

**Crisis Standards of Care:  
Guidance for the Ethical Allocation of  
Scarce Resources during a  
Community-Wide Public Health Emergency**



**Kentucky Public Health**

Prevent. Promote. Protect.

**Approved: March 31, 2020**

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## FOREWORD

This document provides guidance to the decision-making process for allocation of scarce clinical resources that are potentially lifesaving during a widespread public health emergency. It addresses questions concerning the ethical duty to provide care under austere conditions, to manage limited resources in a transparent and responsible manner and to achieve the primary goal of doing what is best for the health and welfare of community and individuals.

This guidance was prepared through partnership among the Kentucky Department for Public Health (KDPH), University of Louisville (U of L), the University of Kentucky (UK), the Kentucky Hospital Association (KHA) and other industry experts. The partnership based its thinking on professional literature concerning ethics, emergency response and public health in consultation with subject matter experts.

To develop Kentucky guidance for altered standards of care, a task force formed in 2012 through a variety of partnerships. The task force reviewed literature on this topic along with the existing plans and guidance from a number of other states that had developed similar guidance to that point. Since that time, additional guidance and resources, such as the Institute of Medicine's Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response, were used to update existing guidance to develop this document. The Department for Public Health is grateful to the task force and many other organizations and groups for their efforts to further this important work.

It is anticipated that this document will serve as a basis for additional discussion concerning best practices to care for the most people in a major public health crisis. The best practices will be incorporated into this guidance in future versions.

The following four distinct phases will be addressed within this plan:

- **Preparedness:** Prior to a surge event that would cause healthcare to resort to crisis standards of care (CSC), agencies should focus on assessments, planning, training, exercises and evaluation to prepare for any all-hazards incident that may involve mass casualties. Early identification, alert, and notification are key activities that will allow agencies to begin coordinating an effective response.
- **Initial Response:** At the beginning of a crisis event, there may be too few resources compared to the needs of the injured or ill. While there may be an initial sense of urgency to provide direct, hands-on emergency patient care, the focus should be on patient triage concurrent with scene evaluation. Establishing a scene management structure is critical so that additional help will be deployed efficiently and effectively.
- **Response through Stabilization:** During this phase of a crisis event, resource needs will be met through varying sources and will require increased attention to scene management. This may include the identification and setup of an alternate care site and patient transportation. The focus is still on patient care; however, attention is also directed to support effective resource allocation.
- **Recovery:** The final stage of a crisis event is cleanup and recovery. The focus on scene coordination remains primary, but with emphasis on termination of response efforts including tracking of patients and equipment, accurate documentation and continued support of family reunification efforts and response personnel, to include critical incident stress debriefings.

## APPROVAL AND IMPLEMENTATION

Crisis Standards of Care: Guidance for the Ethical Allocation of Scarce Resources during a Community-Wide Public Health Emergency was developed through coordination with local, state, and federal agencies in 2019 and is hereby approved for implementation. This plan may be amended by KDPH as outlined in the [PLAN DEVELOPMENT AND MAINTENANCE](#) section of this plan.

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*Note: The original, signed version of this plan is maintained on file by the ESF #8 Planning Coordinator, Kentucky Department for Public Health, Public Health Preparedness Branch*



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## OVERVIEW

### Primary Coordinating Agency

- Kentucky Department for Public Health (KDPH)

### State Primary Agencies

- Kentucky Board of Emergency Medical Services (KBEMS)
- Kentucky Community Crisis Response Board (KCCRB)
- Kentucky Emergency Management (KYEM)
- Kentucky Hospital Association (KHA)

### State Support Agencies

- Cabinet for Health and Family Services (CHFS) - Office of Communications
- Cabinet for Health and Family Services (CHFS) - Office of Inspector General (OIG)

### Purpose

The purpose of this guidance is to provide government leaders and healthcare professionals with an ethical framework to guide and support decision-making at the state, local and facility level during both preparations for and response to a community-wide emergency. By outlining and using these ethical values, the intent is to increase trust and solidarity among all stakeholders, including the general public. Government, medical personnel, communities and individual citizens may face ethical challenges as a result of scarce critical resources and overwhelming surges. This guidance is designed to implement measures rapidly to minimize illness and death, as well as the adverse impact on social order and economic stability.

The hope is that community leaders and healthcare professionals will use this information before public health emergencies as a basis for planning, tabletop exercises, preparatory drills and educational forums. Use of this guidance during a public health emergency will aid in critical decision-making. Community-wide public health emergencies can present critical ethical challenges for healthcare professionals and institutions at every level. In these contexts, the primary duty is to protect the health and welfare of the community, not simply that of the individual.

The ESF #8 Primary and Support Agencies listed in this plan will also reference the Kentucky Emergency Operations Plan (EOP), supporting ESF Annexes, and other relevant plans as listed in the [Authorities and References](#) section when preparing for, responding to, and recovering from a crisis event.

### Scope

For the purpose of this plan and for the purpose of state planning and response, a medical surge event that leads to using CSC is defined as:

*“An incident that will affect the healthcare system and governmental agencies statewide due to an overwhelming demand for healthcare services when resources (space, staff and supplies) are insufficient to allow for usual standards of medical care”.*

This plan is under the assumption that general acute care facilities have exhausted all day-to-day agreements, Memorandums of Understanding (MOU)s and vendor agreements prior to requesting assistance from the State.

The circumstances of the incident that leads to the activation of this plan can range from a large, unexpected and potentially life-threatening incident (e.g., earthquake) to a slow, gradually building or preplanned incident (e.g. partial or full planned evacuation). This plan covers injuries and illnesses due to any all-hazards incident to include, but not limited to, criminal incidents, disease outbreaks (acute), hazardous material incidents, industrial accidents, natural disasters, radiological incidents, terrorism and transportation accidents.

However, this plan *does not* cover the state-level response to pandemic influenza or other long-term infectious disease outbreaks. This is covered under the ESF #8 – Public Health and Medical Service Annex and Kentucky Department for Public Health’s Disease Outbreak Support Plan (DOSP).

## **Background**

The influenza pandemic, caused by the 2009 H1N1 virus, underscores the critical need to prepare for a public health emergency, of significant size and scope, which could overwhelm the healthcare system. While the 2009 H1N1 pandemic was not a severe pandemic in terms of numbers of individuals critically ill, the state’s healthcare resources were severely strained for several weeks. This highlights the relative fragility of the current healthcare system, given that many of Kentucky’s hospitals currently operate at near capacity in “normal” times.

An overwhelming surge on the healthcare system would dramatically strain medical resources and could compromise the ability of healthcare professionals to adhere to normal treatment procedures and conventional standards of care. The 2009 event gave us a glimpse of a scenario, in which thousands of people in a region suddenly sought and require medical care. [Attachment 6](#) is a Pandemic Influenza Triage Guide that may be used to assist patients (who are concerned about influenza) to determine whether they should seek medical help.

## **Guiding Principles**

The following values and principles establish an ethical framework to guide triage and the allocation of scarce resources during a situation resulting in insufficient resources available to meet every individual’s need.

### **Principles to guide decision makers through community-wide public health emergency planning and response:**

- **Duty to Plan:** Healthcare professionals acknowledge the responsibility to plan for allocation of limited resources during a community emergency with a high potential for morbidity and mortality. An absence of guidelines may leave allocation decisions to exhausted and over-taxed front-line providers who already bear a disproportionate burden in major disasters.

- **Duty to Care:** Healthcare professionals have unique responsibilities to provide care during a public health emergency with the potential for high morbidity and mortality. During a public health emergency, the primary duty of healthcare professionals and institutions is to the health of the public as a whole.
- **Reciprocity:** The duties owed to professional staff, non-professional staff and the community as a whole should be clearly established prior to a community-wide medical emergency, with clear lines of authority, fair allocation of schedules and worker protections.
- **Stewardship of Resources:** Due to an unavoidable scarcity of resources that may occur in public health emergencies, healthcare facilities and physicians may not be able to provide every treatment as they typically would. When resources become scarce, healthcare professionals and institutions must leverage limited resources responsibly. Allocation guidelines and triage plans must reflect the goals of reducing morbidity and mortality. A responsible and appropriate stewardship of resources requires some discernment about whether or not use of a scarce resource will be effective for the community as a whole.
- **Respect for Human Dignity:** The most fundamental of these principles is the obligation to respect human dignity. For this reason, emergency operations plans and triage guidelines must be clear to everyone they affect. Every person has an inherent dignity and intrinsic moral worth, regardless of age, race, gender, creed, socioeconomic status, functional ability or any other characteristic. All people deserve equal respect as human beings. With this in mind, the allocation mechanism cannot discriminate based on anything that is not directly relevant to the eligibility of individuals to receive care as established through the triage system.
- **Communication:** Deliberations regarding triage and allocation must be participatory, community-values-based and transparent. Since these guidelines are an alteration from the normal standard of care, there is a responsibility to justify and explain these alterations to the public. Moreover, public and professional cooperation are essential to an effective response. Communicating through forums, continuing education and seeking collaborative input in advance of a public health emergency is a prerequisite to implementation.

