Louisiana Department of Health

ESF-8 Health & Medical Section

State Hospital Crisis Standard of Care Guidelines in Disasters

Version 4.0 February 2019

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

Louisiana Crisis Standards of Care Guidelines in Disasters

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Record of Changes

This plan is subject to information updates and changes. The use of this Record of Change helps manage modifications throughout the life of this document.

Change No.	Date	Description	Signature
001	November 9, 2015	Add record of change table.	Whaley-Martin
	February 2019	Edited Surge section Page 9	
	February 2019	Update plan version	

Introduction

Given the uncertainty about the characteristics of a new pandemic strain, all aspects of preparedness planning for pandemic influenza must allow for flexibility and real-time decision-making that take new information into account as the situation unfolds. This document may serve as a guide for hospital policymakers. All information contained is to be considered a draft 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. It is suggested that each hospital evaluate and apply this document in consideration of its unique needs including staffing, bed capacity, and community resources available to the hospital. Individual hospitals may then develop facility-specific policies and procedures. Furthermore, since community resources will be needed and shared by all hospitals in each region of the state, it is imperative that representatives from facilities in local areas come together to address standards of care guidelines across the region. This will help minimize public confusion and "shopping" for care and maximize the limited resources that will be needed.

Background

The following section is taken directly from the Institute of Medicine's *Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report*, pages 1-23. This document was a summary report of four National Regional Meetings. The participants consisted of policy makers from state and local public health departments, local and state government representatives, providers from the health care community, including relevant medical disciplines, nursing, EMS, palliative care, hospice, home health, and their associated employee unions, and health care and hospital administrators. The objectives for the four workshops were to:

- Illuminate the progress and successes of efforts underway to establish local, state, and regional standards of care protocols.
    - What have been some of the barriers in establishing protocols?
    - What solutions have you developed to operationalize standards of care protocols?
- Improve regional efforts by facilitating a dialog and coordination between neighboring jurisdictions.
- Discuss the roles and responsibilities of each stakeholder community in the development and implementation of standards of care protocols, including officials from state and local health departments and providers.
- Examine what resources, guidelines, and expertise have been used to establish standards of care protocols including legal and ethical expertise that has been used to establish standards of care protocols.
- Identify and discuss resource requirements that will be necessary from federal, state, and regional authorities to advance and accelerate the establishment of standards of care protocols.

The influenza pandemic caused by the 2009 H1N1 virus underscores the immediate and critical need to prepare for a public health emergency in which thousands, tens of thousands or even hundreds

of thousands of people suddenly seek and require medical care in communities across the US. This overwhelming surge on the healthcare system will dramatically strain medical resources and could compromise the ability of healthcare professionals to adhere to normal treatment procedures and conventional standards of care.

There was significant uncertainty about the likely severity and extent of the 2009 H1N1 influenza outbreak leading to a concern that demand for healthcare services would increase dramatically, resulting in a severe strain on medical resources across the state. While the H1N1 pandemic was not a severe pandemic in terms of numbers of individuals critically ill, the nation and Louisiana also faces the possibility of new pandemics due to other strains of influenza viruses (such as avian), as well as, many other potential public health emergencies and disaster that could severely strain medical resources. Other disasters caused by terrorism or by natural causes, such as fires, floods, earthquakes, and hurricanes, have the potential to overwhelm the medical and public health systems. Louisiana has already experienced severe medical crises as a result of Hurricanes Katrina, Rita, Gustav and Ike.

While the U.S. health system affords many Americans a high quality of health care, existing levels of health care in routine situations in the nation and Louisiana are unlikely to be available in times of a mass disaster involving scarce resources. Therefore, the state must continue to plan for a catastrophic public health event that will cause grave injury, disease, or death to potentially thousands within the state.

In preparation for response to any large-scale disaster or public health emergency, healthcare facilities must develop surge plans that include efforts to increase and maximize use of available resources, as well as, to manage demand for healthcare services. In the setting of an influenza pandemic, where the shortage of resources is likely to occur on a national scale, the availability of supplementary support is unlikely to occur. Beyond preparedness stockpiling, facilities can also implement a variety of strategies that permit conservation, reuse, adaptation, and substitution for certain resources, doing so in a way that minimizes the impact on clinical care.

However, these measures may not always be sufficient, especially in a wide-reaching public health emergency or disaster in which resources are simultaneously strained in communities across the state. Faced with severe shortages of equipment, supplies, and pharmaceuticals, an insufficient number of qualified healthcare providers, overwhelming demand for services, and a lack of suitable space, healthcare practitioners will have to make difficult decisions about how to allocate these limited resources if contingency plans do not accommodate incident demands. Under these circumstances, it may be impossible to provide care according to the conventional standards of care used in non-disaster situations, and, under the most extreme circumstances, it may not even be possible to provide the most basic life-sustaining interventions to all patients who need them. The impact of these circumstances will likely carry a tremendous social cost on the healthcare workforce and the state as a whole.

An important consideration regarding the framework for the implementation of crisis standards of care in a disaster includes the recognition that it will never be an "all or none" situation. Disasters will have varying impacts on communities, based on many different variables that might affect delivery of health care during such events. Response to a surge in demand for healthcare services

will likely fall along a continuum ranging from "conventional" to "contingency" and "crisis" surge responses.

Conventional patient care uses usual resources to deliver health and medical care that conforms to the expected standards of care of the community. The delivery of care in the setting of contingency surge response seeks to provide patient care that remains *functionally equivalent* to conventional care. Contingency care adapts available patient care spaces, staff, and supplies as part of the response to a surge in demand for services. Although this may introduce minor risk to the patient compared to usual care (e.g., substituting less familiar medications for those in short supply, thereby potentially leading to medication dosage error), the overall delivery of care remains mostly consistent with community standards. Crisis care, however, occurs under conditions in which usual safeguards are no longer possible. Crisis care is provided when available resources are insufficient to meet usual care standards, thus providing a transition point to implementing *crisis standard of care*. Note that in an important ethical sense, entering a crisis standard of care mode is not optional—it is a forced choice, based on the emerging situation. Under such circumstances, failing to make substantive adjustments to care operations—i.e., not to adopt crisis standards of care—is very likely to result in greater death, injury or illness. The goal for the health system is to increase the ability to stay in conventional and contingency categories through preparedness and anticipation of resource needs prior to serious shortages, and to return as quickly as possible form crisis back across the continuum to conventional care.

Crisis of standards of care can be defined as a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by the state, in recognition that crisis operations will be in effect for a sustained period. The formal declaration (Executive Order) that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources.

Disaster events will be marked by a sudden or gradual increase in demand for healthcare services and a related decrease in the supply of resources available to provide such care. This will result in a healthcare-sector response that requires implementation of a variety of "surge capacity" strategies that include steps taken to reduce demand for care (e.g., the implementation of community-based triage capabilities and risk communication about when to seek care) and the augmentation of ambulatory care capacity in addition to better described inpatient care strategies. Therefore, all healthcare entities, not just hospitals, should have plans to provide crisis care. Outpatient facilities (and community-based clinics, nursing homes, primary care, etc.) may use strategies modified from hospital guidance.

A number of strategies can be used to bolster the supply of key resources (i.e., space to deliver care, clinical staffing availability, and the availability of key supplies). Most likely the crisis will occur over a spectrum of supply and demand spikes, suggesting that a continuum of care will be in place over the course of any disaster response. The Institute of Medicine suggests that surge capacity following a mass casualty incident falls into three basic categories, depending on the magnitude of

the event: conventional, contingency, and crisis surge capacity. Note that the same event may result in conventional care at a major trauma center, but crisis care at a smaller, rural facility.

Conventional, contingency, and crisis care represent a continuum of patient care delivered during a disaster event. As the imbalance increases between resource availability and demand, health care—emblematic of the healthcare system as a whole—maximizes conventional capacity, then moves into contingency, and, once maximized, moves finally into crisis capacity. Concurrent with this transition along a surge capacity continuum is the realization that the standard of care will shift. This occurs primarily as a result of the growing scarcity of human and material resources needed to treat, transport, and provide patient care. The goal of the healthcare agency or facility is to return as quickly as possible to conventional care by requesting resources or transferring patients out of the area, drawing on the resources of partner or coalition hospitals and the health system as a whole. Along the span from conventional to crisis care, healthcare facilities should attempt to minimize changes that significantly impact patient outcomes by changing work practices in order to focus resources on patient care.

Architecture: IOM Report: Guidance for Establishing Crisis Standards of Care

Incident demand/resource imbalance increases →

Risk of morbidity/mortality to patient increases →

← Recovery

	Conventional	Contingency	Crisis
Space	Usual patient car 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

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.

The Institutes of Medicine defines:

- Conventional capacity as the use of spaces, staff, and supplies that is 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.
- Contingency capacity as the use of spaces, staff and supplies that is **not** *c*onsistent with daily practices, but provides care that is *functionally equivalent* to usual patient care practices. These spaces or practices may be used temporarily during a major casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources).
- Crisis capacity as adaptive spaces, staff, and supplies that are not consistent with usual standards of care, but provide sufficiency of care in the setting 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.

Contingency or "surging" Plans

The Louisiana Department of Health (LDH) with the assistance of the Pandemic Influenza Clinical Forum, a committee of healthcare experts around the state from all areas of medicine, developed a State Hospital Pandemic Influenza Plan. This document contains information on how the state can use the CDC's FluSurge software to estimate patient surge, ventilator capacity and deaths spanning several weeks of a pandemic. The plan also highlights planning considerations for hospitals dealing with patient surge.

Crisis Standards of Care

Crisis standards of care guidelines should be used for situations when healthcare resources are overwhelmed. To plan for a catastrophic event, Louisiana needs to ensure that 1) the response offers the best care possible given the resources at hand; 2) decisions are fair and transparent; 3) policies and protocols across the state are consistent; and 4) citizens and stakeholders are included and heard. Laws and the legal environment must support response efforts and create incentives for healthcare practitioners to care for affected populations. Although the usual high quality of health services cannot be assured during a catastrophic event, the state must do all it can to gain the trust of the public by responding fairly and effectively, particularly for vulnerable persons.

The following information is meant to serve as guidelines to provide direction to healthcare providers when the contingency capacity has been exceeded and crisis standards of care and an Executive Order for a declared state of emergency becomes necessary. Criteria should be implemented for determining when crisis standards of care should be implemented, key elements that should be included in the crisis standards of care protocols, and criteria for determining when these standards

of care should be terminated. The guiding principle of Crisis Standards of Care is to do the greatest good for the greatest number of persons.

Core ethical precepts in medicine permit some actions during crisis situations that would not be acceptable under ordinary circumstances, such as implementing resource allocation protocols that could preclude the use of certain resources on some patients when others would derive greater benefit from them. Healthcare professionals are obligated always to provide the best care they reasonably can to each patient in their care, including during crises. When resource scarcity reaches catastrophic levels, clinicians are ethically justified and indeed are ethically obligated to use the available resources to sustain life and well-being to the greatest extent possible.

Definitions

Within these guidelines, several terms will require clarification:

- Surge capacity shall refer to the ability to increase facility space and occupancy, enlist staff, and obtain adequate supplies and equipment to meet the needs of an influenza pandemic or other catastrophic event. It is recognized that surge capacity will not be a static value and may be limited by scarce resources.

- Scarce resources shall refer to diagnostic methods, therapeutic devices (e.g. ventilators, noninvasive positive pressure ventilation), medications (e.g. antiviral medications), healthcare providers (e.g. physicians, nurses, respiratory therapists, technicians) and facility beds. In a crisis standard of care catastrophic event, the number of persons seeking medical care would outstrip these scarce resources.

Development Methods

To ensure equity in utilization of scarce resources, and to provide equal care to all members of the community, the state brought together a broad spectrum of professionals including state and local public health, emergency medicine and response, critical care, infection control, hospital administration, pharmacy, primary care, nursing, palliative care, ethics, legal, behavioral health, and risk communication. These guidelines are based on the Utah Pandemic Influenza Hospital and ICU Triage Guidelines (UPIHITG) and the draft CSOC Guidelines for Acute Care Hospitals during an Influenza Pandemic from Region 2 (Baton Rouge).

Regions of the state then convened a similar panel of experts and reviewed the aforementioned documents and other available resources. This document should serve as guidance for healthcare facilities and professionals in the development of systematic and comprehensive policies and protocols for standards of care in disaster where resources are scarce. These standards should be consistent across all regions of the state.

These guidelines may be superseded by any future guidance that may be provided by public health authorities.

Guiding Principles

In developing guidelines for Crisis Standards of Care in the setting of a pandemic, an ethical framework must guide the allocation of scarce resources. Within this framework, the following concepts were utilized:

Duty to Care

Duty of care is guided by the obligation of health care professionals to care for patients at all times. Any system must sustain the patient-provider relationship ensuring that patients are not abandoned. In an influenza pandemic 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 of 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 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 an influenza pandemic, 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 pandemic.

Distributive Justice

A just system for the allocation of scarce resources must be applied broadly in order to 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. As part of this process, the Louisiana Department of Health contracted with a media consultant firm to develop a "public" version of the state Crisis Standards of Care Guidelines in

order to provide Louisiana's citizens with a basic understanding of how the plan works and how it is designed to be used. Additionally, the contractor conducted statewide public forums. These forums were designed to provide an opportunity for review and comment by the public and to ensure that the "at-risk" (vulnerable) population is 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.

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, 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 "guidelines" but wanted the guidelines 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 fairly as possible under extreme conditions.

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. Some of the ethical principles are:

- First come, first served – this is mostly what is done during normal conditions. However, this principle violates the duty to steward resources, the duty to plan and the distributive justice standards.
- Most likely to recover – this too can violate the duty to steward resources and duty to plan at the extreme of the most likely to recover. Provision of care to those most likely to recover with no further treatment might need to be WITHHELD to better steward resources in a time of great resource scarcity. This will be imperfect in practice but will likely be required under crisis standards of care. People who are deemed only mildly sick may be sent home who might otherwise be admitted and observed, in a time when the resources are scarce and when it is felt these patients would likely not require hospitalization as much as others.
- Instrumental Value (Multiplier effect) – this means that if you provide care for this individual, they would then be able to care for others, increasing the number of people being cared for. An example of this might be a doctor or a nurse. This is a subject for discussion but choosing to allow medical personnel the chance to be put on ventilators makes sense from two standpoints: 1) The medical personnel who survive will be there to take care of patients

in year 2 and 3 of a pandemic. They may even be there to take care of patients in the 3rd month of year one and 2) If the medical personnel have some assurance that they may get a ventilator, they may be more likely to come in to work especially once the fatality rate of the "really bad virus" becomes obvious.

