

## **Long Term Care-Mutual Aid Plan (LTC-MAP) Memorandum of Understanding (MOU)**

### **I. Introduction and Background**

The goal of long term healthcare providers is to ensure safe and effective care for their patients.

Each facility has the potential to encounter situations that may overwhelm or exceed the resources of that individual long term care facility. When a facility activates its disaster plan, some disasters require a need for a higher level of support from the surrounding healthcare facilities. Kitsap County and the surrounding areas are susceptible to disasters, both natural and man-made, that can result in the need for a full scale, coordinated disaster response.

These situations may exceed the resources of more than one long term care facility. Disasters may involve incidents that generate an overwhelming number of patients that exceed the resources of the impacted facilities or from incidents such as building or plant problems resulting in the need for partial or complete facility evacuation. It may also be a response to incidents involving biological outbreaks that overwhelm the facility.

### **II. Purpose of Long Term Care Mutual Aid Plan-MOU**

The LTC-MAP support concept is well established and is considered "standard of care" in most emergency response disciplines. The continuum of mutual aid is coordinated and based on the scale of the incident. Long term care facilities and other agencies participating in this agreement are agreeing to support one another in providing patient care during a catastrophic event or emergency.

This MOU also addresses the loan of long term care staff, pharmaceuticals, supplies, and equipment, or assistance with emergent healthcare facility evacuation, including the acceptance of transferred patients.

This LTC-MAP Memorandum of Understanding (MOU) is a **voluntary** agreement among participating facilities that have agreed to lend support in a disaster or facility emergency. The degree and level of support for the number of patients each facility will accept is clearly outlined in the plan as each facility must be able to expand bed capacity to 110% of licensed bed capacity (while the goal is to use open beds, each facility needs to be prepared to accomplish this level of surge) whereas other resources will be determined at the time of the incident based on available equipment, supplies, staff and transportation capabilities.

For purposes of this MOU, an incident is defined as a catastrophic event that exceeds the effective capability of the impacted long term care facility or facilities. An incident requires the Disaster-Struck Facility (Section III, Definition of Terms) to establish a

Command Center and may involve the city or county to activate an Emergency Operations Center (EOC) to include the activation of the Health & Medical Unit/ESF – 8. An incident of this magnitude will always involve the local emergency responders (via 911), and Kitsap County Emergency Management. The disaster may be an “external” or “internal” incident for the facility and assumes that each affected facility’s Emergency Operations Plans have been implemented through the activation of the facility Command Center.

This document addresses the relationships between and among long term care facilities in disaster situations and is intended to augment, not replace, each facility's disaster plan. The MOU also provides the framework for facilities to coordinate with the County EOC during planning and response. This document does not replace, but rather supplements, the rules and procedures governing interaction with other organizations during a catastrophic event (e.g., law enforcement agencies, emergency medical services, the public health district, fire departments, American Red Cross, etc.).

**By signing this MOU each participating organization is evidencing its intent to support the terms of the MOU by:**

- a. Providing support to a facility that has activated their Emergency Operations Plan.
- b. Providing support in the event of a catastrophic *regional disaster* that exceeds the effective response capabilities of the impacted facility or facilities. The terms of this MOU are to be incorporated into the facility’s Emergency Operations Plan.

### **III. Definition of Terms**

#### **Assistance Costs**

Assistance Costs means any direct material costs, equipment rental fees, fuel, and the fully loaded labor costs that are incurred by the Donor or Patient Accepting Facility in providing any requested assets or services.

#### **Catastrophic Event (Disaster)**

An event expected or unexpected, in which a community’s available, pertinent resources are expended, or the need for resources exceeds availability, and in which a community undergoes severe danger, incurring losses so that the social or economic structure of the community is disrupted and the fulfillment of some or all of the community’s essential functions are prevented.

#### **Census Reduction Plan**

Census Reduction Plan is an internal strategy utilized by a long term care facility to open up existing staffed beds in order to receive additional patients. This plan would include approaches to expedite the safe discharge of patients.

## **Command Center**

Command Center is a location from which the facility's specific Incident Command oversees all incident operations. It is established in a facility during an emergency and is the facility's primary point of administrative authority and decision-making. This term references what individual facilities may call their internal Emergency Operations Center, Incident Command Post or other name for in-house Command.

## **Disaster-Struck Facility**

The Disaster-Struck Facility is a long term care facility where an incident of disaster proportions has occurred. Transportation, staff, equipment or supplies may be requested, or the evacuation and transportation of patients may be required.

## **Donor Facility**

The facility that provides staff, pharmaceuticals, supplies, transportation or equipment to a Disaster-Struck Facility.

## **Emergency**

An incident that exceeds a facility's effective response capability or cannot appropriately resolve solely by using its own resources. .

## **Emergency Contacts**

Emergency Contacts are the persons, in a line of succession. The list includes names, addresses, and 24-hour phone numbers of the emergency contact points of each organization. The people listed as Emergency Contacts have (or can quickly get) the authority of the facility to commit available equipment, services, and staff for the organization.

***Note:** The phone number of a dispatch office staffed 24 hours a day that is capable of contacting the Emergency contact point(s) is acceptable.*

## **EOC**

Emergency Operation Center (EOC) or with some agencies the Emergency Coordination Center (ECC) is established for the purposes of coordinating the incident response on a local or regional level. The EOC provides planning, communications, coordination, and oversight of the disaster response.

## **First Responder Agencies**

First Responder Agencies' refers to local fire, EMS and police; typically accessed through 911 or a non-emergency direct line.

