HEALTHCARE SYSTEM SURGE

AUTHORITY

DEFINITIONS

A. **"Control Facility"** is the facility designated by the EMS Agency to monitor hospital capacity and capability and to assume primary responsibility for directing patient destinations by ambulance during a Multiple Casualty Incident or Healthcare System Surge Event.

B. **"Healthcare Surge Event"** means a proclamation by the local health officer or other appropriate designee, using professional judgment determines, subsequent to a significant event or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services. The local official uses the situation assessment information provided from the healthcare delivery system partners to determine overall local healthcare jurisdiction/operational area medical and health status.

C. **"Level I Surge" (Yellow)** means that most healthcare assets within the county are experiencing a surge and are able to manage the situation with the assistance of the Control Facility; or that two or more hospitals within Placer County have requested Diversion.

D. **"Level II Surge" (Orange)** means, the healthcare assets in the county require participation of additional healthcare assets (e.g. clinics, public health, long term care, etc.) to contain the situation; and regularly scheduled planning sessions or conference calls are necessary in order to strategize, coordinate, collaborate, and communicate among all community medical/health providers, EMS agency, Public Health, Fire, and OES coordinators.

E. **"Level III Surge"** (Red) means hospitals within the county are not capable of meeting the demand for care, and assistance from outside the Operational Area is required. A local Healthcare Surge Event has been proclaimed. Regional, statewide, or national coordination is necessary in order to meet the medical and health needs of the public.

F. **"Level IV Surge"** (black) means the healthcare providers within the Operational Area are not capable of meeting the demand EMS and hospital standards of care must be recalibrated using pre-approved austere care protocols, and less-acute hospital patients should be triaged from hospitals to appropriate alternate care providers. Regional/statewide coordination is necessary.

G. **"Medical/Health Operational Area Coordinator (MHOAC)"** means the Public Health Officer and local EMS Agency Administrator or designee who is responsible, in the event

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of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of resources within the Operational Area (county) border.

II PURPOSE

A. To prevent the escalation of EMS system Surge and mitigate its impact on the EMS community by developing a system for appropriate distribution of available resources during a system overload or disaster.

B. To provide hospital managers, EMS System managers, and emergency managers with timely and accurate information that allows them to mitigate current or pending hospital resource or capacity deficiencies.

C. To augment standard EMS System MCI Policies and Procedures.

III POLICY

A. OPERATIONAL AREA PLANNING AND PREVENTION

1. Public and private-sector agencies should coordinate planning to minimize the impact of predictable events. Emergency planning is always event-specific because the characteristics of each emergency are different. However, there are general concepts that are applicable in most emergencies. Some of these concepts are articulated in this section.

2. Agencies responsible for planning, coordinating, or operational functions, or that are elements of a critical or high-risk infrastructure should work cooperatively to prevent or mitigate the impact of a natural or man-made disaster.

3. Agencies should verify the availability of equipment and supply caches before an incident. Agencies should always assure that supplies are maintained at desired par-levels.

4. Agencies should establish a Joint Information Center (JIC) before an incident to provide coordinated and focused public education and information messages. These messages should provide the public with credible direction or other actionable information that decreases their reliance on scare resources.

5. Public and private-sector first responders and first receivers should receive "just in time" training in topics relevant to the incident.

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6. All organizations should assure that emergency operations plans, phone numbers, and staff call back trees are current. Update documents as time allows.

7. All organizations should assure that local and state government agency contacts are current. Key contacts include the Placer County Health Department, MHOAC, Placer County Office of Emergency Services, the Control Facility, and State Department of Health Services, Licensing and Certification. Maintain 24/7/365 contact information.

8. All agencies should verify that they are prepared to provide critical capabilities and functions.

B. HOSPITAL PLANNING AND PREVENTION

1. Hospitals should work closely with other hospitals within their corporate structure to determine the status of critical hospital services within their regional service area.

2. Hospitals should work with their corporate organization to develop pre-incident inter-facility staffing reciprocity agreements and post-incident expedited credentialing capacity among their corporate facilities.

3. All hospitals should implement recurring training in disaster and emergency operations, to include HICS, ICS, SEMS, NIMS, Haz-Mat/Decontamination, and the hospital's emergency operations plan.

IV PROCEDURE

A. Responses to Healthcare System Surge are organized into four distinct levels. The procedures in this Section are generally applicable to most Healthcare System Surge incidents; however, because each incident has its own unique characteristics, hospitals, EMS Agency, Control Facility, Dispatch, and EMS personnel are always required to use their best professional judgment to respond to emergency and disaster situations.

