



Louisiana Department of Health ESF-8 Health & Medical Response

Framework for Mitigating Crisis Environments: Hospital Crisis Standards of Care Guidance and Resources

Version 1 May 2022

This is a living document and updated versions will be developed as needed.

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Executive Summary

Louisiana's Crisis Standards of Care (CSOC) Plan has been refreshed. The recent pandemic response activities of COVID19 provided influence into this modified CSOC Guidance and Resources document. The crisis environment in healthcare was evident with 5 major peaks of COVID19 from March 2020 to March 2022 concomitant with 8 major storms of 2020 and 5 major storms in 2021.

The refreshed Crisis Standards of Care for Disasters 2022 document includes the following:

- Provides a guidance and examples of contingency practices by facilities in settings of declared emergencies.
- Encourages facilities to engage their institutional Ethics Committee for development and adoption of a facility-based CSOC plan that aligns with the Louisiana CSOC Guidance and Resources. To this end, operational structure, resources and examples are included in the document.
- Identifies the roles and responsibilities of Louisiana's critical agencies in declared emergencies. The Concept of Operations section codifies the information sharing role of the ESF8 Network; and further codifies the importance of conducting Hospital Chief Executive Officer (CEO) and Chief Medical Officer (CMO) conference calls throughout all phases of the response to advance validation of impacts at acute care facilities which shape policy decisions relative to anticipated response activities, State Health Officer (SHO) Orders, Emergency Proclamations, and identifying gaps, solutions, and/or challenges to be addressed.

Introduction

Louisiana's history of catastrophic disasters ranging from Hurricanes Katrina/ Rita 2005, Gustav/Ike 2008, Laura/Delta 2020, and Ida 2021 reinforced the need for an all-hazards crisis care guidance. The recent pandemic response activities of COVID19 from March 2020 to March 2022 provided rich context and influence into this revision of *Louisiana's Crisis Standards of Care for Disasters, Guidance and Resources*. The crisis environment in healthcare was evident with 5 major peaks of COVID19 from March 2020 to March 2022 concomitant with 8 major storms of 2020 and 5 major storms in 2021.

Planning Assumptions

- **Uncertainty in Disasters:** Given the uncertainty about the characteristics of any disaster is that the aspects of preparedness planning must allow for flexibility and real-time decision-making that take new information into account as the situation unfolds.
- **Crisis Environment vs. Crisis Standard:** A 'crisis environment' is descriptive of health care settings where services are compromised by extended disruptions of staff and resources. These disruptions, often with an unknown timeline of resolution, requires the impacted facility to implement government sanctioned contingency practices such as the flexibility to implement nurse staffing ratios, and/or the postponement of elective surgeries to name a few. This document takes the posture that contingency practices shall be utilized in medical facilities to minimize/ mitigate the 'crisis environment.' This plan assumes that hospitals and regions will reach surge at different times. This plan assumes that conventional, contingency, and crisis practices are conducted in medical/clinical settings and influenced by fluctuations and changes in staffing, capacity, and resources. Government assists in minimizing the impact of the crisis environment in medical facilities by issuing proclamations that would limit the spread of disease; and/or set up temporary processes to secure and allocate scarce resources. In government, "standard" infers the publication of a rule(s) that are

subject to the general public’s review and monitoring; and if not met, creates a litigious environment for failing to meet the established measure. A “crisis standard” infers a prescriptive direction of medical care sanctioned by government applicable to an entire jurisdiction upon formal declaration with limited flexibility of implementation. Thus, this document does not issue a government-issued crisis ‘standard’ of care but rather acknowledges that crisis environments may exist in medical settings during all phases of disasters.

- **Disasters cause disruption to Infrastructure.** Most or all of the community’s infrastructure is impacted. Most or all routine community functions are immediately and simultaneously disrupted. In some scenarios, local officials are unable to perform their usual roles for a period of time, extending well beyond the initial aftermath of the incident. Surrounding communities are similarly affected, and thus there are no regional resources (IOM, 2012).
- **State and federal resources remain instrumental in the ability for medical infrastructure to continue to provide patient care while the communities transition into recovery.** While communications, power, and water are restored in disasters, the recovery operation and repatriation of citizens to rebuilding communities puts increasing demands on the impacted and fragile health system. Community recovery adds additional burdens to an already fragile health ecosystem with an increase in medical emergencies commonly associated with rebuilding, and prolonged generator use compiled with the routine time sensitive illnesses and injuries (strokes, heart attacks, traumas).
- **The roles and responsibilities of emergency response are not equally distributed amongst the healthcare industry.** The healthcare industry is composed of a broad array of medical settings. During the response phase of a disaster, it is paramount that casualties are taken to the nearest Tier 1 hospital, defined in Emergency Preparedness as a fully functioning licensed hospital that has an emergency department (ED). “Take me to the nearest hospital” implies a Tier 1 hospital, not a step-down nursing facility, public health unit, or outpatient clinic. During the response phase, step-down facilities and outpatient clinics in the at-risk areas are typically closed. Of the 270 licensed hospitals in Louisiana, 120 are Tier 1 hospitals. These Tier 1 facilities play an important role in disaster response — specifically, casualties are brought by EMS to these sites for patient stabilization and treatment. Nursing homes, assisted living facilities, urgent care clinics, and even alternative care settings/shelters cannot substitute for an acute care bed. This is not to lessen the importance of these definitive care settings; but rather to emphasize that in disasters, acute care beds are a low-density critical resource not only needed to directly address the disaster victims but also to remain available for community needs of trauma and time-sensitive illnesses.
- **Crisis Environments in Medical Settings.** This document may serve as a guide for all medical facility policymakers. All information contained is to be considered a living document and subject to change. The adoption of consistent procedures and recommendations statewide would represent best practices during times of disaster and would assist in gaining public confidence.
- **Each facility should evaluate and apply this document** in consideration of its unique needs including staffing, bed capacity, and community resources available. Individual facilities, systems and/or organizations should develop facility-specific policies and procedures.
- **Regional Coordination:** Furthermore, since community resources exist in a delicate ecosystem, it is imperative that representatives from the facilities as well as health entities in local/regional areas come together to address conventional practices and guidelines implemented across the region.

Plan Outline

The Crisis Standards of Care document (CSOC) addresses several sections. Part 1 covers the Institute of Medicine (IOM) Guidance for Establishing Crisis Standards of Care; a brief overview of Louisiana and its jurisdictions; and Louisiana’s legal authorities and environment for CSOC. Part 2 covers the Guiding Principles for the allocation of scarce resources and how this is implemented in Louisiana with the Ethics Project. Part 3 covers Surge Operations including public-private platforms for communication,

information sharing, emergency operations for surge and logistics implementation, planning assumptions, triggers, checklist for hospitals, and regional load-leveling practices.

Part 1: Crisis Standards of Care Overview

Institute of Medicine (IOM) Guidance

Catastrophic events will have an impact on the entire healthcare delivery system and will affect response and delivery of care that occurs in the home, community, hospitals, primary care offices and long-term care facilities. A number of strategies can be implemented along this continuum of care delivery to reduce the likelihood that standards of care will change in a disaster situation. These include steps taken to substitute, conserve, adapt, and reuse critical resources, including the way staff is used in delivering care. All these steps should be attempted prior to the reallocation of critical resources in short supply. Every attempt must be made to maintain usual practices and the expected standard of care and patient safety.

| | Conventional | Contingency | Crisis |
|-------------------------|---|--|--|
| Space | Usual patient care space fully utilized | Patient care areas repurposed (PACU, monitored units for ICU-level care) | Facility damaged/unsafe or non-patient care areas (classrooms, etc.) used for patient care |
| Staff | Usual staff called in and utilized | Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc.) | Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques |
| Supplies | Cached and usual supplies used | Conservation, adaptation, and substitution of supplies with occasional reuse of select supplies | Critical supplies lacking, possible reallocation of life-sustaining resources |
| Standard of Care | Usual Care | Functionally equivalent care | Crisis standards of care |

Usual Operating Conditions ←————→ Austere Operating Conditions

Conventional Capacity: The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan. (IOM, page 16)

Contingency Capacity: The spaces, staff, and supplies used are not consistent with daily practices, but provide care that is functionally equivalent to usual patient care. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources). (IOM, pg. 16)

Crisis Capacity: Adaptive spaces, staff, and/or supplies are not consistent with usual standards of care but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. (IOM, pg. 16)

Medical Surge: Medical Surge is generally defined as when the patient volumes challenge or exceed a facility's servicing capacity. The IOM Literature review recognized that the use of the term "surge capacity" in mass casualty incidents is not equated with daily variations in Emergency Department volume, although there may be some relationship. (Davidson et al., 2006; Handler et al., 2006; Jenkins et al., 2006).

