

Arizona Crisis Standards of Care Plan

A Framework for the State Disaster Medical Advisory Committee (SDMAC)

Developing a Comprehensive and Compassionate Response



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Project Update

- Initial Planning Workshop – January 2013
- Mid Planning Workshop – June 2013
- CSC Workgroups – October 2013 – Jan. 2014
 - Clinical
 - Legal/Ethical
 - EMS
 - Public Engagement





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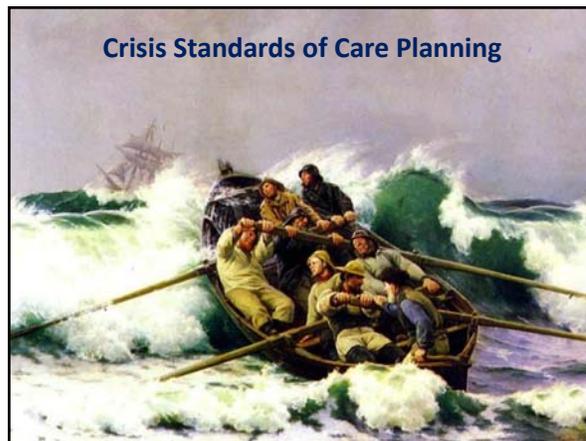
Project Update

- Post-Workgroup Meeting – Feb. 2014
- Plan development ongoing since 2013
- Plan 95% complete
- Plan activation concept of operations approved June 2014
- Clinical Concept of Operations Review Sept. 25, 2014



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CSC Assumptions

for catastrophic disaster response conditions:

- Resources are unavailable or undeliverable to HC facilities
- Similar strategies being invoked by other healthcare delivery systems
- Patient transfer not possible
- Access to medical countermeasures (vaccine, meds, antidotes, blood) likely to be limited
- Available local, regional, state, federal resource caches (equip, supplies, meds) have been distributed- no short term resupply

(IOM, Crisis Standards of Care, 1-10)



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What is the purpose of this CSC Plan?

- Provides structure for the Statewide Disaster Medical Advisory Committee (SDMAC)
- Addresses activation thresholds, interagency coordination, and policy development for public health emergencies
- Provides considerations for adapting care across the healthcare system
- Identifies inclusion criteria for ICU admission and/or life-saving therapies
- Informs and facilitates policy development



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Clinical Guidance vs. Operational Mgmt.

Level	Clinical Guidance & Priorities for Allocation	Operational Management & Support
STATE	Statewide Disaster Medical Advisory Council (SDMAC)	Health Emergency Operation Center (HEOC) State Emergency Operation Center (SEOC)
REGIONAL	Regional Disaster Medical Advisory Council (RDMAC)	Local Public Health EOCs Local Emergency Management EOCs
FACILITY	Clinical Care Committee (CCC)	Hospital Command Center (HCC)

SDMAC *Statewide Disaster Medical Advisory Committee*

- Interdisciplinary committee comprised of state, local, tribal, and healthcare sector representatives, as well as **necessary** subject matter experts (SME)
- Committee will develop guidance and guidelines for healthcare professionals and facilities
- Will serve as the statewide health & medical policy group (ESF 8) during a public health emergency

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Legal and Ethical Foundation

- Create a mechanism to respond to the ethical and moral values of the community related to a paradigm shift from personal care to community care.
- Address the legal barriers for the provision of optimal and ethical medical care and public health for emergency/crisis preparedness and response.
- Develop generally-applied principles of public health emergency ethics via consensus among public and private stakeholders in Arizona.
- Produce a consistent and reasonable public health emergency code of ethical behavior to help guide critical decisions among public and private sectors during public health emergencies.

Ethics in Public Health Emergencies: An Arizona Code of Public Health Emergency Ethics, 2/5/12, The Lincoln Center for Applied Ethics and the Public Health Law and Policy Program, Sandra Day O'Connor College of Law, Arizona State University.