- Broad Social Value – this means that society could imply that someone like the President or Governor or Mayor would have a higher social worth. However, in our morally pluralistic society, it is impossible to agree on "value".
- Life Cycle Principle (fair innings) – this means that younger individuals should have a right to the same number of years to live as an older person has already had. Using this principle, age would become the driving force. All other things being equal, with one ventilator to spare, it would go to someone 28 y/o over someone 82 y/o. Studies show the decline of the immune system with advanced age makes this easier to defend than it would seem based on what we know about the aged immune system. This also brings us back to the most likely to recover principle.
- Maximizing Net Benefit – this is similar to "most likely to recover" but is more encompassing. It is probably the one principle that serves as a basis for much of any crisis standards of care plan.

Population

It is recognized that during an influenza pandemic and declared state of emergency, that patients presenting to acute care hospitals may be suffering from conditions not related to influenza. **These guidelines should apply to ALL patients seeking care at acute care hospitals during an influenza pandemic. Social worth, age and other non-medical factors should not be used in the decision making process.** Additionally, since 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 AND Comfort Measures Only in Section B. However, if the physician order indicates other treatment decisions, the patient will need to be triaged according to Crisis Standards of Care protocols.

Implementation Plan

As an influenza pandemic 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 limiting need protocols and the pursuit of maximizing surge capacity.

Limiting Need shall refer to the non-critical use of potentially scarce resources. As an example of limited need, elective surgical procedures should be postponed during a period of impending emergency unless used to facilitate the discharge of inpatients.

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 a pandemic and ensure that surge capacity is maximized.

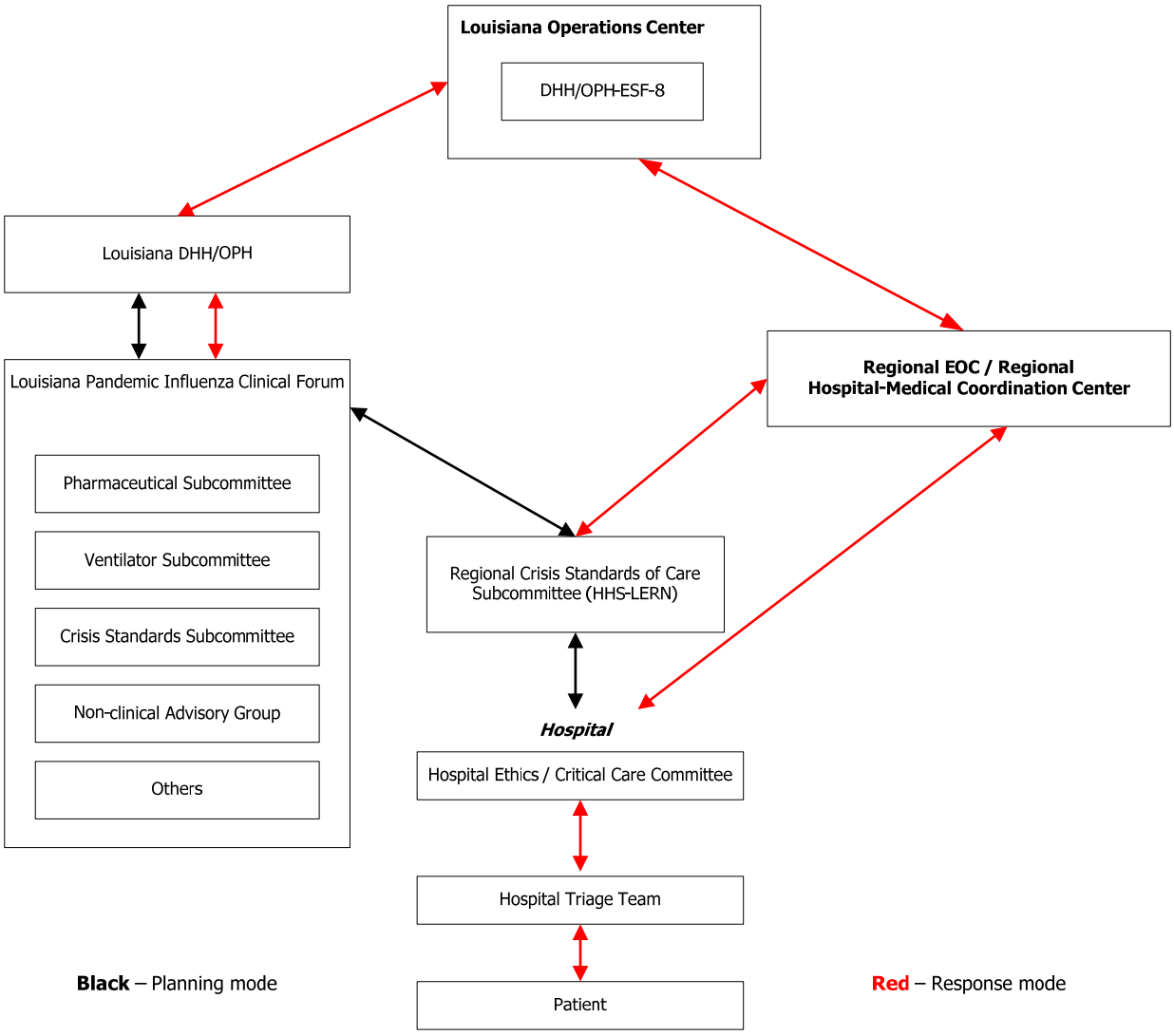
The decision to implement the Crisis Standards of Care guidelines should be based upon the degree of the pandemic (or other disaster) and hospital capacity, in conjunction with a governor ordered state of emergency. Specifically, Crisis Standards of Care may be initiated only after all of the following conditions have been met. It is imperative that all hospitals work together and utilize the ESF-8 Hospital DRC network to maximize all available resources.

1. Initiation of national disaster medical system and national mutual aid and resource Management
2. Surge capacity fully employed within healthcare facility
3. Attempts at conservation, reutilization, adaption, and substitution are performed maximally
4. Identification of critically limited resources (e.g., ventilators, antibiotics)
5. Identification of limited infrastructure (e.g., isolation, staff, electrical power)
6. Request for resources and infrastructure made to local and regional health officials
7. Current attempt at regional, state, and federal level for resource or infrastructure allocation
8. Institutional implementation team has requested initiation of CSOC
9. 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 should consist of (at a minimum):

i. The Chief of Staff (or designee)
ii. The Chief Medical Officer (or designee)
iii. The Chief Nursing Officer (or designee)
iv. The Infection Control and Prevention Nurse (or designee)
v. The Emergency Department Director (or designee)

Upon decision for implementation of crisis standards of care, the Department for Health and Hospitals, and the other regional hospitals shall be notified by the implementing institution. The organizational structure for both the development and response in Crisis Standards of Care is illustrated below:



Community Communication Plan For Pandemic Influenza

Open communication between healthcare facilities is key for an effective response during a pandemic. Ongoing communication between hospitals will be coordinated through the Hospitals' Designated Regional Coordinators system, part of the Louisiana Hospitals Emergency Response Network Plan.

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.

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 will monitor data reports for potential trends across the community.

Pre-Hospital (EMS) Triage System

Pre-hospital care is an essential part of the continuum of patient care. As the provider of pre-hospital emergency medical triage, treatment and transport, EMS plays an important role in every community's efforts to reduce morbidity and mortality from all sudden illness and injury. EMS personnel may be the first to have contact with the patients and to apply crisis standards of care.

In planning for an influenza pandemic, it must be also recognized that persons with medical conditions unrelated to influenza will continue to require emergency, acute and chronic care. In a mass casualty event or crisis situation such as a pandemic influenza event, the demand for EMS services will rise dramatically. It is important to keep the EMS system functioning as effectively as possible and to deliver optimal care. If a pandemic exceeds the healthcare capacity of a region or the state, it may be necessary to modify the provision of emergency medical care. EMS personnel, along with other healthcare entities will be forced to modify their care and move from a conventional level of care to a contingency level of care to a crisis level of care as resources become scarce.

To minimize the impact from the increased volume of calls to the dispatch centers and other public safety answering points, cooperative agreements should be developed with the state's 2-1-1 agencies and hospital nursing hotlines. The 2-1-1 agencies have been a valuable resource during a disaster by assisting with managing various public information processes. These alternate resources can assist with crisis communications and triaging. See Appendix A for a sample Memorandum of Understanding).

Community containment strategies designed to limit the spread of the influenza virus may require patients to be treated and released without transport. Additionally, healthcare facilities may become overwhelmed with patients, making it necessary to consider alternative options for patients who can be safely treated without transport.

Strategic approaches to utilizing scarce resources may include maximizing the use of available personnel, community response teams and health care personnel registries, disaster triage criteria, and altered transport modes and patient destinations. EMS providers can play a role in pandemic influenza mitigation due to their capability to rapidly respond, assess, treat and report patients with signs and symptoms of pandemic influenza. Their early involvement in community mitigation strategies may help to control the spread of the virus and reduce the subsequent use of health care resources.

EMS services should plan to scale back activities if staffing levels drop below a minimum level. A Continuity of Operations Plan should be established to determine what are the essential activities or positions needed to be performed so as to not disrupt emergency service to the citizens of the state should a pandemic occur. The plan should identify and rank critical services, identify and plan for possible disruption, and allow EMS to continue its most important operations. Components of a COOP plan might include the establishment of a steering committee, creating a service impact analysis, planning for service continuity, readiness procedures, and quality assurance.

In a crisis situation, a central dispatch or call center may activate medically approved dispatch protocols and pre-arrival instructions designed to alleviate the burden on EMS response capabilities that are being overwhelmed. This action could assist EMS service agencies and hospitals in utilizing

scarce resources during a disaster. The state of Maryland uses the Medical Priority Dispatch (MPD) protocol system for triage and has developed a "Dynamic System" of EMS triage (See Appendix B) that has been incorporated into the Pandemic Severity Index and is based on the pandemic severity score, EMS/dispatch system demand for services, reductions in EMS/dispatch workforce and hospital bed availability. This new triage/dispatch protocol drafted by the state of Maryland was then "cross-walked" into the Institute of Medicine's Levels of Care (conventional, contingency, and crisis; See Appendix C).

In Louisiana, the two most often computerized medical dispatch systems utilized by EMS service providers are the APCO and the Medical Priority Dispatch (MPD) systems. However, the majority of EMS Service agencies does not have a computerized system and rely on "card sets" of medical dispatch protocols. It has been suggested that those Louisiana EMS service providers that utilize a computerized medical dispatch protocol could 1) switch to a single state dispatch system such as MPD or 2) develop a similar EMS triage system using whatever dispatch system is currently being used. Any modifications to current dispatch protocols will need to include modifying the triage, treatment, equipment, transportation and destination protocols. Also, relationships with parish 911 systems will be a factor as 911 may pass calls to EMS providers and other first responders who dispatch first responders (EMS, Fire, Law Enforcement, etc.). Public safety answering points (PSAPs) and call centers may need to alter their dispatch protocols, sending fewer resources.

It is important to recognize that within certain regions of the state, the ability and expertise to care for certain types of patients will affect an EMS triage system. It will be necessary to not only assess a patient's need for hospital care but also to which medical facility best fits the patient and his/her condition. Institutional routing includes special services such as ECMO, maternity, pediatrics, and the mechanically ventilated. Defining hospitals which may selectively receive these patients pre-hospital will avoid utilization of scarce EMS resources and personnel in transport.

Infection control procedures will play an important role in minimizing the impact on critical healthcare resources. EMS service providers should develop plans for an increased surge in need for appropriate personal protective equipment. The Association for Professionals in Infection Control and Epidemiology, Inc.'s "Guide to Infection Prevention in Emergency Medical Services" provides information on infectious diseases emergency preparedness including pandemics and guidance on such topics as risk factor/risk assessment in EMS, Ambulance cleaning procedures, and education/training.

Transport Protocol for Pandemic Influenza Event

The transport protocol serves as a guide in the event of escalating call load and transport decisions during a pandemic event. The phases correlate to escalating levels of activity both locally and statewide. Although there are no hard numbers expressed, the combinations of the described conditions will act as points of departure for discussions leading to the decisions to enact the appropriate response.

Phase 1 – Conventional Level of Care

Operations continue as normal

Phase 2 – Contingency Level of Care

Conditions warranting response but not transport (self-help)

- Abnormal spike in call load
- Overwhelmed EDs with multiple requests for diversions of influenza patients
    - Triage performed by crewmembers at scene
        - Possible layered response by sprint vehicles
    - Self-help instructions offered

Phase 3 – Crisis Level of Care

Conditions warranting no response to any calls except life-threatening (extreme) - use of telephone triage primarily

- Abnormal consistent spike in call load
- Overwhelmed EDs with multiple requests for diversions of patients due to lack of bed availability
- AASI staffing shortage in extreme state due to influenza affecting staff
- Telephone triage except in very limited situations
    - Dispatch performs call center triage

Phase 1: Conventional Level of Care

PREPARATORY PENDING 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. Assess the status of all necessary supplies to ensure ample resources supplies, especially PPE have been acquired and are being pre-positioned for easy access.

1. Focus: Prevention of Illness
    a. Increased communications re: PPE usage and exposure control (infection control, disinfection, etc.)
    b. Mandatory use of additional PPE (i.e. HEPA mask or CDC recommended PPE) for suspect patients
    c. Strict enforcement of unit and station cleanliness
    d. Pre-positioning and distribution of PPE
2. Pandemic impact on staffing levels: Negligible
3. Procedures for handling employees who call in sick
    a. Begin using the *Daily Report of influenza-related absences* worksheet
    b. Employees with influenza symptoms are asked to remain at home for duration of illness
4. Augmentation of Staff
    a. Management Level
        i. Negotiate use of National Guard and/or reserve military (drivers, supplies, etc.) in the event pandemic escalates

ii. Draft EMAC agreements

iii. Negotiate mechanisms for temporary licensure of medics to work in the state

iv. Apply for Rapid Response training funds in anticipation of quickly training additional staff

v. Contact Medical Reserve Corps and Citizen Corps to determine level of assistance available

vi. Prepare for logistical support of supplementary staff

b. Staff Level

i. 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 EMS service provider in each region of the state based on the local human resource pool and depth of "bullpen" PRN employees. Each EMS service provider 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. EMS service providers should be in contact with their regional EMS DRC to communicate changes in status and assistance needed.

