Pediatric Disaster Coalition

HHS Region VI

Facility Mutual Aid Memorandum of Understanding

I. Introduction and Background

In all parts of the nation, healthcare facilities are susceptible to disasters, both natural and man-made, that could exceed the resources of any individual facility. 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 facility evacuation.

Due to the unique patient populations, associated patient needs, and limited local medical surge capacity, pediatric facilities are placed in a higher category than general adult facilities, when it comes to requiring regional mutual aid agreements with same or similar facilities.

II. Purpose of Mutual Aid Memorandum of Understanding

The mutual aid support concept is well established and is considered "standard of care" in most emergency response disciplines. The purpose of this mutual aid support agreement is to aid facilities in their emergency management response plans by authorizing the Facility Mutual Aid System (F-MAS). F-MAS addresses the loaning of medical personnel, pharmaceuticals, supplies, and equipment, or assistance with emergent facility evacuation by transporting patients, including accepting transferred patients.

This Mutual Aid Memorandum of Understanding (MOU) is a voluntary agreement among the member facilities of the Pediatric Disaster Coalition for the purpose of providing mutual aid at the time of a disaster. For purposes of this MOU, a disaster is defined as an overwhelming incident that exceeds the effective capability of the impacted facility or facilities. An incident of this magnitude should almost always involve emergency management agencies and local/regional public health district/departments. The disaster may be an “external” or “internal” event for facilities and assumes that each impacted facility’s emergency management plan has been fully implemented.

This document addresses the relationships between and among the facilities of the Pediatric Disaster Coalition and is intended to augment, not replace, each facility's disaster plan. 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, the local emergency medical services, local/regional public health district/department, fire departments, American Red Cross, etc).

By signing this Memorandum of Understanding each facility is evidencing its intent to abide by the terms of the MOU in the event of a disaster as described. The terms of this MOU are to be incorporated into the respective regional medical operations plans and the facilities internal emergency management plans.

III. Definition of Terms

Command Center	An area established in a facility during an emergency that is the facility's primary source of administrative authority and decision-making.
Donor Facility	The facility that provides personnel, pharmaceuticals, supplies, or equipment to a facility experiencing a medical disaster.
Emergency Operations Center (EOC)	An EOC develops and maintains awareness of the emergency situation for decision making and to coordinate support for emergency responders. EOCs are established by local jurisdictions.
F-MAS	Facility Mutual Aid System
Impacted Facility	The facility where the disaster occurred or disaster victims are being treated.
Medical Operations Center (MOC)	A MOC is used in a large scale disaster when more than two facilities are affected or multiple jurisdictions are affected. A MOC is a clearinghouse for all health & medical information. All requests for medical support; such as personnel, supplies, etc., should be sent to the MOC. A MOC should coordinate with the local EOCs.
Disaster	An incident that exceeds a facility's effective response capability or cannot appropriately resolve solely by using its own resources. Such disasters may involve the local emergency management agencies and local/regional public health district/departments and may involve loan of medical and support personnel, pharmaceuticals, supplies, and equipment from another facility, or, the emergent evacuation of patients.
Participating Facilities	Health care facilities that have fully committed to F-MAS and participate in the Pediatric Disaster Coalition.

IV. General Principles of Understanding

1. Participating Facilities: Each facility designates a representative(s) to attend the Pediatric Disaster Coalition meetings and to coordinate the response plan, and mutual aid initiatives with the individual facility's emergency management plans. Facilities also commit to participating in F-MAS exercises.

2. Implementation of Mutual Aid Memorandum of Understanding: A facility becomes a participating facility when an authorized administrator signs the MOU. During a disaster, only the authorized administrator (or designee) or command center at each facility has the authority to request or offer assistance through F-MAS. Communications between facilities for formally requesting and volunteering assistance should therefore occur among authorized administrators (or designees) or respective command centers unless the MOC (Medical Operations Center) is activated.