Jurisdiction/ Risk Profile

Louisiana is a south central US state on the Gulf of Mexico. Louisiana is the 25th most populous of the 50 states. Louisiana is bordered by Texas to the west, Arkansas to the north, Mississippi to the east, and the Gulf of Mexico to the south. The political subdivisions are termed parishes. The state's capital is Baton Rouge and its largest city is New Orleans.

Health/ Equity Risk Profile: Demographic groups such as immigrants, seniors, children and people with disabilities may have different and specialized needs. [Race and economic factors](#) increase health and vulnerability factors.

Based on National averages, Louisiana frequently ranks low among the US in terms of [health](#), education, and development, and high in measures of [poverty](#). In 2018, Louisiana was ranked as the least healthy state in the country, with high levels of [drug-related deaths](#) and excessive alcohol consumption, while it has had the highest [homicide rate](#) in the US since the 1990s.

Louisiana has a population of 4,661,468 by [U.S. 2020 Census](#). By 2020 Census statistics, 58.7% of the population is composed of White (non-Hispanic) alone and 32.6% is African-American (non-Hispanic) alone. Hispanic, Asian, Native American, Pacific Islander, and Other represent approximately 10% of the population.

Louisiana is divided into [64 parishes](#). Most parishes have an elected government known as the [Police Jury](#). It is the legislative and executive government of the parish and is elected by the voters. Its members are called Jurors, and together they elect a president as their chairman. A more limited number of parishes operate under [home rule](#) charters, electing various forms of government. This includes mayor-council, council-manager (in which the council hires a professional operating manager for the parish), and others.

Legal Authorities

Under the Louisiana Health Emergency Powers Act, the Governor can suspend administrative policies and procedures to the extent deemed necessary within the parameters of the Louisiana Emergency Assistance and Disaster Act. The intent is to...[protect human life](#), control the spread of disease, meet the immediate emergency needs of Louisiana, restore and continue operations of facilities essential to the health, safety and welfare of Louisianans.

"[Public Health Authority](#)" means the Secretary of Louisiana Department of Health (LDH), his or her designee, and the State Health Officer.

A "[Public Health Emergency](#)" means an occurrence or imminent threat of an illness or health condition that: is believed to be caused by bioterrorism; and/or has the appearance of a novel agent; and/or a disaster, including but not limited to natural disasters, and/or poses a high probability of large number of deaths, large number of serious or long-term disabilities; widespread exposure would pose significant risk of substantial future harm.

Disease Reporting and Tracking: Reporting to detect and track the public health emergency shall be in accordance with directives and procedures established by Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP) in conjunction with the Office of Public Health (OPH).

Information Sharing: The sharing of information on reportable illnesses, clusters, and events between public health and safety authorities shall be restricted to the information necessary for the treatment, control, investigation, and prevention of a public health emergency. The furnishing of the protected health information by any reporting entity shall not expose the entity to liability and shall not be considered a violation of any privileged or confidential relationship. The Act does not prohibit the publishing of statistical compilations pertaining to potential cause of a public health emergency which do not identify individual cases, or confidential sources of information.

Part 2: Guiding Principles for CSOC Implementation

Guiding Principles

The cornerstone to establishing CSOC in the setting of a crisis or declared emergency is an ethical framework for the allocation of scarce resources. The Institute of Medicine (IOM) outlines the principles of an ethical framework (IOM, 2012):

Duty to Care

Duty to care is guided by the obligation of health care professionals to care for all patients at all times. Any system must sustain the patient-provider relationship ensuring that patients are not abandoned. In a crisis with scarce resources, it is understood that all patients may not be eligible for all curative therapies, but all patients are eligible for palliative treatments, and they should be provided.

Duty to Steward Resources

During times of scarce resources, the obligation of duty to care for all patients must be balanced by the duty of care for each individual patient. The estimated benefit of an intervention will need to be balanced against the availability of scarce resources leading to circumstances in which patients may not receive the level of resources or interventions available during non-pandemic or crisis events. Priority should be given to patients for whom treatment would most likely be lifesaving and whose functional outcome would most likely improve. Such patients should be given priority over those who would likely die even with treatment and those who would likely survive without treatment.

Duty to Plan

During a crisis, planning for allocation of scarce resources is an obligation. The absence of guidelines in this situation represents a failure in the responsibility to both patients and providers. It is recognized that any plan for utilization of scarce resources will be imperfect but remains vital in preparation for a declared emergency.

Distributive Justice/ Fairness

A just system for the allocation of scarce resources must be applied broadly in order to be fair. The timing, components and implementation of guidelines in crisis standards of care must be coordinated across an entire community. Patients must have equal access to care. It will be extremely important for healthcare providers to incorporate appropriate cultural competencies in order to improve trust with vulnerable populations and to address issues inherent within these disadvantaged communities. Cooperative agreements must be present to help alleviate shortages of resources thereby decreasing disparities in access to care and resources.

Transparency

During times of scarce resources, clinical practice may need to be adjusted. This must be done in an ethical manner with valid goals and desired outcomes using a population-based approach. The emphasis in a public health emergency must be on improving and maximizing the population's health while tending to the needs of individual patients within the constraints of resource limitations. Even during these times, patients have a right to truth regarding their condition, treatment options and prognosis; honest communication between healthcare providers and patients is paramount. In addition, a just system for the allocation of scarce resources requires transparency with broad input into the design and implementation of the system. Values that drive policy should be explicitly stated so communities can articulate, examine, affirm or reject, and modify proposed choices

Ethical Considerations

In trying to determine the appropriate allocation of extremely scarce healthcare resources during a major disaster, there are several ethical principles to consider. When dealing with large events, the general philosophy is to “provide the most good for the greatest number of people”. It is less about the individual patient and more about the community as a whole.

To plan for a catastrophic event, Louisiana needs to help ensure that

- the response offers the best care possible given the resources at hand
- decisions are fair and transparent
- policies and protocols across the state are consistent
- citizens and stakeholders are included and heard

Implementation Plan

As the disaster situation progresses, it is recognized that individual institutions may be reaching surge capacity at different times. Given this, each individual institution should be responsible for the initiation of contingency protocols and the pursuit of maximizing surge capacity. In addition to decreasing non-essential use of potentially scarce resources, facilities should make every effort to secure additional resources to limit the impact of the crisis and ensure that surge capacity is maximized.

The decision to implement any or all contingency practices/activities should be based upon the degree of the crisis situation and hospital capacity, in conjunction with a governor ordered state of emergency. Specifically, these CSOC guidelines and resources may be instituted only after the following conditions have been met. It is imperative that all hospitals work together and utilize the ESF-8 Hospital Designated Regional Coordinator (DRC) network to maximize all available resources.

- Initiation of national disaster medical system and national mutual aid and resource management
- Surge capacity fully employed within healthcare facility
- Attempts at conservation, reutilization, adaptation, and substitution are performed maximally
- Identification of critically limited resources (e.g., ventilators, antibiotics)
- Identification of limited infrastructure (e.g., isolation, staff, electrical power)
- Request for resources and infrastructure made to local and regional health officials
- Current attempt at regional, state, and federal level requests for resource or infrastructure allocation
- Institutional implementation team has requested initiation of CSOC
- Declared state of emergency or incident of national significance

It is recognized that within individual regions and institutions, the criteria for implementation of these guidelines may occur at different times. As such, the decision to implement the guidelines will be made

by individual institution's committees. The committee of each institution may consist of (at a minimum):

- The Chief of Staff (or designee)
- The Chief Medical Officer (or designee)
- The Chief Nursing Officer (or designee)
- The Infection Control and Prevention Nurse (or designee)
- The Emergency Department Director (or designee)
- The Equity/ Disparities Identified Champion
- The Medical Ethicist or Consultant as appropriate

Louisiana Pandemic Ethics Project

The Crisis Standards of Care project and recommendations goes back to 2005 following the storms of Katrina/Rita (2005) and Gustav/ Ike (2008). The draft framework was shaped by national guidance, clinical recommendations from providers, as well as input after hosting community engagement activities driven at the national level in anticipation of a pandemic influenza.

