CRISIS STANDARDS OF CARE

PROMULGATION

The Idaho Crisis Standards of Care Plan will be used to provide a framework for the development and implementation of crisis standards of care. The development of this plan was directed by a work group comprised of legal, emergency management, emergency medical services, hospital, and public health representatives from throughout the state.

The Idaho Crisis Standards of Care Plan will be implemented when a disaster event overwhelms usual health and medical capabilities and capacities, resulting in an inability of the healthcare system to provide the standard levels of care to patients. This plan provides the structure needed for collaborative development of crisis standards of care clinical guidance by the State of Idaho Disaster Medical Advisory Committee, comprised of subject matter experts, and the dissemination of guidance to the seven public health districts and the healthcare system in Idaho.

In recognition of the emergency responsibilities of Idaho Department of Health and Welfare with the authority vested in me as the Division Administrator, I hereby promulgate the Idaho Crisis Standards of Care Plan.

Digitally signed by
Elke Shaw-Tulloch
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Elke Shaw-Tulloch
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CRISIS STANDARDS OF CARE

INTRODUCTION (PURPOSE, SCOPE, SITUATION OVERVIEW)

INTRODUCTION

The Idaho Department of Health and Welfare (DHW) worked with local public health, emergency management, Emergency Medical Services (EMS), healthcare, and legal partners statewide to develop the Idaho Crisis Standards of Care (CSC) Plan. During the development of this plan, DHW convened a variety of workgroups to discuss CSC implementation, potential response strategies, and healthcare considerations to meet the challenges presented in healthcare delivery during disasters that overwhelm Idaho's healthcare system.

The plan was developed using the Institute of Medicine's (IOM) *Crisis Standards of Care, A Systems Framework for Catastrophic Disaster Response* guidance (IOM, 2012. Washington, DC: The National Academies Press). According to IOM guidance, the framework of CSC planning is based on "ethical considerations that govern planning and implementation and the legal authority and legal environment within which plans are developed." Finally, the plan is based on the five key elements of CSC planning identified by the IOM. They include Emergency Management and Public Safety, EMS, Hospital, Public Health, and Out of Hospital Care.

As part of CSC response, Idaho has adopted a framework which includes convening the State of Idaho Disaster Medical Advisory Committee (SIDMAC). The SIDMAC will meet regularly in anticipation of or upon activation of the Idaho CSC Plan to develop incident-specific priorities and guidance for the delivery of healthcare and use of scarce medical resources. These priorities and guidance will be disseminated throughout the healthcare system for implementation by healthcare organizations and to the public.

The plan aligns with National Incident Management System guidance (U.S. Department of Homeland Security, Federal Emergency Management Agency. *National Incident Management System, Third Edition,* October 2017) to facilitate effective response coordination and is organized in accord with the *Developing and Maintaining Emergency Operations Plans, Comprehensive Preparedness Guide (CPG) 101* (Version 2.0, November 2010. U.S. Department of Homeland Security, Federal Emergency Management Agency).

PURPOSE

This plan has been developed to provide a process that supports healthcare delivery in Idaho during disasters, such as the current coronavirus disease 2019 (COVID-19) pandemic, in which the healthcare system may be overwhelmed by patient surge and/or resource shortages. The plan's framework supports the delivery of SIDMAC guidance intended to assist healthcare organizations achieve the best healthcare delivery outcomes during a crisis for the population of Idaho.

APPLICABILITY

This plan has been developed to support the Idaho *Emergency Operations Plan*, the DHW *Emergency Base Plan* (2020), the DHW *Medical Surge Plan* (2019), and other incident specific DHW emergency response plans. The plan aligns with the *National Response and Recovery Framework, Fourth Edition* (U.S. Department of Homeland Security, October 28, 2019) to facilitate coordination within the state emergency response system. The plan is intended to be activated along with other emergency response plans based on the nature, causes, severity, duration, and other disaster-specific circumstances, including infectious disease public health emergencies.

SCOPE

This plan establishes a framework for Idaho to adopt CSC and for the SIDMAC to develop guidance for healthcare entities during catastrophic public health emergencies or disasters. This plan applies to the state of Idaho and its agencies, other jurisdictional agencies, and organizations that provide healthcare in Idaho.

The plan supports the coordination of public health, emergency management, EMS, and healthcare organizations in Idaho. The plan is intended to guide statewide activation and implementation of CSC during catastrophic public health emergencies and is not intended to be an emergency plan for individual agencies or organizations.

PLANNING ASSUMPTIONS

The Idaho CSC Plan will be activated during disaster situations in which usual standards of care are not possible due to scarcity of resources, and it is necessary to balance the needs of the community with the needs of individuals. Prior to activation of the plan, the care capability continuum may have already moved from conventional standards of care to contingency (functionally equivalent) care. When conventional and contingency care standards are no longer possible due to shortages of space, staff, or supplies, CSC will be activated by the state.

Some or all of the following assumptions must be true for the Idaho CSC Plan to be activated:

- State and federal (e.g., Stafford Act, Public Readiness and Emergency Preparedness (PREP) Act, Public Health Services Act) disaster declarations are in place or have been requested.
- Most or all of the state's healthcare infrastructure has been impacted.
- Resources available to healthcare entities are insufficient to provide the usual standard of care.
- Multiple health organizations within a community or region are similarly affected.
- Patient transfer or transport to other facilities is not possible or feasible, at least in the short term.
- Medical countermeasures (e.g., vaccines, medications, antidotes, blood products) are depleted or otherwise unavailable.
- Trained healthcare staff is unavailable or unable to adequately care for the volume of patients needing care.

- Local, regional, state, tribal, and federal resource caches (of equipment, supplies, and pharmaceuticals) have already been distributed, and no short-term resupply is foreseeable.
- There are disruptions to the healthcare supply chain.

HEALTHCARE FACILITY INDICATORS FOR CONVENTIONAL, CONTINGENCY, AND CRISIS CARE

As a public health emergency moves along the continuum of care (i.e., from conventional, to contingency, to crisis), normal operating conditions will give way to extreme operating conditions. Healthcare resources, including space, staff, and supplies, will become increasingly scarce. The indicators listed in Table 1 may serve as general assumptions or indicators for healthcare facilities during the transition from one level of care to another along the continuum of care.

Table 1 – Indicators Across the Continuum of Care

Normal operating conditions ⟷ Extreme operating conditions

	Conventional	Contingency	Crisis
Space	Usual patient care space fully utilized	Patient care areas repurposed	Facility unsafe/damaged or non-patient care areas (classrooms, etc.) used for patients
Staff	Usual staff called in	Staff extension (deferrals of non-urgent care, treating wider groups of patients, change in responsibilities, etc.)	Trained staff unavailable or unable to adequately care for number of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies	Supplies lacking, possible re-direction of life-sustaining resources
Standard of Care	Usual care	Functionally equivalent care	Crisis care

GENERAL HEALTHCARE RESOURCE MAXIMIZATION STRATEGIES

The following resource maximization strategies can apply to all healthcare access points (e.g., facilities, providers, EMS). The SIDMAC should consider these general approaches when developing specific guidance.

- SUBSTITUTE: Use an essentially equivalent facility, professional, drug, or device for one that would usually be available.
- ADAPT: Use a facility, professional, drug, or device that is not equivalent, but provides the best possible care in the setting of limited resources.

- CONSERVE: Use lower dosages or change practices, e.g., minimize use of oxygen by using air for nebulizers, when possible.
- REUSE: Only after appropriate disinfection or sterilization, use single use items again.
- OPTIMIZE ALLOCATION: Allocate resources to patients whose prognosis is more likely to result in a positive outcome with limited resources.

SIDMAC DECISION AREAS

According to federal guidance and best practices established in other CSC plans, there are five key topic areas that can be addressed by the SIDMAC. These areas include:

- Emergency Medical Services (EMS) dispatch, response, assessment and treatment, and transport.
- Primary, secondary, and tertiary triage for healthcare facilities.
- Expanded scopes of practice, as approved by regulatory authorities.
- Priorities for medical resources including space, staff, and supplies.
- Considerations for healthcare entities, including hospitals, out-of-hospital facilities, and alternate care sites.

ETHICAL CONSIDERATIONS

Under conventional (usual) conditions, healthcare resources are sufficient to allow healthcare professionals and their patients to make choices that best benefit the individual patients. During a disaster, when healthcare resources are overwhelmed, CSC will be adopted to maximize the number of lives saved. Decision-makers, medical providers, and medical practitioners must focus on doing the most good for the greatest number of people based on available health resources. During recovery from a public health disaster, their focus of care shifts back to individual healthcare.

