BOZEMAN HEALTH

TITLE	**Contingency and Crisis Standards of Care Activation**		
SECTION	**Patient Care**	X	**Organizational** **Department Specific**

APPLICABLE LOCATION(S)

X	**SYSTEM: Deaconess Hospital, Big Sky Medical Center and all other System locations**
	DEACONESS HOSPITAL
	BIG SKY MEDICAL CENTER
	MEDICAL GROUP
	URGENT CARE

Select all that apply

X	**POLICY**
X	**PROCEDURE**
	GUIDELINE
	PLAN

CONTRIBUTORS	Nursing Leadership, Operational Leadership, Quality and Safety, Emergency Management	**CURRENT DATE**	**9/21**
APPROVED BY	Policy Management Committee	**REPLACES**	

POLICY: In the event scare resource management and crisis care is needed, the following procedure will be used to navigate the specific situation. This policy is to be considered the framework to provide planning and strategies to manage transition from conventional standards of care to contingency and crisis standards of care based on the Resource Triage Threshold Model. For conventional standards of care refer to the High Census Action Plan. The house supervisor will be solely responsible for activating a change from conventional care into either contingency or crisis standards of care for one or multiple care areas. Deviations from this framework are acceptable depending on the situation and resources needed.

DEFINITIONS: as defined within the *Montana Crisis Care Guidance Front Matters*, accessed September 19, 2021.

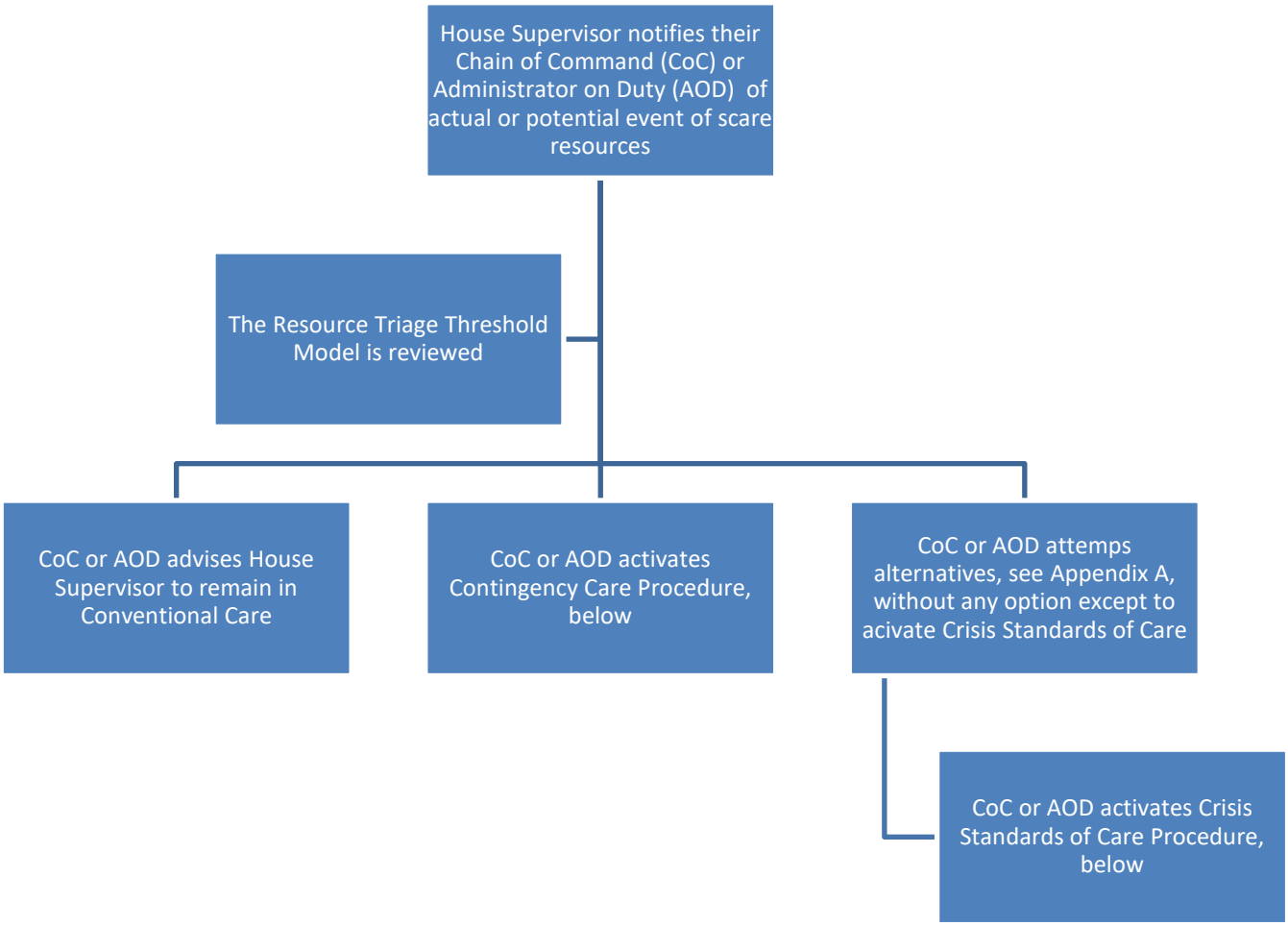
- **Conventional Care:** Usual resources and level of care provided. The maximal use of the facilities beds, staff, and resources is ensured.
- **Contingency Care:** Provisions of functionally equivalent care – care provided is adapted from usual practices. Care provided is functionally equivalent to routine care, however equipment, medications, and even staff may be used for a different purpose or in a different manner than typical daily use. Examples include patient care being delivered in an alternative medical location and antibiotic substitutions covering the same classifications.
- **Crisis Standards of Care (CSC):** A state of being that indicates a substantial change in the health care operations and the level of care that can be delivered in a public health event, justified by specific circumstances. Medical care delivered during disasters shifts beyond focusing on individuals to promoting the thoughtful and equitable stewardship of limited resources intended to result in the best possible health outcomes for the population as a whole. Crisis capacity activation constitutes a significant adjustment to standards of care. Crisis care is distinguished from contingency care by an inability to adhere to the accepted standard of care.

