

Crisis Standards of Care EMS Work Group October 10, 2013

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Why are we here?

- New expectations regarding extreme disaster response from the Feds
- Institutes of Medicine, Crisis Standards of Care
- EMS likely to be the first to implement
- Success only achieved with input from experts
- Desire to take care of our community and support public's health



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EMS Work Group Charter

PURPOSE: Provide guidance in defining the roles and responsibilities of pre-hospital care, an essential component of the continuum of emergency health care, in the provision of **timely medical response to the community** during extreme emergency disaster situations by developing crisis standards of care (CSC) for the state of Arizona .

GOALS:

- Maintain a **coordinated and integrated emergency response** system congruent with the state CSC plan and the guidance of the SDMAC (Statewide Disaster Management Advisory Committee).
- Develop plan to address **shortages** of limited staff, supplies and equipment, a limited supply of fuel and medications, limited mutual aid and **disruption of coordination and communication systems**.
- Explore process for changes in **scope of practice**, functioning in extraordinary settings, providing care for longer periods of time and methods for just-in-time training.
- Ensure proposed practices are **consistent across jurisdictions**.
- Review **EMS authority** currently mandated by Arizona statutes.
- Conduct an **EMS Incident Response and Readiness Assessment (EIRRA)** and perform a gap analysis.
- Determine the current status and capacity of Arizona's **dispatch** centers.
- Address needs of **urban, suburban and rural** locations in planning.



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Agenda

- Informational briefing on Crisis Standards of Care (CSC)
- Importance of EMS in continuum of care
- Arizona's Conceptual Framework: the Balanced Scorecard (AzBSC)
- Cross-walk AZ process with IOM recommendations
- Develop gap analysis and action plan



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Crisis Standards of Care Briefing

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EMS Work Group
October 10, 2013



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Crisis Standards of Care Planning in AZ

- 2008 - 2009 Partners from Arizona Hospital and Healthcare Association, Arizona Medical Association, ADHS, and numerous other partners developed Disaster Triage Protocol Recommendations
- Spring 2009, H1N1 appears, the Assistant Secretary for Preparedness and Response (ASPR) asks the Institutes of Medicine (IOM) to develop guidance
- Later in 2009, IOM defines term "Crisis Standards of Care" in the "letter report"
- Jan. 2011, ADHS conducts Disaster Triage Protocol Workshop with nearly 100 attendees in Phoenix. After Action Report is developed along with recommendations



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Crisis Standards of Care Planning in AZ

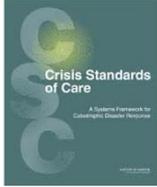
- IOM held public meetings in May & July 2011 to inform CSC guidance
- March 2012, IOM releases 7 volumes of guidance
- Jan. 24, 2013 – Initial Planning Workshop for AZ CSC Plan
- June 27, 2013 – Mid Planning workshop for AZ CSC Plan
- July 17, 2013 -First Workgroup meetings for Clinical and Legal/Ethical Workgroups
- August 28, 2013-First Meeting for Public Engagement WG
- GOAL – Feb 2014 – Plan Developed, Implemented, and Tested

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Crisis Standards of Care

A Systems Framework for Catastrophic Disaster Response

- VOLUME 1: Introduction and CSC Framework
- VOLUME 2: State and Local Government
- VOLUME 3: EMS**
- VOLUME 4: Hospital
- VOLUME 5: Alternate Care Site Facilities
- VOLUME 6: Public Engagement
- VOLUME 7: Appendices



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Catastrophic Disaster Defined

- 1) Most or all of the **community's infrastructure** is impacted.
- 2) Local officials are **unable to perform usual roles** for a period of time extending well beyond the initial aftermath of the incident
- 3) Most or all routine **community functions** are immediately and simultaneously **disrupted**
- 4) Surrounding communities are similarly affected, and thus there are **no regional resources**

(IOM, Introduction and CSC Framework 1-15)

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CSC Assumptions

for catastrophic disaster response conditions:

- Resources are unavailable or undeliverable across the continuum of care
- 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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Five Key Elements for all CSC Plans

- ❖ A **strong ethical grounding**... based transparency, consistency, proportionality, and accountability
- ❖ Integrated and ongoing community and provider **engagement**, education, and communication
- ❖ The necessary **legal authority and protections** and legal environment in which CSC can be ethically and optimally implemented
- ❖ Ensure intrastate & interstate **consistency** during CSC

Clear indicators, triggers, & lines of responsibility

Evidence-based clinical processes & operations

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

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Crisis Standards of Care Defined

The level of care possible during a crisis or disaster due to **limitations in supplies, staff, environment, or other factors**. These standards will usually incorporate the following principles:

- 1) prioritize **population health** rather than individual outcomes;
- 2) respect **ethical principles** of beneficence, stewardship, equity, and trust;
- 3) modify regulatory requirements to provide **liability protection** for healthcare providers making resource allocation decisions;
- 4) designate a **crisis triage officer** and include provisions for palliative care in triage models for scarce resource allocation.

