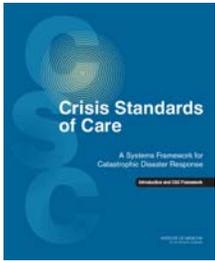


## Arizona Crisis Standards of Care (CSC) Tabletop Exercise

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## Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response



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### ADHS Planning Approach for CSC

- Integrate IOM CSC Framework and Core Functions with
  - Comprehensive Planning Guidance 101
    - Standard format for response plans
  - Previous planning efforts (e.g., Disaster Triage)
  - Existing plans (e.g., ADHS ERP, CERC, HEOC SOP, SERRP)

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### State Disaster Medical Advisory Committee (SDMAC)

The SDMAC will convene to develop incident-specific priorities and guidance for the delivery of healthcare and use of scarce medical resources.

Page 2, AZ CSC Plan

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### SDMAC guidance may address

- Triage for emergency medical services (EMS);
- Primary, secondary, and tertiary triage for healthcare facilities;
- Expanded scopes of practice, as approved by regulatory authorities;
- Priorities for medical resources including space, staff, and supplies; and
- Considerations for healthcare access points, including hospitals, out-of-hospital facilities, and alternate care sites.

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### SDMAC Members

- Agency Director
- ADHS Policy Group Advisor
- ADHS Committee Member
- SDMAC Liaison to the HEOC
- Partner Agency Committee Member (local, state, medical boards, associations, federal)
- Healthcare Coalition Committee Member
- Subject Matter Expert Committee Member



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### CSC Criteria (adapted from IOM, pp. 1-10, 2012)

- Resources are unavailable or undeliverable to HC facilities
- Similar strategies are invoked by other HC delivery systems
- Patient transfer not possible or feasible
- Access to medical countermeasures (vaccine, medications, antidotes, blood products) is likely to be limited
- Available local, regional, state, federal resource caches (equipment, supplies, medications) have been distributed and no short-term resupply of such stocks is foreseeable
- Multiple healthcare access points within a community or region are impacted.

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def-i-ni-tion n. 1.  
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Following definitions adapted from the *Crisis Standards of Care: A Toolkit for Indicators and Triggers* (IOM 2013)

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**Indicator:** A measurement, event, or other data that predicts a change in demand for healthcare. This often requires further monitoring, analysis, information sharing, and/or emergency responses.



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**Trigger Point:** A **decision point** based on the availability of resources, requiring adaptations to healthcare delivery along the continuum of care (conventional, contingency, and crisis).

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**CSC Trigger Point:** The point at which the scarcity of resource requires a transition from contingency care to CSC. This is the point at which resource allocation focuses on the community, **emphasizing population health** rather than individual outcomes.



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**Scripted Tactic:** A tactic that is **predetermined** and is quickly implemented by frontline personnel with minimal analysis.

**Non-Scripted Tactic:** A tactic that **varies** with the situation, based on analyses of multiple or uncertain indicators, recommendations, experience, and expertise.

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**What does this mean for healthcare (HC) facilities?**



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**CSC Indicators for Healthcare (Table 3)**

RESOURCE	CRISIS STANDARDS OF CARE
SPACE	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
STAFF	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
SUPPLIES	Critical supplies lacking, possible reallocation of life-sustaining resources

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**Proposed Crisis Indicators for Counties (Table 4)**

- One or more healthcare facilities must use CSC
- Medical countermeasures depleted
- Patient transfers insufficient or impossible, county-wide or regionally
- Facility resource requests unfillable or undeliverable



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**Crisis Indicators for the State (Table 5)**

- One or more counties/regions request CSC
- Medical countermeasures depleted
- Patient transfers insufficient or impossible statewide
- Local jurisdiction resource requests unfillable or undeliverable
- Multiple healthcare access points impacted



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## What Do Indicators Tell Us?

- Indicators may serve as triggers to change from one standard of care to another.
  - Conventional
  - Contingency
  - Crisis



See Appendix B (pp. 103 – 106) for complete list of indicators



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## Scripted Tactics (Tables 6 - 8)

- AZ CSC Plan has tactics for
  - Healthcare (proposed)
  - Counties (proposed)
  - State
- Addresses each level of care
  - Conventional
  - Contingency
  - Crisis

See Appendix C (pages 107 – 110)



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## Activation Process

- Disaster Occurs or Escalates
- ADHS Director Considers CSC Activation
- ADHS Authorizes CSC Activation
- SDMAC Develops CSC Guidelines
- SDMAC Coordinates On-Going Response
- SDMAC Deactivates CSC



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## Clinical Concept of Operations

### Frank Walter, MD

Medical Director,  
Bureau of Public Health  
Emergency Preparedness



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## Acknowledgements

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



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## Medical Surge & CSC Planning

What is your organization's role in CSC?