In order to help the most people during CSC while aligning with communities' values, it is critical to establish a core ethical framework for this plan to provide guidance for decision-makers, medical providers, and medical practitioners. The core ethical guidance for this plan include accountability, consistency, duty to care, duty to steward resources, proportionality, and transparency as outlined by the IOM CSC Framework Vol. 1, Table 1-1 (2012). These guiding ethical principles may be applied to patient care, equitable resource allocation, professional and legal standards, communications, and other response operations.

STATEWIDE CONCEPT OF OPERATIONS

INDICATORS FOR CRISIS STANDARDS OF CARE ACTIVATION

The indicators listed in Table 2 may be used by the DHW Director and other state policy makers to determine the need for CSC. The precise trigger point for transitioning from contingency to crisis will be determined by the Director in consultation with the Governor's Office, IDHWOC, SIDMAC, the Idaho Office of Emergency Management (IOEM), local health officials, and healthcare system stakeholders.

Table 2 – Indicators for Conventional, Contingency, and Crisis Standards of Care

Conventional	• One or more counties/public health districts at or near capacity. • Patient transfer is temporarily affected.
Contingency	• Local jurisdictions initiate resource requests. • Medical countermeasure availability declining. • One or more hospitals on diversion or damaged. • Patient transfer across all or part of state is limited.
Crisis	• One or more counties or healthcare entities is experiencing crisis level shortages of space, staff, or supplies. • Medical countermeasures depleted. • Patient transfers insufficient or impossible statewide. • Local jurisdiction resource requests unfillable or undeliverable. • Multiple healthcare access points impacted.

CSC ACTIVATION PROCESS

Activation of CSC may be triggered by a no-notice disaster (e.g., earthquake) or a known, pervasive health crisis (e.g., pandemic influenza). During an anticipated public health emergency, such as a pandemic, the SIDMAC may convene multiple times before CSC is activated (i.e., during conventional or contingency care).

The process to activate CSC will include partners and stakeholders from across the state's unified command structure, healthcare system, public health, DHW, the Governor's office, and others.

COORDINATING AGENCIES ROLES AND RESPONSIBILITIES

Statewide activation of this plan requires coordinated efforts among state, regional, and local agencies as well as healthcare organizations and providers. This section of the plan identifies primary, coordinating, and support agencies that are likely to participate in a response; their roles and responsibilities; and how response activities will be directed, controlled, and coordinated. The list below is not intended to be exhaustive, but instead to provide an overview of roles and responsibilities that may be attributed to the organizations listed. Additional organizations may be involved in a response depending on the type, severity, and duration of the emergency situation. This section also describes the indicators for plan activation and deactivation.

PRIMARY AGENCY

Idaho Department of Health and Welfare

- Activate and maintain the Idaho Department of Health and Welfare Operations Center (IDHWOC).
- Send DHW representative (ESF-8 Liaison) to the Idaho Emergency Operations Center (IDEOC).
- Activate and convene the State of Idaho Disaster Medical Advisory Committee (SIDMAC).
- Ensure that SIDMAC guidance is disseminated through public health districts, healthcare organizations, regional healthcare coalitions (RHCCs), professional medical associations, and to the public.
- Provide staff, financial, administrative, and public information support to the IDHWOC.
- Participate in the IOEM After-Action Conference (AAC) and Improvement Plan (IP) development.
- Conduct the DHW AAC and make recommendations for implementing corrective actions based on the DHW AAC.
- Develop DHW After-Action Reports (AARs) and IPs following exercises or real incidents.
- Maintain and coordinate updates of the Idaho CSC Plan.
- Advise the Governor about situational awareness and make public health recommendations.

COORDINATION AGENCIES

Idaho Office of Emergency Management (IOEM)

- Activate emergency support functions within the Idaho Emergency Operations Plan (IDEOP).
- Establish a Unified Command (UC) with DHW and other agencies.
- Support SIDMAC operations, provide logistical support, and participate in the committee as requested.
- Activate and maintain the IDEOC and Joint Information Center (JIC)
- Through the IDEOC:
    - Support Emergency Support Function (ESF-8): Public Health and Medical Services and other ESFs as required.
    - Coordinate county Emergency Operations Center (EOC) requests for resources and requests for federal assets.
    - Advise the Governor about situational status and make recommendations.

  - Coordinate alternate care site information with county officials and other jurisdictional partners.
  - Manage and coordinate communications with response partners.
  - Communicate information, plans, requirements, and strategies with county EOCs.
  - Acquire and manage resources (including voluntary), supplies, and services from core capability service providers via contracts, mission assignments, interagency agreements, and donations.
  - Activate mutual aid agreements for additional resources.
- Provide DHW with AARs/IPs for emergency incidents involving DHW.

PUBLIC HEALTH DISTRICT (PHD) AUTHORITIES

- Activate and maintain public health emergency operations.
- Provide expertise to the SIDMAC as requested.
- Activate the PHD call center, if needed.
- Provide staff, financial, and administrative support to the county EOC as requested.
- Provide public information support to the county EOC.
- In the county EOC (if activated or available):
  - Collaborate and coordinate with DHW.
    - Embed an ESF-8 Liaison in the county EOC.
    - Provide public health situational reports to the IDHWOC or IDEOC, or upload to WebEOC as appropriate.
    - Facilitate implementation of CSC guidance.
- Develop AARs and IPs following exercises or real incidents.
- Make recommendations for implementing corrective actions.

COUNTY EMERGENCY MANAGEMENT AGENCIES

- Activate the appropriate county Emergency Operations Plan Annexes and Appendices.
- Support SIDMAC operations and participate in the committee as requested.
- Activate and maintain county or regional EOCs and support public information needs.
- Through the EOCs:
  - Coordinate county ESF-8: Public Health and Medical Services.
  - Coordinate county EOC resource requests with the IDEOC.
  - Maintain county EOC activation and maintain liaison with other jurisdictional EOCs, Department Operations Centers (DOCs), Incident Command Posts (ICPs), or agencies, as necessary.
  - Advise county officials about situational status and make recommendations.
  - Manage and coordinate communications with response partners.
  - Communicate information, plans, requirements, and strategies to the Idaho and municipal EOCs.

- Acquire and manage resources (including voluntary), supplies, and services from core capability service providers via contracts, mission assignments, interagency agreements, and donations.
- Activate and coordinate deployment with IOEM of any needed ancillary operations and/or facilities (e.g., alternate care sites).
- Activate mutual aid agreements for additional resources.

SUPPORT AGENCIES

Other State Agencies and Programs

- Provide subject matter experts to IDHWOC or SIDMAC as needed.
- Provide staff to IDEOC or IDHWOC as needed.
- Make recommendations for implementing corrective actions.
- Participate in AACs and AAR/IP development.

Emergency Medical Services (EMS)

- Respond to dispatch requests for EMS services.
- Support SIDMAC operations and participate in the committee as needed.
- Provide patient assessment and initial medical treatment services.
- Implement CSC guidance (as recommended by the EMS Physician Commission and approved by agency Medical Directors) during emergency medical services provision.
- Provide transport to hospital or alternate medical facilities, as recommended.

Hospitals, Healthcare Facilities, Long-Term Care Agencies, Ambulatory Care Facilities

- Activate facility/agency EOPs or protocols.
- Implement CSC guidance as approved by the organizations' Clinical Care Committees (CCC), Medical Directors, or Chief Medical Officers as appropriate.
- Provide healthcare facility situational assessments and information to jurisdictional EOCs, as needed.
- Respond to status queries in the Idaho Resource Tracking System (IRTS) to show bed capacity, staffing, equipment, and supply levels, as requested.
- Coordinate and implement patient movement, if necessary.
- Coordinate public information with jurisdictional public information activities.
- Request needed resources that are beyond the capacity of the healthcare organization through the jurisdictional EOC.
- Participate in after-action reporting and planning efforts to mitigate the effects of future disaster/emergency incidents.

Home Health/Hospice Agencies

- Activate agency EOPs.
- Implement CSC guidance as approved by the organizations' Clinical Care Committees (CCC), Medical Directors, or Chief Medical Officers.

- Provide situational assessments and information to jurisdictional EOCs, as needed.
- Coordinate public information with jurisdictional public information activities.
- Request needed resources that are beyond the capacity of the agencies through the jurisdictional EOC.
- Participate in after-action reporting and planning efforts to mitigate the effects of future disaster/emergency incidents.

REGIONAL HEALTHCARE COALITIONS

Idaho has three regional healthcare coalitions (RHCCs) to support hospital and healthcare system preparedness and response activities across the state. During a CSC response, these RHCCs may participate in the SIDMAC and work with regional/local partners and healthcare providers to disseminate SIDMAC guidance across the coalition. The RHCCs may assist in information sharing, including Essential Elements of Information (EEI) collection and dissemination, with DHW, local public health districts, and healthcare organizations.

