

Appendix C: MOU for Hospitals in the District of Columbia

District of Columbia Emergency Healthcare Coalition

Mutual Aid & Cooperative Assistance Memorandum of Understanding

April 7, 2010

I. Introduction and Background

As the capital of the United States and a leading world center, the District of Columbia (the "District" or "DC") is susceptible to both natural and man-made emergencies and disasters that could exceed the resources of any individual District healthcare organization. A health-related emergency/disaster could result in incidents generating an overwhelming number of patients or a smaller number of patients whose specialized medical requirements exceed the resources of the impacted facility (e.g., hazmat injuries, pulmonary, trauma surgery, etc.). Most importantly, an incident could affect a healthcare organization's continuity of operations through impacts to building or plant functions and could potentially result in the need for partial or complete healthcare facility evacuation. It is important to realize that healthcare organizations other than hospitals can be similarly impacted.

Healthcare organizations in the District of Columbia have entered in to an operational relationship to support and enhance each other's emergency management programs across mitigation, preparedness, response and recovery. This relationship, the District of Columbia Emergency Healthcare Coalition (DCEHC), is memorialized in the document "DC Emergency Healthcare Coalition Strategic Administrative Guidance," dated March 3, 2008. These healthcare organizations are also signatories to the DC EHC Emergency Operations Plan (EOP), which describes the DC EHC emergency response coalition and provides guidance for emergency response and recovery.

This Mutual Aid & Cooperative Assistance Memorandum of Understanding (the "MOU") describes the relationship and the associated procedures which participating healthcare organizations can utilize to share resources in supporting each other during response to potential or real emergencies or disasters.

II. Purpose of Mutual Aid and Cooperative Assistance Memorandum of Understanding

The mutual aid support concept is well established and is considered "standard of care" in most emergency response disciplines. Historically, mutual aid was rendered without expectation of cost reimbursement or other financial consideration. Cooperative assistance is a variation on mutual aid, where one organization provides resources to a similar organization during emergencies or disasters and costs are reimbursed to the assisting organization (i.e., compensated mutual aid). DC had one of the first mutual aid instruments in the nation to include all hospitals in an urban jurisdiction. This agreement was originally developed and implemented in 1996. Due to the changing nature of how healthcare emergency response is conducted in the District and in order to provide a more inclusive process that covers both hospitals and non-hospital providers, this MOU has been designed to supersede and replace the original DC Hospital Association mutual aid memorandum of understanding.

The purpose of this MOU is to describe the basis upon which the DC EHC member organizations agree to provide mutual aid and cooperative assistance to each other under

emergency conditions. Resource support is accomplished through the sharing of personnel (healthcare services, engineering, support, administrative and other professionals), equipment (e.g., ventilators), supplies (e.g., pharmaceuticals, bottled water) and facilities (e.g., staffed beds for accepting transferred patients).

III. Definitions

As used in this MOU, the key terms shall be defined as follows:

- “Assisting organization” means a DC EHC member organization that has offered or is rendering assistance to another (i.e., “supported”) organization in response to the supported organization’s request.
- “Mutual Aid” means the sharing of resources between DC EHC Coalition member organizations during healthcare emergencies and disasters pursuant to the terms in this MOU.
- “Cooperative assistance” means compensated mutual aid.
- “Coalition member organizations” means a healthcare organization that participates in the District of Columbia Emergency Healthcare Coalition (DC EHC)
- “Coalition Notification Center (CNC)” means a fixed facility for DC EHC that serves as a single point of contact at the beginning of an incident to receive information about an impending or actual incident, and continues to receive and convey information as an incident evolves.
- “District of Columbia Emergency Healthcare Coalition (DC EHC)” means the group of organizations that has established the preparedness and response platforms for participating entities (i.e., Coalition member organizations) and is responsible for the development and implementation of this MOU.
- “Healthcare Coalition Response Team (HCRT)” means the response team staffed by the DC EHC that serves its member organizations by facilitating situational awareness, providing notifications, coordinating strategies, facilitating mutual aid, and enhancing integration with jurisdictional response organizations.
- “Healthcare disaster” means any incident that exceeds (i.e., overwhelms) a healthcare organization’s resources in meeting critical needs.
- “Healthcare emergency” means any incident that severely challenges a healthcare organization’s resources in meeting critical needs.
- “Healthcare Information System (HIS)” means an on-line software program that permits DC EHC to share files amongst member organizations and to send out] notifications to personal devices of designated persons within member organizations.
- “Hospital Mutual Aid Radio System (HMARS)” means the primary radio communication system used by the DC EHC member organizations to

communicate urgent information verbally during emergencies and disasters.

