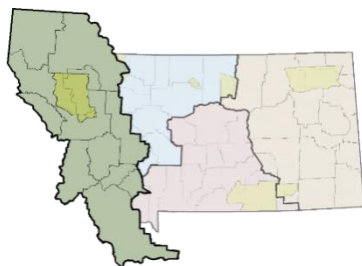
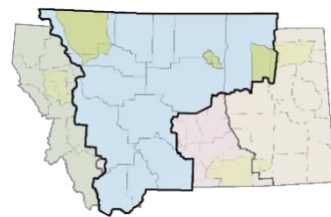
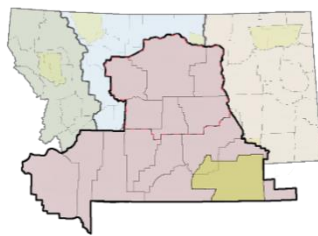


CENTRAL REGION HEALTH CARE COALITION



HIGHLY INFECTIOUS DISEASE PREPAREDNESS ANNEX

December 2023

Version 4.1



PROMULGATION


The Executive Committee of the Central Region Health Care Coalition supports and provides this planning tool to provide assistance to the healthcare communities within the boundaries of the Central Region Health Care Coalition.



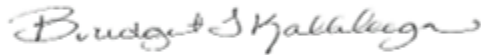
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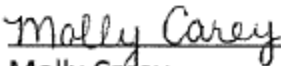


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RECORD OF CHANGE

Date	Description of Change	Initials
October 2019	First Edition	DM
July 2020	Annual revision and updates	KS
March 2021	Updated to align with ASPR Guidance	KS
August 2022	Annual revision and updates	KS
August 2023	Annual revision and updates	KS

RECORD OF REVIEW

Date	Reviewed by Name & Title	Organization
September 2020	Executive Committee Review of Draft	
April 2021	Executive Committee Approval of HID Annex	
November 2022	Executive Committee Reviewed & Approved	
December 2023	Executive Committee Reviewed & Approved	

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SECTION I: PURPOSE, SCOPE, SITUATION, AND ASSUMPTIONS

1.1 Purpose

This Highly Infectious Disease (HID) Preparedness Annex is a response level document intended to describe the parameters, abilities, and responsibilities of the Central Region Health Care Coalition (CRHCC) of Montana in preparation for, response to, and recovery from an event involving a known or emerging and highly infectious pathogen within the region. The elements outlined in this annex involve preparedness planning, training, and exercise, as well as operational assistance for member organizations for managing suspected or confirmed highly infectious patients, their contacts, and any related issues.

Definition: For the purposes of this plan a “highly infectious disease response” is a response to any new, emerging, or severe infectious disease situation that goes above and beyond routine infectious disease investigation, coordination, and response; and likely requires significant multi-agency response.

The primary goals of the CRHCC Highly Infectious Disease (HID) Preparedness Annex are:

- Ensure timely and accurate communication of information
- Reduce morbidity and mortality
- Ensure responder safety and health

The Montana Department of Public Health and Human Services (DPHHS) is the primary agency for response to a HID case or outbreak in the State.

1.2 Scope

The HID Preparedness Annex is an Annex to the larger CRHCC Preparedness and Response Plan and is applicable for any incident in which an individual or population with confirmed or suspected highly infectious disease. This plan outlines the concept of coordination and operations for incidents wherein the complexity or duration requires regional coordination of information, resources and/or response activities. This plan is not applicable for the routine management of infectious diseases such as tuberculosis, measles, foodborne illness, and other sexually transmitted diseases (STDs) within our community, unless the situation requires urgent regional coordination.

This HID Preparedness Annex involves all participating organizations, agencies, and jurisdictions contained within the geographical boundaries of the CRHCC. Many of these participants have their own protocols for responding to cases of patients with highly infectious diseases. This document is designed to work with those protocols and does not define or supplant any emergency operating procedures or responsibilities for any member agency or organization in the CRHCC. It is not a tactical plan or field manual, nor does it provide Standard Operating Procedures (SOP). Rather, it is a framework for organization and provides decision-making parameters to use within an all-hazards planning and response environment. This plan intentionally does not provide specific or quantitative thresholds for activation or demobilization of organizational structures or processes described herein. Such

determinations are situation-dependent and left to incident management. It includes a general concept of operations for the response to highly infectious disease patients.