## **Health & Medical Unit (ESF-8 for large events)**

This Unit is an incident management group used to coordinate health-related emergency response efforts across all jurisdictions in Kitsap County. Health, medical and mortuary response agencies across Kitsap County will utilize the Health and

Medical Unit, to manage information, resources and decisions during disasters. The health, medical and mortuary response are led by the ESF 8 Unit Leader, who reports to the Planning Section Chief in the EOC.

### **Hospital Control**

Disaster Medical Control Center (DMCC) is a facility designated to coordinate Kitsap County pre-hospital patient care and patient distribution between EMS and hospitals. The responsibilities of DMCC include communication with the EMS personnel and Emergency Departments and patient distribution. The primary DMCC for Kitsap County is Harrison Medical Center – Bremerton Emergency Room. .

### **Long Term Care Facility**

A nursing home, convalescent home, skilled nursing facility, care home, rest home or intermediate care provides a type of residential care. They are a place of residence for people who require continual nursing care and have significant deficiencies with activities of daily living.

### **Long Term Care Mutual Aid Plan (LTC-MAP) MOU**

A **voluntary** agreement among participating agencies or facilities that have agreed to lend support in a disaster or emergency.

### **Medical Reserve Corp (MRC)**

The mission of the Medical Reserve Corps (MRC) is to improve the health and safety of communities across the country by organizing and utilizing public health, medical and other volunteers.

### **Participating Facilities**

Facilities that have fully committed to the LTC-MAP MOU.

### **Patient Accepting Facility**

The facility that receives patients from another Participating Facility in an evacuation.

### **Stop Over Point /Alternate Care Facility**

A facility where patients can be held pending return to their original facility or distribution to a Patient Accepting Facility. This building will be assessed for its capability to provide this service. Additionally, the facility should be reviewed from a vulnerability standpoint to ensure that movement to the facility will not endanger evacuated patients or staff at the time of the disaster.

### **Surge Capacity Plan (Patients Influx Plan)**

An internal strategy used by a facility to make available existing beds and open non traditional areas for patient care. Or to potentially open up an alternate site to support a mass influx of patients over a short duration or an extended period of time. This plan might include a Census Reduction Plan, and other strategies employed that are specific to each individual facility.

## **IV. General Principles of Understanding**

### **1. Participating Long Term Care Facility Responsibilities**

Each Participating Long Term Care Facility shall designate Emergency Contacts to participate with community disaster planning and to coordinate the Long Term Care Mutual Aid Plan (LTC-MAP) initiatives with the individual facility's Emergency Operations Plan.

a. Ensure the most current Emergency Contacts are included in the LTC-MAP.

b. Report any changes occurring during the plan year that preclude the Participating Long Term Care Facility from participating or modifies the level of actual participating.

c. Maintain a current hard-copy of the LTC-MAP in the facility Command Center or other designated location.

d. Commit to participating in community exercises and drills to test the plans' effectiveness.

### **2. Implementation of LTC-MAP (MOU)**

A long term care facility becomes a Participating Long Term Care Facility when an authorized administrator signs the MOU. During a declared disaster, only the authorized administrator (or designee) or Command Center at each facility has the authority to **request or offer assistance** through the LTC-MAP.

### **3. Command Center**

The Command Center is activated when a facility activates its disaster plan. The Disaster Struck Facility must activate a Command Center in order to request resources through the LTC-MAP. The impacted facility's' Command Center is responsible for informing the County EOC (when activated during a declared disaster for Kitsap County) of its situation and defining needs that cannot be accommodated by the facility itself. The senior administrator or designee is responsible for requesting staff, pharmaceuticals, supplies, equipment, transportation or authorizing the evacuation of patients. The senior administrator or designee will coordinate both internally, and with the Donor /Patient Accepting Facility, all of the logistics involved in implementing assistance under this LTC-MAP MOU.

### **4. City EOC**

The City EOC may provide resources to the Command Center, as able.

### **5. Kitsap County EOC and Health & Medical Unit**

The Kitsap County EOC is activated by the Kitsap County Department of Emergency Management with requests for activation coming from, city EOCs, law enforcement, fire district, or by other approved sources. The EOC, when fully activated, includes a Health & Medical Unit. This Unit will consist of representatives from the Kitsap Public Health District, participating hospitals, EMS and other agencies/healthcare facilities, as necessary. The Health & Medical Unit has the authority and responsibility

to coordinate and direct all disaster related medical response for the damaged facilities. The long term care facilities remain responsible for internal operational issues.

#### **6. Documentation for Supplies, Transportation, Staff, and Equipment**

Documentation provided by the Donor Facility should detail the items or individuals involved in the transaction, condition of the material prior to the loan (if applicable), and the party responsible for the material (if applicable.)

During a disaster, the Donor Facility will accept and honor the requesting facility's standard requisition forms or (verbal communication in the event of a technological failure). This will be followed by a written requisition form at the earliest possible time and prior to demobilization.

#### **7. Payment for Supplies, Transportation, Staff, and Equipment**

The Patient Accepting Facility will assume responsibility for the supplies, transportation, staff and equipment from the Donor Facility upon receipt and during the time the supplies, transportation, staff and equipment are at the facility. If the Donor Facility requests reimbursement for salaries or expenses, the facility shall reimburse the Donor Facility, to the extent permitted by federal law, for all of the Donor Facility's costs determined by the Donor Facility and the accepting facility working together to determine the appropriate costs. Costs include all use, breakage, damage, replacement, and return costs of borrowed materials. Staff wages, benefits, taxes, insurance, or other compensation is always paid by their home facility (employer). Reimbursement will be made within a mutually agreed upon timeframe between the Donor Facility and the recipient facility following receipt of the invoice. All processes will be consistent for reimbursement of vendors that are supporting the LTC-MAP during a disaster.

