Healthcare System Emergency Response Plan

Regional Scarce Resource Management and Crisis Standards of Care Annex

Version 1, July 2017

"All Network plans will be reviewed to integrate additional counties and partners following the Network's expansion in July 2018 to serve 15 Western Washington counties and contiguous sovereign tribal nations. All references in this plan to specific counties/jurisdictions are in the process of being reviewed and revised"

NORTHWEST HEALTHCARE Response Network

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Seattle & King County

Tacoma - Pierce County Health Department
Healthy People in Healthy Communities
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Regional Scarce Resource Management and Crisis Standards of Care

Concept of Operations

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Record of Changes

Version No.	Description of Change	Date Entered	Posted By
1.	Plan developed and drafted	July 2017	Rebecca Lis

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Executive Summary

As shown in previous responses to large scale disasters, it is vital to the continued operations of our healthcare system to plan for possible changes in orders, protocols, guidelines and standards of care that may occur during this type of emergency.

The Regional Scarce Resource Management and Crisis Standards of Care Concept of Operations is applicable for any incident in King and Pierce which:

- It is suspected or determined that there is or will be a crisis level situation for healthcare delivery; and
- Regional coordination is required to implement standard processes to manage or mitigate a crisis or near crisis situation.

This concept of operations provides a framework for:

- Decision making and coordination during an active or potential crisis situation.
- Identifying processes that can be employed to prevent or mitigate a crisis situation as well as declaring regional crisis standards of care, if needed.
- Defining roles and responsibilities of regional response agencies to a crisis or near crisis situation including:
    - Authorities and decision making framework
    - Implementation process
    - Coordination of healthcare, Local Health Jurisdictions (LHJs), and other regional and State partners' response.
- Specific tools or structures that should be considered to mitigate or respond to a crisis or possible crisis situation. These tools include:
    - Triage team guidelines – for facility and regional triage and prioritization of patients requiring scarce resource
    - Scarce Resource Cards – outlines conservation, mitigation and prioritization strategies for scarce resources
    - Triage algorithms - to aid in the medical triage of patients in times of scarce resources
- Identifies legal, liability, and waiver considerations associated with a crisis situation as well as important communication considerations for healthcare and the public during a crisis or near crisis event.

The plan does not dictate specific actions, requirements, or standards that will be enacted in a crisis situation.

This plan can be activated by the LHO (or their designee) or the NWHRN, and defines processes for facilitating recommendations from healthcare partners through Disaster Clinical Advisory Committee (DCAC), the Healthcare Executive Response Committee (HERC), and other partners as appropriate.

Introduction

As shown in previous responses to large scale disasters, it is vital to the continued operations of our healthcare system to plan for possible changes in orders, protocols, guidelines and standards of care that may occur during this type of emergency.

In 2009 the Institute of Medicine (currently the National Academy of Medicine) published a landmark report, *Guidance for Establishing Crisis Standards of Care for use in Disaster Situation: A Letter Report*. In this report the authors defined Crisis Standards of Care as:

> "A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g. pandemic influenza) or catastrophic (e.g. earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory power and protections for healthcare providers in the necessary task of allocating and using scarce medical resources and implementing alternate care facility operations."[1]

Crisis standards of care may be a secondary impact due to a wide range of potential disruptions to the healthcare delivery system including

- Extremely scarce resources;
- Impacts to healthcare infrastructure;
- Impacts to staffing levels; and/or a
- Shortage of care due to a large scale surge in patients.

A. Continuum of Care

The Institute of Medicine outlines a framework to define surge capacity within the healthcare systems, during normal operations and disaster operations, as a continuum: from conventional to contingency and finally crisis.

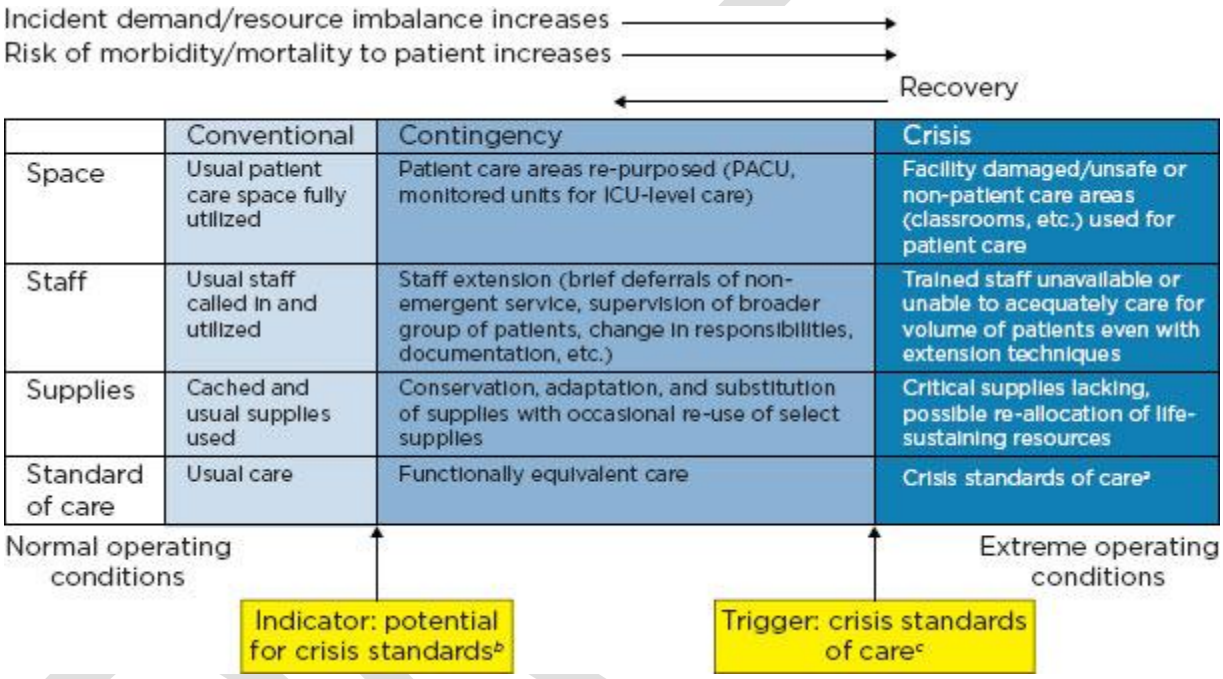
The Institute of Medicine Definitions of the Continuum of Care:

> **Conventional Capacity**: The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.
>
> **Contingency Capacity:** The spaces, staff, and supplies used are not consistent with daily practices but provide care that is functionally equivalent to usual patient care. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources).