This plan is compatible with federal, state, and local emergency response plans, promotes the coordination of an efficient and effective response by utilizing the concepts outlined in the National Incident Management System and it establishes common goals, strategies and terminology with other regional and local plans. Implementation is not contingent on the activation of the CRHCC Emergency Preparedness & Response Plan. CRHCC will conduct its operations under the structure of the Incident Command System (ICS) at the facility or organizational level. Activities in this framework are based on established relationships and partnerships with the public, stakeholders, and contributing agencies.

This plan applies to:

- A highly infectious disease response to any new, emerging, or severe infectious disease situation that goes above and beyond routine infectious disease investigation, coordination, and response; and likely requires significant multi-agency response.
- A highly infectious disease incident within or impacting the Central Health Care Region.

The primary authority for initial response to, and management of, emergencies rests with local governments. Although a highly infectious disease might be identified at any healthcare facility, local and tribal jurisdictions, public health departments will respond with identification, treatment, and community containment efforts. With assistance of other State and Federal partners, Montana Department of Public Health and Human Services (DPHHS) collaborates with local agencies and health care coalitions as needed during disease outbreaks and investigations. DPHHS has the authority to act on the behalf of local public health agencies, when needed, to coordinate a multijurisdictional event or protect the public health. Reporting enables appropriate public health follow-up for patients, helps identify outbreaks and provides a better understanding of disease trends. For further guidance see the State Highly Infectious Disease Plan, which may be accessed by contacting DPHHS Emergency Preparedness.

Planning for HID emergencies includes medical needs associated with mental, behavioral health, and substance abuse considerations of incident victims and response workers. Services also cover the medical needs of individuals classified as having access, functional, or special needs.

The timeframe covered in this Plan begins when an infectious disease incident is declared by DPHHS and will remain active throughout the duration of the incident as determined by DPHHS.

1.3 Overview/Background of HCC and Situation

There have been historical events that the United States Centers for Disease Control and Prevention (CDC), and many other agencies, have coordinated national and global efforts to contain and respond to outbreaks of highly infectious pathogens. In Montana, an assessment of current capabilities and preparedness planning was conducted. Planning continues for improved HID preparedness and response.

Montana is subject to the same risk of encountering highly communicable pathogens as any place in the world. The National Health Security Strategy 2019-2022 states,

Interconnectedness spans national boundaries, remote areas, and long distances, affecting travel, trade, and the distribution of people. Unintended consequences include hastened disease transmission (through increased mobility and access to remote areas) and increased health risks for the nation and U.S. citizens living abroad.¹

Disease specific plans have their place when pathogens have unique characteristics. DPHHS writes emergency plans, trains to, and exercises those plans to counter outbreaks of communicable diseases and engages health care coalitions as their partners in responding to those events. Health Care Coalitions, hospitals, local and tribal jurisdictions, health departments, and other medical related organizations have also engaged in these activities by taking advantage of federal funding offered to prepare for these types of events in their facilities.

Health Care Facilities

Any healthcare facility in Montana could receive a patient at any time with suspected highly infectious disease. However, all facilities might not have adequate capabilities to provide optimal and safe care for that patient. The primary medical provider and DPHHS will consult regarding the need and options for patient transfer in the event of a positive test.

In this Central Region there are:

- 3 Hospitals
- 10 Critical Access Hospitals
- 2 Tribal/IHS Hospitals
- 0 HID Assessment Hospitals
- 1 Veteran's Affairs Hospital
- 1 Children's Specialty Hospital
- 1 Intensive Behavior Center
- 29 Clinics
- 30 EMS
- 12 Long-Term Care Facilities
- 13 Public Health Departments

1.4 Assumptions

The following are the planning assumptions for the purposes of this framework:

- Highly infectious diseases can emerge and re-emerge at any time in Montana.
- Some highly infectious diseases cause significant morbidity and mortality and require an immediate response to prevent further spread of disease.

