(Name of Organization)

Model Hospital Mutual Aid Memorandum of Understanding[1]

(month, day, year)

I. Introduction and Background

As in other parts of the nation, (name of city, county, and or state served by MOU) is susceptible to disasters, both natural and man-made, that could exceed the resources of any individual hospital. A disaster could result from incidents generating an overwhelming number of patients, from a smaller number of patients whose specialized medical requirements exceed the resources of the impacted facility (e.g., hazmat injuries, pulmonary, trauma surgery, etc.), or from incidents such as building or plant problems resulting in the need for partial or complete hospital evacuation.

II. Purpose of Mutual Aid Memorandum of Understanding

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

This Mutual Aid Memorandum of Understanding (MOU) is a voluntary agreement among the hospital members, (name of hospital association or council) or (list hospitals party to MOU), for the purpose of providing mutual aid at the time of a medical disaster. For purposes of this MOU, a **disaster** is defined as an overwhelming incident that **exceeds the effective response capability** of the impacted health care facility or facilities. An incident of this magnitude will almost always involve (name of local) emergency management agency and (name of local) public health department. The disaster may be an “external” or “internal” event for hospitals and **assumes that each affected hospital’s emergency management plans have been fully implemented.**

This document addresses the relationships between and among hospitals and is intended to augment, not replace, each facility's disaster plan. The MOU also provides the framework for hospitals to coordinate as a single H-MAS community in actions with (name of local) management agency, (name of local) public health department, and emergency medical services during planning and response. This document does not replace but rather supplements the rules and procedures governing interaction with other organizations during a disaster (e.g., law enforcement agencies, the local emergency medical services, local public health department, fire departments, American Red Cross, etc).

By signing this Memorandum of Understanding each hospital is evidencing its intent to abide by the terms of the MOU in the event of a medical disaster as described above. The terms of this MOU are to be incorporated into the hospital's emergency management plans.

III. Definition of Terms

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[1] *The American Hospital Association is grateful to the District of Columbia Hospital Association, who developed the original MOU from which this model is adapted.*

Command Post	An area established in a hospital during an emergency that is the facility's primary source of administrative authority and decision-making.
Clearinghouse	A communication and information center that has H-MARS network capabilities allowing for the immediate determination of available hospital resources at the time of a disaster. The clearinghouse must be operational 24 hours a day and requires daily maintenance. The clearinghouse does not have any decision-making or supervisory authority but merely collects and disseminates information, and performs regular radio checks of the H-MARS system.
Donor Hospital	The hospital that provides personnel, pharmaceuticals, supplies, or equipment to a facility experiencing a medical disaster. Also referred to as the patient-receiving hospital when involving evacuating patients.
H-MAS	Hospital Mutual Aid System
H-MARS	Hospital Mutual Aid Radio System – The primary communication system used by hospitals to communicate during an emergency.
Impacted Hospital	The hospital where the disaster occurred or disaster victims are being treated. Referred to as the recipient hospital when pharmaceuticals, supplies, or equipment are requested, or as the patient-transferring hospital when the evacuation of patients is required.
Medical Disaster	An incident that exceeds a facility's effective response capability or cannot appropriately resolve solely by using its own resources. Such disasters will very likely involve the (name of local) emergency management agency and (name of local) public health department and may involve loan of medical and support personnel, pharmaceuticals, supplies, and equipment from another facility, or, the emergent evacuation of patients.
Partner ("Buddy")	The designated facility that a hospital communicates with as a facility's "first call for help" during a medical disaster (developed through an optional partnering arrangement).
Patient-Receiving Hospital	The hospital that receives transferred patients from a facility responding to a disaster. When patients are evacuated, the receiving facility is referred to as the patient-receiving hospital. When personnel or materials are involved, the providing hospital is referred to as the donor hospital.

Patient-Transferring Hospital	An impacted facility. The hospital that evacuates patients to patient-receiving facility in response to a medical disaster. Also referred to as the recipient hospital when personnel and materials are moved to the facility.
Participating Hospitals	Health care facilities that have fully committed to H-MAS.
Recipient Hospital	The impacted facility. The hospital where disaster patients are being treated and has requested personnel or materials from another facility. Also referred to as the patient-transferring hospital when evacuating/transferring patients from the facility during a medical disaster.

IV. General Principles of Understanding

1. Participating Hospitals: Each hospital designates a representative to attend the (name of organization) Hospital Mutual Aid System meetings and to coordinate the mutual aid initiatives with the individual hospital's emergency management plans. Hospitals also commit to participating in H-MAS exercises and maintaining their radio links to H-MARS.