#### **8. Patient Care Responsibility**

Once admitted, the patient is under the care of the Patient Accepting Facility's admitting physician until discharged, transferred, or reassigned. The Disaster Struck Facility is responsible for transferring of extraordinary drugs or other special patient needs (e.g. equipment) if possible. At the end of the disaster, patients may be returned and must be accepted at the Disaster Struck Facility as capable. The following conditions immediately eliminate the potential for a transfer:

- a. The patient is discharged to home or alternate level of care (rehabilitation hospital, skilled nursing facility).
- b. The patient/family/responsible party refuses transfer.
- c. The attending physician deems the patient unstable for transport.

*NOTE 1: The parties hereto recognize that certain parties hereto are religious or church-sponsored entities and that with respect to said parties any services provided hereunder must be provided in a manner that is consistent with said parties' Mission and Core Values and the moral tradition as articulated in such documents as "The Ethical and Religious Directives for Catholic Health Care Services" or other documents as applicable.*

*NOTE 2: It is expected that no marketing efforts will be made by the Patient Accepting Facility.*

### **9. Communications**

The impacted facilities are responsible for informing emergency agencies and the appropriate Washington State licensure agency (DSHS) of its situation and defining needs that cannot be accommodated by the facility itself. The senior administrator (or designee) in the Disaster Struck Facility Command Center is responsible for requesting supplies or authorizing the evacuation of patients. Communications between facilities for formally requesting and volunteering assistance should therefore occur among the different facility senior administrators (or designees).

### **10. Public Relations**

Each Participating Facility is responsible for developing and coordinating with other healthcare agencies, relevant organizations, and the appropriate EOC for the media response to the disaster. Coordination of public information during this time will occur through the Joint Information Center activated by the EOC.

### **11. Hold Harmless Condition**

The recipient facility will hold harmless the Donor Facility for acts of negligence or omissions on the part of the Donor Facility in their good faith response for assistance during a event. The Donor Facility, however, is responsible for appropriate credentialing of personnel and for the safety and integrity of the equipment and supplies provided for use.

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

### **1. Mutual Aid**

When a facility has activated its disaster plan, the impacted facility may request assistance from another healthcare facility for staff, supplies, transportation or equipment and then the Donor Facility will inform the requesting facility of the degree and time frame in which it can meet the request.

### **2. Operational Status**

Participating Disaster Struck Facility, when activated, will notify Kitsap County Emergency Management of their operational status.

### **3. EOC Health & Medical Area Command (Activated upon a disaster declaration)**

All facilities are responsible for notifying the EOC for any non-medical resource needs including staff, supplies, transportation or equipment. Any evacuation of patients and unmet medical needs requests will be via the Health & Medical Unit (if activated) who will request an updated resource assessment to determine the availability of additional staff or material resources, including the availability of beds, as required by the situation. The Health & Medical Unit will prioritize requests and direct the distribution

of the resources in coordination with the EOC. Once resources have been assigned, the recipient facility will be informed to contact the Donor Facility directly and complete the arrangements. The Incident Commander (or designee) of the Disaster Struck Facility, will coordinate directly with the Incident Commander (or designee) of the Donor or Patient Accepting Facility for this assistance.

*\* NOTE: For evacuation of patients, the Disaster Struck Facility may initially be communicating directly with Patient Accepting Facilities and their Stop Over Points with Health & Medical Unit to provide supplemental coordination support.*

## **VI. Specific Principles of Understanding (including sheltering)**

### **Loaning of Staff**

#### **1. Communication of request:**

The Incident Commander (or designee) of the recipient facility authorizes the request. The request for the transfer of staff initially can be made verbally to the Incident Commander of the Donor Facility. The request must be followed up with written documentation before staff will be released and in the event of a technological failure this will be followed by a written requisition form at the earliest possible time and prior to demobilization. The documentation may be sent by any available means. The recipient facility will identify to the Donor Facility the following:

- a. The type and number of requested staff.
- b. An estimate of how quickly the requested staff is needed.
- c. Information regarding parking, entry, where and who to report to.
- d. An estimate of how long the staff will be needed.
- e. The method of transportation.

The Donor Facility will provide a list of names and credentials of the volunteers.

#### **2. Documentation**

The arriving donated staff will be required to present their facility identification badge along with another accepted form of identification at the time of arrival and continue to wear the badge while on duty at the facility. The facility will be responsible for the following:

- a. Meeting the arriving donated staff at the entry point and escorting them to the check in location for sign-in.
- b. The check in process will include:
  - Confirming the donated staff's ID badge with the list of personnel provided by the Donor Facility.
  - Providing additional identification, to the arriving donated staff. This is to be worn in addition to the volunteer's normal badge.
  - Providing a briefing regarding the situation.
  - Designating an assignment and supervisor for each individual based on experience and credentials.

- Escorting or directing staff to assigned area.

c. Completing timesheets and documentation of assignments and providing copies to the Donor Facility.

The recipient facility will accept the current professional credentialing status of the Donor Facility. Additional privileges may be granted at the discretion of the recipient facility with agreement from the appropriate senior physician and/or Medical Director, as determined by the facility, and the individual.

