IDAHO REGION II
STABILIZATION PLAN

Annex E

HEALTHCARE

This annex guides providing healthcare for the most people in a national emergency.

Lead: Medical Advisory Board
Lead medical facility liaison
Public Health

Partners: Hospitals

Support: Clinics
Home Health Organizations
Pharmacies
Nursing Schools
Emergency Medical Services

INTRODUCTION

The existing healthcare system is optimized to take care of the average number of patients expected in daily operations (Conventional Capacity). Should a traditional disaster occur, emergency plans are activated. Staffing is augmented, and disaster victims exceeding hospital capacity or capability, are transferred according to pre-existing agreements (Contingency Capacity).

In a sudden, significant national or global catastrophe, each region will need to be prepared to support its own needs without anticipation of outside help (Crisis Capacity). Preventing a collapse of the healthcare system will require quick adaption to local conditions and an acceptance that the situation will require atypical solutions to emerging problems.

Lead medical facilities are especially vulnerable to collapse in this time, and increased death, illness, and injuries are expected initially. The tiered medical management system pushes care to the lowest level. This will likely result in a lower standard of care for medical emergencies, but keeps critical care facilities functioning.

To plan for a catastrophic event, local jurisdictions need to prepare conscientiously and systematically to ensure that the response offers the best care possible given the resources at hand, decisions are fair and transparent, policies and protocols within and across political boundaries are consistent, and citizens and stakeholders are included and heard.

SCOPE

1. This annex is for significant national or global catastrophic events. Less severe events will use the jurisdictional Emergency Operations Plan and Public Health Response Plan, as appropriate, for health-related incidents.

2. This annex (and plan) does not supersede existing plans written to manage existing hazards/threats. For example, an epidemic occurring during a crisis event would be managed using the Public Health Response Plan.

3. Pre-hospital Emergency Medical Services are discussed in Annex H: Public Safety.

4. Mass fatality procedures are addressed in jurisdictional Mass Fatality Plans.

POLICY

1. Crisis Standards of Care should only follow an emergency declaration from the state. Emergency declarations and ensuing orders can be the first step in authorizing such changes and providing liability protections.

2. Stakeholders should be striving to establish consistent state Crisis Standards of Care under the lead of state public health.

3. State and local governments should explicitly tie existing liability protections (e.g., through immunity or indemnification) for healthcare practitioners and entities to Crisis Standards of Care. Emergency declarations trigger an array of non-traditional powers that are designed to facilitate response efforts through public and private sectors. Emergency laws may:

- Provide government with sufficient flexibility to respond
- Mobilize central commands and infrastructures
- Encourage response efforts by limiting liability
- Authorize interstate recognition of healthcare licenses and certifications
- Allocate healthcare personnel and resources
- Help to change medical Standards of Care and scope of practice

4. Medical oversight will be maintained: from diagnosis to treatment to medications.

5. Continued operation of a jurisdiction's lead medical facility is a top priority for resource allocation (generators, fuel, etc.).

6. Public health will have two primary roles:

   a. Detecting and treating communicable disease.

   b. Resource support for the healthcare profession. Public health will store and distribute medical supplies except for:

   - Those in medical facilities
   - Those in public safety department facilities

SITUATION AND ASSUMPTIONS

1. The healthcare system will face multiple, critical resource limitations:

   - Staffing. Staffing levels just cover present needs. During a catastrophic event, most people will be overwhelmed physically, emotionally, and psychologically. Even with strong leadership, many people will not be fully functional. This means some members of the healthcare profession, including mental health professionals, may not be available

   - Supplies. There are minimal medical supplies on hand. Supplies are re-ordered when stock levels reach a pre-determined point – classic just-in-time inventory management. Shortages of medications, and every item hospitals use in treating seriously ill patients, is expected

   - Facilities. The expected increased patient load will have to be managed using local facilities

2. The change in the level of care delivered is justified by specific circumstances and is formally declared by the State. Example Crisis Standards of Care Implementation Criteria include:

   - Identification of critically limited resources and infrastructure
   - Surge Capacity fully employed within healthcare facility
   - Maximal attempts at conservation, reuse, adaptation, and substitution performed
   - Regional, state, and federal resource allocation insufficient to meet demand
   - Patient transfer or resource importation not possible or will occur too late to consider bridging therapies
   - Request for necessary resources made to local and regional health officials
   - Declared state of emergency (or in process)

3. Hospitals and clinics could be filled with many times the normal amount of casualties expected in a time frame. We must plan for significant mortality and morbidity.