- Coordinate with regional public health districts and DHW.
- Assist in information sharing with regional public health districts and DHW.
- Advise DHW and public health districts of situational status and make recommendations.

FEDERAL RESOURCES

United States Department of Health and Human Services (HHS)

- Upon DHW request, support may include:
  - Training.
  - Funding.
  - Grant opportunities.
  - Guidance.
  - Research and reports.

Office of the Assistant Secretary for Preparedness and Response (ASPR)

- The Regional Emergency Coordinator (REC):
  - Serves as ASPR's primary representative.
  - Consults and makes recommendations to DHW.
  - Provides situational awareness to ASPR.
  - Provides command and control for deployed HHS resources.
- Upon DHW request, support may include:
  - Pharmaceuticals.
  - Medical countermeasures.
  - Equipment and supplies.

Centers for Disease Control and Prevention (CDC)

- Upon DHW request, support may include:
  - Federal advisory committee guidance on CSC.
  - Funding.
  - Disease surveillance.
  - Disease control assistance.
  - Behavioral health recommendations.
  - Subject matter expertise.

STATE OF IDAHO DISASTER MEDICAL ADVISORY COMMITTEE (SIDMAC) ROLES AND RESPONSIBILITIES

The SIDMAC will be convened by the DHW in anticipation of or following activation of the Idaho CSC Plan. The DHW will identify and notify appropriate persons to staff the SIDMAC. Because each type of disaster response is different, a different set of medical professionals, public health staff, partner agency, and subject matter experts may be needed to assist in the development of guidance. The SIDMAC will be headed by an DHW appointee and may be comprised of the following as needed and based on the disaster situation:

- Additional DHW designees.

- Representatives from partner agencies such as public health, emergency management, other stakeholders from local, state, or federal agencies, and representatives from a state medical board or association.
- Representatives from healthcare organizations such as stakeholders from healthcare facilities, healthcare networks, EMS/pre-hospital agencies, board or association involved in the CSC response.
- Subject matter experts with expert training and knowledge in one or more response areas (e.g. Chemical, Biological, Radiological, Nuclear, and Explosive ((CBRNE)), infectious diseases, medical countermeasures, EMS, legal/ethical).
- Clinical care physicians and qualified triage nurses.

SIDMAC guidance will be disseminated to the healthcare system throughout the emergency response and is intended to assist healthcare organizations in maximizing their response capacities. It is not intended as direction for local, state, or facility response activities. SIDMAC guidance may include:

- EMS triage and response guidance.
- Primary, secondary, and tertiary triage guidance for healthcare facilities.
- Expanding scopes of practice for healthcare professional, as legally approved by regulatory authorities.
- Priorities for the allocation and utilization of scarce medical resources.
- Additional considerations for healthcare access points, including hospitals, outpatient facilities, and alternate care sites.

At the healthcare facility level, a Clinical Care Committee (CCC) will receive the SIDMAC guidance and work with their healthcare professionals to implement the guidance. The primary functions of a CCC are to interpret the SIDMAC guidance, implement the guidance and triage standards, and make resource allocation decisions to facilitate the transition from individual to population-based care. Because the guidance is implemented through this process, physicians can better focus on patient care.

DIRECTION, CONTROL AND COORDINATION

During a public health emergency, operational control will reside with IOEM and DHW. The response will be managed at the state level through their respective emergency operations centers or jointly at the IDEOC. The SIDMAC will support the response by providing guidance to these organizations as well as other stakeholders throughout the state, including healthcare providers. In short, the SIDMAC provides healthcare clinical guidance, while IOEM and DHW manage the operational components of the response. Table 3 provides a graphic representation of the shift from operations to policy as well as the transition from state, to regional, to facility-level incident management.

Table 3 – Direction Control and Coordination

	State Level	Regional/County Level	Facility/Local Level
CSC Guidance Groups - Guidance for healthcare - Priorities for scarce resources	SIDMAC	Public Health Districts/Coalitions	Clinical Care Committee
Public Health and Medical - Lead entities for public health and medical services	IDHWOC	Public Health District EOCs	Hospital Command Center
Emergency Management - Lead for response & recovery - Operational mgmt. and support	IDEOC	County EOCs	First Responders and Public Safety EOCs
	State ⟷		Facility/Local

CLINICAL CONCEPT OF OPERATIONS

This section of the plan covers clinical topics relevant to a CSC response. It provides considerations for the SIDMAC to assist committee members during the development of CSC guidance. It includes a number of key decision areas the SIDMAC must focus on when developing conventional, contingency, and crisis level guidance. By focusing on these areas, the SIDMAC can efficiently address the public health emergency and concentrate on the most relevant topics for policy and guidance development.

These areas include:

- Emergency medical services (EMS) triage.
- Primary triage.
- Secondary triage.
- Tertiary triage.
- Expanded scopes of practice, as approved by regulatory authorities.
- Considerations for healthcare facilities, including hospitals, out-of-hospital facilities, and alternate care sites.

EMERGENCY MEDICAL SERVICES (EMS) TRIAGE

During a public health emergency, EMS professionals are often the first to provide healthcare to critically ill or injured individuals. They perform a variety of crucial services including initial patient assessment, primary triage, and transport to a medical facility for definitive care. As a result, the EMS Physician Commission will need to create specific guidance for EMS providers that corresponds with the care continuum, from conventional to contingency to crisis standards of care.

In the case of COVID-19, EMS providers will likely respond to an overwhelming number of calls from people with respiratory illness. Because of this, EMS staff must stringently adhere to infection control and decontamination procedures. This is necessary to protect the health of the workforce throughout the course of the pandemic and ensure EMS availability for seriously ill individuals as well as non-pandemic-related emergencies.

EMS triage guidance must account for the various types of EMS professionals. In Idaho, EMS providers will likely fall into the following classifications, based on their training as well as national standards.

- Community Health Emergency Medical Services (CHEMS).
- Emergency Communications Officer.
- Emergency Medical Responder (EMR).
- Emergency Medical Technician (EMT).
- Advanced Emergency Medical Technician (AEMT).
- Paramedic.
- Credentialed Critical Care Paramedic.
- Ambulance-Based Clinician.

Tables 7 – 10 provide potential considerations that the EMS Physician Commission may consider when developing triage guidance for EMS providers. These are based on the following EMS functions: dispatch, response, patient assessment and treatment, and transportation.

PRIMARY TRIAGE

Primary triage is commonly defined as the first assessment prior to medical intervention. It may occur at a hospital emergency department, clinic, or other healthcare access point. This section applies to situations where EMS transport is not involved, e.g., self-presenting patients at hospital emergency departments. In a CSC response, primary triage will be required to optimize healthcare resources and do the greatest good for the greatest number of patients.

Hospitals and acute care facilities can use Simple Triage and Rapid Treatment (START) for adults, JumpSTART© for pediatrics, or emergency department triage levels 1–5. The SIDMAC has flexibility to modify guidance for hospital-based primary triage as additional evidence-based guidance are published.

Table 4 defines key terms used in START and JumpSTART© triage. IDME (Immediate, Delayed, Minimal, Expectant) is a mnemonic to color-code and summarize the various acuity levels associated with many different triage methodologies.

Table 4 – IDME Mnemonic for Primary Triage

Status	Color Code	Characteristics
Immediate	RED	• Life threatening illness or injury • Lifesaving intervention required • First to treat
Delayed	YELLOW	• Serious but not life-threatening illness or injury • Delaying treatment will not affect outcome • Second to treat
Minimal	GREEN	• Minor illness or injury • Walking wounded • Third to treat
Expectant	BLACK	• Not expected to survive • Will receive comfort care • May be upgraded to red if new resources permit treatment

SECONDARY TRIAGE

Secondary triage occurs after primary triage and may occur after initial medical interventions. During CSC, secondary triage may occur in any area where medical treatment is delivered. It involves continuing reassessment of patients by medical personnel throughout the medical intervention process to sort those patients who may most benefit from scarce medical resources. Based on standard practices, hospitals may employ additional triage tools such as the Emergency Severity Index (ESI), which was developed by the ESI Research Team working with the Agency for Healthcare Research and Quality (AHRQ). The ESI is a five-level triage system based on the estimated number of resources that will be used by individual patients. A brief description of the five levels is provided in Table 5. The SIDMAC may recommend the use of ESI or other secondary triage methodologies as needed throughout the CSC response. Pediatric secondary triage is typically performed using the ESI levels mentioned above. The ESI system has some specific considerations and parameters for pediatric patients. See the *Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4. Implementation Handbook 2012 Edition* for more information.

