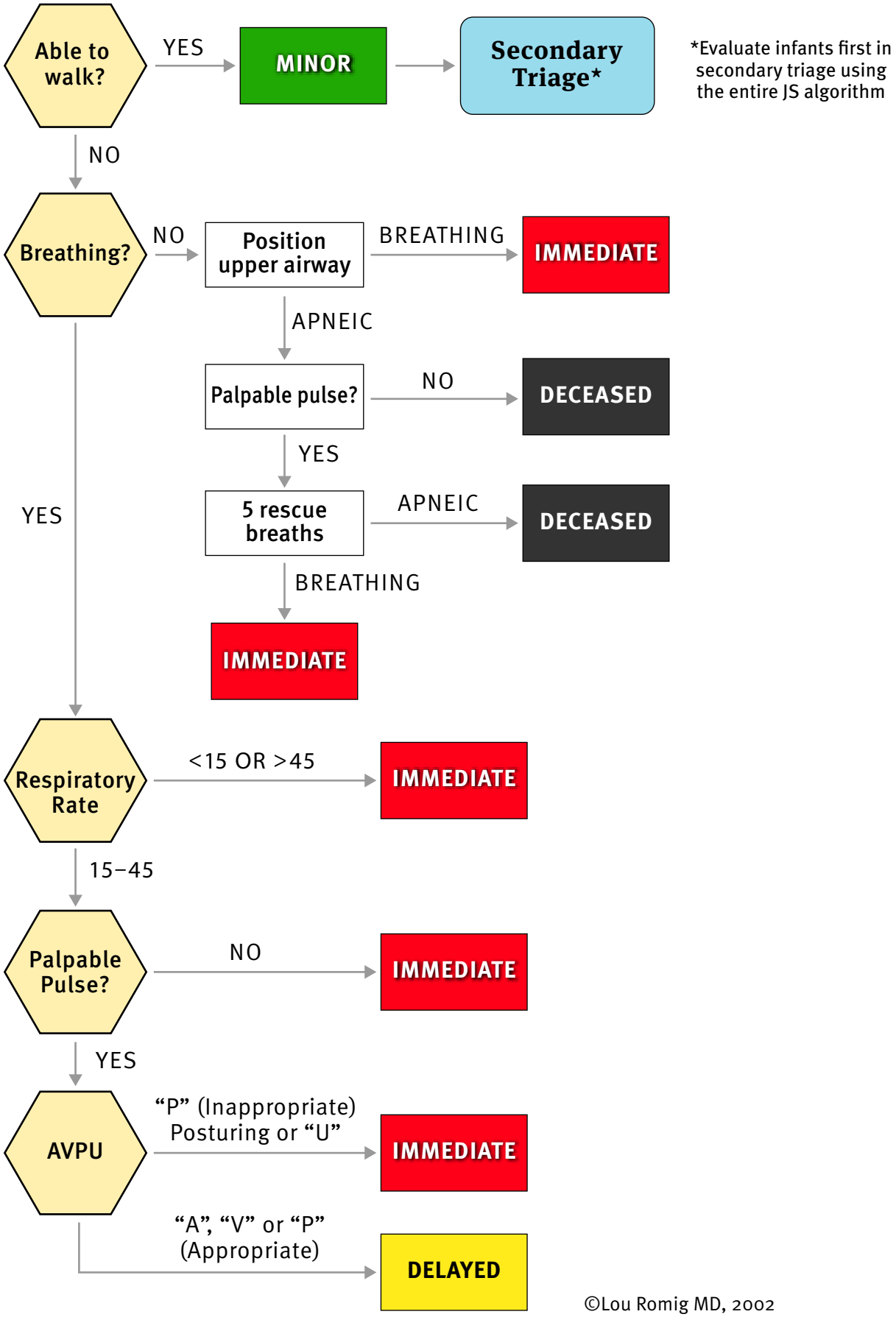
Adult START Triage Algorithm


START Adult Triage
Able to walk?
Yes
MINOR
SECONDARY TRIAGE
No
Spontaneous breathing
No
Position airway
Spontaneous breathing
IMMEDIATE
APNEA
EXPECTANT
Yes
Respiratory Rate
>30
IMMEDIATE
<30
Perfusion
Radial pulse absent[1] or capillary refill > 2 sec
IMMEDIATE
Radial pulse present[1]
or capillary refill < 2 sec
Mental status
Doesn't obey commands
IMMEDIATE
Obeys commands
DELAYED
Triage Categories
EXPECTANT
Black Triage Tag Color
Victim unlikely to survive given severity of injuries, level of available care, or both
Palliative care and pain relief should be provided
IMMEDIATE
Red Triage Tag Color
Victim can be helped by immediate intervention and transport
Requires medical attention within minutes for survival (up to 60)
Includes compromises to patient's Airway, Breathing, Circulation
DELAYED
Yellow Triage Tag Color
Victim's transport can be delayed
Includes serious and potentially life-threatening injuries, but status not expected to deteriorate significantly over several hours
MINOR
Green Triage Tag Color
Victim with relatively minor injuries
Status unlikely to deteriorate over days
May be able to assist in own care: "Walking Wounded"

Attachment 7

Pediatric JumpSTART Triage Algorithm

JumpSTART Pediatric MCI Triage©



Attachment 8

HICS Forms

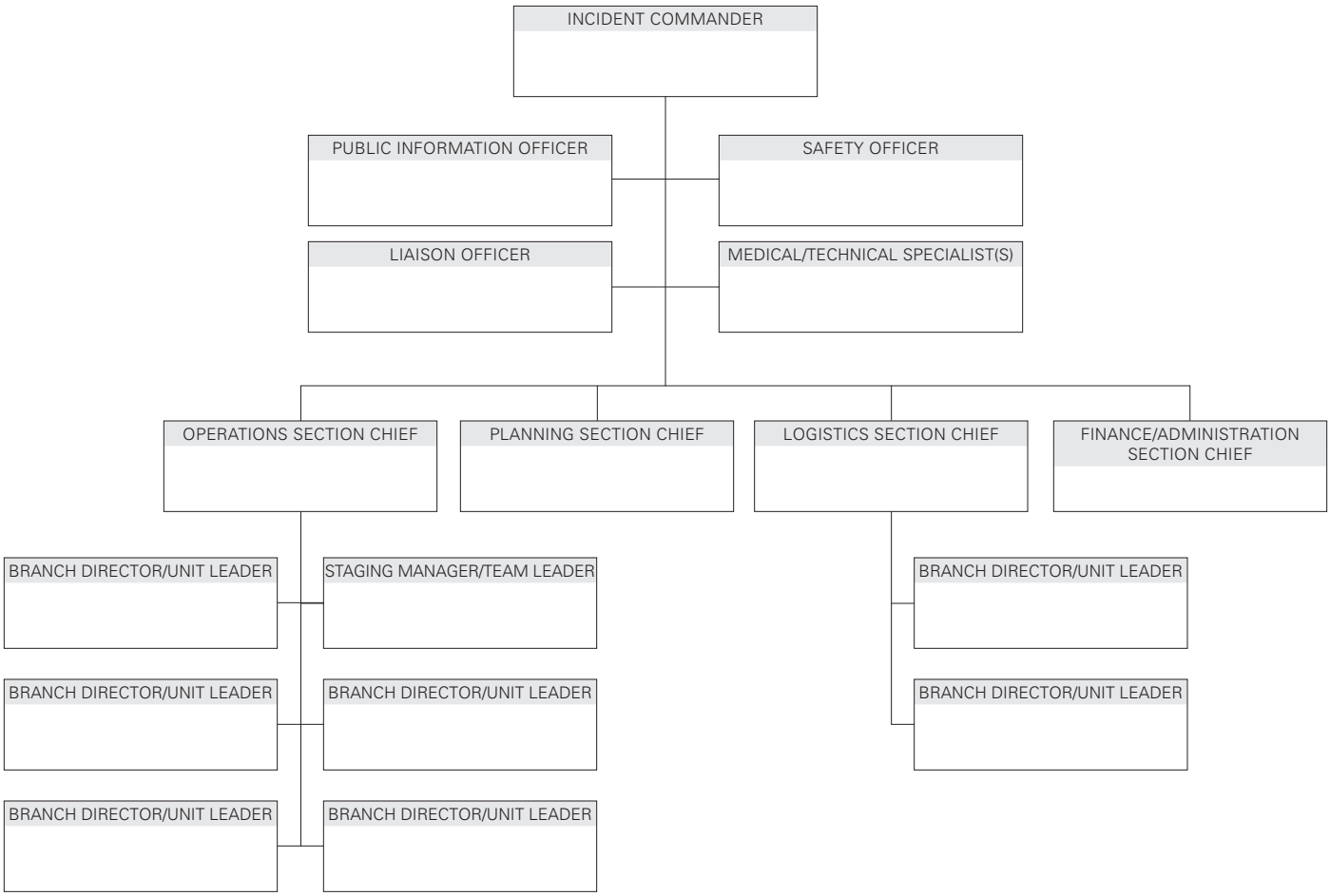
INCIDENT BRIEFING

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME	2. DATE OF BRIEFING	3. TIME OF BRIEFING

4. EVENT HISTORY AND CURRENT ACTIONS SUMMARY

5. CURRENT ORGANIZATION



HICS 201 – INCIDENT BRIEFING

PURPOSE: DOCUMENT INITIAL RESPONSE INFORMATION AND ACTIONS TAKEN AT STARTUP.

ORIGINATION: INCIDENT COMMANDER.

COPIES TO: COMMAND STAFF, SECTION CHIEFS, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

(Page 1 of 2)

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE OF BRIEFING** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME OF BRIEFING** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **EVENT HISTORY AND CURRENT ACTIONS SUMMARY** Document input from Section Chiefs and affected leadership and/or organizations involved.
5. **CURRENT ORGANIZATION** Use proper names to identify personnel who are performing incident management functions as part of the HICS organization structure.

(Page 2 of 2)

6. **NOTES (INCLUDING ACCOMPLISHMENTS, ISSUES, WARNINGS/DIRECTIVES)** Self-explanatory. Use blank space for maps and other diagrams.
7. **PREPARED BY (NAME AND POSITION)** Use proper name and HICS position title.
8. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Prior to briefing in the current operational period.

HELPFUL TIPS: Distribute copies to all staff before initial briefing.

6. NOTES (INCLUDING ACCOMPLISHMENTS, ISSUES, WARNINGS/DIRECTIVES)

7. PREPARED BY (NAME AND POSITION)

8. FACILITY NAME

HICS 201 – INCIDENT BRIEFING

PURPOSE: DOCUMENT INITIAL RESPONSE INFORMATION AND ACTIONS TAKEN AT STARTUP.

ORIGINATION: INCIDENT COMMANDER.

COPIES TO: COMMAND STAFF, SECTION CHIEFS, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

(Page 1 of 2)

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
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4. **EVENT HISTORY AND CURRENT ACTIONS SUMMARY** Document input from Section Chiefs and affected leadership and/or organizations involved.
5. **CURRENT ORGANIZATION** Use proper names to identify personnel who are performing incident management functions as part of the HICS organization structure.

(Page 2 of 2)

6. **NOTES (INCLUDING ACCOMPLISHMENTS, ISSUES, WARNINGS/DIRECTIVES)** Self-explanatory. Use blank space for maps and other diagrams.
7. **PREPARED BY (NAME AND POSITION)** Use proper name and HICS position title.
8. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Prior to briefing in the current operational period.

HELPFUL TIPS: Distribute copies to all staff before initial briefing.

INCIDENT OBJECTIVES

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME

2. DATE PREPARED | 3. TIME PREPARED | 4. OPERATIONAL PERIOD DATE/TIME

5. GENERAL COMMAND AND CONTROL OBJECTIVES FOR THE INCIDENT (INCLUDE ALTERNATIVES)

6. WEATHER / ENVIRONMENTAL IMPLICATIONS FOR PERIOD (INCLUDE AS APPROPRIATE: FORECAST, WIND SPEED/DIRECTION, DAYLIGHT)

7. GENERAL SAFETY / STAFF MESSAGES TO BE GIVEN

Examples: Personal Protective Equipment (PPE), Precautions, Case Definitions (refer to HICS 261 Incident Action Plan Safety Analysis)

8. ATTACHMENTS (MARK IF ATTACHED)

- ☐ HICS 203 - Organization Assignment List
- ☐ HICS 204 - Branch Assignment List
- ☐ HICS 205 - Incident Communications Plan
- ☐ HICS 206 - Medical Plan
- ☐ HICS 251 - Facility System Status Report
- ☐ HICS 261 - Incident Action Plan Safety Analysis
- ☐ Traffic Plan
- ☐ Incident Map
- ☐ Other

9. PREPARED BY (PLANNING SECTION CHIEF) | 10. APPROVED BY (INCIDENT COMMANDER)

11. FACILITY NAME

HICS 202 – INCIDENT OBJECTIVES

PURPOSE: DEFINE OBJECTIVES AND ISSUES FOR OPERATIONAL PERIOD.

ORIGINATION: PLANNING SECTION CHIEF.

COPIES TO: COMMAND STAFF, GENERAL STAFF, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
5. **GENERAL COMMAND AND CONTROL OBJECTIVES FOR THE INCIDENT (INCLUDE ALTERNATIVES)** Use input from Section Chiefs and from affected leadership and/or organizations involved. Key questions to consider include: What is the problem? What are the obstacles? What resources are needed to address the objectives? What are considerations for the next operational period?
6. **WEATHER / ENVIRONMENTAL IMPLICATIONS FOR PERIOD (INCLUDE AS APPROPRIATE: FORECAST, WIND SPEED/DIRECTION, DAYLIGHT)** Document weather and environmental factors that could affect operations.
7. **GENERAL SAFETY / STAFF MESSAGES TO BE GIVEN** Summarize decisions made during Command meetings to convey to staff. Refer to HICS 261, Incident Action Plan Safety Analysis, to identify safety messages.
8. **ATTACHMENTS (MARK IF ATTACHED)** Check boxes that correspond with the attachments to this form.
9. **PREPARED BY (PLANNING SECTION CHIEF)** Use proper name.
10. **APPROVED BY (INCIDENT COMMANDER)** The signature of the Incident Commander indicates approval of the objectives.
11. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Prior to briefing in the current operational period.

HELPFUL TIPS: This document serves as a roadmap to incident management. Use this form during the initial operational period, and use updated versions prior to the beginning of subsequent operational periods. Refer to this form during briefings and debriefings.

ORGANIZATION ASSIGNMENT LIST

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME

2. DATE PREPARED | 3. TIME PREPARED | 4. OPERATIONAL PERIOD DATE/TIME

POSITION	NAME/AGENCY
5. INCIDENT COMMANDER AND STAFF	
Incident Commander	
Public Information Officer	
Liaison Officer	
Safety Officer	
Medical/Technical Specialist (Type)	
Medical/Technical Specialist (Type)	
Medical/Technical Specialist (Type)	
Medical/Technical Specialist (Type)	
Medical/Technical Specialist (Type)	
Medical/Technical Specialist (Type)	
6. OPERATIONS SECTION	
Chief	
Staging Manager	
Medical Care Branch	
Infrastructure Branch	
HazMat Branch	
Security Branch	
Business Continuity Branch	
(Other) Branch:	
7. PLANNING SECTION	
Chief	
Resources Unit	
Situation Unit	
Documentation Unit	
Demobilization Unit	
8. LOGISTICS SECTION	
Chief	
Service Branch	
Support Branch	
9. FINANCE/ADMINISTRATION SECTION	
Chief	
Time Unit	
Procurement Unit	
Compensation/Claims Unit	
Cost Unit	

10. AGENCY REPRESENTATIVE (IN HOSPITAL COMMAND CENTER)

11. HOSPITAL REPRESENTATIVE (IN EXTERNAL EOC)

Name | External Location

12. PREPARED BY (RESOURCES UNIT LEADER) | 13. FACILITY NAME

PURPOSE: DOCUMENT STAFFING. **ORIGINATION:** RESOURCES UNIT LEADER.
COPIES TO: COMMAND STAFF, GENERAL STAFF, AGENCY STAFF, BRANCH DIRECTORS AND DOCUMENTATION UNIT LEADER.

HICS 203 – ORGANIZATION ASSIGNMENT LIST

PURPOSE: DOCUMENT STAFFING.

ORIGINATION: RESOURCES UNIT LEADER.

COPIES TO: COMMAND STAFF, GENERAL STAFF, AGENCY STAFF, BRANCH DIRECTORS, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
5. **INCIDENT COMMANDER AND STAFF** Use proper names to identify personnel assigned to positions, and include agency name if personnel is external.
6. **OPERATIONS SECTION** Use proper names to identify personnel assigned to positions, and include agency name if personnel is external.
7. **PLANNING SECTION** Use proper names to identify personnel assigned to positions, and include agency name if personnel is external.
8. **LOGISTICS SECTION** Use proper names to identify personnel assigned to positions, and include agency name if personnel is external.
9. **FINANCE/ADMINISTRATION SECTION** Use proper names to identify personnel assigned to positions, and include agency name if personnel is external.
10. **AGENCY REPRESENTATIVE (IN HOSPITAL COMMAND CENTER)** Use proper name to identify personnel representing external agency, and include agency name.
11. **HOSPITAL REPRESENTATIVE (IN EXTERNAL EOC)** Use proper name to identify hospital personnel assigned to an external EOC, and identify location of external EOC.
12. **PREPARED BY (RESOURCES UNIT LEADER)** Use proper name.
13. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: At the start of the first operational period, prior to each subsequent operational period, and as additional positions are staffed.

HELPFUL TIPS: Use this form as a reminder of positions to consider when organizing personnel to manage an incident, as indicated by the situation. Retain this form for reference during the incident. Cross-reference information on this form and on HICS 201, Incident Briefing. Post this form in the Hospital Command Center, and make copies available to Branch Directors. Share copies with other agencies (e.g., the local EOC, other hospitals in the area or healthcare system, etc.), as appropriate.

BRANCH ASSIGNMENT LIST

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME

2. SECTION | 3. BRANCH | 4. OPERATIONAL PERIOD DATE/TIME

5. PERSONNEL

Section Chief | Branch Director

6. UNITS ASSIGNED THIS PERIOD

Name	Name	Name	Name	Name	Name
Leader	Leader	Leader	Leader	Leader	Leader
Location	Location	Location	Location	Location	Location
Objective	Objective	Objective	Objective	Objective	Objective
Members	Members	Members	Members	Members	Members

7. KEY OBJECTIVES

8. SPECIAL INFORMATION / CONSIDERATION

9. PREPARED BY (BRANCH DIRECTOR) | 10. APPROVED BY (PLANNING SECTION CHIEF) | 11. DATE | 12. TIME

13. FACILITY NAME

HICS 204 – BRANCH ASSIGNMENT LIST

PURPOSE: DOCUMENT ASSIGNMENTS WITHIN BRANCH.

ORIGINATION: BRANCH DIRECTOR.

COPIES TO: COMMAND STAFF, GENERAL STAFF, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **SECTION** Indicate the Section for which this assignment list is being prepared.
3. **BRANCH** Indicate the Branch for which this assignment list is being prepared.
4. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
5. **PERSONNEL** Use proper names to identify **Section Chief** and **Branch Director**.
6. **UNITS ASSIGNED THIS PERIOD** For each Unit assigned: identify the Unit **Name** (e.g., Spill Response Unit), use proper name to identify the Unit **Leader**, identify the Unit's **Location**, list the Unit's specific **Objectives**, and use proper names to list the **Members** assigned to the Unit.
7. **KEY OBJECTIVES** Summarize the fundamental objectives assigned to this Branch for the current operational period.
8. **SPECIAL INFORMATION / CONSIDERATION** Identify special instructions to convey to personnel on safety, communications, and considerations for the operational period.
9. **PREPARED BY (BRANCH DIRECTOR)** Use proper name.
10. **APPROVED BY (PLANNING SECTION CHIEF)** The signature of the Planning Section Chief indicates approval of the assignments.
11. **DATE** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
12. **TIME** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
13. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: At the start of each operational period.

HELPFUL TIPS: Use this form to identify Units assigned within a Branch, personnel assigned to lead and staff each Unit, and details of their location and assigned objective. Summarize Branch objectives and special information for reference.

INCIDENT COMMUNICATIONS LOG (INTERNAL)

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME	2. DATE/TIME PREPARED	3. OPERATIONAL PERIOD DATE/TIME

4. BASIC CONTACT INFORMATION

Assignment/ Name	Radio Channel/ Frequency	Phone Primary & Alt.	Fax	E-Mail/ PDA	Pager	Alt. Communication Device	Comments

5. PREPARED BY (COMMUNICATIONS UNIT LEADER)	6. APPROVED BY (LOGISTICS SECTION CHIEF)	7. FACILITY NAME

PURPOSE: DOCUMENT THE INTERNAL COMMUNICATIONS EQUIPMENT/CHANNELS TO BE USED WITHIN THE FACILITY. **ORIGINATION:** COMMUNICATIONS UNIT LEADER.
COPIES TO: COMMAND STAFF, GENERAL STAFF, BRANCH DIRECTORS AND DOCUMENTATION UNIT LEADER.

HICS 205 – INCIDENT COMMUNICATIONS LOG (INTERNAL AND EXTERNAL)

PURPOSE: DOCUMENT THE INTERNAL/EXTERNAL COMMUNICATIONS EQUIPMENT/CHANNELS TO BE USED WITHIN THE FACILITY.

ORIGINATION: COMMUNICATIONS UNIT LEADER.

COPIES TO: COMMAND STAFF, GENERAL STAFF, BRANCH DIRECTORS, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE/TIME PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**. Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
3. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
4. **BASIC CONTACT INFORMATION** Identify assigned function and proper names of personnel assigned communication devices. Provide complete channel, frequency, telephone number, e-mail address, etc., information. Note any primary or preferred communication device.
5. **PREPARED BY (COMMUNICATIONS UNIT LEADER)** Use proper name.
6. **APPROVED BY (LOGISTICS SECTION CHIEF)** The signature of the Logistics Section Chief indicates approval of the assignments.
7. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Whenever possible prior to an event, at the start of each operational period, and as changes are made.

HELPFUL TIPS: Display this Log prominently within the Hospital Command Center.

INCIDENT COMMUNICATIONS LOG (EXTERNAL)

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME	2. DATE/TIME PREPARED	3. OPERATIONAL PERIOD DATE/TIME

4. BASIC CONTACT INFORMATION

Assignment/ Name	Radio Channel/ Frequency	Phone Primary & Alt.	Fax	E-Mail/ PDA	Pager	Alt. Communication Device	Comments

5. PREPARED BY (COMMUNICATIONS UNIT LEADER)	6. APPROVED BY (LOGISTICS SECTION CHIEF)	7. FACILITY NAME

PURPOSE: DOCUMENT THE EXTERNAL COMMUNICATIONS EQUIPMENT/CHANNELS TO BE USED WITHIN THE FACILITY. **ORIGINATION:** COMMUNICATIONS UNIT LEADER.
COPIES TO: COMMAND STAFF, GENERAL STAFF, BRANCH DIRECTORS AND DOCUMENTATION UNIT LEADER.

HICS 205 – INCIDENT COMMUNICATIONS LOG (INTERNAL AND EXTERNAL)

PURPOSE: DOCUMENT THE INTERNAL/EXTERNAL COMMUNICATIONS EQUIPMENT/CHANNELS TO BE USED WITHIN THE FACILITY.

ORIGINATION: COMMUNICATIONS UNIT LEADER.

COPIES TO: COMMAND STAFF, GENERAL STAFF, BRANCH DIRECTORS, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE/TIME PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**. Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
3. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
4. **BASIC CONTACT INFORMATION** Identify assigned function and proper names of personnel assigned communication devices. Provide complete channel, frequency, telephone number, e-mail address, etc., information. Note any primary or preferred communication device.
5. **PREPARED BY (COMMUNICATIONS UNIT LEADER)** Use proper name.
6. **APPROVED BY (LOGISTICS SECTION CHIEF)** The signature of the Logistics Section Chief indicates approval of the assignments.
7. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Whenever possible prior to an event, at the start of each operational period, and as changes are made.

HELPFUL TIPS: Display this Log prominently within the Hospital Command Center.

STAFF MEDICAL PLAN

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME

2. DATE PREPARED | 3. TIME PREPARED | 4. OPERATIONAL PERIOD DATE / TIME

5. TREATMENT OF INJURED / ILL STAFF

Location of Staff Treatment Area | Contact Information

Treatment Area Team Leader | Contact Information

Special Instructions

6. RESOURCES ON HAND

STAFF	MEDICAL TRANSPORTATION	MEDICATION	SUPPLIES
MD/DO	Litters		
PA/NP	Portable Beds		
RN/LPN	Transport		
Technicians/CN	Wheelchairs		
Ancillary/Other			

7. ALTERNATE CARE SITE(S)

NAME	ADDRESS	PHONE	SPECIALTY CARE (SPECIFY)

8. PREPARED BY (SUPPORT BRANCH DIRECTOR) | 9. FACILITY NAME

PURPOSE: OUTLINE RESOURCES FOR MEDICAL CARE OF INJURED / ILL HOSPITAL PERSONNEL. **ORIGINATION:** SUPPORT BRANCH DIRECTOR.
COPIES TO: COMMAND STAFF, SECTION CHIEFS, AND DOCUMENTATION UNIT LEADER.

HICS 206 – STAFF MEDICAL PLAN

PURPOSE: OUTLINE RESOURCES FOR MEDICAL CARE OF INJURED/ILL HOSPITAL PERSONNEL.

ORIGINATION: SUPPORT BRANCH DIRECTOR.

COPIES TO: COMMAND STAFF, SECTION CHIEFS, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
5. **TREATMENT OF INJURED / ILL STAFF** Identify location(s) and contact information of treatment areas designated for hospital personnel. Use proper name to identify Team Leader and provide contact information. Document special instructions relevant to the treatment of hospital personnel who are injured or ill from the incident.
6. **RESOURCES ON HAND** Indicate by specialty the number of staff, the number of units of medical transportation equipment, and identify types and quantities of medication and supplies.
7. **ALTERNATE CARE SITE(S)** Identify alternate care site facilities by name, complete street and city address, phone number, and specialty care services offered.
8. **PREPARED BY (SUPPORT BRANCH DIRECTOR)** Use proper name.
9. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: At the start of each operational period.

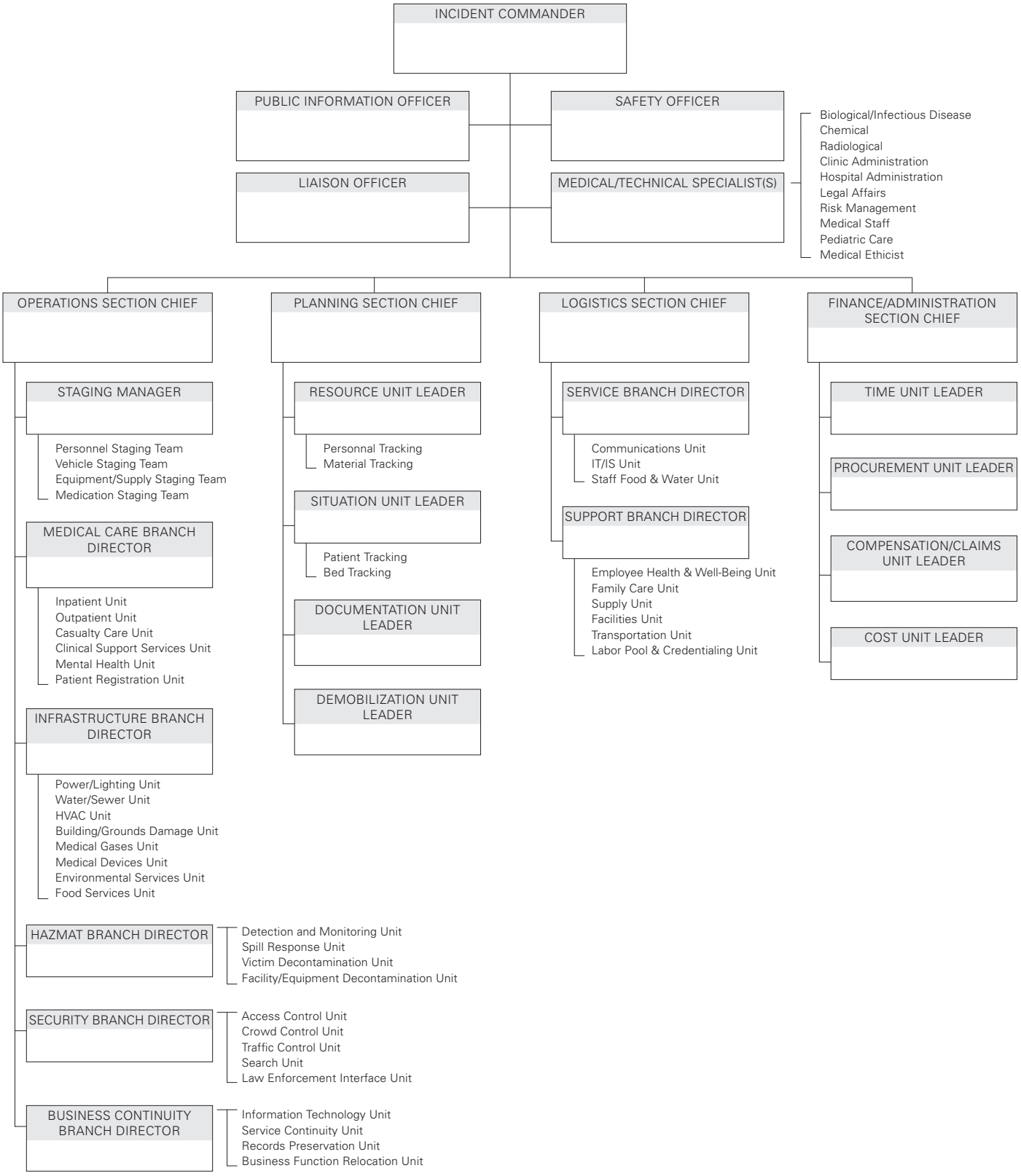
HELPFUL TIPS: This Plan offers a summary of available resources and personnel for the medical care of hospital staff.

ORGANIZATION CHART

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME	2.DATE PREPARED	3. TIME PREPARED	4. OPERATIONAL PERIOD DATE/TIME

5. ORGANIZATIONAL CHART



6. FACILITY NAME

PURPOSE: DOCUMENT HICS POSITIONS ASSIGNED. **ORIGINATION:** INCIDENT COMMANDER.
COPIES TO: COMMAND STAFF, GENERAL STAFF, BRANCH DIRECTORS, UNIT LEADERS, AND DOCUMENTATION UNIT LEADER.

HICS 207 – ORGANIZATION CHART

PURPOSE: DOCUMENT HICS POSITIONS ASSIGNED.

ORIGINATION: INCIDENT COMMANDER.

COPIES TO: COMMAND STAFF, GENERAL STAFF, BRANCH DIRECTORS, UNIT LEADERS, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
5. **ORGANIZATION CHART** Use proper names to identify personnel assigned to positions. Refer to information recorded in HICS 203, Organization Assignment List, as available.
6. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Whenever possible prior to an event, at the start of each operational period, and as changes are made.

HELPFUL TIPS: This form identifies personnel with predefined responsibilities, establishing ideal reporting and communication lines. Display this form prominently in a central location within the Hospital Command Center.

INCIDENT MESSAGE FORM

HOSPITAL INCIDENT COMMAND SYSTEM

1. FROM (SENDER)

2. TO (RECEIVER)

3. DATE RECEIVED

4. TIME RECEIVED

5. RECEIVED VIA

☐ Phone ☐ Radio

☐ Other:

6. REPLY REQUESTED

☐ Yes ☐ No

If Yes, REPLY TO (if different from Sender):

7. PRIORITY

☐ Urgent – High ☐ Non Urgent – Medium ☐ Informational – Low

8. MESSAGE (KEEP ALL MESSAGES/REQUESTS BRIEF, TO THE POINT, AND VERY SPECIFIC)

9. ACTION TAKEN (IF ANY)

RECEIVED BY

TIME RECEIVED

Comments:

Forward To:

RECEIVED BY

TIME RECEIVED

Comments:

Forward To:

10. FACILITY NAME

PURPOSE: PROVIDE STANDARDIZED METHOD FOR RECORDING MESSAGES RECEIVED BY PHONE OR RADIO. **ORIGINATION:** ALL POSITIONS.
ORIGINAL TO: RECEIVER. **COPIES TO:** DOCUMENTATION UNIT LEADER AND MESSAGE TAKER.

HICS 213 – INCIDENT MESSAGE FORM

PURPOSE: PROVIDE STANDARDIZED METHOD FOR RECORDING MESSAGES RECEIVED BY PHONE OR RADIO.

ORIGINATION: ALL POSITIONS.

ORIGINAL TO: RECEIVER.

COPIES TO: DOCUMENTATION UNIT LEADER AND MESSAGE TAKER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **FROM (SENDER)** Use proper name to identify who is sending the message. Include title and agency as appropriate.
2. **TO (RECEIVER)** Use proper name and/or HICS position title as appropriate to identify for whom the message is intended.
3. **DATE RECEIVED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
4. **TIME RECEIVED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
5. **RECEIVED VIA** Indicate communication system.
6. **REPLY REQUESTED** Indicate whether a reply was requested and to whom reply should be addressed, if different from Sender.
7. **PRIORITY** Indicate level of urgency of the message.
8. **MESSAGE (KEEP ALL MESSAGES/REQUESTS BRIEF, TO THE POINT, AND VERY SPECIFIC)** Transcribe complete, concise, and specific content of message.
9. **ACTION TAKEN (IF ANY)** Note any action taken in response to message. When message is routed to any additional recipient, indicate who received, time received, action taken or other comments, and next person to whom message was forwarded.
10. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: When intended Receiver is unavailable to speak with the sender or when a communication includes specific details which accuracy needs to be ensured.

HELPFUL TIPS: This form is suitable for duplication using carbonless copy paper.

OPERATIONAL LOG

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME	

2. DATE PREPARED	3. OPERATIONAL PERIOD DATE/TIME

4. SECTION / BRANCH	5. POSITION

6. ACTIVITY LOG

Time	Major Events, Decisions Made, and Notifications Given

7. PREPARED BY (SIGN AND PRINT)

8. FACILITY NAME

PURPOSE: DOCUMENT INCIDENT ISSUES ENCOUNTERED, DECISIONS MADE, AND NOTIFICATIONS CONVEYED. **ORIGINATION:** COMMAND STAFF AND GENERAL STAFF.
COPIES TO: INCIDENT COMMANDER, PLANNING SECTION CHIEF, AND DOCUMENTATION UNIT LEADER.

HICS 214 – OPERATIONAL LOG

PURPOSE: DOCUMENT INCIDENT ISSUES ENCOUNTERED, DECISIONS MADE, AND NOTIFICATIONS CONVEYED.

ORIGINATION: COMMAND STAFF AND GENERAL STAFF.

COPIES TO: INCIDENT COMMANDER, PLANNING SECTION CHIEF, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
4. **SECTION / BRANCH** Identify the Section and Branch to which the position preparing this form belongs.
5. **POSITION** Identify the title of the position preparing this form.
6. **ACTIVITY LOG** In **Time** column, use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time. Prepare a separate Log for each date. In column for **Major Events, Decisions, Made, and Notifications Given**, note significant details relating to the performance of the position's functions.
7. **PREPARED BY (SIGN AND PRINT)** Use this space for the signature and printed name of the person preparing the Log.
8. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Continuously as a tool used to record major decisions (and critical details as needed) at all levels, from activation through demobilization.

HELPFUL TIPS: Completion of this Log may be delegated to recorders assigned to the Hospital Command Center, Section Chiefs, and appropriate response levels (e.g., Units, Teams, etc.). Once complete, the Log will be forwarded to position's supervisor for immediate review and augmentation; copies are to be distributed at the end of each operational period or sooner as directed by the Section Chief and/or Command Staff. This Log provides documentation of major event response and situational decision-making that can be used later for: briefing of relief personnel, post-incident reimbursement, quality assurance/control, continuous quality improvement processes, identification of safety and/or exposure issues, development of corrective action plans, and improvement of pre-event planning for future events.

FACILITY SYSTEM STATUS REPORT

HOSPITAL INCIDENT COMMAND SYSTEM

1. OPERATIONAL PERIOD DATE/TIME	2. DATE PREPARED	3. TIME PREPARED	4. BUILDING NAME

5. SYSTEM STATUS CHECKLIST

COMMUNICATIONS SYSTEM	OPERATIONAL STATUS	COMMENTS (If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)
Fax	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Information Technology System (email/registration/patient records time card system/intranet, etc.)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Nurse Call System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Paging - Public Address	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Radio Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Satellite System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, External	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Telephone System, Proprietary	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Video-Television-Internet-Cable	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

INFRASTRUCTURE SYSTEM	OPERATIONAL STATUS	COMMENTS
Campus Roadways	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Fire Detection/ Suppression System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Food Preparation Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Ice Machines	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Laundry/Linen Service Equipment	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Structural Components (building integrity)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

PURPOSE: RECORD FACILITY STATUS FOR OPERATIONAL PERIOD FOR INCIDENT. **ORIGINATION:** INFRASTRUCTURE BRANCH DIRECTOR. **ORIGINAL TO:** SITUATION UNIT LEADER. **COPIES TO:** SAFETY OFFICER, LIAISON OFFICER, OPERATIONS SECTION CHIEF, BUSINESS CONTINUITY BRANCH DIRECTOR, PLANNING SECTION CHIEF, AND DOCUMENTATION UNIT LEADER.

HICS 251 – FACILITY SYSTEM STATUS REPORT

PURPOSE: RECORD FACILITY STATUS FOR OPERATIONAL PERIOD FOR INCIDENT.

ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR.

ORIGINAL TO: SITUATION UNIT LEADER.

COPIES TO: OPERATIONS SECTION CHIEF, BUSINESS CONTINUITY BRANCH DIRECTOR, PLANNING SECTION CHIEF, SAFETY OFFICER, LIAISON OFFICER, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

(Page 1 of 3)

1. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **BUILDING NAME** Provide name or other identifier of building for which this status report is being prepared.

(Pages 1-3 of 3)

5. **SYSTEM STATUS CHECKLIST** For each system listed, use the following definitions to assign Operational Status:
   Fully functional 100% operable with no limitations
   Partially functional Operable or somewhat operable with limitations
   Non-functional Out of commission
   Comment on location, reason, and time/resource estimates for necessary repair of any system that is not fully operational. If inspection is completed by someone other than as defined by policy or procedure, identify that person in the comments.

(Page 3 of 3)

6. **CERTIFYING OFFICER** Use proper name and identify the position title of the person preparing this form.
7. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: At start of operational period, as conditions change, or more frequently as indicated by the situation.

HELPFUL TIPS: Data may be obtained from area reports or from inspections by Infrastructure Branch personnel. The hospital determines overall facility functionality.

FACILITY SYSTEM STATUS REPORT

PATIENT CARE SYSTEM	OPERATIONAL STATUS	COMMENTS (If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)
Decontamination System (including containment)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Digital Radiography System (e.g., PACS)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Ethylene Oxide (EtO)/Sterilizers	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Isolation Rooms (positive/negative air)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

SECURITY SYSTEM	OPERATIONAL STATUS	COMMENTS
Door Lockdown Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Surveillance Cameras	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

UTILITIES, EXTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS
Electrical Power-Primary Service	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sanitation Systems	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Natural Gas	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

PURPOSE: RECORD FACILITY STATUS FOR OPERATIONAL PERIOD FOR INCIDENT. **ORIGINATION:** INFRASTRUCTURE BRANCH DIRECTOR. **ORIGINAL TO:** SITUATION UNIT LEADER. **COPIES TO:** SAFETY OFFICER, LIAISON OFFICER, OPERATIONS SECTION CHIEF, BUSINESS CONTINUITY BRANCH DIRECTOR, PLANNING SECTION CHIEF, AND DOCUMENTATION UNIT LEADER.

HICS 251 – FACILITY SYSTEM STATUS REPORT

PURPOSE: RECORD FACILITY STATUS FOR OPERATIONAL PERIOD FOR INCIDENT.

ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR.

ORIGINAL TO: SITUATION UNIT LEADER.

COPIES TO: OPERATIONS SECTION CHIEF, BUSINESS CONTINUITY BRANCH DIRECTOR, PLANNING SECTION CHIEF, SAFETY OFFICER, LIAISON OFFICER, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

(Page 1 of 3)

1. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **BUILDING NAME** Provide name or other identifier of building for which this status report is being prepared.

(Pages 1-3 of 3)

5. **SYSTEM STATUS CHECKLIST** For each system listed, use the following definitions to assign Operational Status:
   Fully functional 100% operable with no limitations
   Partially functional Operable or somewhat operable with limitations
   Non-functional Out of commission
   Comment on location, reason, and time/resource estimates for necessary repair of any system that is not fully operational. If inspection is completed by someone other than as defined by policy or procedure, identify that person in the comments.

(Page 3 of 3)

6. **CERTIFYING OFFICER** Use proper name and identify the position title of the person preparing this form.
7. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: At start of operational period, as conditions change, or more frequently as indicated by the situation.

HELPFUL TIPS: Data may be obtained from area reports or from inspections by Infrastructure Branch personnel. The hospital determines overall facility functionality.

FACILITY SYSTEM STATUS REPORT

UTILITIES, INTERNAL SYSTEM	OPERATIONAL STATUS	COMMENTS (If not fully operational/functional, give location, reason, and estimated time/resources for necessary repair. Identify who reported or inspected.)
Air Compressor	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Electrical Power, Backup Generator	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Fuel status)
Elevators/Escalators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Hazardous Waste Containment System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Heating, Ventilation, and Air Conditioning (HVAC)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Medical Gases, Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Oxygen	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	(Reserve supply status)
Pneumatic Tube	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Steam Boiler	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Sump Pump	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Well Water System	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Vacuum (for patient use)	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Water Heater and Circulators	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	
Other	☐ Fully functional ☐ Partially functional ☐ Nonfunctional	

6. CERTIFYING OFFICER

7. FACILITY NAME

HICS 251 – FACILITY SYSTEM STATUS REPORT

PURPOSE: RECORD FACILITY STATUS FOR OPERATIONAL PERIOD FOR INCIDENT.

ORIGINATION: INFRASTRUCTURE BRANCH DIRECTOR.

ORIGINAL TO: SITUATION UNIT LEADER.

COPIES TO: OPERATIONS SECTION CHIEF, BUSINESS CONTINUITY BRANCH DIRECTOR, PLANNING SECTION CHIEF, SAFETY OFFICER, LIAISON OFFICER, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

(Page 1 of 3)

1. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **BUILDING NAME** Provide name or other identifier of building for which this status report is being prepared.

(Pages 1-3 of 3)

5. **SYSTEM STATUS CHECKLIST** For each system listed, use the following definitions to assign Operational Status:
   Fully functional 100% operable with no limitations
   Partially functional Operable or somewhat operable with limitations
   Non-functional Out of commission
   Comment on location, reason, and time/resource estimates for necessary repair of any system that is not fully operational. If inspection is completed by someone other than as defined by policy or procedure, identify that person in the comments.

(Page 3 of 3)

6. **CERTIFYING OFFICER** Use proper name and identify the position title of the person preparing this form.
7. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: At start of operational period, as conditions change, or more frequently as indicated by the situation.

HELPFUL TIPS: Data may be obtained from area reports or from inspections by Infrastructure Branch personnel. The hospital determines overall facility functionality.

SECTION PERSONNEL TIME SHEET

HOSPITAL INCIDENT COMMAND SYSTEM

1. FROM DATE/TIME	2. TO DATE/TIME	3. SECTION	4. TEAM LEADER

5. TIME RECORD

#	Employee (E) / Volunteer (V)* Name (Please Print)	E/V	Employee Number	Response Function/Job	Date/Time In	Date/Time Out	Signature	Total Hours
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

* May be usual hospital volunteers or approved volunteers from community.

6. CERTIFYING OFFICER	7. DATE/TIME SUBMITTED

8. FACILITY NAME

PURPOSE: RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY. **ORIGINATION:** SECTION CHIEF.
ORIGINAL TO: TIME UNIT LEADER EVERY 12 HOURS. **COPIES TO:** DOCUMENTATION UNIT LEADER.

HICS 252 – SECTION PERSONNEL TIME SHEET

PURPOSE: RECORD EACH SECTION'S PERSONNEL TIME AND ACTIVITY.

ORIGINATION: SECTION CHIEF.

ORIGINAL TO: TIME UNIT LEADER EVERY 12 HOURS.

COPY TO: DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **FROM DATE/TIME** Indicate starting date/time of period covered by this form. Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**. Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
2. **TO DATE/TIME** Indicate ending date/time of period covered by this form.
3. **SECTION** Indicate the Section for which this time sheet is being prepared.
4. **TEAM LEADER** Use proper name to identify the supervisor of the personnel listed.
5. **TIME RECORD** Use proper names to list personnel and indicate status as employee or volunteer by writing E or V in parentheses following the name. Record employee number as appropriate, indicated assigned function or job, and log work start and end times in the Date/Time In and Date/Time Out columns. Have employee/volunteer sign the form. Calculate total hours.
6. **CERTIFYING OFFICER** Use proper name to identify who verified the information on the time sheet.
7. **DATE/TIME SUBMITTED** Indicate date and time that the form is submitted to the Time Unit Leader.
8. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Throughout activation.

HELPFUL TIPS: Data on this form may be summarized at the end of each operational period.

VOLUNTEER STAFF REGISTRATION

HOSPITAL INCIDENT COMMAND SYSTEM

1. FROM DATE/TIME	2. TO DATE/TIME	3. SECTION	4. TEAM LEADER

5. REGISTRATION

Name (Last Name, First Name)	Address City, State, Zip	Social Security Number	Telephone Number	Certification/Licensure And Number	Time IN	Time OUT	Signature

6. CERTIFYING OFFICER	7. DATE/TIME SUBMITTED

8. FACILITY NAME

PURPOSE: VOLUNTEER SIGN-IN FOR OPERATIONAL PERIOD. **ORIGINATION:** LABOR POOL & CREDENTIALING UNIT LEADER.
COPIES TO: TIME UNIT LEADER, PERSONNEL TRACKING MANAGER, AND DOCUMENTATION UNIT LEADER.

HICS 253 – VOLUNTEER STAFF REGISTRATION

PURPOSE: VOLUNTEER SIGN-IN FOR OPERATIONAL PERIOD.

ORIGINATION: LABOR POOL & CREDENTIALING UNIT LEADER.

COPIES TO: TIME UNIT LEADER, PERSONNEL TRACKING MANAGER, AND OCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **FROM DATE/TIME** Indicate starting date/time of period covered by this form. Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**. Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
2. **TO DATE/TIME** Indicate ending date/time of period covered by this form.
3. **SECTION** Indicate the Section for which this time sheet is being prepared.
4. **TEAM LEADER** Use proper name to identify the supervisor of the personnel listed.
5. **REGISTRATION** Use proper name, listing last name first, of volunteers, and record complete address, Social Security number, telephone number, and certification/licensure and number. Indicate work start and end times in the Time IN and Time OUT columns. Have volunteer sign the form.
6. **CERTIFYING OFFICER** Use proper name to identify who verified the information on the registration form.
7. **DATE/TIME SUBMITTED** Indicate date and time that the form is submitted to the Time Unit Leader.
8. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Throughout activation.

HELPFUL TIPS: Data on this form may be summarized at the end of each operational period. This form is suitable for duplication using carbonless copy paper.

DISASTER VICTIM/PATIENT TRACKING FORM

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME	2. DATE/TIME PREPARED	3. OPERATIONAL PERIOD DATE/TIME

4. TRIAGE AREAS (IMMEDIATE, DELAYED, EXPECTANT, MINOR, MORGUE)

MR #/ Triage #	Name	Sex	DOB/Age	Area Triaged To	Location/Time of Diagnostic Procedures (X-Ray, Angio, CT, etc)	Time sent to Surgery	Disposition (Home, Admit, Morgue, Transfer)	Time of Disposition

5. SUBMITTED BY	6. AREA ASSIGNED TO	7. DATE/TIME SUBMITTED

8. FACILITY NAME

PURPOSE: ACCOUNT FOR VICTIMS OF IDENTIFIED EVENT SEEKING MEDICAL ATTENTION. **ORIGINATION:** SITUATION UNIT LEADER.
COPIES TO: PATIENT REGISTRATION UNIT LEADER AND MEDICAL CARE BRANCH DIRECTOR.

HICS 254 – DISASTER VICTIM/PATIENT TRACKING FORM

PURPOSE: ACCOUNT FOR VICTIMS OF IDENTIFIED EVENT SEEKING MEDICAL ATTENTION.

ORIGINATION: PATIENT TRACKING MANAGER.

ORIGINAL TO: SITUATION UNIT LEADER.

COPIES TO: PATIENT REGISTRATION UNIT LEADER AND MEDICAL CARE BRANCH DIRECTOR.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE/TIME PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**. Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
3. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
4. **TRIAGE AREAS (IMMEDIATE, DELAYED, EXPECTANT, MINOR, MORGUE)** For each patient, record as much identifying information as available: medical record number, triage tag number, name, sex, date of birth, and age. Identify area to which patient was triaged. Record location and time of diagnostic procedures, time patient was sent to Surgery, disposition of patient, and time of disposition.
5. **SUBMITTED BY** Use proper name to identify who verified the information and submitted the form.
6. **AREA ASSIGNED TO** Indicate this triage area where these patients were first seen.
7. **DATE/TIME SUBMITTED** Indicate date and time that the form is submitted to the Situation Unit Leader.
8. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Hourly and at end of each operational period, upon arrival of the first patient and until the disposition of the last.

