Utah Crisis Standards of Care Guidelines

Version 2 June, 2018

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About the Guidelines

These guidelines were developed by the Utah Hospital Association (UHA) Crisis Standards of Care Workgroup, as a result of a contract with the Utah Department of Health (UDOH) and the Hospital Preparedness Program Grant CFDA #93.889 U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR). In 2010, the Utah Hospital Association, in cooperation with the Utah Department of Health, issued the Utah Pandemic Influenza Hospital and ICU Triage Guidelines. That document has been merged into this new Crisis Standards of Care document (**Appendix C**). Additionally, this document is supplemented with **Appendix A Pediatric Disaster Surge Planning** and **Appendix B Burn Care Guidelines.** The 2018 Utah Crisis Standards of Care Guidelines (UCSCG) is to be considered as the guideline for both a pandemic or traumatic disaster situation. The original documents are included as an appendix purely as a reference.

The purpose of this document is to guide the allocation of patient care resources during an overwhelming public health emergency of any kind (pandemic or natural disaster) when demand for services dramatically exceeds the supply of the resources needed. These Guidelines represent a consensus view of the entire Crisis Standards of Care Stakeholder Workgroup. The document will be updated as needed and should be modified by facilities to meet the needs and abilities of each hospital. Application of these guidelines will require and depend on physician judgment at the point of patient care. The views expressed in the publication do not necessarily reflect the official policies of the U.S. Department of Health and Human Services or the Utah Department of Health.

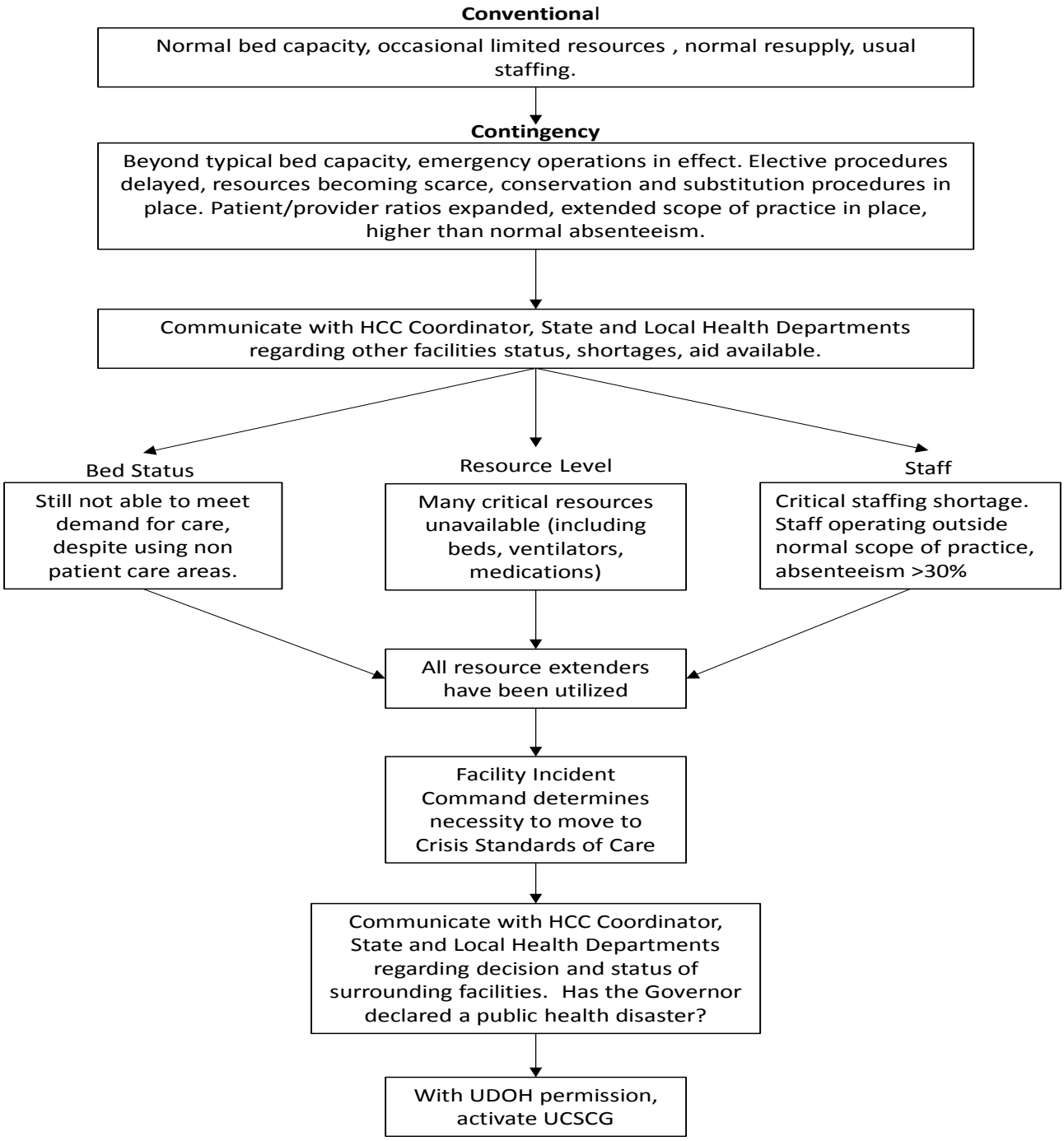
Scope of this Document

When a situation is statewide: These triage guidelines apply to all healthcare professionals, clinics, and facilities in the state of Utah. The guidelines apply to all patients.

When the situation is limited (such as an earthquake) to a specific area of the state, these guidelines will only apply to the medical community affected and the immediate surrounding communities. **However, if non-impacted community medical facilities are overwhelmed as a direct result of the event (population displacement, resource shortages, staffing shortages) consideration will be provided to extend the protections on a case-by-case basis.**

When activated: Guidelines should be activated in the event of a public health emergency declared by the governor of the State of Utah. Individual healthcare facilities and organizations will manage their responses through their designated emergency operations plans and incident command structures. In turn, local hospitals will communicate with both local and state health department emergency operations centers as well as their regional healthcare coalitions to provide situational awareness and coordination regarding local response efforts and requests.

Activation Algorithm



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We would like to take this opportunity to thank those that went before us in developing Crisis Standards of Care Plans throughout the country. Their work was essential in allowing us to develop the Utah CSC. Bits, ideas and pieces have been combined from each of these documents to become a workable program that we pray we may never have to activate.

We would also like to thank Dr. Dan Hanfling for reviewing our draft and offering wise guidance.

The following documents were key to the end product you see today:

- *Guidelines for Crisis Standards of Care during Disasters,* June 2013, American College of Emergency Physicians ACEP Disaster Preparedness and Response Committee Workgroup. Leader: Amy Kaji, MD, MPH, FACEP Workgroup Members: Bhakti Hansoti, MD Milana Boukhman, MD
- *Temporary Suspension or Modification of Statutes and Regulations in New York State During Emergencies: A collaboration between Healthcare Association of New York and the Iroquois Healthcare Association*. August 2014
- *Oregon Crisis Care Guidance* Current January, 2017
- Minnesota Department of Health, *Crisis Standards of Care*
- California Hospital Association, *Emergency Preparedness: Preparing Hospitals for Disasters*.
- Stanford Hospital and Clinics, Lucile Packard Children's Hospital, *Template For Crisis Standards of Care Plan Prepared for the CHA Disaster Planning*, for California Hospitals Conference by Draft October 15, 2012
- *Arizona Crisis Standards of Care Plan: A Comprehensive and Compassionate Response,* February 2015, Arizona Department of Health
- CHEST Consensus http://www.chestnet.org/Publications/CHEST-Publications/Guidelines-Consensus-Statements
- *Crisis Standards of Care*, CHEST 2014; 146 (4_Suppl): 8S - 34S. ABBREVIATIONS: CCTL 5 Critical Care Team Leader; CHEST 5 American College of Chest Physicians, October 23, 2014.
- Kenneth V. Iserson, M.D., MBA, FACEP, FAAEM Professor of Emergency Medicine Director, Arizona Bioethics Program The University of Arizona, Tucson kvi@u.arizona.edu
  Hardest Decisions-Resource Allocation-Ethical Justification part 1
  Hardest Decisions-How To Ration Healthcare Resources part 2
  Hardest Decisions-Who Allocates Scarce Healthcare Resources part 3
- *Pediatric Disaster Preparedness Guidelines for Hospitals*, California Hospital Association

- Pediatric Surge Plan Documents - Rady Children's Hospital-San Diego, https://www.rchsd.org/pedsurgeplan/ Pediatric Surge Plan Documents ... Post-Disaster Reunification of Children: A Nationwide Approach · Pediatric Reunification: National Consensus Conference.

INTRODUCTION

Introduction

Disasters such as Hurricanes Katrina and Sandy, and the earthquake in Haiti, have served as vivid reminders of the challenge of providing healthcare when demand for healthcare services sharply rises and places overwhelming demand on resources and medical staff, all in the midst of severe infrastructure damage. Severe pandemic influenza, catastrophic terrorist incidents (such as the detonation of a nuclear device or the release of a bioterrorism agent) and other natural disasters have the potential to place even greater demands on our healthcare system.

Some catastrophic events would occur in a sudden fashion, without notice, and in a localized area, such as an earthquake. Utah is estimated to have a 43% probability of one or more magnitude (M) 6.75 earthquakes and a 57% probability of one or more M6.0 or greater earthquakes in the region in the next 50 years. The Wasatch Fault zone is the longest, most active and most hazardous fault in the region. This fault borders and crosses the corridor that is home to nearly 80% of Utah's population of 3 million people and more than 75% of Utah's economic activity. Such an earthquake would result in 2,000 – 2,500 dead and, 7,400 – 9,300 life-threatening injuries (*Working Group on Utah Earthquake Probabilities (WGUEP) fact sheet, April 2016).* Sixteen of 39 hospitals on the Wasatch Front could be damaged, resulting in only 25% of existing beds being available for use *(Utah Catastrophic Earthquake Plan, Utah Department of Public Safety, Division of Emergency Services, 2012).*

Following a large earthquake, hospitals could be on emergency generator power, which would drastically reduce the availability of diagnostic tools and other computer-based technology including electronic medical records. Loss of water supplies will affect the ability of a facility to provide heating and air conditioning, and central services capabilities. Surgical capacity may be diminished. If the building is damaged and must be evacuated, healthcare services may need to be made available in alternate sites, such as parking areas, schools, or churches. Transfer of patients to other facilities or re-supply during the first few days will be minimal due to limited transportation resources. Staffing will be severely restricted due to the lack of intact transportation systems and the need for some providers to care for their own families. Due to the localized nature of this type of event, regional and federal assistance would be made available and would gradually increase over the first 48-96 hours.

These probability calculations are a reminder that Utah is seismically active and that large earthquakes can occur anytime, without warning. Other catastrophic events occur over a longer timeframe and are more widespread, such as a pandemic. For example, an influenza pandemic can occur when a non-human (novel) influenza virus changes in such a way that it can infect humans easily and spread easily from person to person. The outbreak would begin in one or several locations and then grow, based on the speed and type of transmission. Viral pandemics tend to come in waves of 4 to 6 weeks where numbers begin small, grow to a peak and then level off again. There is frequently at least one additional wave of patients. It is estimated that a pandemic of similar severity to the 1918 flu would, in Utah alone, leave one million ill and 16,000 dead, while creating 80,000 hospitalizations and 13,000 ICU hospitalizations. We believe that 6,400 patients may require ventilator support, while we have only around 600 ventilators in Utah currently. The

spread would allow for some preparation for a surge of patients requiring hospitalization and critical care, but because a pandemic would likely affect all states, the possibility of federal assistance is severely limited (Pandemicflu.utah.gov).

Planning for these types of overwhelming situations can help healthcare organizations and providers, supported by the entire emergency response system, to take proactive steps that enable them to provide patients with the level of care they would usually receive, or care that is functionally equivalent, for as long as possible. In catastrophic disasters, however, healthcare resources may become so scarce that re-allocation decisions are needed, staff may have to practice outside of their normal scope of practice, and the focus of patient care may need to switch to promoting benefits to the entire population over benefits to individuals. In such crisis situations, strategies are necessary to avoid greater illness, injury, and death by enabling more effective use of limited resources. In addition, the use of a fair, just, and equitable process for making decisions about who should receive treatments that have limited availability, such as ventilators, is crucial.

The Institute of Medicine (IOM) has defined "Crisis Standards of Care" as a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. CSC guidelines are the means to mount a response to an incident that far exceeds the usual health and medical capacity and capabilities of a medical community. Medical care shifts from focusing on individuals to promoting the thoughtful use of limited resources for the best possible health outcomes for the population as a whole. Resources are shifted to patients for whom treatment would most likely be lifesaving and whose functional outcome would most likely improve with treatment. Such patients should be given priority over those who would likely die even with treatment and those who would likely survive without treatment.

The Agency for Healthcare Research and Quality (AHRQ) developed the following characteristics of altered standards of care that might be manifest during a surge situation:

- Equipment and supplies will be in short supply and will need to be allocated to save the most lives.
- There will be an insufficient number of trained staff.
- Severe delays and backlogs in emergency and hospital care will likely exist.
- Treatment decisions may need to be based entirely on clinical judgment as other diagnostic tools become inaccessible.

Purpose

The purpose of the Utah Crisis Standards of Care Guidelines (UCSCG) is two-fold. First, we outline a set of changes from everyday patient care staffing, medical equipment, and treatment decisions that are intended to maximize survival for the overall patient population and, at the same time, to minimize the adverse outcomes that might occur as a result of changes in usual practice. These guidelines are to be implemented only for disasters or pandemics when numbers of seriously ill patients greatly surpass the capability of available care capacity and normal standards of care can no longer be maintained, and then only after a disaster declaration from the Governor. Second, by

acknowledging the grim reality that patient care in the midst of catastrophe will be extremely limited, we hope to foster additional initiatives in planning, education, and practice by which we can do better in our roles as healthcare providers, even in the face of such adversity. It is important that the UCSCG should not be considered a substitute for the good planning in the area of Emergency Management that healthcare organizations have already undertaken. Instead, it is intended to be guide to the rational allocation of scarce resources after other measures, such as resource sparing and sharing strategies, have been exhausted.

The Utah Crisis Standards of Care Guidelines (UCSCG), consistent with the principles of all-hazard preparedness, are applicable to any catastrophe in which the demand for patient care greatly outweighs the supply of the resources needed. But due to special circumstances that some situations may create, we have included appendices that specifically address pandemics, burn mass casualties, and pediatric mass casualties.

Ethical Foundations

In the wake of a catastrophe, the need for healthcare professionals to care for patients will undoubtedly be strained. However, we must strive to sustain the patient-provider relationship, ensuring that patients are not abandoned. During an event with scarce resources, some patients may not be eligible for all therapies, but other curative and/or comfort care treatments should be provided. There is also an ethical duty to maximize preparedness efforts and adopt prevention strategies that will minimize the scarcity of resources and the need to ration resources at some time during a disaster. The UCSCG is based upon several ethical principles that have been recognized as central to a just process:

Fairness – every hospital should attempt to be fair to all those who are affected by the disaster.
Consistency – these standards will be applied equitably across populations without regard to patient race, age, disability, ethnicity, religion, or socioeconomic status.
Proportionality – any alteration in the Standard of Care will be commensurate with the degree of emergency and the degree of scarcity of any limited resources.
Transparency – the UCSCG was developed with input from the community and efforts will be made to engage and educate our community about the UCSCG.
Solidarity - when there are limited resources, all people must consider the greater good of the entire community.

We need to be mindful that disaster triage guidelines tend to have a bias against the disabled and elderly in that they prioritize care towards those most likely to benefit, require the least resources, and have the greatest and longest improvement in health, and thus away from those with chronic illness. The significance of this bias is compounded by the reality that the disabled and elderly are disproportionately affected by disasters. For example, disabled people comprised 25-30% of those impacted by Hurricane Katrina. Fifty percent of those who died were >75 years of age but only made up 11.7% of population. Greater than 35% of those who did not evacuate in Katrina were either physically unable to leave or were caring for a person with disabilities (GAO, *Disaster*

Preparedness: Preliminary Observations on the Evacuation of Vulnerable Populations Due to Hurricanes and Other Disasters, 2006). It is a Utah core value that we protect vulnerable populations, and we cannot abandon this value in times of disaster. We must carefully avoid the use of protocols that too heavily disfavor those with chronic disease and, as a result, further disenfranchise vulnerable populations as an unintended consequence.

Relevant Utah Laws and Statutes

The organization and delivery of health care is highly regulated. In a mass casualty event, it is evident that some provisions for temporary modification of regulatory requirements, at all levels of government, will be necessary. Uncertainty about legal issues, particularly liability, have, in the past, created reluctance to anticipate and plan for a mass casualty event that would require modified medical standards.

Utah has a law that could cover situations encountered by health care providers and facilities. It defines "person" as "any individual, firm, partnership, corporation, company, association, or joint stock association, and the legal successor thereof." It states: "a person who, in good faith, assists governmental agencies or political subdivisions with the activities described on Subsection (2)(b) is not liable for civil damages or penalties as a result of any act or omission unless the person rendering the assistance: is grossly negligent; caused the emergency; or has engaged in criminal conduct." This section "applies to a person even if that person has a duty to respond; or an expectation of payment or remuneration." UCA § 58-13-2.6.

There is nothing in Utah Code which specifically directs that all hospitals enact these Crisis Standards of Care. However, Utah law allows an authorized agency, such as the governor, a municipality, or a county, to make orders, rules, and regulations that have the full force and effect of law during the state of emergency. Therefore, the Utah Department of Health may request the Governor, upon a disaster declaration, to enact these guidelines for the duration of the disaster.

> **Utah Code (effective 5/10/2016) Title 53, Chapter 2a, Part 2, Disaster Response and Recovery Act. 53-2a-209(1) through (3). Orders, rules and regulations having force of law.**
>
> *(1)All orders, rules, and regulations promulgated by the governor, a municipality, a county or other agency authorized by this part to make orders, rules and regulations, not in conflict with existing laws except as specifically provided in this section, shall have the full force and effect of law during the state of emergency.*
>
> *(2)A copy of the order, rule, or regulation promulgated under Subsection (1) shall be filed as soon as practicable with:*
>
> > *(a) the Office of Administrative Rules, if issued by the governor or a state agency; or*

(b) the office of the clerk of the municipality or county, if issued by the chief executive officer of a municipality or county.