[1] IOM (Institute of Medicine) 2009. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. Washington, DC: National Academies Press. (p. 3)

Crisis Capacity: Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. [2]

Figure 1: Institute of Medicine: Allocation of specific resources along the care capacity continuum.[3]



NOTE: ICU = intensive care unit; PACU = post anesthesia care unit.
a Unless temporary, requires state empowerment, clinical guidance, and protection for triage decisions and authorization for alternate care sites/ techniques. Once situational awareness achieved, triage decisions should be as systematic and integrated into institutional process, review, and documentation as possible.
b Institutions consider impact on the community of resource use (consider "greatest good" versus individual patient needs—e.g., conserve resources when possible), but patient-centered decision making is still the focus.
c Institutions (and providers) must make triage decisions—balancing the availability of resources to others and the individual patient's needs—shift to community-centered decision making.

B. Crisis Standards of Care across Levels of Response

Crisis standards of care may be declared at different levels of response including the individual facility level, regionally, and at the state level. These declarations occur independently, sequentially, or in parallel. The consequences and authorities held by these parties differ and are outlined below:

[2] IOM (Institute of Medicine). 2012 *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*. Washington, DC: The National Academies Press. (p.40)

[3] IOM (Institute of Medicine) 2009. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. Washington, DC: National Academies Press. (p. 53)

Level of Response	***Possible Crisis Actions***
Individual Healthcare Facility	• Declare internal crisis situation according to internal protocols, once all possible mitigating factors are attempted and assistance will be significantly delayed • Activate internal protocols to restructure internal care strategies for space, staff, and stuff to address the crisis situation • Communicate their situation and their crisis status with NWHRN as soon as possible • When issued, abide by LHO standard guidance, orders, etc.
Local Health Officer (Regional)	• Has the authority to declare regional crisis standards of care and may provide guidance and orders for the care of patients and use of healthcare resources within their jurisdiction to protect the public's health. • Does not have the authority to implement legal, liability, and waiver changes but maintains the ability to request changes through proper channels at the state level
State Level	• Has the ability to declare state-level crisis standards of care and provide guidance and orders to protect the public's health • Has the authority to make formal requests for legal, liability and waiver changes through appropriate channels

The Institute of Medicine also stresses the importance of an ethically grounded system to guide decision-making in a crisis standards of care situation to ensure the most appropriate use of resources, staff, and care in a crisis. The Institute of Medicine defines these ethical principles as,

- *Fairness* – standards that are, to the highest degree possible, recognized as fair by all those affected by them – including the members of affected communities, practitioners, and provider organizations, evidence based and responsive to specific needs of individuals and the population.
- *Duty to care* – standards are focused on the duty of healthcare professionals to care for patients in need of medical care
- *Duty to steward resources* – healthcare institutions and public health officials have a duty to steward scarce resources, reflecting the utilitarian goal of saving the greatest possible number of lives.
- *Transparency* – in design and decision making
- *Consistency* – in application across populations and among individuals regardless of their human condition (e.g. race, age disability, ethnicity, ability to pay, socioeconomic status, preexisting health conditions, social worth, perceived obstacles to treatment, pass use of resources)
- *Proportionality* – public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources

- *Accountability* – of individual decisions and implementation standards, and of governments for ensuring appropriate protections and just allocation of available resources[4]

In 2009, Public Health – Seattle & King County conducted a series of public engagement forums with members of the public and key stakeholders from healthcare and public health to understand their feelings about key concept concerning crisis standards of care (see full report for more details)[5]. The following concept of operations is based on these findings as well as those identified in publications by the Institute of Medicine and other national leaders and jurisdictions.

The Regional Resource Management and Crisis Standards of Care Concept of Operations defines roles and responsibilities of regional response agencies to a crisis situations including the authorities, decision making framework, implementation process, coordination of healthcare, Local Health Jurisdictions (LHJs), and other regional and State partners' response. It is based on the experience of local, regional, and national guidance and will serves as a template for regional resource management and crisis standards of care response in King and Pierce Counties.

Purpose

The purpose of this concept of operations is to provide a framework for a coordinated regional response in King and Pierce Counties related to the potential consequences of a crisis incident that puts a disproportionate strain on the healthcare systems and requires altering some current process to allow for continued function of healthcare in the community, whether it be due to scarce resources, staff, space, etc. Specifically, the purpose of this concept of operations is to:

1. Describe resources that can be used to help prevent or mitigate a crisis situation.
2. Outline indicators and triggers for movement from contingency to crisis, to better coordinate conservations strategies and identify crisis situations.
3. Describe the decision making structure to be used to determine a crisis or potential crisis situation and implement appropriate guidance, regulations, orders, etc..
4. Describe procedures for creating or updating crisis protocols for patient care or resource management.
5. Describe procedures for implementing scarce resource protocols.
6. Define roles and responsibilities for healthcare, LHJs, the Northwest Healthcare Response Network (NWHRN), local response agencies, emergency management, community, and local, state, federal and tribal partners in crisis standard of care situation.
7. Describe procedures for communications and coordination with public health, healthcare organizations, NWHRN, clinicians, other local partners and the public during a crisis response.