### **3. Supervision**

Each volunteer will be assigned to a direct supervisor. The supervisor will meet the donated staff and brief them on the situation and their assignment. The supervisor is responsible for ensuring that the volunteer is oriented to the work area, understands and is capable of the assignment, and has the ability to ask questions and report concerns. In addition the supervisor will assess the donated worker periodically and relieve the individual if unfit to continue to work.

If appropriate, the staffing rules of the recipient facility will govern assigned shifts. The donated staff's shift will not exceed the shifts outlined in the emergency-staffing plan. The length of the shift may be negotiated in advance with the Donor Facility.

### **4. Demobilization procedures**

Donated staff are expected to remain on duty until relieved, unable or unsafe to continue, or dismissed. The supervisor is responsible for communicating with the individual any change in assignment. All donated staff will be expected to sign out, return the identification badge, and document their time on the timesheet. The recipient facility will provide and coordinate:

- a. Any necessary demobilization procedures and post-incident stress debriefing.
- b. Transportation necessary for return to the Donor Facility.
- c. Copy of the assignment log and time sheets for tracking and payment purposes.

*NOTE: If the Donor Facility is experiencing a disaster, a process for rapid demobilization will be implemented to support returning staff to their primary place of employment.*

### **5. Payment for Services**

Normal payroll procedures will be followed by the Participating Facility. If the Donor Facility requests reimbursement for salaries or expenses, the Donor Facility shall submit the payroll expenses to the recipient facility. The Donor Facility will also accept the timesheets from the recipient facility as evidence of hours worked. All financial matters will be worked out between the participating facilities.

If the Donor Facility requests reimbursement for salaries or expenses, the recipient facility shall reimburse the Donor Facility for the salary expenses incurred by donated personnel while working at the recipient facility. An invoice will be submitted to the recipient facility for reimbursement. Recipient facility shall pay to the Donor Facility all valid and invoiced costs in a mutually agreed upon amount of time following the receipt of the Donor's invoice. All processes will be consistent for reimbursement of vendors that are supporting the LTC-MAP during a disaster.

## **6. Exceptions**

In the event that the Donor Facility is actually the Disaster Struck Facility that has evacuated and sent staff along with patients, it is the requirement of the Disaster Struck Facility to provide transportation to the staff during demobilization.

## **Transfer of Pharmaceuticals, Supplies or Equipment**

### **1. Communication of Request**

The Incident Commander of the recipient facility authorizes the request. The request for the transfer of pharmaceuticals, supplies, or equipment initially can be made verbally to the Incident Commander of the Donor Facility. The request must be followed up with written documentation before pharmaceuticals, supplies or equipment will be released or verbal communication in the event of a technological failure and this will be followed by a written requisition form at the earliest possible time and prior to demobilization. The recipient facility will identify to the Donor Facility the following:

- a. The quantity and exact type of requested items.
- b. An estimate of how quickly the requested items are needed.
- c. Time period for which reusable supplies or equipment will be needed.
- d. Location to which, and to whom, the items should be delivered.
- e. Transportation method

The Donor Facility will identify how long it will take them to fulfill the request. A timely response to the requests is critical for effective disaster response.

### **2. Documentation**

The Donor Facility will honor the recipient facility's standard order requisition form as documentation of the request and receipt of the materials. The receipt of supplies, equipment, and pharmaceuticals will be the responsibility of a designated individual within the recipient facility. The recipient facility's designee will confirm the receipt of the material resources. The documentation will detail the following:

- a. The items delivered.
- b. The condition of the equipment received (if applicable).
- c. Recipient facility's contact person for durable medical equipment or reusable supplies.

The facility receiving the supplies is responsible for tracking the borrowed inventory.

### **3. Transporting of pharmaceuticals, supplies, or equipment**

The **Patient Accepting Facility** is responsible for coordinating the transportation of materials both to and from the Donor Facility. The appropriate EOC will facilitate transportation when requested, and if available. This coordination may involve government and/or private organizations, and the Donor Facility may also offer transport. Upon request, the facility must return and agree to pay or reimburse the transportation fees for returning or replacing all borrowed material.

### **4. Supervision**

The recipient facility is responsible for appropriate use and maintenance of all borrowed pharmaceuticals, supplies, or equipment.

### **5. Demobilization Procedures**

The recipient facility is responsible for the cleaning, maintenance, and prompt return of the borrowed equipment to the Donor Facility. It is expected that the equipment will be returned in good working order. Once the equipment is no longer in use, or upon resumption of normal operations, every reasonable effort will be made to replace the borrowed equipment or return it to the Donor Facility in a timeframe that is acceptable to both institutions. Upon the return of the equipment the original invoice will be co-signed by the Incident Commander or designee of the Donor Facility recording the condition of the returned equipment. A copy of the signed invoice will be provided to the Donor Facility as part of the tracking process.

### **6. Payment for pharmaceuticals, supplies, or equipment**

If the Donor Facility requests reimbursement for materials and expenses, the recipient facility shall reimburse the Donor Facility for its costs in replacing any used, damaged, or lost pharmaceuticals, supplies, or equipment. The Donor Facility is expected to submit an invoice detailing the cost of the pharmaceuticals, supplies, equipment, maintenance, and transportation for reimbursement to the recipient facility. Recipient facility shall pay to the Donor Facility all valid and invoiced costs under this Section in a mutually agreed upon amount of time following the receipt of the Donor's invoice. In the event the Donor provides supplies or parts, the Donor shall have the option to accept payment of cash or in kind for the supplies or parts provided. All processes will be consistent for reimbursement of vendors that are supporting the LTC-MAP during a disaster.