(3) *The governor may suspend the provisions of any order, rule, or regulation of any state agency, if the strict compliance with the provisions of the order, rule, or regulation would substantially prevent, hinder, or delay necessary action in coping with the emergency or disaster.*

Administrative Rules promulgated under the authority of Title 26 Utah Health Code, R432 General Hospital Standards, details the requirements for Utah Health Facility Licensing and Certification. Currently, Utah Administrative Rule R432-100-39 details the requirement for Utah Health Facility Licensing and Certification. There are discussions to have the rule amended to allow hospitals to deliver essential services using this Utah Crisis Standards of Care document when relevant.

There are additional statutes that apply to emergency situations. See UCA 58-13-2.6, "Emergency Care rendered by a person or health care facility"

The foundational elements provided in this Introduction section provide the framework from which the specific guidelines contained in the UCSCG were built.

A CONTINUUM OF CARE

A Continuum of Care

Three levels of care are defined by the Institute of Medicine (IOM) and are the basis for determining likely levels of surge, resources and staffing during a disaster. The following levels are the basis for Crisis Standards of Care planning:

Conventional care: the demand for care is less than the supply of resources. Level of care is consistent with daily practices in the institution.
Contingency care: the demand for care surpasses conventional resource availability, but it is possible to maintain a functionally equivalent level of care by using contingency care strategies. The facility's Emergency Operations Plan is activated.
Crisis care: the demand for care surpasses resource supply despite contingency care strategies. The normal standard of care cannot be maintained.

Refer to the graph on the following page for more information on defining the three levels of care.

Determining the Available Level of Care

Because of the unpredictability and sudden onset of a traumatic mass casualty incident, it is much more difficult to develop specific Crisis Care Standards, as opposed to the Pandemic Crisis Standards. Severity, infrastructure damage and location of damage will play a major role in determining what level of care can be provided. It will vary from hospital to hospital.
It is important to develop useful indicators to recognize where the incident has placed the health care system on the supply and demand curve, and then plan for triggers to alert the system to move from conventional to contingency and to crisis care, as well as back again during the recovery phase.

A list of system-wide potential triggers that might require activation of the UCSCG would include:

- An event (or disease) that affects a large portion of the state's population and/or healthcare resources.
- Lack of or critical shortage of essential equipment or medications such as mechanical ventilators, oxygen, antibiotics, antiviral medication or specific antidotes; vasopressors or other critical care medications; intravenous fluids or blood products; operating room equipment, space and staff, and hospital and/or ICU beds.
- Lack of or critical shortage of critical infrastructure, such as power, water and communications; security to maintain the safety of healthcare providers and patients; lack of personal protective equipment; lack of trained staff, and lack of or shortage of staff support (food, housing, water, etc.).

In the midst of a crisis, there is a very real risk of providing a lower standard of care than is necessary under the circumstances. Past experience, such as that of Memorial Hospital in the aftermath of Hurricane Katrina, has shown that it is common to exaggerate the severity of a situation when immersed in the extreme stress of a crisis. The difficulties inherent in making informed decisions during a crisis situation cannot be overemphasized. It is always difficult to understand where a single healthcare entity is on the supply/demand curve at any given time, much less the healthcare system as a whole. There will be limited, or even inaccurate, information

regarding the scale of a disaster, the current and future demand for patient care services, and the current and future supply of resources.

Continuum of Care Model

SITUATION	Conventional	Contingency	Crisis
SURGE STATUS	Hospitals utilize normal bed capacity. Occasional and temporary surges of demand may occur that are temporary and may incur longer wait times for non-critical care as hospitals, ICUs, and emergency departments temporarily reach capacity.	Hospitals have surged beyond maximum bed capacity. Emergency Operations Plans are in effect. Elective procedures delayed. Hospitals may be adding patients to occupied hospital rooms and non-patient care areas. Community healthcare facilities may be requested to surge. Alternate care sites may be opened.	Expanded capacity is still not sufficient to meet ongoing demand for care. Some patients needing care cannot be admitted to hospitals and instead will be sent home or to alternate care sites. Hospitals are adding patients to occupied hospital rooms and non-patient care areas. Community health care facilities are operating beyond normal scope of practice.
RESOURCE LEVEL	Occasional, limited resource shortages may occur, typically of non-critical supplies or medications with substitution as the most common resource sparing strategy.	Some resources are becoming scarce. Attempts at conservation, reuse, adaptation, and substitution may be performed.	Some or even many critical resources are unavailable, potentially including hospital beds, ventilators, and medications. Critical resources are re-allocated to help as many patients as possible.
STAFF	Usual staffing. Hospital staff absenteeism is not a large problem.	Staff extension (increased patient/provider ratios, expanded scope of practice). Hospital staff absenteeism may be a problem.	Staffing levels at critical shortage. Staff are operating outside normal scope of practice and greatly increased patient/ provider ratios. Hospital staff absenteeism may be greater than 30%.

Figure 1 - Levels of care exist along a continuum as both demand for healthcare services and supply of resources change over time.

Much progress has been made in preparing healthcare entities for disasters. Hospitals have strengthened and tested their emergency operations plans. A forward-leaning approach has been developed at the state and federal level that will allow for resources to be deployed to an area of need early on in the event of a crisis. Given that it is natural to overestimate the demand for care and underestimate the supply of resources, we recommend erring on the side of maintaining contingency care strategies and a functionally normal standard of care until the evidence is overwhelming that the system cannot operate at that level, before moving to crisis standards.

Decisions must be based upon the immediate reality. Is the facility safe? Do we have electricity, water and HVAC? What is our supply situation regarding food, pharmaceuticals and other medical supplies? Which patients can be released home or to other facilities? The ever changing situational awareness must be continually assessed and evaluated against the answers to these questions. Each hospital will be in a different circumstance because of location, age of facility, and level of preparedness.

You will find strategies for specific areas in the **Scarce Resource Strategies** section. (pp. 51-59)

Medical Surge Strategies

There are four core strategies (the Four D's) to be employed (generally in order of preference) during or in anticipation of a scarce resource situation**:**

- **Develop** extra supplies by stockpiling and developing supply chain resiliency.
- **Delay** care for less urgent conditions and focus on more emergent issues. Triage; delay care for patients with less urgent issues. Delayed closure; delay closing wounds. Nurses or techs can cleanse and dress the wound and instruct the patient to return in 72 to 96 hours for suture closure.
- **Degrade** Care - Early discharge of patients to lower levels of care to make space for new patients. Plan for alternate care sites. Expand the scope of practice for nurses through the use of standing orders. Reuse items after appropriate disinfection or sterilization. Substitute essentially equivalent device, drug, or personnel for one that is more available (e.g. morphine for fentanyl). Adapt equipment, drugs, or personnel that are not equivalent but can provide a similar level of care (e.g. anesthesia machine for mechanical ventilation). Conserve resources by using lower doses or changing utilization practices (e.g. minimizing use of oxygen-driven nebulizers).
- **Denial** of Care - Reallocate resources to those patients with a better prognosis or greater need. Withdrawal of care.

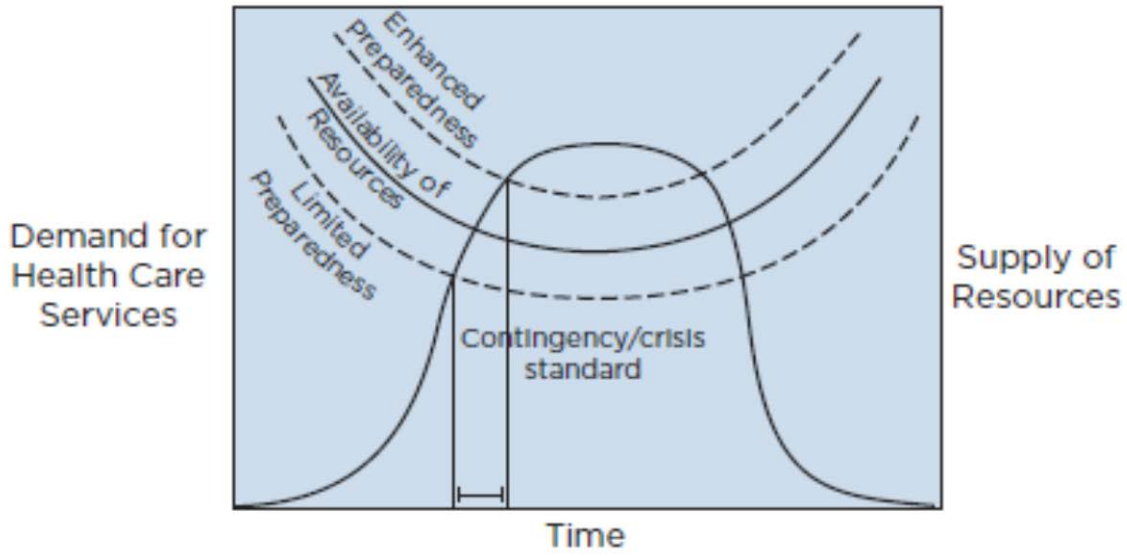


Figure 2 - Through enhanced preparedness, we can practice conventional and contingency care for as much of the time that we are overwhelmed as possible, to minimize the amount of time that Crisis Standards of Care would be required. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*

Contingency Care Strategies

The goal of any hospital should be to remain in a state of contingency care for as long as is possible and avoid having to initiate Crisis Standards. Examples of strategies that may be considered when conventional care is no longer sustainable and contingency care is needed include but are not limited to the following:

- **Move** appropriate patients from critical care units to "step-down" units and stable "step-down" patients to a general floor. Utilize a trained team of case managers and discharge planners to work with the house supervisors in determining where patients can be moved.
- **Early Discharge or Transfer** appropriate patients to home or long term care facilities.
- **Expand** patient care areas to include hospital corridors and hallways.
- Use of a **rapid admission process** to move appropriate patients from the emergency department (ED) to hospital wards to make more room in the ED.
- More consistent **withholding of care** that is either futile (any care that is unlikely to be beneficial) or unnecessary (any care that has unproven benefit). This should include reduced use of imaging and laboratory resources when reasonable.
- **Prioritize** urgent procedures and surgeries, and postpone higher category procedures such as elective surgery:
    - **Category 1:** Urgent patients who require surgery within 30 days.
    - **Category 2:** Semi-urgent patients who require surgery within 90 days.
    - **Category 3:** Non-urgent patients who need surgery at some time in the future.

- **Documentation** should be increasingly focused on what is needed for patient care and away from what is needed for billing. Routine documentation practices (especially redundant documentation in multiple sites) must be minimized during the emergency.

- **Checklists** or a "short form" medical record may be developed to speed the recording of critical information, including pertinent assessment, diagnosis and treatment information, including medications administered. Instead of performing and documenting routine assessments, consider only those assessments that are essential to monitor that patient's condition. Hard copy forms must be developed and available in case of loss of computer, printer or internet capabilities.

- In the clinical setting, staff may also become scarce; shortages of specific types of practitioners may require expanding the roles of others. Move providers to areas needing additional resources, such as the emergency department and/or critical care areas. **Expanded staff roles** also should occur incrementally and only for as long as necessary. Those performing expanded roles should be under the supervision of an experienced, licensed MD or DO, APRN, RN or other person of appropriate discipline for the specific types of care, who delegates and directs a team of healthcare workers and oversees a patient caseload. Planning should incorporate volunteers who are part of the MRC system and other volunteers involved in organized efforts in the state. All staff should receive training and drill their expanded roles, if possible. Staff and volunteers should also receive just-in-time training as needed.

- **Reduce nursing care requirements**. Adjustments may need to be made in the frequency of assessments and routine care, e.g., a diabetic patient having four glucometer measurements each day may have them done twice a day, vital signs may be taken only twice a day. If possible, rely on patient families for patient hygiene and feeding assistance whenever possible. Specific treatments or interventions that are scheduled to be administered on a regular basis may have the interval between them extended. For example, if a patient is scheduled to have respiratory nebulizer treatments every six hours, the treatments may be reduced to every eight hours. Some treatments or interventions may be discontinued completely if the potential harm to the patient is minimal, if there is an absolute lack of staff to perform the task or if no equipment is available. Decision-makers should strive to preserve equity between needs of patients suffering from the emergency and patients who need urgent treatment for other illnesses.

- **Modification of consent/refusal process**. During a prolonged public health emergency, some of these requirements may need to be modified, or if there is not sufficient time to obtain the informed consent/refusal from a person authorized to make healthcare decisions for the patient, e.g. next-of-kin. Make certain that appropriate numbers of hard copies of these documents are available in case of computer or printer failure.

- Change **infection control standards** to permit group isolation rather than single person isolation units, to allow cohorting of patients.

- Change privacy and confidentiality protection procedures temporarily to allow for the establishment and activation of a **Family Support Center**. The Center will have the responsibility of identifying and reunifying patients with next-of-kin and will act as liaison with the Red Cross in establishing missing persons links.

- Increased **focus on proven medical interventions** and therapies that provide significant benefit, while foregoing those interventions lacking clear evidence of benefit.

- **Preserve oxygen capacity** by minimizing its unnecessary use.
- **Communicate** with other facilities for assistance in accepting patients, as well as sharing staffing, pharmaceuticals and necessary equipment. (See the Utah Inter-Hospital Mutual Aid Agreement page 74).
- While difficult, facilities must make every **attempt to comply with regulatory requirements** during a prolonged public health emergency and to document such attempts contemporaneously. Utah Administrative Rules allow hospitals to surge up to 20% above their licensed bed capacity without state approval. If a hospital is going to surge beyond that point, efforts should be made to receive state approval. (Bureau of Licensing & Certification, Utah Dept. of Health) If it is not possible, the efforts should be documented. When no longer able to comply, facilities should utilize the process for requesting emergency modifications and suspensions of regulatory requirements from both state and federal regulatory agencies (e.g., Health Insurance Portability and Accountability Act (HIPAA), provisions of the Emergency Medical Treatment and Labor Act (EMTALA), staffing ratios, scope of practice restrictions). See pages 61-71 for HIPAA and EMTALA waiver factsheets, as developed by ASPR TRACIE.

Crisis Care Strategies

Examples of strategies that may be considered when contingency care is no longer sustainable, and the UCSCG is in effect, include, but are not limited to:

- The contingency care strategies previously listed.
- Ensure facility security by restricting access to the facility to only one or two entrances.
- Other access points should be locked and guarded. Access to the emergency department should also be restricted and uniformed police presence should be in place, if at all possible.
- Create patient care areas in pre-designated locations, such as the hospital cafeteria(s), radiology suites, corridors, atrium, athletic centers or research buildings.
- Emergency Department access must be reserved for immediate-need patients; ambulatory patients may be diverted to other pre-designated ambulatory care settings, such as urgent cares and doctor's offices.
- Create alternate care sites by requesting local, regional, state and/or federal response assets (such as Utah Health Emergency Response Team, Disaster Medical Assistance Teams, Medical Reserve Corps) to be deployed.
- More drastic changes to scope of practice may be needed, requiring healthcare staff to take on expanded roles, and function outside their specialties.
- More drastic reduction of nursing care requirements.
- Apply principles of accepted triage and graded scoring system to determine who should receive aggressive medical care and who should receive palliative care only. Under some circumstances, resource intensive interventions may be withheld.
- Credential providers on an emergency or temporary basis.
- Increased withholding of care and exclusive focus on medical interventions and therapies

that have proven and significant benefit, while foregoing interventions and therapies that lack clear evidence of benefit or have high resource utilization.

- Documentation should be limited only to what is needed for patient care.
- Place limits on oxygen use, such as stopping all hyperbaric treatments.
- Utilization of accepted triage guidelines and use of the Crisis Triage Officer role (see page 23).

Transferring Patients to Other Healthcare Facilities

During a major traumatic incident there will be little possibility of inter-facility transfers for the first 72+ hours. Available ambulances will be involved in initial search and rescue work and inter-facility transfers will be triaged to the bottom of the list. In a pandemic situation, other local facilities will likely be in the same overloaded situation that your facility is facing and they will rarely be able to accept transfers.

In the normal course of care delivery, many hospitals do not regularly care for certain populations (burn or pediatric patients) and would normally transfer such patients out of their facility to a higher level of care. A disaster situation may necessitate keeping patients not normally cared for at a specific facility, despite the high level of stress this would place on any system. Planning for potential situations where providers would have to practice outside their normal scope and comfort area includes an assessment of hospital and staff capabilities and providing guidance for surge situations. Such guidance should include a robust plan of how, where and what a surge would entail, what would be expected of staff members as well as potentially augmenting their capabilities through "just in time" training assets.

Examples of training modules for mass casualty burns, the Burn Crisis Standards of Care, Burn Surge Toolkit (including training DVD), have been published and distributed to Utah hospitals. Pediatric Disaster Surge Guidelines have also been developed. These are included as appendices to the UCSCG.

Smaller Hospitals and the UCSCG

Smaller hospitals, especially those in rural areas, are faced with limited resources and support from other agencies. Challenges include more distant local public health departments, limited technology, a greater reliance on volunteers, limited medical transport units and greater distances from tertiary care facilities. As a result, advance planning for medical surge and allocation of scarce resources is critical. Furthermore, these facilities should recognize and plan for their potential role in caring for populations they might not normally treat, such as pediatric, obstetric or critical care patients.

A scalable plan, similar to what has been discussed in this document, should be developed to meet the needs of the individual facility. It is understood that most rural hospitals do not have the staffing capacity to fill all the positions suggested in the Hospital Incident Command System plans or an Emergency Operations Center.

Therefore, it would be reasonable for hospital leadership to look to different healthcare resources in the community to fill those vacancies.

The hospital may look to private or retired healthcare providers (with notification well in advance of an event), such as local pediatricians or internal medicine physicians, to help guide decisions in their area of expertise. Community religious leaders might meet some of the needs normally falling to hospital-employed ethicists and pastoral care. It will be up to each hospital's executive committee, as well as risk management, to determine the roles community resources could fulfill within their facility.

Furthermore, it will be advantageous for all hospitals to actively participate in Utah's established Regional Healthcare Coalitions. This will ensure consistent decision-making in all areas of the Region as well as decrease the burden of dual functioning roles on staff from the affected hospitals. This type of committee could consist of representation from area healthcare personnel, long-term care and pediatrics. Integration of facility plans into the regional emergency operations and response guidelines will occur during times of scarce medical resources.

