

# State Plan for Mass Patient Care North Dakota

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**State Plan for Mass Patient Care**  
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## **I. Structure and Function of the North Dakota Department of Health (NDDoH)**

Primary responsibility for coordinating emergency patient care with the health care system resides in the Emergency Preparedness and Response Section in the North Dakota Department of Health. The Hospital Preparedness Division within that section has lead responsibility. Although local public health entities may work closely with local health care facilities, it is the intent of NDDoH to coordinate the disaster response of the health care entities within the state as a single health care system.

Other parts of the department with direct responsibility for issues covered by this plan include:

- Emergency Preparedness Section
  - Emergency Medical Services – Provide administration and support of the state EMS system
- Medical Services Section
  - Disease Control – Deals with infectious and toxic disease threats which occur in health care settings
  - Microbiology Lab – Provides support to local health care laboratories and supports state investigations of infectious diseases
- Environmental Health Section
  - Chemistry Lab – Provides support to local health care laboratories and supports state investigations of toxic diseases
  - Environmental health programs – Provides assistance with environmental problems such as spills or regulated medical waste disposal
- Health Resources Section
  - Health Facilities – Provides for state licensure of health care facilities, facility investigation and facility administrative assistance

## **II. Relationships and Spheres of Authority For Patient Care During An Emergency**

### North Dakota Department of Health

During an emergency which threatens the health of North Dakota residents, the Department Operations Center (DOC) of the NDDoH will be in operation and response from the Department of Health will be coordinated through that structure. If the Emergency Operations Center for the State of North Dakota (SEOC) has been activated, the DOC will coordinate its efforts through that structure. A health care facility may request NDDoH assistance by:

- Calling State Radio to reach the case manager
- Contacting the Department Operations Center directly when it has been activated for disaster response
- Contacting the local public health unit
- Contacting the local emergency manager.

If an emergency situation exists, regardless of the method a health care facility uses to reach NDDoH, the department will close the communication loop so that all impacted parts of the emergency response system are aware of events.

During an emergency which threatens the health of North Dakota residents, many events will be handled at the local level and never come to the attention of the state. When state involvement is required, NDDoH will be the lead state agency for the following tasks:

- Inter-facility planning and support
- Stockpiling, allocation and delivery of resources
- Standardized policies, guidance, System-wide data
- Coordination with federal health response in the state
- Emergency laboratory support
- Ensuring access to utilities
- Emergency communications
- Mobilizing volunteers for health care augmentation
- Licensure and expand licensed capacity/waivers
- Coordinate evacuation orders (state or local)
- Support of ancillary health care infrastructure (e.g., EMS)
- Mobilize critical health care to impacted area (e.g., PHSS, DMAT)
- Communicable disease control (including epidemiologic investigation)
- Emergency credentialing of out-of-state providers
- Coordination of executive orders
- Ensure transportation of patients out of disaster area
- Alternative patient access coordination
- Public information
- Access to SME for unusual health care situations
- Facility recovery
- Continuation of critical public health services (e.g., surveillance, outbreak management, environmental health, vector control, )

In addition, NDDoH will be one of the lead agencies for the following tasks:

- Maintenance of public and private potable water
- Maintenance of safe waste water disposal
- Environmental hazard mitigation
- Emergency food and shelter
- Crisis counseling
- Community-specific planning
- Alternative care site (MCF) operations
- Mass fatality management

During the course of an event, it may become necessary for the DOC to set policy, make recommendations or reference existing policy or recommendations which affect health care. This may include the distributing guidance from CDC (e.g., infection control, treatment, case definitions), defining appropriate use of state-controlled assets (e.g., anti-viral use, vaccine), defining actions needed from health care facilities (e.g., surveillance guidelines, HAVBED reporting), providing consensus recommendations derived from consultation with health care facilities before or during a declared disaster, and forwarding draft declarations to the Governor intended to temporarily alter state statutes or regulations. The DOC will use the Health Alert

Network to distribute these policies and post them on the NDDoH HAN website. In addition, briefings (conducted daily during serious events) will include information about the guidelines or policies. Webcasts and/or archived video trainings will be available for information which is complex or extensive or where specific skill transfer is needed.

### Local Public Health

During an emergency, local public health units in the state have authority within their local jurisdictions (county or multi-county), as defined by local emergency response plans, and are partners with NDDoH for all public health needs of the local population. By agreement, epidemiologic investigation will be the primary responsibility of NDDoH, whereas provision of anti-infective medications or mass vaccination will be the primary responsibility of local public health, including ensuring the provision of anti-infective medications or vaccinations to health care personnel and first responders. In addition, local public health has responsibility for implementing and enforcing isolation and quarantine; however, at need, that responsibility may be assisted or assumed by state or federal authorities.

### Private Medical Care

The provision of health services to the public will remain the responsibility of the private medical care system. The expertise and facilities for managing a large surge in patients needing medical care resides almost exclusively within the private medical care system. In rare circumstances, it is possible that facilities for providing health services may have to be established under the authority of state public health. Circumstances, however, in which this would be indicated would be ones in which quality of care has been severely compromised within the private system due to overwhelming demand. It is assumed that if a medical surge is large enough, the private health care system will reach a point at which it cannot provide care to a greater number of patients and some community-based alternative for care may be needed for some patients.

In all circumstances, public health will assist the private health care system to provide the highest level of medical care possible to as many persons as possible given the circumstances of the emergency. It is expected that among private care institutions the burden of excess patient care will be shared as needed to maintain the highest quality of care for as many people as possible. It is expected that the private care system will continue to provide emergency care to every person without regard to any patient demographic factors including ability to pay or state of residence.

It is the responsibility of the private health care system to protect its employees while at work from hazards which may threaten their health. Similarly, public health will provide assistance to the private health care system as needed for the protection of health care workers, including assistance with prophylaxis or securing resources [e.g., personal protective equipment (PPE)] needed to protect employee health.

### Emergency Medical Transport

EMS units may be requested by NDDoH to travel to an area of localized emergency and assist with patient transportation. In the event of a generalized emergency, such as pandemic influenza or other extensive infectious diseases, it is expected that EMS units will need to remain largely within their local jurisdictions. However, this also means that assistance with patient transportation is unlikely to be available from outside. Similar to health care institutions, EMS units are expected to protect

their workers from hazards and work with public health to ensure that the means for personal protection is provided.

### **III. NDDoH Role in Emergency Settings Involving Threats to Citizen Health**

The role of NDDoH in emergencies depends on the specific problem, the geographic scope of the emergency, and whether an emergency has been declared.

#### Local Emergency

NDDoH will provide supportive assistance to health care systems, including assistance obtaining medical resources (equipment, supplies, pharmaceuticals), coordinating assistance from other health care facilities, patient transportation, communications, public communication, personnel recruitment, maintaining the integrity of utilities and the environment, providing guidelines for management of conditions threatening public health, and liaison to federal health agencies and cross-border jurisdictions. Although NDDoH may not be the primary responder to some specific requests (e.g., a request for a generator may have to be passed to NDDES), NDDoH will facilitate requests and follow-up to ensure they are met. Institutional patient care decisions are expected to remain in the hands of the institution. Public health will have responsibilities unrelated to patient care (e.g., mass prophylaxis, epidemiological investigation).

The interaction of the Department of Health with the public health sector (as opposed to the private medical care sector) is described elsewhere.

#### Statewide Emergency

The role of the Department of Health will be similar for a statewide emergency as that described for a local emergency, but resources will be more stretched and the Department of Health will have to balance the competing needs of all parts of the health care sector and multiple institutions that may be affected by the disaster, plus compete with non-medical sectors for available resources. Statewide emergencies affecting health may also be national emergencies, in which case, out-of-state and federal support may be minimal. Nonetheless, the role of the NDDoH will remain primarily supportive for patient care services.

#### Disaster Declaration

A disaster declaration is likely to accompany a substantial threat to the health of the public and provide the authority for NDDoH to act aggressively to prevent spread of contagion, provide prophylaxis, ensure patient safety and ensure the best possible access to treatment for all persons. In a disaster setting involving a serious threat to health, state level management of public health functions is likely. However, the expertise required for managing complex health systems resides within the private medical care system. Consequently, the assumption of a health care delivery management role by the state is unlikely, except in the extreme circumstance in which minimal care facilities are required.

More aggressive coordination and enforced cooperation of private sector care with other institutions and multiple communities may be necessary in the face of dire threat. Such actions may place extraordinary stress on health care institutions, override mechanisms for institutional protection, or nullify local institutional policies in order to preserve life within the state community. Examples of such action include managing patient flow, limiting access or care intensity (triage rules),

preventing institutional closure, and redistributing staff. In emergency of all severities, principles of minimal interference with the private health care system consistent with obtaining the best health outcome for the most people will be observed and are expected to yield the best outcome. Preserving the long-term integrity, including financial viability, of all North Dakota health care institutions is also in the best interest of the people of the state and a high priority for guiding public sector management.

#### **IV. Expectations for Health Care Delivery**

##### Care Management in a Disaster

Principles of disaster care:

1. Save as many lives as possible.
2. Preserve as high a quality of care as possible consistent with saving as many lives as possible.
3. Stabilize and transfer excess patients to other institutions to prevent degradation in quality of care or to restore quality of care toward usual standards as soon as possible.
4. Introduce graded reduction in quality of care, scaleable to the disaster and demand for medical resources.
5. Refuse to compromise those care components which would be counterproductive to saving the most lives, or which would place health care providers at increased risk (e.g., infection control, patient hydration/nutrition).
6. To the extent allowable by law, protect the institution, health care providers, and the state from liability when reductions in quality care are required by disaster circumstances.
7. Maintain the long-term viability of health care institutions to continue to serve the community following a disaster.
8. Maintain the long-term functionality of health care providers to continue serving during a long duration disaster and following a disaster, including protection and treatment of stress, mental illness, and physical exhaustion.

##### Ethical Guidelines

In the course of some emergencies, life-saving medical equipment or other critical resources may be inadequate for all patients who require them. In these circumstances, the Department Operations Center (DOC) of NDDoH will provide hospitals with a recommended set of guidelines, approved by a single ethics committee<sup>1</sup>, for allocation of those resources. At this time, NDDoH will use principles provided by New York State for the ethical allocation of ventilators during a pandemic which can be found at ([www.ama-assn.org/ama1/pub/upload/mm/415/new\\_york\\_state.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/415/new_york_state.pdf)). During a disaster event, specific reference will be provided including summary information for decision making. As private entities, health care institutions are not bound by state recommendations but all are strongly encouraged to follow them. Use of ventilators which belong to the state (purchased with preparedness funds) will be allocated according to standard ethical guidelines and their use is expected to conform to those guidelines. If a facility does not choose to use state provided guidelines for allocation of its own resources, the process by which a facility makes these decisions

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<sup>1</sup> In order to ensure fair allocation of live saving resources across the state, NDDoH will provide a single set of guidelines for the entire state. This set of guidelines will be based on adoption of ethical policies developed through one of the extensive ethical planning efforts which have occurred in a few states and at the federal level. The New York guideline is an example.

must be defensible and ethical. In each individual case, the institution needs to carefully document the decision-making process as it was applied to each patient.

### Expectations Based on Type of Disaster Scenario

1. Rapidly developing, short-term, geographically-localized disaster, such as explosion, tornado, winter storm, chemical release.
  - a. Triage for stabilization – provision of resources first for most-ill persons who are likely to survive with treatment available under current conditions and resources.
  - b. Transfer patients to other institutions when stabilized, if definitive care is compromised by keeping patients due to excessive load.
  - c. Return to full quality of care for all patients once patients are stabilized and resources permit.
  
2. Slowly developing, long-term, geographically localized disaster, such as the release of biological agent within a localized area.
  - a. Maintain full standard of care as long as possible.
  - b. Lower standard of care as slowly as possible, consistent with caring for all patients. Reductions in standard of care should follow a pre-defined protocol with the least critical compromises being implemented first (see below).
  - c. Transfer or divert patients to other facilities with reserve capacity as necessary to maintain standard of care.
  - d. Eliminate non-urgent and elective care before compromising quality of care.
  - e. Maintain urgent and emergent care of non-disaster-related patients, keeping patients safe from any threats posed by disaster contagion or toxicity.
  - f. Adequately protect staff from likely injury or illness. (*Adequate* might include caring for grossly decontaminated patients in order to save lives with complete decontamination as soon as possible. *Adequate* recognizes that some small risk is inherent in the provision of care to the sick, but only if necessary to save life.)
  - g. Use mass care strategies when possible (e.g., mass isolation).
  - h. Maintain staff effectiveness for long-term disaster needs and calculate into maximum surge equation and patient transfer.
  - i. Anticipate supply and equipment needs based on expected escalation of the illness. Secure public health assistance in maintaining adequate resources for ongoing care, including personnel or equipment transfer from other facilities.
  - j. Improve quality of care by stages as possible.
  - k. Keep public informed regarding current local care expectations and alternatives.
  