HELPFUL TIPS: This form may be included in the Incident Action Plan (IAP); however, for patient confidentiality, it must be omitted from IAP copies that are distributed outside of the hospital. Consolidated information such as total number of patients may be shared with local EOC or other coordinating agency. If a Victim Tracking Center is available in the area with which a memorandum of understanding is in place, a copy may be provided. This form is suitable for duplication using carbonless copy paper.

HOSPITAL
INCIDENT
COMMAND
SYSTEM

MASTER PATIENT EVACUATION TRACKING FORM

1. INCIDENT NAME

2. DATE/TIME PREPARED

3. PATIENT TRACKING MANAGER

4. PATIENT EVACUATION INFORMATION

Patient Name	Medical Record #	Disposition (Home or Transfer)	Evacuation Triage Category (Immed., Delayed, Minor, Expired)	Accepting Hospital	Time Hospital Contacted and Report Given	
Transfer Initiated (Time/Transport Company)	Medical Record Sent (Yes/No)	Medication Sent (Yes/No)	Family Notified (Yes/No)	Arrival Confirmed (Yes/No)	Admission Location (Floor, ICU, ER)	Expired (Time)
Patient Name	Medical Record #	Disposition (Home or Transfer)	Evacuation Triage Category (Immed., Delayed, Minor, Expired)	Accepting Hospital	Time Hospital Contacted and Report Given	
Transfer Initiated (Time/Transport Company)	Medical Record Sent (Yes/No)	Medication Sent (Yes/No)	Family Notified (Yes/No)	Arrival Confirmed (Yes/No)	Admission Location (Floor, ICU, ER)	Expired (Time)
Patient Name	Medical Record #	Disposition (Home or Transfer)	Evacuation Triage Category (Immed., Delayed, Minor, Expired)	Accepting Hospital	Time Hospital Contacted and Report Given	
Transfer Initiated (Time/Transport Company)	Medical Record Sent (Yes/No)	Medication Sent (Yes/No)	Family Notified (Yes/No)	Arrival Confirmed (Yes/No)	Admission Location (Floor, ICU, ER)	Expired (Time)
Patient Name	Medical Record #	Disposition (Home or Transfer)	Evacuation Triage Category (Immed., Delayed, Minor, Expired)	Accepting Hospital	Time Hospital Contacted and Report Given	
Transfer Initiated (Time/Transport Company)	Medical Record Sent (Yes/No)	Medication Sent (Yes/No)	Family Notified (Yes/No)	Arrival Confirmed (Yes/No)	Admission Location (Floor, ICU, ER)	Expired (Time)
Patient Name	Medical Record #	Disposition (Home or Transfer)	Evacuation Triage Category (Immed., Delayed, Minor, Expired)	Accepting Hospital	Time Hospital Contacted and Report Given	
Transfer Initiated (Time/Transport Company)	Medical Record Sent (Yes/No)	Medication Sent (Yes/No)	Family Notified (Yes/No)	Arrival Confirmed (Yes/No)	Admission Location (Floor, ICU, ER)	Expired (Time)

5. SUBMITTED BY

6. AREA ASSIGNED TO

7. DATE/TIME SUBMITTED

8. FACILITY NAME

PURPOSE: RECORD INFORMATION CONCERNING PATIENT DISPOSITION DURING A HOSPITAL/FACILITY EVACUATION. **ORIGINATION:** PATIENT TRACKING MANAGER.
COPIES TO: PLANNING SECTION CHIEF AND DOCUMENTATION UNIT LEADER.

HICS 255 – MASTER PATIENT EVACUATION TRACKING FORM

PURPOSE: RECORD INFORMATION CONCERNING PATIENT DISPOSITION DURING A HOSPITAL/FACILITY EVACUATION.

ORIGINATION: PATIENT TRACKING MANAGER.

COPIES TO: PLANNING SECTION CHIEF AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE/TIME PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**. Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
3. **PATIENT TRACKING MANAGER** Use proper name.
4. **PATIENT EVACUATION INFORMATION** List patient by full name and medical record number. Indicate decision to discharge home or transfer. For transfers, record triage category, identify accepting hospital, and record time the accepting hospital was contacted and provided with report. Indicate time transfer was initiated, and record name of transport company. Indicate whether patient medical record was sent, whether medication was sent, and whether patient's family was notified. Indicate whether patient arrival was confirmed, and record where the patient was admitted at the accepting hospital. If patient expired, record time.
5. **SUBMITTED BY** Use proper name to identify who verified the information and submitted the form.
6. **AREA ASSIGNED TO** Indicate area from which these patients were triaged out.
7. **DATE/TIME SUBMITTED** Indicate date and time that the form is submitted to the Planning Section Chief.
8. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: As decisions are made and as information is determined concerning patient disposition during a hospital/facility evacuation.

HELPFUL TIPS: This form may be completed with information recorded in HICS 260, Patient Evacuation Tracking Form, as available.

PROCUREMENT SUMMARY REPORT

HOSPITAL INCIDENT COMMAND SYSTEM

1. PURCHASES

#	P.O./ REFERENCE #	DATE/TIME	ITEM/SERVICE	VENDOR	$ AMOUNT	REQUESTOR NAME/DEPT (PLEASE PRINT)	APPROVED BY (PLEASE PRINT NAME)	RECEIVED DATE/TIME
1								
Comments:								
2								
Comments:								
3								
Comments:								
4								
Comments:								
5								
Comments:								
6								
Comments:								
7								
Comments:								
8								
Comments:								
9								
Comments:								
10								
Comments:								
11								
Comments:								
12								
Comments:								

2. CERTIFYING OFFICER	3. DATE/TIME SUBMITTED	4. FACILITY NAME

PURPOSE: SUMMARIZE AND TRACK PROCUREMENTS BY OPERATIONAL PERIOD AND/OR INCIDENT TIMEFRAME.
ORIGINATION: PROCUREMENT UNIT LEADER. **COPIES TO:** FINANCE/ADMINISTRATION SECTION CHIEF AND DOCUMENTATION UNIT LEADER.

HICS 256 – PROCUREMENT SUMMARY REPORT

PURPOSE: SUMMARIZE AND TRACK PROCUREMENTS BY OPERATIONAL PERIOD AND/OR INCIDENT TIMEFRAME.

ORIGINATION: PROCUREMENT UNIT LEADER.

COPIES TO: FINANCE/ADMINISTRATION SECTION CHIEF AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **PURCHASES** List purchases by purchase order or other reference number. Record date and time of purchase. Describe item or service. Identify vendor name. Record total cost of purchase. Use proper name to identify requestor and department. Use proper name to indicate who approved purchase. Record date and time item or service was received.
2. **CERTIFYING OFFICER** Use proper name to identify who verified the information on the report.
3. **DATE/TIME SUBMITTED** Indicate date and time that the form is submitted to the Finance/Administration Section Chief. Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**. Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Prior to the end of the operational period and as procurements are completed.

HELPFUL TIPS: This form may be completed with information recorded in HICS 260, Patient Evacuation Tracking Form, as available.

RESOURCE ACCOUNTING RECORD

HOSPITAL INCIDENT COMMAND SYSTEM

1. DATE	2. SECTION	3. OPERATIONAL PERIOD DATE/TIME

4. RESOURCE RECORD

Time	Item/Facility Tracking ID Number	Condition	Received from	Dispensed to	Returned (Date/Time)	Condition (or indicate if nonrecoverable)	Initials

5. CERTIFYING OFFICER	6. DATE/TIME SUBMITTED

7. FACILITY NAME

PURPOSE: TRACK REQUESTED EQUIPMENT. **ORIGINATION:** SECTION CHIEF.
COPIES TO: FINANCE/ADMINISTRATION SECTION CHIEF, RESOURCES UNIT LEADER, MATERIAL TRACKING MANAGER AND ORIGINATOR.

HICS 257 – RESOURCE ACCOUNTING RECORD

PURPOSE: TRACK REQUESTED EQUIPMENT.

ORIGINATION: SECTION CHIEF.

COPIES TO: FINANCE/ADMINISTRATION SECTION CHIEF, RESOURCES UNIT LEADER, MATERIEL TRACKING MANAGER, AND ORIGINATOR.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **DATE** Indicate today's date. Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
2. **SECTION** Indicate the Section for which this record is being prepared.
3. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For time, use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
4. **RESOURCE RECORD** For each resource, record time that item is received. Identify item and/or provide tracking number. Describe condition of item. Record from where item was received and to where it was dispensed. Indicate date and time item was returned, and describe condition. Obtain initials of person returning item.
5. **CERTIFYING OFFICER** Use proper name to identify who verified the information on the report.
6. **DATE/TIME SUBMITTED** Indicate date and time that the form is submitted to the Finance/Administration Section Chief.
7. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Prior to the end of the operational period or as needed.

HELPFUL TIPS: Record details and status of resources used for this incident. Be specific.

HOSPITAL RESOURCE DIRECTORY

	Personal Contact (Company/Agency/Name)	Phone Number - Primary	Phone Number - Secondary	E-Mail	Fax	Radio
Agency for Toxic Substances and Disease Registry (ATSDR)						
Ambulance/EMS						
Ambulance, Hospital-Based						
Ambulance, Private						
Ambulance, Public Safety						
American Red Cross						
Automated Teller Machine (ATM)						
Biohazard Waste Company						
Buses						
Cab, City						
CDC						
Clinics						
Coroner/Medical Examiner						
Dispatcher, 911						
Emergency Management Agency						
Emergency Operations Center (EOC), Local						
Emergency Operations Center (EOC), State						
Engineers						
HVAC						
Mechanical						
Structural						
Environmental Protection Agency (EPA)						
Epidemiologist						
Federal Bureau of Investigation (FBI)						
Fire Department						
Food Service						

HICS 258 – HOSPITAL RESOURCE DIRECTORY

PURPOSE: LIST RESOURCES TO CONTACT AS NEEDED AND MAINTAIN CONTACT INFORMATION.

ORIGINATION: RESOURCES UNIT LEADER.

COPIES TO: COMMAND STAFF AND GENERAL STAFF.

INSTRUCTIONS:

Print legibly, and enter complete information.

Record complete contact information for agencies, service providers, vendors, etc., that provide critical resources.

WHEN TO COMPLETE: Whenever possible prior to an event, at the start of each operational period, and as changes are made.

HELPFUL TIPS: Review and update periodically to maintain current information.

HOSPITAL RESOURCE DIRECTORY

	Personal Contact (Company/Agency/Name)	Phone Number - Primary	Phone Number - Secondary	E-Mail	Fax	Radio
Fuel						
Funeral Homes/Mortuary Services						
Generators						
HazMat Team						
Health Department, Local						
Heavy Equipment (e.g., Backhoes, etc.)						
Helicopters						
Home Repair/Construction Supplies						
1.						
2.						
Hospitals						
1.						
2.						
3.						
4.						
Hotel						
Housing, Temporary						
Ice, Commercial						
Laboratory Response Network						
Laundry/Linen Service						
Law Enforcement						
Long Term Care Facilities						
1.						
2.						
3.						

HICS 258 – HOSPITAL RESOURCE DIRECTORY

PURPOSE: LIST RESOURCES TO CONTACT AS NEEDED AND MAINTAIN CONTACT INFORMATION.

ORIGINATION: RESOURCES UNIT LEADER.

COPIES TO: COMMAND STAFF AND GENERAL STAFF.

INSTRUCTIONS:

Print legibly, and enter complete information.

Record complete contact information for agencies, service providers, vendors, etc., that provide critical resources.

WHEN TO COMPLETE: Whenever possible prior to an event, at the start of each operational period, and as changes are made.

HELPFUL TIPS: Review and update periodically to maintain current information.

HOSPITAL RESOURCE DIRECTORY

	Personal Contact (Company/Agency/Name)	Phone Number - Primary	Phone Number - Secondary	E-Mail	Fax	Radio
Media						
Print:						
Print:						
Radio:						
Radio:						
TV:						
TV:						
TV:						
TV:						
Medical Gases						
Medical Supply						
1.						
2.						
3.						
4.						
Medication, Distributor						
1.						
2.						
3.						
4.						
Moving Company						
Pharmacy, Commercial						
1.						
2.						
3.						
Poison Control Center						

HICS 258 – HOSPITAL RESOURCE DIRECTORY

PURPOSE: LIST RESOURCES TO CONTACT AS NEEDED AND MAINTAIN CONTACT INFORMATION.

ORIGINATION: RESOURCES UNIT LEADER.

COPIES TO: COMMAND STAFF AND GENERAL STAFF.

INSTRUCTIONS:

Print legibly, and enter complete information.

Record complete contact information for agencies, service providers, vendors, etc., that provide critical resources.

WHEN TO COMPLETE: Whenever possible prior to an event, at the start of each operational period, and as changes are made.

HELPFUL TIPS: Review and update periodically to maintain current information.

HOSPITAL RESOURCE DIRECTORY

	Personal Contact (Company/Agency/Name)	Phone Number - Primary	Phone Number - Secondary	E-Mail	Fax	Radio
Portable Toilets						
Public Health						
Radios						
Amateur Radio Group						
Satellite						
Service Provider (e.g., Nextel)						
Walkie-Talkie						
Regional Healthcare Coordinating Center/REDDINET						
Repair Services						
Beds						
Biomedical Devices						
Elevators						
Medical Devices						
Oxygen Devices						
Radios						
Restoration Services (e.g., ServiceMaster)						
Salvation Army						
Shelter Sites						
Surge Facilities						
Toxicologist						
Traffic Control						
Trucks						
Refrigeration						
Towing						

HICS 258 – HOSPITAL RESOURCE DIRECTORY

PURPOSE: LIST RESOURCES TO CONTACT AS NEEDED AND MAINTAIN CONTACT INFORMATION.

ORIGINATION: RESOURCES UNIT LEADER.

COPIES TO: COMMAND STAFF AND GENERAL STAFF.

INSTRUCTIONS:

Print legibly, and enter complete information.

Record complete contact information for agencies, service providers, vendors, etc., that provide critical resources.

WHEN TO COMPLETE: Whenever possible prior to an event, at the start of each operational period, and as changes are made.

HELPFUL TIPS: Review and update periodically to maintain current information.

HOSPITAL RESOURCE DIRECTORY

	Personal Contact (Company/Agency/Name)	Phone Number - Primary	Phone Number - Secondary	E-Mail	Fax	Radio
Utilities						
Gas						
Power						
Sewage						
Telephone						
Water						
Vending Machines						
Ventilators						
Water - Nonpotable						
Water Vendor - Potable						
Other						

PURPOSE: LIST RESOURCES TO CONTACT AS NEEDED AND MAINTAIN CONTACT INFORMATION. **ORIGINATION:** RESOURCES UNIT LEADER. **COPIES TO:** COMMAND STAFF AND GENERAL STAFF

HICS 258 – HOSPITAL RESOURCE DIRECTORY

PURPOSE: LIST RESOURCES TO CONTACT AS NEEDED AND MAINTAIN CONTACT INFORMATION.

ORIGINATION: RESOURCES UNIT LEADER.

COPIES TO: COMMAND STAFF AND GENERAL STAFF.

INSTRUCTIONS:

Print legibly, and enter complete information.

Record complete contact information for agencies, service providers, vendors, etc., that provide critical resources.

WHEN TO COMPLETE: Whenever possible prior to an event, at the start of each operational period, and as changes are made.

HELPFUL TIPS: Review and update periodically to maintain current information.

HOSPITAL CASUALTY/FATALITY REPORT

1. INCIDENT NAME	2. DATE PREPARED	3. TIME PREPARED	4. OPERATIONAL PERIOD DATE/TIME

5. NUMBER OF CASUALTIES / FATALITIES

	ADULT	PEDIATRIC (<18 YEARS OLD)	TOTAL	COMMENTS
Patients seen				
Admitted				
Critical care bed				
Medical/surgical bed				
Pediatric bed				
Discharged				
Transferred				
Expired				
Waiting to be seen				

6. PREPARED BY (PATIENT TRACKING MANAGER)	7. FACILITY NAME

PURPOSE: DOCUMENT THE NUMBER OF INJURIES AND FATALITIES.
ORIGINATION: PATIENT TRACKING MANAGER. **COPIES TO:** COMMAND STAFF, SECTION CHIEFS, AND DOCUMENTATION UNIT LEADER.

HICS 259 – HOSPITAL CASUALTY / FATALITY REPORT

PURPOSE: DOCUMENT THE NUMBER OF INJURIES AND FATALITIES.

ORIGINATION: PATIENT TRACKING MANAGER.

COPIES TO: COMMAND STAFF, SECTION CHIEFS, AND DOCUMENTATION UNIT LEADER.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **OPERATIONAL PERIOD DATE/TIME** Identify the operational period during which this information applies. This is the time period established by the hospital's Incident Commander, during which current objectives are to be accomplished and at the end of which they are evaluated. For example, a 12-hour operational period might be 2006-08-16 18:00 to 2006-08-17 06:00.
5. **NUMBER OF CASUALTIES / FATALITIES** For the operational period covered, record total numbers of adult and pediatric patients seen, admitted (specify bed type), discharged, transferred, expired, and waiting to be seen.
6. **PREPARED BY (PATIENT TRACKING MANAGER)** Use proper name.
7. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Prior to briefing in the next operational period.

HELPFUL TIPS: This information is included in the situation reports during the planning meetings.

PATIENT EVACUATION TRACKING FORM

HOSPITAL INCIDENT COMMAND SYSTEM

1. DATE

2. UNIT

3. PATIENT NAME

4. AGE

5. MR#

6. DIAGNOSIS(-ES)

7. ADMITTING PHYSICIAN

8. FAMILY NOTIFIED

☐ Yes ☐ No Contact Information:

9. ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY)

☐ Hospital Bed	☐ IV Pump(s)	☐ Isolette/Warmer	☐ Foley Catheter
☐ Gurney	☐ Oxygen	☐ Traction	☐ Halo-Device
☐ Wheel Chair	☐ Ventilator	☐ Monitor	☐ Cranial Bolt/Screw
☐ Ambulatory	☐ Chest Tube(s)	☐ A-Line/Swan	☐ IO Device
☐ Other	☐ Other	☐ Other	☐ Other

Isolation ☐ Yes ☐ No Type

Reason

10. EVACUATING CLINICAL LOCATION

Room # Time

ID Band Confirmed ☐ Yes ☐ No
By:

Medical Record sent ☐ Yes ☐ No

Addressograph sent ☐ Yes ☐ No

Belongings ☐ with patient ☐ left in room ☐ none

Valuables ☐ with patient ☐ left in safe ☐ none

Medications ☐ with patient ☐ left on unit ☐ to pharmacy

PEDS/INFANTS

Bag/Mask with tubing sent ☐ Yes ☐ No

Bulb Syringe sent ☐ Yes ☐ No

11. ARRIVING LOCATION

Room # Time

ID Band Confirmed ☐ Yes ☐ No
By:

Medical Record received ☐ Yes ☐ No

Addressograph received ☐ Yes ☐ No

Belongings received ☐ Yes ☐ No

Valuables ☐ Yes ☐ No

Medications received ☐ Yes ☐ No

Bag/Mask with tubing received ☐ Yes ☐ No

Bulb Syringe received ☐ Yes ☐ No

12. TRANSFERRING TO ANOTHER FACILITY

Time to Staging Area

Time Departing to Receiving Facility

Destination

Transportation ☐ Ambulance unit ☐ Helicopter ☐ Other:

ID Band Confirmed ☐ Yes ☐ No By:

Departure Time

13. FACILITY NAME

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR PATIENTS TRANSFERRED TO ANOTHER FACILITY.
ORIGINATION: INPATIENT UNIT LEADER, OUTPATIENT UNIT LEADER AND/OR CASUALTY CARE UNIT LEADER. **ORIGINAL TO**: PATIENT.
COPIES TO: PATIENT TRACKING MANAGER, MEDICAL CARE BRANCH DIRECTOR AND EVACUATING CLINICAL LOCATION.

HICS 260 – PATIENT EVACUATION TRACKING FORM

PURPOSE: DOCUMENT DETAILS AND ACCOUNT FOR PATIENTS TRANSFERRED TO ANOTHER FACILITY.

ORIGINATION: INPATIENT UNIT LEADER, OUTPATIENT UNIT LEADER, AND/OR CASUALTY CARE UNIT LEADER.

ORIGINAL TO: PATIENT.

COPIES TO: PATIENT TRACKING MANAGER, MEDICAL CARE BRANCH DIRECTOR, AND EVACUATING CLINICAL LOCATION.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **DATE** Enter today's date. Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
2. **UNIT** Enter the name of the Unit preparing this form.
3. **PATIENT NAME** Enter patient's full name.
4. **AGE** Enter patient's age.
5. **MR#** Enter patient's medical record number.
6. **DIAGNOSIS(-ES)** Briefly list any diagnosis.
7. **ADMITTING PHYSICIAN** Use proper name to identify admitting physician.
8. **FAMILY NOTIFIED** Indicate whether the patient's family has been notified of the evacuation, and note contact information.
9. **ACCOMPANYING EQUIPMENT (CHECK THOSE THAT APPLY)** Check boxes that correspond with equipment that is taken with patient. Also indicate whether patient requires isolation, the isolation type, and reason for isolation.
10. **EVACUATING CLINICAL LOCATION** Record room number from which patient is being evacuated and time of evacuation. [For time, use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.] Indicate whether the patient identification band was confirmed and by whom. Indicate whether patient medical record and addressograph were sent. Indicate disposition of belongings, valuables, and medications. For pediatric patients, indicate whether a bag/mask with tubing and a bulb syringe were sent.
11. **ARRIVING LOCATION** Record room number assigned to patient and time of arrival. Indicate whether the patient identification band was confirmed and by whom. Indicate whether patient medical record, addressograph, belongings, valuables, and medications were received. For pediatric patients, indicate whether a bag/mask with tubing and a bulb syringe were received.
12. **TRANSFERRING TO ANOTHER FACILITY** Indicate time patient arrived at staging area and scheduled departure time to receiving facility. Identify destination and mode of transportation. Indicate whether patient identification band was confirmed by the transportation provider representative and by whom. Record actual departure time.
13. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: As patients are identified for evacuation.

HELPFUL TIPS: Information on this form may be used to complete HICS 255, Master Patient Evacuation Tracking Form. This form is suitable for duplication using carbonless copy paper.

INCIDENT ACTION PLAN SAFETY ANALYSIS

HOSPITAL INCIDENT COMMAND SYSTEM

1. INCIDENT NAME	2. DATE PREPARED	3. TIME PREPARED

4. HAZARD MITIGATION

Potential/Actual Hazards (biohazards, structural, utility, traffic, etc.)	Section or Branch and Location	Mitigations (e.g., PPE, buddy system, escape routes)	Mitigation Completed (Sign Off)

5. SAFETY OFFICER	6. FACILITY NAME

HICS 261 – INCIDENT ACTION PLAN SAFETY ANALYSIS

PURPOSE: DOCUMENT HAZARDS AND DEFINE MITIGATION.

ORIGINATION: SAFETY OFFICER.

COPIES TO: COMMAND STAFF, GENERAL STAFF, BRANCH DIRECTORS, AND UNIT LEADERS.

INSTRUCTIONS:

Print legibly, and enter complete information.

1. **INCIDENT NAME** If the incident is internal to the hospital, the name may be given by the hospital's Incident Commander. If the incident affects the larger community, the name may be given by a local authority (e.g., fire department, local EOC, etc.).
2. **DATE PREPARED** Use the international standard date notation **YYYY-MM-DD**, where YYYY is the year, MM is the month of the year between 01 (January) and 12 (December), and DD is the day of the month between 01 and 31. For example, the fourteenth day of February in the year 2006 is written as **2006-02-14**.
3. **TIME PREPARED** Use the international standard notation **hh:mm**, where hh is the number of complete hours that have passed since midnight (00-24), and mm is the number of complete minutes that have passed since the start of the hour (00-59). For example, 5:04 PM is written as **17:04**. Use local time.
4. **HAZARD MITIGATION** Identify the potential and actual hazards associated with the incident, from which specific Sections or Braches are at risk; identify Section or Branch and location. Define measures to mitigate hazard, including personal protective equipment (PPE), precautions, etc. Safety Officer or designee to sign when mitigation is implemented.
5. **SAFETY OFFICER** User proper name to identify Safety Officer who has completed the analysis.
6. **FACILITY NAME** Use when transmitting the form outside of the hospital.

WHEN TO COMPLETE: Prior to safety briefing that is part of shift briefings conducted for all staff at the start of each operational period.

HELPFUL TIPS: Identification of safety issues is an ongoing process. Hazards and risks should be reported immediately and proper mitigation measures identified and implemented as quickly as possible. This may include cessation of operations if deemed necessary by the Safety Officer to protect the health and safety of responders and the general public, until the hazard or risk has been mitigated. This document identifies specific existing or potential safety risks and hazards and documents assignments as well as progress/completion of mitigation activities. This information is included in the operational period briefing by the Planning Section Chief and archived by the Documentation Unit Leader.

Attachment 10

Alternate Care Site
Job Action Sheets

ALLIED HEALTH UNIT LEADER*

Mission: Address issues related to allied emergency response, manage the allied health care area, and coordinate allied health response activities.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Medical Operations Chief/CNO Signature: _____
TMTS Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Medical Operations Chief/Chief Nurse. Obtain packet containing Mental Health Unit Leader Job Action Sheet.		
Read entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Appoint Allied Health team members and brief on current situation, incident objectives and strategy; outline Unit action plan and designate time for next briefing.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Meet with the Medical Operations Chief/Chief Nurse and Charge Nurse to plan, project, and coordinate allied health care needs.		
Participate in briefings and meetings, as requested.		
Communicate and coordinate with Logistics Section Chief to determine: • Available staff (dental, respiratory, medical assistant, etc.) to provide support, and medical intervention. • Location and type of resources and equipment that can be used to assist with an allied health response.		
Regularly meet with the Medical Operations Chief/Chief Nurse to discuss medical care plan of action and staffing in all allied health areas.		
Receive, coordinate, and forward requests for personnel and supplies to the Medical Operations Chief/Chief Nurse.		
Request a scribe if needed to assist with documentation.		
Receive assigned radio and establish communications with the Communications Unit Leader. Receive just-in-time training if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213) and provide a copy to the Planning Chief/MST.		

*Job function currently being determined by FEMA HHS

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Communicate and coordinate with the Medical Operations Chief/Chief Nurse on the availability of: • Allied health staff needed to deliver medical care and intervention. • Availability of equipment		
Establish regular meeting schedule with allied health staff responding to the incident and the Medical Operations Section for updates on the situation regarding TMTS operation needs.		
Maintain communication with Medical Operations Chief/Chief Nurse to monitor situation updates and maintain information resources availability.		
Ensure patient records are being prepared correctly and collected.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Advise Medical Operations Chief/Chief Nurse immediately of any operational issues you are not able to correct or resolve.		
Report equipment and supply needs to the Supply Unit Leader.		
Ensure that patient status and location information is be regularly submitted to the Patient Tracking Scribe.		
Ensure staff health and safety issues are being addressed; resolve with Medical Ops Chief/ Chief Nurse when appropriate.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue allied health care supervision, including monitoring quality of care, document completion, and safety practices.		
Continue to meet regularly with the allied health staff responding to the incident and the Medical Operations Chief/Chief Nurse to keep apprised of current conditions.		
Rotate staff on regular basis		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send a copy to the Planning Chief/MST at assigned intervals and as needed.		
Continue to provide Medical Operations Chief/Chief Nurse with regular updates.		
Provide staff with situation update information and revised patient care practice standards.		
Continue to ensure allied health needs of patients are being met.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Coordinate a plan to address the ongoing allied health needs of patients.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Medical Operations Chief/Chief Nurse and Operations Chief, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST, as appropriate.		
Submit comments to the after action report.		
Coordinate stress management and after- action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ Incident Action Plan ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

BILLETING UNIT LEADER

Mission: Ensure that the staff has sleeping/resting accommodations during the event.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: Finance Section Chief Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Finance Section Chief. Obtain packet containing Billeting Unit Leader Job Action Sheets.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Collaborate with the Staffing/Accountability Unit Leader and assess the need of staff sleeping/resting accommodations.		
Assign a scribe (if needed) to track the number of staff needing accommodations.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Receive assigned radio and establish two-way radio communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Participate in briefings and meetings as requested.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Section Chief/ MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet regularly with the Finance Section Chief to obtain situation and status reports.		
Ensure the accommodations meet the needs of the staff.		
Meet regularly with the Staffing/Accountability Unit Leader to track the staff leaving and joining the event to ensure ample accommodations are acquired.		
Maintain a message center in the labor pool area or designated area, to inform staff and volunteers of the current accommodations and any changes in accommodations as staff is rotated in and out of facility		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Continue to keep updated records on the number of staff and volunteers needing accommodations for sleeping/resting.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Upon deactivation of your position, brief the Finance Section Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Section Chief/ MST.		
Submit comments in the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
• HICS Form 213 Incident Message Form • HICS Form 214 Operational Log • Local resource phone numbers- lodging • TMTS organization chart • TMTS telephone numbers • Radio/satellite phone - phone numbers and radio assignments

CHARGE NURSE/CHIEF PARAMEDIC

Mission: Coordinate and collaborate with the medical staff to develop and maintain patient treatment area.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Medical Operations Section Chief Signature: _____
TMTS Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Medical Operations Chief/Chief Nursing Officer. Obtain packet containing Charge Nurse Job Action Sheet.		
Read this entire Job Action Sheet and review the organization chart. Put on position identification (if provided).		
Receive assigned radio (when applicable) and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Ensure accurate contact info on hand for command staff; ensure accurate contact info on hand for Medical Director and others (when applicable).		
Assign and brief Team Unit Leaders.		
Establish treatment areas and assign staff to designated treatment areas.		
Assess problems and treatment needs in each treatment area; coordinating the staffing, equipment, and supplies for each treatment area to meet needs. Coordinate with the Section Chiefs as appropriate to meet needs.		
Meet regularly with the Medical Operations Chief/Chief Nurse and Medical Director to discuss the medical care plan of action and staffing in all patient treatment areas.		
Ensure that appropriate standards of care are being used in all patient care areas (blood borne pathogens and personal protective equipment). Arrange for just-in-time training for patient care providers.		
Ensure that patient care providers understand and have access to all nursing notes and pertinent forms needed for patient care.		

Ensure that medical staff checks equipment such as:
• Zoll Monitor
  o Review check off sheet to ensure that all parts are present
  o Ensure that Zoll monitor is functioning properly
  o Ensure that battery is properly charged
  o Ensure that all staff receives just in time training for the Zoll monitor
• Glucose monitor
  o Ensure that staff receives just in time training for the Glucose monitor
  o Ensure that glucose monitor has test strips, lancets, alcohol wipes, and bandages or 2x2 gauze
• Stat Back-packs
  o Review contents of back-pack by reviewing the content list found in each bag- alert assigned team member if contents are missing
  o Review the process for keeping track of items used		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive, coordinate, and forward requests for personnel and supplies to the Medical Operations Chief/Chief Nurse or others if so directed.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Participate in briefings and meetings as requested.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Ensure patient records are being prepared correctly and collected.		
Ensure your physical readiness through proper nutrition, water intake and rest.		
Advise Medical Operations Chief/ Chief Nurse immediately of any operational issues you are unable to correct.		
Report equipment and supply needs to the Medical Operations Chief/Chief Nurse and Logistics Chief, as appropriate.		
Ensure staff health and safety issues are being addressed; resolve with Medical Operations Chief/Chief Nurse, as appropriate.		
Develop and submit an action plan to Medical Operations Chief/Chief Nurse when requested.		
Ensure the patient status and location information is being regularly submitted to the Patient Tracking Scribe or other appropriate person.		
In collaboration with the Medical Operations Chief/Chief Nurse, prioritize and collaborate patient transfers to hospitals and other facilities with the Logistics Chief and the Discharge Team Leader or other appropriate personas directed.		
Upon shift change, brief your replacement on the situation, ongoing operational issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure the quality of care is maintained during the transfer of patients to other facilities.		
Ensure return/retrieval of equipment and supplies and return all assigned equipment.		
Upon deactivation of your position, brief the Medical Operation Chief/Chief Nursing Officer on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Section Chief, as appropriate.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings as directed. Participate in other briefings and meetings as required.		

COMMUNICATIONS UNIT LEADER

Mission: Organize and coordinate internal and external communications; act as custodian of all logged and documented communications.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: Logistics Chief Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Logistics Chief. Obtain packet containing Communications Unit Leader Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Establish a Communications Center.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief Communications Unit team members on current situation; outline Unit action plan and designate time for next briefing.		
Set up and maintain communication equipment and provide ongoing support.		
Initiate the Incident Communications Log (HICS Form 205) and distribute to all TMTS positions.		
Inventory and assess all available radios and distribute the radios to pre-designated areas and personnel.		
Determine radio channels for response and make radio assignments.		
Determine need for just-in-time training for personnel unfamiliar with proper radio communications.		
Evaluate status of internal and external telephone/fax systems and report to Logistics Chief.		
Request the response of assigned ham radio personnel to the facility, if indicated.		
Assess status of all on-site communications equipment, including two-way pagers, satellite phones, public address system, data message boards, and inter and intra-net connectivity. Initiate repairs per the standard operating procedures.		
Prepare for radio checks from personnel that are assigned hand-held radios and other portable communications equipment.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Expand communication network capability and equipment as required to meet needs		
Ensure communication equipment maintains proper functioning.		
If primary communications systems fail, establish mechanism to alert Rapid Response Team, and other designated priority teams.		
Develop and submit an action plan to the Logistics Chief.		
Receive and archive all documentation related to internal and external facility communication systems.		
Advise Logistics Chief of any operational issues you are unable to correct or resolve.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor the Communications Unit staff's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Review and update HICS Form 205 as needed and distribute to all TMTS positions.		
Ensure your physical readiness by proper nutrition, water intake, and rest.		
Continue to document actions and decisions on the HICS Form 214 and give a copy to the Planning Chief/MST.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure that all radios and battery operated equipment is serviced and charged.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Logistics Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ HICS Form 205 – Incident Communications Log
- ☐ HICS Form 213 – Incident Message Form
- ☐ HICS Form 214 – Operational Log
- ☐ TMTS organizational chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone – phone numbers and radio assignments
- ☐ Local resource numbers.

COMMUNITY LIAISON/DISCHARGE TEAM LEADER

Mission: Document the time, transportation, and the facility the patient is discharged to from the treatment area. Track the destination of all patients departing the facility. Function as a contact in the TMTS for representatives from other agencies and community resources to facilitate patient disposition.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: Charge Nurse Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Charge Nurse. Obtain packet containing Community Liaison/Discharge Unit Leader Job Action Sheet.		
Read this entire Job Action Sheet and review organizational chart. Put on position identification (if provided).		
Receive assigned radio and establish communications with the Communication Unit Leader. Receive just-in-time training for the radio if needed.		
Ensure that proper equipment, staffing, and resources are in the discharge areas.		
Brief team members on current situation and incident objectives.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Establish contact with local, county and/or state emergency organization agencies to ascertain current status, appropriate contacts and message routing.		
Obtain initial status and information from the Planning Section Chief/MST. Establish discharge information for patient transfer, which should include the following: • Current census of the “red”, “yellow”, and “green” patients waiting for transfer. • Mode of transportation required for patients transferring to other facilities. • Any current or anticipated shortage of critical resources including personnel, equipment, supplies, medications, etc., if transfer of patients is not expedited in a timely manner.		
Establish communication with hospitals, local EOC, and/or local response agencies (e.g., public health). Report current TMTS status.		
Establish contact with liaison counterparts of each assisting and cooperating agency (e.g., local EOC, local shelters), keeping governmental Liaison Officers updated on changes in TMTS status and critical issues and resource needs.		
Ensure that a scribe has been assigned to the discharge area to update and maintain all documentation, including patient tracking.		
Assess problem and treatment needs in assigned discharge area; coordinate the team assigned to the discharge area to meet needs.		
Coordinate and forward requests for supply and equipment needs to the Logistics Chief.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Participate in briefings and meetings as requested.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Ensure patient documentation is being prepared correctly and collected.		
Continue to track and display patient location and time of discharge for all patients; regularly report status to the Charge Nurse.		
Advise Charge Nurse immediately of any operational issue you are not able to correct or resolve.		
Meet regularly with Discharge Unit for status reports and relay important information to the Chief Nurse and/or Charge Nurse.		
Continue to report equipment and supply needs to Logistics Chief.		
Ensure staff health and safety issues are being addressed; resolve with Charge Nurse when appropriate.		
Upon shift change, brief your replacement on the situation, ongoing operations, issues and other relevant incident information.		
Request information and assistance as needed through the TMTS communication network or from the local and/or regional EOC.		
Attend all command briefings, IAP meetings to gather and share incident and TMTS information. Contribute TMTS information and community response activities and provide goals to the IAP.		

Obtain TMTS HICS Form 259 from Planning Chief and report to appropriate authorities the following:
• Number of casualties received including:
  ○ Name or physical description
  ○ Sex
  ○ Age
  ○ Address
  ○ Serious of injury or condition
• Current patient census.
• Number of patients discharged home or transferred to other facilities.
• Types of injuries or illness treated.
• Number of dead.		

Respond to requests and issues from incident management team members regarding inter-organization (e.g., local hospitals, governmental agencies, response partners) disposition problems.		
Continue to reach out to community resources and facilities for placement for patients needing to be discharged.		
Continue to document all actions and observations on the HICS Form 214 on a continual basis.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Communicate with Logistic Chief on status of supplies, equipment and other resources that could be mobilized to other facilities, if needed or requested.		
Consider need to deploy/maintain a Liaison Officer to local EOC; make recommendation to the Operations Chief.		
Prepare and maintain records and reports as appropriate.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Upon shift change, brief your replacement on the status of all ingoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Compile and finalize the Disaster/Victim Patient Tracking Form (HICS Form 254) and submit copies to the copies to the Planning Chief.		
Ensure return/retrieval of equipment and supplies.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief.		
Upon deactivation of your position, brief the Charge Nurse on current problems, outstanding issues, and follow-up requirements.		
Submit comments to the after action report.		
Submit an after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ HICS Form 213 – Incident Message Form
- ☐ HICS Form 214 – Operational Log
- ☐ HICS Form 254 – Disaster/Victim Patient Tracking Form
- ☐ TMTS organization chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone – phone numbers and radio assignments
- ☐ Local resources

COST ACCOUNTING UNIT LEADER

Mission: Provide cost analysis data for the declared emergency incident and maintenance of accurate records of incident cost.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: Finance Section Chief Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Finance Section Chief. Obtain packet containing the Cost Accounting Unit Leader Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Obtain briefing from Finance Chief; assist in development of section action plan.		
Establish cost reporting procedures, including proper coding.		
Implement procedures for receiving and depositing funds.		
Implement system for collecting all receipts from designated staff for reimbursement.		
Meet regularly with the Finance Chief to plan and project financial issues.		
Receive assigned radio and establish two-way communications with the communications Unit Leader. Receive just-in-time training for the radio if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet routinely with the Finance Section Chief for status reports.		
Maintain cost tracking analysis.		
Collect copies, summaries, or original documentation of cost.		
Inform all Section Chiefs of pertinent cost data at the direction of the Finance Section Chief.		
Prepare cost-to-date summary report for submission to the Finance Section Chief at designated set schedule.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Develop and submit an action plan to the Finance Section Chief when requested.		
Advise the Finance Section Chief immediately of any operational issue you are not able to correct or resolve.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to prepare summaries of all costs incurred during the incident per schedule designated by the Finance Chief.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Continue to document actions and decisions on the HICS Form 214.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Compile final cost accounting report(s) to Finance Chief.		
Complete all cost records and prepare a report/summary of incident costs.		
Ensure return/retrieval of equipment and supplies.		
Upon deactivation of your position, brief the Finance Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Finance Section Chief.		
Submit comments in the after action report.		
Participate in stress management and after–action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS Finance Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radios assignments ☐ Local resources.

DOCUMENTATION UNIT LEADER

Mission: Collect, process, and organize ongoing situation information; prepare situation summaries; and develop projections and forecasts of future events related to the incident. Prepare maps and gather and disseminate information and intelligence for use in the Incident Action Plan (IAP). Ensure vital business/medical records are maintained and preserves. Compile scenario and resource projections from all section chiefs and effect long-range planning. Document and distribute the IAP.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: Planning Section Chief Signature: _____

TMTS Command Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from Planning Section Chief. Obtain packet containing Documentation Unit Leader Job Action sheet.		
Read entire Job Action Sheet and review the organizational chart. Put on position identification (if provide).		
Obtain status report on Information Technology/Information systems.		
Receive, coordinate, and forward requests for personnel to be assigned as Scribes and assign Scribes to designated Section Chiefs.		
Appoint Unit Leaders as appropriate and complete the Branch Assignment List HICS Form (HICS Form 204); distribute corresponding Job Action Sheet. • NIMS/HICS Forms Unit Leader • Staffing/Accountability Unit Leader		
Establish a Planning information area with a status/condition board and post information as it is received. Assign a scribe to keep the board updated with current information.		
Prepare a system to receive documentation and completed forms from all Sections over the course of the TMTS activation.		
Prepare incident documentation for the Planning Section Chief when requested.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		
Receive and record status reports as they are received.		
Assign a scribe to monitor, document and organize all communications sent and received to Documentation Unit.		
Assure the status updates and information provided to Section Chiefs is accurate, complete, and current.		
Participate in briefings and meetings and contribute to the Incident Action Plan, as requested.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet regularly with the Section Chiefs and Unit Leaders to obtain situation and status reports, steps taken to resolve critical issues, and projected actions and needs for the next operational period.		
Ensure that an adequate number of scribes are assigned.		
Continue to accept and organize all documentation and forms submitted to the Documentation Unit.		
Check the accuracy and completeness of records submitted. Correct errors or omissions by contacting appropriate TMTS Section staff.		
Maintain all historical information and record consolidated plans.		
Ensure the security and prevent the loss of written and electronic documentation. Collaborate with Security Officer and IT Unit Leader as appropriate.		
Ensure development of a demobilization plan in collaboration with the Sections Chiefs.		
Continue to develop the IAP at designated intervals as appropriate.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to meet regularly with the Planning Section Chief for status reports.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to appropriate Responder Health & Well Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Continue to revise and implement demobilization plan for all Sections.		
Compile incident summary data and reports, organize all documentation and submit to Planning Chief.		
As needs for the Documentation Unit staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Ensure return/retrieval of equipment and supplies.		
Upon deactivation of your position, advise Operations Section Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Planning Section Chief.		

Demobilization/System Recovery	**Time**	**Initial**
Submit comments to the Planning Section Chief for discussion and possible inclusion in the after-action report; topics include: • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes • Section accomplishments and issues		
Participate in stress management and after-action debriefing. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ Incident Action Plan
- ☐ HICS Form 201 Incident Briefing Form
- ☐ HICS Form 202 Incident Objectives
- ☐ HICS Form 203 Organizational Assignments
- ☐ HICS Form 204 Branch Assignments
- ☐ HICS Form 206 Staff Medical Plan
- ☐ HICS Form 207 Incident Management Team Chart
- ☐ HICS Form 213 Incident Message Form
- ☐ HICS Form 214 Operational Log
- ☐ HICS Form 251 Facility System Status Report
- ☐ HICS Form 253 Volunteer Staff Registration
- ☐ HICS Form 254 Disaster Victim Patient Track Form
- ☐ HICS Form 255 Master Patient Evacuation Tracking Form
- ☐ HICS Form 256 Procurement Summary Report
- ☐ HICS Form 257 Resource Accounting Record
- ☐ HICS Form 258 Hospital Resource Directory
- ☐ HICS Form 260 Patient Evacuation Tracking Form
- ☐ HICS Form 261 Incident Action Plan Safety Analysis
- ☐ TMTS organization chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone – phone numbers and radio assignments
- ☐ Local resources

FINANCE CHIEF

Mission: Monitor the use of financial assets. Oversee the acquisition of supplies and services necessary to carry out the TMTS's medical mission. Supervise the documentation of expenditures relevant to the emergency incident.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: TMTS Administrator Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Operations Chief. Obtain packet containing Finance Section Job Action Sheets.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Determine need for and appropriately appoint Finance Unit Leaders, distribute corresponding Job Action Sheets and position identification.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief Finance Unit Leaders on current situation, incident objectives, and strategy; outline Section action plan; and designate time for next briefing.		
Participate in Incident Action Plan (IAP) as needed and, • Provide cost implications of incident objectives • Ensure that the IAP is within financial limits established by the Operations Chief. • Determine if any special contractual arrangements/agreements are needed.		
Obtain information and updates regularly from the Finance Section Unit Leaders; maintain knowledge of current status of all Units; inform Operations Chief of status information.		
Ensure Finance Section personnel comply with safety policies and procedures.		
Receive assigned radio and establish two-way communication with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213) and provide a copy to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Approve a" cost-to-date" incident financial status report summarizing financial data relative to personnel, supplies, and miscellaneous expenses.		
Initiate the Resource Accounting Record (HICS Form 257) to track equipment used during the response.		
Obtain briefings and updates from the Operations Chief as appropriate. Relate pertinent financial status reports appropriate Section Chief's and Unit Leaders.		
Approve a "cost-to-date" incident financial status report submitted by the Cost Unit Leader at a designated scheduled time summarizing financial data relative to personnel, supplies, and other expenditures and expenses.		
Schedule planning meetings to include the Operations Chief to discuss updating the section's incident action plan and termination procedure.		
Ensure that the Finance Section is adequately staffed and supplied.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to maintain the Resource Accounting Record (HICS Form 257) to track equipment used during the response.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Conduct regular situation update briefings with Finance Section.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		
Schedule planning meetings with Finance Section staff to update the Section action plan and demobilization procedures.		
Ensure that required financial and administrative documentation is properly prepared. Collate and process invoices received.		
Present financial updates to the Operations Chief and Planning Chief/MST at designated time schedule.		
Continue to document on an HICS Form 214.		
Coordinate emergency procurement requests with Logistics Chief.		
Follow local, state, and federal guidelines regarding reimbursement regulations and requirements; ensure required documentation is prepared according to guidelines.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Collect and analyze all financial related data from Finance Sections Units.		
Ensure processing and payment of invoiced costs.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Operations Section Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 207- Incident Management Team Chart ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ HICS Form 257 – Resource Accounting Record ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

FOOD AND NUTRITION UNIT LEADER

Mission: Organize food and water stores for staff and patients. Manage preparation of food. Coordinate rationing during periods of anticipated or actual shortage.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: Logistics Chief Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from Logistics Chief. Obtain packet containing Food/Nutrition Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Appoint team members to assigned positions and brief members on current situation; outline Unit action plan and designate time for next briefing.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Estimate the number of meals that can be served using existing food stores; implement rationing if situation dictates.		
If possible identify an outside catering source and order food to meet the needs of the TMTS.		
Inventory the current emergency drinking water supply and estimate time when resupply will be necessary. Implement rationing if situation dictates.		
Ensure that hand washing stations are located near the food service areas.		
Report inventory levels of emergency drinking water and food stores to Logistic Chief.		
Receive assigned radio and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet with Staffing/Accountability Unit Leader to discuss location of personnel refreshment and nutritional break areas.		
Secure nutritional and water inventories with the assistance of the Security/Safety Unit Leader.		
Communicate facility status with food and water vendors as appropriate, to alert them to a possible need for supplies.		
Prepare to receive donated food items from vendors, restaurants, and others.		
Secure nutritional and water inventories with the assistance of the Security Unit Leader.		
Submit an anticipated need list of water and food to the Logistics Chief. Request should be based on current information concerning emergency events as well as projected needs for patient, staff, and dependents.		
Advise the Logistics Chief immediately of any operational issues you are not able to correct or resolve.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Meet with the Logistics Chief regularly to keep informed of current status.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Continue to coordinate external food service support and supplies and communicate with external vendors and suppliers, as necessary.		
Maintain normal food service if possible for staff and implement rationing if indicated.		
Continue to project food and water needs and coordinate requests and procurement with Logistics Chief.		
Continue to provide regular situation updates to the Logistics Chief.		
Continue to document actions and decisions on the HICS Form 214 and send copies to Planning Chief as designated.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Reorder food and supplies to restore normal inventory.		
Ensure return/retrieval of equipment and supplies and return all assigned equipment.		
Debrief team members on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Incident Commander or Operations Section Chief, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources.

