

# Montana COVID-19 Disease

## Medical Surge Strategy



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# Montana COVID-19 Disease Pandemic Medical Surge Strategy

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# Section I: Purpose, Situation, Scope, and Assumptions

## Purpose

The State of Montana is under a declaration of emergency by the Governor due to the COVID-19 pandemic affecting the State and the nation. As part of the response, the State has developed this COVID-19 Medical Surge Strategy in anticipation of gaps in resources and other possible needs for assistance to local and tribal jurisdictions. Population, state size, and the ratio of critical access hospitals to trauma centers present extraordinary challenges to local level resources and capabilities.

This document sets forth the strategies and operative guidance for the hospitals and other healthcare entities to engage their medical surge plans. Its purpose is to augment a community's needs if a hospital's own medical surge operations are overwhelmed. This strategic document is a declarative collaboration and cooperation with medical partners to support them in this emergency response against COVID-19 and outlines how the State of Montana can utilize its partnership with the medical community to defend the health and welfare of the citizens of Montana.

“Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the health care system to endure a hazard impact, maintain or rapidly recover operations that were compromised, and support the delivery of medical care and associated public health services.” (US Department of Health and Human Services)

The Montana Department of Public Health and Human Services (DPHHS), is the assigned coordinating lead agency for Emergency Support Function #8 Public Health and Medical Services (ESF8) by the Montana Emergency Response Framework (MERF), presents this document as the State of Montana's COVID-19 disease specific medical surge support plan.

## Situation

Governor Steve Bullock declared a state of emergency for Montana on March 12, 2020 in response to the threat of pandemic spread of the novel coronavirus disease known as COVID-19. The first cases of the infection in the state followed soon after. Emergency operations are at Level 2 – Full Activation at the State Emergency Coordination Center (SECC) running seven days a week. The Montana Department of Public Health and Human Services Public Health Laboratory (PHL) also operates seven days a week running tests on patient samples from health care providers from around the state. The first cases of COVID-19 in Montana were identified on March 13, 2020.

On March 23, 2020, Governor Bullock issued a directive to acquire hospital space and medical supplies in anticipation of a medical surge due to a sudden flood of COVID-19 patients. This directive temporarily waived the State's required bidding process to quickly procure or distribute emergency supplies and to contract for additional space to care for patients. The directive also waived “strict compliance with reporting requirements around the transfer of certain patients, in order to more quickly allow patients to receive the medical care they require and to discharge recovering patients back to their home communities without delay.”

DPHHS Public Health Emergency Preparedness (PHEP) and the Healthcare Preparedness Program (HPP) guide Montana's local and tribal jurisdictions in preparations for public health events, such as this COVID-19 pandemic. HPP, in collaboration with the Montana Hospital Association (MHA), distributed grant funds in return for deliverable projects. One of the required projects for 2011/2012 required the hospitals accepting

HPP grant funds to develop medical surge plans. These plans remain in place at the participating hospitals. Each of these plans are unique to the facility's resources, anticipated gaps, and community partnerships. Unknown is the quality of each of the plans or suitability to the COVID-19 emergency within each jurisdiction.

Regional Healthcare Coalitions were formed in Montana in 2017. To qualify for funding from the US Health and Human Services (HHS) Assistant Secretary for Preparedness and Response (ASPR), each coalition wrote and ratified emergency preparedness and response plans. Part of those response plans were regional medical surge plans. Those documents are largely guidance documents for coordination of resources and situational awareness.

PHEP's primary role in public health emergencies is to coordinate resources for public health and health care facilities and other entities that fall under ESF8 DPHHS's Medical Surge Annex describes the coordination operations and responsibilities of the agency and its emergency response partners.

The United States Army Corps of Engineers (USACE) are tasked with assessing structures in Helena, Butte, Missoula, Kalispell, Great Falls, Billings, Pablo, Sidney, and Miles City for viability as Alternate Care Sites (ACS). If suitable, and agreed upon with partnering hospitals, the Corps can make modifications to the structures for medical use. USACE intends to prepare these ACS facilities when approved. See Appendix E for the Alternate Care Site Concept of Operations.

In addition to the State's response to the COVID-19, public health and its healthcare partners must continue efforts to protect Montanan's wellbeing. The impact of cardiovascular disease, cancer, smoking, diabetes, a variety of communicable diseases, and much more will contribute to surge situations. Public safety such as law enforcement and firefighting will also have an impact on funding and health that will stress the medical system.

## **Scope**

The COVID-19 emergency response involves wide-spread state, local, and tribal operations. Medical facilities are a primary partner in this effort. This plan is specific to the COVID-19 response efforts and limited to the extent of the Governors declarations and directives. The duration of medical surge operations is dependent on the course of the pandemic and the length of the recovery.

The State's surge planning efforts are meant to supplement and not supplant local jurisdictions surge planning efforts. Each hospital will retain its medical surge plan. This document and the measures it will provide augment a community's ability to continue to serve both the patients infected with COVID-19 and the typical patient population still requiring hospital care.

The declarations of emergency by the Governor and by the President of the United States resulted in defined waivers of related rules and laws. Authorities granting these waivers broaden the scope of the State's ability to assist local level jurisdictions in managing their emergency operations. Federal waivers allow flexibility in medical care decisions and remove burdens from healthcare workers when making critical choices about medical surge, including implementing Crisis Standards of Care, evacuation, early patient discharge, or other necessary decisions during emergency operations. These Authorities are listed in Appendix A.

The State's role includes facilitation of activities and communications between Federal agencies and local officials in carrying out emergency operations and recovery.

Unfortunately, because of the emergent nature of this plan, we must forgo certain preparedness elements, such as accurately measuring surge capability for each hospital or a targeted examination for surge capability for each community.

### **Access and Functional Need Populations**

Emergency response operations must include coordinating reasonable modifications to programs, policies, procedures, architecture, equipment, services, supplies, and communication methods for Montana's access and functional needs population. For the purpose of emergency preparedness in Montana, this population is defined as people having access or functional health (i.e., mental or medical) or physical (i.e., motor ability) needs beyond their capability to maintain on their own during an emergency. It also refers to the "at risk" or "special needs" populations described in the Pandemic and All-Hazards Preparedness Act, also known as PAHPA (PUBLIC LAW 109-417—DEC. 19, 2006) and in the *National Response Framework (NRF)* (2013). It includes individuals who have medical and other functional needs before, during, and after an incident.

DPHHS conducts disaster response activities in consideration of the urgent circumstances of the emergency and the legal obligation to undertake advance planning and prepare to meet the needs of individuals who have disabilities as defined by the Americans with Disabilities Act Amendments Act of 2008, P.L. 110-325, and those associated with them.

DPHHS coordinates with its local, tribal, non-governmental organizations, and State agency partners to ensure the physical, programmatic, and communication access will encompass the requirements for access and functional need populations.

### **Assumptions**

This plan is written with the assumption that the following conditions exist.

1. Local emergency services have activated the jurisdiction's Emergency Operations Center (EOC) and are actively coordinating with the State Emergency Coordination Center (SECC).
2. The COVID-19 disease will soon overwhelm Montana's healthcare system, stressing resources, facilities, staff, and transportation.
3. All other existing conditions (e.g. cancer patients, trauma, cardiovascular disease, infectious diseases), not including COVID-19 illness, will compete for existing healthcare services and hospitalization.
4. Based on clinical reports, a majority of people infected with COVID-19 will not need to be hospitalized.
5. Resource and medical personnel shortages, including Emergency Medical Systems (EMS) are projected during surge efforts.
6. Hospitals in Montana have medical surge plans, however not all are up to date.
7. Other healthcare provider facilities might not have any medical surge plans.
8. Hospitals under surge conditions will initially employ their own plans until resource shortages overwhelms their functionality.
9. Healthcare facilities will request assistance or resources through local incident management or their local disaster and emergency services representative.
10. Hospitals might adopt crisis standards of care to make medical decisions in a surge resulting in scarce resources.

11. The current healthcare work force in Montana cannot meet the needs of a medical surge.
12. The healthcare workforce affected by working in surge conditions will need mental health support
13. Privately owned healthcare institutions and the State agree that an overarching regionalized medical surge plan is necessary to prepare for a large influx of COVID-19 patients.
14. Critical and acute patients, COVID-19 infected or otherwise, will remain hospitalized and will not be moved to an ACS.
15. The State and Federal partners are currently collaborating with local health jurisdictions and hospital officials to identify ACS facilities.
16. ACS facilities will be designated for lower acuity patients not infected with COVID-19. Some exceptions might exist.

## **Section II: Concept of Operations**

### **Implementation**

The State of Montana and DPHHS follows the principles of the National Incident Management System (NIMS) and conducts its emergency response operations under the structure of the Incident Command System (ICS). Activities in this plan are based on established relationships and partnerships with the public, stakeholders and partners, and contributing agencies, including local, State, and Federal entities.

This plan is implemented immediately upon approval by the Governor of Montana, the COVID-19 Task Force, and the DPHHS Director.

This surge strategy is intended for regional application resulting from the emergency declaration for the COVID-19 pandemic. Individual hospitals and healthcare entities will engage their own Medical Surge Plans. Under the emergency declaration, there is flexibility for increasing bed numbers and staff hours. The Hospital Incident Command System (HICS) team will utilize every strategy until the surge exceeds their ability to manage it. Healthcare facilities in the community, jurisdiction, and region could experience the overwhelming event within a short period.

### **Hospital Surge**

When medical facilities engage medical surge operations, they do so under HICS to manage existing resources and communications. Although each plan is individual to each facility, there are commonalities. Those facility surge operations might include the following:

- Discharging low risk/need patients;
- Implementing new mandatory procedures to accelerate discharging patients who are well enough to leave the hospital;
- Non-acute cases referred to Urgent Care centers or clinics;
- Canceling elective surgeries;
- Telemedicine and internet conferencing for patients at home;
- Moving low-acuity patients to ancillary facilities;
- Inner facility repurposing;
- Converting spaces or areas for low-acuity patients;

- Triaging to place COVID-19 patients into separated care units or transfer to hospitals for higher level of care;
- Adding beds to increase capacity;
- Employing crisis standards of care; or
- Reducing ancillary services to use staff elsewhere.

For more details about surge, surge capacity, and surge capability, visit the ASPR Public Health Emergency Website for medical surge at [US HHS What is Medical Surge](#) or download the full handbook, [Medical Surge Capacity and Capability: A management system for Integrating Medical and Health Resources During Large-Scale Emergencies](#).

## Regional Medical Surge Response Strategy

Engaging this response is dependent on a culmination of factors that represents an overwhelming crisis for medical facilities in a region. Each community may have its own threshold for what constitutes a surge. However, the SECC will require health jurisdictions or healthcare regions to meet certain criteria for surge conditions before deploying resources.

The following progression is contingent on the current situation of the COVID-19 pandemic continuing its projected increase and with the knowledge that the Governor has declared a state of emergency.

**NOTE:** These Phases do not have to occur in succession. The progression of a medical surge might be so rapid that the shifts between them will be indistinguishable. Shifts between phases is determined by conditions defined by individual hospitals and jurisdictions. Determinants might include:

- An increased number of patients who test positive and the severity of their illness;
- An approach to the anticipated peak of the disease;
- An unrelated catastrophic event resulting in mass casualty;
- A majority percentage of hospital patients with COVID-19; or
- Prolonged emergency operational periods.

### Phase 1: Single Facility Surge

**Situation:** The facility has engaged its medical surge plan. Communications with other facilities, the Regional Healthcare Coalition, and DPHHS are already established.

- Facility Resources
  - Hospitals and other healthcare entities have resorted to using internal caches of Personal Protective Equipment (PPE) and other medical materials.
- System Hospital Resources
  - If the facility belongs to a corporate system, it can be supported by its sister entities with staffing and resources.
- Local Resources
  - The facility reaches out to the community to request resources and assistance, such as other practitioners and volunteers.

**SECC/DPHHS Action:** Situational awareness is elevated. At Full Activation for the COVID-19 response, the SECC is already in constant contact with local emergency managers, in addition to Federal and other State partners. DPHHS is communicating with the public health department and the Regional Healthcare Coalitions.

- Healthcare facilities have made no resource requests from the State other than PPE and minimal medical supplies.
- The State maintains contact and situational awareness.
- DPHHS coordinates PPE deliveries to local jurisdictions.
- DPHHS actively monitors statewide bed and equipment inventory.
- DPHHS continues specimen testing and disease consultation.

## **Phase 2: Coordinated Facility Surge**

**Situation:** Phase 1 response has not relieved the surge situation and a facility has been overwhelmed due to staffing shortage, scarce resources, too many patients, or some other system stressor. However, partnerships within the local or regional jurisdiction are still sufficient to manage the incident. Hospitals might coordinate, determining which hospitals will take acute COVID-19 or other respiratory compromised patients and which hospitals will take other acute care patients.

- Facilities
  - Healthcare facilities begin to coordinate response activities.
    - Triage for COVID-19 and respiratory patients, critical-care and acute patients, then lower acuity patients to proper facilities.
    - Transportation coordination with 911 dispatch centers.
  - Supporting healthcare entities might include urgent care clinics, long-term care facilities, mental health facilities, ambulatory surgery centers, private physician offices, tribal facilities, and public health clinics.
  - Lower acute patients are transferred to regional critical care hospitals.
  - Regional Healthcare Coalitions maintain situational awareness and assist in coordination efforts.
  - Hospitals begin to prepare the established ACS buildings (already leased by the State).
- Medical Equipment
  - Healthcare partners enact mutual aid within the jurisdiction to combine or share their medical assets
  - Hospitals increase orders from contracted vendors and seek supplies from other sources. System hospitals might begin to struggle with supplying materials.
- Personnel
  - Mutual aid agreements with other hospitals might be enacted.
  - Requests for licensed volunteers from the community may be utilized.
  - Regional Healthcare Coalitions assist in finding staff relief.
  - Clinical personnel might participate in relieving hospital staff.
  - The Montana Healthcare Mutual Aid System (MHMAS), a volunteer registry for licensed healthcare workers is utilized.
  - Hospitals might contract with private recruitment or staffing companies to assist.
- Public Information
  - Unified command and hospitals coordinate messages to the public to steer acute COVID-19 and other respiratory cases to the correct hospital and other patients to a different healthcare facility for all other care.
  - Risk communications continue promoting disease prevention.

**SECC/DPHHS Action:** Situational awareness is elevated, and a common operating picture is developed. At Full Activation for the COVID-19 response, the SECC is in constant contact with local emergency managers in addition to federal and other State partners. DPHHS is communicating with the public health department and the Regional Healthcare Coalitions.

- SECC begins to process some small requests from hospitals. Healthcare facilities have made no resource requests from the State other than PPE and minimal medical supplies.
- State maintains contact and situational awareness and develops a common operating picture for the region.
- SECC informs Federal partners they are preparing for a surge response; some anticipated equipment requests are negotiated.
- SECC begins to engage ESF partners for assistance standby.
- DPHHS actively monitors MHMAS and the bed and equipment inventory.
- DPHHS coordinates PPE deliveries to local jurisdictions.
- DPHHS continues specimen testing and disease consultation.
- The State Joint Information Center (JIC) assists with public information efforts.

### **Phase 3: Regional or Multiple Jurisdictional Surge**

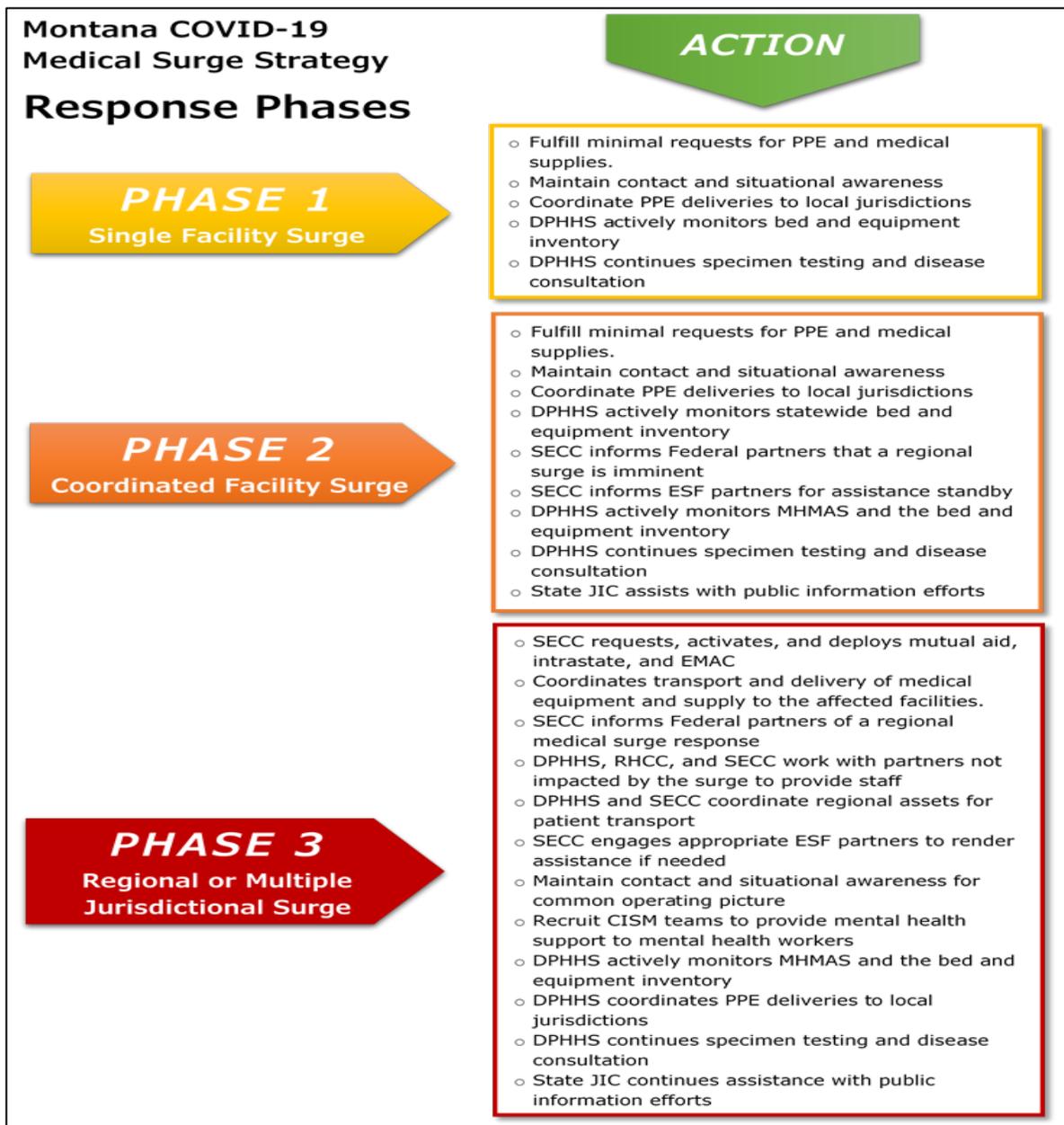
**Situation:** Phase 1 and 2 have not relieved the surge situation and most acute care patients in hospitals are COVID-19 related. Staffing shortages, scarce resources, too many patients, and the customary day-to-day system operations have overrun the current surge response. Providing low-acuity care becomes difficult and regional resources are under stress.

- Facilities
  - Triage for COVID-19 and respiratory patients, critical-care and acute patients, then lower acuity patients to proper facilities.
  - Transportation coordination with 911 dispatch centers.
  - The ACS is opened as receiving facilities and staffed.
  - Inter-Facility and regional patient transfers with critical access hospitals.
- Medical Equipment
  - Request resources from the State.
  - Coordination of resource disbursement.
- Personnel
  - Staffing resources are stretched to cover hospitals and ACS facilities.
  - Local healthcare workers experience fatigue from multiple operational periods.

**SECC/DPHHS Action:** SECC and DPHHS coordinate resource requests with Federal partners such as US HHS and the Federal Emergency Management Agency (FEMA). If needed, an Emergency Management Assistance Compact (EMAC) resource request is initiated to request, activate and deploy mutual aid, intrastate and EMAC resources, including qualified staff.

- SECC requests, activates, and deploys federal aid, intrastate, and EMAC resources to the region or local jurisdictions if needed.
- DPHHS coordinates transport and delivery of medical equipment and supplies to the affected facilities.
- SECC informs federal partners of a regional medical surge response.
- DPHHS, RHCC, and SECC work with state and regional healthcare facilities that are not impacted by the surge to provide staff

- DPHHS and SECC coordinate regional assets for patient transport utilizing the Montana EMS COVID Surge and Crisis Care Guide for EMS (see Appendix D).
- SECC engages appropriate ESF partners to render assistance if needed.
- The State maintains contact and situational awareness for a common operating picture.
- DPHHS works with local and state resources to bring Critical Incident Stress Management (CISM) teams to provide mental health support healthcare workers.
- DPHHS actively monitors MHMAS and the bed and equipment inventory.
- DPHHS coordinates PPE deliveries to local jurisdictions.
- DPHHS continues specimen testing and disease consultation.
- The State Joint Information Center continues assistance with public information efforts.



**Public Information**

The COVID-19 disease response has resulted in powerful public health information campaigns strongly pushing messages encouraging handwashing, social distancing, and other hygiene practices. The information flow has also kept the public abreast of the progress of the disease and the State's efforts to contain it. DPHHS uses its Crisis and Emergency Risk Communications Annex for public information.

The State JIC, hospital public relations teams, and the jurisdictional public information officers must collaborate to keep messages consistent and people safe. The affected residents and those at immediate risk must know the situation of the surge, where to go, what measures they can take, and what areas or barriers to avoid. Crisis and emergency risk communications operate on six principles:

- Be first;
- Be right;
- Be credible;
- Express empathy;
- Promote action; and
- Show respect.

