HOSPITAL MUTUAL AID MEMORANDUM OF UNDERSTANDING
CAPITAL DISTRICT REGION AND CENTRAL REGION OF NEW YORK
SUMMARY OF PROVISIONS

BACKGROUND

The MOU took effect in 2014 and has been executed by the 51 HPP grantee hospitals in the CDRO HEPC and CNYRO HEPC (see executed MOU and signatory tracker). It was developed through work groups led by Iroquois and included input from hospital executives, legal counsel, risk management, and emergency preparedness coordinators. Hospitals were reimbursed $10,000 through the grant for signing the MOU.

PURPOSE & SCOPE

The MOU is intended to support medical surge capacity through mutual aid consisting of:

- equipment, supplies and pharmaceuticals;
- evacuation and transfer of patients; and
- communication and information sharing.

Provision of mutual aid is voluntary (Art. III; Sec. 2). The MOU reflects cooperative understandings when mutual aid is provided, describing information to be communicated and responsibilities for transportation, documentation, costs, insurance and plan maintenance. It is not intended to serve as an emergency operations plan or direct response functions (Art. I; Sec. 2).

MUTUAL AID REQUESTS

Requests may be initiated when resources or capabilities may be exceeded (Art. IV, Sec. 1-2). Hospitals should exhaust internal resources and work through normal supply chains first (Art. IV, Sec. 3.1). Requests may be made directly or through county EM. Hospitals should notify county EM and NYSDOH RO when providing or requesting resources, transferring or receiving patients, or of changes in status or resources which may influence how other incidents or resources may be managed (Art. IV, Sec. 3.2).

Transfer of Patients

Information to be provided by the Transferring Hospital includes:

- the number of patients by acuity level, any special needs;
- equipment, medications and staff needed during transport or for continuity of care (Art. V, Sec. 1).

The Transferring Hospital is responsible for:

- the arrangement and cost of transporting patients;
- providing patient information, medical records and insurance information to the Receiving Hospital;
- tracking patients' destinations (Art. V, Sec. 1.2).

The transfer of responsibility for care occurs upon arrival at the Receiving Hospital. The Receiving Hospital will track incoming patients and their medical records, and promptly confirm the patient's arrival with the Transferring Hospital (Art. V, Sec. 2). Upon Receiving Hospital's request, patients may be returned post incident to the Transferring Hospital, with exceptions as outlined (Art. V, Sec. 3).

Resources

"*Resources*" are defined as equipment, supplies and pharmaceuticals and may mean staff and facilities necessary to assist with hospital evacuations and acceptance of transferred patients. This definition may be limited to equipment, supplies and pharmaceuticals when the context so requires (Art. II).

Requests may be made verbally, but must be followed by written communication to the Lending Hospital's CEO using standard requisition forms (Art. VI; Sec. 1.2). The Requesting Hospital will identify:

- the quantity and exact type of requested resources;
- an estimate how soon and how long the resources are needed; and
- the location to which the supplies should be delivered (Art. VI; Sec. 1.1).

The Lending Hospital is responsible for tracking resources through standard requisition forms. The Requesting Hospital will confirm receipt of the resources. Upon return, the Requesting Hospital's CEO or designee will co-sign the original forms and record the inventory's condition (Art. VI; Sec. 4.1 – 4.2).

The Requesting Hospital is responsible for:

- arrangement and cost of transporting resources (Art. VI; Sec. 2.1);
- examining resources, and assuring appropriate use, maintenance and safety (Art. VI; Sec. 3.1);
- returning or replacing resources, and paying costs incurred by the Lending Hospital in accordance with its standard billing procedures (Art. VI; Sec. 2.3, 3.4, 5.1).

Durable resources should be returned adequately rehabilitated or with reimbursement for rehabilitation. Unused non-durable resources will not be returned unless mutually agreed to (Art. VI; Sec. 5.2).

PLAN MAINTENANCE

The MOU does not have a termination date, remaining in effect through changes in personnel and administration (Art. I; Sec. 1.1). Modifications must be in writing and signed by all partners (Art. III; Sec. 2.5).

The MOU shall be reviewed annually at HEPC meetings to assess the need for changes or additional arrangements (Art. VIII; Sec. 1). The MOU was reviewed most recently in 2020 at the following HEPC meetings: CNYRO HEPC 9/30/21; CDRO HEPC 12/6/21.

An Advisory Group convened in December 2019 to determine the need for updating the MOU and/or facilitating similar agreements among hospitals and LTCFs. The following recommendations were made:

1. No changes to the MOU are necessary at this time;
2. A process to update signatories should be provided;
3. Mutual Aid MOUs among hospitals and LTCFs will further support medical surge and evacuation capabilities. It is recommended that an MOU template for hospitals and LTCFs be developed.

Hospitals will educate and train appropriate staff annually on how to request/receive mutual aid (see MOU Summary & Training presentation). Exercising will also be conducted annually (Art. VIII; Sec. 2). CST and other exercises conducted by HEPCs and hospitals have tested the ability to communicate mutual aid requests and transfer patients.

INSURANCE/INDEMNIFICATION

Insurance and indemnification provisions are outlined in Art. VII; Sec. 1 and 2.

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