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

### **Assumptions**

The following assumptions have been made in the development of this guidance:

- Local government will provide the initial response to any emergency or disaster in accordance with local emergency operations plans, procedures and policies;
- General acute care facilities have exhausted all day-to-day MOUs and vendor agreements prior to requesting assistance from the State;

- State and federal (e.g., Stafford Act, Public Health Services Act) disaster declarations have been requested;
- Resources are unavailable or undeliverable to healthcare facilities from elsewhere in the region or state;
- Patient transfer to other facilities is not possible or feasible, at least in the short term;
- Access to medical countermeasures (e.g., vaccines, medications, antidotes, blood products) is limited;
- Trained healthcare staff is unavailable or unable to adequately care for increased volume of patients;
- Available local, regional, state and federal resource caches (of equipment, supplies and Pharmaceuticals) have already been distributed and no short-term resupply is foreseeable;
- There are disruptions to the healthcare supply chain;
- A crisis event can happen very quickly and without warning in any part of the state due to natural or manmade disasters;
- Some communities will have fewer resources than others to deal with a crisis event and thus an overwhelming crisis event for one area may be within the capabilities for another;
- Triage and patient distribution decisions done in the field will have a significant impact on the subsequent healthcare surge capacity system;
- There may be a significant problem locating and providing information on displaced family members as well as victims and may require family reunification services;
- Major disasters will likely result in immediate local and regional shortages of critical medical resources due to supply chain disruption and/or a higher utilization rate that exceeds on-hand supplies;
- Local and mutual aid capacity for patient transport will be overwhelmed;
- When it is anticipated that local capabilities will be exceeded, including those available through mutual aid agreements and volunteer resources, assistance will be requested from the state. Kentucky's response partners will honor any existing formal agreements;
- Healthcare Coalitions (HCC) in the impacted area may implement medical surge plans to expand health care system capacity in response to a crisis event;
- The initial notification and request for assistance from the state will be through the state's 24-Hour Warning Point. Some counties do not have a dispatch center and may notify the state through other agencies (i.e. Regional 911 Centers or Kentucky State Police);

- The state’s level of response will be determined based upon the local jurisdiction’s request for assistance and the needs of the incident;
- State agencies will conduct emergency operations in accordance with the direction and guidance published in the Kentucky EOP and supporting ESF Annexes
- Management and coordination of medical resources, personnel, equipment and communications will take place through the Incident Command System (ICS) using the concepts within the National Incident Management System (NIMS);
- Hazardous materials or other factors involved in a crisis event may require additional response capabilities;
- Crisis events will produce a need for psychological first aid and/or behavioral health services for response personnel, as well as disaster casualties and their families.
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## CONCEPT OF OPERATIONS

### General

The agencies and organizations listed in this plan will maintain the ability to support and respond to a crisis event as outlined within the Kentucky EOP, supporting ESF Annexes and upon request and activate to coordinate state-level support throughout the response and recovery phases. The acronyms in [Attachment 1](#) may be used in all communications, both written and oral.

### Notification

In the event of a crisis event, local healthcare agencies and ESF #8 partners shall attempt to notify one of the following: their designated Healthcare Preparedness Coordinator (HPC), Healthcare Coalition Readiness and Response Coordinator (RRC), Regional Preparedness Coordinator (RPC) or the Preparedness Branch Manager. Local agencies can notify the state's 24-Hour Warning Point at 800-255-2587 for any crisis event requiring state assistance as outlined in the Kentucky EOP and/or notify KDPH's On-Call Epidemiologist at 888-9REPORT (973-7678).

### Activation

KDPH will activate the State Health Operations Center (SHOC) to coordinate ESF #8 - operations in accordance with this plan, the ESF #8 Annex and SHOC Support Plan. The KDPH's SHOC will operate under a defined ICS as represented by the incident command structure in [Attachment 2](#).

The ICS of the SHOC may expand or contract based upon incident complexity, duration and activation levels. The plan can be activated prior to a declared or proclaimed emergency. In those cases, in which the plan is activated prior to a declaration or proclamation, the gathering of information, assessment of the situation and notification of healthcare facilities and providers will be emphasized to provide a basis for the full implementation of the plan should an emergency be declared and surge be required.

A variety of situations may prompt the need to activate this Plan. Some examples include the following:

- Surge capacity is fully employed within healthcare facilities;
- HCCs have activated their surge plans;
- Attempts at conservation, reutilization, adaption and substitution have been performed maximally;
- Critically limited resources have been identified (e.g., ventilators, antibiotics);
- Infrastructure resource needs have been identified (e.g., isolation, staff, electrical power);
- Resources and/or infrastructure needs cannot be met by local and regional health officials;
- Requests cannot be timely met at the state and federal levels;

- A healthcare facility's institutional committee has reviewed and recommends initiation of the CSC.

During a crisis event, KDPH's SHOC will coordinate ESF #8 operations based upon Kentucky's ESF #8 Regions identified in [Attachment 3](#) and provide support to the hospitals graphically represented in [Attachment 4](#). Local agencies may request resources through mutual aid or from the state as outlined in Kentucky's ESF #8 Resource Request Flowchart in [Attachment 5](#).

KYEM will activate the state EOC and ESFs, as applicable, in accordance with the Kentucky EOP and this guidance. The following ESFs may have a major role during a crisis event and will provide technical and logistical support, as applicable:

- ESF #1 - Transportation
- ESF #5 – Emergency Management
- ESF #6 - Mass Care, Emergency Assistance, Housing and Human Services
- ESF #7 – Logistics Management and Resource Support
- ESF #8 - Public Health and Medical Services
- ESF #13 - Public Safety and Security
- ESF #15 - Public Information

### **Preparedness Phase**

ESF #8 primary and support agencies will maintain the ability to respond to a crisis event through planning, training, exercising and evaluations as outlined in the Kentucky EOP, supporting ESF Annexes, and through the following mechanisms:

- Participate in crisis event surge planning, training and exercise activities;
- Maintain an inventory of equipment and supplies available for distribution if requested, as applicable;
- Pre-positioning medical supplies and equipment in support of a subsequent medical surge;
- Maintain awareness of Kentucky's hospital capabilities and capacity through existing information sharing practices;
- Provide planning support to HCCs and other applicable agencies;
- Maintain the ability to execute the processes necessary to achieve the legal and statutory waivers required to execute a successful crisis event response.

### **Initial Response Phase**

The transition from preparedness to response will occur when there is a crisis event at the local level requiring state-level public health and medical support. Upon request, state agencies will provide support to the impacted jurisdiction by activating ESF #8 through the KDPH's SHOC and supporting ESFs through the state's EOC, as applicable. The major components of a crisis response during the initial response phase may include:

- Alert and notification
- Activation

- Situational awareness
- Hospital bed availability
- Resource management
- Patient tracking
- Mass care
- Public information
- Behavioral health services
- Public safety and security
- Fatality management

### **Response Phase through Stabilization**

The transition from initial response to stabilization will occur when resources begin to meet the available needs. The on-site ICS will continue to assign resources effectively ensuring continuance of care for the injured and/or ill and to support responding personnel. Throughout the response-stabilization phase, state-level support will continue to the impacted jurisdiction(s) through:

- Situational awareness
- Hospital bed availability
- Resource management
- 1135 waivers
- Patient tracking
- Mass care
- Reunification
- Public information
- Behavioral health services
- Public safety and security
- Fatality management
- Deactivation/Demobilization

### **Recovery Phase**

The transition from response-stabilization will occur when the major operations have been completed. Recovery activities will focus on effective documentation, continued support of response personnel and recovery of deployed resources. Throughout the recovery phase, state-level support will continue to the impacted jurisdiction(s) through:

- Continued support
- Situational awareness
- Resource management
- Public information
- Behavioral health services
- 1135 waivers

- Reimbursement
- After action reporting and follow-up of correction actions

## ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

The following are common specific responsibilities that pertain to CSC:

### State Primary Agencies

#### 1. Kentucky Department for Public Health

- a. Serve as the coordinating agency for ESF #8;
- b. Activate KDPH's SHOC to coordinate public health and medical-related services and resources;
- c. Provide personnel, as applicable, to coordinate public health and emergency medical services through KDPH'S SHOC and state EOC, if activated;
- d. Liaise with affected HCCs to receive and act upon requests for assistance from affected county(s);
- e. Request, receive, deploy, track and recover state public health and medical resources;
- f. Maintain communications with state agencies and local jurisdictions regarding the status of response and recovery efforts and to determine if a Public Health Emergency Declaration is needed;
- g. Coordinate the requests for 1135 Waivers through consultation with the Kentucky OIG upon declaration of a national emergency or disaster by the President and determination of a public health emergency by the Secretary of Health and Human Services (HHS);
- h. Coordinate requests for assistance through Mutual Aid, Emergency Management Assistance Compact (EMAC), and/or the federal government when the capabilities of the state to respond to a crisis event are exceeded;
- i. Coordinate epidemiological support to assist local health departments, hospitals and other healthcare agencies in disease outbreak investigations and surveillance measures.
- j. Provide patient tracking assistance to ESF 8 primary and support agencies during an emergency or disaster.

#### 2. Kentucky Board of Emergency Medical Services

- a. Serve as a primary agency for ESF #8;
- b. Provide personnel, as applicable, to coordinate emergency medical services through KDPH'S SHOC, State EOC, if activated;
- c. Organize and coordinate inter/intra-state Emergency Medical Services (EMS) (ground and air) assets and resource mobilization and deployment;
- d. Assist in securing ground and air EMS assets to support the medical transportation of injured, ill and/or hospitalized patients;
- e. Coordinate requests for assistance through Mutual Aid, EMAC, and/or the federal government when the capabilities of the state to respond to a crisis event are exceeded.

### 3. Kentucky Crisis Community Response Board

- a. Serve as a primary agency for ESF #8;
- b. Provide personnel, as applicable, to coordinate behavioral health services through KDPH'S SHOC, state EOC, if activated;
- c. Coordinate the activation and deployment of Crisis Intervention Teams to provide behavioral health services to disaster casualties, emergency workers and others as required;
- d. Coordinate requests for assistance through Mutual Aid, EMAC and/or the federal government when the capabilities of the state to respond to a crisis event are exceeded.

### 4. Kentucky Emergency Management

- a. Serve as the lead agency for ESF #5, ESF #7 and ESF #15;
- b. Liaise with affected jurisdictions to receive and act on requests for assistance from affected county(s);
- c. Alert and activate personnel for the staffing of the state EOC based upon the complexity and duration of a crisis event;
- d. Maintain communications with Governor's Office, state agencies and local jurisdictions regarding the status of response and recovery efforts to determine if an emergency declaration is needed;
- e. Support ESF #8 in coordinating public health and medical response and recovery activities with other ESFs and local, state and federal agencies;
- f. Coordinate resources and request for assistance through ESF #7 to include but not limited to, Mutual Aid, EMAC and/or federal support when the capabilities of the state to respond to a crisis event are exceeded;
- g. Coordinates the release of incident-related information during a crisis event through ESF #15 and/or activation of a Joint Information Center (JIC).

## **State Support Agencies**

The following Support Agencies have a major role during a crisis event as outlined within this plan. Other local, state or federal agencies may provide logistical and technical support per the Kentucky EOP and supporting ESF Annexes.

### 1. American Red Cross (ARC)

- a. Serve as the lead agency for ESF #6;
- b. Opens emergency shelters, provides food, first aid and staff for general population shelters;
- c. Collects, receives and reports information about the status of casualties to assist with family reunification;
- d. Provides first aid, supportive counseling and other related medical support.

2. Cabinet for Health and Family Services - Office of Communications
  - a. Coordinate the communications response and media relations for ESF #8 through coordination with CHFS, KDPH and ESF #8 agencies;
  - b. Serve in the public information role for ESF #8 from a virtual setting or at the state's JIC, KDPH's SHOC or in field settings.
  
3. Cabinet for Health and Family Services - Office of Inspector General
  - a. Serves as the primary point of contact for coordinating response and recovery efforts specific to Division of Healthcare Audits and Investigations;
  - b. Provide technical assistance to healthcare facilities concerning 1135 Waivers upon declaration of a national emergency or disaster and determination of a public health emergency.
  
4. Kentucky Hospital Association
  - a. Support ESF #8 efforts by acting as a liaison between ESF #8, hospitals, HCCs and other community healthcare partners;
  - b. Provide healthcare facility situational awareness;
  - c. Assist with the collection and interpretation of hospital bed data;
  - d. Assist with communication, guidance and information sharing;
  - e. Assist with the deployment of medical prepositioned response assets including, but not limited to, pharmaceuticals, antiviral medications and medical surge units.
  
5. Kentucky State Police (KSP)
  - a. Serve as the lead agency for ESF #13;
  - b. Assist in identification, notification, protection, location and reunification of children and their parents / legal guardians;
  - c. Assist local law enforcement agencies in conducting missing persons investigations and ensuring effective coordination between investigative efforts and survivor and family assistance efforts;
  - d. Coordinate as needed with coroner / medical examiner for communicating death notifications to families, as required;
  - e. Assist local law enforcement with any requested tasks such as law and order, crowd control, evidence collection and casualty assistance;
  - f. Coordinate with the local law enforcement agencies and designated airfields for security and traffic control during operations involving the movement of resources or medical evacuation.

## 6. Kentucky Transportation Cabinet

- a. Serve as the lead agency for ESF #1;
- b. Coordinate the state's transportation resources for the routing and logistical movement of personnel, equipment and supplies;
- c. Assist with routing for the transportation of casualties, patients and evacuees.

## Local Agencies

### 1. Community Hospitals

- a. Alert applicable local and state agencies upon receiving notification of a crisis event;
- b. Maintain specific strategies, plans and protocols for creating capacity to care for a significant surge of patients (includes expanding ambulatory and inpatient capacity beyond licensed capacity);
- c. Have plans and processes in place to address crisis standards of care, including the involvement of the facility's ethics committee and ensuring staff and providers are aware of the plans and processes.
- d. Maintain specific plans and protocols for minimum patient documentation requirements for use during a surge incident and protocols for patient tracking;
- e. Share required essential elements of information (EEI) with KDPH, as requested.
- f. Coordinate with the HCC and support the information and resource needs of healthcare facilities within coalition regions.

### 2. County Emergency Management Agencies

- d. Coordinate with affected agencies to receive and act on requests for assistance;
- e. Maintain communications with local government officials and the KYEM regarding the status of response and recovery efforts.

### 3. Healthcare Coalition Readiness and Readiness and Response Coordinator (RRC)

- a. Function as a liaison between KDPH, county Emergency Management Agency (EMA), healthcare facilities and EMS providers within their region;
- b. Provide necessary situational awareness communications to/from the affected and/or assisting health care facility(s) within the region and to/from KDPH;
- c. Coordinates with healthcare facilities and supports the information and resource needs within the region;
- d. Assist and coordinate resources to augment needs that may arise during a crisis event.

#### 4. Dispatch Center

- a. Answer 911 calls and provides communication support for hospitals, EMS and other first responding agencies;
- b. Monitor radio traffic and receive requests for emergency response personnel and transport vehicles;
- c. Dispatch and track emergency response personnel when a patient is transported to a designated hospital or a ground transfer point;
- d. Maintain situational awareness and keeps senior personnel informed of tactical operations.

#### 5. EMS Agencies

- a. Maintain ambulances, personal protective equipment (PPE), equipment and supplies needed for transporting patients;
- b. Triage patients and prioritize those for transport based upon existing and agreed upon methods;
- c. Transport patients to designated healthcare facilities, as applicable in agency plans, policies and procedures;
- d. Transport patients to a designated location for air transport, through coordination with local command operations and KBEMS (as applicable);
- e. Coordinate with healthcare facilities and other applicable agencies to support patient tracking.

#### 6. Local Law Enforcement Agencies

- a. Assist in identification, notification, protection, location and reunification of displaced patients;
- b. Assist KSP and other applicable agencies in conducting missing persons investigations and ensuring effective coordination between investigative efforts and survivor and family assistance efforts;
- c. Coordinate as needed with local coroner / medical examiner for communicating death notifications to families, as required;
- d. Coordinate or support requested tasks such as law and order, crowd control, evidence collection and casualty assistance;
- e. Coordinate and assist KSP with security and traffic control during operations involving the movement of resources or medical evacuation.