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Today's Agenda – Clinical Concept of Operations

- Prehospital and Emergency Medical Services
- Hospitals and Acute Care Facilities
- Out-of-Hospital
- Alternate Care Sites
- Pediatric Care
- Palliative & Comfort Care
- Behavioral Health



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Prehospital and Emergency Medical Services

Frank Walter, MD

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Acknowledgements

- Members of the Crisis Standards of Care Clinical Workgroup of Arizona
 - Time
 - Dedication
 - Service
 - Expertise



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Prehospital and Emergency Medical Services (EMS)





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IOM CSC: Triage

- **Primary triage**
 - 1st assessment
 - Prior to medical interventions
 - **EMS**
 - START, etc.
 - Alternate Triage, Treatment, & Transport Guidelines for Pandemic Influenza
http://www.aazhs.gov/dtro/admin_rules/guidanceebcs/GD-PANFLU.pdf
- **Hospital Emergency Department (ED)**
 - Level 1-5, normally
 - START, etc. in disaster



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Status	Color	Summary
Immediate	RED	<ul style="list-style-type: none"> Life-threatening injury or illness Lifesaving Interventions (LSI) First to treat
Delayed	YELLOW	<ul style="list-style-type: none"> Serious, but not life-threatening Delaying treatment will not affect outcome Second to treat
Minimal	GREEN	<ul style="list-style-type: none"> Walking wounded Third to treat
Expectant	BLACK	<ul style="list-style-type: none"> Palliative care, unless new resources allow triage upgrade

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Box # 1 PREHOSPITAL AND EMS

1. Issue guidance to use START for adults or JumpSTART[®] for pediatrics during a statewide CSC response
2. In the event of a pandemic, issue guidance to use the State's *Alternate Triage, Treatment and Transport Guidelines for Pandemic Flu* for statewide CSC response
3. Modify recommendations as additional evidence-based guidance is published regarding other primary triage methods

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Prehospital and EMS Discussion Points

- 1) What additional issues should the SDMAC consider to support a CSC response?
- 2) What subject matter experts will be required to develop & disseminate prehospital/EMS guidelines during a CSC response?



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Hospitals & Acute Care Facilities





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IOM CSC: Triage

- **Primary triage**
 - 1st assessment
 - Prior to medical interventions
 - **EMS**
 - START, etc.
 - Alternate Triage, Treatment, & Transport Guidelines for Pandemic Influenza
 - http://www.azdhs.gov/diro/admin_rules/guidancedocs/GD-PANFLU.pdf
 - **Hospital Emergency Department (ED)**
 - Level 1-5, normally
 - START, etc. in disaster

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IOM: CSC Triage

- **Secondary triage**
 - After 1st assessment & diagnostics
 - After *initial* medical interventions
 - **Hospital surgeons, etc.**
 - Determine priority for OR or CT
- **Tertiary triage**
 - After *definitive* diagnostics
 - After *significant* medical interventions
 - **Hospital intensivists, etc.**
 - Determine priority for ICU
 - Ontario guidelines, etc.

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Table 2: CSC Criteria for ICU Admission

Needs a ventilator

- Refractory hypoxemia defined as an SpO2 less than 90% on a non-rebreather reservoir mask or an FIO2 greater than 0.85 or
- Respiratory acidosis (pH less than 7.2) or
- Clinically impending respiratory failure or
- Inability to protect or maintain airway

OR

Hypotension

- Systolic blood pressure (SBP) less than 90mmHg or relative hypotension with clinical evidence of shock, e.g., altered level of consciousness (LOC), or decreased urinary output, etc.
- Refractory to volume resuscitation and requiring vasopressor or inotropic medication

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Sequential Organ Failure Assessment (SOFA)

Resusc. Component	Variable	0	1	2	3	4
A & B	PaO2/FIO2 (mmHg)	>400	<400	<300	<200	<100
C	Hypotension	Adults: None	Adults: MABP <70 mmHg	Dop <5	Dop >5, Epi <0.1, Norepi <0.1	Dop >15, Epi >0.1, Norepi >0.1
		Children: >70 + (2 X age in years)	Children: <70 + (2 X age in years)			
C	Platelets (x 10 ⁶ /L)	>150	<150	<100	<50	<20
D	GCS	15	13-14	10-12	6-9	<6
E	Creatinine (mg/dL)	<1.2	1.2-1.9	2.0-3.4	3.5-4.9	>5
E	Bilirubin (mg/dL)	<1.2	1.2-1.9	2.0-5.9	6.0-11.9	>12

Table 3: SOFA-Based Triage for ICU Admission Priority

SOFA Triage Color Score	Criteria	ICU Admission Priority
Red	SOFA score ≤ 7 or single organ failure	Highest priority for ICU admission
Yellow	SOFA score 8 through 11	Intermediate priority for ICU admission
Blue	SOFA Score > 11	Lowest priority for ICU admission with palliative care as needed
Green	No significant organ failure	No need for ICU admission