3. Pandemic

Same as #2 except:

  - a. Maintain full standard of care as long as possible, but early conservation of potentially irreplaceable resources (e.g., N95 masks).
  - b. Transfer patients to maintain quality of care as long as that is possible.
  - c. Use pre-planned alternative care sites (community operated minimum care sites) with provision of basic supportive care in the event that health care system capacity has reached maximum possible surge.

- d. Consider premature discharge for ill patients with potential for home care or transfer to minimal care facility if patient qualifies for that facility.
- e. Use creative staffing patterns, such as family-provided nursing care within the institution.
- f. Rationing of health care resources as necessary.

#### Hospital and Public Health Roles for Patient Care During a Disaster

The plans described below describe the role of hospitals in disaster, premised on maximizing lives saved.

##### 1. Small Community Hospitals:

###### a. Rapidly developing, short-term, geographically-localized disaster

Small community hospitals may need to receive critical patients for initial stabilization prior to subsequent transport if they are the nearest institution. Whether a particular patient would be stabilized in the field for direct transfer to a referral center or brought to a small community hospital for additional stabilization will be the call of the field triage team and local disaster management protocols. In any disaster of substantial size, the nearest referral facilities may have exceeded their capacity to receive critical patients without compromising quality of care. Transfer may require longer distances and transport times. This may in turn require more aggressive stabilization efforts at a community hospital prior to transport. In addition, less critically ill patients may be transported to the community hospital, or may self-report before or simultaneously, with more critically injured patients. Community hospitals may need to transfer out patients they would normally care for due to excessive numbers of patients. It is expected that quality of care would be maintained at normal or near normal levels and/or any deficit restored quickly.

###### b. Slowly developing, long-term, geographically localized disaster

Small community hospitals will keep only patients who could receive normal quality of care locally. When local capacity is exceeded, patients will be transferred to a referral hospital. Small community hospitals more distant from the population affected may also be expected to receive patients in transfer from both local and referral facilities which need to reduce their patient care load to maintain quality of care. Regardless of size, the primary receiving hospital may need to disperse inpatients on a daily basis to hospitals with reserve capacity regardless of hospital size. Large patient flow volume may necessitate a reduction of inpatient volume through transfer and discharge to free up personnel for large-scale triage, stabilization and patient transfer functions. It is expected that in most circumstances, capacity will exist outside the affected area which will permit maintenance of normal or near normal quality of care.

###### c. Pandemic of moderate or greater severity

Like all hospitals, small hospitals would be overwhelmed in both inpatient and outpatient care arenas. Scaled implementation of reductions in quality of care would be implemented to save as many lives as possible. Some short-term diversion might occur to keep the level of quality of care compromise similar throughout the geographic area. Capacity to transfer patients might be severely limited so each hospital would be caring for patients beyond its usual level of care and expertise.

## 2. Referral Hospitals:

### a. Rapidly developing, short-term, geographically-localized disaster

Depending on the location of the event, referral hospitals may receive patients directly from the event site (triaged or walk-in) or in transfer from small community hospitals. Hospitals which exceed their capacity to a sufficient extent to impair quality of care will arrange to either divert incoming patients when reasonable or transfer patients to another treatment facility when stable. It is expected that normal quality of care will be maintained or restored quickly primarily through patient transfer when the event is localized.

### b. Slowly developing, long-term, geographically localized disaster

Referral hospitals will provide full triage and stabilization as required and provide all levels of care to the point at which compromise of quality of care becomes necessary due to excessive patient load. To the degree possible, patients will be transferred out to both community hospitals and other referral hospitals. Some ongoing residual capacity might be maintained for non-transferable patients. This may include transferring critically ill patients who are more stable than new incoming patients. In large scale events, maintaining the capacity for high volume triage and stabilization for transfer may become more important than providing definitive care, even if the level of definitive care required would normally be within the expected capability of the institution.

### c. Pandemic of moderate or greater severity

Like all hospitals, the referral hospitals will be severely stretched and phased introduction of reduced quality of care will be necessary to save as many lives as possible. Requests for transfer of critically ill patients from community hospitals may be denied when the referral hospital has substantially compromised quality of care. It may be necessary to divert new patients for a short time, if the quality of care is being reduced below the level of care provided by other hospitals in the geographic area.

## 3. Recognition of Altered Standards of Care in Severe Surge Situations

It is not expected that reductions of quality of care will occur (other than for the brief period required to stabilize many patients simultaneously) as long as the potential exists to move that patient to a facility able to offer a normal quality of care. However, in a severe surge situation, the number of patients seeking care may far exceed the capability of the health care system to deliver care. A prolonged outbreak will result in loss of health care workers due to fatigue and emotional exhaustion which accumulate over the course of the outbreak. The health care system will seek to maintain the highest level of care possible given the circumstances (patient load, staff availability, resource availability). Reductions in quality of care will be taken only to the extent that they increase a facility's ability to care for a greater number of sick individuals. At some point, a practical maximum patient load may be reached (given staff and resources), above which hospitals could no longer provide a level of care for any patients other than minimal care (hydration, feeding, hygiene, some medication). Providing a safety valve for patient overflow at a community level will be required to prevent hospital care from degrading to minimal care (minimum care facilities). This concept is discussed in a separate document.

- a. Levels of care (primarily for pandemics when transfer of patients to other facilities is limited or impossible):

- *Normal* – This represents the standard of care encountered during non-emergency periods.
- *Level 1* – Designation of Level 1 care within a geographic area recognizes that given the current patient burden, reductions in care which have a minimal impact on outcomes are reasonable. Examples of the types of reductions which might be implemented at this level are described below.
- *Level 2* – Designation of Level 2 care within a geographic area recognizes that given the current patient burden, reductions in care which have a moderate impact on outcomes are reasonable. Examples of the types of reductions which might be implemented at this level are described below.
- *Level 3* - Designation of Level 3 care within a geographic area recognizes that given the current patient burden, reductions in care which have a severe impact on outcomes are reasonable. Examples of the types of reductions which might be implemented at this level are described below. Designation of Level 3 care within a region of the state (or statewide) should be accompanied by an assessment by the Department of Health to determine the likelihood that the pandemic will progress in that area to the point that minimum care facilities need to be opened in the community and staffed by non-hospital personnel.
- *Minimum* – Designation of minimum care within a region indicates that community minimum care facilities are operational or needed within the region. Provision of minimum care is anticipated only within community facilities using non-hospital staff. Hospitals are expected to regulate their census so they can continue to provide Level 3 care until such time as the minimum care facilities can be closed and the region is capable of reverting to Level 2 care. Minimal care includes some aspects of care which would not be compromised under any circumstance (e.g., aspects of worker protection, patient identification). Examples of this type of care are provided below.

Designation of a level of care other than normal does not imply that no hospitals in the region are providing a higher level of care than the regional designation. However, the level of care in the region is expected to be similar for all hospitals, otherwise transfer from a more highly stressed facility to a less stressed facility should have been recommended rather than a region-wide reduction in care level. Designation of a level of care other than normal does not imply that all of the measures which are listed as appropriate actions for that level have been taken by every hospital in that region and does not imply that hospitals have taken no other actions than those listed to increase their staffs' ability to care for increased numbers of patients.

During a period of high surge, some hospitals may already be implementing actions designated for a lower level of care than what has been recognized by the region. However, it is proposed that when a hospital needs to implement standards which represent a lower level of care than the current designation, the hospital petition the North Dakota Department of Health to request reduction of the designated level of care to the next lower level.

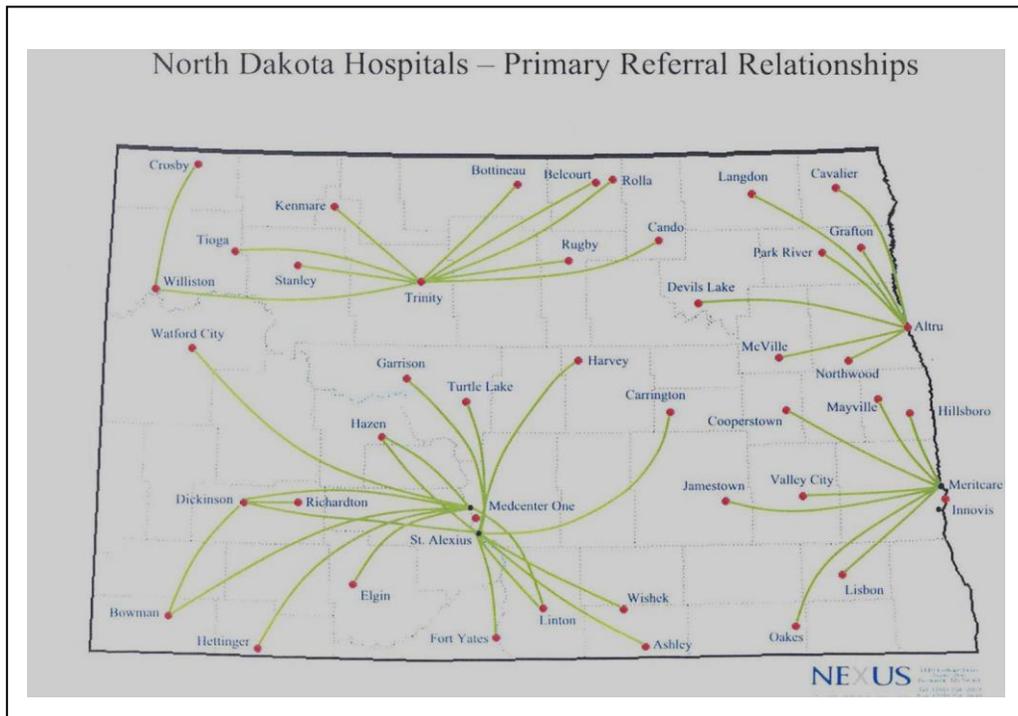
b. Geographic Extent of Designation:

For most purposes, it is expected that levels of care will be applied to the entire state.

Separately recognized levels of care likely will not be applied to specific facilities except in

the circumstance where a facility has sustained a substantial infrastructural support loss and the facility has inadequate shelter-in-place capacity to sustain the designated standard of care. During a pandemic, this infrastructure loss is most likely to take the form of loss of supplies (e.g., medical, food) or loss of utilities (water, power) due to inability of the community to maintain services at usual levels. Whereas such a facility would be expected to be evacuated under other circumstances, that may not be feasible in the face of a massive surge or physical barrier to immediate evacuation. Consequently, the facility may need to provide such care as it can, albeit at a lower standard of care than is expected for other facilities in the region.

Four hospital regions are predefined according to dominant referral patterns; however, regional action does not preclude the transfer of patients between regions if the pattern of spread of the pandemic results in higher level of care in other regions of the state. Limitations of transfer capabilities are liable to make large-scale transfer of patients between different parts of the state difficult. This may result in one region of the state being at a greater level of surge stress than other regions. If transfer to other areas of the state are not possible, it may be necessary to recognize a reduced standard of care within a specific area of the state. In the cases of Fargo and Grand Forks, which receive large numbers of patients from out-of-state, the referral hospitals in those cities may temporarily see a large surge from Minnesota while other hospitals in their local North Dakota region are minimally affected.



c. Implementation of Level Designation:

When a hospital determines that it needs to make changes in the services that it provides in order to provide care to a larger number of patients than it normally cares for, and those changes would potentially change the quality of care that patients receive, the hospital ICS system should contact the Department Operations Center of NDDoH. In response, NDDoH will immediately convene as many designated Medical Directors as are available to determine if a change in quality of care is indicated or if other actions are needed to alleviate hospital overload. (At the time of this writing NDDoH had identified 11 Medical Directors around the state.) A recommendation to resume a higher level of quality of care as the pandemic abates could be initiated by a hospital or NDDoH Medical Directors in response to declining surge stress.