3. Command Center: The impacted facility's command center is responsible for informing the MOC (if activated) or EOC (if MOC not activated) of its situation and defining needs that cannot be accommodated by the facility itself or any existing partner facility. The authorized administrator or designee is responsible for requesting personnel, pharmaceuticals, supplies, equipment, transport vehicles or authorizing the evacuation of patients. The authorized administrator or designee should coordinate both internally, and with the donor facility or MOC, all of the logistics involved in implementing assistance under this Mutual Aid MOU. Logistics include but not limited to: identifying the number and specific location where personnel, pharmaceuticals, supplies, equipment, vehicles with transport teams or patients should be sent, how to enter the security perimeter, estimated time interval to arrival and estimated return date of borrowed supplies, etc.

4. MOC – Medical Operations Center: Each facility should participate in an annual F-MAS exercise that includes communicating to the MOC a set of data elements or indicators describing the facility's resource capacity (see attachments). The MOC should serve as a coordination center for recording and disseminating the type and amount of available resources at each facility. During a disaster drill or emergency, each facility should report to the MOC the current status of their indicators. (For a more detailed account of the MOC's responsibilities, see "MOC Requirements.")

5. Facility Resources: An inventory of equipment, personnel, transport vehicles, capacity, etc. that are reported to the MOC during a disaster drill or actual disaster to assist with patient traffic that could be available for other facilities during a disaster.

6. Documentation: During a disaster, the impacted facility should accept and honor the donor facility's standard requisition forms. Documentation 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.

7. Authorization: The impacted facility should have supervisory direction over the donor facility's staff, borrowed equipment, etc., once they are received by the recipient facility. The recipient facility should safely and responsibly utilize borrowed equipment, etc. The impacted facility should promptly notify the donor facility of any damages, loss of equipment, or personnel injury.

8. General Financial & Legal Liability: The donor facility should continue to assume legal responsibility for the personnel and equipment during the time that the personnel, equipment and supplies are at the impacted facility. The impacted facility should reimburse the donor facility, to the extent permitted by federal law, for all of the donor facility's costs determined by the donor facility's regular rate. Costs includes all use, breakage, damage, replacement, and return costs of borrowed materials, for personnel injuries that result in disability, loss of salary, and reasonable expenses, and for reasonable costs of defending any liability claims, except where the donor facility has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury. Reimbursement should be made within 90 days following receipt of the invoice. ? Will this be a barrier to signing the MOU? Is this pretty typical? What about transport charges?

9. For their own acts of negligence or omission, donor facilities assume the legal and financial responsibility for transferred patients upon arrival into the donor facility.

10. Communications: Facilities should ensure a dedicated and reliable method to communicate with the MOC and other facilities, such as satellite phones.

11. Public Relations: Each facility is responsible for developing and coordinating with other facilities and relevant organizations the media response to the disaster. During a public health emergency, all public relations MUST be coordinated with the local/regional/state public health district/department. In all other disasters or emergencies, public relations should be coordinated with the local EOCs and the MOC (if activated).

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

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

1. MOC: The impacted facility is responsible for notifying and informing the MOC of its personnel or material needs or its need to evacuate and transport patients and the degree to which its partner facility is unable to meet these needs. The MOC should contact the other participating facilities to determine the availability of additional personnel or material resources, including the availability of beds, as

required by the situation. The MOC should maintain an up-to-date list of their specific regional resources. The MOC is also responsible for coordinating with all local EOCs as needed.

2. Initiation of transfer of personnel, material resources, or patients: Only the authorized administrator at each facility has the authority to initiate the transfer or receipt of personnel, material resources, or patients. The authorized administrator, in conjunction with the directors of the affected services, should make a determination as to whether medical staff and other personnel from another facility should be required at the impacted facility to assist in patient care activities.