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

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Crisis Standards of Care cont.

...Crisis standards of care will usually follow a **formal declaration** or recognition by state government during a **pervasive** (pandemic influenza) or **catastrophic** (earthquake, hurricane) disaster which recognizes that contingency surge response strategies (resource sparing strategies) have been **exhausted**, and crisis medical care must be provided for a **sustained period of time**. Formal recognition of these **austere operating conditions** enables specific legal/regulatory powers and protections for healthcare provider allocation of scarce medical resources and for alternate care facility operations...

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

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What are we talking about?

- Multiple healthcare access points within a community or region are impacted
- Resources are unavailable or undeliverable to healthcare facilities
- Similar strategies being invoked by other healthcare delivery systems
- Patient transfer not possible or feasible, at least in the short term
- 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

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CSC Hazard Identification

Outcome: Ensure this CSC plan accounts for all types of hazards that could invoke a crisis-level response within the state, including:

- CBRNE (Chemical, Biological, Radiological, Nuclear, Explosive)
- Natural disasters
- Technological failure
- Other human-caused incidents.

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Does this qualify as a CSC Incident?



Gabrielle Giffords' Shooting

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Does this qualify as a CSC Incident?



Boston Bombing

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Does this qualify as a CSC Incident?



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CBRNE: Chemical – Bhopal India

- December 3, 1984
- Union Carbide plant leaked 32 tons of toxic gas including methyl isocyanine
- 5,000 immediate deaths
- 18,000 deaths w/in 2 weeks
- Many more sickened
- Worlds worst industrial accident



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CBRNE: Bioterrorism - Anthrax

- Unlikely “Black Swan” event with massive public health consequence
- Bioterrorism threat is the main reason for the state/local/federal Strategic National Stockpile (SNS) program



Anthrax Attacks, 2001

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CBRNE: Biological - Pandemic Influenza

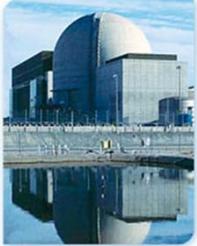
- 50 million deaths worldwide
- Major pandemic like 1918 “Spanish Flu” would be a global catastrophe
- Main reason for public health preparedness funding



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CBRNE: Radiological/Nuclear

- Palo Verde Nuclear Generating Station (PVNGS) - very safe, but threat is real
- Chernobyl – 31 dead, 100+ radiation injuries, 115,000 evacuated right away
- Category includes nuclear detonation (terrorism, act of war)



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CBRNE: Explosion - Madrid Bombing

- March 11, 2004
- Fatalities - 191
- Wounded 1,800 – 2,000



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CBRNE: Explosion - Texas City

- April 16, 1947
- Fatalities – 581
- Missing 113
- Injuries – 5,000+
- Worst industrial accident in U.S.
- Destroyed over 1,000 buildings



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Flood – Natural Disaster

Between October 1977 and February 1980, there were seven floods. Phoenix was declared a disaster area three times and 18 people lost their lives.

Multiple PHX area hospitals are in the 500-year flood plain



1966 Salt River Flood


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Flood – Technological Failure

Previous Dam Failures

- China 1975 – 175,000 fatalities, dam failure from severe rainfall after typhoon
- Numerous key dams in AZ; failure could cause widespread flood, power outage, transportation disruption, etc.



1966 Salt River Flood


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Extreme Weather – Natural Disaster (summer or winter)

Extreme weather can dramatically impact the healthcare delivery system

- Heat-related illness
- Road closures




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Extreme Weather – Hurricane

Hurricanes in Arizona?

- Reception for Katrina evacuees – over 500 evacuees in Coliseum, nearly 200 in Tucson
- Hurricanes can also impact AZ weather (e.g. flooding)




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Earthquake – Natural Disaster

Earthquakes in AZ?