CRISIS TRIAGE OFFICER TEAM

Crisis Triage Officer Team

Under the Crisis Standards of Care Guidelines, the focus of medical care will **shift from the individual patient to promoting the thoughtful use of limited resources for the best possible health outcome of the population as a whole.** Resources are directed to patients for whom treatment would most likely be lifesaving and whose functional outcome would most likely improve with treatment. Such patients should be given priority over those who will likely die even with treatment and those who will likely survive without treatment.

Because this change represents a significant paradigm shift in how we normally care for patients and prioritize treatments, it is important that **Crisis Triage Officers (CTOs)** be identified beforehand from among the facility's medical staff. These physicians should be familiar with the concepts of disaster operations specific to the incident, and should include trauma surgeons, intensive care physicians, emergency physicians, infectious disease and/or internists with extensive hospital experience. Whenever possible, CTOs should be identified ahead of time so that they can receive training in mass casualty triage, ethics, communications, incident management, and crisis resource management.

During an incident in which Crisis Standards are implemented, these CTOs should not be involved in the care of individual patients, but instead will be implementing the CSC Guidelines at the hospital level by making resource allocation decisions for individual patients. They will report to the Operations Section Chief, who is part of the Command Staff within the Hospital Incident Command System (HICS). Senior House Nursing Supervisors should also be identified to oversee the bed availability and patient placement and work closely with the Operations Section Chief and the CTOs.

Depending on the number of CTOs available, (which may be dependent on the size of the facility and scope of the incident) a CTO may be working independently, or preferably as a small group of 2-4, which will be termed the **Crisis Triage Officer Team (CTOT)**. When there are adequate personnel resources, additional members for this CTOT may include other physicians or nursing supervisors. For the purposes of this document, the CTO and CTOT can be used interchangeably as they represent the same role.

Prehospital providers in Utah have been trained in and frequently exercise START triage guidelines (Simple Triage and Rapid Treatment - http://ems.ufhealthjax.org/start-triage/). In a catastrophic event, these providers will do their best to send only yellow (require intervention but can tolerate a brief delay) and red (require immediate intervention) patients to hospitals while sending minor injuries (do not require intervention to prevent loss of life or limb) to local clinics and other alternate care sites. There will still be many patients that will arrive at the hospital on their own.

Each hospital must be prepared to receive patients from EMS as well as those that self-present, and match patients to their appropriate treatment according to need and likelihood of benefit. Initial treatment may include resuscitation, operative management, critical care, inpatient care,

wound care, etc. This sorting will likely be best accomplished by an experienced team of providers, such as Emergency doctors and nurses, and trauma physicians and advanced practice clinicians. Tools such as START were developed for pre-hospital use, but some hospitals may find them of some use in initial prioritization. But the greater focus should be beyond merely categorizing patients based on acuity, and instead every attempt should be made to match patient need to resources.

The CTO or CTOT will review all patients for whom those patients' individual providers (treating physicians) have requested a limited and critical resource (such as ICU admission, ventilator support, or surgical care) to determine which patients will receive the highest priority for receiving those limited resources. In addition, the CTO or CTOT will review patients currently receiving critical resources to assess ongoing need for and priority in receiving those resources.

The CTO has the ultimate responsibility and authority for making that decision. The CTO will share decisions with the treating physician, who is then responsible for informing patients and family members, and seeking critical care or surgical consultation if permitted.

The CTO process has four components:

A. **Inclusion criteria**: These criteria attempt to identify patients who may be more likely to benefit from admission to critical care and primarily focuses on respiratory failure.
B. **Exclusion criteria**: Patients meet exclusion criteria when they have a very high risk of death or little likelihood of long-term survival, and a correspondingly low likelihood of benefit from critical care resources. This includes life-limiting illnesses, such as end-stage congestive heart failure, end-stage COPD, and terminal liver disease or cancer. Another category of exclusion criteria includes patients who may benefit from critical care but would require intense use of resources and prolonged care that cannot be justified during a multi-casualty event or pandemic.
C. **Criteria for withdrawal of critical care**
D. **A prioritization tool**

Crisis Triage Officer Training

The Utah Hospital Association, the Utah Department of Health and the Intermountain Center for Disaster Preparedness are working collaboratively to develop a course to educate providers on serving in the role of Crisis Triage Officer. A successful CTO would need both clinical experience in fields such as emergency medicine, trauma surgery and critical care as well as advanced training in issues pertinent to crisis care situations, such as allocation of scarce resources, triage decision guidelines, ethics and legal issues. The intent is to offer a course designed to introduce these concepts as well as provide the CTO candidate with opportunities to practice the implementation of Crisis Standards of Care in simulated exercises.

IMPLEMENTATION OF TRIAGE GUIDELINES

Implementation of Triage Guidelines

The heterogeneity of disasters dictates that while the UCSCG provides guidance in allocation of limited resources, providers will need to have some flexibility in implementation of this guidance. Physician judgement at individual facilities, coupled with incident-specific guidance from local and state health departments, will be necessary for effective implementation of the UCSCG. It is meant to prompt the provider to reconsider admission if the hospital is stressed and instead consider other options, one of which is utilization of the ICU exclusion criteria. The Crisis Triage Officer should be implemented in both situations.

Pandemic Implementation – The following assumptions were made when the Pandemic Influenza Guidelines were developed:

- There are not enough beds to accommodate all patients needing hospital admission, and not enough ventilators to accommodate all patients with respiratory failure.
- There is a need for social distancing and patient isolation.
- Most patients can be treated at home.
- Comfort care should be provided outside of the hospital setting.
- Influenza patients either require supportive care or ventilator assistance.

Therefore, the plan was designed to utilize EXCLUSION CRITERIA to restrict HOSPITAL admission.

Under the Crisis Standards of Care Guidelines, each facility should evaluate their facility's resource availability and, in consultation with their Local and State Health Department, **consider** implementing Exclusion Criteria to restrict hospital admission.

Mass Casualty Implementation – The rationale regarding a Mass Casualty situation is:

- Dealing mostly with traumatically injured patients.
- Many require immediate treatment, but after a brief recovery, can return home.
- Infrastructure damage and destruction of homes may dictate that patients cannot be sent home for recovery.
- Facility infrastructure may be compromised.

Therefore, Exclusion Criteria should be used to constrain admission/transfer to CRITICAL CARE UNITS.

- Patients arriving at the hospital, by private means or EMS, should first be triaged using a START, SALT or JumpSTART triage system.
- Patients triaged as Black or Green should be placed in separate areas away from the main treatment area (either within the hospital or another location) for care.
- Red and Yellow patients should receive initial stabilization.
- The Patient Prioritization Tool is to be used for patient prioritization. If the patient is suffering from major burns, include the Burn Triage Decision Table (see page 49) in your decision making.
- Taking into consideration the resources immediately available (ORs, surgical equipment, surgeons etc.), surgical patients should be re-triaged to determine priority for surgery.
- Patients determined to require post-operative ICU care should be triaged using the UCSCG and included in the ICU priority of admission list.

- Taking into consideration the resources immediately available (ICU beds, staffing ventilators, etc.), patients requiring ICU care should be re-triaged, using the UCSCG, to determine priority for admission to the ICU or other available beds.
- As stated in the Crisis Triage Officers section, the **CTO process has four components**:
  - **Inclusion criteria**: These criteria attempt to identify patients who require critical care for either ventilator or vasopressor support.
  - **Exclusion criteria**: Patients meet exclusion criteria when they have a very high risk of death or little likelihood of long-term survival, and a correspondingly low likelihood of benefit from critical care resources. This includes life-limiting illnesses, such as end-stage congestive heart failure, end-stage COPD, and terminal liver disease or cancer. Another category of exclusion criteria includes patients who may benefit from critical care but would require intense use of resources and prolonged care that cannot be justified during a multi-casualty event or pandemic.
  - **Criteria for withdrawal of critical care**
  - **A prioritization tool**: The original guideline was to utilize the MSOFA score as the prioritization tool as used in the Pandemic Influenza plan. After conducting a full-scale exercise to test the triage plans, it was determined that the MSOFA score did not work in a trauma situation. This was due to the fact that trauma patients are usually seen at the emergency department within a relatively short time after the onset of the trauma and the systemic measures (such as changing creatinine levels or jaundice) have not started to occur. Whereas, in a pandemic situation, the patient is frequently sick for days or weeks prior to being seen in the emergency department. After a good deal of research, it was found that there are few prioritization tools available that do not rely on that type of systemic measures or are simple enough to be used in a disaster situation.

    Dr. Mark Shah, in consultation with many of the experts in the area, developed what we are referring to as the **UCSCG Patient Prioritization Tool**. This tool is meant to mimic, in a very basic way, the "the greatest good for the greatest number" approach that should be taken when allocating life-saving, but limited, resources. We believe that it would be most helpful to those with the least experience in making this type of decision, but can provide guidance to all providers faced with the difficult decisions outlined in this document.

The **UCSCG Patient Prioritization Tool** uses three categories as follows, with each having three possible scores:

1. The **AGE** category is meant as a way of applying the "fair innings" ethical principal to resource allocation. This principal states that trying to save the lives of younger patients is reasonable in that they have had the least chance to experience a full life. It is not meant to indicate the likelihood of survival. We feel that our choice of age ranges for each score is a reasonable reflection of the major phases of life.

2. The **ASA** score is based on the American Society of Anesthesiologists Physical Classification System. It is included as a marker for increased comorbid illness and thus a trend toward greater resource utilization. Instead of the full 5 point scale, it is thought that ASA scores of 1-3 covers most patients and is all that is needed for our matrix. ASA score of 1 is a healthy individual. ASA score 2 is mild and controlled systemic disease, without functional impairment, such as an individual with reasonably controlled hypertension or diabetes. ASA score 3 is severe or

uncontrolled systemic disease which has led to functional impairment, such as complicated or severe diabetes, or symptomatic heart failure. ASA scores of 4 and 5 can be scored as a 3 on our tool.

3. The **ESTIMATED SURVIVAL** category is the most subjective. It is the treating clinician's gestalt estimated likelihood that the patient will survive to a good neurological outcome, if treated with available resources. This estimate should be based on all available information, and after initial attempts at stabilization. It is divided into three scores, described as unlikely to survive to a good outcome (less than 10% chance), might survive (between 10% and 50% chance), and likely will survive (more than 50% chance). It is our best attempt, given a lack of any other currently validated triage tool for use in the acute care setting, at incorporating the generally accepted idea that resources should be allocated towards those that are more likely to benefit, and away from those whose survival is unlikely even with resources.

After these three categories have been scored and totaled, the final score should be utilized to help determine whether to treat the patient aggressively with life-saving, though limited, resources, or whether it is best if those resources are used on one or more other patients.

The suggested cutoffs within the tool are meant as a guide. There is merit in adjusting those cutoffs, in either direction, depending on how limited life-saving resources are. For example, in a severely overwhelming situation, when clearly there are not enough resources for many of the patients who need them, a cutoff lower than 8-9 may be needed to fairly allocate resources.

A **pregnancy adjustment has been added**. This is included to take into consideration that a pregnant patient represents not just one, but potentially two lives. By subtracting one or two points, the patient becomes more likely to score low enough to receive treatment. Because a fetus less than 32 weeks would be either not yet viable, even with lots of resources (less than 24 weeks or so) or would require lots of resources, which is not realistic in a resource poor situation, we subtract one point for patients less than 32 weeks pregnant. Since patients more than 32 weeks pregnant have a fetus that may survive even in a resource poor situation, we subtract 2 points, and thus further increase the likelihood that the pregnant patient greater than 32 weeks will score low enough to receive resources.

It is accepted that this UCSCG Patient Prioritization Tool is not perfect. It is hoped that it fosters both dialogue and further research leading to a validated, objective, and fair resource allocation tool in the future. Intermountain Health Care is conducting validation retrospective and prospective studies to achieve that validation. But should a massive disaster occur today, the members of this committee believe clinicians can be assured using this matrix, as it was developed and approved by knowledgeable clinicians with extensive experience in trauma care.

Patient Prioritization Tool

CATEGORY	1 POINT	2 POINTS	3 POINTS
AGE	Less than 30 years	30 to 60 years	Greater than 60 years
ASA SCORE	Healthy	No functional impairment, mild systemic disease	Severe systemic disease with functional impairment
ESTIMATED SURVIVAL	Likely to survive (>50% chance of survival)	Might Survive (10 - 50% chance of survival)	Unlikely to survive (<10% chance of survival)

TOTAL the 3 categories	

Pregnancy adjustment: Subtract one point if pregnant and less than 32 weeks. Subtract 2 if pregnant and 32 weeks or more.	
FINAL SCORE	

Score 1-5	Highest priority for treatment
Score 6-7	Second priority for treatment, IF resources allow
Score 8 -9	If resources are Inadequate, DO NOT TREAT

Adult Triage Guidelines (over age 14)

Inclusion Criteria: Patients being considered for critical care have one of the following:

1. Requirement for invasive ventilatory support

a) Refractory hypoxemia (Sp02 <90% on non-rebreather mask or FIO2 >0.85) or Respiratory acidosis (pH <7.2).

b) Clinical evidence of impending respiratory failure.

c) Inability to protect or maintain airway.

2. Hypotension* with clinical evidence of shock**

a) Refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting.

*Hypotension = Systolic BP <90 mm Hg or relative hypotension

**Clinical Evidence of Shock = Altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure.

SpO2/FIO2 ratio: SpO2 = Percent saturation of hemoglobin with oxygen as measured by a pulse oximeter and expressed as % (e.g., 95%); FIO2 = Fraction of inspired oxygen; e.g., ambient air is 0.21 Example: if SpO2=95% and FIO2=0.21, the SpO2/FIO2 ratio is calculated as 95/0.21=452

Exclusion Criteria: A patient may be considered for exclusion from admission or transfer to critical care, depending on available resources, if any of the following is present and is deemed to impact short-term survival:

PRE-EXISTING CONDITIONS

(1) **Severe and irreversible chronic neurological condition** with persistent coma or vegetative state.

(2) **Known severe dementia** medically treated and requiring assistance with activities of daily living.

(3) **Advanced untreatable neuromuscular disease** (such as ALS or end-stage MS) requiring assistance with activities of daily living or requiring chronic ventilatory support.

(4) **Incurable metastatic malignant disease**.

(5) **End-stage organ failure** meeting the following criteria:

Heart: New York Heart Association (NYHA) Functional Classification System Class III or IV (g).

Lung (any of the following):

- Chronic Obstructive Pulmonary Disease (COPD) with Forced Expiratory Volume in one second (FEV1) < 25% predicted baseline, Pa02 <55 mm Hg, or severe secondary pulmonary hypertension.
- Cystic fibrosis with post-bronchodilator FE V1 <30% or baseline Pa02 <55 mm Hg.
- Pulmonary fibrosis with VC or TLC < 60% predicted, baseline Pa02 <55 mm Hg, or severe secondary pulmonary hypertension.
- Primary pulmonary hypertension with NY HA class III or IV heart failure (g), right atrial pressure >10 mm Hg, or mean pulmonary arterial pressure >50 mm Hg.

Liver: PUGH SCORE >7 (h), when available. Includes bili, albumin, INR, ascites, encephalopathy.

ACUTE CONDITIONS

(1) **Acute severe neurologic event with minimal chance of functional neurologic recovery (physician judgment).** Includes traumatic brain injury, severe hemorrhagic stroke, and intracranial hemorrhage.
(2) **Severe acute trauma** with a **REVISED TRAUMA SCORE <2 .**
(3) **Severe burns** with **<50% anticipated survival** (patients identified as **"Low" or worse on the TRIAGE DECISION TABLE FOR BURN VICTIMS.** Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Burn Center under normal circumstances).
(4) **Cardiac arrest** without easily identifiable AND reversible cause (e.g. tension pneumothorax, witnessed arrest in shockable rhythm). Consider NOT initiating aggressive resuscitation in patients with low likelihood of recovery (e.g. traumatic cardiac arrest, unwitnessed cardiac arrest).
(5) **Age:** >90 years
(6) Any patient that has **six or more** organs failing at any time.