1. Focus: Minimizing employee infection
    a. Frequent communications to employees re: infection control and illness prevention
    b. Public information campaign to reduce calls for service from patients with flu-like symptoms
    c. Intense surveillance of unit and equipment disinfection procedures
    d. Mandatory use of additional PPE (.i.e. HEPA mask or as CDC recommends) for all patients
    e. 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
    a. Epidemics are expected to last 6-8 weeks in affected communities
    b. Expect the number of sick employees to escalate quickly to around 20%. The number of sick employees may continue climbing beyond 20% in the latter part of the second week
    c. 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
    a. Continue using the *Daily Report of Influenza-Related Absences* worksheet

b. Expect ill employees to be contagious for up to seven days after onset of symptoms. DO NOT COMPEL EMPLOYEES WITH INFLUENZA SYMPTOMS TO WORK DURING THIS PERIOD to protect other employees from becoming infected.

c. 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 is two days)

d. Employees who are asymptomatic for influenza should be compelled to report for duty if their illness is minor and/or will not affect alertness and safety

4. Augmentation of Staff
    a. Management Level
        i. Request use of National Guard and Reserve troops as driver
            1. Rapid Response Training (First Responder or CPR-First Aid)
            2. Allsafe orientation
        ii. Maintain ambulance staffing as possible
            1. Consider temporarily converting ALS to BLS
            2. Consider temporarily converting 12hr trucks to 24hr (last units converted or least used)
            3. Consider staffing changes from two paramedics to one paramedic plus one emergency medical technician (EMT)
        iii. Activate EMAC agreements
            1. Enact mechanisms for temporary licensure of medics
            2. Make logistical arrangements (lodging, food, etc.)
    b. Staff Level
        i. Cancel pending vacations for essential personnel
        ii. Activate PRN employees and all available support staff medics
        iii. Temporarily reposition and house medics from unaffected areas
5. Transportation
    a. Encourage patients with minor injury/illness to use their own transportation to a more appropriate setting than hospitals
    b. Consider batched transports

Phase 3: Crisis Standards of Care

WORST CASE PANDEMIC IN SERVICE AREA

This may be different for each EMS service provider in each region of the state based on the local human resource pool and depth of "bullpen" PRN employees. Each EMS service provider 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. EMS

service providers should be in contact with their regional EMS DRC to communicate changes in status and assistance needed.

The employees who have surpassed the seven-day period of contagiousness can be re-engaged into the workforce. Finally, 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
    a. Frequent communications to employees re: infection control and illness prevention
    b. Monitor employees who have been ill to determine health status/suitability for duty
    c. Public information campaign to reduce calls for service from patients with flu-like symptoms
    d. Intense surveillance of unit and equipment disinfection procedures]
    e. Mandatory use of additional PPE (i.e., HEPA mask or as CDC recommends) for <u>all patients</u>
    f. 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
    a. Expect the number of sick employees to peak around 40% during this period and then begin to decline in the latter part of week four
    b. 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
    a. Continue using the *Daily Report of Influenza-Related Absences* worksheet
    b. Employees who are asymptomatic for influenza should be compelled to report for duty if their illness is minor and/or will not affect alertness and safety
    c. Expect employees that surpass the contagious period to return to duty
4. Augmentation of Staff
    a. Management Level
        i. Consider Layered response using sprint vehicles
        ii. Consider responding but not transporting
            1. Field medics perform triage and offer self-help instructions
        iii. Consider suspending response for "flu-like calls"
            2. Dispatch performs call center triage
        iv. Continue use of National Guard and Reserve troops as drivers
        v. Activate additional EMAC agreements, as needed
            1. Enact mechanisms for temporary licensure of medics
            2. Make logistical arrangements (lodging, food, etc.)

vi. Consider requesting assistance from Medical Reserve Corps

vii. Hire temporary First Responder/non-certified drivers

1. Rapid Response training (First Responder or CPR-First Aid)
2. Allsafe orientation

b. Staff Level

i. Continue activation of PRN employees and all available support staff medics

ii. Temporarily reposition and house medics from unaffected areas

iii. Reintroduce medics previously deactivated due to illness who are now beyond risk of transmitting the virus

5. Transportation

a. Only severe cases (life-threatening) may be transported

b. May use batch transports as needed

Mental Health

A Crisis Standard of Care event poses unique challenges for all involved in a disaster, including healthcare providers and their families, patients receiving health care and their families, and the public and requires comprehensive planning for the mental health and social consequences of such an event. As part of the ESF-8 Health and Medical Section, the Office of Behavioral Health provides crisis counseling and behavioral health personnel, services and facilities essential to relieve victim trauma and behavioral problems caused or aggravated by a disaster or its aftermath.

Scope of work

A. The Office of Behavioral Health (OBH) is responsible for continuity of regular operations for those individuals in need of immediate access to outpatient treatment and/or in 24 hour care environments. The regional behavioral health provider or Local Governmental Entity (LGE) shall maintain regional protocols for access to emergency psychiatric services, including hospitalization during the contingency, crisis response and recovery phases of the crisis event. OBH will also respond to community requests for behavioral health assistance in alternate care environments, contingent upon availability of financial and human resources.

B. OBH will work through the Louisiana Behavioral Health Partnership to make available excess bed capacity for the temporary sheltering of eligible patients and staff from other public and quasi-public psychiatric facilities within the state during a crisis event.

C. The Office of Behavioral Health will make available trainings and strategies to address the emotional health and well-being of public health/medical responders and communities at risk for trauma related to the event. Cultural competencies that will address issues inherent within the vulnerable populations should be incorporated into these training programs.

Trainings may include:

- Annual offering of statewide and regional Psychological First Aid training for workforce readiness
- Stress management techniques for healthcare providers and staff

- Skills for Psychological Recovery and Grief and Loss trainings for healthcare providers, patients and their families, general public, responders and stakeholders
- Web-based and on-site trainings, as well as, just-in-time training for healthcare providers and the general public, and self-help materials to address the behavioral health-related needs inherent in the crisis event.

Concept of Operations

The Office of Behavioral Health is responsible for coordinating behavioral health care for the citizens of the State of Louisiana under normal or emergency/disaster conditions. The standard health programs will not change under most emergency/disaster conditions. However, in a presidentially declared disaster requiring emergency mental health relief to workers and victims during or in the aftermath of such an event, the OBH may request supplemental federal short-term crisis counseling services under the Crisis Counseling and Training Program (CCP) as authorized under *Section 416 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act.*

Operations and deployment of the behavioral health resources will be managed locally in conjunction with the LDH/Office of Public Health. This shall be based on the level of care needed when the agency's capability to operate has been compromised. Considerations include triggers and phases of response which will be identified and addressed.

EXAMPLE: At the "slow" or "immediate" onset of the crisis, the level of services to be activated/deployed will be determined. Situations to be addressed during the contingency, crisis and recovery phases may include panic and traumatic stress that impede treatment to medical patient in crisis or presentations for behavioral health treatment exceeds the normal surge capacity for psychiatric patients in crisis.

A. Preparedness

- The OBH Emergency Response Coordinator will develop plans that identify behavioral health indicators based on the scope and event type requiring services during the period of operations outside the traditional care environments. Response will be tailored to coordinate, acquire and mobilize behavioral health resources to support the medical community/provider networks, general public, caregivers and families affected by the event.
- In coordination with other ESF-8 partners, OBH will develop and maintain information and liaison with local, parish, state and federal government entities to ensure self-care messaging and just-in-time training is available throughout the event.

B. Response

- OBH staff will coordinate stress counseling, grief and loss support and training to the medical and behavioral health communities, public/volunteer agencies, general public and other special population groups upon request of state/local governing entities, and will be prepared to do so immediately upon learning the gravity of any emergency/disaster (see Plan of Care for Behavioral Health Considerations Chart).

- During an emergency/disaster and afterwards, OBH will coordinate personnel and self-help materials and resources to provide counseling, grief and loss support, and access to a published crisis call line for those communities impacted by the crisis event.
- Clear, consistent, understandable information will be provided via updated fact sheets and/or brochures that can be provided to clients, volunteers and the general public. Messaging for healthcare providers, the general public, responders and stakeholders will be established with details of who, what, when, where fact sheets. Specific information regarding community offerings, hotlines, web-links, tips for managing stress and trauma exposure, and local access to behavioral health emergency services will be included.
- OBH will work with LDH offices on management and release of crisis messaging and media related to crisis events in an effort to raise awareness of potential behavioral health reactions and offer tips and strategies to reduce the onset of behavioral health-related stress on the impacted communities and the public at large.

C. Recovery

- OBH will support and implement recovery actions upon notification that it is safe to return to pre-incident operations. Planning shall also include availability of behavioral health support to address emotional needs of the staff, clients and the impacted communities.

Office of Behavioral Health Crisis Standards of Care Planning
For Behavioral Health Considerations

STATE-LEVEL IMPACT				
COMMUNITY LEVEL IMPACT	Healthcare Providers (HCP)	Training	Psychological First Aid (PFA) Skills for Psychological Recovery (SPR) Grief and Loss	1. Web-based/On-Site 2. Just-in-Time
		Messaging	Who needs what mental health message? • What to do? o Patient o Family o General Public	1. Printed Media 2. Public Service Announcements 3. Radio
		Debriefing	Crisis Care Teams for debriefing HCP	1. Trained HCP counselors 2. External/Volunteer counselors
	Patient/Family	Training	Psychological First Aid (PFA) Grief and Loss	1. Webinar/On-line/On-site 2. Faith-based / Community / Private sector mental health / crisis care professionals
	General Public	Training	Psychological First Aid (PFA)	1. Web-based 2. Community Offerings
		Messaging	Instructions/Tips for Managing Self-Care, etc. • Check on neighbors • Palliative care • Buddy system Where to go for answers/resources • Crisis care • Grief and Loss	1. Establish/Publish Crisis Hotlines 2. Distribute Printed Media 3. Establish Family Call Center 4. Provide Info-links on Web
		Debriefing	Access to Crisis Care	1. Crisis Hotline/Call Center

Cultural Competence

Cultural competence is about learning, understanding and respecting the values of vulnerable populations, minorities and ethnic groups in order to provide quality care for individuals, groups and populations (Galanti, 2008). When caring for individuals from different backgrounds and ethnic groups in disasters, it is essential that healthcare providers have the basic knowledge of providing care and are able to address such issues as: communication, pain, personal space, social organization, religion and spirituality (Harkey, n.d.). It is also important to understand the impact of culture on how a person reacts to a disaster and how this influences the acceptance of disaster relief. Several reasons why culture is important in a disaster include:

- Individuals prepare, respond and recover from a disaster within the perspective of their culture (e.g. beliefs, norms, rituals);
- Culture provides a framework that is supportive and can provide social support to survivors in a disaster;
- Culture defines suitable behavior and provides individuals with a support system with others of a comparable social class. Having a similar background can create a sense of community and a shared vision for recovery within a community.
- Individuals and various groups respond differently in a disaster making some groups more vulnerable than others. Such experiences, present or past, with racism and discrimination may cause vulnerable and minority groups to distrust others offering assistance in a disaster (Harkey, n.d.)

The Center for Mental Health Services (CMHS), *Developing cultural competence in disaster mental health programs: Guiding principles and recommendations* established 9 Guiding Principles for Cultural Competence in Disaster Response that include:

1. Recognize the importance of culture and respect diversity
2. Maintain a current profile of the cultural composition of your communities
3. Recruit disaster workers who are representative of the population you are caring for
4. Provide ongoing cultural competence training to staff
5. Ensure services are accessible , appropriate and equitable;
6. Recognize the role of help-seeking behaviors, customs and natural support networks;
7. Involve "Cultural Brokers" representing diverse groups
8. Ensure services and information are linguistically competent
9. Continue to assess and evaluate (Athey, & Moody-Williams, 2003)

Healthcare organizations can implement strategies that can be used to meet the needs of various cultures:

- Develop a cultural composition profile of the community's various cultures updating it as needed. The cultural composition profile can includes data such as race, ethnicity, language, specific needs, belief, customs and rituals found in certain populations and groups.
- Emergency information should be provided in the community's primary language. This should include written and oral materials; radio and television announcements should also provide languages that are predominant in the community. Information should be provided at the literacy level of the community.

- Ensure that bilingual and bicultural staff is available.
- Provide cultural competency training to health care providers on an ongoing basis in order to understand the community by being respectful of their views, needs and wants in order to provide effective and appropriate care and services.
- Recruit health care providers who are representative of the community in which services are provided.
- Ensure that services and programs are accessible, appropriate and equitable for the various ethnic and racial groups in the community by understanding their culture, beliefs, responses, and views (Harkey, n.d.).

Appendix D: Delivery of Cultural Competence of Care Guidelines suggests a set of interventions that can be used for various vulnerable, racial and ethnic groups in a disaster event.

Pre-Hospital Admission Triage

The following section provides guidelines on the screening of patients to determine the most effective methods of determining how to maximize scarce resources. Decision tools and guidance are not to be construed as to prevent reasonable consideration of other clinical factors that may weigh a decision to provide or reallocate a scarce resource. Instead, the guidelines are listed as to provide consistency and as much weight of evidence as possible to the decision-making process.

Upon the decision to initiate Crisis Standards of Care, operational activities of emergency departments should proceed according to institutional pandemic influenza plans or a Mass Casualty Incident Plan. A necessary component of these plans should include the pre-hospital admission triage of patients. To limit spread of influenza, triage should occur in a fashion that limits exposure of suspected influenza patients to non-suspected influenza patients.

Each institution may designate a Pre-Hospital Admission Triage Officer or implement a CSOC Pre-Hospital Admission Protocol. The Triage Officer may be responsible for the assessment of pregnancy (and estimated gestation age) and exclusion criteria (Table A). If a criterion for exclusion is unknown, it should be assumed to be **NOT** present. Upon identification of exclusion criteria, the Triage Officer should communicate these findings to an emergency room physician. If the Triage Officer and emergency room physician are in agreement, alternative care and/or discharge planning, with attention to palliative care (if indicated) should be initiated for the patient. If the Triage Officer and emergency room physician are in disagreement regarding the presence of an exclusion criterion, a second physician should adjudicate and document the decision.