[4] IOM (Institute of Medicine) 2009. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. Washington, DC: National Academies Press. (p. 3-4, 27-33)

[5] Li-Vollmer, M. *Health Care Decisions in Disasters: Engaging the Public On Medical Service Prioritization During a Severe Influenza Pandemic*. Journal of Participatory Medicine. Vol 2. December 14, 2010.

Scope

The Regional Resource Management and Crisis Standards of Care Concept of Operations is an Annex to the larger King and Pierce County Healthcare System Emergency Response Plan and is applicable for any incident in King and Pierce counties in which it is suspected or determined that there is or will be a crisis level situation for healthcare delivery and requires regional coordination to implement standard processes to manage or mitigate the situation. This concept of operations provides a framework in which decision making and coordination will occur during a crisis or potential crisis situation and does not dictate specific actions, requirements, or standards that can or will be enacted in a crisis situation. This plan is not applicable for the routine management of healthcare systems standards or disasters that are unlikely to reach the crisis level.

The information in this plan applies to the roles and responsibilities of LHJs, the NWHRN, healthcare organizations (including hospitals, ambulatory care, long-term care, home health/home care, and support services) and other emergency preparedness partners. Broader health, medical and mortuary response activities are covered in their respective plans and protocols (See References) This plan is compatible with federal, state, and local emergency response plans, promotes the coordination of an efficient and effective response by utilizing the concepts outlined in the National Incident Management System and it establishes common goals, strategies and terminology with other regional and local plans (See References).

Planning Assumptions

Planning assumptions for this plan include:

1. Activation of this Concept of Operations does not inherently lead to a declaration of Crisis Standards of Care or the altering of medical or healthcare standards.
2. Activation of this Concept of Operations does not inherently lead to all aspects outlined in the plan being implemented.
3. This plan addresses an emergency situation that goes above and beyond normal day to day capacity constraints
4. Local Health Officers (LHOs) have the authority to change or implement procedures to protect the public's health including declaring crisis standards of care.
5. Responses to large scale disasters may require coordination with other regional, state and federal partners.
6. Decision making and implementation of public health orders, guidelines, etc. will be in accordance with the ethical framework outlined above.
7. Implementing this plan and associated protocols is meant to maximize the appropriate use and consistency of use of scarce resources, staff, and medical care. Consistency of implementation across the two-county region allows for the most effective use of resources across the healthcare system and maximizes consistency within healthcare systems that serve multiple counties.
8. Resources and medical staff may be in short supply throughout the region, state, country, or internationally depending on the severity and nature of the disaster.
9. Healthcare organizations and systems throughout the region will commit their own resources and rely on existing contracts with medical suppliers and pharmaceutical vendors to the maximum extent possible to address internal challenges prior to releasing resources to other healthcare organizations.

10. Pediatric, obstetric, burn and other specialty care patients, including those that are critically ill, may present to ANY healthcare facility.
11. Close coordination between LHJs and healthcare organizational executive and clinical leadership is critical to the successful decision making, communications, and implementation of crisis standards of care.
12. External communications with healthcare organizations, clinicians, and the general public is vital to the successful implementation of conservation strategies and crisis standards in a disaster.
13. Medical surge is a continuum, circumstances can change and movement between conventional, contingency and crisis may be fluid.
14. Healthcare organizations will follow outlined regional conservation strategies to mitigate healthcare system impacts throughout the region.
15. Communications modes and processes may be strained and disrupted in the emergency response.
16. Transparent, consistent, and clear communications with the public is vital in times of scarce resource management or crisis situation.
17. The implementation of this concept of operations or protocols therein will have a significant impact on the public perception of the healthcare systems and the response.

Concept of Operations

A. Activation of Concept of Operations

- This concept of operations may be activated during any disaster or emergency that warrants coordination to support the healthcare systems operations in an incident that meets the crisis capacity definition[6] (see p. 6) or may possibly become a crisis environment. The activation of this concept of operations will likely occur concurrently with the activation of other regional plans.
- The activation of this concept of operations does not inherently lead to the declaration of crisis standards of care or the implementation of any orders, guidelines, etc.
- This plan can be activated by the LHO (or their designee) or the NWHRN. Local healthcare organizations, the Disaster Clinical Advisory Committee (DCAC), and the Healthcare Executive Response Committee (HERC), may all request the LHO or the NWHRN to activate this plan. Activating organizations should consider consulting with any of the additional partners listed above, as well as other LHJs, local Emergency operations Centers (EOCs), local EMS, other regional entities or partners, and the Washington State Department of Health (DOH) for activation.
    - Local healthcare organization may activate and declare their own internal crisis situation prior to a regional declaration of crisis standards of care. If this occurs healthcare organizations should immediately notify their LHJ and NWHRN.
- The activation of this Concept of Operations could be driven by the situation or needs in one county but LHO (or designee) coordination should occur between both counties.

[6] IOM (Institute of Medicine) 2009. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. Washington, DC: National Academies Press. (p. 3)

- Concept of Operations Activation Trigger: the following regional triggers should be considered when activating the resource management and crisis standards of care concept of operations.
    - LHO believes there may be a need to declare regional crisis standards of care.
    - There is a formal declaration of an emergency locally, regionally state-wide, or nationally which impacts the ability to ensure adequate resources.
    - Any disaster or emergency that warrants coordination to support the healthcare systems operations in an incident that meets the crisis capacity definition[7] (see p. 6) or may possibly become a crisis environment.
    - Multiple hospitals or hospital systems in the region are operating at crisis conditions, with maximal conservation strategies with regard to equipment, staff, resources, and causing significant strain on the regional healthcare system with no relief available. The following examples are applicable for a delay or lack of assistance available from outside the region. Examples include:
        - Severe shortage of resources, equipment, and/or pharmaceutical causing significant regional restrictions on the ability to provide standard care.
        - Significant shortage and/or delay in assistance for clinical staff resources, or coordination support from other local, regional, state-wide, or national response partners, limiting the ability to provide routine care.
        - Significant loss of critical infrastructure, utilities, etc. that causes a regional disruption to normal level of care and may prevent the delivery of specific types of care (e.g. dialysis, etc.).
        - An exceptional surge in patients seeking medical care that delays standard care with no relief available.
        - Patient movement options have been exhausted or are unavailable.
    - There is a formal declaration of crisis standards of care at the state level or there are healthcare guidelines, orders, and protocols implemented at the state-level that will have regional impacts.