INFECTION CONTROL UNIT LEADER

Mission: Advise the Safety Officer on issues related to biological/infectious disease emergency response.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: Safety Officer Signature: _____

TMTS Command Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Safety Officer. Obtain packet containing Infection Control Unit Leader Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Brief Unit members on current situation, incident objectives and strategy; outline Unit action plan; and designate time for next briefing.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Ensure Unit members comply with safety policies and procedures.		
Report the following information to the Safety Officer, Operations Chief, and the Medical Director: • Number and condition of patients affected, including the non-symptomatic. • Type of biological/infectious disease involved. • Medical problems present in addition to biological/infectious disease involved. • Measures taken (e.g., cultures, supportive treatment) • Potential for industrial, chemical, or radiological material exposure expected in addition to biological/infectious disease exposure and scope of practice.		
Collaborate with the Public Health Department in developing a case definition. Ensure that the case definition is communicated to the Medical Operations Chief/Chief Nurse, Safety Officer, Operations Chief, and Medical Director and all patient care areas.		
Communicate with Operations Section Chief and Safety Officer regarding disease information and staff protection.		
Ensure that appropriate standard of isolation precautions are being used in all patient care areas. Arrange for just-in-time training regarding isolation precautions as required.		
Meet regularly with Safety Officer, Operations Chief, and Medical Operations Chief/Chief Nurse to plan and project patient care needs.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Participate in briefings and meetings and contribute to the Incident Action Plan, as requested.		
Recommend input for PIO press releases as requested.		
Contact the Public Health Department, in collaboration with the Operations Section Chief, as required, for notification, support, and investigation resources.		
Assist the Medical Operations Section in organizing Mass Dispensing or Point of Dispensing for antibiotic prophylaxis or mass vaccination, as indicated and if recommended by the Public Health Department.		
Receive assigned radio and establish two-way communication with the Communications Unit Leader. Receive just-in-time training if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Establish regular schedule with the Operations Chief and Safety Officer for updates on the situation regarding TMTS operation's needs.		
Notify Logistics Chief of special medications needs.		
Maintain communications with the Medical Operations Section and other Sections Chiefs to co-monitor development of the incident and maintain information resources availability.		
Direct collection of samples for analysis or evidence.		
Monitor and ensure all samples are correctly packaged for shipment to the most appropriate testing location/laboratory.		
Continue to recommend and maintain appropriate isolation precautions and staff protection as the incident evolves.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Meet regularly with Operations Chief and Safety Officer to update current status and conditions.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Safety Officer on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ Incident Action Plan ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local public health department reporting forms.

INFORMATION TECHNOLOGY UNIT LEADER

Mission: Provide computer hardware, software and infrastructure support to staff.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: Logistics Chief Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from Logistics Section Chief. Obtain packet containing the Information Technology Units Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Appoint Unit members, as appropriate; distribute any appropriate forms or information to the Unit.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief Unit members on current situation, incident objectives and strategy; outline Unit action plan; and designate time for next briefing.		
Evaluate business capabilities, systems still on-line, recovery plan actions, and projected minimum duration of disruption.		
Confirm off-site data backup are secure and available for system restoration.		
Participate in briefings and meetings as requested.		
Receive assigned radio and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Continue coordinating the Unit's ability to maintain or recover impacted IT business.		
Continue to evaluate IT system performance; troubleshoot issues as indicated.		
Identify specific activities or resources needed to ensure timely resumption of IT business functions.		
Coordinate with Logistics Chief for access to critical power needs or building assessments.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Develop and submit an action plan to the Planning Chief when requested.		
Advise the Logistics Chief immediately of any operational issues are not able to correct or resolve.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Brief the Logistics Chief regularly on current condition of all operations.		
Continue to document actions and decisions on HICS Form 214		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Reorder supplies and equipment to restore normal inventory.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Upon deactivation of your position, brief the Logistics Chief, as appropriate, on current problems, outstanding issues, and follow- up requirements.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

LIAISON OFFICER

Mission: Function as the incident contact person in the Temporary Medical Treatment Station for representatives from other agencies.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: TMTS Administrator Signature: _____

TMTS Command Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive appointment and briefing from the TMTS Administrator		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Appoint Liaison team members and complete the Branch Assignment List (HICS Form 204).		
Brief Liaison team members on current situation and incident objectives; develop response strategy and tactics; outline action plan and designate time for next briefing.		
Establish contact with the Communications Unit Leader, and confirm your contact information.		
Establish contact with local, county and/or state emergency organization agencies to ascertain current status, appropriate contacts and message routing.		
Consider need to deploy a Liaison Officer to local EOC; make recommendation to the TMTS Administrator		
Communicate information obtained and coordinate with Public Information Officer (PIO).		
Obtain initial status and information from the Planning Section Chief to provide as appropriate to the inter-hospital/facility emergency communication network and local and/or county EOC, upon request: • Patient Care Capacity – The number of “immediate (red),” “delayed (yellow),” and “minor (green)” patients that can be received and treated immediately, and current census. • TMTS Overall Status – Current condition of hospital structure, security, and utilities. • Any current or anticipated shortage critical resources including personnel, equipment, supplies, medications, etc. • Number of patients and mode of transportation for patients requiring transfer to other hospitals, if applicable. • Any resources that are requested by other facilities (e.g., personnel, equipment, supplies, medications, etc.). • Media relations efforts being initiated, in conjunction with the PIO.		
Establish communication with hospitals, local Emergency Operations Center (EOC), and/or local response agencies (e.g., public health). Report current hospital/facility status.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Establish contact with liaison counterparts of each assisting and cooperating agency (e.g., local EOC, Red Cross), keeping governmental Liaison Officers updated on changes in facility status, critical issues and resource needs.		
Request one or more recorders as needed from the Labor Pool and Credentialing Unit Leader, if activated, to perform all necessary documentation.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Attend all command briefings and Incident Action Planning meetings to gather and share incident and hospital/facility information. Contribute inter-hospital information and community response activities and provide Liaison goals to the Incident Action Plan.		
Request assistance and information as needed through the inter-hospital emergency communication network or from the local and/or regional EOC.		
Consider need to deploy a Liaison Officer to the local EOC; make this recommendation to the TMTS Administrator.		
Obtain Casualty/Fatality Report (HICS Form 259) from the Public Information Officer and Planning Section Chief and report to appropriate authorities the following minimum data: • Number of casualties received and types of injuries treated. • Current patient capacity (census) • Number of patients hospitalized, discharged home, or transferred to other facilities. • Number dead. • Individual casualty data: name or physical description, sex, age, address, seriousness of injury or condition.		
Respond to requests and issues from incident management team members regarding inter-organization (e.g., other hospitals, governmental entities, response partners) problems.		
Assist the Labor Pool & Credentialing Team Leader with problems encountered in the volunteer credentialing process.		
Report any special information obtained (e.g., identification of toxic chemical, decontamination or any special emergency condition) to appropriate personnel in the receiving area of the hospital (e.g., emergency department), HCC and/or other receiving facilities.		
Continue to document all actions and observations on the Operational Log (HICS Form 214) on a continual basis.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
In coordination with the Labor Pool & Credentialing Unit Leader and the local EOC, request physicians and other medical staff willing to volunteer as Disaster Service Workers, when appropriate.		
Communicate with Logistics Section Chief on status of supplies, equipment and other resources that could be mobilized to other facilities, if needed or requested.		
Consider need to deploy/maintain a Liaison Officer to local EOC; make the recommendation to the TMTS Administrator.		
Prepare and maintain records and reports as appropriate.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Safety Officer or appropriate person.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the TMTS Administrator on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, submit Operational Logs (HICS Form 214) and all completed documentation to the Planning Section Chief.		
Participate in after-action debriefings and document observations and recommendations for improvements for possible inclusion in the After-Action Report. Topics include: • Accomplishments and issues • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ Incident Action Plan
- ☐ HICS Form 207 – Incident Management Team Chart
- ☐ HICS Form 213 – Incident Message Form
- ☐ HICS Form 214 – Operational Log
- ☐ HICS Form 259 – Hospital Casualty/Fatality Report
- ☐ TMTS emergency operations plan
- ☐ TMTS organization chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone
- ☐ Municipal organization chart and contact numbers
- ☐ County organization chart and contact numbers

LOGISTICS CHIEF

Mission: Organize and direct those operations associated with maintenance of the Temporary Medical Treatment Station environment and adequate levels of food, shelter, and supplies to support the medical objectives.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: TMTS Administrator Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the TMTS Administrator. Obtain packet containing Logistics Section's Job Action Sheets.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Determine need to appoint Unit Leaders in Logistics Section; distribute corresponding Job Action Sheet and position identification. Complete the Branch Assignment List (HICS Form 204).		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Establish Logistics Section work area.		
Brief Unit Leaders on current situation, incident objectives and strategy; outline Section action plan and designate time for next briefing.		
Participate in Incident Action Plan preparation, briefings, and meetings as needed; assist in identifying strategies; determine tactics, work assignments, and resource requirements.		
Maintain communication with Medical Operations Section Chief and other Sections Chiefs to assess critical issues and resources needs.		
Ensure resource ordering procedures are communicated to appropriate Sections and requests are timely and accurately processed.		
Ensure Logistics Unit Leaders comply with safety policies and procedures.		
Participate in briefings and meetings and contribute to the Incident Action Plan, as requested.		
Receive assigned radio and establish two-way communications with the Communications Unit Leader.		
Contact the local Public Health Department, in collaboration with the Liaison Officer, as required, for notification, support, and investigation resources.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Obtain information and updates regularly from Unit Leaders; maintain current status of all areas; pass status information to Planning Chief.		
Ensure the following are being addressed: • Communications • Information technology/information services • Provisions for food and water for staff • Responder health and well-being • Family care • Provisions of supplies • Facility maintenance • Transportation service • Documentation		
Initiate the Resource Accounting Record (HICS Form 257) to track equipment used during the response.		
Obtain needed material and fulfill resource requests with assistance of the Finance Section Chief.		
Ensure that the Logistics Section is adequately staffed and supplied.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to conduct regular situation briefings with Logistics Section.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Continue to document actions and decisions on an HICS Forms 214 and 213.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		
Continue to track equipment used during the response on the HICS Form 257.		
Continue to update the Sections action plan and implement demobilization procedures, in coordination with the Planning Chief.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Responder Health & Well-Being Unit Leader. Provide for staff rest periods and relief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Coordinate return of all assigned equipment to appropriate locations and restock TMTS supplies.		
Coordinate replacement of broken or misplaced items.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Operations Section Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Operations Section Chief		
Work with Planning Chief and Finance Sections to complete cost data information.		
Debrief Section staff on lessons learned and procedural/equipment changes needed.		
Submit comments to the after action report.		
Participate in stress management and the after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ Incident Action Plan
- ☐ HICS Form 207 – Incident Management Team Chart
- ☐ HICS Form 213 – Incident Message Form
- ☐ HICS Form 214 – Operational Log
- ☐ TMTS organization chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone – phone numbers and radio assignments
- ☐ Local resources

MEDICAL/NURSING STAFF

Mission: Deliver appropriate health/medical services within the TMTS under the direction of the TMTS Medical Director and Medical Operations Chief.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Assigned Team Leader Signature: _____
TMTS Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive appointment and briefing from the Team Leader.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Obtain briefing from Team Leader.		
Participate in briefings and meetings as requested.		
Deliver care and assistance to patients as required following approved protocols, procedures and recommendations		
Document all patient care, actions, and decisions in a Patient Treatment Note.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Assess the physical condition of patients on an on-going basis		
Maintain patient's medical records and advise the Team Leader of any adverse change in the conditions of the patient.		
Refer patients who need immediate medical attention to the Team Leader		
Determine which treatment area patients should be placed in the TMTS		
Maintain standard precautions and infection control		
Meet regularly with the Team Leader, as appropriate, to brief on medical staff status and projected needs.		
Maintain regular communications with the Team Leader to co-monitor the delivery and quality of medical care in all patient areas.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Participate in briefings at the beginning and end of each shift		
Continue to assess and treat patients according to appropriate standards of care.		
Continue to ensure medical staff related response issues are identified and effectively managed. Report critical issues to the Team Leader, as appropriate.		
Continue to meet regularly with the Team Leader or Charge Nurse, as assigned, to update current conditions and status.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Responder Health & Well-Being Unit Leader.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident and patient information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure return/retrieval of equipment and supplies.		
Upon deactivation of your position, brief the Medical Operations Chief/Chief Nurse on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ Incident Action Plan ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ Triage and Treatment Forms ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radios assignments ☐ Local resources.

MEDICAL OPERATIONS CHIEF/CHIEF NURSING OFFICER

Mission: Organize and direct the overall delivery of medical care in all areas of the TMTS.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: TMTS Administrator Signature: _____
TMTS Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Operations Chief. Obtain packet containing Medical Operations Chief Job Action Sheet.		
Reed this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided)		
Meet with Operations Chief and Section Chiefs for briefing and development of an initial action plan. Establish time for follow up meetings.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Appoint the unit leaders and provide appropriate corresponding Job Action Sheets.		
Assist in establishing a Medical Operations Section. Complete the HICS Form 204 for assignments.		
Evaluate Medical Operations Section to perform: • Patient care • Palliative Care • Causality Care • Clinical Support Services (lab, diagnostic radiology, pharmacy) • Patient tracking including registration and discharge		
Meet with Medical Ops Section Unit staff to discuss medical needs, staffing, and supply needs in all patient care areas.		
Assess problems and needs in Medical Operations Section; coordinate resource management.		
Ensure Medical Operations Sections staff complies with safety policies and procedures.		
Participate in briefings and meetings and contribute to the Incident Action Plan, as requested.		
Recommend input for PIO press releases as requested.		
Instruct all Unit Leaders to evaluate on-hand equipment, supply, and medication inventories and staff needs in collaboration with Logistics Chief: report status to Operations Section Chief.		
Ensure all Unit Leaders are providing just-in-time training as needed.		
Determine need for surge capacity plan implementation and/or modification of existing plan.		
Coordinate with Unit Leaders to prioritize patient transfer needs.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Determine if communicable disease exists; implement appropriate response procedure(s). Coordinate with appropriate Unit Leaders, if activated.		
Regularly meet with the Operations Section Chief to discuss plan of action staffing in all service areas.		
Receive assigned radio and establish two-way communications with the Communication Unit.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Continue to meet regularly with Operations Chief and Medical Director for status reports, and relay important information to the Medical Operations Section staff.		
Continue coordinating patient care, disposition of patients, and clinical services support.		
Ensure patient tracking and transfer is being properly coordinated by Unit Leaders.		
Meet regularly with Medical Ops Section Unit staff to assess current and project future patient care conditions.		
Be sure patients records are being done correctly and collected.		
Ensure patient care needs are being met and policy decisions to institute austere care (altered level of care) practices are determined and communicated effectively.		
Advise Operations Chief and/or Medical Director immediately of any operational issue you are not able to correct or solve. Assess environmental service needs in all patient treatment areas and inform Unit Leader with identified needs.		
Review personal protection practices; revise as needed.		
Ensure patient safety issues are identified and addressed.		
Report equipment and supply needs to Logistics Chief.		
Continue to provide updated clinical information and situation reports to Unit Leaders and staff.		
Ensure patient data is collected and shared with appropriate internal and external officials.		
Ensure staff health and safety issues are being addressed; resolve with the Safety Officer.		
Develop and submit action plan to the Operations Section Chief when requested.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor Medical Operation Section's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to ensure patient transfer coordination and tracking; mitigate identified issues.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		
Ensure that staff is rotated on a regular basis.		
Continue to document actions and decisions on HICS Form 214 and submit to the Planning Chief at assigned intervals as indicated.		
Continue to provide the Operational Chief and Medical Director with regular situation updates.		
Provide Unit Leaders with situation update information.		

Demobilization/System Recovery	**Time**	**Initial**
Debrief staff on lessons learned and procedural/equipment changes needed.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Incident Commander or Operations Section Chief, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ Incident Action Plan
- ☐ HICS Form 206 Staff Medical Plan
- ☐ HICS Form 207 Incident Management Team Chart
- ☐ HICS Form 213 Incident Message Form
- ☐ HICS Form 214 Operational Log
- ☐ TMTS organizational chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone – phone numbers and radio assignments
- ☐ Local public health department reporting forms
- ☐ Local resources

MENTAL HEALTH UNIT LEADER

Mission: Address issues related to mental emergency response, manage the mental health care area, and coordinate mental health response activities.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: Medical Operations Chief/CNO Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Medical Operations Chief/Chief Nurse. Obtain packet containing Mental Health Unit Leader Job Action Sheet.		
Read entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Appoint Mental Health team members and brief on current situation, incident objectives and strategy; outline Unit action plan and designate time for next briefing.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Meet with the Medical Operations Chief/Chief Nurse and Safety Officer to plan, project, and coordinate mental health care needs of patients, their family, and staff. The plan should include addressing the mental health needs of people who arrive at the TMTS with concerns that they are or may be victims of the disaster.		
Participate in briefings and meetings, as requested.		
Communicate with the Medical Operations Chief/Chief Nurse and obtain information, such as: • Type and location of incident. • Number and condition of expected patients. • Estimated arrival time to facility. • Unusual or hazardous environmental exposure. • Location(s) of surge of people (who may or may not be victims of the disaster) who have arrived at the facility or who are calling to ask for assistance (e.g., facility phones, triage area, patient care areas, discharge area, isolation area, palliative care area, etc.). • Any special circumstances that must be addressed due to the nature of the incident, such as special languages, cultural needs, or security concerns.		
Provide mental health guidance and recommendations to Medical Operations Chief/Chief Nurse based on response needs and potential triggers of psychological effects (trauma exposure, perceived risk to staff and family, restrictions on movement, resource limitations, and information unavailability).		
Communicate and coordinate with Logistics Section Chief to determine:		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
• Available staff (mental health, nursing, chaplains, experienced volunteers, etc.) that can be deployed to key areas of the facility to provide psychological support, and intervention. • Location and type of resources that can be used to assist with a mental health response, such as toys and coloring supplies for children, mental health disaster recovery brochures, fact sheets on specific hazards (e.g. information on chemical agents that include symptoms of exposure), private area in the facility where family members can wait for news regarding their loved ones, etc. • Availability of psychotropic medications		
Communicate with Medical Ops Chief/ Chief Nurse and the Planning Chief to determine: • Bed availability in inpatient psychiatry units, if applicable. • Additional short and long range mental health response needs. • Need to provide mental health care guidance to medical community.		
Establish an overall mental health treatment plan for the disaster including priorities for mental health response for patients, families, and staff; staffing recommendations; recommended mental health activities/interventions; resources available and needed; and problems to be addressed in the next operational period.		
Regularly meet with the Medical Operations Chief/Chief Nurse to discuss medical care plan of action and staffing in all mental health areas.		
Receive, coordinate, and forward requests for personnel and supplies to the Medical Operations Chief/Chief Nurse.		
Request a scribe if needed to assist with documentation.		
Receive assigned radio and establish communications with the Communications Unit Leader. Receive just-in-time training if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213) and provide a copy to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Communicate and coordinate with the Medical Operations Chief/Chief Nurse on the availability of: • Mental health staff needed to deliver psychological support and intervention. • Availability of psychotropic medications		
Coordinate with Logistics and Medical Operations/Chief Nurse to expand/create a recognized provisional Mental Health Patient Care area, if necessary.		
Ensure that appropriate mental health standards of care are being followed and mental health needs are being met.		
Establish regular meeting schedule with mental health staff responding to the incident and the Medical Operations Section for updates on the situation regarding hospital/facility operation needs.		
Maintain communication with Medical Operations Chief/Chief Nurse to monitor situation		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
updates and maintain information resources availability.		
Communicate with local governmental mental health department to ascertain community mental status and assess available resources.		
Participate in development of risk communication and public information that addresses mental health concerns.		
Ensure patient records are being prepared correctly and collected.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Advise Medical Operations Chief/Chief Nurse immediately of any operational issues you are not able to correct or resolve.		
Report equipment and supply needs to the Supply Unit Leader.		
Ensure that patient status and location information is be regularly submitted to the Patient Tracking Scribe.		
Ensure staff health and safety issues are being addressed; resolve with Medical Ops Chief/ Chief Nurse when appropriate.		
In collaboration with the Medical Operations Chief/Chief Nurse, prioritize and coordinate patient transfers to other hospitals with mental health facilities		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue mental health care supervision, including monitoring quality of care, document completion, and safety practices.		
Continue to meet regularly with the mental health staff responding to the incident and the Medical Operations Chief/Chief Nurse to keep apprised of current conditions.		
Continue to ensure the provisions of resources for mental health and recovery, and education to children and families.		
Rotate staff on regular basis		
Continue to document actions and decisions on an Operational Log (HICS Form 214) and send a copy to the Planning Chief/MST at assigned intervals and as needed.		
Continue to provide Medical Operations Chief/Chief Nurse with regular updates.		
Provide staff with situation update information and revised patient care practice standards.		
Continue to ensure mental health needs of patient and family are being met.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Coordinate a plan to address the ongoing mental health needs of Patients, families, and staff.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Medical Operations Chief/Chief Nurse and Operations Chief, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST, as appropriate.		
Submit comments to the after action report.		
Coordinate stress management and after- action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ Incident Action Plan ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

PALLIATIVE CARE UNIT LEADER

Mission: Provide comfort measures for patients deemed terminally ill.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Medical Operations Chief/CNO Signature: _____
TMTS Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from Medical Operations Chief/Chief Nurse. Obtain packet containing Palliative Care Unit Leader Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Establish a palliative are area; coordinate with the Charge Nurse and Medical Operations Chief/Chief Nurse.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief team members on current situation, incident objectives and strategy; outline team action plan and designate time for next briefing.		
Assess problems and treatment needs in patient care area; coordinate staffing and supplies needed in area.		
Receive assigned radio and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Establish respite area for family members.		
Establish communications with the Security Officer, in the event they are needed.		
Provide just-in-time training for staff, volunteers, and family for proper PPE and hand washing in the palliative care area.		
Obtain assistance from the Transportation Unit for transporting deceased patients.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet regularly with Medical Operations Chief/Chief Nurse for status reports, and relay important information.		
Continue coordinating needed facility support services.		
Ensure patient records and documentation are prepared correctly and collected.		
Ensure patient care is being prioritized effectively when altered care (austere) standards of practice are implemented.		
Ensure all deceased patients moved from palliative care area are covered, tagged, and		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
identified where possible. Photo identification may be necessary.		
Ensure that the palliative care area has proper support and the following are addressed: • Family Support Center • Safe and respectful storage (of casualties) • Security • Proper handling of personal effects • Documentation		
Ensure you physical readiness through proper nutrition, water intake, and rest.		
Advise Medical Operations Chief/Chief Nurse immediately of any operational issue you are not able to correct or resolve.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue emergency care supervision, including monitoring quality of care, document completion, and safety practices.		
Continue to document actions and decisions on HICS Form 214 and send copy to Planning Chief at assigned intervals and as needed.		
Continue to provide the Medical Operations Chief with situation update information.		
Continue to provide Unit staff with situation update information.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Submit comments to the after action report.		
Upon deactivation of your position, brief the Medical Operations Chief/Chief Nurse on current problems, outstanding issues, and follow-up requirements.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 207 – Incident Management Team Chart ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resource numbers

PATIENT TRACKING MANAGER

Mission: Monitor and document the location of patients at all times within the hospital's patient care system, and track the destination of all patients departing the facility.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: Planning Chief Signature: _____

TMTS Command Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Planning Section Chief/MST. Obtain packet containing Patient Tracking Unit Leader Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Appoint and brief Patient Tracking team members on current situation; outline team action plan and designate time for next briefing (HICS Form 204).		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Implement a system, using the Disaster/Victim Tracking Form (HICS Form 254) to track and display patient arrivals, discharges, transfers, locations and dispositions.		
Obtain current in-patient census from Admitting personnel and/or other sources.		
Initiate the Hospital Casualty/Fatality Report (HICS Form 259), in conjunction with the Medical Operations Section Chief/Chief Nurse.		
Determine patient/victim tracking mechanism utilized by field providers and establish method to ensure integrated and continuity with TMTS patient tracking system.		
If evacuation of the facility is required or is in progress, Initiate the Master Patient Evacuation tracking Sheet (HICS Form 255).		
Receive assigned radio and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet regularly with Public Information Officer, Liaison Officer and Patient Registration Unit Leader to update and exchange patient tracking information (within HIPAA and local guidelines) and census data.		
Continue to track and display patient location and time of arrival for all patients; regularly report status to the Planning Chief/MST		
Develop and submit an action plan to the Planning Chief when requested.		
Advise the Planning Chief immediately of any operational issue you are not able to correct or resolve.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor the Patient Tracking team's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
As needs for the Patient Tracking staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Compile and finalize the Disaster/Victim Patient Tracking Form (HICS Form 254) and submit copies to the copies to the Planning Chief.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Upon deactivation of your position, brief the Planning Chief on current problems, outstanding issues, and follow-up requirements.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ HICS Form 207 – Incident Management Team Chart
- ☐ HICS Form 213 – Incident Message Form
- ☐ HICS Form 214 – Operational Log
- ☐ TMTS organization chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone –phone numbers and radio assignments
- ☐ Local resources

PHARMACY UNIT LEADER

Mission: Ensure the availability of emergency, incident-specific, pharmaceutical and pharmacy services.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Medical Operations Chief/CNO Signature: _____
TMTS Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive appointment and briefing from the Medical Operations Chief/Chief Nurse. Obtain packet containing Pharmacy Unit Leader Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Assign pharmacist to patient care areas, when appropriate.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Inventory most commonly used pharmaceutical items and provide for the continual update of this inventory.		
Ensure that pharmaceutical area is secure by coordinating with the Security Unit Leader.		
Receive assigned radio and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet regularly with Medical Operations Chief/Chief Nurse and Charge Nurse to obtain situation and status reports, and relay important information to team members.		
Communicate with the Logistics Section Unit Leaders to ensure a efficient method of requisitioning and delivery of pharmaceutical inventories within the TMTS. Collaborate with the Medical Ops Chief/Chief Nurse and Charge Nurse to follow-up on trends in the TMTS for resupply pharmaceutical needs.		
Ensure proper documentation for medications checked out of pharmacy is established and maintained.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Provide for routine meetings with the Medical Operations Chief/Chief Nurse.		
Review and approve the scribe's recordings of actions/decisions in the pharmacy service area. Send a copy to the Planning Chief/MST.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Medical Operations Chief/Chief Nurse on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 207 – Incident Management Team Chart ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

PLANNING SECTION CHIEF

Mission: Oversee all incident-related data gathering and analysis regarding incident operations and assigned resources, develop alternatives for tactical operations, conduct planning meetings, and prepare the Incident Action Plan (IAP) for each operational period.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: **Incident Commander** Signature: _____ Initial: _____
TMTS Command Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from Operation Section Chief. Obtain packet containing Planning Section Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Determine need for and appropriately appoint Unit Leaders, distribute corresponding Job Action Sheets and position identification. Complete the Branch Assignment List (HICS Form 204).		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Brief Planning Section Unit Leaders on current situation and incident objectives; develop response strategy and tactics; outline Section action plan and designate time for next meeting.		
In consultation with the Operations Chief, establish the incident objectives and operational period. Initiate the Incident Objectives Form (HICS Form 202) and distribute to all activated TMTS positions.		
Establish Communications with other Section Chiefs to ensure the accurate tracking of personnel and resources.		
Facilitate and conduct incident action planning meetings with Command staff and Section Chiefs and other key positions to plan for the next operational period. Coordinate preparation and documentation of the Incident Action Plan and distribute copies to the Incident Commander and all Section Chiefs.		
Ensure that all Section Chiefs and Unit Leaders regularly update and document status reports.		
Ensure Planning Section personnel comply with safety policies and procedures.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213).		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet regularly with the Operations Chief to brief on the status of the Planning Section and the IAP.		
Initiate the Resource Accounting Record (HICS Form 257) to track equipment used during the response.		
Attend command meetings and briefings.		
Continue to conduct regular planning meetings with Planning Section Unit Leaders, Section Chiefs, Command Staff, and the Incident Commander for continued update and development of the IAP.		
Ensure that the Planning Section is adequately staffed and supplied.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor Planning Section personnel's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Conduct regular situation briefings with Planning Section.		
Continue to receive projected activity reports from Section Chiefs and Planning Section Unit Leaders at designated intervals to prepare TMTS status reports and update the IAP.		
Collaborate with the Section Chiefs and Unit Leaders to develop and implement a demobilization plan.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Continue to meet with Command Staff, Section Chiefs and Planning Section Unit Leaders to evaluate facility and personnel, review the demobilization plan and update the IAP.		
Ensure collection of all TMTS documentation and Operational logs from Command and Sections as positions are deactivated and sections demobilize.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Coordinate final reporting of patient information with external agencies through Liaison/Discharge Unit Leader and Public Information Officer. Work with Finance Section Chiefs to complete cost data information.		
Begin development of the Incident After-Action Report and Improvement Plan and assign staff to complete portions/sections of the report		

Demobilization/System Recovery	**Time**	**Initial**
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted.		
Upon deactivation, brief the Operation Chief on current problems, outstanding issues, and follow-up requirements		
Submit comments to the Operations Chief for discussion and possible inclusion in an after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ Incident Action Plan
- ☐ HICS Form 201 Incident Briefing Form
- ☐ HICS Form 202 Incident Objectives
- ☐ HICS Form 203 Organizational Assignments
- ☐ HICS Form 204 Branch Assignments
- ☐ HICS Form 206 Staff Medical Plan
- ☐ HICS Form 207 Incident Management Team Chart
- ☐ HICS Form 213 Incident Message Form
- ☐ HICS Form 214 Operational Log
- ☐ HICS Form 251 Facility System Status Report
- ☐ HICS Form 253 Volunteer Staff Registration
- ☐ HICS Form 254 Disaster Victim Patient Track Form
- ☐ HICS Form 255 Master Patient Evacuation Tracking Form
- ☐ HICS Form 256 Procurement Summary Report
- ☐ HICS Form 257 Resource Accounting Record
- ☐ HICS Form 258 Hospital Resource Directory
- ☐ HICS Form 260 Patient Evacuation Tracking Form
- ☐ HICS Form 261 Incident Action Plan Safety Analysis
- ☐ TMTS organization chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone – phone numbers and radio assignments
- ☐ Local resources

TMTS PUBLIC INFORMATION OFFICER

Mission: Serve as the conduit for information to internal and external stakeholders, including staff, visitors and families, and the news media, as approved by the TMTS Administrator.

Date: _____ Start: _____ End: _____ Position Assigned to: _____Initials:_____

Position Reports to: TMTS Administrator Signature: _____

TMTS Command Center Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive appointment and briefing from the TMTS Administrator.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Establish a designated media staging and media briefing area located away from the TMTS and patient care activity areas. Inform on-site media of the physical areas to which they have access and those which are restricted. Coordinate designation of such areas with the Safety Officer and the Security Branch Director.		
Contact external Public Information Officers from community and governmental agencies to ascertain and coordinate public information and media messages being developed by those entities to ensure consistent and collaborative messages from all entities.		
Consider need to deploy PIO to local Joint Information Center (JIC), if activated.		
Develop public information and media messages to be reviewed and approved by the TMTS Administrator before release to the news media and the public. Identify appropriate spokespersons to deliver the press briefings and public information announcements.		
Attend all command briefings and incident action planning meetings to gather and share incident and TMTS information.		
Conduct or assign personnel to monitor and report to you incident and response information from sources such as the internet, radio, television and newspapers.		
Request one or more recorders and other support staff as needed from the Labor Pool & Credentialing Unit Leader, if activated, to perform all necessary activities and documentation.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Continue to attend all Command briefings and incident action planning meetings to gather and share incident and hospital information. Contribute media and public information activities and goals to the Incident Action Plan.		
Continue contact and dialogue with external Public Information Officers, in collaboration with the Liaison Officer, from community and governmental agencies to ascertain public information and media messages being developed by those entities to ensure consistent and collaborative messages from the hospital/facility. Coordinate translation of critical communications into multiple languages.		
Determine whether a local, regional or State Joint Information Center (JIC) is activated, provide support as needed, and coordinate information dissemination.		
Continue to develop and revise public information and media messages to be reviewed and approved by the TMTS Administrator before release to the news media and the public.		
Ensure that media briefings are done in collaboration with JIC, when appropriate.		
Develop regular information and status update messages to keep staff informed of the incident and community and TMTS status .		
Utilize communications systems (e.g., email, intranet, internal TV, written report postings, etc.) to disseminate current information and status update messages to staff.		
Review the need for updates of critical information through in way finding and signage for staff, visitors and media. Assist in the development and dissemination of signage.		
Coordinate with the Patient Tracking Manager regarding: • Receiving and screening inquiries regarding the status of individual patients. • Release of appropriate information to appropriate requesting entities.		
Continue to document all actions and observations on the Operational Log (HICS Form 214) on a continual basis.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to receive regular progress reports from the TMTS Administrator, Section Chiefs and others, as appropriate.		
Coordinate with the Logistics Section Chief to determine requests for assistance to be released to the public via the media.		
With approval from TMTS Administrator and in collaboration with community and governmental PIOs, conduct ongoing news conferences, providing updates on casualty information and TMTS operational status to the news media. Facilitate staff and patient interviews as appropriate.		
Ensure ongoing information coordination with other agencies, hospitals, local EOC and the JIC.		
Prepare and maintain records and reports as indicated or requested.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Safety Officer or appropriate person.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Coordinate release of final media briefings and reports.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the TMTS Administrator on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, submit Operational Logs (HICS Form 214) and all completed documentation to the Planning Section Chief.		
Participate in after-action debriefings and document observations and recommendations for improvements for possible inclusion in the After-Action Report. Topics include: • Accomplishments and issues • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ Incident Action Plan
- ☐ HICS Form 207 – Incident Management Team Chart
- ☐ HICS Form 213 – Incident Message Form
- ☐ HICS Form 214 – Operational Log
- ☐ TMTS emergency operations plan
- ☐ Crisis and emergency risk communication plan (Facility, and if available, community plan)
- ☐ TMTS organization chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone
- ☐ Community and governmental PIO and Joint Information Center contact information
- ☐ Local media contact information

RAPID RESPONSE MEDICAL TEAM LEADER

Mission: Assigned team to respond to a code or critical medical situation with the TMTS or designated areas.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Charge Nurse Signature: _____
TMTS Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Charge Nurse. Obtain packet containing the Rapid Response Medical Team Leader Job Action Sheet.		
Read entire Job Action Sheet and review the organizational chart. Put on position identification vest (if provided).		
Collaborate with Chief Nurse, Charge Nurse, and Team Leaders to confirm proper method of communication to contact the Rapid Response Team (RRT) if needed.		
Receive assigned radio and established two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Brief team members on current situation and incident objectives.		
Ensure all RRT staff are provided just-in-time training on equipment and procedures as needed.		
Ensure sufficient equipment, staffing, and resources are provided for the RRT.		
Coordinate and forward requests for supplies to the Logistic Section Chief.		
Document all key activities, actions, and decisions in and Operational Log (HICS Form 214) on a continual basis.		
Document all communications (internal and external) on and Incident Message Form (HICS Form 213) and provide a copy to the Planning Chief/MST.		
Participate in briefings and meetings as requested.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Advise the Charge Nurse of any operational issues you are not able to correct or resolve.		
Meet regularly with Medical Operations Section Unit Leaders for status reports.		
Report equipment and supply needs to the Logistic Section Chief.		
Upon shift change, brief your replacement on the situation, ongoing operations, issues and other relevant incident information.		
Ensure communications is maintained and established with all Unit Leaders and Section Chiefs.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Advise the Medical Operations Chief/Chief Nurse of any operational issues you are not able to correct or resolve.		
Meet regularly with Medical Operations Section Unit Leaders for status reports.		
Report equipment and supply needs to the Logistics Chief.		
Upon shift change, brief your replacement on the situation, ongoing operations, issues and other relevant incident information.		
Ensure communications is maintained and established with all Unit Leaders and Section Chiefs.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor Unit staff's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Continue to document actions and decisions on the HICS Form 214 at assigned intervals as needed.		
Continue to provide Medical Operations Chief/Chief Nurse with situational updates and relay any situational updates to the RRT as provided		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the Medical Operations Chief/Chief Nurse, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your positions, ensure all documentation and HICS Forms are submitted to the Planning Section Chief/MST.		
Submit comments to an after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 207 – Incident Management Team Chart ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

RESPONDER HEALTH & WELLBEING

Mission: Ensure the availability of medical and mental healthcare for injured or ill staff. Coordinate mass prophylaxis/vaccination/immunization of staff, if required. Coordinate medical surveillance program for responders.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: **Safety Officer** Signature: _____ Initial: _____
TMTS Command Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Safety Office. Obtain packet containing the Responder Health & Well-Being Unit Leader Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Assign and brief Unit team members on current situation, incident objectives and strategy; outline Unit action plan; and designate time for next briefing.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Assess current capability to provide medical care and mental health support to staff members. Project immediate and prolonged capacities to provide services based on current information and situation.		
Ensure staff are using recommended PPE and following other safety recommendations.		
Implement staff prophylaxis plan if indicated. Steps to include: • Determine medication, dosage and quantity. • Prioritize of staff to receive medication or immunization. • Point of Distribution (POD) location preparation. • Acquire/distribute medication. • Documentation. • Educational materials for distribution. • Track side effects and efficacy. • Augmentation of Unit staffing to provide services.		
Prepare for the possibility that a staff member or their family member may be a victim and anticipate a need for psychological support.		
Ensure prioritization of problems when multiple issues are presented.		
Anticipate increased Responder Health & Well-Being services needs created by additional patients, longer staff work hours, exposure to sick persons, and concerns about family welfare initiate actions to meet the needs.		
Meet with Medical Operations Chief/Chief Nurse to discuss plan of action and staffing patient care areas requiring assistance.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Notify Safety Officer of any health risks or other clinical problems related to staff.		
Receive, coordinate, and forward requests for personnel to the Staffing/Accountability Unit Leader and supplies to the Logistics Chief.		
Receive assigned radio and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS 213) and provide a copy for the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Coordinate continuing support to staff members.		
Assign mental health personnel to visit patient care areas and evaluate staff needs.		
Coordinate external request for resources with the Logistics Chief; follow community plan if available; develop plan for using outside mental and responder health services.		
Notify Logistics Chief of special medications needs.		
Continue to plan for a marked increase in responder health and wellness service needs for staff/family; announce options and program to staff.		
Monitor exposed staff for signs of illness or injury including infectious disease and exposure to other physical agents such as chemicals or radiation.		
Assign staff to support personnel in TMTS and provide mental health intervention/advice; contact Staffing/Accountability for additional personnel, if needed.		
Ensure medical records of staff receiving services are prepared correctly and maintain confidentiality of records.		
Meet routinely with Unit members for status reports, and relay important information to Operations Chief.		
Address Security issues as needed with the Security Unit Leader.		
Report equipment and supply needs to the Logistics Chief.		
Ensure staff health and safety issues are being addressed; resolve with Safety Officer as needed.		
Develop and submit an action plan to the Planning Chief when requested		
Advise the Medical Operations Chief /CNO of any operational issue you are not able to correct or resolve.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor the Unit staff's ability to meet workload demands, staff health and safety, security and resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Continue to monitor exposed staff for signs of illness or injury including infectious disease and exposure to other physical agents such as chemicals or radiation.		
Continue to document actions and decisions on HICS Form 214 and send to the Planning Chief.		
Continue to provide the Medical Operations Chief/Chief Nurse with periodic updates.		
Continue to provide Unit members with regular situation briefings.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Coordinate long term support needs with external resources including local, state and federal mental health officials.		
In coordination with the Mental Health Unit Leader, identify staff at high risk for post-incident traumatic stress reactions and provide debriefing/stress management programs and activities.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Compile and finalize responder patient information and records and report the Planning Chief. Ensure confidentiality of medical and mental health records. Upon deactivation of your position, brief the Medical Operations Chief/Chief Nurse, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS Forms are completed and submitted to the Planning Chief/MST.		
Submit comments to the after action report.		
Participate in stress management and after-action briefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 207 – Incident Management Team Chart ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

SAFETY OFFICER

Mission: Ensure safety of staff, patients, and visitors, monitor and correct hazardous conditions. Have authority to halt any operation that poses immediate threat to life and health.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: TMTS Administrator Signature: _____

TMTS Command Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive appointment and briefing from the TMTS Administrator.		
Read this entire Job Action Sheet and review incident management team chart (HICS Form 207). Put on position identification.		
Establish contact with the Communications Unit Leader and confirm your contact information.		
Appoint Safety team members and complete the Branch Assignment List (HICS Form 204).		
Brief team members on current situation and incident objectives; develop response strategy and tactics; outline action plan and designate time for next briefing.		
Determine safety risks of the incident to personnel, the TMTS facility, and the environment. Advise the TMTS Administrator and Section Chiefs of any unsafe condition and corrective recommendations.		
Communicate with the Logistics Chief to procure and post non-entry signs around unsafe areas.		
Ensure the following activities are initiated as indicated by the incident/situation: • Evaluate building or incident hazards and identify vulnerabilities • Specify type and level of PPE to be utilized by staff to ensure their protection, based upon the incident or hazardous condition • Monitor operational safety of decontamination operations • Ensure that Safety staff identify and report all hazards and unsafe conditions to the Operations Section Chief • Identify securable area for medication storage and pharmacy operations		
Assess TMTS operations and practices of staff, and terminate and report any unsafe operation or practice, recommending corrective actions to ensure safe service delivery.		
Initiate the Incident Action Plan Safety Analysis (HICS Form 261).		
Ensure implementation of all safety practices and procedures in the TMTS or facility.		
Initiate environmental monitoring as indicated by the incident or hazardous condition.		
Attend all command briefings and Incident Action Planning meetings to gather and share incident and hospital/facility safety requirements.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Request one or more recorders as needed to perform documentation and tracking.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Attend all command briefings and Incident Action Planning meetings to gather and share incident and TMTS facility information. Contribute safety issues, activities and goals to the Incident Action Plan.		
Continue to assess safety risks of the incident to personnel, the hospital/facility, and the environment. Advise the TMTS Administrator and Section Chiefs of any unsafe condition and corrective recommendations.		
Ensure proper equipment needs are met and equipment is operational prior to each operational period.		
Continue to document all actions and observations on the Operational Log (HICS Form 214) on a continual basis.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Re-assess the safety risks of the extended incident to personnel, the hospital/facility, and the environment and report appropriately. Advise the TMTS Administrator and Section Chiefs of any unsafe condition and corrective recommendations.		
Continue to update the Incident Action Plan Safety Analysis (HICS Form 261) for possible inclusion in the facility Incident Action Plan.		
Continue to assess TMTS operations and practices of staff, and terminate and report any unsafe operation or practice, recommending corrective actions to ensure safe service delivery.		
Continue to attend all command briefings and incident action planning meetings to gather and share incident and hospital/facility information. Contribute safety issues, activities and goals to the Incident Action Plan.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the TMTS Administrator.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues, and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, brief the TMTS Administrator on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, submit Operational Logs (HICS Form 214) and all completed documentation to the Planning Section Chief.		
Participate in after-action debriefings and document observations and recommendations for improvements for possible inclusion in the After-Action Report. Topics include: • Accomplishments and issues • Review of pertinent position descriptions and operational checklists • Recommendations for procedure changes		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ Incident Action Plan ☐ HICS Form 207 – Incident Management Team Chart ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ HICS Form 261 – Incident Action Plan Safety Analysis ☐ TMTS emergency operations plan ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone ☐ Material safety data sheets (MSDS) or other information regarding involved chemicals (ATSDR, CHEMTREC, NIOSH handbook)

SCRIBE

Mission: Maintain accurate and complete documentation for the assigned work group.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____
Position Reports to: Planning Chief/Section Chief as assigned Signature: _____
TMTS Command Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Section Chief as assigned. Obtain packet containing Scribe Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Receive assigned radio and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Coordinate with IT Unit to ensure access to IT systems with email/intranet communication to increase communication and document sharing with all Sections (if available).		
Prepare a system to receive documentation and completed forms from all Sections over the course of the TMTS activation.		
Provide duplicates of forms and reports to designated personnel as directed.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214).		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		
Participate in briefings and meetings as requested.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Advise designated personnel immediately of any operational issue you are not able to correct or resolve.		
Continue to accept and organize all documentation and forms submitted to assigned section.		
Check the accuracy and completeness of records submitted. Correct errors or omissions by contacting appropriate TMTS Section staff.		
Maintain all historical information and record consolidated plans.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure all documentation from TMTS Section is received and compiled.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Section Chief.		
Upon deactivation of your position, brief the Planning Chief/MST on current problems, outstanding issues, and follow-up requirements.		
Submit comments to the after-action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ HICS Form 204 Branch Assignment List
- ☐ HICS Form 207 Incident Management Team Chart
- ☐ HICS Form 213 Incident Message Form
- ☐ HICS Form 214 Operational Log
- ☐ HICS Form 251 Facility System Status Report
- ☐ HICS Form 253 Volunteer Staff Registration
- ☐ HICS Form 254 Disaster Victim Patient Track Form
- ☐ HICS Form 255 Master Patient Evacuation Tracking Form
- ☐ HICS Form 256 Procurement Summary Report
- ☐ HICS Form 257 Resource Accounting Record
- ☐ HICS Form 258 Hospital Resource Directory
- ☐ HICS Form 260 Patient Evacuation Tracking Form
- ☐ HICS Form 261 Incident Action Plan Safety Analysis
- ☐ TMTS organization chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone – phone numbers and radio assignments
- ☐ Access to appropriate IT systems

SECURITY UNIT LEADER

Mission: Coordinate all of the activities related to personnel and facility security such as access control, crowd and traffic control, and law enforcement interface.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____

Position Reports to: Safety Officer Signature: _____

TMTS Command Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from Safety Officer. Obtain packet containing Security Unit Leader Job Action Sheet.		
Read entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Establish Security command post.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Identify and secure all facility pedestrian and traffic points of entry, as appropriate.		
Consider need for the following, and report findings to the Safety Officer: • Emergency lockdown • Security/bomb sweep of designated areas • Providing urgent security-related information to all personnel • Need for security personnel to use personnel protective equipment • Removing unauthorized persons from restricted areas • Security of the TMTS, triage, patient care areas, morgue, and other sensitive or strategic areas from unauthorized access • Rerouting of ambulance entry and exit • Security posts in any operational decontamination area • Patrol of parking and shipping areas for suspicious activity • Traffic control		
Brief security team members on current situation, incident objectives and strategy; outline action plan and designate time for next briefing.		
Ensure personnel comply with safety policies and procedures and proper use of personal protective equipment, if available.		
Coordinate immediate security personnel needs from current staff, surrounding resources (police, sheriff, or other security forces), and communicate need for additional external resources through Operations Section Chief and Safety Officer. Receive assigned radio and establish communications with the Communications Unit Leader. Receive just–in-time training for the radio if needed.		
Participate in briefings and meetings as requested.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213) and provide a copy to the Planning Chief/MST.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet regularly with the Safety Officer and Operations Chief for status reports, and relay important information to Unit.		
Communicate the need and take actions to secure areas; post non-entry signs.		
Ensure Security staff identify and report all hazards and unsafe conditions		
Ensure patients valuables are secure; initiate chain of custody procedures as necessary		
Coordinate activities with local, state, and federal law enforcement, as appropriate.		
Confer with Public Information Officer to establish areas for the media.		
Ensure vehicular and pedestrian traffic control measures are working effectively.		
Consider security protection for the following, as indicated based on the nature/severity of the incident: • Food • Water • Medical resources • Blood resources • Pharmaceutical resources • Personnel and visitors		
Ensure proper equipment needs are met and equipment is operational prior to each operational period.		
Develop and submit an action plan to the Planning Chief when requested		
Advise the Operations Section Chiefs and Safety Officer immediately of any operational issue you are not able to correct or resolve.		

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Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue coordination with law enforcement officials.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Continue to monitor Security staff's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Prepare and maintain records and reports, as appropriate.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure that all patients valuable are returned.		
Coordinate completion of work with law enforcement.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Ensure personal protective equipment used by Security is cleaned, repaired, and/or replace.		