#### 7. Mental Health/Behavioral Health Agencies

- a. As determined through consultation with local and state officials, assist and provide behavioral health services for responders and impacted persons in coordination with KCCRB;
- b. Request support or resources to augment services through appropriate channels.

## DIRECTION, CONTROL, AND COORDINATION

### General

Kentucky's CSC Guidance serves as the operational framework for coordinating state-level response and recovery activities for the ethical allocation of scarce resources during a medical surge crisis event within Kentucky through the following:

- KDPH's SHOC will serve as the base of direction, control and coordination of *state level* support, in coordination with the state EOC, when activated;
- Local governments are responsible under all applicable laws, executive orders, proclamations, rules, regulations and ordinances for response within their respective jurisdiction(s);
- Upon activation of ESF #8 in support of crisis event operations, the agencies and organizations identified within this plan will ensure the necessary personnel and resources are available to achieve the operational objectives;
- Personnel from supporting agencies will operate in accordance with the rules, regulations and capabilities of their respective agency or organization.

### Authority to Initiate Actions

This plan and the coordinating structures and agencies named therein, maintain authority to initiate and coordinate actions to support an effective crisis event surge response per the Kentucky EOP.

### Preparedness Phase

#### 1. Prepositioned Resources

- a. KDPH, through coordination with KHA, HCCs and Local Health Departments (LHD) maintains an emergency resource listing and inventory of state prepositioned resources in the ReadyOp System;
- b. State assets are prepositioned strategically throughout the state and may be requested to support a crisis event. Requests for resources (personnel, equipment and supplies) can be requested through mutual aid from local jurisdictions and/or from the state as outlined in Kentucky's ESF #8 Resource Request Flowchart in [Attachment 5](#).

#### 2. Situational Awareness

- a. KDPH and KYEM will coordinate with local, state and federal agencies and disseminate information and warning orders to applicable agencies;
- b. Event/incident related information will be disseminated in a timely manner to ensure agencies are prepared to provide state-level support.

### 3. Planned Events

- a. If requested, KDPH will collaborate with local, state and federal agencies to coordinate health and medical support for large planned events;
- b. KDPH may pre-stage resources and supporting personnel through activation of the SHOC in collaboration with the established ICS and state EOC, if activated.

### 4. Legal/Statutory Waivers:

- a. The Primary Agencies listed in this plan will develop and maintain processes to request and implement the legal and statutory waivers required to execute response and recovery activities.

## **Response Phase (Initial Response through Stabilization)**

### 1. Alert and Notification

- a. Local agencies will notify the state's 24-Hour Warning Point (800-255-2587) for any crisis event requiring state assistance as outlined in the Kentucky EOP and/or notify KDPH's On-Call Epidemiologist at 888-9REPORT (973-7678) for any crisis event;
- b. State agencies notified by other means will immediately notify the state's 24-Hour Warning Point;
- c. KYEM will alert all agencies that have a lead ESF role within the state EOC and applicable Regional Response Managers;
- d. KDPH will notify applicable ESF #8 Primary and Support Agencies using established systems and processes as outlined in the ESF #8 – Public Health and Medical Services Annex.

### 2. Activation

- a. Agencies assigned a lead ESF role during a crisis event will activate upon notification from KYEM and staff the appropriate ESFs at the state EOC, as applicable. The state EOC will be activated to one of five levels based upon incident complexity and requests for assistance;
- b. KDPH will alert local, state and federal ESF #8 agencies upon notification of a crisis event requiring state-level ESF #8 support and stand up the SHOC to coordinate ESF #8 operations. The KDPH SHOC will be activated to one of four levels based upon incident complexity and requests for assistance.

### 3. Situational Awareness

- a. ESF #8 primary and support agencies will maintain situational awareness through communication with their respective counterparts and keep the state EOC, KDPH's SHOC and applicable ESFs aware of current conditions in the impacted area.
- b. Event/incident related information will be submitted to the state EOC and KDPH's SHOC. Information may be obtained from:

- Briefings
  - Health Alert Networks (HAN)
  - Impact assessments
  - Incident Action Plans
  - Onsite Reconnaissance Reports
  - Situation Reports
  - Situational updates
  - Information Sharing Platforms (WebEOC, ReadyOp, etc.)
4. Healthcare System Essential Elements of Information: Upon request, Kentucky's healthcare system partners will report their bed status, operational status and essential elements of information (EEI) through the WebEOC system or EEI form to facilitate allocation of beds and other resources based upon the type and number of patients and resource needs. The map in [Attachment 4](#) graphically shows the location of hospitals within Kentucky.
5. Resource Management
- b. Requests for resources (personnel, equipment and supplies) can be requested through mutual aid from local jurisdictions and/or from the state through the SHOC or state's EOC as outlined in Kentucky's ESF #8 Resource Request Flowchart in [Attachment 5](#);
  - c. Resource requests and tracking will be managed throughout deployment and demobilization through the use of WebEOC. Other systems or processes will be used if WebEOC is not functional; such as paper, ReadyOp or other systems developed during the incident.
  - d. KDPH will coordinate the deployment of state and federal medical assets, to include Strategic National Stockpile (SNS) assets;
  - e. KBEMS will collaborate with aeromedical providers and ambulance agencies to coordinate the movement and operations of air and ground ambulance resources;
  - f. KYEM, through ESF #7 and Resource Support, will provide support to activated ESFs for the request, deployment and recovery of resources;
  - g. Recovery of resources will be addressed in demobilization plans, as required.
6. 1135 Waivers
- a. KDPH, KHA and the affected facilities/agencies will coordinate the request for 1135 Waivers, through consultation with the Kentucky OIG, upon declaration of a national emergency or disaster by the President under the National Emergencies Act or Stafford Act and upon a public health emergency determination by the Secretary of HHS under the Public Health Service Act.

## 7. Medical Evacuation

- a. Medical evacuation is primarily a local responsibility. However, if casualties, patients or residents require transport outside of the impacted jurisdiction, and assistance is requested, KDPH and KBEMS will coordinate with KYEM (ESF #5) and Kentucky Transportation Cabinet (ESF #1) to determine the methods and routes to transport patients to the nearest functional and appropriate facilities;
- b. KBEMS and KDPH will coordinate with local agencies, when requested, for the transportation of evacuated inpatients to decompress facilities.

## 8. Patient Tracking

- a. At the local level, EMS and hospitals will use applicable patient tracking systems to track patients during a crisis event. This may include electronic, web-based or paper-based patient tracking systems and processes. Regardless of the system used, all EMS agencies must have the capability to submit run reports to KBEMS through the Kentucky Emergency Medical Services Information System (KEMSIS);
- b. At the state level, KDPH has made the ReadyOp Patient Tracking available for all EMS agencies and hospitals to use at no cost. KDPH, KBEMS and KYEM will access this system to monitor patient tracking activities during a crisis event, as applicable.

## 9. Mass Care

- a. The ARC and ESF #8 agencies will coordinate with the applicable agencies and organizations to provide mass care support as outlined in the ESF #6, Emergency Assistance, Housing and Human Services Annex.

## 10. Reunification

- a. Upon request of a local hospital or jurisdiction, the local chapter of the ARC will seek to activate their Family Reunification Services Plan;
- b. The ARC, ESF #8 and ESF #13 will support local reunification services and provide reunification support as outlined in the ESF #6, Emergency Assistance, Housing and Human Services Annex;
- c. The request for Federal and Voluntary Organizations Active in Disaster (VOAD) reunification partners/resources external to Kentucky will be coordinated jointly through KCCRB, KDPH and KYEM in cooperation with the impacted jurisdictions.

## 11. Public Information

- d. Public information may be released through coordination with the Commonwealth's Joint Information Center (CJIC) as outlined in the ESF #15 - Public Information Annex. Designated ESF personnel will support the CJIC when activated, through a virtual or physical location;
- e. KDPH will coordinate with the CHFS's Office of Public Affairs for the development and release of public health and medical related information as outlined in the CHFS Emergency Communications Plan.

## 12. Behavioral Health Services

- a. Provide behavioral health services for responders and impacted persons will be coordinated through the KCCRB as determined through consultation with local and state officials;
- b. KCCRB will coordinate with KDPH and KYEM to deploy Kentucky Community Crisis Response Teams (KCCRT) to provide onsite behavioral health assessments and counseling.

