ALABAMA CRISIS STANDARDS OF CARE GUIDELINES

MANAGING MODIFIED CARE PROTOCOLS
AND THE ALLOCATION OF SCARCE MEDICAL RESOURCES
DURING A HEALTHCARE EMERGENCY

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DEFINITION OF CRISIS STANDARDS OF CARE

Crisis Standards of Care (CSC) are defined as a substantial change in usual healthcare operations and the level of care possible to deliver due to severe shortages of critical resources causing the delivery system to be overwhelmed. It is a medico-legal term meaning the prudence and caution required of an individual or organization which is operating with a duty of care to people under the care of the individual or organization.

During times of crisis care, decisions and strategies involving patient care will be made at the healthcare facility or agency level. This will require coordination and collaboration between providers and incident managers to determine the best use of limited resources, and, to establish modifications of care if necessary when patient care moves from Conventional and Contingency phases, into the Crisis phase when care needs exceed available resources. It is critical that this information be passed on to the Healthcare Coalitions and the Alabama Department of Public Health and other response partners.

INTRODUCTION

The possibility of a mass casualty event in Alabama has been proven. On April 27, 2011 Alabama experienced a tornado outbreak that ranks as one of the most severe storm systems to ever cross the southeastern United States. In Alabama alone, there were 251 deaths attributed to the tornadoes. In approximately 18 hours, Alabama experienced a staggering 62 tornadoes. The destruction was catastrophic: entire communities and neighborhoods were leveled, schools and businesses destroyed, over 23,000 homes damaged or destroyed, power outages affected more than 600,000 residents, and thousands of people were injured or hospitalized. One estimate is 4,000 to 5,000 people sought care at some point after the storms. On a national level the April 27 outbreak was historic in terms of the number of storms, and their strength and scope. With a total of 202 confirmed tornadoes and 364 fatalities, April 27, 2011 set a new record for total tornadoes in a single day, surpassing the April 1974 "Super Outbreak", which produced 147 tornadoes across the southeastern United States, and killed over 300 people in 24 hours. The risk of severe weather is one of Alabama's highest-ranking hazards, with the primary threat in the spring, and the secondary threat in late fall into early winter. Alabama also has a risk of hurricanes in the summer and fall; however, with early warning, ongoing mitigation activities, evacuation planning, and the practice of "hide from the wind and run from the water", mass casualties from a hurricane should be significantly less than tornadoes.

All communities have an infectious disease outbreak threat and the true risk is unknown, but, it must not be neglected as we remember the H5N1 influenza pandemic planning in 2005-06, the Ebola panic of 2014 and the Zika outbreak of 2016. With terror attacks still occurring, the possibility of an active shooter or an explosive event has shown that dozens of fatalities and perhaps hundreds of casualties can occur in random and unannounced incidents.

In 2002, the Alabama Department of Public Health, Center for Emergency Preparedness (ADPH-CEP) received healthcare preparedness funding and immediately began implementing preparedness activities outlined in the Department of Health and Human Services/ Health Resources Services Administration (HRSA) guidelines. A portion of the funding targeted biological preparedness. The threat of Biological, Chemical and Radiological terrorism continues to be a concern following the attacks on September 11, 2001, and the Anthrax attack that occurred in October of the same year. Concurrently, healthcare preparedness infrastructure development was underway, establishing Bioterrorism Preparedness Teams

in each of the existing eleven public health areas. Teams were made up of a Bioterrorism Preparedness Coordinator, a Surveillance Nurse, an Environmentalist and an Administrative Assistant.

The Healthcare Preparedness Program (HPP) continuously evolved in Alabama and in 2012 the eleven public health areas were used as the geographic boundaries of our Healthcare Coalitions (HCCs). The development of the HCCs occurred over the first two years, a basic response Emergency Operations Plan (EOP) was written, training was begun and exercises were held in 2015 and 2016. Following an assessment of the HCCs in 2016, it was determined that a set of Crisis Standards of Care Guidelines should be written to provide guidance in the state for HCCs to follow. Each HCC may adopt these Crisis Standards of Care Guidelines and integrate them into their Healthcare Coalition Response Plan**.**

PURPOSE

The purpose of this document is to provide guidance in the decision-making process as well as modify the delivery of healthcare services in disasters and other healthcare emergencies. Under routine circumstances the usual "Standards of Care" apply to the regular events in normal healthcare. However, in disasters and public health emergencies, usual "Standards of Care" may not be possible, especially in extraordinary, emerging or evolving scarce resource situations. To this end, a multi-disciplinary committee was convened in 2017 by ADPH-CEP and the University of South Alabama, Center for Disaster Healthcare Preparedness (USA-CHDP), with the purpose of developing a fair, reasonable, transparent and ethical set of guidelines to help the decision-making process for allocating scarce resources in crisis situations. It is important to recognize that situations of these types of emergencies will necessarily require a shift in focus from individual patients to population outcomes.

MEMBERS OF THE ALABAMA CRISIS STANDARDS OF CARE GUIDELINES WORK GROUP

Jenille Ball	Hospice of Montgomery	Hospice
Krissy Blake	USA Children's and Women's Hospital	Nurse Manager
Ann Brantley	ADPH Center for Emergency Preparedness	RN
Dillon Bullard	ADPH, Asst. General Counsel	Attorney
Randy Causey	East Alabama Medical Center	EM Preparedness
Glenn Davis	University of Alabama EMS	EMS
Tammy Farmer	Baptist Medical Center East	Nurse Manager ED
Tom Geary	ADPH Asst. Health Officer/Regulatory (Retired)	MD, Geriatric
Lauren Gordon	Alabama Primary Healthcare Association	Operations Coordinator
Jan Hannah	Shoals Hospital	Director ED
Scott Harris	State Health Officer	MD
John Higginbotham	North Alabama Healthcare Coalition (Deceased)	MD, EM Preparedness
Ronda Hood	Helen Keller Hospital	Dir. Cardiopulmonary, RT
Danne Howard	Alabama Hospital Association	Legislative Liaison
Acquanetta Knight	Alabama Department of Mental Health	Dir. Policy and Planning
Karen Landers	ADPH Asst. Health Officer/Shoals District	MD, Pediatrics
Julie Lash	Alabama Hospital Association	Grass Roots Coordinator
Andrew Lee	Air Evac Lifeteam	RN, Trauma/Pre-hospital
John Matson	Alabama Nursing Home Association	Communications Director
Mary Mueller	Shelby Baptist Hospital	Dir. Patient Services
Andy Mullins	ADPH Center for Emergency Preparedness	Director

Cindy Murphy	Baptist Medical Center South	RN, ED/Trauma/Critical
Travis Parker	University of Alabama EMS	EMS
Aaron Shinkle	The Center for Pain	MD, Pain Management
Natalie Simpson	Jack Hughston Memorial Hospital	Dir. Cardiopulmonary
Douglas Tanner	Atmore Community Hospital	President
Sylvia Thompson	Baptist South	RN, ED Manager
David Wallace	USA Center for Disaster Healthcare Preparedness	Director
Wendy Walters	UAB Hospital	LCSW, Ethics Committee
Elizabeth Williams	USA Center for Disaster Healthcare Preparedness	Associate Director
Stephen Wilson	ADPH EMS	Director EMS

BACKGROUND

Alabama is the thirtieth-largest state in the United States with 52,419 square miles of total area. Alabama is bordered by the states of Tennessee to the north, Georgia to the east, Florida to the south, and Mississippi to the west. All of the Alabama HCCs that border a state have developed relationships with healthcare systems and/or coalitions in those bordering states' communities. Alabama has coastline at the Gulf of Mexico, in the extreme southern edge of the state.

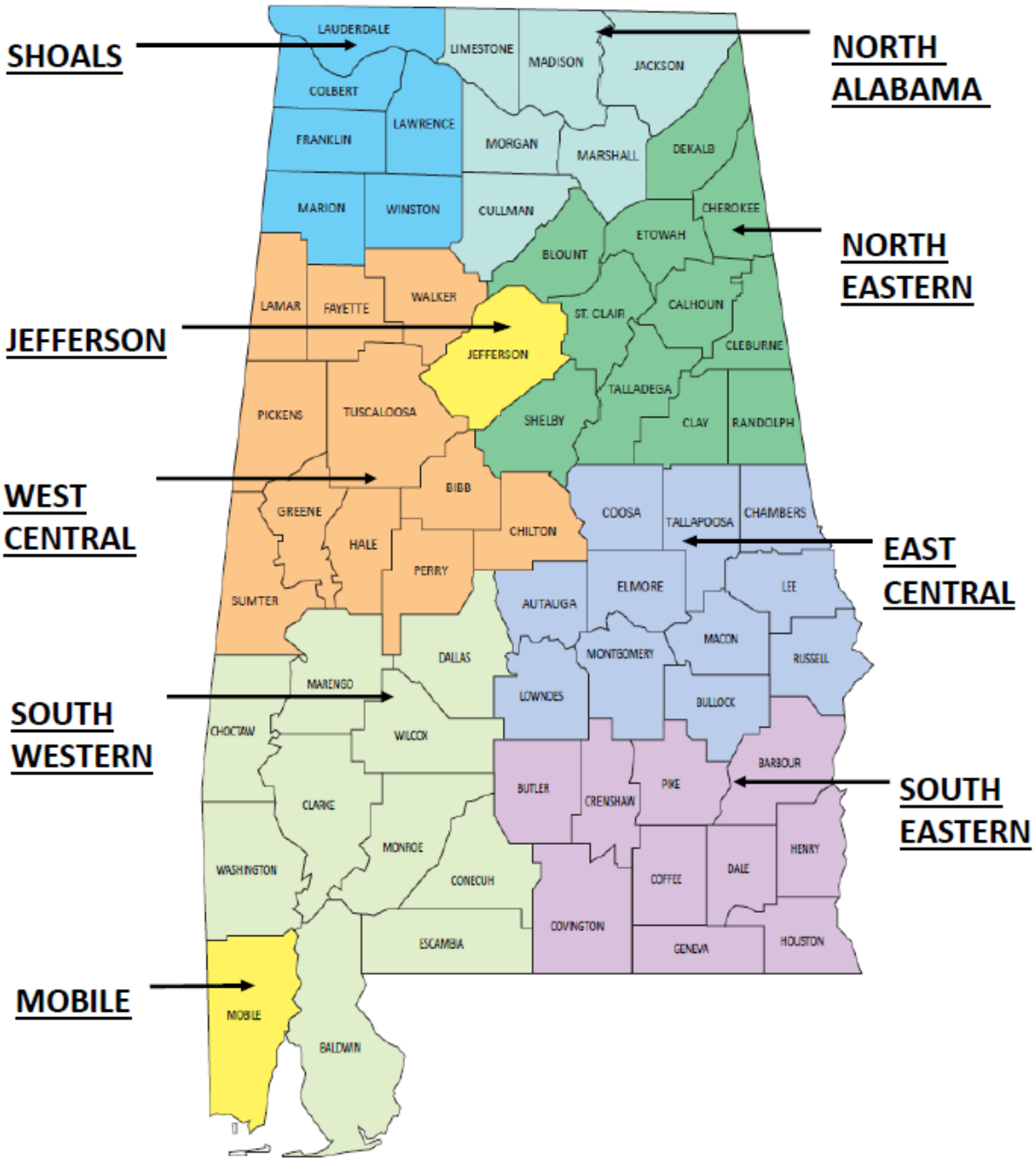
The state is classified as humid subtropical. The average annual temperature is 64 °F. Temperatures tend to be warmer in the southern part of the state with its proximity to the Gulf of Mexico, while the northern parts of the state, especially in the Appalachian Mountains in the northeast, tend to be slightly cooler. South Alabama reports many thunderstorms. The Gulf Coast, around Mobile Bay, averages between 70 and 80 days per year with thunder reported. This activity decreases somewhat further north in the state, but even the far north of the state reports thunder on about 60 days per year. Occasionally, thunderstorms are severe with frequent lightning and large hail; the central and northern parts of the state are most vulnerable to this type of storm. Alabama ranks ninth in the number of deaths from lightning and tenth in the number of deaths from lightning strikes per capita. Alabama, along with Oklahoma, has the most reported EF5 tornadoes of any state, according to statistics from the National Climatic Data Center for the period January 1, 1950, to June 2013. Several long-tracked F5/EF5 tornadoes have contributed to Alabama reporting more tornado fatalities than any other state. Based on this data and related extreme weather potential, as well as a recent history of significant infectious disease events (2009 HIN1), the likelihood of a mass casualty situation stressing the healthcare system is undeniable.

