Arizona Crisis Standards of Care Plan

A Comprehensive and Compassionate Response

ARIZONA DEPARTMENT
OF HEALTH SERVICES

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ARIZONA CRISIS STANDARDS OF CARE PLAN

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ARIZONA CRISIS STANDARDS OF CARE PLAN

Introduction

The Arizona Department of Health Services (ADHS) worked with public health, emergency management, first responders, healthcare, legal, and other partners to create this Crisis Standards of Care (CSC) Plan for the State of Arizona. This collaborative, multi-year project included strategic planning sessions, interagency workgroups, and a public engagement campaign. Ethical considerations and principles have played a key role throughout the course of this initiative. Stewardship of resources, duty to care, soundness, fairness, reciprocity, proportionality, transparency, and accountability are the guiding ethical elements of this plan. This ethical foundation has been integrated into public health and emergency response principles to establish this common framework for statewide CSC.

During a public health disaster, the State Disaster Medical Advisory Committee (SDMAC) will convene to develop incident-specific priorities and guidance for the delivery of healthcare and use of scarce medical resources. This guidance may address:

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

Once activated for a disaster response, the SDMAC will serve as the statewide policy group for the Health Emergency Operating Center (HEOC). The HEOC, managed by ADHS, will operate in a Unified Command (UC) structure with the State Emergency Operation Center (SEOC) to coordinate the public health, medical, and behavioral health responses. Representatives from state and local agencies, healthcare organizations, public health officials, medical and legal experts, and other subject matter experts (SMEs) will participate in the SDMAC.

As the statewide policy group for CSC, the SDMAC will establish guidance for healthcare institutions and providers, but will not manage the emergency response. As such, the following procedures, diagrams, job action sheets, and other resources contained in this plan apply only to the SDMAC and are intended to support the ADHS Health Emergency Operation Center Standard Operating Procedure (2013).

This CSC plan was co-developed by stakeholders from the public health, healthcare, legal, ethical, and emergency management disciplines. During the initial planning phase, a statewide CSC planning committee was convened to build consensus, establish a common awareness of what crisis care means for the State of Arizona, and oversee the development of statewide CSC.

Background

Four workgroups were established to facilitate the planning process: (1) Clinical Workgroup, (2) Emergency Medical Services (EMS) Workgroup, (3) Legal/Ethical Workgroup, and (4) Public Engagement Workgroup. Each group met multiple times to consider issues and approve plan content. During workgroup sessions, an audience response system was used to poll participants and establish priorities and consensus.

The Clinical Workgroup was comprised of healthcare professionals and public health stakeholders. The group established guidelines for multiple types of triage and expanded scopes of practice. The Legal/Ethical Workgroup evaluated regulatory, statutory, and bioethical issues, e.g., scopes of practice, duty to care, and developed a code of ethics for Arizona CSC (see Appendix A). The EMS Workgroup assessed patient transport and clinical issues for EMS professionals. The Public Engagement Workgroup developed and delivered a public engagement campaign.

Public engagement efforts included nine public meetings and deployed an online feedback tool to assess public opinion. Data sets from over 300 community members and stakeholders were collected, analyzed, and informed plan development. The audience response system was used to gauge public opinion during the public outreach sessions.

This CSC project was based on previous initiatives, such as the 2010 Arizona Disaster Triage Protocol Workshop, as well as extensive planning efforts undertaken by the Arizona Hospital and Healthcare Association (AzHHA), the Arizona Department of Health Services (ADHS), and numerous healthcare industry partners.

The statewide CSC planning committee worked together to identify a desired future state, mission, and values for the project, as well as objectives for each of the four workgroups. This facilitated a system-wide planning process, addressing the needs and expectations of a diverse set of stakeholders. The committee approved the following desired future state, mission, and value statements:

Desired Future State

Develop and implement a compassionate and ethically-based healthcare response for catastrophic disasters, using CSC cooperatively developed by key stakeholders.

Mission

Provide a response and recovery framework for catastrophic disasters, enabling optimal community resilience across the statewide healthcare system.

Values

1. Transparency: Provide open, honest, factual, and timely communication and information sharing.
2. Consistency: Implement processes and procedures across the continuum of care, applying the same methods to achieve optimal community health.
3. Fairness: Respect and recognize the dignity of all populations when providing healthcare across the continuum of care.
4. Accountability: Take responsibility for actions, complete work assignments, and follow through on requests and communications.
5. Resilience: Provide for the recovery of emotional, spiritual, intellectual, and behavioral health needs, while facilitating the well-being of the community.
6. Evidence-Based: Formulate decisions based on state-of-the-art, research-supported (when available) facts and processes to promote optimal community health.

PURPOSE, SCOPE, SITUATION OVERVIEW, AND OTHER ASSUMPTIONS

This plan shall be used to implement a compassionate and ethically-based healthcare response for catastrophic disasters within the State of Arizona and is intended to outline how the SDMAC, including representation from across the public health sector and healthcare system, will respond during a public health emergency requiring the activation of CSC.

Purpose

The purpose of this plan is to provide clear and consistent guidance for allocating scarce healthcare resources during a catastrophic disaster. This plan builds on past CSC planning initiatives, strong interdisciplinary relationships, best practices, and lessons learned. Additionally, this plan draws heavily from the Institute of Medicine (IOM) report Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response (2012). This report outlines five principles that should guide CSC planning across the nation, including the following:

1. A strong ethical grounding based in transparency, consistency, proportionality, and accountability;
2. Integrated and ongoing community and provider engagement, education, and communication;
3. The necessary legal authority and legal environment in which CSC can be ethically and optimally implemented;
4. Clear indicators, tactics, and lines of responsibility; and
5. Evidence-based, clinical processes and operations.

Scope, Situation Overview, and Hazards

Scope

This plan contains procedures to guide activating, operating, and demobilizing the SDMAC for the State of Arizona; triage guidelines and considerations for healthcare facilities; and strategies and tactics for using and allocating scarce healthcare resources. Consistent with the Incident Command System (ICS), the scope of SDMAC activities will be determined by the nature, severity, and scale of the disaster.

This plan is intended to work in concert with other state-level emergency response plans, such as the ADHS Health Emergency Operation Center (HEOC) Standard Operating Procedures (SOP) and the State Emergency Response and Recovery Plan (SERRP). Other plans that may support a CSC response include state and local alternate care site/system plans, medical countermeasure plans (including mass prophylaxis and mass vaccination), medical materiel management and distribution plans, and medical surge plans.

It is important to note that this plan does not fully address CSC implementation at the regional, local, or healthcare facility levels. CSC will also need to be coordinated by state-designated healthcare coalitions, counties, tribes, and healthcare facilities. During a catastrophic disaster requiring statewide CSC activation, medical surge and response plans at the local and facility levels will be integrated into the comprehensive, statewide response.

Situation Overview

- Arizona has developed multiple, state-designated healthcare coalitions, complete with memoranda of understandings (MOUs) between key public health and healthcare system stakeholders.
- Representatives from the public health, healthcare, first responder, and emergency management sectors will form the State Disaster Medical Advisory Committee (SDMAC) to guide Arizona's CSC operations.
- State-designated healthcare coalitions and/or local public health jurisdictions will implement CSC at the regional and/or local levels.
- Nearly all hospitals across the state participate in the Hospital Preparedness Program (HPP) and have developed, tested, and evaluated their emergency response plans (ERPs).
- A robust, statewide pandemic influenza response plan has been in place for several years and was updated to reflect lessons learned from the 2009 H1N1 pandemic.

Hazards

Numerous known and unforeseen hazards could prompt the activation of CSC in the State of Arizona. These could include chemical, biological, radiological, nuclear, and explosive threats (CBRNE), as well as natural disasters, such as floods, wildfires, earthquakes, or severe weather. Man-made disasters such as technological failures, accidents, terrorist attacks, civil unrest, and acts of war are also potential hazards. Please see Appendix G for a list of resource challenges by disaster type.

Capability Assessment

A capabilities-based, planning approach was used to guide the developmet of these CSC. Federal Emergency Management Agency (FEMA) defines capabilities-based planning as, "planning under uncertainty to provide capabilities suitable for a wide range of threats and hazards while working within an economic framework that necessitates prioritization and choice. Capabilities-based planning addresses uncertainty by analyzing a wide range of scenarios to identify required capabilities."

By nature, a CSC response is both catastrophic and complex, involving numerous response partners. The IOM report identifies "five pillars" of CSC: (1) hospital, (2) public health, (3) out-of-hospital care, (4) emergency medical services (EMS), and (5) emergency management and public safety. Coordinating these sectors requires integrating standards and systems from a variety of disciplines. These standards, or sets of capabilities, provide the foundation for integrating the "five pillars" into a single system, allowing for capabilities-based planning.

Three sets of capabilities were used to develop this plan: (1) the Healthcare Preparedness Capabilities, (2) the Public Health Preparedness Capabilities, and (3) the FEMA Core Capabilities.

In March 2011, the Centers for Disease Control and Prevention (CDC), Division of State and Local Readiness (DSLR) published the Public Health Preparedness Capabilities: National Standards for State and Local Planning. These fifteen capabilities define "national standards for public health preparedness capabilities-based planning." These capabilities are used by state and local Public Health Emergency Preparedness (PHEP) programs to align planning across jurisdictions and response entities, and ultimately "assure safer, more resilient, and better prepared communities."

In January 2012, the US Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) published the Healthcare Preparedness Capabilities: National Standards for Healthcare System Preparedness. These capabilities provide unified program evaluation standards for healthcare organizations and response entities (e.g., state/local public health, emergency management, licensing) involved with the ASPR's Hospital Preparedness Program (HPP). Additionally these healthcare preparedness capabilities correspond directly with eight of the fifteen Healthcare Preparedness Capabilities, thereby allowing public health and healthcare system planners to collaborate within a common framework.

An additional set of capabilities central to CSC planning is the Federal Emergency Management Agency's (FEMA) Core Capabilities. This system of 31 capabilities provides a planning framework for response entities, including emergency management, public safety, public works, schools, and others not directly involved in public health or healthcare. Table 1 compares and contrasts all three capability sets, highlighting specific capabilities most integral to CSC.

Table 1: Comparing Healthcare, Public Health, and FEMA Core Capabilities

HEALTHCARE PREPAREDNESS CAPABILITIES (HHS, ASPR 2012)	PUBLIC HEALTH PREPAREDNESS CAPABILITIES (CDC, DSLR 2011)		FEMA CORE CAPABILITIES (FEMA 2012)	
• Emergency Operations Coordination • Fatality Management • Healthcare System Preparedness • Healthcare System Recovery • Information Sharing • Medical Surge • Responder Safety and Health • Volunteer Management	• Community Preparedness • Community Recovery • Emergency Operations Coordination • Emergency Public Info. and Warning • Fatality Management • Information Sharing • Mass Care • Medical Countermeasure Dispensing	• Medical Materiel Mgmt. and Distribution • Medical Surge • Non-Pharmaceutical Interventions • Public Health Laboratory Testing • Public Health Surveillance and Epidemiological Investigation • Responder Safety and Health • Volunteer Management	• Access Control and Identity Verification • Community Resilience • Critical Transportation • Cyber Security • Economic Recovery • Environmental Response/Health Safety • Fatality Management Services • Forensics and Attribution • Health and Social Services • Housing • Infrastructure Systems • Intelligence and Information Sharing • Interdiction and Disruption • Long-term Vulnerability Reduction • Mass Care Services • Mass Search and Rescue Operations	• Natural and Cultural Resources • On-Scene Security and Protection • Operational Communications • Operational Coordination • Physical Protective Measures • Planning • Public and Private Services and Resources • Public Health and Medical Services • Public Information and Warning • Risk and Disaster Assessment • Risk Management • Screening Search and Detection • Situational Assessment • Supply Chain Integrity and Security • Threats and Hazard Identification

Planning Assumptions

Statewide CSC activation will only occur during the most extreme disasters that dramatically impact the healthcare system. A CSC disaster has the following attributes: (1) most or all of the community's infrastructure is impacted; (2) local officials are unable to perform their 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; and (4) surrounding communities are similarly affected, and thus there are no regional resources (IOM, 2012).

The care capability continuum includes conventional, contingency, and crisis standards of care (CSC). In many cases, the activation of CSC will proceed from conventional, to contingency, and finally CSC. Sudden onset disasters (e.g., earthquake, nuclear detonation) may immediately escalate to CSC. Table 2 describes the impacts on space, staff, and supplies for each of these categories. See Appendix G for more information on resource requirements for specific types of responses.

Table 2—Allocation of Resources along the Care Capability Continuum

	Conventional	Contingency	Crisis
SPACE	Usual patient care space fully used	Patient care areas re-purposed (e.g. PACU or monitored units for ICU-level care)* Staff extension (brief deferrals of non-emergency service, caring for a broader groups of patients, change in responsibilities or documentation, etc.)	Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care
STAFF	Usual staff called in		Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques
SUPPLIES	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies for an individual patient	Critical supplies lacking, possible re-allocation of life-sustaining resources
STANDARDS OF CARE	Usual care	Functionally equivalent care	Crisis standards of care

*Note: ICU = intensive care unit; PACU = postanesthesia care unit
Source: (Crisis Standards of Care, IOM, p. 1-41, 2012).

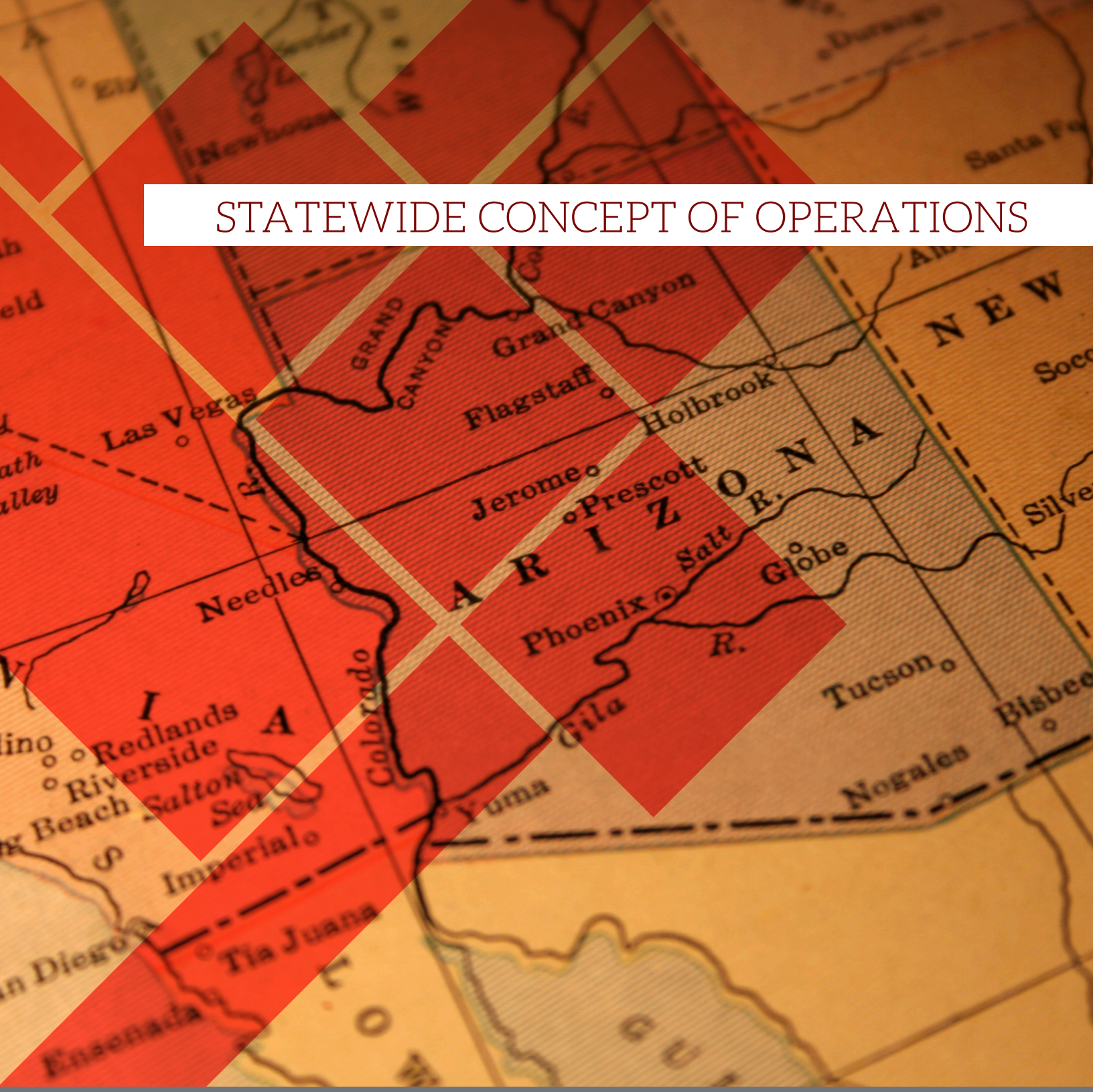
Planning Assumptions

There are several criteria that must be met for the state to activate CSC. A disaster may occur at an individual hospital or healthcare facility requiring short-term, crisis care at that location. However, statewide activation of CSC will only occur during a widespread catastrophic disaster, impacting multiple hospitals/healthcare facilities in a large geographical area or a densely populated urban area. The following criteria describe a situation that will require CSC (Crisis Standards of Care, IOM, p. 1-10, 2012):

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

During an incident that involves emergency response and recovery as well as CSC Plan activation, Arizona strategies will take into account the public health, mental/behavioral health, and medical needs of at-risk populations. At-risk individuals may have additional needs before, during, and after an incident in one or more of the following functional areas (C-MIST): Communication, Medical Care, Independence, Supervision, and Transportation. CSC strategies will involve the integration of state, local, and healthcare organizations serving at-risk individuals in an ongoing capacity and will consider at-risk persons injured or ill as a result of the disaster. The C-MIST framework will be used to address a broad set of common access and functional needs and is supportive of the SERRP, CSC Plan, and both State and local public health emergency operation plans. Policies, Guidance and CSC operations should account for and pay particular attention to the needs of the most at-risk and marginalized people when developing strategies to support equitable and just distribution of scarce resources.

STATEWIDE CONCEPT OF OPERATIONS



CSC activation requires the interaction of multiple disciplines across the response community including hospitals, public health departments, out-of-hospital care providers, emergency management, and public safety. Each of these disciplines operates independently and inter-dependently during routine, non-emergent situations. However, during a catastrophic response, these groups must operate collectively in a complex, dynamic system. The organization of these various entities into a cohesive response structure is the essence of this CSC plan.

CSC activation can occur suddenly, as in the case of an unforeseen terrorist attack, explosion, or abrupt natural disaster (e.g., earthquake), or gradually as in the case of a slowly evolving incident such as a pandemic. In either case, CSC activation and implementation will be guided by this plan. The ADHS Director, in consultation with the Governor's Office, has the authority to convene the SDMAC and initiate CSC for the state of Arizona. A local health officer or healthcare coalition representative may also contact ADHS to request activation of the SDMAC and initiation of CSC.

The exact composition of the SDMAC will be incident specific. Depending on the disaster, various configurations of experts across the health, medical, legal, ethical, and emergency management fields will be required to develop priorities for the allocation of scarce resources and issue clinical guidance. For example, infectious disease specialists may not be part of the SDMAC for a radiological response, but will participate in a pandemic response. In addition to these incident-specific experts, the SDMAC will also include standing members. These standing members include the ADHS Director, PHEP Chief, Chair and Co-Chair of the state's healthcare coalitions, staff from the Governor's Office, representatives from the Arizona Attorney General's Office and the Arizona Division of Emergency Management (ADEM), medical board and association representatives, local health officers from impacted jurisdictions, and private sector representatives. In the event of suspected or actual terrorism, the Arizona Department of Homeland Security would also be engaged. See Appendix H for a list of Job Action Sheets for SDMAC and facility-level CSC positions.

Once SDMAC activation has been approved by state officials, representatives from state and local public health, healthcare, EMS, emergency management, and public safety will convene, virtually or in person, to activate the SDMAC. ADHS staff will coordinate an emergency conference call with the standing SDMAC members to identify additional participants, subject matter experts, and specialists required to address the specific disaster.

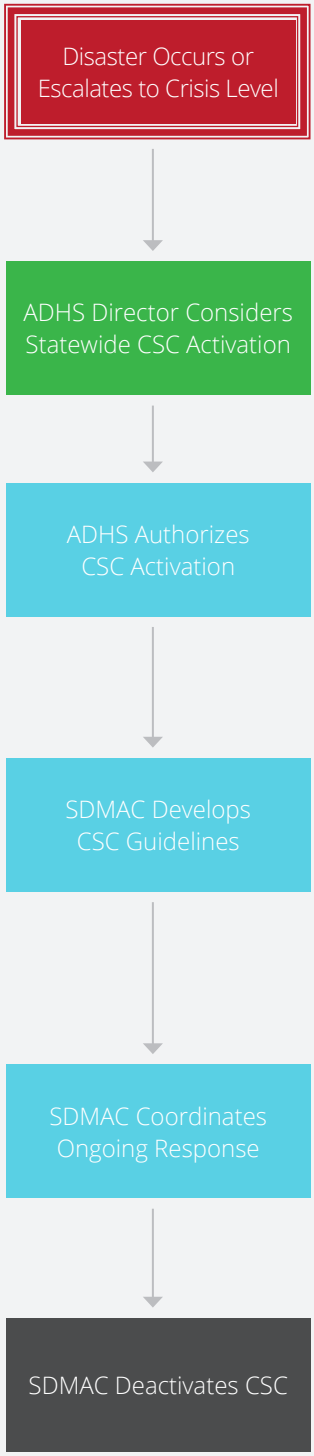
At this point in the activation process, before CSC priorities or clinical guidance have been disseminated, ADHS staff participating in the SDMAC will notify relevant local, state, tribal, and federal agencies of the current situation. The SDMAC team will then work with public information officers (presumably working in a joint information center or virtual joint information center) to develop public messaging explaining the forthcoming adoption of statewide CSC.