### 13. Public Safety and Security

- a. KSP will work in coordination with local law enforcement to coordinate law enforcement and security measures as outlined in the ESF #13 - Public Safety and Security Annex;
- b. ESF #8 Agencies will coordinate with KSP to provide security during the deployment and recovery of response vehicles, equipment, medical supplies and personnel.

### 14. Fatality Management

- a. Fatalities resulting from a crisis event will be coordinated among the incident command structures involved in the response at the direction of the county's Coroner;
- b. Upon request, the State Medical Examiner's Office and the Kentucky Coroner/Medical Examiner Response Team will provide support to the affected jurisdiction in accordance with the Commonwealth of Kentucky Mass Fatality Incident Plan;
- c. The request for Disaster Mortuary Operational Response Teams (DMORT) and other fatality management resources external to Kentucky will be coordinated jointly through KDPH, KYEM and the Kentucky Medical Examiner's Office.

### 15. Deactivation/Demobilization

- a. KDPH and KYEM will coordinate with ESFs and other local and state agencies to determine when KDPH's SHOC and the state EOC will be deactivated, as applicable;
- b. The SHOC and EOC will remain activated during the recovery of personnel but not necessarily during the recovery of equipment and supplies as this may be ongoing for an extended period of time;
- c. Prior to deactivation, KDPH and KYEM will develop and disseminate a Demobilization Plan. Available state-recovered assets will be reconstituted and returned to service during this period.

## Recovery Phase

### 1. Continued Support

- a. ESF #8 primary and support agencies will continue to provide public health and medical support to an affected community throughout the Recovery Phase as outlined in the Kentucky EOP and supporting ESF Annexes. ESF #8 primary and support agencies will continue to coordinate with their impacted agencies until state-level assistance is no longer required;
- b. If required, KDPH will maintain an activated SHOC and KYEM an activated state EOC to coordinate needed support until it has been determined that these services are no longer required.

2. Situational Awareness: ESF #8 primary and support agencies will continue to coordinate the collection and dissemination of event/incident related information through collaboration with local, state and federal agencies as outlined in the response phase until state-level assistance is no longer required.
3. Resource Management: Throughout the recovery phase, ESF #8 primary agencies will organize the return of any state-level assets that were not recovered during demobilization. State-recovered assets will be reconstituted and returned to service.
4. Public Information: ESF #8 primary and support agencies will continue to coordinate with the CJIC (ESF #15) and CHFS' Office of Public Affairs for the development and release of all public information.
5. Behavioral Health Services:
  - a. KCCRB will continue to coordinate behavioral health services for responders and affected persons through the deployment of KCCRTs.
  - b. KCCRB will keep KDPH and KYEM apprised of behavioral health services provided and recovery of teams.
  - c. KCCRB will coordinate all volunteer behavioral health services during the incident.
6. 1135 Waivers: KDPH will continue to receive copies of waivers submitted to the CMS Region Four office in Atlanta waivers in coordination with the Kentucky OIG, if applicable.
7. Reimbursement: KDPH and KYEM will support local and state impacted agencies with the administration, logistics and documentation requirements for state and federal level reimbursement of crisis event-specific operations.
8. After Action Report/Improvement Plan (AAR/IP)
  - a. KDPH and KYEM will coordinate with ESF #8 primary and support agencies to evaluate and document response and recovery activities through AAR/IPs per the Department of Homeland Security's Exercise and Evaluation Program (HSEEP) guidance.
  - b. AAR/IPs will be written to document response and recovery activities within 60 days of an exercise or within 120 days of an incident or planned event.
  - c. Corrective actions identified in the AAR/IP will be tracked and implemented through coordination with applicable agencies per HSEEP guidance.

## PLAN DEVELOPMENT AND MAINTENANCE

### Maintenance

KDPH will conduct an annual review of this plan in coordination with the agencies and organizations identified within this document. Additional reviews may be conducted after an exercise, a significant incident/event occurs, or regulatory changes indicate a need;

- This plan will be updated or modified when there are significant organizational or procedural changes and/or when other events occur that will impact personnel, systems and processes. The updated plan will be submitted to KYEM for publication and distribution;
- KDPH's ESF #8 Planning Coordinator will track and distribute any needed changes to this plan using the Document Change Record in [Table 1](#) when changes/updates are required outside the official cycle of plan review;
- Documentation of annual reviews and revisions to this plan will be maintained on file by the KDPH's ESF #8 Planning Coordinator. Documentation should include, at a minimum, the date of the change, a description of the change with page/section number and the name and title of the person who made the change.
- Elements of this plan will be evaluated during scheduled exercises as outlined in Kentucky's Inter-Agency Multiyear Training and Exercise Plan.

### Document Control

The original, signed copy and digital copy of Kentucky's CSC Guidance will be maintained by KDPH's Public Health Preparedness Branch in coordination with KYEM's Planning Branch.

## AUTHORITIES AND REFERENCES

### Legal Authorities

#### Federal

- The Robert T. Stafford Disaster Relief and Emergency Assistance (Public Law 93-288) as amended
- Homeland Security Presidential Decision 5 (HSPD-5)
- National Emergencies Act of 1976
- Robert T. Stafford Act Disaster Relief and Emergency Assistance Act (Stafford Act)
- Section 319 of the Public Health Service Act – Declaration of a Public Health Emergency
- Social Security Act Section 1135 Waiver Authority in National Emergencies
- The Health Insurance Portability and Accountability Act (HIPAA) of 1996
- Presidential Policy Directive 8 (PPD-8)
- EMTALA: § 489.24(a)(2) (including Interpretive Guidelines for a federal waiver):  
Emergency Medical Treatment and Labor Act (EMTALA) provisions may be waived by the Secretary of HHS during a declared public emergency and under the Stafford act. The Secretary can issue the Section 1135 Waiver to waive sanctions for the “transfer of an individual who has not stabilized for both transfers and redirection for a medical screening examination. Waivers are generally limited to a 72-hour period beginning upon implementation of a hospital disaster protocol, unless the Waiver arises out of a public health emergency involving a pandemic. If related to a pandemic, the Waiver terminates upon the first to occur of either the termination of the underlying declaration of a public health emergency or 60 days after being first published. If the waiver terminates because of the latter, the Secretary may extend it for subsequent 60-day periods.

#### State

- Kentucky Revised Statutes (KRS), Title XVIII-Public Health
- KRS 36.260(5) Duties of board (Crisis Response Services)
- KRS 39A.270 - Use of publicly owned resources at impending, happening or response phase of disaster or emergency
- KRS 39A.950 - Emergency Management Assistance Compact
- KRS 39B.045 - Mutual aid agreements between Kentucky or its agencies or political subdivisions and units of government from another state
- KRS 311A.170 – Paramedics – Permitted activities – Employment by hospitals – Reasonable control by employers
- KRS 311A.175 – Exceeding scope of practice – Discipline prohibited for refusal to exceed scope of practice
- KRS 315.500 - Emergency authority for pharmacists during state of emergency
- KRS 411.148 - Non-liability of licensees and certified technicians for emergency care
- 106 KAR 5:040 - Initiation of a crisis or disaster response
- 202 KAR 7:501- Ambulance Providers and Medical First Response Agencies- Exemptions
- 202 KAR 7:510 - Air Ambulance Services- Exemptions
- 202 KAR 7:701 - Scope of Practice Matters- Exemptions
- 902 KAR 2:020 – Disease surveillance
- Kentucky Emergency Operations Plan
- Commonwealth of Kentucky EMS Patient Care Protocols
- Cabinet for Health and Family Services’ Emergency Communication Plan

- Kentucky Department for Public Health’s State Health Operations Center Support Plan
- Kentucky Radiological Incident Specific Plan
- Kentucky Department for Public Health’s Disease Outbreak Support Plan
- Kentucky Strategic National Stockpile Support Plan

## SPECIAL CONSIDERATIONS

This section of the plan is intended to provide guidelines for healthcare providers to continue to provide treatment in an ethical manner to patients, when there may be a significant imbalance between the needs of the patients and the resources available to the healthcare provider.

Every hospital in Kentucky must be prepared to provide supportive care services to all patients regardless of age. This section of the plan identifies strategies for facilities to address critical resource shortages and the corresponding regulatory considerations that may impact critical resource allocation decision making.

### Space Surge Strategy

Primary Goal: To maintain operations and increase capacity to preserve life and the safety of patients and ensure appropriate healthcare delivery to the community.