- “Supported organization” means a DC EHC member organization that is receiving assistance from another DC EHC member organization or from outside sources through the DC EHC.
- “Worker’s compensation” means the government administered system for providing benefits to individuals injured or killed in the course of employment, regardless of fault.

IV. General Principles of Understanding

- a. Legal construct of the MOU: This MOU reflects the voluntary relationship between the Coalition member organizations for the provision of mutual aid and cooperative assistance at the time of a healthcare emergency or disaster, or in anticipation of an imminent, severe emergency. The instrument expresses the intentions of Coalition member organizations to assist each other in good faith when possible, but is not a legal contract and shall not be construed as binding Coalition members to each other or to any other party.
- b. Healthcare emergency or disaster situation: For the purposes of this MOU, a healthcare emergency or disaster may be an “external” or “internal” incident for Coalition member organizations, and may be severe enough for at least one Coalition member organization to have activated its Emergency Operations Plan. An incident of this magnitude will frequently involve the District of Columbia Homeland Security and Emergency Management Agency (DC HSEMA), the District of Columbia Department of Health (DC DOH), and the District of Columbia Fire and Emergency Medical Services (FEMS) Department. The emergency/disaster This MOU does not govern the exchange of resources among the parties in non-emergency situations, but is used to guide resource allocation during Coalition planning and exercises.
- c. Coverage under the MOU: A healthcare organization becomes covered under this MOU when it becomes a participating Coalition member organization and an authorized executive from the organization signs this MOU. For Coalition members who are signatories to the original DCHA Mutual Aid Memorandum of Understanding, this document supersedes the DCHA Mutual Aid Memorandum of Understanding in guiding resource sharing between DC EHC member organizations.
- d. Limitations regarding outside authority: This instrument does not supplant, but rather supplements, the laws, regulations, rules and procedures governing interaction of Coalition member organizations with other organizations during an emergency or disaster (e.g., law enforcement agencies, District of Columbia (DC) HSEMA, DC DOH, DC FEMS, and independent vendors, suppliers, or other entities).
- e. Expectations regarding Coalition member organizations: This MOU augments, but does not replace, each organization's Emergency Operations Plan (EOP) and its resource acquisition and management processes. Issuing a request for mutual aid or cooperative assistance under this MOU assumes that the affected organization that is requesting assistance has already activated its EOP, has implemented efforts to obtain the requested resource through independent means, and has projected or determined

that additional resources are necessary to maintain healthcare services and/or meet unusual patient needs.

- f. Sovereignty and independence of Coalition member organizations: This MOU recognizes that each organization must act in its own interests and under its own unique operational or regulatory restrictions. Each Coalition member organization will therefore participate in resource sharing hereunder voluntarily. If it is unable, or elects not, to render mutual aid, this MOU does not compel a facility to do so. If an organization determines that it is able to share resources, the supported organization agrees to compensate the costs of resource sharing as defined in this MOU.
- g. Good faith basis: By entering into this MOU, each Coalition member organization is evidencing its good faith intent to abide by the terms of the MOU to the best of its ability during healthcare emergencies or disasters as described above. The terms of this MOU should be incorporated into the appropriate functional elements of the Coalition member organizations' individual Emergency Operations Plans.