If no exclusion criteria are present, the patient should be admitted to the emergency department as is usual care and quantification of the Simple Triage Score (Table J) should occur. Decision to admit, admit to ICU or discharge should proceed per Figure 1.

ICU Triage Model (Figure 2)

The primary physician treating a patient should not be directly responsible for the allocation of scarce resources. Once admitted to the ICU, daily assessment of ICU exclusion criteria should occur (Table B). If no ICU exclusion criteria are present, the Modified Sequential Organ Failure Assessment (MSOFA) should be calculated. The primary physician will be responsible for the clinical

assessment of the patient and calculation of the MSOFA. A triage review officer may determine the appropriate level of care based upon the MSOFA and Figure 2.

Pediatric Triage Model (Table A 2; Figures 3, 4)

The subcommittee on Pediatric Crisis Standards of Care has been assigned the task of developing guidelines for providing care to the pediatric population in the face of a public health disaster. This could be related to weather, disease or bioterrorism. Basically, the goal is to design a system that would provide the greatest care to the most children in a time when hospitals have exceeded surge capacity and resources are scarce, particularly ICU beds and ventilator access.

There is no national consensus on allocation of scarce resources in the pediatric population and how care should be triaged. The dilemma is made more complex in the fact that the pediatric population brings a cohort of patients that are somewhat unique-mainly children with severe genetic diseases, terminal genetic diseases, terminal congenital heart diseases, cystic fibrosis, etc.

There are several other issues that must also be considered. One is that there are few scoring systems that have been validated in children that may accurately predict mortality over a broad age group such as pediatrics and that credit underlining disease states. PRISM III is validated but best at 24 hours. PIM-2 does account for underlying diseases and has a POC of .89 over all age groups and may be the best admission score to predict mortality but not designed or validated to be used over time. An additional advantage is that it does account for pre-existing diseases. However, it cannot be calculated easily or without a pre-set calculator.

PELOD may offer the best predictability of mortality over time since it measures degree of organ dysfunction and because of its ease of measurement, can overcome the problems in obtaining PIM-2. However, it is not meant to be a static measurement for use to predict outcomes on admission so it is not perfect.

In order to address these concerns, the committee recommends the following:

1. All comers should be admitted and triaged based on PELOD.
2. A PELOD score should be obtained at < 24 and 48 hours (called PELOD-24 and PELOD-48). Based on these scores, the patient will be assigned level of care (Figure 1, 2, and 3).
3. The survival expectation rule will be used to help delineate those patients with terminal genetic and congenital disease.
4. Each hospital will enact surge capacity protocols and put all pediatricians, family practice physicians and family nurse practitioners on alert and activate their services.
5. Adopt child custody protocols within each institution to care for separated or abandoned children.

Decisions regarding a change in the level of care may be appealed by the primary physician or designee to a Central Triage Team which should consist of:

1. The Chief of Staff (or designee)
2. The Chief Medical Officer (or designee)
3. The Director of Nursing (or designee)

The Central Triage Team may decide upon the appropriate level of care based upon the above assessment and available resources. The decision should be made in a timely fashion and communicated to the primary physician, patient and family.

Palliative Care

"The needs of those who may not survive catastrophic mass casualty events and the 'existing' vulnerable populations affected by the event should be incorporated into the planning, preparation, response, and recovery management systems of all regions and jurisdictions."

—Joint Commission on Accreditation of Healthcare Organizations, 2004

Aggressive management of symptoms and relief of suffering is what generally have come to be called "palliative care." The World Health Organization defines palliative care as "an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems."

While it is important to understand what palliative care is, it is also important to specify what palliative care is not. Palliative care is not abandonment of the patient or reduction or elimination of treatment. Rather, it involves active treatment for symptom management and aggressive support to ensure the comfort of the patients and their families. Finally, the aggressive and appropriate treatment of pain and other symptoms is not euthanasia, nor does it intend to "hasten death". The application of palliative care principles in a healthcare emergency would include:

- Recognizing that initial prognostication may change if additional resources become available or if the situation deteriorates.
- Honoring the humanity of the dying and those who serve them (whether loved ones, professionals, or strangers) by providing comfort through medical, social, psychological, and spiritual support.

In an MCI (mass casualty incident), standards of care will require adaptation. Unfamiliar personnel will be providing services, supplies will be strained, and command and control lines of authority will need to be established. In the interest of maximizing good outcomes for as many patients as possible, and at the very least, providing palliative care to all, treatment decisions will have to balance utilitarian notions against other ethical values, with medical effectiveness as a key determinant. Priority access to scarce resources, including structural and skilled personnel resources, may be applied or moved to those with the greatest potential for survival. Although, services to those expected to die soon, to a degree, will fall to those who do not have substantial prior health experience and expertise it is important to emphasis that the well-established principles of palliative care must be applied to these patients. The level of skill required to care for a patient who is dying in many ways is no less than the skill required to care for a patient who may survive. Although palliative care may be low tech in some regards, it sometimes warrants high tech interventions with advanced care skills. It should be emphasized that even in the setting of MCI the palliative care skills provided to dying patients should not be diminished. These patients will need aggressive management of dyspnea, pain and anxiety not to mention, psychosocial, spiritual and emotional

needs. The care of these patients will require a substantial commitment to proper medical care and a more coordinated response across multiple disciplines.

Palliative care patients typically have extreme pain and symptom management needs. It will be crucial to have appropriate medication and resources to care for these patients. Palliative pain control and sedation guidelines need to take into consideration patient conditions that include dehydration and impaired nutrition due to lack of intake and air conditioning that may occur during a healthcare emergency. All palliative care patients should be cared for using established guidelines with symptoms assessed and treated with a frequency commensurate with their level of suffering (see Appendix E, F, and G).

Louisiana is becoming increasingly multicultural. Patients triaged to receive palliative care need to have their culture, religion and unique values respected by those involved in their care. This includes awareness of beliefs, practices, communication preferences, and wishes for care especially at time of death. Resources should be available to serve as a guide for those providing care. In anticipation of the need to provide palliative care, facilities should develop plans for transferring patients requiring palliative care to a community based setting. Experts already working with seriously, chronically ill patients should assist with this planning.

Based on the above information from the Joint Commission it is suggested that the Operations Chief appoint a Palliative Care Unit Leader with appropriate skills to manage the community based setting.

The hospital and/or Palliative Care Unit Leader are responsible for:

- Designating an area for the community based Palliative Care
- Staffing: Physician; Allied Health Professionals, Nursing; Social Worker; Case Manager; Respiratory Therapist; Ancillary Support; Clergy; and Volunteers
- Daily review and assessment for change in patient's condition and level of care
    - Better than expected, able to transfer to an acute care setting
    - Transfer to other levels of care such as LTAC, nursing home, hospice or discharge to home
    - Patient/family wishes: Allow Natural Death
- Ongoing assessment of community resources (hospice; home health); ability to move patients out of the acute care hospital or the palliative care unit.

Termination of Crisis Standards of Care

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). Each institution should apply the hospital triage plan based on the availability (or lack thereof) of resources during daily assessments (figure 2).

When scarce resources are no longer present, termination of Crisis Standards of Care should occur and the Governor's office, the Secretary of the Department for Health and Hospitals, and the other regional hospitals should be notified by the institution.

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 a crisis standard of care event.

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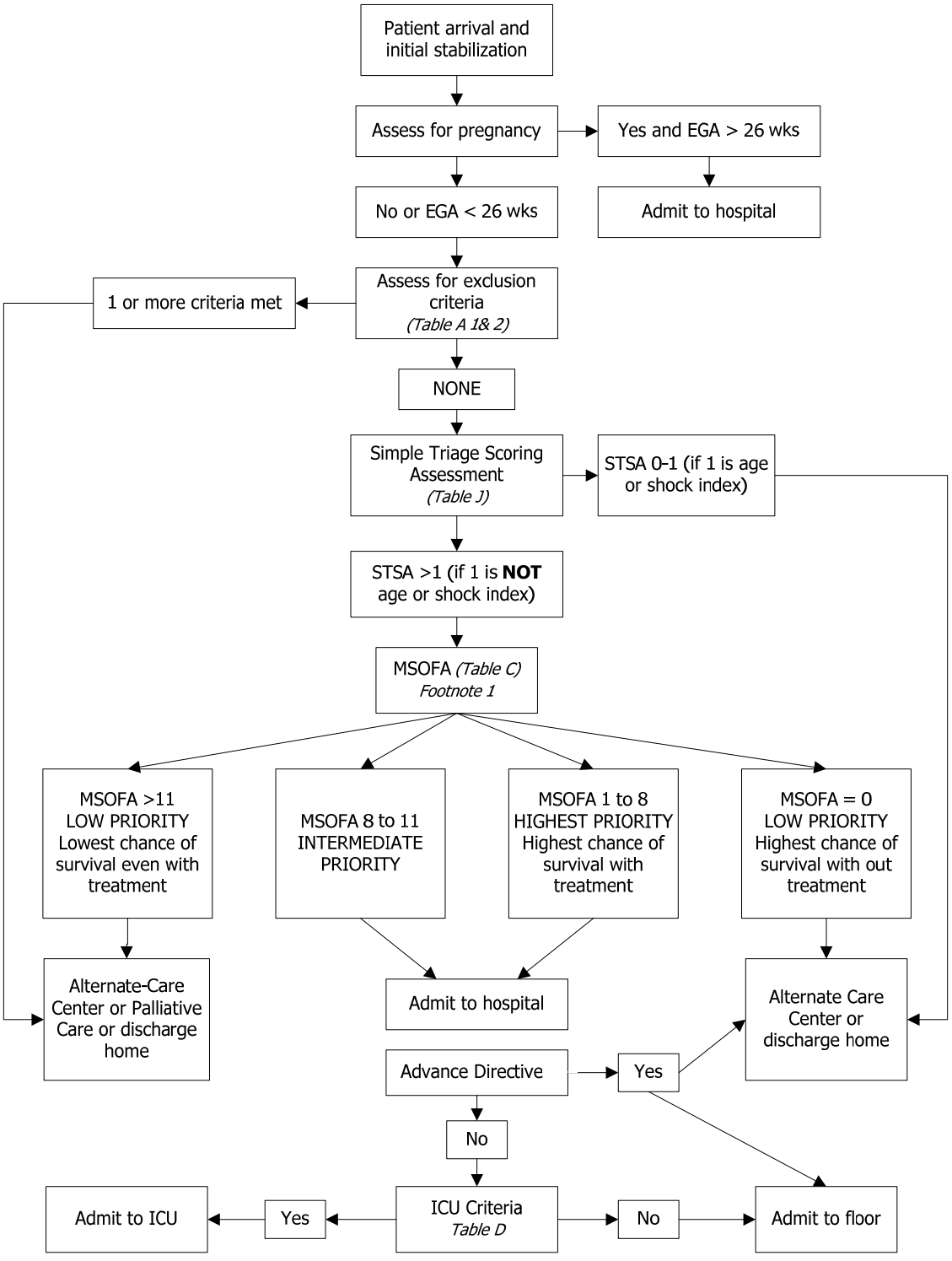
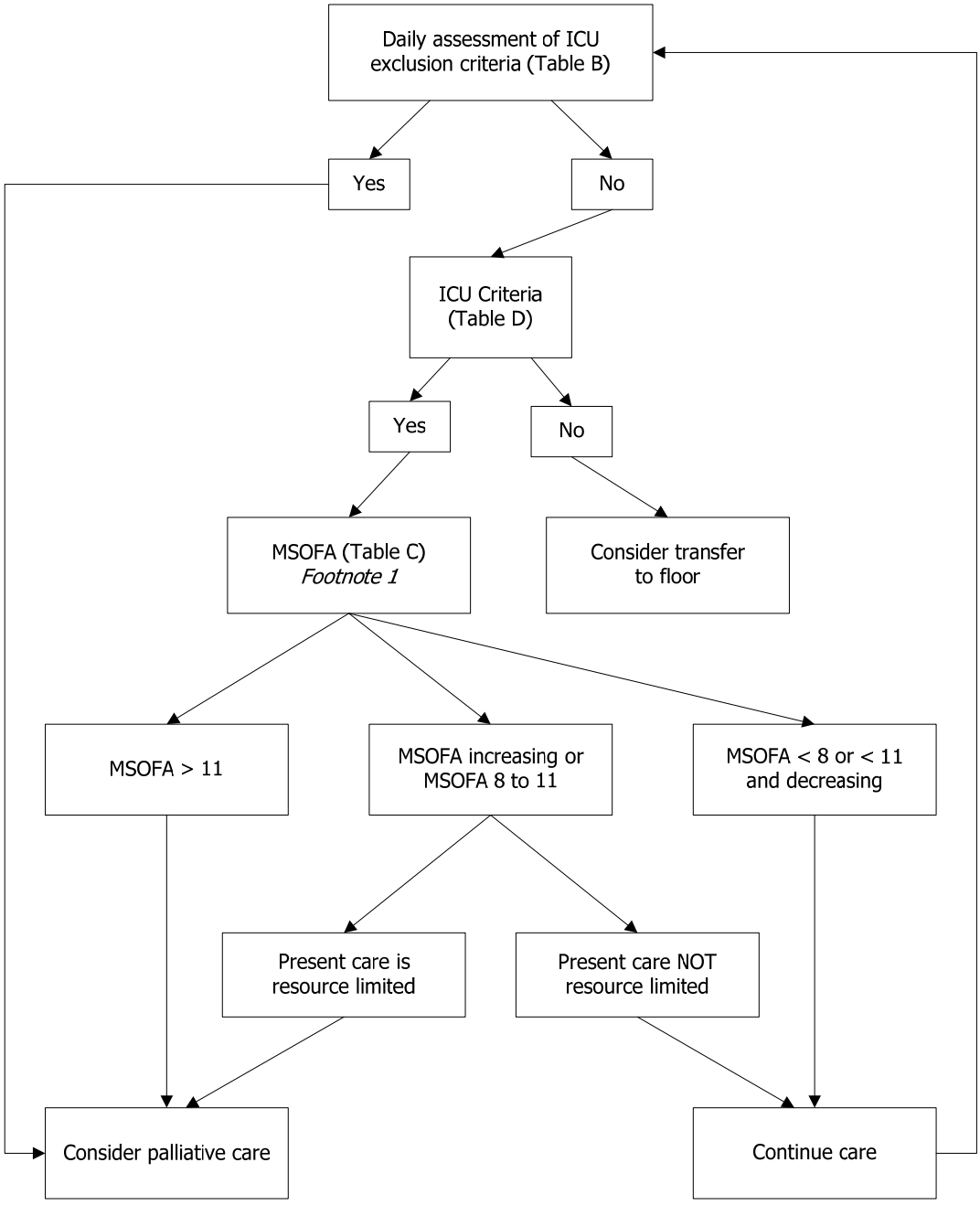
Figure 1: Pre-Hospital Admission Triage Model



Footnote 1: If alternative severity of illness scoring systems are available (e.g. APACHE), may substitute MSOFA with respect to predicted hospital mortality.