KEY ORGANIZATIONS

Healthcare Coalitions

From July 1, 2012 through October 1, 2017, Alabama had eleven (11) Healthcare Coalitions (HCCs). The formation and development of HCCs occurred over this five-year period, building a solid foundation for the realignment and transition to eight HCCs in Alabama. As of October 1, 2017, the geographical boundaries of the HCCs changed to match the new Alabama Department of Public Health Districts. In January of 2018 the Northern Coalition was divided into two, Shoals in the west and North Alabama in the east, creating nine HCCs. The map below depicts the location and size of each coalition, with Mobile and Jefferson still a single county HCC, and the other seven as multi-county HCCs.

Alabama Healthcare Coalitions



Public Health

The Alabama Department of Public Health plays a key role in healthcare preparedness, carrying out both public health and healthcare coalition responsibilities. There is an Emergency Preparedness (EP) Coordinator in each Public Health District. Public Health staff members also take on the roles of Healthcare Coalition Coordinator and Healthcare Coalition AIMS Coordinator. The model in Alabama is the Healthcare Coalitions support all ESF 8 activities during emergency response.

Hospitals

During the 2016-17 Hospital Preparedness Program (HPP) Project-year, the nine multi-county HCCs began the transition of moving some counties into a different HCC by inviting future HCC members to meetings and trainings. The membership of the seven multi-county HCCs has increased because there are fewer HCCs; and, having more counties should result in a greater resource pool for all members to share. As of June 2019:

- North Alabama HCC has 6 counties; 15 hospitals
- Shoals HCC has 6 counties; 9 hospitals
- The Northeastern HCC has 11 counties; 16 hospitals; one county does not have a hospital
- The West Central HCC has 11 counties;15 hospitals; two counties do not have a hospital
- The East Central HCC has 11 counties; 18 hospitals; two counties do not have a hospital
- The Southwestern HCC has 10 counties; 15 hospitals
- The Southeastern HCC has 10 counties; 16 hospitals; one county does not have a hospital
- The Jefferson HCC is Jefferson County alone; 14 hospitals
- The Mobile HCC is Mobile County alone; 7 hospitals

Hospitals play a significant role in disaster response. Each is a member of their Healthcare Coalition and participates regularly in preparedness, planning, training and exercise activities. Additionally, each has a history of excellent response during disasters providing outstanding patient care during patient surges and times of crisis.

Emergency Management Agencies

There are 67 County Emergency Management Agency (EMA) offices – one for each county, as well as the Poarch Band of the Creek Indians in Atmore. County EMAs are assigned to one of 6 EMA Divisions, with the Divisions ranging from 8 to 12 counties each depending on county size, population, etc. The Alabama Emergency Management Agency is located in Clanton, Alabama.

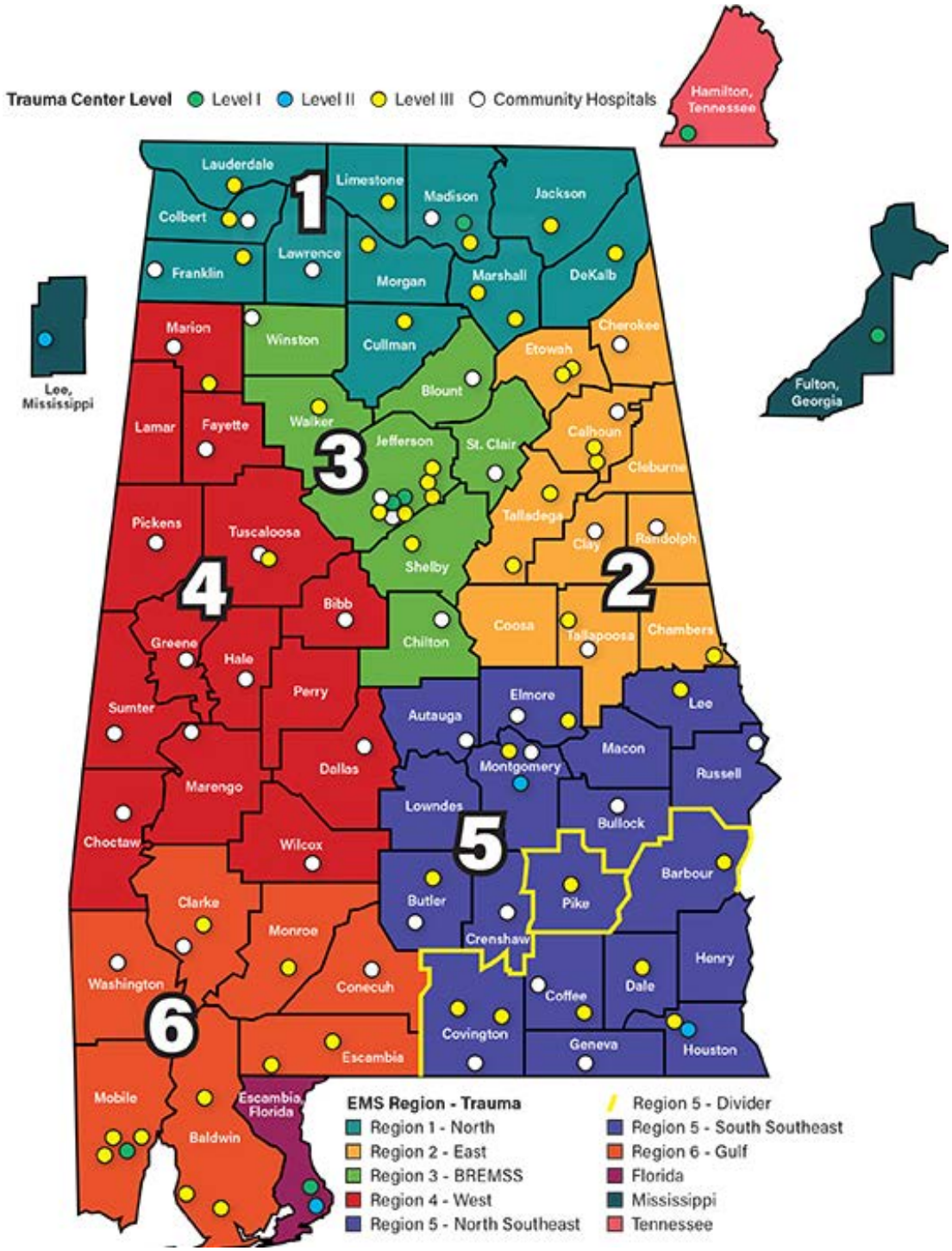
Emergency Medical Services

As of June, 2019, there are approximately 334 ground Emergency Medical Service (EMS) Agencies in Alabama with 232 transport and 102 non-transport services. Approximately 11,600 EMS providers are currently licensed and active under the Alabama Department of Public Health/Office of EMS. There are also over 20 air medical services covering the state of Alabama.

Regional Trauma System

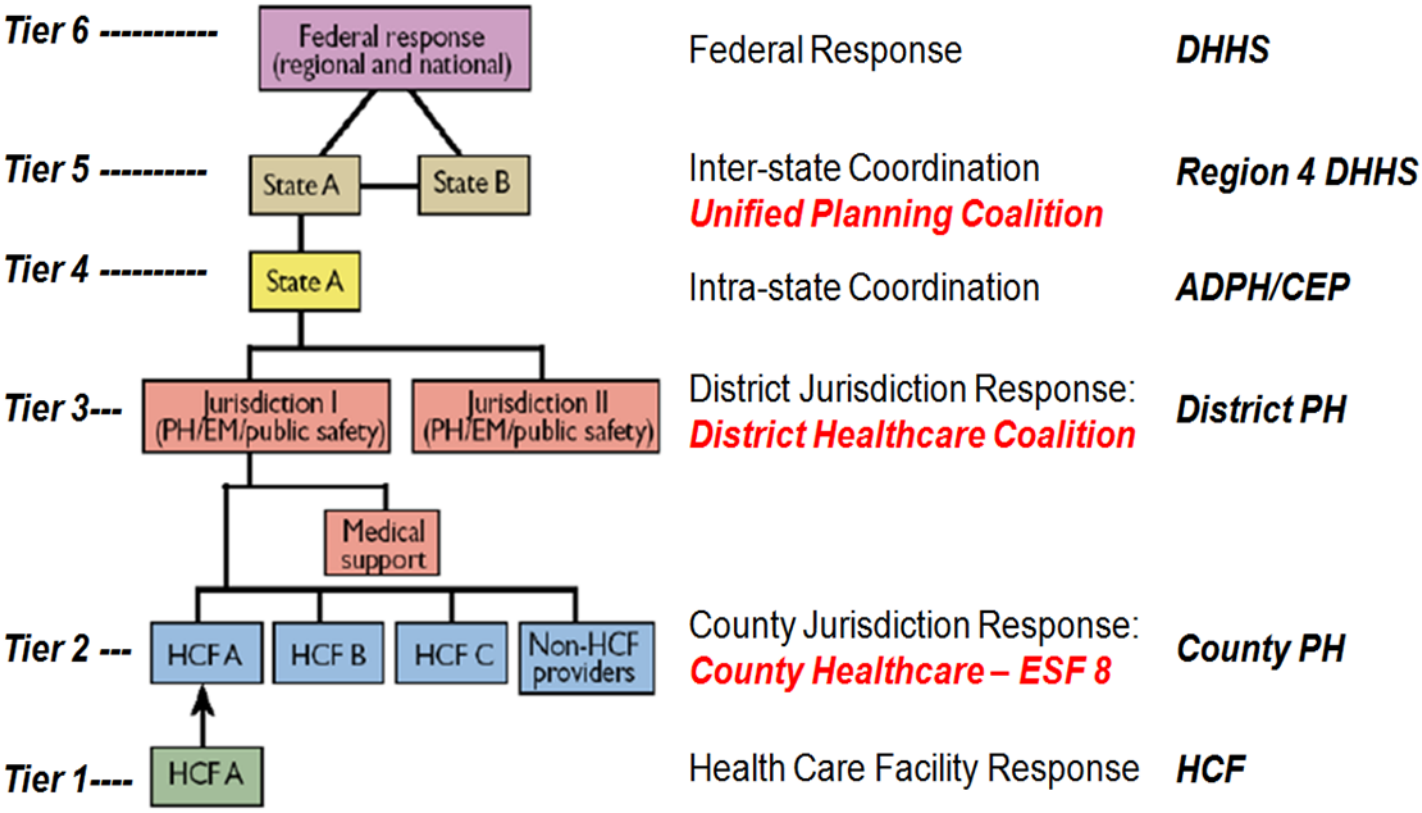
Alabama Trauma Regions' Plans were developed in the same format to ensure consistency and compliance with Alabama Trauma and Health System legislation. In addition, the trauma plans include all currently approved Trauma and Health System Rules. The differences relate to the Regional Advisory Council membership and the secondary triage times.