Criteria for Patient Prioritization and Withdrawal of Critical Care

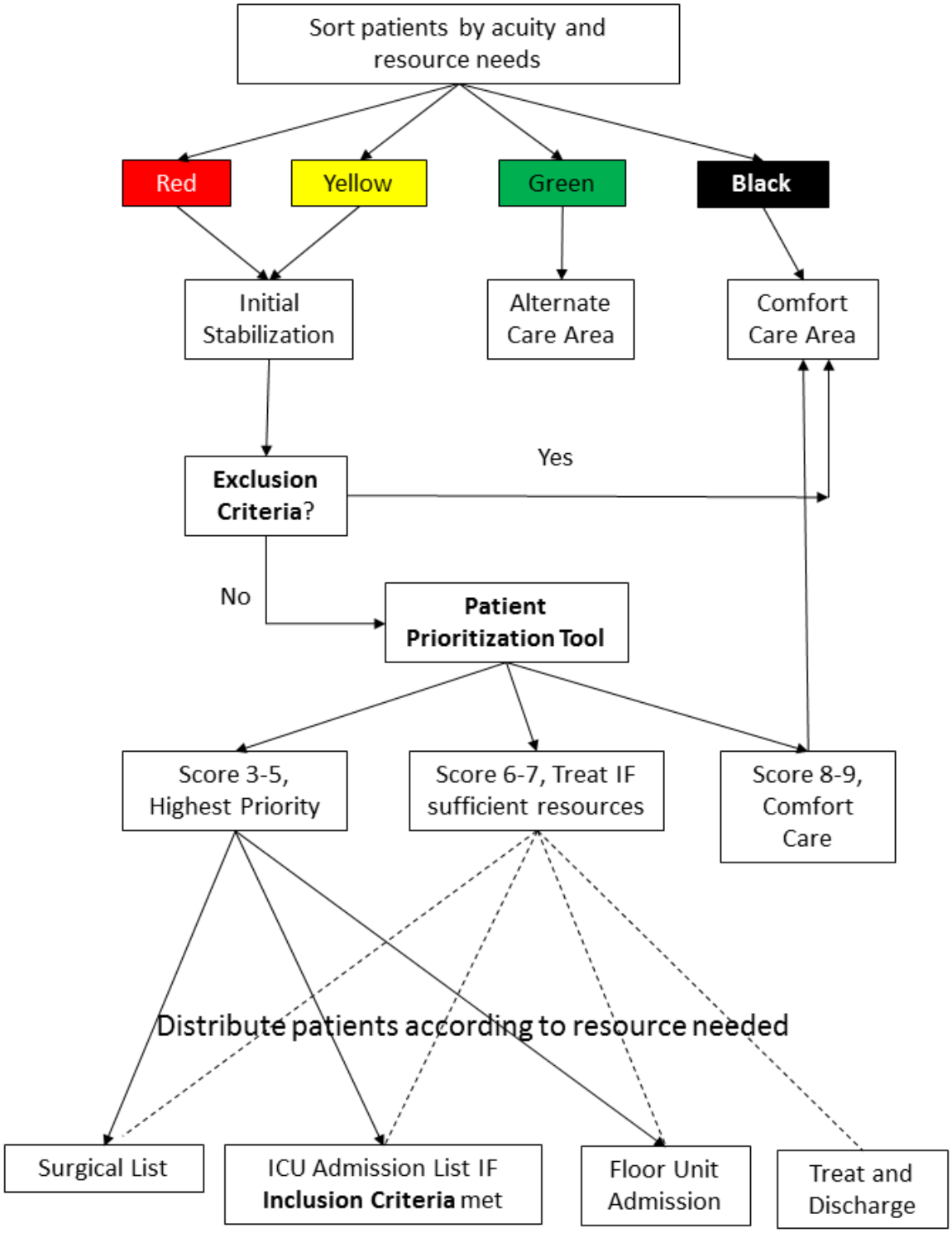
If even after application of the inclusion and exclusion criteria, there is still a greater demand for critical resources than there is supply of those resources, the CTO or CTOT should consider the severity of acute and/or chronic illness, prognosis, and projected duration of resources needed in making a final determination on allocation of scarce resources. If, despite aggressive care, a patient is doing worse and has a low likelihood of a good outcome, care is best reallocated to another patient.

The best available objective measure for the prioritizing of admitted patients is the MSOFA score and daily MSOFA trend. All patients receiving critical care resources should be reassessed at 48 and 120 hours. If a patient has an MSOFA greater than 8 for more than five days, and with a flat or rising trend, or if a patient ever has a MSOFA score of 15 or higher or any other exclusion criteria, they should be considered for withdrawal from ongoing critical care. MSOFA should be a strong determinant in prioritization and withdrawal of care, particularly when ranking patients based on clinical assessment is less certain.

See resources on following pages for more guidance:

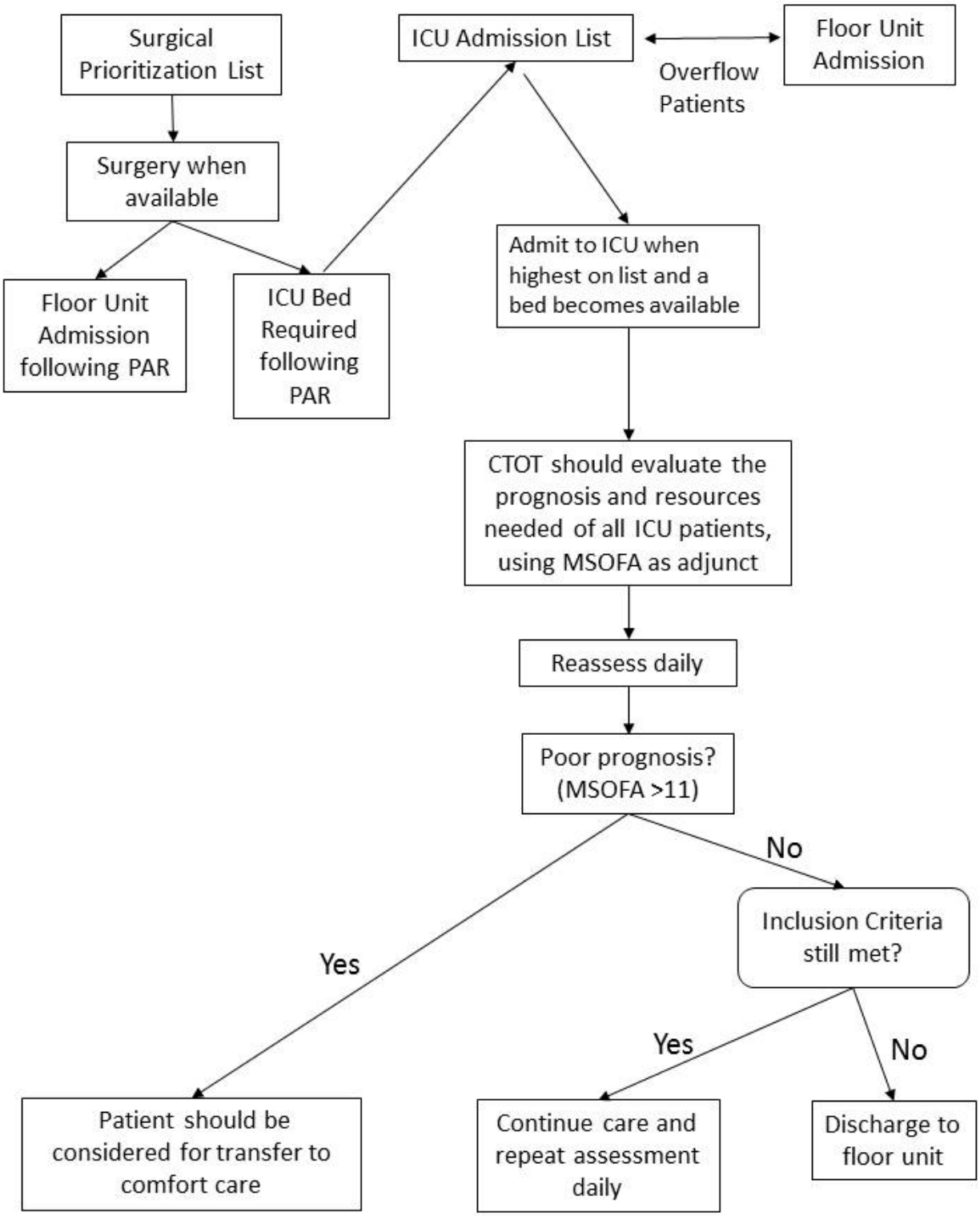
UCSCG Mass Casualty

Adult Hospital Admission Model



UCSCG Mass Casualty

Hospital Adult Inpatient Flow Model



Pediatric Triage Guidelines (Patients age 14 or younger)

Inclusion and exclusion criteria for pediatric patients differ in important ways from the adult criteria and are listed below.

Inclusion Criteria

Applies to all patients except those infants not yet discharged from the NICU.
Patients must have NO Exclusion Criteria and at least one of the following Inclusion Criteria

(1) Requirement for invasive ventilatory support

a) Refractory hypoxemia (Sp02 <90% on non-rebreather mask or FIO2 >0.85)
b) Respiratory acidosis (pH <7.2).
c) Clinical evidence of impending respiratory failure.
d) Inability to protect or maintain airway.

(2) Hypotension* with clinical evidence of shock**

Refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting.
*Hypotension = Systolic BP: Patients age >10 = < 90 mm Hg; Patients ages 1 to 10 = < 70 + (2 x age in years); Infants < 1 year old = <60; Relative hypotension
****Clinical Evidence of Shock = Altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure.

Exclusion Criteria

A patient may be considered for exclusion from admission or transfer to critical care, depending on available resources, if any of the following is present:

(1) **Persistent Coma or vegetative state,**
(2) **Severe acute trauma with a REVISED TRAUMA SCORE <2**
(3) **Severe burns with <50% anticipated survival** (Patients identified as "Low" or worse on the TRIAGE DECISION TABLE FOR BURN VICTIMS.) Burns not requiring critical care resources may be cared for at the local facility (e.g., burns that might have been transferred to the University of Utah Burn Center under normal circumstances).
(4) **Cardiac arrest** not responsive to PALS or PEP interventions within 20-30 minutes
(5) **Short anticipated duration of benefit, e.g., any underlying condition with > 80% mortality rate at 18 to 24 months:**

- Known chromosomal abnormalities such as Trisomy 13 or 18
- Known metabolic diseases such as Zellweger syndrome
- Spinal muscular atrophy (SMA) type 1
- Progressive neuromuscular disorder, e.g. muscular dystrophy and myopathy, with inability to sit unaided or ambulate when such abilities would be developmentally appropriate based on age
- Cystic fibrosis with post-bronchodilator FEV, <30% or baseline PaO2, <55 mm HG
- Severe end-stage pulmonary hypertension.

Other Considerations

- Newborns with low survivability (< 20%) even after lengthy critical care stays (e.g. extreme preterm infants with very low birth weights) may undergo routine Neonatal Resuscitation Program (NRP); however, these newborns would not be candidates for

continued aggressive resuscitation and ICU support, to include prolonged intubation and ventilator support.

- The use of ECMO will be decided on an individual basis by the Crisis Triage Officer (with input from the attending physician, and ECMO Medical Directors) based on prognosis, suspected duration of ECMO run, and availability of personnel and other resources. Patients should have an estimated survival of >70% with an estimated ECMO run of <7-10 days.

Criteria for Patient Prioritization and Withdrawal of Care

Current pediatric research has been unable to identify an ideal pediatric prognostic scoring system, a critical factor required for the development of a tertiary triage protocol that would be appropriate for use.

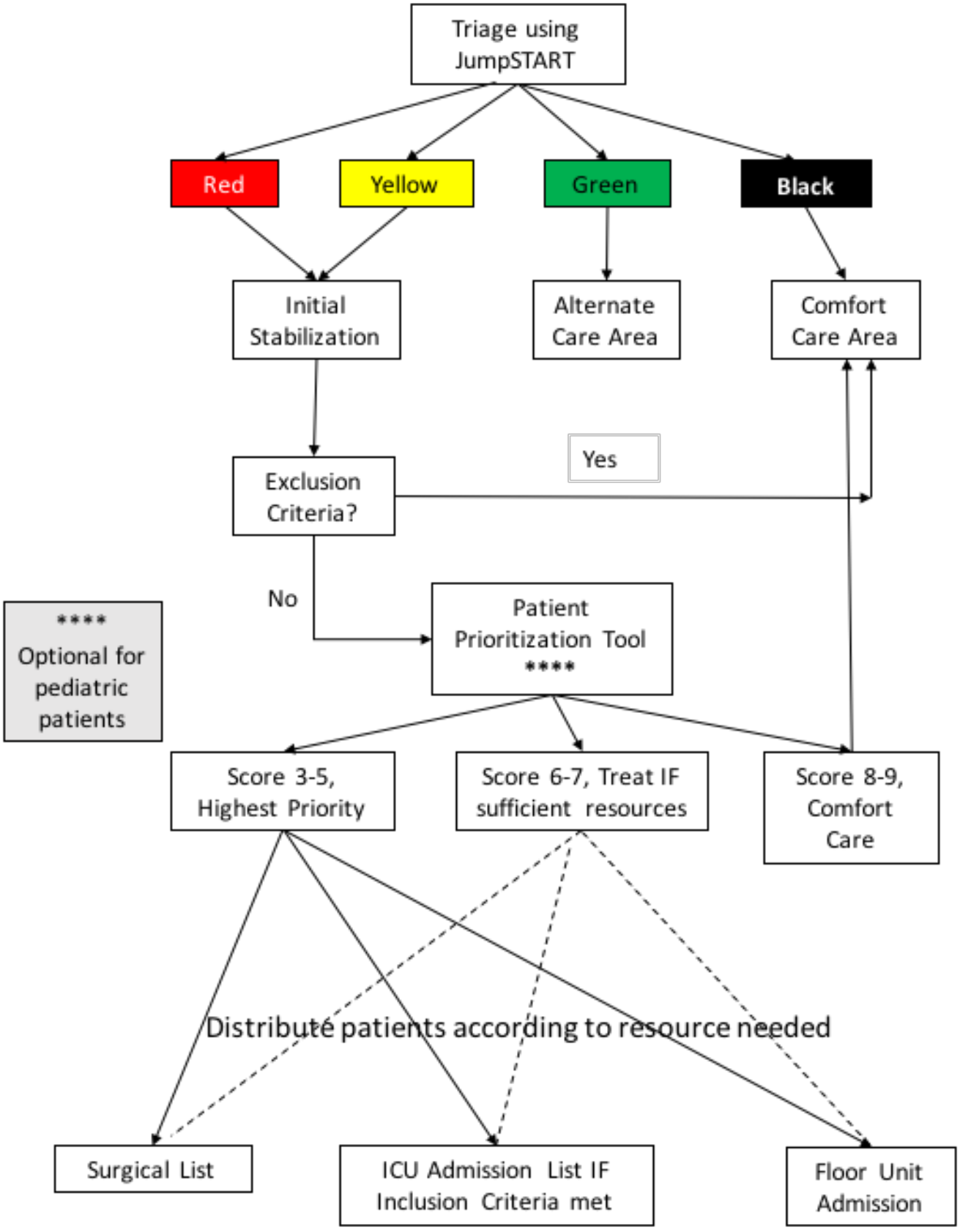
Therefore, the use of the Patient Prioritization Tool should be used with caution, and, when available, consultation with a pediatric critical care expert. Ultimate decisions should be based on physician judgement and/or PICU physician consultation.

After applying the inclusion and exclusion criteria, patients will be prioritized according to overall clinical assessment and the latest clinical trend. The CTO will consider the severity of acute and/or chronic illness, prognosis, and projected duration of resources needed in making these determinations.

See the resources on following pages for more guidance:

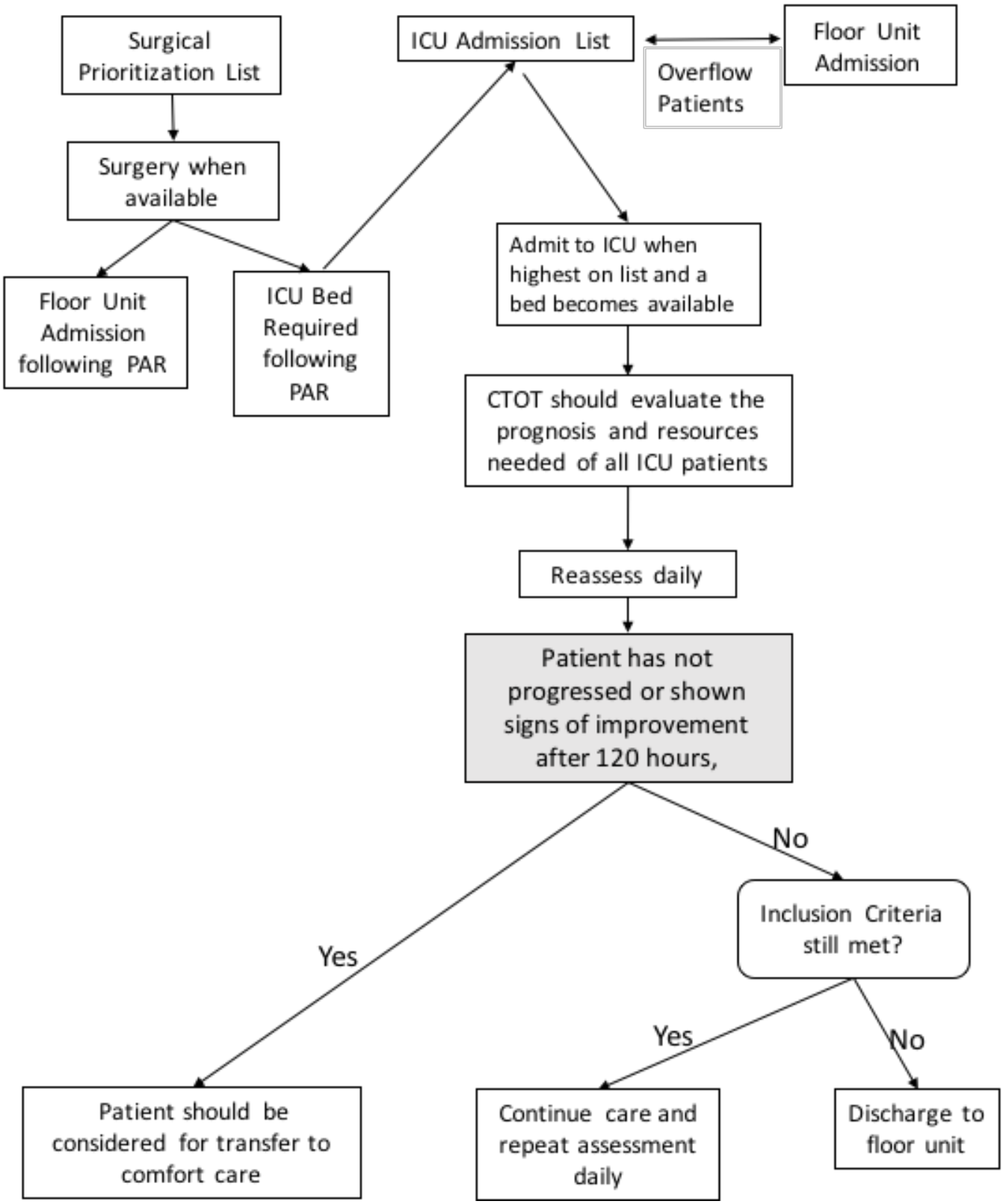
Mass Casualty

Pediatric Hospital Admission Model



UCSCG Mass Casualty

Hospital Pediatric Inpatient Flow Model



TERMINATION OF CRISIS
STANDARDS OF CARE

Termination of Crisis Standards of Care

As the severity of an event subsides, the scarcity of certain resources may be resolved at different times (e.g. critical care beds may be available, but ventilators may remain scarce). Each institution should apply the hospital triage plan based on the availability (or lack thereof) of resources during daily assessments. When resources are no longer scarce, termination of Crisis Standards of Care should occur and the Utah Department of Health should be notified by the institution. Facilities should strive to return to Contingency or Conventional standards of care as quickly as possible.