Interactions between the State JIC and the hospital or local representatives occur in Phases 2 and 3 of a regional medical surge. Following these principles together will be crucial to achieving the following goals:

- Increasing community education through public information;
- Preventing and reducing illnesses;
- Maintaining public trust; and
- Ensuring accurate and timely information about surge operations.

## **Staffing/Human Resources**

Saving lives depends on healthcare workers more than anything else in a medical surge. Although staff for hospitals, other healthcare facilities, and Emergency Medical Services (EMS) are considered as resources under emergency operations, there are special considerations. These are dedicated people with varying limitations, skills, and needs.

Local healthcare entities are responsible for their own staff, which includes scheduling and assignments. In medical surge situations, trained medical workers become a scarce resource very quickly. They are stretched within a hospital and across other healthcare entities, including urgent care clinics, EMS, long-term care facilities, mental health facilities, ambulatory surgery centers, private physician offices, tribal facilities, public health clinics, and alternate care sites. Personnel working during a surge will need relief for their own safety and health.

The State can respond to a local jurisdiction's resource request through the following methods:

- Maintaining MHMAS to access qualified medical volunteers from other jurisdictions;
- Providing alert and notification procedures to partnering agencies, organizations and individuals;
- Assisting with telemedicine technology; and
- Submitting EMAC requests.

The State may also coordinate contracts with personnel agencies to assist local healthcare obtain qualified personnel.

Hospitals and other healthcare entities are responsible for just-in-time training for newly arriving staff. They are also responsible for providing wrap-around services for support. Such wrap-around services would include relief items, resting areas, and mental support. DPHHS and SECC can coordinate assistance if needed. Montana

has several trained critical incident stress management teams that can help emergency responders ease the anxiety they might feel working a surge.

Licensed healthcare workers are protected during the COVID-19 declared emergency by several waivers of regulations by the Governor. For details, see Authorities in Appendix A.

## **Medical Materiel/Equipment**

Because all emergencies are a local obligation, those local and tribal health agencies are responsible for managing public health events within their jurisdictions. If those events develop into emergencies that exhaust resources, the local government may request support from the State. DPHHS, with SECC assistance, coordinates operations to fulfill resource requests and to position assets for deployment when those resource supplies are nearing depletion. When State resources are overwhelmed or anticipated to be insufficient for a response, the State might seek resource assistance from out of state entities, including the Federal government. Resources from the Federal government can include the Strategic National Stockpile (SNS).

These resources comprise of pharmaceuticals, medical supplies, PPE, and medical equipment. DPHHS manages the receipt, staging, storing and distribution of these assets. The agency uses its Medical Supplies Management and Distribution Annex to:

- Request resources through the SNS;
- Receive emergency resources through national stockpiles or other sources;
- Provide alert and notification procedures to partnering agencies, organizations and individuals;
- Include the framework for warehouse selection, staffing, operations, and communication within an Incident Command Structure (ICS) structure;
- Coordinate response partners;
- Coordinate distribution activities; and
- Outline inventory management of resources.

## **EMS/Transportation**

In surge and crisis care, each EMS and Medical Director must determine the most appropriate steps and actions for their agency based on their local situation and resources. Local EMS services and their Medical Directors, health care facilities, public health, regional health care coalitions, and State support systems may determine additional issues and strategies for their specific situation.

- Local EMS services' surge response would, in most cases, rely on mutual aid from neighboring agencies.
- The threat of an extended COVID-19 pandemic might degrade abilities to provide usual or mutual aid services.
- More robust planning is required for when demand could result in poor outcomes for patients unless crisis strategies are implemented.

EMS systems in Montana often operate near or at a surge for short to moderate periods of time (e.g. single vehicle crash with 3 patients). These systems are also spread across the vast area of the state.

- Workforce consists of approximately 4,900 Emergency Care Partners (ECP), over half are volunteers.
- Seventy three percent (73%) of services in rural communities are staffed primarily by volunteers.

- Fifty eight percent (58%) of services are basic life support.
- Thirty five percent (35%) provided limited levels of advanced life support.
- Two percent (2%) (20 services) provided 24/7 advanced life support - located in urban communities.

Local government remains in charge of their jurisdictional authorities and response to disasters within its geographical area. Local, state and federal officials, agencies, and resources from outside the jurisdiction, will provide support and resources in an assisting agency role. They may also have a shared jurisdictional authority to respond to and mitigate a pandemic within the affected area and share coordinating roles with the local government agencies.

Montana's response will include both public and private medical resources that need to operate in a coordinated manner for maximum effectiveness.

The Montana EMS COVID Surge and Crisis Care Guide for EMS is Appendix D.

## **Crisis Care Guidance**

The Governor and Montana's Prospective Payment System (PPS) hospital Chief Executive Officer's created a workgroup to develop a Montana COVID-19 disease specific Crisis Care Guidance with representatives from DPHHS and disability advocacy groups. This complicated and ethically challenging guidance document was developed under an emergency declaration with a limited timeline. As a result, the workgroup could not request the Montana communities they serve to participate in the discussion and help develop this guidance document. However, every effort was made to involve interested and expert stakeholders.

Crisis standards of care situations requiring State action are extremely rare (e.g., severe pandemic) and assume health care facilities, home- and community-based providers and other local agencies have developed their own plans. Therefore, the COVID-19 Crisis Care Guidance framework also provides planning guidance and strategies for health care facilities, community providers, EMS, and other local agencies to develop their own crisis standards of care plans. These strategies provide ethically sound, proactive guidance to provide the best and most equitable care possible when demand for resources far exceeds availability.

The Scarce Resource Management & Crisis Care Guidance document is found in Appendix C.

## **Alternate Care Sites**

Alternate Care Sites are structures of opportunity created to provide a safe and comfortable setting where patients can be isolated and monitored during the COVID-19 pandemic. The safety of patients, care providers, and the general public is the main priority.

These sites include hotels, gymnasiums, civic sports centers, schools, health clubs (only if equipment can be moved/removed), convention centers, and community centers, dormitories, etc. within close proximity to hospital systems. Structures will vary in their capacity and capabilities. For example, some structures have the ability to house patients individually and have scalable room capacity to support an increase of patients, as necessary; some have the potential for individual heating, ventilation, and air-conditioning (HVAC) units, which can limit the spread of infection between rooms; and some can provide food service, security, bathrooms and showers. And some structures can combine any of the above capabilities.

The life cycle of the typical ACS begins with identification and establishment of the site by Federal, State, or local personnel in conjunction with the state public health and local health officials over 48-72 hours. Once a

site is established, staff and services can be supplemented by contractors, temporary hires, volunteers, and other allowable methods, leaving behind an onsite team to administer and manage the ACS. Refer to the *ACS Decision Concept of Operations* in Appendix E for suggested guidance on whether and when to utilize an ACS and which type (General Non-Acute Care or Acute Care model) will best meet the needs of the jurisdictions healthcare system.

### **ACS vs. Non-Congregate Shelters**

FEMA recognizes that non-congregate sheltering may be necessary in this public health emergency to save lives, to protect property and public health, to ensure public safety, and lessen or avert the threat of a catastrophe. The term “medical sheltering” is meant to address the specific needs directly resulting from this Public Health Emergency. For purposes of eligibility under the COVID-19 declarations, FEMA will consider non-congregate sheltering for health and medical-related needs, such as isolation and quarantine resulting from the public health emergency.

**Note:** Alternate care sites and temporary hospitals are not considered non-congregate sheltering and such requests should be routed through the proper channels. The non-congregate sheltering must be at the direction of and documented through an official order signed by a state, local, or tribal, public health official. In order to be eligible under the Public Assistance Program, non-congregate shelters must be pre-approved by FEMA.

Eligible emergency protective measures taken to respond to the COVID-19 emergency at the direction or guidance of public health officials may be reimbursed under the FEMA Public Assistance (PA) program. Options for the State of Montana regarding the FEMA PA program for ACS is at a 75% Federal share and 25% state, local, tribal, and/or territory share. The steps related to standing up an ACS include:

1. Site Assessment.
2. Evaluation and Decision.
3. Leasing Facilities.
  - Should include services such as garbage service, janitorial service, and security in the lease.
4. Contracting and Retrofitting.
  - Hiring a contractor or the State can request that FEMA put in a mission assignment request to have the retrofitting handled by USACE.
  - The mission order through FEMA could be faster than the State doing its own contracting process for retrofitting.
5. Equipping ACS – The State can request an equipment package from the FEMA, procure the equipment itself, or contract with a medical services company.
  - The timeline for going through FEMA may be longer than if the State procured its own equipment or contract with a medical services company.
6. Supplying the ACS (see number 5).
7. Staffing the ACS – FEMA has determined that staffing expenses for the ACS facility are eligible expenses (specifically for doctors and nurses).
  - FEMA recommends the State look to contract with a company who can recruit and provide adequate staffing for the ACS.

See Appendix E for the FEMA Funded ACS Program for more detailed information.

The US Government has assembled a Federal Healthcare Resilience Task Force Alternate Care Site Tool Kit. This document is a guide for the planning, development, and establishment of an ACS in state, local, and tribal jurisdictions. It is described as a blueprint, flexible enough to fit different scenarios.

The tool kit details how to build, operate, and demobilize an ACS. It describes the type and level of care provided, roles and responsibilities of the necessary personnel, and the development. Developed by FEMA and US HHS, it also provides full supply lists, site considerations, forms, and records management procedures.

See the [Federal Healthcare Resilience Task Force Alternate Care Site \(ACS\) Toolkit](#) for full instructions for ACS development and operations.

## **Fatality Management**

The Montana State Medical Examiner's Office relies upon coroners in the state to investigate sudden unexpected and violent deaths. Human deaths requiring an inquiry by a coroner are outlined in Montana code annotated 2000 19 Title 46-4-122 and specifically under 1C "by an agent, disease or medical condition that poses a threat to the public health". COVID-19 is a disease that is a threat to public health. Regardless of Coroner or Medical Examiner involvement, essentially all deaths will involve the services of a funeral home. Therefore, the Montana Coroners, Montana Funeral Homes and State Medical Examiner's Office are the principle entities involved in death care.

Due to the limited Medical Examiner Staff, illness contracted by any one or more of the three currently functioning Medical Examiners could delay final disposition in cases needing an autopsy, possibly extending storage time and local storage need. Mutual aid has been arranged in the event of a Medical Examiner shortage; however, due to very limited availability of medical examiners nationwide and potentially competing jurisdictions, mutual aid may not be available.

During inquiry into a death, a coroner may request a postmortem examination (autopsy) to be performed by the State Medical Examiner's Office. Specifically, with regard to death caused by an agent, disease or medical condition that poses a threat to the public health, a postmortem examination (autopsy) may provide critical information necessary to establish a diagnosis. However, an autopsy may not be necessary if the agent, disease or medical condition (such as COVID-19) has been satisfactorily identified by healthcare providers (hospital, hospice, nursing home, etc.) prior to death unless extenuating circumstances involving potential suicide, accident or homicide are involved. Refer to Appendix F for optimal and realistic case scenario for Coroner/Medical Examiner death investigation and COVID-19.

## **Montana's Decedent Handling Capacity**

Montana has 56 counties each served by a County Coroner and a variable number of Deputy Coroners based on county population and size. Most Montana Coroner's Offices rely on local funeral homes throughout the state for decedent transportation and refrigeration. Some funeral homes are small family-operated businesses with limited staff while other funeral homes operating in larger communities have greater staff resources.

Currently, the Department of Justice - Forensic Science Division – Medical Examiner's Office staff has three full-time forensic pathologists, two full-time autopsy assistants, three part-time autopsy assistants, and two full-time administrative staff working out of two regional offices (Missoula and Billings). The administrative staff have other commitments to multiple sections of the Forensic Science Division; therefore, they cannot commit all of their time to the Medical Examiner's Section.

## **Montana's Decedent Storage Capacity**

Current refrigerated decedent storage capacity in Montana:

- Funeral home storage capacity from 14 funeral homes reporting – 184\*
- Billings Medical Examiner Office storage capacity - 22
- Missoula Medical Examiner Office storage capacity - 22

Total reported storage capacity - 228

\*Source: The Montana Funeral Directors Association

For information on Montana’s decedent storing challenges refer to Appendix G.

## Section III: Roles & Responsibilities

<i>Organization</i>	<b>Roles &amp; Responsibilities</b>
<p><b><i>Department of Public Health &amp; Human Services (DPHHS)</i></b></p>	<p><b>DPHHS is lead coordinating agency in Montana for ESF #6 and ESF #8.</b></p> <ul style="list-style-type: none"> <li>• Provides information on diseases and illnesses affecting the State through epidemiology and surveillance.</li> <li>• Provides public information about prevention of illness and promotes healthy behaviors.</li> <li>• Identifies biological hazards and diseases through laboratory testing.</li> <li>• Maintains immunization records and coordinates processing and shipping of vaccines.</li> <li>• Coordinates assistance to medical facilities and local Emergency Medical Services entities.</li> <li>• Manages vital records and statistics.</li> <li>• Coordinate and facilitate the State’s response and support to incidents affecting the public’s health and medical requirements.</li> <li>• Coordinate risk communication and public information with DPHHS Public Information Office staff.</li> <li>• Maintain a 24-hour duty officer program to facilitate processing and responding to incoming incidents, emergencies, or disasters.</li> <li>• Activate, operate, and maintain the Emergency Operations Center (EOC) to support response operations through planning, logistics, and other incident management functions.</li> <li>• Provide emergency management expertise regarding public health and healthcare infrastructures.</li> <li>• Liaison with other state and local agencies with overlapping areas of response.</li> <li>• Coordinate procurement and distribution of health and medical equipment, medicine, and supplies.</li> <li>• Manage DPHHS resources for emergency response (i.e. communications equipment).</li> <li>• Arrange for healthcare personnel surge activities.</li> </ul>

<p><b><i>Disaster &amp; Emergency Services (DES)</i></b></p>	<p><b>Montana Disaster &amp; Emergency Services (DES) is the primary coordinating agency for all State disasters and emergencies.</b></p> <ul style="list-style-type: none"> <li>• DES manages resources and support to local, state, and non-governmental organizations.</li> <li>• Activate and manage the State Emergency Coordination Center.</li> <li>• Coordinate other State ESF resources in response and recovery operations.</li> <li>• Coordinate mutual aid and federal assistance, including Mutual Aid Agreements (MAA), Emergency Management Assistance Compact (EMAC), and federal assistance.</li> </ul>
<p><b><i>Federal Partners</i></b></p>	<p><b>Army Corps of Engineers</b>  During emergencies the U.S. Army Corps of Engineers (USACE) is the federal government's lead public works and engineering support agency. As part of the response to COVID-19 pandemic and at the request of the Federal Emergency Management Agency, the USACE team(s) roles are to:</p> <ul style="list-style-type: none"> <li>• Evaluate potential facilities for possible conversion into alternate care facilities.</li> <li>• Determine facility retrofitting costs estimates.</li> <li>• Oversee/manage construction process of facility retrofitting when FEMA approves the establishment an alternate care facility.</li> </ul> <p><b>Federal Emergency Management Agency</b>  Under the direction of the White House Coronavirus Task Force, the Federal Emergency Management Agency (FEMA):</p> <ul style="list-style-type: none"> <li>• Coordinates federal response to fight the COVID-19 pandemic and protect the public.</li> <li>• Coordinates federal emergency/disaster relief programs and supporting local and state government capabilities with resources.</li> <li>• Coordinates the USACE in their efforts to support Montana with alternate care facility efforts.</li> </ul> <p><b>US Health &amp; Human Services Assistant Secretary for Preparedness &amp; Response</b>  Regional Emergency Coordinators (RECs) serve as ASPR’s primary representatives throughout the country at the regional level. Building relationships with federal, state, local, tribal, and territorial officials and healthcare representatives (partners and stakeholders) in order to conduct planning for effective federal emergency response, and to facilitate coordinated preparedness and response activities for public health and medical emergencies, is the main role of the RECs.</p> <p>This is accomplished in a variety of ways to include: enhancing cross discipline integration among public health and medical and emergency management partners; providing situational awareness to headquarters responding to events; providing command and control for deployed Departmental resources and assets; and providing exercise support to stakeholders.</p>
<p><b><i>Crisis Care Guidance Work Group</i></b></p>	<p>Task Force assigned group developed state level guidance for COVID-19 disease specific crisis standards of care.</p>

<p><b><i>State Joint Information Center (JIC)</i></b></p>	<p>The State JIC assembled for public information and education during the COVID-19 disease response would assist and collaborate with local and jurisdictional healthcare entities in a COVID-19 related medical surge.</p>
<p><b><i>Montana State Medical Examiner's Office</i></b></p>	<p>Maintains Mutual Aid Agreement with Coroners and funeral homes to assist with decedents.</p>
<p><b><i>Montana Regional Healthcare Coalitions (HCC)</i></b></p>	<p>Healthcare coalitions in Montana coordinate within their geographical boundaries for preparedness, response, and recovery issues. Although not response organizations themselves, the agreements amongst their member entities provide the framework for disaster and emergency response.</p> <ul style="list-style-type: none"> <li>• Serve as a reference point for healthcare related resources.</li> <li>• Advises local emergency managers regarding healthcare needs during disaster response operations.</li> <li>• Maintains healthcare situational awareness during disaster and emergency responses</li> <li>• Coordinates information sharing with DPHHS.</li> </ul> <p><b>Local Health Care Facilities</b></p> <ul style="list-style-type: none"> <li>• Maintain emergency operations plans as required of organizations that receive Medicaid funding.</li> <li>• Coordinate the plans with their local disaster and emergency services representative.</li> <li>• Maintain communication with state agencies and their Healthcare Coalition.</li> </ul>
<p><b><i>Local &amp; Tribal Health Jurisdictions</i></b></p>	<p>All emergency or crisis incidents begin and end locally. Local and tribal authorities bear initial and continuing responsibility for incident response. local health jurisdictions (LHJs) are responsible for identifying and investigating public health events and reporting these events to DPHHS. LHJs assist DPHHS in the administration of public health services and functions.</p> <p>DPHHS supports local authorities during local public health events when their resources are overwhelmed, or anticipated to be overwhelmed, while maintaining their statutory role to protect and promote public health and provide public assistance.</p> <p>Local and Tribal Jurisdictions</p> <ul style="list-style-type: none"> <li>• Maintain and update their employee operations plans to include coordination with DPPHS during an emergency or disaster response.</li> <li>• Maintain open communication with DPHHS to sustain situational awareness.</li> <li>• Comply with PHEP grant requirements that build or sustain their jurisdictional capacities to meet or surpass the National Standards for Public Health Emergency Preparedness and Response Capabilities (2018).</li> </ul> <p>Other jurisdictional support in responding to local emergencies may include law enforcement, coroners, fire departments, search and rescue, Civic Emergency Response Teams (CERT).</p>

<b><i>Non-Governmental Agencies Local Volunteer and Civic Organizations</i></b>	Some volunteer and civic organizations, whether independent or chartered with national or state affiliations, may choose to offer assistance in response to disasters and emergencies. Local public health agencies or emergency managers may request their help as well. Some of these organizations have actively participated in community emergency planning and have agreed to certain roles such as donations management or volunteer management.
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## **IV. Maintenance**

As an event specific developed on an accelerated timeline under an emergency declaration, maintenance of this document could be an ongoing process. Without opportunity to follow standard FEMA principals of exercising then improving a plan before implementation, there can be no maintenance schedule. The COVID-19 emergency After-Action Report process will capture the successes and challenges to this plan if it is used.

Conditions and progression of the disease might change. The planning team will then review this plan to ensure it is up to date and still reflects its utility for the emergency conditions.

## **V. Appendices**

**Appendix A Authorities**

**Appendix B References**

**Appendix C Scarce Resource Management & Crisis Care Guidance**

**Appendix D Montana EMS COVID Surge and Crisis Care Guide for EMS**

**Appendix E Alternate Care Site Concept of Operations**

**Appendix F Fatality Management**

**Appendix G Medical Examiner Recommendations for COVID-19 Respons**



# Appendix A

## Authorities

### **Governor of Montana Executive Order No. 2-2020**

Declaring a State of Emergency to Exist Within the State of Montana Related to the Communicable Disease COVID-19 Novel Coronavirus

### **Governor of Montana Executive Order No. 3-2020**

Amending Executive Order 2-2020 and Providing that the State of Emergency Runs Concurrent with the President's Emergency Declaration

### **Directive Implementing Executive Orders 2-2020 and 3-2020**

Providing for measures to ease the procurement of medical supplies and hospital space and to ease the transfer of patients with COVID-19 to appropriate medical facilities. – March 23, 2020

### **Montana Code Annotated 10-3-110.**

Medical Services During Declared Emergency or Disaster -- Limitation of Liability -- Administrative Disciplinary Sanctions

- (1) Except as provided in subsection (3), a health care professional licensed to practice in Montana who, in good faith and regardless of compensation, renders or fails to render emergency care, health care services, or first aid during a declared emergency or disaster is not liable for any civil damages or injury unless the damages or injury was caused by gross negligence or willful and wanton misconduct and as a result of:
  - (a) an act or omission arising out of activities undertaken in response to the disaster or emergency;
  - (b) any act or omission related to the rendering of or failure to render services; or
  - (c) evacuation or treatment or the failure to evacuate or provide treatment conducted in accordance with disaster medicine or at the direction of military or government authorities.
- (2) A licensing program, licensing board, or any other disciplinary authority in Montana may impose administrative sanctions upon a health care professional for unprofessional conduct in response to a declared public health emergency that occurs in Montana. An administrative disciplinary sanction imposed upon a health care professional who is licensed in another state must be reported to the licensing authority in the health care professional's state and each state in which the health care professional is licensed. The standard of review for administrative disciplinary sanctions must be whether the health care professional exercised good faith clinical judgment given the circumstances under which the judgment was exercised.
- (3) This section does not apply to a health care provider employed by the United States, a state, or a political subdivision acting within the scope of the provider's employment or duties.