Out-of-state hospitals requesting to be a designated hospital in the Alabama Trauma and Health System will follow the same process as outlined in ADPH Rule 420-2-2-.03. Out-of-state hospitals will be required to meet the same standards as Alabama hospitals and follow the same survey and reporting processes.


Trauma Center Level
Level I
Level II
Level III
Community Hospitals
Hamilton, Tennessee
Lee, Mississippi
Fulton, Georgia
Lauderdale
Colbert
Limestone
Madison
Jackson
Franklin
Lawrence
Morgan
Marshall
DeKalb
Marion
Winston
Cullman
Etowah
Cherokee
Blount
Lamar
Fayette
Walker
Jefferson
St. Clair
Calhoun
Cleburne
Pickens
Tuscaloosa
Shelby
Talladega
Clay
Randolph
Bibb
Chilton
Coosa
Talapoosa
Chambers
Greene
Hale
Perry
Sumter
Autauga
Elmore
Lee
Macon
Montgomery
Russell
Marengo
Dallas
Lowndes
Bullock
Choctaw
Wilcox
Barbour
Butler
Pike
Clarke
Monroe
Crenshaw
Henry
Washington
Conecuh
Coffee
Dale
Covington
Geneva
Houston
Escambia
Mobile
Escambia, Florida
Baldwin
1
2
3
4
5
6
EMS Region - Trauma
Region 1 - North
Region 2 - East
Region 3 - BREMSS
Region 4 - West
Region 5 - North Southeast
Region 5 - Divider
Region 5 - South Southeast
Region 6 - Gulf
Florida
Mississippi
Tennessee

TIERED RESPONSE IN ALABAMA

There is a 6-tiered response system in place in Alabama.



The decision process for the allocation of scarce resources starts with the individual healthcare facilities (Tier 1) at the bottom of the tiered response chart and moves up as the event escalates. It is expected that crisis conditions will be experienced primarily by hospitals. How high up the chart the response moves will be dependent on the level of assistance and resources required to resolve the situation. For example, if multiple hospitals in a district, or hospitals in multiple districts are affected, then a state-wide response will be required. A listing of key organizations' roles and responsibilities during disasters, indicated below, will help to clarify what organizations makes these decisions. at each tier.

KEY ORGANIZATIONS' ROLES AND RESPONSIBILITIES:

Health Care Facilities ***Role: Acute patient care***

- Implement surge plans including crisis care plans
- Implement facility, and participate in, HCC coordination activities, as required
- Coordinate information and resource management with other facilities in the district through the HCC
- Provide situational awareness and essential elements of information to HCCs

Local Public Health *Role: Lead agency for public health emergencies*

- Determine jurisdictional public health activities/interventions (ESF 8) and coordinate efforts through HCC partners – especially hospitals and EMS
- Provide health-related community communications during disasters in coordination with local EMA and HCC utilizing AIMS and other means of redundant communication
- Support alternate care sites as appropriate
- Communicate health alerts and other information to partner agencies
- Provide community-based interventions (e.g., prophylaxis or vaccination) as needed.
- Determine need for social distancing and other community infection control measures
- Other duties as necessary

Medical Response Unit/First Responders Role: *First response*

- First healthcare personnel on scene to assess and report on the situation
- Provide initial triage and care and help determine what additional resources may be needed
- Support and assist arriving ambulance personnel on scene

Local EMS Agency Role: *Emergency response and patient transport*

- Coordinate patient destination hospitals to the degree possible to avoid overloading a single facility
- Develop policies for crisis care situations.
- Interface with local hospitals and HCCs members as necessary to share information/status.
- Adjust response and transport guidelines to reflect the situation at the hospital (e.g., if all hospitals overwhelmed may recommend self-transport to clinic for non-emergent problems)

Local Emergency Management Role: *Local lead for incident support*

- Process local resource requests locally
- Coordinate on ESF 8 related resource requests with local public health, HCCs and collaborate with other ESFs
- Facilitate local declarations of emergency
- Facilitate suspension of ordinances/rules as required to support response
- Provide incident information/common operating picture to local and state agencies

Regional Health Care Coalitions (HCCs) Role: *Regional coordination of health/medical response*

- Information sharing/situational awareness for facilities within the coalition, other coalitions, key organizations, and ADPH
- Serve as a resource for subject matter expertise
- Coordination of activities between public health, hospitals, EMS, emergency management, other HCC members, and other HCCs
- Provide/develop regional policies for disaster response/crisis care
- Assist with the management of resources between hospitals and other healthcare facilities in the HCC
- Assist with the coordination of consistent patient care within the region
- Assist with patient transfer coordination
- Coordinate with ADPH CEP

Regional EMS Programs Role: ***Regional coordination EMS response***

- Participates in information sharing between EMS, HCC, hospital, emergency management and local, regional and state emergency operations centers
- Assist in coordination of EMS resources and emergency management in collaboration with the State, Regional or Local Emergency Operations Centers
- May provide or develop regional procedures for EMS disaster response
- Coordinates with ATCC

Director, Center for Emergency Preparedness (CEP), ADPH Role: ***Guides ADPH emergency preparedness and response efforts***

- Coordinates ADPH response; may be given authority by the Health Officer to activate CSC Framework components
- Key liaison to HCCs in the State
- Key liaison to State Emergency Management Agency.

Alabama Hospital Association (ALAHA) Role: ***Health care facility communication & regulations***

- Assist in communications and information sharing with hospitals and health care facilities across the state
- Communicate suspension of selected regulatory statutes/rules to facilitate crisis care activities during declared disaster
- Facilitate sharing of resources
- Communicate facilities' situational awareness to HCCs/ADPH via AIMS and other appropriate methods

Office of Emergency Medical Services (OEMS) ADPH Role: ***State lead agency for EMS disaster issues***

- Support hospitals by regional and state level coordination of EMS surge capacity implementation
- Coordinate overall activities of local EMS agencies within the state during disasters
- Request inter-state (EMAC) or federal (i.e., Federal Ambulance Contract) resources
- Communicate suspension of selected regulatory statutes/rules to facilitate crisis care activities during declared disaster
- Provide support to HCCs' response through regional EMS system program personnel
- Support local EMS medical directors by providing guidance on patient care guideline development.

Regional Trauma System, Alabama Trauma Communications Center (ATCC) Role: ***Coordinate the distribution of trauma patients thru a two-tiered triage process***

- Determine if patients are entered into the trauma system
- Determine what level of trauma hospital patients should be taken to
- Coordinate with 9-1-1, EMS, ambulances, and other health care resources
- Support HCC information exchange, resource requests, and policy development

Alabama Emergency Management Agency, (AEMA) Role: ***State lead for incident coordination***

- State level coordination of overall disaster response/recovery

- Serve as point of contact for resource requests
- Request State declaration of emergency
- Recommend and request a Federal Disaster Declaration request to governor

Alabama Department of Public Health (ADPH) Role: ***State lead agency for health-related issues***

- Facilitate health care resource requests to state/inter-state/federal partners.
- Request State Disaster or Public Health Emergency Proclamations and governor's emergency orders as required to support a response.
- Request CMS 1135 waivers as required during response to allow patient billing when usual conditions cannot be met.
- Provide, develop and/or modify clinical guidelines or recommendations based on information from the CDC, US Public Health Service, and any other specialty groups as necessary for a specific event.
- Support HCC information exchange, resource requests, and policy development.

Governor, State of Alabama Role: ***Oversee response and ensure coordination among relevant state agencies***

- Approves State disaster proclamation requests
- Issues emergency proclamations and specific emergency orders to address incident specific issues
- Ultimate authority for State response
- Requests Federal Emergency or Disaster Declaration

ALABAMA HEALTH CARE PROVIDER MUTUAL AID COMPACT

The Alabama Health Care Provider Mutual Aid Compact is a non-binding agreement which outlines details for sharing resources, including staff, between healthcare facilities during/after disaster events, or, serving as an indicator for the implementation of Crisis Standards of Care when enacted. The use of this compact will facilitate the sharing of resources in austere situations (See Annex 1).

GUIDING PRINCIPLES AND ETHICAL CONSIDERATIONS

Widespread public health emergencies raise ethical challenges for healthcare professionals and institutions at every level. In these situations, the primary duty is to protect the health and welfare of the community, not that of the individual. During a public health emergency with the threat of high morbidity and mortality, demands exceeding capacity for care may result in a situation where the ultimate clinical goal is to do the greatest good for the greatest number of people. Optimal or normal services may not be available during times of disaster. In a large-scale emergency, healthcare may be compromised in the short term and unable to deliver services consistent with established standards of care. Therefore, it is essential to identify, plan and prepare for making necessary adjustments in medical care standards to ensure that the care provided in response to a mass casualty event results in as many lives saved as possible.

Medical care standards will shift based on the recognition of numerous indicators. These indicators include a large sudden or sustained influx of patients, a shortage of staff, a reduction of supplies, equipment and materials, and a loss of infrastructure to adequately and safely care for patients. In sustained events, a healthcare facility or system's business continuity will become a significant challenge, as well. Healthcare providers must adhere to ethical principles during crisis periods as they do during

ordinary care circumstances. Crisis conditions force uncomfortable choices for practitioners in the allocation and/or use of scarce materials and supplies; however, this should not lead to ignoring ethical practice. Healthcare personnel are always obligated to provide the best care they can under given circumstances, follow sensible triage decisions based on his/her sound clinical judgment and avoid triage decisions based on factors that are not fair and equitable.

The following principles are recommended to guide decision makers through public health emergency planning and response to address triage methods and the allocation of scarce resources:

Protection of the Public from Harm

A foundational principle of public health ethics is the obligation to protect the public from serious harm. This principle requires that citizens comply with imposed restrictions to ensure the public's health and/or safety. To protect the public from harm, hospitals, for example, may be required to restrict public access to service areas, impose infectious control practices such as masks or quarantine, limit visitors, and/or, limit the availability of some services such as elective surgeries to conserve resources or better utilize staff or facilities.