Table 5: Emergency Severity Index (ESI) Levels

Level	Name	Description
1	Resuscitation	Immediate, life-saving intervention required without delay
2	Emergent	High risk of deterioration, or signs of time-critical problem
3	Urgent	Stable, with multiple types of resources needed to investigate or treat (such as lab tests plus X-ray imaging)
4	Less Urgent	Stable, with only one type of resource anticipated (such as only X-ray, or only sutures)
5	Nonurgent	Stable, with no resources anticipated except oral or topical medications, or prescriptions

TERTIARY TRIAGE

Tertiary triage occurs after primary and secondary triage. It is normally performed in a hospital or acute care setting, typically by a triage officer. Many tools are available for tertiary triage. As a part of the COVID-19 response, the SIDMAC developed the *Patient Care Strategies for Scarce Resource Situations Annex* to provide clinical guidance for tertiary care.

During CSC, the purpose of tertiary triage is to determine priority for ICU level care. It may not be possible to admit all patients that need intensive care into the ICU or to provide ventilators to all individuals who need them. Therefore, guidance may need to be developed by the SIDMAC to support and guide triage officers during the tertiary triage process.

As with adults, pediatric tertiary triage is typically performed in a hospital setting by a triage officer. During CSC, the purpose of pediatric tertiary triage is to determine priority for ICU-level care. It may not be possible to admit all children that need intensive care into the pediatric intensive care unit (PICU) or neonatal intensive care unit (NICU); therefore, pediatric tertiary triage guidance may need to be developed by the SIDMAC to support and guide triage officers and intensivists during the pediatric tertiary triage process.

HEALTHCARE SECTOR CONSIDERATIONS

This section contains a wide variety of considerations that the SIDMAC may consider when developing guidance for specific types of healthcare access points. The tables provide information to consider for each standard of care along the healthcare continuum (conventional, contingency, and crisis). See the *Patient Care Strategies for Scarce Resource Situations Annex* for specific clinical guidance that the SIDMAC has adopted.

The following categories are addressed in Tables 6 – 19:

- General Considerations for All Types of Healthcare Facilities (Table 6).
- Considerations for EMS Dispatch (Table 7).

- Considerations for EMS Respond (Table 8).
- Considerations for EMS Patient Assessment and Treatment (Table 9).
- Considerations for EMS Transport (Table 10).
- Considerations for Hospital Emergency Department Admissions (Table 11).
- Considerations for Hospital Outpatient Services (Table 12).
- Considerations for Hospital Wards (Table 13).
- Considerations for Hospital Surgical Units (Table 14).
- Considerations for Hospital Critical Care (ICU) (Table 15).
- Considerations for Home Health (Table 16).
- Considerations for Ambulatory Care (Table 17).
- Considerations for Long-Term Care (Table 18).
- Considerations for Alternate Care Sites (ACS) (Table 19).

Table 6 – General Considerations for All Types of Healthcare Facilities

Conventional	Contingency	Crisis
1. Reinforce relevant infection control practices with healthcare workers/ staff, including when to stay home if ill. 2. Screen for contagious -like illness or other relevant symptoms. 3. Use kiosks to supply masks for incoming patients with respiratory or other infectious symptoms. 4. Exclude visitors with symptoms consistent with possible severe transmissible illness.	1. Plan for surge in care of patients in proportion to their representation in the population affected. 2. Ensure mechanisms to maintain connections between patients and their families, and to locate families and reunite them if separated. 3. Report available resources to public health as requested by public health leadership. 4. Implement strict exclusion from patient care of staff with symptoms of transmissible illness. 5. Use trained, non-medical volunteers to provide non-medical care for patients (e.g. providing meals, changing linens) in healthcare and community settings. 6. Foster flexibility in services/privileges within scope of practice (i.e., scope of professional license) provided by nurses, physicians, advanced practice providers, and other care providers. 7. Develop and implement applicable standing orders. 8. Streamlined documentation process to expand capacity to provide healthcare. 9. Incorporate limitations of visitors to patients with confirmed or suspected transmissible disease. Consider if appropriate for those patients at end of life or deceased.	1. Continue efforts to increase surge capacity through changes in care practices, e.g. further changes in documentation, nurse-patient ratios, active recruitment for alternative care providers. 2. Continue bed/resource capacity reporting. 3. Use objective criteria, make referral, care, and resource allocation decisions to maximize number of lives saved.

Table 7 – Considerations for EMS Dispatch

Conventional	Contingency	Crisis
1. Consider initial auto-answer during times of high call volume for medical emergencies. 2. Utilize other regional regulated emergency medical dispatch centers to assist with increased calls.	1. Prioritize calls according to potential threat to life; "pend" apparently non-life-threatening calls (note this requires a medically trained dispatcher, not available at many public safety answering points (PSAPs). 2. Utilize non-medically trained dispatch personnel to handle incoming non-emergent calls. 3. Decline response to, and refer low acuity, non-emergent calls to nurse triage line for referral to appropriate primary/secondary medical care.	1. Utilize non-certified dispatch personnel to handle incoming emergent calls. 2. Decline response to calls without evident potential threat to life (requires certified dispatcher and medical dispatch protocol. 3. Decline or delay response and consider telephone triage recommendations to self-transport for potential life-threatening conditions.

Table 8 – Considerations for EMS Response

Conventional	Contingency	Crisis
1. Modify resource assignments (e.g., only fire/rescue dispatched to motor vehicle crashes unless EMS are clearly required, single agency EMS responses if fire agencies are overtaxed).	1. Modify resource assignments to meet system demands. 2. Change EMS response assignments to BLS versus ALS as resources necessitate. 3. Consider requests for disaster assistance, including mutual aid assistance from surrounding areas. 4. Use non-emergency medical transport for low acuity responses. 5. PPE conservation activities (i.e. one person with PPE goes into residence and implement other PPE conservation activities as necessity dictates).	1. Utilize scheduled BLS providers to staff ambulance in ALS system. 2. Request EMS units from emergency management. 3. Further modify resource assignments as possible. 4. Response resources may be delayed or incapable of response due to surge capacity or system demands.

Table 9 – Considerations for EMS Patient Assessment and Treatment

Conventional	Contingency	Crisis
1. Recommend that patients with very minor injuries self-transport. 2. Treat as appropriate and approved by the medical director when resources are available.	1. Encourage patients with minor injury/ illness to self-transport to a designated facility. 2. Assess patients and determine transport necessity for those without significant injury/illness (according to guidance from local EMS Medical Director). 3. Utilize CHEMS agencies/units in screening, providing instructions, and following up with patients and their primary care providers or alternative treatment facility as appropriate. 4. Minimize aerosol-producing procedures or non-invasive airway support measures (CPAP/BiPAP).	1. Provide alternative resources /destination/ transportation to definitive care dependent on the crisis occurring. 2. Consider critical care guidance modification allowing an experienced critical care Paramedic or RN be the sole provider versus a three-person team if they are comfortable providing that care based on patient needs. 3. Treat and triage appropriately given the circumstances and as approved by the medical director under the recommendation of the EMS Physician Commission.

Table 10 – Considerations for EMS Transportation

Conventional	Contingency	Crisis
1. Transport patients to the appropriate designated facility.	1. Allow transport to urgent care or clinics for minor injury and illness. 2. Continue to assess patients and decline to transport those without significant injury/illness (according to guidance from EMS medical director). 3. Consider batch transportation resources, such as school buses and public transit buses. 4. Ensure proper PPE doffing areas are set up and maintained at the receiving destination as well as possible decontamination area.	1. Employ batch transports, as needed. 2. Transport and destination will be based on triage guidance and bed availability, as established based on the crisis. 3. Allow combining of resources from different agencies (e.g., staff from one agency paired with equipment from another agency).

Table 11 – Considerations for Hospital Emergency Department Admissions

Conventional	Contingency	Crisis
1. Cohort patients with suspected severe transmissible conditions (e.g. influenza), 2. Implement a regionally coordinated phone information line to encourage symptom or injury management at home as appropriate. In mass trauma settings, this would promote most effective use of trauma care resources. In a pandemic setting, it would decrease exposure of those not ill to others who are infected.	1. Recommend aggressive triage/discharge of patients with non-life or limb threatening conditions to an appropriate, less stressed ambulatory setting. Coordinate expectations with these clinics. 2. Use "drive-through" triage area or related strategies to reduce emergency department patient load. 3. Use alternative emergency department waiting areas and care sites for patients with influenza-like illness or other severe transmissible diseases.	1. Triage services to maximize overall lives saved, based on objective criteria. (See *Patient Care Strategies for Scarce Resource Situations Annex* for more information).