   Personnel offered by donor facilities should be limited to staff that are **fully accredited or credentialed in the donor institution**. No resident physicians, medical/nursing students, or in-training persons should be volunteered. In the event of the evacuation of patients, the authorized administrator (or designee) of the impacted facility should also notify the local emergency management coordinator of its situation and seek assistance, if necessary, from the emergency medical services. The local emergency management coordinator should be asked to notify the local/regional public health district/department.

VI. Specific Principles of Understanding

A. *Medical Operations/Loaning Personnel*

1. Communication of request: The request for the transfer of personnel initially can be made verbally. The request, however, must be followed up with written documentation. This should ideally occur prior to the arrival of personnel at the impacted facility. The impacted facility should identify to the donor facility the following:

   a. The type and number of requested personnel.
   b. An estimate of how quickly the request is needed.
   c. The location where they are to report.
   d. An estimate of how long the personnel should be needed.

2. Documentation: The arriving donated personnel should be required to present their donor facility identification badge at the site designated by the impacted facility's command center. The impacted facility should be responsible for the following:

   a. Meeting the arriving donated personnel (usually by the impacted facility's security department or designated employee).
   b. Confirming the donated personnel's ID badge with the list of personnel provided by the donor facility.
   c. Providing additional identification, e.g., "visiting personnel" badge, to the arriving donated personnel.

   The impacted facility should accept the professional credentialing

determination of the donor facility but only for those services for which the personnel are credentialed at the donor facility.

3. Supervision: The impacted facility's authorized administrator (or designee) or the command center identifies where and to whom the donated personnel are to report and professional staff of the impacted facility supervise the donated personnel. The supervisor or designee should 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 impacted facility should govern assigned shifts. The donated personnel's shift, however, should not be longer than the customary length practiced at the donor facility.

4. Legal and financial liability: Liability claims, malpractice claims, disability claims, attorneys' fees, and other incurred costs are the responsibility of the donor facility. The impacted facility should reimburse the donor facility for the salaries of the donated personnel at the donated personnel's rate as established at the donor facility if the personnel are employees being paid by the donor facility. The reimbursement should be made within ninety (90) days following receipt of the invoice.

   The authorized administrator (or designee) of the impacted facility should be responsible for providing a mechanism for granting emergency credentialing privileges' for physicians, nurses and other licensed health care providers to provide services at the impacted facility.

5. Demobilization procedures: The impacted facility should provide and coordinate any necessary demobilization procedures and post-event stress debriefing. The impacted facility is responsible for providing the donated personnel transportation necessary for their return to the donor facility.

B. ***Transfer of Pharmaceuticals, Supplies or Equipment***

1. Communication of Request: The request for the transfer of pharmaceuticals, supplies, or equipment initially can be made verbally. The request, however, must be followed up with a written communication. This should ideally occur prior to the receipt of any material resources at the impacted facility. The impacted facility should identify to the donor facility the following:

   a. The quantity and exact type of requested items.
   b. An estimate of how quickly the request is needed.
   c. Time period for which the supplies should be needed.
   d. Location to which the supplies should be delivered.

   The donor facility should identify how long it should 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 impacted facility should honor the donor facility's

standard order requisition form as documentation of the request and receipt of the materials. The Logistics Officer of the impacted facility should confirm the receipt of the material resources. The documentation should detail the following:

a. The items involved.
b. The condition of the equipment prior to the loan (if applicable).
c. The responsible parties for the borrowed material.

The donor facility is responsible for tracking the borrowed inventory through their standard requisition forms. Upon the return of the equipment, etc, the original invoice should be co-signed by the authorized administrator or designee of the impacted facility recording the condition of the borrowed equipment.

3. Transporting of pharmaceuticals, supplies, or equipment: The impacted facility is responsible for coordinating the transportation of materials both to and from the donor facility. This coordination may involve government and/or private organizations, and the donor facility may also offer transport. Upon request, the impacted facility must return and pay the transportation fees for returning or replacing all borrowed material.