Demobilization/System Recovery	**Time**	**Initial**
Debrief staff on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, ensure all documentation and Operational Logs (HICS Form 214) are submitted to the Planning Chief/MST.		
Upon deactivation of your position, brief the Safety Officer on current problems, outstanding issues, and follow-up requirements		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools

- ☐ HICS Form 207 – Incident Management Team Chart
- ☐ HICS Form 213 – Incident Message Form
- ☐ HICS Form 214 – Operational Log
- ☐ TMTS organization chart
- ☐ TMTS telephone directory
- ☐ Radio/satellite phone – phone numbers and radio assignments
- ☐ Local resources

STAFFING/ACCOUNTABILITY UNIT LEADER

Mission: Collect and inventory available staff and volunteers at a central point. Receive requests and assign staff as needed. Maintain adequate numbers of both medical and non-medical personnel. Ensure that all staff is getting rest, relief, and nourishment. Assist in maintaining staff morale.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____
Position Reports to: Planning Chief Signature: _____
TMTS Command Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive appointment and briefing from the Planning Section Chief. Obtain packet containing Staffing/Accountability Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Brief team members on current situation, incident objectives and strategy; outline Unit action plan; and designate time for next briefing.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Establish labor pool area and communicate operational status to the Planning Chief and all patient care and non-patient care areas.		
Utilize an authorized credentialing system for staffing.		
Inventory the number and classify staff presently available. Use the following classifications: 1) MEDICAL PERSONNEL a. Physician i. Critical Care/E.R. ii. Family Practice/Internal Medicine iii. Other b. Nurse i. Critical Care/E.R. ii. Med-Surg/Ortho-Neuro iii. Other c. Advanced EMTs i. EMT-P ii. EMT-I d. Medical Technicians i. Patient Care (Aides, EMT-B's, Orderlies, etc.) ii. Diagnostic e) Mental Health f) Allied Health 2) NON-MEDICAL PERSONNEL a. Engineering/Maintenance/Materials Management		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
b. Environmental Services c. Food Service d. Scribes e. IT f. Communications g. Security h. Safety i. Financial j. Volunteers k. Other		
Establish a registration desk to obtain staffing personnel information area normally assigned, licensure, specialty and contact information.		
Direct personnel to designated work assignment areas recording the information on Labor Pool Log.		
Anticipate need for and implement the facility's emergency credentialing standard operating procedure when volunteers present: • Establish a credentialing desk in the staffing area. • Initiate intake and processing procedures for solicited and unsolicited volunteers presenting to the facility, record information on the Volunteer Staff Registration form (HICS Form 253). • Obtain assistance from the Security Branch Director in the screening and identification of volunteer staff.		
Meet with Charge Nurse and all other Sections Chiefs to coordinate long-term staffing needs.		
Receive assigned radio and establish communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Maintain copy for records.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Continue to prepare and maintain records and reports, as appropriate.		
Maintain a message center in the labor pool area to inform staff and volunteers of the current situation in coordination with the Operations Chief and Planning Chief/MST.		
Assist the Planning Chief in publishing an informational sheet to be distributed at frequent intervals to update the Section Chiefs.		
Advise the Planning Chief immediately of any operational issue you are not able to correct or resolve. Contact the Food/Nutrition Unit Leader to arrange for nutrition and hydration for the Staffing area		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Brief Planning Chief as frequently as necessary on the status of the staffing numbers and composition.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Continue to document actions and decisions on the HICS Form 214 and present copies as needed to the Planning scribe.		
Provide regular briefings to Unit staff and to staff and volunteers waiting for assignments.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Ensure complete documentation of volunteer information on the Volunteer Staff Registration Form (HICS Form 253).		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Upon deactivation of your position, brief the Planning Chief on current problems, outstanding issues, and follow-up requirements.		
Submit comments in the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 207 Incident Management Team Chart ☐ HICS Form 213 Incident Message Form ☐ HICS Form 214 Operational Log ☐ HICS Form 253 Volunteer Staff Registration ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

SUPPLY UNIT LEADER

Mission: Acquire, inventory, maintain, and provide medical and non-medical care equipment, supplies, and pharmaceuticals.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: Logistics Chief Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Logistics Chief. Obtain packet containing Supply Unit Leader Job Action Sheets.		
Read entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Receive assigned radio and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Brief Unit members on current situation, incident objectives and strategy; outline Unit action plan; and designate time for next briefing.		
Dispatch any pre-designated supplies and equipment to patient care areas, including triage and discharge areas. Request transportation assistance from the Transportation Unit Leader.		
Establish and communicate the operational status of the Supply Unit to the Logistics Chief and Finance Chief.		
Determine on hand inventory of the following, based on the type of event. May include, but is not limited to: • Airway equipment • Dressings/bandages • Chest tubes • Burn kits • Suture material • IV equipment and supplies • Sterile scrub brushes, normal saline, anti-microbial skin cleanser • Waterless hand cleaner and gloves • Fracture immobilization, splinting and casting materials • Backboard, rigid stretchers • Non-rigid transporting devices (litters) • Oxygen, administration masks, ventilators and suction devices • Personal protective clothing/equipment/masks/respirators.		
Place emergency order(s) for the critical supplies, equipment and pharmaceuticals needed to the Logistics Chief.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Prepare to receive additional equipment, supplies, and pharmaceuticals. Collaborate with Logistics Chief and Planning Chief to track arriving supplies.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Receive assigned radio and establish two-way communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Planning Chief/MST.		
Participate in briefings and meetings as requested.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Work through the Logistics Section Chief to request external resource acquisition assistance.		
Closely monitor equipment, supply, and pharmaceutical usage.		
Notify Security Branch Director to insure control of medications, equipment and supplies, as needed.		
Restock carts and treatment areas per request and at least every 8 hours.		
Advise the Logistics Chief immediately of any operational issue you are not able to correct or resolve.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor Unit personnel's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, and rest		
Continue to provide regular situation briefings to Unit staff.		
Anticipate equipment, supplies, and pharmaceuticals that will be needed for the next operational periods, in consultation with the Medical Operations Section. Place orders in collaboration with the Logistics Chief and Finance Chief.		
Continue effective inventory control and replacement measures		
Continue to document actions and decisions on HICS Form 214 and send a copy to the Planning Chief/MST at assigned intervals and as needed.		
Ensure your physical readiness through proper nutrition, water intake, rest, and stress management techniques.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Coordinate return of all assigned equipment to appropriate locations and restock TMTS supplies.		
Coordinate re-supply ordering and restocking.		
Repair/replace broken equipment.		
Ensure return/retrieval of equipment and supplies.		
Coordinate reimbursement issues with the Finance Section Chief.		
Ensure return/retrieval of equipment and supplies and return all assigned incident command equipment.		
Debrief staff on lessons learned and procedural/equipment changes needed.		
Submit comments to the after action report.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief/MST.		
Upon deactivation of your position, brief the Logistics Chief on current problems, outstanding issues, and follow-up requirements.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		
Upon deactivation of your position, brief the Logistics Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Section Chief.		
Submit comments to the after action report.		
Participate in stress management and the after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ Incident Action Plan ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ HICS Form 256 – Procurement Summary Report ☐ HICS Form 257 – Resource Accounting Record ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resource numbers ☐ Inventory list and vendor supply list

SUPPORT UNIT LEADER

Mission: Organize and manage the services required to maintain the TMTS supplies facilities, transportation, and labor pool. Ensure the provision of logistical, psychological, and medical support of TMTS staff and their dependents.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: Logistics Chief Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive appointment and briefing from the Logistics Section Chief. Obtain packet containing Support Branch Director Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Receive assigned radio and establish communications with the Communications Unit Leader. Receive just-in-time training for the radio if needed.		
Brief team members on current situation, incident objectives and strategy; outline Unit action plan; and designate time for next briefing.		
Assess Support Branch areas capacity to deliver needed: • Responder health care • Mental health support to staff • Family support to staff • Medical equipment and supplies • Facility cleanliness • Internal and external transportation support • Supplemental personnel management		
In collaboration with the Safety Officer determine need for staff personal protective equipment; implement protective actions as required.		
Regularly report Service Branch status to the Logistics Section Chief.		
Instruct all Unit Leaders to evaluate on-hand equipment, supply, and medication inventories and staff needs; report status to the Supply Unit Leader.		
Assess mental health status concerns and; determine need for expanded support.		
Assess problems and needs in each Unit area; coordinate resource management.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Continue assessing and coordinating Support Branch's ability to provide needed personnel and support services.		
Ensure prioritization of problems when multiple issues are presented		
Continue to evaluate the need for staff personal protection measures, in coordination with the Safety Officer and the Medical Director and implement actions as indicated.		
Assign mental health personnel to visit patient care areas and evaluate staff needs; in coordination with the Medical Director and report issues to the Logistics Section Chief.		
Coordinate use of external resources to assist with service delivery.		
Advise the Logistics Section Chief immediately of any operational issue you are not able to correct or resolve.		
Meet routinely with the Logistics Section Chief for status reports, and relay important information to staff.		
Assess environmental services needs in all staff activity areas.		
Report equipment needs to the Supply Unit Leader.		
Ensure staff health and safety issues being addressed; resolve with the Safety Officer when appropriate.		

Demobilization/System Recovery	**Time**	**Initial**
As needs for Support Branch staff decrease, return staff to their usual jobs and combine or deactivate positions in a phased manner.		
Assist the Logistics Section Chief and Unit Leaders with addressing staff health and medical concerns.		
Ensure return/retrieval of equipment and supplies.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Logistics Section Chief.		
Upon deactivation of your position, brief the Logistics Section Chief on current problems, outstanding issues, and follow-up requirements.		
Submit comments in the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ Incident Action Plan ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resource numbers ☐ Inventory list and vendor supply list

TMTS Administrator

Mission: Organize and direct all aspects of the Temporary Medical Treatment Station (TMTS). Give overall strategic direction for incident/patient care management and support activities

Date: _____ Start: _____ End: _____ Position Assigned to: _____

Signature: _____ Initial: _____

TMTS Command Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Assume role of Temporary Medical Station Administrator		
Read this entire Job Action Sheet and put on position identification.		
Determine roles for Medical Director and Operations Chief		
Initiate the Incident Briefing Form (HICS Form 201) and include the following information: • Nature of the problem (incident type, victim count, injury/illness type, etc.) • Safety of staff, patients and visitors • Risks to personnel and need for protective equipment • Need for decontamination • Estimated duration of incident • Appoint team required to manage the incident • Overall community response actions being taken • Status of local, county, and state Emergency Operations Centers (EOC) • Status of local, regional and state healthcare infrastructure		
Determine need for and appropriately appoint Command Staff and Section Chiefs, or Branch/Unit/Team leaders and Medical/Technical Specialists as needed; distribute corresponding Job Action Sheets and position identification. Assign or complete the Branch Assignment List (HICS Form 204), as appropriate.		
Brief all appointed staff of the nature of the problem, immediate critical issues and initial plan of action. Designate time for next briefing.		
Assign one or more clerical personnel as the TMTS recorder(s).		
Distribute the Section Personnel Time Sheet (HICS Form 252) to Command Staff and Medical/Technical Specialist assigned to Command, and ensure time is recorded appropriately. Submit the Section Personnel Time Sheet to the Finance/Administration Section's Time Unit Leader at the completion of a shift or at the end of each operational period.		
Initiate the Incident Action Plan Safety Analysis (HICS Form 261) to document hazards and define mitigation.		
Receive status reports from and develop an Incident Action Plan with Section Chiefs and Command Staff to determine appropriate response and recovery levels. During initial briefing/status reports, discover the following: • If applicable, obtain patient census and status from Planning Section Chief, and request a TMTS operations projection report for 4, 8, 12, 24 & 48 hours. Adjust projections as necessary.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
• Identify the operational period and TMTS shift change. • Ensure that appropriate contact with outside agencies has been established and facility status and resource information provided through the Liaison Officer. • Seek information from Section Chiefs regarding current "on-hand" resources of medical equipment, supplies, medications, food, and water as indicated by the incident. • Review security and facility surge capacity and capability plans as appropriate.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213). Provide a copy of the Incident Message Form to the Documentation Unit.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Authorize resources as needed or requested by Command Staff.		
Designate regular briefings with Command Staff/Section Chiefs to identify and plan for: • Update of current situation/response and status of other area hospitals and treatment areas, emergency management/local emergency operation centers, and public health officials and other community response agencies • Deploying a Liaison Officer to local EOC • Critical facility and patient care issues • TMTS operational support issues • Risk communication and situation updates to staff • Implementation of TMTS surge capacity and capability plans • Ensure patient tracking system established and linked with appropriate outside agencies and/or local EOC • Family Support Center operations • Public information, risk communication and education needs • Appropriate use and activation of safety practices and procedures • Enhanced staff protection measures as appropriate • Public information and education needs • Media relations and briefings • Staff and family support • Development, review, and/or revision of the Incident Action Plan, or elements of the Incident Action Plan		
Oversee and approve revision of the Incident Action Plan developed by the Planning Section Chief. Ensure that the approved plan is communicated to all Command Staff and Section Chiefs.		
Communicate facility and incident status and the Incident Action Plan to local and state authorities or designee, on a need-to-know basis.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Ensure staff, patient, and media briefings are being conducted regularly.		
Review and revise the Incident Action Plan Safety Analysis (HICS Form 261) and implement correction or mitigation strategies.		
Evaluate/re-evaluate need for deploying a Liaison Officer to the local EOC.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Evaluate/re-evaluate need for deploying a PIO to the local Joint Information Center.		
Ensure incident action planning for each operational period and a reporting of the Incident Action Plan at each shift change and briefing.		
Evaluate overall TMTS operational status, and ensure critical issues are addressed.		
Review /revise the Incident Action Plan with the Planning Section Chief for each operational period.		
Ensure continued communications with local, regional, and state response coordination centers and other TMTS through the Liaison Officer and others.		
Ensure your physical readiness, and that of the Command Staff and Section Chiefs, through proper nutrition, water intake, rest periods and relief, and stress management techniques.		
Observe all staff and volunteers for signs of stress and inappropriate behavior. Report concerns to the Safety Officer and/or appropriate person.		
Upon shift change, brief your replacement on the status of all ongoing operations, critical issues, relevant incident information and Incident Action Plan for the next operational period.		

Demobilization/System Recovery	**Time**	**Initial**
Assess the plan developed by the Demobilization Unit Leader and approved by the Planning Section Chief for the gradual demobilization of the HCC and emergency operations according to the progression of the incident and TMTS status. Demobilize positions in the TMTS as appropriate until the incident is resolved and the TMTS is cleared. • Ensure outside agencies are aware of status change • Brief Medical Director on any problems, issues as needed		
Ensure demobilization of the TMTS and restocking of supplies, as appropriate including: • Return of borrowed equipment to appropriate location • Replacement of broken or lost items • Cleaning of TMTS facility • Environmental clean-up as warranted		
Ensure that after-action activities are coordinated and completed including: • Collection of all TMTS documentation by the Planning Section Chief • Coordination and submission of response and recovery costs, and reimbursement documentation by the Finance/Administration and Planning Section Chiefs • Conduct of staff debriefings to identify accomplishments, response and improvement issues • Writing the TMTS facility After Action Report and Improvement Plan • Participation in external (community and governmental) meetings and other post-incident discussion and after-action activities • Post-incident media briefings • Post-incident public education and information • Stress management activities and services for staff and volunteers		

Documents/Tools
☐ Incident Action Plan ☐ HICS Form 201 – Incident Briefing Form ☐ HICS Form 204 – Branch Assignment List ☐ HICS Form 207 – Incident Management Team Chart ☐ HICS Form 213 – Incident Message Form ☐ HICS Form 214 – Operational Log ☐ HICS Form 252 – Section Personnel Time Sheet ☐ HICS Form 261 – Incident Action Plan Safety Analysis ☐ TMTS emergency operations plan and other plans as cited in the JAS ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone

TMTS MEDICAL DIRECTOR

Mission: Organize and manage the overall delivery of medical care. Advise the Incident Commander and or Operations Section Chief, as assigned, on issues related to biological/infectious disease, radiological exposure casualties, chemical exposure casualties, trauma casualties ,and explosives exposure casualties as applicable per medical response.

Date: _____ Start: _____ End: _____ Position Assigned to: _____

Signature: _____ Initial: _____

TMTS Command Location: _____ Telephone: _____

Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Incident Commander. Obtain packet containing Medical Director Job Action Sheet.		
Read this entire Job Action Sheet and review the organization chart. Put on position identification (if provided).		
Receive assigned radio (when applicable) and establish two-way communications with the Communications Unit Leader or designee.		
Review the HICS 206-Medical Plan, HICS 205-Communications Plan, HICS 202–Incident Objectives, and the Organizational Chart.		
Ensure accurate contact info on hand for TMTS command; ensure accurate contact info on hand for Incident Command and others (when applicable).		
Collaborate with Medical Operations Chief concerning medical care guidelines.		
Brief Medical Care Branch Unit leaders on current situation, incident objectives and strategy: outline Branch action plan and designate time for next briefing.		
Assess problems and needs in Branch areas: coordinate resource management.		
Ensure responders comply with safety policies and procedures.		
Determine need for surge capacity plan and/or modification of existing plan.		
Coordinate with Medical Operations Chief to prioritize patient treatment and transfer.		
Ensure that appropriate standard of isolation precautions are used in all pt. care areas.		
Meet regularly with the TMTS Command staff to plan and project patient care needs.		
Contact the local Public Health Department, in collaboration with the Liaison Officer, as required, for notification, support, and investigation resources.		
Assess size and location of chemical/radiological exposures. Coordinate with other Branch Directors to implement decontamination and response plans.		
Recommend decontamination procedures and staff personal protection, including respiratory protection.		
Recommend input for PIO press releases as requested.		

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Regularly meet with the Medical Operations Chief to review plan of action and staffing in the treatment area.		
Review personal protection practices; revise as needed.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Participate in briefings and meetings as requested.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Continue to meet regularly with the Incident Commander, Operations Chief and Medical Branch Command for status reports, and insure important information is relayed to the TMTS team members.		
Ensure best practices of patient care, disposition of patients, and clinical services support is maintained.		
Ensure patient tracking and transfer is being properly coordinated by the Incident Command.		
Meet regularly with TMTS Command to assess current and project future patient care conditions.		
Ensure patients records are being maintained and collected.		
Advise Incident Command immediately of any operational issue you are not able to correct or solve.		
Ensure patient/staff safety issues are identified and addressed.		
Ensure staff health and safety issues are being addressed; resolve with the Safety Officer.		
Continue to provide updated clinical information and situation reports to the TMTS Command.		
Ensure patient care needs are being met and policy decisions to institute austere care (altered level of care) practices are determined and communicated effectively.		
Develop and submit action plan to the Incident Commander when requested.		

Demobilization/System Recovery	**Time**	**Initial**
Debrief TMTS responders on lessons learned and procedural/equipment changes needed.		
Upon deactivation of your position, brief the Incident Commander, as appropriate, on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure that all documentation and HICS forms are collected.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

TRANSPORTATION UNIT LEADER

Mission: Organize and coordinate the transportation of all ambulatory and non-ambulatory patients. Arrange for the transportation of human and material resources within or outside the facility.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initials: _____

Position Reports to: Logistics Chief Signature: _____

TMTS Location: _____ Telephone: _____

Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing form Logistics Section Chief. Obtain packet containing the Transportation Unit Leader's Job Action Sheet.		
Read this entire Job Acton Sheet and review the organizational chart. Put on position identification (if provided).		
Brief Unit members on current situation, incident objectives and strategy; outline Unit action plan; and designate time for next briefing.		
Assess transportation requirements and needs for patients, personnel and materials; request patient transporters from the Staffing/Accountability Section to assist in the gathering of patient transport equipment.		
Inventory and assemble Stryker carts, wheelchairs, mega-movers, stair chairs and stretchers in proximity to discharge and triage areas.		
Establish ambulance loading area in cooperation with the Security Unit Leader and Operations Section Chief. Advise EMS of location.		
Assess availability of other resources for transportation (buses, shuttles, ambulances).		
Receive requests for air lift medical evacuation from patient care areas and coordinate requests with Logistics Chief for use of outside air medical access resources for MEDEVAC with the local Emergency Operations Center (EOC) or directly with the transport provider. An appropriate landing area will need to be identified and cordoned off.		
Coordinate request for public/private sector ambulance transportation with the Logistics Chief and the Planning Chief to the local EOC or directly with provider per existing response plans and agreements.		
Receive the radio assignments and establish communications with the Communications Unit Leader. Receive just-in-time radio training if needed.		
Document all communications (internal and external on an Incident Message Form (HICS Form 213) and provide a copy for the Planning Chief.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Continue coordination of transportation/ shipment of resources into and out of the facility by phone/radio, on site unit leader, or local EOC.		
Continue coordination of transportation for patient transfers with: • Staffing/Accountability Unit Leader • Discharge Unit Leader • EMS (public and private) • Other hospitals • Local EOC • Military		
In the event of a TMTS evacuation and /or the relocation of medical services outside of existing structure, anticipated and prepare transportation needs.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitors Unit personnel's ability to meet workload demands, staff health and safety, resource needs, and documentation.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Assign a scribe to the triage area, discharge area, and supply area to maintain a transportation record.		
Continue communication on situation with appropriate external authorities, in coordination with the Logistics chief.		
Request special transport needs from the Supply Unit Leader.		
Address health and safety issues related to volume/location of transportation vehicles with the Safety Officer.		
Continue to document actions and decisions on HICS Form 214 at assigned intervals and as needed.		
Continue to provide regular status updates to the Logistics Chief.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Coordinate cancellations of transport vehicles.		
Via the Logistics Chief or the Planning Chief notify the EOC that there is no longer a need for additional transportation assistance.		
Ensure return/retrieval of equipment and supplies.		
Debrief staff lessons learned and procedural/equipment changes needed.		

Demobilization/System Recovery	**Time**	**Initial**
Upon deactivation of your position, brief the Logistics Chief on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Chief, as appropriate.		
Submit comments to the after action report.		
Participate in stress management and after- action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 207 Incident Management Team Chart ☐ HICS Form 213 Incident Message Form ☐ HICS Form 214– Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

TRIAGE TEAM LEADER

Mission: Oversee and coordinate the primary triage area. Ensuring the prioritization of acuity is executed in a systematic manner.

Date: _____ Start: _____ End: _____ Position Assigned to: _____ Initial: _____
Position Reports to: Charge Nurse Signature: _____
TMTS Location: _____ Telephone: _____
Fax: _____ Other Contact Info: _____ Radio Title: _____

Immediate (Operational Period 0-2 Hours)	**Time**	**Initial**
Receive assignment and briefing from the Charge Nurse. Obtain packet containing Triage Unit Leader Job Action Sheet.		
Read this entire Job Action Sheet and review the organizational chart. Put on position identification (if provided).		
Receive assigned radio and establish communications with the Communication Unit Leader. Receive just-in-time training for the radio if needed.		
Brief team members on current situation and incident objectives.		
Ensure that proper equipment, staffing, and resources are in the triage areas.		
Ensure that all triage staff is provided just-in-time training on equipment and procedures as needed.		
Ensure that a scribe has been assigned to the triage area to update and maintain all documentation, including patient tracking.		
Coordinate with Patient Tracking Unit Leader to ensure that all patients are being properly identified, prioritized, and tracked to the designated treatment area assigned.		
Assess problem and treatment needs in assigned triage area; coordinate the team assigned to the triage area to meet needs.		
Coordinate and forward requests for supply and equipment needs to the Logistic Section Chief.		
Document all communications (internal and external) on an Incident Message Form (HICS Form 213) and provide a copy to the Planning Chief/MST.		
Document all key activities, actions, and decisions in an Operational Log (HICS Form 214) on a continual basis.		
Participate in briefings and meetings as requested.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Ensure patient documentation is being prepared correctly and collected.		
Ensure triage is being prioritized effectively when austere conditions are implemented.		
Advise Charge Nurse immediately of any operational issue you are not able to correct or resolve.		

Intermediate (Operational Period 2-12 Hours)	**Time**	**Initial**
Meet regularly with Triage Unit for status reports and relay important information to the Charge Nurse.		
Continue to report equipment and supply needs to Logistic Section Chief.		
Ensure staff health and safety issues are being addressed; resolve with Charge Nurse when appropriate.		
Assess environmental service needs in the triage area; contact Environmental Service Unit Leader when appropriate.		
Upon shift change, brief your replacement on the situation, ongoing operations, issues and other relevant incident information.		

Extended (Operational Period Beyond 12 Hours)	**Time**	**Initial**
Continue to monitor Triage Unit staff's ability to meet workload demands, staff health and safety, resource needs, and documentation practices.		
Ensure your physical readiness through proper nutrition, water intake, and rest.		
Rotate triage staff on a regular basis.		
Continue to document actions and decisions on the HICS Forms at assigned intervals and as needed.		
Continue to provide the Charge Nurse with situation updates.		
Continue to provide staff with situation updates and revised patient care practice standards.		
Upon shift change, brief your replacement on the status of all ongoing operations, issues and other relevant incident information.		

Demobilization/System Recovery	**Time**	**Initial**
Upon deactivation of your position, brief the Charge Nurse on current problems, outstanding issues, and follow-up requirements.		
Upon deactivation of your position, ensure all documentation and HICS forms are submitted to the Planning Section Chief.		
Ensure return/retrieval of equipment and supplies.		
Submit comments to the after action report.		
Participate in stress management and after-action debriefings. Participate in other briefings and meetings as required.		

Documents/Tools
☐ HICS Form 207 Incident Management Team Chart ☐ HICS Form 213 Incident Message Form ☐ HICS Form 214 Operational Log ☐ TMTS organization chart ☐ TMTS telephone directory ☐ Radio/satellite phone – phone numbers and radio assignments ☐ Local resources

Attachment 11

Alternate Care Site
Forms

__________County Health Department

Alternate Care Site

Communication Log

Description of Events					
Time		Date:		Nurse:	
Log:					

Description of Events					
Time		Date:		Nurse:	
Log:					

Description of Events					
Time		Date:		Nurse:	
Log:					

_____County Health Department

Facility Maintenance Plan/Log

Alternate Care Site Address	

Prevention Interventions/ Inspections/ Maintenance of Sanitary Conditions:	
Date:	
Issue # :	
Intervention :	
Date:	
Issue # :	
Intervention :	
Date:	
Issue # :	
Intervention :	

_____County Health Department

Alternate Care Site Intake Form

ACS Name:_____ ACS City:_____ Admission Date:_____ Time: _____

INDIVIDUAL DEMOGRAPHICS:

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Other Phone: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ SS#: _____ Age: _____

Race: ☐ White ☐ Black ☐ Asian ☐ Hawaiian/Pacific Islander ☐ Amer. Indian/Alaskan Native ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Primary Language at Home:_____

SYMPTOM INFORMATION:

Is the person sick? ☐Yes ☐ No (If the person is not sick, skip to the next section) Onset Date: _____

Symptoms:

☐Fever	☐ Night Sweats	☐ Vomiting	☐ Mental Status change
☐Chills	☐ Dehyration	☐ Rash	☐ Open Wounds
☐Cough	☐ Diarrhea	☐ Jaundice	☐ Puncture wound/bite
☐Bloody Cough	☐ Bloody Diarrhea	☐ Conjunctivitis	☐ Broken bones
☐Productive cough	☐ Nausea	☐ Mental Health Concern (anxiety, depression, other)	

☐Other _____

Comments: _____

_____

MEDICAL INFORMATION (Check all disabilities/conditions that the person may have):

☐ AIDS/ HIV	☐ Electrically Dependent Life Support	☐ Pacemaker
☐ Anemia	☐ Hearing Impaired	☐ Partial Paralysis
☐ Anxiety / Nerves	☐ Heart Condition	☐ Pregnant (_____ Weeks)
☐ Arthritis, Severe	☐ Hepatitis (☐ A ☐ B ☐ C ☐ D ☐ E)	☐ Pulmonary Disease
☐ Asthma	☐ Hereditary Blood Disorder	☐ Psychological Disorder
☐ Back Injury	☐ Hypertension (High Blood Pressure)	Describe _____
☐ Blind (Guide Dog? ☐ Y ☐ N)	☐ Incontinence	☐ Seizures
☐ Breathing Impaired	☐ Kidney Disease (Dialysis? ☐ Y ☐ N)	☐ Skin Disease / Rash
☐ Cancer	☐ Memory Impairment	☐ Transplant Recipient
☐ Complete Paralysis	☐ Ostomy	Describe _____
☐ Diabetes (☐ Oral ☐ Insulin)	☐ Oxygen Supported L/Min. _____	☐ Tuberculosis
☐ Drug Dependent	☐ Tank ☐ O_2 Converter	☐ Active ☐ Skin Test (+) only
☐ Alcohol ☐ Other _____		☐ Wounds
☐ Other _____		

_____

CURRENT MEDICATIONS:

Pharmacy Name: _____ Pharmacy City/State: _____

Please list all medications that the person is currently taking:

Name/ Type	Dose?	How Often?	Do they have any? Yes	How Many?	No	Require med immediately?	Require refill?

CARE AND TREATMENTS:

Is the person currently under medical / psychological care? ☐ Yes ☐ No

If yes, please describe: _____ How often: _____

_____ _____

_____ _____

_____ _____

Name of Personal Dr. or Clinic: _____ Phone: _____

Office Location: _____

Does the person have any known allergies (i.e. medications, food)? ☐ Yes ☐ No

If yes, please describe: _____

_____

MEDICAL ASSESSMENT:

Age: _____ Sex: _____ Weight: _____

Vital Signs: P: _____ R: _____ BP: _____ Temp: _____

General Appearance: _____

_____

Notes: _____

_____

_____

_____

Signature of Nurse: _____ Date: _____ Time Out: _____

_____County Health Department

Alternate Care Site Medical Orders Form

Progress Sheet

ACS Address:		ACS City:	

INDIVIDUAL DEMOGRAPHICS:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ SS#: _____

MEDICAL ORDERS:

Date:	

Signature of Physician:		Date:	

Alternate Care Site
Patient Progress Notes

Date:_____ Time:_____

Patient's Name:_____ Nurse:_____

Patient's DOB:_____ Patient's SS#_____

Describe the problem:_____

_____

_____

_____

Presenting Symptoms:_____

_____

_____

_____

Time	P	R	B/P	Temp	Signature	Time	Meds	Dose	Site	Signature

Alternate Care Site

Address
Telephone: Fax:

SOAP NOTES

PATIENT INFORMATION

Last Name | MI | First Name | SSN# | Date of Birth

Insurance Carrier | Insurance Plan | ID#

S

O

A

P

Provider Name | Title | Date

_____
Provider Signature

Time	P	R	B/P	Temp

Patient Information:
Last Name_____
First Name _____MI_____
DOB_____ SS#_____

Time	Meds	Dose	Route/Site	Signature

Appendix A

Laws Affecting
Alternate Care Sites

LEGAL HANDBOOK FOR ISSUES REGARDING ALTERNATE CARE SITES (ACS)

Prepared by:

UNIVERSITY OF MARYLAND CENTER FOR HEALTH & HOMELAND SECURITY

500 West Baltimore Street
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October 31, 2011

At the Request of the:
Region III Health and Medical Taskforce
and
Greater Baltimore Medical Center (GBMC)

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IMPORTANT INTRODUCTORY NOTE

The *Legal Handbook for Issues Regarding Alternate Care Sites (ACS) ("Handbook")* is intended to aid readers in understanding the framework of relevant laws that may apply during a public health emergency or other medical surge situation requiring the operation of an Alternate Care Site in the State of Maryland.

This Handbook provides an overview of relevant federal, state, and local laws, powers, and authorities that may apply to the creation and operation of an ACS. As such, ***the information contained in the Handbook does not constitute legal advice***, but rather, is intended to educate readers and inform them about the legal landscape in which the ACS will need to operate. Specific questions regarding proposed policies, procedures, and legal issues regarding the Region III Alternate Care Site should be directed to appropriate counsel for each hospital or organization in question.

The Handbook is organized into three parts.

Part I: Summary of Relevant Laws discusses the federal, state, and local laws and programs, as well as the inter-and-intrastate compacts, that may be applicable to creating and operating an ACS in Maryland, including, but not limited to, the:

- Catastrophic Health Emergencies Act (CHE Act);
- Maryland Emergency Management Agency Act (MEMA Act);
- Maryland Governor's Emergency Powers Subtitle;
- Good Samaritan Act;
- Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act);
- National Emergencies Act;
- Public Health Service Act;
- Health Insurance Portability and Accountability Act (HIPAA);
- Emergency Medical Treatment and Active Labor Act (EMTALA);
- Public Readiness and Emergency Preparedness Act (PREP Act);
- National Disaster Medical System (NDMS);

- Emergency Management Assistance Compact (EMAC); and
- Maryland Emergency Management Assistance Compact (MEMAC).

Part II: Select Topics presents detailed explanations of the legal and policy framework regarding a variety of specific legal issues that may arise from creation and operation of an Alternate Care Site, including:

- Liability and Immunity of Health Care Providers and Other Responders;
- Privacy of Information and Reporting Requirements; and
- Professional Licensing and Credentialing.

Part III: Appendices contains the text of several of the state laws referenced in the Handbook, as well as other helpful resources.

Assumptions

Response to an emergency, particularly a medical surge or public health emergency, will vary greatly depending upon the cause of the emergency and the surrounding circumstances. For purposes of addressing issues in this Handbook, readers should presume that the following assumptions, listed below, apply. When these assumptions do not apply, the Handbook will indicate the change in circumstances and explain how these changes affect the prevailing legal framework.

- Readers should always assume that responders must act within the current legal framework, without a declaration or proclamation of a state of emergency, until such a declaration or proclamation is made.
- Readers should assume that the government will invoke some, but not necessarily all, of its emergency powers upon declaration or proclamation of a state of emergency.
- When reviewing the framework for liability and immunity of various response personnel, readers should pay careful attention to whether a specific law provides immunity protections to individuals, organizations/facilities, or both.

TABLE OF CONTENTS

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PART I: SUMMARY OF RELEVANT LAWS

Part I discusses the relevant federal and state laws, programs, and mutual aid compacts that may be relevant to creating, setting up, and running an Alternate Care Site (ACS). Section A highlights the legal framework created by Maryland law, while Section B addresses the various federal laws and programs that may impact operation of an ACS. Finally, Section C details the three main mutual aid compacts in place in the State of Maryland.

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SECTION A: MARYLAND LAWS & PROGRAMS

The legal framework for emergency response in Maryland is created primarily by three main laws: the Catastrophic Health Emergencies Act (CHE Act); the Maryland Emergency Management Agency Act (MEMA Act); and the Governor's Emergency Powers Subtitle. During an emergency, these three laws may be invoked individually, or simultaneously, depending upon the magnitude and context of the emergency and the scope of resources needed to respond. Section A discusses these three laws, along with Maryland's Good Samaritan Act and Volunteer Service Act, as well as highlighting the role played by the Maryland Professional Volunteer Corps.

1. Catastrophic Health Emergencies Act (CHE Act)

The Catastrophic Health Emergencies Act (CHE Act)[1] authorizes the Governor to issue a proclamation of a catastrophic health emergency (CHE), which the Act defines as "a situation in which extensive loss of life or serious disability is threatened imminently because of exposure to a deadly agent."[2] A "deadly agent," as defined in the Act, is a biological, chemical, or radiological agent capable of causing "extensive loss of life or serious disability,"[3] and includes:

- "anthrax, ebola, plague, smallpox, tularemia, or other bacterial, fungal, rickettsial, or viral agent, biological toxin, or other biological agent capable of causing extensive loss of life or serious disability;
- mustard gas, nerve gas, or other chemical agent capable of causing extensive loss of life or serious disability; or
- radiation at levels capable of causing extensive loss of life or serious disability."[4]

If the Governor determines that a catastrophic health emergency exists or is imminent, he may issue a proclamation of a CHE under the Act. The CHE proclamation must state:

- the nature of the emergency;

[1] MD. CODE ANN., PUB. SAFETY § 14-3A-08 (West Supp. 2009)
[2] *Id.* § 14-3A-01(b).
[3] *Id.* § 14-3A-01(c).
[4] *Id.*

- the areas affected or threatened by the emergency; and
- the conditions that led to the emergency.[5]

The Governor's initial proclamation of a CHE terminates after 30 days, or upon a gubernatorial proclamation rescinding it.[6] A proclamation can also be renewed for successive periods of 30 days.[7]

Once a proclamation of a catastrophic health emergency has been issued under the Act, the Governor may order the Secretary of Health and Mental Hygiene or another designated official to:

- "seize immediately anything needed to respond to medical consequences of the catastrophic health emergency;"[8]
- "control, restrict, or regulate the use, sale, dispensing, distribution, or transportation of anything needed to respond to the medical consequences of the catastrophic health emergency" by "rationing or using quotas; creating and distributing stockpiles; prohibiting shipments; setting prices; or taking other appropriate actions[];"[9]
- "work collaboratively, to the extent feasible, with health care providers to designate and gain access to a facility" needed to assist emergency response;[10]
- "require individuals to submit to medical examination or testing; vaccination or medical treatment," if "medically necessary and reasonable to treat, prevent, or reduce the spread of the disease," unless the proposed medical treatment is "likely to cause serious harm to the individual;" and[11]
- "establish places of treatment, isolation, and quarantine"[12] or "require individuals to go to and remain in places of isolation and quarantine" until a designated official determines

[5] *Id*. § 14-3A-02.
[6] *Id*. § 14-3A-02(c)(1).
[7] *Id*. § 14-3A-02(c).
[8] *Id*. § 14-3A-03(b)(1)(i).
[9] *Id*. § 14-3A-03(b)(2).
[10] *Id*. § 14-3A-03(b)(1)(ii).
[11] *Id*. § 14-3A-03(b)(3).
[12] *Id*.

they no longer "pose a substantial risk of spreading the disease or condition to the public."[13]

Additionally, the Governor may order:

- any health care provider to "participate in disease surveillance, treatment, and suppression efforts or otherwise comply with the directives" of the Secretary of Health and Mental Hygiene or other designated official;[14]
- the "evacuation, closing, or decontamination of any facility;"[15] and
- individuals to "remain indoors or refrain from congregating," if "necessary and reasonable to save lives or prevent exposure to a deadly agent."[16]

Orders for isolation and quarantine issued pursuant to a CHE proclamation may be challenged in Maryland's circuit courts using an expedited process set forth in the Act,[17] and either party may appeal the circuit court's decision to an appellate court for review.[18]

Failure of individuals to comply with orders issued under the CHE Act may be punishable by imprisonment "not exceeding 1 year" or a fine not exceeding $5000, or both.[19] Additionally, health care practitioners who fail to comply with an "order, regulation, or directive" issued under the Act may be subject to disciplinary action, including probation, suspension, or revocation of their professional licenses.[20]

[13] *Id*. Orders for isolation and quarantine issued under the CHE Act must be issued in writing and include, among other things, the identity of the individual(s) to be isolated or quarantined; the premises subject to isolation or quarantine; the suspected deadly agent causing the outbreak or disease, if known; the justification for the isolation or quarantine; and the availability of a hearing to contest the directive. *Id*. § 14-3A-05 (a)-(c)(1).
[14] *Id*. § 14-3A-02.
[15] *Id*. § 14-3A-03(d)(1).
[16] *Id*. § 14-3A-03(b)-(d).
[17] *Id*. § 14-3A-05(c)(1)-(4).
[18] MD. R. 15-1107 (West 2006 & Supp. 2008).
[19] MD. CODE ANN., PUB. SAFETY § 14-3A-08 (West Supp. 2008); MD. CODE ANN., HEALTH-GEN. § 18-907 (West Supp. 2008).
[20] MD. CODE ANN., HEALTH-GEN. § 18-907(c) (West Supp. 2008).

SEE *PART II, SECTION B.3: STATE COMMUNICABLE DISEASE REPORTING REQUIREMENTS FOR HEALTH CARE PROVIDERS*, P.62, AND *PART III, SECTION A: CATASTROPHIC HEALTH EMERGENCIES ACT*, P. 93, FOR MORE INFORMATION ABOUT THE CHE ACT.

2. Maryland Emergency Management Agency Act (MEMA Act)

The Maryland Emergency Management Agency Act (MEMA Act) grants the Governor the authority to declare a state of emergency and the power to take certain actions, through use of his emergency powers, to appropriately respond to the emergency and to protect the public health, safety, and welfare.[21]

The Act states that the Governor, if he "finds that an emergency has developed or is impending due to any cause," may "declare a state of emergency by executive order or proclamation."[22] "Emergency" is broadly defined under the MEMA Act and includes a "disaster in any part of the State that requires State assistance to supplement local efforts in order to save lives and protect public health and safety; or an enemy attack, act of terrorism, or public health catastrophe."[23]

During a declared emergency, the MEMA Act provides the Governor with a broad swath of authority to execute a number of powers if he finds them necessary to protect the public health, safety, or welfare. This includes the right to:

- suspend any statute, rule, or regulation of a state agency or a political subdivision;
- "[c]ompel evacuation of a stricken or threatened area;"
- "set evacuation routes and modes of transportation to be used during an emergency;"
- control entry to and exit from an emergency area;
- control movement of people and occupancy of premises in an emergency area;
- authorize the use of private property;

[21] MD. CODE ANN., PUB. SAFETY §§ 14-101 - 14-115 (West 2003 & Supp. 2009).
[22] *Id.* § 14-107(a)(1).
[23] *Id.* § 14-101(c).

- provide for temporary housing; and
- authorize the clearance and removal of debris and wreckage.[24]

The Act also allows the Governor to appropriate and manage funds to respond to a declared emergency, provided that such appropriations comply with a number of conditions, as set forth in the Act.[25]

In the absence of a declared emergency, the MEMA Act grants the Governor "control" of MEMA, as well as a number of other powers to develop, implement, and coordinate emergency plans and programs throughout Maryland.[26] Under some conditions, the Act also authorizes the Governor to provide aid to another state by using Maryland's "personnel, equipment, supplies, or materials," and by suspending any statute, rule, or regulation "if the Governor finds that the suspension is necessary to aid the other state with its emergency management functions."[27]

The MEMA Act requires all emergency management agencies established pursuant to the Act, including MEMA and local emergency management agencies in the state, to execute and enforce orders, rules, and regulations promulgated by the Governor pursuant to the Act. Additionally, in the event of a "threat or occurrence of an enemy attack, act of terrorism, or a public health catastrophe," the Act requires state and local law enforcement officers, as well as every local health officer to "execute and enforce the orders, rules, and regulations made by the Governor" under the Act.[28] Individuals who willfully violate an order issued under the MEMA Act may be subject to fines, imprisonment, or both.[29]

SEE *PART III, SECTION B: MARYLAND EMERGENCY MANAGEMENT AGENCY ACT*, P. 103, FOR STATUTORY TEXT OF THE MEMA ACT.

[24] *Id.* § 14-107(d)(1).
[25] *Id.* § 14-108(a) (West 2003). Conditions for appropriation of funds during a declared emergency include using regularly appropriated money first, and asking the Board of Public Works to make contingency money available in accordance with the state budget. The Governor may also accept federal money to cope with an emergency.
[26] *Id.* § 14-106(a)(1).
[27] *Id.* § 14-108(a).
[28] *Id.* § 14-113(b).
[29] *Id.* § 14-114.

3. Governor's Emergency Powers Subtitle

The Governor's Emergency Powers Subtitle (Subtitle) of the Public Safety article of the Maryland Code provides the Governor with broad authority to use the police power to respond to impending or actual public emergencies.[30] The Subtitle defines "public emergency" as:

- "a situation in which three or more individuals are at the same time and in the same place engaged in tumultuous conduct that leads to the commission of unlawful acts that disturb the public peace or cause the unlawful destruction or damage of public or private property;
- a crisis, disaster, riot, or catastrophe; or
- an energy emergency."[31]

The Governor, on his own initiative or at the request of the chief executive officer or governing body of a county or municipality or the Secretary of State Police, may proclaim a state of emergency under the Subtitle if public safety is endangered, or on reasonable apprehension of immediate danger to public safety.[32]

Once a state of emergency has been proclaimed under the Subtitle, the Governor is authorized to:

- promulgate reasonable orders, rules, or regulations necessary to "protect life and property or calculated effectively to control and terminate the public emergency[,]" including certain temporary restrictions and controls on:
    - traffic;
    - movement of individuals;
    - occupancy and use of buildings and vehicles;
    - places of amusement and assembly;
    - the sale, transportation, and use of alcoholic beverages;

[30] *Id.* § 14-302(a).
[31] *Id.* § 14-301(c). An "energy emergency" is "a situation in which the health, safety, or welfare of the public is threatened by an actual or impending acute shortage of energy resources." *Id.* § 14-301(b) & 14-304(a).
[32] *Id.* § 14-303(a).

  - the possession, sale, carrying, and use of weapons and ammunition, including firearms; and
  - the storage, use, and transportation of explosives or flammable materials or liquid;[33]
- establish curfews;[34]
- order businesses to close, if an emergency is caused by fire, flood, robbery, riot, weather, or other cause;[35] and
- order the closure of offices and branches of banking institutions affected by the emergency.[36]

During a proclaimed state of emergency, the Subtitle provides that:

- all state and local law enforcement agencies, fire companies, and rescue squads must cooperate with the Governor or his designated representative, and allow use of their equipment, facilities, and personnel, unless such use would "substantially interfere" with their normal duties.[37]
- the Governor may call the state militia into action to respond to the emergency, after which:
  - the militia has full power and control over the designated emergency area;
  - all law enforcement agencies, officials, and rescue squads in the emergency area, including the State Police, must cooperate with the militia;[38] and
- the state "shall repair or replace any equipment, facilities, or property that is damaged while being used in accordance with the" proclaimed state of emergency.[39]

Failure to comply with orders, rules, or regulations promulgated under the Subtitle are punishable by a fine of up to $1000, imprisonment, or both.[40]

[33] *Id.* § 14-303(b)-(c) (West 2003).
[34] *Id.* § 14-303(b)(6) & (c).
[35] *Id.* § 14-307(a)-(b).
[36] *Id.* § 14-307(c).
[37] *Id.* § 14-305(a)-(b) (West 2003).
[38] *Id.* § 14-306(b)-(c).
[39] *Id.* § 14-308.
[40] *Id.* § 14-309.

SEE *PART III, SECTION C: MARYLAND GOVERNOR'S EMERGENCY POWERS SUBTITLE*, P. 113, FOR STATUTORY TEXT OF THE GOVERNOR'S EMERGENCY POWERS SUBTITLE.

4. Maryland Good Samaritan Act

Maryland's Good Samaritan statute limits liability for health care professionals and others, including spontaneous lay volunteers, who provide emergency assistance.[41] The Act maintains two different standards of care: one for volunteer health care professionals and emergency response personnel, and another for members of the lay public providing assistance at the scene of an emergency.[42]

For Health Care Professionals and Emergency Responders

The Good Samaritan Act applies to the following health care professionals and emergency responders:

- all health care providers licensed in Maryland;
- members of any fire department, ambulance squad, or rescue squad; and
- members of any law enforcement agency, the National Ski Patrol system, or corporate fire department responding to a call outside the corporate premises.[43]

Under the Act, health care professionals and emergency responders are eligible for immunity from civil liability for any act or omission while providing assistance or medical care, provided that:

- the act or omission is not one of gross negligence;[44]
- the assistance or medical care is provided without compensation of any form from the individual(s) being assisted; and

[41] MD. CODE ANN., CTS. & JUD. PROC. § 5-603 (West 2002 & Supp. 2009).
[42] *Id.*
[43] *Id.* § 5-603(b). Members of fire departments, ambulance squads, rescue squads, law enforcement agencies, corporate fire departments, and the National Ski Patrol System must be either certified in advanced first aid by the American Red Cross, have completed an equivalent certification program, or be state-certified as an emergency medical services provider in order for the liability protections to apply.
[44] *Id.* § 5-603(a) (West 2002 & Supp. 2008). "Gross negligence" is defined as "wanton disregard for human life or for the rights of others." *Floor v. Juvenile Servs.*, 552 A.2d 947, 956 (Md. Ct. Spec. App. 1989) (quoting *White v. King*, 223 A.2d 763, 771 n.2 (1966)).

- the "assistance or medical care is provided at the scene of an emergency, in transit to a medical facility, or through communications with personnel providing emergency assistance."[45]

For Lay Volunteers

The Good Samaritan Act grants immunity from civil liability for lay volunteers in certain situations when assistance or medical aid is provided to victims *at the scene of an emergency*. To qualify for the Act's liability protections, lay volunteers must comply with the following conditions:

- assistance or aid must be reasonably and prudently provided;
- assistance or aid must be provided without receiving any form of compensation from the individual(s) being assisted; and
- the lay volunteer must relinquish care when someone who is licensed or certified in the state to provide medical services becomes available to assist.[46]

It is important to note that, by its statutory text, the Act clearly applies to spontaneous volunteers who provide assistance during an emergency situation, such as a car accident; however, at this time, **it is unclear whether the Good Samaritan Act's protections would limit liability for individuals providing assistance during a declared emergency**, including a public health emergency.

SEE *PART II, SECTION A.3: LIABILITY AND IMMUNITY OF HEALTH CARE PROVIDERS AND OTHER RESPONDERS*, P. 43, FOR MORE INFORMATION ON THE GOOD SAMARITAN ACT.

5. Maryland Volunteer Service Act

The Maryland Volunteer Service Act grants limited liability protections to any individual who provides volunteer service for a variety of non-profit organizations, including business or civic

[45] *Id.* § 5-603(a).
[46] *Id.* § 5-603 (West 2002 & Supp. 2009).

leagues, charitable organizations, and employees' associations.[47] The statute defines "volunteer" as an individual, including an "officer, director, trustee, or other person, who provides services or performs duties for an association or organization without receiving compensation."[48] The Act's liability protections generally apply to qualified volunteers unless:

- the volunteer knew or should have known of an act of misconduct of another in the organization; or
- after an act of misconduct was committed by another in the organization, the volunteer ratified this conduct; or
- the volunteer's act of misconduct "constitutes gross negligence, reckless, willful, or wanton misconduct, or intentionally tortious conduct."[49]

Unlike the other Maryland laws discussed in this section, **the Maryland Volunteer Service Act does NOT provide immunity from suit**; rather, it limits the amount of damages a plaintiff can recover to the amount of the defendant's personal insurance coverage.[50]

SEE *PART II, SECTION A.3: LIABILITY AND IMMUNITY OF HEALTH CARE PROVIDERS AND OTHER RESPONDERS*, P. 43, FOR MORE INFORMATION ON THE MARYLAND VOLUNTEER SERVICE ACT.