### **Montana Code Annotated 10-3-118.**

Interstate licensure recognition -- volunteer professionals.

- (1) (a) Subject to subsection (2), whenever a state of emergency or disaster is in effect, a volunteer professional who possesses an active, unrestricted license in another state may practice in Montana to the extent authorized by law as if the person had been licensed in Montana.  
(b) A volunteer professional shall adhere to the scope and standards of practice set forth in licensing provisions, practice acts, or other laws or policies of Montana.
- (2) (a) Prior to providing services in Montana, a volunteer professional who is licensed for professional services in another state shall register with the appropriate licensing agency in the state of Montana. The licensing agency shall verify the current licensure of the volunteer professional in the other state or states prior to registering the licensee.  
(b) Based on available funding, the licensing agency may request and accept funds for the purpose of implementing the provisions of subsection (2)(a).

### **Montana Code Annotated 46-4-122. Part 1. Investigation of Death -- Autopsy**

Human deaths requiring inquiry by coroner.

The coroner shall inquire into and determine the cause and manner of death and all circumstances surrounding a human death:

- (1) that was caused or is suspected to have been caused:
  - a. in any degree by an injury, either recent or remote in origin; or
  - b. by the deceased or any other person that was the result of an act or omission, including but not limited to:
    - i. a criminal or suspected criminal act;
- ii. a medically suspicious death, unusual death, or death of unknown circumstances, including any fetal death; or
- iii. an accidental death; or
  - c. by an agent, disease, or medical condition that poses a threat to public health;
- (2) whenever the death occurred:
  - a. while the deceased was incarcerated in a prison or confined to a correctional or detention facility owned and operated by the state or a political subdivision of the state;
  - b. while the deceased was being pursued, apprehended, or taken into custody by, or while in the custody of, any law enforcement agency or a peace officer;
  - c. during or as a result of the deceased's employment;
  - d. less than 24 hours after the deceased was admitted to a medical facility or if the deceased was dead upon arrival at a medical facility; or
  - e. in a manner that was unattended or unwitnessed and the deceased was not attended by a physician at any time in the 30-day period prior to death;
- (3) if the dead human body is to be cremated or shipped into the state and lacks proper medical certification or burial or transmit permits; or
- (4) that occurred under suspicious circumstances.

#### **50-6-325 MCA. Waiver of licensing requirements**

- (1) The department may waive any licensing requirements under this part upon submission and approval of a written application for waiver by a person subject to licensing under this part.
- (2) The department may waive a licensing requirement if the person provides sufficient justification to allow a finding by the department that:
  - (a) the waiver is necessary to avoid significant financial or other hardship; and
  - (b) granting the waiver would not jeopardize patient care or the public health and safety.
- (3) A waiver must be issued on a temporary basis, not exceeding 6 months, and may be renewed by the department upon submission and approval of an additional application for waiver of licensing requirements.
- (4) A waiver granted by the department may be revoked for good cause after notice and an opportunity for a hearing before the department have been provided to the person affected by the department's action.

#### **Centers for Medicaid and Medicare Services (CMS)**

Under authorization of the President of the United States' declaration of a national emergency, CMS is waiving certain requirements under the Medicare conditions at 42 C.F.R. §482.41 and §485.623 to allow for flexibilities during hospital, psychiatric hospital, and CAH surges. CMS will permit non-hospital buildings/space to be used for patient care and quarantine sites, provided that the location is approved by the State (ensuring safety and comfort for patients and staff are sufficiently addressed). This allows for increased capacity and promotes appropriate cohorting of COVID-19 patients.

#### **Summary of CMS Emergency Waivers Relevant to COVID-19 Medical Surge Planning**

(Taken from the COVID-19 Emergency Declaration Health Care Providers Fact Sheet - 3/13/2020)

*Skilled Nursing Facilities*

CMS is waiving the requirement at Section 1812(f) of the Social Security Act for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of (SNF services without a qualifying hospital stay, for those people who need to be transferred as a result of the effect of a disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period.

Second, CMS is waiving 42 CFR 483.20 to provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.

#### *Critical Access Hospitals*

CMS is waiving the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours.

#### *Housing Acute Care Patients in Excluded Distinct Part Units*

CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit's beds are appropriate for acute care inpatient. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient's medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.

#### *Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital*

CMS is waiving to allow acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

*Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital* CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver may be utilized where the hospital's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

CMS is waiving requirements to allow IRFs to exclude patients from the hospital's or unit's inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the "60 percent rule") if an IRF admits a patient solely to respond to the emergency and the patient's medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

#### *Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCH)s*

Allows a long-term care hospital (LTCH) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement which allows these facilities to be paid as LTCHs.

## **Coronavirus Aid, Relief, and Economic Security Act of 2020**

### Section 3215: Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response

(a) LIMITATION ON LIABILITY.—Except as provided in subsection (b), a health care professional shall not be liable under Federal or State law for any harm caused 6 by an act or omission of the professional in the provision of health care services during the public health emergency 8 with respect to COVID-19 declared by the Secretary of Health and Human Services (referred to in this section 10 as the “Secretary”) under section 319 of the Public Health Service Act (42 U.S.C. 247d) on January 31, 12 2020, if—

(1) the professional is providing health care services in response to such public health emergency, as a volunteer; and

(2) the act or omission occurs—

(A) in the course of providing health care services;

(B) in the health care professional’s capacity as a volunteer;

(C) in the course of providing health care services that—

(i) are within the scope of the license, registration, or certification of the volunteer, as defined by the State of licensure, registration, or certification; and

(ii) do not exceed the scope of license, registration, or certification of a substantially similar health professional in the State in which such act or omission occurs; and

(D) in a good faith belief that the individual being treated is in need of health care services.

(b) EXCEPTIONS.—Subsection (a) does not apply if—

(1) the harm was caused by an act or omission constituting willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious flagrant indifference to the rights or safety of the individual harmed by the health care professional; or

(2) the health care professional rendered the health care services under the influence (as deter-18 mined pursuant to applicable State law) of alcohol or an intoxicating drug.

(c) PREEMPTION.—

(1) IN GENERAL.—This section preempts the laws of a State or any political subdivision of a State to the extent that such laws are inconsistent with this section, unless such laws provide greater protection from liability.

(2) VOLUNTEER PROTECTION ACT.—Protections afforded by this section are in addition to those provided by the Volunteer Protection Act of 1997 (Public Law 105–19).

(d) DEFINITIONS.—In this section—

(1) the term “harm” includes physical, non- physical, economic, and noneconomic losses;

(2) the term “health care professional” means an individual who is licensed, registered, or certified under Federal or State law to provide health care services;

(3) the term “health care services” means any services provided by a health care professional, or by any individual working under the supervision of a health care professional that relate to—

(A) the diagnosis, prevention, or treatment of COVID-19; or

(B) the assessment or care of the health of a human being related to an actual or suspected case of COVID-19; and

(4) the term “volunteer” means a health care professional who, with respect to the health care services rendered, does not receive compensation or any other thing of value in lieu of compensation, which compensation—

(A) includes a payment under any insurance policy or health plan, or under any Federal or State health benefits program; and

(B) excludes—

(i) receipt of items to be used exclusively for rendering health care services in the health care professional's capacity as a volunteer described in subsection (a)(1); and

(ii) any reimbursement for travel to the site where the volunteer services are rendered and any payments in cash or kind to cover room and board, if services are being rendered more than miles from the volunteer's principal place of residence.

(e) EFFECTIVE DATE.—This section shall take effect upon the date of enactment of this Act, and applies to a claim for harm only if the act or omission that caused such harm occurred on or after the date of enactment.

(f) SUNSET.—This section shall be in effect only for the length of the public health emergency declared by the 23 Secretary of Health and Human Services (referred to in 24 this section as the "Secretary") under section 319 of the Public Health Service Act (42 U.S.C. 247d) on January 1 31, 2020 with respect to COVID-19.

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# Appendix B

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## Appendix C

# **Scarce Resource Management & Crisis Care Guidance**

## **Front Matter**

Adopted and modified for use in Montana in response to the 2020 COVID-19 pandemic emergency



## Introduction

The Montana Department of Public Health and Human Services (DPHHS) is the assigned primary agency of Emergency Support Function 8 – Public Health & Medical Services (ESF-8). This assignment is based on the Montana Emergency Response Framework. The purpose of DPHHS is to protect, maintain, and improve the health of all Montanans. The Crisis Standards of Care (CSC) Framework—referred to as the “CSC Framework” or “the Framework”—addresses specific challenges of a pervasive or catastrophic public health event that warrant a change in standard of care, shifting focus from individual patients to the good of the community. In these situations, demand exceeds available resources, warranting proactive steps to coordinate a statewide response for a prolonged period, assuring the best available appropriate care possible despite resource limitations. Montana is facing an emergency public health event, under threat of the novel coronavirus disease known as COVID-19.

In 2012, the National Academies of Sciences, Engineering and Medicine, Institute of Medicine (IOM)— now the National Academies of Medicine (NAM) — (referred to as the IOM/NAM in this document) published national guidance documents for crisis standards of care planning. They recommend the incorporation of key elements into the development of crisis standards of care plans. Key elements of CSC planning include:

- Strong ethical grounding;
- Integrated and ongoing community and provider engagement, education, and communication;
- Assurances regarding legal authority and environment;
- Clear indicators, triggers, and lines of responsibility; and
- Evidence-based clinical processes and operations<sup>1</sup>.

Montana DPHHS facilitates equitable access to care through public health recommendations, regulatory guidance, support alternate care mechanisms (e.g., telephone informational hotlines, alternate care sites, home- and community-based options), and support public information dissemination in such an event, including the delivery of information in accessible formats. An example of some of these recommendations may include a systematic approach to allocation of scarce resources (e.g., select medications, vaccine, or equipment including ambulances, home

care workers and personal assistance support workers) designed to deliver the best available appropriate care possible given limited resources. This document is derived from the Minnesota Crisis Standards of Care Framework *Minnesota Department of Health Concept of Operations* document and the Washington State Department of Health *Scare Resource Management & Crisis Standards of Care* document, explicitly in response to the 2020 COVID-19 emergency.<sup>2,3</sup>

## Purpose

The goal of this Framework is to:

- Outline the Montana DPHHS response during a Crisis Standards of Care situation resulting from the COVID-19 emergency; and

- Provide planning guidance and strategies to health care entities (e.g., hospitals, emergency medical services, home- and community-based providers, aging services, etc.) and public health organizations to manage the transition from conventional to contingency to crisis care during a Crisis Standards of Care situation and develop their own crisis standards of care plans (Figure1).<sup>4</sup>

## Scope

This document was adopted under the 2020 emergency COVID-19 declaration. The need for a CSC in the setting of the COVID-19 pandemic is unavoidable. The decision to adopt the Minnesota and Washington State plans was deliberate in an attempt to promote fairness, consistency and transparency in the delivery of medical care to Montanans during the 2020 COVID-19 pandemic. The Montana CSC Framework defines actions and roles during a pervasive or catastrophic public health event that generates a change in standard of care due to scarce resources (e.g., staff, space, supplies). Crisis care plans at the agency or health care facility level may be needed anytime and anywhere as extensions of surge capacity plans to address immediate needs when community resources are overwhelmed by an emergency or disaster. Crisis Standard of Care plans involve the support of the State and other levels of government. The government role is to support ongoing, substantial changes in operations and medical care decision- making during a prolonged emergency, when insufficient resources are available, and when the focus of care must shift from the benefit of the individual to the benefit of the community. Montana DPHHS will also rely on the Montana Hospital Association (MHA) to enhance the ability of hospitals and health care systems to prepare for, respond to, and recover from these types of events as part of this response structure. Crisis standards of care situations requiring state action are extremely rare (e.g., severe pandemic) and assume health care facilities, home- and community-based providers and other local agencies have developed their own plans. Therefore, the CSC Framework also provides planning guidance and strategies for health care facilities, community providers, Emergency Medical Services (EMS), and other local agencies to develop their own crisis standards of care plans. These strategies provide ethically sound, proactive guidance to provide the best and most equitable care possible when demand for resources far exceeds availability. These standards are guidelines that provide a framework for decision making but should be seen as flexible and adaptable for local circumstances and changes in understanding about the clinical characteristics of COVID-19.

Montana Code Annotated 10-3-110 *Medical Services During Declared Emergency or Disaster -- Limitation of Liability -- Administrative Disciplinary Sanctions* relieves civil liability to healthcare workers who make their care decisions “in good faith and regardless of compensation” during declared disasters or emergency situations, unless damages or injuries were caused by gross negligence or willful and wanton misconduct.<sup>5</sup> Montana’s response to the COVID-19 crisis is a declared emergency. This law, however, excludes healthcare providers employed by government or political entities or those performing duties on their behalf.

During the timeframe of the COVID-19 emergency, the standards outlined here apply to all patient care (e.g., COVID-19 patient management and non-COVID-19 patient management). Upon resolution of the current COVID-19 emergency, hospital emergency planning teams may initiate a revision of the current

document or creation of a new document, including incorporation of more extensive Montana-specific stakeholder engagement. Before adoption of the Washington plan, Montana DPHHS and MHA convened a Crisis Standards of Care Workgroup to ensure that the Intensive Care Units algorithms reflected Montana-specific resource and population matters.

## Authority

Montana DPHHS will work with the Governor's office to provide incident-specific guidance. On March 15, 2020, Governor Bullock issued executive orders 2-2020 and 3-2020, declaring a state of emergency in Montana due to the global outbreak of COVID-19 novel coronavirus. On March 26, 2020, Governor Bullock issued a Stay at Home Directive to "curtail the spread of the COVID-19 pandemic in Montana, and to protect the health and economic wellbeing of all Montanans." DPHHS will work with the governor's office to determine emergency legal issues that must be addressed in order to facilitate the response. Issues including isolation and social distancing, equal access to resources, the accessibility of resources to people with disabilities, and liability are just a few examples of areas that may require legal interpretation and involvement.

## Planning Assumptions

1. Initiation of the CSC Framework will occur in stages and will be inclusive of a variety of public and private entities.
2. Statewide initiation of CSC will occur only during a pervasive or catastrophic public health event that overwhelms both local and in-state regional capacity.
3. Resources are scarce and cannot be obtained by health care facilities in time to prevent resource triage. Adaptive and alternate strategies have been exhausted or are not appropriate.
4. Crisis strategies have been activated by other health care delivery systems and consistency is needed across the state so equitable levels of care are offered and standardized processes are used.
5. There are circumstances where regional clinical triage teams or committees will transfer patients with a better chance of survival to an institution that can provide a higher level of care. As the emergency situation evolves, this ability to transfer patients may become impossible, at least in the short term.
6. Access to medical countermeasures (e.g., vaccines, medications, antidotes, ventilators, intensive care beds, hospital beds, blood products, etc.) are limited.
7. Available local, regional, state, federal resource caches (e.g., equipment, supplies, and medications) have been distributed, and there is no foreseeable short-term resupply of such stock.
8. Multiple health care access points within a community or region are impacted.<sup>1</sup>

## Methodology

The rapidly evolving circumstances associated with the 2020 COVID-19 pandemic precluded the ideal deliberative and participatory CSC planning with substantial involvement of local public and private entities. However, every effort was made to involve interested and expert stakeholders, to the extent

possible on an accelerated timeline. The source documents used here and created by the Minnesota Department of Health and the Washington State Department of Health have been vetted by their respective stakeholders.

The Minnesota Department of Health engaged a diverse cross section of stakeholders including tribal health and advocates for people with disabilities to address three overlapping goals when developing CSC plans. Minnesota's ethical objectives outlined below demonstrate their commitment to developing a sound CSC plan and this informed Montana's decision to repurpose parts of the Minnesota plan as a Montana document for use during the timeframe of the COVID-19 emergency.<sup>6</sup> The underlying goals of Minnesota's process included:

- Protecting population health by reducing mortality and serious morbidity from:
  - the public health crisis; and
  - disruption to health care, public health, public safety, and other critical infrastructure; and
- Respecting individuals and groups by:
  - promoting public understanding, input, and confidence in the CSC plan/response;
  - supporting a duty to promote the best care possible in crisis circumstances; and
  - ensuring the burdens of CDC response are minimized and justified by benefits; and
- Striving for fairness and protecting against systemic unfairness by:
  - utilizing strategies for public education and public engagement that are inclusive and culturally sensitive;
  - promulgating standardized crisis standards of care response protocols that are publicly available, revised regularly, and tailored to specific crisis responses;
  - ensuring that burdens and benefits associated with crisis response are equitable;
  - making reasonable efforts to remove access barriers and address functional needs;
  - stewarding resources to:
    - reduce significant group differences in mortality and serious morbidity and
    - appropriately reciprocating to groups accepting high risk service of others;
  - using decision-making processes that consistently apply only ethically relevant (non- discriminatory, non-arbitrary) considerations.

This document was adopted under an emergency declaration. The need for a CSC in the setting of the COVID-19 pandemic is unavoidable. The decision to adopt the Minnesota and Washington State plans is deliberate to facilitate the timely development of a CSC that promotes fairness, consistency and transparency in the delivery of medical care during the COVID-19 emergency.

## Definitions

Several terms used throughout this Framework are defined here:

- **Capability:** The ability to manage patients requiring very specialized medical care.<sup>7</sup>
- **Capacity:** A hospital's maximum ability to serve patients including the availability of qualified staff, beds and equipment that accommodate the needs of the whole community, including people with disabilities.
- **Contingency care:** Provision of functionally equivalent care - care provided is adapted

from usual practices; for example, boarding critical care patients in post-anesthesia care areas.<sup>8</sup>

- **Continuum of care:** Medical care that is rendered during a mass casualty incident or declared emergency and occurs across 3 phases on a continuum; conventional to contingency to crisis care.<sup>8</sup>
- **Conventional care:** Usual resources and level of care provided. The maximal use of the facilities' usual beds, staff, and resources is ensured.<sup>8</sup>
- **Crisis Standards of Care (CSC):** A state of being that indicates a substantial change in health care operations and the level of care that can be delivered in a public health event, justified by specific circumstances. Medical care delivered during disasters shifts beyond focusing on individuals to promoting the thoughtful and equitable stewardship of limited resources intended to result in the best possible health outcomes for the population as a whole. Crisis capacity activation constitutes a significant adjustment to standards of care.<sup>4</sup>
- **Health disparities:** Systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups and/or people with disabilities; they may reflect social disadvantage, but causality need not be established.<sup>9,10</sup>
- **Indicator:** A "measurement or predictor of change in demand for health care services or availability of resources" (e.g., a tornado warning, report of several cases of unusual respiratory illness). An indicator may identify the need to transition to contingency or crisis care (but requires analysis to determine appropriate actions).<sup>11</sup>
- **Moral Distress:** "...an emotion that is expressed when the moral complexity of a situation is not leading to a resolution, thereby having the potential to cause harm to the individual [...] painful feelings and associated mental anguish as a result of being conscious of a morally appropriate action, which, despite every effort, cannot be performed owing to organizational or other constraints (such as resource scarcity)."<sup>12</sup>
- **Palliative Care:** "Aggressive management of symptoms and relief of suffering is what generally have come to be called "palliative care." The World Health Organization defines palliative care as 'an approach which improves the quality of life of patients and their families facing life threatening illness, through the prevention, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems.'"<sup>13</sup>
- **Resource triage threshold:** Denotes "triggers" that demonstrate that specific resources are in short supply or are altogether unavailable. As a result, an allocation schema must be implemented and access to a specific care resource must be triaged because of demand. The triage decision involves an assessment of need, benefit, and duration of use.<sup>1</sup>
- **Trigger:** A "decision point about adaptations to health care service delivery" that requires specific action. A trigger event dictates action is needed to adapt health care delivery and resources. Triggers can be scripted or non-scripted. Scripted triggers are built into Standard Operating Procedures (SOPs) and are automatic 'if/then' actions. Non-scripted triggers require additional analysis and consideration involving management and supervisory staff.<sup>11</sup>

## Background

### Continuum of Care

Figure 1 (below) illustrates the continuum of care, from conventional care, transitioning to contingency care and finally crisis care.

During **conventional care**, customary routine services are provided with no issues (e.g., use of available inpatient beds). During **contingency care**, care provided is functionally equivalent to routine care but equipment, medications, and even staff may be used for a different purpose or in a different manner than typical daily use (e.g., substituting one antibiotic for another that covers the same classification). The demands of most incidents can be met with conventional and contingency care. Pursuant to federal and state laws, contingency care does not mean that persons with disabilities may be treated in long term care facilities instead of hospitals as would be available to their family, friends, and other community members. Nor do contingency care plans supplant the rights of persons with disabilities to receive services in the least restrictive setting (e.g., community). **Crisis care** falls at the far end of the spectrum when resources are scarce and the focus changes from delivering the best available appropriate care for each individual patient to delivering the best available appropriate care for the patient population as a whole. This shift in focus, which may require adaptations and non-traditional provision of care, which while necessary to maximize the number of lives saved during a pervasive or catastrophic public health event, increases the risk to the individual patient of a worse outcome. A single resource (e.g., vaccine) or multiple resources (e.g., critical care beds and staffing) may be affected. In crisis delivery of care, all will receive medical care based on an array of objective medical standards including consideration of those most likely to benefit and those least likely to benefit. No patient will be abandoned. With limited resources, some persons will receive fuller, medically indicated treatment(s), some persons will receive limited medical treatment(s), and some persons will receive palliative treatment(s) based on objective medical standards.