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Box # 2 HOSPITALS AND ACUTE CARE FACILITIES

1. Issue guidance to use START for adults, JumpSTART[®] for pediatrics, or emergency department triage levels 1-5 for primary triage for statewide CSC response
2. Coordinate with facility Secondary Triage Officers
3. Issue guidance to use the inclusion criteria and SOFA score for tertiary triage
4. Modify recommendations as additional evidence-based guidance is published regarding other hospital-based primary, secondary, and tertiary triage methods

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Hospital and Acute Care Discussion Points

1) What additional issues should the SDMAC consider to support a CSC response?



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Scope of Practice

- Definition
 - Extent of licensed healthcare professional’s ability to provide services consistent with their
 - Competence
 - License
 - Certification
 - Privileges

Source: IOM, Crisis Standards of Care, 1-41 & 7-4



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Expanded Scopes of Practice

- Require
 - Training
 - Pre-crisis foundational/fundamental training
 - Pre-crisis sustainment training
 - Just-in-time training during crisis
 - Competence
 - License
 - Privileges
 - Medical direction



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Scope of Practice

“Healthcare providers should practice in interprofessional teams, practicing to the top of their license”

Thomas R. Frieden, MD, MPH
U.S. Centers for Disease Control and Prevention (CDC)



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Box # 3 RECOMMENDING CSC EXPANDED SCOPES OF PRACTICE

1. EMTs & PAs may be supervised by a resident beyond their 1st year of residency in that resident’s healthcare facility.
2. Residents beyond 1st year of residency may function to the best of their ability in that resident’s healthcare facility.
3. A licensed physician beyond their 1st year of training (internship) may not be constrained to practice in their assigned facility, but with advanced communication regarding specific needs, may go to another facility and practice under the supervision of a physician from the receiving facility.
4. Licensed Arizona RNs who have met the requirements may perform procedures defined by the AZ Board of Nursing (ABN) Advisory Opinions in facilities where they have privileges.

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Box # 3 RECOMMENDING CSC EXPANDED SCOPES OF PRACTICE

5. Any out-of-state, licensed healthcare professional in good standing may be approved to practice by that professional’s Arizona licensing board at that board’s discretion during a CSC response.
6. Dept. of Defense (DOD) clinical professionals, under the supervision of an AZ licensed clinical professional with similar clinical responsibilities, may use their competencies & privileges obtained through the DOD to exercise their documented skills to assist with healthcare needs of the community.
7. Federal clinical professionals, under the supervision of an AZ licensed clinical professional with similar clinical responsibilities, may use their competencies and privileges obtained through their federal agencies to exercise their documented skills to assist with healthcare needs of the community.

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Expanding Scopes of Practice Discussion Points

- 1) What challenges might the SDMAC face when creating guidelines for expanding scopes of practice?
- 2) What would be the best way to use expanded scopes of practice during a CSC response?
- 3) Which subject matter experts and stakeholders would be needed to develop guidance for expanding scopes of practice during a CSC response?

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Resources 3Ss

- Space
- Staff
- Supplies



Tables 4 – 6: Tactics for Resource Maximization in

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Space Maximization



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Box # 4 STRATEGIES TO MAXIMIZE MEDICAL RESOURCES

1. **SUBSTITUTE:** Use an essentially equivalent facility, professional, drug, or device for one that would usually be available.
2. **ADAPT:** Use a facility, professional, drug, or device that is not equivalent, but provides the best possible care.
3. **CONSERVE:** Use lower dosages or change practices, e.g., minimize use of oxygen by using air for nebulizers, when possible.
4. **REUSE:** Use single use items again, after appropriate disinfection or sterilization.
5. **OPTIMIZE ALLOCATION:** Allocate resources to patients whose need is greater or whose prognosis is more likely to result in a positive outcome with limited resources.

*Adapted from *The Guidelines for Use of Modified Health Care Protocols in Acute Care Hospitals During Public Health Emergencies*, September 2013, Kansas Department of Health and Environment

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Table 5: Space Maximization Tactics

RESOURCE
Hospital

TACTICS

- Designate alternate hospitals to replace damaged and/or non-functional hospitals.
- Encourage regional coalitions.
- Consider temporary field hospitals to provide support, especially in areas with limited healthcare infrastructure.
- Issue guidance to use START for adults, JumpSTART® for pediatrics, or emergency department triage levels 1-5 for primary hospital triage for statewide CSC response.
- Coordinate with facility secondary Triage Officers.