Medical Professional Leadership: Following the catastrophic storms of Katrina/Rita (2005) and Gustav/Ike (2008), a number of physicians and healthcare professionals in the Baton Rouge areas recognized the need for additional guidance that would address the lack of scarce resources in a major event. They met with members of all Tier 1 facilities in the region and developed draft guidance with submission to the state for further socialization to be modified, adopted, and enhanced as appropriate by each regional committee.

Regionalization: In the fall of 2009, regional meetings were conducted across the state. At these meetings, the Chair of the Baton Rouge Committee provided an overview of the purpose and process for initiating their committee and presented the drafted CSOC document. It was important for all regions of the state to initiate their own regional committees as a best practice as: 1) physicians and other healthcare professionals need to have discussions among themselves on this topic, 2) each region may have specific issues that may be different from another region (such as a children's hospital or a large OB facility), and 3) greater involvement of medical professionals would advance medical-decision making on all phases of the response.

Socialization in Public Forums: In the fall of 2010, Louisiana's ESF8 released a Request for Proposal (RFP). The intent was to advance the guiding principle of "transparency to the public" by having a third party conduct statewide public forums. In 2011, numerous public forums were conducted across the state. The public forums were designed to provide an opportunity for review and comment by the public and ensure that the 'at-risk (vulnerable) population was included in this process. A total of one hundred thirty-six (136) organizations and community groups were contacted and invited to participate. The forums included an explanation of the need for crisis standards of care, the process for development of these standards, when and how CSOC would be implemented and individual and group working sessions designed to provide the participants with the opportunity to share their thoughts, belief, values, attitudes and an opportunity to comment on the draft plan.

Public Forum Outcomes: The forum process was designed using the Seattle-King County process for validation purposes and to assess any differences between the results. While Seattle-King County's demographics are different from those in Louisiana, the results were similar. The participants felt that the chance of survivability (in a pandemic scenario), treating the most people and providing care for first responders may be part of a decision-making priority. The least important factors were: first-come, first-served, randomization and ability to pay. The participants acknowledged the importance of and need for state "guidance" but wanted the guidance to be flexible enough to allow the final decisions to be made by

the local physicians (“boots on the ground”). Flexibility is necessary but will require careful deliberation and documentation when local practices do not follow common guidance. Encouragingly, the groups expressed trust in their medical community to make the best decisions as fair as possible under extreme conditions. Appendix E includes a copy of the Final Report including the list of organizations.

From 2012 - 2020, the Crisis Standards of Care Document was adopted, modified, and enhanced under annual reviews – driven by disaster events of the time. The review and subsequent modifications did not greatly change the overall intent or outcome of the CSOC Plan.

COVID19 Event: The Pandemic response activities of COVID19 2020 to 2022 provided context and influence into the revision of the CSOC for Disasters, Guidance and Resources document.

COVID19 re-enforced the following:

- That the healthcare infrastructure can get overwhelmed; despite healthcare facilities developing surge plans to increase and maximize available resource to manage the demand for services.
- That contingency practices will (continue) to be used so as to *prevent* the healthcare facility, healthcare system, healthcare region, from getting in a crisis mode or alternatively from staying in a crisis mode.
- That information sharing amongst medical professionals (CMO Conference Calls); amongst regions (ESF8 and DRC Networks); and with leadership of government (Governor and Hospital Systems) was critical for situational awareness; maintenance of the common operating picture, resource request and allocation, and public information and risk communication.
- That continued situational awareness advanced legal and regulatory mechanisms, including the ability to co-opt resources, space, and staff.

Part 3: Crisis Prevention Plan and Operational Concepts

Purpose

The intent of these CSOC Guidance and Resources is to **avoid reaching crisis care levels whenever possible** by proactive incident management. Information sharing within hospitals, hospital systems, regional HCC Emergency Operations Centers (EOC), and State Level EOC communication and coordination will assist with identifying community indicators and triggers.

Planning Assumptions

- Hospitals and regions will reach surge capacity at different times.
- Conventional, contingency, and crisis standards of care are primarily medically driven given changes in staffing, capacity, and resources.
- Uncertainty: Dynamic conditions exist during all incidents. There will be changing availability of resources and other variables involved in providing care. There will be many different potential resources shortages that could occur throughout all phases of the response.
- Decision-making during times of uncertainty: The decision for issuing a State and Federal Declaration of Public Health Emergency will likely be made with less than the full array of information desired by decision-makers. The imminent threat will have characteristics that would warrant a ‘public health emergency’. These public health emergency declarations would ideally be issued in advance of surge.
- Health/Equity Disparities: Changing availability of resources will invariably impact access to care. Studies have shown that disaster vulnerability replicates the preexisting patterns of inequality and exclusion (Morrow, 1999; Cutter, Boruff, and Shirley, 2003; Gallup, 2005; Rodriquez and Russell 2006). In developing facility, local, regional, and statewide surge plans, rigorous coordinated planning and optimal allocation of resources are necessary for disaster preparedness, community resilience, and response.
- The ability of a community to provide disaster relief and recover depends to a great extent on the effectiveness of its social networks. A community may be at risk if the relationships across the

economic, cultural, social, and political sectors of the civic infrastructure are not understood. The success of surge operations is dependent upon multi-agency coordination and integration with community networks.

Indicators and Triggers

Hospitals will provide ongoing status information as requested by the State. Data will be reported using existing electronic reporting systems. The Hospital Designated Regional Coordinators (DRC) will monitor data reports for potential trends across the community.

Depending upon the agent/event it may be challenging to identify useful indicators and triggers among the varied available data. Specific numeric ‘bright line’ thresholds for indicators and triggers are attractive, but for many situations may require significant data analysis before action. As the amount of information available is expanding, multiple factors may make data-monitoring less useful than it initially appears. It can be challenging to detect or characterize an evolving event amid usual variability in large complex data sets. (IOM, 2013, p. 42). During the COVID-19 pandemic, the indicators below became the minimum data indicators to identify predictors of a change in demand of healthcare resources. The scope, scale, and specific agent/threat should also be considered, and objective metrics should be utilized when defining informative indicators and triggers.

Prevalence Indicator: Prevalence refers to the total number of individuals in a population who have a disease or health condition at a specific period of time, usually expressed as percentage of the population. Throughout the COVID19 pandemic, Office of Public Health/ Epidemiology Section would report the prevalence of COVID19 by parish, region and statewide as a percent positivity.

Incidence Indicator: Refers to the number of individuals who develop a specific disease or experience a specific health-related event during a particular time period. Throughout the COVID19 pandemic, the Office of Public Health/ Epidemiology Section would report the transmissibility of COVID19. Estimates of disease transmission rates are critical for epidemiological simulation models – which ultimately assist in anticipating potential surge impacts. Most often these rates must be estimated from longitudinal field data, which are costly and time-consuming to conduct and are often imprecise.

Hospitalizations Indicator: The Hospitalizations attributable to the agent/disease will serve as an indicator that predicts a change in demand for health care service delivery or availability of resources.

Actionable trigger: Monitoring, analysis, information sharing, and/or select implementation of emergency response system actions.

Control Chart Indicator: The control charts serve as an actionable indicator that a scarcity of resources requires a transition from conventional to contingency strategies with the purpose to prevent the hospital or region from entering ‘crisis’ level of care. Throughout the COVID19 response, Control chart metrics were conducted based on ESF8 Portal ICU and Med Surge data collected from Hospitals. The Control Charts measured ICU/Med Surge deviation from the norm as an attempt to flag decision-makers when ICU/Med Surge beds were becoming saturated.