COMMUNITY PARTNERS IN THE CRISIS STANDARDS OF CARE GUIDELINES

Community Partners in the Crisis Standards of Care Guidelines:

Roles and Obligations

Every individual, institution, and business within the State of Utah has a role in supporting our resiliency.

Utah Residents

Individuals must maximize their own preparedness to the best of their ability and means. We need to let our residents know that our medical care system may be unable to take care of every need in a timely fashion. People may need to take care of their own families and neighbors to the best of their abilities. Resident preparedness cannot stop at just having a "72 hour kit", but should include CERT (Citizens Emergency Response Training) education and enough first aid training that some individuals in the community could care for minor injuries themselves. Individuals going to a hospital for treatment should be prepared for extended wait times and differing levels of care from what they are used to receiving on a normal day.

Communities

Community preparedness must include methods of ensuring care for vulnerable and special needs populations. Some of the methods available for this include **211** referrals, Special Needs Registries (available through local emergency management) and local church preparedness organizations.

Casualty Collection Points, such as fire stations, or CERT Gathering Points, need to be pre-determined and advertised beforehand so that communities and EMS agencies are familiar with their locations. Field triage can then be conducted there and the patients allocated and transported as appropriate, thereby reducing strain on overwhelmed EMS agencies and hospitals.

Ambulatory Healthcare Services

Outpatient healthcare entities should have plans to continue to see patients and thus reduce the demand for care at hospitals. This should include private physicians, clinics, urgent care centers and pharmacies. Each entity should take the opportunity to become better trained in disaster life support methods and determine what their role will be in a disaster situation and educate their personnel.

Making these decisions in advance is essential as past history has shown that medical professionals without a distinct plan and role to play are less effective participants as they could be. Just as homes should have 72-hour kits, it is essential for ambulatory healthcare services to be prepared with education, additional medical supplies and food and water support for their employees.

Pharmacies

As a community partner, pharmacies could take a significant patient load from hospital emergency departments by being willing and able to work with patients who have lost or run out of prescriptions for chronic conditions. Utah State Code **58-17b-608** states:

> *In the interest of the patient's health, a pharmacist or pharmacy intern may, in an emergency, refill a prescription for a patient, but only if the prescribing practitioner is not available promptly to authorize the refill and only if in the professional judgment of the pharmacist or pharmacy intern the prescription should be refilled. Only sufficient medication as necessary in the emergency may be furnished by the pharmacist or pharmacy intern, not to exceed a three-day supply. The practitioner shall be contacted as soon as possible for further instructions concerning the emergency.*

The implementation of this law will help immensely; however, in a major disaster scenario, a three-day supply may not be sufficient. Utah's pharmacy community continues to identify and advance additional flexibilities that may be provided in times of disaster.

Public Health and Government

Public health emergency preparedness planning can foster efforts to eliminate scarcity through the implementation of consistent and coordinated plans to share, stockpile, and estimate needed resources in advance of a predictable public health emergency scenario. Additional strategies may include sharing resources with other entities and possibly transferring patients to other settings that will have access to adequate resources.

Planners should anticipate, to the degree possible, the types of healthcare needs and resource shortfalls that will occur and identify policy and operational adjustments that will be needed in response.

- Assess regional and state surge capacity (beds, ventilators, etc.) to meet expected needs.
- Create procedures and policies for use of supplemental providers.
- Ensure policies are in place to test and manage deployment of nonhospital personnel at both the community and hospital levels.
- Ensure that a plan for managing volunteers is in place.
- Develop communication process so the community understands the rationale behind resource allocation policies.
- Stockpile supplies and equipment including PPE equipment (e.g., gloves, masks).
- Estimate increased need for medical equipment/supplies and develop strategy to acquire additional equipment/supplies if needed. Consider asking for access to the Strategic National Stockpile (SNS).
- Develop healthcare risk communication messages, including criteria for seeking healthcare, such as postponement of elective procedures or surgeries**.**

Hospitals

All hospitals and acute care facilities are required by law to have emergency preparedness plans. These plans currently detail medical surge, evacuation, isolation and other plans specific to each facility's Hazard Vulnerability Assessment (HVA). Hospitals must consider the following as part of their catastrophic planning:

Hospital Command Center – In addition to activation of the Hospital Incident Command System and Emergency Operations Center for overall coordination of response activity, hospitals should consider additional tasks that will likely arise, including (but not limited to):

- Develop a well-trained group of case managers or discharge planners to assist in determining **patient movement** and arranging those moves.
- Activate a **Family Support/Assistance Center** because the hospital may find itself with multiple unaccompanied/unidentified minors and or adults unable to communicate.
    - Identifying and reunifying these patients with loved ones
    - Liaison with the Red Cross in establishing missing person links
    - Coordinate assistance for families that may have been made homeless during a disaster, as families without a home to go to may use the hospital as a sheltering facility
    - Provide or refer to services to address emotional and logistical needs that families may face
- Develop healthcare **risk communication messages**, including criteria for seeking healthcare, such as postponement of elective procedures or surgeries**.** Hospital administration should work with the facility's Public Information Officer (PIO) and local health department to create messaging.
- Each facility must determine where patients receiving **comfort care** will be housed and supported, and should institute a team to provide counseling and care coordination as well as work with the families of loved ones who have been denied life-sustaining treatment.
- Plan to provide **psychological and emotional peer support** and expert consultation to medical staff making triage decisions.
- Develop **facility access guidelines**:
    - Define essential and non-essential visitors and develop policies for restricting visitors during a pandemic or other crisis, and mechanisms for enforcing the policies.
    - Plan to limit hospital entry to a few key entrances.
    - Plan for increased security needs.

Personnel Issues - Institutions should increase the "supply" of human resources, and establish policies regarding the following: In 2008, The Utah State Legislature enacted the **"Uniform Emergency Volunteer Health Practitioners Act." (26-49, Utah Code Annotated)**. This legislation created the ability for the state or local health departments to establish a registration

system for volunteer health practitioners to be pre-screened and trained for use during a disaster situation. The regional groups are referred to as the Medical Reserve Corps.

- Develop a plan to expand staff capacity and meet staffing needs.
  1) Granting privileges to volunteer, licensed, independent practitioners.
  2) Documents required for granting temporary privileges.
  3) Requirements for oversight of medical volunteers.
  4) Utilization of members of the Medical Reserve Corps (MRC) and/or DMATs.
  5) Confirmation of documentation/primary source verification.
  6) Use of healthcare profession students.
  7) Prospectively training individuals whose normal roles will be less urgently required during a mass casualty or disaster event to work in areas of likely shortfall.

- Develop a plan to ensure that the environment of each facility be as safe as possible by instituting infection prevention and control measures as dictated by the circumstances, by working with staff to create policies that promote staff safety, and by educating staff as to these protections and policies in advance of an emergency.
  1) Staff safety begins with staff planning for their families. Facilities should work with their staff to ensure that their families are prepared for a prolonged public health emergency, and all staff should be assisted in developing family emergency plans.
  2) Facilities should develop and implement policies to protect their staff. For example, facilities may stockpile personal protective equipment (PPE) and other infection control modalities, and fit and train staff to use the equipment when performing aerosol generating procedures, cardiopulmonary resuscitation, etc.
  3) Facilities may also have a supply of antiviral medication for staff who have inadvertent exposure to patients with latent or active disease, and staff should understand the limitations of such medications. Staff should understand the likelihood and timeframe for securing vaccines, antivirals and other therapeutics, their limitations, and the established priorities for their administration.
  4) Policies should be developed that address workplace absences during prolonged public health emergencies to care for sick family members, including leave policies and policies for payment of salaries.
  5) Facilities may consider providing care for both well and sick family members at the facility or at alternative care sites, and may plan for transportation, housing, and dietary issues that will emerge as supporting infrastructures break down.
  6) Facilities should encourage sick employees to stay home and implement procedures that enable well employees who are not physically needed at the facility to work from home.
  7) All employees should have advance knowledge of the options that will be available to them.

- Develop plans to support staff families to ensure their willingness to come to work.
- Develop contingency plans for staff absences.
- Create procedures and policies for use of supplemental providers such as staffing agencies or Medical Reserve Corps personnel.
- Ensure policies are in place to test and manage deployment of nonhospital personnel at both the community and hospital levels.
- Develop a plan for managing volunteers.

- Initiate discussions of allocation of hospital resources. Hospital administrators should meet with the hospital ethics committee early in the planning process to establish a hospital process for scarce resource allocation that is consistent with the guidelines in this document.

Training - Adopting altered standards of care, even temporarily, will have a significant impact on healthcare delivery operations and therefore on the needs of providers for training and education to serve in those circumstances. **Hospitals should not assume that individual providers will know how to deliver appropriate care in a mass casualty event, but rather should develop or identify training programs to ensure a knowledgeable and systematic, coordinated response effort.** Hospitals could even consider including requirements for physician disaster training in the granting of privileges. A wide array of preparedness training has been designed and is being delivered throughout the country. A beginning list of the types of training available includes but is not limited to the following:

- General disaster response, including an introduction to altered standards of care and how the move to such standards may affect triage and treatment decisions as well as facility conditions.
- Legal and ethical basis for allocating scarce resources in a mass casualty event.
- How to treat populations with special needs (e.g., children and elderly persons).
- How to recognize the signs and symptoms of specific hazards and a trend of similar types of signs and symptoms.
- How to treat specific conditions.
- How to recognize and manage the effect of stress on caregivers and their patients.

Specific training regarding triage and being responsible for allocation or denial of scarce resources must be provided to ED physicians, intensivists and surgeons who might have to serve as Crisis Triage Officer or as the Medical Subject Expert in the Hospital Incident Command Structure.

While all physicians should participate in facility disaster response drills and respond to actual incidents, several physicians should be identified to fill the Crisis Triage Officer role discussed previously. Hospitals should also determine a chain of command within the hospital staff to determine who will participate in the Incident Command structure and to prevent conflicts over who has medical command.

Supply Chain Issues- Healthcare organizations and providers should take proactive steps to use resources carefully if demand is expected to surge and/or resource shortages are anticipated. "Just in time" restocking practices have led to diminished stockpiles of supplies and can lead to severe shortages of medical supplies and pharmaceuticals, especially if community infrastructure is compromised. Each hospital should consider where their supply warehouses are located and how resupply would be affected if damaged roads and bridges, or other factors, impair delivery.

Pre-event planning for these types of shortages should include implementation of a PACE plan for

all supplies**: Primary Supplier, Alternate Supplier, Contingency Supplier and Emergency Supplier.**

• Stockpile supplies and equipment including PPE equipment (e.g., gloves, masks) in-house.

• Estimate increased need for medical equipment/supplies and develop strategy to acquire additional equipment/supplies if needed. Consult with local and state health departments about access to the Strategic National Stockpile (SNS).

Ethics Policies - All policies or crisis standards should be applied fairly and justly and implemented incrementally according to the severity and duration of the event. Educational initiatives such as disaster drills and public and provider education should be included in planning.

Professional ethics for clinicians generally discourage or prohibit practice outside the scope of one's expertise. Similarly, legal and ethical standards often prohibit laypersons from providing health services. However, during conditions of extreme scarcity of trained personnel, standards of competence may be justifiably lower than during normal conditions. For instance, employing a clinician who normally works in a specialty to instead work in primary care, or providing community volunteers with focused training to administer vaccinations could expand capacity and alleviate some of the scarcity of personnel. When the hospital can no longer meet the increased demand for patient care services using existing healthcare practitioners, each hospital should determine a tiered staffing model appropriate for their facility.

Comfort Care - Comfort care is defined as care that helps or soothes a person who is dying. The goal is to prevent or relieve suffering as much as possible. Comfort care resources should be provided consistently throughout a public health emergency. Access to comfort care resources and services should be provided to all patients not receiving more aggressive care based on allocation decisions. It is essential that each hospital develop the capacity to provide comfort care in-house, to potentially significant numbers of patients.

Palliative care is defined as relieving suffering and improving the quality of life for people of any age and at any stage in a serious illness, whether that illness is curable, chronic or life threatening.

Hospice is a specific type of palliative care for people who likely have six months or less to live. Hospice is simply a type of care that focuses on the current quality of life instead of continuing with treatments to prolong life.

The vast majority of hospice or comfort care in Utah is provided in a home healthcare model. The Utah Association of Home Health and Hospice reports that there is only one free-standing residential hospice (16 beds) in Utah at this time. On any given day, home health and hospice providers are caring for 20,000-25,000 patients throughout the state. In a major disaster situation where there is considerable loss of infrastructure (roads, power and water) and extensive damage to private homes, it will be essential that home health agencies have developed the ability to work with their peers and local long term care facilities to divide the care of their patients into

accessible areas. It is strongly recommended that home health and hospice agencies work with the Red Cross in the development of medical shelters where patients could be congregated for care.

Many long-term care (LTC) facilities have the capability and training to handle comfort care patients. Plans must be developed to identify which facilities are willing to take comfort care patients and how patients will be transferred to those facilities. Many of these facilities have their own vans and can transport patients comfortably. Hospitals should develop a working arrangement with the LTCs in their immediate area as these may be the only ones available to them if road infrastructure is destroyed.

OTHER RESOURCES

Burn Triage Decision Table

Burn Disaster Crisis Standards of Care

Triage decision table of benefit to resource ratio based on patient age and total burn size.

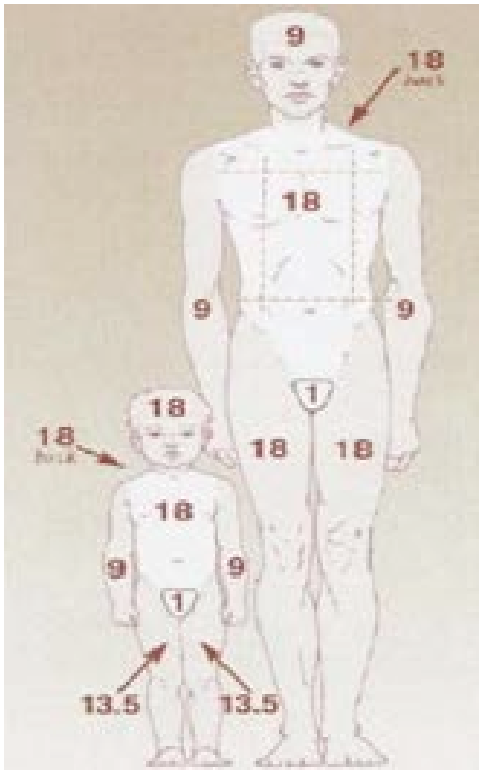
BURN TRIAGE TABLE: This table illustrates the anticipated ratio of resources to benefit from the treatment of burns of various sizes in various aged patients. Each category reflects both the volume of resources necessary to care for the patients in each group, and the expected outcome.

	Burn Size Group, % TBSA All									
Age	0-9.9	10-19.9	20-29.9	30-39.9	40-49.9	50-59.9	60-69.9	70-79.9	80-89.9	≥ 90
0-1.99	Very High	Very High	High	High	High	Medium	Medium	Medium	Low	Low
2-4.99	Outpatient	Very High	High	High	High	Medium	Medium	Medium	Low	Low
5-19.99	Outpatient	Very High	High	High	High	High	Medium	Medium	Low	Low
20-29.99	Outpatient	Very High	High	High	High	Medium	Medium	Medium	Low	Low
30-39.99	Outpatient	Very High	High	High	Medium	Medium	Medium	Low	Low	Expectant
40-49.99	Outpatient	Very High	High	Medium	Medium	Medium	Medium	Low	Low	Expectant
50-59.99	Outpatient	Very High	High	Medium	Medium	Low	Low	Expectant	Expectant	Expectant
60-69.99	Outpatient	High	Medium	Medium	Low	Low	Low	Expectant	Expectant	Expectant
≥ 70	Very High	Medium	Low	Low	Low	Expectant	Expectant	Expectant	Expectant	Expectant

Palmieri TL et al. Triage/Resource Table for a Burn Disaster Developed from the American Burn Association NBR

Categories are defined as follows:

OUTPATIENT: Survival and good outcome expected without requiring initial admission.
VERY HIGH: Mortality ≤10%, anticipated length of stay ≤ 14-21 days, 1-2 surgical procedures.
HIGH: Mortality ≤ 10%, anticipated length of stay ≥ 14-21 days, multiple surgical procedures.
MEDIUM: Mortality 10 – 50%, with provision of aggressive treatment which may require prolonged hospitalization and multiple surgical procedures.
LOW: Mortality 50 – 90%, even with provision of prolonged, intensive resources.
EXPECTANT: Mortality ≥ 90%, even with prolonged aggressive care.



