OROVILLE HOSPITAL CRISIS CARE GUIDELINES

Oroville Hospital has an Emergency Operations Plan that includes the attached Table of Contents. The Oroville Hospital Emergency Operations Plan addresses surge operations and crisis contingencies. Oroville Hospital Executive Leaders are trained and follow the Hospital Incident Command System this includes response to various levels of disaster including Crisis level.

Oroville Hospital agrees with "California SARS-CoV-2 Pandemic Crisis Care Guidelines and we will make our best effort to follow as appropriate for the level of the situation.

Oroville Hospital
Emergency Operations Plan
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California SARS-CoV-2 Pandemic Crisis Care Guidelines

CONCEPT OF OPERATIONS

HEALTH CARE FACILITY SURGE OPERATIONS AND CRISIS CARE

06/2020

Contents

DISCLAIMER

The information contained in this document is meant to provide useful information to health care facilities and systems, but does not in any way alter or diminish health care facilities' and systems' responsibilities during catastrophic public health events. Health care facilities or systems implementing these strategies in crisis situations should assure communication and coordination with their Health Care Coalition (HCC) partners, their Medical and Health Operational Area Coordinator (MHOAC), Regional Disaster Medical and Health Specialist (RDMHS), the California Department of Public Health (CDPH), Emergency Medical System Authority (EMSA), and public safety partners to assure the invocation of appropriate legal and regulatory protections as appropriate in accord with state and federal laws. Recommendations within this document may be superseded by incident specific recommendations by CDPH. Web links and resources listed are provided as examples and their listing does not imply endorsement by CDPH.

Introduction

This document is a framework designed to help health care facilities plan for the COVID-19 pandemic, which may cause overwhelming medical surge. This guidance assumes incident management and incident command practices are implemented and key personnel are familiar with healthcare emergency management planning and processes that underlie scarce resource decision-making.

During a catastrophic public health event that results in medical surge, each health care facility or health care system should use this guidance as a framework to determine the most appropriate steps and actions for their entity based on their environment, hazards, and resources. Since pre-planned actions are always preferred to impromptu decisions, pre-event emergency management planning and training is recommended. This document addresses common categories of health care delivery, triage, staff and space that could arise when available resources are limited or insufficient to meet the medical needs of patients. In California, local or regional HCCs, hospitals and health care systems may determine additional issues and strategies in addition to those outlined in this document.

This document provides an overview of surge capacity and crisis care operational considerations for health care facilities with an emphasis on hospitals for the State of California. In addition to this framework, hospitals and health care systems are encouraged to review federal guidance which can be found on the National Academies of Science webpage.

This document is meant to provide information to support regional or county health entities, including health departments as well as individual health care facility operations, as they develop and implement their operational plans. It is the responsibility of the regional entity or the facility to work with their management team and medical staff to ensure operational plans are in place. This document does not replace the judgment of the regional health care facilities' operational management, medical directors, their legal advisors or clinical staff and consideration of other relevant variables and options during an event. States and national medical

organizations have shared best practices and incorporated relevant medical literature in developing Crisis Care guidelines. California is using this collaborative work as a cornerstone for these guidelines.

California is committed to achieving and sustaining a California for All and to its nation-leading laws and policies, including prohibiting discrimination on such protected bases as, age, disability, race, sex, gender identity and sexual orientation and immigration status.

This document is consistent with the "Guidance Relating to Non-Discrimination in Medical Treatment for Novel Coronavirus 2019 (COVID-19)" issued on March 30, 2020.

Care Continuum

Most health care facilities are familiar with the concepts of surge capacity, the ability to manage a sudden influx of patients[1] and surge capability, the ability to manage patients requiring very specialized medical care.[2] During conventional care, customary routine services are provided through standard operating procedures. During contingency care, care provided is functionally equivalent to routine care but equipment, medications, and even staff may be used for a different purpose or in a different manner than typical daily use (e.g. substituting one antibiotic for another that covers the same classification). The demands of most incidents can be met with conventional and contingency care. Crisis care falls at the far end of the spectrum when resources are scarce and the focus changes from delivering individual patient care to delivering the best care for the patient population.

The goal during a medical surge event is to maximize surge capacity strategies that mitigate the crisis while minimizing the risks associated with deviations from conventional care. Choosing the strategies that are most appropriate to the situation and pose the least risk to the patient and provider first, and then proceeding to riskier strategies as demand increases and options decrease, is the preferred path.