¹ United States, Human Health Services, Assistant Secretary for Preparedness and Response. (2019, January 15). *Phe.gov - National Health Security Strategy 2019-2022*. Retrieved April 23, 2019, from <https://www.phe.gov/Preparedness/planning/authority/nhss/Documents/NHSS-Strategy-508.pdf>

- DPHHS, the CDC, and Health and Human Services (HHS) Region VIII, RHCCs, and Local Health Jurisdictions (LHJs) will coordinate responses to outbreaks of a highly infectious disease to sustain community resilience.
- A communicable disease incident can potentially result in strained capabilities within affected agencies and organizations.
- Healthcare facilities might become overwhelmed with ill patients and the “worried well”.
- Highly infectious disease outbreaks may be anticipated and provide the ability to plan in advance, or there may be no notice and require immediate response.
- Patients with a highly infectious disease could present to healthcare organizations in the region through two modes:
 - A patient presents with or without symptoms with or without a history of exposure and no advance notification to the healthcare facility,
 - A patient being monitored or treated for a disease/exposure and is directed to a healthcare facility for evaluation or treatment in the region.
- Not all healthcare facilities in the CRHCC or Montana may be able to care for all highly infectious disease patients.
- All healthcare facilities must be able to maintain a base level of preparedness to safely screen (in-person or remotely), stabilize, isolate if necessary, and arrange for the transport of a possible highly infectious disease patient.
- Resources such as personnel, equipment, and personal protective equipment may be in short supply throughout the region, state, country, or the globe depending on the severity and nature of the highly infectious disease.
- The objectives of public health and hospitals may differ in a highly infectious disease response: public health is primarily concerned with community disease control and healthcare facilities are focused on the clinical care of patients.
- Counties have the authority to change or implement procedures to protect the public’s health, up to and including isolation and quarantine.
- Healthcare organizations and systems throughout the region will commit their own resources to address internal challenges prior to releasing resources to other healthcare organizations.
- Pediatric, obstetric and other specialty care patients, including those that are critically ill, may present to ANY healthcare facility during a highly infectious disease response.
- Healthcare organizations will rely on existing contracts with medical suppliers and pharmaceutical vendors to the maximum extent possible.
- Hospitals and healthcare systems have, or are in the process of completing, internal plans and systems for a highly infectious disease response.

SECTION 2: CONCEPT OF OPERATIONS

2.1 Activation

Activation of this plan will occur upon request for assistance from any healthcare entity within the region. However, local efforts may quickly become exhausted and require external resources, care and coordination assistance. This may occur concurrently with activation of other plans.

This plan is meant to facilitate a need to activate a response quickly. Plan activation triggers may include, but are not limited to any of the following:

- One or more suspected or laboratory confirmed highly infectious disease patients identified in the region by local public health;
- Regional coordination required to assist with monitoring, laboratory testing, patient care, patient movement, as well as risk communication, public information, and/or media response, and other activities;
- Multiple counties affected by a highly infectious disease requiring a coordinated response;
- DPHHS declares an occurrence of a HID;
- CDC has confirmed cases of a HID.

For any event originating at the local level, it is the responsibility of the affected organization to notify the County Disaster and Emergency Services Coordinator. The county will then notify the State Disaster and Emergency Services (DES) Duty Officer to initiate the coordination response.

2.2 Notifications

Local Health Jurisdictions (LHJs) are the first line of contact for healthcare organizations in the event of a highly infectious disease response.

- In the event of a highly infectious disease response of an unannounced patient that presents to a healthcare organization, healthcare providers should contact their LHJ, who will then contact the County DES Coordinator and DPHHS Duty Officer.
- In the event of a known highly infectious disease emergency in a patient being monitored locally or transferred into the region, healthcare providers should contact their LHJ, who will then contact the County DES Coordinator and DPHHS Duty Officer.

Following notification, the LHJs, DES and DPHHS will coordinate the notification of other appropriate partners. Partners may include:

- Local healthcare organizations/providers
- Local EMS
- Local emergency management
- Neighboring LHJs
- Additional DPHHS Sections (i.e. preparedness and communicable disease)
- Regional Health Care Coalition Coordinator
- CDC/Administration for Strategic Preparedness and Response (ASPR)

- Other health partners as necessary

2.3 Roles and Responsibilities

The CRHCC’s member organizations collaborate in response planning to sustain community resilience. This activity is also essential for immediate and effective coordination with other emergency response partners.

Each of the partnering agency capabilities are affected by available resources and the size and scope of an incident. As such, response support is “as able.”