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

5. Financial and legal liability: The impacted facility, to the extent permitted by federal law, is responsible for all costs arising from the use, damage, or loss of borrowed pharmaceuticals, supplies, vehicles? or equipment, and for liability claims arising from the use of borrowed supplies and equipment, except where the donor facility has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury. Costs includes all use, breakage, damage, replacement, and return costs of borrowed materials, for personnel injuries that result in disability, loss of salary, and reasonable expenses, and for reasonable costs of defending any liability claims, except where the donor facility has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury. Reimbursement should be made within 90 days following receipt of the invoice.

6. Demobilization procedures: The impacted facility is responsible for the rehabilitation and prompt return of the borrowed equipment to the donor facility.

C. ***Transfer/Evacuation of Patients***

1. Communication of request: The request for the transfer of patients initially can be made verbally. The request, however, must be followed up with a written communication prior to the actual transferring of any patients. The impacted facility should identify to the donor facility:

a. The number of patients needed to be transferred.
b. The general nature of their illness or condition.
c. Eventually a list of patient names, parents to transport with the patient, diagnosis, IV drips infusing, ventilator type, isolette required, other specialty equipment such as nitric, ECMO, etc.
d. Any type of specialized services or equipment required, e.g., ICU bed, burn bed, trauma care, transplants, CV surgery, etc.

2. Documentation: The impacted facility is responsible for providing the donor facility with the patient's complete medical records, insurance information and other patient information necessary for the care of the transferred patient. The impacted facility is responsible for tracking the destination of all patients transferred out.

3. Transporting of patients: The impacted facility is responsible for coordinating and financing the transportation of patients to the donor facility. The point of entry should be designated by the donor facility's authorized administrator or designee. Once admitted, that patient becomes the donor facility's patient and under care of the donor facility's admitting physician until discharged, transferred, reassigned or repatriated. The impacted facility 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 donor facility.

4. Supervision: The donor facility should designate the patient's admitting service, the admitting physician for each patient, and, if requested, should provide at least temporary courtesy privileges to the patient's original attending physician.

5. Financial and Legal Liability: Upon admission, the donor facility is responsible for liability claims originating from the time the patient is admitted to the donor facility. Reimbursement for care should be negotiated with each facility's insurer under the conditions for *admissions without pre-certification requirements* in the event of emergencies.

6. Notification: The impacted facility is responsible for notifying both the patient's family or guardian and the patient's attending or personal physician of the situation. The donor facility may assist in notifying the patient's family and personal physician.

D. Medical Operations Center (MOC) Function

The F-MARS provides the means for the facilities to coordinate among themselves, and as a unit to integrate with local emergency management agency, local/regional public health district/department, police, fire, and emergency medical services during a disaster event.

The MOC serves as the coordinating entity and data center for collecting and

disseminating current information about equipment, bed capacity and other facility resources during a disaster (see appendices). The information collected is to be used only for disaster preparedness and response. In the event of a disaster or during a disaster drill, facilities should be prepared to provide the following information:

1. The total number of injury victims your emergency department can accept, and if possible, the number of victims with minor and major injuries

2. Total number of operating beds **current 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
   - ECMO
   - burn
   - psychiatric
   - sub-acute care
   - skilled care beds
   - transplant capabilities
   - operating suites

3. The number of items **currently available for loan or donation** to another facility:

   - ventilators
   - IV infusion pumps (type)
   - isolettes
   - dialysis machines
   - hazmat decontamination equipment
   - MRI
   - CT scanner
   - hyperbaric chamber
   - ECMO pumps
   - external pacemakers

4. The following number of personnel **currently available for loan** to another facility:

   <u>Physicians</u>
   - 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

The Mutual Aid Memorandum of Understanding is entered into by, between, and among the participating facilities of the Pediatric Disaster Coalition and is fully executed by the facilities hereto, each facility acting by and through its duly authorized official.

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