SPACE	
Strategies	Regulatory Considerations
<ul style="list-style-type: none"> <li>• Utilize licensed space for other types of patients</li> <li>• Use outpatient beds for inpatient care</li> <li>• Use internal skilled beds as acute patient areas</li> <li>• Convert adult space into pediatric space</li> <li>• Convert pediatric space to adult space</li> </ul>	
<ul style="list-style-type: none"> <li>• Increase capacity in patient rooms or hallways in patient care areas                             <ul style="list-style-type: none"> <li>○ Two (2) patients in a single room</li> <li>○ Three (3) patients in a double room</li> </ul> </li> </ul>	
<ul style="list-style-type: none"> <li>• Open Hospital Floors that are vacant</li> <li>• Use areas of the hospital for inpatients                             <ul style="list-style-type: none"> <li>○ GI Lab</li> <li>○ Recovery Room</li> <li>○ Outpatient Surgery</li> <li>○ Physical Therapy</li> <li>○ Other</li> </ul> </li> <li>• Use non-traditional areas of the hospital for inpatients                             <ul style="list-style-type: none"> <li>○ Cafeterias</li> <li>○ Conference Rooms</li> <li>○ Parking Structures</li> </ul> </li> <li>• Other</li> </ul>	
<ul style="list-style-type: none"> <li>• Shut off floor ventilation system to make a cohort of infected patients</li> </ul>	
<ul style="list-style-type: none"> <li>• Use tents to create additional patient care areas</li> </ul>	
<ul style="list-style-type: none"> <li>• Request relaxation of nurse/patient ratios to allow occupancy of all licensed beds</li> </ul>	

**Staff Surge Strategy**

STAFF	
Strategies	Regulatory Considerations
<ul style="list-style-type: none"> <li>• Cross train clinical staff</li> </ul>	<ul style="list-style-type: none"> <li>• Age limits to MD Malpractice Coverage</li> </ul>
<ul style="list-style-type: none"> <li>• Contact Nurse Staffing Agencies (registries/traveling nurses) to assist with supplemental staffing needs</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>
<ul style="list-style-type: none"> <li>• Use of non-conventional staff or expand scope of practice                             <ul style="list-style-type: none"> <li>○ Student nurses</li> <li>○ Medical students</li> <li>○ Military licensed staff</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Regulations to expand clinical professionals' scope of practice may require waiver and a Governor's order. Need clarification from professional boards.</li> </ul>
<ul style="list-style-type: none"> <li>• Use of non-conventional staff                             <ul style="list-style-type: none"> <li>○ Volunteers</li> <li>○ Paramedics</li> <li>○ Retired health professionals with an active license</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Professionals with inactive licenses will need to go through the process to reactivate it</li> <li>• Liability/licensing regulations</li> <li>• State laws regarding malpractice coverage for granted a fire clearance by the State Fire Marshal volunteers</li> </ul>
<ul style="list-style-type: none"> <li>• Utilize pediatric skilled RNs to supervise adult skilled patients and vice versa</li> </ul>	<ul style="list-style-type: none"> <li>• Liability regulations and insurance limitations</li> </ul>
<ul style="list-style-type: none"> <li>• Utilize families to render care under direction of a healthcare provider</li> </ul>	
<ul style="list-style-type: none"> <li>• Implement and/or develop just in time training for clinical staff normally assigned to non- direct patient care positions</li> </ul>	

**Supplies Surge Strategy**

**Primary Goal:** Ensure adequate levels of supplies and equipment are available.

The following three (3) areas to prioritize when developing strategies for the allocation of scarce supply and equipment resources:

- Airway
- Breathing
- Circulation

<b>SUPPLIES</b>	
Airway	Oral Pediatric Airway Nasopharyngeal Airway Laryngeal Masks Endotracheal Intubation Tubes Laryngoscope Blades
Breathing	Face Masks Non-rebreather Masks Ambubags Chest Tubes Nasogastric Tubes
Circulation	Intravenous Supplies Invasive Mechanical Vents HFO Ventilators OR Invasive Mechanical Ventilators Portable Invasive Mechanical Non-invasive Ventilators
Pediatric Specific	Broselow Bags Broselow Carts

Steps should also be taken to substitute, conserve, adapt and reuse critical resources, including the way staff are utilized in delivering care. All of these steps should be implemented prior to the reallocation of critical resources in short supply. Every attempt must be made to maintain the appropriate standards of care and patient safety until the use of altered standards is necessitated.

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 consistent 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). See: [Table 1](#)

**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). CSC constitutes a significant adjustment to standards of care. See: [Table 1](#)

### **Institutional Committees**

It is imperative that all HCCs and hospitals work together as much as possible to maximize all available resources. 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 institutional committees. The recommended committee of each institution should consist of (at a minimum):

- The Chief of Staff (or designee)
- The Chief Medical Officer (or designee)
- The Chief Nursing Officer (or designee)
- The Infection Control and Prevention Nurse (or designee)
- The Emergency Department Director (or designee)

Table 2: Institute of Medicine matrix for treatment capacity and level of care

<p><b>Incident demand/resource imbalance increases</b> →</p> <p><b>Risk of morbidity/mortality to patient increases</b> →</p>			
	<b>Conventional</b>	<b>Contingency</b>	<b>Crisis</b>
<b>Space</b>	Usual patient care space fully utilized	Patient care areas repurposed (PACU, monitored units for ICU-level care)	Facility damaged/unsafe or nonpatient care areas (classrooms, etc.) used for patient care
<b>Staff</b>	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
<b>Supplies</b>	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
<b>Standard of Care</b>	Usual care	Functionally equivalent care	<b>Crisis standards of care</b>
<p><b>Usual Operating Conditions</b> ←————→ <b>Austere Operating</b></p> <p>←————→ <b>Recovery</b></p>			

## TRANSPORTATION

Medical transport is primarily a local responsibility. However, if casualties, patients or residents require transport outside of the impacted jurisdiction, and assistance is requested, KDPH and KBEMS shall coordinate with KYEM (ESF 5) and KY Transportation Cabinet (ESF 1) to determine the methods and routes to transport patients to the nearest functional appropriate facilities.

Hospitals lacking specialized services may need to transfer patients, after initial evaluation and stabilization, to centers with advanced or specialized capabilities. Keep in mind, however, that transfer (or evacuation, if necessary) might be impossible due to local conditions, safety concerns, lack of appropriate transport vehicles or personnel or lack of capacity at other hospitals.

Even when transfer to specialized centers is possible, usual staff and equipment will be stretched thin by the crisis event; therefore, hospitals should develop alternative mechanisms for safely transferring patients based on the following guidelines from the American College of Emergency Physicians:

1. The optimal health and well-being of the patient should be the principal goal of patient transfer.
2. Emergency physicians, advance practice providers and facility personnel should abide by applicable laws regarding patient transfer. All patients should be provided a medical screening examination (MSE) and stabilizing treatment within the capacity of the facility before transfer.
3. The transferring facility is responsible for informing the patient or responsible party of the risks and the benefits of transfer and document these.
4. The medical facility's policies and procedures and/or medical staff bylaws should identify the individuals responsible for and qualified to perform MSEs. The policies and procedures or bylaws must define who is responsible for accepting and transferring patients on behalf of the hospital. The examining physician at the transferring hospital will use his or her best judgment regarding the condition of the patient when determining the timing of transfer, mode of transportation, level of care provided during transfer and the destination of the patient.
5. The mode of transportation used for transfers should be at the discretion of the treating provider and based on the individual clinical situation, available options, needed equipment and patient preference. Options for transport include but are not limited to ambulance, air-transport and private vehicle. Regardless of the method of transfer, intravenous access may remain in place if deemed appropriate by the referring provider.
6. Agreement to accept the patient in transfer should be obtained from a physician or responsible individual at the receiving hospital in advance of transfer. When a patient requires a higher level of care other than that provided or available at the transferring facility, a receiving facility with the capability and capacity to provide a higher level of care may not refuse any request for transfer.
7. All pertinent records and copies of imaging studies should accompany the patient to the receiving facility or be electronically transferred as soon as is practical.

### Communication

Open communication between healthcare facilities is key for an effective response during a public health emergency or crisis event. Ongoing communication between hospitals will be coordinated through the Regional HCCs as part of the Kentucky ESF # 8 Annex. Situational awareness will be ensured through frequent communication with each hospital regarding patient volume and acuity, as well as resource status information. This information will be used to facilitate decision-making to determine when and how CSC is implemented.