Surge capacity is described across a spectrum of three categories (Figure 1):

- **Conventional:** Usual resources and level of care provided.[3] For example, during a surge in patients, maximizing bed occupancy and calling in additional staff to assist.
- **Contingency:** Provision of functionally equivalent care that may incur a small risk to patients. Care provided is adapted from usual practices. For example, boarding critical care patients in post-anesthesia care areas using less traditional, but appropriate resources.[4]
- **Crisis:** Disaster strategies used when demand forces choices that pose a significant risk to patients but is the best that can be offered under the circumstances. For example, cot-based care, severe staffing restrictions, or restrictions on use of certain medications or other resources.[5]

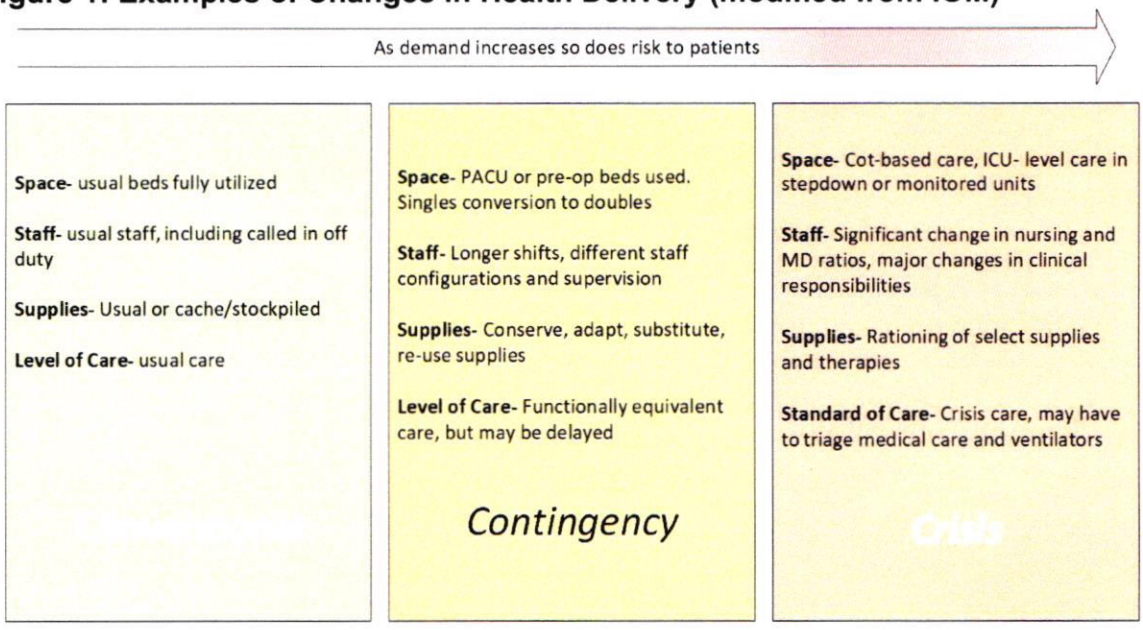
[1,2] ASPR. *2017-2022 Health Care Preparedness and Response Capabilities.* pg. 44

[3] Hick, J. L. Hanfling, D. & Cantrill, S. V. (2012). Allocating Scarce Resources in Disasters: Emergency Department Principles. *Annals of Emergency Medicine, 59*(3), p 178.

[4] Hick, J. L. Hanfling, D. & Cantrill, S. V. (2012). Allocating Scarce Resources in Disasters: Emergency Department Principles. *Annals of Emergency Medicine, 59*(3), p 178.

[5] Hick, J. L. Hanfling, D. & Cantrill, S. V. (2012). Allocating Scarce Resources in Disasters: Emergency Department Principles. *Annals of Emergency Medicine, 59*(3), p 178.

Figure 1: Examples of Changes in Health Delivery (modified from IOM)



Key Points about Crisis Care

- Crisis care is not a separate triage plan. These strategies are extensions of surge-capacity plans.
- Crisis care may occur during long-term events such as pandemics when resource constraints are likely to persist for long periods of time, or during short-term, no-notice events where help will arrive, but too late to solve an acute resource shortfall.
- Health care facilities will not have an option to defer caring for patients in a crisis. Demand, guided by ethics, will drive the choices that have to be made.
- Healthcare decisions, including allocation of scarce resources, cannot be based on age, race, disability (including weight-related disabilities and chronic medical conditions), gender, sexual orientation, gender identity, ethnicity (including national origin and language spoken), ability to pay, weight/size, socioeconomic status, insurance status, perceived self-worth, perceived quality of life, immigration status, incarceration status, homelessness, or past or future use of resources.
- If strategies are not planned for ahead of time, they might not be considered and/or will be difficult to implement.
- Strategies should be proportional to the resources available. As more resources arrive, you should move back toward strategies that are less demand driven (and therefore, back toward contingency and eventually conventional status)

The principles of crisis care must be integrated into Emergency Operations Plans (EOPs) at all levels of health care.