Notably, emergencies are dynamic, and care moves back and forth along this continuum during an incident. The goal is to avoid the crisis state through good contingency planning and implementation, and to recover from the crisis state as soon as possible. For example, a hospital in a crisis after a local emergency can usually transfer patients and bring in resources within hours to get back to contingency or conventional status. In this example, a State response is not warranted. The activation of a State response is at the end of the continuum of care and is only utilized in an extreme prolonged event for a statewide response. Indicators and triggers aid decision-makers in recognizing when care is moving along this spectrum from conventional to contingency to crisis care and can help prompt requests for assistance. For example, if a hospital is providing cot-based care, this indicates crisis care is occurring and outside support is needed.



response and recovery. Additionally, many community members rely on persons with disabilities as neighbors, family members, friends, employers, co-workers, students, and volunteers.

Based on national survey data collected prior to the COVID-19 pandemic (National Survey of Children's Health 2017/2018), Montana children will have needs for health care and community support that can be described in several ways. Protecting and strengthening community support for managing these issues (e.g., home visiting, case management, and child welfare checks modified for frequency, content and social distancing) is one strategy for preventing emergent health care events and added pressure on the health care systems. Some of the conditions experienced by children may make them more vulnerable to COVID-19 warranting review and updates of health care goals and plans within the child's medical home. Note that some children may be in one or more of the following needs categories, so percentages should not be totaled across categories. Nearly 1 in 5 Montana children (19.1%) has more than two current or lifelong health conditions (e.g., allergies, asthma, cerebral palsy). A similar number of children in Montana meets national criteria for having a *special health care need*, resulting from a medical or other health condition with a duration or expected duration of the condition that is 12 months or longer. More than one in six Montana children at any point during the year (17.3%), will have limitations in one of twelve areas of functioning (e.g., breathing, digesting food, physical pain, walking or climbing stairs, concentrating, and hearing). Finally, half of Montana children (51.2%) will have health conditions that consistently and often greatly affect their daily activities during the past 12 months. The rates of these pediatric needs among children should be considered in critical standards of care planning in Montana.<sup>14</sup>

There are seven federally recognized Tribal Reservations and five Urban Indian Centers located in Montana. Approximately 65,000 American Indians live in Montana with roughly 70% of them living on a reservation.<sup>15</sup> These reservations are located in very rural or frontier areas where access to care is limited, and the distance to a major medical facility is over an hour away. Historical trauma, ongoing discrimination, socioeconomic disparities (income, housing, transportation, health care), and the burden of certain chronic disease (e.g., cardiovascular disease, asthma, diabetes mellitus, etc.) among American Indians create disproportionate vulnerability for this population. Thirty-five percent of American Indian residents reported they did not have a person they regarded as their usual health care provider (2017 Montana State Health Assessment).<sup>16</sup> According to the 2016 American Community Survey, 7% of Montana American Indians were aged 65 years or older. According to the 2017 Montana State Health Assessment, the prevalence among Montana American Indian adults of chronic conditions associated with an increased risk for severe illness from COVID-19 were: asthma (13%), chronic obstructive lung disease (8%), cardiovascular disease (10%), diabetes (17%), kidney disease (5%), and obesity (32%). In 2018 17.2% of American Indian/Alaska Natives in Montana reported a diagnosis of diabetes compared to 8.7% of white, non-Hispanics.<sup>17</sup> The negative impacts of COVID-19 also may be greater among American Indians in Montana with jobs that do not have paid leave or opportunities to take leave to recover from illness or provide care to others who are ill. These factors may influence how COVID-19 impacts on American Indians and tribal communities, and it is critical that ongoing CSC planning efforts include this perspective.<sup>18</sup>

Table 1: State of Montana Demographics - OS Census		
Category	Demographics	Number or Percent
C o u n t y	Total	1,068,778
	Under 5 years	5.9%
	Under 18 years	21.6%
	Over 65 years	18.7%
	Foreign born persons (2014-2018)	2.2%
	With a disability, under age 65 years, percent 2014-2018	9.2%
C e n s u s	White	89.0%
	American Indian/ Alaska Native	6.6%
	Hispanic or Latino	41.0%
	Asian	0.9%
	Black/ African American	0.6%
	Native Hawaiian/ other Pacific Islander	0.1%
E c o n o m i c	Person per household (2014-2018)	2.39
	Median household income (2014 -2018)	\$52,559
	Persons in poverty <sup>2</sup>	13.0%
	Households with computer (2014-2018)	87.3%
Health	Persons without health insurance, under age 65 years, percent <sup>2</sup>	10.0%

" U.S. Census Bureau. Quick facts. July 1, 2019 estimates  
 " 2018 American Community Survey 1-year estimates, es\_ [http://data.census.gov/cedsci/table?t=AGE&tid=ACSDP5Y2018-D0102&cid=4000000US0&tid=PREVIEW=false&vintage=2018&\\_lang=en](http://data.census.gov/cedsci/table?t=AGE&tid=ACSDP5Y2018-D0102&cid=4000000US0&tid=PREVIEW=false&vintage=2018&_lang=en)

Table 2: State of Montana Demographics - American Community Survey 5-year estimates		
Category	Demographics	Number or Percent
C o u n t y	Total with a disability	1,026,586
	Total under 18 years	139,635 (13.6%)
C e n s u s	Total with a disability	226,630
	Total 18 to 64 years	9,196 (4.1%)
	Total 65 years and over	620,841

" American Community Survey 2018 5-year estimates data profiles [https://data.census.gov/cedsci/table?t=AGE&tid=ACSDP5Y2018-D0102&cid=4000000US0&tid=PREVIEW=false&vintage=2018&\\_lang=en](https://data.census.gov/cedsci/table?t=AGE&tid=ACSDP5Y2018-D0102&cid=4000000US0&tid=PREVIEW=false&vintage=2018&_lang=en)

## Concept of Operations

### Indicators/Triggers

Montana DPHHS might consider the following indicators and triggers to activate a Crisis Standards of Care response:<sup>22</sup>

**Indicators with no associated Trigger** (require analysis and decision-making):

- Disruption of facility or community infrastructure and function (e.g., utility or system failure in health care organizations, more than one hospital affected in the region, more than five hospitals affected, or critical-access hospitals affected in the state);
- Failure of hospital “contingency” surge capacity (i.e., resource-sparing strategies overwhelmed);
- Availability of material resources;
- Availability of space for patient care;
- Shortage of community resources to support patient discharge and care coordination;
- Pandemic phase/impact.

**Potential Indicators with associated local Trigger** (threshold that ‘triggers’ specific action is specified in agency/facility plans):

- Unable to answer all EMS calls;
- More than 12 hours of wait time for emergency department visits;
- Unable to maintain staffing in the Intensive Care Unit (ICU);
- Fewer than 5 percent of hospital beds available, no beds available;
- No ICU beds available in the healthcare organization; or a disaster declaration affects more than one area hospital;
- Shortage of specific equipment (ventilators) or of medications that have no substitute.

It is important to note that ‘triggers’ are more common at the initial levels of response. At the State level it will be much more common that indicators are reviewed, and appropriate actions determined based on the problem and potential solutions.

## Communications

A crisis standards of care situation will require extensive communication, coordination and collaboration among all response partners, so messaging is clear and consistent statewide. All communication materials should be available in accessible alternative formats.

### *On-Going Communication*

During a crisis standards of care situation, transparent communication is of the utmost importance. DPHHS Public Health Emergency Preparedness (PHEP) follows the principles of the National Incident Management System (NIMS) and will conduct its operations under the structure of the Incident Command System (ICS). Activities in this annex are based on established relationships and partnerships with the public, stakeholders and partners, and contributing agencies, including local, state, and federal entities. Methods for communicating both internal and external stakeholders may include:

- Health Alert Network (HAN) messages; and
- Public Information Officer (PIO) advisories and guidance documents

## Public Information

DPHHS is responsible for directing and coordinating health-related communications activities during an incident with public health implications. During states of emergency, public/media communications are coordinated through the State Joint Information Center (JIC) via the Lead Public Information Officer (PIO). The Lead Public Health PIO will assume primary responsibility DPHHS has activated an incident response structure, the DPHHS PIO will assume lead responsibility for public communication associated with an emergency or incident (see the DPHHS Public Health Crisis and Emergency Risk Communication Annex). The Federal Emergency Management Agency (FEMA) is committed to providing accessible Information and Communication Technology to individuals with disabilities, including members of the public, disaster survivors and federal employees, by meeting or exceeding the requirements of Section 508 of the Rehabilitation Act (29 U.S.C. 794d). The availability of communications in accessible formats is required.<sup>23</sup>

## Maintenance

The rapidly evolving circumstances associated with the 2020 COVID-19 pandemic precluded the ideal deliberative and participatory CSC planning with substantial involvement of local public and private entities. However, every effort was made to involve interested and expert stakeholders, to the extent possible on an accelerated timeline. The source documents used here and created by the Minnesota Department of Health and the Washington State Department of Health have been vetted by their respective stakeholders. Minnesota's ethical objectives outlined under *Planning Assumptions* above demonstrate their ethical commitment to developing a sound CSC plan and this informed Montana's

decision to repurpose their plan as a Montana document for use during the timeframe of the COVID-19 emergency. Upon resolution of the current COVID-19 emergency, hospital emergency planning teams will initiate a revision of the current document or creation of a new document, including incorporation of more extensive Montana-specific stakeholder engagement.

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## Appendix D



MONTANA  
EMS & TRAUMA  
SYSTEMS PROGRAM

# Montana COVID-19 Surge and Crisis Care Guide for Emergency Medical Services

The goal of this guide is to provide background on surge and crisis care issues related to the COVID-19 pandemic and present a structured approach to potential challenges in the provision of response by EMS services, first responders and public safety answering points (PSAP). While this guide recognizes the supporting role of regional and State assisting agencies, it is the responsibility of the EMS service leadership and medical director, in partnership with your local health facility and public health, to ensure operational plans are in place to protect your staff and provide quality care to your patients in challenging conditions. These guidelines provide a framework for decision making and should be flexible and adaptable for local circumstances.

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## Preface

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In surge and crisis care, each EMS service and medical director will have to determine the most appropriate steps and actions for their agency based on their local situation and resources.

- Pre-planned actions are always preferred to ad hoc decisions.
- Pre-event familiarization with the contents of this guide and development of local and regional plans is recommended to aid with event preparedness, response and anticipation of specific resource shortfalls.
- This guide addresses common categories of pre-hospital EMS response, triage, treatment and transport.
- Local EMS services and their medical directors, health care facilities, public health, regional health care coalitions, and State support systems may determine additional issues and strategies for their specific situation in addition to those outlined in this guide.

*"In a crisis standards of care event the focus changes from individual to population needs. The evolution from conventional to contingency to crisis modes isn't simply an operational shift, this is a legal shift as well involving changes in the applicable standards used to determine whether the duty of care was met for those who required assistance to the best degree possible given the circumstances."<sup>198</sup>*

<sup>198</sup> IOM/NAM, *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*

Disclaimer: Much of this guide is based upon the work of the Minnesota Department of Health and Minnesota EMS Regulatory Board & various national framework documents. To expedite development of this guide for Montana EMS, incorporation of portions of these public works have been

## Overview of Montana's EMS Services

In providing an EMS response to Montana's COVID-19 pandemic, Montana has the following EMS response services:

- 103 non-transporting units;
- 141 ground transporting ambulance services;
- 5 rotor-wing flight services; and
- 9 fixed-wing flight services.

Under typical circumstances, characteristics of the Montana EMS include:

- EMS responds to over 100,000 9-1-1 calls annually;
- Workforce consists of approximately 4,900 ECPs, over half are volunteers;
- 73% of services in rural communities are staffed primarily by volunteers;
- 58% of services are basic life support;

- 35% provided limited levels of advanced life support (ALS);
- 2% (20 services) provided 24/7 ALS – located in urban communities.
- It is not uncommon for EMS systems to operate near or at a surge for short to moderate periods of time (e.g. single vehicle crash with 3 patients). Under these circumstances:
- Local EMS services surge response would, in most cases, rely on mutual aid from other emergency responders or neighboring agencies;
- The threat of an extended COVID-19 pandemic may decrease the capacity for EMS to provide usual or mutual aid services;
- More robust planning is required when demand could result in poor outcomes for patients unless crisis strategies are implemented.

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## *Assumptions*

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Montana's local jurisdictions vary widely in the threats they face, the vulnerability of their populations, and the response resources immediately available to respond to emergencies. They also employ a variety of strategies for coordination and oversight of day-to-day EMS services including local EMS providers that:

- cover single counties - some cover multi-county regions;
- operate as a governmental, tribal, hospital-based unit, non-profit organization, private entities and other forms of management;
- have varying levels of responsibilities for emergency management.

Montana's disaster medical system generally functions under a framework of Incident Command System (ICS) and National Incident Command System (NIMS) through which Disaster and Emergency Services (DES), Department of Public Health and Human Services (DPHHS), and other state agencies can support. Other key assumptions include:

- All incidents start at the local level. If or when local resources are overwhelmed, there is a request for assistance from neighboring jurisdictions, the State, or the federal government, in that order.
- Local government remains in charge of their jurisdictional authorities and response to disasters within its geographical area. Local, State and federal officials, agencies, and resources, from outside the jurisdiction who provide support and resources to the response will do so in an "Assisting Agency" role.
- State and federal governmental agencies may have a shared jurisdictional authority to respond to and mitigate a pandemic within the affected area. They may have a role to coordinate their activities with the local government agencies.

- Montana’s response will include both public and private medical resources that need to operate in a coordinated manner for maximum effectiveness.
- Public safety EMS resources frequently have dual roles during disaster response and on a day- to-day basis. Communities may find EMS service curtailed as personnel are required to support other response and leadership responsibilities.

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## ***Planning and Implementation - General***

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### **Medical direction**

Crisis strategies and tactics need to balance community versus individual needs. Risk to the individual patients must be balanced against the demand. Therefore, involvement of medical directors is critical to the success of the plans, strategies and tactics. Important consideration regarding the role of the medical director includes the following.

- Optimally, the medical director should have a role during the crisis situation to provide subject matter expertise, while acting as a liaison among the hospital, public health and EMS service.
- Since the medical director is ultimately responsible for the care provided, any change to usual Standard Operating Procedures (SOPs) will require physician input and approval.
- Engagement level of medical directors varies widely across the state, so the COVID-19 response may introduce additional challenges. The EMS service and the medical director will need to agree on an appropriate level of participation early on.

### **Integration with Health Care Coalitions**

It’s critical that EMS services do *not* work on surge and crisis care plans in isolation but do so in concert with their regional framework and partners. Consistency of plans and knowing what others in the region (and adjacent regions) are planning is critical to success. Surge strategies and SOPs do not have to be identical, but if they are similar or complementary, it will optimize mutual aid response.

[Health Care Coalitions \(HCC\)](http://mthcc.org/) (<http://mthcc.org/>) have been formed to assist with regional coordination, planning and response. Each HCC also has at least one Regional Health Care Preparedness Coordinator to facilitate information sharing, situational awareness and resource coordination among members for pandemic surge. The HCCs have mechanisms in place to communicate among partners and support among disciplines.

## Surge Capacity

Most EMS services are familiar with the concept of *surge capacity*, which is the ability to increase services to match demand. *Surge capability* is slightly different - it requires increased capabilities in equipment, staff and resources to meet the patient's needs. COVID-19 surge response may present new challenges for adequate PPE, staff availability, alternate transportation modes and alternate care sites. Considerations for surge capacity planning include the following.

- EMS must plan for COVID-19 surge capacity across multiple functions (e.g., dispatch, response, treatment, transport).
- Available resources must be utilized to their maximal capacity and additional resources obtained from known sources via pre-existing mechanisms (e.g., mutual aid agreement)
- Some actions can be accomplished with minimal risk (e.g. mutual aid to meet demand) and some carry significant risk (e.g., not responding to some 911 calls due to overwhelming demand).
- The goal is to maximize the potential benefits of surge capacity strategies to mitigate the crisis, while minimizing the risks associated with deviations from routine operations.
- Strategies that are most appropriate to the situation and offer the least risk to the patient and EMS personnel should be identified and selected, proceeding to riskier strategies as demand increases and options decrease.

Surge capacity is best visualized as three categories across a continuum (see Figure 1):

**Conventional** - usual strategies and resources (e.g., dispatch of additional ambulances, mutual aid, extending staff shifts for a few hours);

**Contingency** - uncommon strategies and resources that incur a small risk to patients such as staffing ambulances with less personnel or a delayed level of response;

**Crisis** - disaster strategies used when demand forces choices that pose a significant risk to patients but is the best that can be offered under the circumstances (e.g. recommending self- transport, shelter in the home, medical personnel accompanying patient in a private vehicle).

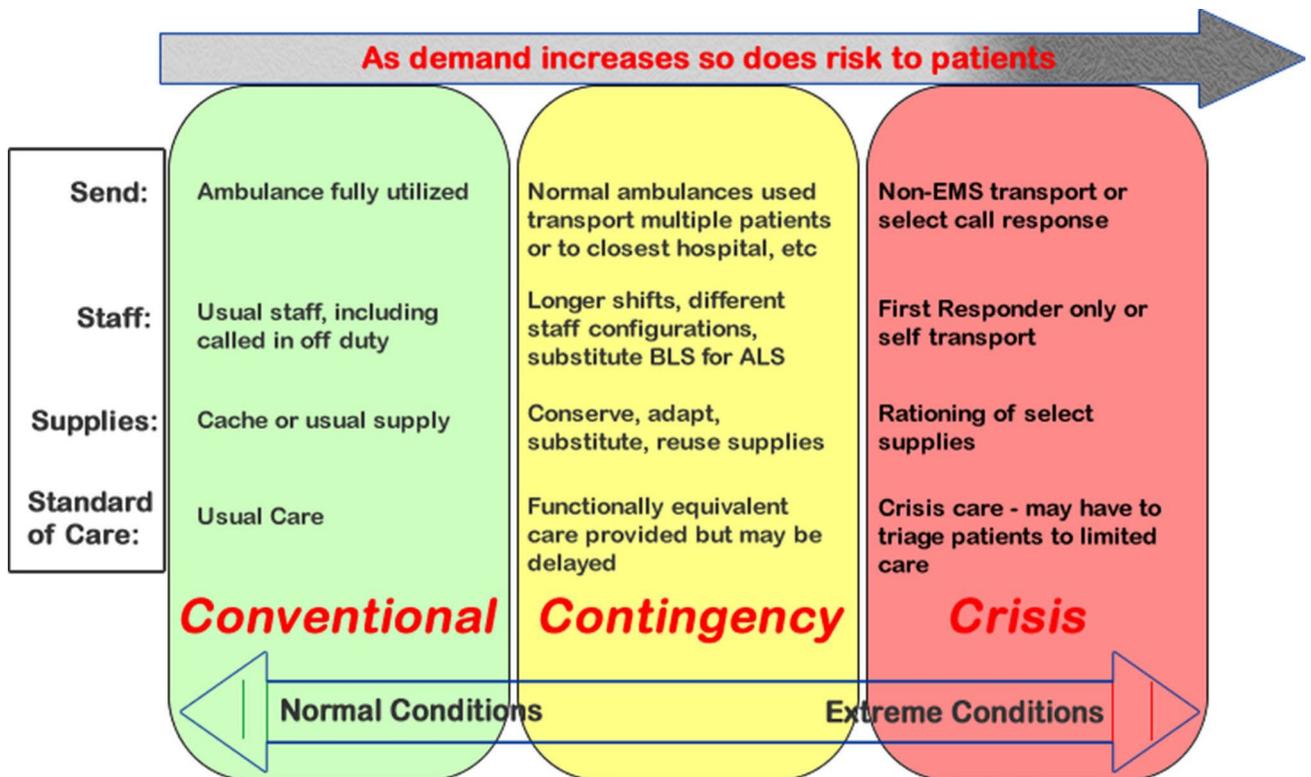


Figure 1: Continuum of surge capacity demand

## Crisis Care

Crisis Care is required for a longer-term and more pervasive situation where adequate resources are not available to meet the needs and a systematic approach is required. At a minimum, EMS services and their staff, the medical director and local health care facility need to be engaged in decisions and triggers. This may include, but is not limited to, dispatch and triage decisions, alternate care sites, alternate care systems, and treatment recommendations.

Crisis Care is invoked when demand forces the agency to make decisions that may place the patient at a higher risk of a poor outcome but are the best that can be offered given the circumstances. Key points about Crisis Care include:

- Strategies not thought out ahead of time likely will not be considered or cannot be implemented.
- Strategies should be proportional to the resources available and this may result in moving back and forth along the surge capacity continuum (see Figure 1). As more resources arrive, you should shift to lower risk strategies (e.g., back to contingency and eventually conventional status).

## Indicators and triggers

An "indicator" is a predictor of a possible event (e.g., increasingly positive testing of COVID patients in

a community) that requires analysis to decide if a "trigger point" has been reached, which will initiate action. Characteristics of these triggers are included below.

- Scripted triggers are automatic if/then decisions - Whenever possible, scripted triggers should be developed for staff so they have actions they can take immediately to prevent delay. If there is less specific information available, a manager or medical director should be involved to process the information and decide on necessary actions.
- Responder and dispatch personnel should have a low threshold for passing indicator information along to supervisors for situational awareness and potential action.

The EMS service should determine what strategies or options it may employ in a disaster and then decide on indicators that might be available and a trigger point for staff to take tactical action. These will vary by service. For example, in a very rural area, a longer response time for an ambulance may be normal, but in an urban area, this could prompt implementation of call triage and recommendations for private transport for stable patients.

For an extended event such as COVID-19, the agency should review and modify their procedures, as needed. Plans should be flexible and not "lock in" for the duration of an incident. Allow transition back to conventional care as more resources arrive or demand falls, or both (see Figure 1). For the example above, this would mean the recommendation for private transport should cease once ambulances are available.