What might trigger your organization moving from contingency to CSC?



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## Prehospital & Emergency Medical Services (EMS)



### Triage

- **Primary triage**
  - 1<sup>st</sup> 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](http://www.azdhs.gov/diro/admin_rules/guidancedocs/GD-PANFLU.pdf)
- **Hospital Emergency Department (ED)**
  - Level 1-5, normally
  - **START, etc. in disaster**



Table 1: IDME Mnemonic

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



### Box 1: PREHOSPITAL & EMS

1. Issue guidance to use START for adults or JumpSTART<sup>®</sup> 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



## Hospitals & Acute Care Facilities



### Triage

- **Primary triage**
  - 1<sup>st</sup> 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](http://www.azdhs.gov/diro/admin_rules/guidancedocs/GD-PANFLU.pdf)
- **Hospital Emergency Department (ED)**
  - **Level 1-5, normally**
  - **START, etc. in disaster**



## Triage

### • Secondary triage

- After 1<sup>st</sup> 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.

Table 10: CSC Criteria for ICU Admission

- Needs a ventilator
- Refractory hypoxemia defined as an SpO<sub>2</sub> less than 90% on a non-rebreather reservoir mask or an FIO<sub>2</sub> 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

Sequential Organ Failure Assessment (SOFA)

Resusc. Component	Variable	0	1	2	3	4
A & B	PaO <sub>2</sub> /FiO <sub>2</sub> (mmHg)	>400	<400	<300	<200	<100
C	Hypotension	Adults: None  Children: >70 + (2 X age in years)	Adults: MABP <70 mmHg  Children: <70 + (2 X age in years)	Dop <5	Dop >5, Epi <0.1, Norepi <0.1	Dop >15, Epi >0.1, Norepi >0.1
C	Platelets (x 10 <sup>6</sup> /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

### Box 2: HOSPITALS & ACUTE CARE FACILITIES

1. Issue guidance to use START for adults, JumpSTART<sup>®</sup> 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

## 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

### 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



### Resource 3Ss

- Space
- Staff
- Supplies



#### 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.

### CSC Space Maximization



#### Table 13: Space Maximization Tactics

##### Hospital

- 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.

#### Table 13: Space Maximization Tactics

##### Intensive Care Unit (ICU)

- 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- & bradycardias when cardiac monitors are unavailable.



**Table 13: Space Maximization Tactics**

**Dialysis facilities for renal replacement therapy**

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

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**Table 13: Space Maximization Tactics**

**Facilities with extracorporeal membrane oxygenation (ECMO)**

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

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**Table 13: Space Maximization Tactics**

**Prehospital Facilities and Vehicles for Medical Transport**

- 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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**CSC Staff Maximization**




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**Table 14: 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 14: Staff Maximization Tactics**

**Healthcare Professional**

- 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 14: Staff Maximization Tactics**

**Healthcare Professional**

- 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 14: Staff Maximization Tactics**

**Healthcare Professional**

- 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 14: Staff Maximization Tactics**

**Essential Services**

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

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**CSC Supply Maximization**




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**Table 15: Supplies Maximization Tactics**

**RESOURCE**  
**Blood & 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 15: Supplies Maximization Tactics**

**Surgical Equipment**

- 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 15: Supplies Maximization Tactics**

**Wound & Burn Care Supplies**

- 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 15: Supplies Maximization Tactics**

**Ventilators and Components**

- 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.

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**Table 15: Supplies Maximization Tactics**

**Vascular Access Devices**

- 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 15: Supplies Maximization Tactics**

**Medical Gases**

- 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.

