

PLANNING AND PREPARATION CONSIDERATIONS FOR ALTERNATE CARE SITE/FIELD HOSPITAL OPERATIONS

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1. LEVELS OF MEDICAL CARE

- » Determination of categories of patients in field hospitals
 - Low acuity patient care/medical clinic/urgent care
 - Specialty-based hospital care
 - Rehab/long-term recovery
- » Prepare to care for vulnerable populations - hospitalized children, special needs, patients requiring dialysis, and elderly patients
- » Use formal triage and treatment protocols and complete triage and treatment in those designated areas
- » Triage plan [immediate (red), delayed (yellow), minimal (green), expectant (black)]
- » Triage and evaluate patients efficiently
- » Evacuation (urgent, urgent-surgical, priority, routine)
- » Incorporate home care into pharmacy planning, especially if patient may be appropriately managed at home either because illness or injury is not severe enough to warrant hospital care, or because, given scarce resources, inpatient treatment may be considered futile or wasteful.

2. LEADERSHIP

- » Trained/knowledgeable in National Response Framework to learn about incident command and its tenets for supporting operational requirements
- » Be prepared to play a role in institution emergency operations center
- » Forge partnerships at all levels (federal, state, and local government response agencies, as well as between public and private entities), coordinating community and regional response planning for hospital/acute care such as local/tribal/state hospital preparedness coalition partners
- » Know capability and capacity of field hospital operations
- » Identify the must dos, should dos, nice to dos – identify the critical pharmacy workflow procedures and identified essential pharmacy staff needed to perform them – shed non-essential activities
- » Work with interagency partners to operationalize the processes
- » Build teams and identify key personnel
- » Maintain healthy relationships
- » Continually modify and refine plans
- » Chain of command/task organization
- » Stay focused and avoid mission creep
- » Show empathy for the workers, the scared, and the suffering
- » Warn of impending bad news as soon as you know about it
- » Rest and recuperation areas and decompression techniques for staff well-being and resilience (e.g., [ASHP Well-Being and You](#) resources , Headspace app, chaplain access, prayer/meditation space)

3. PLANNING AND FORECASTING

- » Develop a planning framework for allocating scarce resources to decompress hospital-wide saturation
- » Determine limits for medical surge capacity and capability
- » Considerations for cohorted patient care areas
- » Employ rapid patient discharge for those who can continue their care at home
- » Calculate demand of drugs and consumables
- » Consider proximity to bathrooms, nourishment, and medication storage cabinets
- » Plan for eight-week pandemic with subsequent eight-week pandemic waves
- » Develop exit strategy
- » Determine if expanding of critical care capacity beyond fixed facility hospital is part of planning calculations
- » Work with Board of Pharmacy to operate as a virtual unit of the hospital, license separately, or exception made for alternate site of care

4. ETHICAL CONSIDERATIONS

- » Apply systematic approach to sorting through ethical disagreements
- » Assignment of limited resources to those patients most expected to benefit
- » Crisis standards of care activation/altered standards of care (ethical considerations, balancing individual and communal interests, suspension of existing legal requirements, liability and other protections for healthcare workers [HCWs] and volunteers)

5. ASSESSING THE LEGAL ENVIRONMENT

- » Suspension of existing legal requirements
- » Professional licensure reciprocity (e.g., NABP Passport)
- » Interjurisdictional legal coordination
- » Making allocation decisions (legal triage)
- » Liability and other protections for HCWs and volunteers
- » Be prepared to explain legal conclusions through tailored communications to planners and affected individuals
- » Revisit regularly the utility of legal guidance related to allocation decisions
- » The Drug Enforcement Administration (DEA) is allowing [flexibilities for satellite hospitals or clinics](#) as a result of COVID-19, including:
 - Allowing a DEA-registered hospital or clinic to handle controlled substances at a satellite hospital or clinic location under their current registrations. (See qualifying requirements).
 - Providing flexibility to allow distributors to ship controlled substances directly to these satellite hospitals or clinics. ([See qualifying requirements](#)).

- » The DEA also recognizes there will be cases where hospital patients are cared for in a satellite hospital or clinic that is not a corporate affiliate of, or owned by, the entity that holds the DEA registration of the hospital or clinic. In those situations, DEA recommends entering into a written agreement to create an agency relationship with the satellite hospital or clinic.
- » Consider suspension of some medical protocols (e.g., expansion of scope of practice)
- » Requests for 1135 waivers from CMS

Public Health Emergency Legal Resources:

[Uniform Emergency Volunteer Health Practitioners Act](#)

[Emergency Legal Preparedness and Response \(Network for Public Health Law\)](#)

[Legal Preparedness for Public Health Emergencies](#)

[Public Health Emergency Law \(ASTHO\)](#)

[Administrative Preparedness Legal Guidebook \(NACCHO\)](#)