2. Partner Hospital Concept: Each hospital has the option of linking to a designated partner or "buddy" hospital as the hospital of 'first call for help' during a disaster. The hospitals comprising each partner-network should develop, prior to any medical disaster, methods for coordinating communication between themselves, responding to the media, and identifying the locations to enter their buddy hospital's security perimeter.

3. Implementation of Mutual Aid Memorandum of Understanding: A health care facility becomes a participating hospital when an authorized administrator signs the MOU. During a medical emergency, only the authorized administrator (or designee) or command center at each hospital has the authority to request or offer assistance through H-MAS. Communications between hospitals for formally requesting and volunteering assistance should therefore occur among the senior administrators (or designees) or respective command centers.

4. Command Center: The impacted facility's command center is responsible for informing the clearinghouse of its situation and defining needs that cannot be accommodated by the hospital itself or any existing partner hospital. The senior administrator or designee is responsible for requesting personnel, pharmaceuticals, supplies, equipment, or authorizing the evacuation of patients. The senior administrator or designee will coordinate both internally, and with the donor/patient-accepting hospital, all of the logistics involved in implementing assistance under this Mutual Aid MOU. Logistics include identifying the number and specific location where personnel, pharmaceuticals, supplies, equipment, or patients should be sent, how to enter the security perimeter, estimated time interval to arrival and estimated return date of borrowed supplies, etc.

5. Clearinghouse: Each hospital will participate in an annual H-MAS exercise that includes communicating to the clearinghouse a set of data elements or indicators describing the hospital's resource capacity (see appendices). The Clearinghouse will serve as an information center for recording and disseminating the type and amount of available

resources at each hospital. During a disaster drill or emergency, each hospital will report to the Clearinghouse the current status of their indicators. (For a more detailed account of the Clearinghouse's responsibilities, see "Clearinghouse Requirements.") Hospitals also participate in daily radio checks performed by the Clearinghouse.

6. Hospital Indicators: A set of hospital resource measures that are reported to the Communication Center during a disaster drill or actual disaster. The indicators are designed to catalogue hospital resources that could be available for other hospitals during a disaster.

7. Documentation: During a disaster, the recipient hospital will accept and honor the donor hospital's standard requisition forms. Documentation should detail the items involved in the transaction, condition of the material prior to the loan (if applicable), and the party responsible for the material.

8. Authorization: The recipient facility will have supervisory direction over the donor facility's staff, borrowed equipment, etc., once they are received by the recipient hospital.

9. Financial & Legal Liability: The recipient hospital will assume legal responsibility for the personnel and equipment from the donor hospital during the time the personnel, equipment and supplies are at the recipient hospital. The recipient hospital will reimburse the donor hospital, to the extent permitted by federal law, for all of the donor hospital's costs determined by the donor hospital's regular rate. 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 hospital has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury. Reimbursement will be made within 90 days following receipt of the invoice.

10. Patient-accepting hospitals assume the legal and financial responsibility for transferred patients upon arrival into the patient-accepting hospital.

11. Communications: Hospitals will collaborate on the H-MARS radio communication system to ensure a dedicated and reliable method to communicate with the Clearinghouse and other hospitals. The back-up conference call landline telephone system may be used as a semi-secure system for discussing sensitive information.

12. Public Relations: Each hospital is responsible for developing and coordinating with other hospitals and relevant organizations the media response to the disaster. Hospitals are encouraged to develop and coordinate the outline of their response prior to any disaster. The partner hospitals should be familiar with each other's mechanisms for addressing the media. The response should include reference to the fact that the situation is being addressed in a manner agreed upon by a previously established mutual aid protocol.

13. Emergency Management Committee Chairperson: Each hospital's Emergency Management Committee Chairperson is responsible for disseminating the information regarding this MOU to relevant hospital personnel, coordinating and evaluating the hospital's participation in exercises of the mutual aid system, and incorporating the MOU

concepts into the hospital's emergency management plan.

14. Hold Harmless Condition: The recipient hospital should hold harmless the donor hospital for acts of negligence or omissions on the part of the donor hospital in their good faith response for assistance during a disaster. The donor hospital, however, is responsible for appropriate credentialing of personnel and for the safety and integrity of the equipment and supplies provided for use at the recipient hospital.