Roles and Responsibilities

The primary focus of this guidance is on the operational strategies for health care facilities during crisis. Health care facilities should be supported by regional HCCs, their MHOAC, RDMHS, CDPH, EMSA, and public safety partners, local EMSA, and state and local government agencies. HCCs includes partnerships between local public health, emergency medical services (EMS), health care facilities, and emergency management that provide planning and response coordination.

Planning and Implementation

Indicators and Triggers

An indicator is a "measurement or predictor of change in demand for health care services or availability of resources."[6] An example of an indicator is a report of several confirmed cases of COVID-19 in the community by the local health department. A trigger is a "decision point about adaptations to health care service delivery" that requires specific action.[7] An indicator may identify the need to transition to contingency or crisis care (but requires analysis to determine appropriate actions), while a trigger event dictates action is needed to adapt health care delivery and resources. It is important for organizations to identify indicators and triggers prior to an event due to the "stress, complexity, and uncertainty inherent in a crisis situation."[8]

There are two types of triggers – scripted and non-scripted. Build scripted triggers into standard operating procedures, which are automatic 'if/then' decisions. Whenever possible, scripted triggers should be developed for frontline personnel (point of entry health care facility staff, reception, etc.) so they have actions they can take immediately to prevent delay. An example may be isolation protocols for individuals showing certain signs or symptoms of a particular disease.

Non-scripted triggers require additional analysis involving supervisory staff. These are often part of an incident action planning cycle. The less specific the information available, the more difficult it is to apply a scripted trigger and the more likely an experienced supervisor or subject matter expert should be involved to process the information and decide on necessary actions. Frontline personnel should have a low threshold for passing indicator information along to supervisors for situational awareness and potential decision-making.

In addition to identifying response specific indicators and triggers, hospitals should determine the trigger or threshold to identify when they are in crisis care whenever possible. For example, if a hospital is providing cot-based care or any intensive care unit (ICU) care is provided outside usual intermediate and pre/post op areas, these are indicators that operations are now into crisis care and should trigger a response action.

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6 Dan Hanfling, John Hick, and Clare Stroud, Editors; Committee on Crisis Standards of Care: A Toolkit for indicators and Triggers; Board on Health Sciences Policy; Institute of Medicine, "Crisis Standards of Care: A Toolkit for Indicators and Triggers" (the National Academies Press, 2013) 2

7 Ibid

8 Ibid

These triggers will vary by facility depending on size and resources. Facility level indicators and triggers should be communicated with health care coalition partners, MHOACs and RDMHSs.

Detailed information on indicators and triggers (including templates for health care facilities) is available in the 2013 IOM/NAM Crisis Standards of Care: A Toolkit for Indicators and Triggers.

How to identify and incorporate Indicators and Triggers in your EOP

1. Do not focus on indicators and triggers in isolation.
2. Determine what response strategies or options you may use during a disaster.
3. Determine what indicators might be available during a disaster that would trigger hospital action.
4. Identify trigger points for your health care facility including, but not limited to:
    a. Implementing triage
    b. Temporarily closing your facility to new admissions or transfers
    c. Canceling elective procedures
    d. Stockpiling or ordering more supplies
    e. Implementing staffing changes
5. Determine what staff actions should happen based on the indicator. These should be specific and tell staff exactly *when* they should take certain actions. This is critical to the success of the response.

Having specific actions staff should take at a clearly defined trigger is critical to the success of the response. Delays in decision-making occur in unfamiliar situations and with unclear authority.

Supply Management

Healthcare facilities are expected to anticipate supply needs and make every effort to procure in advance supplies through usual supply chains and standing vendor contracts. In addition, when resources are scarce, facilities must continue aggressive measures to acquire needed equipment such as ventilators. Such measures can include coordination with healthcare coalition partners and local reserves that may provide a source of supplies otherwise in shortage

When usual supply chain sources are exhausted, supply resource requests can be made through the local MHOAC, who in turn will attempt to fill these requests through regional and state level stores of supplies and various procurement capability.

During declared disasters CDPH and the state EMS authorities track health care resources including hospital med/surge and ICU surge capacity and ventilators, and will help coordinate the allocation and distribution or re-distribution of those scarce resources when available.

