# SMRRC REGIONAL HEALTHCARE DISASTER MUTUAL AID MEMORANDUM OF UNDERSTANDING (MOU)

This SMRRC Regional Healthcare Disaster Mutual Aid Memorandum of Understanding is entered into as of **_____(date), by _____,** a Maine nonprofit corporation operating a licensed healthcare facility in _____, Maine, and other participating healthcare facility as set forth in appendix 1.

## I. Introduction and Background

As in other parts of the nation Maine is susceptible to natural and man-made disasters that could exceed the effective resource and response capacity of any individual healthcare region. A disaster could result from incidents generating an overwhelming number of patients, a smaller number of patients whose specialized medical needs may exceed the resources of the affected facility (e.g., hazmat injuries, infectious disease, trauma services, etc.), or incidents such as critical infrastructure problems that may result in the need for partial or complete hospital or healthcare system evacuation and medical treatment at alternate care sites.

## II. Purpose of Mutual Aid Memorandum of Understanding

The mutual aid support concept is well established and is considered "standard of practice" in most public safety and emergency planning/response disciplines. The purpose of this mutual aid support agreement is to aid healthcare agencies (including long term care centers and all medical offices) in their emergency management by authorizing a SMRRC regional Coalition healthcare system Mutual Aid System that addresses the temporary loan of medical and support personnel, pharmaceuticals, supplies, equipment, and/or assistance with hospital and or healthcare centers evacuation, patient transfer, and alternate care.

This mutual aid Memorandum of Understanding (MOU) is a voluntary agreement among the healthcare members within the SMRRC 4 county region (York, Cumberland, Sagadahoc, Lincoln) for the purpose of providing mutual aid (pooling resources) at the time of a medical or public health disaster. For purposes of this MOU, a *disaster* is defined as an overwhelming incident that *exceeds the effective response capability* of the affected health care facility or facilities. An incident of this magnitude will almost always involve the local and county emergency management agencies (coordinating with Maine Emergency Management Agency) and the Southern Maine Regional Resource Center (SMRRC) coordinating their response with the Maine Centers for Disease Control (CDC). The disaster may be an “external” or “internal” event for healthcare centers and it is assumed that each affected agency’s emergency management plans have been fully implemented, and that every effort is made to effectively respond to the disaster with available institution or system resources.

This document addresses the relationships between and among healthcare centers and is intended to support and supplement, rather than replace each facility's emergency Operations plan (EOP). This document supplements the policies and procedures governing interaction with other organizations during a disaster (e.g., emergency management, law enforcement agencies, emergency medical services, public health,

fire departments, American Red Cross, volunteer agencies, private sector businesses and organizations and the Southern Maine Regional Resource Centers etc.).

By signing this MOU each healthcare center is demonstrating its intent to abide by the terms of the MOU in the event of a disaster. The terms of this MOU are to be incorporated into each agency's EOP.

**III. General Principles of Understanding**

A. Disaster - An incident that exceeds a facility's effective response capability or cannot be appropriately resolved solely by a facility's own resources. Such disasters will likely involve Emergency Management Agencies (EMA), public safety, and Southern Maine Regional Resource Center (SMRRC), and may involve loan of medical and support personnel, pharmaceuticals, supplies, and equipment from another facility, or the emergent evacuation of patients and alternate care site support.

B. Incident Command System (ICS): is a Maine adopted, (US national standard) scalable system response tool, used for the command, control, and coordination of emergency response. ICS has a specific structure for healthcare response called: the Hospital Incident Command System (HICS). This system coordinates all response within a healthcare facility and works with the ICS system outside the healthcare facility on the community response. It gives flexibility and consistent structure to agencies that do not normally work together on a daily basis. HICS will be incorporated and adopted in each healthcare agencies EOP.

C. Emergency Operations Center: Each healthcare center will maintain an Emergency Operations Center (EOC) during the disaster and it will act as a communication coordination and information center that is available to facilitate the transfer or support of healthcare resources. This EOC may be a single point of contact (staffed phone) for smaller agencies. The healthcare EOC will communicate with local and county EMA and the Southern Maine Regional Resource Center (SMRRC), through this position (typically called the Liaison Officer in ICS).