RESOURCE TRIAGE THRESHOLD MODEL: When triggers or a decision point about adaptations to health care delivery demonstrate a specific resource is in short supply or is unavailable.

RESOURCES	CONVENTIONAL CARE	CONTINGENCY CARE	CRISIS STANDARDS OF CARE
SPACE	Usual patient care space fully utilized	Patient care areas re-purposed. Old Nursery, ED Annex, PACU or surgical units re-purposed for medical patients	Facility damaged/unsafe or non-patient care areas used for patient care (cafeteria, conference rooms, etc.)
STAFF	Usual staff called in and utilized	Staff extension - brief deferral of non-emergent services in order to use staff from non-critical units, changes to staffing assignments and staff matrix to support the supervision of broader group of patients, change in responsibilities, and alterations to documentation requirements	Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques

RESOURCES	CONVENTIONAL CARE	CONTINGENCY CARE	CRISIS STANDARDS OF CARE
SUPPLIES	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies	Critical supplies lacking possible reallocation of life sustaining resources
STANDARDS OF CARE	Usual standard of care	Functionally equivalent care	Crisis standards of care

PROCEDURE FOR EXISTING OR ANTICIPATED SCARCE RESOURCES:



CONTINGENCY CARE PROCEDURE: Patient care will occur in the most appropriate surge care unit(s) as defined below in Appendix B when scarce resources require contingency care standards.

- Chain of Command Leadership or Administrator on Duty assures that a change to contingency care is communicated to the affected care area leadership to include medical director, clinical and/or operational director, manager, supervisor, and team leader.
- Chain of Command Leadership or Administrator on Duty contacts compliance and legal to assure that DPHHS licensing bureau is notified and that the revenue cycle policies are initiated.
- Chain of Command Leadership or Administrator on Duty contacts on-call Epic Application specialist to activate Surge Care Unit documentation abilities.
- Chain of Command Leadership or Administrator on Duty notifies switchboard of new Surge Care Unit location to alert the need to activate emergency codes for that area when indicated.

- The care area leadership supports the staff through workflow development, supply relocation, updating staffing matrices, and determining further communication strategies with other support staff, patients, and families.

CRISIS STANDARDS OF CARE PROCEDURE: Patient care will occur in the most appropriate location based on extent of facility damage or patient population care delivery needs.