Table 12 – Considerations for Hospital Outpatient Services

Conventional	Contingency	Crisis
1. Recommend screening all scheduled outpatients 24 hours in advance, with cancellation for anyone with influenza-like illness or other relevant symptoms.	1. Defer health promotion/chronic disease management activities, including screening procedures (mammography, colonoscopy, etc.). 2. Relocate essential services such as chemotherapy offsite, e.g. through visiting nurses, or appropriately trained Volunteer Idaho or MRC staff.	1. Defer non-life-sustaining outpatient services, including physical and occupational therapy. 2. Adapt services and venue for cardiac/stroke rehab and cancer therapy (in pandemic setting) to minimize risk of exposure to severe transmissible illness and free staff for other duties.

Table 13 – Considerations for Hospital Wards

Conventional	Contingency	Crisis
1. Screen all scheduled elective admissions 24 hours in advance, with cancellation for anyone with influenza-like illness or other relevant symptoms. 2. Inventory and order needed supplies and equipment. 3. Isolate caring for influenza patients in areas separated from non-influenza patients. 4. Top off oxygen tanks.	1. Discharge patients not requiring acute in-patient care. 2. Use alternate care sites/systems. 3. Modify nurse-to-patient ratios. 4. Change documentation practices to increase numbers of patients who can safely be cared for.	1. Triage services to maximize overall lives saved. 2. Continue bed/resource capacity reporting. 3. Cancel all job duties considered non-essential and reassign personnel as appropriate. 4. Move patients who cannot be discharged but who are stable to alternate facilities experiencing less surge. 5. Ensure availability of high-quality palliative care and symptom management services to all patients through a prearranged palliative care team consisting of physicians, nurses, clergy, and lay volunteers.

Table 14 – Considerations for Hospital Surgical Units

Conventional	Contingency	Crisis
1. Consider deferring elective surgeries for patients with influenza-like illness or other relevant symptoms in a pandemic setting.	1. Defer surgeries unless the situation is emergent or, in the judgment of the surgeon, the operation is medically required within the next 14 days. 2. Free staff and operating rooms to care for injured in a mass trauma setting. 3. Free staff for alternate duties, makes post-anesthetic recovery space available for acute care in a pandemic setting.	1. Defer surgeries not essential to preserve life and limb or not needed to facilitate discharge from hospital. Triage services to maximize overall lives saved. 2. In mass trauma settings, pull staff with surgical experience from other areas of hospital to support trauma response capacity. 3. Have surgical staff assist in other units of the hospital as needed in a pandemic setting. 4. Maintain a 24/7 call schedule for emergency lifesaving surgery, with back-up staff identified to address staff illness.

Table 15 – Considerations for Hospital Critical Care (ICU)

Conventional	Contingency	Crisis
1. Stress use of infection control practices appropriate to the situation. 2. Cohort patients (to the extent possible) who have the same severe, transmissible infections.	1. Recommend strategies to increase the number of patients who can receive critical care services, including: a. Increase numbers of available critical care beds. b. Use non-ICU settings for care of ventilated patients. c. Modify nurse-to-patient ratios. d. Change documentation practices. e. Expand services provided by nurses and other staff. 2. Develop and use guidance for early discharge from ICU to free bed capacity.	1. Triage services using objective criteria to maximize lives saved (See *Patient Care Strategies for Scarce Resource Situations Annex*). 2. Conduct periodic reassessments, using objective criteria, to determine if critical care should be continued. 3. Identify a Triage Officer (group or individual not involved in patient care) to make triage decisions, if possible. 4. Implement "family support teams" (where possible) to provide information and comfort to families of patients receiving on-going critical care services as well as to patients triaged to comfort care. 5. Continue bed/resource capacity reporting.

Table 16 – Considerations for Home Health

Conventional	Contingency	Crisis
1. Train home health staff and other potential care providers for care of transmissible illness, trauma, or other prevalent conditions. 2. Use a variety of strategies including hotlines, internet sites, and social networking tools to share information about prevalent conditions, when they can be self-managed, when they require medical evaluation, and where to go for evaluation.	1. Consider limiting home visits as indicated by transmissible illness and incorporating telehealth visits as appropriate, serve as educational resource for patients home bound, provide basic care and evaluate whether a higher level of care indicated. 2. Coordinate with hospitals to identify patients discharged and provide needed at-home follow-up.	1. Use objective inclusion criteria to evaluate patients needing higher or lower level of care. 2. Provide comfort care per patient request and for those triaged to comfort care measures only by triage protocols approved by the SIDMAC. 3. Expand scope of illnesses and injuries monitored and cared for through services in the home. 4. Explore alternative care sites/arrangements for patients as indicated due to spread of transmissible illness to caregivers.

Table 17 – Considerations for Ambulatory Care

Conventional	Contingency	Crisis
1. Decrease number of scheduled ambulatory care visits. 2. Use phone triage and standing orders for routine refills. 3. Establish objective criteria of illness/injury severity to determine treatment venue.	1. Cancel all non-essential scheduled ambulatory care visits, consider implementing telehealth visits and phone check-ins. 2. Use separate areas for evaluation and care of patients with suspected severe communicable disease. 3. Develop collaborative therapy agreements with pharmacists to: a. Facilitate pharmacy refills and transfer of prescriptions ordered/dispensed at other pharmacies. b. Implement care plans to assist with routine refills per established protocols.	1. Make decisions on referral to inpatient facilities using objective criteria (as established by SIDMAC) to maximize number of lives saved in order to minimize unnecessary illness transmission. 2. Use alternate sites for comfort/palliative care of patients near death and/or not triaged to hospital care.

Table 18 – Considerations for Long-Term Care

Conventional	Contingency	Crisis
1. Coordinate with state public health, local health departments, and designated coalitions to maintain situational awareness. 2. Consider limiting face-to-face visits as indicated by transmissible illness and incorporating telehealth visits and video communication as appropriate, provide basic care and evaluate whether a higher level of care indicated. 3. Establish objective criteria of illness/injury severity to determine treatment venue.	1. Coordinate with hospitals and ambulatory care to determine appropriate admits and dispositions. 2. Consult with medical licensing for Part 1135 waivers to be in place for waiver of CMS regulations, which will facilitate the admission of new patients not necessarily requiring long-term care. 3. Form coalitions with other facilities to establish “contagious” and “non-contagious” facilities to limit unnecessary exposures.	1. Use objective inclusion criteria to evaluate patients needing higher or lower level of care. 2. Provide comfort care per patient request and for those triaged to comfort care measures only by triage protocols approved by the SIDMAC. 3. Expand scope of illnesses and injuries monitored and cared for through services in the facility. 4. If unable to transfer contagious/non-contagious to appropriate facility, ensure patients are separated to the greatest degree possible.

Table 19 – Considerations for Alternate Care Site (ACS)

Conventional	Contingency	Crisis
1. Identify ACSs (e.g. long-term care facilities, veterinary hospitals, surgery centers, gymnasiums, etc.) with infrastructure to support acute vs. comfort care of ill or injured patients. 2. Develop or confirm existing memoranda of agreement with potential alternate care sites to ensure availability.	1. Activate ACSs for patients who require care beyond that available at home, and do not meet criteria for hospitalization. 2. Use available providers and volunteers to staff ACSs. 3. Use non-hospital-based triage systems (in-person, phone, or internet-based) to provide consultation for patients, to identify those in need of additional care or further evaluation. 4. Identify specific ACSs for care of contagious or non-contagious patients to lessen spread.	1. Use objective inclusion criteria to evaluate ill patients for appropriate placement. 2. Provide comfort care per patient request and for those triaged to comfort care measures only by triage protocols approved by the SIDMAC.

PALLIATIVE CARE/COMFORT CARE

During a CSC response, palliative care will focus on providing relief of pain and symptoms following a serious diagnosis. Palliative care can be offered to patients who might benefit from curative therapies. In contrast, comfort care is focused on relieving pain and symptoms of terminal patients who will not benefit from available curative resources. At a minimum, comfort cares should include relief of severe symptoms and support as people face end-of-life.

The SIDMAC will develop guidance for healthcare providers and organizations, first responders (e.g., EMS), and other caregivers regarding palliative and comfort care. Guidance should promote the delivery of consistent, compassionate, and equitable palliative and comfort care across the state. Guidance must apply to victims of the CSC disaster, as well as patients facing end-of-life decisions from other illnesses and injuries.

The following definitions of palliative and comfort care, and bulleted items are adapted from the World Health Organization (http://www.who.int/cancer/palliative/en/).

The intent of palliative and comfort care is to improve the quality of life for patients and their families who face problems associated with life-threatening illnesses and injuries, by preventing and relieving suffering, by means of early identification and treatment of pain and other, physical, psychosocial, and spiritual issues.