4. The medical personnel shortage will be amplified by the effects of the disaster. Some medical personnel may be unable to provide services due to personal injury or loss, emotional breakdown, or fear.

5. Maintaining public health throughout the disaster is critical to maintaining order.

- Cholera, dysentery, typhus, and other bacterial and viral infections, especially involving the digestive tract and the lungs, often accompany catastrophes. Young children, the elderly, and the immune-compromised are the primary targets; however, anyone can be struck.

- Long term implications of community deprivation, such as water borne diseases and disease outbreaks should be anticipated. Mitigation will be critical for these issues. Reacting to small outbreaks with force will prevent the outbreaks from spreading.

6. For worst-case events, of long duration, healthcare may evolve to include holistic approaches. Natural medicines may see greater use as the supply of pharmaceuticals declines. There will need to be a deliberate, constant encouragement by the government to the people regarding preventative care rather than sick care. The citizens must be continually reminded that caution, safety in everything from tool use to food preparation, and prevention of illness and accidents are necessary as supplies and resources dwindle.

CRITICAL RESOURCES

The highest standard of care will be provided if a jurisdiction's lead medical facility remains functional. Two critical requirements are:

- Managing resources, including logistics (people, supplies, and facilities) to assure continued operation (discussed below)
- Managing the patient care to prevent overloading (discussed in the next section, "Healthcare Organization")

The degree of infrastructure degradation/collapse will determine which, and to what extent of, the following resource augmentation measures are necessary.

1. **Staff.** Currently there is a shortage of medical personnel in many areas. We need to look into the community for additional personnel who might be able to provide varying levels of care. Potential highly qualified personnel – who would need minimal training and orientation - include:

- Formerly licensed healthcare professionals
- Veterinarians and vet techs
- Mental health professionals (counseling services, etc.)
- Dentists and dental hygienists
- Naturopaths
- Physical therapists
- Pharmacists
- Emergency Medical Technicians
- Critical Incident Stress Management (CISM) Teams
- Respiratory therapists
- Students in healthcare professions

If needed, staffing could be further augmented with potentially adequately qualified personnel, who would need varying training, orientation, and supervision. As an example, people who have had a loved one who needed respiratory therapy and other extensive home care often know how to clean and administer feeding tubes, oxygenation, foley catheters, wound management, etc.

2. **Supplies**. Critical resources should be identified and guidelines developed for their effective distribution. Our community medical centers rely on a just-in-time delivery system. However, many supplies can be found within the community. These "post-delivery" supplies should be considered critical resources for the survival of the community and taken into government control if directed by federal authorities.

- Pharmacies. Pharmaceutical supplies must be protected. Pharmacies will house some of the most highly valued and necessary supplies for the most critically ill and injured. Protecting these resources (removing from pharmacies to areas that can be secured and constantly monitored) MUST be accomplished during the initial crisis before organized looting can take place.
- Veterinary supplies should also be protected. Veterinary supplies often come off of the same processing lines as human supplies and may be used to treat humans during a crisis.
- Dental offices.
- Grocery stores, farm stores, home medical supply stores, home improvement stores, food warehouses also have stocks of various useable medical supplies such as gloves, alcohol, CPAP and BIPAP machines, cath-eters, veterinary antibiotics, oxygen, masks, coveralls, etc.
- Medical equipment suppliers.

3. **Facilities**. Certain buildings in the immediate vicinity of a jurisdiction's lead medical facility will be needed in the event of an overflow. Minor or moderate injuries and minor psychological problems can be treated away from the main hospital. Buildings that can be used include:

- Medical clinics.
- Malls, hotels, schools, enclosed parking facilities, warehouses, etc.
- Churches, with benches, can also be used for treating the non-emergent cases or for convalescent care. Consideration should be given primarily to proximity to the main medical facility.

Consider buildings (such as dormitories, conference centers, etc.) near the lead medical facility that can be offered for use as temporary housing for the families of healthcare workers. This is critical. It allows healthcare workers to serve their community, while being near their families.

FRAMEWORK FOR CRISIS STANDARDS OF CARE

This section outlines a framework for developing Crisis Standards of Care, and is based on "Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations", published by the National Academies Press. The goal is to develop guidance that state and local public health officials and health-sector agencies and institutions can use to establish and implement Standards of Care that should apply in disaster situations under scarce resource conditions

"Crisis Standards of Care" is defined as a substantial change in usual healthcare operations and the level of care it is possible to deliver due to a pervasive or catastrophic disaster.