D. Unified Command: On larger scale events SMRRC may act as or be part of a Regional Unified Command Center (RUCC). In which case the participation of each healthcare organization is expected to give accurate and continual communications (if they are open for business) about their status to the RUCC and also communicate their medical needs and what resources they may offer other facilities. Typically the county EMA's are part of this RUCC but there may be a separate RUCC for Healthcare in addition to county EMA depending on the nature of the emergency.

During a disaster drill or actual emergency, each healthcare agency through the Liaison officer, will use utilize the SMRRC Regional Communications plan. This plan (which includes the Maine Health Alert Network (HAN), EMResource and WeBEOC as referenced in appendix 9, 10) will be used to contact the other participating healthcare facilities within their region to determine the availability of additional personnel or material resources, including the availability of beds, as the situation warrants.

E. Evacuation and Alternate Care Sites: Healthcare Agencies may consider evacuation of their facility. While this can occur within a facility and is considered a horizontal evacuation, there is also the possibility of a larger vertical evacuation in which either whole floors and or whole facilities may be evacuated. In these circumstances a healthcare facility may have the need for evacuating patients to another facility or to receive patients from another evacuated facility. In any of these events an Alternate Care Site (ACS) may be needed. Healthcare agencies will determine thresholds to trigger ACS set up in their EOP. An ACS can be set up to divert demand from the primary facility such as in a pandemic for vaccinations or a fever clinic, or for full scale alternate medical facility. A healthcare agencies may be asked to help set up the Southern Maine Regional Alternate Care site and to donate staff, supplies and materials for that site. This can include the use of facilities normally used for other purposes.

F. Participating healthcare facility: Each healthcare agency designates a point of contact for all emergency management planning and coordination. healthcare facility also commit to participate in pre-planned disaster drills and exercises (including ACS planning, that include, the use and adoption of the regional communications plan (appendix 9, 10 The participating healthcare facility will incorporate this MOU into their EOP.

1. Donor Hospital or healthcare facility - Is the agency, which provides personnel, pharmaceuticals, supplies, or equipment to a facility experiencing a medical disaster.
2. Recipient Hospital or healthcare facility - The agency where the disaster occurred or disaster victims are being treated. This agency is referred to as the recipient agency when personnel, pharmaceuticals, supplies, or equipment are requested and received from another healthcare facility.

G. Implementation of mutual aid Memorandum of Understanding: A healthcare facility becomes a participating healthcare facility when an authorized administrator signs this MOU. During a disaster, the incident commander (or designee), senior administrator (or designee) at each healthcare agency has the authority to request or offer assistance. Communications between agencies for requesting and offering assistance should therefore occur through the agencies EOC using the regional communications plan.

H. Requisition Documentation: During a disaster, the recipient healthcare facility will accept and honor the donor healthcare facility's standard (HICS) requisition forms (see appendix). 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 materials. All requests given through electronic means, such as WebEOC shall be considered valid requests.

I. Authorization to Use Equipment: The recipient healthcare facility will have supervisory direction over the donor facility's staff, borrowed equipment, etc., once they are received by the recipient healthcare facility.

J. Independent Contractor: The parties (participating healthcare facility) shall at all times be acting and performing as independent contractors. Each party has the responsibility of paying its employees as required by law (including payment of social security taxes, workers compensation and unemployment compensation) and generally determining any and all appropriate forms of compensation and fringe

benefits for them, and except as specified herein terms of employment, evaluation, discipline and qualifications.

K. Liability Insurance: Each party shall maintain general and professional liability for itself and its employees. A current certificate of insurance shall be furnished to the other party upon request. Each party shall notify the other party of any and all incidents, untoward occurrences, or claims made arising out of its services hereunder. The parties shall cooperate in any investigation of claims or incidents to the extent that doing so does not jeopardize a party's own liability insurance coverage.

L. Communications: Healthcare facility will adopt and utilize the regional communications plan as described in the appendix 9, 10. This includes monthly regional communications drills utilizing this plan.

M. Public Relations: Each healthcare facility is responsible for developing and coordinating a disaster media response with other healthcare facility's and responding organizations through the use of the Public Information Officer (PIO) and possible a Joint Information System (JIS) utilizing ICS/HICS standards. The JIS may be lead and coordinated by SMRRC working with county EMA. The PIO of small sized facilties may be the same contact noted above, (Liaison officer). (Healthcare facility's are encouraged to develop and coordinate the outline of their response prior to any disaster. 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.