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**Table 15: Supplies Maximization Tactics**

**Medications and IV Fluids**

- 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
- Ebola Treatment Centers



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# Out-of-Hospital Care




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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** of outpatient professionals can be used in different care settings or assignments
- **Infrastructure** may be adjusted to meet demand
  - Expanded hours of operation
  - Repurposed



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## Box 5: OUTPATIENT PROVIDERS

**During CSC, the SDMAC will coordinate with the HEOC & local health departments to**

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

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## Clinics & Surgical Centers





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## Boxes 6 & 7: CLINICS & SURGICAL CENTERS

**During CSC, the SDMAC will coordinate with the HEOC & local health departments to**

1. Maintain situational awareness with all types of clinics and surgical centers through their associations and healthcare coalition partners
2. Develop and implement CSC guidelines to expand hours of operation and repurpose staff, space, and supplies

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## Long-Term Care



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### Box 8: LONG TERM CARE

During CSC, the SDMAC will coordinate with the HEOC & local health departments to

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

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## Group Homes & Congregate Settings, Home Care & Durable Medical Equipment, and Family-Based Care



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### Boxes 9 - 11: GROUP HOMES & CONGREGATE SETTINGS, HOME CARE & DURABLE MEDICAL EQUIPMENT VENDORS, and FAMILY-BASED CARE PROVIDERS

During CSC, the SDMAC will coordinate with the HEOC & local health departments to

1. Establish and maintain situational awareness with these partners
2. Develop and implement CSC guidelines for these partners
3. Develop public messaging for families, friends, and caregivers and coordinate its dissemination with public information staff

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## Alternate Care Sites & Systems



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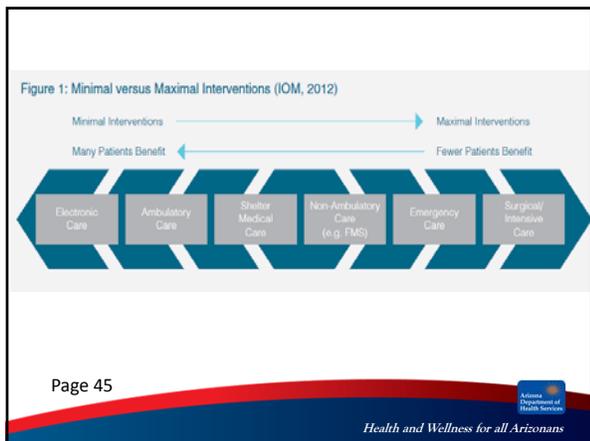
### Alternate Care Sites: Not Part of Regular Care System

- 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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**Box 12: ALL TYPES OF ALTERNATE CARE SITES**

**During CSC, the SDMAC will coordinate with the HEOC & local health departments to**

1. **Work** with hospitals & other healthcare access points to determine which treatments & healthcare services are most needed
2. **Coordinate** with healthcare coalition partners including facilities, public health, & emergency management to identify safe & accessible locations for alternate care sites
3. **Identify** strategies to maximize healthcare delivery using emergency medical services, out-of-hospital, & 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 CSC, the SDMAC will coordinate with the HEOC & local health departments to**

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

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**Ambulatory Care Facility**

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

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**Box 14: AMBULATORY CARE FACILITIES (e.g., casualty collection point or “flu center”)**

**During CSC, the SDMAC will coordinate with the HEOC & local health departments to**

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

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## Shelter-Based Care

- AZ durable medical equipment stockpile
- Can support ~1,000 peoples' basic medical needs



### Box 15: SHELTER-BASED CARE

During CSC, the SDMAC will coordinate with the HEOC & local health departments 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 shelters
3. Coordinate with AZ Board of Pharmacy to obtain waiver for managing medications for shelters
4. Develop and implement statewide guidance for shelters

## Federal Medical Station



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

During CSC, the SDMAC will coordinate with the HEOC & local health departments 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 these types of resources, statewide
3. Coordinate with local, state, and federal partners, including Region IX Emergency Coordinator
4. Assess 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

### Box 20: FATALITY MANAGEMENT

During CSC, the SDMAC will coordinate with the HEOC & local health departments to

1. Develop guidelines for the coordinating statewide fatality management operations, using the ADHS Fatality Management Plan



## Pediatrics



## Key Issues for Pediatrics in AZ

- Children are not little adults
- Arizona Pediatric Disaster Coalition
  - AZ Academy of Pediatrics
  - Memorandum of Understanding
  - Activation Process
  - Tiers



## Box 21: PEDIATRIC CARE

1. **COMMUNICATION:** Modify messaging and communication 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 should be available.
3. **DECONTAMINATION:** Children may need to be decontaminated with or by adult family members/caregivers. Tepid water (37°C) 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.

## Box 21: PEDIATRIC CARE

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 will be set up 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 use available resources until transfer is possible.