Respect for Human Dignity

The most fundamental of these principles is the obligation to respect human dignity. For this reason, formal state and facility emergency operations plans and triage guidelines must be clear to everyone they affect. Every person has inherent dignity and intrinsic moral worth, regardless of age, race, gender, creed, socio-economic status, functional ability or any other characteristic. All people deserve compassion and equal respect, and with this in mind, the allocation of care cannot discriminate based race, color, national origin, disability, age, sex, exercise of conscience or religion.

Duty to Plan

Healthcare systems have a responsibility to plan for an event that may result in a forced initiation of Crisis Standards of Care. The plan must address the allocation of scarce resources during times of high morbidity and/or mortality. Planning is necessary and vital in preparation and response. Planning, to maximize prudent use of scarce resources, should include preexisting agreements among facilities to share these resources when possible. Adoption of the Alabama Disaster Mutual Aid Compact by health care facilities provides a framework for sharing of resources among these entities.

Duty to Provide Care

Healthcare professionals and organizations have unique responsibilities in providing care during an event with high morbidity and/or mortality. Their primary duty is to give the best care to the most patients. In times of scarce resources, it is understood that all patients may not be cared for equally; however, other treatments should be provided to the best of the professionals' ability, according to prudent usage of resources. At a minimum, all patients will receive palliative care.

Reciprocity

During a Public Health emergency healthcare professional and non-professional staff should have clearly defined duties with established, clear lines of authority, a fair allocation of schedules and all appropriate worker protections available. The implementation of Alabama's plan must be coordinated across entire communities and across the state. Patients deserve equal access to care. Cooperative agreements between providers and communities should be in place to help minimize shortages and minimize any

system-wide inequalities in access to care and resources. Adoption of the Alabama Health Care Provider Mutual Aid Compact by health care facilities provides a framework for as fair and equitable response as possible.

Stewardship of Resources

Due to an unavoidable scarcity of resources that could occur in a Public Health emergency, patients and physicians will not be able to request every possible treatment as they typically would. When resources become scarce, healthcare professionals and facilities must use and manage the remaining limited resources responsibly. Allocation guidelines and triage plans must reflect the goals of preventing the spread of disease and preserving the greatest number of lives possible, while best allocating resources. To maximize effective use of scarce resources there should be obvious clinical evidence showing that using a particular resource could be effective. When an extreme disaster overwhelms healthcare resources, priority should be given to patients whose lives would most likely be saved and patients whose outcomes would most likely improve. Those patients should be given priority over patients who would likely die even with treatment and patients who would likely survive without treatment.

Communication/Education of the Public

Decisions regarding triage and allocation must be participatory, community values-based and transparent to the public. Since these guidelines are an alteration from the normal standard, there is a responsibility to justify and explain these alterations to the public. Moreover, public and professional cooperation are essential to an effective response. Communicating through forums, continuing education and collaborative input in advance of a public health emergency is a prerequisite to implementation.

Trust

Trust is an essential component in the relationships between clinician and patient, staff and, the public and healthcare providers, as well as among organizations within a healthcare system. In a healthcare crisis, citizens may perceive the change in public health measures as a betrayal of trust, or abandonment at a time of greatest need when access to needed care is restricted or denied. Decision-makers will be confronted with the challenge of maintaining the community's trust while at the same time providing care during an event of high morbidity and mortality, patient surges, and scarce resources. Transparency in decision making is essential in building and maintaining trust.

Equity

The principle of equity states that, if all things are equal, all patients have an equal claim to receive needed healthcare. During disaster response, however, difficult decisions will need to be made about which health services to provide and which to restrict due to the extraordinary circumstances caused by disaster.

Solidarity

This principle suggests that disaster response is distributed equally across the HCC and perhaps the entire healthcare system of Alabama so that triage and care processes are as comparable and fair as possible.

Individual Liberties

Individual liberty is an essential value in healthcare practice under the principle of respect for a citizen's freedoms and rights. Under usual circumstances, healthcare providers balance a respect for individual freedoms and rights with a duty to protect patients from harm. In a Public Health emergency, however, restrictions to individual freedoms and rights may be necessary to protect the public from serious harm. Patients, staff, and members of the public may be affected by such restrictions.

Privacy

Individuals have a right to privacy in healthcare; however, in a Public Healthcare disaster, it may be necessary to override this right to protect the public from serious harm. A proportionate response to the need for private information requires that it be released only if there are no less intrusive means to protect public health.

Decision-Making Process for the Ethical Allocation of Scarce Resources

The implementation of resource rationing, including rationing of equipment, may take place when a healthcare emergency forces a healthcare system to focus its response on the benefit to the overall population, with the goal of saving the most lives possible while respecting the ethical considerations for individuals. Rationing of resources is a measure of last resort, only occurring when all other efforts to procure, extend or substitute limited resources have been exhausted. In this situation, a patient's access to critically short resources will be determined by individualized and comparative assessments of patients who need the same resource, at the same time. A clinical assessment and prognosis initiate this rationing decision-making process based on the best available objective medical evidence or on pure clinical data.

This clinical assessment process includes both the need for the resource and the likelihood that the patient(s) will benefit from access to the resource, up to the point of recovery and discharge. Periodically, individualized reassessments of the patient(s) must occur and any significant change in prognosis may result in a redistribution of resources. The consistent ultimate standard is the likelihood of recovery and discharge from the hospital, or healthcare facility.

Significant differences in prognosis are what is ethically important in comparing patients in need of the same resources. By using this process of comparative, recurring individualized assessments all potential biases should be eliminated from consideration in the allocation of scarce resources, while remaining true to the goal of maximizing lives saved, and, using limited resources in the most equitable way.

Resource allocation decisions **should not** be based on the following:

- Race, sex, color, national origin, disability, age, socio-economic status, perceived quality of life, perceived social worth, or past or future use of medical resources;
- Ability to pay;
- Age, on its own. This **does not** limit consideration of the patient's age in a clinical prognosis as one of the factors in assessing a patient's likelihood to survive to discharge;
- Predictions about baseline life expectancy beyond the current episode of care **unless** the patient is terminally ill (life expectancy of less than six (6) months), or is a hospice patient;
- Order of presentation for care and/or treatment;

- Perceptions of a patient's "Quality of Life", as referenced in the first bullet point above.

Patients who are chronically dependent on medical equipment (including a ventilator) prior to the event creating a shortage of resources will not have their equipment withdrawn or redistributed in order to expand or provide resources to another patient.

Statement on Application of Civil Rights Laws During an Emergency

The Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act prohibit discrimination in HHS funded health programs or activities. These laws, like other civil rights statutes, remain in effect during an emergency. As such, persons with disabilities should not be denied medical care on the basis of stereotypes, assessments of quality of life, or judgments about a person's relative "worth" based on the presence or absence of disabilities or age. Decisions by covered entities concerning whether an individual is a candidate for treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence.

As resources allow, government officials, health care providers, and covered entities should not overlook their obligations under federal civil rights laws to help ensure all segments of the community are served by:

- Providing effective communication with individuals who are deaf, hard of hearing, blind, have low vision, or have speech disabilities through the use of qualified interpreters, picture boards, and other means;
- Providing meaningful access to programs and information to individuals with limited English proficiency through the use of qualified interpreters and through other means;
- Making emergency messaging available in plain language and in languages prevalent in the affected area(s) and in multiple formats, such as audio, large print, and captioning, and ensuring that websites providing emergency-related information are accessible;
- Addressing the needs of individuals with disabilities, including individuals with mobility impairments, individuals who use assistive devices, auxiliary aids, or durable medical equipment, individuals with impaired sensory, manual, and speaking skills, and individuals with immunosuppressed conditions including HIV/AIDS in emergency planning;
- Respecting requests for religious accommodations in treatment and access to clergy or faith practices as practicable.

BULLETIN: Civil Rights, HIPAA, and the Coronavirus Disease 2019 - https://www.hhs.gov/sites/default/files/ocr-bulletin-3-28-20.pdf .

LEGAL PRINCIPLES

Emergency Proclamations and Liability Protection

Health care professionals and institutions should consult with their respective legal counsel on specific questions, situations, and concerns they may encounter during a public health emergency.

Legal standards of care are defined by this document as the care and skill that a healthcare practitioner or facility must exercise in particular circumstances based on what a reasonable and prudent practitioner or facility, in the same general neighborhood and in the same general line of practice, would do in similar circumstances. During proclaimed states of emergency, however, the legal environment changes.

Emergency proclamations activate an array of non-traditional powers designed to facilitate response efforts through both public and private sectors. Pursuant to the Alabama Emergency Management Act,[1] Code of Alabama, Title 31, Chapter 9, Section 31-9-8 Emergency powers of the Governor, the Governor may: (1) mobilize central commands and infrastructures; (2) encourage response efforts by limiting liability; (3) authorize interstate recognition of healthcare licenses and certifications; (4) allocate healthcare personnel and resources; and (5) alter medical standards of care and scope of practice. The extent of legal powers used by the Governor during emergencies, however, depends on the type of emergency declared.

1. Proclamations of Emergency

Pursuant to the Alabama Emergency Management Act (the Act),[2] the Governor may declare a state of emergency or a public health emergency under certain circumstances. A "State of Emergency" is defined as: When the Governor duly proclaims the existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by fire, flood, storm, epidemic, technological failure or accident, riot, drought, sudden and severe energy shortage, plant or animal infestation or disease, earthquake, explosion, terrorism, or man-made disaster, or other conditions, other than conditions resulting from a labor controversy or conditions causing a state of war emergency, which, by reason of their magnitude, are or are likely to be beyond the control of the services, personnel, equipment, and facilities of any single county, city and county, or city and require the combined forces of a mutual aid region or regions to combat, or energy shortage requires extraordinary measures beyond the authority vested in the Alabama Public Service Commission.[3]

"**State Public Health Emergency**" is defined as an occurrence or imminent threat of an illness or health condition that does all of the following:

A. Is believed to be caused by any of the following:

1. Bioterrorism
2. The appearance of a novel or previously controlled or eradicated infectious agent or biological toxin
3. A natural disaster
4. A chemical attack or accidental release
5. A nuclear or radiological attack or accident

[1] ALA. CODE § 31-9-1 (1975).
[2] ALA. CODE § 31-9-1 (1975).
[3] ALA. CODE § 31-9-3(5) (1975).