N. Personnel or Labor Pool: Clinical personnel offered by donor healthcare facility should be limited to staff that are privileged and credentialed in the donor institution. The **Maine Responds website (see appendix 8)** will be used to verify the credentials of all medical professionals in Maine. Non-clinical personnel should be limited to staff that are employed by, and in good standing with, the donor institution. Personnel will be treated as a member of the recipient work force for purposes of complying with HIPPA.

O. Evacuation of Patients: In the event of the evacuation of patients, the healthcare facility incident commander (or designee) of the transferring (evacuating) healthcare facility will use the regional communications plan to notify the local fire department, Emergency Medical Services (EMS) and/or emergency management agency of its situation and seek assistance. Partial or complete evacuation may lead to the use of an Alternate Care Site.

IV. Specific Principles of Understanding for Medical Operations/Loaning Personnel, Pharmaceuticals, Supplies, and/or Equipment.

A. Communication of request: The request initially may be made verbally and or using **WebEOC**. The request then must be followed up with written or electronic documentation. This should ideally occur **prior** to the arrival of personnel at the recipient healthcare facility. The recipient healthcare facility will identify to the donor healthcare facility the following:

1. The type and number of requested personnel, pharmaceuticals, supplies and/or equipment.
2. An estimate of how quickly the request is needed.

3. The location where people are to report or supplies are to be delivered.
4. A time estimate of how long the personnel, pharmaceuticals, supplies and/or equipment will be needed.

Documentation: The arriving donated personnel will be required to present their donor healthcare facility identification badge at the site designated by the recipient healthcare facility's EOC. A badging and identification system with Maine Responds and or the donor/receiver healthcare facility system may be used. The recipient healthcare facility will be responsible for the following:

1. Meeting the arriving donated personnel (usually by the recipient healthcare facility's security personnel or designated employee).
2. Confirming the donated personnel's ID badge with the list of personnel provided by the donor healthcare facility (this can be done using the Maine Responds badging system, part of the Maine Volunteer professional registry).
3. Providing additional identification, e.g., "visiting personnel" badge, to the arriving donated personnel, as appropriate (also potentially using the Maine Responds badging system)

Credentialing**:** The recipient healthcare facility will use the Maine Responds state credentialing System for credentialing and granting emergency privileges' for physicians, nurses and other licensed health care providers to provide services at the healthcare facility.

D. Transporting of pharmaceuticals, supplies, or equipment: The recipient healthcare facility is responsible for coordinating the transportation of materials to the donor healthcare facility, and for the return of all materials not consumed by the event. This coordination may involve government and/or private organizations, and the donor healthcare facility may also offer transport. Upon request, the receiving healthcare facility must reimburse the donor healthcare facility for all used equipment and supplies, including transportation costs. For critical supply transport that is time sensitive such as antidotes the use of the Metropolitan Medical Response Team (MMRS) and also the Northern New England Poison Control Center (NNEPCC) should be considered (requests going the NNEPCC).

E. Supervision:
   1. The recipient healthcare facility's incident commander (or designee) identifies where and to whom the donated personnel are to report, and those professional staff of the recipient healthcare facility should supervise the donated personnel. The supervising personnel (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. As appropriate, the "emergency staffing" rules of the recipient healthcare facility will govern assigned shifts. The donated personnel's shift, however, should not be longer than the customary length practiced at the donor healthcare facility.
   2. The donor healthcare facility is responsible for tracking the borrowed inventory through their HICS Form 257 (see appendix) Upon the return of the equipment, etc., the original invoice will be co-signed by the senior administrator or designee of the recipient healthcare facility recording the condition of the borrowed equipment.

F. Compensation: The receiving healthcare facility will reimburse the donor

healthcare facility as follows:

1. For supplies – the cost of the supplies.
2. For personnel – the individual's wages or salary (unless already paid by donor facility).
3. For equipment – the cost to repair or replace damaged or destroyed equipment.

G. Demobilization procedures:

1. The recipient healthcare facility will provide and coordinate, as appropriate, any necessary demobilization procedures and post-event stress debriefing.
2. The recipient healthcare facility is responsible for coordinating return transport of donated personnel to the donor healthcare facility.
3. The recipient healthcare facility is responsible for the rehabilitation and prompt return of the borrowed equipment to the donor healthcare facility.
4. All these should be outlined in the healthcare facility Emergency Response Plans (Continuity of Operations and recovery section).