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Table 5: Space Maximization Tactics (continued)

RESOURCE
Intensive Care Unit (ICU)

TACTICS

- Use CSC criteria for ICU admission (tertiary triage) to optimize ICU resources.
- Consider using oxygen saturation monitors with high & low heart rate alarms as surrogate monitors for tachy & brady dysrhythmias when cardiac monitors are unavailable.

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Table 5: Space Maximization Tactics (continued)

RESOURCE
Dialysis facilities for renal replacement therapy

TACTICS

- Activate ADHS information sharing regarding hospital and community dialysis availability statewide.
- Coordinate dialysis use statewide to optimize availability.

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Table 5: Space Maximization Tactics (continued)

RESOURCE
Facilities with extracorporeal membrane oxygenation (ECMO)

TACTICS

- Activate ADHS information sharing regarding ECMO availability statewide.
- Coordinate ECMO use statewide to optimize ECMO availability.

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Table 5: Space Maximization Tactics (continued)

RESOURCE
Prehospital Facilities and Vehicles for Medical Transport

TACTICS

- Coordinate with local EMS and emergency management to optimize prehospital resources and collaboration.
- Use START for adults or JumpSTART® for pediatrics for statewide CSC response.
- Use the State's Alternate Triage, Treatment and Transport Guidelines for Pandemic Flu for statewide CSC response during a pandemic.

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Staff Maximization



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Table 6: Staff Maximization Tactics

RESOURCE
Healthcare Professional

TACTICS

- Activate facility disaster plans to optimize availability of all healthcare professionals, particularly those serving in emergency departments, ICUs, burn units, operating rooms, etc.
- Activate professionals in county Medical Reserve Corps (MRC) and the AZ Emergency System for the Advanced Registration of Volunteer Health Professionals (ESAR-VHP) to assist local healthcare professionals.
- Request federal healthcare teams, e.g., Disaster Medical Assistance Teams (DMATs) to assist local healthcare professionals.

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Table 6: Staff Maximization Tactics (continued)

RESOURCE
Healthcare Professional

TACTICS

- Credential, privilege, orient, mentor, manage, house, and feed MRC, ESAR-VHP, DMAT, and volunteer healthcare professionals.
- Allow EMTs and PAs to be supervised by a resident beyond their 1st year of residency (internship) in that resident's healthcare facility.
- Allow Residents beyond their 1st year of residency (internship) to function to the best of their ability in that resident's healthcare facility.

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Table 6: Staff Maximization Tactics (continued)

RESOURCE
Healthcare Professional

TACTICS

- Allow a licensed physician beyond his/her 1st year of training (internship), with advanced communication regarding specific needs, to go to another facility and practice under the supervision of a physician from the receiving facility.
- Allow licensed Arizona RNs who have met the requirements to perform procedures defined by the Arizona Board of Nursing (ABN) Advisory Opinions in facilities where they have privileges.
- Allow out-of-state, licensed healthcare professionals in good standing to practice, if permitted by the applicable Arizona licensing board.

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Table 6: Staff Maximization Tactics (continued)

RESOURCE
Healthcare Professional

TACTICS

- Consider allowing Department of Defense (DOD) clinical professionals, under the supervision of an Arizona licensed clinical professional with similar clinical responsibilities to use their competencies and privileges to assist with healthcare needs of the community.
- Federal clinical professionals, under the supervision of an Arizona licensed clinical professional with similar clinical responsibilities, may use their competencies and privileges obtained through their federal agencies to exercise their documented skills to assist with healthcare needs of the community.

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Table 6: Staff Maximization Tactics (continued)

RESOURCE
Essential Services

TACTICS

- Activate facility disaster plans to optimize availability of all essential services personnel, e.g., housekeeping, food service, laundry, maintenance, engineering, etc.

Supply Maximization



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Table 7: Supplies Maximization Tactics

RESOURCE
Blood and Blood Products

TACTICS

- Organize blood donation drives to increase availability of blood and blood products.
- Activate ADHS information sharing regarding blood and blood product availability.
- Coordinate blood and blood product use statewide to optimize availability.