Whenever possible, it is desirable to prevent deterioration in quality of care, using other approaches to ease the patient care burden on the overloaded hospitals. However, most actions that a hospital might take to expand its capacity to care for more patients have at least some potential to alter the standard of care, including transfer to another facility or the use of qualified replacements from other hospitals. It is quite common, however, for a hospital to temporarily alter some services to accommodate a sudden surge. For example, nurses may spend little time with individual patients in a busy emergency department compared to what they would during a period of relative quiet. These types of accommodations fall under Level 1 care representing a deviation from the care that patients expect to receive.

d. Proposed Examples of Changes in Service Associated with Care Level:

ISSUES	STAGE 1 REDUCTION	STAGE 2 REDUCTION	STAGE 3 REDUCTION	MINIMAL CARE STANDARD (MINIMAL CARE FACILITIES ONLY)
<b>Admission and Discharge</b>				
Elective procedures	Reduction in elective procedures	Elimination of elective procedures		Minimal invasive action: IV, NGT, Foley if indicated
Discharge procedures	Early discharge			Discharge when self-care or alternative care available
Transfer	Movement of patients to facilities with residual capacity	Movement of acute care patients to long term care institutions		NA
Nursing homes	Nursing homes retain sick patients			Nursing homes retain sick patients
Clinics	Reduction in specialty	Discontinuation of non-critical outpatient services		NA

	clinics			
Minimal care			Movement of non-critical care patients to minimal care facility if available	Movement of critical patients to hospital when space available
Admission	More stringent admission criteria			Admit only patients in need of hydration or without adequate alternative care
<b>Patient Services</b>				
Comfort care	Reductions in comfort care nursing			Minimum comfort care nursing
Interaction	Reduction in social interaction	Reduction in family interactions	Reduction in patient education/therapeutic interaction	Minimum interaction
Post mortem	Limited post mortem care	Minimal post-mortem care (death tracking, case reporting)	Death tracking and case reporting	Death tracking and case reporting
Linens	Linens not changed daily			Linens changed when soiled
Dishes	Disposable dishes			Disposable dishes
<b>Staffing Patterns</b>				
Shifts	Increased shift length	Reach limitation of staff mental health and accommodation		Maximum shift length 12 on/12 off
Provider roles	EMT assigned nursing roles	Limited expansion of provider privileges	Marked expansion of provider privileges	Minimal provider staff available (two licensed staff per care area)
Ancillary staff		Recruitment and use of retired professionals		Most work done by volunteers and minimal non-system professionals
EMS	Non-EMS transport	Non-EMS transfer		Non-EMS transport
Ratios	Increased patient to staff ratios	Further increase in patient to staff ratios	Further increase in patient to staff ratios	Ratios as high as necessary

Cohorting	Cohorting			Only pandemic patients accepted
Non-medical providers		Use of family members for some care	Extensive use of non-medical volunteers for many patient care duties	Non-medical volunteers assume most nursing care duties
<b>Facility Changes</b>				
Access	Restricted access to hospital for non-hospital personnel not providing patient care			Access only to patients and staff
<b>Treatment and Advanced Care Options</b>				
Vitals		Reduction in frequency of vital signs		Vital signs once daily
Diagnostics		Restrict elective diagnostics	Clinical judgment substituting for most diagnostics	No diagnostics available
Dietary	Restriction of dietary preference, snacks		No special diets or family meals provided	No special diets
Assessments	Patient assessments limited to problems			Limited to problems
Advance care		Elimination of advance care options (telemetry, invasive monitoring)		None
Palliative care		No treatment for non-survivable conditions	No treatment for low survivable conditions	Palliative care designation – last to receive care
CPR		Change in criteria for CPR (e.g., CCU and ER only?)	No CPR except children	No CPR
Patient placement	Change in criteria for ICU admission, Expansion of ICU space	Admission of moderately critical patients to med-surg beds		Accept patients of all severity if no other option
Supportive care				Nutrition, hydration, hygiene
Restraints		Increase use of restraints		Increased use of restraints

Therapies		Restriction of rehabilitation services and therapies	No rehab services or therapies	No rehab or therapy
Med administration		Relaxation of medication schedule	Administration of some medication by patient or family	Reduction in medication administration (essential only)
<b>Administration and Documentation</b>				
Charting	Minimal reduction in charting	Marked reduction in charting	Minimal charting	Minimal charting
Informed consent			Elimination of formal informed consent for lower risk procedures	No procedures requiring informed consent
Patient identification				Maintenance of patient tracking/ Identification
Billing procedures		Alteration in billing procedures		Maintenance of some billing records
Standard orders		Standard orders for all pandemic patients		Standing orders for supportive care
<b>Staff Care</b>				
Staff mental health	Staff mental health care increased			Staff mental health care high
Infection control				Minimal alteration in infection control procedures as possible

Note: It is not intend that hospitals reduce care to minimal.

Note: Italics indicate inter-region negotiation required.

**Actions Dependent on Situation:**

- Use of expired drugs
- Cleaning and re-use of disposable items
- Alteration in infection control procedures (e.g., item re-use)

e. Communications to Public:

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It is anticipated that discussions of quality of care reduction will be received by the public with some reluctance initially; however, it is preferable to discuss inevitable changes in the face of overwhelming surge capacity before a pandemic in order to lower expectations than to try to initiate discussion after quality of care degradation has become necessary. However, in all circumstances, the public should know what level of care to expect based on public communications from the public health system.

#### 4. Public Health Support of Patient Care

##### a. Resource Procurement:

In a disaster setting, the NDDoH will act as a broker for securing and allocating available resources. For localized disasters, obtaining equipment and resources from the federal government and long distance from other health care institutions will be facilitated by public health. However, expanding resources beyond the capability of personnel using the equipment is pointless. Transfer will remain the primary method for providing definitive care in a super-surge setting as long as other institutions have residual capacity. If a facility feels that it has the resources to accommodate additional patients without compromise of quality of care, NDDoH will assist the facility to obtain a CMS waiver to that effect. If in doubt of the wisdom of further expansion of bed capacity during a disaster, NDDoH will consult with its Medical Director network.

##### b. Transfer:

The NDDoH will utilize HC Standard to assist hospitals locate additional capacity to receive patients, and seek additional transportation capacity for the affected area (to move patients to receiving facilities). The Department of Health will seek to maintain quality of care during patient transport for as long as resources allow, at which point alternatives will be initiated (such as, mass transport via bus or family-provided transport) reserving usual medical transport for critically ill patients. In a pandemic, transport may be impossible on any large scale, both due to lack of transport capacity and lack of receiving facilities.

##### c. Minimum Care:

In the pandemic setting in which hospitals have exhausted their capacity to provide care for additional patients without dropping below level 3 care, public health will use community volunteers to set up minimum care facilities which will provide only minimum level care (This option is not appropriate for non-pandemic settings since transfer should remain an option and minimum care facilities will only provide supportive care which would be reasonable for pandemic patients). The decision to provide minimum care must be premised on a medical assessment that provision of supportive care by lay community members may save the lives of some patients. Minimum care facilities will be a joint effort between local health care institutions, public health and local communities. Since this is the lowest level of care provided above family care, this will be adopted as a last resort to preserve a higher level of care within hospitals for as long as possible.

Hospitals in the state will be overwhelmed and unable to assist with the care of MCF patients. The primary roles of hospitals will be selection of patients for specific facilities (hospital or MCF) and consultative assistance to the medical director of the facility when needed.

Community-provided care can serve as a safety valve for hospitals in the event that the demand for care exceeds the capacity expansion of hospital-based care. Community-based care in the form of minimal care facilities will be instituted as a last resort and terminated as soon as hospitals reach a point of being able to resume all care. The care provided by the community would of necessity be of minimal quality, that is, not greatly better than a patient might receive at home from a well family member. Minimal care may include hydration (by mouth, NG tube or IV), feeding, and hygiene, but likely few other interventions. Patients will be admitted to a minimal care facility if they could not receive care at home (e.g., no family member to care for them) or if they were dehydrated or malnourished under home care. In the absence of those factors, it is not assume that an MCF can provide better care than a family can provide.

An MCF will be considered a contagion facility suitable only for pandemic patients; that is, only patients with the transmissible disease will be permitted in the facility. Patients might come to the minimal care facility directly from the community, from an outpatient triage site set up by the health care system or as a direct transfer from a hospital (e.g, a patient entering recovery who cannot go home yet).

Although implementation of a minimal care facility will be accomplished through the cooperative efforts of the community and the health care system, during its operation, the minimal care facility will be functionally and administratively distinct from the private health care system and would be located away from the hospital in a facility identified by the community. The minimal care facility will function as an independent health care facility and will have the authority to receive supplies from the state cache or from the Strategic National Stockpile (SNS). A minimal care facility will attempt to provide workers the same protection as health care workers in a hospital.

Volunteers will provide the staffing for minimal care facilities with one or more health care providers overseeing the work of the lay volunteers. Hospital staff will not be used to staff the minimal care facility since these persons will be more effectively used in the hospital to provide care at a higher level than the minimal care facility can provide. Staff will work under the authority of NDDoH and be covered under state government tort protection. Effective operation of the minimal care facility will be dependent on identification of sufficient volunteer staff to provide care for the patients admitted.

The decision to open a minimal care facility will be made by the NDDoH. A hospital may request the opening of a minimal care facility based on an assessment that the hospital cannot further increase its patient load. If the Department of Health likewise concludes that further capacity expansion at the hospital is unwise, and that the strain on the facility cannot be relieved by transfer of patients to another facility in the state with greater capacity, then it will provide assistance to the community to set up a minimal care facility. The provision of care by a minimal care facility will be a last resort only and its existence will be at the discretion of the Department of Health and the affected community. NDDoH will not support operation of a minimal care facility which is not supported and staffed by the

community in which it is located. A request to close a minimal care facility can be made by a hospital; however, it may be closed at the discretion of the NDDoH or the community.

d. Information:

Public health will use its data systems to assist facilities: 1) track patient information (central data repository for patient location and status), 2) monitor hospital status including capacity level and level of care being offered, 3) monitor facility resources, and 4) coordinate deployment of state assets.

e. Personnel:

Public health will assist hospitals locate additional personnel needed, including both medical personnel and unskilled volunteers. This process is described later in this plan.

f. Public Information:

Public health will act as the primary coordinator of information to the media and the public, including where to seek hospitalization to divert as many potential patients away from health care facilities as possible that are not sufficiently ill to seek hospital care. This does not preclude hospital release of its own public information and does not prevent the public from calling the hospital. The public health hotline is intended to take as much burden off health care institutions as possible; however, the public health hotline will not offer medical advice.

g. Liaison to federal resources :

Requests for federal medical assistance would flow through state government at the request of public health. Allocation of federal resources will be coordinated with the State Emergency Operations Center (SEOC) and federal responders.

h. Communications:

The Department of Health will maintain facilitate communication between health care organizations. Two separate, but compatible, wide-area networks are utilized to communicate with public health units and hospitals. The wide-area networks provide communication through the exchange of data, video conferencing and limited voice applications. The wide-area networks are secure, redundant and do not rely on normal public communication systems, such as telephones and the Internet. All local public health units, hospitals, the Department of Health, the North Dakota Healthcare Association, and the University of North Dakota School of Medicine are part of the HAN system. The network has the capacity to connect with any of the other sites located on the North Dakota Stagenet system (i.e., local government, K-12 education, higher education, and state government). Back-up systems include phones, cell phones, Internet, fax, and state radio communications.

In addition to the wide-area networks, the HAN also distributes messages through email, faxes, video streaming on the Internet, and telephone. The HAN also has capability for automated public health and medical personnel alerting system. This system allows personnel to enter contact information (i.e., work phone, cell phone, home phone, pager) into a website profile. The automated system allows activation of personnel in institutions making use of the system.

- i. Mass Mortality:  
Health care facilities will need to be able to clear beds for care of the living, but removal of bodies and storage when that exceeds the capacity of the funeral homes will become the responsibility of the local emergency manager. In many localities the local emergency manager has assigned this task to local public health. Although the first priority will be to remove bodies from health care facilities, in a major disaster it may not be possible to retrieve bodies quickly from health care facilities meaning the facility may need to store a greater number of bodies than their facility is normally equipped to handle short term until they can be picked up.
- j. Declaration of Emergency:  
Although a local jurisdiction can declare a disaster, such a declaration has no official standing with the state or federal government. The Governor can declare a local or state disaster. If NDDoH perceives a public health disaster and believes a Governor's Disaster declaration is needed, it will route a request to Department of Emergency Services (NDDoS).