Patient's palm inclusive of fingers = 1% Total Body Surface Area

SCARCE RESOURCE

STRATEGIES

Oxygen Recommendations

Inhaled Medications		
Restrict use of Small Volume Nebulizers when inhaler substitutes are available.		
Restrict continuous nebulization therapy.		
Minimize frequency through medication substitution that results in fewer treatments (6h -12h instead of 4h-6h applications).		
High-Flow Applications		
Restrict use of high flow cannula systems (these can demand 12 to 40 LPM flows).		
Restrict the use of simple and partial rebreathing masks to 10 LPM maximum.		
Restrict use of Gas Injection Nebulizers (require 10 to 75 LPM flows).		
Eliminate oxygen-powered Venturi suction systems (consume 15-50 LPM).		
Air-Oxygen Blenders		
Eliminate the low-flow reference bleed occurring with any low-flow metered oxygen blender. Reserve air-oxygen blender use for mechanical ventilators using high-flow non-metered outlets.		
Disconnect bleeders when not in use.		
Oxygen Conservation Devices		
Use reservoir cannulas at 1/2 the flow setting of standard cannulas.		
Replace simple and partial rebreather mask use with reservoir cannulas at flowrates of 6-10 LPM.		
Oxygen Concentrators if Electrical Power is Present		
Use hospital-based or independent home medical equipment supplier oxygen concentrators if available to provide low-flow cannula oxygen for patients and preserve the primary oxygen supply for more critical applications.		
Monitor Use and Revise Clinical Targets		
Employ oxygen titration protocols to optimize flow or % to match targets for SP02 or PaO2.		
Minimize overall oxygen use by optimization of flow.		
Discontinue oxygen at earliest possible time.		
Starting Example	**Initiate 02**	**02 Target**
Normal Lung Adults	SP02 <90%	SP02 90%
Infants and Peds	SP02 <90%	SP02 90 - 95%
Severe COPD History	SP02 <85%	SP02 90%

Note: Targets may be adjusted further downward depending on resources available, the patient's clinical presentation or measured Pa02 determination		
Expendable Oxygen Appliances		
Use terminal sterilization or high-level disinfection procedures for oxygen appliances, small and large-bore tubing and ventilator circuits. Bleach concentrations of 1:10, high-level chemical disinfection or irradiation may be suitable. Ethylene oxide gas sterilization is optimal, but requires a 12-hour aeration cycle to prevent ethylene chlorohydrin formation with polyvinyl chloride plastics.		
Oxygen Re-Allocation		
Prioritize patients for oxygen administration during severe resource limitations.		
Mechanical Ventilation/External Oxygenation		
Access Alternative Sources for Ventilators/Specialized Equipment		
Obtain specialized equipment from vendors, healthcare partners, regional, state, federal stockpiles via usual emergency management processes and provide just-in-time training and quick reference materials for obtained equipment.		
Decrease Demand for Ventilators		
Increase threshold for intubation/ventilation.		
Use non-invasive ventilatory support when possible.		
Re-use Ventilator Circuits		
Appropriate cleaning must precede sterilization.		
If using gas (ethylene oxide) sterilization, allow full 12-hour aeration cycle to avoid accumulation of toxic by-products on surfaces.		
Use irradiation or other techniques as appropriate.		
Use Alternative Respiratory Support Technologies		
Use transport ventilators with appropriate alarms- especially for stable patients without complex ventilation requirements.		
Use anesthesia machines for mechanical ventilation as appropriate/capable.		
Use bi-level (BIPAP) equipment to provide mechanical ventilation.		
Consider bag-valve ventilation as a temporary measure while awaiting definitive solution/ equipment (as appropriate to situation) - extremely labor intensive and may consume large amounts of oxygen.		
Assign Limited Ventilators to Patients Most Likely to Benefit if no Other Options are Available		

Based upon documents from the Minnesota Healthcare System Preparedness Program.

Medication Administration

Cache/ Increase Supply Levels	
Patients should have at least 30 days supply of home medications and obtain 90 day supply if pandemic, epidemic or evacuation is imminent.	
Examine formulary to determine commonly-used medications and classes that will be in immediate, high demand.	
Increase supply levels or cache critical medications, particularly for low cost items and analgesics.	
Analgesia	Morphine, other narcotic and non-narcotic (non-steroidal, acetaminophen) class, injectables and oral (narcotic conversion tool at http://www.globalrph.com/narcoticonv.htm).
Sedation	Particularly benzodiazapine (lorazepam, midazolam, diazapam) injectables
Anti-Infective	Narrow and broad spectrum antibiotics for pneumonia, skin infections, open fractures, sepsis (e.g. cephalosporins, quinolones, tetracyclines, Macrolides, aminoglycosides, clindamycin, etc.) select antivirals.
Pulmonary	Metered dose inhalers (albuterol, inhaled steroids), oral steroids (dexamethasone, prednisone)
Behavioral Health	Haloperidol, other injectable and oral anti-psychotics, common anti-depressants, anxiolytics
Other	Sodium bicarbonate, paralytics, induction agents (etomidate, propofol,) proparacaine/tetracaine, atropine, pralidoxime, epinephrine, local anesthetics, antiemetics, insulin, common oral anti-hypertensive and diabetes medications.
Use Equivalent Medications	
Obtain medications from alternate supply sources (pharmaceutical representatives, pharmacy caches)	
Pulmonary	Metered dose inhalers instead of nebulized medications.
Analgesia/Sedation	Consider lorazepam for propofol substitution and other agents in short supply.
	ICU analgesia/sedation drips Morphine 4-10mg IV load then 2mg/hr and titrate/re-bolus as mg IV load as needed. Usual 3-20 mg/h; Lorazepam 2-8mg or midazalam 1-5mg IV load then 2-8mg/h drip
Anti-infective	Examples: cephalosporin, gentamicin, clindamycin substitutes for unavailable broad spectrum antibiotic

	Target therapy as soon as possible based upon organism identified.
Other	Beta blockers, diuretics, calcium channel blockers, ace inhibitors, anti-depressants, anti-infectives
Reduce Use During High Demand	
Restrict use of certain classes if limited stocks likely to run out. Restrict prophylactic/empiric antibiotics after low risk wounds, etc.	
Decrease dose; consider using smaller doses of medications in high demand/likely to run out (reduce doses of medications allowing blood pressure or glucose to run higher to ensure supply of medications adequate for anticipated duration of shortage).	
Allow use of personal medications (inhalers, oral medications) in hospital.	
Do without - consider impact if medications not taken during shortage (statins, etc.).	
Modify Medication Administration	
Emphasize oral, nasogastric, subcutaneous routes of medication administration.	
Administer medications by gravity drip rather than IV pump if needed. IV drip calculation - drops/minute = amount to be infused x drip set/time(minutes) (drip set = qtt/mL - 60, 10, etc.)	
Rule of 6: Pt wgt(kg) x 6 = mg drug to add to 100 mL fluid = 1mcg/kg/min for each 1mL/hour. Note: For examples, see http://www.dosagehelp.comiv rate drop.html	
Consider use of select medications beyond expiration date. (Legal protection such as Food and Drug Administration approval or waiver required.)	
Restrict Allocation of Select Medications	
Allocate limited stocks of medications with consideration of regional/state guidance and available epidemiological information (e.g. anti-viral medications such as oseltamivir).	
Allocate limited stock to support other re-allocation decisions (ventilator use, etc.)	

Based upon documents from the Minnesota Healthcare System Preparedness Program.

Staffing Strategies

Focus Staff Time on Core Clinical Duties
Restrict elective appointments and procedures.
Reduce documentation requirements.
Cohort patients to conserve PPE and reduce staff PPE donning and doffing time and frequency.
Use Supplemental Staff
Bring in equally trained staff from whatever resources available.
Adjust personnel work schedules (longer but less frequent shifts, etc.) If this will not result in skill/PPE compliance deterioration.
Use family members/lay volunteers to provide basic patient hygiene and feeding, releasing staff for other duties.
Focus Staff Expertise on Core Clinical Needs
Personnel with specific critical skills (ventilator, ICU) should concentrate on those skills; specify job duties that can be safely performed by other medical professionals.
Have specialty staff oversee larger numbers of less-specialized staff and patients (for example, a critical care nurse oversees the intensive care issues of nine patients while three medical/surgical nurses provide basic nursing care to three patients each.)
Use Alternative Personnel to Minimize Changes to Standards of Care
Use less trained personnel with appropriate mentoring and just-in-time education (e.g. healthcare trainees or other healthcare workers, Medical Reserve Corps, etc.)
Use less trained personnel to take over portions of skilled staff workload for which they have been trained.
Provide just-in-time training or specific skills.

Based upon documents from the Minnesota Healthcare System Preparedness Program.

Hemodynamic Support and IV Fluids

Recommendations
Cache additional IV cannulas, tubing, fluids, medications and administration supplies.
Use scheduled dosing and drip dosing when possible
Reserve IV pump use for critical medications such as sedatives and hemodynamic support.
Minimize invasive monitoring
Substitute other assessments (e.g., clinical signs, ultrasound) of central venous pressure (CVP).
When required, assess CVP intermittently via manual methods using a bedside saline manometer or transducer moved between multiple patients as needed, or by height of blood column in CVP line held vertically while patient is supine.
Emphasize oral hydration instead of IV hydration when possible.
Utilize appropriate oral rehydration solution
Oral rehydration solution: 1 liter of water (5 cups) + 1 tsp salt +8 tsp sugar, add flavor such as 1/2 cup orange juice, as necessary.
Rehydation for moderate dehydration = 50-100ml/kg over 2 to 4 hours.
Pediatric hydration
Pediatric maintenance fluids:
4ml/kg/h for first 10kg of body weight (40ml/hr for 1st 10 kg).
2 ml/kg/hr for second 10kg of body weight (20 ml/hr for 2nd 10 kg = 60ml/hr for 20kg child.)
1 ml/kg/h for each kg over 20 kg (60ml/hr plus 20ml/hr = 80ml/hr
Supplement for each bout of diarrhea or emesis.
Note: Clinical (urine output, etc. and laboratory (BUN, urine specific gravity) assessments and electrolyte correction are key components of fluid therapy and are not specifically addressed by these recommendations. For further information and examples, see http://www.ped.med.utah/cai/howto/IntravenousFluidOrders.PDF
Provide Nasogastric Hydration instead of IV hydration when practical.
Patients with impediments to oral hydration may be successfully hydrated and maintained with nasogastric tubes.
For fluid support, 8-12 f tubes (pediatric infant 3.5 f, <2yrs 5f) are better tolerated than standard sized tubes.
Substitute Epinephrine for other vasopressor agents
For hemodynamically unstable patients who are adequately volume resuscitated, consider adding 6mg epinephrine (6ml of 1:1,000) to 1000ml NS on minidrip tubing and titrate to target blood pressure.
Epinephrine 1:1000 (1mg/ml) multi-dose vials available for drip use.

Re-use CVP, NG and other supplies after appropriate sterilization/disinfection
Cleaning for all devices should precede high-level disinfection or sterilization.
High-level disinfection for at least twenty minutes for devices in contact with body surfaces (including mucous membranes); gluteraldehyde, hydrogen, peroxide 6%, or bleach (5.25%) diluted 1:20 (2500ppm) are acceptable solutions.
Note: Chlorine levels reduced if stored in polyethylene containers. Double the bleach concentration to compensate.
Sterilize devices in contact with bloodstream (e.g., ethylene oxide sterilization for CVP catheters.
Intraosseous/Subcutaneous (hypodermoclysis) replacement fluids
Consider as an option when alternative routes of fluid administration are impossible/unavailable.
Intraosseous before percutaneous.
Intraosseous
Intraosseous infusion is not generally recommended for hydration purposes, but may be used until alternative routes are available. Intraosseous infusion requires a pump or pressure bag. Rate of fluid delivery is often limited by pain of pressure within the marrow cavity. This may be reduced by pre-medication with lidocaine 0.5 mg/kg slow iv push.
Hypodermoclysis
Cannot correct more than moderate dehydration via this technique.
Many medications cannot be administered subcutaneously.
Common infusion sites: pectoral chest, abdomen, thighs, upper arms.
Common fluids: normal saline (NS), D5NS, D5 1/2 NS (Can add up to 20-40 mEq potassium if needed.)
Insert 21-24 gauge needle into subcutaneous tissue at a 45-degree needle. Adjust drip rate to 1-2 ml per minute. May use 2 sites simultaneously if needed.
Maximal volume about 3 liters/day: requires site rotation.
Local swelling can be reduced with massage to area.
Hyaluronidase 150 units/liter facilitates fluid absorption but not required; may not decrease occurrence of local edema.
Consider use of veterinary and other alternative sources for intravenous fluids and administration sets.

Based upon documents from the Minnesota Healthcare System Preparedness Program.

Blood Products

Healthcare Facility Recommendations
Packed Red Blood Cells
Use cell-saver and auto-transfusion to degree possible.
Limit O negative use to women of child-bearing age.
Use O positive in emergent transfusion in males or non-child bearing females to conserve O negative.
More aggressive crystalloid resuscitation prior to transfusion in shortage situations (blood substitutes may play future role).
Long term shortage, collect autologous blood pre-operatively and consider cross-over transfusion.
Enforce lower hemoglobin triggers for transfusion (for example, HGB 7).
Consider use of erythropoietin (EPO) for chronic anemia in appropriate patients.
Further limit PRBC use, if needed, to active bleeding states, consider subsequent restrictions including transfusion only for end organ damage, then shock states only.
Consider limits on use of PRBCs (for example, only initiate for patients that will require <6 units PRBCs and/or consider stopping transfusion when >6 units utilized).
Fresh Frozen Plasma
Though not a true substitute, consider use of fibrinolysis inhibitors or other modalities to reverse coagulopathic states (tranexamic acid, aminocaproic acid, activated coagulation factor use, or other appropriate therapies).
Consider reduction in red cell: FFP ratios in massive transfusion protocols in consultation with blood bank medical staff.
No anticipatory use of FFP in hemorrhage without documented coagulopathy.
Platelets
Though not a true substitute, consider use of desmopressin (DDAVP) to stimulate improved platelet performance in renal and hepatic failure patients.
Transfuse platelets only for active bleeding; further restrict to life-threatening bleeding if required by situation.
No prophylactic use of platelets.
Blood Bank Recommendations
All Blood Products
Increase donations if required, and consider local increase in frozen reserves.
Increase O positive levels.
Consider maintaining a frozen blood reserve if severe shortage.
Increase recruitment for specific product needs.

Consider adjustments to donor HGB/HCT eligibility.
Relax travel deferrals for possible malaria and BSE (bovine spongiform encephalitis) (FDA approval/variance required via American Association of Blood Banks).
Packed Red Blood Cells
Change donations from whole blood to 2x RBC apheresis collection if specific shortage of PRBCs.
Reduce or waive usual 56 day inter-donation period (FDA approval/variance required via American Association of Blood Banks) based upon pre-donation hemoglobin.
Reduce weight restrictions for 2x RBC pheresis donations according to instruments used and medical director guidance. (FDA approval/variance required via American Association of Blood Banks).
Fresh Frozen Plasma
Obtain FDA variance to exceed 24 collections per year for critical types (FDA approval/variance required via American Association of Blood Banks).
Platelets
May use leukoreduced whole blood pooled platelets (and, if required, consider non-leukoreduced whole blood pooled platelets).
Convert less needed ABO whole blood to apheresis.
Accept female platelet donors without HLA antibody screen.
Apply for variance of 7 day outdate requirement (FDA approval/variance required via American Association of Blood Banks).
Consider a 24 hour hold until the culture is obtained and immediate release for both Pool and Apheresis.
Obtain FDA variance to allow new Pool and Store sites to ship across state lines. (FDA approval/variance required via American Association of Blood Banks).
Reduce pool sizes to platelets from 3 whole blood donations.

Based upon documents from the Minnesota Healthcare System Preparedness Program.

EMTALA, HIPAA

AND 1135 WAIVERS

Emergency Medical Treatment and Labor Act (EMTALA) Factsheet

Reprinted with permission from the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources Assistance Center and Information Exchange (TRACIE)

EMTALA and Disasters

Updated May 7, 2018
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This fact sheet addresses several frequently asked questions regarding the Emergency Medical Treatment and Labor Act (EMTALA) and disasters, and provides links to resources for more information. It is not intended to be used as regulatory guidance or in place of communications with or guidance from the Centers for Medicare & Medicaid Services (CMS) who oversee EMTALA compliance.

What is "EMTALA?"

EMTALA is a federal law that requires all Medicare-participating hospitals with emergency departments (ED) to perform the following for all individuals that come to the ED regardless of the individual's ability to pay:

- An appropriate medical screening exam (MSE) to determine if the individual has an emergency medical condition (EMC). If there is no EMC, the hospital's EMTALA obligation ends.
- If there is an EMC, the hospital must:
  - Treat and stabilize the EMC within its capability (including admission) OR
  - Appropriately transfer the individual to a hospital that has the capability and capacity to stabilize the EMC if the presenting hospital is unable to do so. Outside of a mass casualty, transfers prior to stabilization are generally only "appropriate" if the transfer is requested in writing by the patient after being informed of the hospital's obligations and the risks of transfer, or a physician or qualified medical person in consultation with a physician, certifies that the benefits of transfer outweigh the risks. (Updated May 7, 2018)

Response modified from EMTALA & Surges in Demand for Emergency Department Services During a Pandemic

Can EMTALA be Waived in an Emergency or Disaster?

Under certain circumstances, sanctions for violations of EMTALA obligations may be waived for a hospital. The EMTALA MSE and stabilization sanctions can be waived under the following circumstances:

1) The President declares an emergency or disaster under the Stafford Act or the National Emergencies Act; AND
2) The Secretary of Health and Human Services declares that a Public Health Emergency (PHE) exists and also authorizes EMTALA waivers under section 1135 of the Social Security Act. Notice of EMTALA waivers will be provided through CMS to covered entities; AND
3) Unless EMTALA waivers are granted for an entire geographic area, the hospital applies for a waiver; AND
4) The hospital must have activated its emergency operations plan; AND
5) The State must have activated its emergency operations plan or pandemic plan for an area that covers the affected hospital.

The waiver generally lasts for 72 hours after the emergency is declared and the facility's emergency plan is activated (in case of a pandemic the waiver will last until the termination of the PHE declaration). Even in the case of a waiver, however, the hospital is still responsible for ensuring the safety of the patients in its care.

Local or state declarations or waivers cannot alter, waive, or otherwise address EMTALA, as EMTALA is a federal law.

Response modified from EMTALA & Surges in Demand for Emergency Department Services During a Pandemic and CMS Public Health Emergency Declaration Questions and Answers

Can EMTALA be Waived Retroactively?

An EMTALA waiver can be applied back to the effective date of the emergency period AND activation of the hospital emergency operations plan. The emergency period begins on the date in which there are both a disaster or emergency declaration by the President and a PHE declaration by the HHS Secretary for the event. A waiver cannot be applied before the effective date of the emergency period.

For example, if a precipitating event occurs on a Saturday at noon, the hospital activates its emergency plan immediately following the event, a presidential declaration is made, effective Sunday at noon, and a public health emergency is declared and 1135 waiver authority invoked, effective Monday at noon, the EMTALA waiver could not be effective any earlier than Monday at noon. Please note that this is an extreme example to demonstrate the hierarchy of the declaration process. Generally, FEMA and HHS work together to ensure the effective dates of declarations are issued to provide the regulatory relief and aid necessary to support the response and the presidential declarations, PHE declarations, and 1135 waiver authorization can be issued and dated retroactively, as has been done numerous times during past responses.

Response modified from EMTALA & Surges in Demand for Emergency Department Services During a Pandemic

How Can Hospitals Comply with EMTALA in a Disaster or Emergency?