6. COMMUNICATION/COORDINATION

- » Communications (phone rosters, phone, secure texting, hand-held comms, on-call pagers, runners, regional contact list for community pharmacies, departments of health, healthcare organizations)
- » Daily and frequent huddles; change of shift reports (e.g., SBAR formats); conduct after-action reviews
- » Real-time communication plan for pharmacy, medical, nursing, and other clinical staff
- » Provide daily and frequent situation reports to leadership/emergency operations center (e.g., inventory status of essential medications, staffing, safety events)
- » Help coordinate destination choices to avoid hospital overloading and best use of other available resources
- » Coordination with local/state Hospital Preparedness Program contact (e.g., interface with Army Corps of Engineers, interjurisdictional legal coordination)
- » Institute daily meetings of a clinical care committee to examine in new guidance, the current local and regional situations, and to determine appropriate levels of care to be offered based on staffing and other resources.
- » Determine methods for patient/family information provision including alternate languages/interpretive services

7. OPERATIONS

- » Split-based vs. stand-alone with own command structure
- » Ensure that backup utility support is in place (equipment, recharging, communications, cold chain storage units, potable water)
- » Electrical power (generator power, watt/frequency considerations)
- » Cold chain management of temperature-sensitive medical products and relocation plan for power failure
- » Plumbing/waste streams (sinks, showers, toilets)
- » Spot dehumidifiers/coolers for temperature control
- » Create and simplify policies and procedures to conduct tactical medical pharmacy operations – prepare to operate in “downtime” procedure mode.
- » Establish administrative adaptations to reduce documentation, billing and coding, registration, and administrative policy burdens.
- » Only modest patient care documentation can be expected; EMR are not likely to be available or practicable. Rather, simple paper-based charting will be required.
- » Establish clinical adaptations such as triage of patients
- » Code response/defibrillator (crash carts, aid bags/kits)
- » Access to professional references (apps, hardcopy, hardwired internet)
- » Job action sheets for HCW volunteers and non-HCW volunteers
- » Paper backup copies (MAR, controlled substance inventories)
- » Paper documentation and charting (e.g., medication reconciliation)

8. LOGISTICS

- » Formulary
 - Ensure adequate stock of routine chronic care medications
 - Acute respiratory support medications (e.g., albuterol MDI conservation strategy)
 - Acute hemodynamic support medications
 - Pain control and anxiolysis medications
 - Antibiotics
 - Behavioral health medications
 - Palliative care medications
 - Oral/IV hydration and electrolyte replacement
 - Ensure adequate stock of basic first aid supplies, including bandages, antipyretics/analgesics (e.g., acetaminophen, ibuprofen)
- » Use of a pharmacy surge demand planning calculator (non-COVID vs. COVID critical drugs) consistent with planned mission

- » Coordinate supplier agreements or direct shipments to new alternate site of care
- » Recharging stations (phones, tablets, etc.)
- » Increase pharmacy supplies to 7-day supply if possible; order, inventory, and increase par levels of IV fluids, medications, and other consumables (e.g., syringes, needles, tubing).
- » Monitor HRSA guidance and updates for 340B program (if applicable)
- » Sterile compounding operations (premixes, immediate use/tabletop laminar air flow hood, increase 503B support, vial activation)
- » Arranging for supplies and equipment
- » Have a list of alternative vendors for essential medications, medical devices and contracted services and a strategy to address related shortages
- » Securing pharmaceuticals (environmental storage, stock rotation, legal control)
- » Strategic National Stockpile may be of assistance in supplying pharmaceuticals, but this is not guaranteed and should not be depended upon.
- » Clipboards, hardcopy forms (e.g., prescription pads), notepads, pencils, pens

9. STAFFING/MANPOWER

- » Allocation of scarce resources (make the best use of available trained personnel and volunteers)
 - » Increasing system capacity (state emergency systems for advanced registration of volunteer healthcare professionals, repurposed healthcare staff from other areas that have suspended operations, the Medical Reserve Corps (MRC), federal public health teams (e.g., NDMS, PHS, military healthcare professionals/members*, CERTs, retired healthcare professionals, patient family members, lay volunteers).
- * military task forces are intended to augment medical support in arenas and convention centers that have been retrofitted into hospitals*
- » Evaluate potential staffing and responsibility changes and how less-trained staff and families could contribute to operations
 - » Develop a process for rapid credentialing and training of non-facility supplemental healthcare staff
 - » Engage union/labor leaders in relevant discussions of staff responsibilities and hours during pandemics.
 - » Changing staff scheduling (e.g., duration of shifts, staffing ratios, staff assignments; modified/staggered shifts)
 - » Assign a shift lead pharmacist to each shift
 - » Conduct a daily assessment of staff status and needs
 - » Contingency plans for staff absences
 - » Plan for managing volunteers (e.g., lodging, nourishment, transportation) – coordinate with personnel/manpower pool section of emergency operations center
 - » Basic first aid skills; BLS/ACLS certification