Montana Department of Public Health and Human Services

DPHHS is the lead agency for coordinating state level health and medical emergency responses to highly infectious disease emergencies. The Department will work directly with facilities that are assessing and treating any patient that has, or is suspected of having, a highly infectious disease. DPHHS is mandated by statute to protect the public health, including collaborating with partners to address conditions of public health importance under the general powers and duties statute (MCA [50-1-202](#)).

Regional Preparedness & Response Specialist

The CRHCC Regional Preparedness & Response Specialist will assist with the ESF8 coordination operations through DPHHS PHEP/HPP in concert with both local emergency management and ESF8 partners. Coordination and resource assistance for tribal and local jurisdiction is on an as able basis.

The CRHCC and its members are collaborating partners; participating in information sharing and resource coordination. The coalition serves as an integral component for medical mutual aid, providing a mechanism to provide surge support and rapid distribution of aid when it is needed. The coalition supports and maintains tools and strategies for mutual systems, including professional volunteer recruitment and resource requests.

Priorities in a HID response may include:

- Support infection prevention efforts
- Assistance to DPHHS operations
- Communication
 - Maintaining situational awareness
 - Risk communication message consistency
 - Information sharing
- Situational awareness for surge capacity

During an infectious disease outbreak, the CRHCC Coordinator will work with DPHHS to ensure the ability to surge to meet the demands of a highly infectious disease response. Support activities to DPHHS may include:

- Establishing a Medical Common Operating Picture
- Establishing key indicators and Essential Elements of Information (EEl)s
- Providing real-time information sharing
- Coordination of public messaging.

CRHCC Executive Committee

The CRHCC Executive Committee will remain in an advisory role, connected remotely in an electronic virtual environment (internet, telephone, etc.). Executive Committee members have responsibilities to their own facilities' response operations.

Local Jurisdictions

Local organizations and agencies within the impacted jurisdiction will have primary responsibility for response, including initial triage and casualty distribution.

The roles and responsibilities of the responding agencies and participating healthcare facilities will be determined by each individual entity. It is the responsibility of the entities to acquire and provide appropriate education and training. The CRHCC does not have the authority to dictate or recommend roles and responsibilities but will provide education and training related to best practices in burn care.

2.4 Operational Mission Areas

2.4.1 SURVEILLANCE

Surveillance processes will be determined by local public health or DPHHS. The CRHCC may provide education and training on industry best practices. The CRHCC will provide opportunities for healthcare entities to test their policies, procedures and protocols during exercises.

2.4.2 SAFETY AND INFECTION CONTROL AND PREVENTION

The recommendations for highly infectious disease protocols will be provided by the CRHCC, local public health, DPHHS or the CDC. The CRHCC will refer to the CDC guidance regarding specifics related to the HID. Coalitions will support healthcare system response through provision of guidance and available resources to staff and healthcare facilities. Staff at affected organizations need to obtain training and competencies on safety and health protocols. The CRHCC may provide training and education on industry best practices.

See Appendix 3 for PPE use and conservation guidance.

2.4.3 NON-PHARMACEUTICAL INTERVENTIONS

The CRHCC will share information and support the recommendations provided by DPHHS and local public health regarding:

- Personal protective actions
- Recommendations for quarantine operations and isolation protocols
- Restrictions impacting healthcare facilities such as visitors, mass gatherings and social distancing measures

2.4.4 SURGE STAFFING

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care. As a highly infectious disease event progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and

processes in place to mitigate these, including communicating with HCP about actions the facility is taking to address shortages and maintain patient and HCP safety and providing resources to assist HCP with anxiety and stress.

CDC's mitigation strategies offer a continuum of options for addressing staffing shortages. More information on Strategies to Mitigate Healthcare Personnel Staffing Shortages can be accessed [here](#). Contingency and then crisis capacity strategies augment conventional strategies and are meant to be considered and implemented sequentially (i.e., implementing contingency strategies before crisis strategies). For example, if, despite efforts to mitigate, HCP staffing shortages occur, healthcare systems, facilities, and the appropriate state, local, territorial, and/or tribal health authorities might determine that HCP with suspected or confirmed COVID-19 could return to work before the CDC full Return to Work Criteria have been met.