B. Notification and Warning

- If not notified prior to the activation of the concept of operations, once activated the LHJ(s) and NWHRN will notify each other and their respective partners.
    - The NWHRN, Public Health – Seattle & King County (PHSKC), and the Tacoma-Pierce County Health Department (TPCHD) each maintain a 24/7 after hours contact numbers for healthcare clinicians and a duty officer phone line, and are the first line of contact in an event. See Attachment A for Duty Officer contact information
    - Every attempt should be made by healthcare organizations to notify the NWHRN of a healthcare facility's internal activation of crisis situation.
- Following notification, the LHJs, in consultation with NWHRN as appropriate, will identify the appropriate partners to further notify. Partners may include:

[7] IOM (Institute of Medicine) 2009. *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*. Washington, DC: National Academies Press. (p. 3)

- Neighboring LHJs
- DOH
- Local healthcare organizations/clinicians
- Local EMS
- Local emergency management
- County Medical Examiner
- Elected Officials

C. Command, Control and Coordination

1. Policy Recommendation Structure and LHO Decision Making

   - The LHO(s) has the authority to declare regional crisis standards of care and provide guidance and orders for the care of patients and use of healthcare resources within their jurisdiction to protect the public's health.
   - LHOs and LHJs should collaborate as much as possible to provide a consistent approach to healthcare guidance, orders, protocols, etc. during a crisis situation.
   - Depending on the situation, the LHO(s) may call on groups to advise on the appropriate clinical care, policy decision, or use of resources but the final authority to enact these recommendations lies with the LHO(s) alone.
   - For the purpose of scarce resource management and crisis standards of care decision making the LHO(s) should consult the HERC and DCAC and may consult with other partners or groups including LHJ senior leadership, EMS Medical Directors, other healthcare executives, DOH, and other partners as appropriate.
   - If all or some of the advisory groups are convened to support a crisis situation the following topics should be considered:
     - What is the current healthcare delivery situation (infrastructure, staffing, supplies, etc.)?
     - Is it projected that the current situation will worsen, stay the same, or improve?
     - Is there a timeline that might bring relief from outside assistance or declining urgency?
     - What is the best clinical recommendation for supporting the current healthcare situation? What is the most clinically feasible recommendation to support the current healthcare situation?
     - What is the best healthcare policy recommendation for supporting the current healthcare situation?
     - Do the advisory entities support the implementation of the identified recommendations within the community?
     - Is there a potential for outside resources (inter-state, intra-state, federal) and have processes been put in place to implement these strategies?

2. Declaring Crisis Standards of Care

   Several topic areas are involved as part of the overall concept of crisis standards of care. Some or all of the following topic areas should be considered when declaring crisis

standards of care but also when enacting orders, guidelines, policies or regulations to address and help mitigate a crisis standards of care situations. Topics include:

- Resource conservation (including but not limited to: equipment, disposable and non-disposable resource, pharmaceutical resources, utilities [e.g. water, power], infrastructure)
- Changes to staffing (including: sharing staff, using volunteer staff, staff operating outside their normal scope of care, changing staffing ratios)
- Legal and regulatory changes (including: waivers, protections, regulations)
- Changes to clinical practices standards (including but not limited to: infection control, types of care provided, allocation/restriction of scarce resource or practices)

The situation must warrant changes to one or more of these topics to declare crisis standards of care within the community. To determine if the situation has met the threshold for activating crisis standards of care based on one or more of the outlined topics refer to Attachment B for a full outline of all triggers and indicators for each of these topic areas. No one trigger or indicator determines whether or not the threshold has been met, it is up to the judgement of the LHO(s) in consultation with their advisory group to determine, based on the current situational awareness information, if by their best judgement the community has reached a crisis situation.

3. Clinical and Healthcare Policy Recommendations Structure

In crisis or impending crisis situations the LHO(s) may require clinical and healthcare policy recommendations from local healthcare clinicians and organizations. The LHO(s) may seek recommendations to provide evidence for a crisis standards of care declaration, to determine what mitigation guidance to provide healthcare organizations around the region, and guidance on how to implement change to standards of care, etc. The NWHRN administers and may activate the DCAC and/or the HERC to support the need for clinical and/or healthcare policy guidance and recommendations. The DCAC and the HERC may be activated individually or together to respond to an incident. Additionally, it is advantageous to have the LHO(s) participate in the DCAC and/or HERC meetings and discussions.

- ***Disaster Clinical Advisory Committee (DCAC):*** The DCAC will provide independent clinical guidance and expertise to the LHOs, to support healthcare system planning and response on key issues such as medical surge, allocation of limited resources (conservation or rationing), and clinical care strategies, including altering the standards of care in a response. The DCAC will be activated to provide input on a clinical issue of importance, and may be used to support clinical decision making during major events if needed. Membership includes specialists in areas relevant to clinical management during all types of disasters.
    - The DCAC is activated by the NWHRN in coordination with the NWHRN Senior Medical Advisor, DCAC Chair and Vice Chair. DCAC can be

activated at the request of LHOs, DCAC members, any King or Pierce County healthcare institution, or by request from WA State DOH and WA State DMAC.
    - NWHRN will coordinate the notification and convening (in-person or remotely) of DCAC members. The NWHRN in coordination with the DCAC chair or Vice Chair will facilitate discussions.
    - All DCAC recommendations to the LHO, the HERC, and healthcare facilities will be documented in writing including the signature of the Chair and Vice Chair, date, and time of the recommendation and distributed to all relevant parties. If there is a dissenting opinion, then the dissenting party will compile the recommendation in a timely manner to be delivered with the DCAC majority recommendation.
    - All recommendations from DCAC will be clinical, based on the delivery of the best medical care possible given the situation at hand. Final decision recommendations will be open and transparent and be provided to relevant parties.