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

1. Partner hospital concept: Each hospital has the option of designating a partner or *buddy* hospital that serves as the hospital of "first call for help" (see lists under Clearinghouse Function). During a disaster, the requesting hospital may first call its pre-arranged partner hospital for personnel or material assistance or to request the evacuation of patients to the partner hospital. The donor hospital will inform the requesting hospital of the degree and time frame in which it can meet the request.

2. Clearinghouse: The recipient hospital (patient-transferring hospital) is responsible for notifying and informing the Clearinghouse of its personnel or material needs or its need to evacuate patients and the degree to which its partner hospital is unable to meet these needs. Upon the request by the senior administrator or designee of the impacted hospital, the Clearinghouse will contact the other participating hospitals to determine the availability of additional personnel or material resources, including the availability of beds, as required by the situation. The recipient hospital will be informed as to which hospitals should be contacted directly for assistance that has been offered. The senior administrator (or designee) of the recipient or patient-transferring hospital will coordinate directly with the senior administrator (or designee) of the donor or patient-accepting hospital for this assistance.

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

   Personnel offered by donor hospitals should be limited to staff that are **fully 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 medical director of the patient-transferring hospital will also notify the (name of local) fire department of its situation and seek assistance, if necessary, from the emergency medical services. (Name of local) fire department will be requested to notify the (name of local) emergency management agency and the (name of local) public health 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 recipient hospital. The recipient hospital will identify to the donor hospital the following:

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

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

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

   The recipient hospital will accept the professional credentialing determination of the donor hospital but only for those services for which the personnel are credentialed at the donor hospital.

3. Supervision: The recipient hospital's senior administrator or designee, (the command center) identifies where and to whom the donated personnel are to report, and professional staff of the recipient hospital supervise the donated personnel. The supervisor or designee will meet the donated personnel at the point of entry of the facility and brief the donated personnel of the situation and their assignments. If appropriate, the "emergency staffing" rules of the recipient hospital will govern assigned shifts. The donated personnel's shift, however, should not be longer than the customary length practiced at the donor hospital.

4. Legal and financial liability: Liability claims, malpractice claims, disability claims, attorneys' fees, and other incurred costs are the responsibility of the recipient hospital. An extension of liability coverage will be provided by the recipient facility, to the extent permitted by federal law, insofar as the donated personnel are operating within their scope of practice. The recipient hospital will reimburse the donor hospital for the salaries of the donated personnel at the donated personnel's rate as established at the donor hospital if the personnel are employees being paid by the donor hospital. The reimbursement will be made within ninety days following receipt of the invoice.

   The Medical Director of the recipient hospital will be responsible for providing a mechanism for granting emergency credentialing privileges' for physician, nurses and other licensed health care providers to provide services at the recipient hospital

5. Demobilization procedures: The recipient hospital will provide and coordinate any necessary demobilization procedures and post-event stress debriefing. The recipient hospital is responsible for providing the donated personnel transportation

necessary for their return to the donor hospital.

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 recipient hospital. The recipient hospital will identify to the donor hospital 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 will be needed.
   d. Location to which the supplies should be delivered.

   The donor hospital will identify how long it will take them to fulfill the request. Since response time is a central component during a disaster response, decision and implementation should occur quickly.

2. Documentation: The recipient hospital will honor the donor hospital's standard order requisition form as documentation of the request and receipt of the materials. The recipient hospital's security office or designee will confirm the receipt of the material resources. The documentation will 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 hospital is responsible for tracking the borrowed inventory through their standard requisition forms. Upon the return of the equipment, etc, the original invoice will be co-signed by the senior administrator or designee of the recipient hospital recording the condition of the borrowed equipment.

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

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

5. Financial and legal liability: The recipient hospital, to the extent permitted by federal law, is responsible for all costs arising from the use, damage, or loss of borrowed pharmaceuticals, supplies, or equipment, and for liability claims arising from the use of borrowed supplies and equipment, except where the donor hospital has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury.

6. Demobilization procedures: The recipient hospital is responsible for the

rehabilitation and prompt return of the borrowed equipment to the donor hospital.

C. Transfer/Evacuation of Patients

1. Communication of request: The request for the transfer of patients initially can be made verbally. The request, however, must be followed up with a written communication prior to the actual transferring of any patients. The patient-transferring hospital will identify to the patient-accepting hospital:

   a. The number of patients needed to be transferred.
   b. The general nature of their illness or condition.
   c. Any type of specialized services required, e.g., ICU bed, burn bed, trauma care, etc.