6. Maryland Professional Volunteer Corps (MPVC)

The Maryland Professional Volunteer Corps (MPVC) is a Medical Reserve Corps (MRC) under the direction of the Maryland Department of Health and Mental Hygiene that consists of a variety of health care and community professionals who "assist with disaster and emergency recovery during a declared emergency situation."[51] The MRC relies on both practicing and

[47] *Id.* § 5-407(a)(2)-(9) (West 2010). Application of the Maryland Volunteer Service Act's protections hinge on an organization's tax-exempt status under the Internal Revenue Service's Code. Organizations should check with appropriate legal counsel to determine if the Act's protections apply to their volunteers.
[48] *Id.* § 5-407(a)(11)(i).
[49] *Id.* § 5-407(b)-(c).
[50] *Id.* § 5-407(b).
[51] Maryland Department of Health and Mental Hygiene, Office of Preparedness and Response, MPVC, available at http://preparedness.dhmh.maryland.gov/Pages/Programs/Emergency-Operations/Operations/Maryland-Professional-Volunteer-Corps/Default.aspx, last accessed June 17, 2011.

retired physicians, nurses, and other professionals "to address their community's ongoing public health needs and to help large-scale emergency situations."[52]

During an emergency, MPVC volunteers may perform a variety of tasks, including "deliver[ing] necessary public health services during a crisis, assist[ing] emergency response teams with victims, and provid[ing] care directly to those with less serious injuries and other health-related issues."[53] MPVC volunteers may also provide aid during emergency response efforts by "assisting their communities with ongoing public health needs[,]" such as administering immunizations, conducting screenings, and providing health and nutrition education, as well as assisting with response efforts at community centers and hospitals.[54]

SEE *PART II, SECTION C.1: LICENSING, CERTIFICATION, AND CREDENTIALING OF HEALTH CARE PROFESSIONALS*, P. 69 FOR MORE INFORMATION REGARDING THE MPVC AND DISASTER PRIVILEGES.

[52] *Id.*
[53] *Id.*
[54] *Id.*

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SECTION B: FEDERAL LAWS & PROGRAMS

While all emergency response begins locally, some incidents may be so large in scope or magnitude, or have an interstate impact, that they require the federal government to intervene to provide additional guidance or assistance to local and state response efforts. Section B discusses the federal laws and programs that may be relevant during a medical surge or public health emergency in Maryland.

1. Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act)

The Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) establishes the programs and processes to provide federal disaster and emergency assistance to state and local governments, individuals, and certain non-profit organizations during an emergency or major disaster.[55]

The Act defines "emergency" and "major disaster" in the following ways:

- **Emergency**: "any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States."[56]
- **Major Disaster**: "any natural catastrophe…or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under [the Stafford Act] to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby."[57]

[55] Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5207 (West 2003 & Supp. 2007).
[56] 42 U.S.C. § 5122(1) (West 2003 & Supp. 2008).
[57] *Id.* § 5122 (2).

The Stafford Act outlines a process through which governors may request federal disaster and emergency assistance from the President. If the governor of an affected state finds that a disaster is of "such severity and magnitude that effective response is beyond the capabilities of the State and the affected local governments and that Federal assistance is necessary," he may request that the President declare a "major disaster" or an "emergency."[58] The governor must then comply with the Act's procedural requirements and certify that the state will comply with the Act's cost-sharing requirements.[59]

A unilateral declaration of emergency or of a major disaster may be made by the President if an emergency affects an area within the exclusive authority of the federal government.[60] Such a declaration could be made for federally-owned or managed property, such as a national park, or for areas like military bases. For unilateral declarations, the Act requires the President to consult with the governor(s) of the affected state(s), if practicable.[61]

The Act provides a wide range of assistance from federal agencies, including but not limited to, debris removal, use of essential facilities, loans to local governments, use of federal troops, and resources, such as medicine, medical supplies, and food, for states and local areas affected by a disaster.[62]

2. National Emergencies Act

The National Emergencies Act[63] establishes procedures for Presidential declaration of national emergencies and provides the President with powers that may be exercised if the nation is "threatened by crisis, exigency, or emergency circumstances (other than natural disasters, war, or

[58] *Id*. § 5170. The process and requirements for declaring a "major disaster" and an "emergency" are quite similar. However, a declaration of "emergency" under the Stafford Act provides a more limited, but still significant, range of available federal assistance to affected state and local governments. *Id*. §§ 5192-5193.
[59] *Id*.
[60] *Id.* § 5191(b).
[61] *Id*.
[62] *Id*. § 5170(b)-5189(e).
[63] 50 U.S.C.A. §§ 1601-1651 (West 2003 & Supp. 2005).

near war situations)."[64] The Act provides the President with powers that "may be stated explicitly or implied by the Constitution, assumed by the Chief Executive to be permissible constitutionally, or inferred from or specified by statute."[65] However, the Act requires the President to "declare formally the existence of a national emergency and to specify what statutory authority, activated by the declaration, would be used" in dealing with the declared national emergency, and it places certain limits and restraints upon the President's use of his emergency powers.[66] For example, with the exception of the habeas corpus clause of the Constitution, the President may not use his or her powers under the Act to suspend any Constitutional provisions.[67] Additionally, disputes over the legality of the President's use of emergency power are judicially reviewable, and both the judiciary and Congress can restrain the President's use of emergency power in certain situations.[68]

The National Emergencies Act contains a "sunset provision" by which all emergency declarations automatically terminate after one year, unless formally renewed by the President.[69] While the Act's powers have been triggered several times throughout history, including during the Vietnam War, its powers were most recently used by President Barack Obama during the 2009 H1N1 influenza pandemic.[70] President Obama declared the H1N1 influenza pandemic a "national emergency," enabling the U.S. Department of Health and Human Services to use its authority under Section 1135 of the Social Security Act to "temporarily waive or modify certain requirements of the Medicare, Medicaid, and State Children's Health Insurance programs and of the Health Insurance Portability and Accountability Act Privacy Rule…" in order to remove potential limitations to the ability of the nation's health care system to respond to the pandemic.[71]

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[64] CRS Report for Congress, *National Emergency Powers*, Summary, available at http://www.fas.org/sgp/crs/natsec/98-505.pdf, last accessed 6/13/11.
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.*
[69] 50 U.S.C.A. §§ 1621-1622.
[70] *Declaration of a National Emergency with Respect to the 2009 H1N1 Influenza Pandemic*, The White House, Office of the Press Secretary (October 24, 2009), available at http://www.whitehouse.gov/the-press-office/declaration-a-national-emergency-with-respect-2009-h1n1-influenza-pandemic-0, last accessed June 16, 2011.
[71] *Id.*

Although these waivers and modifications can also be triggered in conjunction with the Stafford Act, the National Emergencies Act allows for this power to be used in situations, like the 2009 H1N1 influenza pandemic, when the Stafford Act may not be clearly applicable.[72]

3. Homeland Security Act of 2002, Homeland Security Presidential Directive No. 5 (HSPD-5), and Presidential Policy Directive No. 8 (PPD-8)

The Homeland Security Act of 2002 vests the U.S. Department of Homeland Security (DHS) with the legal authority and responsibility to protect the public from the threat of terrorism.[73] In the Act, Congress assigned DHS with a number of primary tasks, including the responsibility to:

- "prevent terrorist attacks within the United States;"
- "reduce the vulnerability of the United States to terrorism;"
- "minimize the damage, and assist in the recovery, from terrorist attacks that do occur;" and
- act as the focal point regarding natural and man-made crises and emergency planning.[74]

The Act gives the Secretary of Homeland Security full authority and control over DHS in order to carry out the department's mission of protecting the American homeland.[75] This mission is further supported by the President's homeland security directives, which are designed to create a nationally unified approach to domestic prevention, preparedness, response, and recovery activities for man-made and natural disasters through the National Response Framework.[76]

Of the various Homeland Security Presidential Directives, until 2011, HSPD-5 and HSPD-8 were the most significant to emergency response for public health or medical emergencies;

[72] *October 24, 2009 – President Obama Signs Emergency Declaration for H1N1 Flu*, Flu.gov, *available at* http://www.flu.gov/professional/federal/h1n1emergency10242009.html, last accessed June 15, 2011.
[73] Homeland Security Act, Pub. L. No. 107-296, 116 Stat. 2135 (codified as amended in various sections of Titles 3,5,6,7,10,14,18,20,21,28,37,38,42,49, & 50 of the U.S.C.A.) (West 2007).
[74] 6 U.S.C.A. § 111(b)(1)(A)-(D) (West 2007).
[75] *Id.* § 112(a)-(b).
[76] Directive on Management of Domestic Incidents: Homeland Security President Directive (HSPD-5), 3/10/03 WEEKLY COMP. PRES. DOC. 280 (Feb. 28, 2003), *available at* http://www.DHS.gov/xabout/laws/gc_1214592333605.shtm#1, last accessed June 8, 2010.

however, in March 2011, following a comprehensive review of national preparedness policy, President Obama replaced HSPD-8 with Presidential Policy Directive 8 (PPD-8). Summaries of HSPD-5 and PPD-8 are below:

- **HSPD-5** directs DHS to enhance the nation's ability to "manage domestic incidents by establishing a single, comprehensive national incident management system"[77] and to ensure that all levels of government "have the capability to work efficiently and effectively together" to coordinate resources for responding to or recovering from "terrorist attacks, major disasters, or other emergencies…"[78] HSPD-5 also requires DHS, among other things, to "administer a [National Response Framework (NRF)]…" in order to "integrate Federal Government domestic prevention, preparedness, response, and recovery plans into one all-discipline, all-hazards plan."[79]
- **PPD-8** "is aimed at facilitating an integrated, all-of-Nation, capabilities-based approach to preparedness."[80] PPD-8 emphasizes three national preparedness principles: an integrated effort among federal, state, local, tribal, and territorial governments and between the public, private, and non-profits sectors; a focus on capabilities as the cornerstone of preparedness; and an outcome-focused assessment to track the progress of the nation's efforts to build and sustain capabilities over time.[81] PPD-8 also calls for development of an overarching National Preparedness Goal that identifies the core capabilities necessary for preparedness, including prevention, protection, mitigation, response, and recovery, and requires the establishment of a National Preparedness System to guide activities that will enable the United States to achieve the Directive's goal.[82]

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[77] *Id*. § (3).
[78] *Id*. § (4).
[79] *Id*. § (16). Note: In 2007, FEMA renamed the *National Response Plan (NRP)* as the *National Response Framework (NRF)* to "better align the document with its intent and to encourage the continued development and refinement of detailed, robust all-hazards emergency operations plans." *See* Press Release, Dep't of Homeland Security, National Response Framework, Released (Jan. 22, 2008) & National Response Framework, 72 Fed. Reg. 51,833 (Sept. 11, 2007). *See also* http://www.fema.gov/pdf/emergency/nrf/NRF_FAQ.pdf, last accessed June 16, 2011.
[80] Presidential Policy Directive/PPD-8 (March 30, 2011), *available at* http://www.dhs.gov/xabout/laws/gc_1215444247124.shtm, last accessed June 16, 2011.
[81] *Id*.
[82] *Id*.

4. Public Health Service Act

The Public Health Service Act provides the Secretary of the Department of Health and Human Services (HHS) with authority to declare a public health emergency.[83] Under the Act, a public health emergency declaration may be issued if, after consultation with the necessary public health officials, the Secretary determines either:

- that a public health emergency is posed by a disease or disorder; or
- that "a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists."[84]

The Public Health Service Act is unique in that, unlike many disaster relief statutes, a request for assistance from an affected jurisdiction is not required for the Secretary of HHS to issue a declaration of a public health emergency under the Act. The Act requires that written notice of the Secretary's determination be sent to Congress within 48 hours of issuance of the declaration, and all declarations continue for 90 days, unless terminated or renewed earlier by the Secretary of HHS. Upon declaration of a public health emergency, the Secretary may take measures to respond appropriately to the emergency, including conducting investigations, conducting emergency procurement, and issuing grants to support response activities.

Under the Act, the Secretary of HHS has authority and responsibility to:

- create and implement a plan under which all available resources of the Public Health Service -- including personnel, equipment, and medical supplies -- and other agencies under the Secretary's jurisdiction may be used to respond to emergency health problems;
- "enter into agreements providing for the cooperative planning between the Service and public and private community health programs[];"[85] and
- "encourage cooperative activities between the States" regarding planning and response activities.[86]

[83] Public Health Service Act, 42 U.S.C. §§201-300jj-38 (West 2003 & Supp. 2010).
[84] *Id*. § 247d(a) (West 2003).
[85] *Id*. § 243(c)(1).
[86] *Id*. § 243(b) & (c)(1).

When a public health emergency is declared, the Secretary of HHS has authority to use money from the Public Health Emergency Fund (the Fund), established by the U.S. Department of the Treasury, to carry out response activities. While the Fund is intended to supplement, not supplant, other public funds provided by federal, state, and local governments to address the public health emergency, Congress may appropriate money to the Fund as necessary.

5. Health Insurance Portability and Accountability Act (HIPAA)

Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996 in order to "improve portability and continuity of health insurance coverage[.]"[87] Pursuant to HIPAA, the U.S. Department of Health and Human Services promulgated the HIPAA Privacy Rule,[88] which outlines the Act's protections for privacy of health information.[89] While HIPAA provides a baseline for protection of privacy of health information, it does not preempt state laws related to privacy of protected health information that provide greater protection.[90]

The Privacy Rule requires "covered entities"[91] to obtain consent and authorization from an individual before they may use or disclose that individual's "protected health information." Protected health information (PHI) includes:

- any information about health status, provision of health care, or payment of health care that can be linked to an individual patient; and
- any "individually identifiable health information," including, but not limited to, names, Social Security numbers, and addresses of patients.[92]

[87] Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in parts of Titles 18, 26, 29, & 42 U.S.C.A.)
[88] 45 C.F.R. § 160.164 (2009).
[89] *See generally* 45 C.F.R. §§ 160.203, 164.502, and 164.512 (2006). *See also* Office for Civil Rights, U.S. Dep't of Health and Human Services, Summary of the HIPAA Privacy Rule (last revised May 2003), *available at* http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf , last accessed June 17, 2011.
[90] 45 C.F.R. § 160.203 (2009).
[91] *Id*. § 160.103 (2009). "Covered entities," as defined by the Act, include health care providers, health plans, and health care clearinghouses who conduct certain transactions electronically, as well as business associates whose function involves the use or disclosure of protected health information while acting on behalf of a covered entity.
[92] *Id*.

The Privacy Rule mandates disclosure of protected health information for only two purposes: 1) to HHS during a compliance investigation, review, or enforcement action; or 2) to individuals or their personal representatives when they request such access, or for an accounting of disclosures of their protected health information.[93]

However, numerous exceptions to the Privacy Rule allow for unauthorized disclosures of protected health information under specific circumstances. Exceptions to the HIPAA Privacy Rule permit covered entities to disclose protected health information, without an individual's consent and authorization, in a number of situations that may be applicable to a medical surge or public health emergency.[94] These include:

- disclosures required by law;
- disclosures for public health purposes;
- disclosures for law enforcement purposes; and
- disclosures to mitigate or prevent a serious and imminent threat to health or safety of individuals or the public.[95]

HHS guidance also indicates that, during a public health emergency, the Privacy Rule permits unauthorized disclosures of protected health information to public officials in order to assist their response for a public health emergency.[96] Additionally, health care providers may disclose information necessary for treatment, or to identify, locate, or notify family members of patients during a public health emergency.[97]

SEE *PART II, SECTION B.1: HIPAA PRIVACY RULE AND EXCEPTIONS*, P. 57, FOR ADDITIONAL INFORMATION REGARDING THE HIPAA PRIVACY RULE.

[93] *Id.* § 164.502(a)(2).
[94] OFFICE OF THE SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, HURRICANE KATRINA BULLETIN (2009).
[95] *Id.*
[96] OFFICE OF THE SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, HURRICANE KATRINA BULLETIN #2: HIPAA PRIVACY RULE COMPLIANCE GUIDANCE AND ENFORCEMENT STATEMENT FOR ACTIVITIES IN RESPONSE TO HURRICANE KATRINA 3-4 (September 9, 2005), *available at* http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/enforcementstatement.pdf, last accessed June 17, 2011.
[97] *Id.*

It is important to note that the **HIPAA Privacy Rule is NOT suspended during a public health emergency**; however, the Secretary of HHS *may*, under Section 1135 of the Social Security Act,[98] issue a waiver or modify the application of sanctions and penalties against a covered hospital that fails to comply with provisions of the HIPAA Privacy Rule.[99] As such, it is important that health care providers and other covered entities follow basic procedures for compliance at all times to avoid being subject to sanctions or penalties under the Act.

SEE *PART I, SECTION B.9, SECTION 1135 WAIVERS*, P. 26, FOR MORE INFORMATION REGARDING SECTION 1135 WAIVERS.

6. Emergency Medical Treatment and Active Labor Act (EMTALA)

The Emergency Medical Treatment and Active Labor Act (EMTALA)[100] requires hospitals that participate in Medicare and provide emergency services to comply with three main directives. When an individual presents at an emergency department seeking medical care, a hospital must take the following steps:

- provide an appropriate medical screening to determine if the individual has an emergency medical condition;[101]
- if the hospital determines the individual has an emergency medical condition, it must treat the emergency condition and stabilize the individual, or transfer the individual to another hospital;[102]
- if the hospital determines the individual has an emergency medical condition, it must not transfer an individual who has not been stabilized unless:
    - the individual has requested a transfer and has been informed of the risks of a transfer; or
    - a physician has certified that the medical benefits of the transfer outweigh the potential risks to the patient; or

[98] 42 U.S.C. § 1320b-5 (West 2003 & Supp. 2010).
[99] *Id*. § 1320b-5(b)(7).
[100] Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2006)
[101] *Id*. § 1395dd(a).
[102] *Id*. § 1395dd(b).

- the transfer is an "appropriate transfer," meaning that the facility to which the patient is being transferred has available space and qualified personnel and has agreed to accept the individual and provide treatment.[103]

It is important to note that, while EMTALA only applies to hospitals that participate in the Medicare program through the Department of Health and Human Services, **its provisions apply to ALL patients, not just to patients who are on Medicare**.[104] Sanctions for non-compliance with EMTALA include fines and possible exclusion from the Medicare program.

During a declared national emergency or public health emergency, the Secretary of HHS may, through authority under Section 1135 of the Social Security Act,[105] authorize waivers of certain provisions of EMTALA or sanctions for certain transfers that would otherwise violate the Act, including:

- transfers of an individual who has not been stabilized, if the transfer arises out of the circumstances surrounding the declared emergency; and
- directing individuals to receive medical screenings in an alternate location, pursuant to state emergency preparedness or pandemic preparedness plans.[106]

SEE *PART I, SECTION B.9, SECTION 1135 WAIVERS*, P. 26, FOR MORE INFORMATION REGARDING SECTION 1135 WAIVERS.

7. Pandemic and All-Hazards Preparedness Act

Designed to improve the United States' ability to prevent, prepare for, and respond to bioterrorism and other public health emergencies, the Pandemic and All-Hazards Preparedness Act[107] gives the Secretary of HHS authority to "lead all Federal public health and medical

[103] *Id*. § 1395dd(c).
[104] *Id*. § 1395dd(a).
[105] 42 U.S.C. § 1320b-5 (West 2003 & Supp. 2010).
[106] *Id*. § 1320b-5(b)(3).
[107] Pandemic and All-Hazards Preparedness Act, Pub. L. No. 109-417, 120 Stat. 2831 (codified as amended in sections of Titles 21 & 42 U.S.C.)

response to public health emergencies and incidents covered by the National Response [Framework]."[108] The National Response Framework (NRF) was created to:

- provide for the operation of the National Disaster Medical System to mobilize and address public health emergencies;[109]
- create programs for the education and training of public health professionals to improve preparedness of hospitals and state and local governments, as well as enhancing their response to bioterrorist attacks and other public health emergencies;[110]
- clarify and streamline quarantine provisions for communicable diseases;[111] and
- enhance controls on dangerous biological agents and toxins to protect the safety and security of food and drug supplies.[112]

The Act also requires the Secretary of HHS to collaborate with the Secretaries and head officials of various federal departments, including the Departments of Transportation, Defense, and Homeland Security, to create an interagency agreement giving HHS "operational control of emergency public health and medical response assets."[113]

SEE *PART I, SECTION B.10: NATIONAL DISASTER MEDICAL SYSTEM*, P. 28, FOR MORE INFORMATION ON THE PANDEMIC AND ALL HAZARDS PREPAREDNESS ACT.

8. Public Readiness and Emergency Preparedness Act (PREP Act)

Under the Public Readiness and Emergency Preparedness Act (PREP Act),[114] the Secretary of HHS is authorized to issue a PREP Act declaration providing immunity from tort liability related to the administration or use of "covered countermeasures" for diseases or threats determined by

[108] 42 U.S.C.A. § 300hh(a) (West Supp. 2010)
[109] *Id*. §§ 300hh-11(a)(3)(A)-(C).
[110] *Id*. § 247d-7a(a).
[111] *Id*. §§ 254e, 264-267 (West 2003).
[112] *Id*. § 262(a) (West Supp. 2010).
[113] *Id*. § 300hh(b) (West Supp. 2010).
[114] Public Readiness and Emergency Preparedness Act, Pub. L. No. 109-148, 119 Stat. 2818; §§ 247d-6d, 247d-6e (West Supp. 2010).

the Secretary to constitute a present or future risk of a public health emergency.[115] A PREP Act declaration provides immunity protections to individuals and entities involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures, provided that the individual or entity does not act with willful misconduct.[116]

Unlike many other similar laws, a PREP Act declaration can be made independently, in the absence of a declared state of emergency or public health emergency. The Secretary can specify the conditions, such as effective dates or geographic areas, to which her declaration will apply.

Finally, the PREP Act also authorizes creation and maintenance of an emergency fund within the U.S. Treasury to provide compensation to individuals whose injuries are directly caused by the use or administration of a countermeasure covered by a PREP Act declaration.[117]

SEE *PART II, SECTION A.3: LIABILITY AND IMMUNITY OF HEALTH CARE PROVIDERS AND OTHER RESPONDERS*, P. 43, FOR MORE INFORMATION ON THE PREP ACT.

9. Section 1135 Waivers

Section 1135 of the Social Security Act provides the Secretary of Health and Human Services with authority to temporarily waive or modify application of certain regulatory requirements for health care facilities, including some provisions of Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), HIPAA, and EMTALA.[118]

To issue a Section 1135 waiver:

- the President must declare an emergency or disaster pursuant to either the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act; and

[115] *Id*.
[116] *Id*. § 247d-6d(a)(2)(b).
[117] http://www.hhs.gov/disasters/emergency/manmadedisasters/bioterrorism/medication-vaccine-qa.html.
[118] Social Security Act, Pub. L. No. 107-188, 116 Stat. 594, 627 (2002) (codified as amended at 42 U.S.C. § 1320b-5 (West Supp. 2010).

- the Secretary of HHS must declare a public health emergency under Section 319 of the Public Health Service Act.[119]

A Section 1135 waiver may be made retroactive to the beginning of a declared emergency period or any subsequent date specified by the Secretary of HHS. These waivers terminate upon either the termination of the related disaster or emergency, or 60 days after the waiver is published, unless the Secretary wishes to extend the waiver pursuant to law.[120]

Section 1135 waivers are designed mainly to ensure that:

- "sufficient health care items and services are available to meet the needs of individuals in area[s]" affected by a declared disaster or emergency who are enrolled in Medicare, Medicaid, or SCHIP; and
- health care providers who provide goods or services in good faith may "be reimbursed for such items and services and exempted from sanctions" if they are unable to comply with program requirements during a declared emergency or disaster, "absent any determination of fraud or abuse."[121]

Examples of some of the provisions or requirements that **may** be temporarily waived or modified through a Section 1135 waiver include, but are not limited to:

- conditions of participation, certification requirements, program participation requirements, and pre-approval requirements for health care providers participating in Medicare;
- limitations on payments for certain health care items and services furnished to individuals enrolled in a Medicare+Choice plan by health care providers (both individuals and facilities) not included in such a plan;
- requirements that health care providers be licensed in the state in which they provide services;
- sanctions for transfers of patients that would otherwise violate EMTALA;

[119] 42 U.S.C. § 247d(a) (West 2003).
[120] *Id*. § 1320b-5(a)(1).
[121] *Id*. § 1320b-5(a)(2).

- sanctions regarding federal physician self-referral prohibitions;
- sanctions and penalties arising from noncompliance with regulations pertaining to HIPAA and the HIPAA Privacy Rule.[122]

SEE *PART I, SECTION B.6: EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT*, P. 23, *PART I, SECTION B.5: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT*, P. 21, FOR MORE INFORMATION REGARDING HOW PROVISIONS OF EMTALA AND HIPAA MAY BE WAIVED THROUGH A SECTION 1135 WAIVER, AND *PART II, SECTION C.1: LICENSING, CERTIFICATION, AND CREDENTIALING OF HEALTH CARE PROFESSIONALS*, P. 69, FOR MORE INFORMATION REGARDING MARYLAND LICENSURE REQUIREMENTS FOR HEALTH CARE PROFESSIONALS.

Finally, it is important to note that **a Section 1135 waiver affects only those provisions of law or regulations named in the waiver; any provisions or regulations not contained in the waiver remain unchanged**. For example, during a declared public health emergency, the Secretary of HHS may issue a Section 1135 waiver that modifies limitations on payments for certain items and services furnished to patients through Medicare; however, unless explicitly stated, this particular waiver would not affect any provisions of HIPAA or EMTALA, and sanctions for violations of those laws would continue to apply. **While the above list includes a number of provisions that may be waived, response personnel should always assume that all laws and regulations not listed in the Section 1135 waiver are still in full effect and should make every effort to comply with the requirements of the current legal framework.**

10. National Disaster Medical System (NDMS)

The Secretary of Homeland Security manages the operation of the National Disaster Medical System (NDMS), in coordination with the Secretary of Health and Human Services, the Secretary of Defense, the Federal Emergency Management Agency (FEMA), and the

[122] *Id*. § 1320b-5(b)(1)-(7) (West Supp. 2010).

Department of Veterans Affairs, as well as with states and other public and private entities, as appropriate.[123]

As necessary, the "Secretary [of Homeland Security] may activate the National Disaster Medical System to – (i) provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency…; or (ii) be present at locations, and for limited periods of time, specified by the Secretary on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified."[124]

One key component of the NDMS is the Disaster Medical Assistance Team (DMAT). A DMAT is a group of medical and support personnel that provide emergency medical care during disasters and other emergencies.[125] DMATs deploy to disaster areas with sufficient supplies and equipment to allow them to function as medical care providers at a fixed or temporary site for up to 72 hours. DMATs may also provide primary health care and/or supplement overloaded health care staff at local facilities. They are designed to provide rapid response to augment local medical care capabilities until other federal or contractual resources can be mobilized, or until the disaster or emergency has ended.[126]

11. Advance Registration of Health Profession Volunteers

The Public Health Service Act directed the Secretary of Health and Human Services to "link existing State verification systems to maintain a single national interoperable network of systems, each system being maintained by a State or group of States, for the purpose of verifying the credentials and licenses of health care professionals who volunteer to provide health services during a public health emergency."[127]

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[123] *Id*. § 300hh-11(b) (West 2010).
[124] *Id*. § 300hh-11(b)(3)(A) (West 2010).
[125] DEPARTMENT OF HOMELAND SECURITY, NATIONAL DISASTER MEDICAL SYSTEM, NATIONAL DISASTER MEDICAL SYSTEM TEAMS, DISASTER MEDICAL ASSISTANCE TEAMS, *available at* http://www.phe.gov/Preparedness/responders/ndms/teams/Pages/dmat.aspx (last accessed September 19, 2011).
[126] *Id*.
[127] 42 U.S.C § 247d-7b (West Supp. 2010).

This network was required to include information about each volunteer, including:

- information that would allow the health professional to be rapidly identified and contacted; and
- credentials, certifications, and licenses held by the volunteer.

This network was also required to contain the names of members of the "Medical Reserve Corps, the National Disaster Medical System, and any other relevant federally-sponsored or administered programs determined necessary by the Secretary."[128]

Finally, the Act also required the Secretary to "encourage States to establish and implement mechanisms to waive the application of licensing requirements applicable to health professionals, who are seeking to provide medical services (within their scope of practice), during a national, State, local, or tribal public health emergency upon verification that such health professionals are licensed and in good standing in another State and have not been disciplined by any State health licensing or disciplinary board."[129]

SEE *PART I, SECTION B.10: NATIONAL DISASTER MEDICAL SYSTEM*, P. 28, FOR MORE INFORMATION REGARDING THE NDMS AND *PART II, SECTION C.1: LICENSING, CERTIFICATION, AND CREDENTIALING OF HEALTH CARE PROFESSIONALS*, P. 69,69 FOR MORE INFORMATION ON THE ADVANCE REGISTRATION SYSTEM.

12.Strategic National Stockpile (SNS)

"The Secretary [of Health and Human Services], in collaboration with the Director of the Centers for Disease Control and Prevention, and in coordination with the Secretary of Homeland Security,…shall maintain a stockpile of drugs, vaccines, and other biological products, medical devices, and other supplies in such numbers, types, and amounts as are determined by the Secretary to be appropriate and practicable, taking into account other available sources, to

[128] *Id*. § 247d-7(b)(6)(2).
[129] *Id*. § 247d-7b(i)

provide for the emergency health security of the United States, including the emergency health security of children and other vulnerable populations, in the event of a bioterrorist attack or other public health emergency."[130]

The Secretary of HHS must periodically review and revise the stockpile's contents to "ensure that emerging threats, advanced technologies, and new countermeasures are adequately considered;" and to devise plans, in coordination with public and private health care providers and relevant federal, state, and local agencies "for the effective and timely supply-chain management of the stockpile[.]"[131]

The stockpile may be deployed at the discretion of the Secretary of HHS, and must be deployed when the Secretary of Homeland Security requests it "to respond to an actual or potential emergency[.]"[132]

[130] *Id*. § 247d-6b(a)(1) (West Supp. 2010).
[131] *Id*. § 247d-6b(2)(D)-(E).
[132] *Id*. § 247d-6b(2)(F)-(G).

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SECTION C: MUTUAL AID AGREEMENTS

During a disaster or public health emergency, an affected state may request assistance from other states for additional resources and personnel to supplement their response efforts. As such, many jurisdictions at the local, state, and regional level have entered into mutual aid agreements or mutual aid compacts in order to streamline this process and to enhance their emergency preparedness and response efforts. Section C discusses the three main mutual aid agreements that impact Maryland's emergency management efforts.

1. Emergency Management Assistance Compact (EMAC)

The Emergency Management Assistance Compact, or EMAC, is a congressionally ratified mutual aid compact between all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.[133] EMAC provides for state-to-state assistance in the form of resources, equipment, and personnel during a Governor-declared emergency; however, the compact provides that a state "may withhold resources to the extent necessary to provide reasonable protection" for itself.[134]

EMAC's purpose is to provide for mutual assistance among party states in order to manage "any emergency or disaster that is duly declared by the Governor of the affected state(s), whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspects of resource shortages, community disorders, insurgency, or enemy attack."[135] The compact provides a general framework for interstate assistance; however, states may agree to modify its provisions through supplementary agreements if they wish to do so.[136] Such supplementary agreements may include, but are not limited to, "provisions for evacuation and reception of injured and other persons and the exchange of medical, fire, police, public utility, reconnaissance, welfare, transportation, and communications personnel, and equipment and supplies."[137]

[133] Emergency Management Assistance Compact, Pub. L. No. 104-321, 110 Stat. 3877 (1996).
[134] MD. CODE ANN., PUB. SAFETY §§ 14-702(1), (3)-(4) (West 2003 & Supp. 2009).
[135] *Id*. § 14-702(1).
[136] *Id*. § 14-702(7).
[137] *Id*.

EMAC covers a number of important issues, including:

- **Professional Licensure and Certification**: A health care provider or other person holding a "license, certificate, or other permit issued by a state party to [EMAC] evidencing the meeting of qualifications for professional, mechanical, or other skills" by the party state "shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving such skill to meet a declared emergency or disaster, subject to such limitations and conditions as the Governor of the requesting state may prescribe by executive order or otherwise."[138]
- **Liability and Immunity of Response Personnel**: "Officers or employees of a party state rendering aid in another party state pursuant to [EMAC] shall be considered agents of the requesting state for tort liability and immunity purposes[;]"[139] that is, personnel responding to a party state's request for assistance under EMAC are subject to the same liability protections and immunities as the state's own responders. Additionally, EMAC includes an immunity provision, stating "No party state or its officers or employees rendering aid in another state pursuant to [EMAC] shall be liable on account of any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith."[140] (It is important to note that "good faith" does not include "willful misconduct, gross negligence, or recklessness.")[141]
- **Allocation and Reimbursement of Costs**: Each party state is liable for compensating its own employees and officers or representatives of its own employees or officers who are injured or killed while rendering aid to a party state "as if the injury or death were sustained within their own state."[142] Similarly, the state receiving aid must reimburse the aid-rendering state for the loss, damage, or expense of operation of any equipment during the emergency. However, the aid-rendering state may voluntarily assume incurred

[138] *Id*. § 14-702(5).
[139] *Id*. § 14-702(6).
[140] *Id*.
[141] *Id*.
[142] *Id*. § 14-702(8).

expenses; or, alternatively, two or more states may enter into cost allocation agreements to modify EMAC's default reimbursement rule.[143]

- **Evacuation**: Party states must cooperate to create a plan for mass evacuation of one member state's citizens to another member state.[144] Such evacuation plans are activated when a member state requests its citizens to evacuate.[145] These plans must also describe procedures for providing medical care, supplies, medication, etc. to evacuees, as well as estimating the number of evacuees that will be delivered to each area of the recipient state.[146]

SEE *PART II, SECTION A.3: LIABILITY AND IMMUNITY OF HEALTH CARE PROVIDERS AND OTHER RESPONDERS*, P. 43, FOR MORE INFORMATION ON EMAC'S LIABILITY AND IMMUNITY PROVISIONS, AND *PART II, SECTION C.1: LICENSING, CERTIFICATION, AND CREDENTIALING OF HEALTH CARE PROFESSIONALS*, P. 69, FOR MORE INFORMATION REGARDING EMAC'S LICENSING AND CERTIFICATION PROVISIONS.

2. Maryland Emergency Management Assistance Compact (MEMAC)

The Maryland Emergency Management Assistance Compact (MEMAC) provides for intrastate assistance and cooperation among Maryland's counties, Baltimore City, and Ocean City in order to manage intrastate emergencies.[147] Like EMAC, member-jurisdictions may "withhold resources to the extent necessary to provide reasonable protection to its own jurisdiction,"[148] and like EMAC, member jurisdictions are permitted to enter into supplementary agreements with each other regarding, but not limited to, "(i) provisions for evacuation and reception of injured and other persons; and (ii) the exchange of medical, fire, police, public utility, reconnaissance, welfare, transportation, and communications personnel, equipment and supplies."[149]

[143] *Id*.
[144] *Id*. § 14-702(10).
[145] *Id*.
[146] *Id*.
[147] *Id*. § 14-803(a)(1) (West 2003).
[148] *Id*. § 14-803(3)(c)(2).
[149] *Id*. § 14-803(5)(e)(2).

MEMAC requires that "frequent" consultations occur between MEMA and appropriate officials and representatives of member-jurisdictions to achieve "free exchange of information and plans generally relating to emergency capabilities."[150] Additionally, MEMAC provides "for mutual cooperation in emergency-related exercises, testing, or other training activities using equipment or personnel simulating performance of any aspect of the giving and receiving of aid by party jurisdictions during emergencies."[151]

MEMAC provides a framework for a variety of issues, including the following:

- **Liability and Immunity Protections**: Similar to EMAC, "[o]fficers or emergency responders of a party jurisdiction rendering aid in another jurisdiction pursuant to [MEMAC] shall be considered agents of the requesting jurisdiction for tort liability and immunity purposes."[152] Also like EMAC, the compact provides immunity from liability for member jurisdictions and their officers and emergency responders when they provide aid "in good faith" and "pursuant to the compact."[153]
- **Allocation of Costs and Reimbursement**: Under MEMAC, responding jurisdictions must pay workers' compensation and death benefits to injured members of the emergency responders of their own jurisdictions.[154] However, responding jurisdictions may agree to waive part or all of the costs of losses, damages, expenses, or other costs; may loan or donate equipment or services to the requesting jurisdiction free of charge; and may agree to any allocation of expenses with the requesting jurisdiction.[155] Finally, if an emergency ultimately requires the federal government to assist with response and FEMA allocates funding to help manage the emergency, the federal government can reimburse the responding jurisdiction(s) for some of their expenditures through a claim made by the jurisdiction requesting aid.

[150] *Id*. § 14-803(2)(b)(6).
[151] *Id*. § 14-803(1)(a)(2).
[152] *Id*. § 14-803(d)(1).
[153] *Id*. § 14-803(d)(2).
[154] *Id*. § 14-803(6)(f)(2).
[155] *Id*. § 14-803(6)(f)(2)(i)-(iii).

SEE *PART II, SECTION A.3: LIABILITY AND IMMUNITY OF HEALTH CARE PROVIDERS AND OTHER RESPONDERS*, P. 43, FOR MORE INFORMATION ON MEMAC'S LIABILITY AND IMMUNITY PROVISIONS.

3. National Capital Region Mutual Aid Agreements (NCR Agreements)

Pursuant to the Intelligence Reform and Terrorism Prevention Act of 2004 (IRTPA), mutual aid agreements between Maryland, Virginia, and the District of Columbia may be created to respond to or mitigate any emergency within the National Capital Region (NCR).[156] (Note: The National Capital Region refers to "the geographic area located within the boundaries of (A) the District of Columbia, (B) Montgomery and Prince George's Counties in the State of Maryland, (C) Arlington, Fairfax, Loudoun, and Prince William Counties and the City of Alexandria in the Commonwealth of Virginia, and (D) all cities and other units of government within the geographic areas of such District, Counties, and City.")[157]

Like EMAC and MEMAC, the NCR Agreements provide a framework for dealing with many emergency response issues, including but not limited to, the following:

- **Professional Licensure and Certification**: Under the NCR Agreements, a person holding a "license, certificate, or other permit issued by any responding party evidencing the meeting of qualifications for professional, mechanical, or other skills and assistance" will be "deemed licensed, certified, or permitted by the receiving jurisdiction to render aid involving such skill[.]"[158]
- **Liability and Immunity Protections**: Unlike EMAC and MEMAC, the NCR Agreements do not provide general immunity to responding jurisdictions and individuals who act in good faith. However, pursuant to these Agreements, a responding party that renders aid or fails to render aid "shall be liable on account of any act or omission of its officers or employees while so engaged…to the extent permitted under the laws and

[156] Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. No. 108-458, § 7302, 118 Stat. 3638 (2004)
[157] 10 U.S.C. § 2674(f)(2) (West 1998 and Supp. 2005) (as referenced by IRTPA at Pub. L. No. 108-458, § 7302(a)(7), 118 Stat. 3638 (2004)).
[158] Intelligence Reform and Terrorism Prevention Act, Pub. L. No. 108-458, § 7302(f), 118 Stat. 3638 (2004).

procedures of the State of the party rendering aid."[159] Essentially, the NCR Agreements subject responding jurisdictions and individuals only to the same level of liability to which they would be subject when responding in their own jurisdiction.

- **Allocation of Costs and Reimbursement**: Each party to an NCR Agreement is required to provide for the payment of workers' compensation and death benefits to injured members of the party's emergency forces, if such members "sustain injuries or are killed while rendering aid" to a party state or while "engaged in training activities."[160] These payments must be provided "in the same manner and on the same terms as if the injury or death were sustained within" the party's own jurisdiction.[161]

SEE *PART II, SECTION A.3: LIABILITY AND IMMUNITY OF HEALTH CARE PROVIDERS AND OTHER RESPONDERS*, P. 43, FOR MORE INFORMATION ON THE LIABILITY AND IMMUNITY PROVISIONS CONTAINED IN THE NCR AGREEMENTS, AND *PART II, SECTION C.1: LICENSING, CERTIFICATION, AND CREDENTIALING OF HEALTH CARE PROFESSIONALS*, P. 69, FOR MORE INFORMATION REGARDING THE NCR AGREEMENTS' LICENSURE AND CERTIFICATION PROVISIONS.

[159] *Id*. § 7302(f).
[160] *Id*. § 7302(e)(1).
[161] *Id*.

PART II: SELECT TOPICS

Part II discusses a variety of specific issues that may be relevant to creation and operation of an Alternate Care Site (ACS). Section A highlights the various state and federal liability and immunity laws that may be applicable to health care providers and responders working in an ACS, while Section B discusses privacy of patient information and disease reporting requirements. Finally, Section C details some of the requirements for licensing of health care providers and facilities.

It is important to note that, while Part II addresses a number of issues that may be relevant to the creation and operation of an ACS, it is not intended to constitute a comprehensive discussion of all the potential concerns that may arise in setting up and managing an ACS. Individual concerns regarding actual implementation and management of an ACS should be handled in coordination and consultation with each organization's respective legal counsel.

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SECTION A: LIABILITY AND IMMUNITY

During an emergency response, public and private sector representatives, officials, and entities – particularly health care providers and other responders -- may need to take actions that cause some individuals to feel that they have somehow been treated negligently or in an improper fashion. While the actions taken by these public and private sector entities may be perfectly legal, it is possible that some individuals may still try to file civil law suits and hold these entities liable for their actions. Additionally, health care providers and other response personnel may not always find it possible or practical to comply with all statutory, regulatory, and other legal requirements while operating under the extraordinary restraints on time and resources that are common during an emergency response. As such, it is best to be aware of the legal framework surrounding issues of liability and immunity so that health care providers and other emergency responders can do their best to comply with legal requirements and minimize their exposure to potential liability.

Section A discusses a number of liability concerns that may be relevant to an Alternate Care Site (ACS). While the information contained in this section is designed to provide key information regarding liability issues, it is intended only for educational purposes; **individuals with specific questions regarding potential liability for ACS management should always consult with appropriate counsel for their organization.** In addition to the laws highlighted in this Section, best practices for management of ACS patients, facilities, personnel, and volunteers can be found in *Best Practices for Alternate Care Sites (ACS)*.

1. Liability, Generally

Plaintiffs' claims for injuries or harm arising out of a medical emergency or public health emergency will most likely be filed as negligence claims. Negligence is broadly defined as "the failure to do what a person of ordinary prudence would have done under the circumstances of the

situation, or doing what such a person, under such circumstances, would not have done."[162] In Maryland, a successful claim for negligence must prove all of the following elements:

- **Duty**: The plaintiff must prove that the defendant had a duty of care to the plaintiff imposed by statute, contract, or specific relationship or role.
- **Breach of Duty**: The plaintiff must prove that the defendant failed to meet his duty according to the accepted standard of care.
- **Harm**: The plaintiff must prove that he suffered harm.
- **Causation**: The plaintiff must prove that his harm was directly or proximately caused by the defendant's breach of duty.

2. Standards of Care

Legally, health care providers owe a duty of standard care to the patients they treat; falling below this standard of care can constitute negligence and result in a provider being held liable for malpractice if the breach of duty causes harm to a patient. **Maryland law does not officially legally recognize any altered standard of medical care that may be adopted during an emergency.** Because of this, health care providers are held to the same standard of care during both emergency and non-emergency situations; however, this standard may be interpreted in a way that should likely help to shield health care providers from liability for decisions made regarding care during an emergency.

Standards of Care: Emergency vs. Non-Emergency Situations

Under Maryland law, the standard of medical care for all situations requires health care facilities and providers to:

- use the degree of care expected of a **reasonably competent practitioner**;
- under the **same or similar circumstances**, accounting for:
    - advances in the profession;

[162] *Ottenheimer v. Molohan*, 126 A. 97, 100 (Md. 1924) (quoting *Geiselman v Schmidt*, 68 A.202 (Md. 1907)).

- availability of specialized facilities and/or providers; and
- other relevant factors.

Maryland law does not recognize a different, or altered, standard of care for use during emergency situations. However, the above standard could be interpreted to account for the circumstances of the emergency under which health care facilities and providers are forced to perform. For example, to account for the "same or similar circumstances" prong of the medical standard of care, a court or jury hearing a malpractice claim arising from care provided during an emergency or disaster situation would need to consider the exigencies of the situation when determining the appropriate standard of care to which the health provider should be held. As such, the fact that the providers were administering care during an emergency would need to be considered when determining if the defendant met the required standard of care, and this may result in the jury or court finding that the defendant was not, in fact, negligent in his or her conduct. Due to the legally-required consideration of the circumstances in which care was provided, a court or jury might find that care that ordinarily would be considered as negligence or malpractice meets the expected standard of care for a provider who is forced to operate under the emergency circumstances created by a medical surge or public health emergency.[163]

In addition to the consideration of the circumstances in which care is given, Maryland and federal law also provides liability and immunity protections for health care providers in certain situations. Specific liability and immunity protections provided by state and federal law will be discussed in more detail throughout Section A.

3. Liability and Immunity of Health Care Providers and Other Responders

Generally, health care providers in the State of Maryland are obligated to meet the legally-recognized standard of care, discussed above. In some circumstances, however, state and federal

[163] See Elizabeth West, *Lessons from Katrina: Response, Recovery, and the Public Health Infrastructure*, 10 DePaul J. Health Care L. 251, 286-7 (2007) (discussing malpractice issues faced by medical providers during disasters).

laws provide limitations on liability or immunity protections for defined health care providers, first responders, and volunteers. These laws are discussed below.

When reviewing the various liability limitations and immunity protections that may be available under certain circumstances, it is important to note whether such laws provide immunity to individuals, facilities, or both. Additionally, some immunity protections are not in effect unless certain prerequisite conditions, such as a proclamation of a catastrophic health emergency, have occurred, and none of the immunity laws discussed herein apply to actions performed with willful misconduct or gross negligence. Before the narrative discussion of each law's immunity protections, a "Snapshot" text box is included that provides a brief description of the law's application and lists any pre-requisites that may be needed to trigger the law's immunity protections or other limitations that may be imposed. *While this Snapshot is provided to give readers a quick glance at the law's applicability, readers should refer to the narrative discussion for full information regarding the law's immunity protections and application to individuals and facilities.* Finally, eligibility for many of the liability and immunity protections discussed in this section hinges on whether health care providers, facilities, or individuals meet the defined criteria set forth in the statutes. **As such, when determining eligibility for immunity or limited liability under a specific law, individuals should always check with their organization's legal counsel.**

Immunity Under the Catastrophic Health Emergencies Act (CHE Act)

SNAPSHOT

Applies to: Individuals and facilities

Triggers/Limitations: Only applies upon DHMH Secretary's proclamation of a catastrophic health emergency.

Because the Catastrophic Health Emergencies Act provides authority to the Governor and the Secretary of the Maryland Department of Health and Mental Hygiene to compel the service of health care providers in responding to a public health emergency, the Act also provides

immunity protections to those responders for actions taken pursuant to an order or directive issued under the Act.

Pursuant to the CHE Act, a health care provider acting under a proclamation of a catastrophic health emergency is "immune from civil or criminal liability if the health care provider acts in good faith[.]"[164] The Act's immunity protections also apply to health care providers who perform actions in good faith in accordance with the "catastrophic health emergency disease surveillance and response program."[165]

Unlike many of the other immunity laws discussed in this section, **the CHE Act provides immunity to both individuals and facilities**. By definition under the Act, a **health care provider** includes:

- a health care facility as defined in § 19-114(e)(1) of the Health-General Article of the Maryland Code;
- a health care practitioner as defined in § 19-114(f) of the Health-General Article of the Maryland Code; and
- an individual licensed or certified as an emergency medical services provider under § 13-516 of the Education Article of the Maryland Code.[166].

Finally, the immunity protection provided under the CHE Act only applies once the Secretary of DHMH has issued a proclamation of a catastrophic health emergency.[167] While such a proclamation can be issued retroactively, health care providers should never assume that a CHE proclamation will be issued.

SEE *PART I, SECTION A.1: CATASTROPHIC HEALTH EMERGENCIES ACT*, P. 3, FOR MORE INFORMATION ON THE CHE ACT.

[164] MD. CODE ANN., PUB. SAFETY § 14-3A-06 (West Supp. 2009).
[165] MD. CODE ANN., HEALTH-GEN. I § 18-907(d) (West 2009).
[166] MD. CODE ANN., HEALTH-GEN. § 14-3A-01 (West Supp. 2009).
[167] *Id*. § 14-3A-06.

Immunity for Vaccine Administration

SNAPSHOT

Applies to: Individuals

Triggers/Limitations: In order to receive immunity for participating in an "immunization project," the project must be officially certified by the Secretary of the Department of Health and Mental Hygiene.

Maryland law states that any "person lawfully administering a drug or vaccine" is immune from liability for injuries that vaccine may cause.[168] Additionally, similar immunity applies for medical personnel who participate in DHMH-sanctioned "immunization projects." Health care providers who participate in immunization projects will receive immunity for liability stemming from the project, provided that the Secretary of the Department of Health and Mental Hygiene certifies that the project "conform[s] to good medical and public health practice and gives written approval for the project to be administered in [Maryland]."[169]

It is important to note that immunity provided for vaccine administration does not confer immunity for vaccine manufacturers against products liability claims.[170]

Immunity Under the Good Samaritan Act

SNAPSHOT

Applies to: Individuals

Triggers/Limitations: Immunity does not apply if person assisting victim receives ANY form of compensation from the victim. The Act has different requirements for health care professionals and lay volunteers.