## Palliative & Comfort Care



## WHO Palliative Care Concepts

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

## 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, such as shelters & federal medical stations

**Box 22: PALLIATIVE CARE**

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

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# Behavioral Health



## Behavioral Health Response

- Behavioral Health Branch
  - Major part of Public Health Incident Management System (PHIMS) in ADHS HEOC
- Division of Behavioral Health Services
  - Coordinate with Regional Behavioral Health Authorities (RBHAs)



## CSC Behavioral Health Response Components



**Box 23: BEHAVIORAL HEALTH**

1. Develop public messaging & guidelines for healthcare & behavioral health practitioners, regarding behavioral impact on general population.
2. Develop guidelines for healthcare workers, behavioral health practitioners, & first responders, regarding behavioral health impact on responder community.
3. Develop guidelines for continuing care, including medications, for people with serious mental illness & individuals receiving treatment for substance dependency.

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# Organization & Assignment of Responsibilities



**Figure 3: Health Emergency Ops and Policy Groups**



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### Information Collection, Analysis, & Dissemination

The SDMAC will support these risk communication components from the ADHS Crisis Emergency Risk Communication (CERC) Plan

- Information Gathering and Analysis
- Information Planning and Production
- Information Dissemination
- Agency Spokesperson Identification and Preparation

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### Communications (Table 16)

- Arizona Emergency Information Network (AzEIN)
- Arizona Health Alert Network (AzHAN)
- EMResource™
- EMTrack™
- Hospital Available Beds in Emergencies and Disasters (HAVBED)
- WebEOC

Pages 82 - 83

### Legal Considerations

- Personnel
- Access to Treatment
- Coordination of Health Services
- Patients' Interests
- Allocation of Resources
- Liability
- Reimbursement
- Inter-jurisdictional Cooperation



Pages 88 – 92

### APPENDIX A—CSC CODE OF ETHICS FOR THE STATE OF ARIZONA

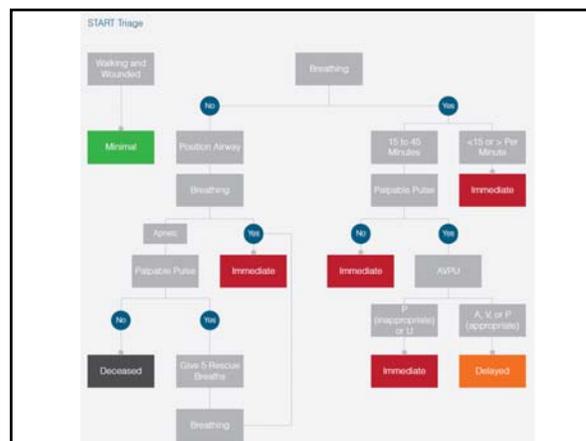
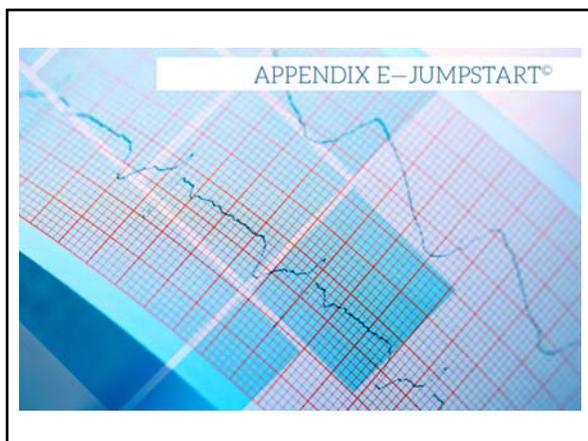
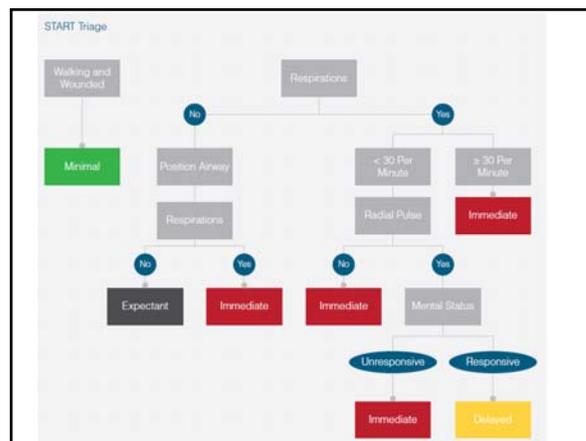
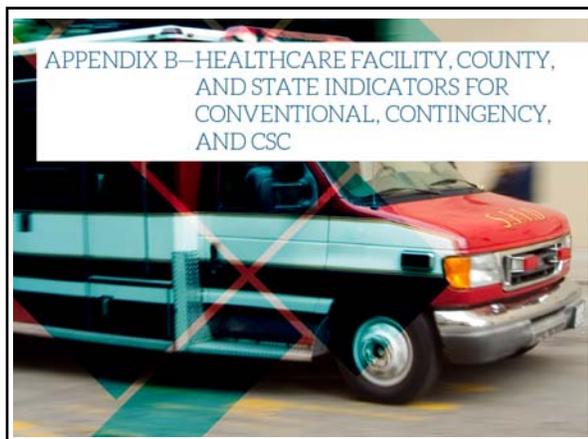