At baseline, healthcare facilities must:

- Understand their staffing needs and the minimum number of staff needed to provide a safe work environment and safe patient care.
- Be in communication with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional HCP (e.g., hiring additional HCP, recruiting retired HCP, using students or volunteers), when needed.

Contingency Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are anticipated, healthcare facilities and employers, in collaboration with human resources and occupational health services, should use the CDC Contingency Capacity Strategies to plan and prepare for mitigating this problem.

Facilities facing a short-term staffing shortage may utilize the Montana Healthcare Mutual Aid System (MHMAS). MHMAS is a secure, web based online registration system used to register, verify and credential volunteer health care professionals BEFORE a major disaster or public health emergency occurs.

2.4.5 SUPPLY CHAIN, SUPPLIES, PERSONAL PROTECTIVE EQUIPMENT

The CRHCC will refer healthcare entities to the CDC guidance regarding PPE for the specific highly infectious disease. See Appendix 3 for Strategies for Optimizing the Supply of PPE During Shortages. See Appendix 15 in the Preparedness and Response Plan regarding the HCC Cache. Additionally, facilities may utilize the [Disaster Available Supplies in Hospitals](#) (DASH) tool to help estimate supplies that may need to be immediately available.

2.4.6 SUPPORT SERVICES

Support services may include any healthcare or non-healthcare staff or material resources required to support the care of highly infectious disease patients. This may include dialysis providers, blood banks/blood product providers, laboratory services, infection prevention/control, waste and material management, food and dietary services, and environmental services.

- Support service providers will work with local healthcare, the CRHCC, and LHJs to prepare and respond by assisting healthcare organizations in the care of highly infectious disease patients.
- LHJs will work with healthcare organizations to coordinate testing of highly infectious disease patients with the Montana State Public Health Laboratory and/or the CDC Laboratories.
- The ESF8 lead agency will work with the CRHCC, LHJs, and healthcare organizations to share recommendations on standardized patient care protocols, practices, and support services across the region. LHJs will issue guidance to healthcare organizations and providers concerning these issues.

2.4.6.1 Laboratory

The timely diagnosis of a highly infectious disease patient is critical to a coordinated and efficient response. Relevant healthcare organizations, LHJs, and DPHHS should coordinate with appropriate laboratories to test specimens and communicate results of laboratory testing. Based on the suspected pathogen, the Montana State Laboratory may be responsible for testing specimens and/or coordinating the provision of specimens to the Centers for Disease Control and Prevention (CDC). Healthcare organizations and laboratories should coordinate closely concerning specimen collecting and timing of testing needs. If a healthcare organization's incident command structure has been activated, laboratories should report all testing results through the healthcare organization's response structure, as well as to the patient's attending physician directly. Additionally, laboratories should communicate testing results to the LHJ.

2.4.6.2 Waste Management, Decontamination

Healthcare organizations will work through their normal vendors and channels to ensure all waste produced in the screening and care of highly infectious disease patients will be handled and disposed of appropriately. Where necessary, LHJs and DPHHS may coordinate or contract with specific waste management contractors for the safe handling and removal of waste associated with healthcare for highly infectious disease patients as well as coordinating with the appropriate utilities as needed. Waste management agencies will maintain protocols for the handling of waste from highly infectious disease patients.

2.4.7 PATIENT CARE/MANAGEMENT

The CRHCC will maintain support for the coordination of patient care, including persons under investigation, throughout the duration of the highly infectious disease event.

2.4.8 MEDICAL COUNTERMEASURES

The CRHCC will support public health and healthcare systems in the distribution and administration of medical countermeasures during a highly infectious disease event.

2.4.9 COMMUNITY-BASED TESTING

The CRHCC will support coalition stakeholders in community-based testing during a highly infectious disease event.

2.4.10 PATIENT TRANSFER

Transfers could occur by ground or air transport depending on patient need, resources, and ultimate destination. The CRHCC will support EMS with their transport policies, practices, and procedures. The CRHCC will encourage EMS agencies to notify the receiving healthcare facility when transporting a suspected high-risk infectious patient so that appropriate infection control precautions may be prepared prior to patient arrival. The CRHCC will help maintain situational awareness by making visible bed capacity of facilities within the region.

2.4.11 MASS FATALITY

The CRHCC will support the proper recovery, handling, transportation, tracking, storage, and disposal of human remains based on guidance from the State Medical Examiner, County Coroner and Local Public Health.