[168] MD. CODE ANN., HEALTH-GEN. § 18-401(a) (West 2009).
[169] *Id*. § 18-401(b).
[170] *See Doe v. Miles Labs, Inc.*, 675 F. Supp. 1466 (D. Md. 1987), aff'd 927 F.2d 187 (4th Cir. 1991).

Maryland's Good Samaritan Act provides limitations on liability for health care professionals, under certain circumstances, and for spontaneous volunteers who assist victims during an emergency.[171] While the Act does provide immunity to both health care providers/emergency responders and spontaneous volunteers, its eligibility requirements are different for each group.

For Health Care Professionals and Emergency Responders

The Good Samaritan Act provides immunity from civil liability for any act or omission while providing assistance or medical care, provided that:

- the act or omission is not one of gross negligence;[172]
- the assistance or medical care is provided without compensation of any form from the individual(s) being assisted; and
- the "assistance or medical care is provided at the scene of an emergency, in transit to a medical facility, or through communications with personnel providing emergency assistance."[173]

For Lay Volunteers

Under the Good Samaritan Act, spontaneous volunteers have immunity from civil liability in certain situations when assistance or medical aid is provided to victims *at the scene of an emergency* and the following conditions are satisfied:

- assistance or aid must be reasonably and prudently provided;
- assistance or aid must be provided without receiving any form of compensation from the individual(s) being assisted; and
- the lay volunteer must relinquish care when someone who is licensed or certified in the state to provide medical services becomes available to assist.[174]

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[171] MD. CODE ANN., CTS. & JUD. PROC. § 5-603 (West 2002 & Supp. 2009)
[172] *Id*. § 5-603(a) (West 2002 & Supp. 2008). "Gross negligence" is defined as "wanton disregard for human life or for the rights of others." *Floor v. Juvenile Servs*., 552 A.2d 947, 956 (Md. Ct. Spec. App. 1989) (quoting *White v. King*, 223 A.2d 763, 771 n.2 (1966)).
[173] *Id*. § 5-603(a).
[174] *Id*. § 5-603 (West 2002 & Supp. 2009).

As a general rule, the Good Samaritan Act applies to assistance provided during emergency situations, including events such as car accidents. However, at this time, it is unclear whether the Act would offer immunity protections to individuals who assist with response activities during a proclaimed public health emergency.

SEE *PART I, SECTION A.4: MARYLAND GOOD SAMARITAN ACT*, P. 10, FOR MORE INFORMATION ON THE GOOD SAMARITAN ACT.

Immunity Under the Maryland Tort Claims Act (MTCA)

SNAPSHOT

Applies to: Individuals

Triggers/Limitations: For immunity provisions to apply to volunteers of state agencies, .such volunteers must be formally recognized as volunteers before they perform actions on behalf of the State.

The Maryland Tort Claims Act (MTCA) is the primary authority providing immunity from liability to state personnel. Pursuant to the MTCA, "[s]tate personnel…are immune from suit in courts of the State and from liability in tort for a tortious act or omission that is within the scope of the public duties of the State personnel and is made without malice or gross negligence and for…which immunity has been waived under Title 12, Subtitle 1 under the State Government Article."[175]

"**State personnel**" is broadly defined in the MTCA and includes "an individual who, without compensation, exercises a part of the sovereignty of the State."[176] Generally, this definition includes any State employee paid by the Central Payroll Bureau in the Office of the Comptroller

[175] MD. CODE ANN., CTS. & JUD. PROC. § 5-522(b); *See generally* MD. CODE ANN., STATE GOV'T. § 12-105.
[176] MD. CODE ANN., STATE GOV'T. § 12-101(a)(4).

of the Treasury,[177] but also includes "an individual who, without compensation, exercises a part of the sovereignty of the State."[178]

Additionally, the Maryland Tort Claims Act provides immunity for some individuals who volunteer for the State. Pursuant to Title 25, Subtitle 2, Chapter 1 of the Code of Maryland Regulations, a "**volunteer**" is an individual who:

a) [i]s performing services to or for a unit of State government, the employees of which are considered State personnel…
b) [i]s engaged in the actual performance of the services…at the time of the incident giving rise to a claim; and
c) [i]n the performance of services:
    i. is participating in a formal volunteer program, or
    ii. [b]efore the beginning of those services, is formally recognized by the unit as a volunteer."[179]

It is important to note that, by the COMAR definition's requirement of advance formal recognition of volunteers for state agencies, the MTCA likely provides no protection to spontaneous volunteers.

Immunity Under the Local Government Tort Claims Act (LGTCA)

SNAPSHOT

Applies to: Individuals

Triggers/Limitations: Volunteers must be providing services at the request of the local government in order for immunity provisions to apply.

[177] *Id*. § 12-101.
[178] *Id*. § 12-101(a)(4). For the full definition of "State personnel," see *id*. § 12-101.
[179] MD. CODE REGS. 25.02.01.02B(8).

Like the MTCA, the Local Government Tort Claims Act (LGTCA) provides immunity protections for local government employees who, in good faith, perform activities within the scope of their duties.[180] Under the LGTCA, "a person may not execute against an employee on a judgment rendered for tortious acts or omissions committed by the employee within the scope of employment with a local government[,]"[181] unless the employee is found to have "acted with actual malice."[182] In situations in which a local government employee is found to have acted with actual malice, "the judgment may be executed against the employee and the local government may seek indemnification for any sums it is required to pay…"[183]

Pursuant to the LGTCA, a volunteer also meets the definition of "employee" for purposes of liability and immunity protections provided by the Act, as long as the volunteer is providing services or performing duties at the request of the local government at the time the allegedly tortious act or omission occurs.[184]

Immunity Under the Maryland Volunteer Service Act

SNAPSHOT

Applies to: Individual volunteers performing service for a qualified "association or organization"

Triggers/Limitations: Does not provide immunity from suit; merely limits defendant's liability in damages to the extent of his personal insurance.

Unlike the other statutes discussed in this section, the Maryland Volunteer Service Act does not provide immunity to individuals; rather, it limits the extent of possible damages that can be collected in a judgment against a defendant. Under the Act, "[a] volunteer is not liable in damages beyond the limits of any personal insurance he may have in any suit that arises from the volunteer's act or omission in connection with any services provided or duties performed by

[180] MD. CODE ANN., CTS. & JUD. PROC. § 5-301 (West 2002 & Supp. 2009).
[181] *Id*. § 5-302(b)(1) (West 2002).
[182] *Id*. § 5-302(b)(2)(i).
[183] *Id*. § 5-302(b)(2)(ii).
[184] *Id*. § 5-301(c)(2)(iii).

the volunteer on behalf of the association or organization, unless an act or omission of the volunteer constitutes gross negligence, reckless, willful, or wanton misconduct, or intentionally tortious conduct."[185]

The Act defines a **volunteer** as any "officer, director, trustee, or other person who provides services or performs duties for an association or organization without receiving compensation."[186] While the Act's specific application to volunteers of an association or organization varies depending upon an organization's taxation status, an "association or organization," as defined in the Act, generally would include "a business league; a charitable organization; a civic league; a club; a labor, agricultural, or horticultural organization; or a local association of employees."[187] (Organizations and associations should consult with their entity's own legal counsel to determine if the Act's protections may apply to their volunteers.)

Finally, the Maryland Volunteer Service Act is slightly different from the other statutes discussed in this section in that it also contains exceptions from its liability protections for volunteers who somehow ratify the misconduct of others within the organization. The Act states that its limitations on liability do not apply if a volunteer "knew or should have known of an act or omission of a particular officer, director, employee, trustee, or another volunteer, and the volunteer authorizes, approves, or otherwise actively participates in that act or omission; or, after an act or omission…with full knowledge…ratifies it."[188]

SEE *PART I, SECTION A.5: MARYLAND VOLUNTEER SERVICE ACT*, P. 11, FOR MORE INFORMATION ON THE ACT'S PROVISIONS.

[185] *Id*. § 5-407(c).
[186] *Id*. § 5-407(a)(11).
[187] *Id*. § 5-407(a)(2)-(9).
[188] *Id*. § 5-407 (b)(1)-(2).

Immunity Under the Public Readiness and Emergency Preparedness Act (PREP Act)

SNAPSHOT

Applies to: Individuals and Entities

Triggers/Limitations: A PREP Act declaration must be issued by the Secretary of Health and Human Services for the specific countermeasure in question.

The Public Readiness and Emergency Preparedness Act (PREP Act) provides immunity from tort liability to a broad array of individuals and facilities involved in the administration or use of "covered countermeasures."[189] The Act authorizes the Secretary of Health and Human Services (HHS) to issue a declaration under the Act that provides immunity from tort liability for the administration or use of countermeasures to diseases or public health threats determined by the Secretary to pose a present or future risk of a public health emergency.[190]

A PREP Act declaration provides immunity protection to both individuals and entities involved in the development, manufacture, testing, distribution, administration, and use of covered countermeasures specified in the declaration.[191] The Secretary, within the declaration, can specify the conditions under which her declaration will apply, including effective dates and geographic areas. Unlike other emergency laws discussed in this Handbook, a PREP Act declaration is not dependent upon another emergency declaration; it can be issued independently by the Secretary of HHS, as its primary purpose is to provide immunity from liability to enhance quick response to public health threats in the U.S.

SEE *PART I, SECTION B.8: PUBLIC READINESS AND EMERGENCY PREPAREDNESS ACT*, P. 25 FOR MORE INFORMATION REGARDING THE PREP ACT.

[189] Public Readiness and Emergency Preparedness Act, Pub. L. No., 109-148, 119 Stat. 2818; §§ 247d-6d, 247d-6e (West Supp. 2010)
[190] *Id*.
[191] *Id*. § 247d-6d(a)(3).

Immunity Pursuant to Mutual Aid Agreements

SNAPSHOT

Applies to: Individuals

Triggers/Limitations: Some mutual aid agreements depend upon the governor's proclamation of an emergency before their provisions apply.

The three major mutual aid agreements discussed in *Part I, Section C* – the Emergency Management Assistance Compact (EMAC), the Maryland Emergency Management Assistance Compact (MEMAC), and the National Capital Region Agreements (NCR Agreements) – contain provisions that define limitations on liability and immunity protections available under the agreements. The liability protections for each are discussed below.

Emergency Management Assistance Compact (EMAC)

EMAC is a mutual aid compact that has been adopted by all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. EMAC's application requires a governor-declared emergency; however, once that declaration is made, a state may make requests for additional resources, equipment, and personnel through the Compact.

Under EMAC, "[o]fficers or employees of a party state rendering aid in another party state pursuant to [EMAC] shall be considered agents of the requesting state for tort liability and immunity purposes,"[192] In other words, out-of-state personnel providing assistance pursuant to an EMAC request are eligible for the same limitations on liability and immunity protections as the state's own employees. Additionally, EMAC provides immunity from liability for "any act or omission in good faith on the part of such forces while so engaged or on account of the maintenance or use of any equipment or supplies in connection therewith."[193] (Note that acts constituting "willful misconduct, gross negligence, or recklessness[]" would not be subject to the immunity protections available through EMAC.)[194]

[192] MD. CODE ANN., PUB. SAFETY § 14-702(6).
[193] *Id*.
[194] *Id*.

SEE *PART I, SECTION C.1: EMERGENCY MANAGEMENT ASSISTANCE COMPACT*, P. 33, FOR ADDITIONAL INFORMATION ON EMAC.

Maryland Emergency Management Assistance Compact (MEMAC)

The Maryland Emergency Management Assistance Compact (MEMAC) is a statewide compact that provides for mutual aid assistance among Maryland jurisdictions to manage intrastate emergencies.[195]

Like EMAC, "officers or emergency responders of a party jurisdiction rendering aid in another jurisdiction pursuant to this Compact shall be considered agents of the requesting jurisdiction for tort liability and immunity purposes."[196] Additionally, MEMAC provides that "[n]o party jurisdiction or its officers or emergency responders" rendering aid pursuant to MEMAC can be held liable for "any act or omission in good faith on the part of responding personnel."[197] Finally, like EMAC, MEMAC does not provide immunity protection for acts or omissions that constitute "willful misconduct, gross negligence, or recklessness."[198]

SEE *PART I, SECTION C.2: MARYLAND EMERGENCY MANAGEMENT ASSISTANCE COMPACT*, P. 35, FOR MORE INFORMATION ON MEMAC.

National Capital Region Mutual Aid Agreements (NCR Agreements)

The National Capital Region includes the District of Columbia and several counties in Maryland and Virginia that surround the District.[199] Under the NCR Mutual Aid Agreements (NCR Agreements), a responding party that renders aid or fails to render aid pursuant to an Agreement "shall be liable on account of any act or omission of its officers or employees while so engaged," but "only to the extent permitted under the laws and procedures of the State of the party rendering aid."[200] Unlike EMAC and MEMAC, the NCR Agreements subject out-of-state responders only to the same liability and immunity protections that they would experience in

[195] *Id*. § 14-803.
[196] *Id*.
[197] *Id*. § 14-803(4)(d)(2).
[198] *Id*. § 14-803(4)(d)(3).
[199] *Id*. § 14-8A-01, *et seq*
[200] 10 U.S.C. § 7302(f) (West 1998 and Supp. 2005).

their home state. Additionally, the NCR Agreements require that civil actions against an aid-rendering party must be brought "only under the laws and procedures of the party rendering aid and only in the Federal or State courts located therein."[201]

SEE *PART I, SECTION C.3: NATIONAL CAPITAL REGION MUTUAL AID AGREEMENTS*, P. 37, FOR MORE INFORMATION ON THE NCR AGREEMENTS.

[201] *Id*. § 7302(d)(2).

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SECTION B: PRIVACY OF INFORMATION AND REPORTING REQUIREMENTS

Health care providers in Maryland must maintain a delicate balance between compliance with mandatory public health reporting requirements and protection of patient privacy. During a medical surge event or public health emergency, this balance can become much more tenuous as resources and personnel are stretched thin during the response.

Section B first discusses state and federal privacy laws and exceptions to these laws to ensure that providers are aware of the framework within which they must operate. It then moves on to address the reporting requirements of various health care providers, including physicians, institutions, and medical laboratories, before finally discussing liability issues surrounding the protection of patient information.

1. HIPAA Privacy Rule and Exceptions

The primary federal law governing privacy of patient information is the Health Insurance Portability and Accountability Act (HIPAA).[202] HIPAA, and the corresponding HIPAA Privacy Rule (Privacy Rule),[203] mandate that "covered entities" and their "business associates" protect the privacy of patient's "protected health information" (PHI) in a number of different ways.

Under HIPAA:

- **Covered entities** include health care providers, health plans, health care clearinghouses, and health care providers who transmit health information in electronic form.[204]
- **Business associates** include any individual or organization that uses or discloses a patient's protected health information while providing services to, or in the course of performing functions or activities on behalf of, covered entities.[205]

[202] Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 18, 26, 29, & 42 U.S.C.A.)
[203] 45 C.F.R. §§ 160 & 164 (2009).
[204] *Id.* § 160.103 (2009), see HHS, Summary of the HIPAA Privacy Rule, *supra* note 89, at 2.
[205] *Id*.

- **Protected health information (PHI)** includes any information about a patient's health status, provision of care, or payment of care that can be linked, or reasonably could be linked, to an individual patient, including, but not limited to, a patient's name, Social Security number, and address.[206]

To protect patient privacy, the HIPAA Privacy Rule requires covered entities to obtain a patient's consent and authorization before using or disclosing any of that person's protected health information.[207] However, the Privacy Rule contains numerous exceptions to ensure that important public health and safety activities can continue without interruption or delay. These exceptions provide, among other circumstances, that **covered entities may use or disclose PHI without a patient's consent and authorization if the disclosure is**:

- *Required by federal, state, or local law*: The Privacy Rule's exceptions permit disclosures required by law, including statutes, regulations, and court orders.[208]
- *For the purpose of public health activities*: Exceptions to the Privacy Rule permit public health authorities to collect information necessary or relevant for public health purposes, including disease surveillance, investigations, and interventions.[209] This exception also permits covered entities to disclose protected information to individuals who may have contracted or been exposed to a communicable disease.[210]
- *Necessary to prevent or mitigate a serious and imminent threat to individual health and safety or the public*: This exception allows covered entities to disclose protected health information if they hold a good faith belief that such a disclosure is necessary to prevent or mitigate a serious and imminent threat to the health and safety of an individual or the public at large, as long as the disclosure is made to someone reasonably able to prevent or mitigate the threat in question.[211] This exception would be highly relevant to disclosures required to respond to the threat of a bioterrorist attack or public health emergency.

[206] *Id*.
[207] *Id*. §§ 160 & 164 (2009).
[208] *Id*. § 164.512(a) (2004)
[209] *Id*. § 164.512(b) (2004).
[210] *Id*. § 164.512(b)(1)(iv) (2004).
[211] *Id*. § 164.512(j) (2004).

- *For the purpose of reporting confirmed or suspected abuse or neglect*: The Privacy Rule contains exceptions permitting disclosures to appropriate government authorities while reporting confirmed or suspected cases of abuse, neglect, or domestic violence.[212]
- *For law enforcement purposes*: This exception allows covered entities to disclose PHI, without a patient's consent, pursuant to a court order or subpoena; to help identify or locate a suspect, fugitive, or missing person; to report a crime; or to provide information related to a victim of a crime.[213]
- *Necessary to facilitate execution of essential government functions*: Exceptions to the Privacy Rule permit disclosure of PHI without a patient's consent if such disclosure is necessary to facilitate execution of a military mission or national security activities. Such disclosure is also allowed to help protect the health and safety of prison inmates, to make medical suitability determinations for U.S. State Department employees, and to determine individuals' eligibility for government benefits.[214]
- *For judicial and administrative proceedings*: Information requested through court order or request from an administrative tribunal is permitted to be disclosed without an individual's consent.[215]
- *Necessary to facilitate health oversight*: This Privacy Rule exception allows disclosures to oversight activities that are authorized by law, such as for audits of government benefit programs and licensing investigations.[216]

During a national emergency or public health emergency, the Secretary of HHS ***may*** waive certain provisions of HIPAA through a Section 1135 waiver to help health care providers better respond to the emergency.[217] A Section 1135 waiver may only be issued after the President has declared a state of emergency under either the Stafford Act or the National Emergencies Act and the Secretary of HHS has declared a public health emergency. **It is important to note that a Section 1135 waiver does NOT suspend HIPAA; it merely waives the applicable provisions**

[212] *Id*. § 164.512(a) & (c) (2004).
[213] *Id*. § 164.512(f) (2004).
[214] *Id*. § 164.512(k) (2004).
[215] *Id*. § 164.512(e) (2004)
[216] *Id*. § 164.512(d) (2004).
[217] *Id*. § 1320b-5(b).

of HIPAA that are specifically included in the waiver. Additionally, a Section 1135 waiver will only apply for:

- the emergency area and period of time specified in the Secretary's declaration of a public health emergency;
- patients in hospitals that have instituted disaster protocol; and
- up to 72 hours from the time the hospital implements disaster protocol, unless the Presidential declaration of emergency or the Secretary's declaration of public health emergency expires sooner, in which case, the waiver expires when the declaration expires.[218]

Finally, during a declared emergency or disaster, covered entities may also disclose protected health information, without an individual's consent, to public or private entities that are authorized by law or charter to assist with disaster relief.[219] This provision of the Privacy Rule allows covered entities to share patient information with disaster relief and other aid organizations, like the American Red Cross, so that these entities can assist in notifying family members or others of a patient's location, general condition, or death.

SEE *PART I, SECTION B.5: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT*, P. 21, AND *PART I, SECTION B.9: SECTION 1135 WAIVERS*, P. 26, FOR MORE INFORMATION ON THESE TOPICS.

2. Maryland Privacy Law

Because Congress did not want to inhibit states from creating or maintaining privacy laws that were more stringent than HIPAA, it allows state laws to vary from HIPAA as long as their provisions provide at least as much protection to individuals as HIPAA. Maryland's state privacy laws are very similar to HIPAA and permit disclosures for the same basic exceptions as those provided for the HIPAA Privacy Rule.

[218] 42 U.S.C. § 1320b-5 (sect. 1135 of the Social Security Act); Project Bioshield Act of 2004, Pub. L. No. 108-276, 118 Stat. 935; *see* U.S. Dep't of Health and Human Servs., Frequently Asked Questions: Health Information Privacy, http://www.hhs.gov/ocr/privacy/hipaa/faq/disclosures_in_emergency_situations/1068.html (last visited June 21, 2010) (noting that the HHS Secretary's authority to issue waivers of Privacy Rule provisions in an emergency derives from the Project Bioshield Act of 2004 and section 1135(b)(7) of the Social Security Act).
[219] 45 C.F.R. § 164.510(b)(4) (2004).

SEE *PART I, SECTION B.5: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT*, P. 21, AND *PART II, SECTION B.1: HIPAA PRIVACY RULE AND EXCEPTIONS*, P. 57, FOR MORE INFORMATION REGARDING THE HIPAA PRIVACY RULE AND ITS EXCEPTIONS.

In addition to the exceptions listed above, Maryland's privacy law also permits, among others, disclosures:

- *for mandatory communicable disease reporting*: Maryland's privacy law permits disclosures of PHI to officials from the Maryland Department of Health and Mental Hygiene, local health officers, and other designees for the purpose of complying with the State's requirements for communicable disease reporting.[220]
- *between health care providers necessary to facilitate transfers of patients*;[221]
- *to provide for the emergency health care needs of a patient*;[222]
- *for purposes of offering, providing, evaluating, and seeking payment for health care*: Maryland's privacy law allows disclosures to a health care provider's authorized employees, agents, medical staff, and medical students for the purpose of treating a patient and seeking payment for such treatment;[223]
- *to immediate family members or individuals in close personal relationships with a patient*: Such disclosures are permitted, provided that they are consistent with good practice and that the patient has not instructed the health care provider not to disclose such information.[224]
- *to the Maryland Insurance Administration for investigative purposes*;[225] and
- *necessary for investigation or review of health professional licensing and disciplinary boards*: Disclosures are permitted to health professional licensing boards and disciplinary boards pursuant to investigation or review of health care professionals.[226]

[220] *See generally* MD. CODE ANN., HEALTH-GEN. §§ 18-201, 18-202, 18-205, and 18-904 (West 2009 & Supp. 2009); MD. CODE REGS. 10.06.01.03 – 07.
[221] MD. CODE ANN., CRIM. LAW. § 4-306(b)(5)
[222] *Id*. § 4-305(6).
[223] *Id*. § 4-305(b)(1)(i).
[224] *Id*. § 4-305(7).
[225] *Id*. § 4-306(b)(8)
[226] *Id*. § 4-306(b)(2).

However, Maryland's privacy laws differ from HIPAA in the following significant ways:

- *Maryland's privacy laws allow individuals to seek civil damages for violations of the law,* while HIPAA does not provide for a private civil cause of action for violations; and
- Maryland's privacy laws **mandate** disclosures of protected health information, while HIPAA merely **permits** such disclosures on a voluntary basis. As such, Maryland health care providers MUST disclose certain protected health information if it is requested by an appropriate authority. Such mandatory disclosures include disclosures required for communicable disease reporting and disclosure of medical records to the Secretary of Health and Mental Hygiene for investigative purposes or to control and respond to a public health emergency.[227]

3. State Communicable Disease Reporting Requirements for Health Care Providers

Physicians

Under Maryland law, a physician who has reason to believe that a patient has an infectious or contagious disease, other than HIV or AIDS, that may endanger the public health and that is a reportable disease,[228] must "submit immediately a report to the health officer for the county where the physician cares for that patient."[229] The report, which is confidential and "not open to public inspection,"[230] must be in a format approved by the Secretary of DHMH and identify the patient's name, age, race, sex, residential address, and communicable disease from which the patient is infected.[231] Additionally, while the Secretary of DHMH may disclose the reported information to a governmental agency when the report's recipient agrees to maintain confidentiality and the "disclosure is necessary to protect the public health or to prevent the

[227] *See generally* MD. CODE ANN., HEALTH-GEN. §§ 18-201, 18-202, 18-205, and 18-904 (West 2009 & Supp. 2009); MD. CODE REGS. 10.06.01.03 – 07.
[228] Pursuant to Title 18 of the Health-General Article of the Maryland Code and corresponding regulations in MD. CODE REGS., a complete list of reportable diseases is included in *Part III, Section D: List of Reportable Diseases and Conditions*, p. 81.
[229] MD. CODE ANN., HEALTH-GEN. § 18-201(a).
[230] *Id*. § 18-201(c)(1)(i) and (iii).
[231] *Id*. § 18-201(b).

spread of an infectious or contagious disease,"[232] such reports are "not discoverable or admissible in evidence" in any civil or criminal proceeding "except in accordance with a court order sealing the court record."[233]

Institutions and Facilities

Like a physician, the administrative head of a health care institution has a duty to report the presence of communicable diseases on the premises. Pursuant to Maryland law, when "the administrative head of an institution has reason to believe that an individual on the premises of the institution has an infectious or contagious disease, except human immunodeficiency virus [HIV] or acquired immunodeficiency syndrome [AIDS]," he must immediately report this finding to the health officer for the county in which the institution is located.[234] The report must contain:

- the name and address of the patient believed to be infected;
- the disease with which they are believed to be infected;
- the name of the administrative head of the institution; and
- the location of the institution.[235]

Institutional reports of communicable disease are also confidential and not open to public disclosure, like physician's reports, above.[236]

Medical Laboratories

Maryland law requires the director of a medical laboratory within the State to "submit a report to the health officer for the county where the laboratory is located within 48 hours" of discovering a

[232] *Id*. § 18-201(c)(5).
[233] *Id*. § 18-201(c)(1)(iv).
[234] *Id*. § 18-202(b).
[235] *Id*. 18-202(c).
[236] *Id*.

human specimen found to contain evidence of a reportable disease.[237] Upon receipt of the laboratory's report, the health officer must then report the disease to the Secretary of DHMH.[238] The report must include:

- the "date, type, and result of the test that shows evidence of a disease required to be reported[;]"
- the patient's name, age, sex, and residential address; and
- the treating physician's name and address.[239]

Both the health officer and the Secretary of DHMH are permitted to discuss the report with the patient's attending physician or other attending health care provider.[240]

Additionally, if the director of a medical laboratory outside of the State finds a reportable disease while examining a "human specimen acquired from a person [in Maryland]," the director must report this finding to the Secretary of DHMH within 48 hours.[241]

Notification of Law Enforcement, Emergency Personnel, and other Public Servants

It is possible that emergency responders, law enforcement personnel, and other public servants may, during the course of their duties, be exposed to individuals who are subsequently diagnosed with a communicable disease. To protect them, Maryland law mandates that health care providers and medical examiners promptly notify firefighters, EMTs, rescue squad members, correctional officers, law enforcement officers, sworn employees of the Maryland Fire Marshal, and first responders of potential exposure to a communicable disease.[242]

[237] *Id*. § 18-205(b) (West 2009 & Supp. 2009).
[238] *Id*. § 18-205(g)(1)
[239] *Id*. § 18-205(e)(2)(i)-(iii).
[240] *Id*. § 18-205(g) – (i).
[241] *Id*. § 18-205(b)(2).
[242] *Id*. § 18-213(a)-(d),. § 18-213.1(b), 18-213.2(b). This includes notification of potential contact with individuals who have HIV, AIDS, meningococcal meningitis, tuberculosis, mononucleosis, viral hepatitis, diphtheria, plagues, hemorrhagic fevers, and rabies. § 18-213(a)(2), 18-213.1(a)(3), 18-213.2(a)(3) (West 2002)

Such notification must be:

- made by the attending physician, medical examiner, a designee of the medical care facility, or the Chief Medical Examiner (or his designee);
- made within 48 hours of confirmation;
- provided in writing after initial notification; and
- completed in a manner that protects both the patient's and the public servant's confidentiality.[243]

As long as the individual notifying the public servant acts in good faith in providing such notification, he may not be held liable in a cause of action related to a breach of patient confidentiality.[244] Additionally, as long as the individual provides good faith notification, he may not be held liable in a cause of action for "failure to give the required notice" if the public servant "fails to properly initiate the notification procedures developed by the health care facility" or if the public servant's employer or employer's designee subsequently fails to notify the public servant of the possible exposure.[245]

Under the Catastrophic Health Emergencies (CHE) Act

On top of the general reporting requirements mandated for health care providers by Maryland law, the Catastrophic Health Emergencies Act (CHE Act) imposes another layer of communicable disease surveillance in the State through its reporting requirements. Pursuant to the CHE Act, the Secretary of DHMH is authorized, regardless of the confidential nature of the information, to require health care providers and other authorized individuals to report information necessary to prevent or respond to an actual or potential catastrophic health emergency.[246]

[243] *Id*. § 18-213(e).
[244] *Id*. § 18-213(h).
[245] *Id*. § 18-213(i).
[246] *Id*. § 18-904(a)-(b)(1).

By order, directive, or regulation, the Secretary may require reporting of:

- "[t]he presence of an individual or group of individuals with specified illnesses or symptoms;
- diagnostic and laboratory findings relating to diseases caused by deadly agents;
- statistical or utilization trends relating to potential disease outbreaks;
- information needed to conduct contact tracing for exposed individuals; and
- other data deemed by the Secretary to have epidemiological significance in detecting possible catastrophic health emergencies."[247]

The Secretary may also require health care providers and others to submit reports to DHMH and other federal, state, and local health care providers or hospitals regarding the presence of deadly agents.[248] This information may be "redisclose[d]…to another health care provider or public official" provided that the health care provider or agency ensures the confidentiality of the information and the Secretary "determines the disclosure is necessary to treat, prevent, or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent."[249] The CHE Act mandates that, to the extent possible, the Secretary must "[r]equest and use nonidentifying information" and only use confidential information "to the extent necessary to detect and investigate actual or potential exposures to a deadly agent."[250]

SEE *PART I, SECTION A.1: CATASTROPHIC HEALTH EMERGENCIES ACT, P. 1,* FOR ADDITIONAL INFORMATION REGARDING THE CHE ACT.

4. Privacy and Health Information Liability

The liability scheme in Maryland regarding health care providers' protection of patient privacy is largely governed by both HIPAA and the Maryland Confidentiality of Medical Records Act (MCMRA).[251] Unlike HIPAA, which can only be enforced by the U.S. Department of Health

[247] *Id*. § 18-904(b)(1)(i)-(v).
[248] *Id*. § 18-904(b)(4) and (d)(2)-(3).
[249] *Id*. § 18-904(d)(3).
[250] *Id*. § 18-904(c).
[251] MD. CODE ANN., CRIM. LAW § 4-301 *et seq*. (West 2003).

and Human Services, Office of Civil Rights, the MCMRA provides a private cause of action against a "covered entity" for an individual who believes that his medical information has been illegally disclosed.[252]

In addition to seeking enforcement of HIPAA through the U.S. Department of Health and Human Services or through a private cause of action under the MCMRA, individuals may seek to hold health care providers and other entities accountable for improper release of protected health information through other theories of liability, including a) invasion of privacy and b) breach of doctor-patient confidentiality.

SEE *PART I, SECTION B.5: HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT*, P. 21 AND *PART II, SECTION B.1: HIPAA PRIVACY RULE AND EXCEPTIONS*, P. 57 FOR MORE INFORMATION ON HIPAA.

Invasion of Privacy

In Maryland, the success of an invasion of privacy cause of action depends on the reasonableness of the disclosure of private information and the defendant's intent when disclosing such information. As such, it is unlikely, although still possible, that an accidental or negligent release of a patient's protected health information would satisfy the elements of a claim for invasion of privacy under current Maryland law. Additionally, Maryland law requires that, even if an individual's private information is intentionally disclosed, the fact disclosed must not be something that could be considered of public concern (and thereby provide unreasonable publicity to an individual's private life.)

[252] *Id*.

Breach of Doctor-Patient Confidentiality

Most states, including Maryland, place a high priority on the maintenance of doctor-patient confidentiality. As such, Maryland law generally imposes a legal duty on physicians and other health care providers to maintain the confidentiality of information obtained through the doctor-patient relationship and therefore forbids doctors to disclose such information to a third party without the patient's consent. However, even in the presence of this duty of confidentiality between health care providers and patients, it is unlikely that a health care provider who discloses information as required by law (i.e. for the purpose of mandatory communicable disease reporting) would be found in breach of his duty of confidentiality.

SECTION C: PROFESSIONAL LICENSING AND CREDENTIALING

During a medical surge or public health emergency, health care professionals within a certain jurisdiction or region may be overwhelmed and need additional assistance from professionals who are not currently licensed within the State. In emergency situations, licensing requirements may be temporarily modified, pursuant to certain laws, to allow out-of-state responders who hold valid professional licenses in other states to provide assistance in Maryland. Section C addresses Maryland's requirements for the licensing and credentialing of health care professionals, during emergency and non-emergency circumstances.

1. Licensing, Certification, and Credentialing of Health Care Professionals

As a general rule, an individual is prohibited from practicing medicine in Maryland without a valid Maryland license.[253] The Maryland Code defines the practice of medicine as "to engage, with or without compensation, in medical diagnosis; healing; treatment; or surgery."[254]

Specific licensure requirements for various health care professionals are discussed below.

Scope of Practice During Non-Emergency

For Physicians: Maryland permits physicians who possess out-of-state/non-Maryland licenses to practice in Maryland only in limited circumstances. For example, a physician possessing a valid out-of-state license may practice in Maryland if he is consulting with a licensed Maryland physician,[255] or if he works for the federal government and such practice is within the course of performing duties of his job.[256] Additionally, any physician who resides in and is licensed in an adjoining state, and whose practice extends into Maryland, may

[253] MD. CODE ANN., HEALTH OCC. §§ 14-301 & 14-601 (West 2008).
[254] *Id*. § 14-101(l)(1).
[255] *Id*. § 14-302(2).
[256] *Id*. § 14-302(3).

practice medicine here so long as the physician does not have an office in Maryland and the adjoining state provides reciprocity of this privilege to Maryland physicians.[257]

Maryland law also permits licensed physicians to delegate certain duties to non-physicians, including nurses, physician assistants, radiation oncology/therapy technologists, medical radiation technologists, and nuclear medicine technologists, provided that such non-physicians are certified or licensed by the State.[258]

Credentialing of Physicians: The Secretary of Health and Mental Hygiene must, by regulation and through consultation with "hospitals, physicians, interested community and advocacy groups, and representatives of the Maryland Defense Bar and Plaintiff's Bar,"[259] establish minimum standards for credentialing of physicians. Pursuant to these minimum standards, a hospital must have "[a] formal written appointment process documenting the physician's education, clinical expertise, licensure history, insurance history, medical history, claims history, and professional experience[,]"[260] and require physicians desiring to be credentialed at its facility to successfully complete a "probationary period."[261] Maryland law also requires a "formal, written reappointment process to be conducted at least every 2 years [which] shall document the physician's pattern of performance by analyzing claims filed against the physician, data dealing with utilization, quality, and risk, a review of clinical skills, adherence to hospital bylaws, policies and procedures, compliance with continuing education requirements, and mental and physical status."[262]

Additionally, to ensure a certain measure of uniformity in physician credentialing throughout the State, the Maryland Department of Health and Mental Hygiene (DHMH) requires State-licensed hospitals to use a "uniform standard credentialing form" as the initial application for any

[257] *Id*. § 14-302(4).
[258] *Id*. § 14-306. MD. CODE REGS. 10.32.10.01-14 provides the regulations for certification of radiation oncology/therapy technologists, medical radiation technologists, and nuclear medicine technologists. Chapter 12 of the same subtitle provides the regulations regarding physicians' delegation of duties to a licensed or certified assistant, and Chapter 3 lists the requirements for delegation of physician duties to a physician assistant.
[259] MD. CODE ANN., HEALTH-GEN. § 19-319(e)(4) (West 2009 & Supp. 2009).
[260] *Id*. § 19-319(e)(4)(i).
[261] *Id*. § 19-319(e)(4)(ii).
[262] *Id*. § 19-319(e)(4)(iii).

physician who seeks "to be employed by or have staff privileges at a hospital."[263] Because each licensed Maryland hospital is legally required to "[e]stablish a credentialing process" for physicians who are "employed by or who have staff privileges" there,[264] a hospital may, in addition to the standard credentialing form, require supplemental information as part of its credentialing process.[265]

Finally, at the request of DHMH, a hospital must supply documentation of compliance with State credentialing requirements prior to hiring a physician or renewing a physician's employment or privileges.[266] Failure to comply with credentialing requirements may result in "[d]elicensure of the hospital…or…[a fine of] $500 per day for each day the violation continues."[267]

For Physician Assistants: The Maryland Code defines a physician assistant as an "individual who is certified under [title 15] to perform delegated medical acts under the supervision of a physician."[268] A physician assistant's defined scope of practice includes "the performance of medical acts that are: (1) [d]elegated by a supervising physician to a physician assistant; (2) [w]ithin the supervising physician's scope of practice; and (3) [a]ppropriate to the physician assistant's education, training, and experience."[269] This scope of practice includes "prescriptive authority," defined as "the authority delegated by a supervising physician to a physician assistant to prescribe and administer controlled dangerous substances, prescription drugs, medical devices, and the oral, written, or electronic ordering of medications."[270] (Note that this authority allows physician assistants to prescribe medication, but not to dispense prescriptions.)[271]

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[263] *Id*. § 19-319(e)(1)-(2).
[264] *Id*. § 19-319(e)(2)(i).
[265] *Id*. § 19-319(e)(3).
[266] *Id*. § 19-319(e)(5); Physician credentialing is further addressed in MD. CODE REGS. 10.07.01.24.
[267] *Id*. § 19-319(e)(6).
[268] MD. CODE ANN., HEALTH OCC. § 15-101(m) (West 2008).
[269] *Id*. § 15-101(n).
[270] *Id*. § 15-101(o).
[271] *See* 80 Md. Op. Atty. Gen. 173 (1995).

A licensed Maryland physician is authorized to delegate certain duties to a physician assistant under a delegation agreement created between the physician and the physician's assistant and approved by the Board of Physicians.[272] Such an agreement must include:

- a description of the qualifications of the physician and the physician assistant;
- a description of the setting in which the physician assistant will be working;
- an explanation of the supervision the physician will provide;
- a description of any delegated medical acts that are within the supervising physician's scope of practice and which may require specialized education or training;
- documentation that all medical acts delegated to the physician assistant will be within the scope of practice of the supervising physician and appropriate given the assistant's education, training, and level of competence;
- a statement by the supervising physician accepting responsibility for any care provided to patients by the physician assistant;
- a statement by the supervising physician that he will respond in a timely manner when contacted by the physician assistant;
- a description of the process the supervising physician will use to review the physician assistant's practice; and
- "[a]ny other information deemed necessary by the Board [of Physicians] or [the Physician Assistants Advisory] Committee."273

Note that a physician may NOT specify an alternate supervising physician in a delegation agreement for any physician assistant working in a non-hospital setting.[274]

For Nurses: Maryland law categorizes nurses into three main types: certified nurse practitioner, registered nurse, and licensed practical nurse.[275] Generally, nurses

[272] MD. CODE ANN., HEALTH OCC. § 15-302(a) (West 2008).
[273] *Id*. § 15-302(b)(1)-(10) (detailing the requirements of a delegation agreement).
[274] *See* 86 Md. Op. Atty. Gen. No. 157 (2001).
[275] *See* MD. CODE ANN., HEALTH OCC. § 8-302(b) (West 2008) (defining requirements for a nursing license or certification).

must possess a Maryland license in order to practice nursing in the State.[276] As defined in the Code:

- A **certified nurse practitioner** must be both licensed as a registered nurse and certified "to practice as a nurse practitioner" by the State Board of Nursing.[277] To "[p]ractice as a nurse practitioner" means to "independently:
    - [p]erform an act under subsection (h) of [§ 8-101];
    - [c]onduct a comprehensive physical assessment of an individual;
    - [e]stablish a medical diagnosis for common chronic stable or short-term health problems;
    - [o]rder, perform, and interpret laboratory tests;
    - [p]rescribe drugs as provided under § 8-508 of [title 8 of the Health Occupations Article];
    - [p]erform diagnostic, therapeutic, or corrective measures;
    - [r]efer an individual to an appropriate licensed physician or other health care provider; and
    - [p]rovide emergency care."[278]

- A **registered nurse** is any individual "who is licensed by the [State Board of Nursing] to practice registered nursing."[279] To "practice registered nursing" means "the performance of acts requiring substantial specialized knowledge, judgment, and skill based on the biological, physiological, behavioral, or sociological sciences as the basis for assessment, nursing diagnosis, planning, implementation, and evaluation of the practice of nursing in order to:
    - [m]aintain health;
    - [p]revent illness; or
    - [c]are for or rehabilitate the ill, injured, or infirm.[280]

[276] *Id*. § 8-301(a)-(b).
[277] *Id*. § 8-101(e).
[278] *Id*. § 8-101(f)(1)-(8).
[279] *Id*. § 8-101(i).
[280] *Id*. § 8-101(h)(1).

Under this definition, the practice of registered nursing includes "[a]dministration; [t]eaching; [c]ounseling; [s]upervision, delegation, and evaluation of nursing practice; [e]xecution of therapeutic regimen, including the administration of medication and treatment; [i]ndependent nursing functions and delegated medical functions; and [p]erformance of additional acts authorized by the [State Board of Nursing] under § 8-205 of [title 8 of the Health Occupations Article.][281]

- A **licensed practical nurse** is "an individual who is licensed by the [State Board of Nursing] to practice licensed practical nursing."[282] The practice of licensed practical nursing is defined as "perform[ing] in a team relationship an act that requires specialized knowledge, judgment, and skill based on principles of biological, physiological, behavioral, or sociological science to:
    - [a]dminister treatment or medication to an individual;
    - [a]id in the rehabilitation of an individual;
    - [p]romote preventive measures in community health;
    - [g]ive counsel to an individual;
    - [s]afeguard life and health;
    - [t]each or supervise; or
    - [p]erform any additional acts authorized by the [State Board of Nursing] under §8-205 of [title 8 of the Health Occupations Article].[283]

Maryland law prohibits an individual from practicing, attempting to practice, or offering to practice as a registered, licensed, or certified nurse; a certified nursing assistant; medication technician; or medicine aide without a valid Maryland license to practice that profession, in addition to prohibiting a nurse to practice above his level of knowledge or skill.[284] However, if a nurse does not possess a valid Maryland license and is employed by the federal government, he may "practice registered nursing or licensed practical nursing" as long as he is "practicing within

[281] *Id*. § 8-101(h)(2).
[282] *Id*. § 8-101(d).
[283] *Id*. § 8-101(g).
[284] *Id*. § 8-701(c) & (f).

the scope of [federal] employment" and is "authorized by any state to practice registered…or licensed practical nursing."[285]

Finally, an unlicensed nurse may practice in Maryland as part of an "approved education program,"[286] or if the individual: "(i) otherwise has qualified to practice registered…or licensed practical nursing in any other state or country and is in [Maryland] temporarily; or (ii) [h]as an application for a license pending before the [State Board of Nursing]: 1. [b]ut has not yet taken the examination [or] 2. [h]as taken an examination…but the results of the examination are not yet known."[287]

Under the Nurse Licensure Compact (NLC): Pursuant to the Nurse Licensure Compact (NLC), a nurse with a multi-state nursing license (but not a Maryland license) may practice nursing in Maryland, as long as the nurse meets all of his home state's requirements for licensure.[288] Basically, the NLC allows party states to recognize a license to practice "registered nursing" and/or "licensed practical or vocational nursing" issued by "a home state to a resident in that state" as "authorization for a multistate licensing privilege to practice" in a party state.[289] To obtain or retain a license, an applicant must meet his home state's qualifications for licensure and license renewal, as well as any other applicable state laws or requirements.[290] The Code of Maryland Regulations (COMAR) currently details the regulations covering nurses practicing in Maryland under the NLC.[291]

For Certified Nursing Assistants: Under Maryland law, a certified nursing assistant is defined as someone "who routinely performs nursing tasks delegated by a

[285] *Id*. § 8-301(c)(2).
[286] *Id*. § 8-301(c)(1).
[287] *Id*. § 8-301(c)(3)
[288] *See* MD. CODE ANN., HEALTH OCC. §8-7A-01 for complete coverage of the Nursing Licensure Compact in Maryland.
[289] *Id*. § 8-7A-01.4
[290] *Id*.
[291] MD. CODE REGS. 10.27.22.01-04; For a list of states participating in the Nurse Licensing Compact, please refer to the National Council of State Boards of Nursing, Nurse Licensing Compact, Compact Map, available at https://www.ncsbn.org/nlc.htm (last accessed September 19, 2011). As of September 2011, the following states participated in the Compact: Arkansas, Arizona, Colorado, Delaware, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, North Carolina, Nebraska, New Hampshire, New Mexico, North Dakota, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wisconsin.

registered nurse or licensed practical nurse for compensation."[292] All nursing assistants practicing within the State must be certified by the State Board of Nursing,[293] pursuant to regulations contained in COMAR.[294]

For Pharmacists: All pharmacists practicing in Maryland must possess valid State licenses.[295] In Maryland, the "practice of pharmacy" is defined as engaging in "any of the following activities:

- [p]roviding pharmaceutical care;
- [c]ompounding, dispensing, or distributing prescription drugs or devices;
- [c]ompounding or dispensing nonprescription drugs or devices;
- [m]onitoring prescriptions for prescription and nonprescription drugs or devices;
- [p]roviding information, explanation, or recommendations to patients and health care practitioners about the safe and effective use of prescription or nonprescription drugs or devices;
- [i]dentifying and appraising problems concerning the use or monitoring of therapy with drugs or devices;
- [a]cting within the parameters of a therapy management contract, as provided under Subtitle 6A of [title 12 of the Health Occupations Article]; or
- [a]dministering an influenza vaccination in accordance with § 12-508 of [title 12 of the Health Occupations Article]."[296]

Generally, a licensed pharmacist may only dispense and distribute medications or devices from a location that possesses a valid pharmacy permit; however, a pharmacist may be permitted to dispense and distribute medications from an alternate location if he obtains prior approval from the State Board of Pharmacy.[297] Finally, although Maryland prohibits the practice of pharmacy without a license (except for certain emergency situations), Maryland law does allow for

[292] *Id*. § 8-6A-01(h)(1).
[293] *Id*. § 8-6A-02(a).
[294] MD. CODE REGS. 10.39.01.01-08 (for regulations governing certification of nursing assistants).
[295] MD. CODE ANN., HEALTH OCC. § 12-301(a) (West 2008).
[296] *Id*. § 12-101(s)(1) (West Supp. 2009).
[297] *Id*. § 12-307(b)-(c).

pharmacy students to practice without a license as part of a "learning program of a college or school of pharmacy under the supervision of a licensed pharmacist."[298]

Emergency Privileges, Credentialing, and Practice

Generally: Maryland law recognizes that, during disasters or public health emergencies, procedures for emergency licensure and credentialing of health care professionals may be necessary to help Maryland's health care providers adequately respond. A number of specific laws and mutual aid agreements provide the framework through which emergency licensure and credentialing of health care professionals may occur to ensure that appropriate practitioners are permitted to assist with response activities. These include:

- Catastrophic Health Emergencies Act (CHE Act): The CHE Act requires the Secretary of Health and Mental Hygiene to "coordinate with the Health Occupations Boards to develop a process to license, certify, or credential both licensed health care practitioners and out-of-state health care practitioners who may be needed to respond to a catastrophic health emergency."[299] *It is important to note that, for the CHE Act's licensure provisions to apply, a catastrophic health emergency must have first been proclaimed by the Secretary.*

  SEE *PART I, SECTION A.1: CATASTROPHIC HEALTH EMERGENCIES ACT (CHE ACT)*, P. 13, FOR MORE INFORMATION ABOUT THE CHE ACT.

- Emergency Management Assistance Compact (EMAC): Under EMAC, upon receipt of a request for interstate assistance from an affected state, health care practitioners – including, but not limited to, physicians, nurses, and pharmacists – who are validly

[298] *Id*. § 12-301(b) (West 2008).
[299] *Id*. § 18-903(c) (West 2009 & Supp. 2009).

licensed in their home states are considered to be licensed in the requesting state for purposes of emergency response.[300]

SEE *PART I, SECTION C.1: EMERGENCY MANAGEMENT ASSISTANCE COMPACT (EMAC)*, P. 33, FOR MORE INFORMATION ABOUT EMAC.

- National Capital Region Agreements (NCR Agreements): For jurisdictions within the National Capital Region in Maryland, the District of Columbia, and Virginia, the NCR Agreements provide that an individual holding a "license, certificate, or other permit issued by any responding party evidencing the meeting of qualifications for professional, mechanical, or other skills and assistance" will be "deemed licensed, certified, or permitted by the receiving jurisdiction to render aid involving such skill" in the jurisdiction requesting assistance.[301]

SEE *PART I, SECTION C.3: NATIONAL CAPITAL REGION MUTUAL AID AGREEMENTS (NCR AGREEMENTS)*, P. 37, FOR MORE INFORMATION REGARDING THE NCR AGREEMENTS.