#### Triage, Screening and Care of the Worried Well

During disasters involving biological, chemical or radiological emergencies where potential exposure and illness may be subjective, it is expected that a large number of people will seek medical care that do not have an illness requiring medical attention. While media communications can help to inform the public regarding who does and does not need to seek medical care, the volume of patients seeking care to rule out illness may be several times that of persons who actually need medical assistance due to exposure to the disaster-related agent. In addition, stress/emotional trauma, reduced access to medications and routine care, and illnesses arising during the recovery phase of disasters may also increase patient load (e.g., skin infections or gastrointestinal infections during floods, chain saw injuries after wind storms). The nature of health care delivery to the worried well and the non-critically ill and the methods for separating the seriously ill from less seriously affected patients will depend on the type of disaster and the strain on the medical care system. The situation specific goals of the health care delivery system are as follows:

1. Biological Event
  - a. Prevent disease transmission from patients to staff.
    - i. Use of appropriate, fit-tested PPE.
    - ii. Enforcement of infection control procedures.
    - iii. Provision of preventive care to staff, such as vaccination or antibiotic prophylaxis.
  - b. Provide definitive care.
    - i. Triage-scaled incident severity.
    - ii. Rationed care to salvageable patients.
  - c. Prevent disease transmission from patient-to-patient.
    - i. Separation of likely contagious patients from patients being screened for agent-related disease, from those not ill from disaster agent (e.g., MI patients).
    - ii. Screening facility separate from usual care area.
    - iii. Patient directional signage/assistance guiding them to the appropriate site.
    - iv. Aggressive screening of patients for symptoms stress or emotional illness and in need of crisis counseling.

- d. Protect health care personnel and prevent transmission to patients.
    - i. Identification of ill staff and exclusion from work while contagious.
    - ii. Use of strict infection control procedures.
    - iii. Provide for emotional care for staff.
  - e. Prevent contamination of health care facility or other persons (e.g., anthrax spores).
    - i. Decontamination of patients outside of facility or in alternative site.
    - ii. Controlled access to the facility.
  - f. Separate seriously ill patients requiring immediate treatment from those needing less urgent care.
    - i. Triage with severity scaled to capacity of health care system to respond to patient load.
  - g. Tracking patient flow and disposition.
  - h. Opening reserve capacity for additional surge care consistent with current level of quality of care being provided.
  - i. Restore quality of care to normal as quickly as possible.
    - i. Staff expansion (borrowing or recruitment).
    - ii. Transfer patients out.
    - iii. Move equipment in.
    - iv. DMAT teams.
  - j. Safe disposal of contaminated material and infectious bodies.
  - k. Preservation of forensic evidence and chain of custody.
2. Chemical and radiological events
- a. Prevent exposing unexposed persons.
    - i. Decontamination
    - ii. Controlled access to facility
    - iii. Screening patient for potential exposure and directing patient flow.
  - b. Protect the safety of health care personnel.
    - i. Personal protective equipment and adequate training.
    - ii. Designated staff caring for contaminated and decontaminated patients.
    - iii. Rotation of staff out of PPE before they reach limit of tolerance.
    - iv. Provide for emotional care of staff.
  - c. Provide life saving treatment as quickly as possible.
    - i. Disaster situation awareness and agent identification.
    - ii. Patient triage scaled to severity of incident.
    - iii. Rationed care to salvageable patients.
    - iv. Receipt of grossly decontaminated patients from the field (hazmat) with provision of final decontamination.
  - d. Prevent contamination of the health care facility.
    - i. Controlling access to the building.
    - ii. Aggressive screening of patients for possible exposure to agent, including use of radiation detectors.
  - e. Prevent consumption of all available health care resources by less-ill patients self-presenting after an acute event.
    - i. Disaster situation awareness.
    - ii. Reallocation of resources as magnitude of event unfolds.
  - f. Track patient flow and disposition.

- g. Restore quality of care to normal as quickly as possible.
  - h. Safe disposal of contaminated material and contaminated bodies.
  - i. Preservation of forensic evidence and chain of custody.
3. Other large-scale disasters
- a. Provide definitive treatment as quickly as possible.
    - i. Triage scaled to event severity.
    - ii. Rationing health care to salvageable patients as indicated by event severity.
  - b. Track patient flow and disposition.
  - c. Assessment of medical/pharmaceutical/mental health needs in the community.
  - d. Acquisition of additional patient care resources (e.g., DMAT teams).
  - e. Preservation of forensic evidence and chain of custody if indicated.

#### Maintenance of Service

It is expected hospitals will remain open, even though the admission of additional patients may further compromise quality of care, except in circumstances in which continued operation of the facility increases the risk to patients (e.g., structural damage to the building or risk of contamination of the facility). Application of government resources through the public health system will seek to mitigate the impact of patient surge on a local facility to the extent possible through resources, personnel, and ordered transfer. In a disaster and especially during a pandemic, closure of any health care facility increases critical stress on all other facilities and may increase the risk of a health care system collapse. Situations of critical stress resulting in marked reductions in quality of care at an institution may require temporary diversion to equalize quality of care among regional institutions when diversion is less threatening to patient welfare than further deterioration in quality of care at that institution at that time. Such diversion will be coordinated with the North Dakota Department of Health and communicated to all other facilities in the region.

Maintenance of care provision is particularly important in the situation where an infectious agent is geographically isolated (e.g., smallpox or plague in a local area of the state). Attempts to contain the infection will be seriously compromised by facility closure as patients seek alternative care outside the immediate care area. Rather, movement of contagious patients to other care areas should occur with infectious disease isolation, which avoids transmission to the public in other communities.

#### Community Isolation

Although not an option in a surge situation, during a localized outbreak of a highly threatening agent, public health may request that a hospital be the site of isolation of one or a few patients as an extension of hospitalization. For instance, a patient hospitalized for smallpox who is ready for discharge clinically (near the end of the illness), might be held for a few additional days until scabs fall off and patient is no longer infectious. The use of inpatient isolation may provide the best protection to the community to prevent an epidemic because of superior facilities and enforcement of infection control procedures. Home isolation, or use of an alternative facility, will be considered when the number of patients exceeds the isolation capacity of the hospital in the community.

### **V. Hospital Plans**

Many aspects of health care in a disaster setting require specific planning on the part of each health care institution. State or regional surge disaster health care plans cannot substitute for facility specific plans. At a minimum, the plan for each facility should cover the following procedures:

1. Isolation and surveillance
  - a. Rooms and equipment.
  - b. Staffing.
  - c. Monitoring and enforcement.
  - d. Provisions for families including families of small children.
  - e. Emergency department isolation.
  - f. Changes in infection control surveillance.
  - g. Building regional isolation.
2. Surge staffing
  - a. Changes in shift length and frequency in a disaster.
  - b. Personnel expansion.
    - i. Staff callback.
    - ii. Recruitment inside the facility.
    - iii. Recruitment from outside the facility.
  - c. Work allocation, orientation and supervision for non-employee expansion staff and volunteers.
  - d. Provisions for families of health care workers.
3. Screening and exclusion of contagious or contaminated patients
  - a. Access control and lockdown.
  - b. Signage for protection and guidance to correct care sites.
  - c. Patient receiving and screening procedures.
  - d. Cohorting, including protection of worried well from ill or contaminated patients.
  - e. Preservation of non-disaster-related care.
  - f. Visitor policies.
  - g. Patient movement in facility.
4. Patient transfer
  - a. Transportation surge.
  - b. Alternative destination facilities and contacts
  - c. Direct access to specialty care transfer (pediatrics, surgical subspecialty, including burn and neurosurgery, peri-natal care).
5. Level of care provision in surge and super-surge settings
6. Staff protection and screening
  - a. PPE.
  - b. Infection control procedures,.
  - c. Screening for worker illness and exclusion policies.
  - d. Rotation off duty
  - e. Mental health of staff.

- f. Prophylaxis.
  - g. Decontamination.
7. Emergency in-service/training
  8. Special medical waste
  9. Contagious human remains
  10. Special procedures for ancillary service areas
    - a. Laundry, housekeeping, maintenance
    - b. Diagnostic services
    - c. Surgery
  11. Procedures for documentation in surge and super-surge settings
  12. Evacuation
  13. Operations of associated clinics during surge settings

## **VI. Information Sharing**

### Disclosure of Personally Identifiable Health Information under HIPAA

HIPAA disclosure rules provide broad exemptions for public health to receive protected health information without individual authorization for purposes of disease surveillance, investigation and control measures. The North Dakota Department of Health follows state law for release of individually identifiable information. State laws provide for release of information regarding quarantine orders and to persons at risk for infection with certain communicable diseases to members of the public. Public health shares personal health information with other agencies (e.g., law enforcement, health care facilities) on a need-to-know basis when involved with investigations or control measures for communicable diseases. Public health does not release personally identifiable information from routine surveillance data when not involved with an epidemiologic or public health forensic investigation and when not necessary to protect the health of the public except as provided under the North Dakota Century Code.

Law enforcement may seek protected health information from health care providers. Specific HIPAA language guides release under these circumstances, including the need for a subpoena or court order for release.

### Notification Procedures During Emergencies

The Health Alert Network (HAN) managed by the Department of Health provides for notification of health care institutions and providers during emergencies. Information will be sent to specified individuals in the health care system as an “Alert” (24/7 notification via call-down procedures) when high threat events require immediate notification of the health care sector. Less urgent messages are sent through routine channels (fax, email) as an “Advisory” (first notice of non-urgent problem). Additional information related to a previous alert or advisory notification is sent through routine channels as an “Update.”

### Inter-organizational Communications in Emergencies and Resource Tracking

During an event which is creating surge conditions in the health care system, it is expected that conferencing between the health care entities and public health entities will occur on a regular basis via the hospital BTWAN and Stagenet systems. Updating patient capacity and inventories will occur through HC Standard, direct communications and conferencing.

### Reporting of emergencies

The reporting of a health emergency, such as identification of a Category A bioterrorism agent, evacuation of a health care facility or other threats to public health, can be reported to the NDDoH Case Manager, reachable 24 hours a day, 7 days a week, through North Dakota State Radio: (1-800-472-2121 or 701-328-9921).

### Laboratory Procedures: Collection, Notification and Referral Testing

Emergency surge capacity activities of the North Dakota State Laboratory include the following actions:

- Enhance the Sentinel provider networks for reporting and specimen submission.
- Ensure consistent and timely reporting of illnesses and specimen submission.
  - Follow-up calls to Sentinel providers who have not reported by required time each week.
  - Follow-up with Sentinel providers, laboratories and assisted-living facilities who have not submitted specimens within previous week.
  - Monitor Red Bat data daily to determine increases and decreases in specific disease syndromes (i.e., symptom complexes).
- Implement enhanced laboratory surveillance.
- Coordinate with neighboring jurisdictions.

### Volunteers for Assisting Health Care Delivery: Assignment, Allocation and Reserve

Volunteers can be requested through any of the access points into the Emergency Management System.

- ND Department of Health Case Manager via State Radio (800-472-2121 or 701-328-9921).
- Your local emergency manager.
- Your regional emergency preparedness coordinator.

When a need for volunteers in North Dakota is identified, the Department of Health will notify pre-registered volunteers utilizing the Health Alert Network notification system and volunteers will be managed using the MAVEN system. Those who are available to deploy will participate in a brief orientation meeting either at a defined staging area or via telephone conference. Volunteers will receive information about the event and the roles to be filled and will be assigned to a specific area of need.

Volunteers may be assigned to assist the state (e.g., staffing patient buses during mass transfer), local public health (e.g., staffing a vaccination clinic) or a private entity (e.g., assisting a hospital during a pandemic). Although NDDoH will recruit volunteers on request, the responsibility for the volunteer lies with the requesting organization. NDDoH typically chooses to provide some reimbursement to its volunteers; that is not required from other entities, but volunteers should know

what to expect from the entity for which they work. Ensuring the volunteers are eligible for the work assigned, meeting the volunteer needs including needs for worker protection, lodging and food if indicated, **liability for the worker**, and any costs associated with their use is the responsibility of the requesting institution.

The Department of Health does carry a worker's compensation package for volunteers deployed through this state-based system. Social security numbers are required to list the volunteer on the worker's compensation policy and will be requested during the orientation/staging meeting. **For LPHU or privately assigned volunteers?**

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## **VII. Inpatient Surge Capacity Expansion—Patient Placement and Transferring**

During a governor-declared emergency, the DOC may seek limited ceding of authority to the DOC, preferably by pre-signed MOU if this has occurred. This authority is intended to encompass transfer between hospitals and termination of elective admissions. These actions would be expected to directly affect health care facilities and require some release of their authority. The Medical Director will have additional decision responsibility (e.g., care procedures within minimum care facilities, allocation of state medical equipment) which affects the health care system but does not require health care facilities to cede authority since these actions fall under the authority of NDDoH. A pre-defined list of medical directors will be maintained by NDDoH and provided to the hospitals on request. All medical directors are North Dakota licensed physicians with both administrative and clinical skills and selected to be representative of all areas of the state. The DOC will provide support staffing for these positions within the DOC to enable these persons to remain on-site within their health care institution. When a decision from the Medical Directors is needed, as many as are immediately available will be asked to consult with NDDoH. In addition during disaster, NDDoH will request one medical director to be on call on a rotating basis so that the department is certain to have at least one available.