2.5 Special Considerations

2.5.1 BEHAVIORAL HEALTH

In coordination with direct medical care, behavioral health care may be necessary to support patients with a highly infectious disease. Plans should be enacted early in a highly infectious disease response to address and plan for behavioral health care needs as appropriate, based on the pathogen. Additionally, due to impact of being infected, exposed, or treating individuals with a highly infectious disease, plans may be required to support a surge in behavioral health needs of patients, family members, community members, healthcare staff and employees during a highly infectious disease incident. LHJs, healthcare organizations, and the CRHCC should work together to facilitate information coordination and standardizations of resources provided to address behavioral health concerns based on the incident. Behavioral health response may need to continue long after a highly infectious disease response is demobilized.

2.5.2 AT-RISK POPULATIONS

The CRHCC will work with its ESF8 members and DPHHS to coordinate timely and appropriate support to organizations serving individuals with functional or special needs. Functional need populations are 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 before, during, and after an incident. 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) 2019*

Refer to the Functional Need and Vulnerable Population portion of the Preparedness and Response Plan.

2.5.3 SITUATIONAL AWARENESS

Refer to Appendix 4 - Information Sharing, Management and Situational Awareness of the Preparedness and Response Plan.

2.5.4 COMMUNICATIONS

The CRHCC provides guidance and information via coordinated communications between facilities, agencies and regions. This coordinated communication provides support for coalition members, local emergency responders, tribal and local jurisdictions, State agency partners, and volunteer organizations to ensure the delivery of care for patients that might have an HID. This might require augmenting medical and responder supplies.

Refer to Appendix 5 – Communications Plan of the Preparedness and Response Plan.

2.5.5 JURISDICTIONAL-SPECIFIC CONSIDERATIONS

The Central Region covers 13 counties and within are the Blackfeet and Fort Belknap Reservations. Much of this region is designated rural and facilities have limited capacities. The Central Region houses one designated ACS level 2 / State Regional Trauma Center that would be the primary receiving facilities for the region as well as other areas of the state. The remainder of hospitals in the region are Critical Access Hospitals with a varying degree of staff, resources and capabilities. The majority of EMS services within this region are volunteer agencies and may have limited capacity and capability to transport a highly infectious disease patient. Many communities utilize transient and/or migrant workers during various seasons. This may increase the spread of a highly infectious disease and lead to challenges with isolation and quarantine as well as contact tracing. While telehealth is a viable option for many facilities, facilities may encounter a lack of providers for consults. The CRHCC will utilize emPower and Social Vulnerability Index (SVI) to identify the needs of patients within the region.

2.6 Training and Exercise

This plan or any of its components could be exercised separately or in conjunction with other exercises. Exercises will be used under simulated, but realistic conditions to validate policies and procedures for responding to specific emergency situations and to identify deficiencies that need to be corrected. Personnel participating in these exercises should be those who will make policy decisions or perform the operational procedures during an actual event (i.e. critical personnel). Exercises are conducted under no-fault pretenses. The CRHCC will identify and share as many opportunities as possible.

2.7 Deactivation and Recovery

When the CRHCC, in consultation with local healthcare organizations, LHJs, and DPHHS, determines that the need for advanced coordination with healthcare for the highly infectious disease response has passed, the decision will be made to demobilize and transfer any outstanding coordination back to normal operational channels.

Triggers and indicators for ending highly infectious disease response and monitoring:

- If the level of regional coordination necessary to manage existing patients is comparable to that of normal operating procedures
- If the immediate danger has passed and there is no longer a threat
- Completion of the monitoring period for all exposed persons.
- The passage of at least two incubation periods without reported cases.
- The healthcare system has sufficient resources and capacity to resume normal operations

- Healthcare emergency department volume decreases in general, or decreases to usual census levels (social and clinical measure of change)
- Syndromic surveillance markers indicate a return to baseline
- School/childcare attendance return to 'normal'
- Call center volume (911 and other call centers) return to 'normal' threshold
- EMS call reports (type and volume) return to 'normal' threshold
- Community and social media concerns decrease
- Media requests for information decrease

The LHJs and DPHHS will lead in notifying staff and partners of the demobilization. At that time:

- All activations are demobilized.
- Final situational awareness information is sent to all partners.
- All partners notified of the demobilization.
- A debrief and after-action process is established for internal operations and all partners.