- Appropriate Executive Team Member or Administrator on Duty activates the Emergency Operations Plan to use an official Hospital Incident Command Structure to manage the implementation of crisis standards of care.
- Hospital Incident Command Structure will function as the centralized-decision-making authority to manage the crisis.
    - Commander assures the identification of an Ethics Panel of individuals, who are not delivering care, for scarce resource determinations in accordance with best ethical approach.
    - Liaison notifies regulatory and licensing bodies of requirement to move into crisis standards of care and triggers revenue cycle policies for appropriate coding and billing.
    - Public Information Officer initiates internal and external communication plans to include specific cascades of all levels of leadership, staff and the public.
    - Operations Chief reviews the Resource Redistribution and Decreasing Services Table to increase capacity to advise best operations, see Appendix C.
    - Section Chiefs and Officers manage the situation according to their scope within the Hospital Incident Command Structure until crisis standards of care are no longer necessary.

Additional policies for reference:
BDH Surge Care Unit Billing Policy - Revenue Cycle Org wide - 11.30.2020.docx
Surge Care Unit EHR Documentation Policy - 11.30.2020.docx

REFERENCES

Scarce Resource Management and Crisis Care, Front Matters, published by Montana Department of Public Health and Human Services. Accessed on 9/22/2021 from Scarce Resource Management and Crisis Care Guidance - Front Matter (mt.gov)

Appendix A

ALTERNATIVES TO ATTEMPT PRIOR TO IMPLEMENTING CRISIS STANDARDS OF CARE:

- Environmental services teams have focused their efforts on room turnover tasks, pausing cleaning duties in non-patient care areas; non-clinical team members, including leaders and shared services staff members, have been redistributed to assist.
- Nurse staffing ratios and care models have been re-evaluated and adjusted.
- Nurses and other clinical staff, have been redistributed into direct patient care roles, harnessing team-based nursing to ensure safety and further expand the capacity of more experienced nurses.
- Student rotations are being leveraged to support care and students are being hired to provide services within their scope of practice, helping to preserve other resources.
- Anesthesiologists are providing intubations in critical care areas to support intensivist teams.
- Staff are being redeployed to assist with patient proning and other needs within critical care areas.
- Agency traveler nurses, therapists and other clinicians have been engaged to fill additional care needs.
- Compensation strategies have been used to incentivize care teams to work extra shifts, with our caregivers now at their limit.
- Internal medicine and family medicine physicians who ordinarily work in the ambulatory clinic setting have been redirected to provide acute inpatient hospital patient care.
- Specialist providers such as those in cardiology and oncology have begun admitting their own patients to allow hospitalists to focus on most challenging patients.
- Emergency medicine, critical care, and adult hospitalist medicine providers have begun working more and longer shifts to meet the needs of increasing patient volumes.
- Telemedicine strategies have been employed to expand nursing and physician capacity in acute care settings, covering for admit, discharge, transfer clinician, and/or second nurse functions for medication administration, etc.
- Palliative medicine teams have expanded and are utilizing trained members of behavioral health team for in-person and remote consultation to assist with end-of-life care, address advanced directives, and facilitate discharges to home hospice care when appropriate.
- Disaster privileges have been granted to qualified providers to expand urgent care access so as to reduce pressures on our emergency departments and reduce potential hospitalizations.
- Pharmacists have been trained to administer treatments to reduce demands on acute care nursing staffing – dependent on scope of practice allowances.
- Members of volunteer services team have been activated to support non-patient care duties that would otherwise be performed by nursing staff.

Appendix B

CONTINGENCY SURGE CARE UNITS: Clinical care unit where conventional acute care patients are not typically located for routine hospital care.

CONTINGENCY SURGE EXPANSION LOCATIONS AND NEEDED ITEMS				
OLD NURSERY (RCU) SCU A	**PACU SCU B**	**ED ANNEX SCU C**	**ENDOSCOPY ROOMS SCU D**	**PRE-OP SCU E**
Patient Care Monitors				
Omnicells/Medication Distribution	Omnicells/Medication Distribution	Omnicells/Medication Distribution	Omnicells/Medication Distribution	Omnicells/Medication Distribution
Gases				
Airborne Infection Isolation Room (AIIR)	Airborne Infection Isolation Room (AIIR)	Airborne Infection Isolation Room (AIIR)	Airborne Infection Isolation Room (AIIR)	Airborne Isolation Infection Room (AIIR)
Epic Location	Epic Location	Epic Location	Epic Location	Epic Location
Beds	Beds			
Medical Supplies	Medical Supplies	Medical Supplies	Medical Supplies	Medical Supplies
Linens		Linens		

CRISIS SURGE CARE UNITS: Non-clinical care unit when contingency surge care units cannot be used because of facility damage or patient demands. Epic build needed for Crisis Standards of Care locations with beds to be build 1-100.