B. Poses a high probability of any of the following harms:

1. A large number of deaths in the affected population
2. A large number of serious or long-term disabilities in the affected population
3. Widespread exposure to an infectious or toxic agent that poses a significant risk of substantial future harm to a large number of people in the affected population [4]

Emergency declarations trigger an array of non-traditional powers designed to facilitate response efforts through both public and private sectors. Such powers may include altering standards of care or suspending licensure requirements for healthcare professionals.[5]

2. Immunity and Other Protections

a. State Liability Protection

(1). The Alabama Emergency Management Act

The Emergency Management Act also provides immunity from civil liability for individuals and organizations carrying out emergency management activities or activities relating to emergency management under the Act, except for cases of willful misconduct, gross negligence, or bad faith.[6] Although this provision has not been interpreted by the Alabama courts, a plain reading of the provision shows the "above-described grant of immunity . . . is not limited to declared emergencies, but extends to all emergency management activities, except cases of willful misconduct, gross negligence, or bad faith."[7]

(2). The Alabama Volunteer Service Act[8]

Additionally, the Alabama Volunteer Service Act provides immunity from civil liability to any volunteer acting in good faith and within the scope of such volunteer's official duties for a nonprofit organization, nonprofit corporation, hospital, or a governmental entity.[9] For purposes of the Volunteer Service Act, "volunteer" is defined as "a person performing services for a nonprofit organization, a nonprofit corporation, a hospital, or a governmental entity without compensation, other than reimbursement for actual expenses incurred. The term includes a volunteer serving as a director, officer, trustee, or direct services volunteer."[10]

b. Federal Liability Protection

(1). Federal Volunteer Protection Act[11]

The federal Volunteer Protection Act protects volunteers working for a nonprofit organization or governmental entity from liability, so long as the volunteer does not receive compensation other than the reimbursement of actual expenses and is acting within the course and scope of his or her responsibility in compliance with state laws. The protection provided under this Act does not apply to harm caused by willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights and safety of the individual harmed by the volunteer.

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[4] ALA. CODE § 31-9-3(4) (1975).
[5] ALA. CODE §§ 31-9-6(1), 31-9-8(a)(5) (1975).
[6] ALA. CODE § 31-9-16(b) (1975).
[7] Ala. Att'y Gen. Op. No. 2006-010 (Oct. 25, 2005).
[8] ALA. CODE § 6-5-336 (1975).
[9] ALA. CODE § 6-5-336(d) (1975).
[10] ALA. CODE § 6-5-336(c) (1975).
[11] 42 U.S.C. §§ 14501 – 145105.

(2). Public Readiness and Emergency Preparedness (PREP) Act[12]

The PREP Act authorizes the Secretary of the Department of Health and Human Services (HHS) to issue a declaration that provides immunity from tort liability for claims of loss caused by countermeasures[13] against diseases or other threats of public health emergencies. The immunity provided by a PREP Act declaration applies to the development, manufacture, testing, distribution, administration, and use of countermeasures and only applies to those covered entities specified in the declaration. Covered entities may, at the Secretary's discretion, include manufacturers, distributers, and qualified persons who prescribe, administer, or dispense countermeasures.[14]

(3). 1135 Waivers

When the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act and the HHS Secretary declares a public health emergency, the HHS Secretary may waive or modify certain requirements under section 1135 of the Social Security Act.[15] At the discretion of the HHS Secretary, a waiver or modification of requirements may be made retroactive to the beginning of the emergency or any subsequent date within the emergency period as specified by the Secretary.[16]

For purposes of Medicaid, Medicare, and CHIP reimbursement only, the Secretary is authorized to waive or modify the requirement that physicians and other health care professionals hold licenses in the State in which they provide services, if they have a license from another State and are not affirmatively barred from practice in that State or any State in the emergency area.[14]

(3a). Health Insurance Portability and Accountability Act (HIPAA)[15]

Under the Privacy Rule, covered entities may disclose, without a patient's authorization, protected health information about a patient as necessary to treat[16] the patient or to treat a different patient.[17] The Privacy Rule also permits health care providers to share patient information with anyone as necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public consistent with applicable law and the provider's standards of ethical conduct.[18]

Although the HIPAA Privacy Rule is not suspended during a state of emergency or a public health emergency, the Secretary of HHS may waive certain provisions of the Privacy Rule, if the President declares an emergency or disaster and the Secretary declares a public health emergency.[22] Those provisions include: (1) the requirements to obtain a patient's consent before speaking with family

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[12]Pub. L. No. 109-148. Codified in the Public Health Service Act at 42 U.S.C. §§ 247d-6d, 247d-6e.
[13]Countermeasures can include vaccines, drugs, or medical devices to be used against chemical, biological, radiological, and nuclear (CBRN) agents of terrorism, epidemics, and pandemics. 42 U.S.C. § 247d-6d(i)(1).
[14]42 U.S.C. § 247d-6d(i)(2).
[14]Ala. Code § 31-9-1 (1975).
[15]Pub. L. No. 104-191. 110 Stat. 56 (1996)
[16]Treatment includes the coordination and management of health care and related services by one or more health care providers, consultation between providers, and the referral of patients for treatment. 45 C.F.R. § 164.501.
[17]45 C.F.R. §§ 164.502(a)(1)(ii), 164.506(c).
[18]45 C.F.R. § 164.512(j).
[19]45 C.F.R. § 164.510(b).
[20]45 C.F.R. § 164.520.
[21]45 C.F.R. § 164.522(a).
[22]45 C.F.R. §164.522(b).

members or friends involved in the patient's care[19]; (2) the requirement to distribute a notice of privacy practices[20]; (3) the patient's right to request privacy restrictions[21]; and (4) the patient's right to request confidential communications.[22]

(3b). Emergency Medical Treatment and Active Labor Act (EMTALA)

In a declared emergency, the HHS Secretary may waive sanctions under EMTALA for (1) a transfer of an individual, who has not been stabilized, if the transfer is necessitated by the circumstances of the declared emergency or (2) for the redirection or relocation of an individual to receive a medical screening pursuant to an appropriate State emergency preparedness plan.

A waiver of EMTALA sanctions is effective only if actions under the waiver do not discriminate on the basis of a patient's source of payment or ability to pay. EMTALA waivers are also subject to special time limits. Waivers of EMTALA that do not involve a pandemic disease are effective for 72 hours, which begins at the implementation of a hospital disaster protocol. A waiver of EMTALA in connection with an emergency involving a pandemic disease is effective until the termination of the pandemic related public health emergency.

LICENSURE, CREDENTIALING AND STAFFING CONSIDERATIONS

Two state documents outline the requirements and process for hospital medical staff to work in Alabama hospitals during normal and emergency conditions. Alabama Administrative Code Chapter 420-5-7 on Licensure and Certification of Hospitals and the Alabama Health Care Provider Mutual Aid Compact cover licensing and credentialing of staff for normal and emergency situations when crisis standards of care apply.

The Alabama State Board of Health, Division of Licensure and Certification Administrative Code, Chapter 420-5-7 on Hospitals specifies the requirements for physician and nursing staff working in Alabama hospitals. Section 420-5-7-.06 Personnel (1) indicates that personnel records shall include information on registration or licensure if applicable. Section 420-5-7-.09 Medical Staff (1) requires that the hospital have an organized medical staff operating under bylaws approved by the governing authority. Section (2)(b) specifies that the medical staff shall examine the credentials of candidates for medical staff membership and make recommendations to the governing authority on the appointment of candidates. Similarly, Section 420-5-7-.11 Nursing Services (3)(b) states that "The nursing service shall have a procedure to ensure that hospital nursing personnel for whom licensure is required have valid and current licensure". Section 420-5-7-.27 Emergency Preparedness requires hospitals to develop and implement a comprehensive plan including (1) (i) Identification, availability and notification of personnel that are needed to implement and carry out the hospital's emergency plans. These requirements would also apply in situations where facilities are sharing staff and as such the facility receiving staff would need to follow its internal policies already in place.

This process is also specified in the Alabama Health Care Provider Mutual Aid Compact language related to the temporary credentialing of medical personnel in Section 3.00 Personnel, 3.2 Credentialing of Practitioners and Licensed Independent Practitioners, 3.4 Receiving of Assisting Personnel, and 3.8 Non-Employed Medical Staff. In emergency situations where staff shortages become a critical factor, facilities should adhere to existing credentialing protocol if possible. When circumstances prohibit this, facilities should have an emergency credentialing policy in place. Facilities accredited through the Joint Commission are referred to the "Utilization of Volunteers in Disasters "Standards. EM.02.02.13 titled

"Volunteer Licensed Independent Practitioner" and EM.02.02.15, titled "Volunteer Practitioner" which outline what is required for compliance.

In addition, several Federal programs could become relevant during situations of staff shortages. The Emergency System for Advance Registration of Volunteer Health Professional (ESAR-VHP) is administered by the DHHS through ASPR to support states in establishing standardized volunteer registration programs for disasters and public health and medical emergencies. This program is administered at the state level through Alabama Responds which verifies health professionals' identification and credentials so they can respond more quickly. These volunteers' identities, licenses, credentials, accreditations and hospital privileges are all verified in advance. Disaster Medical Assistance Teams (DMAT) could also be called upon in the event of a crucial need for medical staff. These teams are a component of the National Disaster Medical System (NDMS). The Medical Reserve Corps (MRC) is a nationwide network of community-based groups of medical and non-medical volunteers. In Alabama, ADPH-CEP also administers MRC units which identify, credential, train, and prepare volunteers at the local level in advance of emergencies.

Finally in the event of an emergency resulting in a presidential disaster declaration pursuant to the National Emergencies Act or the Stafford Act and a Public Health Emergency declared by the Secretary of DHHS, state and local officials and individual facilities may request a section 1135 waiver of the CMS requirement that physicians and other health care professionals hold licenses in the State if they have a license from another State and are not affirmatively barred from practicing in that State or any other State in the emergency area. The waiver is for purposes of Medicare, Medicaid and CHIP reimbursement only.

DESCRIPTION OF SURGE/CRISIS SITUATIONS

Conventional capacity is defined as the use of space, staff, and supplies that is consistent with daily practices within the healthcare facility. These space, staff, supplies and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.

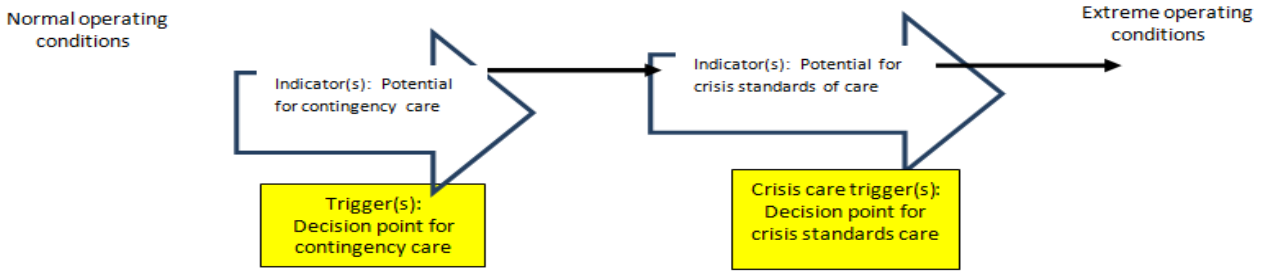
Contingency capacity is defined as the use of space, staff and supplies that is *not* consistent with daily practices, but provides care that is functionally equivalent to usual patient care practices. These spaces, staff, supplies or practices may be used temporarily during a major casualty incident or during a disaster when the demands of the incident exceeds or nearly exceeds facility and/or community resources.

Crisis capacity is defined as adaptive space, staff, and supplies that are not consistent with usual standards of care, but provide sufficient care during a catastrophic disaster to provide the best possible care to patients given the circumstances and resources that are available. Crisis capacity activation constitutes a significant adjustment to standards of care and are forced changes.