Once operational, SDMAC will: (1) establish priorities for allocation of medical resources, (2) establish and disseminate clinical guidance for CSC, (3) develop guidelines for hospitals, out-of-hospital facilities/providers, and alternate care sites, and (4) determine the need for expanded scopes of practice based on regulatory authority and direction.

During statewide CSC operations, it may be necessary to involve one or more of the state designated healthcare coalitions. The purpose of these coalitions is to assist with the implementation and execution of CSC locally, and at healthcare facilities. In keeping with Incident Command System (ICS) principles of scalability and flexibility, state-designated healthcare coalitions will be used to coordinate CSC implementation with state partners.

At the facility level, a Clinical Care Committee (CCC) will be in charge of implementing statewide priorities and guidance for individual healthcare facilities. The CCC will work under the direction of the hospital or healthcare facility Incident Command (IC). The main purpose of the CCC is to separate the difficult task of triage and allocation of scarce resources from the ongoing responsibility of providing patient care. By separating triage from the act of caring for patients, the healthcare facility will be able to more easily transition from individual care to community-wide or population-based care. See the following Clinical Concept of Operations section for more information on facility-level CSC implementation. Figure 1 on the next page graphically depicts the activation process for the SDMAC.

Figure 1: Arizona Crisis Standards of Care (CSC)—Activation Process



Indicators for Statewide CSC

- One of more counties/regions request state to implement CSC
- Medical countermeasures depleted
- Patient transfers insufficient or impossible, statewide
- County resource requests unfillable or undeliverable
- Multiple healthcare access points impacted

Considerations for Statewide CSC Activation

- The Governor's Office or ADHS Director initiates CSC activation
- Local Health Officer or healthcare coalition asks ADHS to activate CSC
- ADHS Director evaluates any local, state, federal disaster declarations that may be in place

CSC Activation Steps

- SDMAC members and required subject matter experts identified
- ADHS emergency conference call with SDMAC members
- ADHS staff notifies other local, state, tribal and federal partners
- SDMAC works with public information officers in the Joint Information Center (JIC) to distribute messaging about forthcoming CSC
- SDMAC notifies healthcare coalitions to support CSC at the local level

SDMAC Activities

- Recommend priorities for allocation of medical resources
- Recommend EMS, triage, and clinical protocols (e.g., ventilator use)
- Coordinate with healthcare coalitions and EOCs, as appropriate
- Work with JIC/PIO staff to develop public messaging regarding CSC
- Distribute priorities and protocols to healthcare facilities, providers, and EMS
- Work with JIC/public information officers to ensure timely delivery of public messaging describing CSC implementation at healthcare facilities

SDMAC Activities

- Evaluate the effectiveness of protocols and priorities, and the availability of resources throughout the response
- Maintain communication with response partners (e.g., coalitions, EOCs)
- Identify threshold(s) for the suspension or rescinding of CSC and resumption of contingency or conventional care

SDMAC Activities

- Work with response partners to monitor situation and identify the appropriate time to return to contingency or conventional standards of care
- Recommend to the ADHS Director to suspend or rescind CSC

Indicators for CSC Activation

Some disasters may immediately mandate CSC, while other disasters may gradually transition across the continuum of care to CSC. Tables 3–5 list the indicators for CSC at the healthcare facility, county, and state levels. These indicators are designed to assist healthcare and public health officials assessing the need for conventional, contingency, and crisis standards of care during a disaster. Definitions for key CSC activation terms are listed below:

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

Trigger Point: A decision point based on the availability of resources, requiring adaptations to healthcare delivery along the continuum of care (contingency, conventional, and crisis). For purposes of this plan, the terms "threshold" and "trigger point" are synonymous.

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

Healthcare Facility Indicators for CSC

Most hospitals and other healthcare facilities experience some level of medical surge on a regular basis. The conventional indicators listed in Table 3 represent normal levels of surge for most healthcare facilities. In general, if one or more contingency or crisis level indicators are true, then the healthcare facility may decide to activate contingency or crisis standards of care.

The indicators listed in Tables 3 provide guidance for hospitals and other healthcare facilities in determining the level of care during a disaster. These indicators should serve as triggers for activating facility-level plans and procedures and may also prompt resource requests to other healthcare facilities and county health departments. See Table 6 for a list of tactics for healthcare facilities.

Table 3—Conventional, Contingency, and Crisis Indicators for Healthcare Facilities

Conventional Indicators for Healthcare Facilities

- Usual patient care space fully occupied
- Usual staff called in and utilized
- Cached and usual supplies being used

Contingency Indicators for Healthcare Facilities

- Patient care areas re-purposed (e.g., PACU or monitored unit used for ICU-level care)
- Staff extension in place (brief deferrals of non-emergency patient-care services, supervising broader groups of patients, changes in responsibilities and documentation, etc.)
- Conservation, adaptation, and substitution of supplies with selective re-use of supplies for an individual patient
- Hospital on diversion

Crisis Indicators for Healthcare Facilities

- Healthcare facility unsafe or closed
- Non-patient care areas used for patient care
- Trained staff unavailable or unable to care for the volume of patients
- Critical supplies lacking
- Re-allocation of life-sustaining resources
- Patient transfer not possible or sufficient

County Public Health Indicators for CSC

As indicated previously in Figure 1, local health officers may request the activation of statewide CSC. The following indicators in Table 4 may be used by county health departments to identify trigger points for transitioning across the continuum of care. See Table 7 for a list of tactics that correspond with the indicators listed below.

Table 4—Conventional, Contingency, and Crisis Indicators for Counties

Conventional Indicators for Counties

- One or more healthcare facilities are at or near capacity
- Patient transfer may be impacted

Contingency Indicators for Counties

- One or more healthcare facilities initiate local resource requests for space, staff, and supplies
- Medical countermeasure availability declining
- One or more hospitals on diversion or damaged
- Patient transfer limited between healthcare facilities

Crisis Indicators for Counties

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

State Public Health Indicators for CSC

The indicators listed in Table 5 will be used by the ADHS Director and other state policy makers to determine the need for CSC. The precise trigger point for CSC will be determined by the ADHS Director in consultation with the Governor's Office and local health officers. See Table 8 for a list of tactics corresponding with the indicators listed below.

Table 5—Conventional, Contingency, and Crisis Indicators for the State

Conventional Indicators for the State

- One or more counties/regions at capacity
- Patient transfer may be impacted

Contingency Indicators for the State

- Local jurisdictions initiate resource requests
- Medical countermeasure availability declining
- One or more hospitals on diversion or damaged
- Patient transfer across all or part of state is limited

Crisis Indicators for the State

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

See Appendix B for a combined table of indicators for healthcare facilities, county health departments, and the State.

Tactics for CSC

There are a variety of tactics to address medical surge along the continuum of care (conventional, contingency, and crisis). A number of tactics for clinical operations are addressed below in the Clinical Concept of Operations section. CSC tactics are also important for emergency management staff at healthcare facilities, county health departments, ADHS, and state agencies. These tactics are listed below in Tables 6–8.

Predetermined (scripted) tactics are established during the planning phase and integrated into checklists, job action sheets, and other response procedures. Non-predetermined (non-scripted) tactics will be incident specific and will be determined by the SDMAC during a CSC response. Non-scripted tactics will typically require more analyses and time to develop and implement than scripted tactics. The following definitions apply to this plan:

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

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

Healthcare Facility Scripted Tactics for CSC

Response guidelines will vary with the specific ICS structure used at each healthcare facility. However, these scripted tactics provide general planning guidance for adjusting standards of care.

Table 6—Scripted Tactics for Healthcare Facilities

Conventional Tactics for Healthcare Facilities

- Place facility Incident Command staff on standby
- Notify county PHEP and/or emergency management partners of conventional surge conditions

Contingency Tactics for Healthcare Facilities

- Activate incident command and Emergency Operations Plan/Emergency Response Plan
- Notify county PHEP and/or emergency management partners of contingency surge conditions

Crisis Tactics for Healthcare Facilities

- Notify PHEP/emergency management partners of crisis level
- Consider alternate care sites
- Implement facility CSC plans and procedures
- Re-use and repurpose supplies
- Assign primary, secondary, and tertiary Triage Officers, as needed

County Public Health Scripted Tactics for CSC

Response guidelines will vary with the specific ICS structure used in each county. However, these scripted tactics provide general planning guidance for adjusting standards of care.

Table 7—Scripted Tactics for County Health Departments

Conventional Tactics for Counties

- Place emergency operations/incident command staff on standby
- Notify state PHEP and emergency management partners of surge conditions

Contingency Tactics for Counties

- Activate EOC
- Participate in unified command with on scene operations and state EOCs
- Process space, staff, and supply requests from facilities

Crisis Tactics for Counties

- Activate state-designated healthcare coalition to implement CSC locally
- Participate in public information activities with the JIC
- Activate medical countermeasure, medical materiel, volunteer management, and alternate care site plans

State Public Health Scripted Tactics for CSC

Figure 1 above and the scripted tactics in Table 8, below, will assist ADHS leadership during CSC activation.

Table 8—Scripted Tactics for the State

Conventional Tactics for the State

- Place emergency operations/incident command staff on standby
- Notify statewide partners of surge conditions

Contingency Tactics for the State

- Activate state EOCs
- Participate in unified command with on scene operations and local EOCs
- Process space, staff, and supply resource requests from local jurisdictions
- Notify SDMAC committee of possible activation
- Notify federal partners of medical surge

Crisis Tactics for the State

- Activate SDMAC to develop and implement CSC
- Direct statewide public information activities
- Activate state medical countermeasure, medical materiel, volunteer management, and alternate care site/system plans

See Appendix C for a combined table of scripted tactics for healthcare facilities, county health departments, and the State.

CLINICAL CONCEPT OF OPERATIONS

This portion of the plan covers clinical topics relevant to a Crisis Standards of Care (CSC) response and provides considerations for the State Disaster Medical Advisory Committee (SDMAC) to assist committee members during the development of CSC guidance. The following topics are covered in this section:

(1) Prehospital and Emergency Medical Services

(2) Hospital and Acute Care Facilities

(3) Out-of-Hospital Care

(4) Alternate Care Sites and Systems

(5) Pediatrics

(6) Palliative and Comfort Care

(7) Behavioral Health

Prehospital and Emergency Medical Services

Emergency Medical Services (EMS) and the entire prehospital system will play a major role during a CSC response. As first responders, EMS providers will have to adapt practices and standards of care to address the most difficult circumstances. During a CSC response, the SDMAC will issue guidance to EMS providers and authorities in an effort to ensure consistent care across the State and to assist EMS providers in dealing with an overwhelming number of patients.

Primary Triage

In a CSC response, primary triage will be required to optimize healthcare resources and do the greatest good for the greatest number of patients. Primary triage is commonly defined as the first assessment prior to medical intervention. A variety of triage systems have been developed for use in emergencies and disasters. Triage protocols that should be considered during a CSC response in the State of Arizona include: START for adults, JumpSTART© for pediatric patients, and the ADHS Alternate Triage, Treatment and Transport Guidelines for Pandemic Influenza. Depending on the situation, all or some of these triage methodologies may be used by first responders in a CSC response.

The SDMAC should weigh many factors when considering guidance for triage. Flexibility is needed to modify triage methods recommended by the Arizona CSC Clinical Workgroup as additional evidence-based guidance is published regarding primary triage. Additional evidence may become available for other triage methods, e.g., Sort, Assess, Lifesaving interventions, Treatment/Transport (SALT).

Table 9 defines key terms used in START and JumpSTART© triage. IDME (Immediate, Delayed, Minimal, Expectant) is a mnemonic to color-code and summarize the various acuity levels associated with many different triage methods. See Appendix D for an example of START triage and Appendix E for JumpSTART© triage.

Table 9: IDME Mnemonic

Status	Color	Summary
Immediate	RED	• Life-threatening injury or illness • Lifesaving Interventions (LSI) • First to treat
Delayed	YELLOW	• Serious, but not life-threatening • Delaying treatment will not affect outcome • Second to treat
Minimal	GREEN	• Walking wounded • Third to treat
Expectant	BLACK	• Comfort care, unless new resources allow triage upgrade

Box 1 lists considerations for the SDMAC when developing guidance for EMS providers.

SDMAC Considerations Box 1

PREHOSPITAL AND EMS

1. Issue guidance to use START for adults or JumpSTART© for pediatrics during a statewide CSC response.
2. In the event of a pandemic, issue guidance to use the State's **Alternate Triage, Treatment and Transport Guidelines for Pandemic Influenza** for statewide CSC response.
3. Modify recommendations as additional evidence-based guidance is published regarding other primary triage methods.

Hospital and Acute Care Facilities

This section applies to all hospitals with emergency departments as well as other types of acute care facilities, excluding long-term care facilities. Hospital and acute care facilities will play a critical role in all types of CSC responses. An overwhelming demand for medical care at hospitals may trigger the expansion of out-of-hospital care and the activation of alternate care sites and systems. During a catastrophic response, hospitals will have to implement CSC guidance to address the overwhelming surge of patients. The SDMAC will develop and disseminate guidance to help ensure consistent care across the State's hospitals and other healthcare access points. These shifts in care practices are summarized below.

Primary Triage

Primary triage may occur at a hospital emergency department, clinic, or other healthcare access point. This section applies to situations where EMS transport is not involved, e.g., self-presenting patients at hospital emergency departments. Based on feedback from the AZ CSC Clinical Work Group, hospitals and acute care facilities can use START for adults, JumpSTART© for pediatrics, or emergency department triage levels 1–5. The SDMAC has flexibility to modify these recommendations for hospital-based primary triage as additional evidence-based guidance is published.

Secondary Triage

Secondary triage occurs after the first assessment and diagnostics, and after initial medical interventions. It is recommended that an acute care facility's medical expert, such as an emergency physician, intensivist, or trauma surgeon, is appointed to serve as the Secondary Triage Officer. This medical expert shall determine the need and priority for the operating room (OR), computerized tomographic (CT) scanning, burn care, etc. The Arizona Burn Telemedicine Network, coordinated by the Arizona Burn Center, may also be used to assist in burn triage. During CSC activation, the Triage Officer's sole responsibility is triage. The Triage Officer should not perform patient care. See the Job Action Sheet for the Triage Officer in Appendix H for more information. The SDMAC has flexibility to modify these recommendations for hospital-based secondary triage as additional evidence-based guidance is published.

Tertiary Triage

Tertiary triage occurs after primary and secondary triage. Tertiary triage is done in a hospital to prioritize patients for intensive care unit (ICU) admission.

The Arizona CSC Clinical Workgroup recommends using the inclusion criteria and Sequential Organ Failure Assessment (SOFA) scores detailed in CMJ 2006; 175 (11): 1377-1381, as summarized in Tables 10 through 12.

Table 10: CSC Inclusion Criteria for ICU Admission

Needs a Ventilator	• Refractory hypoxemia defined as an SpO^2 less than 90% on a high oxygen flow non-breather reservoir mask or an FIO^2 greater than 0.85 or • Respiratory acidosis with a pH < 7.2 or • Clinically impending respiratory failure or • Inability to protect or maintain airway
OR	
Hypotension	• Systolic blood pressure (SBP) less than 90 mm Hg or relative hypotension with clinical evidence of shock, e.g., altered level of consciousness (LOC) or decreased urinary output, etc. • Refractory to volume resuscitation and requiring vasopressor or ionotropic medication

After the need for ICU admission has been established, the hospital Tertiary Triage Officer for CSC, usually an intensivist, shall determine the priority for ICU beds based on the criteria listed below in Tables 11 and 12. ICU admission priority is based on the sequential organ failure assessment (SOFA) score that measures a patient's clinical data, including blood pressure, platelet count, Glasgow Coma Scale (GCS), creatinine, and bilirubin.

Table 12 below indicates patients with a SOFA score equal to or less than seven (7) have the highest priority for ICU admission. These highest priority patients are classified as "red". Patients with a SOFA score of eight (8) through eleven (11) have intermediate priority for ICU admission and are classified as "yellow". Patients with a SOFA score greater than 11 are classified as "blue" and have the lowest priority for ICU admission; they will receive comfort or other care. Patients with no significant organ failure do not need ICU admission and are classified as "green".

Box 2 lists key considerations for SDMAC members when developing guidance for hospitals and acute care facilities.

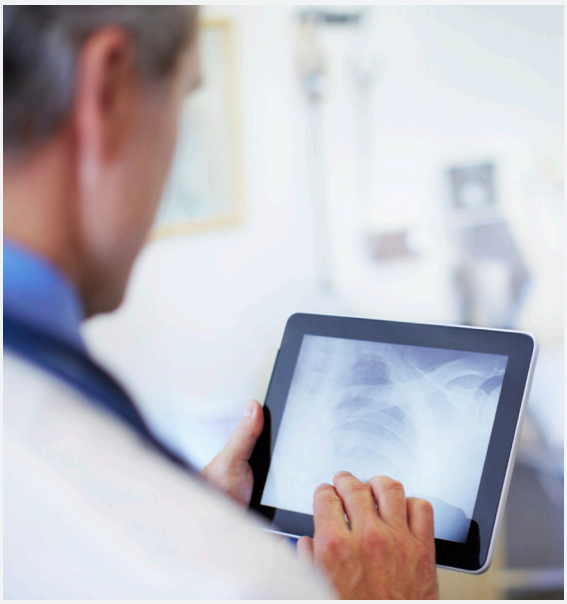


Table 11: Sequential Organ Failure Assessment (SOFA) Score

Resuscitation Component	Variable	0	1	2	3	4
A & B	PaO2/FiO2 (mm Hg)	> 400	< 400	< 300	< 200 (with respir. support)	< 100 (with respir. support)
C	Hypotension [↓ BP] (BP in mm Hg) (doses in mcg/kg/min)	**Adults:** No ↓ BP **Children:** SBP >70+(2X age[yrs])	**Adults:** MAP <70 **Children:** SBP <70+(2X age[yrs])	Dop <5 or any dobutamine	Dop > 5 or Epi < 0.1 or Norepi < 0.1	Dop > 15 or Epi > 0.1 or Norepi > 0.1
C	Platelets (x 10^6/L)	>150	< 150	< 100	< 50	< 20
D	GCS	15	13 – 14	10 – 12	6 – 9	< 6
E	Creatinine (mg/dL)	< 1.2	1.2 – 1.9	2.0 – 3.4	3.5 – 4.9	>5
E	Bilirubin (mg/dL)	< 1.2	1.2 – 1.9	2.0 – 5.9	6.0 – 11.9	> 12

Table Source for column 1 modification of SOFA Score © 2014: ABCDE Resuscitation (Resus.) Component Column © 2014: Frank G. Walter, MD, FACEP, FACMT, FAACT

A = airway B = breathing C = cardiovascular D = disability = nervous system E = elimination via liver or kidneys Adrenergic agent doses (Dop, Epi, & Norepi) administered for at least 1 hour (doses are in mcg/kg/min). SOFA has not been validated in children.

Table 12: SOFA-Based Triage for ICU Admission Priority*

SOFA Triage Color Score	Criteria	ICU Admission Priority
Red	SOFA score ≤ 7 or single organ failure	Highest priority for ICU admission
Yellow	SOFA score 8 through 11	Intermediate priority for ICU admission
Blue	SOFA Score > 11	Lowest priority for ICU admission
Green	No significant organ failure	No need for ICU admission

** Adapted from Canadian Journal of Medicine CMJ 2006; 175 (11): 1377-1381*

SDMAC Considerations Box 2

HOSPITAL AND ACUTE CARE FACILITIES

1. Issue guidance to use START for adults, JumpSTART© for pediatrics, or emergency department triage levels 1–5 for primary triage for statewide CSC.
2. Coordinate with facility Secondary Triage Officers.
3. Issue guidance to use the inclusion criteria and SOFA score for tertiary triage as detailed in Tables 10 and 11 above.
4. Modify recommendations as additional evidence-based guidance is published regarding other hospital-based primary, secondary, and tertiary triage methods.

Expanding Scopes of Practice

Scope of clinical practice is defined as the extent of a licensed healthcare professional's ability to provide services consistent with their competence, license, certification, and privileges. Most healthcare professionals' scopes of practice are delineated by rules and regulations describing requirements for training and skill levels. Evidence of competence is required before a license to practice is issued by the professionals' state board. Any changes in scope of practice must be granted by the appropriate supervisory board and may require additional legislation. Examples of potential expanded scopes of practice are displayed in Box 3; these will likely require additional administrative actions, waivers, or emergency declarations by EMS agencies, hospitals, acute care facilities, the Arizona Department of Health Services (ADHS), emergency management, licensing boards, the Attorney General's Office, the Governor's Office, etc.

Table 13 details clinical procedures that may be used to treat patients during a CSC. The table lists six types of healthcare professionals and indicates which procedures they can perform under various circumstances, such as routine (R), military (M), or CSC (C) conditions. In addition to clinical procedures, the table addresses dispensing of medications and vaccines, which may be especially relevant during deployment of medical countermeasures. While five of the six types of healthcare professionals are familiar to most people, the independent duty medical technician (IDMT) is specific to U.S. military healthcare.

An IDMT can obtain medical histories, as well as examine, assess, and treat patients in the absence of a physician. IDMTs are trained in emergency medical, dental, and surgical procedures to stabilize patients until evacuation to definitive care. IDMTs are assigned to remote or isolated military duty stations or other service missions as directed by the U.S. Department of Defense.