## **Transfer/Evacuation of Patients**

*NOTE: A facility is not required to provide beds with a confirmed admission as a bed for evacuated patient.*

### **1. Communication of request**

The Incident Commander or designee of the Disaster Struck Facility will authorize the decision to transfer or evacuate patients. Patients may be transferred or evacuated if facility conditions are not safe to continue to provide patient care. The request for the transfer or evacuation of patients initially can be made verbally to the

senior administrator or designee of the Patient Accepting Facility. Requests for transfers or evacuation during a declared disaster should be coordinated with Health & Medical Unit except when there is an immediate threat to life and the local authority orders an evacuation of the facility or the Health & Medical Unit is acting in a support role where the Disaster Struck Facility, EMS and Patient Accepting Facilities have coordinated all patient transfers. The request must be followed up with written documentation prior to the actual transferring/ evacuating of any patients or verbal communication in the event of a technological failure or immediate threat to life. This will be followed by a written requisition form at the earliest possible time and prior to demobilization.

## **2. Medical Staff**

The Patient Accepting Facility is responsible for coordinating with the Medical Staff to assign a care provider. Whenever possible, the transferring physician will contact the receiving physician and provide information regarding the care. In the event that the physician is credentialed in both facilities, the physician may continue to care for the patient unless the disaster prevents this from occurring. If time and condition permits, patient permission for transfer should also be obtained.

## **3. Documentation**

The Disaster Struck Facility will provide the following information to the Patient Accepting Facility (certain disaster conditions may impact the timeliness of this ability):

- a. The number of patients needing to be transferred
- b. The general nature of their illness or condition
- c. Any type of specialized services required (i.e. cyclor)
- d. Patient condition reports
- e. Mode of transportation
- f. Expected time of arrival
- g. *Resident Evacuation Tracking Form/Tag* for each patient
- h. *Patient/Medical Record and Equipment Tracking Sheet* for the total number of patients being transferred
- i. If time and situation permits, the Disaster Struck Facility is responsible for providing the patient's complete medical records, insurance information and other patient information necessary for care. The Disaster Struck Facility is responsible for tracking the destination of all patients transferred out and providing such tracking information to the Health & Medical Unit who will work in coordination with the Disaster Struck Facility and the Patient Accepting Facilities to ensure all patients are accounted for.
- j. All HIPAA requirements should be maintained by the Participating Healthcare Facilities unless removed by Federal Waiver.

*NOTE: Many facilities have electronic medical records. If electronic medical records are currently in place, it is critical that a strong effort be made to provide a clear and concise Resident Evacuation Tracking Form in the event that computer use is limited. The facility should attempt to batch print the records, if possible, on each evacuating unit. Additionally, if the facility was unable to print the appropriate sections of the records*

*prior to evacuation, an attempt should be made to access electronic medical records from an off-site location and be printed out from that location to support patient care.*

#### **4. Transporting of patients**

The Disaster Struck Facility is responsible for coordinating and financing the transportation of patients to the Patient Accepting Facilities. The evacuating facility is responsible for transferring extraordinary drugs or other special patient needs (e.g., equipment, blood products) as time and condition permits with the patient. The Patient Accepting Facility will:

- a. Designate a point of entry
- b. Assign medical staff and other care providers
- c. Identify the location for care
- d. Communicate back to the transferring/evacuating facility to inform them of the receipt of the patients

The Health & Medical Unit may facilitate this communication if the evacuating facility can not do it.

#### **5. Supervision**

Once admitted, that patient becomes the Patient Accepting Facility's patient and under care of the Patient Accepting Facility's admitting physician until discharged, transferred or reassigned.

#### **6. Notification**

The Disaster Struck Facility is responsible for notifying both the patient's family or authorized surrogate decision maker and the patient's attending or personal physician of the situation. The Patient Accepting Facility may assist in notifying the patient's family and personal physician.

#### **7. Exceeding Licensed Bed Capacity**

It is the intent of this Mutual Aid Plan to support patients with placement into licensed beds. In situations where the bed capacity is going to exceed licensed beds, this will be addressed in conjunction with DSHS or with decisions being made by local authorities responsible for protecting the lives of patients.

a. **Fast-out Evacuation:** If you are receiving immediate transfers of evacuated patients from a Disaster Struck Facility, you are allowed to exceed the number of licensed beds by the amount stated in the plan (10%) and provide appropriate care for them in "open space" (i.e. activity rooms, OT/PT rooms, etc.) or in existing patient rooms. Additionally, this disaster may include the movement of patients to a Stop Over Point (YMCA, Gymnasium, etc.) to provide protection of the patients until they can return back or transported to other area Patient Accepting Facilities. In coordination with, DSHS, and the Patient Accepting Facility, a waiver will be requested (post-incident due to the fast-out evacuation.) If the disaster exceeds a certain period of time or the acuity of the patient dictates it, the patient may be moved to another facility with more capacity or beds available.

b. **Evacuation but returning:** Whether it is a fast or slow evacuation the patient will be returning within a few days to the Disaster Struck Facility (loss of HVAC during high heat or extreme cold, a fire that does not affect the safety of the patients but does require relocation, a generator failure during a power loss). While the Mutual Aid Plan is activated and patients are being moved, additional requests and communication will take place through DSHS to find open beds. The goal is to keep the patients in close proximity to the Disaster Struck Facility to ensure that staff from the evacuating facility can go with them, if necessary, and that families can visit them. Additionally, this disaster may include the movement of patients to a Stop Over Point to provide protection of the patients until they can return to the Disaster Struck Facility or a distributed to other area Patient Accepting Facilities. A waiver would be requested, as necessary, for a Patient Accepting Facility.