10. SECURITY/SAFETY

- » Personal/life safety (e.g., fire suppression, shelter-in-place/evacuation plans)
- » Monitoring of hospital premises and surroundings by security personnel/law enforcement presence; develop robust security plans
- » Limit number of entrances
- » Lockable cabinets/secure location for controlled substances, sensitive items, personal belongings
- » Use of medication carts for storage/cart exchange
- » USP Chapter <797> and <800> compliance to the maximum extent possible with an emphasis on preserving PPE for direct patient care
- » Plan for a process to identify, track, and report pandemic-related adverse drug events

11. HEALTH INFORMATION TECHNOLOGY

- » Telehealth and remote order entry support
- » Hardwired internet/Wifi
- » EMR (+/-) → plan on hardcopy documentation (paper documentation, pens, pencils, clipboards)
- » ADC access and control processes
- » IT (laptops, access to EMR, tablets)

12. INFECTION PREVENTION AND CONTROL

- » Provide maximum personal protective equipment available to personnel
- » If necessary, enact extended use or limited reuse of PPE and consider use of supplies brought from home
- » Cleaning and disinfection wipes and isopropyl alcohol for surfaces, kits, carts, etc.
- » Ensure pharmacy staff have been medically cleared, fit-tested, and trained for N95 respirator use
- » Collaborate with infection prevention and control staff
- » Availability of restrooms, port-o-Johns, bedside commodes/bedpans for human waste (workers and patients)
- » Handwashing stations
- » Be prepared to take temperature of workers once a shift – if fever, cough, and/or shortness of breath present, sent worker to designated COVID-19 triage site

13. FINANCIAL AND ADMINISTRATIVE IMPLICATIONS

- » Tracking labor, procurement of supplies, expenses, accounting, and cost analysis
- » Refer to CARES Act provisions for labor reimbursement due to lost revenue from unengaged “stand-by workforce”
- » Drug waste tracked and reported to be considered for reimbursement by government

- » If applicable, bill via credit card to avoid handling checks or money

14. EDUCATION AND TRAINING

- » Conduct just-in-time and on-going education and training for staff and volunteers – streamlined on-boarding and site orientation
- » Make use of ASHP resources made widely available for no charge (critical care resources, webinars) for baseline competency of volunteer staff
- » Educate on infection prevention and control measures, social distancing practices, PPE, and treatment of COVID-19
- » Cross-training of existing staff from other practice settings where services have been curtailed
- » Care delivery by telehealth
- » ASHP COVID-19 Resource Center (e.g., Assessment of Evidence Table for COVID-19 Treatments) www.ashp.org/coronavirus

15. PERSONAL PREPAREDNESS

- » Personal preparations/family concerns (will/advanced medical directive/POAs/plans for final arrangements, life insurance, finances)
- » Food and potable drinking water (e.g., power bar type snacks, water bottles)
- » Toiletry items
- » Flashlight, batteries
- » Utility tools
- » Personal comfort items
- » Family and pet care plans
- » Physical, mental, and spiritual fitness

16. PUBLIC AFFAIRS

- » Focus messaging on managing expectations and providing updates on the community plan for pandemic response
- » Inform and educate public about infection prevention and control
- » Channel all public communications and media inquiries through the public information officer

REFERENCES

1. [Federal Healthcare Resilience Task Force Alternate Care Site \(ACS\) Toolkit: First Edition](#)
2. [Deploying Health Care Provider, Tactics, Techniques, and Procedures](#)
3. [Alternate Care Sites \(including shelter medical care\) - ASPR TRACIE](#)
4. [ASPR - COVID-19 Healthcare Planning Checklist](#)
5. [US Army Corps of Engineers \(Alternate Care Sites\)](#)
6. [Mass Medical Care with Scarce Resources: The Essentials](#)
7. [COVID-19 Pandemic Assessment Tool for Health-System Pharmacy Departments](#)
8. [Fair Allocation of Scarce Medical Resources in the Time of Covid-19](#)
9. [Allocation of Scarce Critical Care Resources during a Public Health Emergency](#)
10. [Army Field Hospitals and Expeditionary Hospitalization](#)
11. Dasher T. Pharmaceutical services in a United States Army field hospital. *Am J Hosp Pharm.* 1985; 42: 576-80.
12. Turner III GH, Lobner T, Patrick J. Pharmaceutical services required during setup of an Army combat support hospital. *Am J Hosp Pharm.* 1991; 48: 533-5.
13. Frank KJ. Pharmaceutical services in an Army field hospital in Haiti during Operation Uphold Democracy. *Am J Health-Syst Pharm.* 1996; 53:1691-3.
14. Chin TWF, Chant C, Tanzini R, et al. Severe Acute Respiratory Syndrome (SARS): The Pharmacist's Role. *Pharmacotherapy.* 2004; 24(6):705-712.

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