SDMAC Considerations Box 3

RECOMMENDED CSC EXPANDED SCOPES OF PRACTICE

1. EMTs and PAs may be supervised by a resident beyond their first year of residency (internship) in that resident's healthcare facility.
2. Residents beyond their first year of residency (internship) may function to the best of their ability in that resident's healthcare facility.
3. A licensed physician beyond their first year of training (internship) may not be constrained to practice in their assigned facility, but with advanced communication regarding specific needs, may go to another facility and practice under the supervision of a physician from the receiving facility.
4. Licensed Arizona RNs who have met the requirements may perform procedures defined by the Arizona Board of Nursing (ABN) Advisory Opinions in facilities where they have privileges.
5. Any out-of-state, licensed healthcare professional in good standing may be approved to practice by that professional's Arizona licensing board at that board's discretion during CSC.
6. Department of Defense (DOD) clinical professionals, under the supervision of an Arizona licensed clinical professional with similar clinical responsibilities, may use their competencies and privileges obtained through the DOD to exercise their documented skills to assist with healthcare needs of the community.
7. Federal clinical professionals, under the supervision of an Arizona licensed clinical professional with similar clinical responsibilities, may use their competencies and privileges obtained through their federal agencies to exercise their documented skills to assist with healthcare needs of the community.

Table 13: Comparing Routine (R), Military (M), and CSC (C) Procedures by Profession

SKILLS:	Paramedic	Military Medic	IDMT	Registered Nurse	Pharmacist	Qualified Advanced Practice Nurse & Physician Assistant	Qualified Physician
Airway and Breathing							
Respiratory Treatment	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Bag-Valve-Mask Ventilation	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Endotracheal Intubation	R,C	M,C	M,C	M,C		R,M,C	R,M,C
Cricothyroidotomy	R,C		M,C			R,M,C	R,M,C
Needle Thoracostomy	R,C	M,C	M,C	R,M,C		R,M,C	R,M,C
Chest Tube Insertion		M,C	M,C	C		R,M,C	R,M,C
Circulation							
Tourniquet	R,C	M,C	M,C	R,M,C		R,M,C	R,M,C
IV Peripheral Access Insertion	R,C	M,C	M,C	R,M,C		R,M,C	R,M,C
IO Access Insertion						R,M,C	
Central Line Insertion			M,C			R,M,C	R,M,C
Arterial Line Insertion						R,M,C	R,M,C
Cardioversion/Defibrillation	R,C	M,C	M,C	R,M,C		R,M,C	R,M,C
Disability (Nervous System)							
Finger Stick Blood Glucose	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Administer Oral Glucose	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Administer IV or IO Glucose	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Administer IM Glucagon	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Musculoskeletal							
Splint Application	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Dislocation Reduction	C	M,C	M,C	C		R,M,C	R,M,C
Closed Fracture Reduction	C	M,C	M,C	C		R,M,C	R,M,C
Wound Management							
Wound Repair—Staple	C	M,C	M,C	M,C		R,M,C	R,M,C
Wound Repair—Suture	C	M,C	M,C	M,C		R,M,C	R,M,C
Medication Administration							
Immunizations and Vaccines	R,C	M,C	M,C	R,M,C	R,C	R,M,C	R,M,C
Oral	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Intramuscular (IM) & Subcutaneous	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Intravenous (IV) & Inraosseous (IO)	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C
Inhaled	R,C	M,C	M,C	R,M,C	C	R,M,C	R,M,C

R = Routine procedure practiced by clinician in daily, non-emergent setting

M = standard procedure in military settings

C = Crisis standard of care procedure with ongoing or just-in-time training

Considerations for Supply Shortages

One of the key planning assumptions for CSC is shortages of space, staff, and supplies, as well as the short-term inability to receive shipments through regular channels or from emergency supply caches. Strategies and tactics to maximize resources will be necessary. Box 4 below outlines some strategies the SDMAC should consider when developing and issuing clinical guidance.

SDMAC Considerations Box 4

STRATEGIES TO MAXIMIZE MEDICAL RESOURCES

1. SUBSTITUTE: Use an essentially equivalent facility, professional, drug, or device for one that would usually be available.
2. ADAPT: Use a facility, professional, drug, or device that is not equivalent, but provides the best possible care.
3. CONSERVE: Use lower dosages or change practices, e.g., minimize use of oxygen by using air for nebulizers, when possible.
4. REUSE: Use single use items again, after appropriate disinfection or sterilization.
5. OPTIMIZE ALLOCATION: Allocate resources to patients whose need is greater or whose prognosis is more likely to result in a positive outcome with limited resources.

*Adapted from **The Guidelines for Use of Modified Health Care Protocols in Acute Care Hospitals During Pubic Health Emergencies**, September 2013, Kansas Department of Health and Environment

In addition to strategies for maximizing medical resources listed above, Tables 14–16 list some tactics to help maximize healthcare resources, such as space, staff, and supplies. SDMAC members should be familiar with strategies and tactics that can be used to streamline healthcare delivery and maximize resources during CSC.

Table 14: Space Maximization Tactics for CSC

RESOURCE	TACTICS
Hospital	• Designate alternate hospitals to replace damaged and/or non-functional hospitals. • Encourage regional coalitions. • Consider temporary field hospitals to provide support, especially in areas with limited healthcare infrastructure. • Issue guidance to use START for adults, JumpSTART© for pediatrics, or emergency department triage levels 1–5 for primary hospital triage for statewide CSC. • Coordinate with facility Secondary Triage Officers.
Intensive Care Unit (ICU)	• Use CSC criteria for ICU admission (tertiary triage) to optimize ICU resources. • Consider using oxygen saturation monitors with high and low heart rate alarms as surrogate monitors for tachy and brady dysrhythmias when cardiac monitors are unavailable.
Dialysis Facilities for Renal Replacement Therapy	• Activate ADHS information-sharing regarding hospital and community dialysis availability, statewide. • Coordinate dialysis use, statewide, to optimize availability.
Facilities with Extracorporeal Membrane Oxygenation (ECMO)	• Activate ADHS information-sharing regarding ECMO availability, statewide. • Coordinate ECMO use, statewide, to optimize ECMO availability.
Prehospital Facilities and Vehicles for Medical Transport	• Coordinate with local EMS and emergency management to optimize prehospital resources and collaboration. • Use START for adults or JumpSTART© for pediatrics for statewide, CSC response. • Use the State's Alternate Triage, Treatment and Transport Guidelines for Pandemic Influenza for statewide CSC during a pandemic.

Table 15: Staff Maximization Tactics for CSC

RESOURCE	TACTICS
Healthcare Professionals	• Activate facility disaster plans to optimize availability of all healthcare professionals, particularly those serving in emergency departments, ICUs, burn units, operating rooms, etc. • Activate professionals in county Medical Reserve Corps (MRC) and the AZ Emergency System for the Advanced Registration of Volunteer Health Professionals (ESAR-VHP) to assist local healthcare professionals. • Request federal healthcare teams (e.g., Disaster Medical Assistance Teams [DMATs] to assist local healthcare professionals). • Credential, privilege, orient, mentor, manage, house, and feed MRC, ESAR-VHP, DMAT, and volunteer healthcare professionals. • Allow EMTs and PAs to be supervised by a resident beyond their 1st year of residency (internship) in that resident's healthcare facility. • Allow Residents beyond their 1st year of residency (internship) to function to the best of their ability in that resident's healthcare facility. • Allow a licensed physician beyond his/her 1st year of training (internship), with advanced communication regarding specific needs, to go to another facility and practice under the supervision of a physician from the receiving facility. • Allow licensed Arizona RNs who have met the requirements to perform procedures defined by the Arizona Board of Nursing (ABN) Advisory Opinions in facilities where they have privileges. • Allow out-of-state, licensed healthcare professionals in good standing to practice, if permitted by the applicable Arizona licensing board.
Essential Services	• Activate facility disaster plans to optimize availability of all essential services personnel, e.g., housekeeping, food service, laundry, maintenance, engineering, etc.

Table 16: Supply Maximization Tactics for CSC

RESOURCE	TACTICS
Blood and Blood Products, e.g., Platelets, Fresh Frozen Plasma	• Organize blood donation drives to increase availability of blood and blood products. • Activate ADHS information-sharing regarding blood and blood product availability, statewide. • Coordinate blood and blood product use, statewide, to optimize availability.
Surgical Equipment	• Substitute an essentially equivalent surgical device for one that would usually be available. • Adapt a device that is not equivalent to a standard surgical device, but provides the best possible care. • Conserve surgical supplies (e.g., suture materials, by using the least amount possible). • Reuse single use items again, after appropriate disinfection or sterilization. • Allocate surgical supplies (e.g., procedure trays, orthopedic equipment, and chest tubes) to patients whose need is greater or whose prognosis is more likely to result in a positive outcome with limited surgical equipment.
Wound and Burn Care Supplies	• Substitute essentially equivalent wound and burn care supplies for those that would usually be available. • Adapt supplies that are not equivalent to standard wound and burn care supplies, but provide the best possible care. • Conserve wound and burn care supplies (e.g., sterile dressings, by using the least amount possible). • Reuse single use items again, after appropriate disinfection or sterilization. • Allocate wound and burn care supplies (e.g., tourniquets, dressings, and splinting materials) to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.
Ventilators and Components	• Substitute anesthesia machines for ventilators when necessary. • Use BiPAP whenever possible to preclude endotracheal intubation and ventilator use. • Reuse single use items again, after appropriate disinfection or sterilization. • Allocate respiratory care resources (e.g., staff, BiPAP, ventilators, and components) to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.

RESOURCE	TACTICS
Vascular Access Devices	• Substitute essentially equivalent vascular access devices for those that would usually be available. • Adapt supplies that are not equivalent to standard vascular access devices, but provide the best possible care. • Conserve vascular access devices (e.g., IV extension tubing, by using the least amount possible). • Allocate vascular access devices (e.g., adult and pediatric peripheral and central lines) to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.
Medical Gases, including Oxygen and Oxygen Delivery Devices	• Substitute essentially equivalent oxygen delivery devices for those that would usually be available. • Use alternate anesthetic gases that are equivalent to standard anesthetic gases to provide the best possible care. • Conserve medical gases and delivery devices by using the least amount possible. • Reuse single use oxygen delivery devices on the same patient, after appropriate disinfection. • Allocate medical gases, including oxygen and oxygen delivery devices (e.g., adult and pediatric cannulas, masks, and bag-valve devices) to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.
Medications and IV Fluids	• Substitute essentially equivalent medications and IV fluids for those that would usually be available. • Adapt available medications and IV fluids that are not equivalent to standard medications and IV fluids, but still provide the best possible care. • Conserve medications and IV fluids by using the least amount possible. • Allocate medications and IV fluids (e.g., analgesics, antidotes, antibiotics, antivirals, inotropes, sedatives/hypnotics, and anti-hyperkalemic medications) to patients whose need is greater or whose prognosis is more likely to result in a positive outcome.

Out-of-Hospital Care Providers

During a CSC response, many healthcare access points across the state will need to adapt their practices to the overwhelming number of patients seeking care. Ideally, the most acutely injured or ill patients will be routed to a hospital, and lower acuity patients will seek care in out-of-hospital settings. Unfortunately, a CSC incident will be felt across the entire healthcare continuum as large numbers of people look for care wherever it can be found. Out-of-hospital care will be an important part of the CSC response and will naturally expand operations (e.g., extended hours of operation or repurposed infrastructure and equipment) to meet demand. Out-of-hospital care refers to the following types of healthcare access points:

- Outpatient providers
- Clinics
- Surgical centers
- Long-term care facilities
- Group care
- Home care
- Family-based care systems.

Outpatient Providers

To ensure consistent care across the state, the SDMAC and HEOC will need to coordinate CSC implementation and maintain situational awareness with all types of out-of-hospital providers. The size, duration, and scope (e.g., regional, statewide, or national) of the CSC response will determine the level of coordination between the SDMAC and the provider community. The development and implementation of guidelines for facilities and providers will be an interactive process between the SDMAC and the provider community.

The specific medical skills and the infrastructure and equipment available to out-of-hospital providers will be considered during a CSC response:

- Medical skills—may be used in their usual practice environment; in alternate care systems/ assignments (e.g., serving as members of the Medical Reserve Corps [MRC], answering patient hotlines); and perhaps even in their neighborhood/community settings.
- Infrastructure—practice environments may be adjusted to help meet the demands of an overwhelming incident. For example, clinic functions may be:
  - (1) Expanded—using expanded hours, modifying care practices, and adjusting schedules to accommodate increased acute care (e.g., deferring elective appointments);
  - (2) Repurposed—outpatient infrastructure may be repurposed during an incident as, for example, when a subspecialty clinic adjusts its hours or closes to enable the space to be used for acute care; and
  - (3) Referral and Routing—outpatient providers will stay informed of existing healthcare access points and can refer or route patients to higher acuity care as appropriate during a CSC response (IOM, 2012).

SDMAC Considerations Box 5

OUTPATIENT PROVIDERS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Maintain situational awareness, through medical boards and associations, with all types of providers to assess demand for healthcare and resource availability.
2. Develop guidance and messaging on referring and routing higher acuity patients to available healthcare access points.
3. Develop and Implement guidance for various types of outpatient providers.

Clinics

This category includes a wide variety of healthcare access points such as urgent care centers, federally qualified health clinics (FQHC), multi-specialty clinics, and independently operated healthcare practitioners. Many clinics are privately owned, although there are publically operated institutions in the state. For the purposes of this Plan, urgent care facilities, clinics located in retail stores, and pharmacies that provide basic medical screening are all considered to be clinics. Other types of non-traditional providers (e.g., dentists, veterinarians, and others) may also be considered as a part of this group.

SDMAC Considerations Box 6

CLINICS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Maintain situational awareness with all types of clinics through medical boards and associations.
2. Develop and implement CSC guidelines for clinics to expand hours of operation and repurpose space, staff, and supplies as appropriate.

Surgical and Procedure Centers

Surgical and procedure centers may be repurposed to provide acute care, non-ambulatory hospital overflow care, or elective surgeries not possible at hospitals (during infectious disease incidents), depending on the demands of the incident, the specifics of the facility, and the needs of the community. The need for modified regulatory and licensure standards (e.g., changes in the scope of care) will need to be addressed in advance in the event that federal, state, or local government entities (such as public health) authorize the delivery of triaged care in these facilities (IOM, 2012).

SDMAC Considerations Box 7

SURGICAL CENTERS

During a CSC response, the SDMAC will coordinate with the HEOC, healthcare coalitions, local health departments, and state-designated healthcare coalitions to:

1. Maintain situational awareness with all types of surgery and procedure centers through medical association partners.
2. Develop and implement CSC guidelines for surgery and procedure centers.

Long-Term Care Facilities

Several types of facilities are part of this category. Many long-term care facilities have limited surge capacity to accommodate hospital discharges, although they should not be overlooked as a resource. In Arizona, long-term care facilities have implemented the Nursing Home Incident Command System (NHICS), and many are prepared to shelter in place (including without power) during a major incident, and to modify patient care and referral policies. In general, the long-term care industry understands the disproportionate impact of certain incidents (e.g., infectious disease outbreak, pandemic influenza, evacuations) on their residents (AHRQ, 2007a). Many long-term care facilities in Arizona have memoranda of understanding (MOU) in place both with jurisdictional partners to transfer patients during a disaster. However, many of these agreements are with hospitals, which are expected to be overcapacity during a CSC event.

SDMAC Considerations Box 8

LONG-TERM CARE

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

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

Group Home and Congregate Settings

Organizations with on-site medical care (e.g., large business operations, group homes, schools, universities, etc.) can support dispensing or vaccination/prophylaxis services in conjunction with ADHS and local public health departments. Group homes and congregate settings may need to provide sheltering or isolation for residents/students/staff, and may even need to conduct referral and routing of patients during CSC (IOM, 2012).

SDMAC Considerations Box 9

GROUP HOMES AND CONGREGATE SETTINGS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Establish and maintain situational awareness with group homes and congregate settings.
2. Develop and implement CSC guidelines for group homes and congregate settings.

Home Care/Durable Medical Equipment Vendors

During CSC, the SDMAC should coordinate with home care/durable medical equipment vendors to prioritize their services based on the nature of an incident, and be able to adjust plans as the incident changes over time. These plans also should cover clients that are quarantined, isolated, or sheltering in place because of weather or other emergencies. Device-dependent persons should have a care plan in case of a system failure or power outage. Emergency departments may be inundated with patients' chronic care needs when home care cannot be continued. Home care and durable medical equipment vendors will play a critical role in providing basic medical equipment to individuals and facilities across the healthcare community (AHRQ, 2011).

SDMAC Considerations Box 10

HOME CARE AND DURABLE MEDICAL EQUIPMENT VENDORS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Establish and maintain situational awareness with home care and durable medical equipment vendors.
2. Develop and implement CSC guidelines for home care and durable medical equipment vendors.

Family-Based Care

A large number of Arizonans receive care from family members, domestic partners, or cohabitants. Friends and family members provide basic care to people with a wide variety of conditions including behavioral health issues, chronic diseases, end-of-life, developmental disabilities, and traumatic injuries. These non-clinical caregivers can play a key role in preventing the medical system from being overloaded by helping limit unnecessary visits to healthcare providers and ensuring at-risk people receive the most appropriate available care. To effectively reach these groups, public information messages should be disseminated statewide to inform the general public of available healthcare resources for homebound persons and other at-risk groups. Families and friends should be prepared for expanded responsibilities during a catastrophic incident.

SDMAC Considerations Box 11

FAMILY-BASED CAREGIVERS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Develop public messaging for family/friend caregivers and coordinate dissemination with public information staff.

Alternate Care Systems

Emergencies or disasters that impact the healthcare infrastructure or cause a large number of casualties may require the establishment of alternate care sites and systems. For the purposes of this Plan, an alternate care site or system, is not a routine part of the healthcare system, but is activated or initiated during a disaster to meet the surging demand for healthcare services. Alternate care sites range in complexity and level of care and may be used during CSC to augment hospital-based and out-of-hospital care.

During the course of CSC guideline development and implementation, the SDMAC must assess the need for and impact of alternate care systems. The activation of alternate care sites, such as deployment of a federal medical station (FMS) or establishment of shelters providing basic medical care, will inevitably influence medical surge at nearby hospitals and other healthcare access points. Consequently, the SDMAC will need to coordinate and optimize alternate care site/system strategies (e.g., placement, type, number, etc.) with healthcare system stakeholders.

The previous section lists many of the healthcare access points that are a routine part of healthcare in Arizona and across the nation. During a public health disaster or CSC, alternate care sites and systems will play an important role in reducing medical surge at hospitals. In addition to these traditional healthcare providers, alternate or contingency healthcare access points may also be activated. These include electronic care, ambulatory care, shelter medical care, non-ambulatory care overflow, emergency care replacement/overflow, and surgical/intensive care overflow (IOM, 2012 p. 5-6–5-9). Box 12 includes considerations for SDMAC members related to all types of alternate care sites and systems.

SDMAC Considerations Box 12

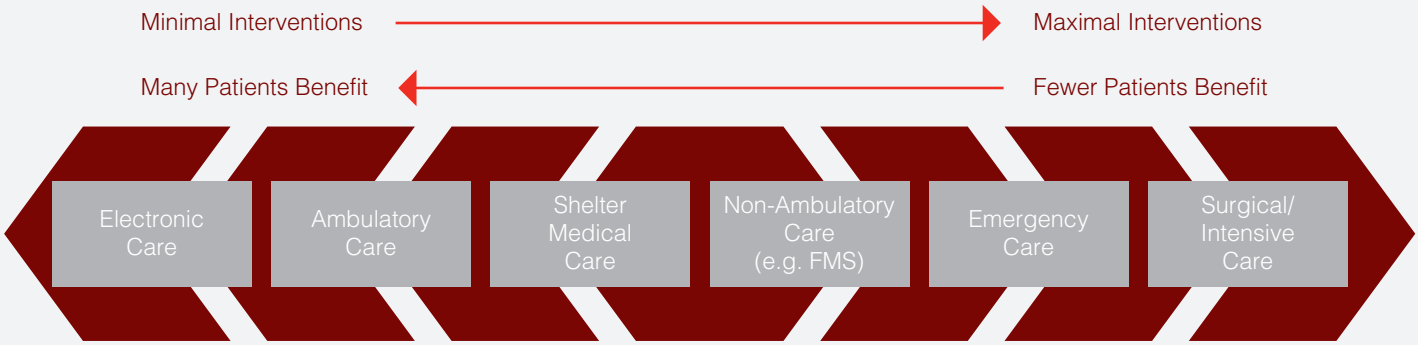
ALL TYPES OF ALTERNATE CARE SITES

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

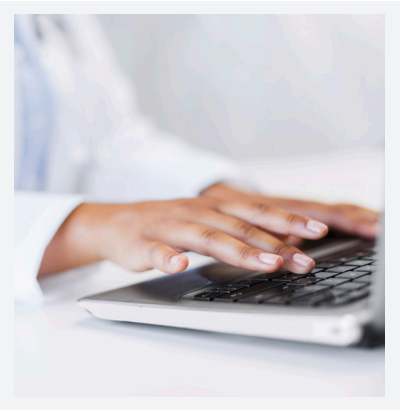
1. Work with hospitals and other healthcare access points to determine which treatments and healthcare services are most needed.
2. Identify safe and accessible locations for alternate care sites.
3. Identify strategies to maximize healthcare delivery by coordinating emergency medical services, out-of-hospital, and alternate care sites.