c. **Slow-out evacuation:** The Disaster Struck Facility will clearly not be opening anytime soon (flooding inside the building, substantial fire, etc.) This will involve movement of patients to open beds and may spread to a larger geographic area. Patients without beds would be moved further out as beds become available. A waiver may need to be requested for the short term care provided at a Patient Accepting Facility. In each of these situations, the Patient Accepting Facility will work on preplanning how they can either open beds for the patients they receive or ensure that every effort is being made to provide an appropriate level of care. It is assumed that patients may not have beds initially, but the planning should include requesting beds/equipment/supplies from other Mutual Aid Plan members not affected by the disaster, or from the City or County EOCs.

## **8. Payment for Patient Care**

The participating facilities will work with the appropriate payer (Medicare, Medicaid or Private Payer) to work through the payment of services for the care of patients. If it is required that there be a division of payment, each party will attempt to work out the division of payment amicably and incorporate into the discussions, as necessary, the Washington State DSHS and the appropriate payer (private, state or federal.)

**NOTE:** *Reimbursement covers facility costs but not necessarily ambulance/ transportation costs. Please review your facility specific business interruption insurance and agreements with private Emergency Medical Services transportation firms or private bus contracts.*

## **9. NURSING FACILITIES (NF)**

a. NF to NF Transfer – Licensed Beds: In the event that the patient **WILL** be able to return in 30 days, DSHS would continue to reimburse the Disaster-Struck Facility during this 30 day period. It will be the responsibility of the two Nursing Facilities (disaster-struck and patient accepting) to divide the payment

amicably. In the event the patients will **NOT** be able to return in 30 days, the Disaster-Struck Facility should proceed with discharge documentation on day 16 (DSHS does not pay for day of discharge) and the Patient Accepting Facility should commence with admission procedures on day 16 for these DSHS members (DSHS does pay for day of Admission.) In effect, on day 16 these patients would be treated like any new admission. The Patient Accepting Facility would follow all standard admission procedures and practices.

**NOTE 1:** *DSHS may make a determination with the Disaster Struck Facility and the Patient Accepting Facility that the facilities should move forward with the discharge and admit process in advance of the day 15, decision-making process.*

**NOTE 2:** *Consistent with the Center for Medicare and Medicaid Services (CMS) guidelines, the discharge and admission process should be completed within the 30 day timeframe. Ensure the discharge forms and the admissions forms are filled out on the same day by the Disaster Struck Facility and the patient receiving facility. The day of discharge is not paid for, but the day of admissions is and would therefore limit the financial impact on both organizations. This model should be reviewed by other payers for acceptance.*

b. NF to NF Transfer: Un-licensed Beds –overflow/surge:

The same provisions as above would apply provided DSHS issues the necessary approvals (licensure and certification) to the Patient Accepting Facility to commence with and continue in an overflow situation. The approvals would need to be effective from the first day of the emergency.

**NOTE:** *It is assumed private paying patients will follow the same guidelines*

c. Patient Choice – Regarding Discharge from Disaster Struck Facility:

In the event that a patient chooses, during the first 30 days of the emergency period to become a full time patient of the Patient Accepting Facility OR wishes to transfer to a new Nursing Facility, then the Disaster Struck Facility should initiate standard discharge and transfer procedures while the Patient Accepting Facility should initiate standard admission practices. This situation may not work because the facility does not have a contract with the insurance company or does not take Medicaid. Therefore a patient would not be allowed formal admission to the facility and a transfer request would be put into effect.

**NOTE:** *While DSHS will continue to pay for a DSHS member during this 30 day period, the process does not prohibit or preclude a DSHS member from seeking a different nursing facility to care for their needs. In that event, standard operating procedures governing admissions and discharges would apply.*

## **VII. Payment for Services and Assistance Disputes**

a. All parties agree upon working to secure payments for emergency services and support amongst themselves (as detailed in Sections IV and VI). If there are any disputes, see Section XIII for Mediation and Arbitration approaches.

b. All processes will be consistent for reimbursement of vendors that are supporting the LTC-MAP during a disaster.

## **VIII. Term and Termination**

This LTC-MAP MOU is effective upon execution by two or more Participating Long Term Care Facilities. A Participating Facility opting to terminate its participation in this LTC-MAP shall provide written termination notification to the Kitsap County Department of Emergency Management. A Notice of Termination becomes effective 60-days following receipt and Kitsap County Emergency Management shall in turn notify all Participating Agencies /Healthcare Facilities. Any terminating Participating Facility shall remain obligated for any expenses incurred during its period of participation, until the obligation is satisfied.

## **IX. Independent Contractor**

Each party is an independent contractor with respect to the other parties of this MOU. Neither party is authorized or permitted to act or to claim to be acting as an agent or employee of the other party. Nothing in this MOU alters in any way control of the management, assets or affairs of any party. No party by virtue of this MOU assumes any liability for any debts or obligations of any kind incurred by any other party to this MOU. Nothing in this MOU shall be construed as limiting the rights of any party to contract with any other facility unless under the supervision of the recipient facility. (See section VI, Loaning of Staff, 3. Supervision.)