Actionable trigger: hospitals, hospital systems, regional coalitions should consider contingency practices such as controlling elective surgeries, enabling load-leveling practices, telemedicine, and other tactics to prevent, mitigate, and limit crisis care. The intent is to avoid reaching a crisis care whenever possible by proactive incident management within hospitals, hospital systems, Health care Coalition EOCs, and State Level EOC communication and coordination.

Response Architecture, Roles and Responsibilities

1. The State's Response Architecture: The State Emergency Operations Plan can be found at: [State of Louisiana Emergency Operations Plan](#) Louisiana's response plan for disasters is anchored in the National Response Framework, which identifies Emergency Support Functions (ESFs) to coordinate and integrate response activities. Each state agency identifies an Emergency Support Function (ESF) Primary Lead Coordinators. The Louisiana Department of Health (LDH) is the ESF-8 Health and Medical primary agency as identified in the State Emergency Response Plan. The LDH Secretary and the State Health Officer are the legislated health authorities. During a state declared disaster and/or public health emergency proclamation, the health authorities provide guidance to the Governor.

Governor:

Role: Oversee response and ensure coordination among relevant state agencies

Responsibilities:

- Approves State Declaration requests
- Requests Federal Emergency or Disaster Declaration using federal thresholds for applicability
- Ultimate authority for state response

Louisiana Department of Health (LDH):

Role: State lead agency for health-related issues

Responsibilities:

- Engage in ESF8 response activities with state, inter-state, federal partners.
- Work with Governor's Office for Public Health Emergency (PHE) declarations and/or proclamations
- The Public Readiness and Emergency Preparedness Act (PREP act) provides broad immunity protections to health care professionals who administer or use countermeasures covered by declarations issued by the Secretary of HHS. The Volunteer Protection Act of 1997 (VPA) provides liability protections to volunteers, including physicians, who are performing services for nonprofit organizations or government entities. Compacts or Uniform Laws, include liability protections for volunteers responding to a declared emergency. These laws referenced above typically include exceptions for gross negligence or reckless or intentional misconduct.
- Convene, engage, solicit, and facilitate meetings, and discussions that would inform the development of Incident Action Plans (IAPs) and/or mitigation strategies.
- Notify, activate, develop, and implement surge contracts as appropriate.
- Support health care coalition (HCC) information exchange and policy development.
- Provide and/or inform providers of clinical guidelines, CDC guidance, state and/or federal policy via communication methodologies such as Health Alert Network (HAN) and/or Public Information Officer (PIO).
- Through the Health Standards Section: Requests/ interfaces with Centers for Medicaid & Medicare Services (CMS) for 1135 Waivers and/or other Blanket Waivers to address disaster scenario.
- Through OPH/ Infectious Disease Section provides infection control information, development of public health population-based intervention recommendations based on CDC guidance.
- Through the Regulatory Boards: coordinate and inform mechanisms and adjustments related to scope of practice.
- Through the Offices of Behavioral Health (OBH), Office of Citizens with Developmental Disabilities (OCDD), Office of Adult and Aging Services (OAAS), and Office of Addictive Disorders (and their networks) advance planning, policy direction, and network integration with vulnerable population groups.

Louisiana Governor's Office of Homeland Security & Emergency Preparedness (GOHSEP)

Role: State lead for incident coordination

Responsibilities:

- State level coordination of overall disaster response and recovery

- Serve as point of contact for resource requests that filter up through the parish EOCs
- Request State Declaration of Emergency
- Recommend and request a federal disaster declaration to the Governor

Regional Health Care Coalitions (HCC): For Emergency Preparedness and Response purposes, the 64 parishes are organized into 9 regions. For each of the regions, there is a Regional ESF8 Network. The ESF-8 Network is composed of: a LDH/Office of Public Health Regional Medical Director/Administrator; a Public Health Emergency Response Coordinator (PHERC), a Hospital Designated Regional Coordinator (DRC); and an Emergency Medical System (EMS) Designated Regional Coordinator. This network is growing to include volunteers for a Nursing Home Regional Coordinators, Home Health Regional Coordinators, among others. When appropriate HCCs will engage with other agencies and stakeholder groups for planning purposes, including but not limited to Louisiana-Mississippi Hospice and Palliative Care Organizations (LHMPCO) and LeadingAge Gulf States (assisted living). This regional partnership network will ensure that coordination of care (needs and movement of patients), assets (types of beds available), and resources (e.g. security needs, pharmaceutical needs, sheltering care, and case management activities) are integrated at a regional level.

Regional Medical Director (RMD)

Role: Regional coordination of health/medical response

Responsibility:

Advance State Health Officer (SHO) authority in each region of the state.

Conduct information sharing and coordination related to public health implications

Hospital and EMS Designated Regional Coordinators (DRC):

Role: Coordinate health/ medical response in certain industries.

Responsibilities:

- Serve as the liaison for hospitals and EMS with other health-related entities (e.g. Office of Public Health, Bureau of Emergency Medical Services) as well as with non-health related entities (e.g.) Office of Emergency Preparedness (OEP).
- Support the patient transfer process during a declared state of emergency
- Facilitate the identification of a medical evacuation queue during a declared state of emergency.
- Facilitate the development and implementation of regional and inter-hospital emergency preparedness plans for designated regions in Louisiana.
- Lead the region’s process for development of, testing of, continuous improvement of and management of regional response to an emergency situation:

Health Care Facilities (HCF)

Role: Acute Patient care

Responsibilities:

- Implement surge plans including conventional, load-leveling practices for the prevention of crisis care.
- Implement facility or regional triage/treatment plans as required
- Coordinate information and resource management with other facilities via regional HCCs and DRCs.

Louisiana Hospital Association (LHA)

Role: Health care facility communication

Responsibilities:

- Assist LDH in communicating pertinent information with hospitals and health care facilities across the state.
- Assist LDH in advancing the Hospital Preparedness Program (HPP) Capability Program Guidelines (CPG) which address preparedness and response capabilities in all phases of disasters.

Information Sharing and Response Coordination

Open communication between healthcare facilities is key for an effective response during a pandemic. Ongoing communication between hospitals will be coordinated through the ESF8 Network and the Chief Medical Officer (CMO) Conference Calls.

Situational awareness will be ensured with frequent communication between each hospital regarding patient volume and acuity experienced by the facility, as well as resource status information. This information will be used to facilitate decision-making to determine when and how altered standards of care are implemented across the community.

The following EOCs are activated throughout the duration of the disaster to ensure communication, coordination, collaboration (C3). Information sharing directly advances resource management.

GOHSEP Emergency Operations Center: ESF-8 partners that also report to the GOHSEP State Emergency Operations Center (EOC) are: the Louisiana Hospital Association, the Louisiana Nursing Home Association, and representatives from the LDH Offices. During an imminent or actual threat, the State EOC maintained by GOHSEP will be activated. All ESF state agencies and organizations will report to the State EOC to coordinate the response efforts. During a disaster, the 9 Regional ESF-8 structures will report to the State ESF-8 during regularly scheduled intervals (conference calls) for updating and reporting purposes. Formal requests for assets are placed into the WebEOC system, which is a web-based system to track information and formal requests for resources.

EMS Tactical Operations Center/ Patient Movement Coordination: During a state-declared event, the Louisiana Emergency Response Network (LERN) becomes the EMS Tactical Operations Center (EMS TOC) to manage statewide EMS surge assets. The EMS TOC is supported by the Hospital and EMS Designated Regional Coordinators (DRCs) to coordinate patient movement.

LDH Emergency Operations Center: During a State-Declared event, the Office of Public Health engages with other key agency leads to activate the LDH EOC. Representatives from other Offices – i.e. OBH, OAAS, OCDD, and Office of Addictive Disorders – have seats at the LDHEOC to ensure integration of services especially for shelter response activities. The LDHEOC includes logistics related to a modest cache of equipment and supplies. The LDHEOC operates hotlines that can be utilized during an incident response. The information hotline can be activated during a state declaration and often coordinates FAQs and operations with 211.