CRISIS STANDARDS OF CARE INDICATORS AND TRIGGERS

Incident demand/resource imbalance increases →
Risk of morbidity/mortality to patient increases →
← Recovery

	Conventional	Contingency	Crisis
Space	Usual space fully utilized	Pre-designated internal alternate care locations repurposed to serve to care for patients whose care is not normally utilized for elective surgeries, procedures, cancelled/rescheduled	Partial loss or full loss of facility due to damages or long term utility loss - utilization of spaces that ordinarily does not provide patient care, such as classrooms, physician practices, clinics, etc.
Staff	Usual staff called in and utilized	Staff extension - Staff to patient ratio reconsidered, utilization of non-bedside care nurses from departments who employ nurses, but not as bedside nurses. Utilization of non-patient care personnel to serve in patient support roles	Trained staff unavailable or unable to adequately care for volumes of patients, even with extension techniques
Supplies	Cached and usual supplies	Conservation, adaption, and substitution of supplies with occasional reuse of supplies	Critical supplies lacking, supplies not available - possible re-allocation of life sustaining resources
Standard of Care	Usual care	Functionally equivalent care	Crisis standards of care



It is recognized that facilities within an affected region would not all reach the point of implementation of Crisis Standards of Care at the same time. The common indicators below are predictive of approaching circumstances which may force the implementation of Crisis Standards of Care. This decision is made by each institution once the following indicators are observed and triggers are met, or, facility management determines that conditions justify implementation.

Common Indicators for Crisis Standards of Care – Examples:

- Situation is causing individual healthcare organizations to consider initiation of surge protocols
- Healthcare facilities are maximizing surge capacity at their facility and throughout the HCC
- HCC members are working together to utilize/maximize available resources including the use of the Alabama Healthcare Provider Mutual Aid Compact and other sharing arrangements
- HCC members are working together to avoid the non-critical use of scarce resources
- Healthcare facilities are considering/initiating postponing elective medical and surgical procedures
- Healthcare facilities are using appropriate resources to facilitate the discharge of inpatients
- HCC members are making every effort to secure additional resources to limit impact of the situation
- Healthcare facilities have placed additional staff on stand-by

- HCC members are using AIMS to monitor facilities' and HCC status related to resource availability
- HCC members are collecting and responding to the Essential Elements of Information

Healthcare Facility Triggers for Crisis Standards – Examples:

- Surge capacity is fully employed within the facility and HCC
- Resources and/or infrastructure needs cannot be met locally or by HCC
- Facility is unsafe or closed
- Critical infrastructure lacking (power, water, etc.)
- Unavailability of PPE, if required
- Non-patient care areas used for patient care
- Trained staff unavailable or unable to care for the volume of patients
- Critical supplies lacking (e.g. ventilator, oxygen, IV fluids or blood products)
- Attempts at conservation, reutilization, adaptation, and substitution have been maximized
- Patient transfer not possible or sufficient
- Lack of security to maintain safety of healthcare providers and patients
- Inadequate staff support
- Mutual Aid Compacts unable to provide resources needed
- District HCC unable to provide resources needed
- An institutional committee reviewed the situation and recommends implementation of Crisis Standards

Statewide Triggers of Crisis Standards of Care – Examples

The decision to implement the Crisis Standards of Care guidelines should be based upon an assessment of the degree of the disaster and the healthcare system's capacity and capability, in conjunction with a Governor ordered State of Emergency. Specifically, Crisis Standards of Care may be initiated only after some or all of the following conditions have been met:

- Initiation of NDMS and National Mutual Aid/Resource Management
- Statewide, healthcare facilities' and/or healthcare system surge capacity has been fully maximized and every available effort to secure additional resources has been made
- ADPH CEP EOC has been activated and is receiving numerous calls to assist with patient transfers beyond the capability of Healthcare Coalitions
- Facilities have requested resources and infrastructure assistance; Alabama Health Care Provider Mutual Aid Compacts have been activated
- Facilities are practicing resource conservation, reutilization, adaption, and substitution to the greatest extent possible
- Facilities have identified critically limited resources
- Facilities have identified critical infrastructure limitations
- Healthcare Coalitions have exhausted their resources and ability to respond
- A designated committee of medical leaders has requested the implementation of Crisis Standards of Care
- A Proclamation of Emergency is issued by the Governor
- A State of Emergency is declared by the President of the United States

COMMUNICATIONS AND SITUATIONAL AWARENESS

Open communication between healthcare facilities is crucial for an effective response during public health emergencies. Situational awareness and effective communication will be crucial in determining when circumstances meet the threshold justifying the implementation of emergency proclamations and crisis standards. Ongoing communication among hospitals and the District Healthcare Coalitions will be important for a prompt and efficient response to disaster situations. Hospitals, and other HCC members as appropriate, will provide ongoing status reports on bed availability, staffing, systems and other key factors thru the Alabama Incident Management System (AIMS), the state's Public Health and Healthcare Coalitions' emergency response situational awareness tool. AIMS will allow coalitions, their members, and ADPH-CEP staff to monitor facility status and help coordinate sharing of resources. Additionally, AIMS reporting forms can be customized for HCCs and/or the State to monitor indicators at healthcare facilities. This list will be routinely completed indicating which triggers have been met and which not, providing an overview at local, district (HCC) and state levels. The use of AIMS will also provide a method to document information related to the event and serve as an indicator that implementation of crisis standards may be needed.

PRE-HOSPITAL PROTOCOLS AND PROCEDURES

The EMS system will have a crucial response role during a public health disaster. Protocols and standards may need to be adapted to deal with the most extreme situations. Pursuant to the Alabama EMS Patient Care Protocol, when the Governor proclaims a state of emergency, the ADPH Office of Emergency Medical Services (OEMS) will activate a protocol to provide authorization for the adjustment in prehospital standards of care. Depending upon the Governor's proclamation or the State Health Officer's declaration, ADPH OEMS may activate a protocol statewide or at a regional or local level.

During an emergency, Alabama EMS providers are the critical link between the incident scene and medical care at healthcare facilities. EMS provides crucial continuity of care from initial patient contact, assessment and primary triage through transport to the receiving facility for definitive medical care. EMS providers also provide a valuable resource of knowledge and expertise during medical surge and a Crisis Standard of Care plan implementation. This section will discuss the Emergency Medical Services (EMS) during a catastrophic event.

The Alabama Office of EMS, under the Alabama Department of Public Health, will maintain authority over the EMS Providers and Emergency Medical Provider Services (EMPS) during a disaster. In Alabama, EMPS is made up of a system of public, private, and volunteer EMS providers. They are all regulated and licensed by the State with Regional EMS oversight. Emergency Medical Dispatchers (EMDs) can collect and assess caller information to determine response priorities, dispatch appropriate EMS units, and provide pre-arrival instructions to callers.

Disaster planning and preparation is a critical part of EMS for many years. Mass Casualty training, mass gathering event planning, natural disasters, terrorist events, etc. have all combined to influence the EMS community to prepare for the worst. During these events, EMPS will be the primary providers of pre-hospital and out-of-hospital patient care and transport. EMS will also be critical during medical surge events.

EMPS are frequently the initial medical care providers for patients, assessing the need for emergency care, evaluating injury and/or illness status, providing the first medically supervised care for victims of natural or human-caused emergency incidents, and transporting patients to the appropriate medical care facilities. EMPS may also provide transport to alternative locations such as mental health facilities, medical specialty centers or alcohol and drug treatment facilities.

EMS response involves the staff and resources available on the responding unit. A responding unit with a Paramedic and a compliment of advanced life support supplies and equipment would be considered an ALS response vehicle. An A-EMT or EMT with basic life support supplies and equipment would be considered a BLS response vehicle. Staff and resources should match the response. Patient assessment and treatment involves the initial on-scene assessment and triage of patients per established rules and protocols. (see Triage section of this plan). During a Crisis Standard of Care plan implementation, and upon approval of their medical directors, EMS personnel may need to change their usual triage procedures to a mass casualty incident (MCI) plan that is focused on saving the greatest number of individuals. EMS providers in urban areas are more likely to have access to greater numbers of qualified staff and resources. Rural EMS providers may only have access to staff in limited classification categories. Thus, EMS providers in the rural areas may be the primary source of healthcare services during both emergency and non-emergency situations. Rural areas face additional challenges, including fewer mutual aid resources, coverage of large geographical areas, unpredictable communications coverage, medical facility availability, extreme weather conditions, and long response and transport times. During emergencies, some rural EMPS may be supported by private EMS resources, including corporate EMS staff, as well as Fire, Rescue and Hazardous Materials teams.

During normal operations with conventional levels of care, transportation involves the movement of patients using ground or air ambulances. Patients are typically transported to hospitals or between hospitals. During a Crisis Standard of Care event, transportation operations may require changes to normal procedures, such as mass transports, private operated vehicles (POV) by families of non-critical patients, and/or transports to non-hospital facilities or alternate care sites. When necessary, the Alabama Trauma Communications Center (ATCC) will be utilized to get the patient to the most appropriate facility. This will also assist with documentation of where patients are transported.

The three key areas for EMS activities during a Crisis Standards of Care situation are:

A) Triage:

As the first assessment prior to medical intervention, triage is a critical function during mass casualty public health disaster events. OEMS uses the START Adult Triage and JumpSTART pediatric protocols during mass casualty incidents where the number of patients exceeds the capabilities of the EMS providers on the scene. As situations change and resources vary, periodic re-triage may be appropriate. These protocols are meant to serve as guidelines. Different triage algorithms may be used if approved by individual EMS agencies in the state.

B) Modification to Scope of Practice:

EMS providers are licensed by ADPH. Scope of practice for EMS personnel is governed by state law, Chapter 18, Section 22-18-41 of the Alabama Code 1975. A proclamation of public health disaster by the Governor's office and implementation of Crisis Standards of Care could modify this scope.