V. Specific Principles of Understanding

- a. Activation of the MOU: The MOU is activated when a Coalition member organization submits a request through the DC EHC Coalition Notification Center (CNC), to an activated position on the DC EHC Healthcare Coalition Response Team (HCRT), or directly to another DC EHC Coalition member organization. Requests should be documented utilizing forms provided in the DC EHC Emergency Operations Plan, Resource Functional Annex. Extremely urgent requests may be submitted verbally but should be confirmed using the form documentation as soon as feasible.
- b. Authorizing Mutual Aid or Cooperative Assistance: During an impending or actual emergency or disaster, only the authorized administrator (or designee) at each Coalition member organization has the authority to request or offer assistance through this MOU. Communications to finalize mutual aid or cooperative assistance between organizations should therefore occur among the senior administrators or their designees, which during emergencies are the parties' respective operations center or command post. Upon request by either party, the HCRT may facilitate these communications.
- c. Situation awareness for the DC EHC: The impacted facility's incident management team is responsible for informing the Coalition (through the Duty Officer, HCRT, or CNC) of its emergency situation and defining needs that cannot be accommodated through its own internal processes. Though in emergent situations, requests may be broadly described, they should provide appropriate specificity regarding the requested resource description, quantity, and timeframe as soon as feasible.
- d. Resource description: There is currently no national or local resource description standard (i.e., National Incident Management System or NIMS resource typing) for health and medical resources. All requests and offers should therefore be communicated in plain English with the appropriate level of detail necessary to fully describe the intended use of the requested or offered resource(s). These include:
 - i. The kind, type, and number of resources needed
 - ii. An estimate of how quickly and for how long the resources may be needed

- iii. The reporting location for resources arriving at the supported organization's facilities.

- e. Prompt consideration of resource requests: Participating member organizations agree that a decision as to whether their organization can offer resources to support the request will be made and reported in the time frame specified in the resource request. An offer of assistance in response to a member request should be documented as soon as feasible, using appropriate forms from the DC EHC EOP Resource Functional Annex.

- f. Confirmation of the sharing arrangement between parties: Mutual aid and/or cooperative assistance will be provided promptly upon notice of resource availability and acceptance of the offered assistance by the supported (requesting) organization. Confirmation of the sharing arrangement between the parties regarding the offered and accepted resources should be accomplished using appropriate forms from the DC EHC EOP Resource Functional Annex. Confirmation of the sharing arrangement constitutes full acknowledgement of the mutual aid and cooperative agreement terms set forth in this MOU. If the request is for immediate and critical assistance, the assisting and supported Coalition member organizations may act based upon an oral understanding, with form documentation following as rapidly as is feasible.

- g. Communications: Coalition member organizations participating in this mutual aid and cooperative assistance process will use the DC EHC communication systems (H-MARS, teleconference, and HIS) and information processing methods for communicating needs, for responding to requests and for tracking of resources as requested by the supported organization(s) and/or by assisting organization(s). These technologies and associated procedures are described in the DC EHC EOP and associated communications support annex.

- h. Supervisory authority: The supported organization will have direct operational supervision authority over the assisting organization's personnel, loaned equipment, and supplies once received. For loaned personnel, the assisting organization remains administratively responsible for its personnel (direct pay, personal and professional benefits) with the supported organization reimbursing the assisting organization for its costs as stipulated in paragraph u. below.

- i. Personnel resources offered in response to resource requests:
 - i. The supported organization shall determine the authority, scope of practice, and level of supervision for personnel loaned by assisting organizations pursuant to the terms of this MOU. This information will be conveyed to personnel arriving at the supported organization, ideally through an orientation briefing.
 - ii. Personnel offered by assisting organizations should be limited to staff that are fully accredited or credentialed in their home institution. No resident physicians, medical/nursing students, or other in-training persons should be volunteered unless this is specifically acceptable to the requesting facility.
 - iii. Upon arrival, accepted personnel shall work directly for an assigned supervisor at the supported facility, but the assisting organization remains administratively responsible for their pay and for their personal and professional benefits.
 - iv. The Medical Director (or in the case of non-hospitals, the equivalent position) and Human Resources Department of the supported organization are responsible for providing a mechanism to grant emergency credentialing privileges for physicians,

nurses and other independent (licensed) healthcare providers to provide services at the supported (recipient) healthcare organization.