- ***Healthcare Executive Response Committee (HERC):*** The committee is comprised of designated executive representatives from NWHRN healthcare member organizations and local public health departments. The HERC is an advisory body of executive-level healthcare representatives that:
    - Provides guidance on emergency response-related healthcare policy issues during preparedness and response.
    - Provides healthcare executive endorsement/approval of NWHRN response plans and strategies.
    - Provides healthcare executive outreach and coordination with peers during preparedness and response.

  The HERC will be activated when there is an issue requiring healthcare executive input and may be used to support decision making concerning healthcare response in a major event.
    - All HERC recommendations to the LHOs will be documented in writing including the date and time of the recommendation, approved by the HERC chair and vice chair(s), and distributed to all relevant parties. The NWHRN in coordination with the HERC chair will facilitate committee discussion and decision-making. Final decision recommendations will be open and transparent and be provided to relevant parties.

- ***Regional Clinical and Healthcare Advisory Process Outline***
  <u>If both committees are activated:</u> In the event that both committees are activated they will work together to produce one common set of recommendations to the LHO(s).

  1. DCAC and HERC will be activated by NWHRN if requested or determined to be necessary, in close coordination with DCAC and HERC committee chairs and vice chairs.

2. Activation notifications sent to both committees and LHJs.
3. Meeting dates, times, and modes (in-person vs. conference call) are established for both committees. The committees may meet sequentially or jointly.
    a. DCAC convened. Written recommendations from the DCAC compiled by NWHRN, approved by the DCAC chair, and provided to the HERC.
    b. HERC convened, jointly with DCAC or with representatives from the DCAC.
    c. Written recommendations from healthcare as a whole to include recommendations from the HERC and DCAC will be compiled by NWHRN and approved by the HERC and DCAC chairs. Written recommendations provided to the LHOs and other partners as appropriate. See Figure 1 below.

Figure 1: Healthcare Clinical and Policy Recommendations Sequencing

	1st Meeting	2nd Meeting	Written Recommendations
Option #1	DCAC	HERC	One written recommendation delivered to the LHOs with supporting materials (using the SBAR outlined in Attachment C)
Option #2	DCAC	DCAC + HERC	
Option #3	∅	DCAC + HERC	

<u>If only one committee is activated:</u>

1. Request for DCAC or HERC input received by NWHRN, or NWHRN determines the need for DCAC or HERC activation in close coordination with DCAC or HERC committee chairs.
2. Activation notifications sent to committee and LHJs.
3. Meeting dates, times, and modes (in-person vs. conference call) are established for the committee.
4. DCAC or HERC convened. Written recommendations from the DCAC or HERC compiled by NWHRN and approved by the committee chair.
5. Written recommendations provided to the LHOs and other partners as appropriate using the SBAR format outlined in Attachment C.

- ***Clinical and Policy Recommendations Report***
  Written recommendations from the DCAC and the HERC will be compiled by the NWHRN in close coordination with LHJs using the SBAR (situation, background, assessment, recommendations) format included in the template in Attachment C. Decisions and recommendations could include enacting orders, guidelines or

protocols to prevent the progression into a crisis situation or declaring crisis standards of care for the region. This tool will provide a structure to compile strategies and their assessment from DCAC and HERC conversations to deliver to the LHO(s) during a response. Recommendations should be compiled concisely and nimbly to adjust to the situation at hand. Recommendations should identify and explain any areas which expert advisory groups diverge in opinion. Additional detailed supporting information should be attached to the recommendations. Following the submittal of recommendations to the LHOs, the LHJs and NWHRN will collaborate to host a conference call between LHOs and DCAC and HERC leaders to discuss recommendations.

D. Clinical Implementation

In an emergency response, every effort should be made to prevent the need to declare crisis standards of care. Many regional plans and the scarce resource management guidance materials below can provide strategies on how to mitigate a contingency and crisis situation effectively.

Declaring crisis standards of care or enacting orders, guidelines, recommendations, etc. to control a crisis situation will have significant impacts on the delivery of care within the healthcare community. It is vital in these situations to maintain an ethical and transparent process, which means all healthcare organizations will agree to operate under and according to the same public health orders and guidelines outlined by the LHJs. If one or more organizations chooses to not follow the public health orders and guidelines this could cause inequality of care provided among healthcare organizations and would be counter to the ethical principles agreed to above.

To aid in the implementation of conservation strategies or scarce resource allocation the DCAC along with other regional clinical and healthcare partners has created several tools to include: scarce resource cards, algorithms, worksheets and triage team guidelines. Some tools below are only applicable for a crisis situation (triage team, scarce resource algorithms). The scarce resource cards provide strategies that can be used in conventional or contingency situations to help prevent the progression of a resource shortage to becoming a crisis level situation. Procedures and mechanisms for input, change and updating these resources are provided in the tools themselves

Scare Resource Management Materials:

1. Scarce Resource Triage Team Guidelines

   A Scarce Resource Triage Team Guideline has been developed by clinical experts (DCAC and other clinical subject matter experts) within King and Pierce Counties that can be implemented in a crisis standards of care situation to provide a framework for the transparent, fair, equitable, and consistent approach to the allocation of scarce resources during a declared emergency in which crisis standards of care has been implemented. It is assumed these triage teams will only be enabled when the following criteria have been met:

   - LHO declaration of crisis standards of care

- All efforts at surge capacity have been overwhelmed or will be shortly overwhelmed
- Federal assets have been requested but may be delayed

The triage guidelines outline three possible tiers of triage, their composition, and the team's purpose, including:

- Hospital clinical triage teams
- Hospital system triage teams
- Regional clinical triage teams

The guidelines additionally outline the process for triage oversight, re-evaluation of process/protocols, and communications concerning the triage teams. Any requests for re-evaluation of the triage protocols, resource conservation guidelines or other guidelines should follow the process outlined in the triage guidelines protocol. If a request for re-evaluation is received at the regional level by DCAC and needs to escalate further, DCAC can provide a written copy of the request to the LHO(s) for review and consideration.