## **X. Loans of Equipment**

Use of equipment, such as construction equipment, road barricades, vehicles, and tools, shall be at the Donor Facility's current equipment rate, or if no written rates have been established, as mutually agreed between recipient facility and Donor Facility. Equipment and tool loans are subject to the following conditions:

a. At the option of the Donor Facility, loaned equipment may be loaned with an operator. See XII for terms and conditions applicable to use of borrowed staff.

b. Loaned equipment shall be returned to the Donor Facility upon release by the recipient facility, or immediately upon the recipient facility's receipt of an oral or written notice from the Donor Facility for the return of the equipment. When notified to return equipment to a Donor Facility, the recipient facility shall make every effort to return the equipment to the Donor Facility's possession within 24 hours following notification.

c. Recipient facility shall, at its own expense, supply all fuel, lubrication and maintenance for loaned equipment. The recipient facility takes proper precaution in its operation, storage and maintenance of Donor's equipment. Equipment shall be used only by properly trained and supervised operators. Recipient facility takes responsibility

to assure users are properly trained in the use of any equipment or supplies. Donor Facility shall endeavor to provide equipment in good working order. All equipment is provided “as is”, with no representations or warranties as to its fitness for particular purpose.

d. Donor Facility’s cost related to the transportation, handling, and loading/unloading of equipment shall be chargeable to the recipient facility. Donor Facility shall provide copies of invoices for such charges where provided by outside sources and shall provide hourly accounting of charges for Donor Facility’s employees who perform such services.

e. In the event loaned equipment is lost or damaged while being dispatched to recipient facility, or while in the custody and use of the recipient facility, or while being returned to the Donor Facility, recipient facility shall reimburse the Donor Facility for the reasonable cost of repairing said damaged equipment. If the equipment cannot be repaired within a time period indicated by the Donor Facility, then recipient facility shall reimburse Donor for the cost of replacing such equipment with equipment, which is of equal condition and capability. Any determinations of what constitutes “equal condition and capability” shall be at the discretion of the Donor Facility. If Donor Facility must lease or rent a piece of equipment while the Donor Facility’s equipment is being repaired or replaced, recipient facility shall reimburse Donor for such costs. Recipient facility shall have the right of subrogation for all claims against persons other than parties to this LTC-MAP MOU who may be responsible in whole or in part for damage to the equipment. Recipient facility shall not be liable for damage caused by the sole negligence of Donor Facility’s operator(s).

## **XI. Exchange of Materials and Supplies**

If the Donor Facility requests reimbursement for materials and expenses, the recipient facility shall reimburse Donor Facility in kind or at Donor Facility’s actual replacement cost, plus handling charges, for use of partially consumed or non-returnable materials and supplies, as mutually agreed between recipient facility and Donor Facility. Other reusable materials and supplies which are returned to Donor in clean, damage-free condition shall not be charged to the recipient facility and no rental fee is charged. Donor Facility shall determine whether items returned are “clean and damage-free” and items shall be treated as partially consumed or non-returnable materials and supplies if item is found to be damaged.

## **XII. Loans of Staff**

If the Donor Facility requests reimbursement for salaries and expenses, the recipient facility shall reimburse the Donor Facility appropriately. Donor Facility may, at its option, make such employees, as are willing to participate, available to recipient facility at recipient facility’s expense equal to Donor Facility’s full cost, including employee’s salary or hourly wages, call back or overtime costs, benefits and overhead, and consistent with Donor Facility’s personnel union contracts, if any, or other conditions of employment. Costs to feed and house loaned staff, if necessary, shall be chargeable to and paid by the recipient facility. The recipient facility is responsible for assuring such arrangements as may be necessary to provide for the safety, housing, meals, and transportation to and from job sites/housing sites (if necessary) for loaned staff. The

Participating Facility's Emergency Contacts or their designees shall develop planning details associated with being a recipient facility or Donor Facility under the terms of this LTC-MAP MOU. Donor Facility staff providing Emergency Assistance shall be under the operational control of the command structure of the recipient facility. Donor Facility shall not be liable for cessation or slowdown of work if Donor Facility's employees decline or are reluctant to perform any assigned tasks if said employees judge such task to be unsafe.

### **XIII. Limitation of Liability and Disputes**

a. DELAY/FAILURE TO RESPOND. No Participating Facility shall be liable to another Participating Facility for, or be considered to be in breach of or default under this LTC-MAP MOU on account of any delay in or failure to perform any obligation under this LTC-MAP MOU, except to make payment as specified in this LTC-MAP MOU.

b. MEDIATION AND ARBITRATION. If a dispute arises out of delay or failure to make payment, and if said dispute cannot be settled through direct discussions, the parties agree to first endeavor to settle the dispute in an amicable manner by mediation. Thereafter, any unresolved controversy or claim arising out of or relating to this Agreement, or breach thereof, may be settled by arbitration, if the parties agree to do so, and judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. The parties to this MOU may seek to resolve disputes pursuant to mediation or arbitration, but are not required to do so.

### **XIV. Worker's Compensation and Employee Claims**

Each party's employees, officers or agents, made available to a recipient facility, shall remain the general employee, officer or agents of such party while engaged in carrying out duties, functions or activities pursuant to this LTC-MAPMOU , and such party shall remain fully responsible as employer for all taxes, assessments, fees, premiums, wages, withholdings, workers' compensation and other direct and indirect compensation, benefits, and related obligations with respect to its own employees. Likewise, each party shall provide worker's compensation in compliance with statutory requirements of the state of residency.