- In Coordination with American Red Cross Disaster Response: During a disaster or emergency in Maryland, an individual assigned by the American Red Cross to assist the State in emergency response activities may practice registered or licensed practical nursing if such individual has a valid license to practice the respective type of nursing in another state.[302]

Disaster Privileges for Hospital Medical Staff: The Code of Maryland Regulations addresses the granting of disaster privileges for physicians.[303] Pursuant to COMAR, a Maryland hospital must develop a medical staffing plan for granting of disaster privileges that identifies "[t]he individual responsible for granting disaster privileges; [t]he responsibilities of

[300] MD. CODE ANN., PUB. SAFETY § 14-702(5) (West Supp. 2009).
[301] Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. No. 108-458, § 7302(f), 118 Stat. 3638 (2004).
[302] MD. CODE ANN., HEALTH OCC. § 8-301(c)(4) (West 2008).
[303] MD. CODE REGS. 10.07.01.24G

that individual; [a] system to manage, assign, and supervise the physicians who have been granted disaster privileges; and [t]he process by which credentials and privileges are verified as soon as the situation allows[.]"[304]

To grant disaster privileges, a hospital must first activate its disaster or emergency management plan in response to a declared state of emergency or pursuant to an order of the Secretary of Health and Mental Hygiene under § 18-905 of the Health-General Article of the Maryland Code.[305] Once its plan is activated, the hospital's "chief executive officer, medical staff president, or designee may grant temporary disaster privileges to licensed physicians who have not been appointed to the hospital's medical staff."[306]

Physicians granted disaster privileges by a hospital must meet a number of requirements, including the following:

- The physician must be either "registered and trained by [DHMH] as part of [DHMH's] Maryland [Professional] Volunteer Corps and possess the Department-issued photo identification; or [c]omply with the hospital's medical staff plan for granting privileges in a disaster."[307]
- The physician must possess **one** of the following:
    - A current Maryland medical license and an official photo identification card (such as a driver's license or passport);
    - A current medical license from another state if the physician's assistance has been requested pursuant to EMAC;
    - A current photo identification card from another Maryland hospital where the physician currently has privileges; or
    - Verification by a hospital medical staff member that he knows the physician and the physician is licensed to practice medicine in Maryland.[308]

[304] *Id*. 10.07.01.24G(2).
[305] *Id*. 10.07.01.24G(1).
[306] *Id*.
[307] *Id*. 10.07.01.24G(3)(a)-(b).
[308] *Id*. 10.07.01.24G(3)(b).

For all physicians granted disaster privileges, the hospital is required to maintain proper records that include: "(a) [t]he number of hours worked by each physician; (b) [t]he type of service provided by each physician; (c) [t]he location where these services were provided; and (d) [a]ny additional information required by [DHMH] for federal and State reimbursement."[309]

Finally, COMAR provides that disaster privileges are "discontinued when the hospital's chief executive officer, medical staff president, or designee determines that the emergency condition no longer exists and that the hospital has adequate resources to meet the patient's needs."[310]

Federal Credentials/License Verification Systems for Health Care Professionals: The U.S. Secretary of Health and Human Services is required to establish a system at the federal level for advance registration of health care professionals "for the purpose of verifying credentials, licenses, accreditations, and hospital privileges" of such professionals who volunteer to provide health care services during a public health emergency.[311] Such a system may be established either directly or through "an award of a grant, contract, or cooperative agreement."[312]

SEE *PART I, SECTION B.11: ADVANCE REGISTRATION OF HEALTH PROFESSION VOLUNTEERS*, P. 29, FOR MORE INFORMATION REGARDING THE FEDERAL LICENSING AND CREDENTIALING SYSTEM.

2. Licensing of Facilities

A hospital license is required for hospitals operating in Maryland. Licenses are issued by the Secretary of the Department of Health and Mental Hygiene to operate a hospital, related institution, or residential treatment center in the State.[313] Licensing requirements, application processes, and revocations vary by facility type, which is statutorily defined in Subtitle 19 of the Maryland Annotated Code, Health—General. This Subtitle provides the framework for licensing

[309] *Id*. 10.07.01.24G(5).
[310] *Id*. 10.07.01.24G(4).
[311] 42 U.S.C.A. § 247d-7b(a) (West 2003).
[312] *Id*.
[313] MD. CODE ANN., HEALTH-GEN. § 19-301(g).

by type of health care facility. Hospitals and other related institutions are addressed in Subtitle 19, Part III. Hospitals and related institutions subject to this are statutorily defined and further classified in the statutes; these definitions are discussed first in this section. Hospitals and related institutions that meet these statutory definitions are subject to certain conditions for licensing, which are discussed below, prior to applying for a license from the Secretary of DHMH. A hospital must continue to meet these conditions as a requirement for continued license renewal. Hospitals subject to Subtitle 19 must also follow specific procedures for applying for, obtaining, and renewing a license, and the scope of this license is clearly defined in the statutes as well. Finally, a licensed hospital failing to meet certain statutory requirements or conditions is subject to license revocation, denial, or delicensure; the statutes governing these activities are discussed are in the final portion of this section.

Hospitals and Related Institutions

In Maryland, a "hospital" is defined as an institution that keeps individuals overnight for care, has at least 5 physicians comprising a medical staff "organized for the institution," and has facilities that provide "diagnostic and treatment services for 2 or more unrelated individuals."[314] An "accredited hospital" is a hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[315] Hospitals may be further classified as general hospitals, special hospitals, special rehabilitation hospitals, or limited service hospitals.[316] A general hospital can provide "at least [. . .] the services that are necessary for the general medical and surgical care of patients."[317] A "special hospital" has a defined program of specialized services (such as obstetrics, mental health, or communicable disease), has the facilities to provide those specialized services, and admits "only patients with medical or surgical needs within the program."[318] A special rehabilitation hospital must meet the requirements of Subtitle 19 and other regulations set by the Secretary.[319] A "limited service hospital" does not keep individuals

[314] *Id*. §19-301(f). Effective October 1, 2011. For corresponding COMAR requirements, see 10.07.01.00 et seq.
[315] *Id*. §19-301(b). For more on accredited organizations, see below (§19-2301 and §19-2302).
[316] *Id*. § 19-307.
[317] *Id*. § 19-307(a).
[318] *Id*. § 19-307(a)(1)(ii).
[319] *See* Subtitle 12, Annotated Code of Maryland, Health—General.

overnight, but keeps an emergency or urgent care center, and complies with other regulations set by the Secretary.[320]

A "related institution" means an organized institution, environment, or home that keeps individuals for overnight care and maintains conditions, facilities, and equipment to "provide domiciliary, personal, or nursing care for 2 or more unrelated individuals who are dependent on the administrator, operator, or proprietor for nursing care or the subsistence of daily living in a safe, sanitary, and healthful environment."[321] "Related institutions" do not include nursing facilities or visiting nurse services "conducted only by or for adherents of a bona fide church or religious organization."[322] According to § 19-307(b), related institutions can also be classified as home care or a nursing home.

A "residential treatment center" is a psychiatric institution that treats children and adolescents with "severe and chronic emotional disturbances."[323] Residential treatment centers provide "campus-based intensive and extensive evaluation and treatment" of those minors who "require a self-contained therapeutic, educational, and recreational program in a residential setting."[324]

Standards for Hospitals and Related Institutions Acquiring a License

According to Subtitle 19, the Secretary can adopt reasonable rules and regulations that set standards of services for related institutions, accredited hospitals, nonaccredited hospitals, accredited residential treatment centers, and nonaccredited residential treatment centers in specific areas. These standards can cover the care and medical supervision of patients; the physical environment of the facility; disease control; sanitation and safety; and dietary matters.[325] To assure compliance with these standards, the Secretary will ensure licensed accredited and nonaccredited hospitals, residential treatement centers, and related institutions are inspected.[326]

[320] MD. CODE ANN., HEALTH-GEN. §19-307(a)(1)(iv). *See also* §19-307.1.
[321] *Id*. § 19-301(o)(1).
[322] *Id*. § 19-301(o)(2).
[323] *Id*. § 19-301(p).
[324] *Id*. § 19-301(p).
[325] *Id*. §19-308(a).
[326] *Id*. §19-308(b).

At least two of these inspections are unannounced, and a report on hospital inspections is made to the General Assembly.[327]

In addition to setting standards of services, Subtitle 19 sets out a number of conditions necessary for a hospital's licensure. Failure to meet any of these conditions generally can result in fines or delicensure,[328] and cover a variety of areas. Licensed hospitals must establish a credentialing system for physicians who are employed by or who have staff privileges at the hospital.[329] In addition, licensed hospitals -- both accredited and nonaccredited -- must develop a protocol for the procurement of organs and tissues.[330] Other conditions of licensure include the establishment of a risk management program, which must meet set minimum standards and is the responsibility of an assigned risk management program coordinator, and which includes ongoing risk management education programs for all staff.[331] As a condition of licensure, each hospital "shall establish a utilization review program for all patients admitted to the hospital."[332]

A special psychiatric hospital or a hospital with "separately identified inpatient psychiatric service" must adopt written policies and procedures to implement patient rights for the mentally ill as a condition of licensure.[333]

Another condition of licensure includes policies that adopt patient care services that comply with Centers for Disease Control and Prevention guidelines.[334] Furthermore, licensed acute general hospitals or special hospitals are required to comply with select sections of the Hospital Accreditation Standards' Emergency Management standards,[335] and are also required to make executive summaries of evacuation procedures available upon request to patients, family members, or legal representatives.[336] Licensed hospitals must have a tracking system to help the

[327] *Id*. §19-308(b)(1)(ii).
[328] *Id*. *See*, for example, § 19-319 (e)(6)(i-ii).
[329] *Id*. § 19-319 (2)(i).
[330] *Id*. §19-319(f).
[331] *Id*. §19-319 (g)(1)-(2).
[332] *Id*. §19-318 (d)(1).
[333] *Id*. §19-319.2 (a), (b).
[334] *Id*. §19-318(h)(1)(i). Failure to comply can result in fines. §19-318(h)(1)(ii)(2).
[335] COMAR 10.07.01.28(A).
[336] COMAR 10.07.01.28(B).

hospital and other authorized stakeholders locate and identify patients "in the event of displacement due to an emergency or disaster."[337]

Related institutions that provide long-term care and programs for Alzheimer's patients are subject to prerequisites for licensing and license renewal. Such related institutions are required to have "an in-service education program that includes instruction on dementia and the techniques necessary to manage dementia patients'" physical, intellectual, and behavioral manifestations.[338]

Obtaining and Renewing a License

Hospitals and related institutions that meet the standards and requirements for licensing in Maryland must apply for a license from the Secretary of DHMH. In order to operate a hospital or related institution in Maryland, a person must be licensed by the Secretary.[339] To qualify for a license, an applicant for the hospital or related institution must meet a number of qualifications set forth in § 19-319 of the Maryland Health—General code. An individual applicant or an individual applying on behalf of a corporation, association, or government agency must be at least 18 years old, "of reputable and responsible character,"[340] and submit a certificate of need for the hospital, residential treatment center, or related institution to be operated.[341] The hospital to be operated must meet all requirements adopted by the Secretary under subtitle 19 (discussed previously), as well as subtitle 12 of the Health—General Article.[342]

An applicant for a license must submit an application and pay the Secretary a set application fee.[343] The application must be on the required form, signed, and verified by either the submitting individual or by two officers of the organization (if the application is submitted by a

[337] COMAR 10.07.01.28(C).
[338] MD. CODE ANN., HEALTH-GEN. §19-319.1.
[339] *Id*. § 19-318.
[340] *Id*. § 19-318 (b).
[341] *Id*. § 19-318(c)(1).
[342] *Id*. § 19-318(c)(2).
[343] *Id*. §19-320.

corporation, association, or government agency).[344] License applications must include the applicant's name, a statement that the applicant meets all license requirements, and the proposed hospital or related institution's class and location.[345] The application must include the name of the proposed administrative head, and may be required to submit other information the Secretary requires.[346] An effective license "authorizes the licensee to operate the hospital or related institution named in the license under the classification set forth in the license."[347] A license issued under this subtitle is not transferable,[348] and expires on the first anniversary of its effective date, unless renewed under the provisions of § 19-323.

Under § 19-323(b), a licensee may renew the license for an additional term if the licensee pays the renewal fee, is "otherwise [] entitled to the license," and submits the proper renewal application form with "satisfactory evidence of compliance with any requirements" under subtitle 19 for license renewal.[349] According to COMAR 10.07.01.04(c), applications for license renewals of accredited hospitals must be submitted within 30 calendar days of an approved accreditation organization's triennial survey of that hospital. Nonaccredited hospitals must submit applications for license renewal at least 60 days before the currently-issued license expires.[350]

The Secretary annually calculates licensed bed capacity of hospitals classified as general hospitals.[351] The annual licensed bed calculation for each hospital "shall equal 140 percent of the average daily census for the 12-month period immediately preceding the calculation."[352] A hospital may exceed its licensed bed capacity to adequately meet demand for services if, on average for the 12-month period, the hospital does not exceed its licensed bed capacity; and it reports the number of days it exceeded its licensed capacity and the number of beds that were in

[344] *Id*. § 19-319(b). Additional application requirements are discussed in COMAR10.07.01.04, Licensure Application Procedure.
[345] *Id*. § 19-319 (b)(3).
[346] *Id*. §19-319 (b)(3)(v)-(vi).
[347] *Id*. §19-322.
[348] *Id*. § 19-324.
[349] *Id*. §19-323(b)(1-2).
[350] COMAR 10.07.01.04(c)(1), (2).
[351] MD. CODE ANN., HEALTH-GEN. § 19-307.2(a).
[352] *Id*. § 19-307.2(b).

excess on those days, in its monthly report to the Health Services Cost Review Commission.[353] The Secretary can also delicense hospital beds determined to be excess bed capacity.[354]

In addition to licensing requirements, hospitals and related institutions must have the approval of the Secretary before building a hospital or related institution, or making any "conversion, alteration, or addition" that affects "the functional structure or normal bed capacity of a hospital or related institution."[355] Similarly, for major renovations, construction of patient care areas, or the establishment of a medical service that was not previously provided by the hospital,[356] the hospital must notify DHMH 60 days before the occupancy or operation to ensure DHMH has time to complete a review or inspection.[357]

Institutions that are on separate premises must have separate licenses, even if they are operated by the same management; however, for separate buildings on the same ground, separate licenses are not required.[358]

In addition to licensing, Title 19, Subtitle 23 discusses accreditation of health care facilities. The Secretary can approve an accreditation organization, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), to conduct surveys of health care facilities. An accreditation organization is a private entity that uses nationally recognized standards in its surveys and inspections of health care facilities.[359] When an approved accreditation organization finds a health care facility, including a hospital or related organization, is in substantial compliance with that organization's standards, DHMH will use the accreditation organization's report as "evidence that the [facility] has met State licensure requirements," and thereby grant the facility "deemed status."[360] Deemed status means the facility may then be exempt from routine DHMH inspections and surveys.[361]

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[353] *Id*. § 19-307.2(c).
[354] *Id*. § 19-307.2(d).
[355] *Id*. § 19-311(1)-(2).
[356] This applies to medical services that fall under Health-General Article, §19-120.
[357] COMAR 10.07.01.04.(F).
[358] COMAR 10.07.01.06 (A), (B).
[359] MD. CODE ANN., HEALTH-GEN. § 19-2301(b).
[360] *Id*. § 19-2302(c)(1).
[361] *Id*. § 19-2301(c).

Denial, Revocation, or Delicensure of Hospitals

As mentioned briefly above, licensed hospitals and related institutions are subject to standards set by the Secretary, and a person must be issued a registration permit or license from the Secretary to operate a hospital or related institution.[362] Failure to comply with standards set out in subtitle 19, or by an approved accreditation organization, can result in penalties, including fines or license revocation or delicensure.

The Secretary can deny or revoke a license to any applicant or licensee that has a felony conviction relating to Medicaid or a nursing home, or if the applicant or licensee fails to meet any requirement of subtitle 19, or other rules or regulations adopted under it,[363] or if the applicant or licensee violated Title 6.5 of the State Government Article of the Maryland Code.[364] Prior to revocation or denial, the applicant or licensee is entitled to an opportunity for a hearing, has the right to notice of that hearing at least 10 days before the hearing occurs, and has the right to be represented by counsel at the hearing.[365] Additionally, hospitals subject to delicensure, or denial or revocation of a license under COMAR 10.07.01.00 et seq., may request a hearing.[366]

Additionally, the Maryland Heath Care Commission and Health Services Cost Review Commission can petition the Secretary to delicense a hospital, or part of a hospital, to reduce excess capacity. Such a petition generally requires a public hearing and a finding that delicensure is consistent with the State health plan or institution-specific plan.[367] Upon such a petition, the Secretary may order delicensure. Delicensure is generally a last resort when hospital services are "excessive or inefficient,"[368] and the hospital must be given an opportunity for notice and a hearing.[369] Anyone aggrieved by a final decision of the Secretary can make a

[362] *Id*. § 19-358(a).
[363] *Id*. § 19-327(a)(1)(2).
[364] *Id*. § 19-327(b).
[365] *Id*. § 19-328(c)(1)-(3).
[366] See Annotated Code of Maryland State Government Article, §10-201 et seq., and COMAR 10.01.03.
[367] MD. CODE ANN., HEALTH-GEN. §1 9-325(a).
[368] *Id*. § 19-325(b)(1).
[369] *Id*. § 19-325(b).

direct judicial appeal; similarly, the Secretary can appeal to the Court of Appeals for review of an adverse decision.[370]

If an accredited or nonaccredited hospital, residential treatment center, or heath care facility is deemed by the Secretary to have a "serious or life-threatening patient care deficiency" that it fails to correct through "implementation of immediate corrective action," the Secretary can take a number of corrective actions, including restricting or revoking the facility's license.[371]

Related institutions that do not take steps to correct a "life-threatening, health or fire safety deficiency" after the Secretary determines the deficiency exists, restricts new admissions, and holds a hearing to determine if the related institution has taken steps to correct the deficiency, may face license revocation.[372]

In Montgomery County or Prince George's County, a county licensing authority proposing to suspend or revoke a related institution's county license must give the "Secretary notice of the proposed suspension or revocation," and the reasons it seeks that action, prior to notifying the related institution.[373] If the Secretary disapproves the proposal within 14 days after receiving notice, the county licensing authority cannot proceed with suspension or revocation.[374]

Any person "aggrieved by a final decision of the Secretary in a contested case, as defined in the Administrative Procedure Act," may appeal the Secretary's decision to the Board of Review of the Department, after which the person can take any further appeal allowed by the APA.[375] If the party's grievance arises from a Secretary's final decision under § 19-329(a), the party cannot appeal.[376]

[370] *Id*. § 19.325(d); §19.325 (f).
[371] *Id*. § 19-360(a), (d).
[372] *Id*. § 19-328(b)(ii).
[373] *Id*. § 19-329(a).
[374] *Id*. § 19-329(a)(2).
[375] *Id*. § 19-330.
[376] *Id*. § 19-330(b).

Finally, if an operator of an unlicensed hospital or unlicensed or unregistered related institution is ordered to pay civil money penalties, the operator can appeal that order under the Administrative Procedure Act-Contested Cases.[377]

[377] *Id*. § 19-359(c)(2). The Administrative Procedure Act is located in the State Government Article, Title 10, Subtitle 2.

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PART III: APPENDICES

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SECTION A: CATASTROPHIC HEALTH EMERGENCIES ACT (CHE ACT)

MD. CODE ANN., PUB. SAFETY § 14-3A-01. Definitions.

(a) *In general*.- In this subtitle the following words have the meanings indicated.

(b) *Catastrophic health emergency*.- "Catastrophic health emergency" means a situation in which extensive loss of life or serious disability is threatened imminently because of exposure to a deadly agent

(c) *Deadly agent*.- "Deadly agent" means:
(1) anthrax, ebola, plague, smallpox, tularemia, or other bacterial, fungal, rickettsial, or viral agent, biological toxin, or other biological agent capable of causing extensive loss of life or serious disability;
(2) mustard gas, nerve gas, or other chemical agent capable of causing extensive loss of life or serious disability; or
(3) radiation at levels capable of causing extensive loss of life or serious disability.

(d) *Exposure to a deadly agent*.- "Exposure to a deadly agent" means a threat to human health caused by the release, distribution, or transmission of a deadly agent in:
(1) this State; or
(2) another jurisdiction because of movement into the State of the deadly agent or of individuals exposed to the deadly agent.

(e) *Health care provider*.- "Health care provider" means:
(1) a health care facility as defined in § 19-114(e)(1) of the Health - General Article;
(2) a health care practitioner as defined in § 19-114(f) of the Health - General Article; and
(3) an individual licensed or certified as an emergency medical services provider under § 13-516 of the Education Article.

(f) *Secretary*.- "Secretary" means the Secretary of Health and Mental Hygiene.

MD. CODE ANN., PUB. SAFETY § 14-3A-02. Governor's proclamation.

(a) *In general*.- If the Governor determines that a catastrophic health emergency exists, the Governor may issue a proclamation under this subtitle.

(b) *Contents of proclamation*.- The proclamation shall indicate:
(1) the nature of the catastrophic health emergency;
(2) the areas threatened or affected; and
(3) the conditions that:
(i) led to the catastrophic health emergency; or
(ii) made possible the termination of the emergency.

(c) *Duration of proclamation*.-

(1) The Governor shall rescind a proclamation issued under this section whenever the Governor determines that the catastrophic health emergency no longer exists.
(2) Unless renewed, the proclamation expires 30 days after issuance.
(3) The Governor may renew the proclamation for successive periods, each not to exceed 30 days, if the Governor determines that a catastrophic health emergency continues to exist.

MD. CODE ANN., PUB. SAFETY § 14-3A-03. Governor's orders.

(a) *In general*.- After the Governor issues a proclamation under this subtitle, the Governor may issue the orders authorized in this section.

(b) *To the Secretary or designee*.-

(1) The Governor may order the Secretary or other designated official to:
    (i) seize immediately anything needed to respond to the medical consequences of the catastrophic health emergency; and
    (ii) work collaboratively, to the extent feasible, with health care providers to designate and gain access to a facility needed to respond to the catastrophic health emergency.
(2) The Governor may order the Secretary or other designated official to control, restrict, or regulate the use, sale, dispensing, distribution, or transportation of anything needed to respond to the medical consequences of the catastrophic health emergency by:
    (i) rationing or using quotas;
    (ii) creating and distributing stockpiles;
    (iii) prohibiting shipments;
    (iv) setting prices; or
    (v) taking other appropriate actions.
(3) If medically necessary and reasonable to treat, prevent, or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent, the Governor may order the Secretary or other designated official to:
    (i) require individuals to submit to medical examination or testing;
    (ii) require individuals to submit to vaccination or medical treatment unless the vaccination or treatment likely will cause serious harm to the individual;
    (iii) establish places of treatment, isolation, and quarantine; or
    (iv) require individuals to go to and remain in places of isolation or quarantine until the Secretary or other designated official determines that the individuals no longer pose a substantial risk of transmitting the disease or condition to the public.

(c) *To health care provider*.- The Governor may order any health care provider, who does not voluntarily participate, to participate in disease surveillance, treatment, and suppression efforts or otherwise comply with the directives of the Secretary or other designated official.

(d) *To the public*.-

(1) The Governor may order the evacuation, closing, or decontamination of any facility.
(2) If necessary and reasonable to save lives or prevent exposure to a deadly agent, the Governor may order individuals to remain indoors or refrain from congregating.

MD. CODE ANN., PUB. SAFETY § 14-3A-04. Isolation or quarantine after refusal to be tested or treated.

The Secretary may require an individual to go to and remain in a place of isolation or quarantine until the Secretary determines that the individual no longer poses a substantial risk of transmitting a disease or condition to the public if the individual:

(1) is a competent adult; and
(2) refuses an order under § 14-3A-03(b)(3) of this subtitle for:
    (i) vaccination;
    (ii) medical examination;
    (iii) treatment; or
    (iv) testing.

MD. CODE ANN., PUB. SAFETY § 14-3A-05. Directive for isolation or quarantine.

(a) *In general*.- If the Secretary or other designated official requires an individual or a group of individuals to go to and remain in places of isolation or quarantine under § 14-3A-03(b)(3) of this subtitle, the Secretary shall issue a directive to the individual or group of individuals.

(b) *Contents and notice*.-

(1) The directive shall specify:
    (i) the identity of the individual or group of individuals that are subject to isolation or quarantine;
    (ii) the premises that are subject to isolation or quarantine;
    (iii) the date and time when the isolation or quarantine starts;
    (iv) the suspected deadly agent causing the outbreak or disease, if known;
    (v) the justification for the isolation or quarantine; and
    (vi) the availability of a hearing to contest the directive.
(2) Except as provided in paragraph (3) of this subsection, the directive shall be:
    (i) in writing; and
    (ii) (ii) given to those subject to the directive before the directive takes effect.
(3) (i) If the Secretary or other designated official determines that the notice required in paragraph (2) of this subsection is impractical because of the number of individuals or geographical areas affected, the Secretary or other designated official shall ensure that the affected individuals are fully informed of the directive using the best possible means available.
    (ii) If the directive applies to a group of individuals and it is impractical to provide individual written copies under paragraph (2) of this subsection, the written directive may be posted in a conspicuous place in the isolation or quarantine premises.

(c) *Hearing*.-

(1) An individual or group of individuals isolated or quarantined under § 14-3A-03(b)(3) of this subtitle may request a hearing in a circuit court to contest the isolation or quarantine.
(2) A request for a hearing does not stay or enjoin an isolation or quarantine directive.
(3) A court that receives a request under this subsection shall hold a hearing within 3 days after receipt of the request.
(4) In any proceedings brought for relief under this subsection, the court may extend the time for a hearing:
    (i) if the Secretary or other designated official shows that extraordinary circumstances exist that justify the extension; and

(ii) after considering the rights of the affected individual or group of individuals, the protection of the public health, the severity of the catastrophic health emergency, and the availability of any necessary witnesses and evidence.

(5) (i) The court shall grant the request for relief unless the court determines that the isolation or quarantine directive is necessary and reasonable to prevent or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent.

(ii) The court in making its determination may consider, if feasible, the means of transmission, the degree of contagion, and, to the extent possible, the degree of public exposure to the disease.

(6) Subject to paragraph (7) of this subsection, if the court issues an order that authorizes the isolation or quarantine, the order shall:

(i) identify the isolated or quarantined individual or group of individuals by name or shared characteristics;

(ii) specify factual findings warranting isolation or quarantine; and

(iii) be in writing and given to the individual or group of individuals.

(7) If the court determines that the delivery required by paragraph (6)(iii) of this subsection is impractical because of the number of individuals or geographical area affected, the court shall ensure that the affected individuals are fully informed of the order using the best possible means available.

(d) *Duration of court order*.-

(1) An order under subsection (c) of this section may authorize isolation or quarantine for not more than 30 days.

(2) Before the order expires, the Secretary or designated official may request the court to continue the isolation or quarantine for additional 30-day periods.

(3) The court shall base its decision on the standards provided under subsection (c)(5) of this section.

(e) *Inability to appear*.- If an individual cannot appear personally before the court, proceedings may be conducted:

(1) by the individual's authorized representative; and

(2) in a way that allows full participation by other individuals.

(f) *Procedures*.-

(1) Subject to any emergency rules that the Court of Appeals adopts under paragraph (3) of this subsection, the court may order the consolidation of individual claims into group claims in proceedings brought under this section if:

(i) questions of law or fact that are common to the individual claims or rights must be determined;

(ii) the group claims or rights to be determined are typical of the affected individual's claims or rights; or

(iii) the entire group will be adequately represented in the consolidation.

(2) The Court of Appeals shall appoint counsel to represent individuals or a group of individuals who are not otherwise represented by counsel.

(3) The Court of Appeals shall adopt emergency rules of procedure to facilitate the efficient adjudication of proceedings brought under this section.

MD. CODE ANN., PUB. SAFETY § 14-3A-06. Immunity.

A health care provider is immune from civil or criminal liability if the health care provider acts in good faith and under a catastrophic health emergency proclamation.

MD. CODE ANN., PUB. SAFETY § 14-3A-07. Construction.

The authority granted under this subtitle is in addition to, and not in derogation of, any other authority that the Governor, the Secretary, or any other public official may exercise under other law.

MD. CODE ANN., PUB. SAFETY § 14-3A-08. Failure to comply.

(a) *Prohibited.*- A person may not knowingly and willfully fail to comply with an order, requirement, or directive issued under this subtitle.

(b) *Penalty.*- A person who violates subsection (a) of this section is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 1 year or a fine not exceeding $ 5,000 or both.

MD. CODE ANN., HEALTH-GEN. § 18-901. Definitions.

(a) *In general.*- In this subtitle the following words have the meanings indicated.

(b) *Catastrophic health emergency.*- "Catastrophic health emergency" has the meaning stated in § 14-3A-01 of the Public Safety Article.

(c) *Deadly agent.*- "Deadly agent" has the meaning stated in § 14-3A-01 of the Public Safety Article.

(d) *Exposure to a deadly agent.*- "Exposure to a deadly agent" has the meaning stated in § 14-3A-01 of the Public Safety Article.

(e) *Health care facility.*- "Health care facility" has the meaning stated in § 19-114(e) (1) of this article.

(f) *Health care practitioner.*-
(1) "Health care practitioner" has the meaning stated in § 19-114 (f) of this article.
(2) "Health care practitioner" includes an individual licensed or certified as an emergency medical services provider under § 13-516 of the Education Article.

(g) *Health care provider.*- "Health care provider" means:
(1) A health care facility; or
(2) A health care practitioner.

MD. CODE ANN., HEALTH-GEN. § 18-902. Authority of Secretary of Health and Mental Hygiene; investigation and prevention of actual or potential exposure.

Notwithstanding any other provision of law, the Secretary may exercise the authority granted in this subtitle to:

(1) Continuously evaluate and modify existing disease surveillance procedures in order to detect a catastrophic health emergency;
(2) Investigate actual or potential exposures to a deadly agent; and

(3) Treat, prevent, or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent.

MD. CODE ANN., HEALTH-GEN. § 18-903. Development and implementation of contingency plans.

(a) *Power of Secretary to require adoption of accredited contingency plans.*-
(1) In accordance with procedures to be adopted by the Department, the Secretary, in consultation with health care facilities, may require health care facilities to develop and implement contingency plans addressing:
(i) Staff training needs;
(ii) Stockpiling of equipment, medication, and supplies necessary to address a catastrophic health emergency;
(iii) Treatment and decontamination protocols;
(iv) The coordination of services with other public and private entities; and
(v) Any other area that the Secretary determines is necessary to assist in the early detection and treatment of an individual exposed to a deadly agent.
(2) To the extent feasible, the procedures to be adopted by the Department under paragraph (1) of this subsection shall be consistent with accreditation requirements of the Joint Commission on the Accreditation of Health Care Organizations.

(b) *Protocols and plans.*- After consulting with the appropriate licensing board, the Secretary:
(1) Shall publish protocols to assist health care practitioners in developing plans to respond to a catastrophic health emergency; and
(2) May, if necessary, require health care practitioners to implement the plans developed under item (1) of this subsection.

(c) *Process for licensing, certifying or credentialing providers.*- The Secretary shall develop a process to license, certify, or credential health care practitioners who may be needed to respond to a catastrophic health emergency.

MD. CODE ANN., HEALTH-GEN. § 18-904. Reporting requirements.

(a) *Information defined.*- In this section, "information" means medical, epidemiological, or other data concerning a specific individual or a group of individuals, regardless of whether the information is otherwise deemed confidential under Title 4 of this article or as otherwise provided under law.

(b) *Methods of reporting or disclosing information.*- In order to maintain an effective disease surveillance system for detecting whether individuals have been exposed to a deadly agent, the Secretary may by order, directive, or regulation
(1) Require a health care provider or other person to report information to the Secretary or other public official on the following:
(i) The presence of an individual or group of individuals with specified illnesses or symptoms;
(ii) Diagnostic and laboratory findings relating to diseases caused by deadly agents;
(iii) Statistical or utilization trends relating to potential disease outbreaks;
(iv) Information needed to conduct contact tracing for exposed individuals; and
(v) Other data deemed by the Secretary to have epidemiological significance in detecting possible catastrophic health emergencies;
(2) Obtain access to information in the possession of a health care provider;
(3) Require or authorize a health care provider to disclose information to an agency of the federal, State, or local government or another health care provider;

(4) Require a health care provider or other person to submit reports to the Department containing information detailing the presence and use of deadly agents;
(5) Obtain access to premises in order to secure environmental samples and otherwise investigate actual or potential exposures to deadly agents; and
(6) Require a veterinarian or other person to report data relating to specified illnesses or symptoms in animal populations.

(c) *Limitation on use*.- The Secretary, in acquiring information under subsection (b) of this section, shall:
(1) Request and use nonidentifying information whenever possible; and
(2) Limit the use of confidential information to the extent necessary to detect and investigate actual or potential exposures to a deadly agent.

(d) *Confidentiality*.-
(1) Any information that the Secretary receives under subsection (b) of this section is confidential and may be used or disclosed only in accordance with this section.
(2) If the information requested in subsection (b) of this section is otherwise confidential under Title 4 of this article or as otherwise provided under law, the Secretary or person that receives the information may not redisclose the information except as provided in paragraph (3) of this subsection.
(3) A person may redisclose the information to another health care provider or public official provided that:
(i) The health care provider or public agency to whom the information is disclosed will maintain the confidentiality of the disclosure; and
(ii) The Secretary determines the disclosure is necessary to treat, prevent, or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent.

MD. CODE ANN., HEALTH-GEN. § 18-905. Enforcement.

(a) *Orders*.- In investigating actual or potential exposures to a deadly agent, the Secretary:
(1) (i) May issue an order requiring individuals whom the Secretary has reason to believe have been exposed to a deadly agent to seek appropriate and necessary evaluation and treatment;
(ii) When the Secretary determines that it is medically necessary and reasonable to prevent or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent, may order an individual or group of individuals to go to and remain in places of isolation or quarantine until the Secretary determines that the individual no longer poses a substantial risk of transmitting the disease or condition to the public; and
(iii) If a competent individual over the age of 18 refuses vaccination, medical examination, treatment, or testing under this paragraph, may require the individual to go to and remain in places of isolation or quarantine until the Secretary determines that the individual no longer poses a substantial risk of transmitting the disease or condition to the public;
(2) May coordinate and direct the efforts of any health officer or health commissioner of any subdivision in seeking to detect or respond to threats posed by a deadly agent; and
(3) May order any sheriff, deputy sheriff, or other law enforcement officer of the State or any subdivision to assist in the execution or enforcement of any order issued under this subtitle.

(b) *When issued*.- The Secretary may issue an order under subsection (a) of this section:
(1) If, prior to the issuance of a proclamation under § 14-3A-02 of the Public Safety Article, the Secretary determines that the disease or outbreak can be medically contained by the Department and appropriate health care providers; and

(2) As necessary to implement an order issued by the Governor under § 14-3A-02 of the Public Safety Article.

MD. CODE ANN., HEALTH-GEN. § 18-906. Quarantine; appeal.

(a) *Directives.*-

(1) If the Secretary requires an individual or a group of individuals to go to and remain in places of isolation or quarantine under § 18-905 of this subtitle, the Secretary shall issue a directive to the individual or group of individuals.

(2) The directive shall specify:

(i) The identity of the individual or group of individuals subject to isolation or quarantine;

(ii) The premises subject to isolation or quarantine;

(iii) The date and time at which isolation or quarantine commences;

(iv) The suspected deadly agent causing the outbreak or disease, if known;

(v) The basis upon which isolation or quarantine is justified; and

(vi) The availability of a hearing to contest the directive.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, the directive shall be in writing and given to the individual or group of individuals prior to the individual or group of individuals being required to go to and remain in places of isolation and quarantine.

(ii) 1. If the Secretary determines that the notice required under subparagraph (i) of this paragraph is impractical because of the number of individuals or geographical areas affected, the Secretary shall ensure that the affected individuals are fully informed of the directive using the best possible means available.

2. If the directive applies to a group of individuals and it is impractical to provide written individual copies under subparagraph (i) of this paragraph, the written directive may be posted in a conspicuous place in the isolation or quarantine premises.

(b) *Hearings.*-

(1) An individual or group of individuals isolated or quarantined under subsection (a) of this section may request a hearing in circuit court contesting the isolation or quarantine.

(2) A request for a hearing may not stay or enjoin an isolation or quarantine directive.

(3) Upon receipt of a request under this subsection, the court shall conduct a hearing within 3 days from receipt of the request.

(4) (i) In any proceedings brought for relief under this subsection, the court may extend the time for a hearing upon a showing by the Secretary or other designated official that extraordinary circumstances exist that justify the extension.

(ii) In granting or denying an extension, the court shall consider the rights of the affected individual, the protection of the public health, the severity of the catastrophic health emergency, and the availability, if necessary, of witnesses and evidence.

(5) (i) 1. The court shall grant the request for relief unless the court determines that the isolation or quarantine directive is necessary and reasonable to prevent or reduce the spread of the disease or outbreak believed to have been caused by the exposure to a deadly agent.

2. If feasible, in making a determination under this subparagraph, the court may consider the means of transmission, the degree of contagion, and, to the extent possible, the degree of public exposure to the disease.

(ii) 1. An order authorizing the isolation or quarantine issued under this paragraph shall:

A. Identify the isolated or quarantined individual or group of individuals by name or shared characteristics;

B. Specify factual findings warranting isolation or quarantine; and

C. Except as provided in sub-subparagraph 2 of this subparagraph, be in writing and given to the individual or group of individuals.

2. If the court determines that the notice required in sub-subparagraph 1C of this subparagraph is impractical because of the number of individuals or geographical areas affected, the court shall ensure that the affected individuals are fully informed of the order using the best possible means available.

(iii) An order authorizing isolation or quarantine is effective for a period not to exceed 30 days.

(iv) 1. Prior to the expiration of an order, the Secretary or designated official may move to continue isolation or quarantine for subsequent 30-day periods.

2. The court shall base its decision on the standards provided under this paragraph.

(6) In the event that an individual cannot personally appear before the court, proceedings may be conducted:

(i) By an individual's authorized representative; and

(ii) Through any means that allows other individuals to fully participate.

(7) In any proceedings brought under this subsection, the court may order the consolidation of individual claims into group claims where:

(i) The number of individuals involved or affected is so large as to render individual participation impractical;

(ii) There are questions of law or fact common to the individual claims or rights to be determined;

(iii) The group claims or rights to be determined are typical of the affected individual's claims or rights; or

(iv) The entire group will be adequately represented in the consolidation.

(c) *Appointment of counsel.*- The court shall appoint counsel to represent individuals or a group of individuals who are not otherwise represented by counsel.

(d) *Emergency rules.*- The court of appeals shall develop emergency rules of procedure to facilitate the efficient adjudication of any proceedings brought under this section.

(e) *Discharge from employment unlawful.*- It shall be unlawful for any public or private employer to discharge an employee who is under an order of isolation or quarantine or because of such an order.

MD. CODE ANN., HEALTH-GEN. § 18-907. Failure to comply.

(a) *Noncompliance by individuals.*-

(1) A person may not knowingly and willfully fail to comply with any order, regulation, or directive issued in accordance with § 18-905 of this subtitle.

(2) A person who violates paragraph (1) of this subsection is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 1 year or a fine not exceeding $ 3,000 or both.

(b) *Noncompliance by health care facilities.*- If a health care facility fails to comply with an order, regulation, or directive issued under § 18-903 or § 18-904 of this subtitle, the Secretary may impose a civil penalty not to exceed $ 3,000 for each offense.

(c) *Noncompliance by health care practitioners.*- If a health care practitioner fails to comply with an order, regulation, or directive issued under § 18-903 or § 18-904 of this subtitle, the Secretary may request the appropriate licensing board to take disciplinary action against the health care practitioner, including:

(1) Placing the licensee or certificate holder on probation;
(2) Suspending or revoking the license or certificate holder; or
(3) Imposing a civil penalty not to exceed $ 3,000 for each offense.

(d) *Immunity from liability*.- A health care provider acting in good faith and in accordance with a catastrophic health emergency disease surveillance and response program is immune from civil or criminal liability related to those actions, unless the health care provider acts with willful misconduct.

MD. CODE ANN., HEALTH-GEN. § 18-908. Report by Secretary.

(a) *Reports*.- On or before December 31, 2002, the Secretary shall submit a report to the Governor and to the General Assembly in accordance with § 2-1246 of the State Government Article regarding any plans, procedures, or protocols developed under this subtitle or any recommendations for additional legislation that may be necessary to respond to a catastrophic health emergency.

(b) *Updates to reports*.- The Secretary shall update the report required under subsection (a) of this section every 3 years or when any plan, procedure, or protocol developed under this subtitle or any other provision of this subtitle is used in order to detect a catastrophic health emergency.

SECTION B: MARYLAND EMERGENCY MANAGEMENT AGENCY ACT (MEMA ACT)

§ 14-101. Definitions.

(a) *In general*.- In this subtitle the following words have the meanings indicated.

(b) *Director*.- "Director" means the Director of MEMA.

(c) *Emergency*.- "Emergency" means the threat or occurrence of:
(1) a hurricane, tornado, storm, flood, high water, wind-driven water, tidal wave, earthquake, landslide, mudslide, snowstorm, drought, fire, explosion, and any other disaster in any part of the State that requires State assistance to supplement local efforts in order to save lives and protect public health and safety; or
(2) an enemy attack, act of terrorism, or public health catastrophe.

(d) *Emergency management*.-
(1) "Emergency management" means the preparation for and carrying out of functions in an emergency in order to save lives and to minimize and repair injury and damage that result from emergencies beyond the capabilities of local authorities.
(2) "Emergency management" does not include the preparation for and carrying out of functions in an emergency for which military forces are primarily responsible.

§ 14-102. Legislative policy.

(a) *In general*.- To ensure that the State will be adequately prepared to deal with emergencies that are beyond the capabilities of local authorities, to provide for the common defense, to protect the public peace, health, and safety, and to preserve the lives and property of the people of the State, it is necessary to:
(1) establish a Maryland Emergency Management Agency;
(2) authorize the establishment of local organizations for emergency management in the political subdivisions;
(3) confer on the Governor and on the executive heads or governing bodies of the political subdivisions the emergency powers provided in this subtitle; and
(4) provide for the rendering of mutual aid among the political subdivisions and with other states in carrying out emergency management functions.

(b) *Effective use of resources*.- It is the policy of the State and the purpose of this subtitle to coordinate, to the maximum extent possible, all emergency management functions of the State with the comparable functions of the federal government, other states, other localities, and private agencies, so that the most effective preparation and use may be made of the resources and facilities available for dealing with any emergency.

§ 14-103. Maryland Emergency Management Agency established.

(a) *In general*.- There is a Maryland Emergency Management Agency in the Military Department.
(b) *Unit of State government*.- MEMA is a unit of State government.

§ 14-104. Director of MEMA.

(a) *Appointment.*- The Adjutant General shall appoint the director of MEMA with the approval of the Governor.
(b) *Term.*- The Director serves at the pleasure of the Adjutant General.
(c) *Salary.*-
(1) The Director is in the executive service of the State Personnel Management System and is entitled to the salary provided in the State budget.
(2) The Director's employment is not subject to the conditions and limitations of the State Personnel and Pensions Article.
(d) *Duties.*-
(1) The Director is the executive head of MEMA.
(2) The Director is responsible to the Governor and the Adjutant General for carrying out the State emergency management program.
(3) If the Governor has formally declared the threat or occurrence of an emergency, the Director shall coordinate the activities of all organizations for emergency management operations in the State.
(4) With the approval of the Adjutant General and in collaboration with other public and private agencies in the State, the Director shall develop or cause to be developed mutual aid agreements for reciprocal emergency aid and assistance in case of emergency of an extreme nature that affects two or more political subdivisions.
(5) The Director shall maintain liaison and cooperate with emergency management agencies and organizations of other states and the federal government.

(e) *Staff.*- Subject to the authority of the Adjutant General, the Director may employ personnel in accordance with the State budget and subject to the conditions and limitations of the State Personnel and Pensions Article.

(f) *Expenditures for emergency management.*- The Director may make expenditures within the appropriations in the State budget or from other money made available to the Director for purposes of emergency management as necessary to carry out this subtitle.

§ 14-105. Emergency Management Advisory Council.

(a) *Established.*- There is an Emergency Management Advisory Council.

(b) *Membership.*- The Council consists of the members that the Governor designates, including:
(1) fair and reasonable representation for local government;
(2) representation for organizations that represent volunteer firefighters and rescue squads; and
(3) representation from manufacturing, utilities, and communications industries.

(c) *Compensation and reimbursement for expenses.*- A member of the Council:
(1) may not receive compensation for service on the Council; but
(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.

(d) *Duties.*- The Council shall advise the Governor on all matters that relate to emergency management.

(e) *Annual reports.*- On or before December 31, 2005, and on or before December 1 of each year thereafter, the Council shall submit a report to the Governor and, in accordance with § 2-1246 of the State Government Article to the General Assembly concerning its activities and recommendations.

§ 14-106. Emergency management powers of Governor.

(a) *In general.*-
(1) The Governor:
(i) has control of and is responsible for MEMA; and
(ii) is responsible for carrying out this subtitle.
(2) In the event of the threat or occurrence of an emergency, the Governor may assume direct operational control over all or part of an emergency management function created or authorized by this subtitle and Subtitles 2 and 4 of this title.
(3) The Governor may delegate the powers the Governor sees fit to an individual who is employed:
(i) as a secretary of a principal department; or
(ii) as the head of an independent State agency.

(b) *Specific powers.*- In performing duties under this subtitle, the Governor:
(1) may cooperate with the federal government, other states, and private agencies in all matters that relate to the emergency management operations of this State and the United States;
(2) may issue orders, rules, and regulations necessary or desirable to:
(i) carry out this subtitle;
(ii) prepare and revise, as necessary, a comprehensive plan and program for the emergency management operations of this State;
(iii) integrate the plan and program of this State with the emergency management operations plans of the federal government and other states; and
(iv) coordinate the preparation of plans and programs for emergency management operations by the political subdivisions;
(3) may authorize the procurement of supplies and equipment, the institution of training programs including the process for licensing, certifying, or credentialing health care practitioners developed under § 18-903(c) of the Health - General Article, public information programs, and other steps to prepare for an emergency;
(4) may authorize studies and surveys of industries, resources, and facilities in the State as necessary or desirable to:
(i) ascertain the State's capabilities for emergency management operations; and
(ii) prepare plans for the emergency management of resources in accordance with the national plan for emergency preparedness;
(5) may appoint, in cooperation with local authorities, directors of local organizations for emergency management, may delegate to the directors any administrative authority vested in the Governor under this subtitle, and may provide for the subdelegation of that authority; and
(6) may delegate the Governor's authority under this subsection to an individual who is employed:
(i) in the Executive Department of State government;
(ii) as a secretary of a principal department; or
(iii) as the head of an independent State agency.

(c) *Harmful consequences of potential emergencies.*-
(1) In addition to emergency prevention measures included in the State, local, and interjurisdictional emergency plans, the Governor shall consider, on a continuing basis, steps that could be taken to prevent or reduce the harmful consequences of potential emergencies.
(2) (i) At the direction of the Governor, and in accordance with any other authority and competence they have, State agencies shall study matters related to emergency prevention.
(ii) State agencies required to study matters related to emergency prevention include those charged with responsibilities in connection with flood plain management, stream encroachment

and flow regulation, weather modification, fire prevention and control, air quality, public works, land use and land-use planning, and construction standards.

§ 14-107. State of Emergency – Declaration by Governor.

(a) *In general.*-

(1) If the Governor finds that an emergency has developed or is impending due to any cause, the Governor shall declare a state of emergency by executive order or proclamation.

(2) The state of emergency continues until the Governor:

(i) finds that the threat or danger has passed or the emergency has been dealt with to the extent that emergency conditions no longer exist; and

(ii) terminates the state of emergency by executive order or proclamation.

(3) A state of emergency may not continue for longer than 30 days unless the Governor renews the state of emergency.

(4) (i) The General Assembly by joint resolution may terminate a state of emergency at any time.
(ii) After the General Assembly terminates a state of emergency, the Governor shall issue an executive order or proclamation that terminates the state of emergency.

(b) *Contents of declaration; publicity.*-

(1) Each executive order or proclamation that declares or terminates a state of emergency shall indicate:

(i) the nature of the emergency;

(ii) the area threatened; and

(iii) the conditions that have brought about the state of emergency or that make possible the termination of the state of emergency.

(2) Each executive order or proclamation shall be:

(i) disseminated promptly by means calculated to publicize its contents; and

(ii) unless prevented or impeded by the circumstances of the emergency, filed promptly with:

1. MEMA;
2. the State Archives; and
3. the chief local records-keeping agency in the area to which the executive order or proclamation applies.

(c) *Responsibility of Director; effect of declaration.*-

(1) After the Governor declares a state of emergency, the Director shall coordinate the activities of the agencies of the State and of those political subdivisions included in the declaration in all actions that serve to prevent or alleviate the ill effects of the imminent or actual emergency.

(2) An executive order or proclamation that declares a state of emergency:

(i) activates the emergency response and recovery aspects of the State and local emergency plans applicable to the political subdivision or area covered by the declaration; and

(ii) is authority for:

1. the deployment and use of resources to which the State or local plans apply; and
2. the use or distribution of supplies, equipment, materials, and facilities assembled, stockpiled, or arranged to be made available in accordance with this subtitle or any other law that relates to emergencies.