When identifying strategies to maximize healthcare resources during CSC, the SDMAC must consider all types of alternate care sites. For the purposes of this Plan, alternate care sites encompass electronic alternate care systems, ambulatory care, shelter medical care, non-ambulatory care (e.g., a Federal Medical Station), emergency care replacement overflow, and surgical/intensive care or inpatient replacement/overflow. Figure 2 below depicts the relationship between the degree of intervention at various alternate care sites and the number of patients that can benefit from the intervention. Maximal interventions can only be offered to the smallest number of patients, while minimal interventions may be more broadly delivered.

Figure 2: Minimal versus Maximal Interventions (IOM, 2012)



Electronic Alternate Care Systems



In the past, ADHS has activated call centers and executed social media campaigns with local partners to support public health emergency operations, e.g., Hurricane Katrina evacuation, 2009 H1N1, and seasonal vaccine shortages. These practices and partnerships will be used and/or expanded to support CSC operations. Electronic care systems can be used to inform the general public of protective actions and deliver basic health information to a large number of people without surging inpatient or outpatient care settings. Online and telephone assessment and prescribing can be used to screen patients and route them to higher acuity care, as needed during many types of disasters.

The SDMAC will develop guidance to ensure that electronic (online, telephone) referral policies and scripting are consistent across the State. Behavioral health subject matter experts will be consulted to ensure the development of guidance for electronic behavioral health assessments.

The Arizona Burn Disaster Network Telemedicine Program can be used to provide electronic care via state-of-the-art equipment. For example, burn experts from outside the disaster zone can provide consultation when local experts are overwhelmed. The AZ Burn Disaster Network's equipment may also be used to provide telemedicine support for other types of responses, (e.g., rash identification during an infectious disease outbreak).

Social media platforms will play a major role in electronic alternate care systems by providing information on protective actions and guidance on where and when to seek medical treatment. State and local resources such as public safety answering point (PSAPs), the two Arizona Poison Control Centers, and other state/local hotlines such as community information and referral should also be leveraged to provide telephone triage and screening. The SDMAC will coordinate closely with public information professionals to develop and disseminate consistent CSC messaging across the state via all available media.

SDMAC Considerations Box 13

ELECTRONIC ALTERNATE CARE SYSTEMS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions:

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

Ambulatory Care Facilities

Ambulatory care facilities (e.g., casualty collection points or "flu centers") are intended to serve the minimally ill or injured who cannot be accommodated by the usual outpatient infrastructure. The need for such facilities, as well as their staffing and supply, varies greatly depending on the type and phase of the incident. Acute need for such sites may be seen during a pandemic or after a massive no-notice incident, such as an earthquake, large explosion, or other mass casualty incident (IOM, 2012).

Healthcare facilities should coordinate with the ADHS Division of Licensing staff in the HEOC to activate these facilities (units) on hospital grounds. Public sites may be initiated if the capacity of the healthcare system is overwhelmed or if selected populations or areas are disproportionately affected. These public sites also may be in nontraditional locations (e.g., veterinary clinics, dental clinics, schools). Preplanned supplies for infectious disease and trauma incidents should be considered for ambulatory care facilities. It is important for facilities to work with the ADHS Division of Licensing Services to ensure that appropriate waivers are obtained.

SDMAC Considerations Box 14

AMBULATORY CARE FACILITIES

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

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

Shelter-Based Care

According to the US Census Bureau, nearly 20% of Americans have a disability (access and/or functional need). As a result, general population shelters must be prepared to deal with basic to moderate healthcare needs. In Arizona, state and local public health, emergency management, and access and function needs (AFN) organizations are prepared to meet basic medical needs in general population shelters. ADHS maintains a cache of durable medical equipment that can be used to support healthcare services at shelter sites. During CSC, the SDMAC will develop guidance for the delivery of healthcare at shelters based on available space, staff, and supplies.

SDMAC Considerations Box 15

SHELTER-BASED CARE

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Establish situational awareness with shelter operations.
2. Work with Emergency Support Function (ESF) 6 and ESF 8 agencies, e.g., ADHS/HEOC, DEMA, Red Cross, etc., to identify medical capabilities and equipment needs at shelter locations.
3. Coordinate with AZ Board of Pharmacy to obtain waivers for managing medications for shelter populations.
4. Develop and implement statewide guidance for shelters.

Non-ambulatory Care/Hospital Overflow

Typically set up in flat-space areas (convention or event centers, gymnasiums, armories), these sites provide overflow for patients that are non-ambulatory but have less intensive medical needs than hospitalized patients (IOM, 2012). Assets required to activate one of these sites would be coordinated and/or requested by the ADHS HEOC in conjunction with ADEM. During CSC the SDMAC will develop guidance for the activation and use of these non-ambulatory care sites, i.e., hospital overflow sites.

SDMAC Considerations Box 16

NON-AMBULATORY CARE/HOSPITAL OVERFLOW

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Work with HEOC and emergency management partners to establish need for non-ambulatory care, and identify possible locations, staffing, and supplies.
2. Develop and implement statewide guidance for non-ambulatory care/hospital overflow.

Federal Medical Stations

These 150-bed units are designed to provide basic non-ambulatory care to hospital overflow patients with minimal medical needs or to shelter patients with more advanced outpatient needs. These assets can be requested by the ADHS HEOC in coordination with ADEM. They are designed to be moved into "structures of opportunity" in the community, such as schools or convention centers. Although multiple federal medical stations are available, the supply is clearly inadequate for a multistate or national event (e.g., a pandemic, a major earthquake), and the request and setup process requires days. Federal medical stations may be integrated with shelter-based or non-ambulatory care or be independent (ASPR, 2012). The SDMAC will collaborate with local, state, and federal partners to optimize the placement of federal medical stations.

SDMAC Considerations Box 17

FEDERAL MEDICAL STATIONS

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Collaborate with local, state, and federal partners, including the Region 9 Emergency Coordinator (REC).
2. Conduct assessments to determine optimal locations for federal medical stations based on disaster location and demand for healthcare services.

Emergency Care Replacement/Overflow

Usually provided in a specialty trailer or temporary specialty structure, emergency care replacement or overflow sites provide replacement capacity for damaged emergency departments (particularly in smaller communities). They also can provide temporary increased capacity for a single facility or area during a special event or major incident, particularly one involving healthcare or transportation infrastructure damage that limits access to emergency care. Healthcare facilities that activate an emergency care replacement/overflow site must do so in coordination with the ADHS Division of Licensing. The level of care provided often may be equal to that provided in a hospital (IOM, 2012).

SDMAC Considerations Box 18

EMERGENCY CARE REPLACEMENT OVERFLOW

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Identify availability of this type of resource in the state.
2. Conduct assessments to determine optimal locations for emergency care replacement overflow based on disaster location and demand for healthcare services.

Surgical/Intensive Care or Inpatient Replacement/Overflow

Like the emergency care replacement/overflow sites, the surgical/intensive care or inpatient replacement/overflow sites could provide services in areas where healthcare facilities are damaged or inadequate. Federal assets such as expeditionary medical facilities may fall into this alternate care site category.

SDMAC Considerations Box 19

SURGICAL/INTENSIVE CARE OR INPATIENT REPLACEMENT OVERFLOW

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Identify availability of this type of resource in the disaster area.
2. Conduct assessments to determine optimal locations for Surgical/Intensive Care or Inpatient Replacement Overflow based on disaster location and demand for healthcare services.

Fatality Management

During CSC, structured planning and incident-specific guidance for mortuary services is critical to maintaining the dignity, and timely and orderly processing of the deceased, as well as social order. Incident-specific guidance for surge-capacity mass mortuary sites should be developed in coordination with local medical examiners. In addition, guidelines should consider the National Disaster Medical System (NDMS) Disaster Mortuary Operational Response Team (DMORT) if available, as well as state-based resources to support a mass fatality response. SDMAC guidance will be developed in accordance with the ADHS Fatality Management Plan and will support local fatality management plans.

SDMAC Considerations Box 20

FATALITY MANAGEMENT

During a CSC response, the SDMAC will coordinate with the HEOC, local health departments, and state-designated healthcare coalitions to:

1. Develop guidance for the coordination of statewide fatality management operations in accordance with the ADHS Fatality Management Plan.

Pediatrics

According to the US Census Bureau, nearly 25% of the population in Arizona is under the age of 18. Consequently, the availability of pediatric care will be a major concern during all types of disasters. As previously mentioned, JumpSTART© will be used to triage pediatric patients during CSC. In addition to this pediatric-specific triage technique, many other aspects of the public health and medical disaster response must be tailored to meet the unique requirements and needs of children during disasters. These issues include but are not limited to communication, personal protective equipment (PPE), decontamination, behavioral health, evacuation and transfer, family reunification, and pediatric space, staff, and supplies.

Communication

Communication with pediatric patients, especially younger, non-verbal patients will present challenges during CSC. Hospitals, along with other healthcare access points, should be prepared to communicate basic information and provide companionship to children. During disaster, use of toys, pens and paper, coloring books, child-friendly signs, and other modalities may help children establish communication with caregivers and supervising adults.

Personal Protective Equipment

PPE worn by healthcare providers may be frightening or strange to children. As a result, communication strategies must be in place to address fears and concerns. Additionally, pediatric sizes of masks and other types of PPE should be available for potentially infectious pediatric patients during transport or while in common areas.

Pediatric Decontamination

Decontamination of pediatric patients will pose extra challenges for healthcare and emergency response personnel. For example, pediatric patients may be more susceptible to hypothermia and require tepid (98.6 °F) water during wet decontamination. Children may not be able to adequately wash themselves, follow verbal instructions, or use decontamination equipment. When possible, children should be sent through decontamination with an adult family member. Hospital decontamination teams should be prepared to accommodate children and their adult caregivers, and provide instruction on how to effectively decontaminate all ages of patients.

Pediatric Behavioral Health

Children may have unique behavioral health and psychological needs during disasters. Pediatric patients, both accompanied and unaccompanied, may be especially upset by the disaster and prone to fear and panic. Consequently, hospitals and other healthcare access points will need to establish methods for emotional comfort, psychological assessments, and behavioral healthcare, ensuring coordination with appropriate behavioral health and social service providers.

Pediatric Evacuation and Transfer

During CSC, pediatric patients need special considerations for evacuation and transfer. The Arizona Pediatric Disaster Coalition Memorandum of Understanding (MOU) outlines the process for distributing patients among the undersigned pediatric acute healthcare facilities within the state.

In the event of a large-scale disaster impacting more than one of the State's pediatric acute healthcare facilities, the evacuation and transfer protocols outlined in the above-mentioned MOU may be inadequate. Priority for evacuation and transfer will be within the State of Arizona according to the system outlined by the Arizona Pediatric Disaster Coalition.

Several hospitals within the State are certified as Pediatric Prepared Emergency Care facilities by the Arizona Chapter of the American Academy of Pediatrics (AzAAP). Pediatric Prepared Emergency Care is a private-public partnership among hospitals, healthcare professionals, emergency personnel, and state agencies, committed to an effective, regionalized pediatric emergency care system. The certification includes three levels—Prepared, Prepared Plus Care and Prepared Advanced Care.

If all of the certified pediatric facilities are overwhelmed, then transfer to other in-state facilities will be necessary. Evacuation and/or transfer procedures will be initiated by hospital incident commands at impacted healthcare facilities, according to the Arizona Pediatric Disaster Coalition Activation Process. If in-state capacity to evacuate/transfer pediatric patients is completely exhausted, transfer to facilities in other states will be considered.

Family Reunification

Family reunification is a major concern after any disaster requiring evacuation from the field or inpatient healthcare facilities. These issues are compounded when pediatric patients are evacuated or transferred to distant facilities out of the impacted area. Pediatric acute healthcare facilities have plans to activate hospital reception sites (HRSs) to assist families seeking information about missing loved ones. Planning for a HRS involves the following considerations:

- Pediatric space, staff and supplies
- Planning and activation
- Pediatric safe area
- Security
- Just-in-time training
- Communications and information management

Under normal conditions, pediatric care requires specialized equipment, facilities, medications, and training. Per the Arizona Pediatric Disaster Coalition's Activation Process and related MOU, a pediatric acute care facility will transfer patients when space, staff, and supplies are not available to meet the needs of patients. When patient transfer or evacuation is not possible and resources are unavailable, medical facilities and personnel may be forced to adapt space, staff, and supplies to best accommodate pediatric patients. The latest evidence-based research and guidance related to pediatric emergency care should be incorporated into a CSC response.

SDMAC Considerations Box 21

PEDIATRIC CARE

1. COMMUNICATION: Messaging and communication will need to be modified for pediatric patients, especially those who are non-verbal.
2. PERSONAL PROTECTIVE EQUIPMENT (PPE): Masks, gloves, gowns, and other PPE may frighten pediatric patients. Pediatric sizes of masks and other types of PPE should also be available.
3. DECONTAMINATION: Children may need to be decontaminated with or by adult family members/caregivers. Tepid (98.6 °F) water will be needed because children are more prone to hypothermia.
4. MENTAL HEALTH: Children have unique psychological needs and may be prone to fear and panic.
5. EVACUATION/TRANSFER: The Arizona Pediatric Disaster Coalition Memorandum of Understanding (MOU) outlines the process for transferring patients within the state. Out-of-state transfer will be a last resort.
6. REUNIFICATION: Hospital reception sites will be set up at hospitals to assist families seeking information about missing loved ones.
7. PEDIATRIC SPACE, STAFF, AND SUPPLIES: When possible, pediatric patients should be brought to pediatric acute healthcare facilities. If evacuation or transfer is not possible, healthcare professionals will have to use available resources until transfer is possible.

Palliative Care and Comfort Care

For the purposes of this document, palliative care patients are defined as individuals who may benefit from available curative therapies. Comfort care patients are defined as individuals for whom curative therapies are futile, given available resources.

During CSC, decisions must be made to balance needs for lifesaving care for those in triage categories who will likely benefit from treatment, while providing comfort care for those for whom lifesaving care is likely futile. At a minimum, comfort care services for disaster victims will include relief of severe symptoms and support as people face end-of-life decisions.

The delivery of palliative and comfort care will be adapted according to the type and severity of the disaster. The SDMAC will develop guidance for healthcare facilities and personnel, community responders, and other caregivers. It is the intent of this plan to guide the delivery of consistent, compassionate, and equitable palliative and comfort care across the state. This applies to casualties of the CSC disaster, as well as patients facing end-of-life decisions from other illnesses and injuries.

Disaster triage is a dynamic process; therefore, patients initially triaged with START or JumpSTART© at a higher priority than expectant may be re-triaged as expectant, if their condition deteriorates or resources are depleted. Patients with a SOFA score >11 are the lowest priority for ICU admission and should receive available comfort care, as needed. The SDMAC will assist comfort care personnel, either medical or non-medical, by developing and issuing guidance specific to the scope and type of response.

The following definitions of palliative and comfort care, and bulleted items are adapted from the World Health Organization (http://www.who.int/cancer/palliative/en/):

The intent of palliative and comfort care is to improve the quality of life for patients and their families who face problems associated with life-threatening illnesses and injuries, by preventing and relieving suffering, by means of early identification and treatment of pain and other, physical, psychosocial, and spiritual problems.

Palliative and Comfort Care:

- Provide relief from pain and other distressing symptoms
- Affirm life and regard dying as a normal process
- Seek neither to hasten or postpone death
- Integrate the psychological and spiritual aspects of patient care
- Offer a support system to help patients live as actively as possible until death
- Offer a support system to help the family cope during the patient's illness and the family's bereavement
- When possible, uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- Enhance the quality of life and may positively influence the course of the illness or injury

Palliative and comfort care for children represent a special, albeit closely related field to adult comfort care. In addition to the above considerations, the following apply to pediatric patients:

- Palliative and comfort care for children are the active total care of the child's body, mind, and spirit, and also involves giving support to the family.
- Palliative and comfort care begin when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease.
- Healthcare professionals should evaluate and alleviate a child's physical, psychological, and social distress.
- When possible, effective comfort care requires a broad multidisciplinary approach that includes the family and makes use of available community resources, even when resources are limited.
- Palliative and comfort care can be provided in acute care facilities, out-of-hospital care settings, alternate care sites, or in children's homes.

Palliative and Comfort Care in Hospitals and Acute Care Facilities

One key strategy during CSC is to optimize resource use at hospitals and acute care facilities. One part of this is transferring palliative and comfort care patients to other care facilities. There are many types of healthcare facilities that may be able to assist with a surge of comfort care patients (e.g., out-of-hospital settings, alternate care sites). Additionally, hospice service providers may be engaged to deploy comfort kits for home-based comfort care.

During a CSC response, the SDMAC will coordinate with triage officers and emergency management staff at healthcare facilities to facilitate transfer of existing palliative and new comfort care patients from acute care to other healthcare facilities or home healthcare settings. This will require coordination with local health departments, ADHS, and state designated healthcare coalitions.

Palliative Care and Comfort Care

The SDMAC will develop guidance for healthcare professionals and facilities on delivering and continuing palliative and comfort care in a consistent and equitable manner across the state. This will include assessing the number of people needing comfort care versus the number of disaster casualties needing curative therapies or treatments. Consideration will also be given to persons receiving comfort care or lifesaving treatments prior to the disaster. The SDMAC will need to assess available inventories, caches, and stockpiles of comfort care medications to develop recommendations for allocating scarce resources to palliative and comfort care patients.

Palliative and Comfort Care at Out-of-Hospital Facilities

Depending on the type and severity of the response, the SDMAC may also develop guidelines for comfort care in non-hospital settings that do not normally provide care to medical surge patients. Long-term care facilities, which are very familiar with providing palliative and comfort care, may be able to expand operations and take in disaster victims or evacuees from other facilities requiring end-of-life care. To facilitate this, the SDMAC will coordinate with healthcare coalition partners to assess available beds and the ability to expand operations at long-term care and other facilities. This assessment should include both existing, licensed in-patient beds, as well as non-licensed emergency beds at alternate care sites.

Palliative and Comfort Care at Alternate Care Sites and Systems

Alternate care sites (e.g., casualty collection points, shelter-based care, and federal medical stations) may be activated and used to provide palliative and comfort care. The SDMAC will consider these resources when developing statewide strategies and guidance for the delivery of comfort care. This will require coordination between healthcare coalitions, state, and federal partners.

Just-in-Time Training for Palliative and Comfort Care

Based on the severity of the response, the SDMAC may need to consider just-in-time training recommendations for palliative and comfort care. These guidelines will address shortages of key resources (e.g., space, staff, and supplies) and will follow the strategies to maximize medical resources listed previously in Box 4. Under the most extreme conditions, these training guidelines may address the use of non-medical personnel in the delivery of comfort care, including helping a patient take their own medications.

Psychosocial Support

Medical intervention is only one component of palliative and comfort care. During a CSC response with limited clinical resources, psychosocial support may be the only available source of comfort. As with other types of clinicians, behavioral health staff and others qualified to provide psychosocial support in a disaster (social workers, religious/spiritual advisors, and other responders trained in psychological first aid) will be in short supply. The SDMAC will need to address this aspect of comfort care when developing guidance for healthcare professionals and other CSC responders.

SDMAC Considerations Box 22

PALLIATIVE AND COMFORT CARE

1. Develop plans to transfer expectant patients to comfort care sites.
2. Assess available inventories, caches, and stockpiles of palliative and comfort care medications, and develop recommendations for allocating scarce resources to comfort care patients.
3. Leverage medical support at out-of-hospital healthcare facilities, including long-term care, surgical centers, clinics, etc.
4. Coordinate with alternate care sites (ACS) such as shelters, federal medical stations, etc.
5. Develop guidelines for just-in-time training for medical and non-medical personnel at healthcare access points to provide basic care (e.g., helping patients take their own medicines).
6. Integrate behavioral health, spiritual, and psychosocial support for casualties and providers.
7. Coordinate guidance for hospital triage officers and/or emergency responders.

Behavioral Health

The ADHS Division of Behavioral Health Services (DBHS) contracts with three regional behavioral health authorities (RBHA) and various tribal regional behavioral health authorities (TRBHAs) to provide behavioral health services across the state. In a CSC response, the DBHS will work with the ADHS HEOC to coordinate the statewide behavioral health response with the RBHAs and TRBHAs. The SDMAC will include behavioral health representation and will work with the HEOC and ADHS Director to develop guidelines for the delivery of behavioral health services across the state during emergencies and disasters.

During CSC, the SDMAC must consider the behavioral health and psychosocial impact of the disaster on the general public, on first responders and medical professionals, and on the state's seriously mentally ill population, and their continuing mental health care. The ADHS Behavioral Health Emergency Response Plan and the Behavioral Health Response Guide contain additional information on the coordination of behavioral health services during a disaster.

Behavioral Health Impact on the General Population

In the aftermath of a disaster, many people may require behavioral health services to cope with grief and post-traumatic stress. Psychological first aid and social support systems will play an important role in addressing these issues. Incident specific risk communication strategies should be developed and disseminated to help people manage the stress of the incident and direct them to additional resources as necessary. Community resilience programs encouraging neighbor-to-neighbor and family-to-family outreach are important. The SDMAC will coordinate with behavioral health experts in the HEOC to develop guidelines for behavioral health providers and risk communication messaging for the public.

Behavioral Health Impact on Responders and Medical Providers

Responders and healthcare providers may be especially prone to post-traumatic stress and other conditions during and after a CSC response. Peer-to-peer support, counseling, and other behavioral health support services, e.g., critical incident stress management (CISM), may be useful for responders and providers. CISM interventions may include a three step approach: (1) defusing, (2) debriefing, and (3) follow-up.