EMTALA was enacted to ensure the safety of all patients seeking care in EDs, therefore in disaster, mass casualty, or emergency situations, EMTALA provisions must be followed. In these cases, hospitals remain responsible for MSE examinations, which can be conducted by licensed health professionals including physicians, nurse practitioners, physician assistants, and nurses trained to conduct such exams. The MSE can be adjusted for the appropriateness of the event and for the presenting signs and symptoms, (e.g. assessing a group of people for high acuity injury or illness by visual exam and group questions by exclusion). After an MSE is conducted and documented to the best of the clinician's ability, under the circumstances, the patients can be transferred or referred to other hospitals that are less affected by the event/volume of patients in accordance with the hospital's emergency/community response plan. For tips for managing an influx of patients in a mass casualty, review the ASPR TRACIE tip sheet, No Notice Incidents: Hospital Triage, Intake, and Throughput.

What Strategies Can Hospitals Use to Manage Surge and Comply with EMTALA?

Hospitals may set up alternative screening sites on campus for emergencies such as pandemics or other events where an alternative area is appropriate.

Hospitals, working with their local emergency medical service (EMS) providers, can determine diversion criteria and protocols to limit the amount of patients arriving by EMS. Hospitals can also work with their local healthcare coalitions and emergency management agencies to develop emergency department saturation plans, public communication campaigns, and other appropriate measures to help evenly disperse patient load. Communities may also opt to establish alternate care sites not affiliated with any particular hospital or located on the grounds of any licensed facility. In this case/within these sites, EMTALA would not apply.

Most importantly, regardless of EMS diversion or plans in the community to direct patients to specific facilities, once a patient arrives at an ED, EMTALA applies. For example, a patient suspected of having a highly infectious disease that requires stabilization cannot be transferred to another facility without an MSE and any necessary stabilization or treatment.

NOTE: ASPR TRACIE has received inquiries regarding a specific scenario and recommended strategies to address surge under those specific circumstances:

In the event that an incident with the potential to massively overwhelm available resources occurs within close proximity to a hospital, the hospital may quickly become overwhelmed yet patients may continue to present to the hospital outside of EMS (e.g., walk-ins and in personally owned vehicles, police vehicles) and can't be diverted.

Question: *Under this scenario, how can a hospital comply with EMTALA, while also ensuring patients receive care as quickly as possible, which may involve transfer to another facility?*

Answer: A hospital can consider coordinating triage and redistribution of patients in partnership with EMS and other local hospitals. Triage can be established inside or outside the hospital. A qualified healthcare provider from the affected hospital can conduct an MSE as described above. Once triaged/evaluated, these patients can either be sent inside the affected hospital or appropriately redistributed to other receiving facilities that have agreed to accept patients through EMS, medical command, or other coordinating entities, based upon the number of patients and severity of injury.

For example, if it had been determined through pre-existing plans and planning or other real-time means (e.g., by onsite EMS, dispatch, a healthcare coalition, or other process specific to the affected jurisdiction) that local hospitals A, B, and C can accept 50 critical, 100 immediate, and 300 walking wounded, onsite EMS and the hospital-based qualified healthcare provider(s) could complete the MSE and redirect and coordinate transfer of those patients without having to speak (clinician to clinician) directly to the receiving hospitals for each individual patient.

In addition, for those providers affected by the CMS Emergency Preparedness Final Rule, these specific issues should be considered in the development of a facility's risk assessment and overall emergency preparedness program. MSEs can occur based on numerous hazards to include flooding and active shooter incidents, therefore it is encouraged that facilities document their policies and procedures for transfer situations. (Updated May 7, 2018)

Response modified from EMTALA & Surges in Demand for Emergency Department Services During a Pandemic, EMTALA Questions and Answers, and EMTALA Requirements and Implications Related to Ebola Virus Disease

Are there Additional Actions that Can be Taken to Address Patient Surge without an EMTALA Waiver? (Updated May 7, 2018)

CMS has provided considerable information on ways to increase inpatient and outpatient capacity **without the need for 1135 waivers**. Inpatient surge activities include early discharge planning, opening already certified beds or units, and the use of remote locations. Outpatient surge activities include the use of tents or mobile facilities located on/within the hospitals' campus as a temporary means of allowing for the management of outpatient surge. These temporary facilities must meet all of the CMS Conditions of Participation AND must comply with all state and county licensure and life safety code requirements.

This information is described in detail in the fact sheet Hospital Alternative Care Sites during H1N1 Public Health Emergency starting on page 7 of 14 for inpatient surge, and page 9 of 14 for outpatient surge actions and impacts on conditions of participation permissible without waivers. Page 13 and 14 of this fact sheet describe implications of surge sites on Life Safety Code and discuss degraded but safe conditions.

As always, when using surge strategies, notify your state licensing agency and CMS Regional Offices to discuss the specifics of your facility's solution.

Resources

ASPR TRACIE CMS and Disasters: Resources at Your Fingertips
ASPR TRACIE EMTALA and Disasters
Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Options for Hospitals in a Disaster
Hospital Alternative Care Sites during H1N1 Public Health Emergency

Are there any EMTALA Provisions that Address Safety and Security of Staff, Patients, and Visitors in a Situation Where the Hospital is Potentially Unsafe?

In a situation where the hospital is a potential site of emergency operations (e.g., an on-campus shooter, fire, flood, or other event where the hospital is potentially compromised), ED personnel still have a duty to protect the health and safety of their patients, staff, and visitors. If an individual presents to the affected emergency department, despite security or safety issues, EMTALA still applies and the patient must receive an MSE to determine if an EMC is present. They must also receive stabilizing care and/or be transferred to an appropriate facility to provide care as warranted. The MSE can be adjusted to the specific patient and scenario, as appropriate. If a law enforcement perimeter is established that prevents patients from coming onto the campus or into the hospital, then EMTALA would not apply. Further, if there is an immediate risk to providers and the providers feel they cannot provide an MSE or stabilizing care without risking their lives, it might be necessary to delay care until the security or safety issue is resolved.

Does EMTALA Apply if a Shooting or Other Event Occurs Outside my Facility?

Yes. EMTALA applies to any injured, ill, or laboring person on the hospital grounds, which includes hospital-owned or operated parking areas, sidewalks, and other grounds. As previously mentioned, if the scene presents an immediate safety risk to the providers, the provision of an MSE and stabilizing treatment may have to await the arrival of law enforcement to secure the safety of the situation.

Where Can I Find Examples of Previous EMTALA Waivers and Information on Requesting a Waiver?

The Secretary of Health and Human Services can waive EMTALA sanctions under section 1135 of the Social Security Act. CMS provides information on requesting an 1135 waiver, information to provide for an 1135 waiver, and related content on its 1135 waiver web page. ASPR has provided examples of previous waiver or modification of requirements under section 1135 of the Social Security Act on their website.

Who Can Answer Questions About my Hospital's Emergency Operations Plans and EMTALA Considerations?

Questions on EMTALA compliance and violations should be addressed to your regional/local CMS Office.

Additional Resources

American Academy of Emergency Medicine. (2017). EMTALA

American College of Emergency Physicians. (2017). EMTALA: News Media.

American Hospital Association. (2001). EMTALA Questions and Answers.

Centers for Medicare & Medicaid Services. (2017). Emergency Medical Treatment and Labor Act (EMTALA).

Centers for Medicare & Medicaid Services. (2014). Emergency Medical Treatment and Labor Act Requirements and Implications Related to Ebola Virus Disease (Ebola).

Centers for Medicare & Medicaid Services. (2009). Emergency Medical Treatment and Labor Act (EMTALA) Requirements and Options for Hospitals in a Disaster.

Centers for Medicare & Medicaid Services. (n.d.). Public Health Emergency Declaration Questions and Answers. (Accessed 12/11/2017.)

Finan, S., et al. (2006). Disaster Preparedness: Legal Issues Faced by Hospitals in the Post-Katrina Environment. American Bar Association – ABA Health eSOURCE.

Zibulewsky, J. (2001). The Emergency Medical Treatment and Active Labor Act (EMTALA): What It is and What it Means for Physicians.

Health Insurance Portability and Accountability Act (HIPAA) Factsheet

Reprinted with permission from the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources Assistance Center and Information Exchange (TRACIE)

HIPAA and Disasters: What Emergency Professionals Need to Know

Updated September 11, 2017

Disasters and emergencies can strike at anytime with little or no warning and the local healthcare system in the midst of an emergency response can be rapidly inundated with patients, worried family and friends looking for their loved ones, and media organizations requesting patient information. Knowing what information can be released, to whom, and under what circumstances, is critical for healthcare facilities in disaster response. This guide is designed to answer frequently asked questions regarding the release of information about patients following an incident.

NOTE: This guide does NOT replace the advice of your facility Privacy Officer and/or legal counsel who should be involved in planning for information release prior to an event, developing policy before a disaster that guides staff actions during a disaster, and during an emergency when contemplating disclosures.

This guide does address what information can be disclosed and under what circumstances. Covered entities can disclose needed patients' protected health information (PHI) without individual authorization:

- If necessary to treat the patient or a different patient or if the information would help treat a different patient
- To a public health authority, as outlined below
- At the direction of a public health authority, to a foreign agency acting in collaboration with the public health authority
- To persons at risk of contracting or spreading a disease or condition (if authorized by other law)
- With certain people involved with patient's care/ responsible for the patient
- When there is imminent threat to public health/ safety

Covered entities:

- Health plans
- Healthcare clearinghouses
- Healthcare providers (e.g. hospitals, clinics, pharmacies, nursing homes) who conduct one or more covered healthcare transactions electronically.

Business associates:

- Persons or entities that perform functions or activities on behalf of, or provide certain services to, a covered entity that involve creating, receiving, maintaining, or transmitting PHI.
- Subcontractors that create, receive, maintain, or transmit PHI on behalf of another business associate.

What is HIPAA and the Privacy Rule?

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementing regulations, the HIPAA Privacy, Security, and Breach Notification Rules, protect the privacy and security of patients' PHI, but is balanced to ensure that

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HEALTHCARE EMERGENCY PREPAREDNESS INFORMATION GATEWAY

appropriate uses and disclosures of the information may still be made when necessary to treat a patient, to protect the nation's public health, and for other critical purposes.

Does HIPAA Apply to Me or My Organization?

The HIPAA Privacy Rule applies to disclosures made by employees, volunteers, and other members of a covered entity's or business associate's workforce. Covered entities are health plans, healthcare clearinghouses, and those healthcare providers that conduct one or more covered healthcare transactions electronically, such as transmitting healthcare claims to a health plan.

Business associates generally include persons or entities (other than members of the workforce of a covered entity) that perform functions or activities on behalf of, or provide certain services to, a covered entity that involve creating, receiving, maintaining, or transmitting PHI. Business associates also include subcontractors that create, receive, maintain, or transmit PHI on behalf of another business associate.

HIPAA does not apply to disclosures made by those who are not covered entities or business associates (although such persons or entities are free to follow the standards on a voluntary basis if desired).

When Can PHI Be Shared?

Patient health information, or PHI, can be shared under the following circumstances:

Treatment. Under the HIPAA Privacy Rule, covered entities may disclose, without a patient's authorization, PHI about the individual as necessary to treat the patient or to treat a different patient. Treatment includes the coordination or management of healthcare and related services by one or more healthcare providers and others, consultation between providers, providing follow-up information to an initial provider, and the referral of patients for treatment.

Public Health Activities. The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to PHI that is necessary to carry out their public health mission. Therefore, the HIPAA Privacy Rule permits covered entities to disclose needed PHI without individual authorization:

- **To a public health authority** that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability, or to a person or entity acting under a grant of authority from or under contract with such public health agency,. This could include, for example: the reporting of disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions.
- **At the direction of a public health authority**, to a foreign government agency that is acting in collaboration with the public health authority.

- **To persons at risk** of contracting or spreading a disease or condition if other law, such as state law, authorizes the covered entity to notify such persons as necessary to prevent or control the spread of the disease or otherwise to carry out public health interventions or investigations.

Disclosures to Family, Friends, and Others Involved in an Individual's Care and for Notification. A covered entity may share PHI with a patient's family members, relatives, friends, or other persons identified by the patient as involved in the patient's care. A covered entity may also share information about a patient as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient's care, of the patient's location, general condition, or death. This may include—if necessary to notify family members and others—the police, the press, or the public at large.

- The covered entity should get verbal permission from individuals or otherwise be able to reasonably infer that the patient does not object, when possible; if the individual is incapacitated or not available, covered entities may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest.
- In addition, a covered entity may share PHI with disaster relief organizations such as the American Red Cross, which are authorized by law or by their charters to assist in disaster relief efforts, for the purpose of coordinating the notification of family members or other persons involved in the patient's care, of the patient's location, general condition, or death. It is unnecessary to obtain a patient's permission to share the information in this situation if doing so would interfere with the organization's ability to respond to the emergency.

Covered entities can disclose needed PHI without individual authorization:

- If necessary to treat the patient or a different patient
- To a public health authority authorized by law to collect or receive such information
- At the direction of a public health authority, to a foreign agency acting in collaboration with the public health authority
- To persons at risk of contracting or spreading a disease or condition (if authorized by other law)
- With certain people involved with patient's care/ responsible for the patient for reunification or when in the patient's best interest
- When there is imminent threat to public health/ safety

Imminent Danger. Healthcare providers may 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 (such as state statutes, regulations, or case law) and the provider's standards of ethical conduct.

Disclosures to the Media or Others Not Involved in the Care of the Patient/Notification. Upon request for information about a particular patient by name, a hospital or other healthcare

facility may release limited facility directory information to acknowledge an individual is a patient at the facility and provide basic information about the patient's condition in general terms (e.g., critical or stable, deceased, or treated and released) if the patient has not objected to or restricted the release of such information or, if the patient is incapacitated, if the disclosure is believed to be in the best interest of the patient and is consistent with any prior expressed preferences of the patient. Reference 45 CFR 164.510(a). In general, except in the limited circumstances described elsewhere, affirmative reporting to the public or media of specific information about treatment of an identifiable patient, such as specific tests, test results or details of a patient's illness, may not be done without the patient's written authorization (or the written authorization of a personal representative who is legally authorized to make healthcare decisions for the patient).

General or aggregate information in mass casualty events that does not identify an individual or meets the requirements of the HIPAA Privacy Rule's de-identification provisions is *not* considered PHI (e.g., X number of casualties were received by the hospital with the following types of injuries).

Minimum Necessary. For most disclosures, a covered entity must make reasonable efforts to limit the information disclosed to that which is the "minimum necessary" to accomplish the purpose. (Minimum necessary requirements do not apply to disclosures to health care providers for treatment purposes.) Covered entities may rely on representations from a public health authority or other public official that the requested information is the minimum necessary for the purpose.

Note: The disclosures listed above are at the discretion of the covered entity and are not required disclosures under the Rule. Some of these disclosures may be required by other federal, state or local laws (for example, mandatory reporting of positive infectious disease test results).

Does the HIPAA Privacy Rule Permit Disclosure to Public Officials Responding to a Bioterrorism Threat or other Public Health Emergency?

Yes. The HIPAA Privacy Rule recognizes that various agencies and public officials will need PHI to deal effectively with a bioterrorism threat or emergency. The public health threat does not have to reach a declared emergency status. If information is needed by a government agency to protect the health of the public (e.g., a food-borne outbreak), the agency may request and receive appropriate clinical and other information about the patient's disease, care, and response to treatment. To facilitate the communications that are essential to a quick and effective response to such events, the HIPAA Privacy Rule permits covered entities to disclose needed information to public officials in a variety of ways. Further, if the covered entity has obligations to report test results and other information to public health agencies by statute, rule, or ordinance, the HIPAA Privacy Rule generally permits these disclosures.

Covered entities may disclose PHI, without the individual's authorization, to a public health authority acting as authorized by law in response to a bioterrorism threat or public health emergency (reference 45 CFR 164.512(b)), public health activities). The HIPAA Privacy Rule also permits a covered entity to disclose PHI to public officials who are reasonably able to prevent or lessen a serious and imminent threat to public health or safety related to bioterrorism (reference 45 CFR 164.512(j)), to avert a serious threat to health or safety). In addition, disclosure of PHI, without the individual's authorization, is permitted where the circumstances of the emergency implicates law enforcement activities (reference 45 CFR 164.512(f)); national security and intelligence activities (reference 45 CFR 164.512(k)(2)); or judicial and administrative proceedings (reference 45 CFR 164.512(e)).

Is the HIPAA Privacy Rule "Waived" or "Suspended" During an Emergency?

The HIPAA Privacy Rule is not suspended during a public health or other emergency; however, under certain conditions the Secretary of the U.S. Department of Health and Human Services may waive certain provisions of the HIPAA Privacy Rule section 1135(b)(7) of the Social Security Act, if such a waiver is deemed necessary for the particular incident when the Secretary declares a public health emergency and the President declares an emergency or disaster under the Stafford Act or National Emergencies Act. For more information, access "Is the HIPAA Privacy Rule suspended during a national or public health emergency?" Access Hurricane Irma and HIPPA Bulletin: Limited Waiver of HIPAA Sanctions and Penalties During a Declared Emergency for an example of how sanctions and penalties could be waived in a declared emergency.

Does the HIPAA Privacy Rule Permit Disclosure to Law Enforcement?

A HIPAA-covered entity may disclose PHI to law enforcement with the individual's signed HIPAA authorization. A covered entity may disclose directory information as mentioned above to law enforcement upon request. Further disclosures to law enforcement for purposes of re-unification and family notification are permitted as discussed above.

A HIPAA-covered entity also may disclose PHI to law enforcement without the individual's signed HIPAA authorization in certain incidents, including:

- To report to a law enforcement official reasonably able to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public.
- To report PHI that the covered entity in good faith believes to be evidence of a crime that occurred on the premises of the covered entity.
- To alert law enforcement to the death of the individual, when there is a suspicion that death resulted from criminal conduct.
- When responding to an off-site medical emergency, as necessary to alert law enforcement about criminal activity.
- To report PHI to law enforcement when required by law to do so (such as reporting gunshots or stab wounds).
- To comply with a court order or court-ordered warrant, a subpoena or summons issued

by a judicial officer, or an administrative request from a law enforcement official (the administrative request must include a written statement that the information requested is relevant and material, specific and limited in scope, and de-identified information cannot be used).

- To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person, but the information disclosed must be limited to certain basic demographic and health information about the person.
- To respond to a request for PHI about an adult victim of a crime when the victim agrees (or in limited circumstances if the individual is unable to agree). Child abuse or neglect may be reported, without a parent's agreement, to any law enforcement official authorized by law to receive such reports.

