Arizona Department of Health Services

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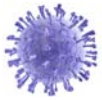
Arizona Crisis Standards of Care (CSC)
Proof of Concept Discussion
February 26, 2014, 2PM – 4PM



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Agenda

- Desired Future State, Mission, Vision
- Crisis Standards of Care Landscape
- Working Outline and Structure for CSC Plan
- Discussion 1 – Plan Structure and Roles
- Discussion 2 – Activation Procedures
- Discussion 3 – Deactivation Procedures
- Next Steps
- Open Discussion

Desired Future State

Development and implementation of a compassionate and ethically-based healthcare response for disaster situations using crisis standards of care co-developed by key stakeholders.

Mission

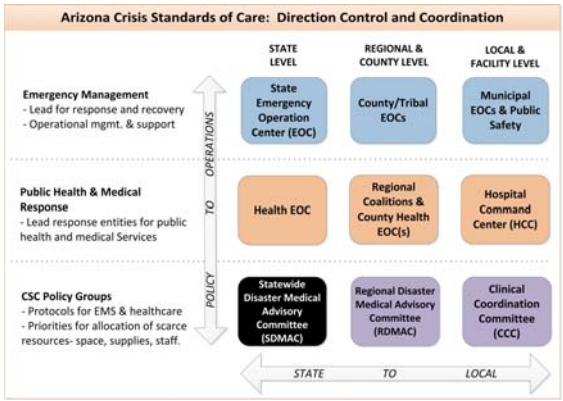
Provide a framework and standards for response to and recovery from catastrophic disasters that enables optimal community resilience across the statewide healthcare system.

Values

1. **Transparency:** Providing open, honest, factual and timely communication and information sharing.
2. **Consistency:** Implementing processes and procedures across the continuum of care; applying the same methodology(s) to achieve optimal community health.
3. **Fairness:** Supporting respect and dignity for all populations in the provision of healthcare across the continuum of care.
4. **Accountability:** Taking responsibility for actions, completing work assigned, following through on requests and communications.
5. **Resiliency:** Providing for the recovery of emotional, spiritual, intellectual and mental health needs and facilitating the wellbeing of the community.
6. **Evidence-Based:** Formulating decisions on medically founded, state-of-the-art, and research tested (when available) facts and processes to promote optimal community health.

CSC Landscape

- **Focus of CSC Plan is policy development**
  - Plan scope covers interagency policy development, not operations
  - HEOC will provide operational support for Statewide Disaster Medical Advisory Committee (SDMAC)
- **Many other agencies and plans come into play**
  - State public health and emergency management plans
  - Local public health and emergency management plans
  - CERC, JIC, and communication plans
  - Hospital, long term care, and out-of-hospital care response plans and medical surge plans
  - Federal programs, Federal Medical Stations, National Disaster Medical system, Disaster Medical Assistance Teams, etc.



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Key Policy Considerations

1. Triage protocols and inclusion criteria
2. Expanded scopes of practice
3. Medical countermeasure & materiel allocation guidelines
4. Alternate care site/system guidance
5. Public information and partner communication

Outline for CSC Plan

- Follows CPG 101 format with standard sections
- Introduction, Purpose, **Concept of Operations**, Direction Control and Coordination, Organization and Assignment of Responsibilities, Communications, etc.

Concept of Operations

- Statewide Activation, Operations, and Deactivation
- EMS Concept of Operations
- Primary, Secondary, and Tertiary triage Guidelines
- Considerations for Expanded Scopes of Practice
- Considerations for Allocation of Medical Countermeasures and Materiel
- Alternate Care System, out-of-hospital
- Special Issues for Small Hospitals

Standing SDMAC Members

The following positions would likely be included in SDMAC activation. Other partners and subject matter experts will be contacted after initial activation.

- ADHS Director
- ADHS PHEP Chief
- ADHS Policy Group Advisor
- Arizona Governor's Office
- Arizona Attorney General's Office
- Arizona Division of Emergency Management
- Local Health Officers from impacted counties
- Representative from regional healthcare coalitions
- Medical boards and association representatives

CSC Roles at healthcare facilities

It's important to separate triage from patient care during a CSC event.