CRISIS SURGE EXPANSION LOCATIONS AND NEEDED ITEMS				
BHDH Conference Rooms	**OUTDOOR MASH UNIT**	**EDUCATION ROOMS**	**TBD**	**TBD**
Care Areas located in Meadowlark and Bitterroot	Portable locations outside BHDH	Patient Care Areas	Patient Care Rooms	Donning and Doffing Stations
Nursing station location in Sapphire	Nursing Station	Nursing Station	Nursing Station	Nursing Station
Donning and Doffing Stations	Donning and Doffing Stations	Donning and Doffing Stations	Donning and Doffing Stations	Donning and Doffing Stations
Patient Care Monitors	Patient Care Monitors	Patient Care Monitors	Patient Care Monitors	Patient Care Monitors
Omnicells/Medication Distribution	Omnicells/Medication Distribution	Omnicells/Medication Distribution	Omnicells/Medication Distribution	Omnicells/Medication Distribution
Gases	Gases	Gases	Gases	Gases
Airborne Infection Isolation Room (AIIR)	Airborne Infection Isolation Room (AIIR)	Airborne Infection Isolation Room (AIIR)	Airborne Infection Isolation Room (AIIR)	Airborne Infection Isolation Room (AIIR)
Epic Location	Epic Location	Epic Location	Epic Location	Epic Location
Beds	Beds	Beds	Beds	Beds
Medical Supplies	Medical Supplies	Medical Supplies	Medical Supplies	Medical Supplies
Linens	Linens	Linens	Linens	Linens

Appendix C

RESOURCE REDISTRIBUTION AND DECREASING SERVICES TABLE:

When resource needs cannot be met by usual and customary processes the following table should be utilized to identify services that must be maintained and those services that can be limited or temporarily paused in order to redistribute resources. Resources include, but are not limited to:

- Space
- Staff
- Supplies
- Standards of Care

In contingency care, it may be the case where not all resources are scare. In that situation, the priority rankings should be considered based on the resource needed. For example, if staffing is the scarce resource requiring contingency care, the priority ranking should be considered based on the resource redistribution for staff that allow for functionally equivalent care.

SYSTEM SERVICES PRIORITY RANKING DEFINITIONS		
Life threatening and/or critical to operations of these care areas	**PRIORITY RANKING 5**	• Services that need to be maintained despites volumes, time sensitive and life threatening care such as strokes, STEMIs, Sepsis, Traumas, Respiratory Support (COVID) to the emergency department • Required patient care services are required that cannot be transferred elsewhere • Only services providing direct patient care or those services that directly impact patient care • Cannot deploy resources elsewhere and will require resource redistribution support
	PRIORITY RANKING 4	• Services that keep patients out of the hospital and Emergency Department • Shared services that keep the priority 5 functions running • Services could lend to resource redistribution for short periods of time • Clinical area key to the support of priority 5 • Consideration for services that would increase pressure priority 5 • Maintain treatments that prevent risk that would lead to hospitalizations or ED visits
Services to be limited or paused in order of priority with 1 being first		
Non-Life Threatening or Services that be temporarily delayed, limited, or stopped without major impact	**Priority Ranking 3**	• Services that can be maintained that would not impact priorities 4 and 5 • Essential Care that can be modified telehealth, etc. without impact to priorities 4 and 5 • Holds minimal resources that would benefit the resource redistribution
	Priority Ranking 2	• Care that does not impact 4 or 5 and that does not impact resources • Care that cannot be received anywhere else in the community • Care that does not require ongoing monitoring or follow up • Has some resources that would benefit the resource redistribution
	Priority Ranking 1	• Essential services that could be centralized for efficiencies • Has critical resources that would benefit resource redistribution • Services that can be delayed that would not impact the health of a patient or that is not medically necessary • Discretionary Services

Once services have been identified to reduce, limit, or pause, staff will be redeployed to services in need. Other strategies to support patient flow and efficiencies for resources include the following:

- Discharge lounges have been created to facilitate swifter room turnover once patients are discharged, freeing up beds for emergency department boarders.
- Patients with lower-acuity medical needs have been transferred from tertiary care emergency departments to critical access hospitals with the capacity to provide care.
- Remote patient monitoring has been employed to allow for earlier discharge and to reduce readmissions and repeat emergency department visits; current enrollments are upward of 300 patients, with approximately 30 patients pending in the queue.
- Ensuring appropriate coordination and facilitation with local morgues and coroners' offices.