1. **LEVEL I SURGE**:

a. CRITERIA
Criteria for Level I Surge includes:

(i) Two or more hospitals within the system experiencing a sudden unexpected increase in the number or severity of patients.

b. IMPACTED HOSPITAL(S):

(i) Notify the Control Facility of status change.

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(ii) Update facility status in EMSystem to Advisory (including reason for necessity) and provide additional updates every two hours, or as requested by Control Facility.

(iii) Initiate or continue with internal hospital surge policies.

c. NON-IMPACTED HOSPITAL(S):

(i) ED charge nurse will receive Level 1 notification from Control Facility via EMSystem.

(ii) ED charge nurse monitors status in their ED.

(iii) Investigate/confirm capacity of service(s) in facility.

(iv) Update facility status in EMSystem and provide additional updates every two hours or as requested by Control Facility.

(v) Consider activation of internal hospital surge policies.

d. MHOAC

i. Consider establishing ongoing planning sessions/coordination with all potentially impacted agencies/facilities.

ii. Consider site visits of hospitals to verify statuses and Level I activities.

e. CONTROL FACILITY

(i) Assess capacity and capability of other hospitals within county.

(ii) Consider assessing capacity and capability of neighboring counties, when appropriate.

(iii) Notify hospitals, EMS Agency, dispatch providers, and ambulance providers of Level 1 Surge in system.

(iv) Coordinate all patient distribution until Surge level indicators have been resolved.

g. DISPATCH PROVIDERS

(i) Notify supervisors and ambulances providers of Surge Level 1 activation in system.

h. AMBULANCE PROVIDERS

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(ii) Contact Control Facility for destination decisions.

2. **LEVEL II SURGE:**

a. CRITERIA

Criteria for Level II Surge includes concurrence of two or more EMS or hospital providers that regularly scheduled planning sessions are necessary to mitigate the impact of the surge.

b IMPACTED HOSPITALS

(i) Take any actions not previously completed for Level I Surge.

(ii) ED charge nurse to notify ED Director and House Supervisor of Level II Surge.

(iii) House Supervisor to notify Hospital Administration and the Director of Nursing of the Level II Surge.

(iv) ED Director and house supervisor respond to ED to assess critical hospital services and supplies. Attempt to forecast event.

(v) Update Facility Status in EMSystem at least every 2 hours or as requested by the Control Facility

(vi) Consider activating HICS structure.

(vii) Consider contacting DHS Licensing and Certification for staffing and bed capacity flexibility.

(viii) Augment hospital's staff, i.e. alternate staffing schedules, consider call-back staff, and receive staff from corporately-related hospitals.

(ix) House Supervisor evaluates the need to use outpatient and recovery room to house admissions

(x) House Supervisor approves placement of new admit in hallway of inpatient department that will admit patient.

(xi) Hospital Administration should consider cancellation of elective procedures.

c. MHOAC

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(i) Take any actions not previously completed for Level I Surge.

(ii) Attempt to forecast trend of impaction.

(iii) Determine capability and capacity for critical hospital services at all hospitals within the county.

(iv) Notify County Health Officer and EMS Agency Duty Officer

(v) Notify OES Director

(vi) Coordinate community medical/health planning sessions/coordination for as necessary

(vii) Consider requesting activation of Operational Area EOC.

(viii) Consider activation of county-specific volunteer program or state ESAR-VHP program.

(ix) Consider requesting activation of JIC.

(x) Coordinate Risk Communication messages with Public Health Department, including: advisory messages to the medical/health community, media updates, etc.

(xi) Consider request for declaration of local state of emergency.

(xii) Monitor capabilities and status of ambulance providers.

(xiii) Consider need for alternate medical triage for 911 medical aid requests and austere care protocols for field EMS personnel.

(xiv) Evaluate the need for additional health/medical resources:

1. Ambulance Strike Teams
2. Hospital Staff
3. Equipment/Supplies

(xv) Prioritize Medical Resource Requests

(xvi) Prioritize Medical Transportation Requests

(xvii) Notify RHDMC

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d, CONTROL FACILITY

(i) Take any actions not previously completed for Level I Surge.

(ii) Determine available capacity for critical hospital services at all hospitals within the county.

(iii) Notify hospitals, EMS Agency, dispatch providers, and ambulance providers of Level II Surge.

(iv) If appropriate to situation, direct ambulances to non-impacted destinations, based on service capability.

(v) Standby—consider additional staffing for future operational periods.

e. DISPATCH PROVIDERS

(i) Notify EMS Providers of Level II Surge Status.