Hospital bed capacity will be reported to the DOC using HC Standard tables which have been designed to be consistent with HAvBED requirements. All hospitals have been trained and exercised in the provision of this data. Reporting of this data following a federal request will be completed by NDDoH which will input the results into the format (e.g., web site) designated by the federal request.

In any emergency situation, all attempts will be made to place patients to maximize patient outcomes and provide the highest quality of care possible. Transfers to a higher level of care will continue until all potential receiving facilities (both in-state and out-of-state) are exhausted. Patient transfer to a facility capable of rendering a normal standard of care (or a higher standard of care than can be provided at the overloaded facility) is considered a preferable action to reduction in standard of care. The DOC will calculate the percentage of existing hospital-specific overload based on a pre-determined formula (see overload formula v3.xls) and determine the impact of patient transfers on receiving hospitals' overload. Information required for this determination will be derived from HC Standard tables which report nurse staffing levels and patient census for critical and non-critical beds. This information will be provided to the Medical Director who will make the decision regarding the advisability of transfer including the specific facilities, types and numbers of patients. The decision to proceed with transfer will be issued by the DOC based on the

determination of the Medical Director. The name of the Medical Directors making a specific decision will not be released; rather the decision authority will reside with the DOC and any hospital concerns will be reported back to the DOC. If the DOC incident commander has concerns about a determination of the Medical Director, he or she will negotiate the answer and if necessary call for the advice and negotiation of the State Health Officer.

Hospitals will be defined as 1) receiving eligible, 2) transfer eligible, or 3) transfer recommended, based on a scale established by the DOC as the event progresses. The scale will be based on number of critical care patients and staffing ratios, number of non-critical care patients and staffing ratios, and expected level of quality of care which can be provided. The difference between *transfer eligible* and *transfer recommended* would be the degree of overload in comparison to other hospitals in the state. A hospital will not become transfer eligible unless the hospital has a patient overload substantially greater than a hospital designated as “receiving eligible.” A transferring hospital must still confirm the proposed transfer with the receiving hospital prior to the patient being shipped.

Patients will be selected for transfer based on the following priorities:

- Emergency Room patients awaiting admission will be transferred first beginning with the most critically ill patients stable enough to be transferred.
- Second will be the most recently admitted patients stable enough to be transferred.
- Surgical and post-surgical patients will not be transferred to reduce inpatient burden during an emergency surge event, but may be transferred to a higher level of care based on patient need, provided a receiving hospital can be found.

A rapid patient classification tool for transfer patients is included as Appendix A.

## **VIII. Health Care Facility Evacuation**

Maintenance of specific plans for evacuation of a health care facility is the responsibility of the individual health care institution. The Department of Health should be notified immediately if a health care institution needs to be evacuated or may need to be evacuated. NDDoH will provide assistance identifying destinations, securing transport, and resolving the crises that lead to the evacuation.

Public health will assist health care facilities to determine safety for re-occupying a facility. This might involve environmental testing or structural evaluation. In some cases, standards for determining safe occupancy have not been established (e.g., anthrax spore contamination) and re-occupancy will require a judgment call by public health. Health care facilities re-occupying a facility must comply with applicable licensure regulations.

## **IX. Mass Fatality in Health Care Surge Settings**

Management of deaths is under the jurisdiction of the local coroner, unless assumed by the state medical examiner. In many communities, hospital morgue space represents the largest available

storage for bodies and will be used to the extent possible. Public health will assist health care facilities with management of deceased during mass fatality events in order to preserve health care capacity from being further compromised by care of the deceased. The highest priority for mass fatality in a hospital surge setting is protection of persons from contaminated or contagious remains and clearing beds for living patients. Other priorities include death reporting, identification tracking until the body is delivered to the community or to public health authorities, grief management and respect for the deceased.

Situations are possible which lead to use of practices normally viewed as disrespectful of the deceased (storage situations, mass burial<sup>2</sup>) and their families (e.g., shortcuts in grief management, limited access to remains). However, because loss of ritual for post-mortem care leads to increased psychological morbidity for the community, it should remain part of quality of care, except as specified under quality of care reduction protocols. Remains identification tracking should not be compromised. Detailed reporting of deaths to public health may be delayed if necessary, but reporting of names and counts of deaths should be maintained on a daily basis in disaster settings regardless of severity. Names of deceased and mortality counts will be released to the public, as well as to other public health agencies. In most disaster settings associated with substantial mortality, funeral directors should be able to support the staffing of family assistance centers. Funeral directors may receive information about the ill or deceased since in surge situations transfer to the morgue or a temporary morgue facility may precede family consultation. In severe pandemic settings, provision for funeral directors staffing family assistance centers may not be possible, but patient tracking and patient remains tracking should be maintained. (See state mass fatality plan.)

## **X. Surge Staffing of Health Care Facilities**

Approaches to surge staff will be hospital specific, as well as, draw on publicly available resources. The availability of surge staff depends on whether the disaster is localized or generalized and the time frame during which it unfolds. For acute, localized events, emergency staffing will require calling back staff, shift extension, borrowing staff from other facilities, and use of volunteers for specific functions. Events which continue for more than a few days may be assisted by DMAT teams (but unlikely to be available during a generalized pandemic). Generalized events which stress the entire country (pandemics) will require heavy dependence of non-traditional staff and volunteers. Increases in staffing demands may last for several weeks and staff resources will have to be carefully allocated to preserve staff emotional and physical endurance. Specific issues related to staffing include:

### **1. Shift scheduling**

Most facilities will choose to convert to some variation of 12- to 16-hour shifts soon after surge situations develop. While this can be maintained for a considerable time, it cannot be maintained indefinitely without relief. For prolonged periods, days off will be necessary for all staff. Incident command staff also needs to be rotated out every 12 hours.

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<sup>2</sup> Mass burial is unlikely to be necessary. It is much more likely that in a high mortality situation new graves will be rapidly opened in existing cemeteries and bodies interred without family consultation and without usual ceremony rendered to the deceased. However, in this case, location of each person's remains in the cemetery will be carefully maintained and memorial services may be held when it is safe and reasonable to do so after the event.

2. Staffing ratio  
Modest increases in staffing ratios may not seriously compromise care for non-critical patients, but substantial shifts in staffing ratios likely reflect quality of care compromise and should be implemented during periods when reduction in quality of care is a recognized necessity. Staffing ratios may continue to increase as quality of care declines.
3. Clinic staff  
Depending on the type of disaster, clinic staff may be available for application to acute inpatient care. For infectious disease agents, outpatient care is expected to be overwhelmed. During a pandemic it is expected that health system staff assigned to communities other than the location of the primary medical center will continue to serve in their assigned communities if those communities are seriously affected by the pandemic.
4. Privileging  
Expansion of provider privileges to provide care for patients outside their usual expertise will represent a compromise on quality of care, but would be an acceptable compromise early as quality of care declines in a surge setting. Some more marked alteration in privileges may be dependent on changes in health care practice acts; however, that would be expected in an event of great enough severity that compromise of quality of care is unavoidable.
5. Credentialing of fully qualified health care providers from other North Dakota hospitals is provided in the hospital memorandum of agreement currently signed by 45 of 51 hospitals.
6. Emergency credentialing of licensed external providers is the responsibility of each healthcare facility.
7. Use of non-medical volunteers  
Facilities should pre-plan roles for non-medical volunteers for each level of quality of care. As quality of care must be compromised to increase patient care loads, volunteers may be assigned progressively more patient care tasks and have personal protection based on exposure risk of their assigned duty just as any employee. An approach to informed consent for volunteers detailing the risks associated with specific types of tasks (e.g., laundry, direct patient care) should be pre-planned by each facility. Use of patient families to help provide care may also be an option.
8. Family care for staff  
In order to maintain staff availability, health care institutions should ensure that families receive prophylaxis, if available, and have alternative opportunities for child care. In an infectious disease disaster where the agent is transmissible, out-of-home child care may not be a viable option due to fears of contagious disease spread in a child care setting; however, some preservation of small cell groups with shared child care will likely be necessary. If institutions support child care using cells, the number of children per cell should be small and specific children assigned to each cell should be stable.
9. DMAT

DMAT teams, which include physicians, nurses and support personnel, can be mobilized from unaffected areas of the nation. Teams may set up as mobile units in open fields or parking lots or may be integrated into a health care facility. Normally, a team will stay for up to two weeks but may be replaced with another team in the event of an ongoing crisis. For generalized disasters such as pandemics, these units will not be available. Requests for DMAT team assistance should be made through public health. Public health may also take the initiative to request DMAT resources, but the need to integrate incoming capacity with existing health care make consultation with health care facilities necessary.

#### 10. Military

Support from military medical units may be available and should be requested if needed through state government (public health). Although these units are a valuable asset, availability will depend on the specific missions of medical units in the time of crisis.

### **XII. Home Health Care**

Home health care nurses may represent an important source of ancillary health care personnel during some types of crises. While the removal of community home health care, which could precipitate an acute deterioration in the health of some fragile home clients leading to hospitalization or death, the provision of home based care is resource intensive and that staff may be more efficient used in center-based care in the event of serious surge stress on facilities. Prioritization of home clients may permit a reduced home health staff to care for more patients (increased staffing shifts, shorter visits) and visits for only the sickest patients.

### **XI. EMS Surge**

Emergency surge EMS and PSAP protocols (specifically designed to address surge situations which overwhelm the entire system such as pandemic influenza) are provided under separate cover since regional response is unlikely to be available as it is for a localized disaster.

#### Organization of EMS Services

The North Dakota EMS Regional Response Plan is a regionalized EMS mutual assistance plan, which can be quickly expanded into a statewide EMS mutual assistance plan, to respond to regional or statewide disasters, or to react and respond to the activation of North Dakota hospitals' surge capacity plans. The EMS Regional Response Plan is grounded on the premise that all North Dakota ambulance services cannot be trained to the level of expertise or equipped with the capacity to respond to and manage all potential disaster scenarios which may occur in their primary service area.

The North Dakota Regional EMS response plan relies upon a basic and uniform squad disaster plan in place at each North Dakota ambulance service. The plan also relies upon the effective use of local mutual aid to respond to and manage smaller scale mass casualty incidents within a service area. If local mutual aid is exhausted or overwhelmed, the North Dakota regional response plan will be activated by a local ambulance service through State Radio or other formal organizational means. EMS regional response team members are activated by the Health Alert Network alerting system. The NDDoH will receive notification of the activation of the regional response plan simultaneously with notification of the response team members.

Once activated, the EMS regional response plan is based upon bringing cached disaster equipment and supply assets from the major population centers of the State, and bringing trained personnel assets and ambulances from other areas of the region or State to the disaster scene, or to assist in the patient transportation requirement of hospital surge capacity response. The regional lead EMS service has a trailer which contains equipment needed for disaster response, or much of the equipment can serve as replacement equipment if needed during a prolonged event when immediate commercial replacement may not be available (e.g., pandemic influenza). (See Appendix C for equipment list). For a more prolonged event in which medical supplies may be come exhausted or difficult to replace, emergency medical supplies will be mobilized from the state cache as needed. Delivery destination will be the request-initiating hospital, but material will be designated for use by the requesting EMS service.

The plan sets out a tiered EMS response capability scheme with all ND ambulances trained and equipped at Tier 3 Level; the ability to triage, treat and transport ten patients with local mutual aid. Tier 2 Level ambulance services have the ability to triage and treat 35 patients, and Tier 1 Level ambulance services located in Fargo, Bismarck, Grand Forks, and Minot have the ability to triage and treat 100 patients.

The North Dakota regional response plan sets out a uniform system of triage for patients, which will be followed by each EMS organization and other first responder entities, as well as, hospitals in North Dakota. The triage system is “START Triage” (Simple Treatment and Rapid Transport) for adult patients and the “Jump START Triage” system for pediatric patients.

#### Capacity

North Dakota has 140 ambulance services, of which the vast majority are entirely volunteer staffed or almost entirely volunteer staffed. Many of the ambulance services respond to fewer than 50 calls per year. The state EMS system is decentralized; the extent to which individual services are tied to local hospitals is variable from little to complete (employed by the hospital). EMS services and individual responders are licensed by the North Dakota Department of Health.

Ambulance services have no jurisdictional limitations; they can freely move throughout the state. By law, the nearest ambulance service is required to respond to an emergency; however, there is no penalty for failure to respond. Out-of-state ambulances which do not have a North Dakota license are somewhat more limited when working within the state – they can pick up in North Dakota or they can drop off in North Dakota, but they cannot do both.