Impact on Seriously Mentally Ill Population and Continuation of Care

People with serious mental illness (SMI) may be disaster victims, e.g., injured, infected, or experience emotional crises related to the disaster. Additionally, there are thousands of Arizonan's suffering from SMI that require ongoing behavioral health services that may be disrupted during a disaster. As behavioral health providers, spiritual advisors, and social workers address the needs of disaster victims and comfort care patients, there will be an impact on the overall availability of resources for behavioral healthcare within the state. The SDMAC must consider both the ongoing treatment needs of the SMI population, as well as additional emotional and behavioral issues this group may experience as a result of the disaster. Behavioral health guidelines must also address the continuation of substance dependency treatment, including administering medications.

SDMAC Considerations Box 23

BEHAVIORAL HEALTH

1. Develop public messaging and guidelines for healthcare and behavioral health practitioners regarding the behavioral impact on the general population.
2. Develop guidelines for healthcare workers, behavioral health practitioners, and first responders regarding the behavioral health impact on the responder community.
3. Develop guidelines for the continuation of care to persons with serious mental illness and individuals receiving treatment (including medication) for substance dependency.

Statewide CSC Deactivation

The ADHS Director, in consultation with the Governor's Office and the SDMAC, will deactivate CSC when healthcare facilities are no longer operating at a crisis level. This deactivation will occur when all impacted healthcare facilities are able to meet patient demand using contingency-level surge standards, or when patient transfer or evacuation becomes a feasible tactic to alleviate crisis-level surge at affected healthcare facilities.

In the case of a severe resource shortage prompting CSC, deactivation may occur when supply levels become sufficient to meet healthcare system demands. The following procedures will be employed to ensure a coordinated deactivation of CSC standards across the state:

- Throughout the response, the HEOC, SDMAC, and healthcare facility staff will analyze situation reports (SitReps), bed polls, and updates from healthcare system partners to determine the continued need for crisis-level care across the state.
- When at least 50% of impacted facilities (facilities at crisis-level) have returned to contingency level care, the SDMAC will coordinate with the JIC to prepare Health Alerts and public messaging to prepare for CSC deactivation.
- When it is anticipated that all healthcare facilities will return to contingency-level care within 48 hours, the SDMAC will send notice to statewide healthcare partners stating that "it is anticipated that CSC will be rescinded within 48 hours". This timeframe will allow healthcare facilities to prepare for transitioning back to contingency surge, conventional surge, or normal operations, as appropriate.
- When all impacted healthcare facilities are able to return to contingency-level care, or patient transfer/evacuation becomes possible to alleviate crisis-level conditions, the ADHS Director, in consultation with the Governor's Office and the SDMAC, will deactivate CSC across the state.

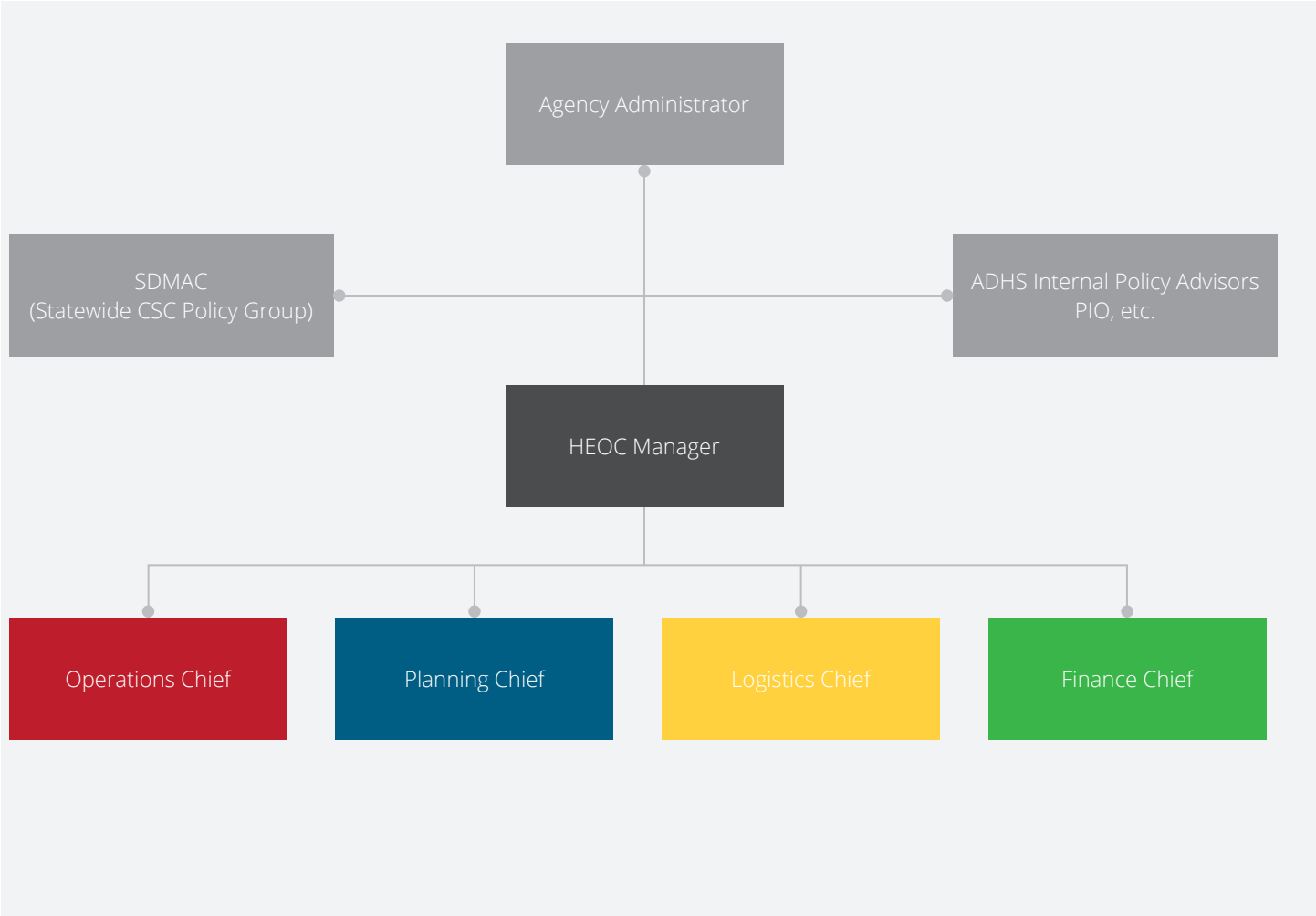
It is important to note that the deactivation of CSC does not stop emergency operations at the state, local, or facility level. Emergency operations and emergency declarations may still be in place despite the fact that CSC have been deactivated.

ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

During a declared disaster or public health emergency, the ADHS Director, in consultation with the Governor's Office, may activate the SDMAC to develop and disseminate crisis standards of care across the State. In addition to this capacity, the SDMAC will also serve as a multi-disciplinary, interagency policy group for the ADHS Director and the HEOC. In keeping with ICS guidelines, the SDMAC will only be responsible for policy development, while operational management will be conducted by the State Emergency Operation Center (SEOC), HEOC, and local/tribal EOCs. The SDMAC will defer to the Joint Information Center or System (JIC or JIS) for information dissemination to the general public.

Figure 3 depicts the relationship between the SDMAC and the HEOC. The HEOC is charged with Emergency Support Function (ESF) 8, Public Health and Medical. The HEOC will coordinate ESF 8 functions with the SEOC, managed by the Arizona Division of Emergency Management (ADEM). Figure 3 also includes a separate designation for "ADHS Internal Policy Advisors". This policy group will be comprised of ADHS staff and will address internal issues associated with on-going emergency operations, such as business continuity, human resources policies, and other internal operations.

Figure 3—Health Emergency Operation Center and Policy Groups



SDMAC Staff

The SDMAC will require a wide range of medical professionals, public health experts, and official decision makers. The following list of positions provides a framework for staffing the SDMAC. In keeping with ICS principles of flexibility and scalability, the makeup of the SDMAC will depend on the nature, scope, and severity of the disaster. At a minimum, the following positions should be considered for any response requiring CSC. Detailed descriptions of the qualifications, training, and responsibilities for each of these positions are provided in Appendix H: Job Action Sheets.

ADHS Director

The ADHS Director or designee will act as the SDMAC Chair and will oversee developing CSC guidelines by the SDMAC. As SDMAC Chair, he or she will liaison with elected officials and agency directors during CSC development and implementation.

ADHS Policy Group Advisor

The ADHS Policy Group Advisor will manage the details of CSC policy development and implementation. Under the direction of the SDMAC Chair, he or she will ensure timely development of CSC guidance and will coordinate CSC messaging with the Joint Information Center or System (JIC or JIS). This position will be the main point of contact for CSC policy, statewide, and will supervise the SDMAC Liaison. This position will be filled by a senior ADHS staff member. He or she will have extensive knowledge of healthcare system preparedness and ADHS operations.

ADHS SDMAC Members

ADHS Committee Members will be added to the SDMAC based on the specifics of the response. These SDMAC members will be program managers or medical directors from ADHS bureaus and divisions, such as Public Health Emergency Preparedness, Emergency Medical Services and Trauma Systems, Epidemiology and Disease Control, the Arizona State Public Health Laboratory, Licensing, Behavioral Health, Immunizations, or other areas, as needed. These staff members may have a dual role in the Health Emergency Operation Center, but may be called upon to assist with CSC policy recommendations and implementation.

SDMAC Liaison

The SDMAC Liaison will work under the direction of the ADHS Policy Group Advisor and will be responsible for coordinating SDMAC activities with ADHS HEOC operations. He or she will communicate and coordinate with the HEOC Manager to relay policy decisions of the SDMAC and obtain logistical

support for SDMAC operations.

Partner Agency SDMAC Member

CSC policy development will require input and representation from state agencies, counties, and tribal partners. The exact number of committee members will depend upon the scope and geographic reach of the catastrophe, but at a minimum should include representation from state agencies, such as ADEM, the Arizona Attorney General's Office, the Governor's Office, Arizona Department of Education, local health departments, and the state's healthcare coalitions. Partner Agency SDMAC Members will contribute to developing CSC, including guidance and priorities for allocating scarce medical resources. These committee members will also liaison between their respective agencies and the SDMAC.

Healthcare SDMAC Member

Input from healthcare representatives is vital to implementing CSC. The exact number of Healthcare SDMAC Members will depend upon the scope of the response. These individuals will contribute to developing statewide CSC guidance, including priorities for allocating scarce medical resources. They will also liaison between their respective healthcare entities and the SDMAC. If the number of healthcare representatives is too large (e.g., greater than 20), it would be advisable to activate a regional group (e.g., state-designated healthcare coalition) to coordinate CSC regionally and locally.

Subject Matter Expert SDMAC Member

CSC policy will require input from a variety of subject matter experts (SMEs). The number and type of experts will depend upon the type and severity of the response. SMEs will provide technical information, data analysis, and advice related to the response. They will contribute to developing and implementing statewide CSC, including guidance and priorities for allocating scarce medical resources.

Clinical Care Committee Staff at Healthcare Facilities

During a statewide CSC response, healthcare facilities will need to assign specific tasks to both clinical and incident command staff. The following staff descriptions can serve as a guide for healthcare facilities to use when developing or updating medical surge or CSC plans. See sample job action sheets in Appendix H. These can be modified as needed to fit the Incident Command System in place at individual healthcare facilities or healthcare systems. Small healthcare facilities may only have one person available to implement CSC, whereas a large hospital may have a team of staff. Planners should adjust these positions, as needed, but should remember to separate the task of CSC triage from patient care, whenever possible. See "Clinical Concept of Operations", previously, for information on primary, secondary, and tertiary triage.

Clinical Care Director

In larger healthcare facilities, the Clinical Care Director will report to the facility Incident Commander and will coordinate CSC priorities and guidance within the facility's incident command. The Clinical Care Director will liaison between the SDMAC and the healthcare facility to provide situational awareness and implement CSC at the facility level.

CSC Triage Officer

The CSC Triage Officer reports to the Clinical Care Director. He or she will triage patients according to CSC priorities and guidance developed by the SDMAC. Healthcare facilities should consider developing separate job action sheets for Primary, Secondary, and Tertiary Triage Officers. RNs usually perform primary triage, whereas physicians typically perform secondary and tertiary triage. Most importantly, to preserve objectivity, these Triage Officers should not be providing patient care.

DIRECTION, CONTROL, AND COORDINATION

As mentioned in the preceding "Organization and Assignment of Responsibilities" section, the SDMAC will serve as the state's lead policy advisory group during CSC operations. The direction, control, and coordination of this policy group will require an interagency, system-wide approach detailed in Figure 4, below, including three "levels" of response: (1) state, (2) regional and county, and (3) local and facility.

The vertical axis represents a shift from operations to policy, whereas the horizontal represents a change from the state level to the local and facility level. Figure 4 describes the relationship between the SEOC, the HEOC, and the SDMAC, and how policy and operational control will flow from the state down to the local and facility levels.

CSC policy groups, such as the SDMAC, state-designated healthcare coalitions, and the clinical care committees (CCC) will develop and implement policy, but not manage incident command or operations. Public health, medical providers, and emergency management response entities will provide incident command and operational management to support CSC policy. All of the response entities listed below must function together in a "systems approach" (IOM, 2012) to ensure delivering consistent, quality healthcare under the most extreme conditions.

Figure 4—Arizona CSC: Direction, Control, and Coordination

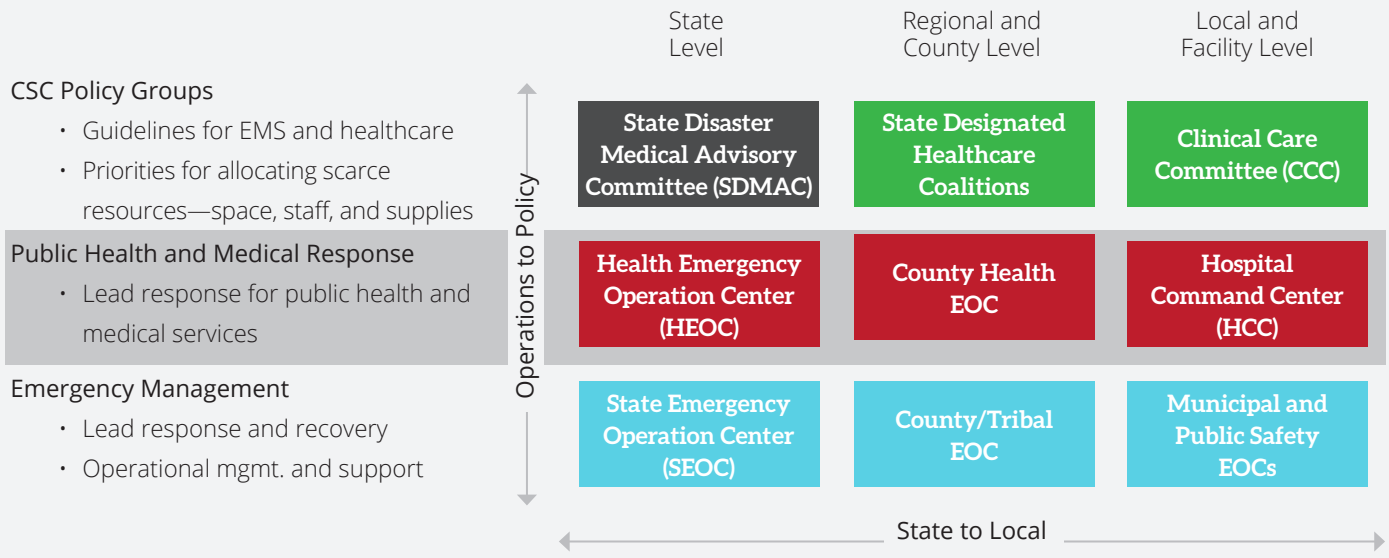


Figure 4 also depicts the strong partnership between emergency management, public health, and healthcare. The Arizona State Emergency Response and Recovery Plan (SERRP) indicates DEMA will provide overall operational management, whereas the ADHS will lead public health and medical operations across the state. Emergency management and public health integration is assured by liaising between departments during responses and exercises. ADHS will send a staff person to act as the Health and Medical Branch Director during CSC operations in the State Emergency Operations Center (SEOC).

INFORMATION COLLECTION, ANALYSIS, AND DISSEMINATION

CSC will require a massive public information campaign. Partners from across the public health, medical, and emergency management communities must coordinate key messages, address public inquiry, and develop hazard-specific protective actions. Policies and protocols for conducting risk communication are documented in the ADHS Crisis Emergency Risk Communication (CERC) Plan. During CSC, the HEOC, SEOC, and Joint Information Center (JIC) will all be activated, and the SDMAC will participate in public information operations. The SDMAC will support the following risk communication components:

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

As the lead policy group, the SDMAC will need to obtain real-time information from incident command (SEOC, HEOC, etc.) and provide clear and consistent messaging, regarding SDMAC operations. SDMAC members, representing their respective agencies or facilities, will be major sources of information. This two-way flow of information requires close collaboration between the CSC Policy Advisor and Public Information Officers at the JIC.

Information Planning and Production

SDMAC members will help develop media releases, talking points, and online content, regarding CSC. Close coordination with JIC staff will be required to ensure messaging is developed clearly and consistently across all jurisdictions. Special emphasis should be placed on developing messaging that reduces medical surge at affected facilities. SDMAC staff should coordinate with risk communication professionals to create messaging that explains policies in a clear, easy-to-read (6th grade reading level) format.

Information Dissemination

The CSC Policy Advisor and CSC Liaison will coordinate with HEOC logistics staff to disseminate CSC guidance to healthcare providers, public health departments, emergency management agencies, and other stakeholders. The CSC Policy Advisor and CSC Liaison will also coordinate with JIC staff to ensure that policy messaging is appropriately distributed to the general public.

Agency Spokesperson

As an ADHS staff person, the CSC Policy Advisor may also serve as a spokesperson for ADHS, or may brief other spokespersons involved in the CSC response. The SDMAC will contribute to developing talking points, message maps, and other risk communication tools to ensure consistent and clear policy messages.

COMMUNICATIONS

A variety of communication pathways and systems will be used to support a CSC response and the SDMAC. In general, the SDMAC will rely on the HEOC for communications. In the event that the HEOC is unable to provide communications, the SDMAC will rely on the SEOC or federal entities for support. Current communication systems available to support SDMAC operations are listed in Table 17.

Table 17—Communication Systems to Support CSC Response

SYSTEM	DESCRIPTION	SYSTEM ADMINISTRATOR	TARGET
AzEIN	The Arizona Emergency Information Network (AzEIN) is the state's online source for real-time emergency updates, preparedness and hazard information, and multimedia resources. The AzEIN website will be used during CSC to post guidance and protective actions for the general public	Arizona Division of Emergency Management (ADEM)	The general public
AzHAN	The Arizona Health Alert Network (AzHAN) is a communication network between ADHS and public health and healthcare partners. During CSC, AzHAN will be used to send targeted messages to a variety of different distribution lists. Most messages are sent via email, but the system can also send text, voice, and fax alerts.	Arizona Department of Health Services (ADHS)	Local health depts., hospitals, healthcare providers, epidemiologists, infection control practitioners, etc.
EMResource™	EMResource™ is a web-based tool used by state public health and healthcare system partners to share real-time information, such as diversion status, bed availability, amber alerts, resource shortages, etc.	ADHS	Local health depts., hospitals, healthcare providers, public safety answering point (PSAPs), etc.
EMTrack™	EMTrack™ is a web-based patient tracking tool used to enter/scan limited patient information using triage tags, hand held scanners, and input devices. The system can support mass casualty, patient evacuation, and CSC by tracking and coordinating patient movements through the healthcare system (on-scene, transport, destination, and discharge).	ADHS	Local health depts., hospitals, and EMS.

SYSTEM	DESCRIPTION	SYSTEM ADMINISTRATOR	TARGET
HAvBED	The Hospital Available Beds for Emergencies and Disasters (HAvBED) system is used to track statewide bed availability during disasters. ADHS can initiate a HAvBED poll to assess hospital capacity. Hospitals enter data on various bed types. These data are aggregated and analyzed at the state level. This information is crucial for situational awareness during CSC policy development and implementation.	ADHS	Federal partners, local health depts., and hospital.
WebEOC	This electronic incident management tool is used by ADHS, DEMA, and other response entities to share situational awareness, submit reports/ICS forms, and to request resources. WebEOC or other online tools can be used to support SDMAC activities during CSC.	DEMA	DEMA, ADHS, and other response entities

ADMINISTRATION, FINANCE, AND LOGISTICS

Administration, Finance, and Logistics

During CSC, the SDMAC is responsible for developing policies, priorities, and clinical guidance associated with resource (space, staff, and supply) shortages. SDMAC Incident Command System (ICS) functions, including Command, Operations, Planning, Logistics, and Finance, will be coordinated by the ADHS Health Emergency Operation Center (HEOC). The SDMAC will serve as a policy making entity that supports the existing ICS structure.

Administration

The SDMAC will be administered by the ADHS Director. The CSC Policy Advisor and CSC Liaison will work with the HEOC Manager and ADHS Director to ensure proper management of the SDMAC. Non-ADHS staff participating in the SDMAC will remain under the administration of their respective organizations and will only serve in a liaison capacity. See Appendix H for Job Action Sheets for SDMAC staff.

Finance

The HEOC Finance Section will coordinate and oversee all financial activities of the SDMAC. Key activities may include time tracking, facilitating emergency expenditures, managing human resources, etc.

Logistics

The HEOC Logistics Section will provide support for the SDMAC. The SDMAC may meet in person or virtually to develop and oversee policy implementation. The SDMAC may require meeting space near the HEOC to operate effectively or may conduct conference calls and webinars to operate virtually from multiple locations across the state. Logistics personnel will provide just-in-time communication and information system training to both ADHS and non-ADHS SDMAC staff, as needed.