- Clinical Care Director
- Triage Officer

Discussion Round 1: CSC in AZ

- How would CSC activation impact your organization?
- What are some existing strengths in Arizona's preparedness system, and how could they support a CSC response?
- How can this CSC Plan bridge gaps in Arizona's healthcare preparedness system?

CSC Activation

Threshold:

"A level, point, or value above which something is true or will take place and below which it is not or will not" (Merriam-Webster Dictionary, 2013).

Trigger Point may be designed to occur at a threshold recognized by the community or agency to require a specific response. **Trigger points and thresholds may be the same in many circumstances, but each threshold does not necessarily have an associated trigger** (IOM CSC Toolkit (2013) p. 43).

Crisis care trigger:

The point at which the scarcity of resources requires a transition from contingency care to crisis care, implemented within and across the emergency response system. This marks the transition point at which resource allocation strategies focus on the community rather than the individual.

Scripted trigger: A predefined decision point that can be initiated immediately upon recognizing an associated indicator. Scripted triggers lead to scripted tactics.

Non-scripted trigger: A decision point that requires analysis and leads to implementation of non-scripted tactics.

Conventional Thresholds

HOSPITAL	• Usual patient care space fully utilized • Usual staff called in and utilized • Cached and usual supplies being used
COUNTY/REGION	• Healthcare (HC) facilities at or near capacity • Patient transfer may or may not be impacted
STATE	• One or more counties/regions at capacity • Patient transfer may or may not be impacted

Contingency Thresholds

HOSPITAL	• Patient care areas re-purposed for ICU level • Staff extension in place • Conservation, adaptation, re-use supplies • Hospital on diversion
COUNTY/REGION	• HC facilities initiate local resource requests for space, staff, and supplies • Patient transfer limited between regional partners • Medical countermeasures still available • One or more hospitals on diversion or closed
STATE	• Local jurisdictions initiate resource requests • Patient transfer across state is limited • Medical countermeasures still available • One or more hospitals on diversion or closed

Crisis Thresholds

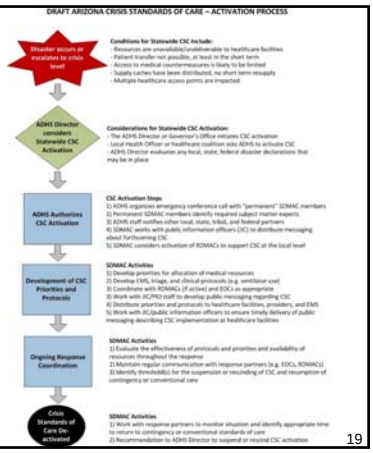
HOSPITAL	• Facility unsafe or closed • Non-patient care areas used for care • Trained staff unavailable for volume of patients • Re-allocation of life-sustaining resources • Patient transfer not possible/adequate
COUNTY/REGION	• One or more healthcare facilities in crisis • Patient transfer not possible • Facility resource requests are unavailable/ undeliverable • Limited access to medical countermeasures
STATE	• One or more counties/regions in crisis • Patient transfer not possible • Resource requests are unavailable or undeliverable • Limited access to medical countermeasures

What happens after the trigger?

Scripted tactic: A tactic that is predetermined (i.e., can be listed on a checklist) and is quickly implemented by frontline personnel with minimal analysis.

Non-scripted tactic: A tactic that varies according to the situation; it is based on analysis, multiple or uncertain indicators, recommendations, and, in certain circumstances, previous experience.