Figure 2: ICU Triage Model



Footnote 1: If alternative severity of illness scoring systems are available (e.g. APACHE), may substitute MSOFA with respect to predicted hospital mortality.

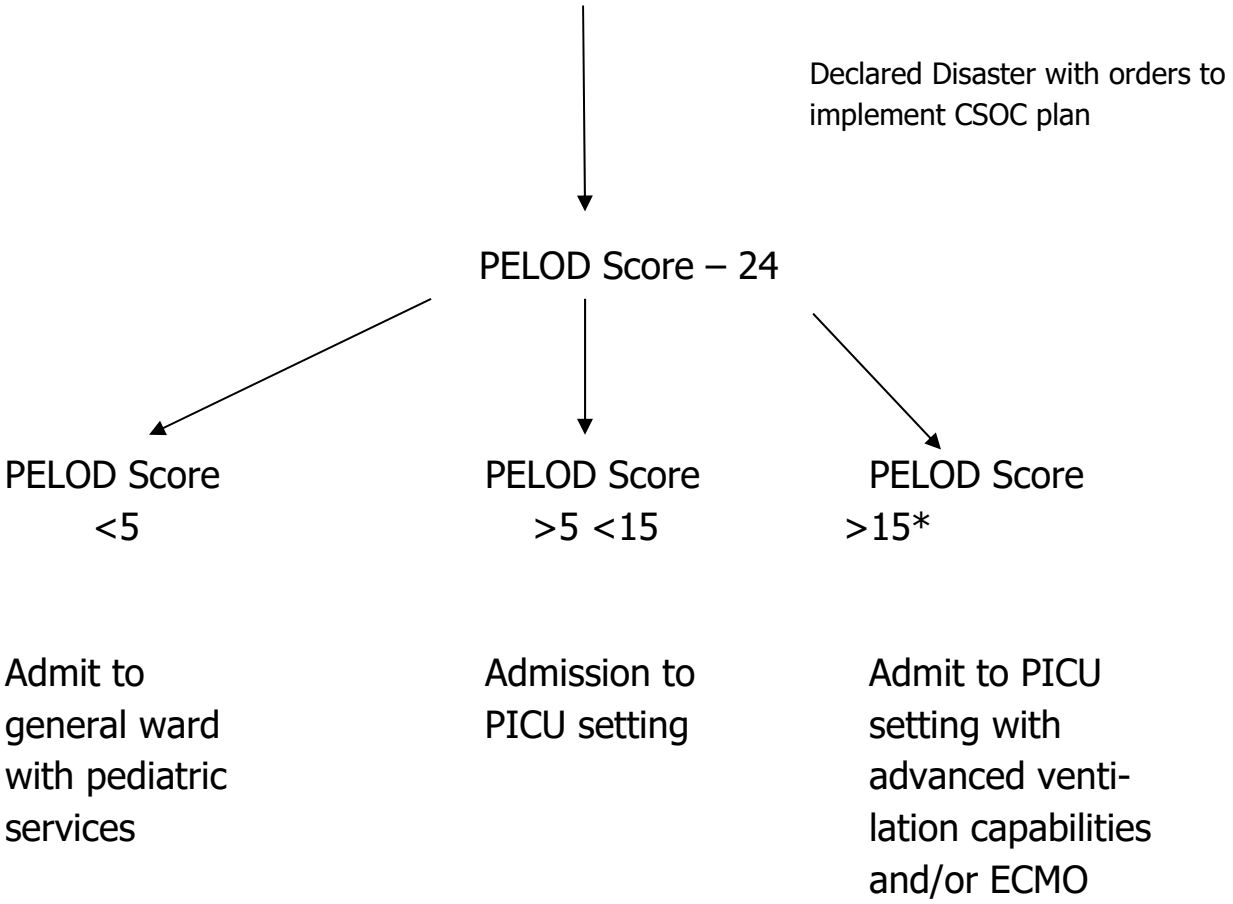
Table A 1: Exclusion Criteria For Pre-Hospital Admission Triage

Any unknown value is assumed to NOT be present at time of triage.

1. *Severe Trauma with a Revised Trauma Score of < 2 (Table E)*
2. *Severe and irreversible neurologic event or condition with persistent (>72 hours) coma and GCS < 6 (Table F)*
3. *Severe burns with a Low/expectant or Expectant outcome on the Triage for Burn Victims Assessment (Table G)*
4. *Cardiac Arrest without return of spontaneous circulation.*
5. *Known severe dementia (Limited speech ability, no independent ambulatory ability, cannot sit up without assistance, loss of ability to smile, loss of ability to hold up head independently).*
6. *Advanced untreatable neuromuscular disease (such as ALS, end stage MS or SMA) requiring assistance with activities of daily living or requiring chronic ventilator support*
7. *Patient is currently admitted / enrolled in hospice.*
8. *Incurable metastatic malignant disease*
9. *End-stage organ failure meeting the following criteria:*
    a. *NYHA Class IV heart failure (Table H)*
    b. *Lung*
        i. *COPD with FEV1 < 25% predicted or severe secondary pulmonary hypertension*
        ii. *Cystic fibrosis with post-bronchodilator FEV1 < 30% predicted*
        iii. *Pulmonary Fibrosis with VC or TLC < 60% predicted, baseline PaO2 < 55 mmHg, or severe secondary pulmonary hypertension*
        iv. *Primary pulmonary hypertension with Class IV heart failure*
    c. *Liver*
        i. *Pugh score of > 9 (Table I)*
    d. *Renal*
        i. *Refusal of dialysis or dialysis not indicated*
10. *Completed LaPOST document with Do Not Attempt Resuscitation (DNR) in Section A AND*

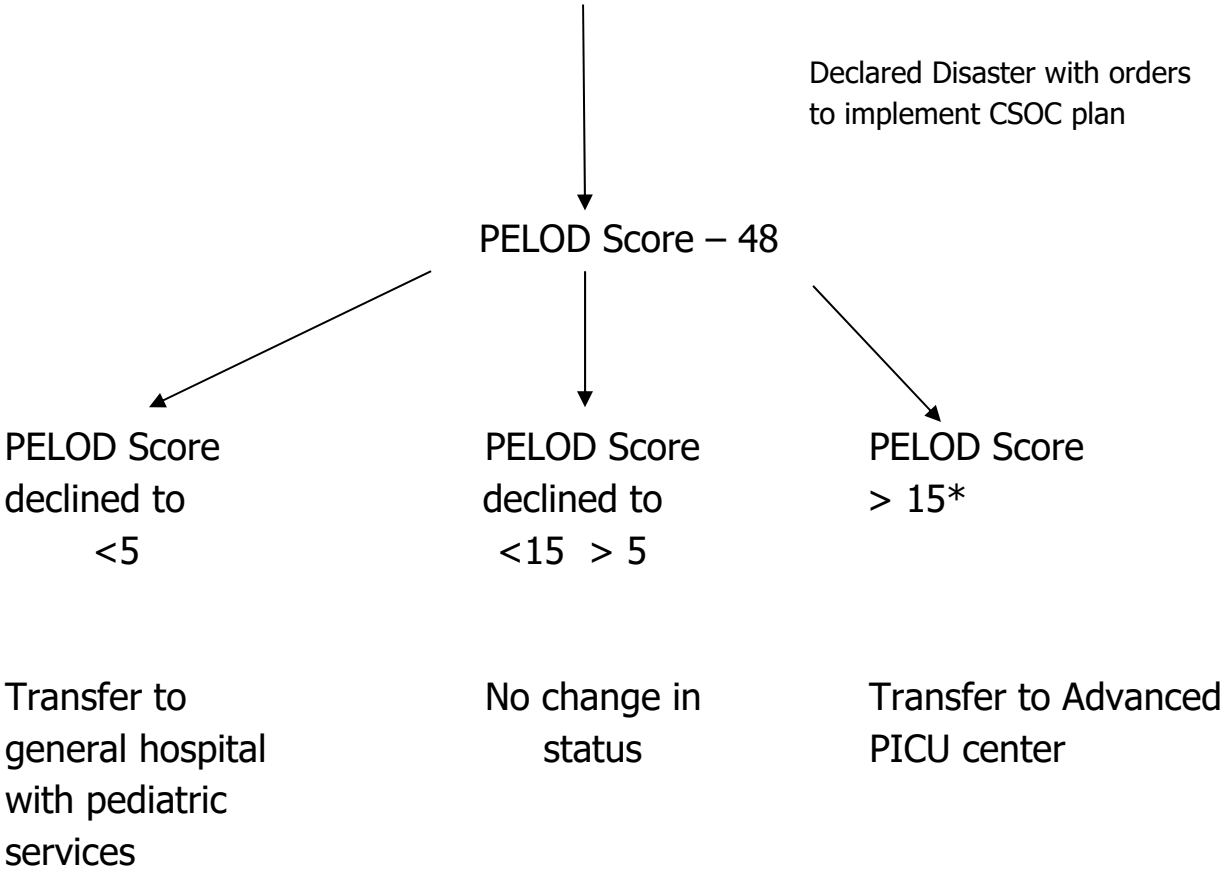
    Comfort Measures only in Section B (Appendix I).

Pediatric Triage Plan Diagram (at 24 hours)



*Positive expectation rule

Pediatric Triage Plan Diagram (at 48 hours)



*Positive expectation rule

Table A 2: Pediatric Criteria

	Scoring system			
	0	1	10	20
Organ dysfuction and variable Neurological*				
(Glasgow coma score)	12-15 **and**	7-11	4-8 **or**	3
Pupillary reactions	Both reactive	NA	Both fixed	NA
Cardiovascular†				
Heart rate (beats/min)				
< 12 years	≤195	NA	>195	NA
> 12 years	≤150	NA	>150	NA
	And		**or**	
Systolic blood pressure (mm Hg)				
< 1 month	>65	NA	**35-65**	<35
1 month - 1 year‡	>75	NA	**35-75**	<35
1 - 12 years‡	>85	NA	**45-85**	<45
≥ 12 years	>95	NA	**55-95**	<55
Renal				
Creatinine (µmol/L)				
<7 days	<140	NA	≥140	NA
7 days - 1 year‡	<55	NA	≥55	NA
1 - 12 years‡	<100	NA	≥100	NA
> 12 years	<140	NA	≥140	NA
Respiratory€				
PaO2 (kPa)/FIO2 ratio	>9▪3 **and**	NA	≤9▪3 **or**	NA
PaCO2 (kPa)	≤11▪7 **and**	NA	>11▪7	NA
Mechanical ventilation€	No ventilation	Ventilation	NA	NA
Haematological				
White blood cell count (x109/L)	≥4▪5 **and**	1▪5-4▪4 **or**	<1▪5	NA
Platelets (x109/L)	≥35	<35	NA	NA
Hepatic				
Aspartate transaminase (IU/L)	<950 **and**	≥950 **or**	NA	NA
Prothrombin timeβ (or INR)	>60 (<1▪40)	≤60 (≥1▪40)	NA	NA

PaO2 = arterial oxygen pressure. FIO2 = fraction of inspired oxygen. PaCO2 = arterial carbon dioxide pressure. INR = international normalized ratio. *Glasgow coma score: use lowest value. If patient is sedated, record estimated Glasgow coma score before sedation. Assess patient only with known or suspected acute central nervous system disease. Pupillary reactions: non-reactive pupils must be >3 mm. Do not assess after iatrogenic pupillary dilatation. †Heart rate and systolic blood pressure: do not assess during crying or latrogenic agitation. ‡Strictly less than. €PaO2: use arterial measurement only. βPercentage of activity. PaO2/FIO2 ratio, which cannot be assessed in patients with intracardiac shunts, is considered as normal in children with cyanotic heart disease. PaCO2 may be measured from arterial, capillary, or venous samples. Mechanical ventilation: the use of mask ventilation is not counted as mechanical ventilation.