If crisis standards of care has been declared, LHJs should provide guidance on how the triage team outline will be implemented in the region. To ensure consistency and adherence to the ethical principles outlined above, LHOs may be required to standardize the adherence or use of the triage teams throughout the region(s). See Attachment D for a copy of the triage team guideline.

2. Scarce Resource Cards

   Several scarce resource cards have been developed by clinical experts (DCAC and other clinical subject matter experts) within King and Pierce Counties. These scarce resource cards aid in the conservation, adaptation, substitution, re-use, and re-allocation of some critical resource during an emergency. Additionally, these cards outline strategies for conservation of resources across the whole continuum of care (conventional, contingency, and crisis) and can be applicable for non-crisis events, crisis events, or in aid of preventing a crisis situation. These cards are meant to be used by healthcare provider and organizations to provide guidance on ways to conserve vital resources. The scarce resources cards do not supersede any public health orders or guidance.

   If crisis standards of care has been declared, LHJs should provide guidance on the use of the resource management strategies outlined in these cards (if applicable). To ensure consistency and adherence to the ethical principles outlined above, LHOs may be required to standardize the adherence or use of the strategies within these or other clinical guidelines. These scarce resource cards can be used alone or in combination with other scarce resource management materials to address the current clinical and resource situation.

   Scarce resource cards have been created for the following potentially limited resources:

- Blood products
- Burn
- Hemodynamic support and IV fluids
- Mechanical ventilation
- Medication administration
- Nutritional support
- Oxygen
- Renal replacement therapy
- Respirator
- Staffing

3. Triage Algorithm

   In addition to the scarce resource card, clinical experts in King and Pierce Counties have created triage algorithms for the triage of specific clinical areas during a crisis situation, should they be required. The triage algorithms can be used alone or in combination to address the current clinical and resource situation. The triage algorithms are meant to be used by healthcare organizations across the region for a standardized approach to the distribution of scarce medical care and resources. Algorithms have been created for the following potentially limited clinical areas:

   - Burn
   - Adult Critical Care
   - Pediatric Critical Care
   - Renal Replacement Therapy

   If a crisis situations occurs that involves a scarce resource not listed above, the DCAC and other clinical subject matter experts can be called upon during a response to consider creating additional clinical recommendations, tools, algorithms, or scarce resource cards. See Attachment E for a copy of all scarce resource cards, algorithms, and affiliated documentation.

   A description of the review, validation and roll-out plan for the scarce resource cards, algorithms and triage teams can be found in Attachment F.

E. Legal, Liability and Waiver

Crisis standards of care is defined as "a substantial change in usual healthcare operations and the level of care it is possible to deliver". Therefore, to be able to fully implement changes to the provision of healthcare there may be legal, liability, and waiver issues that may need to be addressed in a crisis situation. Depending on the disaster, the types of legal, liability and waiver issues that arise can vary dramatically. To enact some of the liability and waiver changes that are built into the healthcare regulatory system there will most likely need to be a local, state, and/or federal declaration of disaster and/or public health emergency. Most changes to legal and liabilities issues as well as petitions for waivers will need to be requested up through the state

department of health to the appropriate parties. Issues that may arise in a crisis standards of care situation that could trigger the need for legal and waiver involvement could include, but are not limited to:

- Liability of clinicians and institutions for care provided under stress with less than a full complement of resources
- Certification and licensing issues to meet either limited or emergent staffing needs.
- Scope of practice – it may be necessary to grant permission to certain professionals on a temporary and emergency basis to function outside their legal scope of practice or above their level of training
- Institutional autonomy - If organizations and institutions cede their authority in order to participate in a unified incident management system in a crisis, those organizations may have to address the legal implications.
- Facility standards – standards of care that pertain to space, equipment, and physical facilities may have to be altered.
- Patient privacy and confidentiality. Provisions of HIPAA and other laws and regulations that require signed releases and other measures to ensure privacy and confidentiality of a patient's medical information may have to be altered
- Documentation of care – altered levels of documentation of care may need to be instituted.
- Property seizures - including facilities, supplies, and equipment for the delivery of care or to destroy property deemed unsafe
- Provisions for isolation and quarantine or mass immunization[8]

F. Support Processes

Declaring crisis standards of care and/or enacting public health orders, guidelines, recommendations, etc. to support healthcare in a crisis or near crisis situation is a vital part of the healthcare response coordination. It also requires the coordination with several other local and regional plans, procedures, protocols, and planning efforts to ensure a complete response to the disaster. Some local and regional plans may help mitigate healthcare capacity issues and prevent the progression into crisis (public information call centers, alternate care systems, pediatric planning, and acute infectious disease). Other plans may be activated along with the Resource Management and Crisis Standards of Care Concept of Operations to support healthcare capacity issues that may arise in a crisis situation (palliative care, behavioral health, fatality management, family reunification). All of these plans are maintained as separate documents and are not attached to this plan. Below is a brief description of the planning, how it coordinates with the Resource Management and Crisis Standards of Care Concept of Operations and the responsible entity. Refer to the original plans for complete descriptions of the response procedures.