Systems are also encouraged in times of scarce resources to explore alternatives to

single-use invasive ventilation by gathering data on the utility and safety of non-invasive ventilation and to investigate the efficacy and safety of splitting ventilators.

Core Strategies

Six core strategies can be employed in anticipation of a shortage of space, supplies, and/or staff. These strategies can help avoid or mitigate a crisis of care situation. When writing an EOP consider how your facility will utilize these strategies:

- **Prepare:** pre-event actions taken to minimize resource scarcity (e.g. stockpiling of personal protective equipment (PPE), medications or supplies, planning, training).
- **Substitute:** use an equivalent device, drug, or personnel for one that would usually be available (e.g. exchanging morphine for fentanyl).
- **Adapt:** use a device, drug, or personnel that are not equivalent but that will provide sufficient care (e.g. anesthesia machine for mechanical ventilation; licensed practical nurse (LPN) with registered nurse (RN) supervision instead of multiple RNs).
- **Conserve:** use less of a resource by lowering dosage or changing utilization practices (e.g. minimizing use of oxygen driven nebulizers to conserve oxygen).
- **Re-use:** re-use (after appropriate disinfection/sterilization) items that would normally be single-use items.
- **Re-allocate:** restrict or prioritize use of resources to those patients who are likely to benefit and survive in the immediate short-term or to those with greater need only in times of actual shortage.

Acute Care Hospitals

1. Review available resources and determine potential strategies to address Crisis Care Guidelines across the surge capacity continuum from conventional to crisis care.
2. Review your hospital's capabilities in managing surge, critical care, infectious disease, isolation, just-in-time training, and pediatrics to meet their objectives.
    a. Involve in this review: nursing, administration, emergency management, emergency services, ancillary and support services—lab, radiology, respiratory therapy, pharmacy, facilities etc.—and physician personnel.
    b. Include critical care if your institution provides those specialties.
3. Determine what number of pandemic patients should be planned for based on suspected hazards. Consider your role in the community and the presence or absence of other health care facilities in the area.
4. Incorporate indicators and triggers (surge capacity information throughout the care continuum) into your EOP.
5. This should also include the notifications to supervisors and partner agencies that need to occur when these triggers are activated. Delegating authority to activate the disaster plan to emergency department (ED) staff or nursing supervisors/charge nurses should be done when possible to facilitate rapid action. The adoption of clear policies helps facilitate decisions as well as provides accountability. Education and training of staff should be conducted to assure successful implementation of the plan.
    a. Keep in mind the training practice of educating to an awareness,

knowledge, and proficiency level. Not all staff members need to be proficient in the plan, but those frontline decision-makers (charge nurses, unit supervisors etc.) should know how to incorporate surge capacity into their respective units prior to an incident. See below for more detail on Health Care Worker Engagement.

   b. Job aids—such as brief task cards or job action sheets—should be widely used to help frontline personnel with initial decisions and actions.
   c. Education prior to crisis events, as well as appropriate reminders integrated into job aids and training materials, should increase awareness of antidiscrimination responsibilities and the role that explicit and implicit bias can play in reinforcing health disparities that affect at-risk populations.

6. During an event response, the facility should review and modify their procedures as needed as part of the incident action planning process. Plans should be adaptable and not "lock in" disaster response protocols for the duration of an incident but allow flexibility and transition toward conventional care as more resources arrive or demand falls, or both.
7. Exercising the plan is an important part of training and testing your plan. It is important when testing any EOP that you really push the exercise into the crisis care mode.
8. Review and updates to the plan should occur when new information is available.

Non-Acute Care Facilities and Services

The role of non-acute care facilities, such as ambulatory care centers, clinics, hospices, home care, skilled nursing facilities, alternative care facilities, etc. is different than that of acute care hospitals during a pandemic. These facilities can provide critical capacity, both outpatient and post-acute care, and may be needed to broaden their scope of care during such incidents.

1. Examine your resources and determine potential contingencies such as:
   a. Extended hours
   b. Conversion of space and staff from specialty care to primary care duties
   c. Changes to charting and administration to enhance work flow (template charts and prescriptions for the event)
   d. Changes to scheduling (e.g. cancel or re-schedule elective procedures and appointments)
   e. Enhanced use of tele-medicine, telephone prescribing, and e-visits to manage workload
   f. Adjust clinic flow to avoid exposing well persons to ill persons
   g. Communicate and implement guidance on scarce resources (e.g. guidelines for prescribing anti-viral medications or administering vaccine)
   h. Increase your normal acuity of patients to support acute care hospitals
   i. Consider the utilization of volunteers to provide check-in and other services
2. The applicable activities to your agency or facility should be incorporated into your EOP.