Hospital Emergency Operations Center: At the facility level, individual hospitals activate the Hospital Incident Command System (HICS), which assists the hospital with planning, response, and recovery capabilities for unplanned and planned events. At the facility level, hospitals have ethics committees, or similar institutional or system-level mechanisms that offer assistance and guidelines in addressing ethical issues that arise in patient care and facilitate sound decision making that respects participants' values, concerns, and interests.

ESF8 Conference Calls: Throughout all phases of the COVID19 pandemic response, ESF8 Conference Calls were conducted to ensure information sharing across all regions. The intent was to ensure that communications on 'hot topic' issues was advanced between public and private entities. The information sharing assisted in validating current status of impact in regions and facilities, anticipating potential future impacts of the unfolding event, identifying potential

courses of action that would ameliorate the impact(s), and discussing the feasibility of implementing proposed immediate or long term solutions. The information sharing also assisted in shaping various metrics and implementation of reporting tools.

Chief Medical Officer (CMO) Conference Calls: Throughout all phases of the COVID19 pandemic response, the CMO and Chief Executive Officer (CEO) conference calls were conducted to ensure information sharing and awareness. The information sharing assisted government in: validating current status of impact of COVID in facilities with regards to surge, facilitated discussion related to policy guidelines relative to HAN notifications, SHO Orders, State PHE proclamations, and identifying gaps, solutions, and/or challenges to be addressed.

Health Alert Network (HAN):

The Office of Public Health manages the HAN for advisories and guidance documents related to disease threat and treatment modalities.

Public Information:

LDH/ Bureau of Media and Communications (BMAC) is responsible for coordinating and posting health-related communications activities with public health implications throughout all phases of the response. BMAC works with GOHSEP Joint Information Center (JIC) to coordinate press releases for a multi-agency response.

Information Sharing Platform, ESF8 Portal: Hospital Preparedness Program (HPP) grant funds were used to develop a web-based platform entitled the ESF8 Portal. The ESF8 Portal is a secure web-based platform for reporting and messaging to a multiple range of health care entities to include, but not limited to: hospitals, nursing homes, assisted living facilities, EMS, Intermediate Care Facilities for the Developmentally Disabled (ICFDD). There are over 4,000 end-users and 1700 facilities identified in the system. The ESF8 Portal's *Resource Management* module captures Essential Elements of Information (EIs) throughout all phases of a response. Elements include: operating status, evacuation status, power status, fuel status, census and bed polls, and utility status. It also contains specific information on each generator/fuel tank for each facility along with the services powered by each generator. For non-hospital facilities, it contains evacuation transportation contract and evacuation destination contract information. All data is accessible through a data warehouse, an analytics platform and a geographic information systems (GIS) platform.

Throughout all phases of the pandemic event, the state and federal data requirements were streamlined into the ESF-8 Portal. Since March 2020, there were approximately 107 fields of COVID data fields. The data fields included data such as COVID19 hospital admissions, personal protective equipment (PPE), clinical supplies, treatment modalities from Remdesivir and monoclonal antibodies. Daily outreach was conducted by the Hospital DRCs and Portal team for reporting compliance. Data rules and verifications were implemented to ensure outliers were addressed for accuracy and overall quality assurance. The Portal team developed templates for ease of reporting. Application Program Interface (API) were developed that enabled seamless integration of daily data uploads to Federal HHS platforms. Investments were also made for mobile applications for remote reporting and greater compliance.

Facility Guidelines

The following is a generalized checklist of preparations for an impending event. The threat-matrix of the event should be considered when implementing. Hospitals should include in their threat matrix the likelihood that concurrent events may be probable such as hurricane response during a pandemic. These

risk scenarios are already outlined, planned for, and exercised within a facilities Hazard Vulnerability Assessment (HVA).

It is recognized that during a pandemic and declared state of emergency, that patients presenting to acute care hospitals may be suffering from conditions not related to the pandemic. **These guidelines should apply to ALL patients seeking care at acute care hospitals during a pandemic. Social worth, age and other non-medical factors should not be used in the decision making process.**

Additionally, since Do Not Resuscitate (DNR) orders are not an accurate estimate of survival and state guidelines recommend life-limiting medical conditions as triage criteria, patients with DNR orders are not considered a part of the state's exclusion criteria.

In Louisiana, patients with a life limiting disease and irreversible condition may have the Louisiana Physician Orders for Scope of Treatment (LaPOST). This is a physician order that must be followed in the event the patient desires Do Not Attempt Resuscitation (DNR) in Section A AND Comfort Focused Treatment in Section B (see Appendix B). However, if the physician order indicates other treatment decisions, the patient will need to be triaged according to the facilities established CSOC guidelines.

Phase 1: Conventional Level of Care

PREPARATORY PHASE: Pandemic with minimal impact

During this phase, preparations are being made for an impending pandemic event. The pandemic's effect on staffing and daily operations is negligible. The focus is on increased awareness and the education of staff regarding threat-matrix, potential impacts on staffing and resources, and identification of contingency practices. General intent is to assess the status of all supplies, potential burn-rate, acquisition of surge caches, and timeline for pre-positioning.

1. Focus: Prevention of Illness
 - Mandatory use of additional PPE (i.e. HEPA, N-95 mask or CDC recommended PPE) for suspect patients.
 - Strict enforcement of unit and station cleanliness
 - Pre-positioning and distribution of PPE
2. Pandemic impact on staffing levels: Negligible
3. Procedures for handling employees who call in sick
 - Begin using daily reports of pandemic-related absences to track staffing impacts.
 - Employees with pandemic symptoms are asked to remain at home for duration of illness
4. Augmentation of Staff

Management Level

- Explore feasibility/possibility use of alternative staffing (i.e. expand staffing contracts; state or federal assets; etc.) in the event pandemic escalates.
- Review and develop mechanisms for temporary licensure for out-of-state medical providers.
- Review and identify contingency staffing ratios and protocols for care.
- Contact state and/ or federal ESF8 to determine level of assistance available.
- Prepare for logistical support of supplementary staff

Staff Level

- Prepare staff for possibility of extended work hours/shift changes

Phase 2: Contingency Level of Care

ESCALATING PANDEMIC IN SERVICE AREA

This may be different for each facility/organization in each region of the state based on the local human resource pool and depth of “bullpen” PRN employees. Facilities must evaluate personnel needs as the situation escalates. These are suggestions for maintaining staffing and reasonable response times. According to the Centers for Disease Control and Prevention, one can expect to lose up to 20% of staff due to illness, or childcare issues during this phase.

1. Focus: Minimizing employee infection
 - Frequent communications to employees re: infection control and illness prevention
 - Establish 800 lines and Public information campaign(s) to effectively direct patients with pandemic-like symptoms to appropriate setting
 - Intense surveillance of unit and equipment disinfection procedures
 - Mandatory use of additional PPE (i.e. HEPA, N-95 mask or as CDC recommends) for all patients
 - Consider working with the Office of Public Health to become a closed Point of Dispensing (POD) site for administration of vaccines and/or antivirals (if available) for employees and family members.

2. Pandemic impact on staffing levels
 - Epidemics are expected to last a minimum of 6-8 weeks in affected communities; however, the threat-matrix of the given pandemic should be considered.
 - Expect the number of sick employees to escalate quickly to around 20%. The number of sick employees may continue climbing beyond 20% if an outbreak is identified.
 - Absenteeism will stem not only from illnesses, but also from employees taking care of family members (especially single parents), and potentially from bereavement and critical incident stress

3. Procedures for handling employees who call in sick
 - Continue using the daily report of pandemic-related absences to identify current status; and to assist with shaping near future imminent staffing projections.
 - Expect ill employees to be contagious for several days after onset of symptoms. **DO NOT COMPEL EMPLOYEES WITH PANDEMIC SYMPTOMS TO WORK DURING THIS PERIOD** to protect other employees from becoming infected.
 - If the employee worked within two days (either before or after) of the onset of symptoms, anticipate their partner (and other employees with whom they had close contact) may also soon become ill (virus incubation period should be considered)

4. Augmentation of Staff
Management Level
 - Explore staffing arrangements, contingency plans, and contingency contracts.
 - Conduct Just In Time (JIT) training on any new lines of effort
 - All safe orientation(s)
 - Maintain staffing as possible/feasible
 - Consider temporarily converting management to clinical
 - Consider temporarily converting/ extending hours
 - Consider out-of-state or extender coverage using other skillsets
 - Activate agreements/arrangements
 - Enact mechanisms for temporary licensure of medics

- Make logistical arrangements (lodging, food, etc.)