- j. Facilities: Facilities offered by supporting organizations can be utilized for a range of purposes. Facilities accepting patient transfers from the supported organizations are addressed separately in section k. below.
 - i. Supported organizations must convey to the assisting organization the intended use and expected duration of occupation (i.e., use) of the loaned facility.
 - ii. For situations in which the loaned facility will be utilized for clinical care by the supported organization and its personnel, the supported organization is responsible for all costs, administrative and otherwise, related to the use and post-use rehabilitation of the facility.
 - iii. The supported organization will be responsible for return of the facility in its original condition (structural and non-structural) or for reimbursing the cost of restoring the facility to its original condition by the assisting organization, including administrative costs for supervising the restoration.

- k. Patient beds (for emergency patient transfer from the supported organization): In situations involving an emergency evacuation of a Coalition member organization's residential healthcare facility, such organization is responsible for the decision to evacuate and determines, possibly with the assistance of DC FEMS and DC DoH, the healthcare destination of each evacuated patient and staff member. The patient remains the responsibility of the evacuating (supported) facility and the patient transport authority until reaching the premises of the accepting (assisting) healthcare organization.
 - i. The assisting healthcare organization that accepts patients assumes the healthcare responsibility for those transferred patients upon arrival and reception at the assisting facility. An appropriately credentialed healthcare provider will be assigned as the responsible provider of record. The patient's original provider may be granted emergency or courtesy privileges (and would potentially remain the provider of record) according to the assisting facility's credentialing and privileging policies.
 - ii. Transferred staff may be granted temporary privileges at the assisting facility and come under the supervisory operational authority of the assisting facility where they are working. Transferred staff members remain administratively under the responsibility of the supported facility for the purposes of pay and personal and professional benefits.
 - iii. The supported organization has ultimate responsibility for reimbursing the cost of care provided by the assisting organizations to its transferred patients. They should, therefore, contact third party payers once capable of doing so to address continued payment for covered services for transferred patients.

- l. Equipment & supplies: Requested equipment and supplies may include durable and non-durable goods (e.g. pharmaceuticals). The responsibility for transportation of these resources resides primarily with the supported organization. The HCRT can facilitate communications with the jurisdiction for alternative transportation methods. Assisting organizations should be provided with a delivery point/staging location at the supported organization.
 - i. Durable goods: Durable goods will typically be loaned to the supported organization. If the assisting organization charges a fee for the use of such

item(s), this rate should be determined and documented at the time the offer is accepted or as soon as feasible thereafter when time is of the essence. The DC EHC EOP forms can be used for this purpose. Upon return of resources, the supported organization is responsible for any associated rehabilitation costs for the durable item(s).

- ii. **Non-durable goods:** Non-durable items can be returned or retained by the supported organization. The supported organization is responsible for costs to replace retained items or rehabilitate returned resources.
- m. **Resource recall:** The assisting organization may recall its personnel or other resources from a supported organization through a formal request for recall consistent with Section (V.a.) above. Recall requests may be submitted by the assisting organization at any time in its discretion, but will be made in good faith based upon the immediate or projected needs of the assisting organization. Supported organizations shall honor the assisting organization's request for recall at the earliest opportunity while protecting against significant adverse effects on existing patients that are supported by the recalled resources.
- n. **Documentation:** During a healthcare emergency or disaster when time is of the essence, the supported organization may submit initial resource requests orally (e.g. through the HCRT or directly to other Coalition member organizations). As soon as feasible, these requests should be documented and conveyed in the appropriate fashion (typically also through the HCRT). Resources may not be committed by assisting organizations until written documentation is obtained. All documents are provided in the DC EHC EOP (Resource Functional Annex).
- o. **Mutual aid and cooperative assistance procedures:** The specific procedures not addressed in this document for requesting, providing resource support, resource tracking, and other issues are described in the DC EHC Emergency Operations Plan and its annexes, appendices and attachments.
- p. **Transportation of resources:** The supported organization is responsible for arranging transportation of loaned resources to and from their facility. They are also responsible for transportation arrangements for patients to other facilities. This may be facilitated by the HCRT, at the request of any involved member organization, and supported by the jurisdiction.
- q. **Media interaction:** Each healthcare organization agrees to discuss only its specific situation regarding mutual aid and cooperative assistance under this MOU. Assisting organizations will avoid discussing the situation at the supported organization unless specifically released to do so by the supported organization. All parties are encouraged to follow the media procedures in the DC EHC EOP (Public Information Functional Annex).
- r. **Demobilization procedures:** The supported healthcare organization will provide and coordinate any necessary demobilization procedures for loaned resources. The supported organization is also responsible for providing the loaned personnel, equipment and other resources with the transportation necessary for return to their home facility.
- s. **Exercise:** Each healthcare organization will participate in scheduled exercises that

include communicating to the Coalition Notification Center (CNC) a set of data elements or indicators describing the organization's resource capacity.