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

3. Transporting of patients: The patient-transferring hospital is responsible for coordinating and financing the transportation of patients to the patient-receiving hospital. The point of entry will be designated by the patient-receiving hospital's senior administrator or designee. Once admitted, that patient becomes the patient-receiving hospital's patient and under care of the patient-receiving hospital's admitting physician until discharged, transferred or reassigned. The patient-transferring hospital is responsible for transferring of extraordinary drugs or other special patient needs (e.g., equipment, blood products) along with the patient if requested by the patient-receiving hospital.

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

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

6. Notification: The patient-transferring hospital is responsible for notifying both the patient's family or guardian and the patient's attending or personal physician of the situation. The patient-receiving hospital may assist in notifying the patient's family and personal physician.

D. Clearinghouse Function

The H-MARS provides the means for the hospitals to coordinate among themselves, and as a unit to integrate with (name of local) emergency management agency, (name of local) public health department, police, and emergency medical services during a disaster event.

The Clearinghouse serves as the data center for collecting and disseminating current information about equipment, bed capacity and other hospital resources during a disaster (see appendices). The information collected by the Communication Center is to be used only for disaster preparedness and response.

In the event of a disaster or during a disaster drill, hospitals will be prepared to provide the communication center 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
   - burn
   - psychiatric
   - subacute care
   - skilled care beds
   - operating suites

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

   - respirators
   - IV infusion pumps
   - dialysis machines
   - hazmat decontamination equipment
   - MRI
   - CT scanner
   - hyperbaric chamber
   - ventilators
   - external pacemakers
   - atropine
   - kefzol

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

   <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

E. Partner Hospital Concept (Optional)

Each "paired" hospital should standardize a set of contacts to facilitate communications during a disaster.

The procedural steps in the event of a disaster are as follows:

1. Determine the total number of patients the emergency department and hospital can accept, and if possible, the total number of patients with major and minor injuries.
2. Impacted hospital contacts partner hospital to determine availability of beds, equipment, supplies, and personnel. (Contacts secondary partner hospital if primary hospital is unable to meet needs.)
3. Impacted hospital contacts the clearinghouse and notifies the center of its needs, how they are being met, and any unmet needs.
4. At the request of the impacted hospital, the clearinghouse will contact other hospitals to alert them to the situation and to begin an inventory for any possible or actual unmet needs.

Appendix 1: PRIMARY DATA COLLECTION FORM

In the event of an emergency, record the time of communication, the total number of injury victims the receiving hospital can accept, and, if possible, the number of major* and minor** injury victims the hospital can accept.

Date: _____

Page #: _____

Hospitals (list abbreviated name of each member hospital)	**Time**	**Total Number of Patients**	**Minor Injuries**	**Major Injuries**	**Comments**

* Major injury victims: Those expected to require admission and/or significant medical/ hospital resources (operating room, critical care, extensive orthopedics intervention, etc.)

** Minor injury victims: Those expected to be treated and released or require very little medical/ hospital resources.

Appendix 2a: SECONDARY DATA COLLECTION FORM*

If time or need permits, request the following information from the donating hospital.

Hospital Name:
_____

Person completing form:
_____

Date: _____ Time: _____

Number of Open/Available Beds		Total Available to Donate	
General medical (adult)		Respirators	
General surgical (adult)		IV Infusion Pumps	
General medical (pediatric)		Dialysis Machines	
General surgical (pediatric)		Hazmat De-contamination Equipment	
Obstetrics		MRIs	
Cardiac ICU		CT Scanners	
NICU		Hyperbaric Chamber	
PICU		Ventilators	
Burn		external pacemakers	
Psychiatric		atropine	
Trauma		kefzol	
OR Suites			
Skilled Nursing & Subacute Care			

* During an actual disaster or disaster drill, hospitals should complete the above form with the most current information available and have this information ready for dissemination to (name of local) emergency management agency, fire department, requesting hospitals, and the H-MARS clearinghouse.

Appendix 2b: SECONDARY DATA COLLECTION FORM*

Hospital Name: -

_____

Person completing form:

_____

Date: _____ Time: _____

Physician	Number of Personnel Currently Available to Loan/Donate to Partner Hospital*
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	
Other as indicated	

* During an actual disaster or disaster drill, hospitals should complete the above form with the most current information available and have this information ready for dissemination to (name of local) emergency management agency, fire department, requesting hospitals, and the H-

MARS clearinghouse.