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Table 7: Supplies Maximization Tactics (continued)

RESOURCE
Surgical Equipment

TACTICS

- Substitute an essentially equivalent surgical device for one that would usually be available.
- Adapt a device that is not equivalent to a standard surgical device, but provides the best possible care.
- Conserve surgical supplies, e.g., suture materials, by using the least amount of suture possible.
- Reuse single use items again, after disinfection or sterilization.
- Allocate surgical supplies, e.g., procedure trays, orthopedic equipment, and chest tubes, to patients whose need is greater or whose prognosis is more likely to result in a positive outcome with limited surgical equipment.

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Table 7: Supplies Maximization Tactics (continued)

RESOURCE

Wound & Burn Care Supplies

TACTICS

- Substitute essentially equivalent wound & burn care supplies for those that would usually be available.
- Adapt supplies that are not equivalent to standard wound & burn care supplies, but provide the best possible care.
- Conserve wound & burn care supplies, e.g., sterile dressings, by using the least amount possible.
- Reuse single use items again, after disinfection or sterilization.
- Allocate wound & burn care supplies, e.g., tourniquets, dressings, and splinting materials, to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.

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Table 7: Supplies Maximization Tactics (continued)

RESOURCE

Ventilators and Components

TACTICS

- Substitute anesthesia machines for ventilators.
- Use BiPAP when possible to preclude endotracheal intubation and ventilator use.
- Reuse single use items after disinfection/sterilization.
- Allocate respiratory care resources, e.g., staff, BiPAP, ventilators, and components, to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.
- Substitute essentially equivalent wound & burn care supplies for those that would usually be available.

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Table 7: Supplies Maximization Tactics (continued)

RESOURCE

Ventilators and Components

TACTICS

- Adapt supplies that are not equivalent to standard wound & burn care supplies, but provide the best possible care.
- Conserve wound & burn care supplies, e.g., sterile dressings, by using the least amount possible.
- Reuse single use items again, after appropriate disinfection or sterilization.
- Allocate wound & burn care supplies, e.g., tourniquets, dressings, and splinting materials, to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.

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Table 7: Supplies Maximization Tactics (continued)

RESOURCE

Vascular Access Devices

TACTICS

- Substitute essentially equivalent vascular access devices for those that would usually be available.
- Adapt supplies that are not equivalent to standard vascular access devices, but provide the best possible care.
- Conserve vascular access devices, e.g., IV extension tubing, by using the least amount possible.
- Allocate vascular access devices, e.g., adult and pediatric peripheral and central line, to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.

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Table 7: Supplies Maximization Tactics (continued)

RESOURCE

Medical Gases

TACTICS

- Substitute essentially equivalent oxygen delivery devices for those that would usually be available.
- Use alternate anesthetic gases that are equivalent to standard anesthetic gases to provide the best possible care.
- Conserve medical gases and delivery devices by using the least amount possible.
- Reuse single use oxygen delivery devices on the same patient, after appropriate disinfection.
- Allocate medical gases, including oxygen & oxygen delivery devices, e.g., adult and pediatric cannulas, masks, and bag-valve devices, to patients whose need is greater or whose prognosis is more likely to result in a positive outcome. Page 14

Table 7: Supplies Maximization Tactics (continued)

RESOURCE

Medications and IV Fluids

TACTICS

- Substitute essentially equivalent medications and IV fluids for those that would usually be available.
- Adapt available medications and IV fluids that are not equivalent to standard medications & IV fluids, but still provide the best possible care.
- Conserve medications & IV fluids by using the least amount possible.
- Allocate medications & IV fluids, e.g., analgesics, antidotes, antibiotics, antivirals, inotropes, sedatives/hypnotics, and anti-hyperkalemic medications, to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.

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AZ Specific Resources for Space, Staff, & Supplies

- AZ Burn Disaster Network
- AZ Infectious Disease Referral Centers
- AZ Poison Control Centers
- Pediatric Hospitals
- Radiation Injury Treatment Network
- Specialty Hospitals
- Surgery Centers
- Trauma Centers



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Maximizing Medical Resources - Discussion Points

- 1) What additional supply issues should the SDMAC consider to support a CSC response?
- 2) What subject matter experts will be required to develop guidance for maximizing medical resources during a CSC response?