[8] *Altered Standards of Care in Mass Casualty Events*. Prepared by Health Systems Research Inc. under Contract No. 290-04-0010. AHRQ Publication No. 05-0043. Rockville, MD: Agency for Healthcare Research and Quality. April 2005. (p.24)

- Call/Contact Centers – LHJs and local emergency management have plans in place to coordinate the activation of call or contact centers to manage and/or triage the influx of calls concerning an emergency response. The coordination of messaging, direction to care, and self-care advice can help mitigate a response from becoming a crisis. Additionally, in a crisis standards environment these avenues can additionally provide support to the overwhelmed healthcare system.
- Alternate care systems – LHJs maintain plans that support alternate care systems within the community. These coordinated systems may help expand healthcare delivery through multiple modes including: triage, outpatient care, hospital care, evacuation support, and additional healthcare facilities (Pierce County only). This can reduce the additional burden on the healthcare system and may help mitigate the movement into a crisis. During a crisis standards of care situation these additional avenues of care will need to be brought into the overall guidance and strategies.
- Acute Infectious Disease – The NWHRN and LHJs maintain plans for an acute infectious disease response. During an acute infectious disease response, that may also be a crisis standards of care response, all associated plans should be coordinated together to address the situations at hand.
- Pediatric Planning – All local hospitals (especially non-pediatric hospitals) have resources available to plan for pediatric care during a disaster response. In a crisis standards situation, all healthcare facilities whether or not they have primary pediatric providers will be caring for pediatric patients. It is particularly vital to plan for and coordinate the care of pediatric patients.
- Fatality Management and Family Reunification – In a crisis standards of care situation there will most likely be additional fatalities and family reunifications efforts required. LHJs and county medical examiners maintain plans for managing a surge in decedents and coordinating with families. Hospitals have also planned for increases in family reunification efforts and coordination with LHJs and medical examiners during a response.
- Palliative Care and Behavioral Health – The National Academy of Science underscores the importance of incorporating palliative care and behavioral health care throughout the response to a crisis situation. The region will need to provide a structure to support a surge in palliative care and behavioral health needs throughout the community if a crisis standards of care event is declared. LHJs, healthcare organizations, and the NWHRN should work together to facilitate information coordination and standardizations of resources provided to address palliative care and behavioral health concerns based on the incident. Palliative care and behavioral health response may need to continue long after the crisis has resolved and the concept of operations is demobilized.

Demobilization

A. Demobilization Process

The need for crisis standards of care, or changes to guidance, recommendations or protocols should be assessed continually by LHJs, NWHRN, and local healthcare organizations. As soon

as the emergency response no longer meets the crisis standards of care triggers and indicators LHJs should determine when and how to demobilize crisis standards, returning to normal care standards. When the LHJs in consultation with NWHRN, local healthcare organizations, and DOH determine that the need for crisis standards has passed, or a situational does not warrant the declaration of crisis standards of care the Resource Management and Crisis Standards of Care Concept of Operations should be demobilized. Once demobilized operations will be transferred back to normal operational channels.

The NWHRN and the LHJs will lead in notifying staff and partners of the demobilization. At that time:

- All concept of operation activations are demobilized.
- Situational awareness and response coordination may continue past demobilization according to other outlined plans and procedures.
- All partners notified of the demobilization.
- Palliative care and behavioral health response may need to continue for an extended period of time.
- A debrief and after action process is established for all partners and stakeholders.
- Communication should be made to the public concerning the demobilization.
- All records should be consolidated, organized, and maintained appropriately.

B. Debriefing

Due to the nature and complexity of this type of crisis response it is important to provide a forum for gathering feedback, suggestions, and responses from all stakeholders including (but not limited to):

- Healthcare organizations (clinicians, administrators, leadership, etc.)
- The general public
- Local emergency response agencies
- EMS
- LHJs (staff and leadership)
- Response committees (DCAC, HERC)
- Neighboring regions
- The state (DOH)

Transparency in process for incorporating learnings is vital to the success further emergency response planning and response concerning crisis standards of care. Documentation and implementation of learnings builds confidence locally and aids in the response of other regions, organizations, and entities in the future.

Communications

A. Public Communications Messaging and Risk Communications

Public communications and risk communication concerning the current state of the healthcare system, actions being taken by authorities, resource conservation strategies and changes to the standards of care, guidance, etc. is vital to the coordinated effort to respond to a healthcare crisis or near crisis situation. LHJs will be the lead for providing appropriate public communication but all healthcare, NWHRN, and other response partners should be coordinated in the approach to public messaging in a crisis standards situation. There should be forums for gathering feedback and conversing with the public and public entities to address concerns or issues that may arise during a crisis or near crisis situations. Additionally, it may be necessary to coordinate messaging with the public to mitigate and prevent the progression into a crisis standards of care situation.

- The LHJ will coordinate public information and risk communications messaging and education for the public. NWHRN, LHJs, healthcare organizations, and DOH will coordinate to ensure consistency of messaging.
- LHJs will lead in the coordination of forums or outlets for the gathering of feedback, input and concerns from the public, affected communities, public entities, and stakeholders concerning conservation strategies, crisis standards of care, or any guidelines, recommendations, protocols, etc.

B. Communications with Healthcare and Partners

Coordinated and ongoing communications between LHJs, clinical leadership, and healthcare organizations is vital to the success of a standardized approach to a crisis standards of care situation that adheres to the ethical principles outlined above. It is important to include all stakeholders in the communications of changes of guidance, protocols, etc. to ensure consistency.

- LHJs will lead in providing risk communication and official guidance to all healthcare organizations, clinicians, clinical leadership, and medical transport providers.
- LHJs and NWHRN will coordinate on providing additional information to medical vendors and suppliers as appropriate
- NWHRN and LHJs will participate in any Joint Information System (JIS) established for the acute infectious disease incident. NWHRN and LHJs will active their Public Information Officer (PIO) to coordinate on public messaging.

Responsibilities

A. Primary Agencies

1. Local Health Jurisdictions
    - Through the authority of the LHO, declare crisis standards of care if appropriate.
    - Lead policy decision making for healthcare and public health response in coordination with healthcare partners.

- Assess the public health threat, evaluate potential consequences based on established criteria and determine whether guidelines, orders, protocols, mitigation and/or conservation strategies, are required to protect the public are necessary in any given response situation.
- Activate Public Health emergency response structure (e.g. ICS).
- Coordinate public information and media communications concerning the response.
- Coordinate communications with healthcare clinicians concerning and order, guidelines, or protocols implemented.
- Responsible for coordinating requests for legal, liability and waiver issues up to DOH through appropriate channels

2. Northwest Healthcare Response Network
    - Establish the HECC to support the healthcare response.
    - Coordination of regional healthcare for local response and surge.
    - Distribution of situational awareness information to and from healthcare organizations, LHJs, and regional partners.
    - Coordination of medical and non-medical resource requests from healthcare organizations.
    - Provide communications materials and support for healthcare information and communications needs.
    - Convene the DCAC and the HERC to support clinical/healthcare guidance and policy decisions, respectively.
    - Convene the Washington State Disaster Medical Advisory Committee (WA State DMAC) on behalf of the Washington State Department of Health as appropriate.