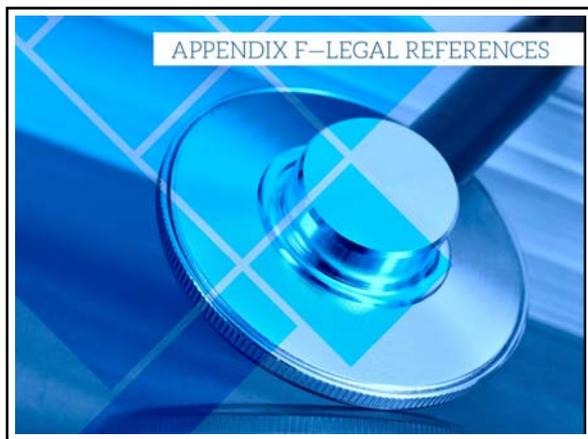
### Appendix A – CSC Code of Ethics

- Stewardship of Resources
- Duty to Care
- Soundness
- Fairness
- Reciprocity
- Proportionality
- Transparency
- Accountability



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### Job Action Sheets



- Agency Director
- ADHS Policy Group Advisor
- ADHS Committee Member
- SDMAC Liaison to the HEOC
- Partner Agency Committee Member (local, state, medical boards, associations, federal)
- Healthcare Coalition Committee Member
- Subject Matter Expert Committee Member
- Clinical Care Director
- Triage Officer

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### Arizona CSC Tabletop Exercise - Purpose

- To evaluate the ADHS Crisis Standards of Care Plan, jurisdictional medical surge planning, and facility medical surge and emergency response plans.
- The exercise will focus on CSC indicators, triggers, and interagency coordination related to a catastrophic disaster impacting the public health and healthcare system.



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### Exercise Objectives

Exercise Objective	Capabilities	Functions
1) Identify potential gaps in interagency coordination for healthcare, public health, emergency management, & first responders	<b>Emergency Operations Coordination - HPP</b>	Function 2: Assess & notify stakeholders of healthcare delivery status  Function 3: Support healthcare response efforts through coordination of resources
2) Explore solutions to expand emergency public information & electronic triage systems	<b>Emergency Public Information &amp; Warning - PHEP</b>	Function 3: Establish & participate in information system operations  Function 5: Issue public information, alerts, warnings, & notifications

### Exercise Objectives

Exercise Objective	Capabilities	Functions
3) Assess the flow of information between response partners	<b>Information Sharing - HPP</b>	Function 1: Provide healthcare situational awareness that contributes to the incident common operating picture
4) Evaluate indicators and tactics documented in Arizona CSC Plan for the state, local jurisdictions, and healthcare facilities	<b>Medical Surge - HPP</b>	Function 3: Assist healthcare organizations with surge capacity and capability Function 4: Develop Crisis Standards of Care guidance

### Exercise Structure

Players will participate in the following two modules:

- **Module 1: Blast Injury**
- **Module 2: Influenza Like Illness (ILI)**

- **Each module begins** with a summary of key events & assumptions. After the presentation, participants review the situation & engage in group discussions surrounding key policy & response issues.
- **After the discussions**, participants will engage in a moderated plenary discussion in which a spokesperson from each group will present a synopsis of the group's discussions, based on the scenario.

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### Module 1 Blast Injury

- Thousands of spectators are gathered for a popular sporting/entertainment event.
- State and local emergency management, EMS, law enforcement, and public health are on standby for the large event, but no definite threats have been identified.
- Around 4:00 PM a series of explosions occur at the event.
- Additional explosions occur outside the event as people attempt to evacuate.
- Victims begin arriving at local area hospitals in private vehicles; EMS cannot keep up with the number of injured.