CSC Activation Process



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Conditions for Statewide CSC Include:

- Resources are unavailable/undeliverable to healthcare facilities
- Patient transfer not possible, at least in the short term
- Access to medical countermeasures is likely to be limited
- Supply caches have been distributed, no short term resupply
- Multiple healthcare access points are impacted

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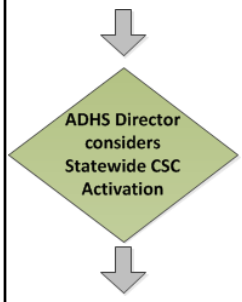
Considerations for Statewide CSC Activation



- ADHS Director or Governor's Office can activate CSC
- Local public health and healthcare partners help determine need for CSC
- ADHS Director evaluates any local, state, federal disaster declarations that may be in place, and coordinates with local and state agencies as appropriate.
- Health Emergency Operation Center is operational to support SDMAC

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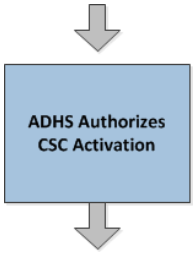
CSC Activation Steps



1) ADHS organizes emergency conference call with standing SDMAC members

2) Standing SDMAC members identify required subject matter experts

3) ADHS staff notifies other local, state, tribal, and federal partners

4) SDMAC works with public information officers (JIC) to distribute messaging about forthcoming CSC

5) SDMAC considers activation of RDMACs to support CSC at the local level

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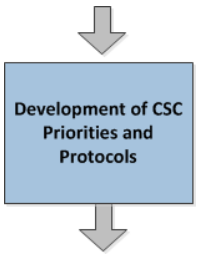
SDMAC Activities



1) Develop priorities for allocation of medical resources

2) Develop EMS, triage, and clinical protocols (e.g. ventilator use)

3) Coordinate with RDMACs (if active) and EOCs as appropriate

3) Work with JIC/PIO staff to develop public messaging regarding CSC

4) Distribute priorities and protocols to healthcare facilities, providers, and EMS

5) Work with JIC/public information officers to ensure timely delivery of public messaging describing CSC implementation at healthcare facilities

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SDMAC Activities

1) Evaluate the effectiveness of protocols and priorities and availability of resources throughout the response

2) Maintain regular communication with response partners (e.g. EOCs, RDMACs)

3) Identify threshold(s) for the suspension or rescinding of CSC and resumption of contingency or conventional care

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SDMAC Activities

CSC Deactivation

1) Work with response partners to monitor situation and identify appropriate time to return to contingency or conventional standards of care

2) Recommendation to ADHS Director to suspend or rescind CSC activation

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Discussion Round 2: CSC Activation

- What are some strengths associated with this activation procedure?
- How can it be refined to ensure development of timely, ethical, and appropriate CSC policy?
- What are some barriers to policy implementation?

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CSC Deactivation

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Draft Deactivation Procedures

1. The following procedures will be employed to ensure a coordinated deactivation of CSC standards across the state:
2. Throughout the response, HEOC, SDMAC, and healthcare facility staff will analyze situation reports (SitReps), bed polls, and updates from healthcare system partners to determine the need for crisis-level care across the state.
3. When at least 50 percent of impacted facilities (facilities at crisis-level) have returned to contingency level care, prepare Health Alerts and public messaging that rescinds CSC.

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Draft Deactivation Procedures (2)

4. When it is anticipated that all healthcare facilities will return to contingency-level care within 48 hours, send notice to statewide healthcare partners stating that "it is anticipated that CSC will be rescinded within 48 hours". This timeframe will allow healthcare facilities to prepare for the transition back to contingency surge, conventional surge, or normal operations as appropriate.
5. When all impacted healthcare facilities are able to return to contingency-level care, or patient transfer/evacuation becomes possible to alleviate crisis-level conditions, the ADHS Director, in consultation with the Governor's Office and the SDMAC, will rescind CSC across the state.

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Discussion Round 3: CSC Deactivation

- What are some strengths associated with this deactivation procedure?
- How can it be refined to ensure timely, ethical, and appropriate withdrawal of CSC policy?
- What are some barriers to deactivation?

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Next Steps

- Draft remaining plan sections March – May
- Send draft copy out to partners end of May
- Prepare for Tabletop in June
- Develop after action report and improvement plan (AAR/IP) August
- Revise plan and distribute for public comment, date TBD.

Questions