C) Resource Utilization:

During public health disasters, OEMS would maximize personnel and other resources. Strategies to maximize resources would include:

- Extended shifts
- Non-medical drivers
- One-person response vehicles for patient evaluation
- Use of non-traditional transport vehicles to maximize transport capability

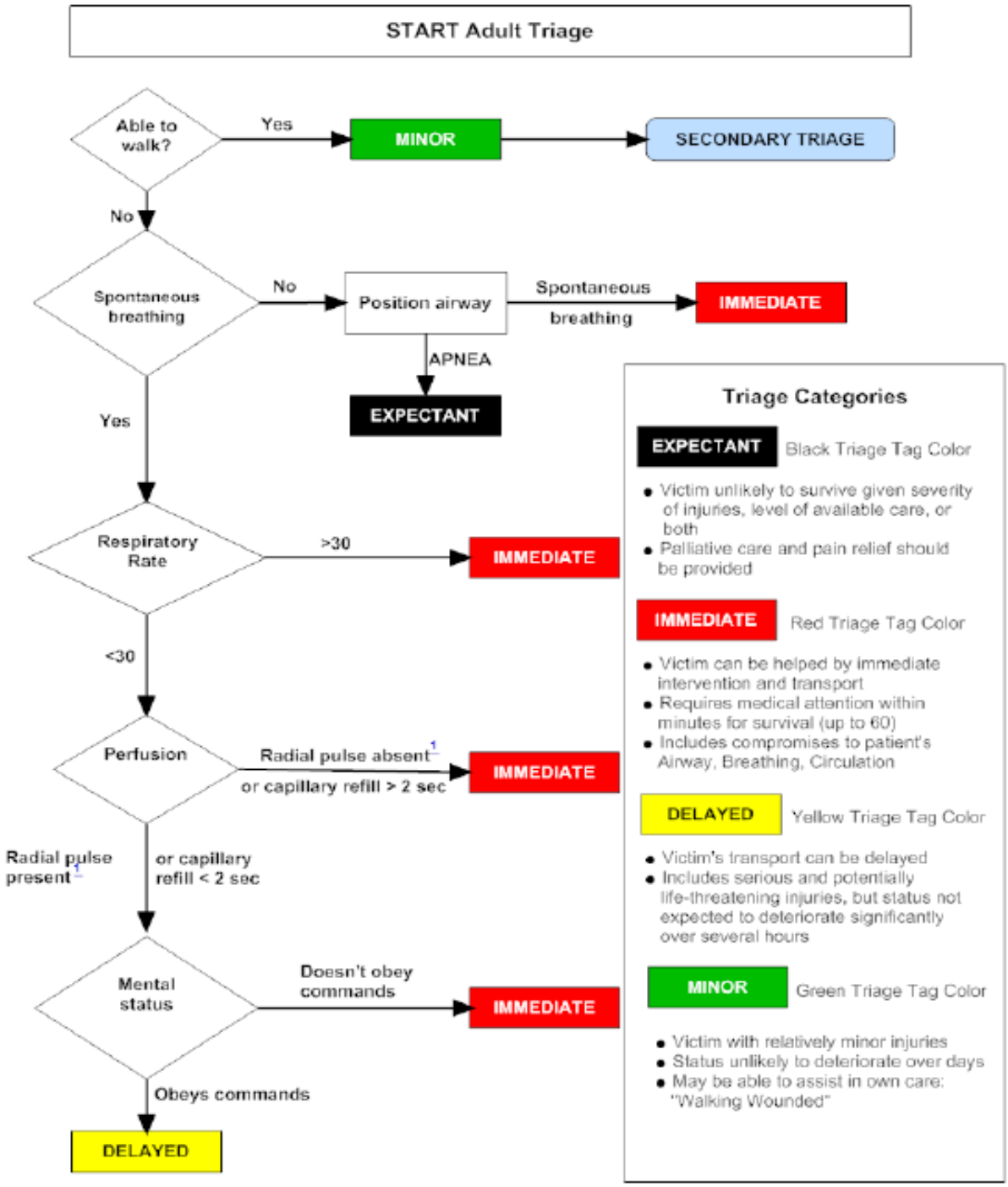
CLINICAL PROTOCOLS AND PROCEDURES:

When it is obvious that an emergency situation resulting in high morbidity and/or mortality is occurring, a Governor Proclamation or Presidential Declaration has been issued, or, when there is an immediate need to provide for patients under Crisis Standards of Care, a system-wide implementation of common protocols and procedures developed at the HCC should occur. HCCs should be confident that the event is fairly and equally supported by all facilities.

Triage for EMS

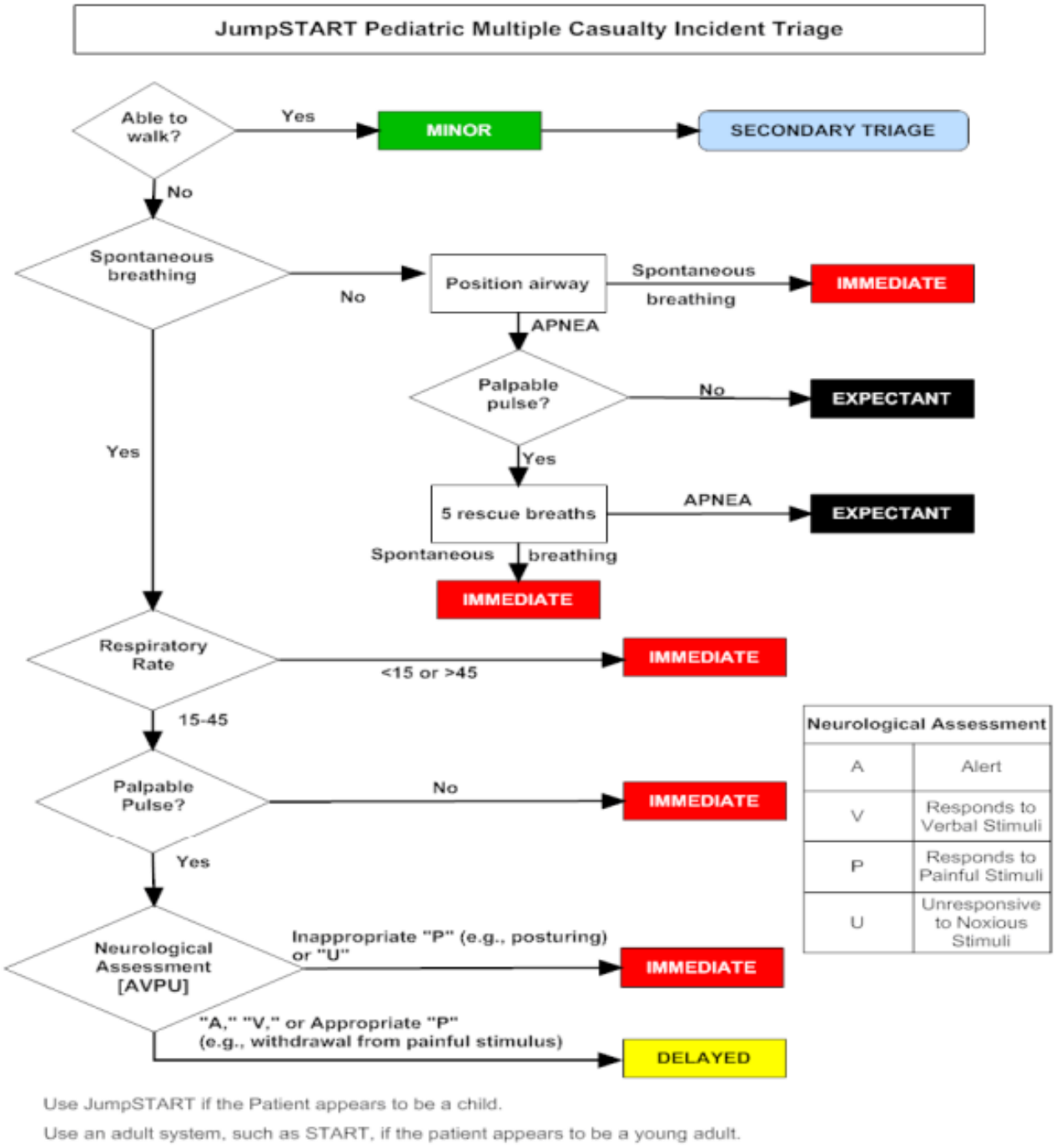
Triage is the ability to systemically sort patients based on the severity of illness or injury and the probability of survival and should not be based on race, sex, color, national origin, disability, age, socio-economic status, perceived quality of life, perceived social worth, or past or future use of medical resources. The preferred method of pre-hospital triage as outlined in Alabama Department of Public Health Office of EMS (ADPH/ EMS) protocol 7.03 titled Triage of Mass Casualties is the Simple Triage and Rapid Treatment (S.T.A.R.T) method. This process insures a consistent method to evaluate patients during a mass causality event. Education and familiarization with this type of triage method is recommended before the event occurs.

ADULT Simple EMS Triage and Rapid Treatment Triage Algorithm



Adopted from http://www.start-triage.com

PEDIATRIC Simple EMS Triage and Rapid Treatment Triage Algorithm



Adopted from http://www.jumpstarttriage.com

Patient Transfer

Patients may need to be evacuated from a facility, or transferred to other facilities. A uniform and common All-Hazards approach to planning improves the chances of a successful move of patients in a safe manner. For seriously injured trauma patients the State of Alabama uses the Alabama Trauma Communication Center (ATCC) to track the movement of patients and the availability of trauma hospital readiness to accept those patients. The use of ATCC by EMS and hospitals will help ensure the correct placement of these patients, reduce the possibility of system overload, and allow for ease of transfer of the patient.

ATCC phone Number: 1-800-359-0123. A call to ATCC will:

- Place the patient in the trauma system
- Allow for ease of transfer if necessary
- Contact the closest appropriate hospital for the patient needs
- Help arrange transport if needed

All transfers must include:

- Accepting physician
- Copy of medical record

During a crisis it is understood that a detailed medical record may not be available; however, as much information as possible should be sent with the patient.

For non-trauma patients, individual healthcare facilities will directly coordinate with another healthcare facility, or, work through the HCC to arrange patient transfers or evacuations. Patient transfer situations beyond the capability of HCCs to coordinate will be managed by ADPH CEP EOC which will coordinate between HCCs (intra-state) and cross (inter-state) State transfers.

AIMS is available to every healthcare facility, can be used to track available unit beds and other resources, and share notifications, messages and information.

Implementation of the Alabama Health Care Provider Mutual Aid Compact will facilitate the transfer of patients between hospitals (See Annex 1)

Patient Evacuation

The evacuating facility should implement their Evacuation Plan and notify HCC members in accordance with the HCC Communication Plan, of the need for support. The affected facility should follow their internal evacuation protocols. Common Evacuation or Shelter-in-Place decisions algorithms:

Hospital Evacuation and Shelter in Place Decisions

Event

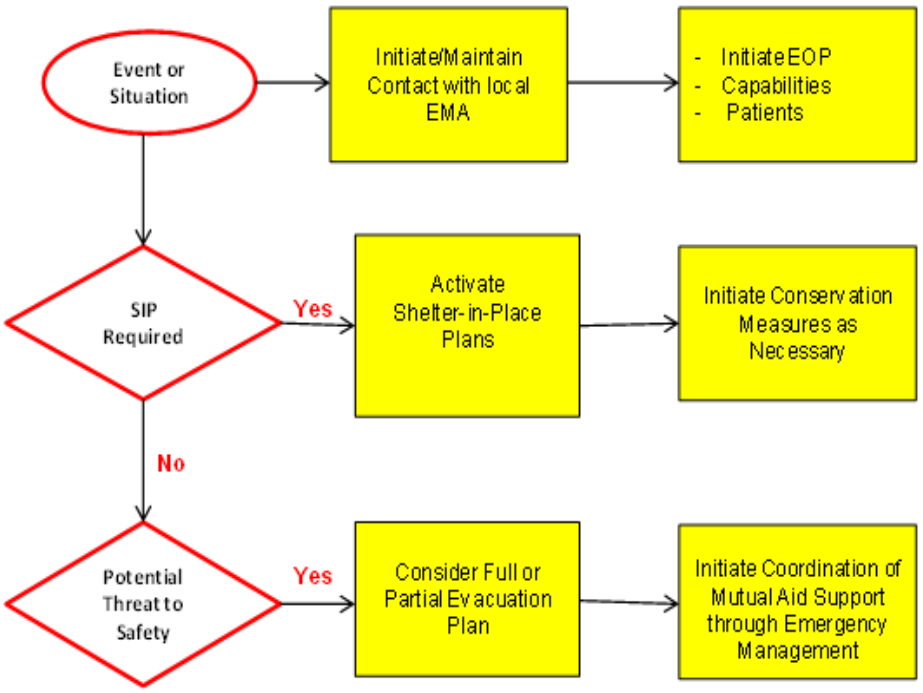
- Event Requiring facility to consider whether evacuation or shelter in Place Plans should be activated
- External and Internal information regarding event