Palliative and Comfort Care:

- Provide relief from pain and other distressing symptoms.
- Affirm life and regard dying as a normal process.
- Intend neither to hasten or postpone death.

- Integrate the psychological and spiritual aspects of patient care.
- Offer a support system to help patients live as actively as possible until death.
- Offer a support system to help the family cope during the patient's illness and the family's bereavement.
- Use a team approach to address the needs of patients and their families, including bereavement counselling, if indicated.
- Enhance the quality of life and may positively influence the course of the illness or injury.
- Provide support for patients and families who are triaged to comfort care only.

In addition to the above considerations, the following apply to pediatric patients:

- Palliative and comfort care for children are the active total care of the child's body, mind, and spirit, and also involves giving support to the family.
- Palliative and comfort care begin when illness is diagnosed and continues regardless of whether a child receives treatment directed at the disease.
- Healthcare professionals should evaluate and alleviate a child's physical, psychological, and social distress.
- Palliative and comfort care require a broad, multidisciplinary approach that includes the family and makes use of available community resources, even when resources are limited.
- Palliative and comfort care can be provided in acute care facilities, out-of-hospital care settings, alternate care sites, or in children's homes.

DISABILITY, ACCESS, AND FUNCTIONAL NEEDS (DAFN)

At-risk populations include infants, children, the elderly, pregnant women, individuals with disabilities, or others who may have disabilities or access and functional needs (DAFNs). During CSC, at-risk individuals will require fair and equitable access to healthcare services, both for disaster-related illness or injury as well as pre-existing conditions.

One method of addressing DAFN during emergencies and CSC is the CMIST Framework. CMIST is an acronym for the following categories: **C**ommunication, **M**aintaining Health, **I**ndependence, **S**afety and Support, and **T**ransportation. The CMIST Framework can help clinical staff and other response entities to address a wide range of needs for DAFN and other at-risk groups without having to define a diagnosis, status, or label.

Figure 1 – CMIST Framework

Source: https://www.phe.gov/Preparedness/planning/abc/Pages/at-risk.aspx

Communication

Clinical staff and other responding entities should be prepared to support individuals with communication needs during CSC operations. This may include accommodations for people with hearing or vision impairments as well as limited English proficiency populations. It is anticipated that many healthcare professionals can address the needs of Spanish speakers. Speakers of languages other than Spanish and English may require additional resources. The following resources may be considered to support communication with at-risk groups:

- Language translation and interpretation services (virtual or in person).
- American Sign Language (ASL) services.
- Other communications accommodations.

Communication services may be obtained through resources such as:

- Colleges and universities.
- Interpreters for court system may also be available for language services.
- Public Information Officers from state and local agencies may provide support and identify additional resources for people with communication challenges.

Maintaining Health

Individuals from the DAFN community may have significant health issues (i.e., comorbidities) that complicate the delivery of healthcare. They may require medical devices, medications, or access to other therapies for the treatment of chronic conditions. Supplies and considerations for individuals with medical needs (e.g., people with oxygen concentrators or other durable medical equipment [DME]) may include extension cords, power strips, refrigerator or cooler (for insulin or other heat sensitive medications), or a nursing room or room divider for privacy. During CSC, hospitals and other healthcare access points that routinely address these needs may not have the same ability to address the needs of all individuals with DAFN.

Independence

In order to maintain the well-being of individuals with DAFN, healthcare facility staff will need to provide accommodations for people needing assistive devices or other items that facilitate independence. This may include mobility devices (wheelchairs, walkers, canes, and crutches), communication aids, as well as service animals.

Safety and Support

Clinical staff will need to provide a safe and supportive environment for individuals with DAFN and other at-risk family members during their time at a healthcare facility. Individuals may experience high levels of stress and require support for anxiety. Others may need support for psychological or behavioral health needs. Safety and support may also entail the supervision of children, elderly persons with DAFN, individuals with cognitive disabilities, and people with serious mental illness or substance abuse issues.

Transportation

Transportation for infectious disease patients with serious symptoms will likely occur via EMS. Transportation needs for non-infectious disease patients with DAFN may include transport to regular medical appointments, including dialysis and other life-sustaining therapies.

PUBLIC INFORMATION CONSIDERATIONS

The dissemination of timely, accurate, and consistent public information is critical during the transition from conventional, to contingency, to crisis standards of care. The following action items could be considered by DHW and the SIDMAC to inform the public of any relevant information, including changes to accessing healthcare, warning signs, and social distancing strategies.

- Ensure that the Joint Information Center (JIC) receives all guidance developed by the SIDMAC.
- Work with the JIC to determine which guidance requires a public information message.
- Advise JIC staff on CSC messaging that decompresses the healthcare system.
    - When to seek treatment, emergency warning signs, etc.
    - Where to seek treatment.
    - Other protective action and risk communication messages as appropriate.

Advise JIC staff on the development of public information related to electronic alternate care systems (e.g., infectious disease hotlines, other telephone-based information services).

PLAN DEVELOPMENT AND MAINTENANCE

The Idaho CSC Plan is a living document that will be updated based on strengths and challenges from real world emergencies and emergency exercises. The plan will be adapted to maintain the flexibility needed to address diverse threats as they are identified. The plan will be tested during exercises and real responses. Improvements and corrective actions will be incorporated into document changes and revisions.

DHW will maintain this document and coordinate reviews, changes, and revisions with partner agencies. The Idaho CSC Plan will be reviewed at a minimum of every three years and changed or revised as needed. The date of the Idaho CSC Plan will be determined by the most recent signature date.

A document change involves making specific changes to a limited number of pages to update the document. A document revision is a complete rewriting of the existing Idaho CSC Plan. Revisions are advisable when numerous pages of the document are updated, major portions of the document are deleted, or substantial text needs to be added. Changes or revisions in the plan may be needed when:

- Hazard consequences or risk areas change.
- The concept of operations changes.
- Departments, agencies, or groups which perform emergency or recovery functions are reorganized or can no longer perform tasks laid out in this plan.
- Warning and communications systems are upgraded.
- Additional emergency or recovery resources are obtained through acquisition or agreement, the disposition of existing resources changes, or anticipated emergency or recovery resources are no longer available.
- A training, exercise, or actual emergency reveals significant deficiencies in the existing plan.
- State or federal planning standards are revised.

Updated versions of this document will be distributed by DHW to partner agencies. Directors of partner agencies and stakeholders are responsible for maintaining their internal plans, standard operating procedures (SOPs), and resource data to ensure timely and effective responses to emergencies and disasters.

APPENDIX A: STATE OF IDAHO DISASTER MEDICAL ADVISORY COMMITTEE RESPONSIBILITIES

SIDMAC responsibilities for Idaho Department of Health and Welfare staff

Qualifications: Appointed by the State Health Official for the Idaho Department of Health and Welfare (DHW).

Overall Responsibilities

- Coordinate SIDMAC functions in assigned program areas.
- Contribute to the timely development of CSC guidance and priorities for treatment.
- Coordinate with DHW Operations Center (IDHWOC) and public information staff.

Pre-declaration

- Identify and convene members of the SIDMAC appropriate to the crisis situation.
- Work with DHW State Health Official and Leadership to prioritize and coordinate guidance development.
- Begin to develop guidance specific to the crisis situation.

CSC Activation and Operations

- Consult with IDHWOC Policy Group to establish goals and objectives for SIDMAC operations.
- Participate in meeting(s) with SIDMAC members to continue to develop and refine guidance and priorities for treatment and allocation of scarce medical resources.
- Monitor and track the dissemination and implementation of CSC guidance and priorities in collaboration with IDHWOC and SIDMAC members.
- Assist with revising and re-distributing CSC guidance and priorities as needed.

General SIDMAC Member Responsibilities

Qualifications for prospective State of Idaho Medical Advisory Committee (SIDMAC) members:

- Subject Matter Expert Committee Members - Expert training and knowledge in one or more response areas (e.g. Chemical, Biological, Radiological, Nuclear, and Explosive [CBRNE], infectious diseases, medical countermeasures, EMS, legal/ethical).
- Health Care Committee Members - Stakeholder from a facility, health care network, EMS/pre-hospital, board, or association involved in the CSC response.
- Partner Agency Committee Members - Public health, emergency management, or other stakeholder from local, state, or federal agencies, or a representative from a state medical board or association.

Overall Responsibilities

- Contribute to the development and implementation of statewide CSC guidance and priorities for the allocation of scarce medical resources.

Pre-declaration

- Confirm receipt of notification message from Idaho Department of Health and Welfare (DHW) requesting participation in SIDMAC operations.