LEGAL CONSIDERATIONS

During CSC, the overwhelming demand for healthcare will force a shift from individual care to care for the entire community. This requires emphasis on the values of transparency, consistency, fairness, accountability, and resiliency.

An ethical framework serves as the bedrock for public policy and cannot be added as an afterthought. Ethically and clinically sound planning will promote fair and equitable resource allocation to the general population, including vulnerable groups. The context of a disaster may make certain resources unavailable for some or even all patients, but it does not provide a license to act without regard for professional or legal standards. Healthcare professionals are obligated to provide the best care they reasonably can to each patient in their care, including during crises. When resource scarcity reaches catastrophic levels, clinicians are ethically justified—and indeed are ethically obligated—to use the available resources to sustain life and well-being to the greatest extent possible. The CSC Code of Ethics for the State of Arizona is provided in Appendix A.

Emergency declarations trigger an array of non-traditional powers that are designed to facilitate response efforts through public and private sectors. Emergency laws may (1) provide government with sufficient flexibility to respond, (2) mobilize central commands and infrastructures, (3) encourage response efforts by limiting liability, (4) authorize interstate recognition of healthcare licenses and certifications, (5) allocate healthcare personnel and resources, and (6) help to change medical standards of care and scope of practice.

The IOM CSC Framework (2012) identifies the following legal issues for healthcare practitioners and entities responsible for emergency preparedness: personnel, access to treatment, coordination of health services, patient's interest, resource allocation, liability, reimbursement, and inter-jurisdictional cooperation.

PERSONNEL

IOM CSC Framework legal question: How are employees, independent contractors, and volunteers legally distinguished for the purpose of coordinating services and benefits during an emergency?

> Due to the severity of a CSC response, it is expected that a declared state of emergency would be in place. "State of emergency" means the duly proclaimed existence of conditions of disaster or of extreme peril to the safety of persons or property within the state caused by air pollution, fire, flood or floodwater, storm, epidemic, riot, earthquake or other causes, except those resulting in a state of war emergency, which are or are likely to be beyond the control of the services, personnel, equipment and facilities of any single county, city or town, and which require the combined efforts of the state and the political subdivision (see ARS § 26-301).
>
> In a declared disaster, both federal and state laws protect the actions of employees, independent contractors and volunteers. The Public Readiness and Emergency Preparedness (PREP) Act will protect responders in a federally declared emergency. First responders and healthcare providers are covered during a state declared emergency (see ARS § 26-314 and ARS § 26-402).

Personnel engaged in a CSC response could have an expanded scope of practice defined by the type of emergency declaration. The expanded scope of practiceguidelines are more fully defined in the previous Clinical Concept of Operations section of this Plan. Protection from exposure to liability is guided by working within those guidelines.

ACCESS TO TREATMENT

IOM CSC Framework legal question: Has the entity assessed its strategy for conducting medical triage under legal requirement for treating existing and forthcoming patients? Is the entity prepared to screen and potentially divert excess numbers of patients during an emergency consistent with the Emergency Medical Treatment and Active Labor Act (EMTALA), absent its waiver during a declared emergency?

The severity and duration of a disaster may make certain resources unavailable for some or even all patients. However, medical standards will remain. Strategies for addressing medical triage and resource shortages can be found in Clinical Concept of Operations section.

IOM CSC Framework legal question: Do healthcare personnel who are designated to treat existing and forthcoming patients pose any risks to patients either through (1) exposure to infectious or other conditions or (2) the use of personal protective equipment that may impede the delivery of medical services?

According to the Crisis Standards of Care Emergency Code of Ethics for the State of Arizona, healthcare practitioners are ethically obligated to (a) provide care to the extent such care is effective and appropriate (soundness), even if doing so will expose them to greater than normal risks to their own health, and (b) avail themselves of relevant and available protective measures. A healthcare practitioner's duty to care is balanced against ethical obligations that society and institutions owe practitioners (reciprocity), as well as against competing ethical obligations practitioners may have to their families or others to whom they owe a duty of care.

COORDINATION OF HEALTH SERVICES

IOM CSC Framework legal question: Are adequate mechanisms in place to ensure compliance with surveillance, reporting, testing, screening, partner notification, quarantine, isolation, and other public health mandates during an emergency?

The HEOC will monitor the situation in a CSC event to ensure adequate mechanisms are in place to comply with surveillance, reporting, testing, screening, partner notification, quarantine, isolation, and other public health mandates during an emergency. State and local public health departments routinely engage in disease surveillance, reporting, testing, partner notification, quarantine, isolation, and other public health mandates. Planning, training, exercising, and evaluation with partner agencies enable ADHS and local public health departments to scale up these routine activities during disaster response.

IOM CSC Framework legal question: Are healthcare personnel aware of the legal effects of a shift to CSC and changes relating to scopes of practice during a declared emergency?

This Plan will inform county public health planners, and facility-level surge planners about shifts in legal effects and scopes of practice. A top-down approach will ensure that healthcare institutions and practitioners integrate the same planning concepts across the statewide healthcare system.

IOM CSC Framework legal question: Are legal issues concerning the use of volunteer health professionals during an emergency addressed through the entity's emergency plan?

County public health departments have a plan in place to request, deploy, and manage volunteer health professionals. The various entities involved in CSC should have a plan in place concerning volunteer health professionals. In a declared emergency, volunteer health professionals fall under Arizona and Federal laws mentioned in other parts of this annex.

Volunteers enrolled in the program are eligible for state and/or local-sponsored liability and legal coverage and workers compensation within the borders of the state or local jurisdictions during a declared state of emergency or public health emergency crisis or, if officially deployed by the governor to a disaster area outside the state, under the national Emergency Management Assistance Compact (EMAC) or by other mutual aid agreements. Any of the participating hospital CEOs may declare a large-scale disaster for his or her specific hospital and request assistance from volunteers enrolled in the program. In this scenario, program volunteers may be eligible for coverage under the professional liability and workers compensation programs offered by the requesting hospital (see ARS § 26-314, ARS § 36-2263, and Notice of Final Rulemaking: Title 8 Emergency and Military Affairs, Chapter 2, Article 7 Registration of Emergency Workers).

Volunteer health practitioners cannot provide services that are outside the practitioner's own scope of practice (see ARS § 36-787). Similar guidance covers out-of-state volunteer health professionals (see ARS § 26-314 and ARS § 26-402).

PATIENT'S INTEREST

IOM CSC Framework legal question: Can patients with physical or mental disabilities be accommodated during the emergency consistent with disability protection laws?

A CSC incident will likely create challenges for many patients, but in particular for people with functional and access needs and those deemed most "at risk". The AZ CSC Emergency Code of Ethics establishes a duty to care, which includes a duty not to abandon, a duty of care despite risks, and a duty to provide comfort care (see ARS § 26-314 and ARS § 26-402). Healthcare practitioners must strive to protect all patients according to guidelines and policies put in place during CSC.

IOM CSC Framework legal question: Are appropriate measures in place for attempting to ascertain patients' informed consent? Barring waiver of national, state, or local privacy laws through emergency declarations, is the entity and its personnel prepared to respect patients' health information privacy rights during an emergency?

Healthcare professionals must endeavor to follow normal rules and laws (HIPAA) in getting a patient's informed consent. They must also maintain privacy information during CSC. The exigent circumstances surrounding CSC may present challenges to full compliance with consent and privacy, but ARS §26-314 and ARS §36-790 protect health practitioners from breaches of those duties when done in good faith.

ALLOCATION OF RESOURCES

IOM CSC Framework legal question: Is there a legitimate process for determining allocation of limited resources that is fair, reasonable, nondiscriminatory, and credibly based on protecting the health of patients and the public, and are there federal, state, and/or local policies regarding resource allocation that should be followed?

Legal authorization is generally required to shift the provision of care and resource allocation (e.g., space, staff and supplies) during emergencies. Emergency declarations and ensuing orders are the first step in authorizing such changes and providing liability protections (see ARS §35-192 and ARS §26-303). Emergency declarations will facilitate the recognition of out-of-state healthcare licenses and certificates for the limited duration of a declared emergency to allow for the interstate sharing of healthcare personnel.

Memoranda of understanding (MOU) and mutual aid agreements will also facilitate the sharing of scarce healthcare resources during emergencies. The Emergency Management Assistance Compact (EMAC) formalizes interstate mutual aid among all 50 states and the District of Columbia. These legal declarations, mutual aid agreements, and compacts provide the basis for allocation of scarce resources during CSC.

LIABILITY

IOM CSC Framework legal question: When may the entity and its personnel be liable for their actions in treating patients under CSC during an emergency, and what legal protections from liability for entities, their healthcare personnel, independent contractors, and volunteers (including insurance coverage) apply during an emergency?

Legal protections help to assure healthcare practitioners, who act in good faith, will not be held liable for their civil wrongs that cause unintended harms to patients during emergencies:

- Governmental (sovereign) immunity prevents government entities or their political subdivisions (e.g., departments, agencies) from being sued without consent.
- According to Good Samaritan Acts (see ARS 36-2263), persons and entities are not subject to civil liability for any personal injury that results from any act or omission that does not amount to willful misconduct or gross negligence.
- The federal PREP Act provides immunity from liability for any loss caused, arising out of, relating to, or resulting from administration or use of countermeasures for diseases, threats and conditions determined in the Declaration to constitute a present or future credible risk of a public health emergency.
- Arizona Emergency System for the Advance Registration of Volunteer Health Professionals (AzESAR-VHPs) enables ADHS, local health departments, and emergency management to rapidly identify and mobilize healthcare volunteers. Moreover, the system enables hospitals and other medical entities to meet crisis and surge capacity needs and ensure the continuance of critical healthcare services.
- Entity liability protections create incentives for private and non-profit entities to join with government agencies as they prepare for, and respond to, public health emergencies.

- Despite these protections, healthcare practitioners must act within the scope of practice allowed them, and not act in a negligent way or commit an intentional tort, an act of misrepresentation, or abandon a patient.

REIMBURSEMENT

IOM CSC Framework legal question: Are there established reimbursement protocols for treating patients during an emergency, and are private health insurers or other payers legally required to reimburse for care delivered to patients in furtherance of the public's health?

Just as there are many administrative functions involved in CSC, there will be many financial transactions that will take place. Documenting all financial expenditures of the incident is critical for possible cost recovery for services or supplies, and for compensation and claims for injuries. The HEOC Finance Section will work with Healthcare Incident Command System Finance and Administration Section to define documentation standards required for reimbursement. However, healthcare systems must comply with their own insurance requirements to ensure reimbursement for private sector operations.

INTERJURISDICTIONAL COOPERATION

IOM CSC Framework legal question: Is the entity's all-hazards emergency plan integrated with community-level emergency planning and objectives?

Yes. However, this is an ongoing iterative process. This statewide CSC plan is the cornerstone for county and facility-level medical surge plans that will be developed and/or updated according to concepts in this document and nationwide best practices. Additional legal references are provided in Appendix F.

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

Approved by the Legal/Ethical Work Group of the Crisis Standards of Care,

SDMAC Development/Planning Committee

12/4/13

Overview

Ethical issues are pervasive in public health emergency responses. Examples include decisions related to the allocation and use of scarce resources, the appropriate application of limitations on personal liberty to protect the public, and the provision of public health and healthcare services to individuals and populations. Lack of consensus for public health ethical norms applicable in emergencies has led to widely divergent approaches nationally and regionally. In Arizona, the Crisis Standards of Care Legal/Ethical Work Group was tasked to bring together public and private stakeholders to engage in consensus-building efforts to develop guidelines to assist in ethical decision-making in emergencies of a catastrophic nature in Arizona.

Goals

- Create a mechanism to respond to the ethical and moral values of the community related to a paradigm shift from personal care to community care.
- Address the legal barriers for the provision of optimal and ethical medical care and public health for emergency/crisis preparedness and response.
- Develop generally-applied principles of public health emergency ethics via consensus among public and private stakeholders in Arizona.
- Produce a consistent and reasonable public health emergency code of ethical behavior to help guide critical decisions among public and private sectors during public health emergencies.

Disclaimer and Limitations

Please note that the information provided in this document is based on Ethics in Public Health Emergencies: An Arizona Code of Public Health Emergency Ethics, 2/5/12, The Lincoln Center for Applied Ethics and the Public Health Law and Policy Program, Sandra Day O'Connor College of Law, Arizona State University.

Format

The Crisis Standards of Care Emergency Code of Ethics for the State of Arizona includes core guidelines of public health emergency ethics (numbers 1, 2, 3 . . .) together with proposed code language (1.1, 2.1, . . .) that reflects or is consistent with the corresponding ethical principle. Please note that the numbered order of the ethical principles (depicted in bold lettering) below is not intended to reflect their relative priority.

Application

The Crisis Standards of Care Emergency Code of Ethics for the State of Arizona code is meant to apply to Arizona healthcare, public health, and emergency response and preparedness officials and practitioners in public and private sectors seeking to implement a crisis standard of care as defined by the National Academies of Science, Institute of Medicine (IOM).

The code is not intended to apply to responses to localized emergency events of limited duration, state-wide emergencies that do not implicate the public's health, or events that do not require critical decisions on the use of scarce resources to protect or promote the public's health. In addition, the code is intended to supplement, not supplant, relevant portions of existing codes of ethics and professionalism for healthcare practitioners, hospitals, hospice care, public health practitioners, emergency responders, or other relevant persons or entities.

Definitions of Key Terms

Decision-makers: Persons tasked with making decisions regarding emergency responses or the allocation of scarce resources during a public health emergency on behalf of governmental bodies (e.g., federal, state, tribal, or local) or private sector entities (e.g., emergency response organizations, hospitals, healthcare providers, health insurance companies, or pharmaceutical companies). The State Disaster Management Advisory Committee (SDMAC), composed of healthcare experts will advise the state health department regarding crisis standards of care, as outlined in the Arizona Crisis Standards of Care Plan.

Healthcare practitioner: A person that furnishes healthcare or public health services.

Healthcare provider: An organization or institution that furnishes healthcare or public health services.

Public health emergency: Either (1) a declared state of emergency or public health emergency in which the health of the public is at risk; or (2) circumstances that require implementing a crisis standard of care as defined by IOM.

Core Guidelines

1. **Stewardship of Resources.** To the extent possible, scarce resources must be managed during a public health emergency to prevent morbidity and mortality while maintaining respect and care for individuals and the community.

    1.1. Duty to plan. **Decision-makers** must plan ahead and develop affirmative, advance guidance for healthcare providers, healthcare practitioners, emergency responders, and others involved in the emergency response.

    1.2. Triage allocation plan. **Decision-makers** must develop an advance triage allocation plan for scarce, essential resources that is consistent with the principles and rules of this Code.

    1.3. Specificity. To ensure that guidance on resource allocation is most effective, uniformly applied, and comprehensible, guidance will be as specific as possible.

1.4. Duty to recover and restore. **Decision-makers** must develop plans to recover and restore resources mobilized during the emergency.

2. **Duty to Care.** To the extent possible, healthcare providers and practitioners have a duty to provide care during public health emergencies

2.1. Duty **NOT** to abandon. **Healthcare providers and practitioners**, to the extent possible, will triage patients to the most feasible level of care and will **NOT abandon patients** who have a reasonable expectation of care based on prior commitments and available resources.

2.2. Duty to care despite risks. **Healthcare practitioners** are ethically obligated to (a) provide care to the extent such care is effective and appropriate (Soundness) even if doing so will expose them to greater than normal risks to their own health, and (b) avail themselves of relevant and available protective measures. A healthcare practitioner's duty to care is balanced against reciprocal ethical obligations that society and institutions owe practitioners (Reciprocity), as well as against competing ethical obligations practitioners may have to their families or others to whom they owe a duty of care.

2.3. Duty to provide comfort care. To the extent possible, patients who are ineligible to receive limited allocations of scarce preventive, life-saving, or life-sustaining resources or services for any reason will be offered available forms of curative, palliative, and/or preventative treatment or services.

3. **Soundness.** To the extent possible, responses in public health emergencies will be consistent with known or empirically-supported "best practices."

3.1. Effectiveness. Responses will be demonstrably effective and based on existing data or known efficacy.

3.2. Priority. Responses will prioritize protecting the public from preventable causes of morbidity and mortality.

3.3. Non-Diversion. Essential emergency resources will not be diverted to address **non**-emergency conditions.

3.4. Information. Decision-making will be based on solid, well-informed situational awareness, promote consistency, be coordinated with others involved in the response, and limit ad hoc decisions.

3.5. Appropriateness. Decision-makers will be duly qualified (or consult with those who are qualified) to understand and assess public health and ethical consequences and alternative courses of action.

3.6. Risk Assessment. Responses will undergo risk assessment when possible to avoid creating additional undue risks to others or undermining response efforts to the greater harm of the larger community.

3.7. Flexibility. Public and private sector decision-making processes must be flexible and revisable to reflect current information based on the prevailing and emerging circumstances.

4. **Fairness.** In a public health emergency, to the extent possible, similarly-situated individuals and groups will be treated in similar ways. (A disability in and of itself is NOT a criteria for decision-making).

4.1. Consistency. To the extent possible, decision-making criteria and methodology will be applied consistently across settings, populations, institutions, and jurisdictions.

4.2. Justice. Public health responses and allocation of scarce resources (such as vaccines, ventilators, or evacuation assistance) may not be based on factors unrelated to health status and emergency response needs. Impermissible factors include, but are not limited to: race, gender, ethnicity, religion, social status, location, education, income, ability to pay, disability unrelated to prognosis, immigration status, or sexual orientation.

4.3. Medical need and prognosis. Allocations of scarce medical resources will prioritize individuals or groups with greater medical needs, based on:

- medical prognoses,
- likelihood of positive medical response to available treatment or services,
- relative risk of harm posed by withdrawing or withholding treatment, or
- other indicators of survivability.

5. **Reciprocity.** To the extent possible, those who face disproportionate burdens or greater risks for the benefit of the community in public health emergencies will receive additional support.

5.1. Protections for individuals. To encourage compliance with voluntary public health restrictions (such as quarantine, social distancing measures, or disease reporting), affected individuals' compliance will be recognized through measures that protect them from job loss and negative repercussions, such as, but not limited to, immigration status or job loss.

5.2. Protections for essential personnel. Healthcare practitioners, emergency first responders, and others who perform or support essential emergency functions will receive priority for protective measures in limited supply (e.g., vaccines or protective equipment) and will receive other protections or services (e.g., childcare services, workers' compensation coverage, or limited liability protections) as the ability to provide these services exists.

5.3. Protections for essential providers. Additional support and resources will be allotted to healthcare providers that take on disproportionate financial or logistical burdens as part of emergency response efforts.

6. **Proportionality.** To the extent possible, the least restrictive means (vaccination, shelter-in-place, isolation, quarantine) will be used during a public health emergency, reserving restrictive measures only for when they are essential to effective response.

6.1. Balancing obligations. **Decision-makers** will balance obligations to protect community health with respect for individual liberties and other interests. If more than one equally effective option exists, decision-makers must choose the option that poses the fewest risks to individual liberty, privacy, justice, or other legally- or ethically-grounded rights.

6.2. Limited application and duration. To the extent possible and consistent with public health purposes, restrictive measures (e.g., isolation, quarantine, curfews, or other social distancing efforts) will be voluntary and imposed only if it is determined that other public health measures are insufficient or unavailable. Restrictive measures must be limited in duration and not be continued after significant risks to individuals or the public's health have abated.

6.3. Well-targeted. Restrictive measures must be well-targeted to apply only to individuals or groups in the population who must be restricted to avoid significant risks to the public's health.

6.4. Privacy. To encourage compliance with recommended screening programs and other interventions, **decision-makers** will respect individual and group privacy and confidentiality expectations (according to institutional and/or governmental policy) to the best of their ability. The rationale for sharing identifiable personal health or other data to protect the public's health will be clearly communicated.

7. **Transparency.** To the extent possible, policy decisions and their justifications prior to and during public health emergencies will be open to the public with opportunities for public consultation and input.

7.1. Public engagement. Plans for public health emergency responses, including specific methods for allocation of scarce resources and decisions regarding any limitations on personal liberties, will be made available to the public. Public input and comment will be solicited and considered to the extent possible, consistent with public health purposes, given time and circumstance.

7.2. Openness. To the extent possible, decisions that affect the public will be communicated consistently, openly, honestly, and in a thorough manner.

7.3. Communication systems. **Decision-makers** will use multiple, available, and effective communication systems to consult with various relevant stakeholders and the public.

7.4. Documentation. Decisions will be documented to the extent possible.

7.5. Full disclosure. Emergency responders will be fully informed of the known risks, prior to participating in the response and informed of developing risks as they become known, to the extent possible.

7.6. Accessibility. **Decision-makers** will communicate vital information in a way that is accessible to those of different ages, disabilities, and linguistic abilities, to the extent possible.

8. **Accountability. Decision-makers** and individuals are responsible for their actions (or failures to act) in a public health emergency.

8.1. Individual responsibility. All individuals are responsible for the consequences of their decisions of compliance or non-compliance with emergency response orders or recommendations. Those who choose not to comply with public health emergency measures (e.g., evacuation, quarantine, or vaccination) may lose access priority for future aid, to the extent the need for such aid stems from their prior decisions.

8.2. Duty to evaluate. To the extent possible, **decision-makers** must monitor the effects and evaluate the efficacy of decisions and responses implemented.

8.3. Public accountability. **Decision-makers** are accountable for failures to abide by applicable crisis standards of care or the principles and guidelines articulated by this Code.