Lead Agency. Crisis Standards of Care protocols are expected to be developed under the lead of state health departments, in partnership with other state agencies and localities. State management of Crisis Standards of Care offers important advantages:

- Ensures intrastate and interstate consistency among neighboring jurisdictions.
- Provides necessary legal protection for healthcare practitioners and institutions implementing Crisis Standards of Care.
- Federal directives during a national emergency are expected to come through the state. This provides rapid and uniform policy dissemination, including changes in indicators or triggers for Crisis Standards of Care.

Process. The broad process to develop Crisis Standards of Care ensures stakeholder and public involvement. The following key elements underlie development of guidance:

1. A strong ethical grounding.
2. Integrated and ongoing community and provider engagement, education, and communication.
3. Assurances regarding legal authority and environment.
4. Clear indicators, triggers, and lines of responsibility.
5. Evidenced-based clinical processes and operations.

Outcomes. Desired outcomes of the process are a consistent and fair healthcare system that meets the highest ethical standards in a disaster situation. Example ways to provide this include:

- Crisis Standards of Care protocols
- Identification of potential indicators and triggers for enacting Crisis Standards of Care
- Guidance for triage officers/teams
- Guidance for other parts of the healthcare system (EMS, home care, long-term care, and ambulatory care)

HEALTHCARE ORGANIZATION

Management Structure

1. Medical Advisory Board. The Medical Advisory Board is a jurisdiction-wide board that provides executive oversight for healthcare in a catastrophic emergency. The Board might consist of:

- Chief Elected Official (chair)
- Lead medical facility executive
- Physician with medical control responsibilities
- Public Health representative
- Emergency Medical Services representative

Advisory members include representatives from holistic medicine practice and citizens. Building cooperative relationships with non-traditional healing practitioners will be important if supplies cannot be delivered for months or longer.

Example responsibilities of the Medical Advisory Board include:

- Monitor Crisis Standards of Care indicators and triggers for level of care designation, in coordination with the state
- Draft liability protection documents (for healthcare practitioners and entities) to Crisis Standards of Care, for review by jurisdictional legal personnel and adoption by chief elected officials
- Make healthcare-related resource allocation recommendations to chief elected officials

2. Clinical Care Committees. Each entity has their own clinical care committee, composed of clinical and administrative leaders. During a catastrophic event, this committee monitors and prioritizes their entity's resources.

3. Triage Officer/Teams. Triage officer/teams may be designated by entities, by jurisdiction, or by region.

- An entity triage officer/team makes scarce resource allocation decisions based on the entity's triage guidelines
- A jurisdiction or regional triage team makes resource decisions based on the larger perspective. An example is determining the priorities for rural patient transfers

Implementation

With minimal external resources or mutual aid expected, the healthcare system must be reorganized to minimize overloading and subsequent collapse of the lead medical facility. This will require a new way of thinking about managing illness. A tiered medical management system is proposed, wherein diagnosis and treatment is done at the lowest possible level. Triage is performed at succeeding levels, to quickly elevate serious illness or injury to the appropriate facility.

Level I is the home. Citizens will need to take more responsibility for treatment of minor injuries/illness, such as colds, seasonal flu, and minor cuts and scrapes. Since emergency medical service response times may be delayed, citizens also need to be trained to manage life-threatening conditions: airway obstruction, bleeding, and shock (see Annex M: Education). Level I is augmented by:

- Visits from the NET Team healthcare leader (see Annex K: Neighborhood Emergency Teams)
- Guidance from an EMT located at the 9-1-1 dispatch center

If the injury or illness exceeds home treatment measures, patients will go to Level II. This may be by walking, assistance from the NET Team, or contacting 9-1-1.

Level II is the neighborhood gathering point (school, etc.). As a minimum, each neighborhood gathering point will serve as a Neighborhood Emergency Help Center (NEHC). As many non-life threatening conditions as possible will be diagnosed and treated here. The NEHC serves as an out-of-hospital medical treatment facility for patients requiring a lower acuity level of care than that supported in a hospital critical care setting, but not well enough to be managed at home. Staffing will include an EMT, with possible augmentation by other healthcare professionals, as personnel availability allows. Medical supplies at the gathering point will be appropriate for the diagnoses and treatments authorized by the medical advisory board. Level II is augmented by guidance from medical control.

Life-threatening injuries or illnesses will go to Level III, as will non-life threatening cases directed by medical control.