- Seismic activity possible in AZ
- Impact from big Southern CA quake – receiving thousands of evacuees with medical needs (reception scenario)



Northridge, 1994


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Power Outage – Natural Disaster or Human Caused

Transformer fire June 2011

- 80,000 people no power in Mesa, AZ
- Sustained outage in summer months would be a major healthcare system emergency




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Wildfire – Natural or Human Caused

- Biggest recurring threat in AZ – happens every year
- Major environmental health response
- Evacuation of healthcare facilities and hospitals can be a massive strain on healthcare system



Wallow Fire, 2011

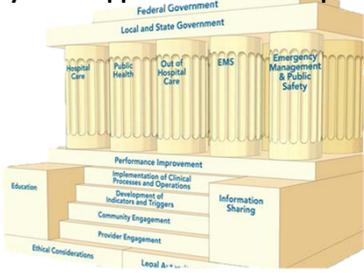
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How do we organize ourselves?

- Across the continuum of care
- Systematic and sensible decision making
- Rapid response from all levels
- Pre-planned process and protocols
- Training and education
- Working outside “the Box”
- Ensuring ethical treatment for all
- Providing legal protections for those caring for others

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Systems Approach to Catastrophic Care



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

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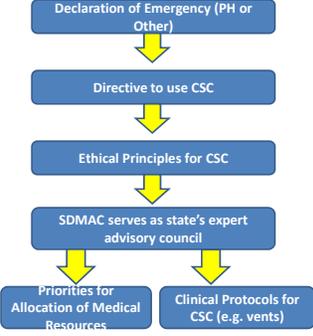
Systems Defined Approach for crisis, disaster, and risk mgmt.

A management strategy that recognizes that **disparate components must be viewed as interrelated** components of a single system, and so **employs specific methods** to achieve and maintain the overarching system. These methods include the use of **standardized structure and processes** and foundational knowledge and concepts **in the conduct of all related activities**.

(George Washington University, 2009)

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CSC Implementation Action and Decision



IOM, Crisis Standards of Care, 2-24

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Planning Vs. Response

PLANNING	RESPONSE
Creation of a CSC Plan for state-level activation with input from stakeholders and the public	Implemented by SDMAC during response
Adoption of CSC plan at the regional level	Implemented by RDMAC as appropriate during response
Coordination of CSC plans for hospitals, hospital systems, EMS, out-of-hospital providers, public health, emergency management	Implemented by Clinical Coordination Committee (CCC) during response

IOM, Crisis Standards of Care, 2-24

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Approach thus far...

- Two planning meetings (Jan. & June) with SDMAC
- Four workgroups identified: 1) Clinical, 2) Legal/Ethical, 3) EMS, 4) Public Engagement
- Consensus building with SDMAC- desired future state, mission, vision, values
- Drafting stock portions of the plan
- Scheduling additional planning meetings
- Workgroups to draft and/or approve specific plan elements
- Obtain buy in from SDMAC Development committee
- Compile first draft (Dec)
- Conduct public engagement sessions (Nov. – Dec.)
- Compile second draft (Jan, 2014)
- Legal Review (Dec. – Jan.)
- Plan Implementation Workshop and Tabletop Exercise (Feb. 2014)


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How do we get there?

- Have a common understanding of the task at hand
- Building consensus among constituents and stakeholders
- Develop key operating guidelines to provide consistency
- Educate and communicate with experts


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CSC Requires a Paradigm Shift in Focus

SDMAC Focus Shift:

Providers
Care of Individual → Care of Community

Public Health
Direct Services → Policy Initiatives


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Allocation of Specific Resources along the Care Capacity Continuum

Incident demand/resource imbalance increases →
Risk of morbidity/mortality to patients increases →

CSC Triggers	Conventional Capacity	Contingency Capacity	Crisis Capacity
Space	Usual patient care, space fully utilized	Patient care areas repurposed	Facility damaged, unsafe or non-patient care areas used for patient care
Staff	Usual staff called in and utilized	Staff extension: brief deferrals of non-emergent service, supervision of broader groups of patients, change in responsibilities	Trained staff unavailable or non-patient care areas used for patient care
Supplies	Cached and usual supplies used	Conservation, adaptation and substitution with safe re-use of select items	Critical items lacking, possible re-allocation of life-sustaining resources
Standard of Care	Usual care	Functionally equivalent care	Crisis standards of care: requires state empowerment, clinical guidance and protection for triage decisions, authorization for alternate care sites. SDMAC Advisory Panel initiated.

Normal Operations ↑ **Indicator: potential for CSC (patient-centered decision-making)** **Trigger: CSC (Community-centered decision-making)** ↑ Extreme Operations


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Why is Consensus so Important?