(d) *Other actions by Governor*.-

(1) After declaring a state of emergency, the Governor, if the Governor finds it necessary in order to protect the public health, welfare, or safety, may:
   (i) suspend the effect of any statute or rule or regulation of an agency of the State or a political subdivision;
   (ii) direct and compel the evacuation of all or part of the population from a stricken or threatened area in the State;
   (iii) set evacuation routes and the modes of transportation to be used during an emergency;
   (iv) direct the control of ingress to and egress from an emergency area, the movement of individuals in the area, and the occupancy of premises in the area;
   (v) authorize the use of private property, in which event the owner of the property shall be compensated for its use and for any damage to the property;
   (vi) provide for temporary housing; and
   (vii) authorize the clearance and removal of debris and wreckage.

(2) The powers of the Governor under this subsection are in addition to any other authority vested in the Governor by law.

§ 14-108. Same – Declared in another state.

(a) *Powers of Governor*.- After a state of emergency is declared in another state and the Governor receives a written request for assistance from the executive authority of that state, the Governor may:

(1) authorize use in the other state of personnel, equipment, supplies, or materials of this State, or of a political subdivision with the consent of the executive officer or governing body of the political subdivision; and

(2) suspend the effect of any statute or rule or regulation of an agency of the State or, after consulting with the executive officer or governing body of a political subdivision, a rule or regulation of an agency of a political subdivision, if the Governor finds that the suspension is necessary to aid the other state with its emergency management functions.

(b) *Issuance of executive order; contents; publicity*.-

(1) The Governor shall authorize the use of resources or the suspension of the effect of any statute, rule, or regulation under subsection (a) of this section by executive order.

(2) An executive order issued under this section may not continue for longer than 30 days unless the Governor renews the executive order.

(3) Each executive order issued under this section shall indicate:
   (i) the nature of the emergency in the other state; and
   (ii) any circumstances that make suspension of a statute, rule, or regulation necessary to aid the other state with its emergency management functions.

(4) Each executive order shall be:
   (i) disseminated promptly by means calculated to publicize its contents; and
   (ii) filed promptly with:
      1. MEMA;
      2. the State Archives; and
      3. each agency of the State or a political subdivision that is authorized by the order to use resources in the other state or responsible for the enforcement of any provisions that are suspended by the executive order.

§14-109. Local organizations for emergency management.

(a) *Established.*- Each political subdivision shall
(1) establish a local organization for emergency management in accordance with the State emergency management plan and program; and
(2) participate in federal programs for emergency management.

(b) *Directors of local organizations for emergency management.*-
(1) On recommendation of the mayor, executive, or governing body of the political subdivision, the Governor shall appoint a director of emergency management for each local organization for emergency management.
(2) Each director of a local organization for emergency management is directly responsible for the organization, administration, and operation of the local organization for emergency management.
(3) Each director of a local organization for emergency management is subject to the direction and control of the mayor, executive, or governing body of the political subdivision, under the general power of the Governor.

(c) *Personnel.*-
(1) Subject to the budget of the political subdivision, each local organization for emergency management shall include those programs and positions recommended periodically by MEMA to meet federal and State standards.
(2) (i) In a county in which there is a local merit system or classified service for the general employees of the county, the employees and officers of the local organization for emergency management are included in and subject to all rights, duties, privileges, and responsibilities of that system or service.
(ii) Subparagraph (i) of this paragraph does not apply to the director of the local organization for emergency management.
(3) (i) If a county does not have a local merit system or classified service, the governing body of the county, or the board of estimates of Baltimore City, may include by regulation the employees and officers of the local organization for emergency management in the classified service of the State Personnel Management System.
(ii) Subparagraph (i) of this paragraph does not apply to the director of the local organization for emergency management.
(iii) 1. Except as otherwise provided by law, during the effective period of the regulation the employees and officers are subject to the rights, duties, privileges, and responsibilities of Division I of the State Personnel and Pensions Article.
2. The governing body of the county or the Mayor of Baltimore is the appointing officer under Division I of the State Personnel and Pensions Article.
(4) Paragraph (3) of this subsection does not remove from the governing body of a county or from the Mayor and City Council of Baltimore the power to establish and regulate the compensation, vacation allowance, or sick leave of all employees and officers of the local organization for emergency management in the county or Baltimore City.

(d) *Funding.*- Each political subdivision may make appropriations in the manner provided by law to pay the expenses of its local organization for emergency management.

§ 14-110. Local emergency plans.

(a) *Emergency Preparedness Plan for hazardous materials.*-
(1) Each county shall:

(i) prepare an Emergency Preparedness Plan for responding to an emergency that involves hazardous materials or controlled hazardous substances, as defined in the Environmental Article; and
(ii) review the Plan annually and submit any changes to the Director so that the Director may maintain current and accurate information about the Plan.

(2) Each county shall submit its Emergency Preparedness Plan to the Director on or before October 1, 1998.

(b) *Radiological emergency response plan.*-

(1) A local organization for emergency management shall submit to the Director a radiological emergency response plan if the political subdivision in which the local organization for emergency management is located:
(i) falls within the plume or ingestion zone of a commercial nuclear reactor; or
(ii)might reasonably be expected to host evacuees from another jurisdiction in a plume or ingestion zone.

(2) The radiological emergency response plan shall provide for the evacuation of the residents of the political subdivision as a result of an emergency caused by a dangerous release of radiation.

§ 14-110.1. Emergency plans for human service facilities.

(a) *"Human service facility" defined.*- In this section, "human service facility" means a facility licensed by the State that is:

(1) a nursing home, as defined in § 19-1401 of the Health - General Article;
(2) an assisted living facility, as defined in § 19-1801 of the Health - General Article;
(3) a hospital, as defined in § 19-301 of the Health - General Article;
(4) a related institution as defined in § 19-301 of the Health - General Article;
(5) a State-operated institution for mental disease;
(6) a group home as defined in § 7-101 of the Health - General Article;
(7) an alternative living unit as defined in § 7-101 of the Health - General Article; and
(8) a State residential center as defined in § 7-101 of the Health - General Article.

(b) *In general.*- A human service facility shall develop an emergency plan.

(c) *Procedures to be included in plan.*- An emergency plan shall include procedures that will be followed before, during, and after an emergency to address:

(1) the evacuation, transportation, or shelter-in-place of individuals served by the human service facility;
(2) the notification to families, staff, and licensing authorities regarding the action that will be taken concerning the safety and well-being of the individuals served by the human service facility;
(3) staff coverage, organization, and assignment of responsibilities; and
(4) the continuity of operations, including:
(i) procuring essential goods, equipment, and services; and
(ii) relocation to alternate facilities.

(d) *Regulations.*-

(1) On or before November 30, 2007, a State agency that is responsible for the licensing of a human service facility shall adopt regulations governing the development of emergency plans under this section.
(2) Regulations adopted under paragraph (1) of this subsection shall be developed in consultation with representatives of:
(i) the Maryland Emergency Management Agency;

(ii) the Maryland Institute for Emergency Medical Services Systems;
(iii) local organizations for emergency management; and
(iv) human service facilities.

(e) *Access to plans.*- For purposes of coordinating local emergency planning efforts, a human service facility shall provide access to the emergency plans developed under this section to local organizations for emergency management.

§ 14-111. Local state of emergency.

(a) *Declaration.*- Only the principal executive officer of a political subdivision may declare a local state of emergency.

(b) *Duration.*-
(1) Except with the consent of the governing body of the political subdivision, a local state of emergency may not continue or be renewed for longer than 7 days.
(2) An order or proclamation that declares, continues, or terminates a local state of emergency shall be:
(i) given prompt and general publicity; and
(ii) filed promptly with the chief local records-keeping agency.

(c) *Effect of declaration.*- Declaration of a local state of emergency:

(1) activates the response and recovery aspects of any applicable local state of emergency plan; and
(2) authorizes the provision of aid and assistance under the applicable plan.

§ 14-112. Emergency expenditures; use of existing resources.

(a) *Emergency expenditures.*-
(1) Expenditures necessitated by emergencies shall first be made using money regularly appropriated to State and local agencies.
(2) If the Governor finds that regularly appropriated money is inadequate to cope with an emergency, the Board of Public Works may make contingency money available in accordance with the State budget.

(b) *Federal money.*- The State may:
(1) accept any allotment of federal money and commodities and manage and dispose of them in whatever manner may be required by federal law; and
(2) take advantage of the federal Disaster Relief Act of 1974 and any amendments or supplements to it, and any other federal law that provides grants and public assistance for the purposes of this subtitle and Subtitles 2 and 4 of this title.

(c) *Use of existing resources.*-
(1) In carrying out this subtitle, the Governor, Adjutant General, and executive officers or governing bodies of the political subdivisions shall use the services, equipment, supplies, and facilities of existing agencies and units of the State and the political subdivisions to the maximum extent practicable.

(2) The officers and personnel of the agencies and units of the State and the political subdivisions shall cooperate with and extend services and facilities to the Governor, Adjutant General, Director, and the local organizations for emergency management on request.
(3) At the direction of the Governor, the Maryland National Guard shall use its services, equipment, supplies, and facilities in life-threatening emergencies that are beyond the capabilities of local authorities.

(d) *Gifts, grants, or loans for emergency management.*-
(1) If the federal government, another state, or an agency or officer of the federal government or another state offers to this State or a political subdivision services, equipment, supplies, materials, or money by way of gift, grant, or loan for purposes of emergency management, the State acting through the Governor, or the political subdivision acting with the consent of the Governor and through its executive officer or governing body, may:
(i) accept the offer; and
(ii) authorize an officer of this State or the political subdivision to receive the services, equipment, supplies, materials, or money.
(2) If a person offers to the State or a political subdivision aid or assistance, the State or political subdivision may accept the aid and assistance in accordance with paragraph (1) of this subsection.

§ 14-113. Enforcement.

(a) *By emergency management agency.*- Each emergency management agency established under this subtitle and its officers shall execute and enforce the orders, rules, and regulations made by the Governor under authority of this subtitle.

(b) *By law enforcement and health officers.*- With respect to the threat or occurrence of an enemy attack, act of terrorism, or public health catastrophe, each law enforcement officer of the State or a political subdivision and each health officer of a political subdivision shall execute and enforce the orders, rules, and regulations made by the Governor under authority of this subtitle.

§ 14-114. Prohibited acts; penalties.

(a) *Violation of order, rule, or regulation prohibited.*- A person may not violate an order, rule, or regulation issued under the authority of this subtitle.

(b) *Penalties.*-
(1) A person who violates this section is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 6 months or a fine not exceeding $1,000 or both.
(2) A person who willfully violates this section is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 1 year or a fine not exceeding $5,000 or both.

§ 14-115. Short title.
This subtitle may be cited as the Maryland Emergency Management Agency Act.

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SECTION C: MARYLAND GOVERNOR'S EMERGENCY POWERS SUBTITLE

§ 14-301. Definitions.

(a) *In general.*- In this subtitle the following words have the meanings indicated.

(b) *Energy emergency.*- "Energy emergency" means a situation in which the health, safety, or welfare of the public is threatened by an actual or impending acute shortage in energy resources.

(c) *Public emergency.*- "Public emergency" means:
- (1) a situation in which three or more individuals are at the same time and in the same place engaged in tumultuous conduct that leads to the commission of unlawful acts that disturb the public peace or cause the unlawful destruction or damage of public or private property;
- (2) a crisis, disaster, riot, or catastrophe; or
- (3) an energy emergency.

§ 14-302. Legislative intent.

(a) *In general.*- The General Assembly recognizes the Governor's broad authority in the exercise of the police power of the State to provide adequate control over persons and conditions during impending or actual public emergencies.

(b) *Construction of subtitle.*- This subtitle shall be broadly construed to carry out the purpose of this subtitle.

§ 14-303. Governor's proclamation of state of emergency.

(a) *Authority to proclaim state of emergency.*- During a public emergency in the State, the Governor may proclaim a state of emergency and designate the emergency area:
- (1) if public safety is endangered or on reasonable apprehension of immediate danger to public safety; and
- (2) on:
  - (i) the Governor's own initiative; or
  - (ii) the application of:
    1. the chief executive officer or governing body of a county or municipal corporation; or
    2. the Secretary of State Police.

(b) *Orders, rules, and regulations to control and terminate public emergency - Issuance.*- After proclaiming a state of emergency, the Governor may promulgate reasonable orders, rules, or regulations that the Governor considers necessary to protect life and property or calculated effectively to control and terminate the public emergency in the emergency area, including orders, rules, or regulations to:
- (1) control traffic, including public and private transportation, in the emergency area;
- (2) designate specific zones in the emergency area in which the occupancy and use of buildings and vehicles may be controlled;
- (3) control the movement of individuals or vehicles into, in, or from the designated zones;
- (4) control places of amusement and places of assembly;

(5) control individuals on public streets;
(6) establish curfews;
(7) control the sale, transportation, and use of alcoholic beverages;
(8) control the possession, sale, carrying, and use of firearms, other dangerous weapons, and ammunition; and
(9) control the storage, use, and transportation of explosives or flammable materials or liquids considered to be dangerous to public safety, including "Molotov cocktails."

(c) *Same - Notice.*- Before an order, rule, or regulation promulgated under subsection (b) of this section takes effect, the Governor shall give reasonable notice of the order, rule, or regulation:
(1) in a newspaper of general circulation in the emergency area;
(2) through television or radio serving the emergency area; or
(3) by circulating notices or posting signs at conspicuous places in the emergency area.

(d) *Same - Effect.*- An order, rule, or regulation promulgated under subsection (b) of this section:
(1) takes effect from the time and in the manner specified in the order, rule, or regulation;
(2) may be amended or rescinded, in the same manner as the original order, by the Governor at any time during the state of emergency; and
(3) terminates when the Governor declares that the state of emergency no longer exists.

§ 14-304. Energy emergencies.

(a) *Governor's authority to proclaim state of emergency.*- On reasonable apprehension that an energy emergency exists, the Governor may proclaim a state of emergency.

(b) *Orders, rules, and regulations - Issuance and contents.*- Notwithstanding any other provision or limitation of State or local law, if the Governor proclaims a state of emergency under this section, in addition to any other order, rule, or regulation promulgated under this subtitle, the Governor may promulgate orders, rules, or regulations to:
(1) establish and implement programs, controls, standards, priorities, and quotas for the allocation, conservation, and consumption of energy resources;
(2) suspend and modify existing standards and requirements affecting or affected by the use of energy resources, including those that relate to air quality control, the type and composition of various energy resources, the production and distribution of energy resources, and the hours and days during which public buildings and commercial and industrial establishments are authorized or required to remain open; and
(3) establish and implement regional programs and agreements to coordinate the energy resource programs and actions of the State with those of the federal government and of other states and localities.

(c) *Same - Imposition of civil penalties.*- Instead of or in addition to the penalties provided in § 14-308 of this subtitle, an order, rule, or regulation promulgated by the Governor under this section may provide for:
(1) the imposition of a civil penalty not exceeding $1,000 for each violation; and
(2) the method and conditions of collecting the civil penalty.

(d) *Same - Legislative approval.*-

(1) In this subsection, "Committee" means:
(i) the Joint Committee on Administrative, Executive, and Legislative Review; or

(ii) any other joint committee substituted by the General Assembly by law to carry out the responsibilities of the Joint Committee on Administrative, Executive, and Legislative Review with respect to an energy emergency.

(2) Before promulgating an order, rule, or regulation under this section, the Governor shall submit the order, rule, or regulation to the Committee for approval or rejection.

(3) (i) Except as provided in subparagraph (ii) of this paragraph, if the Committee fails to take action on the order, rule, or regulation within 7 days after its submission, the order, rule, or regulation takes effect as promulgated by the Governor.

(ii) 1. If because of extraordinary circumstances it is not feasible to secure the prior approval of the Committee, an order, rule, or regulation takes effect immediately.

2. Within 2 days after it takes effect, the order, rule, or regulation shall be communicated to the chairman of the Committee.

3. The full Committee shall be convened within 5 days after the order, rule, or regulation is communicated to the chairman.

4. The order, rule, or regulation is subject to disapproval by the full Committee.

(4) All records of orders, rules, regulations, and Committee meetings are open to the public.

(e) *Construction of section.*- This section does not authorize the establishment of oil refineries, deep water ports, offshore drilling facilities, or other similar major capital facilities.

(f) *Governor's authority to implement federal programs.*- In addition to the specific emergency powers contained in this subtitle, the General Assembly recognizes and confirms the Governor's power to exercise fully the authority necessary to implement any federal mandatory energy emergency program as set forth in any federal programs, laws, orders, rules, or regulations that relate to the allocation, conservation, or consumption of energy resources.

§ 14-305. Cooperation among State and local law enforcement agencies.

(a) *In general.*- If the Governor proclaims that a state of emergency exists, each law enforcement agency, fire company, or rescue squad of the State, a county, or municipal corporation shall:

(1) cooperate in any manner requested by the Governor or the Governor's designated representative; and

(2) subject to subsection (b) of this section, allow the use of its equipment, facilities, and personnel if the use is required by the Governor or the Governor's designated representative.

(b) *Use of equipment, facilities, and personnel.*- The use of equipment, facilities, and personnel under subsection (a)(2) of this section may not substantially interfere with the normal duties of a law enforcement agency, fire company, or rescue squad located outside an area designated by the Governor as an emergency area.

(c) *Authority of State Police to assist local law enforcement.*-

(1) Subject to paragraph (2) of this subsection, if the Governor proclaims that a state of emergency exists, the Department of State Police may take any action it considers necessary to assist local law enforcement agencies.

(2) Any action that the Department of State Police takes under this subsection shall be reasonably calculated effectively to control and terminate the public emergency.

(d) *Duty of local law enforcement to notify Secretary of disturbance.*- A law enforcement agency of a county or municipal corporation shall notify the Secretary of State Police if the local law enforcement

agency receives notice of a threatened or actual disturbance that indicates the possibility of serious domestic violence.

(e) *Person designated by Governor to direct operations.*- Except as provided in § 14-306 of this subtitle, each law enforcement agency, fire company, or rescue squad of the State, a county, or municipal corporation within an emergency area shall operate under the direction of the person designated by order of the Governor.

§ 14-306. Militia.

(a) *"Militia" defined.*- In this section, "militia" means the organized and unorganized militia as described in § 13-203 of this article.

(b) *Authority of Governor to call militia into action.*- If the Governor proclaims that a state of emergency exists, the Governor may call the militia into action.

(c) *Power of militia.*-
(1) The militia shall have full power and responsibility for the area designated by the Governor as an emergency area.
(2) Each law enforcement agency, law enforcement official, fire company, and rescue squad in the emergency area, including the Department of State Police, shall cooperate with the militia and operate under its direction.

(d) *Authority of local governments to request militia.*- The chief executive officer or governing body of a county or municipal corporation may request the Governor to provide the militia to help bring under control conditions existing within the county or municipal corporation that, in the requestor's judgment, the local law enforcement agencies cannot control without additional personnel.

§ 14-307. General cessation of business during emergency; closing of banking institution.

(a) *"Emergency" defined.*- In this section, "emergency" includes an emergency that results from fire, flood, riot, robbery, weather, or other cause.

(b) *General cessation of business during emergency.*- If an emergency exists in a political subdivision, the Governor may proclaim a day for the general cessation of business in that political subdivision.

(c) *Closing of banking institution.*- If an emergency exists as to a banking institution, the Governor:
(1) may proclaim a day on which the banking institution may remain closed; and
(2) shall limit the proclamation to the principal banking office and branch offices of the banking institution that the emergency affects.

§ **14-308. Duty of State to repair damaged property.**

The State shall repair or replace any equipment, facilities, or property that is damaged while being used in accordance with the proclamation of a state of emergency.

§ 14-309. Prohibited acts; penalties.

(a) *Violation of subtitle, order, rule, or regulation prohibited.*- A person may not violate this subtitle or an order, rule, or regulation promulgated under this subtitle.

(b) *Fraudulent representations prohibited.*- In meeting the requirements of an order, rule, or regulation promulgated under this subtitle or in applying for a service or benefit provided by the State in the allocation or assignment of energy supplies, a person may not willfully:

(1) conceal a material fact;
(2) make a false, fictitious, or fraudulent statement or representation; or
(3) use a false writing or document that contains a false, fictitious, or fraudulent statement.

(c) *Penalty.*-

(1) A person who violates this section is guilty of a misdemeanor and on conviction is subject to imprisonment not exceeding 6 months or a fine not exceeding $1,000 or both.
(2) A violation of the Maryland Vehicle Law for which a penalty is provided is not subject to the penalties of this section.

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SECTION D: LIST OF REPORTABLE DISEASES AND CONDITIONS

Pursuant to Title 18 of the Health-General Article of the Maryland Code and corresponding regulations in COMAR 10.06.01.03, the following diseases and conditions are reportable in the State of Maryland:

1. Amebiasis
2. Animal bites
3. Anthrax
4. Arboviral infections, including:
    a. Eastern equine encephalitis
    b. LaCrosse virus
    c. St. Louis encephalitis
    d. Yellow fever
    e. Western equine encephalitis
    f. West Nile virus
5. Botulism
6. Brucellosis
7. Campylobacter infection
8. Chancroid
9. Chlamydia infection
10. Cholera
11. Coccidioidomycosis
12. Creutzfeldt-Jakob disease
13. Cryptosporidiosis
14. Cyclosporiasis
15. Dengue fever
16. Diphtheria
17. Ehrlichiosis
18. Encephalitis

19. Epsilon toxin of Clostridium perfringens
20. Escherichia coli O157:H7 infection
21. Giardiasis
22. Glanders
23. Gonococcal infection
24. Haemophilus influenza
25. Invasive disease
26. Hantavirus infection
27. Harmful algal bloom related illness
28. Hepatitis, Viral (A, B, C, Delta, non-ABC, E, F, G, undetermined)
29. Isosporiasis
30. Kawasaki syndrome
31. Legionellosis
32. Leprosy
33. Leptospirosis
34. Listeriosis
35. Lyme disease
36. Malaria
37. Measles (rubeola)
38. Meningitis, infectious
39. Meningococcal invasive disease
40. Microsporidiosis
41. Mumps (infectious parotitis)
42. Mycobacteriosis, other than tuberculosis and leprosy
43. Pertussis
44. Pertussis vaccine adverse reactions
45. Pesticide related illness
46. Plague
47. Pneumonia in a health care worker resulting in hospitalization
48. Poliomyelitis
49. Psittacosis

50. Q Fever
51. Rabies
52. Ricin toxin
53. Rocky Mountain spotted fever
54. Rubella (German measles) and congenital rubella syndrome
55. Salmonellosis (non-typhoid fever types)
56. Septicemia in newborns
57. Severe acute respiratory syndrome (SARS)
58. Shiga-like toxin producing enteric bacterial infections
59. Shigellosis
60. Smallpox and other orthopoxvirus infections
61. Staphylococcal enterotoxin B
62. Streptococcal invasive disease, Group A
63. Streptococcal invasive disease, Group B
64. Streptococcus pneumonia, invasive disease
65. Syphilis
66. Tetanus
67. Trichinosis
68. Tuberculosis and suspected tuberculosis, as indicated by
    a. A laboratory-confirmed acid-fast bacillus on smear;
    b. An abnormal chest radiograph suggestive of active tuberculosis;
    c. A laboratory confirmed biopsy report consistent with active tuberculosis; or
    d. Initiation of two or more anti-tuberculosis medications
69. Tularemia
70. Typhoid fever (case or carrier, or both, of Salmonella typhi)
71. Varicella (chickenpox), fatal cases only
72. Vibriosis, non-cholera types (except as provided in COMAR)
73. Viral hemorrhagic fevers (all types)
74. Yellow fever
75. Yersinosis

Appendix B

Templates for Accounting Forms

TEMPLATES FOR ACCOUNTING FORMS

The Accounting Record Templates for Supplies Received and Supplies Donated, shown on the next two pages, are from the *Advanced Practice Center Hospital Surge Capacity Toolkit*, created by Cameron Bruce Associates in consultation with the California Department of Public Health. The Toolkit is available at:

http://www.sccgov.org/sites/sccphd/en-us/HealthProviders/BePrepared/Pages/Hospital-Surge-Capacity-Toolkit.aspx

Resource Accounting Record – Supplies Received

Donating Facility Name: _____ Donating Facility Contact: _____ Phone: _____

Operational Period (date/time): _____

Received		Supply	Quantity	Condition	Dispensed to (Unit/Location)	Comments	Initials
Date	Time						

Certifying Officer: _____ Date/Time Submitted: _____

Purpose: Track supplies received from donor facility. Origination: Section Chief
Copies to Finance/Administration Section Chief, Resources Unit Leader, Material Tracking Manager, and Originator.

Resource Accounting Record – Supplies Donated

Receiving Facility Name: _____ Receiving Facility Contact: _____ Phone: _____

Operational Period (date/time): _____

Sent		Supply	Quantity	Condition	Comments	Initials
Date	Time					

Certifying Officer: _____ Date/Time Submitted: _____

Purpose: Track donated supplies. Origination: Section Chief
Copies to Finance/Administration Section Chief, Resources Unit Leader, Material Tracking Manager, and Originator.

Appendix C

Prescription Drug Refills in a Disaster

Prescription Drug Refills during a Disaster

After Hurricane Katrina, a public-private partnership of drug prescription entities formed ICERx.org (In Case of Emergency Prescription Database), an online resource that provided licensed prescribers and pharmacists secure access to a patient's medication history. This allowed those physicians and pharmacists to accurately provide additional medications that might have been lost during the disaster to those patients or evacuees that needed them. The prescription history information was pooled from a variety of sources participating in ICERx.org, including the nation's community pharmacies, pharmacy benefit managers, and state Medicaid programs. Unfortunately, as of April 15th, 2011, ICERx.org became unavailable and can no longer be activated for any future disasters or emergencies.

Currently, there are no readily available alternatives that allow prescribers and pharmacists to access this information in most states. Some states, however, have enacted additional legislation that cooperatively acts to allow physicians/prescribers to mimic the intent of ICERX.org in a more limited manner. For example, Chapter 465 of the Florida Statutes[1]:

> **465.0275 Emergency prescription refill.**--In the event a pharmacist receives a request for a prescription refill and the pharmacist is unable to readily obtain refill authorization from the prescriber, the pharmacist may dispense a one-time emergency refill of up to a 72-hour supply of the prescribed medication, with the exception of those areas or counties included in an emergency order or proclamation of a state of emergency declared by the Governor, in which the executive order may authorize the pharmacist to dispense up to a 30-day supply, providing that:

[1]http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=Ch0465/SEC0275.HTM&Title=-%3E2000-%3ECh0465-%3ESection%200275#0465.0275

(1) The prescription is not for a medicinal drug listed in Schedule II appearing in chapter 893.

(2) The medication is essential to the maintenance of life or to the continuation of therapy in a chronic condition.

(3) In the pharmacist's professional judgment, the interruption of therapy might reasonably produce undesirable health consequences or may cause physical or mental discomfort.

(4) The dispensing pharmacist creates a written order containing all of the prescription information required by this chapter and chapters 499 and 893 and signs that order.

(5) The dispensing pharmacist notifies the prescriber of the emergency dispensing within a reasonable time after such dispensing.

The above statute can work in conjunction with a state emergency declaration or executive order, as stated. For example, during Tropical Storm Fay, the Governor of Florida issued an Executive Order (08-170) stating[2]:

D. In accordance with 465.0275, Florida Statutes, any pharmacist in the areas or counties covered under this Executive Order are authorized to dispense up to a 30-day emergency prescription refill.

Many states, including Maryland, have passed legislation to develop Prescription Drug Monitoring Programs (PDMP), originally intended to curb prescription drug abuse, which could possibly be adapted to have a secondary utility during an emergencies. At present, 37 states have operational PDMPs, and 11 states (including Maryland) have

[2] http://www.floridadisaster.org/eoc/PressReleases2008/EO08-170.pdf

enacted legislation to establish a PDMP, but are not fully operational[3]. The legislation for the State of Maryland (SB 883) limits reporting to Schedule II-V controlled dangerous substances (CDS)[4] and, therefore, has limited utility in refilling prescriptions during disasters.

Beyond the issue of the database, many states have developed mechanisms by which insurers may allow for a waiver of the standard time restrictions associated with refilling a prescription. For example, Florida Statute 252.358[5] states:

> All health insurers, managed care organizations, and other entities that are licensed by the Office of Insurance Regulation and provide prescription medication coverage as part of a policy or contract shall waive time restrictions on prescription medication refills, which include suspension of electronic "refill too soon" edits to pharmacies, to enable insureds or subscribers to refill prescriptions in advance, if there are authorized refills remaining, and shall authorize payment to pharmacies for at least a 30-day supply of any prescription medication, regardless of the date upon which the prescription had most recently been filled by a pharmacist, when the following conditions occur:
>
> (1) The person seeking the prescription medication refill resides in a county that:
>
> (a) Is under a hurricane warning issued by the National Weather Service;
>
> (b) Is declared to be under a state of emergency in an executive order issued by the Governor; or
>
> (c) Has activated its emergency operations center and its emergency management plan.
>
> (2) The prescription medication refill is requested within 30 days after the origination date of the conditions stated in this section or until such conditions are terminated by the issuing authority or no longer exist. The

[3] http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm
[4] http://www.dhmh.state.md.us/pressreleases/pdf/2011/SB883_factsheet_2.pdf
[5] http://www.lawserver.com/law/state/florida/statutes/florida_statutes_252-358

time period for the waiver of prescription medication refills may be extended in 15- or 30-day increments by emergency orders issued by the Office of Insurance Regulation.

This section does not excuse or exempt an insured or subscriber from compliance with all other terms of the policy or contract providing prescription medication coverage. This section takes effect July 1, 2006.

Appendix D

Templates for MOUs

TEMPLATES FOR MEMORANDA OF UNDERSTANDING (MOUS)

The ―Hospital Mutual Aid System Memorandum of Understanding (MOU) Model),‖ shown on the next 16 pages, is from the *Advanced Practice Center Hospital Surge Capacity Toolkit*, created by Cameron Bruce Associates in consultation with the California Department of Public Health. The Toolkit is available at: http://www.sccgov.org/sites/sccphd/en-us/HealthProviders/BePrepared/Pages/Hospital-Surge-Capacity-Toolkit.aspx

Please note that the following resource is simply a model agreement and should be tailored for each hospital's needs. **Also, all legal agreements, including MOUs, should be reviewed by each organization's legal counsel before agreement is reached on final terms and the document is signed.**

Hospital Mutual Aid System Memorandum of Understanding (MOU) (Model)

[Insert Jurisdiction Here]

([Insert Effective Dates Here)]

I. Introduction and Background

As in other parts of the nation, **[Insert Jurisdiction Here]** is susceptible to both natural and man-made to disasters that could exceed the resources of any individual hospital. A disaster could result from incidents generating an overwhelming number of patients, from a smaller number of patients whose specialized medical requirements exceed the resources of the impacted facility (e.g., hazmat injuries, pulmonary, trauma surgery, etc.), or from incidents such as building or plant problems resulting in the need for partial or complete hospital evacuation.

II. Purpose of Mutual Aid Memorandum of Understanding

The mutual aid support concept is well established and is considered to be the "standard of care" in most emergency response disciplines. The purpose of this mutual aid support agreement is to aid hospitals within **[Insert Jurisdiction Here]** in their emergency management response by creating a Hospital Mutual Aid System (H-MAS). H-MAS address the loan of medical personnel, pharmaceuticals, supplies, and equipment, or assistance with emergent hospital evacuation, including accepting transferred patients.

This Mutual Aid Memorandum of Understanding (MOU) is a voluntary agreement among the undersigned county hospitals for the purpose of providing mutual aid at the time of a medical disaster. For purposes of this MOU, a disaster is defined as an overwhelming incident that exceeds the effective response capability of the impacted health care facility or facilities. An incident of this magnitude will almost always involve the local emergency management agency and the Jurisdiction Public Health Department. The disaster may be an ―external" or ―internal" event for hospitals and it is assumed for the purposes of this MOU that each affected hospital's emergency management response plans have been fully implemented.

This document addresses the relationships between and among hospitals and is intended to augment, not replace, each facility's disaster plan. The MOU also provides the framework for participating hospitals to coordinate as a single H-MAS community in actions with Jurisdiction Public Health Department, and Jurisdiction Emergency Medical Services (EMS) during planning and response. This document does not replace but rather supplements the rules and procedures governing interaction with other organizations during a disaster (e.g., law enforcement agencies, EMS, Public Health Department, fire departments, American Red Cross, etc).

By signing this Memorandum of Understanding each hospital is evidencing its intent 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 each of the hospital's emergency management plans.

The master MOU will reside with Jurisdiction Emergency Medical Services (EMS).

III. Definition of Terms

Hospital Command Center (HCC)	An area established in a hospital during an emergency that is the facility's primary source of administrative authority and decision-making.
Jurisdiction DOC/EOC (Jurisdiction Department of Public Health, Department Operations Center)	A communication and information center that has H-MAS network capabilities allowing for the immediate determination of available hospital resources at the time of a disaster. The Jurisdiction DOC/EOC does not have any decision-making or supervisory authority and merely collects and disseminates information.
Donor Hospital	The hospital that provides personnel, pharmaceuticals, supplies, or equipment to a facility experiencing a medical disaster. Also referred to as the patient-receiving hospital when the disaster involves evacuating patients.
H-MAS	Hospital Mutual Aid System
EMSystem or equivalent	One of the primary networked communication systems used by hospitals to communicate during an emergency.

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.
Medical Disaster	An incident that exceeds a facility's effective response capability or a situation that cannot be appropriately resolved solely by using the facility's own resources. Such disasters will very likely involve the local city emergency management agency, Jurisdiction Emergency Management Agency, the Jurisdiction Public Health Department and may involve the mobilization of publicly owned response materials and equipment or the loan of medical and support personnel, pharmaceuticals, supplies, and equipment from another facility, or, the emergent evacuation of patients.
Partner ("Buddy")	The designated facility that a hospital communicates with as a facility's "first call for help" during a medical disaster (developed through an optional partnering arrangement. Partner hospitals should meet at least twice a year to discuss contingency plans.
Patient-Receiving Hospital	The hospital that receives transferred patients from a facility responding to a disaster. When patients are evacuated, the receiving facility is referred to as the patient-receiving hospital. When personnel or materials are involved, the providing hospital is referred to as the donor hospital.
Patient-Transferring Hospital	An impacted facility. The hospital that evacuates patients to the patient-receiving facility in response to a medical disaster. Also referred to as the recipient hospital when personnel and materials are moved to the facility.
Participating Hospitals	Health care facilities that have fully committed to H-MAS and signed the Hospital Memorandum of Understanding.

Recipient Hospital	The impacted facility. The hospital where disaster patients are being treated and have requested personnel or materials from another facility. Also referred to as the patient-transferring hospital when evacuating/transferring patients from the facility during a medical disaster.
Staff (or personnel)	Staff or personnel are employees of a specific hospital. Physicians who are not employees of a given hospital are currently not included in this definition.

IV. General Principles of Understanding

1. Participating Hospitals: Each hospital designates a representative to attend the Hospital Mutual Aid System meetings and coordinate the mutual aid initiatives with the individual hospital's emergency management plans. Hospitals also commit to participating in H-MAS exercises and maintaining their link to EMSystem (or equivalent networked communication system.)

2. 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 hospitals 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.

3. Implementation of Mutual Aid System Memorandum of Understanding: A health care facility becomes a participating hospital when an authorized administrator signs the H-MAS MOU. During a medical emergency, only the authorized administrator (or designee) or HCC at each hospital has the authority to request or offer assistance through H-MAS. Communications between hospitals for formally requesting and volunteering assistance should therefore occur among the senior administrators (or designees) or respective command centers. If the Jurisdiction DOC/EOC has been established, communications for assistance should go through the Jurisdiction DOC/EOC.

4. HCC: The impacted facility's hospital emergency operations center is responsible for informing the Jurisdiction DOC/EOC of its situation and defining needs that cannot be accommodated by the hospital itself or any existing partner hospital. The senior administrator or designee is responsible for requesting personnel, pharmaceuticals, supplies, equipment, or authorizing the evacuation of patients. The senior administrator or designee will coordinate both internally, and with the donor/patient-accepting hospital, all of the logistics involved in implementing assistance under this 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 supplies, etc.

5. Jurisdiction DOC/EOC: Each hospital will participate in an annual H-MAS exercise that includes communicating to the Jurisdiction DOC/EOC a set of data elements or indicators describing the hospital's resource capacity (see attached Forms). The Jurisdiction DOC/EOC will serve as an information center for recording and disseminating the type and amount of available resources at each hospital. During a disaster drill or emergency, each hospital will report to the Jurisdiction DOC/EOC the current status of their indicators. (For a more detailed account of the Jurisdiction DOC/EOC's responsibilities, see "Jurisdiction DOC/EOC Requirements.")

6. Hospital Indicators: A set of hospital resource measures that are reported to the Jurisdiction DOC/EOC 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.

7. Documentation: During a disaster, the recipient hospital will accept and honor the donor hospital's standard requisition forms. Documentation (see attached Resource Accounting Records) should detail the items involved in the transaction, condition of the material prior to the loan (if applicable), and the party responsible for the material.

8. Authorization: The recipient facility will have supervisory direction over the donor facility's staff, borrowed equipment, etc., once they are received by the recipient hospital.

9. 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, to the extent permitted by federal law, for all of the donor hospital's costs determined by the donor hospital's regular rate or in the case of materials, at the fair market rate. Costs shall include all costs arising fro the use, damage, loss, and return of borrowed materials. The recipient hospital will also be responsible for all injuries to donor hospital personnel that result in disability, loss of salary, and reasonable expenses, and for reasonable costs of defending any liability claims, or malpractice claims, except where the donor hospital has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury. Reimbursement will be made within 90 days following receipt of the invoice.

10. Patient-accepting hospitals assume the legal and financial responsibility for transferred patients upon arrival into the patient-accepting hospital.

11. Communications: Hospitals along with Jurisdiction Public Health Department will collaborate on maintaining a robust contact information matrix of telephone, email, satellite telephone, pager, and other communication pathways to ensure a reliable method to communicate with the Jurisdiction DOC/EOC and other hospitals

12. Public Relations: Each hospital is responsible for developing and coordinating with other hospitals and relevant organizations the media response to the disaster. Hospitals are encouraged to develop and coordinate the outline of their response prior to any disaster. The partner hospitals should be familiar with each other's mechanisms for addressing the media. The response should include reference to the fact that the situation is being addressed in a manner agreed upon by a previously established mutual aid protocol.

13. 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.

14. Hold Harmless Condition: The recipient hospital should hold harmless the donor hospital for acts of negligence or omissions on the part of the donor hospital in their good faith response for assistance during a disaster. The donor hospital, however, is responsible for appropriate credentialing of personnel and for the safety and integrity of the equipment and supplies provided for use at the recipient hospital.

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

1. Partner hospital concept: Each hospital has the option of designating a primary and secondary partner or *buddy* hospitals, that may be contacted first when a hospital needs to make a "first or second call for help" (see lists under Jurisdiction DOC/EOC Function). During a disaster, the impacted hospital may first call its pre-arranged primary or secondary partner hospital for personnel or material assistance or to request the evacuation of patients to the partner hospital. The partner hospital will inform the impacted hospital of the degree and time frame in which it can meet the request.

2. Jurisdiction DOC/EOC: The impacted hospital is responsible for notifying and informing the Jurisdiction DOC/EOC of its personnel or material needs or its need to evacuate patients and the degree to which its partner hospitals are unable to meet these needs. Upon the request by the senior administrator or designee of the impacted hospital, the Jurisdiction DOC/EOC will contact the other participating hospitals to determine the availability of additional personnel or material resources, including the availability of beds, as required by the situation. The impacted hospital will be informed as to which hospitals should be contacted directly for assistance that has been offered. The senior administrator (or designee) of the impacted hospital will coordinate directly with the senior administrator (or designee) of the potential donor hospital for this assistance.

3. Initiation of transfer of personnel, material resources, or patients: Only the senior hospital administrator or designee at each hospital has the authority to initiate the transfer or receipt of personnel, material resources, or patients. The senior administrator (or designee) and medical director, in conjunction with the directors of the affected services, will make a determination as to whether medical staff and other personnel from another facility will be required at the impacted hospital to assist in patient care activities.

Personnel offered by donor hospitals should be limited to staff that are **fully qualified, and licensed, accredited or credentialed (if applicable) by the donor hospital**. No resident physicians, medical/nursing students, or in-training persons should be volunteered. In the event of the evacuation of patients, the senior administrator or designee of the patient-transferring hospital will also notify the local fire department of its situation and seek assistance, if necessary, from EMS. The local fire department will be requested to notify the Jurisdiction Public Health Department.

VI. Specific Principles of Understanding

A. Medical Operations/Loaning Personnel

1. Communication of request: The impacted hospital's initial request for the transfer of personnel can be made verbally. However written documentation of the request should be received by the donor hospital prior to the transfer of personnel to 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 requested personnel are needed
    c. The location where personnel are to report and
    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 and a copy of their professional license (if applicable) at the site designated by the recipient hospital's HCC. 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. Confirming the donated personnel's ID badge, professional license and any accreditations or credentials (if applicable) using information contained in the list of personnel provided by the donor hospital, and
    c. Providing additional identification, e.g., "visiting personnel" badge, to the arriving donated personnel.

    The recipient hospital will accept the professional credentialing determination of the donor hospital but only for those services for which the personnel are credentialed at the donor hospital.

3. Supervision: The recipient hospital's senior administrator or designee identifies where and to whom the donated personnel are to report, and the professional staff of the recipient hospital who will supervise the donated personnel. The supervisor or designee will meet the donated

personnel at the point of entry of the facility and brief the donated personnel of the situation and their assignments. If appropriate, the "emergency staffing" rules of the recipient hospital will govern the assigned shifts. The donated personnel's shift, however, should not be longer than the customary length practiced at the donor hospital.

4. Legal and financial liability: Liability claims, malpractice claims, disability claims, attorneys' fees, and other incurred costs are the responsibility of the recipient hospital. An extension of liability coverage will be provided by the recipient facility, to the extent permitted by federal law, insofar as the donated personnel are operating within their scope of practice. The recipient hospital will reimburse the donor hospital for the salaries 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.

   The medical director of the recipient hospital will be responsible for providing a mechanism for granting emergency credentials and or temporary privileges' for donor hospital physicians. The hospital's senior administration will be responsible for providing a mechanism for granting emergency credentialing privileges for nurses and other licensed health care providers to provide services at the recipient hospital

5. Demobilization procedures: The recipient hospital will provide and coordinate any necessary demobilization procedures and post-event stress debriefing. The recipient hospital is responsible for providing the transportation necessary for donated personnel's return to the donor hospital.

B. Transfer of Pharmaceuticals, Supplies or Equipment

1. Communication of Request: The impacted hospital's initial request for the transfer of pharmaceuticals, supplies, or equipment (hereafter —materials") can be made verbally. However, written documentation of the request should be received by the donor hospital prior to the receipt of any materials by the recipient hospital. The recipient hospital will identify to the donor hospital the following:

   a. The quantity and exact type of requested materials,
   b. An estimate of how quickly the request materials are needed,
   c. Time period for which the materials will be needed and
   d. Location to which the materials 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 materials. The documentation will detail the following:

   a. The materials, received from the donor hospital,
   b. The condition of the materials upon receipt (if applicable).
   c. The contact information for the party, or department that is responsible for the borrowed materials.

   The donor hospital is responsible for tracking the borrowed inventory and documenting the original condition of the donated materials through its standard requisition forms. When returning materials, the recipient hospital will provided the original requisition form to the donor hospital along with the documentation of the condition of the borrowed materials being returned. The requisition form will be co-signed by the senior administrator 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 of borrowed 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 recipient hospital must return and pay the transportation fees for returning or replacing all borrowed materials.

4. Supervision: The recipient hospital is responsible for appropriate use and maintenance of all borrowed materials.

5. Financial and legal liability: The recipient hospital, to the extent permitted by federal law, is responsible for all costs arising from the use, damage, or loss of borrowed materials and for liability claims arising from the use of borrowed materials except where the donor hospital has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury.

6. Demobilization procedures: The recipient hospital is responsible for the rehabilitation and prompt return of the borrowed materials to the donor hospital. The recipient hospital is also responsible for returning materials to the donor hospital in the same condition as when they were received from 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 that is received by the patient-accepting hospital prior to the actual transferring of any patients. The patient-transferring hospital will identify to the patient-accepting hospital the following:

    a. The number of patients that need to be transferred,
    b. The general nature of their illness or condition and
    c. The type of specialized services that each patient requires, (e.g., ICU bed, Med/Surg bed, burn bed, trauma care bed, dialysis services etc.).

2. Documentation: The patient-transferring hospital is responsible for providing the patient-receiving hospital with the patient's complete medical records, insurance 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 and confirming that each patient ahs reached their destination.

3. Transporting of patients: The patient-transferring hospital is responsible for coordinating and financing the transportation of patients to the patient-receiving hospital. The patient receiving hospital's senior administrator or designee will designate the point of entry. Once admitted, that patient becomes the patient-receiving hospital's patient and is under the care of the patient-receiving hospital's admitting physician until discharged, transferred or reassigned. The patient-transferring hospital is responsible for 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 each patient's admitting service and admitting physician and, if requested, will provide at least temporary courtesy privileges to the patient's original attending physician.

5. Financial and Legal Liability: The patient–receiving hospital is responsible for liability claims originating from the time of the patients admission to the patient-accepting hospital. Reimbursement for care should be negotiated with each hospital's insurer under the conditions for *admissions without precertification requirements* in the event of emergencies.

6. Notification: The patient-transferring hospital is responsible for notifying both the patient's family or guardian and the patient's attending or personal physician of the situation. The patient-receiving hospital may assist in notifying the patient's family and personal physician.

D. Jurisdiction DOC/EOC Function

The H-MAS provides the means for the hospitals to coordinate among themselves, and as a unit to integrate with Jurisdiction Public Health Department, Disaster Medical Services, police, fire and EMS during a disaster event.

The Jurisdiction DOC/EOC serves as the data center for collecting and disseminating current information about equipment, bed capacity and other hospital resources during a disaster. The information collected by the Jurisdiction DOC/EOC is to be used only for disaster preparedness, response and recovery.

In the event of a disaster or during a disaster drill, hospitals will be prepared to provide the Jurisdiction DOC/EOC with the Forms as found in the attachments to this documents. This information includes the following:

1. The total number of injury victims the emergency department is capable of receiving using the standard categories of Immediate, Delayed and Minor.

2. Total number of operating beds **currently available to accept patients** in the following units:

   - general medical (adult)
   - general surgical (adult)
   - general medical (pediatric)
   - general surgical (pediatric)
   - obstetrics
   - cardiac intensive care
   - neonatal intensive care
   - pediatric intensive care
   - burn
   - psychiatric
   - subacute care
   - skilled care beds
   - operating suites

3. The number of items **currently available for loan or donation** to another hospital:

   - ventilators
   - IV infusion pumps
   - dialysis machines
   - hazmat decontamination equipment
   - MRI
   - CT scanner
   - hyperbaric chamber
   - ventilators

- external pacemakers
- atropine
- kefzol

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

Physicians (staff)

- Anesthesiologists
- Emergency Medicine
- General Surgeon
- OB-GYN
- Pediatricians
- Trauma Surgeons

Registered Nurses

- Emergency
- Critical Care
- Operating Room
- Pediatrics

Other Personnel

- Maintenance Workers
- Mental Health Workers
- Respiratory Therapists
- Plant Engineers
- Security Workers
- Social Workers
- Others as indicated

E. Partner Buddy Hospital Concept

Each partner buddy hospital shall standardize a set of contacts to facilitate communications during a disaster.

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

1. Determine the total number of patients the emergency department and hospital are able to receive.
2. The Impacted hospital contacts the 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 Jurisdiction DOC/EOC and notifies the center of its needs, how they are being met, and any unmet needs.
4. At the request of the impacted hospital, the Jurisdiction DOC/EOC will contact other

hospitals to alert them to the situation and to begin an inventory for any possible or actual unmet needs.

VII. Limiting Obligations of the Veterans Administration Facilities

A. Veterans Administration Facilities

1. The VA's ability to assist local, non VA facilities during a disaster or emergency is subject to the VA's obligations under the Stafford Act and the Federal Response Plan.
2. The VA is therefore unable to participate in the Hospital Mutual Aid System Memorandum of Understanding.

[Insert Jurisdiction Here]

Hospital Mutual Aid System Memorandum of Understanding

The below signed representative agrees to the provisions of this a voluntary agreement.

Signature:

Insert Hospital Name Here

By _____ _____

Name, Title Date

Department

Collocate

[Insert Jurisdiction Here]

Hospital Mutual Aid System Memorandum of Understanding

List of obtained signatures and dates

Hospital	**Representative Name**	**Last Date Signed**

List of Buddy Hospitals

Hospital	Primary Buddy (System)	Secondary Buddy (Locality)

Attachments:

A. H-MAS MOU Quick Reference Guide
B. *Hospital Status Report Form*
C. *Resource Request Form*
D. *Resource Accounting Record – Supplies Received*
E. *Resource Accounting Record – Supplies Donated*