#### On-Line Control and Protocols

For most of the ambulance services, the hospital(s) with which they most closely work do not have 24/7 physician coverage in-house. Consequently, on-line medical control is not a consistent option. All services must have a medical director; 75 total medical directors oversee the operations of the 140 EMS services.

NDDoH has established standards for patient management; however; enforcement of these standards has been limited by the volunteer nature of most of the EMS services. Data is not available to describe the extent to which services do or do not meet standards for patient

management. Protocols for patient management are established by each local medical director; consequently, they are not consistent across the state. NDDoH provides model protocols, revised as needed. New medical practice standards may result in revisions to state recommended protocols; however, local adoption of state protocols is not required. Treat and release is permitted by state statute, but only by a physician decision for each patient to whom it is applied.

Information which needs to reach EMS providers and medical directors related to urgent information about patient care (e.g., policy, standards, outbreak data, case definitions) can be pushed to providers through the HAN (including a calldown system), the SOAR system or through a listserv used by EMS services statewide.<sup>3</sup> Communication which needs to reach specific EMS providers urgently can also be sent through local or state dispatch capabilities (see Dispatch). During a pandemic wave, NDDoH will also be conducting daily briefings of the public health and health care systems over StageNet and the BTWAN. EMS providers and medical directors will have access to this information at any hospital or public health unit statewide.

#### Patient Diversion

Diversion is not an issue in the state; distances are too far to make bypassing a local facility a viable option. In the two cities which have more than one hospital, by mutual agreement, one of the hospitals may go on diversion if the other facility still has available capacity. Otherwise, all ambulances go to the nearest available facility where the patient can, at a minimum, be stabilized prior to transfer.

#### Training

Each local EMS service has a contract relationship with a trainer or training organization. In most cases this is a private individual or company, although in some instances colleges offer EMS training. Regionalization of training is being supported by the state. The North Dakota EMS Association provides training during its annual meeting which is available to all EMS providers regardless of membership in the association. However, participation in this training is patchy. Training for local EMS medical directors has been developed and made available for the first time in the state. Some EMS services have been involved in local and state exercises and additional resources have been provided to the North Dakota EMS Association to provide scenario-based exercise training specifically for EMS services.

A cadre of EMS providers around the state is trained in Critical Incident Stress Management. Usually the service is provided by a team; however, in a few rural areas the response may be limited to a single individual. These individuals are available to deal with the emotional/mental health issues that may arise among EMS workers or other public safety workers. They are not available to the families of these workers. Additional mental health capacity is provided through the Department of Human Services and its local agencies. Families will need to use community services.

#### Dispatch (PSAP)

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<sup>3</sup> HAN messages can be distributed with speed and precision (while confirming receipt of the message if that is important); hence, it will be the primary mechanism by which EMS providers and medical directors receive emergency notifications.

Many local jurisdictions support a local 911 dispatch system; those that do not depend on State Radio; in those areas covered by State Radio dispatch, dialing 911 automatically sends the call to State Radio. State Radio has towers that cover nearly the entire land area of the state. During a pandemic, protocols will be provided to all PSAP providers which allow them to triage calls including the provision of alternative recommendations for care other than dispatch. For a moderate or severe pandemic, protocols which differ by the severity with which they curtail response will be introduced according to the severity of the service short fall. Legal authority for alterations in local PSAP services will be covered under executive orders which have been prepared by NDDoH.

### EMS communications

EMS services all have interoperable communication systems which permit them to reach each other and other public safety responders. P25 radio communications are to be implemented statewide. All EMS units use standard frequencies for radio communication and all can be reached through the state radio system while in transit.

### Data Collection

Statewide, EMS services enter data into an on-line data system called SOAR. Two large hospitals have near real time data entry into the system and three additional facilities do a direct dump of data into the system daily. Other services enter data into the system online but with up to a 30 day delay. The SOAR has the capability to download data directly into the data system used by NDDoH Disease Control for infectious disease surveillance.

### Pandemic Influenza Response

The roles of the EMS system during a pandemic are:

1. Minimizing the risk of exposure of both EMS providers and general public to the pandemic influenza virus through appropriate use of personal protective equipment and infection control procedures;

EMS providers are expected to follow infection control<sup>4</sup> and social distancing guidelines, whether issued pre-pandemic or during the event, to protect the EMS workers.

Implementation will depend on use of PPE, including correctly fit tested N95 masks, and on infection control practices to limit spread of the organism (hand washing, respiratory hygiene, not touching the face except immediately after hand washing, cleaning environmental surfaces including transport vehicles, maintaining social distance (e.g., six feet) to the extent possible. These same practices are expected to protect patients from exposure through the EMS system.

In addition, given that EMS providers are likely to be the first trained health care contacts, they are in a position to provide guidance/education on how to limit spread of the infection to others when in contact with a person who may be infectious or have been exposed to a person who was infectious. Procedures would provide for the initiation of isolation or quarantine procedures if those measures are in use at the time. NDDoH will issue instructions to EMS providers and medical directors regarding implementation of social distancing measures.

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<sup>4</sup> Guidelines for Infection Control in Health Care Personnel, 1998 found at [http://www.cdc.gov/ncidod/dhqp/gl\\_hcpersonnel.html](http://www.cdc.gov/ncidod/dhqp/gl_hcpersonnel.html)

2. Disease surveillance

Early during pandemic spread, EMS providers will be given information which defines a possible case of pandemic influenza; EMS providers would immediately report by phone to NDDoH any person meeting those criteria. (At this point in the outbreak, EMS would be expected to see few such cases.) During this phase when rapid case detection is needed (and health care burden has not yet increased), all services will be asked to initiate real time data entry. (This need would cease when the state moved away from individual level disease containment methods to community containment methods.)

3. Health care system surveillance

In addition to disease detection and reporting, EMS will be able to provide to NDDoH information related to overload of the health care system, its support services (e.g., communications) or resources, whether those events occur within EMS itself or in health care institutions receiving from EMS.

4. Maximizing patient outcomes by prioritization of care and transport according to guidelines to be provided by the Department Operations Center of the North Dakota Department of Health

In a moderate or severe pandemic, EMS may be substantially impaired by loss of personnel due to sickness or no-show and by increased demand for services. In order to maximize survival, NDDoH will issue guidelines, which should be implemented with the concurrence of the local EMS medical directors, to maximize patient survival by optimally using the EMS resources that are available.

5. Initiating patient tracking of patients

Upon implementation of patient tracking, each patient being transported by EMS will receive a START triage tag the number of which will be entered into the patient tracking system (or scanned in using the tag bar code). The tracking system will be kept updated with patient location and status as the patients move through the health care system until they are either discharged home or permanently interred. EMS will need to ensure that patients transported are initially entered into the system (although data entry is likely to be the primary responsibility of ER staff).

6. Facilitating the integration of untrained transportation workers into the emergency transport system whether they will function as part of EMS teams or as independent transporters.

Whether untrained volunteers fill personnel gaps in the transport of patients by working with trained volunteers or by filling the gap in transport left by prioritization of EMS resources toward those of highest need, EMS workers will need to facilitate the integration of volunteers through communication and immediate training/guidance. Surge protocols (separate cover) provide additional information regarding when and how volunteers are used.

7. Participation and facilitation of just-in-time training conducted through NDDoH or local training providers;

During the course of the pandemic wave, NDDoH will provide through webcast and videoconference information and training specific to the emergency transport of patients and

to changes in policy. EMS providers will need to ensure that they and their medical director participate and learn the content of the information. Recommendations issued may cover prioritization of services, use and conservation of PPE, use of limited equipment resources, cross jurisdictional response protocols, alterations in triage, treatment or transport options, limitations in available hospital destinations, or changes in legal requirements through executive orders (e.g., change the scope of practice of EMS providers or use of antivirals and vaccines).

8. Receiving/accepting prophylactic treatments provided by NDDoH (vaccine or antivirals) to limit the spread and ensure the ongoing functional availability of the EMS workforce;  
Vaccine will be prioritized to EMS providers as part of the hospital prioritization system (see State Mass Care Plan; see Antiviral Distribution Plan; see Influenza Mass Vaccination Plan). Specific protocols are in place to ensure that those responders who should be receiving the vaccine are the actual recipients and that persons who receive their first dose also receive their second dose (if indicated) in a timely manner. In addition, EMS workers may be prioritized to receive prophylactic antivirals based on an exposure to a possible case identified early in the outbreak.<sup>5</sup>

9. Compliance with isolation or quarantine orders

Because EMS providers have first professional contact with ill individuals, they may be at some increased risk of exposures to the pandemic agent which could result in an order of quarantine, or, in the event of illness, isolation. If an EMS provider has been exposed or becomes ill with pandemic influenza, they will be managed according to protocols established for management of all other persons who require isolation or quarantine orders.

If an EMS provider becomes ill during a time when individual social distancing measures have been abandoned (i.e., isolation and quarantine have been replaced by community social distancing measures), recommendations for preventing exposure of patients or other workers will be the same as for other health care workers. The default assumption is if an EMS worker is ill with pandemic influenza, they will not be allowed to work until they have passed the stage of communicability. (If a provider who has the infection feels able to work, he or she may be allowed to work exclusively with pandemic patients in a health care facility, at the discretion of that facility, assuming that is not likely to have a negative impact on the health of the health care worker.)

10. Identify and rapidly responding the mental or emotional impairment of EMS worker brought on by exposure to high levels of stress or emotional trauma.

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<sup>5</sup> For purposes of treatment of pandemic influenza with antivirals, the state makes no distinction between persons ill who are in a “priority group” such as EMS workers and those who are not. (Patterns of illness and recovery from pandemic influenza suggest that persons who are already ill can be assumed to be out of the workforce during the remainder of the current wave.) Rather all ill individuals who are seen within the 48 hour window for treatment initiation are considered priority. In the event that the supply of antivirals becomes very limited, the DOC may make some treatment groups higher priority than others, likely on the basis of greatest likelihood of dying as determined by demographics. This will be an incident command decision made in the DOC.

EMS workers are expected to be aware of the functional level of those they work with and seek to ensure that those persons experiencing emotion difficulty coping with the stress obtain professional assistance.

### Maximizing Patient Outcomes in a Pandemic

Pandemic influenza poses special problems for EMS surge in North Dakota, including the following:

- Regional response plans are not expected to be particularly helpful during most of a pandemic wave since all medical transportation resources are expected to be stretched past their capability.
- The volunteer staffing of EMS services means that a high percentage of non-response may occur due to increasing the burden of response from occasional to continuous or nearly continuous operations and due to fear of exposure to the pandemic agent among EMS responders. Volunteer status means non-response is a more viable option since livelihood is not dependant on response; in fact, livelihood may be dependent on not responding since many volunteer responders have jobs from which they cannot be continuously away.
- Many services have very little personnel depth such that a very small number of illnesses among responders would be expected to seriously impair the capability of the EMS service.
- The prolonged nature of a pandemic wave will lead to fatigue of the available responders with degradation of response capability.

Maximizing transport capability will require multiple compensatory actions:

1. Prioritization by severity – For pandemics which overwhelm the local EMS system, calls will be prioritized to respond to those which represent the highest threat to health which is survivable (see surge response protocols). The state will issue specific guidelines (which may vary during the course of the pandemic based on disease severity) which recommend non-response to certain low-survival conditions and low risks situations, but require prioritization of other calls. The harsh natural climate requires consideration of the physical location of the person needing transport in addition to the severity of the illness or injury with persons in adverse environments potentially receiving a response over those in controlled environments.
  - a. Call center prioritization – State guidelines will be issued to provide guidance regarding how and when call centers will prioritize response from information gained over the phone rather than on the ground.
  - b. Treat and release – State guidelines will provide information on when to treat and release; however, these guidelines may change during the course of the pandemic wave as the stress of the EMS system increases or decreases. Under non-disaster conditions, state law limits treat and release to a physician decision; however, NDDoH has prepared draft executive orders for signature by the Governor which can override this limitation during disaster which has activated emergency powers. .
2. Alternative transport – Untrained responders using any available transport vehicle and family transport are expected to be primary means of transport for a large percentage of patients.
3. Public communication – NDDoH will provide guidance to the public regarding its recommendations for transport. This will include guidance on when family should provide transport immediately without calling on an ambulance for assistance.
4. Maximizing number of EMS providers capable of providing services including rapid identification and treatment of impairing conditions and provision of priority prophylaxis.

## Debriefing

Following a disaster response (e.g., a pandemic wave), NDDoH will take the lead in debriefing EMS services related to functioning during the wave including alternative procedures which would have improved services. This will be part of a broader after action assessment conducted to assess the response of NDDoH, the local public health system and the health care system. Results of this assessment will be documented in an AAR. Subsequent preparedness planning will focus on areas of inadequate planning which became apparent during the disaster response.