- To assure community safety
- To enable rapid decision-making
- To ease the stress of difficult situations
- To provide consistent compassionate care
- To maintain the best possible health for the community
- To protect patient care providers
- To provide the same level of care
- To reduce individual and institutional liability
- To maintain legal and regulatory guidelines


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What is/ is not Consensus?

- Consensus is:
 - General agreement
 - Majority of opinion
 - Based on valid and true facts
 - Negotiation
 - Entire group abides by decision
- Consensus is not:
 - Unanimous agreement
 - Lone ranger mentality


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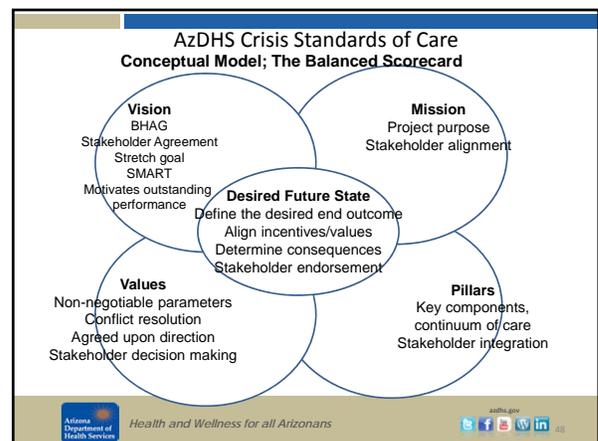




- ### How do we Reach Consensus?
- Discussing issues and concerns openly and honestly
 - Recognizing differences of opinion
 - Honoring individual and group values
 - Listening actively
 - Developing a methodology for decision making
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- ### Balanced Scorecard Methodology
- Co-develop common themes with stakeholder groups to address issues, set priorities and assign responsibilities.
 - Understand that every issue, goal, priority carries equal weight
 - Agree on purpose, goals, outcomes and performance measures
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Arizona CSC Balanced Scorecard Approach

Approved by SDMAC Planning Committee 6/27/13

Desired Future State	Develop and implement a compassionate, ethically-based healthcare response for catastrophic disasters, using crisis standards of care (CSC) co-developed by key stakeholders.
Vision	Arizona will become a national model in CSC planning and implementation by February, 2014.
Mission	Provide framework and standards for response to and recovery from catastrophic disasters, enabling optimal community resilience for the healthcare system, statewide.
Values	<p>Transparency: Provide open, honest, factual and timely communication and information sharing.</p> <p>Consistency: Implement processes and procedures across the continuum of care; applying the same methodologies to achieve optimal community health.</p> <p>Fairness: Support respect and dignity for all populations when providing healthcare across the continuum of care.</p> <p>Accountability: Take responsibility for actions, complete work assigned, follow through on requests and communications.</p> <p>Resiliency: Provide for the recovery of emotional, spiritual, intellectual and mental health needs and facilitate the well-being of the community.</p> <p>Evidence-based: Formulate decisions on medically founded, state-of-the-art, and research tested (when available) facts and processes to promote optimal community health.</p>

CSC BSC June 27, 2013

Pillars & Outcomes	Objectives	Overarching Goals	Clinical Workgroup Objectives	Legal/Ethical Workgroup Objectives	EMS Workgroup Objectives	Public Engagement Objectives
Public Health Provide open, honest, factual and timely communication and information sharing.	Coordinate activities and operations of the SDMAC and KEMAC and public health emergency operations.					
Healthcare System Support of healthcare system during crisis situations.	Coordinate emergency operations, emergency decisions, and public safety activities during disaster.					
EMS Coordinate emergency operations, emergency decisions, and public safety activities during disaster.	Coordinate emergency operations, emergency decisions, and public safety activities during disaster.					
Public Engagement Facilitate resource requests for staff, supplies, medical interventions, etc.	Facilitate resource requests for staff, supplies, medical interventions, etc.					

Crisis Standards of Care Activation Needs

Implementation

- Declaration of Emergency (PH or Other)
- SDMAC, expert advisory council

Action

- Directive to use CSC (Triggers)
- Ethical Principles for CSC

Decision Making

- Priorities for Allocation of Medical Resources
- CSC Clinical Protocols
- Communications

CSC Planning Structure

Arizona Department of Health Service
Bureau of Public Health and Emergency Preparedness

SDMAC Advisory Planning Committee

Legal/Ethical Work Group

Clinical Practice Work Group

EMS Work Group

Public Engagement Work Group

Questions ?