### **XV. Modifications**

No provision of this LTC-MAP MOU may be modified, altered, or rescinded by any individual Participating Facility without two-thirds affirmative concurrence of the all the Participating Facilities . The facilitating agency for making modifications of this LTC-MAP Agreement will be KCDEM. Modifications to this LTC-MAP MOU must be in writing and becomes effective upon approval by a two-thirds affirmative vote of the Participating Facilities. Modifications must be signed by an authorized representative of each Participating Facility.

### **XVI. Non-Exclusiveness and Prior Agreements**

This MOU shall not supersede any existing mutual aid agreement, transfer agreements or any other agreements between two or more Participating Facilities, and as to assistance requested by a party to such mutual agreement within the scope of the

mutual aid agreement, such assistance shall be governed by the terms of the mutual aid agreement and not by this LTC-MAP MOU.

#### **XVII. Governmental Authority and Law**

This MOU is subject to laws, rules, regulations, orders, and other requirements, now or hereafter in effect, of all governmental authorities having jurisdiction over the emergencies covered by this LTC-MAP MOU, the Participating Facility or either of them. This LTC-MAP MOU shall be interpreted, construed, and enforced in accordance with the laws of Washington State.

#### **XVIII. No Dedication of Facilities**

No undertaking by one Participating Facility to the other Participating Facilities under any provision of this LTC-MAP MOU shall constitute a dedication of the facilities or assets of such Participating Facility, or any portion thereof, to the public or to the other Participating Facility. Nothing in this LTC-MAP MOU shall be construed to give a Participating Facility any right of ownership, possession, use or control of the facilities or assets of the other Participating Facility.

#### **XIX. No Partnership**

This LTC-MAP MOU shall not be interpreted or construed to create an association, joint venture or partnership among the Participating Facilities or to impose any partnership obligation or liability upon any Participating Facility. Further, no Participating Facility shall have any undertaking for or on behalf of, or to act as or be an agent or representative of, or to otherwise bind any other Participating Facility.

#### **XX. No Third Party Beneficiary**

Nothing in this LTC-MAP MOU shall be construed to create any rights in or duties to any Third Party, nor any liability to or standard of care with reference to any Third Party. This MOU shall not confer any right, or remedy upon any person other than the Participating Facilities. This LTC-MAP MOU shall not release or discharge any obligation or liability of any Third Party to any Participating Facilities.

#### **XXI. Entire Agreement**

This MOU constitutes the entire agreement amongst the Participating Facilities.

#### **XXII. Successors and Assigns**

This LTC-MAP MOU is not transferable or assignable, in whole or in part, and any Participating Facility may terminate its participation in this LTC-MAP Agreement subject to Section VIII.

#### **XXIII. Venue**

Any action which may arise out of this LTC-MAP MOU shall be brought in Washington State and Kitsap County.

#### **XXIV. Waiver of Rights**

Any waiver at any time by any Participating Facilities of its rights with respect to a default under this LTC-MAP MOU, or with respect to any other matter arising in connection with this MOU, shall not constitute or be deemed a waiver with respect to any subsequent default or other matter arises in connection with this MOU. Any delay short of the statutory period of limitations, in asserting or enforcing any right, shall not constitute or be deemed a waiver.

#### **XXV. Invalid Provision**

The invalidity or unenforceability of any provisions hereof, and this LTC-MAP MOU shall be construed in all respects as if such invalid or unenforceable provisions were omitted.

#### **XXVI. Notices**

Any notice, demand, information, report, or item otherwise required, authorized, or provided for in this LTC-MAP MOU shall be conveyed and facilitated by the Kitsap County Emergency Management. Such notices, given in writing, and shall be deemed properly given if (i) delivered personally, (ii) transmitted and received by telephone facsimile device and confirmed by telephone, or (iii) sent by United States Mail, postage prepaid.

**The document will be reconfirmed annually and be maintained at Kitsap County Emergency Management.**

#### **Long Term Care Mutual Aid Plan (LTC-MAP) MOU**

*This Memorandum of Understanding (MOU) is effective on by and among signatory long term care facilities, the designated representatives of which have signed hereto.* It is understood that **this MOU is not a legally binding document**, but rather signifies single facility, multiple facility and/or a region-wide disaster, the medical needs of the community will be best met if they cooperate and coordinate their response efforts. This MOU and any attached exhibits constitute the entire MOU between the signatory long term care facilities. Amendments to this MOU must be in writing and signed by participating facilities. A signatory facility may at anytime terminate its participation in the MOU by providing sixty-day written notice to the lead administrative agency for the LTC-MAP in accordance with Section VIII (b).

IN WITNESS WHEREOF, this agreement is signed this  
\_\_\_\_\_ day of \_\_\_\_\_, 2014

**BOARD OF COUNTY COMMISSIONERS  
KITSAP COUNTY, WASHINGTON**

\_\_\_\_\_  
**CHARLOTTE GARRIDO, Chair**

\_\_\_\_\_  
**ROBERT GELDER, Commissioner**

\_\_\_\_\_  
**LINDA STREISSGUTH, Commissioner**

ATTEST:

\_\_\_\_\_  
Dana Daniels, Clerk of the Board

**Kitsap County Department of Emergency Management**

\_\_\_\_\_  
**Mike Gordon, Director**

**Participating facility:**

Name of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_ Message Telephone: \_\_\_\_\_

Point of Contact: \_\_\_\_\_

Email: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Authorization Signature for participating facility:**

\_\_\_\_\_  
Name Title

Date signed: \_\_\_\_\_