- Participate in meetings or conference calls.
- Assist with information gathering and situational awareness from local/regional jurisdictions and/or health care facilities as needed.
- Contribute to the development of initial status report, meeting minutes, and other documentation as needed.
- Under the direction of the DHW, collectively develop initial CSC guidance and priorities with other SIDMAC members.

CSC Activation and Operations

- Continue to develop and refine guidance and priorities for treatment and allocation of scarce medical resources.
- Serve as the primary point of contact between the SIDMAC and the SIDMAC member's respective local/regional agency/organization.
- Continue to gather information and provide situational awareness from local/regional jurisdiction and health care facilities.
- Contribute to the development of on-going status reports, meeting minutes, and other documentation as needed.
- Work collectively with SIDMAC staff to evaluate and update guidance and priorities as needed.

APPENDIX B: LEGAL AUTHORITIES AND REFERENCES

State Authorities

Idaho Administrative Code, Department of Health and Welfare
Idaho Administrative Procedure Act (IDAPA) 16.01.03, EMS – Agency Licensing Requirements Reauthorized Rules Temporary Effective Date (06-30-19)T
https://adminrules.idaho.gov/rules/current/16/160103.pdf

Idaho Administrative Code, Department of Health and Welfare
Idaho Administrative Procedure Act (IDAPA) 16.01.07, EMS – Personnel Licensing Requirements Reauthorized Rules Temporary Effective Date (06-30-19)T
https://adminrules.idaho.gov/rules/current/16/160107.pdf

Idaho Statutes, Title 5 Proceeding in Civil Actions in Courts of Record, Chapter 3 Parties to Actions
5-330. IMMUNITY OF PERSONS GIVING EMERGENCY FIRST AID FROM DAMAGE CLAIM.
Summary: No action shall lie or be maintained for civil damages in any court of this state against any person or persons, or group of persons, who in good faith and without compensation, being at, or stopping at the scene of an accident or emergency, offers and administers emergency first aid or emergency medical attention to any person or persons injured in such accident or emergency unless it can be shown that the person or persons offering or administering emergency first aid or emergency medical attention, is guilty of gross negligence in the care or treatment of said injured person or persons or has treated them in a grossly negligent manner. The immunity described herein shall cease upon delivery of the injured person to either a generally recognized hospital for treatment of ill or injured persons, or upon assumption of treatment in the office or facility of any person undertaking to treat said injured person or persons, or upon delivery of said injured person or persons into custody of an ambulance attendant.
https://legislature.idaho.gov/statutesrules/idstat/title5/t5ch3/sect5-330/

Idaho Statutes, Title 19 Criminal Procedure, Chapter 51 Peace Officer Standards and Training Council
19-5101, Definitions (f) "Emergency communications officer" means any emergency call taker or dispatcher whose primary responsibility is to receive or dispatch calls for emergency services in the state of Idaho.
https://legislature.idaho.gov/statutesrules/idstat/Title19/T19CH51/SECT19-5101/

Idaho Statutes, Title 46 Militia and Military Affairs, Chapter 10, State Disaster Preparedness Act
46-1008. THE GOVERNOR AND DISASTER EMERGENCIES.
Summary: Under this act, the governor may issue executive orders, proclamations and amend or rescind them. Executive orders and proclamations, including disaster emergency declarations, have the force and effect of law. An executive order or proclamation of a state of disaster emergency shall activate the disaster response and recovery aspects of the state, local and intergovernmental disaster emergency plans applicable to the political subdivision or area in question and be authority for the deployment and

use of any forces to which the plan or plans apply and for use or distribution of any supplies, equipment, and materials and facilities assembled, stockpiled, or arranged to be made available pursuant to this act or any other provision of law relating to disaster emergencies. During the continuance of any state of disaster emergency, the governor is commander-in-chief of the militia and may assume command of all other forces available for emergency duty. This Act describes additional powers of the Governor, including but not exclusive to:

- Suspend the provisions of any regulations prescribing the procedures for conduct of public business that would in any way prevent, hinder, or delay necessary action in coping with the emergency.
- Utilize all resources of the state, including, but not limited to, those sums in the disaster emergency account as he shall deem necessary to pay obligations and expenses incurred during a declared state of disaster emergency.
- Transfer the direction, personnel, or functions of state departments and agencies or units thereof for the purpose of performing or facilitating emergency services.
- Subject to any applicable requirements for compensation under section 46-1012, Idaho Code, commandeer or utilize any private property, real or personal, if he finds this necessary to cope with the disaster emergency.
- Direct and compel the evacuation of all or part of the population from any stricken or threatened area within the state if he deems this action necessary for the preservation of life or other disaster mitigation, response, or recovery.
- Prescribe routes, modes of transportation, and destinations in connection with evacuation.
- Control ingress and egress to and from a disaster area, the movement of persons within the area, and the occupancy of premises therein.
- Suspend or limit the sale, dispensing or transportation of alcoholic beverages, explosives, and combustibles.
- Make provision for the availability and use of temporary emergency housing.

https://legislature.idaho.gov/statutesrules/idstat/title46/t46ch10/sect46-1008/

Idaho Statutes, Title 39 Health and Safety, Chapter 77 Volunteer Health Care Provider Immunity
39-7703 IMMUNITY FROM LIABILITY FOR HEALTH CARE PROVIDERS PROVIDING CHARITABLE MEDICAL CARE.

Summary: This statute describes liability immunities and requirements for any healthcare provider who voluntarily and without the expectation of compensation provides needed medical or healthcare services to any person at a free medical clinic or who provides health screenings at a community health screening event without compensation or the expectation of compensation. Liability immunities are not extended to the healthcare provider for any acts constituting intentional, willful or grossly negligent conduct or to acts by a healthcare provider that are outside the scope of practice authorized by the provider's licensure, certification or registration.

https://legislature.idaho.gov/statutesrules/idstat/title39/t39ch77/

Idaho Statutes Title 54 Professions, Vocations, and Businesses, Chapter 17 Pharmacists
54-1704. PRACTICE OF PHARMACY. "Practice of pharmacy" means:
Summary: This section describes the practice of pharmacy, responsibilities, and prescribing of select pharmaceuticals by pharmacists.
https://legislature.idaho.gov/statutesrules/idstat/Title54/T54CH17/SECT54-1704/

Idaho Statutes Title 56 Public Assistance and Welfare, Chapter 10 Department of Health and Welfare Definitions. EMS
https://legislature.idaho.gov/statutesrules/idstat/title56/t56ch10/sect56-1012/

Federal Authorities

Centers for Medicare and Medicaid Services (CMS) Emergency Medical Treatment and Labor Act (EMTALA)
Summary: Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.
https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html

Employee Retirement Income Security Act (ERISA)
Summary: The ERISA regulates employers who offer pension or welfare benefit plans for their employees. Title I of ERISA is administered by the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration) and imposes a wide range of fiduciary, disclosure and reporting requirements on fiduciaries of pension and welfare benefit plans and on others having dealings with these plans. These provisions preempt many similar state laws. Under Title IV, certain employers and plan administrators must fund an insurance system to protect certain kinds of retirement benefits, with premiums paid to the federal government's Pension Benefit Guaranty Corporation (PBGC). EBSA also administers reporting requirements for continuation of health-care provisions, required under the Comprehensive Omnibus Budget Reconciliation Act of 1985 (COBRA) and the healthcare portability requirements on group plans under the Health Insurance Portability and Accountability Act (HIPAA).
https://www.dol.gov/general/aboutdol/majorlaws#workerscomp

Fair Labor Standards Act (FLSA)
Summary: The FLSA prescribes standards for wages and overtime pay, which affect most private and public employment. The act is administered by the Wage and Hour Division.
https://www.dol.gov/general/aboutdol/majorlaws#workerscomp

***Federal Continuity Directive 1 (FCD 1)*, Federal Executive Branch National Continuity Program and Requirements**, October 2012.
Summary: This Federal Continuity Directive (FCD) provides direction to the Federal Executive Branch for developing continuity plans and programs. The ultimate goal of continuity in the executive branch is the continuation of National Essential Functions (NEFs).
https://www.fema.gov/media-library-data/20130726-1903-25045-0080/fcd_1_october_2012.pdf

Federal Food, Drug, and Cosmetic Act (FD&C Act), Section 564
Summary: The FDA Commissioner may allow unapproved medical products or unapproved uses of approved medical products to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions caused by CBRN threat agents when there are no adequate, approved, and available alternatives. Section 564 of the FD&C Act was amended by the Project Bioshield Act of 2004 and the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA), which was enacted in March 2013.
https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/summary-pahpras-mcm-provisions