Staff Level

- Cancel pending vacations for essential personnel
- Activate PRN employees and all available support staff / Registered Nurse (RN) extenders
- Consider feasibility and implementation of temporarily repositioning and housing providers from unaffected areas

5. Case Management and Discharge Planning

- Use 800 lines to encourage patients with minor injury/illness to use their own transportation to a more appropriate setting than hospitals
- Identify discharge options for at-home remedies – i.e. portable oxygen therapies, and other medical therapies.

Phase 3: Crisis Standards of Care

WORST CASE PANDEMIC IN SERVICE AREA

This may be different for each facility in each region of the state based on the local human resource pool and depth of “bullpen” PRN employees. Each facility must evaluate personnel needs as the situation escalates. These are suggestions for maintaining staffing and reasonable response times. According to the Centers for Disease Control and Prevention, one can expect to lose up to 40% of staff due to illness, or childcare issues during this phase. Facilities should be in contact with their respective DRC to communicate changes in status and assistance needed.

The employees who have surpassed the period of contagiousness can be re-engaged into the workforce. Protocols should be reviewed, clearly identified, and implemented to address the return of personnel after infection. This phase will ramp down to Phase 2 (and eventually, Phase 1) as the peak wave of illnesses subsides. Be prepared for resurgence of illness in case a secondary outbreak (wave) arises.

1. Focus: Minimizing employee infection and returning employees to work

- Frequent communications to employees re: infection control and illness prevention
- Monitor employees who have been ill to determine health status/suitability for duty
- Public information campaign to reduce calls for service from patients with flu-like symptoms
- Intense surveillance of unit and equipment disinfection procedures
- Mandatory use of additional PPE (i.e., HEPA, N95 mask or as CDC recommends) for all patients
- Consider working with the Office of Public Health to become a closed POD for administration of vaccines and/or antivirals (if available) for employees and family members

2. Pandemic impact on staffing levels

- Expect the number of sick employees to peak around 40% during this period and then begin to decline over time
- Absenteeism will stem not only from illnesses, but also from employees taking care of family members (especially single parents), and potentially from bereavement and critical incident stress

3. Procedures for handling employees who call in sick

- Continue using the Daily Report of Pandemic Related Absences worksheet
- Employees who are asymptomatic for the pandemic should be compelled to report for duty if their illness is minor and/or will not affect alertness and safety
- Expect employees that surpass the contagious period to return to duty.

4. Augmentation of Staff

Management Level

- Layered response of management personnel within care environments for provider extension purposes.
- Car-triage and call-in prior to patients walking into outpatient/ scheduled treatments.
- Car-based rapid testing prior to hospital entry for scheduled treatments.
- Augmentation of medical staff with temporary surge alternatives available – ie. Medical volunteers, 800 lines, paramedics, state contracted staff, and/or federal teams. Ensure protocols for staff augmentation to include onboarding, Just in Time training documents, oversight of temporary staff, staffing ratios.
- Enact facility mechanisms for temporary licensure of out-of-state providers
- Make logistical arrangements (lodging, food, etc.) for augmentation staffing contracts as appropriate.

Staff Level

- Continue activation of PRN employees and all available support staff
- Temporarily reposition and house providers from unaffected areas
- Reintroduce providers previously deactivated due to illness who are now beyond risk of transmitting the virus

5. Case Management and Discharge Planning

- Identify discharge options for at-home remedies – i.e. portable oxygen therapies, and other medical therapies
- Consider batch transports to available quarantine/isolation sites if appropriate for eligible patients.

Regional Load-leveling Strategies: Lessons from COVID

COVID19 pandemic from March 2020 to March 2022 provided an opportunity to catalogue the range of contingency practices throughout various phases of the response. The live-lab conditions over an extended 2 year time-frame allowed contingency practices and patterns to be discovered, discussed, and socialized with multiple levels of government, healthcare coalitions, and hospital echelons.

Appendix D lists load-leveling practices sorted by Pre-Hospital, Hospital and Community Based Settings. The activity is described in context of the COVID conditions existing at that time. Louisiana experienced waxes and wanes with COVID19 prevalence and subsequent impacts on Hospitalizations. The list also identifies whether a legal document was issued that served to enable/influence a behavior (i.e. social distance), protect/preserve a scarce resource needed during COVID; or prevent/ameliorate the healthcare infrastructure from reaching crisis levels.

Recovery Planning from Crisis Environments

As the severity of pandemic subsides, the scarcity of certain resources may be resolved at different times (e.g. critical care beds may be available, but ventilators may remain scarce). Ongoing and intermittent assessments related to prevalence, incidence, hospitalizations, scarcity/availability of resources will shape the return from contingency to conventional practices.

Should a severe pandemic occur, all areas and levels of healthcare would be affected. It is essential that healthcare entities including but not limited to primary care/rural health, nursing homes, hospices and

home health agencies also develop guidelines for managing their patients during an event that triggered implementation of care based on crisis environments.

Appendix A: Glossary

Acronyms and Definitions

- **AAR** – After Action Report (Review)
- **ACS** – Alternative Care Site
- **ADRC** – Administrative Designated Regional Coordinator
- **ASPR** – Assistant Secretary for Preparedness and Response within DHHS.
- **BCP** – LDH Bureau of Community Preparedness
- **BMAC** – LDH Bureau of Media and Communications
- **CEO/CMO** – Chief Executive Officer/Chief Medical Officer
- **CDC** – U.S. Centers for Disease Control and Prevention
- **CMS** – Centers for Medicare and Medicaid Services
- **CSOC** – Crisis Standards of Care
- **DRC** – Designated Regional Coordinator
- **DHHS (HHS)** – U.S. Department of Health and Human Services
- **EDs** – Emergency Departments (i.e. emergency room)
- **EEIs** – Essential Elements of Information
- **EMS** – Emergency Medical Services
- **EOC** – Emergency Operations Center
- **EOP** – Emergency Operations Plan
- **ESF** – Emergency Support Function
- **ESF 8** – Emergency Support Function 8, public health & medical preparedness and response
- **ESF 8 Portal** – LDH managed platform to track healthcare facility bed information and facility operational status in real-time during disasters
- **GOHSEP** – Governor’s Office of Homeland Security and Emergency Preparedness
- **HAN** – Health Alert Network
- **HCC** – Health Care Coalition
- **HCF** – Health Care Facilities
- **HPP** – Hospital Preparedness Program under the office of ASPR
- **IAP** – Incident Action Plan
- **LANG** – Louisiana National Guard
- **LAVA** – Louisiana Volunteers in Action
- **LDH** – Louisiana Department of Health
- **LHA** – Louisiana Hospital Association
- **LNHA** – Louisiana Nursing Home Association
- **LTC** – Long Term Care
- **LERN** – Louisiana Emergency Response Network
- **MOU/MOA** – Memorandum of Understanding/Agreement
- **OEP/OHSEP** – office of emergency preparedness/office of homeland security and emergency preparedness
- **OPH** – Office of Public Health (within the Louisiana Department of Health)
- **Pandemic** – an epidemic that has spread over several countries or continents, usually affecting many people
- **PHE** – Public Health Emergency
- **PIO** – Public Information Officer