How Does the HIPAA Privacy Rule Apply to Disclosures Involving Foreign Nationals?

Covered entities may disclose PHI for all persons, regardless of nationality, according to the disclosures listed in the Privacy Rule and discussed above. Disclosure of PHI to embassies, consulates or other third parties, such as the American or International Red Cross acting in a capacity to facilitate notifications or repatriation following an emergency, is permitted under the existing disclosures of the HIPAA Privacy Rule, as referenced above.

For More information

- Bulletin: HIPAA Privacy in Emergency Situations
- Can healthcare information be shared in a severe disaster?
- Health Information Privacy – Is HIPAA Privacy Rule Suspended during a National or Public Health Emergency?
- Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule: A Guide for Law Enforcement
- HIPAA Privacy Rule: Disclosures for Emergency Preparedness – A Decision Tool
- Hurricane Katrina Bulletin: HIPAA Privacy and Disclosures in Emergency Situations
- Incorporating Active Shooter Incident Planning into Health Care Facility Emergency Operations Plans. Appendix A: Information Sharing. (Page 29 of 33)
- When does the Privacy Rule allow covered entities to disclose PHI to law enforcement officials?
- HIPAA Policy Brief

For more information on HIPAA and Public Health:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/index.html
For more information on HIPAA and Emergency Preparedness and Response:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/emergency/index.html
General information on understanding the HIPAA Privacy Rule may be found at:
http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

Requesting an 1135 Waiver

Definition of an 1135 Waiver

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act, and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to his/her regular authorities. For example, under section 1135 of the Social Security Act, he/she may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient healthcare items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

Examples of these 1135 waivers or modifications include:

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other healthcare professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure
- Emergency Medical Treatment and Labor Act (EMTALA) sanctions for direction or relocation or of an individual to receive a medical screening examination in an alternative location pursuant to an appropriate state emergency preparedness plan (or in the case of a public health emergency involving pandemic infectious disease, a state pandemic preparedness plan) or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency. A waiver of EMTALA requirements 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.
- Stark self-referral sanctions
- Performance deadlines and timetables may be adjusted (but not waived).
- Limitations on payment for healthcare items and services furnished to Medicare Advantage enrollees by non-network providers.

These waivers under section 1135 of the Social Security Act typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period. Waivers Revised: November 4, 2009 for EMTALA (for public health emergencies that do not involve a pandemic disease) and HIPAA requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the termination of the pandemic-related public health emergency.

The 1135 waiver authority applies only to Federal requirements and does not apply to State requirements for licensure or conditions of participation.

Other Flexibilities
In addition to the 1135 waiver authority, Section 1812(f) of the Social Security Act (the Act) authorizes the Secretary to provide for skilled nursing facility (SNF) coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the SNF benefit's "acute care nature" (that is, its orientation toward relatively short-term and intensive care).

Determining if Waivers Are Necessary
In determining whether to invoke an 1135 waiver (once the conditions precedent to the authority's exercise have been met), the Assistant Secretary for Preparedness and Response (ASPR) with input from relevant OPDIVS determine the need and scope for such modifications. Information considered includes requests from Governor's offices, feedback from individual healthcare providers and associations, and requests to regional or field offices for assistance.

How States or Individual Healthcare Providers Can Ask for Assistance or a Waiver
Once an 1135 Waiver is authorized, healthcare providers can submit requests to operate under that authority or for other relief that may be possible outside the authority to the CMS Regional Office with a copy to the State Survey Agency. Request can be made by sending an email to the CMS Regional Office in their service area. Information on your facility and justification for requesting the waiver will be required.

Review of 1135 Waiver requests
CMS will review and validate the 1135 waiver requests utilizing a cross-regional Waiver Validation Team. The cross-regional Waiver Validation Team will review waiver requests to ensure they are justified and supportable.

Implementation of 1135 Waiver Authority
Providers must resume compliance with normal rules and regulations as soon as they are able to do so, and in any event the waivers or modifications a provider was operating under are no longer available after the termination of the emergency period. Federally certified/approved providers must operate under normal rules and regulations, unless they have sought and have been granted modifications under the waiver authority from specific requirements.

Email Address for CMS Regional Office

ROSFOSO@cms.hhs.gov (Western Consortium): Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming, Alaska, Idaho, Oregon, Washington, Arizona, California, Hawaii, Nevada, Pacific Territories.

INTER-HOSPITAL MUTUAL AID AGREEMENT

The following pages include a copy of the Utah Hospital Association Inter-Hospital Mutual Aid Agreement, which was originally developed and implemented in 2006. The purpose of the document is to facilitate the ability of hospitals throughout the state to share personnel, equipment, supplies and pharmaceuticals as well as accepting patient transfers during a disaster situation. The agreement details definitions, implementation methods, indemnification, limitations, and reimbursement procedures. No participating hospital shall be required to provide assistance unless it determines that it has sufficient resources to do so.

The following document is an example of the Utah Mutual Aid Agreement currently in use. Signed copies from each hospital are maintained by the Utah Hospital Association. This document will be reviewed and re-issued every three years unless circumstances dictate otherwise.

Inter-Hospital Mutual Aid Agreement

January, 2018

An Agreement to Facilitate:

Personnel and Staff Sharing During Disasters;

Equipment, Supplies and Pharmaceutical Sharing During Disasters; Transfer of Patients During Disasters.

Nothing in this agreement shall require the Veteran's Administration Hospital to act in violation of the Federal Laws governing their operations.

ARTICLE I - INTRODUCTION

During times of disaster or crisis, hospitals will depend on cooperative working agreements with other hospitals, healthcare facilities and other medical providers. All manners of need for cooperation cannot be foreseen until the time of the event. However, it is reasonable to predict, based upon lessons learned, that cooperation in the following areas will be needed:

1. Personnel and staff sharing;
2. Equipment, supplies and pharmaceutical sharing;
3. Transfer of patients to appropriate facilities that can continue care, and
4. Administrative functions.

While the Utah Hospital Association and the hospital community have long-standing agreements to help our fellow citizens, visitors and providers during times of crisis, it is time to formalize these agreements. There are several reasons for this, which include, but are not limited to: (a) ensuring that any faulty presumptions are clarified; (b) ensuring that the understandings will continue in force even if personnel or other institutional processes change, and (c) providing documentation for accreditation agencies, standards organizations and the community at large regarding the high level of commitment that the hospital community has regarding preparedness.

This cooperative working Agreement shall provide for mutual assistance among the participating hospitals, other healthcare facilities and medical providers (herein referred to as "Hospital(s)" in the prevention of, response to, and recovery from any disaster that results in a formal state of emergency subject to the State's criteria for declaration.

This document will be reviewed and re-issued every three years unless circumstances dictate otherwise.

ARTICLE II – DEFINITIONS

The following terms are defined exclusively as they are referred to within this agreement. These definitions shall not be construed, carried over or otherwise applied to other documents, plans or procedures that are not an explicit counterpart of this instrument.

Hospital(s)—is inclusive of any participating hospital within the geographical boundaries of the state of Utah; any other healthcare facility which is owned or operated by a Hospital within the geographic boundaries of the State of Utah; any medical provider who is employed by an participating healthcare

facility within the geographical boundaries of the state of Utah.
Participating Hospital(s)—A hospital that has signed this instrument and has agreed to provide mutual aid under the terms of this agreement.
Assisting Hospital(s)—A hospital that is the provider of aid to another hospital under the terms of this agreement.
Receiving Hospital(s)—A hospital that has requested mutual aid under the terms of this agreement.

ARTICLE III – RESPONSIBILITIES OF HOSPITALS

No participating hospital shall be required to provide assistance unless it determines that it has sufficient resources to do so.

Each participating Hospital has the following responsibilities under this Agreement:
1. On an "as-needed" basis, provide aid and assistance to other participating Hospitals as requested.

2. Adopt and put into practice the standardized National Incident Management System (NIMS) and Hospital Incident Command System (HICS).

ARTICLE IV - IMPLEMENTATION

A participating Hospital may request the assistance of any other participating Hospital in preventing, responding to, mitigating and recovering from emergencies or disasters that result in a need for additional assistance. Requests for assistance shall be made through the Chief Executive Officer of a participating Hospital or a designee. Requests may either be verbal, written or emailed. A written request will follow all verbal requests as soon as is practicable.

1. SUPERVISION AND CONTROL: When providing assistance under the terms of this agreement, the personnel, equipment and resources of any Assisting Hospital will be under the operational control of the Requesting Hospital, which shall advise supervisory personnel of the Assisting Hospital concerning assignments.

a. The Assisting Hospital shall maintain daily personnel time records, material records, and a log of equipment sent to the requesting hospital. The Assisting Hospital's personnel and other resources shall remain subject to recall by the Assisting Hospital at any time, subject to reasonable notice to the Requesting Hospital.

b. At least 24-hour advance notification of intent to withdraw personnel or resources shall be provided to the Requesting Hospital unless such notice is not practicable, in which case the Assisting Hospital shall provide as much notice as possible.

2. CREDENTIALS AND PRIVLEGING: During any internal or external emergency or declared disaster, the Requesting Hospital shall consider the Assisting Hospital as an external medical credential verifications organization (CVO) and accept the credentials of the practitioner(s) who are dispatched as the result of a formal request for assistance under this Agreement. The Assisting Hospital's practitioner(s) shall present a copy of their current Utah professional license, driver's license, and ID card from the Assisting Hospital to the Requesting Hospital before being placed into service or being allowed to render care.

The Requesting Hospital shall grant disaster privileges per their internal disaster plan(s) and/or medical staff bylaws.

3. **FOOD, HOUSING AND SELF-SUFFICIENCY**: Unless specifically instructed otherwise, the Requesting Hospital shall have the responsibility of providing food and housing for the personnel of the Assisting Hospital from the time of their arrival at the designated location to the time of their departure. However, Assisting Hospital personnel and equipment should be, to the greatest extent possible, self-sufficient while working in the emergency or disaster area.

4. **TRANSFER AND ACCEPTANCE OF HOSPITAL PATIENTS**: There may be times when the assistance required is the immediate transfer and acceptance of patients from one Hospital to another. Under this Agreement, the Requesting Hospital must contact the Assisting Hospital and provide as much information as possible regarding the numbers and types of patients that are to be transferred. The Assisting Hospital shall accept these patients solely on the ability to provide the care needed to the transferred patient(s) and not on the requirements of the patient's specific insurance provider network (PPO, HMO, etc.) or the patient's ability to pay for services. Consider, where possible, sending staff to the Assisting Facility along with transferred patients (such as one nurse per every ICU patient transferred.)

   After a patient is transferred, the Receiving Hospital assumes all responsibilities for the patient's care. Each Hospital shall be responsible for billing the patient or the patient's agent or representative only for services that are rendered at that facility. Neither party shall look to the other party to pay for services rendered to the patient transferred by virtue of this Agreement, except to the extent that such liability would exist separate and apart from this Agreement.

5. **LOGISTICS AND PATIENT MOVEMENT**: The Requesting Hospital is responsible for arranging for the transportation of the patient and shall send all records, test results, X-rays and any other information, unless this would result in a delay that could increase the risk of the transfer, delay the safe evacuation of the facility or delay the treatment of other person's involved in the disaster or emergency. At a minimum, the patient's name and identification number should be written with a permanent marker directly onto the patient's arm. If records are not transferred with the patient, they should be transferred as soon as possible.

   If the Assisting Hospital is sending personnel, equipment, supplies or pharmaceuticals, it shall arrange for the safe and efficient transportation of these materials to the Requesting Hospital.

6. **COMMUNICATION**: Unless specifically instructed otherwise, the Requesting Hospital shall have the responsibility for coordinating communication with the personnel of the Assisting Hospital and the Requesting Hospital. Assisting Hospital personnel should be prepared to furnish equipment (e.g. cell phones) to maintain communication among their respective operating units.

7. **TERM OF DEPLOYMENT**: With the exception of the inter-facility patient transfers, the initial duration of the request for assistance is normally five (5) days and may be extended or shortened, as necessary.

ARTICLE V – LIMITATIONS

A Hospital's obligation to provide assistance in the prevention of, response to and recovery from an emergency is subject to the following conditions:

1. The Hospital requesting assistance must have either declared an internal disaster/emergency or is involved in an external disaster which has been declared by the State.

2. An Assisting Hospital may withhold resources to the extent necessary to provide reasonable protection and services for or within its own facility.
3. Personnel of an Assisting Hospital shall continue under the human resource policies and procedures of their own organization to include medical protocols, standard operating procedures and other protocols. On an operational basis, however, assisting personnel shall be under the control of the appropriate officials within the incident management system of the Requesting Hospital receiving the assistance.
4. Assets and equipment of an Assisting Hospital shall be considered "loaned equipment" for the purpose of this Agreement and the Requesting Hospital shall ensure the safe and medically prudent operation of said equipment by appropriately licensed, trained and professional personnel.

ARTICLE VII – REIMBURSEMENT AND DISPUTES REGARDING REIMBURSEMENT

Any Requesting Hospital shall reimburse the Assisting Hospital rendering aid under this system. A Hospital providing assistance may determine to donate assets of any kind to a Requesting Hospital.

The Requesting Hospital will reimburse the Assisting Hospital for deployment-related costs as outlined in the Agreement. All such costs must be well documented in order to be eligible for reimbursement.

Within 30 days of termination of assistance, each Assisting Hospital will provide notice to the Requesting Hospital of its intention whether or not to seek reimbursement. Such notification should include a brief summary of the services provided, an estimated total amount to be requested (the Requesting Hospital will need this for budgeting purposes), and an official point-of-contact or finance representative who will be responsible for the request. The Requesting Hospital shall officially acknowledge receipt of each letter of notification once the required documentation has been provided.

The Assisting Hospital will then prepare and submit a request for reimbursement to the Requesting Hospital within 60 days of the termination of assistance if the intent of the Assisting Hospital is to seek reimbursement. This request shall consist of:

- A cover letter summarizing the assistance provided under this Agreement and officially requesting reimbursement for expenses incurred. The finance representative responsible for the request should be identified as the point-of-contact for ongoing questions.
- A copy of the written request for assistance.
- A single invoice listing resources provided with the total cost.
- Supporting documentation (copies of invoices, travel claims, etc.)

Should a dispute arise between parties to the Agreement regarding reimbursement, involved parties will make every effort to resolve any dispute within 30 days of the written notice of the dispute by the Hospital asserting non-compliance.

In the event that the dispute is not resolved within 90 days of the notice of dispute, either Hospital may request the dispute be solved through binding arbitration, which shall be conducted in Salt Lake City, Utah, in accordance with the American Health Lawyers Association's Alternative Dispute Resolution Service Rules of Procedure for Arbitration. Judgment of the award rendered by the arbitrator may be entered in any court having jurisdiction thereof.

SECTION VIII – REIMBURSABLE EXPENSES

The terms and conditions governing reimbursements for any assistance provided pursuant to this Agreement shall be in accordance with the following provisions, unless otherwise agreed upon by the Requesting and Assisting Hospital and specified in writing.

1. **PERSONNEL**: During the period of assistance, the Assisting Hospital shall continue to pay its employees according to its then prevailing ordinances, rules and regulations. The Requesting Hospital shall reimburse the Assisting Hospital for all direct payroll costs and expenses incurred during the period of assistance.

2. **EQUIPMENT:** The Assisting Hospital shall be reimbursed by the Requesting Hospital for the use of its equipment during the period of assistance at the fair market rental rates.

3. **MATERIALS AND SUPPLIES:** The Assisting Hospital shall be reimbursed for all materials and supplies furnished by it and used or damaged during the period of assistance at the cost to the Assisting Hospital, except to the extent that such damage is caused by the negligence of the Assisting Hospital's personnel. In the alternative, the Assisting and Requesting Hospital may agree that the Requesting Hospital will replace, with the kind and quality as determined by the Assisting Hospital, the materials and supplies used or damaged.

4. **RECORD KEEPING:** The Assisting Hospital shall maintain records and submit invoices for reimbursement to the Requesting Hospital in accordance with existing policies and practices.

5. **PAYMENT:** Unless otherwise mutually agreed upon, the Assisting Hospital shall bill the Requesting Hospital for all reimbursable expenses with an itemized statement as soon as practicable after the expenses are incurred, but not later than sixty (60) days following the period of assistance. The Requesting Hospital shall pay the bill, or advise of any disputed items, within thirty (30) days of receipt of the invoice, subject to the procedures in Section VII.

6. **WAIVER OF REIMBURSEMENT:** A Member may assume or donate, in whole or in part, the costs associated with any loss, damage, expense or use of personnel, equipment and resources provided. If a Hospital elects to assume or donate any costs, that Hospital shall waive, in writing, any rights to reimbursement for the costs of the resources or items donated.

ARTICLE IX – WORKER'S COMPENSATION

Personnel of a Hospital organization responding to or rendering assistance for a request who sustain injuries or death in the course of, and arising out of, their employment, are entitled to all applicable benefits normally available to personnel while performing their duties for their employer. All responding personnel shall remain covered under the Assisting Hospital's industrial insurance policy(s).

ARTICLE X – SEVERABILITY

Should a court of competent jurisdiction rule any portion, section or subsection of this Agreement invalid or a nullity, that fact shall not affect or invalidate any other portion, section or subsection; and all remaining portions, sections or subsections shall remain in full force and effect.

ARTICLE XI – TERMINATION

The undersigned Hospital may, at any time, terminate its participation in this Agreement by providing sixty (60) days written notice to the Utah Hospital Association. The Utah Hospital Association shall notify all Hospitals within the state of the effective change in status. A Hospital's withdrawal from the Agreement shall not affect its reimbursement obligations or any other liability or obligations incurred under the terms of this Agreement.

ARTICLE XII – COUNTERPARTS AND AMENDMENTS

This Agreement may be executed in any number of counterparts, each of which together shall constitute one and the same instrument. This Agreement may be modified at any time upon the mutual written consent of all parties to the Agreement.

ARTICLE XIII– SIGNATURE

The person executing this Agreement on behalf of the Hospital and on behalf of their respective agency(ies), hereby represents and warrants that he or she has the right, power, legal capacity and appropriate authority to enter into this Agreement on behalf of the entity for which he or she signs.

Signature Date

_____

Name of Hospital (or Hospital Group)

_____

Printed Name and Title of Person Who Signed

_____