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Out-of-Hospital Care



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Out-of-Hospital Care Defined

- **Out of Hospital Care** includes all parts of the healthcare system except EMS and hospitals
- **Out-of-Hospital Sites** are licensed and are operational parts of the healthcare system
- **Alternate Care Sites** have to be activated for a response, e.g., shelter or federal medical station (FMS)

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Types of Out-of-Hospital Care

- Outpatient providers
- Clinics
- Surgical centers
- Long-term care facilities
- Group care
- Home care
- Family based care systems

SDMAC will address each of these provider types during a CSC response



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Outpatient Providers

- Medical skills can be used in alternate care setting or assignment
- Infrastructure (practice environments) may be adjusted to meet demand
 - Expanded hours of operation
 - Repurposed
 - Referral & Routing

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Box # 5 OUTPATIENT PROVIDERS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Maintain situational awareness, through medical boards & associations, with all types of providers to assess demand for healthcare and resource availability
2. Develop guidance & messaging on referring & routing higher acuity patients to available healthcare access points
3. Develop and implement guidance for various types of outpatient providers

Clinic



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Box # 6 CLINICS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Maintain situational awareness with all types of clinics through medical boards & associations and healthcare coalition partners
2. Develop and implement CSC guidelines for clinics to expand hours of operation and repurpose staff, space, and supplies as appropriate

Surgical Center



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Box # 7 SURGICAL CENTERS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Maintain situational awareness with all types of surgery and procedure centers through medical association partners and healthcare coalitions
2. Develop and implement CSC guidelines for surgery and procedure centers

Long Term Care



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Box # 8 LONG TERM CARE

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Maintain situational awareness with all types of long term care facilities through medical association partners and healthcare coalitions
2. Implement and/or develop CSC guidelines for long term care
3. Consult with HEOC for Part 1135 waivers to be in place allowing for waiver of Medicare regulations, which will facilitate the admission of new patients not necessarily requiring long-term care

Box # 9 GROUP HOMES AND CONGREGATE SETTINGS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Establish and maintain situational awareness with group homes and congregate environments
2. Develop and implement CSC guidelines for group homes and congregate environments



Box # 10 HOME CARE & DURABLE MEDICAL EQUIPMENT VENDORS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Maintain situational awareness with family-based care providers across the state relative to stock and inventory levels
2. Develop and implement CSC guidelines for durable medical equipment vendors

Family-Based Care



Box # 11 FAMILY-BASED CARE PROVIDERS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Develop public messaging for family/friend care givers and coordinate dissemination with public information staff

Out-of-Hospital Care - Discussion Points

- 1) What additional issues should the SDMAC consider to support a CSC response?
- 2) How can CSC guidelines best be developed and disseminated to all the different types of out-of-hospital care providers?
- 3) What subject matter experts will be required to develop guidance for out-of-hospital care providers?

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Alternate Care Sites



Teresa Ehnert, Bureau Chief
Public Health Emergency Preparedness
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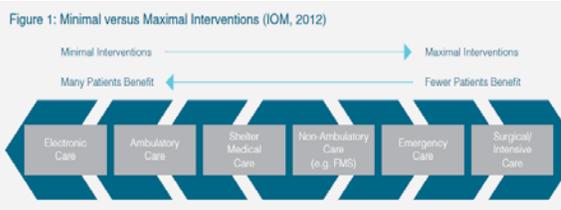
Alternate Care Sites (ACS)

- Electronic alternate care systems
- Ambulatory care facilities
- Shelter medical care
- Non-ambulatory care (e.g. Federal Medical Station)
- Emergency care replacement overflow
- Surgical/Intensive Care or Inpatient Replacement/Overflow

SDMAC will consider these ACS types when developing CSC strategies and guidelines

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Figure 1: Minimal versus Maximal Interventions (IOM, 2012)



Minimal Interventions → Maximal Interventions
Many Patients Benefit ← Fewer Patients Benefit

Electronic Care, Ambulatory Care, Shelter Medical Care, Non-Ambulatory Care (e.g. FMS), Emergency Care, Surgical/Intensive Care

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Box # 12 ALL TYPES OF ALTERNATE CARE SITES

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Work with hospitals and other healthcare access points to determine which treatments and healthcare services are most needed
2. Coordinate with healthcare coalition partners including facilities, public health, and emergency management to identify safe and accessible locations for alternate care sites
3. Identify strategies to maximize healthcare delivery using emergency medical services, out-of-hospital, and alternate care sites/systems