Table B: ICU Triage Exclusion Criteria

1. Change in patient or proxy decision to withdraw life-sustaining measures.
2. Severe and irreversible neurologic event or condition with persistent (>72 hours) coma and GCS < 6

Table C: Modified Sequential Organ Failure Assessment (MSOFA)

MSOFA Scoring Guidelines

Variable	Score 0	Score 1	Score 2	Score 3	Score 4	Score for each row
Sp02/FiO2 ratio OR nasal cannula to keep SpO2 > 90%	Sp02/Fi02 >400 Or Room air Sp02 > 90%	Sp02/Fi02 216-400 Or Room air Sp02 >90% at 1-3 LPM	Sp02/Fi02 231-315 Or Room air Sp02 >90% at 4-6 LPM	Sp02/Fi02 151-230 Or Room air Sp02 >90% at 7-10 LPM	Sp02/Fi02 ≤ 150 Or Room air Sp02 >90% at > 10 LPM	
Bilirubin (mg/dL)	< 1.2 Or No Scleral icterus	1.2 to 1.9	2.0 to 5.0 Or Scleral icterus	6.0-11.9 Or clinical jaundice	≥12	
Hypotension	None	MABP < 70	DOP < 5	DOP 5 to 15 Or EPI ≤ 0.1 Or NOREPI ≤ 0.1	DOP > 15 Or EPI > 0.1 Or NOREPI > 0.1	
Glasgow Coma Score	15	13 to 14	10 to 12	6 to 9	<6	
Creatinine (mg/dL)	<1.2	1.2 to 1.9	2.0 to 3.4	3.5 to 4.9 Or Urine output < 500 in 24 hours	>5	

MSOFA score = total scores from all rows

Table D: ICU Criteria

Patients must have NO exclusion criteria (Table A) AND at least one of the following criteria:

1. Requirement for invasive ventilator support as evidenced by:
    a. Refractory hypoxemia (SpO2 < 90% on non-rebreather mask or FiO2 > 0.85), or
    b. Severe acidosis (pH < 7.2), or
    c. Clinical evidence of impending respiratory failure
    d. Inability to maintain airway
2. Hypotension with clinical evidence of shock refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in the ward setting.
    a. Hypotension is defined by a SBP < 90 or MAP < 60.
    b. Clinical evidence of shock shall consist of an altered level of consciousness, decreased urine output or other evidence of end-organ failure

Table E: Revised Trauma Score

(online calculator available at http://www.trauma.org/archive/scores/rts.html)

REVISED TRUMA SCORE CALCULATION

Criteria	Score	Coded Value	Weighting	Adjusted Score
Glasgow Coma Score	3	0	X 0.9368	
	4 to 5	1		
	6 to 8	2		
	9 to 12	3		
	13 to 16	4		
Systolic Blood Pressure	0	0	X 0.7326	
	1 to 49	1		
	50 to 75	2		
	76 to 89	3		
	>89	4		
Respiratory Rate (BPM)	0	0	X 0.2908	
	1 to 5	1		
	6 to 9	2		
	>9	3		
	10 to 29	4		
REVISED TRAUMA SCORE (add 3 adjusted scores)				

Table F: Glasgow Coma Score			
GLASGOW COMA SCORING CRITERIA			
Criteria	**Adults and Children**	**Score**	**Criteria Score**
Best Eye Response 4 possible points	No eye opening	1	
	Eye opens to pain	2	
	Eye opens to verbal command	3	
	Eyes open spontaneously	4	
Best Verbal Response 5 possible points	No verbal response	1	
	Incomprehensible sounds	2	
	Inappropriate words	3	
	Confused	4	
	Oriented	5	
Best Motor Response 6 possible points	No motor response	1	
	Extension to pain	2	
	Flexion to pain	3	
	Withdraws from pain	4	
	Localizes to pain	5	
	Obeys commands	6	
TOTAL SCORE	Range 3 to 15		

Table G: Triage Decision for Burn Victims

Age (yrs)	Burn Size (%TBSA)									
	0-10%	**11-20%**	**21-30%**	**31-40%**	**41-50%**	**51-60%**	**61-70%**	**71-80%**	**81-90%**	**91%**
0-1.9	Very High	Very High	Very High	High	Medium	Medium	Medium	Low	Low	Low expectant
2.0-4.9	Outpt	Very High	Very High	High	High	High	Medium	Medium	Low	Low
5.0-19.9	Outpt	Very High	Very High	High	High	High	Medium	Medium	Medium	Low
20.0-29.9	Outpt	Very High	Very High	High	High	Medium	Medium	Medium	Low	Low
30.0-39.9	Outpt	Very High	Very High	High	Medium	Medium	Medium	Medium	Low	Low
40.0-49.9	Outpt	Very High	Very High	Medium	Medium	Medium	Medium	Low	Low	Low
50.0-59.0	Outpt	Very High	Very High	Medium	Medium	Medium	Low	Low	Low expectant	Low expectant
60.0-69.9	Very High	Very High	Medium	Medium	Low	Low	Low	Low expectant	Low expectant	Low expectant
70.0 +	Very High	Medium	Medium	Low	Low	Low expectant	Expect-ant	Expectant	Expectant	Expectant

Outpt – outpatients – Survival and good outcome expected without initial admission

Very High – Survival and good outcome expected with limited/short-term initial admission and resource allocation.

High – Survival (>90%) and good outcome expected

Medium – Survival 50-90%

Low – Survival <50%

Expectant – Predicted survival ≤ 10%

Table H: New York Heart Association Stages (NYSA) of Heart Failure	
NYSA	Classes
Class	Patient Symptoms
Class I Mild	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitations or dyspnea.
Class II Mild	Slight limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitations or dyspnea.
Class III Moderate	Marked limitation of physical activity. Comfortable at rest, but les than ordinary activity causes fatigue, palpitations or dyspnea.
Class IV Severe	Unable to carry out physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased.

Table I: Pugh Score			
Scoring	**Criteria**		
Criteria	**Value**	**Points**	**Total for Criteria**
Total serum	<2	1	
Bilirubin mg/dL	2-3	2	
	>3	3	
Serum Albumin g/dL	>3.5	1	
	2.8-3.5	2	
	<2.8	3	
INR	<1.70	1	
	1.71-2.20	2	
	>2.20	3	
Ascites	None	1	
	Controlled medically	2	
	Poorly controlled	3	
Encephalopathy	None	1	
	Controlled medically	2	
	Poorly controlled	3	
		Total Pugh Score	
Score Interpretation			
Total Pugh Score			
5-6	A	Life expectancy 15-20 years	
7-9	B	Liver transplant evaluation indicated	
10 to 15	C	Life expectancy 1-3 years	

Table J: Simple Triage Scoring (STSA)	
Age $\geq$ 65	
Respiratory Rate > 30	
Shock Index > 1 (HR > SBP)	
Low oxygen saturation*	
Altered mental status	

*Hypoxemia is defined as initial oxygen saturation of <90% on room air or <93% on supplemental oxygen

Appendix A: Sample MOU

MEMORANDUM OF UNDERSTANDING
BETWEEN
LA 2-1-1 (LA 2-1-1)
And
_____ Parish Communications District (9-1-1)

Purpose:
This memorandum describes and documents the working relationship between Louisiana 2-1-1 (LA 2-1-1) and _____ Parish Communications District (9-1-1) in order to enhance delivery of Information & Referral and Crisis Intervention services to _____ Parish reducing the number of non-emergency calls to 9-1-1 in a Pandemic Influenza or Mass Fatality Event.

Each party to this memorandum is a separate and independent organization and nothing herein shall be constructed to create a joint venture or legal partnership. Each organization shall retain its own identity in providing services.

Each party agrees to the following components:

Component I: Operational Referral Agreements

1. 9-1-1 may direct callers requesting non-emergency related information and referral services related to a Pandemic Influenza or Mass Fatality Event to LA 2-1-1 through referral, call transfer, or call conferencing processes.

2. LA 2-1-1 Information & Referral Specialists will refer callers in an emergency situation to 9-1-1.

Component II: Confidentiality

1. Client confidentiality is to be maintained by LA 2-1-1 staff and volunteers **at all times**, except:

    - when the client gives the LA 2-1-1 Information & Referral Specialist explicit verbal permission to share specific information to an agreed upon entity for purposes of client advocacy
    - in the event that the LA 2-1-1 Information & Referral Specialist learns of imminent danger to a person or persons
    - as mandated by law, in cases where the Information & Referral Specialist learns of abuse or neglect of a minor, disabled adult, or elder.

2. Services provided to a client should, in no way, be affected by their choice to maintain anonymity. However, certain demographic and other information is requested and recorded for purposes of maintaining confidential client records and aggregated call reports.

3. LA 2-1-1 and 9-1-1 will comply with all applicable federal, state and local confidentiality laws.

4. LA 2-1-1 Information & Referral Specialists will consult with a LA 2-1-1 Counselor Consultant prior to breaching caller confidentiality, except with suicide in progress calls, violence in progress calls, or calls where the caller has become unconscious.

Component III: Community Collaboration

1. In the event of activation of this agreement, LA 2-1-1 and 9-1-1 will communicate regarding implementation of this plan, as needed.

2. LA 2-1-1 and 9-1-1 will communicate, as needed, to make changes to this memorandum of understanding.

Component VI: Termination

In the event that either LA 2-1-1 or 9-1-1 decides to terminate this memorandum of understanding, a written notice of intent will be sent to the other party 30 days prior to termination.

Agency	Agency
Signature	Signature
Name/Title/Date	Name/Title/Date

Appendix B: EMS Dynamic System

SAMPLE Protocols	**Response** (Standard Operating Mode)	**Dynamic System** Status Category 1 (Pandemic Severity Index Category 1)	**Dynamic System Status Category 2** (Pandemic Severity Index Category 2-3)	**Dynamic System Status Category 3** (Pandemic Severity Index Category 4-5)
Triage *(to occur both at the 9-1-1 center and on scene)*	Daily use algorithms and protocols	Determine whether to implement triage and treatment protocols that differentiate between non-infected and potentially infected patients based on CDC case definition	Triage would focus on identifying and reserving immediate treatment for individuals who have a critical need for treatment and are likely to survive. The goal would be to allocate resources in order to maximize the number of lives saved	Using screening algorithm to ensure only severe get response
Treatment	Jurisdictional daily treatment protocols	Ambulatory patients will be redirected to alternate care sites within or outside of the hospital	Treatment protocols may be modified to enable and encourage patients to receive care at home. Consider provision of antiviral prophylaxis if effective, feasible and quantity sufficient.	Certain lifesaving efforts may have to be discontinued. Provision of antiviral prophylaxis if effective, feasible and quantity sufficient
Equipment	No restrictions	Prudent use of equipment. Implementation of strict PPE/Infection control protocols for patients meeting case definition established by CDC during the response phase of a 9-1-1 call	Selective criteria in place for priority use. Some scarce and valuable equipment, such as ventilators, may not be used without staff available who are trained to operate them.	Strict criteria in place for equipment use. Some scarce and valuable equipment, such as ventilators, may not be used without staff available who are trained to operate them.
Transportation	Routine use of EMS resources	Non-urgent and ambulatory victims may have to walk or self-transport to the nearest facility or hospital	Emergency medical services may transport victims to specific quarantine or isolation locations and other alternate care sites	Only severe cases transported via ambulance
Destination	Routine hospital based facilities	Alternate care sites will be used for triage and distribution of vaccines or other prophylactic measures, as well as for quarantine, minimum care, and hospice care	Ambulatory and some non-ambulatory patients may be diverted to alternate care sites (including non-medical space, such as cafeterias within hospitals, or other non-medical facilities)	Emergency department access may be reserved for immediate need patients

Dispatch Priority Level (match vendor or call center based dispatch protocol/tiered algorithm)	**Response** (Standard Operating Mode)	**Level 1 (A)** Activation of Card 36 and ONLY for use in 6, 10, 18, and 26 DSSI BELOW IS BACK UP STRATEGY FOR EMD WITHOUT CARD 36	**Level 2(B)** Implement Declining Response / Configuration CAD Table (Moderate) + Card 36 (6,10,18 & 26) DSS2	**Level 3 (C)** Implement Declining Response / Configuration CAD Table (Severe) + Card 36 (6,10,18 & 26) DSS3
Classification 1 (*Echo) Confirmed Cardiac Arrest (Not Breathing, Unresponsive per 911 Call) (MPD cards- 2, 6, 9, 11, 15, 31)	Closest AED Unit and Closest 1st Responder andClosest ALS Ambulance	Closest AED Unit and Closest 1st Responder andClosest BLS Ambulance if available	Closest AED Unit and Closest 1st Responder if available	Closest AED Unit if available. If not unit available, no response
Classification 2 (*Delta) Life Threatening Emergency / Potentially Life Threatening / Confirmed Unstable Patient(s)	Closest 1st Responder and Closest ALS Ambulance	Closest 1st Responder and Closest ALS Ambulance if available; BLS ambulance if ALS unit not available	Closest 1st Responder and Closest Ambulance available (ALS or BLS)	Closest 1st Responder and if availableClosest Ambulance available (ALS or BLS)
Classification 3 (*Charlie) Non-Critical / Currently Stable Patient(s) Requiring ALS Assessment	Closest ALS Ambulance	Closest Ambulance available (ALS or BLS)	Closest Ambulance available (ALS or BLS)	Closest 1st Responder if available Or Closest stand-in responder unit
Classification 4 (*Bravo) BLS Assessment for unknown / possibly dangerous scenes	Closest 1st Responder and Closest BLS Ambulance	Closest 1st Responder and Closest BLS Ambulance if available	Closest 1st Responder	• Trauma - Closest 1st Responder • Medical – referral to Nurse or Health Department Advice Telephone service if available or self-transport advice to Alternate Care Site
Classification 5 (*Alpha) BLS treatment	BLS Ambulance	Alternate Care Referral	Alternate Care Referral	Alternate Care Referral
Classification 6 (*Omega) Non Ambulance Care	Alternate care such as Poison Control Center; Police/Fire service call; etc.	Alternate care such as Poison Control Center; Police/Fire service call; etc.	Alternate care such as Poison Control Center; Police/Fire service call; etc.	Alternate care such as Poison Control Center; Police/Fire service call; etc.

Appendix C: EMS Pandemic Response Tool

Draft *- EMS Pandemic Response Tool - Version 2*

	Surge Capacities (IOM, 2009)			
	Conventional (usual care)	**Contingency** (functionally equivelant care)	**Crisis** (crisis care)	
Environment	***Usual*** ⟷		***Austere***	
Protocol	Standard Operating Mode	***Dynamic System Status - Category 1*** ; **(Pandemic Severity Index - Category 1)**	***Dynamic System Status - Category 2*** ; **(Pandemic Severity Index - Category 2 - 3)**	***Dynamic System Status*** **- Category 3; (Pandemic Severity Index - Category 4 - 5)**
Triage	Daily use algorithms and protocols	Determine whether to implement triage and treatment protocols that differentiate between non-infected and potentially infected patients based on CDC case definition.	Triage would focus on identifying and reserving immediate treatment for individuals who have a critical need for treatment and are likely to survive. The goal would be to allocate resources in order to maximize the number of lives saved	Using screening algorithm to ensure only severe get response
Treatment	Jurisdictional daily treatment protocols	Safe substitutions may take place. Example: bag-valve-mask may be used in place of mechanical ventilator during transport. Medication substitutions may be required.	Treatment protocols may be modified to enable and encourage patients to receive care at home. Consider provision of antiviral prophylaxis if effective, feasible and quantity sufficient. Medication substitutions may become unavailable. Certain lifesaving efforts may have to be discontinued.	Certain lifesaving efforts may have to be discontinued. Provision of antiviral prophylaxis if effective, feasible and quantity sufficient.
Equipment	No restrictions	Prudent use of equipment. Implementation of strict PPE/infection control protocols for patients meeting case definition established by CDC during the response phase of a 9-1-1 call.	Selective criteria in place for priority use. Some scarce and valuable equipment, such as ventilators, may not be used without staff available who are trained to operate them.	Strict criteria in place for equipment use. Some scarce and valuable equipment, such as ventilators, may not be used without staff available who are trained to operate them. Some scarce supplies may need to be reused when possible.
Transportation	Routine use of EMS resources	Non-urgent and ambulatory victims may have to walk or self-transport to the nearest facility or hospital. Buses could be used to transport stable, ambulatory patients.	Emergency medical services may transport victims to specific quarantine or isolation locations and other alternate care sites Only severe cases transported via ambulance. Ambulances of opportunity may used	Only severe cases transported via ambulance. "Ambulances of opportunity" may be used.
Destination	Routine hospital-based facilities , nursing homes, residences, etc.	Ambulatory patients may be redirected to alternate care sites within or outside of the hospital. Alternate care sites may need to be used for triage and distribution of vaccines or other prophylactic measures, as well as for quarantine, minimum care, and hospice care	Ambulatory and some non-ambulatory patients may be diverted to designated facilities and alternate care sites (including non-medical space, such as cafeterias within hospitals, or other non-medical facilities). Emergency department access may be reserved for immediate-needs patients.	Emergency department access may be reserved for immediate-need patients.