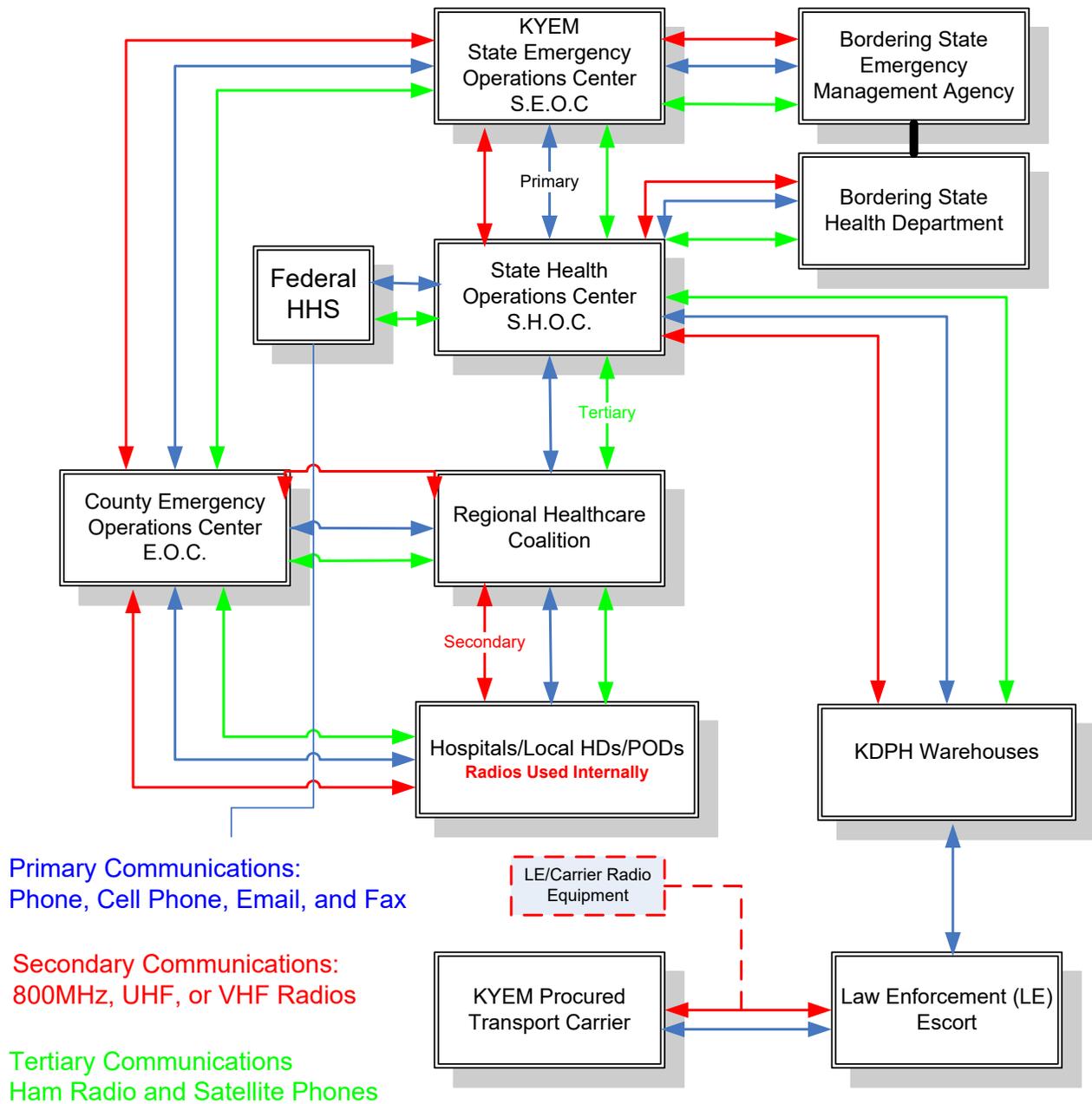
Hospitals will provide ongoing status information as requested by the State. Data will be reported using existing reporting systems (WebEOC and ReadyOp). The RRCs will monitor data reports for potential trends across the affected regions.

Upon a decision to implement the CSC Guidance, the local EMA, the county or regional state health office and the applicable healthcare partners will be notified by the implementing institution. The SHOC communication structure for activation and monitoring is illustrated in Figure 1.

Hospitals within the same affected region would likely reach the need for implementation of these guidelines at different times. However, recognizing the scope and size (and perhaps, duration) of the event, hospitals still in the contingency phase will not be expected to share their remaining limited resources. As such, the decision to implement the CSC guidelines will be made by the individual institution after the qualifying conditions are met and consensus has been reached by hospital leadership.

Upon the decision to implement the CSC, the hospital will notify KDPH, which will immediately notify the appropriate personnel including other hospitals in the region, KYEM and the HCC. It is anticipated, that KDPH will also function to communicate with the hospitals in the affected region to determine when the CSC can be lifted and provide the appropriate notifications.

Figure 1: Communication Flowchart



## **Information Management**

In the aftermath of a disaster, people immediately try to seek information. The lack of timely information to the public about a disaster can result in more chaotic circumstances, such as increased crowds, increased call volume and presence of anxious family members seeking their loved ones. Hospital communications plans and plans for information sharing should ensure that the hospital gathers and disseminates the best possible internally and externally available, credible and verified information to families and staff. Ensuring that all families have regular updates to their understanding of the incident status and the hospital response relevant to them will help minimize some of the potential psychological and security concerns that are generally associated with these incidents. KDPH will coordinate with the CHFS's Office of Public Affairs for the development and release of public health and medical related information as outlined in the CHFS Emergency Communications Plan. Public information may be released through coordination with the CJIC as outlined in the ESF #15 - Public Information Annex. Designated ESF personnel will support the CJIC when activated, through a virtual or physical location.

Some considerations for information sharing include:

- Decide what information can be shared with community representatives ahead of time;
- Decide how and what kinds of critical information can be shared considering HIPAA and other laws, regulations or policies;
- Decide how to rapidly implement communication processes, including pre-scripted messaging;
- Decide how emergency management and public health communities will coordinate their public messaging with hospitals;
- Decide how to inform hospital staff regarding what information they can or cannot share;
- Decide how best to establish good relationships with local news agencies.

Hospitals must be able to manage the ways in which family members will utilize their existing public-facing infrastructure (such as an Information Desk, an Emergency Department Reception Area or a Hospital Operator) as they inquire whether a loved one is present within the facility. If hospitals manage these points of contact effectively, they can support facilitation of rapid identification of survivors by family members whose presence is confirmed at the hospital.

Internal sharing of information among response roles and centers is paramount to ensure a common operating picture for the facility. Hospitals should consider the following approaches to help maintain situational awareness among response roles:

- Establish a process for the Family Reunification Center Director to obtain updated lists of patients at regular, prescribed intervals and distribute these lists to all appropriate staff aiding in reunification efforts;
  - Frontline staff must know when to expect the next update (i.e., every 30minutes)
- Maintain consistency; that is, ensure that family members seeking information receive the same correct information (when they have an appropriate right to know) whether they present in person or call on the telephone to speak with an operator;
- Designate key points of contact for information collection and sharing in each area, including the emergency department, the Family Reunification Site and the Information Desk, to ensure proper oversight and communication among involved locations.

When family members cannot definitively be told that their relative is not present as a hospital patient, family members should then be directed to a predesignated area or to other appropriate municipal reunification resources. Hospitals should include detailed contact information for municipal reunification resources (if available) in all their communications to the public and to families to assist with the family reunification process overall.

## **Security**

Security will play an integral role in any event requiring the activation of CSC. Many of these events could involve increased security risks, such as in the case of an active shooter scenario or terrorist activities. In addition, as families attempt to find available healthcare for themselves or their loved ones, crowds will form requiring an increased need for security personnel. As such, it is important to engage the institution's security leadership early in the planning process. At a minimum, the hospital emergency operations plan should include the creation of a security leader within its command structure. Hospital security personnel can also assist with coordination of interface between the institution and outside law enforcement. Ideally, an individual with preexisting relationships with law enforcement on local and regional levels, including relevant federal entities (e.g., Federal Bureau of Investigation, Bureau of Alcohol, Tobacco, Firearms and Explosives), may fill this position.