3. Healthcare Organizations
    - Provide medical care for patients during the response.
    - Communicate with LHJs regarding patient care during a crisis standards of care situation.
    - Communicate with the NWHRN all medical and non-medical resource needs.
    - Provide timely situational awareness information regarding the response to the NWHRN.
    - Provide assistance to other healthcare organizations during a response in line with signed mutual aid agreements.

B. Support Agencies

1. Local Emergency Management
    - The NWRHN will work with local emergency management on behalf of area healthcare partners to coordinate non-medical resource requests and needs.

2. State Government (DOH)

- Through the State Secretary of Health and the State Health Officer, declare crisis standards of care at the state level.
- Convene the WA State DMAC (with the NWHRN) to support clinical recommendations, guidelines, orders, etc. at the state level.
- Coordinate multi-jurisdictional response to a crisis standards of care response.
- Coordinate with federal and neighboring state partners if the response exceeds local and state resources.
- Provide support for medical and non-medical resource needs of local healthcare organizations, including the coordination of local and national stockpiles of resources.
- Provide direction on legal and statutory regulations and modifications.
- Standardize care guidance throughout Washington State as warranted.

3. Federal Government
    - Coordinate with DOH when a response exceeds local and state resources.
    - Provide standardized clinical care guidance throughout the nation as warranted.
    - Coordinate federal level resource requests and any national stockpiles of resources.

Authorities and References

A. Review Process and Plan Update

1. Sections of this concept of operations will be updated as needed based on the evolution of planning activities and partnerships or in coordination with the Regional Improvement Plan after exercises or real world events.
2. The concept of operations will be provided to the healthcare organizations and regional partners for review and input.
3. Following review, modifications will be made and a copy will be provided to regional partners. Healthcare organizations are expected to share the updated concept of operations internally within their appropriate committees and with their leadership.
4. The NWHRN Board of Directors will be briefed when updates to this plan are completed.

B. Maintenance

The concept of operations will be reviewed every other year or as needed following the process outlined above.

C. Training and Exercise

Training on roles and responsibilities for all relevant partner agencies will occur following the adoption of the finalized Resource Management and Crisis Standards of Care Concept of Operations. Exercises including tabletops and functional will occur with healthcare organization, LHJs, DCAC, HERC, and other relevant stakeholders. As appropriate crisis standards of care decision making will be incorporated into and exercised during larger regional or state-level exercises.

D. References

King and Pierce County Healthcare System Emergency Response Plan
King County ESF 8 Basic Plan – Health, Medical, and Mortuary Services
Pierce County Emergency Support Function 8 – Health, Medical, and Mortuary Services Regional Disaster Plan
King County Alternate Care Systems Plan
Pierce County Alternate Care Systems Plan
King County Disaster Behavioral Health Plan
King County Public Information Contact Center Plan
King County Mass Fatality and Family Assistance Operations Response Plan
Pierce County Mass Fatality Plan
Pierce County Family Assistance Center Plan

Definitions & Acronyms

A. Definitions

Northwest Healthcare Response Network (NWHRN) – Is a regional Healthcare Coalition that leads a regional effort to build a disaster-resilient healthcare system through collaboration with healthcare organizations, public health agencies and the community partners they depend on. NWHRN works to keep hospitals and other healthcare facilities open and operating during and after disasters, enabling them to continue serving the community.

Healthcare Emergency Coordination Center (HECC) – In the event of an emergency the NWHRN will activate the Healthcare Emergency Coordination Center (HECC) to facilitate situational awareness, resource matching, communications, and coordination among regional healthcare organizations and partner agencies.

Disaster Clinical Advisory Committee (DCAC) - Is an integral component of an ethical, responsive, transparent and clinically responsible health emergency decision-making structure for King and Pierce counties. This multi-disciplinary committee meets quarterly and as necessary in an emergency to provide expert clinical advice on issues such as regional medical surge and crisis standards of care. The DCAC also advises the local health officers and other policymakers during health emergencies.

Healthcare Executive Response Committee (HERC) – Is the committee that advises the LHO on healthcare related policy issues during an emergency. The committee is made up of members of the NWHRN Board of Directors and representatives from the LHJ. The Executive Response Committee meets as needed in an emergency.

B. Acronyms

DCAC – Disaster Clinical Advisory Committee
DMCC – Disasters Medical Control Center
DOH – Washington State Department of Health
EMS – Emergency Medical Services
EMTALA – Emergency Medical Treatment and Labor Act

EOC – Emergency Operations Center
ESF-8 – Emergency Support Function-8
HECC – Healthcare Emergency Coordination Center
HERC – Healthcare Executive Response Committee
ICS – Incident Command System
LHJ – Local Health Jurisdiction
LHO – Local Health Officer
MAC – Multi-agency Coordination
MAP – Mutual Aid Plan
NIMS – National Incident Management System
NWHRN – Northwest Healthcare Response Network
PHSKC – Public Health – Seattle & King County
PIO – Public Information Officer
TPCHD – Tacoma-Pierce County Health Department
WA State DMAC – Washington State Disaster Medical Advisory Committee

Attachments

A. Attachment A: Duty Officer Contact Information

B. Attachment B: Master Trigger and Indicator List

C. Attachment C: Scarce Resource Management and Crisis Standards of Care Decision Making Template

D. Attachment D: Triage Team Protocol

E. Attachment E: Scarce Resource Cards and Triage Algorithms

F. Attachment F: DCAC Product Development and Roll-out Process