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### Module 1: Blast Injury

- A make-shift triage area is established in the vicinity, away from the immediate scene of the blasts.
- Terrorism is suspected, and the FBI is on scene to handle the investigation.
- Hospitals and other healthcare facilities are notified and placed on alert, statewide.
- Blood supplies were low before the blast and the need for donations has increased dramatically.

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### Module 1: Blast Injury

- The number of casualties is approximately 1,500 with:
  - 200 red,
  - 400 yellow,
  - 700 green.
  - 100 black, and
  - 100 dead.

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#### Table 9: IDME Mnemonic

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

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### Module 1: Primary Discussion Questions

- 1) Which agencies and partners need to be notified regarding activating the State Disaster Medical Advisory Committee (SDMAC)?
- 2) What resources (e.g., space, staff, and supplies) would be in greatest demand during this type of disaster? What additional resources might be considered? See “Appendix G Resource Challenges by Disaster Type” on pages 117 – 121.
- 3) How would local public health and emergency management coordinate with the SDMAC to help healthcare facilities implement CSC?



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### Module 1: Primary Discussion Questions

- 4) What elements of the “Appendix A – Code of Ethics” will be most important for policy makers? See pages 96 – 101.
- 5) What additional tactics might be used to assist healthcare facilities and county health departments during this response? See pages 107 – 109.
- 6) How can the SDMAC coordinate with county health departments and healthcare system partners to quickly implement CSC guidance?
- 7) How can policy and guidance developed by the SDMAC be most efficiently integrated into public messaging? See pages 81 – 83.



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### Module 1: Questions for Further Consideration

- 1) What additional indicators and tactics should healthcare facilities consider for a CSC response?
- 2) What additional indicators and tactics should local health departments consider for a CSC response?
- 3) How will SDMAC members balance the needs of existing patients receiving treatment with the huge influx of new casualties resulting from the blast?
- 4) How can existing systems and resources be used to provide electronic alternate care, e.g., telephone triage, online triage, electronic prescriptions? See page 49 of the *AZ CSC Plan* for additional information on electronic alternate care.
- 5) What guidance or recommendations could be implemented to increase and/or maximize blood supplies across the state?



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# Facilitated Discussion Module 1



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### Module 2: Influenza Like Illness (ILI)

- It is December and flu season is getting underway.
- Many hospitals are operating at or near capacity.
- An unusual cluster of severe respiratory disease is detected in the state.
- Within weeks, cases spread to most AZ counties.
- Hospitals, urgent care facilities, and other clinics are inundated with ILI cases.
- IV solution supplies were thin before the outbreak. Over the last several weeks, shortages are reaching a critical level.



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### Module 2: Influenza Like Illness (ILI)

- Personal Protective Equipment (PPE) is also in short supply and local/statewide distributors & caches have been exhausted.
- This new form of ILI is impacting neighboring states as well & the supply shortage is now nationwide.
- It is estimated that thousands of people across the state have contracted this new form of ILI & approximately 1,000 of them have required hospitalization over the last 2 weeks.
- The SDMAC has been convened to develop guidance & help establish priorities.



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### Module 2: Primary Discussion Questions

- 1) What steps can the SDMAC take to ensure equitable allocation of resources (space, staff, and supplies) across the state? See "Appendix G" in the AZ CSC Plan for information.
- 2) How can CSC guidance be integrated into public messaging to address considerations for access and functional needs (AFN) populations?
- 3) What priorities would the SDMAC consider when developing guidance and recommendations for healthcare professionals?



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### Module 2: Primary Discussion Questions

- 4) During an infectious disease crisis, how will the SDMAC coordinate guidance and recommendations with public information staff in charge of public inquiry and media relations?
- 5) How will electronic and telephone-based information systems be used to support public information and electronic triage/prescriptions? See section on electronic alternate care systems on p. 49 of the AZ CSC Plan.



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### Module 2: Questions for Further Consideration

- 1) How can hospitals implement decompression procedures (e.g., early release, transfer to home health/long term care) to increase capacity for ILI patients?
- 2) What guidance might the SDMAC develop/implement for laboratory testing (i.e., policies for what gets tested & when to stop testing)?
- 3) What policy decisions, guidance, or recommendations could be implemented to increase and/or maximize PPE supplies across the state?



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# Facilitated Discussion Module 2



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## Next Steps and Closing Remarks



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Thank You for  
Your Attendance