H. Use of volunteers:

1.Healthcare facility will use the Medical Reserve Corp (Cumberland County MRC is requested through CCEMA) as the basis of volunteers for all Alternate Care Site Staffing, flu and medical dispensary sites and with medical help during disasters.

## V. Emergency Operations Center Function

A. The Emergency Operations Center (EOC) provides a means for the healthcare facility to coordinate internally among themselves, and externally with local, county, regional and state response partners (e.g., emergency management, law enforcement, emergency medical services, SMRRC-Regional Resource Center, public health, fire departments, American Red Cross, volunteer agencies, etc.) during a disaster event. This EOC functions under the rules of HICS.

A. The EOC serves as the data center for collecting and disseminating timely information about equipment, bed capacity and facility closures (See appendix 9, 10 for use of EMResource), and other healthcare facility resources during a disaster..

B. In the event of a disaster or during a disaster drill, healthcare facility will be prepared to provide the EOC of requesting or receiving healthcare facility, the following information, and post (items 1-4) using **EMResource**, the web resource management tool.

1. Whether your facility is open or closed and operational hours.
2. Total number of operating (staffed) beds (Long Term Care) currently available to accept patients, and their type (private/Male/Female).
3. Number of personnel **currently available for loan** to another healthcare facility and what type they are.
4. All other fields listed in EMResource for your facility.

## VI. TERM

The term of agreement shall be for a period of one (1) year beginning **(**_____**)** and ending **(**_____***).*** This agreement shall be automatically renewed for successive periods of one (1) year unless either party gives written notice of non-renewal to the other party at least 90 days in advance of the then current term.

**VII. MHA**

A copy of this signed agreement is to be forwarded to the Maine CDC. All healthcare facility will be provided with a list of participating Maine healthcare facility that have sent signed agreements to the Maine CDC. In the event of termination, the Maine CDC will immediately notify all other signatory healthcare facility by sending notification to the healthcare facility President/CEO by letter or e-mail.

Healthcare Facility: _____

**Address: _____**

_____

By: _____**President / CEO**

**Appendix**

1. **PARTICIPATING HEALTHCARE FACILITY LIST**
2. **SECONDARY DATA COLLECTION FORM**
3. **HICS 257 – RESOURCE ACCOUNTING RECORD (Link)**
4. **HICS 253 - VOLUNTEER STAFF REGISTRATION (Link)**
5. **HICS 254 - DISASTER VICTIM/PATIENT TRACKING FORM (Link)**
6. **HICS 255 - MASTER PATIENT EVACUATION TRACKING FORM (Link)**
7. **HICS 260 – PATIENT EVACUATION TRACKING FORM (Link)**
8. **MAINE RESPONDS WEBSITE (Link)**
9. **SMRRC REGIONAL COMMUNICATIONS PLAN (Link)**

**Appendix 1 Participating Healthcare Facilities and Hospitals**

1.Parkview Adventist Medical Center, Brunswick, ME
2.Midcoast Medical Center, Brunswick, ME
3.Maine Medical Center, Portland, ME
4.Southern Maine Medical Center, Biddeford, ME
5.York Hospital, York, ME
6.HD Goodall Hospital, Sanford, ME
7.Spring Harbor Hospital, Portland, ME (*only for specific mental health services)
8.Lincoln County Health St Andrews -Boothbay Harbor and Miles Campus - Damariscotta)
9.Mercy Hospital, Portland, ME

**Participating Healthcare Facilities (FQHC, Medical Facilities, Long Term Care):**

Appendix 2: SECONDARY DATA COLLECTION FORM

Healthcare Facility Name:
_____
Person completing form: _____
Date: _____ Time: _____

| **Physician** | **Number of Personnel Currently Available to Loan/Donate to Partner Healthcare Facility*** |
|---|---|
| Anesthesiology | |
| Emergency Medicine | |
| General Surgeon | |
| General Medicine | |
| OB-GYN | |
| Pediatrician | |
| Trauma Surgeon | |
| Other as indicated | |
| **Registered Nurses** | |
| Emergency | |
| Critical Care | |
| Operating Room | |
| Pediatrics | |
| Other as indicated | |
| **Other Personnel** | |
| Maintenance Workers | |
| Mental Health Workers | |
| Respiratory Therapists | |
| Plant Engineers | |
| Security Personnel | |
| Social Workers | |
| Environmental Services | |
| Other as indicated | |

- During an actual disaster or disaster drill, healthcare facility should complete the above form with the most current information available and have this information ready.