Must Shelter-in-Place

- The external environment would pose a greater danger to patients, staff and visitors than evacuation (e.ge. Chemical/biological agent release, nuclear incident plume)
- Adequate and timely facility and/or mutual aid resources are not available or accessible (e.g., earthquake)

Must Evacuate

- The proximity, scope and/or expected duration of event poses an immediate threat to patient and staff safety
- Adequate and timely facility and/or mutual aid resources are available and accessible to support Full or Partial Evacuation



Patient Evacuation

Triage Level	Priority for Evacuation of Patient Care Units Reversed START Priority	Priority for Transfer to Another Healthcare Facility Traditional START Priority
Green- Go	These patients require minimal assistance and can be moved FIRST from the unit. Patients are ambulatory and 1 staff member can safely lead several patients who fall into this category to the staging area.	These patients will be moved LAST as transfers from your facility to another healthcare facility.
Yellow- Caution	These patients require some assistance and should be moved SECOND in priority from the inpatient unit. Patients may require wheelchairs or stretchers and 1-2 staff members to transport.	These patients will be moved SECOND in priority as transfers from your facility to another healthcare facility.
RED- Stop	These patients require maximum assistance to move. In an evacuation, these patients move LAST from the inpatient unit. These patients may require 2-3 staff members to transport.	These patients require maximum support to sustain life In an evacuation. These patients move FIRST as transfers from your facility to another healthcare facility.

Patient Management

The need of each facility's patients and the required resources will be a part of the overall resource allocation.

When an emergency situation occurs involving a surge and crisis standards of care, all healthcare facilities and Healthcare Coalition members should implement the following general activities, as appropriate:

The usual practice may not apply.

1. Equipment and supplies will be used in ways consistent with achieving the ultimate goal of saving the most lives.
2. Current documentation standards may be reduced or impossible to maintain.
    a. EMRs
    b. Patient Tracking/Transfers
    c. HIPAA
3. Providers may need to make treatment decisions based solely on clinical judgment when utilities are compromised preventing the use of sophisticated diagnostic equipment.
4. Increase space capacity.
    a. Implement rapid discharge of Emergency Department (ED) and other patients who can safely continue their care at home.
    b. Cancel elective surgeries and procedures with reassignment of surgical staff members and space.
    c. Monitor staffed bed and resource capacities using AIMS.
    d. Expand critical care capacity by placing select critical patients on monitored beds in non-critical care areas.
    e. Convert single rooms to double rooms or double rooms to triple rooms, if possible.
    f. Use beds and cots in non-patient care areas for non-critical patient care.
5. All available means of "surge capacity" must be created.
    a. Expand staffing:
        - Implement calls systems for additional staff members.
        - Provide daycare and pet care services, if possible.
        - Adjust staff scheduling as necessary (e.g., duration of shifts, staffing ratios, changes in staff assignments).
        - Reassignment of qualified administrative staff members to clinical roles.
        - Use family members or friends for non-medical, basic patient care.

Enable Hospital Decompression:

1. Establish alternate care sites in conjunction with other HCC members and ADPH-CEP EOC
2. Request resources from the HCC, private transport companies, Emergency Medical Services, and ADPH-CEP EOC to decompress the hospital, as needed.
3. Transfer patients to and from facilities as needed based on hospital resources. (See Annex 1)
4. Utilize AIMS, as indicated.

Emergency Department:

1. Triage/Re-assessment (at hand-off from Pre-Hospital Disaster Triage – SMART) efforts must focus on maximizing the number of lives saved, and implement emergency triage protocols, if

necessary.

2. Continuously assess the availability of facility resources that may have an impact on Triage/Re-assessment.
3. Utilize alternative triage sites for minor symptoms, potentially infectious patients, non-disaster patients, etc.
4. Use simpler documentation methods, such as triage or patient forms, to help expedite care.
5. Patient tracking within the facility and for those patients moved to another facility is critical. The AIMS People Tracking module is available for use, statewide.

Supplies and Equipment:

1. Supplies must be used in a consistent and logical way to achieve the ultimate goal of saving the most patients possible.
2. Disposable supplies may need to be re-used during severe shortages or in extreme, unavoidable situations.
3. If laboratory and radiology equipment are not available, or are exhausted, treatment decisions will need to be made based solely on physical exam, history, and clinical judgment.
4. MOU's with HCCs, governmental and private entities should be implemented to maintain resources.

Hospital and ICU Decision-Making/Triage Process During a Crisis:

During a public health emergency with the threat of high morbidity and mortality, demands exceeding capacity for care may result in a situation where the ultimate clinical goal is to do the greatest good for the greatest number of people. Optimal care may not be available to every patient during times of disaster. Physician judgement should be used in applying these guidelines. Decisions should be based on an individualized assessment of the patient based on the best available objective medical evidence. These patients may include:

- Those who are too ill to likely survive the acute illness. For those healthcare facilities who use standardized patient scoring instruments, such as the Sequential Organ Failure Assessment (SOFA), a reasonable modification of SOFA may be necessary to accommodate patients with a disability (e.g., deafness, cognitive or mobility limitations) not related to their likelihood of surviving treatment. Standardized patient scoring instruments should be used in conjunction with an individualized assessment of the patient, based on the best available objective medical evidence.
- Those who have such severe medical issues that the mortality risk is extremely high and death is imminent. It is not reasonable to allocate critical resources to these patients in a crisis situation when this decision is based on an individualized assessment and does not consider any exclusionary categories.

Where time and conditions permit, if possible, triage-based resource allocations should be made by a Triage Officer, or Triage Peer-Based Team independent of the clinician proving care. This will allow the clinician to advocate for the patient while ensuring that resource allocation is made as fairly and consistently as possible, based on the best available objective medical evidence. Palliative care should be provided to all patients for whom resource allocations cannot be made.

Palliative Care

The goals of palliative care are relief from suffering, treatment for pain, psychological and spiritual care, and a support system to help the patient, the family, and caregivers.

Palliative care provides comfort to improve the quality of life by preventing and relieving suffering for the patients and families facing life threatening illness or injury. It provides comfort to caregivers, as well. Palliative care is not abandonment of the patient, reduction or elimination of treatment, hastening of death, or euthanasia. It is treatment for symptom management and aggressive support for the patients. The application of palliative care principles in a healthcare emergency would include:

- Understanding that initial care protocols may change if additional resources become available, or, if the situation deteriorates
- Honoring the dying and those who serve them (loved ones, professionals, or strangers) by providing comfort through medical, social, psychological, and spiritual support.

Considerations for Palliative Care would include:

- Designating an area for Palliative Care to be provided
- Staff may be Physicians, Nurses, Social Workers, Case Managers, Respiratory Therapists, Ancillary Support Teams, Clergy, and Volunteers
- Daily review and assessment for change in patient's condition and level of care
- Transfer to other levels of care such as Long-Term Acute Care (LTAC), nursing home, hospice or discharge to home
- Patient/family wishes: Allow Natural Death
- Ongoing assessment of community resources (hospice; home health)

FATALITY MANAGEMENT

During a Mass Casualty Event (MCE) event, there is potential for a large number of deaths in a short period of time, overwhelming healthcare systems capabilities and capacities to maintain the dignity, and timely and orderly processing of the deceased, as well as social order. Specific guidance for mass fatality management and response has been developed in coordination with local mass fatality working groups (Tiers 1 through 4) and is available through the ADPH Emergency Operations Plan- Mass Fatality Annex. The HCC should consider facility, local, and district fatality management plans, including collaboration with their respective Medical Examiners/Coroners to identify capabilities and capacities to support a mass fatality response including the process to request resources and assistance from the State Mortuary Response Team (SMORT) and Family Assistance Center. Following the Alabama tiered response, local EMA will forward the request to State EMA who will communicate and coordinate with ADPH-CEP and the SMORT Commander to meet local needs. If the event exceeds state resources, ADPH-CEP will request Federal mass fatality resources and support through the National Disaster Medical Systems, Disaster Mortuary Operational Response Team (DMORT).

MENTAL ILLNESS, SUBSTANCE ABUSE DISORDERS, INTELLECTUAL DISABILITIES

Individuals with serious mental illness, substance use disorders and/or intellectual disabilities may be impacted by disaster. Recipients of publicly supported services in Alabama are encouraged to shelter in place with their provider or move to a safe location with their provider or family during disaster. Service recipients living independently, with family or friends, are eligible for treatment and support from providers when disaster conditions permit. Also, as phone service is accessible, service recipients may contact their provider for services. Additionally, some providers have the ability to conduct outreach to service recipients. Should conditions become so severe that a provider is unable to sustain treatment, assistance may be coordinated through the network of public providers to continue services.

It is possible that public treatment and support becomes temporarily compromised during a disaster, which could result in people presenting to emergency departments for services, to include medications. Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Locator can be found at https://www.findtreatment.samhsa.gov/.

PSYCHOLOGICAL NEEDS OF THE PUBLIC AND HEALTHCARE STAFF

Psychological Needs of the Public

As a preventive measure, providers, facilities and HCCs should provide public messages and guidelines for the general population regarding the potential psychological impact of the emergency and available resources. Consult the Alabama Department of Public Health (ADPH), Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA) websites for information to promote resilience during disaster at the following sites: Alabama Department of Public Health: www.alabamapublichealth.gov, Centers for Disease Control and Prevention: www.cdc.gov or Substance Abuse and Mental Health Services Administration: www.samhsa.gov

Psychological Needs of Healthcare Staff

Responders and healthcare providers may be prone to psychological distress during and after a disaster. Educate healthcare workers, behavioral health practitioners, and first responders regarding the psychological impact of providing services during disasters. Consult the SAMHSA website at www.samhsa.gov and other resources for information and materials. Supervisors will also need to take measures to observe and relieve staff that may become overwhelmed while providing care. Following the emergency, staff may benefit from Employee Assistance Programs (EAPs), counseling, peer-to-peer support, and other behavioral health support services.

Also, Healthcare Coalitions and/or ADPH-CEP should publicize the 24/7 Disaster Distress Helpline at 1-800-985-5990 or text “TalkWithUs” to 66746. Spanish Speakers may Text “Hablanos” to 66746. Individuals who are deaf or hard of hearing may call 1-800-846-8517.

ADOPTION OF THE CRISIS STANDARDS OF CARE GUIDELINES

These guidelines are designed to advise and recommend strategies to be considered during times of crisis and may be adopted by the Healthcare Coalitions of the state.