Appendix D: Delivery of Cultural Competence of Care Guidelines

Vulnerable Populations

Children & Adolescents

Toddler/pre-K **Response to Disasters**

- Separation anxiety
- Avoidance
- Regression
- Fear of the dark
- Sleep problems
- Fearfulness
- Clinging
- Temper tantrums

School age

- Sleep problems
- Concerned with safety
- Preoccupied with disaster
- Physical complaints
- Depression
- Excessive guilt
- Poor concentration
- Angry outbursts
- Withdrawal from friends
- Aggressive behavior at home/school
- Re-telling the story related to trauma

Adolescents

- Sleep problems
- Physical complaints
- Depression
- Guilt
- Aggressive behavior
- Increased risk-taking behavior
- Social withdrawal, isolation
- Apathy
- Rebellious home/school

Interventions

- Talk calmly and openly at their level
- Ask them what they think about their fears
- Share your own fears and reassure the child/adolescent
- Try to keep a normal routine

- Allow expression in private ways (playing, drawing)
- Encourage positive coping, not blaming
- Foster social support
- Create a pediatric safe zone in the organization during disasters
- Utilize interpreters to include sign-language
- Use community leaders/members as cultural brokers
- Try not to make children/adolescents feel guilty for behaviors
- Develop age-specific materials
- Provide mental and behavioral health services

Adults/Seniors

Response to Disaster

- Loneliness
- Physical illness
- Financial limitations
- Depression
- Suicidal ideation

Interventions

- Treat with respect
- Address immediate problems
- Encourage reminiscing
- Active advocacy
- Utilize risk assessment tools (i.e. mini-cog, Katz Index)
- Address advanced directives and living wills
- Provide interpreter services

Mental Illness

Response to Disaster

- Depression, sadness
- Mood swings
- Angry outbursts
- Fear, anxiety
- Despair
- Self-doubt
- Hopelessness
- Helplessness
- Difficulty falling asleep/staying asleep
- Tiredness/fatigue/exhaustion
- Increased or decreased appetite
- Somatic complaints (Mitchell et al., 2005)

Interventions

- Identify individuals at risk and make appropriate referrals
- Educate person about normal responses to disasters
- Limit the number of persons with whom the victim most interact for services
- Distinguish between normal reactions and actual pathological reactions
- Provide cognitive behavioral therapy, if appropriate
- Knowledgeable about crisis interventions (ie. active listening, paraphrase and reflect feeling, allow the person to express feelings/emotions)

Limited English Proficiency

Response to Disaster

- May have lack of trust of public officials/health care professionals
- The LEP may have literacy issues, requiring longer timeframe to explain instructions and to provide services
- They may not receiving messages in an understandable or timely manner

I**nterventions**

- Strengthen LEP resources within the organization
- Ensure essential documents are translated into key languages (consent, intake forms, patient right)
- Plan on how to notify LEP client on updates in an emergent situation
- Determine client's preferred language
- Availability of interpreters, including sign language
- Conduct self-assessment of organization's capacity related to cultural competence
- Recruit and train community members of the same racial/ethnic background as the community you serve in a disaster response
- Provide social support
- Avoid stereotypes and generalizations
- Health care providers should be genuine when caring for this population
- Health care providers need to identify own biases, beliefs of culture
- Bilingual and bicultural staff

Persons with Disabilities

Response to Disaster

- Visually impaired – may be reluctant to leave familiar surroundings when evacuation request comes from a stranger
- Hearing impaired – may need special arrangements to receive warnings
- Developmental or intellectual disabilities – may need help responding to emergencies and getting to a shelter
- People with physical disabilities – may need special equipment, transportation, and shelter access, oxygen canister refill, dialysis supplies

Interventions

- Use person first language
- A person with disability, not "disabled person"
- Focus on individual, not disability
- Do not refer to disability unless relevant
- Avoid labeling people that stereotype
- Emphasize each person's value, dignity, individuality and capabilities
- Contact social service agencies and support groups
- Utilization of interpreters (sign language)
- These individuals need access for needed equipment and supplies (i.e. TTT/TDD, oxygen canisters, dialysis supplies)
- Assessment of psychological needs -depression and suicidal ideation may be prevalent

Medically Needy/Terminally Ill

Response to Disaster

- Personal assistance required for ADL
- Confused easily
- Afraid to leave their know health care provider
- Didn't plan to have enough medical supplies (i.e. medication)
- Depression
- Anxiety
- Psychological disorders
- Risk for inability to evacuate
- Can't care for themselves

Interventions

- Provide optimal symptom management (pain management, incontinence)
- Ensure family support and education
- Provide protection from abuse and fraud

Perinatal/Neonatal

Response to Disaster

- Fear of delivering in an unknown health system
- Lack of support
- Stress

Interventions

- Support mother/family during the delivery
- Inform the mother that natural childbirth may be only option during a disaster
- Teach labor support techniques and basics of assisted birth
- Respectful of mother's beliefs and practices related to mother's intake of foods and diet of lactating mothers

People living in poverty

Response to Disaster

- Powerless and lack of finances prevail
- Self-efficacy may be low

Interventions

- Be aware of middle bias and barriers
- Look for anxiety and depression
- Focus on strength of persistence and survival

Homeless

Response to Disaster

- Lack of trust for authority personnel
- Mental illness is high for this population
- Lack of transportation

Interventions

- May need to go out in community and find the homeless population
- Lack of trust for authority personnel
- May need assistance in placement in shelters
- After disaster will need assistance to returning to previous site
- Coordination with homeless service providers is essential
- Provide information as if it is the first time the person is hearing it

Gays and Lesbians

Response to Disaster

- Increase anxiety and fear due to prior discrimination
- Isolation, due to limited social support from family

Interventions

- Respond in an open and respectful manner
- Refer to safe places for support
- Assess your own biases

Ethnic Group

Hispanics/Latinos

Response to Disasters

- May refuse certain foods or medications that upset hot/cold body balance
- Typically are expressive (loud) when dealing with pain
- Family members usually want to withhold a fatal diagnosis from the patient

Interventions

- Have available informational material in Spanish
- Communicate with extended family and/or religious person
- Develop a nurturing relationship

Racial Groups

Asian/Pacific Islander

Response to Disasters

- May not express pain
- May not express feelings or discuss events during a trauma
- Somatic symptoms

Interventions

- Avoid eye contact
- Avoid giving ice water, unless requested
- Coining and cupping are traditional medical practices in China, Korea, Vietnam
- Use of herbs are common
- Avoid the number 4 – may signify death for Chinese, Japanese, and Koreans
- Avoid asking questions that require a "yes" or "no" answer
- Offer things several times, due to the fact that this ethnic group may refuse the first or second time
- Encourage interaction with spiritual leaders and family
- Respect privacy

Native Americans

Response to Disasters

- May show hostility toward health care providers due to history of mistreatment
- May be unwilling to sign informed consent or advanced directives
- Extended family important,
- Stoicism is highly valued and may not express pain
- May not want to discuss terminal prognosis or DNR
- May avoid contact with the dying, others will be present24/hours a day

Interventions

- Use silence as sign of respect
- View culture as treatment through spiritual rituals
- Allow family community, traditional healers to participate in healing
- Direct eye contact may be avoided
- Loudness associated with aggressiveness and should be avoided

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U.S. Department of Health and Human Services. Office of Minority Health. *Culturally and Linguistically Appropriate Standards (CLAS standards)*.

Appendix E: Delivery of Care Guidelines for Essential Inpatient Nursing Care

Essential In patient Nursing Care during a healthcare crisis is defined as those patient care tasks that have higher priority for completion when patient care staff and supply/equipment resources are limited. As the needs of patients increase and resources become limited, patient care services may have to be limited. The most critical aspects of patient care for clinicians providing care are: a) maximizing worker and patient safety, b) maintaining airway and breathing, circulation and control blood loss; and c) maintaining or establishing infection control (ANA, 2008). The following information provides several examples of recommendations on methods on how patient care staff productivity may be increased and how staff time and supply resources may be conserved; overall providing safe and quality care to the patient. It is recommended that each hospital develop its own recommendations for Essential Inpatient Nursing Care.

CARE ELEMENTS	ESSENTIAL PATIENT CARE

1. Assessment	• Resuscitation status – identify upon admission and review daily
	• Screenings (i.e. nutrition, immunizations)
	  o Limit according to nursing assessment and judgment
	  o Screenings and education limited to situations that pose an immediate threat to the patient in areas such as:
	  ▪ Fall risk
	  ▪ Skin care
	  ▪ Alcohol abuse
	  ▪ Suicide risk
	• Initial patient assessment – within first 4 hours
	• Patient reassessment – every 24 hours
	• Patient observation – every 4 hours or more often based on nursing judgment

2. Patient Hygiene	• Baths or partial baths performed only as needed or by family members or volunteers • Oral hygiene performed daily, when possible • Change linen only when soiled
3. Infection Control	• Maintain infection control procedures as much as possible • Hospital should have a procedure for the conservation of personal protective equipment • Trash should be picked up daily or when containers are full
4. Respiratory	• Cough and deep breath should be within nursing judgment • Suction patients prn
5. Patient and family education	• Patient and family education provided prn and at discretion of nursing staff

6. Vital signs	• Every 24 hours and Nursing judgment based on the patient's condition
7. Nutrition	• Nursing assessment completed for patients who have feeding problems such as swallowing difficulties, potential for aspiration of food or drink • Encourage family members, volunteers or other hospital staff to feed patients that are unable to feed themselves • For tube feedings, provide as ordered by the physician • Prescription diets may not be available and Food Service should develop alternative menus • Artificial nutrition and hydration are ethical decisions and should be subject to the protocols for the allocation of scarce resources
8. Medication/Fluid Administration	• Medications – administered as ordered by a physician • IV site care – follow according to hospital policy • <u>Medication reconciliation</u> o Done in collaboration with a physician o May be limited to verification that the medications are being dispensed to the right patient and at the right dose • <u>Home medications</u> o To the extent possible and based on the nature of the incident, patients may be encouraged to bring their own medications o Collaborate with physician regarding home medications o Collaborate with patient taking their home medications and properly document the administration of home medications on the MAR o Ensure that home medication is properly labeled and identified
9. Elimination	• Patients who need assistance – provide bedpan • Incontinent patients – change prn • Patients with an ostomy – change prn • I & O – completed as ordered
10. Treatments	• Dressings – change only when soiled • Weighing patients – based on nursing assessment • NG irrigation, glucometer checks – implement as ordered
11. Patient Safety	• Fall prevention – maintain at all times • Restraint protocols o <u>Medical (Non-behavioral) Restraints</u> ▪ RN monitors physical and emotional well-being of patient at least every 2 hrs, including behavior,

	checking pulses and/or vital signs, ensuring that restraint device is safely intact and documents assessment ▪ Recognize clinically relevant observations to report and/or document ▪ RN or designee **must provide comfort care at least every two hrs**, including turning patient to a different position; range of motion to extremities; skin care to pressure pts; offering food and fluid; and toileting ▪ Maintain the patient's rights, dignity, and safety ▪ Recognize changes in the pt.'s behavior or clinical condition needed to initiate the removal of restraints ▪ Conduct ongoing checks to ensure that the restraint has been appropriately applied, removed, or reapplied o <u>Behavioral Restraints</u> ▪ Continuous monitoring – Ancillary staff must continuously monitor every pt. in behavioral restraints ▪ RN must document an assessment of the patient every hour ▪ A trained staff member must document assessment of the patient every 15 minutes. This includes vital signs, pulse checks, patient behaviors, device integrity and circulation ▪ Provide comfort care at lease every two hours, including turning patient to a different position; range of motion to extremities; skin care to pressure points; offering food and fluid; and toileting
12. Indirect Care	• All physician orders – transcribe as soon as possible
13. Documentation	• Patient care documentation – document at least every shift and as needed when any type of care, treatment and daily physician assessment is provided • Document patient location and when patient is moved to alternate locations • Extensive documentation should be limited • Implement computer down-time procedures if computer systems for documentation are not available • Print out patient care summary, if available
14. High-risk populations	• Discharge early if possible • Place high-risk populations in isolation or in patient areas that mitigate risk of cross-contamination • Candidates for self-care as appropriate, based on nursing assessment

15. Diagnostic testing	• For life saving measures as ordered by a physician
16. Discharge of patients	• Establish standardized discharge orders • RNs should be permitted to initiate patient transfers to a lower level of care following pre-identified criteria
17. Staffing	• Assess current numbers of health care workers and skill levels • Hospital should consider alternative staffing models with the trigger being the number of patients being cared for plus the number of staff available and length of time that the incident is expected to occur; o Using nurses from other in-house services (i.e.. human resources, employee health, administration, home health) o Using professions that have nursing skills such as paramedics o Using other hospital staff to perform ADL patient care support functions o Hospital, prior to an incident, prioritizes hospital service and functions that can be closed or down-sized so that staff from these areas can be used for pt. care support functions o Hospital should consider, prior to the incident, its policies for limiting vacation and other time-off benefits • Job action sheets should be developed so staff have available their responsibilities for particular tasks • Identify multiple shifts 2, 4, 6, 6, or 12 hours • Ensure that there is an “active” team of employees to work the incident, and a “relief” team of employees that is stationed nearby to come in and relieve employees • Support staff through critical incident debriefing, grief counseling, child care, and other types of support that the hospital deem necessary
18. Bed Assignment	• Cohort patient populations as much as possible

Appendix F: Guidelines for Delivery of Palliative Nursing Care

Palliative Nursing Care during a healthcare crisis is defined as those tasks that aim to add to the comfort of the patient and relieve suffering to support a respectful and peaceful death when patient care staff and supply/equipment resources are limited. The most critical aspect of care at this time is compassionate end of life care including the promotion of comfort and the relief of pain and distressing symptoms, as well as, psychosocial and spiritual support of patients and families. At the same time, it is important to maximize worker, volunteer and patient safety, and maintain or establish infection control. The following information provides several examples of recommendations on methods on how care can be provided while conserving staff and volunteer time and supply resources. It is recommended that each community develop its own recommendations for providing Palliative Nursing Care.