## Roles and responsibilities

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
Public Safety Answering Point/9-1-1 Dispatch Center	Support agency	<ul style="list-style-type: none"> <li>• Answers 911 calls</li> <li>• Provides emergency medical dispatch support</li> <li>• If equipped, may transfer to secondary center/ public safety answering point (PSAP)</li> <li>• Determines appropriate response based on situation</li> <li>• Provides communication point for incident responders</li> </ul>
Non-Transporting Units / QRUs	First response	<ul style="list-style-type: none"> <li>• Frequently the first personnel on scene to assess and report on the situation</li> <li>• Provides initial triage and care and help determine what additional resources may be needed</li> <li>• Support and assist arriving ambulance personnel on scene as needed</li> </ul>
Ground and Air Transport Services	Emergency response and patient transport	<ul style="list-style-type: none"> <li>• Interface with local and regional hospitals</li> </ul>

		<ul style="list-style-type: none"> <li>• Adjust response and transport guidelines to reflect the situation at hospitals</li> <li>• Coordinate patient destination hospitals to the degree possible to avoid overloading a single facility</li> </ul>
Local / Regional Disaster and Emergency Services (DES)	Support agency	<ul style="list-style-type: none"> <li>• Local assistance for all supply and resources requests</li> </ul>
Local Public Health	Support agency	<ul style="list-style-type: none"> <li>• Local assistance to EMS service and medical director for public health and other coordination of emergency response issues</li> </ul>
Regional Health Care Coalitions	Support agency	<ul style="list-style-type: none"> <li>• Regional resource for sharing of information and coordination of emergency response with other services. Local requests for assistance may be forward to the HCC.</li> </ul>
State Disaster and Emergency Services	State support agency	<ul style="list-style-type: none"> <li>• State resource for issues and requests that cannot be met at the local or regional level.</li> <li>• Statewide coordination of all response efforts</li> </ul>
EMS & Trauma Systems / DPHHS	State support agency	<ul style="list-style-type: none"> <li>• State EMS resource for information about EMS capabilities and needs</li> <li>• Works on mission specific activities delegated from the State DES level</li> <li>• EMS and Trauma Systems (<a href="#">EMSTS</a>) <a href="#">COVID-19 web pages</a></li> </ul>

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## **Functional Planning Considerations**

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### **Dispatch**

As in normal operations, the goal of COVID-19 dispatch response is to provide the most appropriate services available. While many dispatch centers utilize Emergency Medical Dispatch (EMD) to assess the call and prioritize responses, public safety answering point-PSAPs in many rural areas often do not have these resources or training. Irrespective, coordination among dispatch, the EMS service and medical director is essential. Determining the best services to match a request can be difficult. A possible dispatcher algorithm for consideration is presented in Attachment #1.

Implementation of Centers for Disease Control and Prevention (CDC) recommendations for dispatch screening questions and the close coordination with response to suspected or reported COVID patients should assure that emergency responders arrive on scene prepared and safe. A standard page or radio code such as “PPE Advised” should be employed consistently and provided to all emergency responders.

Dispatch centers should examine their operations and determine:

- Are there options for adding supplemental staff and dispatchers to support additional communications call volumes when appropriate?
- Is there a technical capability to roll calls over to other dispatch centers if call volumes exceed pre-determined call wait times?
- Is there a capability to develop arrangements, policy and procedures to transfer calls to a clinical provider that could help prioritize the need for an ambulance in areas where EMD's are not normally available? This could be hospital-based personnel or Part of the goal during a crisis is to decrease the call volume at the PSAP. This may be accomplished by keeping the public up to date with incident information to reduce non-emergency 911 calls. Work with emergency management, local public health and local media to communicate to the public the stress on the system and to only call 9-1-1 for life-threatening emergencies.

## Staffing

During a pandemic, EMS service staff could be severely and disproportionately affected by self-quarantine and other factors. Agencies should examine the following possibilities when planning for surge situations:

- Maximal utilization of current staff - consider extending shifts and changing schedules;
- Explore mutual aid from nearby services - though current mutual aid focuses on ambulances, it may also be possible to share staff across services to maximize the use of the available vehicles;
- Change in crew configuration – e.g. one Paramedic/EMT rather than two Paramedics or one Emergency Medical Responder / one EMT rather than two EMT's;
- Use of direct response by staff in personal vehicles - this could involve emergency care providers (ECPs) not affiliated with the EMS service that can respond to provide assessment and basic care if an ambulance is not available.

While Community Integrated Health (CIH) providers are limited at this point, plans are being considered to provide for a CIH “Light” program with “just-in-time” training specific to COVID-

19. Further information will be forthcoming.

50-6-322 MCA allows volunteer, rural EMS services to staff and ambulance with one EMT and one trained driver. EMSTS has waived traditional staffing requirements to allow all EMS services to provide staffing with one EMT and one trained driver. A [prepopulated waiver form](#) is available on the EMSTS website that the service needs to complete and return and it will be approved.

*The State is activating the Montana Healthcare Mutual Aid System (MHMAS). This registry is being utilized to track information and credentialing for healthcare providers who are available to respond to staffing needs in hospitals, alternate care sites, ambulances, etc. Persons interested in deployment to communities can register at:*

## [Montana Healthcare Mutual Aid System](#)

### Supplies & Resources

Current supply chain models rely on "just-in-time" inventory processes with minimal stock. Few EMS services can maintain significant contingency stocks of disposable supplies. The COVID-19 pandemic has necessitated increased usage of personal protective equipment (PPE) and other supplies and a challenge with supply chains not yet able to meet demand. While some national stockpile resources have become available, EMS is likely to be challenged with adequate supplies throughout this event.

Resource requests (supplies, staff, equipment) for response and recovery originate at the local level and are progressively forwarded to the next level until filled. If a local jurisdiction is unable to provide the necessary requested assistance from within the jurisdiction, they would then request mutual aid from nearby areas. If resources are not available within their mutual aid "region", the request will be forwarded to the State as appropriate.

*The State Emergency Coordinating Center is asking that all local resource orders be submitted through local emergency operation center procedures and validated by the local DES coordinator or their designee. Medical supplies, such as PPE, should be submitted on the electronic reporting form below. An order form is needed for each facility/organization needing assistance.*

### [COVID-19 Medical Resource Request Form](#)

Strategies and tactics to maximize resources will be necessary. Consider the following:

- Substitute: Use an essentially equivalent device resource for one that would usually be available.
- Adapt: Use a resource that is not equivalent but provides the best possible care.
- Conserve: Use smaller quantities or change practices (e.g. limit number staff in contact with a patient).
- Reuse: Use single use items again, after appropriate disinfection or sterilization.
- Optimize Allocation: Allocate resources to patients whose need is greater or whose prognosis is more likely to result in a positive outcome with limited resources.

### Transport Considerations

Ambulance services (urban and rural) generally do not have significant additional ambulance capacity available. Any alteration of transport consideration will be done collaboratively among EMS leadership, the medical director and others as appropriate. In the COVID-19 pandemic, ambulance resources may be severely limited and alternate transport options may need to be considered. Plans should consider maximal use of existing ambulances including:

- Mutual aid from surrounding agencies, including neighboring states. This should include agencies typically providing non-emergency transportation. Significant aid from surrounding states or through Emergency Management Assistance Compact (EMAC) will be unlikely during COVID-19.
- Many non-transporting units, fire departments and search and rescue have vehicles capable of patient transports. Work with these agencies to determine their capabilities in terms of staff and equipment.

- National Guard ambulances and potentially airlift capacity could contribute to patient movement. Use of these assets would only be activated through resource requests through local DES to the State.

Ambulance service providers need to weigh the risks and benefits of patient transport in a non-traditional vehicle (e.g., wheelchair vans, school or public transit buses) versus the risks and benefits of waiting for an ambulance to arrive. Some considerations that should be considered include:

- Time sensitivity - Does the patient have a time sensitive condition?
- Decreased time to treatment - Does the time to the hospital by a non-ambulance increase the chances of the patient having a successful outcome?
- Can the patient be appropriately stabilized on-scene while awaiting arrival of an ambulance?
- Patient restraints - Although not always possible, patients and any attendants being transported to a hospital in a non-ambulance should have appropriate patient restraints (child and adult).

Use of private vehicles, with or without medical personnel, may need to be used to augment ambulance services. In general, it may be better to get a patient to the hospital faster rather than wait long periods of time for an ambulance. Prioritizing ambulatory and other selected patients to private transport can significantly reduce burden on ambulance service agencies. Depending on the patient condition and availability of staff resources, make plans for the following options:

- Family members or others transporting stable patient in private vehicle without escort/attendant (e.g., low acuity patient with non-life-threatening conditions).
- Family members or others transporting patient in vehicle with EMS personnel following in another vehicle (e.g., stable but with potential for deterioration).
- Others transporting in private vehicle with EMS personnel in the vehicle with them monitoring or providing care (e.g., unstable - highest risk to patient and provider).
- Non-ambulance public safety vehicle (fire or police) transporting patient (e.g., professional driver and marked vehicle but limited ability to provide any medical care).

## Destinations

While rural EMS services usually transport patients to a single hospital, urban services may have a choice of more hospitals. A conscious decision should be made early in response to distribute patients across facilities rather than overburden a single hospital.

In a pandemic surge, hospitals may set up a screening site for those with mild symptoms so they can focus on the sickest individuals. Additionally, alternate care sites for low acuity patients may be implemented such as a clinic, urgent care center, field hospital other community venue. It is appropriate for ambulance service personnel to transport to those locations provided they are open, appropriately staffed, and the patient does not have any severe symptoms. These are generally surge dependent options for the ambulance service leadership and medical director to consider, develop event-specific policy, and communicate to the crew.

CMS Ambulance Flexibilities to fight COVID-19 - CMS is temporarily expanding the list of allowable destinations for ambulance transports. During the COVID-19 event, ambulance

transports may include any destination that is able to provide treatment to the patient. These destinations may include but are not limited to: any location that is an alternative site determined to be part of a hospital, critical access hospital (CAH) or skilled nursing facility (SNF), community mental health centers, federally qualified health centers, physician's offices, urgent care facilities, ambulatory surgery centers, any other location furnishing dialysis services outside of the end-stage renal disease (ESRD) facility, and beneficiary's home.

Consideration may be made for transport out of the community to a nearby community that is not in a surge status. The disadvantage of spreading patient transports between other and more distant hospitals or facilities is that increasing distance results in additional time.

- Particularly in rural areas, inter-facility transfers can take essential local EMS resources out of the service area for hours at a time
- Utilizing EMS units from the receiving facility/community or more aggressive use of air ambulances for transfer may be of substantial benefit to preserve community response.
- EMS may be tasked with balancing patient load between facilities. i.e. EMS may transport a critical patient from a CAH to a higher level of care but may need to transport a lower acuity patient from receiving facility back to the CAH.

During this pandemic, the medical director and EMS service leadership may also approve broader discretion for patients being left at scene by the ambulance service crew (if the condition is not emergent and appropriate follow-up and/or alternate transportation can be arranged). This should **only** be invoked when additional calls are pending in the system and **only** for conditions and circumstances that the medical director approves via SOP or online medical control. Consider using the Board of Medical Examiners Influenza Pandemic Protocol (Attachment #2) for guidance.

## Legal and regulatory considerations

Crisis care actions that will occur during this pandemic should be undertaken with consideration for the impact of legal and regulatory standards. Guidance and support from local, tribal and Federal governments and State agencies will be provided as it evolves. The ability of the Governor and the President to issue emergency declarations and promulgate enforceable orders and rules to address the contingencies created by the pandemic are provided by law. This is a very dynamic facet of this pandemic.

*EMS leadership and medical directors need to review The Governor's declarations and directives for application to EMS operations, professional licensing, etc.*

[Governor's Coronavirus Task Force – Joint Information Center](#)

### Waiver of EMS Service Licensing Requirements

50-6-325 MCA. Waiver of licensing requirements

- (1) The department may waive any licensing requirements under this part upon submission and approval of a written application for waiver by a person subject to licensing under this part.
- (2) The department may waive a licensing requirement if the person provides sufficient justification to allow a finding by the department that:

- (a) the waiver is necessary to avoid significant financial or other hardship; and
  - (b) granting the waiver would not jeopardize patient care or the public health and safety.
- (3) A waiver must be issued on a temporary basis, not exceeding 6 months, and may be renewed by the department upon submission and approval of an additional application for waiver of licensing requirements.
  - (4) A waiver granted by the department may be revoked for good cause after notice and an opportunity for a hearing before the department have been provided to the person affected by the department's action.

To date, the department has waived various requirements for personnel on EMS services (i.e. two licensed persons on all calls). The waiver provides for relieve for EMS services that are not included under 50-6-322 MCA which allow volunteer, rural EMS services to staff an ambulance with at least one EMT and one trained driver. Services who completed and return the [waiver](#) will be allowed the same.

### **Department of Labor / Health Care Provider Licensing**

The Department of Labor is accommodating adjustments to licensing allowed under their statutes. The department has implemented an [Interstate Licensing Registration](#) process allowing out-of-state health care providers to be able to quickly become authorized to practice in Montana.

### **Liability**

Response by healthcare providers may raise legal and liability concerns among health care and public health professionals. While traditional liabilities and protections continue to be in place, extreme service demands coupled with constrained supplies and diminished personnel, will challenge EMS provision of usual services and care expected by the community. EMS leadership and medical directors need to work closely with legal (private liability carrier, county attorney, etc.) to understand their role and risks in crisis care. The federal Coronavirus Aid, Relief, and Economic Security Act strengthens the provision of liability for certain volunteer healthcare professionals:

#### **Section 3215: Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response**

- Limits liability for health care volunteers under Federal and State law for “any harm caused by an act or omission of the professional in the provision of health care services during a public health emergency” for the duration of the COVID-19 emergency.
- This applies if:
  - (1) the professional is providing health care services in response to such public health emergency, as a volunteer; and
  - (2) the act or omission occurs
    - (A) in the course of providing health care services;
    - (B) in the health care professional’s capacity as a volunteer;
    - (C) in the course of providing health care services that
      - (i) are within the scope of the license, registration, or certification of the volunteer, as defined by the State of licensure, registration, or**

**certification; and**

**(ii) do not exceed the scope of license, registration, or certification of a substantially similar health professional in the State in which such act or omission occurs; and**

(D) in a good faith belief that the individual being treated is in need of health care services.

This section ensures liability protections for health-care volunteers during the COVID-19 public health emergency by preempting **“the laws of a State or any political subdivision of a State to the extent that such laws are inconsistent with this section, unless such laws provide greater protection from liability.”**

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## Recovery

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Planning for recovery should begin while the event is ongoing. Recovery is the restoration of services to their pre-existing or optimized conventional state. The basic philosophy of recovery is to "build back better" after an incident.

However, because of the dynamic nature of the COVID-19 pandemic, a return to conventional care may be temporary, and does *not* mean the recovery phase has truly begun. EMS services should assure they are prepared to be flexible across the surge continuum and be certain the situation has concluded prior to ending the response. For example, EMS services may be able to operate in conventional status during the night in a pandemic, but during daytime hours may remain in crisis mode due to call volumes.

During recovery, there are multiple priorities. Some priorities for EMS services specifically include:

- Complete, detailed documentation of supply and time costs for potential reimbursement;
- Return of borrowed equipment;
- Restoration of equipment to usual state;
- Replacement of supplies;
- **Provision of mental health support to affected staff** (psychological first aid or more specific strategies depending on the situation);
- Support for provider families affected by the incident;
- After-action reviews of the event and development of a corrective action plan for future similar events.

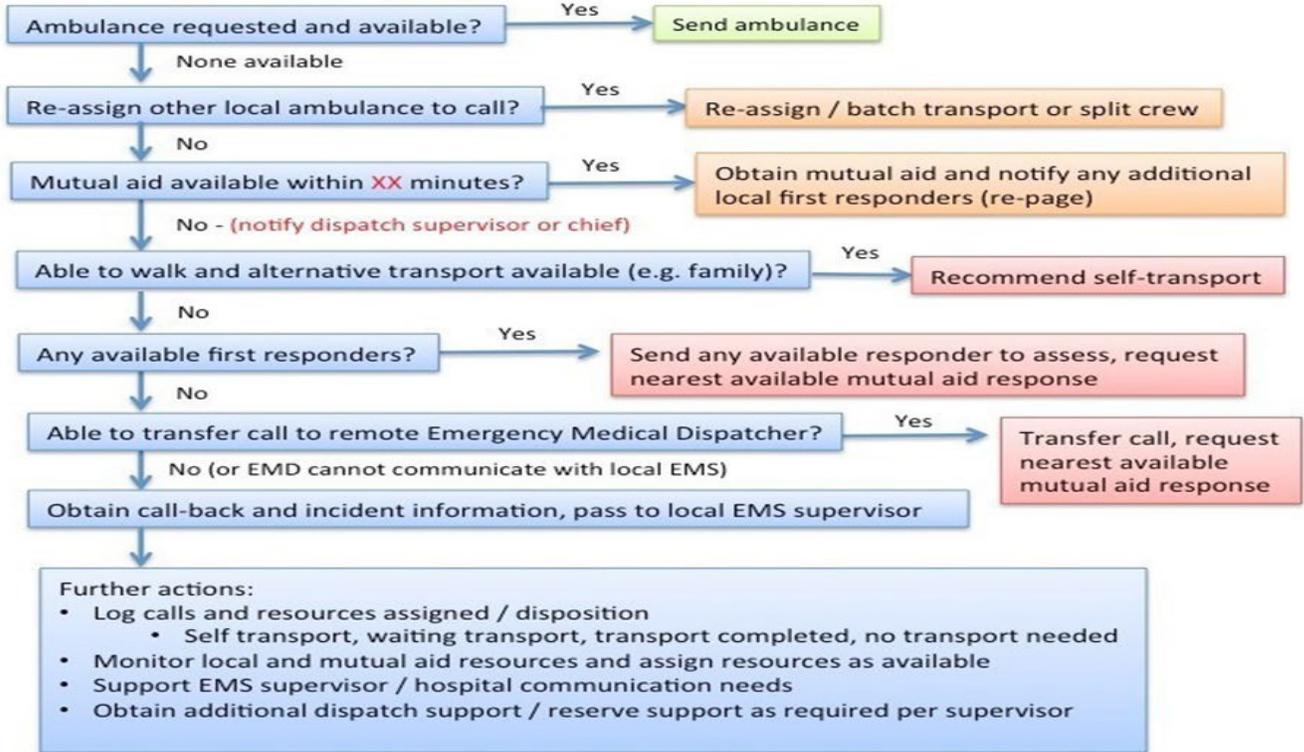
EMS services may need to provide ongoing support to other agencies as they continue their operations. EMS services should also confirm with local Emergency Management there are no other functions required of them and participate in community recovery planning and after-action analysis.

# Attachment #1

## Example EMS dispatch-triage tree

### EMS Dispatch - Triage Tree

v. April 28, 2016



#### Notes:

- Assumes non-EMD PSAP - for EMD PSAP triage calls based on priority dispatch levels and in conjunction with medical direction
- Supervisors for EMS and public safety should be notified when any 'red box' / 4<sup>th</sup> level is used
- Dispatcher should have authority, process, and contact numbers for activating this algorithm
- Dispatcher should have contact information for regional ground and rotor-wing resources
- Identify support mechanism for call triage decisions (EMS supervisor / lead medic, hospital personnel and document responsibilities / contact information prior to event)
- Identify role of EMS supervisor / medical director in this process
- First responders without an ambulance should coordinate appropriate care with receiving hospital / EMS supervisor
- Consider *not* sending EMS initially on calls for potential injury accidents until confirmed significant injuries.
- Consider other call type triage based on local system and dispatcher training

Reference: [Minnesota Crisis Standards of Care Framework](#)

## Attachment #2

### [Montana BOME ECP Practice Guidelines](#)

## BOME Influenza Pandemic Protocol

**General Comment:**

*In the event that there is a public health or safety emergency in which health care resources are overwhelmed by demand, the EMT response will have to adapt to the severity of the situation and the available resources. This Influenza Pandemic protocol is to be used as a guide in the development of a local plan (based on the severity of the situation and the available resources) remembering that the local situation will change frequently, perhaps daily or hourly. This protocol is assuming that an Influenza Pandemic has overwhelmed the medical community and normal EMT operating procedures are not feasible or practical. The Montana Board of Medical Examiners recognizes that an organized "treat and release protocol" would not only be advantageous but necessary to maintain control and order to providing medical assistance in the community.*

**ALL RESPONDERS: Physical Assessment:**

When conducting your initial assessment, a patient, maintain a safe distance (6 feet) and utilize personal protection until you determine if influenza like symptoms exist. If no symptoms exist, then proceed with your patient assessment as normal. If influenza symptoms are present; utilize the triage tool identified below to assess and determine the severity of the illness and assist in transport decisions. The local medical director must determine, in consultation with the local public health department and health care facilities, what scores would facilitate transport or treat and release; this could change depending on the evolving characteristics of the viral infection and may change daily or even hourly depending on available medical resources.

<u>Demographics:</u>	<u>Score</u>
Age <6 months:	2
6 mo – 5 yrs	1
5 yrs- 65 yrs	0
65 yrs- 75 yrs	1
>75 yrs	5
Caregiver at home	-1

<u>O2 saturation:</u>	<u>Score</u>
> or = to 90%	0
86% - 89%	3
76% - 85%	4
= to or < 75%	5

<u>Respiratory rate:</u>	<u>Score</u>
8 - 24 resp / min	0
24 - 60	2
< 8 or > 60	3

<u>Heart rate:</u>	<u>Score</u>
< 6 mo & > 150 HR	2
Children > 6 mo & > 120 HR	2
Adults: > 110 HR	2

<u>Blood pressure:</u>	<u>Score</u>
<6 mo & cap refill > 2 seconds	2
90 - 100mmHg	2
< 90mmHg	4

<u>Temperature:</u>	<u>Score</u>
>103 F (39.4 C)	1

<u>Mental Status:</u>	<u>Score</u>
Confused	2
Unresponsive/ Obtunded	3

<u>Able to tolerate PO?</u>	<u>Score</u>
Yes	-1
No	1

<u>Co morbidities:</u>	<u>Score</u>
DM, asthma/COPD, CHF	1 each
Obesity	1
Pregnancy	2

<u>Evaluator discretion:</u>	<u>Score</u>
Evaluator may assign subjective	-1, 0, or +1

**Patients who score:**

- >14 Patient should remain home with comfort measures provided
- 8 - 14 Should be transported to the emergency department for treatment
- 4 - 8 Should be directed for additional screening/assessment but does not require ambulance transport
- < 4 Should not be transported and should remain home with provided instructions

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## **Attachment #3 EMS Mutual Aid Considerations**

### **Local Activation of EMS Mutual Aid for a Surge**

Local EMS leadership, the medical director, hospital leadership and DES should coordinate through frequent communication regarding availability of ambulances and crews including the level of care available. This communication should include anticipated interfacility transfer needs.