- **POD** – Point of distribution; Point of dispensing
- **PPE** – Personal Protective Equipment
- **REC** – DHHS Regional Emergency Coordinator
- **RMD** – Regional Medical Director
- **SHO** – State Health Officer
- **SitRep** – Situation Report
- **SME** – Subject Matter Experts
- **SNS** – Strategic National Stockpile, federal program managed by CDC for storing and dispensing disaster resources
- **SVI** – Social Vulnerability Index
- **Tier 1 Hospitals** – Hospitals with emergency department capabilities 24/7
- **Tier 2 Hospitals** – Hospitals that do not provide emergency room capabilities and are more single service in nature such as psychiatric, rehabilitation, and/or long term acute service.
- **TOC** – Tactical Operations Center for Louisiana EMS Emergency Response
- **WebEOC** – emergency management information and resource request platform used during response by Parishes and the State EOCs
- **211** –hotline used by LDH EOC to share information with the public including access to resources

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Appendix C: Resources & Tools

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Appendix D: COVID-19 Regional Load Leveling Strategies

Pre-Hospital Setting: contingency practices and/or activities conducted in the pre-hospital setting.

| Activity | Legal Document Issued | Description |
|---|-----------------------|--|
| Medical Monitoring Station | State/Federal PHE | <p>Early into the pandemic, NHs were mass discharging patients to the Hospitals. The Emergency Departments were reporting holding NH patients that did not meet admit criteria. It should also be noted that early-on in the outbreak, the NHs didn't have the capability of isolation and accessibility to larger volumes of PPE much needed during the initial response phase.</p> <p>The State and Federal PHE assisted the state with securing a funding source for the state-secured contracts; as well as obtaining reciprocity for out-of-state providers.</p> <p>The initial intent of establishing a Medical Monitoring Station was to assist hospitals with surge. During the initial phase of the COVID pandemic, the elderly especially those in congregate settings like NHs, were identified as being a vulnerable population susceptible to COVID complications. By COVID Wave #3, the effort of an MMS changed to a more meaningful model of directing state-contracted staff directly into certified facilities to assist with surge.</p> |
| Quarantine/Isolation Camps for Homeless | State/Federal PHE | <p>Throughout all phases of the pandemic, there were outbreaks within the homeless community. Initially, multiple sites were established across the state for quarantine/isolation of homeless. By COVID Wave 3, two (2) isolation camps were being used. Chicot Camp Grounds was established composed primarily of campers - which were not conducive to those with functional or ADA needs. Hence, Chicot was used for COVID positive, homeless, with non-ADA needs. Caldwell Hospital, delicensed some of their beds and the site was used for COVID positive, homeless, ADA clients.</p> <p>The State and Federal PHE assisted the state with a funding source via FEMA Public Assistance funds as multiple contracts were needed to support these two sites. Transportation contracts with Acadian were also established to 'haul' COVID positive patients to the sites.</p> |
| Testing Sites | State/Federal PHE | <p>During the initial phase of COVID, the testing capability was sparse. Testing kits and the operation to implement took several weeks of adjustment. Production, assembly, delivery, and allocation models were complicated requiring weekly communication with healthcare infrastructure - i.e. Tier 1 and Tier 2 hospitals, pharmacies, parishes, partners, and healthcare coalitions. Establishing community testing sites not only expanded accessibility to the transportation-challenge but also prevented the Hospital ED from getting further overwhelmed and reaching crisis-mode.</p> |

| | | |
|---|----------------------------------|---|
| Postpone Elective Surgeries | State Health Officer (SHO) Order | During the initial phase of COVID, there were gaps in PPE. Local, state and federal government made purchases of available PPE. The Strategic National Stockpile (SNS) Program pushed available caches to the state. Much of the SNS caches were expired materiel. Efforts to conserve or extend available PPE supply were conducted to include Battelle System. The SHO Order to post-pone elective surgeries was intended to temporarily delay medical procedures and thereby 1) prevent unnecessary exposure and 2) conserve PPE. The SHO Order was issued at a time of high-levels of Hospital Staff being exposed and fallen sick, reducing the overall staffed bed availability in the community. |
| Shut Down Dental practices | SHO Order | This SHO Order was also directly related to the SHO Order of postponing elective procedures. The dental hygienists had actively reached out to the SHO to request specific prevention strategies to limit their exposure. By this time in the COVID response, distribution of PPE by large chain suppliers were allocating the distribution of material to large volume contracts (such as government) and with large health systems likely to be handling more emergent needs of COVID patients. Larger systems/contracts were more likely to be honored than smaller volume, non-emergent settings such as dental offices. |
| Visitation Suspended in NHs and Hospitals | CMS; SHO Order | <p>SHO Order: During COVID Wave 1 and Wave 2, there were gaps in PPE and testing capabilities. The elderly in congregate settings were identified as the vulnerable population susceptible to higher morbidity and mortality outcomes when exposed to COVID. NH Task Force was created to address frequency of testing in NH for both clients and staffing so as to measure and prevent exposure. In Wave 3, vaccination capability was unfolding with targeted efforts for those in NHs and other high risk groups. NH visitation was suspended in a concerted effort to prevent exposure from the community into the NH. As PPE increased, testing capability increased, vaccination options increased and community levels of COVID prevalence decreased, visitation was revisited and adjusted.</p> <p>CMS Blanket Waiver: CMS waived Patient Rights under 42CFR for hospitals impacted by an outbreak of COVID. Hospital located in a state with widespread confirmed cases, would not be required to meet the requirements..."related to patient visitation, including the requirement to have written policies and procedures on visitation of patients who are in COVID19 isolation and quarantine process.</p> |

Hospital/System Setting: contingency practices and/or activities conducted in the hospital/ system setting.

| | | |
|---|--------------------|--|
| Lack of PPE/ lack of proper PPE | CMS Blanket Waiver | <p>During the initial phase of COVID, there were gaps in PPE. Local, state and federal government made purchases of available PPE. The Strategic National Stockpile (SNS) Program pushed available caches to the state. Much of the SNS caches were expired materiel. Efforts to conserve or extend available PPE supply were conducted to include Battelle System. The SHO Order to post-pone elective surgeries was intended to temporarily delay medical procedures and thereby 1) prevent unnecessary exposure and 2) conserve PPE and hospital bed capacity. The SHO Order was issued at a time of high levels of Hospital Staff were being exposed, reducing the overall staffed bed availability in the community.</p> <p>PPE contingency practices changed with fluctuating availability. The CMS Blanket Waiver waived Sterile Compounding to allow used face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only. This was intended to conserve scarce face mask supplies. CMS would not review the use and storage of face masks.</p> |
| Placing Patients on Vents; moving away from vents | | <p>Medical parameter was to place patient on a vent with O2 and CO2 was at a certain level; noticed that patients were not doing well...went to an Altered protocol with putting patients on O2 early, treating with steroids; and positive pressure Oxygen.</p> |
| Triage in off-site locations | CMS Blanket Waiver | <p>CMS waived enforcement of EMTALA section 1867 which allowed hospitals, psychiatric hospitals, and critical access hospitals to screen patients at a location offsite from the hospital's campus to prevent COVID spread.</p> |
| Holding in ED/ areas in non-traditional areas of hospital | CMS Blanket Waiver | <p>CMS waived certain physical environment requirements under the Medicare Conditions of Participation to allow for increased flexibilities for surge capacity and patient quarantine at hospitals, psychiatric hospitals, and critical access hospitals as a result of COVID19. CMS permitted facility and non-facility space that is not normally used for patient care to be utilized for patient care quarantine. This would allow for increased capacity and promote appropriate cohorting of COVID19 patients.</p> |
| Flexibility in Discharge Planning | CMS Blanket Waiver | <p>CMS provided flexibility regarding discharge planning. CMS waived requirements related to post-acute care services so as to expedite the safe discharge and movement of patients among care settings. CMS maintained that discharge planning should ensure a patient is discharged to an appropriate setting with the necessary medical information and goals of care.</p> |