APPENDIX B—HEALTHCARE FACILITY, COUNTY, AND STATE INDICATORS FOR CONVENTIONAL, CONTINGENCY, AND CSC

Conventional Indicators for Healthcare Facilities

- Usual patient care space fully occupied
- Usual staff called in and utilized
- Cached and usual supplies being used

Contingency Indicators for Healthcare Facilities

- Patient care areas re-purposed (e.g., PACU or monitored unit used for ICU-level care)
- Staff extension in place (brief deferrals of non-emergency patient-care services, supervising broader groups of patients, changes in responsibilities and documentation, etc.)
- Conservation, adaptation, and substitution of supplies with selective re-use of supplies for an individual patient
- Hospital on diversion

Crisis Indicators for Healthcare Facilities

- Healthcare facility unsafe or closed
- Non-patient care areas used for patient care
- Trained staff unavailable or unable to care for the volume of patients
- Critical supplies lacking
- Re-allocation of life-sustaining resources
- Patient transfer not possible or sufficient

Conventional Indicators for Counties

- One or more healthcare facilities are at or near capacity
- Patient transfer may be impacted

Contingency Indicators for Counties

- One or more healthcare facilities initiate local resource requests for space, staff, and supplies
- Medical countermeasure availability declining
- One or more hospitals on diversion or damaged
- Patient transfer limited between healthcare facilities

Crisis Indicators for Counties

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

Conventional Indicators for the State

- One or more counties/regions at capacity
- Patient transfer may be impacted

Contingency Indicators for the State

- Local jurisdictions initiate resource requests
- Medical countermeasure availability declining
- One or more hospitals on diversion or damaged
- Patient transfer across all or part of state is limited

Crisis Indicators for the State

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

APPENDIX C—HEALTHCARE FACILITY, COUNTY, AND STATE TACTICS FOR CONVENTIONAL, CONTINGENCY, AND CSC

Conventional Tactics for Healthcare Facilities

- Place facility Incident Command staff on standby
- Notify county PHEP and/or emergency management partners of conventional surge conditions

Contingency Tactics for Healthcare Facilities

- Activate incident command and Emergency Operations Plan/Emergency Response Plan
- Notify county PHEP and/or emergency management partners of contingency surge conditions

Crisis Tactics for Healthcare Facilities

- Notify PHEP/emergency management partners of crisis level
- Consider alternate care sites
- Implement facility CSC plans and procedures
- Re-use and repurpose supplies
- Assign primary, secondary, and tertiary Triage Officers, as needed

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Conventional Tactics for Counties

- Place emergency operations/incident command staff on standby
- Notify state PHEP and emergency management partners of surge conditions

Contingency Tactics for Counties

- Activate EOC
- Participate in unified command with on scene operations and state EOCs
- Process space, staff, and supply requests from facilities

Crisis Tactics for Counties

- Activate state-designated healthcare coalition to implement CSC locally
- Participate in public information activities with the JIC
- Activate medical countermeasure, medical materiel, volunteer management, and alternate care site plans

Conventional Tactics for the State

- Place emergency operations/incident command staff on standby
- Notify statewide partners of surge conditions

Contingency Tactics for the State

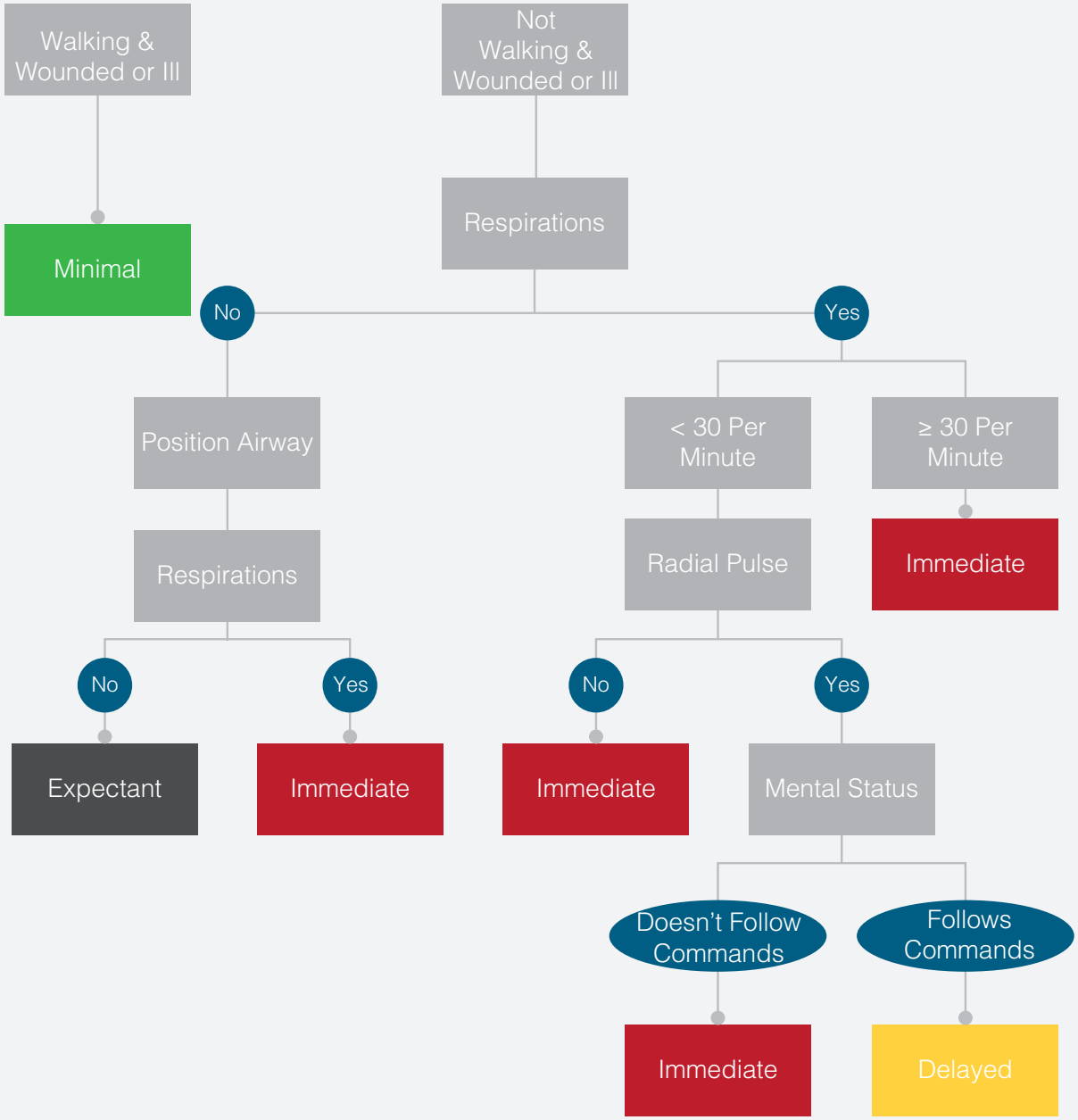
- Activate state EOCs
- Participate in unified command with on scene operations and local EOCs
- Process space, staff, and supply resource requests from local jurisdictions
- Notify SDMAC committee of possible activation
- Notify federal partners of medical surge

Crisis Tactics for the State

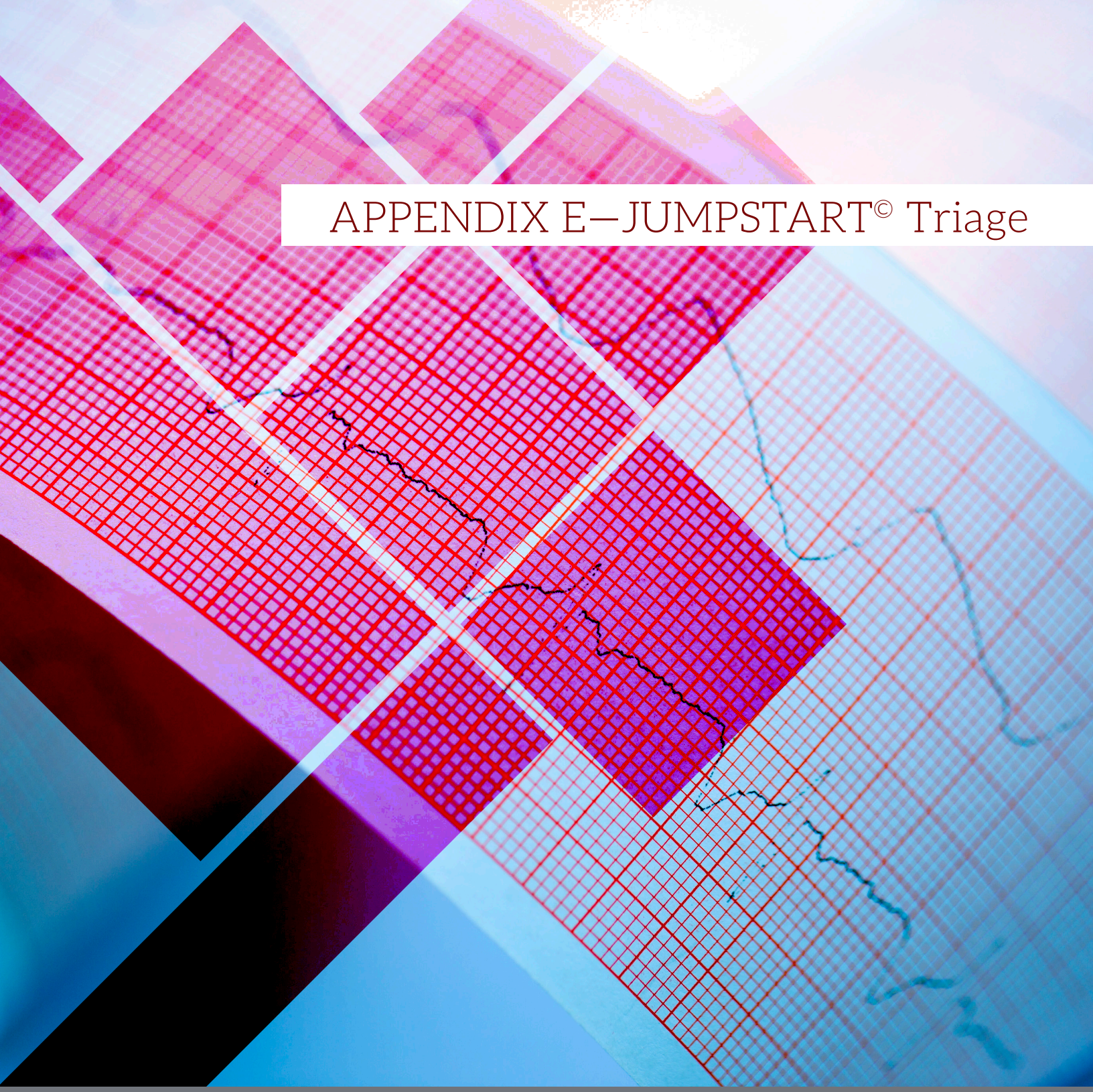
- Activate SDMAC to develop and implement CSC
- Direct statewide public information activities
- Activate state medical countermeasure, medical materiel, volunteer management, and alternate care site/system plans

APPENDIX D—START TRIAGE

START Triage



APPENDIX E—JUMPSTART© Triage



JumpSTART© Triage

APPENDIX F—LEGAL REFERENCES

Federal Laws and Statutes

Code of Federal Regulations, Title 44, Chapter 1, Federal Emergency Management Agency

Emergency Management Assistance Compact.

Emergency Medical Treatment and Active Labor Act

Federal Employees Compensation Act.

Nurse Licensure Compact.

Public Readiness and Emergency Preparedness Act.

Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988, 42 U.S.C. §5121, et seq., as amended

Uniform Emergency Volunteer Health Practitioners Act.

Volunteer Protection Act of 1997.

Arizona Revised Statutes

A.R.S. § 23-901.06 Volunteer workers

A.R.S. § 26, Chapter 2, Article 1 (emergency management)

A.R.S. § 26–301 Definitions

A.R.S. § 26-303 Emergency powers of governor; termination; authorization for adjutant general; limitation

A.R.S. § 26-310 Use of Professional Skills

A.R.S. § 26-314 Immunity of state, political subdivisions and officers, agents and emergency workers; limitation; rules

A.R.S. § 26–402 Compact

A.R.S. § 32-1910 Emergencies; continued provision of services

A.R.S. § 35-192 Authorization for declaration of disaster; authorization for liabilities and expenses; priorities and limitations; review and report of expenditures

A.R.S. § 36-136 Powers and duties of director; compensation of personnel

A.R.S. § 36, Chapter 6, Article 9 (Public health control) enhanced surveillance advisories and public health emergencies

A.R.S. § 36-787 Public health authority during state of emergency or state of war emergency

A.R.S. § 36-790 Privileges and immunities

A.R.S. § 36-2263 Good Samaritan Acts

APPENDIX G—RESOURCE CHALLENGES BY DISASTER TYPE

Chemical

SPECIFIC CHALLENGES

- Mass airway management and ventilatory therapy
- Antidotal treatment (atropine, pralidoxime, etc.)
- Mass decontamination

SPACE/STAFF/SUPPLY CONSIDERATIONS

- Intubation equipment
- Antidotes (onsite and community/SNS)
- Critical care equipment
- "Dry decontamination" kits (redressing kits)
- Chemical PPE and hazmat training for staff

TRIAGE ISSUES

- Temporizing (bag-valve-mask, etc.) therapies reasonable while awaiting outside resources
- May still have good outcomes in cardiac arrest in organophosphate poisoning, but in mass casualty situation may have to prioritize care to those prior to respiratory arrest

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Pandemic

SPECIFIC CHALLENGES

- PPE use and type required
- Vaccine, antiviral, antibiotic supply and use
- Critical care capacity
- Outpatient care capacity
- Alternate care site establishment (early treatment—flu centers, also hospital overflow sites)
- Mechanical ventilation capacity
- ECMO criteria and capacity

SPACE/STAFF/SUPPLY CONSIDERATIONS

- PPE supplies, particularly N95 masks, if required
- Medications, including antivirals, antibiotics, analgesics, paralytics , etc.
- Outpatient care and inpatient care spaces may be insufficient and require alternate care sites
- Ventilators, ECMO supplies, and equipment and staffing plans
- Staff illness, family obligations, or reluctance to report may contribute to difficulty with adequate staffing

TRIAGE ISSUES

- Contingency plans for PPE and medication shortages
- Outpatient referral/triage plans (hotlines, phone prescribing, etc.)
- Triage criteria and process for life-saving interventions
- Triage criteria for emergency care vs. referral to "flu center" or similar location

Pediatric Mass Casualty

SPECIFIC CHALLENGES

- Age-specific sizes of equipment, airway, intravenous access, catheters, operative equipment , etc.
- Educational background often lacking for pediatric-specific resuscitation and management

SPACE/STAFF/SUPPLY CONSIDERATIONS

- All facilities should be prepared to stabilize and initially treat pediatric patients
- Community plan should concentrate critical patients and those five-years-old or less at pediatric facilities
- Just-in-time education for staff, regarding initial treatment resources
- Consider pediatric technical expert availability (telemedicine or telephone consult—preferably to experts outside affected area) to facilities that have to manage patients out of their usual range of expertise
- Facility should plan for managing unaccompanied children (including once medically cleared) and their transport needs

TRIAGE ISSUES

- Trauma care—see below
- Assessment may be difficult due to verbal skills and fear
- Physiologic compensation may mask "usual" signs of shock, until advanced
- EMS triage procedures should emphasize keeping families together when possible (e.g., critically injured child to pediatric center along with parents with minor injuries)

Trauma

SPECIFIC CHALLENGES

- Triage bottlenecks
- Airway and initial interventions
- CT and imaging bottlenecks
- Operative bottlenecks
- Surgical and trauma supplies

SPACE/STAFF/SUPPLY CONSIDERATIONS

- All hospitals should be prepared to manage trauma patients and stock adequate supplies according to their role in the community
- Consider caching operative supplies (especially major procedure, chest tube, orthopedic trays , etc.)
- Plan and exercise selective use of CT and other imaging

TRIAGE ISSUES

- Basic trauma triage, including knowledge of impact of GCS, age, and multisystem trauma on prognosis
- Provide palliative care to those who cannot be offered definitive interventions
- The larger the event, the higher the concentration on targeted, brief interventions with high impact (hemorrhage control, pneumothorax decompression, airway management , etc.)
- Limit definitive imaging and procedures (e.g., limit CT to cranial for decreased level of consciousness, perform bailout surgical procedures with temporary closures)
- Ultrasound may contribute to rapid assessments of casualties

Burn

SPECIFIC CHALLENGES

- Lack of burn beds and burn centers
- Educational background often lacking for burn resuscitation and management
- Intravenous fluids, dressings, and analgesics limited
- Limited number of burn surgeons and nurses

SPACE/STAFF/SUPPLY CONSIDERATIONS

- Burn centers should stock supplies for large-scale burn incidents, including adequate analgesia
- All facilities should be prepared to stabilize and initially treat burn patients
- Community plan should concentrate critical burns at burn centers (may involve redistributing other patient groups)
- Just-in-time education for staff
- Consider burn technical expert availability (telemedicine or telephone consult—consider experts from another unaffected area) for facilities that have to manage patients out of their usual range of expertise

TRIAGE ISSUES

- Use knowledge of contributing injuries, inhalational injury, age, and extent of burns when triaging burn patients
- Provide palliative care to those who cannot be offered definitive interventions
- Provide temporizing measures such as escharotomy and airway management while deferring formal burn dressings initially in favor of sterile sheets and towels

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Blast/Crush

SPECIFIC CHALLENGES

- Triage—education on blast/crush injuries may be lacking
- Intravenous fluids and medications may be limited
- Surgical bottlenecks
- Dialysis capacity may be challenged, especially if infrastructure damaged in community

SPACE/STAFF/SUPPLY CONSIDERATIONS

- Cache common medications (sodium bicarbonate, narcotic analgesia, antibiotics, etc.) needed for blast/crush injuries
- Cache equipment such as tourniquets, major procedure trays, external fixators and ortho trays, additional suture trays, ocular trays, ENT trays
- Just-in-time education on crush injury and other specific syndromes
- Activate necessary community (and national, if needed) dialysis capacity

TRIAGE ISSUES

- Triage based on knowledge of injuries, contributing underlying disease, for blast injuries. multiple extremity injuries and low GCS are correlated with poor outcomes
- Assess carefully for subtle penetrating injury and compartment syndrome
- Provide temporizing treatments such as hemorrhage control (including tourniquets when tissue destruction is significant) and analgesia

Nuclear

SPECIFIC CHALLENGES

- Overwhelming acute trauma for hospitals near incident
- Overwhelming numbers of acute radiation syndrome (ARS) casualties in subsequent days/weeks
- Identification/categorization of ARS casualties—difficulty accessing lab testing or results
- Shortages of cytokines and blood products (especially platelets during bone marrow failure phase)
- Large number of expectant patients from initial trauma, radiation, or combined injury

SPACE/STAFF/SUPPLY CONSIDERATIONS

- Plan with community according to hazard vulnerability for overall response, including evacuation of patients in latent phase of ARS to other jurisdictions with intact infrastructure
- Identify areas for alternate ambulatory triage sites
- Identify equipment for triage areas (tourniquets, bandages, early; later, antiemetics and antidiarrheals)
- Identify sources of radiation illness information, cytokines, and other supplies

TRIAGE ISSUES

- Triage for injured is according to usual trauma priorities
- Vomiting in early hours is non-specific and can be due to many causes
- Use of Absolute Lymphocyte Count (ALC) is optimal for assessment of ARS, but may not be easily available
- Victim information (proximity, particulate debris) and symptoms can allow rough classification within a few days after the event
- All forms of triage likely to be needed with more proactive processes and guidance the farther out from the event both temporally and geographically

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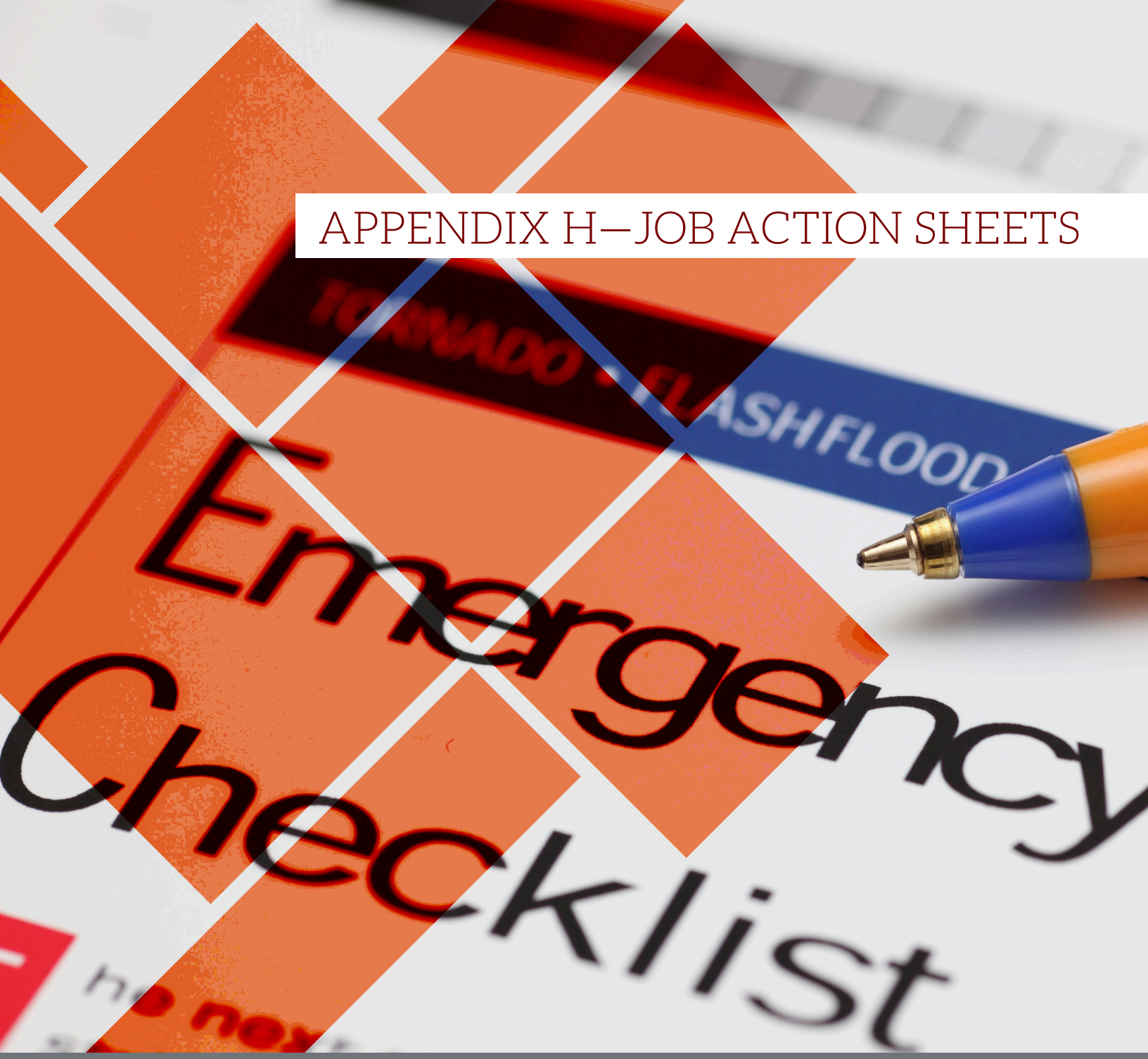
APPENDIX H—JOB ACTION SHEETS



The following job action sheets outline qualifications and responsibilities for State Disaster Medical Advisory Committee (SDMAC) staff.