If local EMS has reached capacity and can no longer meet the 911 and interfacility transport needs of their community, a resource order needs to be placed with the local DES. The hospital, in consultation with their local EMS leadership and medical director, will determine the number of ambulances and personnel needed to meet the demand.

Local DES will communicate with surrounding communities regarding their availability to fill the resource need. If the need cannot be met by surrounding communities, local DES will elevate the request to the SECC.

### Local Considerations:

- Incident check in location (direction should be given to incoming units regarding where to check into incident);
- Staging area for incoming ambulances;
- Communication, including radio channel for event;
- Documentation requirements (EMS will continue to use ImageTrend or other electronic patient care record (ePCR) for documentation of patient care);
- Shift structure (what hours will EMS crews be expected to work, 8 hrs, 12 hrs, 24 hrs?);
- Housing of ambulance personnel for down time;
- Refueling procedures (is local area providing or incoming resource providing?);
- Plan for restocking of ambulances (disposable equipment, PPE, oxygen, etc.).

### **EMS Considerations for Surge Response to an Event**

EMS leadership and medical direction should assess daily their agency's ability to respond to a surge request. This information should be entered daily in EMResource – Juvare during the COVID-19 response period.

- ECPs available for deployment should have a personal bag ready. They should have enough supplies to sustain them for a minimum of two days to include: food, water, medications, clothing, etc.
- Ambulances should be overstocked with disposable supplies to sustain multiple responses without restock.
- A plan for restocking should be developed prior to response.
- Record keeping is vitally important for cost reimbursement. All expenses related to the response should be tracked. An expense form should be developed for use during deployment.
- A fuel card should be available for the duration of the incident.
- Ambulances should be equipped with computers or tablets for documentation of patient care.
- EMS should use the same documentation format during the surge event as they use in their day- to-day operations.

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# Appendix E

## Alternate Care Site Concept of Operations

### Alternate Care Site Decision Making Framework

The decision framework below provides suggested guidance on whether and when to utilize an ACS and which type (General Non-Acute Care or Acute Care model) will best meet the needs of the jurisdictions healthcare system.

The jurisdiction or healthcare system should consider the following when contemplating the need to establish an ACS:

- 1) Trends and rate of patients testing positive for COVID 19:
  - Are the number patients being tested positive for COVID-19 currently trending upward or downward?
  - Is it trending at a rapid speed or slow speed?

*Note: This will help project possible upcoming surges in hospital admissions*

- 2) Projected "PEAK" for overall COVID 19 incident in region
  - Is the current situation behind or ahead of the projected "peak" for COVID 19 in the region?  
There are projection tools that indicate which months and

*Note: This will help indicate if the overall COVID 19 trend for the region is supposed to continue an upward downward trend. This also helps project possible upcoming surges in hospital admissions.*

- 3) Hospital occupancy
  - Is the occupancy level maxed, normal, or minimal?

*Note: By assessing COVID 19 trends and hospital occupancy, hospitals can projet whether there is a need for establishing ACS.*

- 4) Bed and staff availability
  - Is there enough bedding to cover admissions in the event of a surge in COVID 19 patients?
  - Is there enough staff to cover hospital fill status in the event of a surge in COVID 19 patients?
  - Is admission from patients going from Emergency Department into the hospital surging and reducing available beds?
  - Does your jurisdiction or healthcare system have the ability to staff an ACS using traditional or non-traditional medical providers?

Table 1 shows the different ACS models that jurisdictions or healthcare systems can utilize to meet their needs:

Table 1

<b>General (non-acute) Care Model</b>	<b>Acute Care Model</b>
Capacity Building (increase beds)	Capacity Building (increase ventilators)
Requires Minimal Structural Alteration	Requires Significant Structural Alteration
Lower Cost	Higher Cost
Operational in 72 Hours	Operational in > 72 Hours
Basic Level Care	Advanced Level Care
ED or Low/Mid-Level Providers	ICU/Critical Care Providers
Designed for minimal acuity patients requiring minimal activities of daily living support (e.g. Non-COVID patients with minimal symptoms or require <2L of oxygen)	Designed for higher acuity patients requiring closer monitoring or respiratory support (e.g. COVID-positive with pneumonia or respiratory distress requiring ventilator support)

### Alternate Care Site Set-Up

The ACS set-up process requires an orderly approach to ensure that the site footprint is properly configured for safe occupancy. It is important to adapt these basic principles to the realities of the specific site chosen.

1. Identify Potential Sites
  - See Appendix B: Alternate Care Site Checklist.
  
2. Conduct Site Assessment
  - Physical Considerations
    - Comply with the Architectural Barriers Act and Americans with Disabilities Act
    - Should not be in the Special Flood Hazard Area (SFHA), but acknowledges that there may not be a practical location outside of the floodplain
    - Must be capable of being adequately secured on perimeter
    - Should not have structural issues or be in a state of unsafe disrepair
    - Identify location for aeromedical transport if available/needed
    - Should have a fire sprinkler system. If not, must conduct additional monitoring in accordance with local fire jurisdiction
    - Should have elevator access for patients, if the building is more than one floor and ensure an ambulance stretcher can fit in the elevator
    - Should have a designated secure ambulation/exercise area for patients
    - Should have a functional kitchen
    - Should have bathrooms in each room
    - Should have an individual HVAC in each room
  
  - Logistical Considerations
    - Should be otherwise vacant of patrons
    - Should allow for photocopier and printer setup
    - Should be able to accommodate a tent or other structural barrier for ambulance arrival at entrance to protect patients' privacy

- Should allow for the separation of patients who are persons under investigation (PUI) and those that have tested positive for COVID-19
  - Should have a dedicated space for a 24/7 dispatch center with one dedicated phone number
  - Should have separate areas for donning and doffing PPE
  - Should be able to accommodate a team staging area at least 12 feet away from patients (e.g., hotel lobby)
  - Should have an arrival and disinfecting/cleaning area for EMS
- Operational Considerations
    - Obtain building engineer contact information
    - Walk site with building manager and engineer to understand key systems in the building and emergency procedures for each such as water, power, phone, internet for patients, and fire suppression systems
    - Work with the local Fire Marshal to identify fire exits and ensure site floor plan is in step with evacuation plans as they are developed
    - Walk through rooms to ensure clean linen, towels, refrigerators, etc. and identify what is already at the site and what will be provided by the wraparound service contractor
    - Develop map layout of site with bed types, suite types, Americans with Disabilities Act-compliant (ADA-compliant) rooms, and adjoining rooms for family units
    - Identify closed-circuit television (CCTV) systems in building and make sure that they are disabled with no way of reactivating them remotely
    - Make sure cable and internet work on patient floors
    - Understand site key system
    - Master keys for room access (need more than one for teams)
    - Keys made and labeled for all rooms to facilitate patient arrival and room check-in
    - Knowledge of how to make additional keys, including emergency override keys
    - Find keys to lock out elevators to the lobby so patients do not show up in the lobby unannounced
    - Close off all public bathrooms in anticipated patient areas due to infection control concerns
    - Clean out any food in common areas
    - If applicable, ensure pool area is secured or blocked off

- Infection Prevention and Control Considerations

Consideration should be given to conducting surveillance for potentially transmissible infectious diseases (e.g., Infectious diarrhea) to ensure clusters are detected early and addressed. Have local hospital's Infection Preventionist walk through structure and provide recommendations and concerns.

For additional information on infection prevention and control consideration refer to the CDC website for the latest infection prevention and control recommendations at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html>, including infection control considerations for ACS at: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/alternative-care-sites.html>

- Pharmaceutical Considerations

All medical supplies should be stored in a secure, climate-controlled area in close proximity to the patient treatment area. Most pharmaceuticals are labeled with storage temperatures. United States Pharmacopeia (USP) defines the various temperatures as:

- Controlled room temperature: 59 to 86 degrees Fahrenheit (F) or 15 to 30 degrees Celsius (C)
- Refrigerator: 36 to 46 degrees (F) or 2 to 8 degrees (C)
- Freezer: 32 degrees (F) and lower or 0 degrees (C) and lower

Pharmaceuticals that are stored at other than USP standard temperatures are considered to be "adulterated" and therefore unsuitable for human use. It is the responsibility of the Logistics section to ensure that the cold chain storage is maintained once pharmaceuticals are received at the ACS.

3. Secure Funding

Funding is generally secured after specific sites are identified. The ACS may be funded by the State or local government or may be funded by FEMA through the State and local government under a Direct Federal Assistance (DFA) (cost shared) mission assignment based on FEMA-State agreement.

4. Secure Property

States often identify property that they already own. If not, they are responsible for securing the property through an agreement or lease. If the State will be receiving Federal Assistance, they must provide the lands, easements, and rights of way necessary to accomplish any approved modifications to the property.

5. Convert Site for Healthcare Use

If site modifications are required to convert it for medical use, prepare a design and issue a contract for this work. Alternately, FEMA may provide a mission assignment to have US Army Corps of Engineers (USACE) issue the contract and manage the work.

6. Secure Wraparound Services

The ACS setup process requires an orderly approach to ensure that the site footprint is properly configured for safe occupancy. It is important to adapt these basic principles to the realities of the specific site chosen. See Appendix C: Wraparound Services Checklist.

- Critical Actions to Consider:

- Obtain Wraparound services Contract. See Appendix E: Sample Statement of Work for Wraparound Services
- Ensure fencing is installed around perimeter to enforce the isolation and prevent unauthorized access to the site
- Ensure the site is secured with onsite guard force
- Establish the appropriate number of fire-compliant access points to the site depending on local regulations
- Establish a separate staging/ingress/egress point for patients and EMS

- Establish a separate ingress/egress point for staff
- Determine safe evacuation routes with designated rally point
- Establish Command Post/Administrative Area in Lobby or other suitable location.
- Delineate between Hot Zone/Operational Area and Clean/Support Area
- Clearly mark with signage
- Clearly designate Clean/Support Areas for both staff staging and PPE donning
- Clearly identify Transition Area for PPE doffing
- Clearly identify Hot Zone/Living Quarters in individual rooms for patients
- Designate separate floors for COVID-19-positive and COVID-19-negative/unknown patients
- Conduct safe isolation practices in common areas, stairwells, and elevators
- Utilize plastic dividers to effectively demarcate and reinforce site footprint
- Establish designated media area

7. Staff, Equip, and Supply Site

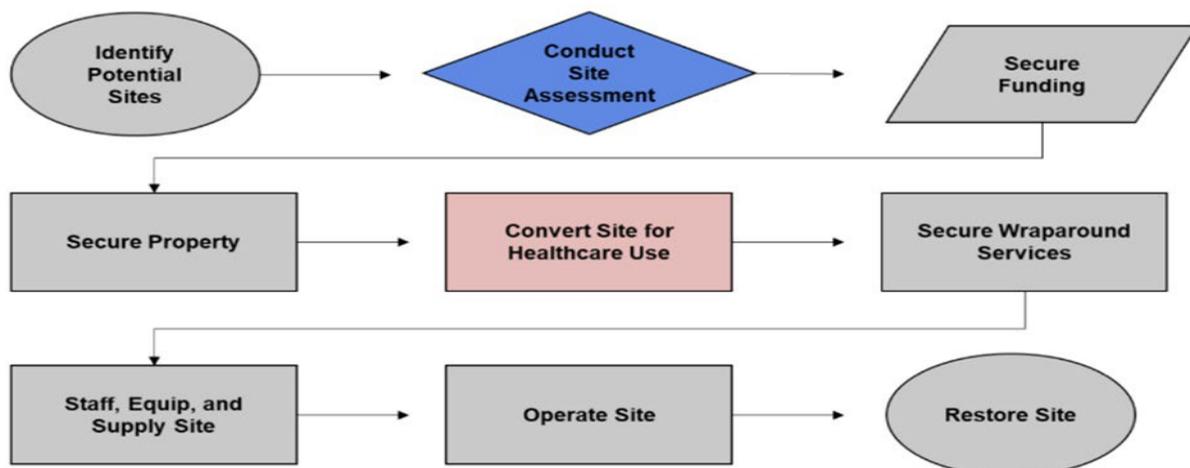
Based on initial analysis of healthcare system need, select the staffing and equipment configuration for the site as either a General (non-acute) Care ACS Model or Acute Care ACS Model.

8. Operate Site

ACS management focuses on the operation of a safe and comfortable setting where patients can be isolated and monitored during the COVID-19 pandemic. Ensure that all onsite staff are provided with proper oversight and supervision. Ensure that patients under quarantine/isolation orders (and release criteria) is based on most current CDC guidance.

ACS assets should be capable of rapid integration into and interoperability within the community's existing healthcare infrastructure. As such, ACS operations should be deliberate and synchronized for maximum efficiency and effectiveness. Linkage of the site to the adjacent healthcare system should include a communications networking strategy and telemedicine options. From the selection of an ACS site to contracting logistical site support requirements, every effort should be made to rapidly achieve operational capability and effective integration and interoperability. All applicable jurisdiction statutory, regulatory, and related authorities, policies and other governing documents should be observed. If they compete, the ACS Site Manager in coordination with governments should consult with their legal counsel to determine how to proceed.

**Figure 1: Alternate Care Site Set-Up Flowchart**



## FEMA Funded ACS Program

Eligible emergency protective measures taken to respond to the COVID-19 emergency at the direction or guidance of public health officials may be reimbursed under the Federal Emergency Management Agency (FEMA) Public Assistance (PA) program. Below is an overview of events that take place and the options for the State of Montana regarding the FEMA PA program for Alternate Care Site (ACS):

1. Site Assessment – Potential sites are assessed by the U.S. Army Corps of Engineers (USACE)
  - Per FEMA, anything that involves FEMA funding is at a 75% federal share and 25% state share.
2. Evaluation and Decision - State leadership and DPHHS evaluate the feasible facilities against the projected need and high-risk locations to determine which facilities should be stood up as an ACS as part of this program.
3. Leasing Facilities - State enters into lease agreement with property owner of facilities chosen to become an ACS. If the state would like, they could request assistance from the General Services Agency (GSA), however this process will most likely take longer.
  - It is recommended to include services such as garbage service, janitorial service, and security in the lease agreement, as it makes it cleaner and easier from a reimbursement perspective.
  - Reimbursement requests for the leasing expenses will need to be submitted through the FEMA PA program.
  - 75% federal share / 25% state share.
4. Contracting and Retrofitting - This can be handled at the state level (hiring a contractor to complete work) or the State can request that FEMA put in a mission assignment request to have the retrofitting handled by USACE.
  - The mission order through FEMA could be faster than the State doing its own contracting process for retrofitting.
  - Reimbursement requests for the retrofitting expenses will need to be submitted through the FEMA PA program.
  - 75% federal share / 25% state share.
5. Equipping ACS – The state can request an equipment package from the FEMA, procure the equipment itself, or contract with a medical services company to acquire the necessary equipment for the ACS.
  - Given the number of facilities that are being stood up, the timeline for going through FEMA may be longer than if the State procured its own equipment or contract with a medical services company.
  - Reimbursement requests for the equipment expenses will need to be submitted through the FEMA PA program.
  - 75% federal share / 25% state share.
6. Supplying the ACS – The State can request a supply package from the FEMA or contract with a medical services company to acquire the necessary supplies for the ACS.
  - Given the number of facilities that are being stood up, the timeline for going through FEMA may be longer than if the State contracted with a medical services company.
  - Consideration should be given to contracting with companies who could manage the facility equipment and supply needs under one contract. This simplifies the reimbursement process.
7. Staffing the ACS – FEMA has determined that staffing expenses for the ACS facility are eligible expenses (specifically for doctors and nurses).

- Recommended that the State looks to Contract with a company who can recruit and provide adequate staffing for the ACS.
- Reimbursement requests for the staffing expenses will need to be submitted through the FEMA PA program.
- 75% federal share / 25% state share.

ALTERNATE CARE SITE CHECKLIST

Site name \_\_\_\_\_ Phone number \_\_\_\_\_

Site point of contact \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Geo coordinates \_\_\_\_\_

Nearest hospital name / address \_\_\_\_\_

Nearest hospital name / address \_\_\_\_\_

Structure construction type \_\_\_\_\_

How many parking spaces for staff \_\_\_\_\_ trucks \_\_\_\_\_ daily cost \_\_\_\_\_

Loading docks: Yes No Location \_\_\_\_\_

Entry door 48" or greater with no obstructions: Yes No

Location \_\_\_\_\_

Sidewalks ADA compliant: Yes No Helipad: Yes No

Location \_\_\_\_\_

Perimeter lighting \_\_\_\_\_

Entry door locks and have panic bars for exit from inside: Yes No

How many restrooms (1 / 20 people):

Men \_\_\_\_\_ ADA compliant \_\_\_\_\_

Women \_\_\_\_\_ ADA compliant \_\_\_\_\_

How many showers (3 people / hour / 24 hours):

Men \_\_\_\_\_ ADA compliant \_\_\_\_\_

Women \_\_\_\_\_ ADA compliant \_\_\_\_\_

Hot water (120 degrees – 6 gallons per patient)

Number of tanks \_\_\_\_\_

Size of tanks (gallons) \_\_\_\_\_

Flooring type \_\_\_\_\_

Protective covering available: Yes No

Pallet Jack permitted on flooring: Yes No

Bariatric capable: Yes No

Staff billeting prearranged on-site: Yes No

Site POC \_\_\_\_\_

Local hotels \_\_\_\_\_ within \_\_\_\_\_ miles

Pharmacy has a separate room with locking door/limited access: Yes No

Refrigerator size \_\_\_\_\_ Freezer size \_\_\_\_\_

Kitchen facilities: Yes No

Available for staff: Yes No

#### Electrical

40 Amp, 480 volt, 3 phase, 80 Amp Service

200 Amp, 120/240 volt, 3 phase)

#### Power coming into site

Volts \_\_\_\_\_

Amps \_\_\_\_\_

Phase \_\_\_\_\_

Number of outlets \_\_\_\_\_

Back-up generator on-site: Yes No

Operational: Yes No

Type \_\_\_\_\_

KW \_\_\_\_\_

Phase \_\_\_\_\_

Volt \_\_\_\_\_

Number of outlets dedicated to generator power \_\_\_\_\_

Fuel on-site: Yes No

Amount in gallons \_\_\_\_\_ burn rate \_\_\_\_\_ gallons/hour \_\_\_\_\_

HVAC operational in entire site: Yes No

Location of shut-off valve \_\_\_\_\_

Flood Zone \_\_\_\_\_

*Note: Regarding flood zones, the following steps should be taken when considering the placement of a temporary facility providing medical services or other critical facility to determine if the function, building systems, and equipment can remain operational in the event of a flood:*

- *Determine if the site, as well as ingress and egress to the site, is in a Coastal High Hazard Area (Zone V), the Special Flood Hazard Area (SFHA, or 1-percent-annual-chance flood hazard area), or the 500year floodplain (0.2-percent-annual-chance flood hazard area);*
- *If the site is located in any of these high-risk flood hazard areas, the facility should not be located at that site.*
- *If no practicable alternative sites exist, and the site must be used, an assessment of the type of flood hazards at the site should be conducted (e.g., flood velocity, flood depth, wave action, etc.), practicable opportunities for flood mitigation assessed, and a flood evacuation plan/emergency plan developed.*
- *The emergency plan should include a plan for site evacuation and contingency for loss of facility's function in the event the facility is damaged and can no longer serve its intended purpose.*
- ***Keep in mind that locating a facility in a 500year floodplain will not be eligible for federal funding.***

Shelter in place areas \_\_\_\_\_

Evacuation areas \_\_\_\_\_

## WRAPAROUND SERVICES CHECKLIST

Site name \_\_\_\_\_ Phone number \_\_\_\_\_

Site point of contact \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Geo coordinates \_\_\_\_\_

Nearest hospital name / address \_\_\_\_\_

Nearest hospital name / address \_\_\_\_\_

Capacity \_\_\_\_\_ Primary power source \_\_\_\_\_ Restrooms \_\_\_\_\_

Helo Pad Yes No      Alternate/Back-up power      ADA Restrooms

GPS coordinates      Available Yes No      Showers

\_\_\_\_\_

Wrap-around services	Quantity	Organization name / location	POC for service contract information	Timeframe in place by	Status	Comments
Building requirement						250-bed = 40K sq. ft. 100-bed = 25K sq. ft. 50-bed = 15K sq. ft.
Lease / MOU for use of site						On-file at:
Staffing						
Security inside (24-hr)						

Security outside (24-hr)						
Total occupants beds / staff / security						
Billeting for staff						On-site  On-site list local hotels in comments at end of form
Fire Suppression						System operational
Secure room						For pharmacy
Parking for staff						
Parking for trucks						
Electrical distribution						Uninterrupted service for 40+ outlets
HVAC						Operational for entire site
Heat						Operational for entire site
Ventilation						Operational for entire site
Set-up labor						
Forklift						Operate on pavement

Pallet jack						Permitted to operate on floor
Toilet						1 / 20 ADA compliant
Showers						3 persons per hour for 24hrs ADA compliant
Hot water						
Hand washing station						
Meals						
Drinking water						
Ice						
Oxygen						
Medical resupply						
Lab arrangement with local hospital						To conduct lab
Lab arrangement with local lab						To conduct lab
Transportation for outpatient services						

Waste removal						Normal day-to-day waste
Biohazard waste removal						Daily pickup
Cleaning services						Common areas, restrooms, showers
Laundry						Service for 250 set of clothes daily for patients / caregivers
Washer / Dryer						5 each for emergency laundry service
Wi-Fi						No interference or signal shielding
Telephone service						Number of lines into site
EMS / ALS ambulance						
Mortuary services						
Additional comments						

## SAMPLE STATEMENT OF WORK FOR WRAPAROUND SERVICES

### Emergency Response Service Support

This sample SOW is being sent to all field operations to give everyone visibility on what services we have been providing through XXX. **Your site may vary by specification, counts, start and end dates, etc.**

(ERSS)

### Statement of Work (SOW)

Task Order **SAMPLE ONLY Mod N/A**

#### 1.0 INTRODUCTION

The contractor shall provide the following services under the Emergency Response Service Support (ERSS) contract to support the Department of Health and Human Services (DHHS)/Assistant Secretary for Preparedness and Response (ASPR). The services will be for meals, laundry transportation and rooms for up to **120 people for up to 20 days** at location listed below (1.2). See section 1.2 below for the dates of services. Demobilization will occur on the day following the last day of service.