## **XIV. Information for Patients Regarding Health Care Services**

### Changes in Health Care Services and Expected Thresholds

Although a key principle of US health care is patient choice in determining when and from whom to seek health care, during any disaster which results in a prolonged surge in health care demand (e.g., pandemic influenza), requests for health care will exceed health care availability. To the extent that patients can be educated to avoid seeking health care when their health care needs are elective or their expected benefit from receiving health care is small, available health care services can be preserved for those with the greatest need. No single threshold for accessing health care can be established pre-event since as health care services become increasingly strained by large numbers of ill patients and ill health care workers, health care access will be tightened. This should occur not only at point of service (through triage) but also by patient self-triage based on public information messages. Health care access choke points may be important points of disease transmission for contagious illnesses; hence, minimizing unnecessary health care seeking behavior becomes a community containment strategy.

State standard of care guidelines (see Standard of Care section of this document) for hospital inpatient care recommend that the health care system begin to restrict admission criteria during a Stage I standard of care reduction with further tightening of admission criteria for higher stages. Simultaneously, messages will be delivered by both health care and the public health system (see public information plan) regarding who should seek outpatient care for disaster-related illness.

For pandemic influenza (the most likely scenario causing prolonged health care surge), recommendations to the public regarding when to seek professional health care and how to care for a sick family member at home can be found in Appendix J of the minimum care facility concept of operations document. Because treatment of influenza is primarily supportive (with the exception of delivery of anti-viral medications discussed below), these recommendations assume that access to health care is needed when the patient can no longer be managed at home (that is the patient is a potential candidate for admission). Recommendations for other disease conditions causing prolonged surge may not be able to make this assumption (i.e., care is primarily supportive).

Specific criteria (e.g., based on severity of dehydration, mental status, vital signs, social factors, presence of secondary complications, underlying medical conditions, and treatment availability) for determining when a patient with pandemic influenza may be admitted will change as surge stress on the health care system changes, and will be determined by the health care systems. Through consultation with hospitals, NDDoH will provide proposed sets of criteria for admission which approximate the de facto standards being used at that time by most hospitals. A sample for use during the early stage of pandemic influenza is provided in Attachment D of this document.

### Limitations on Health Service Availability during a Surge

During a prolonged surge, state standard of care guidelines recommend that certain types of services be suspended or severely curtailed in order to free up personnel time which can be devoted to surge patients. Services may be curtailed in a staged manner at the discretion of the health systems. For outpatient services service reduction is likely to include the delay of routine follow-up care for most patients; however, patients with unstable or high threat conditions would continue to be seen (e.g., brittle diabetes, advanced stage heart failure, end stage renal disease). As soon as a disaster declaration is in place, NDDoH would act by executive order to ensure that routine medications could continue to be refilled without physician consultation (at pharmacist discretion) until outpatient care capacity could recover. (See executive order template).

### Information Regarding Special Facilities

During the course of a disaster, special health care facilities may be opened to provide health care services. The likely types of special facilities would be:

- Minimum Care Facility – an alternative inpatient care facility capable of provide supportive nursing care and hydration when inpatient care becomes limited (primarily during pandemic influenza)
- DMAT, DOD mobile hospital or federal medical station – Localized disaster requiring short term boost or replacement of health care capacity (inpatient or outpatient)
- Pandemic influenza clinic – large scale clinic specifically designed to see a large number of influenza outpatients

The public would be notified (see public information plan) of the location, hours of operation, types and severity of patients that could be seen, security, cost to user, what to bring and not bring to the site.

### Self Care and Self Diagnosis

When health care for the disaster health condition is expected to be supportive, that is, no specific treatment is required, most diagnosis can be become presumptive self-diagnosis by the patient or family. (Pandemic influenza, but not category A bioterrorism agents, would fit this model.)

Appendix J of the minimum care facility concept of operations paper provides information regarding signs and symptoms of influenza; however, this may be modified if a pandemic strain demonstrates unusual features. Presumptive self-diagnosis would be the norm during most phases of an influenza pandemic since a visit to a provider will result in an empiric diagnosis for almost all pandemic patients. During a period of high surge, once a patient had made a presumptive self diagnosis, they and their families will

- Need to practice patient isolation with voluntary quarantine of the family;
- Need to seek antivirals (preferably through telephone-based prescribing if available at that time);
- Not need to seek health care unless the patient is very ill and can no longer be managed at home.

### Expectations from Health Care

One of the expected outcomes of a health care surge will be a reduction in the expected standard of care. An important part of the message that the public will need to receive is information which provides them with a realistic appraisal of the quality and availability of health care. This would include waiting times, eligibility to receive treatment, likelihood of being admitted, and services that will not be provided or be provided a reduced level. The Stage Standard of Care table in this

document provides specific indications of the restrictions on inpatient health care that the public would expect to encounter as inpatient surge triggers different standards of care thresholds. This specific table is intended for health care management purposes but its concepts will be translated into public use language as the stages of care are implemented.

#### Access to Emergency Medical Treatment Including Antiviral Drugs

The public information plan will be activated to disseminate information about public access to emergency antibiotics, antivirals or vaccines (see state and local mass dispensing in SNS plans and pandemic influenza mass vaccination plan) or antivirals (see antiviral dispensing plan). The priority for antiviral dispensing in North Dakota is to preserve social distancing while ensuring patients with influenza receive the drug within 48 hours of symptom onset and, secondarily, to prevent pandemic patients who are seeking antiviral medications from flooding the health care system. As detailed in the antiviral dispensing plan, emphasis is placed on telephone-based prescribing and remote site pick-up of antiviral prescriptions.

#### Answering Questions

During some disaster, NDDoH will have a contract in place with 411 information services in the state which will be able to answer general questions about community services during a disaster as well as identify specific individuals who need social assistance. The NDDoH hotline will also be activated. While there will be some overlap in the types of questions received by each, the hotline will expect questions about health care, preventive health, disaster response and adverse effects of drugs. Details of hotline operation can be found in the public information plan. To the extent possible, anticipated or commonly identified questions from the public will be addressed proactively through repetitive mass media messaging, in addition to information regarding access to 411 and the NDDoH hotline.

### **XV. Social Services and Care of Special Populations**

#### Social Service Outreach

Social service outreach will be continued as long as community resources allow. The preparation and delivery of meals, feeding centers, assessment of medication needs, assessment of access to services/essentials, transportation, and other social services may become needed more during certain types of disasters, including pandemics (e.g., children may be uncared for when all adults in the household are ill). In severe situations, the ability of communities to provide these services will be compromised. The North Dakota Department of Health will assist the North Dakota Department of Human Services anticipate and identify areas of need and assist with delivery of service through the deployment of qualified volunteers.

Special populations identified for special considerations have been defined as “people with functional needs”. People with functional needs are all ages and have a varying range of learning, understanding, emotional, hearing, visual, and physical abilities. People with functional needs are those who need assistance with communication, medical issues, maintaining functional independence, supervision, or transportation. This framework is referred to as **C-MIST**. The social services response will attempt to provide for the needs of those with functional needs.

### **XVI. Medical Supply Control and Distribution**

June, 2005

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Revised January 30, 2013

\_PLAN State Health Care Plan for Emergency Response.doc

## Pharmaceuticals

The state of ND has established a vendor-managed inventory with a pharmaceutical distributor in the state. A contract has been signed and inventory of Doxycycline and Amoxicillin has been purchased (not unit of use). The inventory is rotated to maintain a minimum remaining shelf-life of at least 90 days. Although the cache is intended for the use of health care facilities and public health staff and family members, the North Dakota Department of Health is the cache owner.

Hospitals or public health units may request deployment of the antibiotic cache by contacting the NDDoH Case Manager via North Dakota State Radio or by contacting the DOC once activated. Upon notification by the Department of Health, the vendor will deliver pharmaceuticals to designated locations within six hours. Influenza vaccine during a pandemic will be delivered according to the State Strategic National Stockpile plan.

For details of priority vaccination of the hospitals, see Appendix A of the pandemic vaccination plan. The NDDoH Department Operations Center (DOC) will determine the percentage of available pharmaceutical resources that would go to different sectors (e.g., public health, health care, first responders, municipal infrastructure). Prioritization of available vaccine to infrastructure would be limited to a pandemic of sufficient severity to substantially damage infrastructure; otherwise, vaccine would be targeted first toward those at greatest risk of adverse outcome. The DOC will designate the categories eligible for vaccination or prophylaxis.

## Disposable Medical Supplies and Personal Protective Equipment

The North Dakota medical supply cache represents a large amount of medical equipment and supplies which are warehoused by NDDoH. NDDoH purchased the material using monies from the PHEP, HPP, and PHER grants from the federal government; these resources are primarily intended to be used in the event of an emergency to prevent health care facilities and public health entities from exhausting available inventories held by those institutions. A list of the current content of the cache can be found in Appendix B.

### 1. Cache Materiel Ownership

Although the cache is intended for the use of health care facilities and public health, the North Dakota Department of Health is the cache owner and custodian. Disaster distribution of material is handled through the DOC to ensure that materiel is released in an equitable manner and transport to its destination is arranged.

### 2. Sources of Medical Materiel

Prior to the establishment of the cache, it is assumed that when a health care facility runs short of a needed supply, that additional materiel would be purchased within a few days through a vendor with re-supply. If supplies were needed more urgently than a vendor could re-supply them, a health care institution would borrow or purchase supplies from a nearby institution. It is expected that these mechanisms would continue to be common ways that institutions acquire needed supplies, particularly during non-emergency periods.

During many types of emergencies, the state may expect to receive assistance with medical supplies through the Strategic National Stockpile (SNS). Both the 12-hour push pack and managed inventory can rapidly make medical supplies available to the state once the SNS is activated during an emergency. During some emergencies, the SNS may not be activated (e.g., if the magnitude of the emergency is not sufficient to overwhelm state resources) or the SNS will not be able to meet the needs of the state (e.g., a pandemic requiring nationwide response, or exhaustion of vendor supplies).

To gain access to the cache, the requesting institution (whether hospital, nursing home, assisted living facility, public health unit or other approved users, orders the material on-line using a process much like ordering from a typical online vendor (<http://hanassets.nd.gov>). The request process is open to anyone but only an approved user will get a response. The DOC will call the user/requestor to clarify any uncertainties about the order and the order is tracked against prior requests by that entity. If the amount is reasonable and supplies are sufficient, the order will be approved and sent to the warehouse for filling; otherwise, the DOC will modify the order by negotiating with the requesting entity. .

### 3. Eligible Recipients

Any North Dakota facility/health care provider, permanent or temporary, providing direct patient care or public health services to patients, may request materiel from the cache. This includes facilities which may have been established in response to the emergency (e.g., Federal Disaster Medical Assistance Team (DMAT), minimum care facility). In addition, certain state certified caregivers (such as home health care providers) may be eligible to receive material.

Although the materiel is primarily intended for use during a disaster situation, requests for materiel may be made during non-disaster situations. If the Department of Health determines that use of the cache is appropriate, the materiel will be released. Requests for cache materiel during non-emergency periods should be directed toward the NDDoH Case Manager on duty. During an emergency, all requests for materiel release from the cache should be directed to the DOC. (A regional Emergency Preparedness and Response Coordinator (EPR) who receives a request from an institution would transmit the request to the state in this manner as well.)

### 4. Reimbursement of the Cache (NOTE: This section is on-hold pending federal decision on permissibility of requesting reimbursement for re-stocking for materials purchased with federal funds.)

Because the materiel in the cache was purchased with emergency preparedness dollars, which may not be available a few years hence, it is prudent that the cache be self-sustaining. Consequently, a facility which draws down materiel from the cache will be expected to reimburse the North Dakota Department of Health within three months for the purchase cost of the items used so that replacement materiel may be purchased as soon as possible. Alternatively, if the facility has drawn down from the cache pending arrival of a shipment, exact replacement materiel may be returned to the cache for re-stocking.

## 5. Implementation of Conservation Measures

Circumstances of severe national shortage and limited cache resources (e.g., severe pandemic) may make it necessary for the North Dakota Department of Health to require that receiving institutions requesting supplies from the cache adopt conservation measures (e.g., materiel re-use of disposable material). Conservation measures are expected to be implemented statewide, such that all hospitals in the state drawing from the cache during the disaster event would be expected to implement such procedures. During a prolonged, severe surge event, conservation measures would be implemented early while cache supplies are still plentiful in order to maximize the availability of supplies throughout the event.