The following activities should be considered:

- Return of any borrowed assets
- Debrief, local, regional, and/or state partners with after action report and improvement plan and coordinated approach to incorporating recommendations into future planning
- Encourage accurate documentation in regards to payment and reimbursement for the response
- Encourage communication of any screening or surveillance activities that need to be revised or maintained longer term.

SECTION 3: MAINTENANCE & REVIEW

The CRHCC formally reviews all components of this annex annually. The Executive Committee offers advice and suggestions on appropriate emergency planning and construction of the document. This process allows the coalition to determine if it meets all essential factors, remains applicable, and affords the opportunity to update and change the plan as the coalition changes and grows.

Minor corrections, edits, updates, or adjustments to this document might occur on occasion without a formal review. Changes may also take place as part of the improvement plans from exercise after action reports. All changes are tracked in a versioning method and in the Record of Change log.

SECTION 4: APPENDICES

Appendix 1: References

Appendix 2: Acronyms

Appendix 3: PPE Recommendations

Appendix 4: Resources

Appendix 1: References

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Appendix 2: Acronyms

ACS – American College of Surgeons

ARM – Administrative Rules of Montana

ASPR – Assistant Secretary for Preparedness and Response

CDC – Centers for Disease Control and Prevention

CRHCC – Central Region Health Care Coalition

DES – Montana State Disaster and Emergency Services

DPHHS – Montana Department of Public Health & Human Services

EMS – Emergency Medical Services

EVD – Ebola Virus Disease

HCC – Health Care Coalition

HCP – Health Care Personnel

HHS – US Health and Human Services

HID – Highly Infectious Disease

IHS – Indian Health Service

ICS – Incident Command System

LHJ – Local Health Jurisdiction

MCA – Montana Code Annotated

PHEP – Public Health Emergency Preparedness

PPE – Personal Protective Equipment

RHCC – Regional Health Care Coalition

SOP – Standard Operating Procedure

STD – Sexually Transmitted Disease

Appendix 3: PPE Recommendations

The CDC provides a quick reference which summarizes [CDC's strategies to optimize personal protective equipment \(PPE\)](#) supplies in healthcare settings and provides links to CDC's full guidance documents on optimizing supplies which provide additional strategies and details. These strategies offer a continuum of options using the framework of surge capacity when PPE supplies are stressed, running low, or absent. When using these strategies, healthcare facilities should:

- Consider these options and **implement them sequentially**
- Understand their current PPE inventory, supply chain, and [utilization rate](#)
- Train healthcare personnel on PPE use and have them demonstrate competency with donning and doffing any PPE ensemble that is used to perform job responsibilities
- Once PPE availability returns to normal, promptly resume conventional practices



Once availability of PPE returns to normal, healthcare facilities should promptly resume conventional practices. Considerations affecting this decision include:

- The anticipated number of patients for whom PPE should be worn by HCP providing their care
- The number of days' supply of PPE currently remaining at the facility
- Whether or not the facility is receiving regular resupply with its full allotment.

CDC PPE Optimization website

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

PPE Burn Rate Calculator

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html>

NIOSH PPE Tracker

<https://www.cdc.gov/niosh/topics/pandemic/ppe.html>

2022 Guideline for Isolation Precautions

<http://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html>

EMS Infectious Disease Playbook

<https://files.asprtracie.hhs.gov/documents/aspr-tracie-transport-playbook-508.pdf>

Appendix 4: Resources

ASPR TRACIE Developed Resources

Infectious Disease

- [ASPR Tracie Infectious Disease Select Resources](#)
- [CDC Guidance on Diseases](#)

Communications

- [Communication Systems](#)
- [Information Sharing](#)
- [Risk Communications/Emergency Public Information and Warning](#)
- [Social Media in Emergency Response](#)

Other

- [Crisis Standards of Care](#)
- [Ethics](#)
- [Fatality Management](#)
- [Healthcare-Related Disaster Legal/Regulatory/Federal Policy](#)
- [Hospital Patient Decontamination](#)
- [Hospital Surge Capacity and Immediate Bed Availability](#)
- [Mental/Behavioral Health \(non-responders\)](#)
- [Partnering with the Health Care Supply Chain During Disasters](#)