**1.1 Services:** All services required by site shall be provided as noted below in (1.2) and final cleaning and demobilization will occur on the day following the last day of service (see chart below for dates of service). Services may include: delivery to each room with individually wrapped catered meals and beverages (see 2.0 chart); transportation to/from the lodging to airport (see 2.2 chart); ALS and/or BLS Ambulance service may be requested to reside on site to transport ill patients to designated medical site/s or airport (see 2.3 chart); perimeter fencing, lighting and barriers (see 2.7 chart); facilities management (see 2.9 chart); laundry pickup from each room and delivery laundry services to each room to include linen exchange (see 2.6 chart); custodial services (see 2.4 chart); biomedical waste removal (see 2.5 & 2.8 charts); and HVAC with generator power and equipment fueling/serving as defined in 2.11 (see 2.11 chart).

#### 1.2 Support Locations:

Name/Location	Support Dates

## 2.0 REQUIREMENTS

### 2.1 Catered Meals and Beverages: (PARA 19.3/19.6)

- 2.1.1 The Contractor shall provide drinking water: Bottled water should be provided with every meal (breakfast, lunch and dinner) (PARA 19.6.1b{4}) of this TO SOW. Additional bottled water shall be provided to ensure each person is provided a minimum of 2 liters per day.
- 2.1.2 The Contractor shall provide meals: Hot meals three times per day (breakfast, lunch, dinner **and daily snack, coffee bar**) delivered to lodging location and specifically to each room in (TO SOW Paragraph 1.2). Meals shall be nutritionally balanced and varied daily with servings of meat, vegetables, and starches. Meals Times: Breakfast: 08:00 AM, Lunch: 12:00 PM, Dinner: 6:00 PM. Any dieting or dietary restrictions shall be conveyed per site. On the final day lunch may be required at an earlier time and a bag lunch maybe required. Dinner may or may not be needed for the final day.

Name/Location	Meal Type	Quantity
Holiday Inn Express	Breakfast	120
	Lunch	120
	Snack	120
	Dinner	120
	Breakfast	
	Lunch	
	Snack	
	Dinner	
	Breakfast	
	Lunch	
	Snack	
	Dinner	

**2.2 Transportation:** The Contractor shall provide vehicle transportation as noted in chart below to lodging locations (TO SOW Paragraph 1.2) and designated international airport provided by ASPR onsite or regional representative. (PARA 19.15). The contractor shall provide baggage handling support (staffing & equipment) in moving passenger baggage as noted in the chart below (PARA 19.15).

Buses will be utilized for transportation of travelers from XXX to local billeting and or airport locations. Stage all buses at or near the location listed above for the potential moves as directed by the Deputy Federal Health Coordinating Officer (DFHCO).

Name/Location	Vehicle Type	Quantity	Date/s	Start Time	End Time
Holiday Inn Express	15-PAX Shuttle Van	0			
	30-PAX Minibus	0			
	56-PAX Coach	0			
	Other	0			

Baggage handlers will provide the offloading of baggage from the cruise ship and uploading of baggage to either busses or airplanes. At locations XXX the baggage handlers will provide the unloading of baggage from the airplane, transport from airfield to the billeting location, and offloading of baggage at billeting location. See chart below for details by site.

Name/Location	Number of Passengers	Quantity of Planes	Quantity of luggage	Start Time	End Time
Holiday Inn Express	0				

**2.3 Ambulance:** Location, Quantity, Types, Schedules noted in chart below.

- 2.3.1 Be equipped to transport patients exhibiting symptoms related to Coronavirus.
- 2.3.2 Ambulance will be required to transport patients to a predetermined hospital (TBD) within XX miles of the XXXX station. Replace ambulance on site for coverage within one (1) hour of departure of the first ambulance when transport is required as directed by the CO and COR through the onsite IMT. The contractor must notify the CO when 75% of the funding is remaining on the Contract Line Item Number (CLIN) for the replacement ambulances.
- 2.3.3 Transit destination site solely determined by the government through the CO and COR.
- 2.3.4 Furnish all labor, management, travel, supplies, equipment, materials, and vehicles to perform the work described herein, unless otherwise specifically stated.
- 2.3.5 Comply with applicable federal, state, and local laws, regulations, and guidance; and perform all work in accordance with these requirements and any applicable agreements.
- 2.3.6 Provide a dispatch-managed standby full service transportation 24 hours a day. The Contractor shall manage dispatch requirements, transport schedules and requests for transport to ensure timely transportation.
- 2.3.7 Maintain a serviceable transportation fleet that meet DOT inspection standard, service ADA loading and unloading equipment, and appropriate safety equipment such as fire extinguishers, breakdown markers. Operators must be properly licensed in accordance with federal and state requirements, to operate in the county.
- 2.3.8 Must be license to transport to and pick up from local hospitals.

2.3.9 Provide courteous customer service during operations and driver or and assistant should be able to assist non-ambulatory clients in and out of vehicles, and assist into facilities if other support is not available, if required by the patient.

Name/Location	Vehicle Type	Quantity	Date/s	Start Time	End Time
Holiday Inn Express	BLS Ambulance (2-EMTs, 1-Driver)	0			
	ALS Ambulance (2-EMT-Ps, 1-Driver)	0			

**2.4 Custodial Services:** The Contractor shall provide house cleaning service and daily waste removal to community housing occupants at lodging locations, as noted in chat below (TO SOW Paragraph 1.2) and dispose at authorized trash sites per local laws. (PARA 19.20) Waste should be disposed of in accordance with PARA 19.13.1.

Name/Location	Total Patients	Total Rooms	Cleaning Type	Start Time	End Time
Holiday Inn Express	120	120	Daily	1100	1400
	120	120	Final	Start after patients depart	Complete NLT 2330 on final day

**2.5 Biomedical Bodily Fluids Cleanup:** The contractor shall provide biomedical bodily fluid removal as required. This will be added via option CLIN and funded as noted in chart below. If more incidents are need they will be added via modification.

Name/Location	Total Events Funded	Total Rooms	Cleaning Type	Remarks
Holiday Inn Express	2-Per Day	All	Biomed	As required

**2.6 Laundry Services:** The Contractor shall perform laundry operations for community housing occupants at lodging locations (TO SOW Paragraph 1.2) as stated in section 19.71 and noted in chart below. (PARA: 19.7). Contractor will initially provide two (2) sets of linens for all patients. All individuals may not require laundry service every day, but it should be available daily. (Wash and fold). All laundry must be returned by the evening of the day prior to the end of the period of performance.

Name/Location	Laundry Pick-Up	Number Of Patients	Cleaning Type	Remarks
Holiday Inn Express	Daily	120	Fluff-N-Fold	Pick-up and return to central location
	Final	120	Fluff-N-Fold	Must be returned by 1700 prior to departure day

**2.7 Perimeter Fencing:** The Contractor shall provide perimeter fencing or crowd control barriers with personnel and vehicle gates to create and maintain zones and separations as defined by the government. (PARA: 19.29.7) see chart below for locations and linear feet required.

Name/Location	Linear Feet Required
Holiday Inn Express	1,500

**2.8 Biomedical Waste Removal:** The Contractor shall provide routine pickup of biomedical waste items (biohazard, medical/surgical, expired and partly used pharmaceuticals) at government occupied sites or facilities and disposal of such items per Federal and state laws. Service shall include all sharps containers and red bags at designated locations. (PARA: 19.13).

Name/Location	Frequency
Holiday Inn Express	As Required

**2.9 Facilities Management:** The Contractor shall provide on-call Operations and Maintenance (O&M) Services such as plumbing and handy-man repairs to maximize life expectancy of government occupied sites or facilities. (PARA: 19.27).

Name/Location	Service Required (Yes/No)
Holiday Inn Express	Yes

**2.10 Final/Exit Day Cleaning:** Cleaning rooms and common areas will be a requirement at end of mission. Routine cleaning is required. If this changes during the task order period of performance, a modification will be issued for this change. Full final cleaning to comply with CDC guidelines after site shut down.

Name/Location	Date
Holiday Inn Express	04/05/20

**2.11 HVAC:** (reference: basic contract SOW para-19.10.2): Provide HVAC units, cabling, ducting and power generation/fueling capable of cooling/heating in accordance with industry standards. (4-tons per 400s.f.).

Name/Location	Number HVAC Units
Holiday Inn Express	0

**2.12 Americans with Disabilities Act (ADA) compliant Latrines, Showers and Ablution units (19.29.8/19.28.9):** Provide trailer mounted Latrines and Showers for both male and female patients (note: anticipate 50/50 gender requirement) see chart below for needs by site. Must meet OSHA minimum requirements for capacity. Facilities must provide privacy and come with internal lighting, toilet paper, paper towels, and liquid soap. Provide daily custodial cleaning services two times per day to clean and replace supplies (toilet paper etc.). Contractors must provide their own water supply and waste removal. Comply with the 2010 ADA Standards for Accessible Design to the greatest extent possible. Additional information can be found online at: [https://www.ada.gov/2010ADASTandards\\_index.htm](https://www.ada.gov/2010ADASTandards_index.htm)

2.12.1 All units shall be fully serviced once weekly, or as site capacity requires, or as directed by the COR.

2.12.2 All wastewater if generated shall be collected with vacuum trucks, transported offsite, and disposed of through legally permissible methods.

2.12.3 When available, public utilities shall be utilized pending authorization with local authorities vetted (by the local IMT) through the CO and COR.

2.12.4 Ten percent (10%) of restroom facilities must be ADA compliant.

2.12.5 The Contractor shall ensure the toilets are adequately stocked with toilet paper.

Name/Location	Hand Washing Stations	Latrines	Showers
Holiday Inn Express	10	10	0

2.12.6 The Contractor shall ensure the hand wash stations remain stocked with water, hand soap and paper towels and cleanliness maintained at all times.

2.12.7 Disposal trucks shall maintain a service schedule to remove the wastewater and portable toilets from the site and transport offsite to dispose of at a permitted treatment site. Local utilities shall be used if available.

**2.13 Light Tower with Generator:** Provide light towers (4,000 watt min) with generator to include fueling services. Quantity needed per site listed in chart below.

<b>Name/Location</b>	<b>Number Light Towers</b>
Holiday Inn Express	10

**3 GOVERNMENT FURNISHED EQUIPMENT/PROPERTY**

No Government furnished equipment/Property will be provided.

# CDC Coronavirus Disease 2019 (COVID-19) Alternate Care Site (ACS) and Isolation Site Assessment Checklist/Worksheet

**Definition:** **Isolation sites** are intended to be locations for patients who do not require medical care, while **ACS** are intended to be locations for patients who require some degree of medical care.

**Guidance:** This guidance provides critical infection prevention and control (IPC) considerations for isolation sites and ACS and is intended to supplement existing plans (created by jurisdictions as part of pandemic planning).

The following information is for isolation sites and ACS that house adult patients with confirmed COVID-19, but the patient:

- Still needs Transmission-Based Precautions,
- Does not require the level of care available at an acute care hospital, and
- Cannot remain in or return to their place of residence.

This could apply to:

- Nursing home residents who have COVID-19 and need to be moved out of the facility
- People with COVID-19 in the general population who cannot return to their place of residence for social reasons (e.g., there are elderly relatives in the home)
- Patients with COVID-19 who are currently hospitalized but can be discharged to a lower level of care
- People with COVID-19 who are currently experiencing homelessness and cannot be discharged to a congregate setting

**Duration:** The expected duration of care for patients in an isolation site or ACS would be based on their clinical needs and the timeline for [discontinuation of Transmission-Based Precautions](#).

## **Facility Type:**

**Isolation Sites (Tier one):** Temporary housing for a cohort of patients with COVID-19 who do not need medical attention but who cannot stay at home (e.g., they have high-risk family members). A separate facility could be considered to quarantine people who have been exposed to SARS-CoV-2 but do not have symptoms. Patients in this type of facility would require limited monitoring and could care for themselves (e.g., do not need assistance with medications or activities of daily living (ADLs)). These facilities would have limited medical staff on hand. These patients could be housed in a dedicated hotel or dormitory meant for this purpose (in their own rooms with their own bathroom).

**Low-acuity Alternate Care Sites (ASC) (Tier two):** This level of ACS provides medical care to convalescing cases of COVID-19 after hospital discharge and are equipped to provide low-acuity care for other medical conditions in this population (e.g., assistance with managing blood glucose). These facilities could also house residents with COVID-19 who need to be moved from nursing homes that are experiencing COVID-19 outbreaks. These patients would often require some level of assistance (e.g., help with ADLs or medications) and a higher level of monitoring than required for patients in isolation sites. These patients may be better suited in a facility that has an open layout (e.g., school gymnasium) to allow limited numbers of healthcare personnel to more easily monitor their status.

**(High-acuity Alternate Care Sites)** would provide hospital-level care for patients who do not have COVID-19 to increase capacity for hospitals to care for COVID-19 patients. These facilities could also be established to provide hospital level care for patients with COVID-19. State and local healthcare leaders should consider their local situation when deciding which of these facility tiers are needed.

Alternate Care Site Assessment for Infection Prevention Focus Conducted by:

Alternate Care Site Name:

Alternate Care Site Address:

Alternate Care Site Could be used for (Check all that apply)

- Isolation Site (Tier 1)
- Low Acuity Alternate Care Site (Tier 2)
- High Acuity Alternate Care Site (Tier 3) NOTES:

**Physical Infrastructure:**

Component	Planning Considerations	Examples
Layout	Layout plan for all areas of the facility	Layout should include the following areas:
<b>Indicate Yes, Included in layout or No, Not Included in layout for each area:</b>		
YES	NO	Patient triage
YES	NO	Staff respite area separate from patient care area with a bathroom for staff use only: staff can store personal belongings, take breaks, and eat
YES	NO	Area for staff to put on and remove personal protective equipment (PPE)
YES	NO	Patient care area or rooms with access to patient bathrooms/shower areas
YES	NO	Designated area in patient care area where staff can document and monitor patients
YES	NO	Clean supply area
YES	NO	Medication storage/preparation area
YES	NO	Dirty utility area

Notes:

**Physical Infrastructure:**

Component	Planning Considerations	Examples
Air conditioning and heating	Functional HVAC (heating and cooling) system	
<b>DOES HVAC UNITS MEET CRITERIA?</b>		
YES	NO	<p><b>Tier one:</b> Ideally a facility whose HVAC units are mounted on an external wall and able to accommodate some outdoor air dilution as opposed to internal, 100% recirculation units</p>
YES	NO	<p><b>Tier two:</b> Care is provided in a large open space; ideally the HVAC has air supply at one end of the space and air return at the other end of the space</p> <ul style="list-style-type: none"> <li>• Staff respite area would ideally be in a room separate from the patient care area; at a minimum it should not be in a location near the air return</li> <li>• Facilities with generator support are optimal</li> </ul>
YES	NO	

Notes:

**Physical Infrastructure:**

Component	Planning Considerations	Examples
Spacing between patients	<ul style="list-style-type: none"> <li>• Determine maximum number of patients who can safely receive care in the facility</li> <li>• Plan for safe spacing between patients</li> </ul>	NOTE- Army Corp of Engineers determines # of beds that can be placed in any area.
<b>Indicate Yes, Enough room for Safe spacing layout or No, Not Safe Spacing Layout for each area:</b>		
Yes	No	<b>Tier one</b> (e.g., hotel rooms): Each patient should have a separate room with a separate bathroom
Yes	No	<b>Tier two:</b> There should be: <ul style="list-style-type: none"> <li>• At least 6 feet of space between beds</li> <li>• Physical barrier between beds, if possible</li> <li>• Bed placement alternating in a head-to-toe configuration; ideally beds and barriers should be oriented parallel to directional airflow (if applicable)</li> </ul>

Notes:

**Physical Infrastructure:**

Component	Planning Considerations	Examples
Storage areas	<ul style="list-style-type: none"> <li>• Space for clean storage</li> <li>• Space for dirty storage</li> </ul>	
Answer Yes or NO if there is a storage area or space with capacity as described		
YES	NO	Clean storage would ideally have a refrigerated section for medications and a room temperature section for other clean supplies (e.g., linen, PPE)
YES	NO	Dirty storage would have space for medical and non-medical waste and dirty equipment waiting to be reprocessed

Notes:

Component	Planning Considerations	Examples
Contamination prevention	<ul style="list-style-type: none"> <li>• Cleanable floors and surfaces<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Avoid porous surfaces (e.g., upholstered furniture, carpet, and rugs) as much as possible</li> </ul>
YES	NO	Cleanable floors or surfaces?
YES	NO	Porous Surfaces?

Notes:

## Physical Infrastructure:

Component	Planning Considerations	Examples
Accessibility	<ul style="list-style-type: none"> <li>Facility is functional for patient movement, including doors that are wide enough for wheelchairs and stretchers</li> </ul>	YES  NO
Visitor access	<ul style="list-style-type: none"> <li>No visitors or pets to avoid unnecessary risks to patients and staff; post signage at entrances to the facility indicating this policy</li> </ul>	Space able to restrict visitors?  YES  NO

Notes:

## Services:

Component	Planning Considerations	Examples
Food services	<ul style="list-style-type: none"> <li>Area for Catering or Food Prep (provided with disposable plates/utensils)</li> <li>Separate place for staff to eat without wearing PPE</li> </ul>	YES  NO  YES  NO
Environmental services	<ul style="list-style-type: none"> <li>Environmental services can be provided regularly and safely by trained staff</li> <li>Environmental</li> </ul>	YES  NO  YES

	<p>services staff have all necessary training and wear appropriate PPE for exposure to disinfectants and patients with COVID-19</p> <ul style="list-style-type: none"> <li>EPA-registered disinfectants from List N are used according to label instructions</li> </ul>	<p>NO</p> <p>YES</p> <p>NO</p>
		<p><b>Tier one</b> (e.g., hotel rooms): Environmental services staff perform terminal cleaning of rooms and patients perform daily cleaning:</p> <ul style="list-style-type: none"> <li>Patients should be provided cleaning materials (i.e.,</li> </ul>
		<p>disinfectant wipes, gloves) and instructed to clean high-touch surfaces and any surfaces that may have blood, stool, or body fluids on them daily, according to the label instructions</p> <ul style="list-style-type: none"> <li>Establish a process for at least daily removal of trash from rooms</li> </ul>
		<p><b>Tier two</b> (e.g., large open space): Environmental services staff would perform both daily and terminal cleaning:</p> <ul style="list-style-type: none"> <li>Wipe-down of all floors and horizontal surfaces at least once daily</li> <li>Immediate clean-up of all spills of blood or</li> </ul>

		body fluids <sup>3</sup> <ul style="list-style-type: none"> <li>Regular disinfection of high-touch surfaces (e.g., doorknobs)</li> <li>At least daily cleaning of bathrooms</li> </ul>
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Notes:

**Services:**

Component	Planning Considerations	Examples
Sanitation	<ul style="list-style-type: none"> <li>Sanitation and waste services are available for medical waste (if required)</li> <li>Sanitation and waste services are available for routine waste</li> </ul>	YES
		NO
Laundry facilities	<ul style="list-style-type: none"> <li>Laundry services are provided in accordance with routine laundering practices using either washer and dryers on site or through a contract with a laundry service</li> </ul>	YES
		NO

<p>Pharmacy access</p>	<ul style="list-style-type: none"> <li>• Medications are properly labeled and stored</li> <li>• The layout has designated a space for medication preparation activities that is not in the immediate patient care area and is away from potential sources of contamination (e.g., sink)</li> <li>• Staff who prepare and administer medications have been appropriately trained on methods to prevent medication errors and contamination</li> </ul>	<ul style="list-style-type: none"> <li>• To the extent possible, patients should arrive with all necessary medications</li> <li>• Ensure patients' medications are properly labeled to prevent use on the wrong patient</li> <li>• <b>Tier one:</b> Patients should be able to self-administer all medications; medications may be stored in their room</li> </ul>
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Notes:

**Services:**

Component	Planning Considerations	Examples
<p>Diagnostics</p>	<ul style="list-style-type: none"> <li>• On-site glucose monitoring using personal glucometers (no sharing of glucometers)</li> <li>• If oxygen is provided, pulse oximeters are required</li> </ul>	<ul style="list-style-type: none"> <li>• On-site anticoagulation monitoring might also be needed depending on patient characteristics</li> </ul>

Notes:

## Patient Care:

Component	Planning Considerations	Examples
Staffing	<ul style="list-style-type: none"><li>• Staffing plan (including medical, IPC, occupational health, administrative, and support staff)</li><li>• Implement sick leave policies for staff/employees that are flexible and non-punitive</li><li>• Ensure at least one individual with IPC training is included in planning and is regularly available to address questions and concerns</li><li>• This individual would ensure that staff receive job-specific IPC training, including educating them on hand hygiene, proper selection and use of PPE and to not report to work when ill</li><li>• Ensure staff have access to occupational health services if they experience a workplace exposure or become ill</li></ul>	<ul style="list-style-type: none"><li>• Staff should be appropriate for the level of care provided</li><li>• Nurse practitioners and physician assistants might be required to conduct activities at limit of their scope of practice</li><li>• If trainees are recruited to assist, IPC training must be provided prior to working</li></ul>

Notes:

Component	Planning Considerations	Examples
Medical supplies	Necessary medical supplies are available at or accessible to staff at the facility	<ul style="list-style-type: none"> <li>• To the extent possible, patients should arrive with all necessary medications</li> <li>• Sharps containers should be located near point of use</li> <li>• Examples of additional supplies include alcohol- based hand sanitizer, soap and paper towels, briefs, bedside commodes, urinals, personal hygiene supplies, vital sign machines, thermometers, wheelchairs</li> </ul>
PPE	Necessary PPE are available at or accessible to the facility	<ul style="list-style-type: none"> <li>• At a minimum, staff should wear an N95 respirator (or a facemask if respirator is not available) and eye protection while in the patient care area</li> <li>• Staff should wear gloves for contact with patients or their environment</li> <li>• Staff should put on a clean lab coat or isolation gown at the beginning of each shift, and, at a minimum, change the coat or gown if it becomes soiled</li> <li>• Staff should remove PPE and perform hand hygiene when leaving the patient care area</li> <li>• PPE should not be worn in the staff respite area</li> <li>• Refer to Strategies for Optimizing PPE Supply<sup>4</sup> for additional guidance</li> </ul>

**Patient Care:**

Component	Planning Considerations	Examples
Hygiene	<ul style="list-style-type: none"><li>• Adequate sinks for hand hygiene are available</li><li>• Adequate numbers of toilets, including a separate toilet for staff are available</li><li>• Adequate shower facilities are available</li><li>• Based on the population being served, an appropriate supply of bedside commodes, urinals, and personal hygiene supplies (e.g., soap, toothpaste) should be available</li></ul>	<ul style="list-style-type: none"><li>• <b>Tier one:</b> Each patient should have a separate room with a separate bathroom</li><li>• <b>Tier two:</b><ul style="list-style-type: none"><li>○ Minimum of 1 toilet for every 20 persons, or 1 toilet for every 6 persons with disabilities.</li><li>○ Approximate ratio of 1 shower for every 25 persons, or 1 shower for every 6 persons with disabilities</li></ul></li></ul>

Notes:

## Footnotes:

- <sup>1</sup><https://asprtracie.hhs.gov/technical-resources/48/alternate-care-sites-including-shelter-medical-care/47>external icon
- <sup>2</sup><https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html>
- <sup>3</sup><https://www.cdc.gov/infectioncontrol/guidelines/environmental/index.html>
- <sup>4</sup><https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

## Resources:

- Some jurisdictions have developed ACS plans informed by the Crisis Standards of Care framework published by the National Academy of Medicine (formerly the Institute of Medicine) in 2012; volume 5 of the document addresses ACS. <https://www.nap.edu/catalog/13351/crisis-standards-of-care-a-systems-framework-for-catastrophic-disaster>external icon
- The HHS Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) maintains a list of resources on ACS. <https://asprtracie.hhs.gov/technical-resources/48/alternate-care-sites-including-shelter-medical-care/47>external icon
- The FEMA and American Red Cross Shelter Field Guide (not specifically for ACS, but includes considerations about spacing, lighting, toilet- and shower-to-person ratios in shelter settings): [http://www.nationalmasscarestrategy.org/wp-content/uploads/2015/10/Shelter-Field-Guide-508\\_f3.pdf](http://www.nationalmasscarestrategy.org/wp-content/uploads/2015/10/Shelter-Field-Guide-508_f3.pdf)pdf iconexternal icon
- Army Corps of Engineers Guidance on Alternate Care Sites: <https://www.usace.army.mil/Coronavirus/Alternate-Care-Sites/>external icon
- Examples of jurisdiction ACS plans include:
  - Arizona Department of Health Services ACS Plan <https://azdhs.gov/documents/preparedness/emergency-preparedness/response-plans/alternate-care-site-plan.pdf>pdf iconexternal icon
  - Kansas Department of Health ACS Emergency Operations Plan [http://www.kdheks.gov/cphp/operating\\_guides.htm](http://www.kdheks.gov/cphp/operating_guides.htm)external icon
  - Florida Department of Health ACS Standard Operating Procedure and Operations Guide <http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/preparedness-planning/documents/alternate-care-site-sop.pdf>pdf iconexternal icon and <http://www.floridahealth.gov/programs-and-services/emergency-preparedness-and-response/documents/alternate-care-site-ops.PDF>external icon

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# Appendix F

## Fatality Management

The Institute for Health Metrics and Evaluation (IHME) at the University of Washington provides COVID-19 forecasting and can be found at: <https://covid19.healthdata.org/projections>. Based on the current IHME predictions, the number of COVID-related deaths in Montana will peak on April 26, 2020 at 9 deaths/day. The total COVID-19 related deaths for Montana projected to August 4, 2020 is currently 266. It is important to consider that in any given population, 1% of that population will die of all combined causes (e.g., trauma, cancer, other diseases) per year not including COVID-19 deaths. Therefore, based on the current Montana population, there are approximately 10,000 deaths each year in Montana or approximately 27 deaths/day. With an estimated 9 COVID-19 related deaths each day by April 26, 2020 the daily death rate may be 36 deaths/day. Without any cremation or burial and assuming equal distribution of decedents, the estimated 228 refrigerated decedent storage capacity would be exceeded in 6.3 days (vs. 8.4 days without COVID-related deaths). Therefore, it is essential for timely cremation or burials to take place. Based on the IHME projections, with timely cremation or burial it is probable that existing storage capacity will not be exceeded.

We can hope for this scenario, but we must plan for the following alternatives:

- Storage: Local volume exceeds local storage capacity. Consider local refrigerated trailer placement.
- Decedent Transport: Local workforce incapacitated due to illness. Consider back up staffing alternatives for transport. Possible resources include the: National Guard and mutual aid arrangements between jurisdictions.
- Staffing: Due to the limited Medical Examiner Staff, illness contracted by any one or more of the three currently functioning Medical Examiners may/or will delay final disposition of cases needing an autopsy, thereby extending storage time and local storage need. Mutual aid has been arranged in the event of a Medical Examiner shortage; however, due to very limited availability of medical examiner nationwide and potentially competing jurisdictions, mutual aid may not be available.

Planning scenarios for deaths exceeding storage capacity:

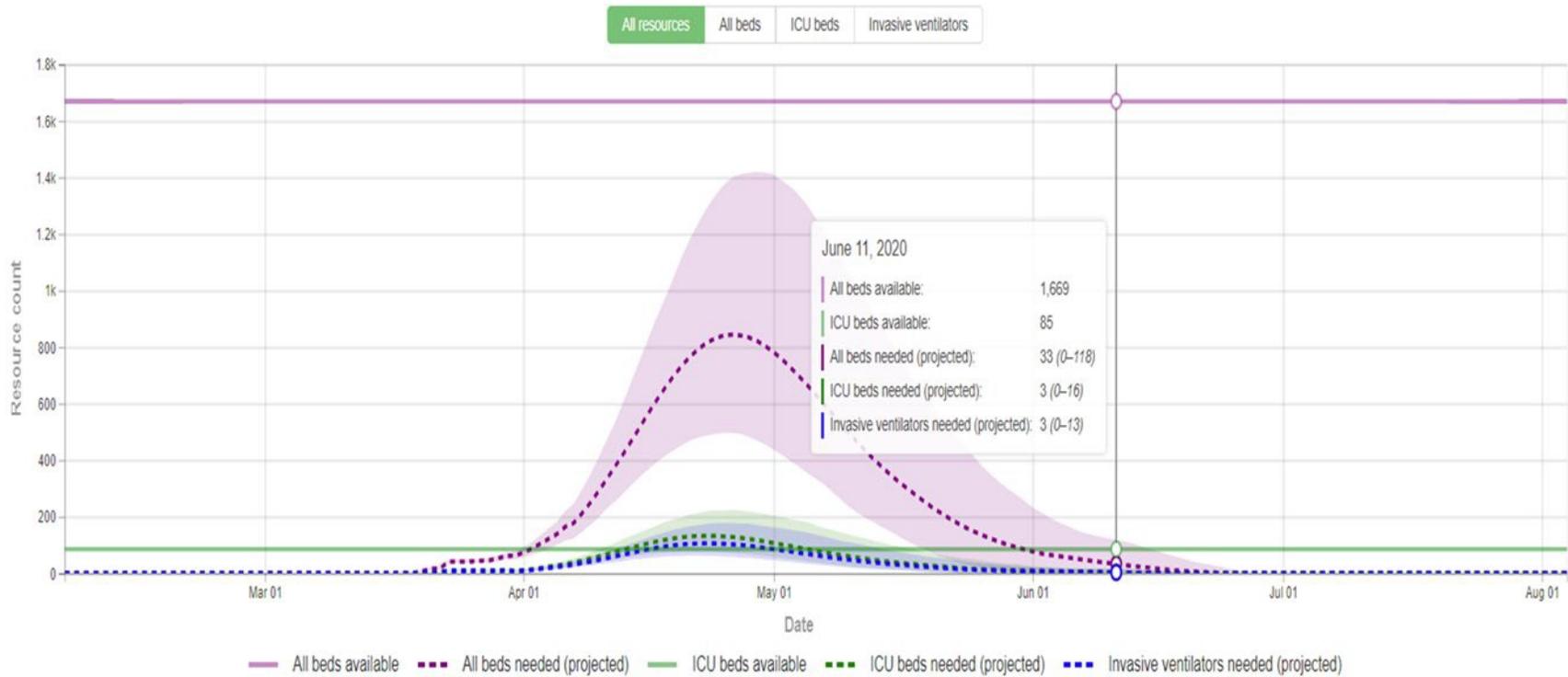
- Centralized storage with one or more refrigerated trailers strategically placed in the state will require staffing for potentially long-distance decedent transport, decedent loading and unloading and local storage administration and security. Will require fewer refrigerated trailer rental(s) and will likely result in purchase following storage of human remains.
- Community based storage with multiple refrigerated trailers, one in each county or jurisdiction as dictated by local need. Each trailer will require staffing for short distance decedent transport, decedent loading and unloading and local storage administration and security. Will require greater refrigerated trailer rentals and will likely result in purchase following storage of human remains.

## Health Metrics and Evaluation Montana COVID 19 Projection

24 days until peak resource use on  
**April 26, 2020**

### Resources needed for COVID-19 patients on peak date

All beds needed <b>844 beds</b>	→	All beds available <b>1,669 beds</b>	→	Bed shortage <b>0 beds</b>
ICU beds needed <b>128 beds</b>	→	ICU beds available <b>85 beds</b>	→	ICU bed shortage <b>43 beds</b>
Invasive ventilators needed <b>102 ventilators</b>				

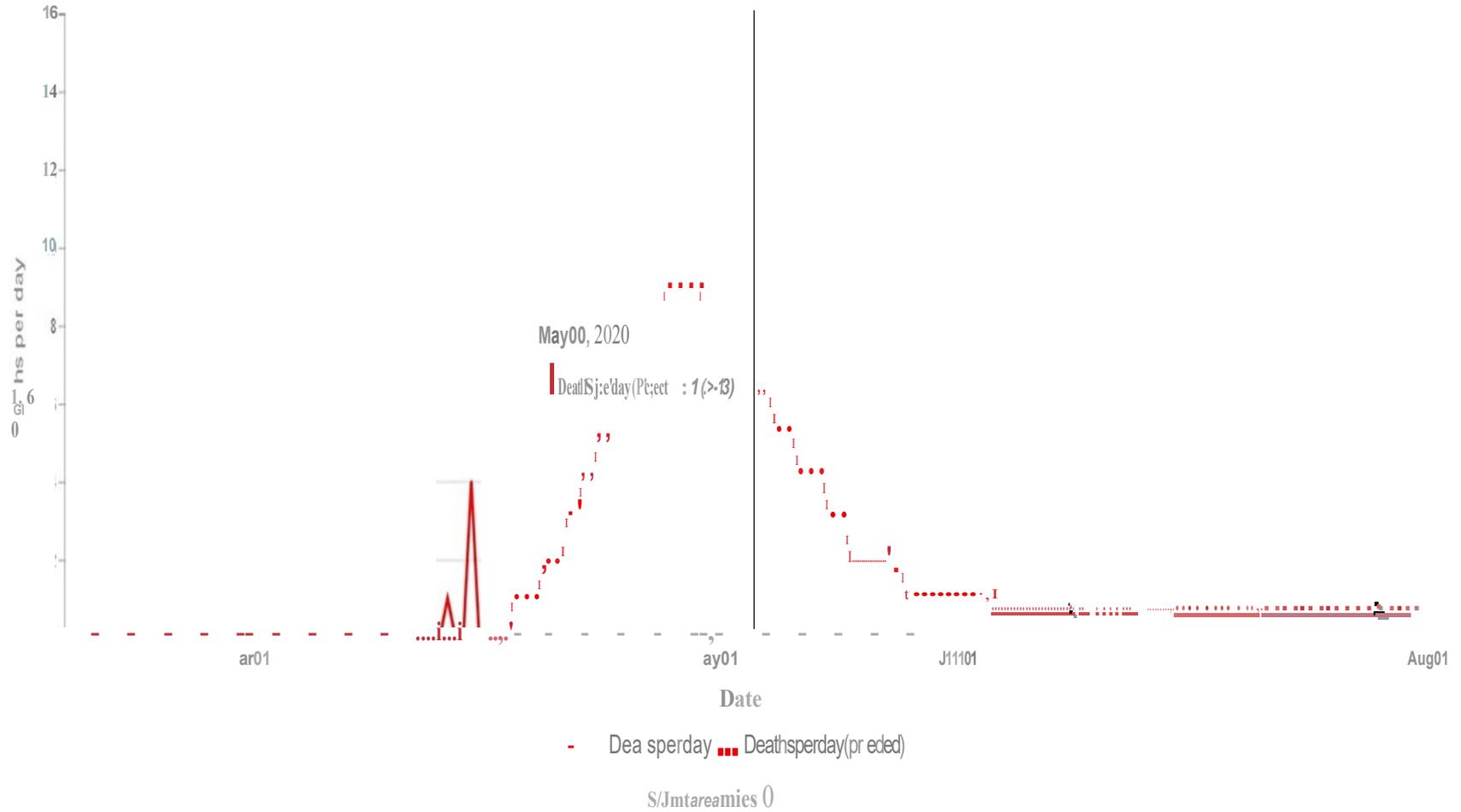


Shaded areas indicate uncertainty ☺

# Deaths per day

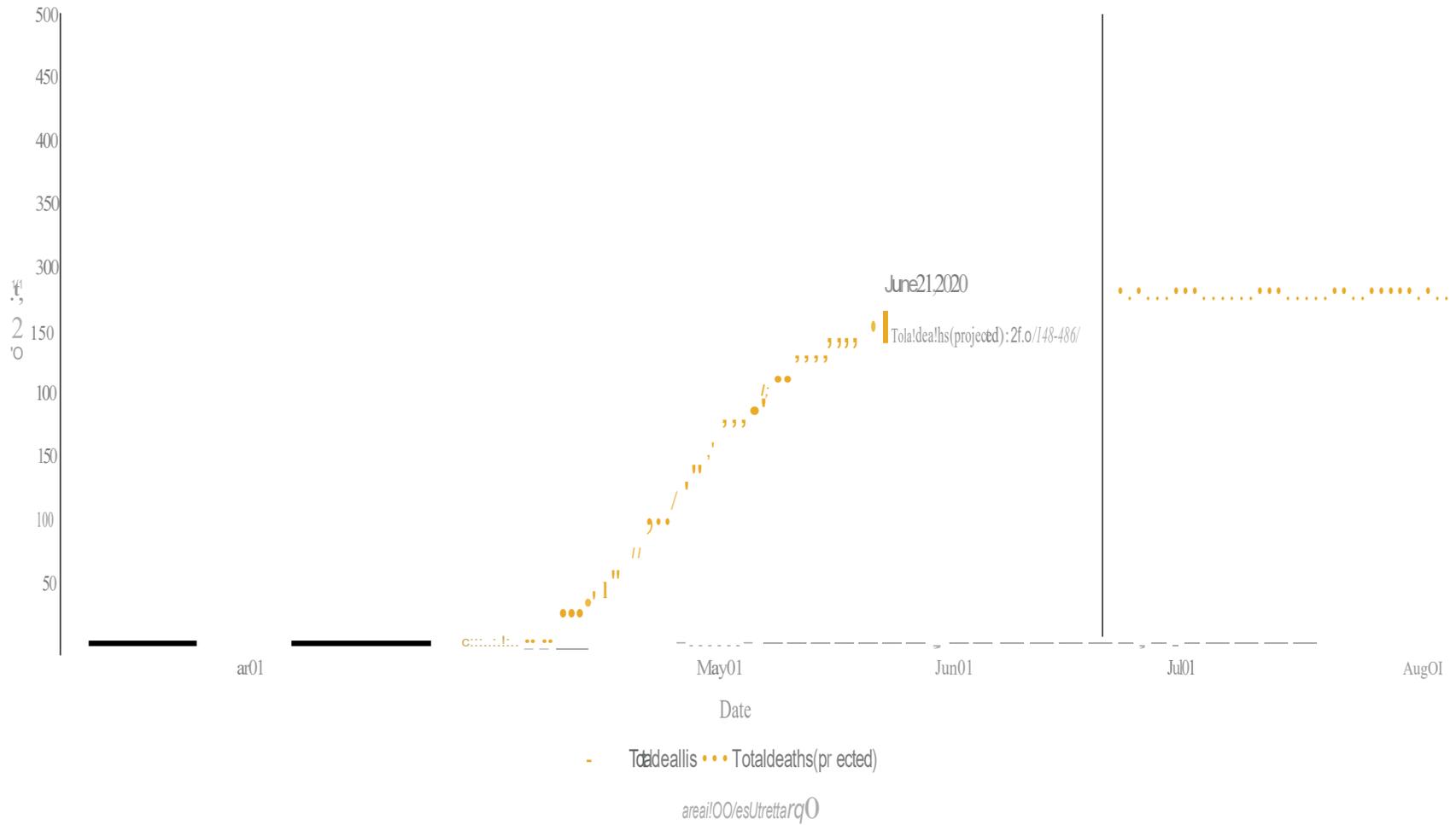
**23** days  
until peak count of daily deaths

**9** COVID,19 deaths  
projected on April 25, 2020



# Total deaths

**266** COVID,19 deaths  
projected by August 4, 2020



# Appendix G

## Medical Examiner Recommendations for COVID-19 Response

### All-inclusive case scenario:

Adequate COVID-19 test sample collection supplies

- Adequate COVID-19 laboratory testing reagents

Procedure: A nasal swab collection and COVID-19 testing is performed in all out-of-hospital deaths attended by a Montana Coroner and/or examined by a State Medical Examiner.

The advantage of testing all coroner-investigated-deaths is screening a subset of the Montana population for the presence or absence of COVID-19 with the benefit of additional epidemiological information and the associated implications thereof to direct healthcare decisions.

### Focused case scenario:

As of March 31, 2020, Montana does not currently have adequate COVID-19 test sample collection supplies to test all previously un-tested decedents for COVID-19. Prioritization of COVID-19 test sample collection supplies should be preserved for the living.

As of March 31, 2020, Montana may not currently have adequate COVID-19 laboratory testing reagents to test all not-previously-tested decedents for COVID-19. Prioritization of COVID-19 laboratory testing reagents should be preserved for the living.

Procedure: In order to conserve and make best use of available COVID-19 diagnostic supplies the following triage will be used for COVID-19 testing by Coroners and Medical Examiners.

- For in-hospital deaths **where COVID-19 has been confirmed**, no additional COVID-19 testing is necessary.
- For unattended deaths not in a hospital or from an emergency department, with **no significant pre-existing disease, no apparent cause of death** and the individual has **potential risk factors for exposure to COVID-19**, a postmortem examination (autopsy) should be requested. The Medical examiner will collect a sample for COVID-19 testing.
- For unattended deaths not in a hospital or from an emergency department, **with significant pre-existing disease, with an apparent cause of death and the individual has potential factors for exposure to COVID-19**, a postmortem examination (autopsy) is not necessary; however, the Coroner will collect a nasal swab for testing, unless the autopsy findings suggest possible COVID-19 pathology.
- For unattended deaths not in a hospital or from an emergency department, with **no significant pre-existing disease, no apparent cause of death** and the individual does not have **potential risk factors for exposure to COVID-19**, a postmortem examination (autopsy) should be requested. The Medical examiner will not collect a sample for COVID-19 testing unless the autopsy findings suggest possible COVID-19 pathology.
- For unattended deaths not in a hospital or from an emergency department, **with significant pre-existing disease, with an apparent cause of death and the individual does not have potential factors for exposure to COVID-19**, a postmortem examination (autopsy) is not necessary and the Coroner will not collect a nasal swab for COVID-19 testing.
- For unattended deaths not in a hospital or from an emergency department, with or without significant pre-existing disease; with or without an apparent cause of death and the individual does

or does not have potential risk factors for exposure to COVID-19, but lives or works in a congregant setting (e.g., hospital, nursing home, prison, etc.) that poses a high risk for communication of COVID-19, the Coroner or Medical examiner will collect a sample for COVID-19 testing. The need for an autopsy will be determined on a case-by-case basis.