### Oxygen

Oxygen usage may expand greatly during certain types of disasters, especially biologic or chemical disasters involving respiratory compromise. Medical facilities in large cities with reservoir storage should not be seriously affected by localized events. However, they should maintain a high level of oxygen supply prior to an impending pandemic and attempt to re-supply far in advance given that supply systems may be compromised by increased demand and reduced personnel in the supply industry if community attack rates are high. Facilities without substantial oxygen reserves may need to develop a re-supply plan in the event of vendor delays and increased demand (e.g., SARS, pandemic influenza).

## **XVII. Security of Health Care Facilities**

Security arrangements at health care facilities vary substantially. A few large facilities have on-site designated security staff whereas most of the smaller facilities depend on local law enforcement to come on scene when a security threat is detected. As part of pandemic influenza plan development, each facility should complete an assessment of security vulnerabilities including lockdown procedures, access restriction, control of open doors, assignment of personnel to security roles and identification requirements with subsequent security plan development.

## **XVIII. Recovery**

Following a disaster involving the health care community, the DOC will remain functional during the recovery period to assist local public health and health care with recovery efforts. Facilitation of recovery will include continued briefings on a frequency consistent with need. Recovery efforts will focus on assisting the health care system to stabilize (continued operation and solvency of critical infrastructure), re-placement of supplies and equipment and recovery of staffing.

Also during this period NDDoH will perform an incident debriefing for the DOC, for health care and for the public health system to identify gaps in planning and response that became apparent during the disaster response. The two evaluation positions within the Emergency Preparedness and Response Section of NDDoH will take the lead responsibility for completing this process.

It is during this period that post-event mental health trauma and social disruption will become apparent and require long term management. By directive of the Division of Emergency Services, the primary response to mental health need will be the responsibility of the Department of Human Resources. NDDoH will play an assistive role particularly as mental health or social disruption impacts the health care delivery or public health system.



# **Appendix A**

## **Evacuation Triage**

## Rapid Triage Form for Evacuation

Date: \_\_\_\_\_

Last Name: _____	First Name: _____	
Allergies: _____		Age: _____
Triage Tag #: _____	DOB: _____	Male <input type="checkbox"/> Female <input type="checkbox"/>

<b>Assign (circle) one type designation and one or more status indicators for each patient.</b>		
TYPE	STATUS	
1. Obstetrical 2. Newborn 3. Neonatal 4. Pediatric 5. Medical 6. Psychiatric 7. Surgery, general 8. Surgery, neurological 9. Surgery, cardiothoracic 10. Surgery, burn 11. Other _____	A. Critical care B. Hemodynamically unstable. C. Ventilator dependent or respiratory unstable D. Pre-operative, urgent or emergent E. Post-operative F. Invasive diagnostics G. Dialysis H. Severe immunocompromise I. Airborne isolation J. Telemetry	K. Complicated wound care L. Complicated nutritional care M. Complicated medication administration N. Temporary invasive (drains, tubes) O. Transfusion P. Non-ambulatory Q. Agitated R. Intensive nursing care (e.g., incontinence, feeding, turning) S. Routine T. Other _____

NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Appendix B**

### **State Cache Material**

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**Can be found in the WASP System.**

**APPENDIX C**  
**Regional Response Team Equipment List**

<b>REGIONAL RESPONSE TEAM EQUIPMENT LIST</b>	
<b>Description</b>	<b>Qty</b>
Escape Hoods	300
Lifepak500 AED Trainer	3
AutoVent 3000 Transport Vent	79
Berman Airway Kit	100
Bio hand cleaner	80
Adult bag valve mask	58
Child bag valve mask	58
Barrier tape	12
CPAP circuits/masks	1
CPAP Portavent	16
Evac chair	7
Ferno Litter Model 108D	12
First Line Medical MCI Kit	4
First Line Medical Spill Kit-Bio clean up	30
Micro Mist Nebulizer	170
Spiracle Multi-Manager 8 port	24
Nasopharyngeal Airway Kit w/jelly	40
Nonbreathing Mask-P Pediatric masks case of 50	3
Night Rider light pens	500
Pelican Case Model 1650	5
Portapottie	7
Rusch Advanced Airway Equip/laryngoscope Kit	21
Sani-cloth HB, PDI	32
Stethoscopes dual head combo	55
Tent w/plumbing	1
Portable heater for tent	1
Uni-Vent ATV Impact Ventilator	12
Ventilator Circuits single use	10

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Ventilator Quick Connect Assy	6
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V-Vac Starter Kit	14
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**EMS SUPPLY LIST FOR FOUR SUB-ANCHOR SITES:  
WILLISTON, DICKINSON, JAMESTOWN AND RUGBY**

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<b>DESCRIPTION</b>	<b>Qty</b>
Autovent 3000 Transport Ventilator w/Case	12
Ventilator Single Use Circuits for Autovent	40
Ventilator Quick Connect Assembly for Autovent	12
Pulse Oximeter BCI 3301 or Equal w/Case	12
Emergent CPAP Portovent 1900-01 or Equal	12
CPAP Single Use Circuits for Above	40
Evacuation Chair JSA-800 or Equal	4
Adult C-Collar Ambu Perfit or Equal	100
Pediatric C-Collar Ambu Perfit or Equal	20
First Line MCI Kit	4
Spiracle Multi-Manager Port w/Case	8
Long Backboards	80
Short Backboards	20
Port-A-Pottie w/ Curtains	4
Basic Blanket	80
Rusch Advanced Airway Equip Laryngoscope Kit	12
Stethoscopes Dual Head Combination	20
<b>RADIO EQUIPMENT</b>	<b>Qty</b>
Icom F21 16-channel Switchable Rotary (radios)	48
6-unit charger	8
Razor-S6 Lightweight Behind Head In-Line PTT w/clip	48
Battery Case	48
Cloning Cable Portable	4
Icom Repeater	4
PC Cable and software for repeater	4

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Line 100' coax cable	4
Antenna	4

# Appendix D.

## MeritCare Triage and Admission Protocols

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3/14/20

## Pediatric Pandemic Triage Form (0-18 years)

Date:

Time:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

### Triage 1:

**Apply mask to Patient \* If Patient meets *Red: Immediate* Criteria → transport to ED**

**Does Patient Have:**

Fever > 100.4 F \_\_\_\_\_

**and** one of the following criteria:

Cough

Sore Throat

Shortness of Breath

Vomiting/Diarrhea

Meets epidemiological criteria (per Medical Officer)

**Directed to:**

Influenza Treatment Location (if fever + one other criteria)

Non-influenza Treatment Location: \_\_\_\_\_ With Complaint of \_\_\_\_\_

Home

Time:

Triage Staff:



Notes: \_\_\_\_\_  
\_\_\_\_\_

Triage Time: \_\_\_\_\_ Triage RN: \_\_\_\_\_

**Additional Assessment**

Height: \_\_\_\_\_  
Weight: \_\_\_\_\_ lbs \_\_\_\_\_ kg \_\_\_\_\_ Estimated      BSA \_\_\_\_\_

**Pain:**    **No**     **Yes**     **Scale (0-10)**    **Location:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_ « **Reaction:** \_\_\_\_\_  
\_\_\_\_\_ « \_\_\_\_\_  
\_\_\_\_\_ « \_\_\_\_\_  
\_\_\_\_\_ « \_\_\_\_\_

Latex Allergy: Yes \_\_\_\_\_ No \_\_\_\_\_

**MEDICATIONS**

See Medication Profile from Logician

Name	Dose	Frequency


**Vaccinations:**

• Flu: \_\_\_\_\_ • Pneumonia: \_\_\_\_\_

**\*\*PAST MEDICAL HISTORY\*\***

- Denies
- Home oxygen
- Cardiovascular/Congenital Heart: \_\_\_\_\_
- Pulmonary Disease: \_\_\_\_\_
- Diabetes: \_\_\_\_\_ Insulin Dependent
- Transplant: \_\_\_\_\_
- Renal Disease: \_\_\_\_\_
- Liver Disease: \_\_\_\_\_
- Other
- Surgery:     Appendectomy     Tonsillectomy
- Other \_\_\_\_\_  Other \_\_\_\_\_

TRIAGE NOTES: \_\_\_\_\_

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3/15/2007

# Adult Pandemic Triage Form

Date:

Time:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

## Triage 1:

**Apply mask to Patient \* If Patient meets *Red: Immediate* Criteria → transport to ED**

### Does Patient Have:

Fever > 100.4 F \_\_\_\_\_

**and** one of the following criteria:

Cough

Sore Throat

Shortness of Breath

Vomiting/Diarrhea

Meets epidemiological criteria (per Medical Officer)

### Directed to:

Influenza Treatment Location (if fever + one other criteria)

Non-influenza Treatment Location: \_\_\_\_\_ With Complaint of \_\_\_\_\_

Home

Time:

Triage Staff:

## Triage 2

### TRIAGE ASSESSMENT

Color Pink

Alert and Oriented

Respirations regular

Color Flushed

Confused

Respirations labored

Color Cyanotic

Unresponsive

Respirations shallow

Color Pale

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Temperature	
Respirations	
O2 Saturation	
Blood Pressure	
Pulse	
Capillary Refill	

- Red: Immediate:**  
 Unresponsive  
 Resp > 30 or < 12  
 BP: diastolic > 100 or < 50  
 Pulse: > 120 or < 50, Cap Refill  
 > 4 secs  
 O2 Sat <90%
- Yellow: Delayed:**  
 Temp > 38C (100 F)  
 Cap Refill >2-4 sec  
 Shortness of Breath  
 Cough, sore throat  
 Meet epidemiological criteria
- Green: Minor:**  
 Cap Refill < 2 secs  
 Minor discomfort  
 Vital signs normal
- Blue: Palliative** Criteria per Medical Officer

- Emergency Center
- Day Unit
- Discharge Home from Triage

Notes: \_\_\_\_\_

Triage Time: \_\_\_\_\_ Triage RN: \_\_\_\_\_

**Additional Assessment**

Height: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs \_\_\_\_\_ kg \_\_\_\_\_ Estimated

**Pain:**  **No**     **Yes**     **Scale(0-10)**    **Location:** \_\_\_\_\_

**Allergies:** \_\_\_\_\_ « **Reaction:** \_\_\_\_\_

\_\_\_\_\_ « \_\_\_\_\_  
 \_\_\_\_\_ « \_\_\_\_\_  
 \_\_\_\_\_ « \_\_\_\_\_  
 \_\_\_\_\_ « \_\_\_\_\_

Latex Allergy: Yes \_\_\_\_\_ No \_\_\_\_\_

**MEDICATIONS**

See Medication Profile from Logician

Name	Dose	Frequency


**Vaccinations:**

• Flu: \_\_\_\_\_ • Pneumonia: \_\_\_\_\_

**\*\*PAST MEDICAL HISTORY\*\***

- Denies
- Home oxygen
- Cardiovascular: \_\_HTN \_\_CHF \_\_PTCA \_\_CABG Other: \_\_\_\_\_
- Pulmonary: \_\_COPD other: \_\_\_\_\_
- Diabetes: \_\_\_\_\_Insulin Dependent
- Liver Disease: \_\_Cirrhosis other: \_\_\_\_\_
- Renal Disease: \_\_Dialysis other: \_\_\_\_\_
- Other \_\_\_\_\_
- Surgery:
  - Appendectomy
  - Tonsillectomy
  - Hysterectomy
  - Cholecystectomy
  - Pregnancy

TRIAGE NOTES: \_\_\_\_\_

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## Pediatric Admissions Criteria

### Two Pediatricians must agree on admission.

### Admit for shock and severe respiratory compromise .

- Temperature  $>38^{\circ}\text{C}$  and  
cough, sore throat or dyspnea and meets [epidemiologic criteria](#)
- Respiratory Distress:  
Oxygen Saturation  $< 85\%$   
Resp Rate severe for age. e.g in an infant RR  $> 70$
- Level of Dehydration as evidenced by:  
BUN  $> 30$   
or  
NA  $>145$  or  $< 130$
- O2 Saturation \_\_\_\_\_
- Croup Score:\_\_\_\_\_
- Asthma Score:\_\_\_\_\_
- 

For additional information see [HHS Influenza Pandemic Planning](#)

## Adult Admissions Criteria

- Temperature  $>38^{\circ}\text{C}$  and cough, sore throat or dyspnea and meets [epidemiologic criteria](#)
- Respiratory Distress:  
Oxygen Saturation  $< 90\%$   
Resp Rate  $> 30$
- Level of Dehydration as evidenced by: BUN/Creatinine ratio  $>30$  (or 2x baseline if available), or NA  $>145$
- PSI ([Pneumonia Severity Index](#))  $>90$

For additional information see [HHS Influenza Pandemic Planning](#)