(ii) If appropriate to situation, hold or direct non-emergency interfacility transfers with the objective of developing additional Critical Hospital Service capacity.

(iii) Consider adding additional staff for potentially increased volume of EMS System calls and interfacility transfers.

f. AMBULANCE PROVIDERS

(i) Contact Control Facility for destination decisions.

(ii) Upon request of MHOAC, staff and deploy additional ALS, BLS, and Critical Care Units for potentially increased volume of EMS System calls and interfacility transfers.

(iii) If appropriate to situation, hold or direct non-emergency inter-facility transfers with the objective of developing additional Critical Hospital Service capacity.

(iv) Add additional staff for increased volume of EMS System calls and inter-facility transfers.

3. **LEVEL III SURGE:**

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a. CRITERIA
Criteria for Level III Surge includes:

Healthcare System Surge proclaimed by Public Health Officer or designee.

b. ALL HOSPITALS

(i) Take any actions not completed under Level II Surge.

(ii) Hospital Command Center will notify appropriate personnel of Level III Surge.

(iii) Participate in community medical/health planning sessions/coordination for:

1. Attempted forecasting of the duration and impact of the event
2. Coordination of personnel, resource, and supply needs
3. Recruitment of community medical personnel and volunteers
4. Activation of alternate care sites
5. Implementation of Alternate or Austere Medical Protocols

c. MHOAC

(i) Take any actions not completed under Level II Surge.

(ii) Determine available capacity for critical hospital services at all hospitals within the county.

(iii) Participate in community medical/health planning sessions/coordination for:

a. Attempted forecasting of the duration and impact of the event
b. Coordination of personnel, resource, and supply needs
c. Recruitment of community medical personnel and volunteers
d. Activation of alternate care sites

(iv) Evaluate the need for additional health/medical resources:

a. Personnel:
    i. Cal-MAT, DMAT, ESAR-VHP

b. Equipment/Supplies :
    i. Ambulance Strike Teams
    ii. Mobile Field Hospital
    iii. Pharmaceutical Caches, SNS

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d. CONTROL FACILITY

(i) Determine available capacity for critical hospital services at all hospitals within the county.

(ii) Consider additional staffing for future operational periods.

e. DISPATCH PROVIDERS

(i) Notify EMS Providers of Level III Surge Status.

(ii) If appropriate to situation, hold or direct non-emergency interfacility transfers with the objective of developing additional Critical Hospital Service capacity.

(iii) Consider adding additional staff for potentially increased volume of EMS System calls and interfacility transfers.

f. AMBULANCE PROVIDERS

(i) Contact Control Facility for destination decisions.

(ii) Upon request of MHOAC, staff and deploy additional ALS, BLS, and Critical Care Units for potentially increased volume of EMS System calls and interfacility transfers.

(iii) If appropriate to situation, hold or direct non-emergency inter-facility transfers with the objective of developing additional Critical Hospital Service capacity.

(iv) Add additional staff for increased volume of EMS System calls and inter-facility transfers.

4. SURGE LEVEL IV:

a. Criteria for Surge Level IV includes:

Altered or Austere Protocols have been adopted by the local coalition of healthcare providers in order to adapt to the increased demand

b. ALL HOSPITAL(S)

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(i) Take any actions not taken under Level III.

(ii) Hospital Command Center will notify appropriate personnel of Level III Surge.

(iii) Participate in community medical/health planning sessions/coordination for:
1. Implementation of Alternate or Austere Medical Protocols

c. MHOAC

(i) Take any actions not completed under Level II Surge.

(ii) Determine available capacity for critical hospital services at all hospitals and Alternate Care Sites within the county.

(iii) Participate in community medical/health planning sessions/coordination for:
1. Altered levels of care

(iv) Consider public recruitment of licensed professional volunteers to assist hospitals.

(v) Prioritize requests for medical and health assets

(vi) Notify RHDMC

d. CONTROL FACILITY

(i) Notify hospitals, dispatch providers, and ambulance providers of Level IV Surge in system.

(ii) Add additional staff for increased volume of EMS System calls and inter-facility transfers

e. DISPATCH PROVIDERS

(i) Notify EMS Providers of Level IV Surge status.

(ii) Add additional staff for increased volume of EMS System calls and inter-facility transfers.

f. AMBULANCE PROVIDERS

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(i) Contact Control Facility for destination decisions.

(ii) Upon request of the EMS Agency, staff and deploy additional ALS, BLS, and Critical Care Units for increased volume of EMS System calls and inter-facility transfers.

(iii) Add additional staff for increased volume of EMS System calls and inter-facility transfers

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