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Electronic Alternate Care

- Could be:
 - AZ Poison Control Centers
 - Community Info & Referral
 - Other state/local call centers
 - Federal call center
 - Online prescriptions & triage
 - Telemedicine, e.g., AZ Burn Disaster Network



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Box # 13 ELECTRONIC ALTERNATE CARE SITES

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Work with HEOC and public information staff to identify existing and alternate electronic care providers across the state
2. Establish situational awareness with electronic care providers
3. Develop and implement statewide guidance for electronic care to promote consistent electronic triage, messaging, and prescribing across the state

Ambulatory Care Facility

- Flu Center
- Casualty Collection Point
- On hospital grounds
- On a public site, e.g., school, community center



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Box # 14 AMBULATORY CARE FACILITIES

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Establish situational awareness with facilities considering the activation of temporary (alternate) ambulatory care facilities
2. Develop and implement statewide guidance for the activation, operation, and demobilization of these temporary facilities

Shelter-Based Care

- AZ durable medical equipment stockpile
- Able to support ~1,000 people with basic medical needs



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Box # 15 SHELTER-BASED CARE

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Establish situational awareness with shelter operations through local public health departments or healthcare coalition partners.
2. Work with Emergency Support Function (ESF) 6 and ESF 8 agencies, e.g., ADHS/HEOC, ADEM, Red Cross, etc., to identify medical capabilities and equipment needs at shelter locations
3. Coordinate with AZ Board of Pharmacy to obtain waiver for managing medications for shelter populations
4. Develop and implement statewide guidance for shelters

Federal Medical Station



Box # 16 – 19 AMBULATORY CARE/HOSPITAL OVERFLOW, FEDERAL MEDICAL STATIONS, SURGICAL/INTENSIVE CARE, OR INPATIENT REPLACEMENT OVERFLOW

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs (if activated) to:

1. Work with HEOC and emergency management partners to establish need for various categories of care, and identify possible locations, staffing, and supplies
2. Identify availability of this type of resource in the state
3. Coordinate with local, state, and federal partners including Region IX Emergency Coordinator (REC)
4. Conduct assessment to determine optimal locations for FMS or other assets/units based on location of disaster and demand for healthcare services
5. Develop guidance for professionals and facilities

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Box # 20 FATALITY MANAGEMENT

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and RDMACs to:

1. Develop guidelines for the coordination of statewide fatality management operations in accordance with the ADHS Fatality management Plan



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Pediatrics



Deb Roepke
Director, Coyote Crisis Collaborative



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Key Issues for Pediatrics in AZ

- One size does not fit all
- Arizona Pediatric Disaster Coalition
 - AZ Academy of Pediatrics
 - Memorandum of Understanding
 - Activation Process
 - Tiers



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Box # 21 PEDIATRIC CARE

1. **COMMUNICATION:** Messaging and communication will need to be modified for pediatric patients, especially those who are non-verbal.
2. **PERSONAL PROTECTIVE EQUIPMENT (PPE):** Masks, gloves, gowns, and other PPE may frighten pediatric patients. Pediatric sizes of masks and other types of PPE should also be available.
3. **DECONTAMINATION:** Children may need to be decontaminated with or by adult family members/caregivers. Tepid water will be needed because children are more prone to hypothermia.
4. **BEHAVIORAL HEALTH:** Children have unique psychological needs and may be prone to fear and panic.

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Box # 21 PEDIATRIC CARE (continued)

5. **EVACUATION/TRANSFER:** The Arizona Pediatric Disaster Coalition Memorandum of Understanding (MOU) outlines the process for transferring patients within the state. Out-of-state transfer will be a last resort.
6. **REUNIFICATION:** Hospital reception sites (HRS) will be set up at hospitals to assist families seeking information about missing loved ones.
7. **PEDIATRIC SPACE, STAFF, & SUPPLIES:** When possible, pediatric patients should be brought to pediatric acute healthcare facilities. If evacuation or transfer is not possible, healthcare professionals will have to use available resources until transfer is possible.

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Pediatric Care - Discussion Points

1. Regarding **communication** with pediatric patients and stakeholders, what other considerations will be important for the SDMAC?
2. What about **PPE**?
3. What about **decontamination**?
4. What about **behavioral health**?
5. What about **evacuation & transfer**?
6. What about **reunification**?
7. What about **space, staff, & supplies**?