t. Legal Liability:

- i. Responsibility for expenses: The supported healthcare organization assumes responsibility for the legal liability of personnel, equipment, and supplies loaned by the assisting organization during the time the personnel, equipment and supplies are at the supported organization's facility or in transit thereto. Liability claims, malpractice claims, disability claims, attorneys' fees, and other costs incurred by assisting organizations related to the loan of resources are the responsibility of the supported healthcare organization. An extension of liability coverage will be provided by the assisting organization, to the extent permitted by federal and District of Columbia law, insofar as the loaned personnel are operating within their scope of practice.
- ii. Hold Harmless Clause: The supported healthcare organization(s) holds harmless the assisting organization for acts or omissions on the part of the assisting organizations in their good faith response to requests for assistance during an emergency or disaster. The supported organization is responsible for appropriate credentialing of personnel operating under its supervision, and for the safety and integrity of the equipment and supplies provided for use at the supported organization's facilities. The supported organization, however, is not responsible for acts of the assisting organization's personnel that are deemed to constitute gross negligence or are criminal in nature.

u. Personnel expenses

- i. Salary and pay: The supported organization will make a good faith effort to provide payment to reimburse the assisting organization for the salary or hourly pay of the loaned personnel. This will be determined at the loaned personnel's rate as established at the assisting organization, with salary pro-rated from the time of deployment to the time of physical return to the assisting organization. Payment to hourly wage employees will be determined by the hours worked at the supported organization, and the supported organization will reimburse the assisting organization for this cost. This section is in force only if the loaned personnel are employees being paid by the assisting organization or its subsidiaries.
 - ii. Other personnel expenses: Reimbursable personnel costs include expenses related to personnel injury or illness from the deployment that result in disability, loss of salary, and reasonable expenses charged to workers' compensation or other cost centers in the assisting organization.
 - iii. Payment for services of independent personnel resources: The supported organization will make a good faith effort to provide payment for services to contractors, independent healthcare providers and other personnel deployed through assisting organizations but not paid by them or their subsidiaries as salaried or hourly wage employees.
- v. Non-personnel resource expenses: Reimbursable resource costs include all use, breakage, damage, replacement, rehabilitation and return costs of borrowed equipment and supplies, and for reasonable costs of defending any liability claims, except where the assisting organization has not provided preventive maintenance or proper repair of loaned equipment which resulted in patient injury.

w. Repayment terms: All payments and reimbursements will be made by the supported

organization within ninety (90) days following receipt of the invoice from the assisting organization.

- x. Determination of costs: Parties to this MOU accept that responsibility for personnel costs begin at the time the resource support is dispatched to the supported organization. Personnel resource expenses include any costs associated with worker's compensation or liability expense (including legal representation in case of liability or malpractice actions) incurred by deployed personnel traveling to and from or working at the supported organization. All personnel, equipment, and supplies provided through cooperative assistance are reimbursed at the actual cost to the assisting organization, or if actual cost data is unavailable, at estimated actual cost. The determination of cost shall be made in good faith by the assisting organization, and the calculation of cost shall be made available to the supported organization upon request.

- y. Mediation and Dispute Resolution: This MOU is not intended to provide a framework for addressing post-emergency litigation claims. However, to the extent that litigation could result from the acts of the parties in carrying out the MOU (e.g., claims related to actual costs of reimbursement), the parties agree to submit any actionable claim to non-binding arbitration and dispute resolution (or an analogous mechanism) prior to the inception of litigation.

IN WITNESS WHEREOF, the parties, each by its respective duly authorized officer and representative, have executed and delivered this Memorandum of Understanding as of the date written below.

WASHINGTON HOSPITAL CENTER

By: _____

Name:

Its: President

HOSPITAL

By: _____

Name: _____

Its: _____