Federal Volunteer Protection Act (VPA).
Summary: Applies to uncompensated, individual volunteers of nonprofit organizations or governmental entities. Volunteers shall not be liable for harm caused by their acts or omissions on behalf of the organization or entity so long as they are: (1) acting within the scope of the volunteer's responsibilities; (2) properly licensed, certified, or authorized by the appropriate authorities as required by law in the state in which the harm occurred; (3) have not engaged in willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual(s) harmed by the volunteer; and (4) have not caused the harm by operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires its operator to possess an operator's license or maintain insurance.
https://www.gpo.gov/fdsys/pkg/PLAW-105publ19/pdf/PLAW-105publ19.pdf

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Summary: Establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, healthcare clearinghouses, and those healthcare providers that conduct certain healthcare transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.
https://www.hhs.gov/hipaa/for-professionals/privacy/index.html

***National Security Presidential Directive (NSPD) 15/Homeland Security Presidential Directive (HSPD) 20*,**
May 9, 2007

Summary: This directive establishes a comprehensive national policy on the continuity of Federal Government structures and operations and a single National Continuity Coordinator responsible for coordinating the development and implementation of Federal continuity policies.
https://fas.org/irp/offdocs/nspd/nspd-51.htm

National Disaster Medical System (42 U.S. Code § 300hh–11)
Summary: Regarding reimbursement for medical care, in general the Secretary may activate the National Disaster Medical System (NDMS) to:
(i) provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency, including at-risk individuals as applicable (whether or not determined to be a public health emergency under section 247d of this title); or
(ii) be present at locations, and for limited periods of time, specified by the Secretary on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified.
http://uscode.house.gov/view.xhtml?req=(title:42%20section:300hh-11%20edition:prelim)

Occupational Safety and Health (OSH) Act
Summary: The OSH Act is administered by the Occupational Safety and Health Administration (OSHA). Safety and health conditions in most private industries are regulated by OSHA or OSHA-approved state programs, which also cover public sector employers.
https://www.dol.gov/general/aboutdol/majorlaws#workerscomp

Public Health Service Act (PHSA), Section 319. Public Health Emergencies.
Summary: Section 319 provides the legal authority for the Department of Health and Human Services (HHS), among other things, to respond to public health emergencies.
https://www.astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Emergency-Authority-and-Immunity-Toolkit/Public-Health-Service-Act,-Section-319-Fact-Sheet/https://www.congress.gov/109/plaws/publ417/PLAW-109publ417.htm

Public Law 104-321. Emergency Management Assistance Compact (EMAC).
Summary: The purpose of this compact is to provide for mutual assistance between the states entering into this compact in managing any emergency disaster that is duly declared by the Governor of the affected state, whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspects of resources shortages, community disorders, insurgency, or enemy attack.
https://www.gpo.gov/fdsys/pkg/PLAW-104publ321/html/PLAW-104publ321.htm

Public Readiness and Emergency Preparedness Act (PREP Act)

Summary: The Public Readiness and Emergency Preparedness (Prep) Act authorizes the Secretary of the Department of Health and Human Services (Secretary) to issue a declaration (PREP Act declaration) that provides immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats and conditions determined by the Secretary to constitute a present, or credible risk of a future public health emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. A PREP Act declaration is specifically for the purpose of providing immunity from liability, and is different from, and not dependent on, other emergency declarations.

https://phe.gov/preparedness/legal/prepact/pages/default.aspx

Notice of Declaration under the Public Readiness and Emergency Preparedness Act for medical countermeasures against COVID-19. DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of the Secretary

Summary: The Secretary is issued this Declaration pursuant to section 319F-3 of the Public Health Service Act (42 U.S.C. 247d-6d) to provide liability immunity for activities related to medical countermeasures against COVID-19. The Declaration is effective as of February 4, 2020.

https://www.phe.gov/Preparedness/legal/prepact/Pages/COVID19.aspx#2

Robert T. Stafford Disaster Relief and Emergency Assistance Act, As Amended, June 2019.
U.S. Public Law 93-288

Summary: Provides authority to respond to emergencies and provide assistance to protect public health; implemented by Federal Emergency Management Act. The Stafford Act constitutes the statutory authority for most Federal disaster response activities especially as they pertain to the Federal Emergency Management Agency (FEMA) and FEMA programs. https://www.fema.gov/media-library/assets/documents/15271?from_Search=fromsearch&id=3564

Social Security Act, Section 1135 (42 U.S.C. § 1320b-5).

Summary: When the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency, the Secretary is authorized to, among other things, waive or modify certain Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) requirements as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient healthcare items and services are available to meet the needs of individuals enrolled in Social Security Act (SSA) programs and that providers of such services in good faith who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse.

https://www.ssa.gov/OP_Home/ssact/title11/1135.htm
https://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx

Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)

Summary: The UEVHPA, promulgated by the Uniform Law Commission (ULC) in 2006 and amended in 2007 allows state governments during a declared emergency to give reciprocity to other states' licensees on emergency services providers so that covered individuals may provide services without meeting the disaster state's licensing requirements. UEVHPA establishes a system whereby health professionals may register either in advance of or during an emergency to provide volunteer services in an enacting state. Registration may occur in any state using either governmentally established registration systems, such as the federally funded "ESAR VHP" or Medical Reserve Corps programs, or with registration systems established by disaster relief organizations, licensing boards or national or multi-state systems established by associations of licensing boards or health professionals.

http://uniformlaws.org/legislativefactsheet.aspx?title=Emergency%20Volunteer%20Health%20Practitioners

42 U.S.C. § 247d-6d. Targeted liability protections for pandemic and epidemic products and security countermeasures.

Summary: Subject to the other provisions of this section, a covered person shall be immune from suit and liability under Federal and State law with respect to all claims for loss caused by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure if a declaration under subsection (b) has been issued with respect to such countermeasure.

https://www.gpo.gov/fdsys/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap6A-subchapIIpartB-sec247d-6d.htm

U.S.C. Title 42-264

Summary: Title 42-264 of the U.S.C. provides the U.S. Surgeon General the authority to apprehend and examine any individual(s) reasonably believed to be infected with a communicable disease for purposes of preventing the introduction, transmission, or spread of such communicable disease only:

1. If the person(s) is moving or about to move from state to state.
2. If the person, upon examination, is found to be infected, he may be detained for such time and in such manner as may be reasonably necessary.

https://www.govinfo.gov/content/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap6A-subchapII-partG.htm

U.S.C. Title 42-139 Sec. 14503 Liability protection for volunteers

Summary: No volunteer of a non-profit organization or governmental entity shall be liable for harm caused by an act of omission of the volunteer on behalf of the organization or entity.

https://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter139&edition=prelim

APPENDIX C: REFERENCES

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APPENDIX D: ACRONYMS

AAC	After-Action Conference
AAR	After-Action Report
ASPR	Office of the Assistant Secretary for Preparedness and Response
BOM	Board of Medicine
CBRNE	Chemical, Biological, Radiological, Nuclear, and Explosive
CDC	Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CHEMS	Community Health Emergency Medical Services
CHIP	Children's Health Insurance Program
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
COVID-19	Coronavirus Disease 2019
CPG	Comprehensive Preparedness Guide
CSC	Crisis Standards of Care
DAG	Deputy Attorney General
DHW	(Idaho) Department of Health and Welfare
DOC	Department Operations Center
EMAC	Emergency Management Assistance Compact
EMC	Emergency Medical Condition
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ERISA	Employee Retirement Income Security Act
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FCD	Federal Continuity Directive
FD&C	Federal Food, Drug, and Cosmetic
FEMA	Federal Emergency Management Agency
FLSA	Fair Labor Standards Act
HHS	U.S. Department of Health and Human Services
HICS	Healthcare Incident Command System

HIPAA	Health Insurance Portability and Accountability Act
ICP	Incident Command Post
IDAPA	Idaho Administrative Procedure Act
IDEOC	Idaho Emergency Operations Center
IDHWOC	Idaho Department of Health and Welfare Operations Center
IOEM	Idaho Office of Emergency Management
IOM	Institute of Medicine
IP	Improvement Plan
JIC	Joint Information Center
MSE	Medical Screening Examination
NDMS	National Disaster Medical System
NEF	National Essential Function
NSPD	National Security Presidential Directive
OSH	Occupational Safety and Health
PAHPRA	Pandemic and All-Hazards Preparedness Reauthorization
PHSA	Public Health Service Ac
PREP	Public Readiness and Emergency Preparedness
REC	Regional Emergency Coordinator (ASPR representative)
SIDMAC	State of Idaho Disaster Medical Advisory Committee
SOP	Standard Operating Procedure
SSA	Social Security Act
UEVHPA	Uniform Emergency Volunteer Health Practitioners Act
ULC	Uniform Law Commission
VPA	Volunteer Protection Act