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

A set of example job action sheets has also been developed to support CSC planning at the facility level. These position descriptions generally reflect hospital operations, and may serve as an example for facility-level planners involved in CSC and/or Medical Surge planning. Sample hospital job action sheets include:

- Clinical Care Director
- Triage Officer

ADHS Director

CRISIS STANDARD OF CARE JOB ACTION SHEET

Qualifications and Training

- ADHS Director or designee
- IS 100, 200, 700, 800, 300, 400
- Knowledge of HEOC Standard Operating Procedures, the Statewide Emergency Response and Recovery Plan (SERRP), the Arizona Crisis Standard of Care Plan and CSC Code of Ethics

Overall Responsibilities

- Activate the SDMAC
- Oversee the development and/or implementation of CSC guidelines by the SDMAC
- Coordinate with policy makers and elected officials to develop, implement, evaluate, revise, and deactivate CSC policy

CSC Activation—First 12 Hours

- Consult with elected officials and recommend CSC activation, as appropriate
- Authorize the HEOC staff to convene the SDMAC, i.e., identify and notify SDMAC members, SMEs, jurisdictional partners, and private sector partners
- Meet with HEOC Command Staff and SDMAC members to establish incident specific policy goals and objectives for CSC

CSC Operations—On-going

- Direct the development of policy, guidance, and priorities for CSC response
- Oversee coordination between HEOC and SDMAC

ADHS POLICY GROUP ADVISOR

CRISIS STANDARD OF CARE JOB ACTION SHEET

Qualifications and Training

- Senior ADHS staff person (e.g., Assistant Director, Medical Director, Legislative Liaison, Bureau Chief (e.g., Public Health Emergency Preparedness, Emergency Medical Services, Epidemiology and Disease Control)
- IS 100, 200, 700, 800, 300, 400
- Knowledge of HEOC Standard Operating Procedures, the Statewide Emergency Response and Recovery Plan (SERRP), the Arizona Crisis Standard of Care Plan and CSC Code of Ethics

Overall Responsibilities

- Report to Agency Director
- Oversee SDMAC operations
- Coordinate with HEOC, SEOC, and public information staff
- Ensure the development of timely guidance and priorities

CSC Activation – First 12 Hours

- Coordinate with HEOC Manager to ensure SDMAC members are identified and notified to serve on the SDMAC
- Identify and supervise the SDMAC Liaison to coordinate SDMAC activities with HEOC operations
- Consult with Agency Director, HEOC Manager, Public Information Officer, and other Command Staff to establish goals and objectives for SDMAC operations
- Conduct initial meeting(s) with SDMAC members to develop guidance and priorities for treatment and allocation of scarce medical resources
- Verify with HEOC staff (e.g., HEOC Manager) timely distribution of CSC guidance and priorities within the first 12-hour operational period

CSC Operations – On-going

- Work with HEOC Manager to monitor and track the dissemination and implementation of CSC priorities and guidelines across the healthcare system
- Revise and re-distribute CSC priorities and guidelines as needed

ADHS SDMAC MEMBERS

CRISIS STANDARD OF CARE JOB ACTION SHEET

Qualifications and Training

- ADHS senior staff including Medical Directors, Bureau Chiefs, and managers from key programs such as PHEP, EMS, EDC, Licensing, Immunizations, etc.
- IS 100, 200, 700, 800, 300, 400
- Knowledge of HEOC Standard Operating Procedures, the Statewide Emergency Response and Recovery Plan (SERRP), the Arizona Crisis Standard of Care Plan and CSC Code of Ethics

Overall Responsibilities

- Collaborate with the ADHS Policy Group Advisor overseeing SDMAC operations
- Coordinate SDMAC functions in assigned program areas
- Coordinate with HEOC, SEOC, and public information staff
- Contribute to the timely development of CSC guidance and priorities for treatment

CSC Activation – First 12 Hours

- Work with HEOC Manager and staff as needed to coordinate guidance and priority development and dissemination
- Consult with HEOC Manager, Agency Director, Public Information Officer, and other Command Staff to establish goals and objectives for SDMAC operations for assigned program areas
- Participate in initial meeting(s) with SDMAC members to develop guidance and priorities for treatment and allocation of scarce medical resources

CSC Operations – On-going

- Monitor and track the dissemination and implementation of CSC guidance and priorities related to assigned program area through collaboration with HEOC staff and SDMAC members
- Assist with revising and re-distributing CSC guidance and priorities as needed

SDMAC LIAISON to HEOC

CRISIS STANDARD OF CARE JOB ACTION SHEET

Qualifications and Training

- ADHS staff person with knowledge of healthcare system, regulatory environment, public health, and medical surge
- IS 100, 200, 700, 800, 300, 400
- Knowledge of HEOC Standard Operating Procedures, the Statewide Emergency Response and Recovery Plan (SERRP), the Arizona Crisis Standard of Care Plan, and CSC Code of Ethics

Overall Responsibilities

- Report to the ADHS Policy Group Advisor
- Coordinate SDMAC operations with HEOC operations
- Work with HEOC staff to obtain resources for SDMAC operations

CSC Activation – First 12 Hours

- Coordinate with HEOC Manager and staff to ensure that logistical requirements are in place to support virtual and/or on-site SDMAC operations
- Develop reports (see HEOC forms) for first operational period, reports shall include name, organization, and contact information for all SDMAC members
- Take meeting minutes for initial SDMAC meetings and/or conference calls
- Work with HEOC Manager and PIO staff to ensure that distribution lists are in place for the dissemination of CSC priorities and guidelines to response partners and the general public within the first 6 hours of operation
- Under the direction of the ADHS Policy Advisor work with HEOC staff (e.g., HEOC Manager, Logistics Section Chief) to draft and distribute CSC guidance and priorities within the first 12-hour operational period

CSC Operations – On-going

- Serve as the primary point of contact for SDMAC members
- Serve as the primary point of contact between the SDMAC and the HEOC for logistical and operational support
- Ensure meeting minutes are produced for every in-person meeting, conference call, or web conference and distributed appropriately
- Ensure status reports are produced for every operational period
- Under the direction of the ADHS Policy Advisor, compile and draft revised CSC guidance and priorities
- Work with HEOC Manager and staff to ensure that CSC distribution lists are maintained and updated accordingly to reflect the dynamic environment

PARTNER AGENCY COMMITTEE MEMBER

CRISIS STANDARD OF CARE JOB ACTION SHEET

Qualifications and Training

- Public health, emergency management, or other stakeholder from local, state, or federal agencies, or a representative from a state medical board or association.
- IS 100, 200, 700, 800, 300, 400 recommended
- Knowledge of government, healthcare system, emergency management, or public health emergency preparedness
- Review Arizona Crisis Standard of Care Plan and CSC Code of Ethics

Overall Responsibilities

- Contribute to the development and implementation of statewide CSC guidance and priorities for the allocation of scarce medical resources
- Liaison between respective agency and the SDMAC.

CSC Activation – First 12 Hours

- Confirm receipt of notification message from HEOC requesting participation in SDMAC operations
- Participate in initial meeting or conference call
- Assist with information gathering and situational awareness from local/regional jurisdictions and/or healthcare facilities
- Contribute to the development of initial status report, meeting minutes and other documentation as needed
- Under the direction of the ADHS Policy Advisor, collectively develop initial CSC guidance and priorities with other SDMAC members

CSC Operations – On-going

- Serve as the primary point of contact between the SDMAC and the local/regional agency
- Continue to gather information and provide situational awareness from local/regional jurisdiction and healthcare facilities
- Contribute to the development of on-going status reports, meeting minutes, and other documentation as needed
- Work collectively with SDMAC staff to evaluate and update guidance and priorities as needed

HEALTHCARE COMMITTEE MEMBER

CRISIS STANDARD OF CARE JOB ACTION SHEET

Qualifications and Training

- Stakeholder from a facility, healthcare network, EMS/pre-hospital, board, or association involved in the CSC response
- IS 100, 200, 700, 800 recommended
- Knowledge of healthcare system, public health emergency preparedness, and medical surge
- Review Arizona Crisis Standard of Care Plan and CSC Code of Ethics

Overall Responsibilities

- Contribute to the development and implementation of statewide CSC guidance, including guidelines and priorities for the allocation of scarce medical resources
- Liaison between healthcare entity and SDMAC during CSC operations

CSC Activation – First 12 Hours

- Confirm receipt of notification message from HEOC requesting participation in SDMAC operations
- Participate in initial meeting or conference call
- Assist with information gathering and situational awareness from healthcare organizations
- Contribute to the development of initial status report, meeting minutes and other documentation as needed
- Under the direction of the ADHS Policy Advisor, collectively develop CSC priorities and guidelines with other SDMAC members

CSC Operations – On-going

- Serve as the primary point of contact between the SDMAC and the healthcare organization
- Continue to gather information and provide situational awareness from healthcare organization
- Contribute to the development of on-going status reports, meeting minutes, and other documentation as needed
- Work collectively with SDMAC staff to evaluate and update guidance and priorities as needed

SUBJECT MATTER EXPERT SDMAC MEMBER

CRISIS STANDARD OF CARE JOB ACTION SHEET

Qualifications and Training

- Expert training and knowledge in one or more response areas (e.g., CBRNE, infectious disease, medical countermeasures, EMS, legal/ethical)
- Knowledge of healthcare system, public health emergency preparedness, and medical surge
- IS 100, 200, 700, 800, 300, 400 recommended
- Review Arizona Crisis Standard of Care Plan and CSC Code of Ethics

Overall Responsibilities

- Provide and interpret technical information and data related to the response
- Contribute to the development and implementation of statewide CSC guidance and priorities

CSC Activation – First 12 Hours

- Confirm receipt of notification message from HEOC requesting participation in SDMAC operations
- Participate in initial meeting or conference call
- Assist with information gathering and situational awareness from the field related to area(s) of expertise
- Contribute to the development of status reports, meeting minutes and other documentation as needed
- Under the direction of the ADHS Policy Advisor, collectively develop CSC guidance and priorities with other SDMAC members

CSC Operations – On-going

- Serve as a subject matter expert for the SDMAC and HEOC as needed
- Interpret technical information into commonly understood language
- Continue to gather information and provide situational awareness from other technical experts in the field
- Contribute to the development of on-going status reports, meeting minutes, and other documentation as needed
- Work collectively with SDMAC staff to evaluate and update policy and guidelines as needed

CLINICAL CARE DIRECTOR

CRISIS STANDARD OF CARE JOB ACTION SHEET

Qualifications and Training

- Physician
- Knowledge of healthcare system, public health emergency preparedness, and medical surge
- Hospital Incident Command System (HICS)
- Review Arizona Crisis Standard of Care Plan and CSC Code of Ethics

Overall Responsibilities

- Oversee the implementation of CSC priorities and guidelines at healthcare facility
- Coordinate between SDMAC and healthcare facility
- Coordinate CSC guidance and priorities with facility emergency operations (Incident Command)
- Provide situational awareness related to medical surge and CSC to SDMAC as appropriate

CSC Activation – First 12 Hours

- Confirm receipt of CSC guidance and priorities from SDMAC
- Identify and supervise Triage Officer(s)
- Brief Incident Command and clinical staff to inform them of CSC guidance and priorities
- Ensure that Triage Officers are in place so that clinicians providing patient care are solely focused on the treatment and survival of the patients under their care
- Develop report outlining CSC activities for initial operational period according to facility policy

CSC Operations – On-going

- Coordinate with Incident Command to provide situational awareness for local and state response agencies and the SDMAC
- Contribute to the development of facility status reports, meeting minutes and other documentation as needed
- Ensure separation of duties between Triage Officer(s) and clinicians providing patient care
- Consult with Incident Command staff regarding the need for critical incident stress management (CISM), psychological first aid, or other behavioral health support for Triage Officers and healthcare practitioners/professionals involved in CSC implementation
- Work with Incident Command Staff to determine incident-specific thresholds for de-escalating CSC into either contingency or conventional care

CSC TRIAGE OFFICER

CRISIS STANDARD OF CARE JOB ACTION SHEET

Qualifications and Training

- Physician or qualified triage nurse
- Knowledge of healthcare system and medical surge
- Hospital Incident Command System (HICS)
- Critical Incident Stress Management (CISM) training as needed
- Review Arizona Crisis Standard of Care Plan and appended CSC Code of Ethics

Overall Responsibilities

- Reports to the Clinical Care Director
- Triage patients according to CSC guidance and priorities developed and implemented by the SDMAC
- Reports space, staff, and supply needs to the facility emergency operations center
- Provide information to the Clinical Care Director for inclusion in status reports

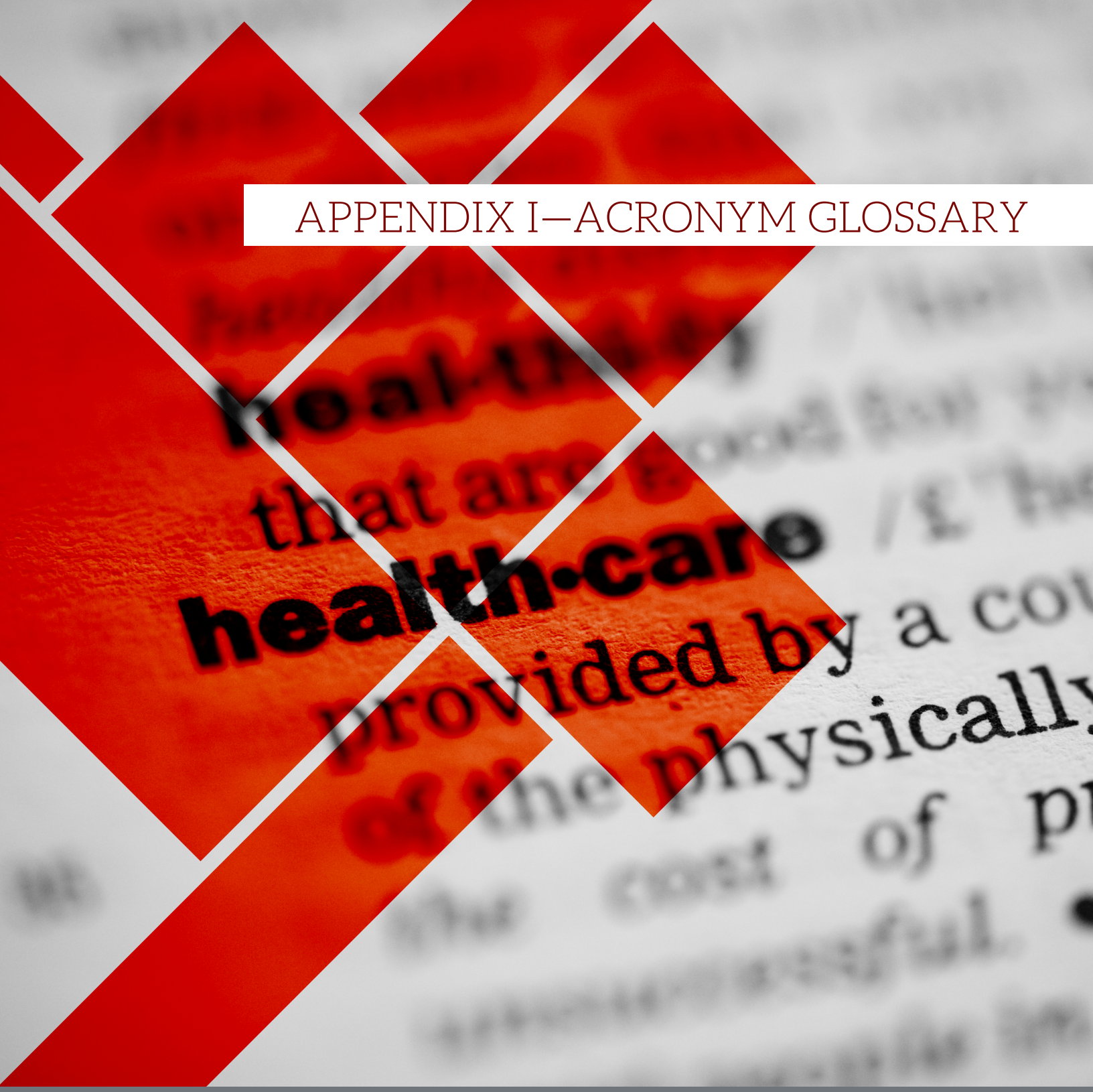
CSC Activation – First 12 Hours

- Attend initial briefing with Clinical Care Director to discuss CSC implementation
- Perform primary (RN), secondary (ED Physician), and tertiary (intensivist or physician of comparable status) triage of patients as needed to support CSC operations
- Refrain from providing patient care to ensure objectivity

CSC Operations – On-going

- Attend regular briefings with Clinical Care Director, and facility incident command staff
- Continue to perform triage of patients as directed to support CSC operations
- Continue to refrain from providing patient care to ensure objectivity
- Consult with Clinical Care Director regarding the need for critical incident stress management (CISM), psychological first aid, or other behavioral health support for healthcare providers involved in CSC implementation
- Work with Incident Command Staff and Clinical Care Director to determine incident-specific thresholds for de-escalating CSC into either the contingency or conventional care

APPENDIX I—ACRONYM GLOSSARY



Appendix I—Acronym Glossary

ACS

Alternate Care Sites/Systems

ADHS

Arizona Department of Health Services

APN

Advanced Practice Nurse

ARS

Acute Radiation Syndrome

ASPR

Assistant Secretary for Preparedness and Response

ADEM

Arizona Division of Emergency Management

AVPU

Alert, Voice, Pain, Unresponsive

AzHHA

Arizona Hospital and Healthcare Association

AZDOHS

Arizona Department of Homeland Security

AzHAN

Arizona Health Alert Network

CBRNE

Chemical, Biological, Radiological, Nuclear, and Explosive

CCC

Clinical Care Committee

CDC

Centers for Disease Control and Prevention

CERC

Crisis Emergency Risk Communication (Plan)

CSC

Crisis Standards of Care

DSLR

Division of State and Local Readiness

ED

Emergency Department

EM

Emergency Management

EMS

Emergency Medical Services

EMT

Emergency Medical Technician

ERP

Emergency Response Plan

ESAR-VHP

Emergency System for the Advanced Registration of Volunteer Health Professionals

ESF

Emergency Support Function

FEMA

Federal Emergency Management Agency

HAvBED

Hospital Available Beds in Emergencies and Disasters

HC

Healthcare

HEOC

Health Emergency Operation Center

HHS

Health and Human Services

IC

Incident Commander

ICS

Incident Command System

IDME

Immediate, Delayed, Minimal, Expectant

IDMED

Immediate, Delayed, Minimal, Expectant, Deceased

IOM

Institutes of Medicine

JIC

Joint Information Center

JIS

Joint Information System

MCI

Mass Casualty Incident

MRC

Medical Reserve Corps

NP

Nurse Practitioner

PHEP

Public Health Emergency Preparedness

PIO

Public Information Officer

PSAP

Public Safety Answering Point

RN

Registered Nurse

SDMAC

State Disaster Medical Advisory Committee

SEOC

State Emergency Operation Center

SERRP

State Emergency Response and Recovery Plan

SME

Subject Matter Expert

SOP

Standard Operating Procedure

The Arizona Department of Health Services (ADHS) worked with public health, emergency management, first responders, healthcare, legal, and other partners to create the Arizona Crisis Standards of Care (CSC) Plan. Ethical considerations and principles have played a key role throughout the course of this initiative. Stewardship of resources, duty to care, soundness, fairness, reciprocity, proportionality, transparency, and accountability are the guiding ethical elements of this plan. This foundation has been integrated into public health and emergency response principles to establish this common framework for statewide CSC.

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