Level III is the jurisdiction's lead medical facility (hospital, clinic, etc.). The lead medical facility has the most skilled medical personnel, and associated supplies. Access to this facility is only by direction of medical control to Level II facilities: for life-threatening injuries or illnesses, and cases where conditions are uncertain and further diagnosis is required.

- Transportation to and from the lead medical facility may be by ambulance or other available mode, including buses.
- Triage should be implemented immediately. Injuries involving life and limb should be treated at the lead medical facility. If bed capacity nears maximum, moderate or minor injuries and convalescing patients can be treated in facilities near the lead medical facility.
- Major psychiatric problems should be treated in the psych ward of the hospital. However, there will be many "worried well" and emotionally traumatized patients who will need to be assessed and counseled. These people should be moved away from the triage center where exposure to significant wounds and death will increase their psychological damage. Consider using places such as churches, libraries and other quiet buildings that people naturally associate with calm and serene experiences. Deploy psychologists, counselors, social workers to these sites to monitor and counsel patients, as well as a nurse practitioner or psychiatrist who can assess medication needs in the patients.

The exception to this tiered medical care system is communicable disease outbreak or epidemic. To minimize disease spread, isolation and quarantine measures may be implemented. In these cases, a temporary field medical facility may be brought to the affected neighborhood.

SUSTAINABLE HEALTH CARE

Sustaining healthcare will require both trained personnel and pharmaceuticals. Potential resources include:

- Refresher training for retired healthcare workers
- Field training (for example, Community Emergency Response Teams—CERT)
- Certified Nursing Assistant (CNA) classes
- Education on holistic approaches and alternative medicine
- Growing medicinal herbs
- Traditional tribal remedies

Program development is under the direction of the Medical Advisory Board.

CONCEPT OF OPERATIONS

Disaster events can have a sudden or gradual increase in demand for healthcare services and a related decrease in resources available to provide such care. Because of these imbalances, healthcare facilities may be operating at varying points along a continuum from conventional to contingency to crisis capacity. Concurrent with this transition along a surge capacity continuum is the realization that the standard of care will also shift.

Existing plans address conventional and contingency capacities. This annex implements the most severe condition (crisis care). The transition should be anticipated by taking appropriate response actions in advance. For example, Neighborhood Emergency Help Centers can be established and stocked while the lead medical facility is at contingency capacity on the continuum, and personnel can be identified in advance for timely assignment when crisis capacity is determined.

Although the lead for this annex is public health, the responsibility and control of healthcare is spread among a variety of entities and jurisdictions, including public health, hospitals/clinics, Medical Advisory Board, and suppliers (such as pharmacies). This poses unique challenges to healthcare, since the actions of one entity may likely impact others. The role of public health is primarily coordination, with potential additional authorities as determined by federal directives.

During crisis response operations, the Medical Advisory Board provides direction and resource allocation to representatives from the lead medical facility, emergency medical services, and public health.

PREPARATION

1. Public Health – Supplies: Work with medical facilities and pharmacies, and develop a plan to purchase, manage, and distribute medical supplies to sustain the local healthcare system during large-scale, long duration disasters.

2. Public Health – Personnel:

- Maintain a personnel list of practicing healthcare professionals.
- Continue to recruit Medical Reserve Corps volunteers across a wide range of medical personnel.
- Create/maintain the management structure: Medical Advisory Board, Clinical Care Committees, and Triage Officer/Teams. Include these groups in exercises.

3. Annex F: Shelter: Identify buildings in the immediate vicinity of the lead medical facility that can be used for overflow and residency for healthcare workers AND their families.

RESPONSE - HEALTHCARE

____ Establish communications with the state and satellite public health offices

____ Provide status updates

____ Monitor indicators and triggers for transition from conventional to contingency to crisis care.

NOTE: Level of care is unique to each facility. The same event may result in conventional care at one facility, but crisis care at another.

____ For facilities at crisis capacity, receive authorization from state to:

____ Institute Crisis Standards of Care

____ Adjust scopes of practice for licensed or certified healthcare practitioners

____ Alter licensure and credentialing practices as needed

____ Resource allocation

____ Make recommendations to chief elected officials for allocation of government-controlled resources

____ Neighborhood Emergency Help Centers

____ Healthcare entities

____ Facilitate resource sharing between healthcare entities as determined by events and agreements between entities

____ Consider wineries/breweries to make large batches of medical alcohol (for disinfection, etc.)

This plan is only activated in the event of a national emergency and attendant local disaster/emergency declarations