CARE ELEMENTS	ESSENTIAL PATIENT CARE

1. Assessment	• Resuscitation status - No efforts are to be made to restore cardiac or pulmonary function following a cardiac or pulmonary arrest
	• Screenings
	  o Limit according to nursing assessment and judgment
	  o Screenings and education limited to situations that pose an immediate threat to the patient in areas such as:
	  • Fall risk
	  • Skin care
	  • Alcohol abuse
	  • Suicide risk
	  • Aspiration risk
	• Assess daily and as needed for nonverbal signs of pain such as grimacing or crying out if the patient cannot speak

2. Patient Hygiene	• Baths or partial baths performed only as needed or by family members or volunteers • Oral hygiene performed by family members or volunteers every 2 hours and as needed, when possible • Reposition bed bound patients by family members or volunteers every 2 hours and as needed, when possible • Change linen only when soiled
3. Infection Control	• Maintain infection control procedures as much as possible • Follow procedures for the conservation of personal protective equipment • Trash should be picked up daily or when containers are full
4. Respiratory	• Cough and deep breath prn
5. Patient and Family Support	• Patient and family emotional and spiritual support should be provided as needed
6. Nutrition	• Encourage family members or volunteers to feed patients that are able to swallow and unable to feed themselves

7. Medication Administration	• Medications - administered by a physician (See Appendix G-H)
	• Medication reconciliation
	  o Limited to verification that the medications are being dispensed to the right patient and at the right dose
	• Home medications
	  o Patients need to bring their home medications
	  o Collaborate with physician regarding home medications
	  o Collaborate with patient taking their home medications
	  o Ensure that home medication is properly labeled

8. Elimination	• Patients who need assistance - provide bedpan • Incontinent patients - change prn • Patients with ostomy - change prn
9. Treatments	• Dressings - change only when soiled
10. Patient Safety	• Fall prevention - maintain at all times
11. Indirect Care	• Provided by volunteers and family as needed
12. Documentation	• Patient care documentation - document at least every day and as needed when any type of care, treatment or assessment is provided
13. High-risk populations	• Place high-risk populations in areas that mitigate risk of cross-contamination
14. Discharge of patients	• RNs should be permitted to initiate patient transfers to a lower level of care following pre-identified criteria
15. Staffing	• Assess current numbers of health care workers and volunteers and skill levels • Assess utilization of family in delivery of patient care • Job action sheets should be developed so staff have available their responsibilities for particular tasks • Identify multiple shifts 2,4, 6, or 12 hours • Ensure that there is an "active" team of employees to work the incident, and a "relief" team of employees that is stationed nearby to come in and relieve employees • Periodic emotional and psychological relief for this group through critical incident debriefing and grief counseling will be necessary for the welfare and morale of this group of providers
16. Bed Assignment	• Cohort patient populations as much as possible
17. Management of deceased	• Managing the number of deaths and disposal of the bodies will need to be done respectfully

Appendix G: Adult Palliative Care Drug List

Generic Names (Brand Name)	Indication/Drug Class	Typical Starting Dose	Formulation Considerations	Comments
Acetaminophen (Tylenol)	Pain, fever/ Non- opioid	Oral: 650mg, every 4 hours prn Rectal: 650mg, every 4 hours prn		
Atropine EYE drops (isopto atropine)	Secretions / Anti cholinergic	Sublingual: 2 drops every 4 hours prn	1% ophthalmic solution	Ophthalmic drops can be used for sublingual admin-istration
Bisacodyl (Dulcolax)	Constipation / Stimulant Laxative	Rectal: 1 suppository daily prn		
Dexamethasone (Decadron)	Bone pain, Pruritus, Seizures, Inflammation, Increased intracranial pressure, Bowel obstruction, Vomiting / Corticosteroid	Oral: 4mg, every 12 hours	Tablet: 4 mg	
Diphenhydramine (Benadryl)	Anxiety, Pruritus, Insomnia / Antihistamine	Oral: 25mg, every 4 hours prn	Oral solution: 12.5 mg/5ml	
Haloperidol (Haldol)	Nausea, Vomiting, Delirium, Agitation Anxiety, Bowel Obstruction, Hiccups / Neuroleptic	Oral: 1mg, every 6 hours prn	Tablet: 1mg	
Hydromorphine (Dilaudid)	Pain, dyspnea / Opioid	Oral: 2mg, every 3 hours prn	Tablet: 2mg	Preferred drug for patients with renal failure
Lorazepam (Ativan)	Anxiety, Agitation, Insomnia, Acute seizure / Benzodiazepine	Oral: 0.5mg. every 4 hours prn Sublingual: 0.5mg every 4 hours prn		
morphine	Pain, dyspnea / Opioid	Oral: 5 mg, every 3 hours prn	Oral concentrated solution: 20mg/ml	
Ondansetron (Zofran)	Nausea, Vomiting/ Antiemetic	Oral: 4mg, every 6 hours prn	Oral disintegrating tablet: 4mg	

Polyethylene glycol (Miralax)	Constipation	Oral: 17g in 8 ounces of water or juice daily prn		
Prochlorperazine (Compazine)	Nausea, Vomiting/ Antiemetic	Oral: 5mg, every 6 hours prn Rectal: 25mg, every 12 hours prn		
Tears Naturale	Dry eyes / Ocular lubricant ophthalmic solution	2 drops, both eyes every hour prn		
senna	Constipation	Oral: 2 tablets, at bedtime prn		

Appendix H: Pediatric Palliative Care Drug List

Generic Name (Brand Name)	Indication / Drug Class	Typical Starting Dose	Formulation Considerations	Comments
Acetaminophen (Tylenot)	Pain, Fever / Non-opioid	Oral: 10-15mg/kg. every 4-6 hours prn Rectal: 10-20mg/kg, every 4-6 hours prn	Oral solution 160 mg/5ml Suppository: 80,120, 326, 650 mg	Maximum daily dose: <2 years 60 mg/kg/day 2-12 years 75 mg/kg/day
Bisacodyl (Dulcolax)	Constipation / Stimulant Laxative	Oral: 0.3mg/kg daily Rectal: 5-10mg daily	Suppository 10 mg	Do not crush tablets
Diazepam (Valium)	Acute Seizures, Anxiety, Muscle Spasms, Dyspnea / Benzodiazepine	Oral: 0.05-0.2 mg/kg every 6-8 hours Rectal: 2-5 yrs 0.5 mg/kg 6-11 yrs 0.3 mg/kg >12 yrs 0.2 mg/kg		
Diphenhydramine (Benadryl)	Anxiety, Pruritus, Insomnia / Antihistamine	PO: 0.5-1mg/kg every 4-6 hrs Alternate dosing: 2-5 yrs 6.25mg every 4-6 hrs 6-11 yrs 12.5-25 mg every 4-6 hrs	Oral elixir, liquid solution, syrup: 12.5 mg/5ml	
Fentanyl (Duragesic)	Pain / Opioid	Intranasal: Initial dose: 1.5mcg/kgx1 NOT TO EXCEED 100 mcg/dose Then 0.3-0.5 mcg/kg every 5 minutes NOT TO EXCEED total dose of 3 mcg/kg	Use IV solution intranasal	Intranasal administration: Use 50 mcg/ml injectable solution; 1/2 dose to each nostril using atomizer (nasal drug delivery device) or drip into the nostril slowly with syringe
Hyoscyamine (Levsin)	Secretions, Nausea, Vomiting, Abdominal Spasm, Cramping, Urinary Spasms, Bowel Obstruction,	Oral or Sublingual: 0.0625-0.125 mg every 4 hours	Oral elixir: 0.125 mg/5ml	Oral elixir and oral solution may contain ethanol

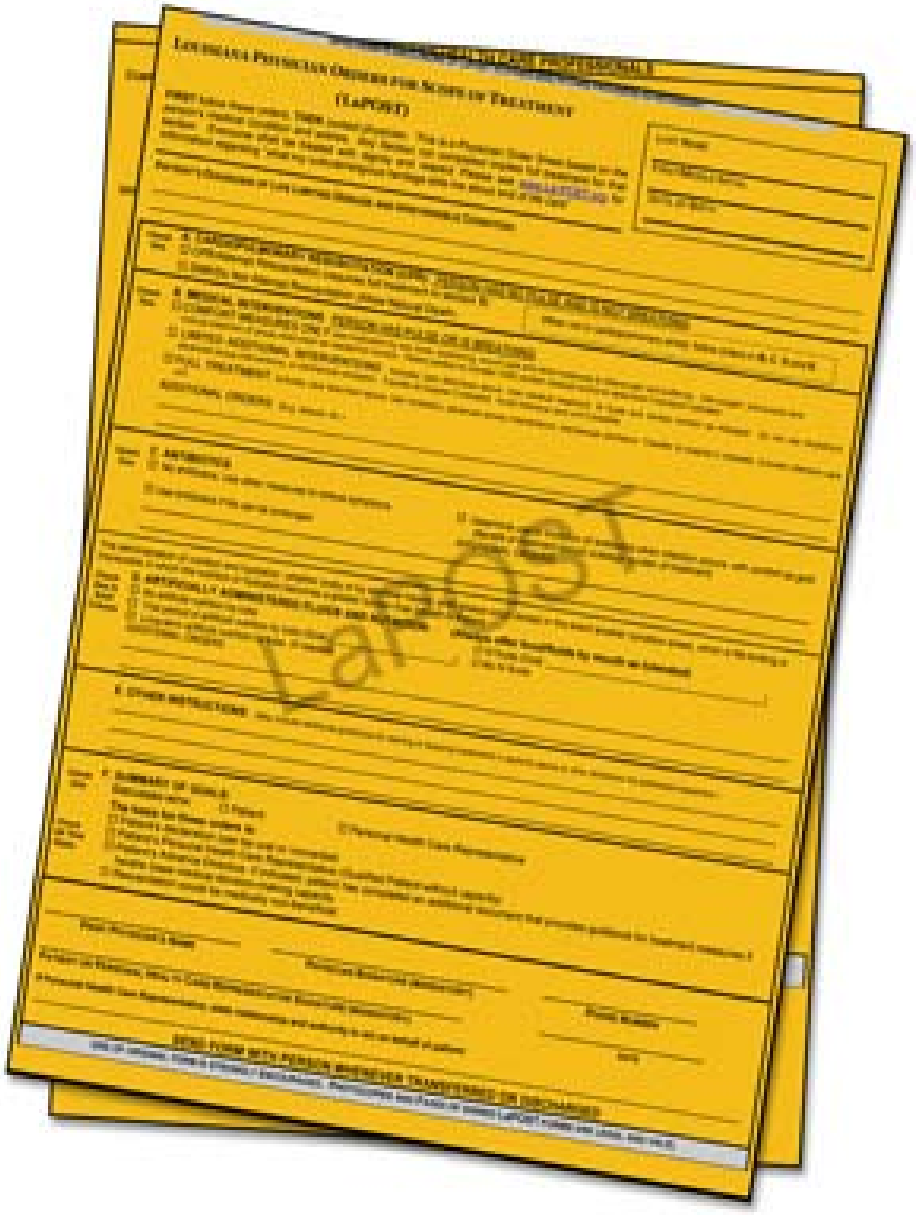
	Dysphagia, Pain / Anticholinergic		Oral solution (drops): 0.125 mg/ml Chewable tablets: 0.125 mg	
Ibuprofen (Advil/Motrin)	Fever, Pain, NSAID	Oral: 4-10 mg/kg every 6-8 hours	Oral suspension: 100mg/5ml Concentrated oral drops: 40mg/ml Chewable tablets: 100 mg	
Midazolam (Versed)	Agitation*, Acute Seizure**, Delirium Bensodiazepine	Oral/Buccal: 0.2-0.5 mg/kg Intranasal/Rectal: 0.2 mg/kg NOT TO EXCEED 10 mg/dose for all routes	Oral syrup 2 mg/ml	Intranasal administration: use 5 mg/ml preservative free injectable solution via needleless syringe or atomizer device - 1/2 dose in each nostril *Use intranasal as first line for agitation **Use for seizure only if not responsive to valium
morphine	Pain, dyspnea / Opioid	Oral : 0.1 mg/kg every 3-4 hours	Oral solution: 10 mg/5ml Concentrated oral solution: 20 mg/ml	
Ondansetron (Zofran)	Nausea, Vomiting / Antiemetic	Oral: 0.1-0.15 mg/kg every 6-8 hours	Oral solution: 4 mg/5ml Orally disintegrat-ing tablets: 4 mg	Orally disintegrat-ing tablets: 1-3 yrs: 2 mg 4-11 yrs: 4 mg > 12 yrs: 8 mg
Polyethylene glycol (Miralax)	Constipation / Osmotic laxative	Oral: 0.5-1.5 g/kg daily NOT TO EXCEED 17 g/day		Initial dose: 0.5 g/kg; titrate to effect
Prednisone (Deltasone)	Anorexia, Bone Pain, Respiratory Inflammation, Pruritus, Excessive	Oral: 0.5-2 mg/kg every 6 hours	Oral solution: 1 mg/ml	

	Sedation / Corticosteriod	NOT TO EXCEED 80 mg/day	Concentrated oral solution: 5 mg/ml Tablet: 10 mg	

Notes:

These doses are NOT intended for use in the neonatal population.
Do Not Exceed usual maximum adult starting doses.

Appendix I: Louisiana Physician Orders for Scope of Treatment (LaPOST)



To access and download the LaPOST form, click the following link Louisiana Physician Orders for Scope of Treatment Form.