Palliative & Comfort Care



Frank Walter, MD

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WHO Palliative Care Concepts

- Relieve pain & other distressing symptoms
- Affirm life & regard dying as normal process
- Neither hasten nor postpone death
- Integrate psychological & spiritual care
- Support patients living as actively as possible
- Support family during patient's illness & bereavement
- Use team approach to address needs of patients & families
- Enhance quality of life & may positively influence course of illness or injury

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Box # 22 PALLIATIVE CARE

1. Develop plans to transfer expectant patients to palliative & comfort care facilities
2. Assess available inventories, caches, and stockpiles of palliative & comfort care medications, and develop recommendations for allocating scarce resources to palliative & comfort care patients
3. Leverage medical support at out-of-hospital healthcare facilities, including long-term care, surgical centers, clinics, etc.
4. Coordinate with alternate care sites (ACS) such as shelters, federal medical stations (FMS), etc.

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Box # 22 PALLIATIVE CARE (continued)

5. Develop guidelines for just-in-time training for medical and non-medical personnel at healthcare access points to provide basic care, e.g., helping patients take their own medicines.
6. Integrate behavioral health, spiritual, and psychosocial support for casualties and providers
7. Coordinate guidance for hospital triage officers and/or emergency responders

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Palliative Care - Discussion Points

1. What issues should the SDMAC consider when developing & disseminating palliative care guidelines for healthcare professionals & institutions?
2. What subject matter experts will be needed to develop guidance for palliative care during a CSC response?

Behavioral Health



Andrew Lawless

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Behavioral Health Response

- ADHS Health Emergency Operation Center (HEOC)
- Behavioral Health Branch is a big part of Public Health Incident Management System (PHIMS)
- Division of Behavioral Health Services staff and management coordinate response
- Regional Behavioral Health Authorities (RBHAs)

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CSC Behavioral Health Response Components



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Box # 23 BEHAVIORAL HEALTH

1. Develop public messaging and guidelines for healthcare and behavioral health practitioners regarding the behavioral impact on the general population.
2. Develop guidelines for healthcare workers, behavioral health practitioners, and first responders regarding the behavioral health impact on the responder community.
3. Develop guidelines for the continuation of care to persons with serious mental illness and individuals receiving treatment (including medication) for substance dependency.

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Behavioral Health - Discussion Points

1. What subject matter experts will be needed to develop guidance for behavioral health to the general population and first responder community?
2. What issues should the SDMAC consider when developing guidelines the continuation of care for individuals with serious mental illness and substance dependency, including the continuation of medications?

Next Steps

- Finalize and public plan by December, 2014
- December – May 2015 – Plan Integration
 - Local public health plans
 - Facility medical surge planning
 - Emergency management, etc.
- Tabletop exercise May 2015
 - Evaluate plan with public health, healthcare, emergency management, EMS partners

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Tabletop Exercise May 2015

- Discuss exercise purpose, scope, & objectives
- Identify PHEP/HPP Capabilities for evaluation
- Discuss participating agencies and partners
- Discuss possible scenarios

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CSC Tabletop Exercise – Purpose:

- To evaluate the Arizona CSC Plan and provide participants an opportunity to evaluate their local/facility-level medical surge and emergency response plans in the context of a catastrophic public health emergency.

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CSC TTX Scope

- Transition across surge levels, from Conventional, to Contingency, to Crisis Standards of Care
- 30 – 60 Day Period to allow for ramp up and demobilization
- Have teams (tabletop groups) develop basic SDMAC guidance & discuss state/local/facility planning gaps
- Look at the intersection between policy and operations

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CSC TTX Objectives

- ?
- ?
- ?
- ?

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CSC TTX – PHEP/HPP Capabilities

<ul style="list-style-type: none"> • Community Preparedness • Community Recovery • Emergency Operations Coordination • Emergency Public Information and Warning • Fatality Management • Information Sharing • Mass Care 	<ul style="list-style-type: none"> • Medical Countermeasures Distribution and Mgmt. • Medical Supplies Mgmt. & distribution • Medical Surge • Non-Pharmaceutical Intervention • Public Health Lab Testing • Public Health Surveillance & Epi Investigation • Responder Safety and Health • Volunteer Mgmt.
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CSC TTX Participants

- Hospitals
- State/Local/Fed Public Health
- Out-of-Hospital Care
- Emergency Medical Services
- Emergency Management & Public Safety
- Legal/Regulatory/Ethical Experts

FIGURE: A Systems Framework for Catastrophic Disaster Response

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