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| Telemedicine | CMS Blanket Waiver | <p>CMS waived provisions related to telemedicine for Critical Access Hospitals (CAH), making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospitals. The CMS Waiver allowed for increased access to necessary care for hospital and CAH patients, including access to specialty care. CMS also granted flexibility with the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. Health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others.</p> <p>COVID facilitated a gap in staffed beds. Telemedicine was a load-leveling activity to ameliorate crisis care. Hospitals that normally transferred complex patients had to keep them on-site; the provider may not have done the procedures/ treatment before (even after telemedicine consult). Challenges were likely faced from the both the specialist and from the provider expecting to transfer to a specialist.</p> |
| Fluctuating Nurse to Patient Ratios | CMS Blanket Waiver | <p>CMS provided flexibility related to nursing services. The waivers allow nurses increased time to meet the clinical care needs of each patient and allow for the provision of nursing care to an increased number of patients. CMS also provided flexibility in certain settings related to licensure and certification so as to use all available clinicians.</p> |
| Paramedics as nurse extenders | CMS Blanket Waiver | |
| Federal Teams embedded at Hospitals | State/Federal PHE CMS Blanket Waiver | <p>The State and Federal PHE provided for reciprocity for out-of-state providers.</p> <p>CMS Waiver: CMS allowed flexibility for physicians to be able to practice before full medical staff/governing body review and approval so as to address workforce concerns related to COVID19. CMS also provided flexibilities with the credentialing and privileging process.</p> |
| State Contracted Providers embedded at Hospitals | State/Federal PHE | <p>The Federal PHE allowed the state to access FEMA Public Assistance (PA) Program funds for the State-Hospital Staffing Program.</p> <p>The State and Federal PHE provided for reciprocity for out-of-state providers.</p> <p>CMS Waiver: CMS allowed flexibility for physicians to be able to practice with a temporary license. CMS also provided flexibilities with the credentialing and privileging process.</p> |

Community Settings: contingency practices and/or activities conducted in the community setting. Note that there may be some overlap between pre-hospital and community setting activities.

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| Mask Mandates | State/Federal PHE Executive Orders | Federal and State Public Health Emergency and concomitant Executive Orders were issued at federal and state levels to recommend, and at times, mandate the wearing of masks to prevent spread of disease. |
| Stay at Home Orders and Social Distancing practices | State/Federal PHE Executive Orders Local Government Orders | Federal and State Public Health Emergency and concomitant Executive Orders were issued at federal state and local levels to recommend, and at times, mandate the social distancing and occupancy levels in businesses as a means of preventing spread of disease. |
| EMS/ Treat, Triage, Transport (T3) | State/Federal PHE CMS Blanket Waiver | CMS Waiver provided flexibility for "Ambulance Treat in Place." |
| National Guard, RNS, LPNS, Pharmacists, Phlebotomists to provide vaccines. | State/ Federal PHE Executive Order State Health Officer (SHO) Order | State PHE directed the State Health Officer to develop protocols for allowing National Guard to administer vaccines. SHO Orders allowed LAANG, RNS, LPNs, Pharmacists and Phlebotomists to administer vaccines to those 16 years and up without specific MD orders, provided that they follow established protocols. |
| Monoclonal Antibodies (MAB) and other pharmaceuticals | Federal PHE | The Federal PHE enabled rapid development and distribution of various treatments under EUA. Allocation models were developed with the intent of effective yet fair distribution of resources. Facilities would develop criteria based on clinical eligibility and availability of treatment. |

Appendix E: Baton Rouge Public Engagement Session

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| Family Service of Greater Baton Rouge | Coastal Communities Consulting | Louisiana Interchurch Conference |
| Together Baton Rouge | Vietnamese Initiatives in Education and Training (VIET) | Congregational Development and Disaster Recovery |
| Urban Restoration Enhancement Corporation | Louisiana School for the Deaf | Islamic Circle of North America |
| Catholic Charities – New Orleans | First United Methodist Church | Baton Rouge Speech and Hearing Foundation |
| Catholic Charities – Baton Rouge | HIV/AIDS Alliance for Region Two Inc., or HAART | Baton Rouge Sickle Cell Anemia Foundation |
| AARP – Baton Rouge | Acadiana CARES | Capital City Alliance |
| 100 Black Men – Baton Rouge | Youth Oasis | Healing Place Church |
| New Orleans Mayor’s Office | Autism Society of Southwest Louisiana | Jefferson Baptist Church |
| Baton Rouge Mayor’s Office | Calcasieu Association for Retarded Citizens | Catholic Daughters of the Americas –St. Jean Vianney Chapter |
| Forum 35/Chamber – Baton Rouge | Cameron Council on Aging | Capital Area United Way |
| YWCA – Baton Rouge | Islamic Society of Lake Charles | Together Baton Rouge |
| Department of Health and Hospitals –OCDD | Potters House | St. Jean Vianney Catholic Church |
| Department of Health and Hospitals –OBH | Southwest Louisiana AIDS Council | East Baton Rouge Council on Aging |
| Louisiana Workforce Commission –LRS | Calcasieu Council on Aging | American Diabetes Association-Baton Rouge Chapter |
| Family Road of Greater Baton Rouge | ACORN, the Association of Community Organizations for Reform Now | Juvenile Diabetes Research Foundation – Baton Rouge Chapter |
| Alzheimer's Services of the Capital Area | Catholic Charities – Diocese of Lake Charles | Arthritis Association of Louisiana |
| St. James Place | Deaf Action Center | The ALS Association – Louisiana-Mississippi Chapter |
| American Heart Association | United Way of Southwest Louisiana | Families Helping Families Region 7 |
| Cancer Services of Greater BR | Families Helping Families of Southwest Louisiana | Bossier Parish Community College |
| Boys Hope/Girls Hope | Family and Friends of Louisiana’s Incarcerated Children | Shreveport Community Foundation |
| St. Vincent de Paul | La Familia Resource Center | American Cancer Society |
| Louisiana Baptist Convention | Families Helping Families of Acadiana | Maria Lorick Heart of Hope Cancer Foundation |
| Star Hill Church | Families Helping Families of Greater Baton Rouge | Juvenile Diabetes Research Foundation –statewide |
| Louisiana Health Care Quality Forum | World Religions Council of New Orleans | American Heart Association |
| Louisiana Business Group on Health | Office of Public Health – Regional Office (Region 3) | Northwest Louisiana Food Bank |
| LCTCS – Policy | Hispanic Chamber of Commerce | Goodwill Industries of North Louisiana |
| Jewish Federation of Greater Baton Rouge Southern | Black Chamber of Commerce | Salvation Army |
| University Student Government | ULL Student Government | The Philadelphia Center |
| Southern University Foundation | BR Mayor's Office of Homeland Security and Emergency Planning | Providence House |
| LSU Student Government | Louisiana Interfaith Disaster Relief Network | Alzheimer's Association of North Louisiana |
| LSU Hispanic Student Cultural Society | Lutheran Disaster Response | |
| Catholic Diocese – Baton Rouge | Louisiana United Methodist Disaster Recovery Ministry | |
| Christ the King Catholic Church LSU campus | | |
| Mary Queen of Viet Nam Community | | |
| Development Center (MQVN CDC) | | |

Re-Vitalize Philanthropic
Foundation for Medical
Disorders
Shreveport District of United
Methodist Church
Light House Mentors
Big Brothers Big Sisters of
America
Caddo Council on Aging
Louisiana Association for the
Blind
St. Catherine Community Center
B'nai Zion Congregation
Ruston-Lincoln Chamber of
Commerce
Monroe Chamber of Commerce
Children's Coalition for
Northeast Louisiana
MDA Association
Ark-La-Tex Pregnancy Center

Shreveport Chamber of
Commerce
Catholic Diocese of Shreveport
Catholic Charities
United Way
United Way – distributed to
targeted membership
Union Community Action
Association
Volunteers of America -
Lighthouse
Heart of Hope Ministries
Pool Siloam Medical Ministry
Multicultural Center of the
South
CenterPoint
ARC of Caddo Bossier
AARP – Shreveport
Shreveport Deaf Action Center
One Hundred Men of
Shreveport

St. Joseph Hospice – Shreveport
TEAMS LA
Alzheimer's Agency of North
Louisiana
Martin Luther King Health
Center
Food Bank of Northwest
Louisiana
Bossier Council on Aging
Red River Council on Aging
Sabine Council on Aging
Natchitoches Council on Aging
Hope for Homeless
Louisiana Association of
Nonprofit Organizations
(LANO) –
North Louisiana Office
LANO – distributed to targeted
membership