## **TRIAGE**

Triage will occur at the local level. Disaster triage is a method of quickly identifying victims who have life-threatening injuries and the best chance of survival. Identification of such victims serves to direct other rescuers and health care providers to these patients first when they arrive on the scene. The use of disaster triage involves a change of thinking from everyday care to the following:

- High intensity care should go to the sickest patient doing the greatest good for greatest number;
- Identify victims with best chance of survival for immediate intervention focusing care on those with serious and critical injuries but who are salvageable;
- Identify victims at extremes of care by sorting those who are lightly injured and those who are so severely injured that they will not survive;
- Immediate treatment to only those victims that procedure or intervention may make difference in survival;
- Altered standards of care based on resource availability.

Disaster triage must be dynamic and fluid in its execution. Primary triage is done at the scene by first responders; the triage category is assigned rapidly and is based on physiologic parameters and survivability. Secondary triage occurs typically at the facility where the patient is transported. The initial triage assignments may change and evolve as the patient's condition changes so reassessment is crucial. It is essential that medical personnel prioritize transport and treatment based on level of injury and available resources.

In Kentucky, **prehospital primary triage of pediatric and adult patients is accomplished using the Simple Triage and Rapid Treatment (START) method**. The first arriving medical personnel will use a triage tag or some other form of identification, to categorize the victims by the severity of their injury. The victims should be easily identifiable in terms of what appropriate care is needed by the triage method that were used. Once the evaluation is complete, the victims are labeled with one of the four color-coded triage categories:

- Minor (Green) – delayed care/can delay up to three hours
- Delayed (Yellow) – urgent care/can delay up to one hour

- Immediate (Red) – immediate care/life threatening
- Deceased (Black) – victim is dead, or mortally wounded/no care required

## HOSPITAL AND ICU EXCLUSIONS

Given the charge to do the best for the most, saving as many lives as possible with a marked scarcity of resources, there are certain medical conditions or situations where maximally aggressive care will not be able to be provided to every individual. These individuals would include:

- Those who are too ill to likely survive the acute illness (as evidenced by the Sequential Organ Failure Assessment (SOFA) score). See [attachment 7](#);
- Those whose underlying medical issues make their one-year mortality probability so high that it is not reasonable to allocate critical care resources to them; for example, end-stage ALS, metastatic carcinoma refractory to treatment and end stage organ failure;
- Those who require a larger-than-normal amount of resources, which makes it not feasible to accommodate their hospitalization in a prolonged mass-casualty situation.

All of the medical states or long-term conditions excluded from hospital care in this guidance meet at least one of the above criteria. In these cases, comfort care will be the priority.

There could be several possible exclusion groups but these decisions will be decided locally. Those with known DNR status do not necessarily meet any of the three criteria above. Those with known severe dementia have a relatively high mortality and may require more care resources than may be available, but there is wide variance in the severity of the disease between individuals. The same could be said of those over 85 years old. Certainly as a group, this older population is less likely to survive an acute illness, has a relatively high one-year mortality rate and may require more resources than will be available for both acute care as well as convalescence. Again, however, there may be a wide variation in individual functional status. For all the reasons listed above, these groups of individuals were not placed in the exclusion list and would be decided on by local facilities.

## CARE MODELS FOR PEOPLE WHO ARE NOT ADMITTED TO THE HOSPITAL

When activating CSC, certain hospital admission criteria will also be activated. Communities should consider and plan for palliative care models for those people who do not meet hospital admission criteria or who no longer meet criteria to remain in the hospital.

Home health and hospice providers will likely be overwhelmed with the event as hospitals discharge patients in order to provide care for others. However, if home health and hospice staff are available, hospitals should consider planning for these staff to support the overall community efforts, including:

- Admit to home health and hospice services, if capacity is available;
- In-house Hospices units could potentially admit additional patients if hospital space is available;
- Directly support hospital staff with palliative care expertise;
- Support for the “atrium” model of care in the hospital by providing medical/palliative care to groups of people who choose or are forced to remain at the hospital but not in a patient care area.

*Comfort packs:* Many hospice agencies currently provide “comfort packs” for families caring for loved ones at home. In a crisis event, a physician could be on site to write an order for the comfort pack to be sent home (or another location) with the patient/family being discharged from the facility. Each hospice agency’s protocol would establish what is included in the packs. A comfort pack generally includes items that help to manage pain, anxiety, nausea and increased secretions.

*Public Dispensing:* The current Kentucky Point of Dispensing (POD) strategies could also be used to dispense the comfort packs. The POD network, that is maintained by KDPH, has identified at least one dispensing site in each of the 120 counties in Kentucky. In addition, KDPH has contracted with the Kentucky Pharmacists Association to assist in providing emergency medical countermeasures, which can be activated to respond to public health emergencies or crisis events.

*Teaching sheets:* Comfort care teaching sheets would also be provided to patients and their families. This written information would provide useful ideas for caring for a loved one at home, including information about those diseases not directly related to the event.

These efforts would be in conjunction with an on-going, regularly-updated, disease/event-specific education of the public by state experts and officials. The public should be provided information about:

- Accessing informational phone hot-lines; (palliative care professionals may be asked to assist)
- When and how to try and access limited services;
- When and why to stay home;
- How to care for yourself;
- How to care for others;
- How to stop the spread of the disease;
- Creating a family plan;
- Creating advance directives.

## **EMERGENCY CREDENTIALING**

In a significant public health event, hospitals may experience severe staff shortages in critical areas. At the same time, hospitals are likely to experience physician and other healthcare volunteers presenting to assist who are not members of the hospital/health system staff. Hospitals should do everything possible to adhere to existing credentialing protocols. However, the circumstances of the situation may require the use of their emergency credentialing system.

## **INFECTION CONTROL**

Activation of the DOSP will be coordinated with and through the SHOC (if activated). Hospital Command Centers should also activate their infectious disease response plan and coordinate response activities with the LHD.

## ACCESS AND FUNCTIONAL NEEDS

KDPH's Access and Functional Needs (FAN) coordinator, or designee, will work in coordination with KCCRB and the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities (BHDID) to ensure that citizens with access and functional needs have the resources that they require: Further information can be found in the KDPH Public health and Medical Shelter Booklet for FAN populations.

Although disasters can affect anyone in a given community or region, those with FAN needs have the highest rates of morbidity and mortality during an emergency or disaster due to the following:

- Unavailability of a caregiver or support services such as power outages;
- Limited supply of potable water;
- Limited heat/air conditioning (depending upon the climate) availability due to power outages;
- Inability to access needed medications;
- Inability to access treatments due to lack of availability or transportation such as dialysis;
- Limited supply of ventilators;
- Limited supply of suction devices;
- Limited supply of nebulizers or nebulizer medication;
- Unable to charge mechanized wheelchairs or other equipment due to power outages;
- Lack of any plan for alternative care during the disaster.

There are many unique and complex issues that should be considered when planning and caring for these individuals in a disaster situation. Many may come to or be sent to the ED for evaluation whether or not there is a new illness or injury. They may experience an exacerbation of their underlying disease and may experience significant morbidity and even, mortality should there be an interruption in their medical care and/or in their activities of daily living.

A critical step in preparing for any event is to gain an understanding of the extent to which an issue or situation exists. Each local jurisdiction should have a working knowledge of the FAN population within their area. This can be accomplished by using the following websites:

- Kentucky specific SVI information  
<https://ky-dph.maps.arcgis.com/apps/MapSeries/index.html?appid=b051448dfb4b4a69a39e8adf2e8ac44e>
- CDC Social Vulnerability Index Site  
<https://svi.cdc.gov/>
- HHS emPOWER Map: The HHS [emPOWER](https://empowermap.hhs.gov/) Map is a public, interactive map that displays the total number of at-risk electricity-dependent Medicare beneficiaries at the state, territory, county, and ZIP Code levels.  
<https://empowermap.hhs.gov/>

**CRISIS STANDARD OF CARE TASK FORCE**

*The Kentucky Crisis Standards of Care Task Force led the original development of this guidance:*

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Commissioner of Health  
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## **ADDITIONAL RESOURCES**

- Office of the Assistant Secretary for Preparedness and Response (ASPR) Communities of Interest for Crisis Standards of Care and the Allocation of Scarce Resources - <https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/hpp-pmi-guidance-2017.pdf>
- Agency for Healthcare Research and Quality (AHRQ) Altered Standards of Care in Mass Casualty Events - <http://archive.ahrq.gov/research/altstand/>
- Directory of licensed healthcare facilities in Kentucky: <https://chfs.ky.gov/agencies/os/oig/Pages/default.aspx>

**ATTACHMENT 1: ACRONYM LIST UPDATE LIST**

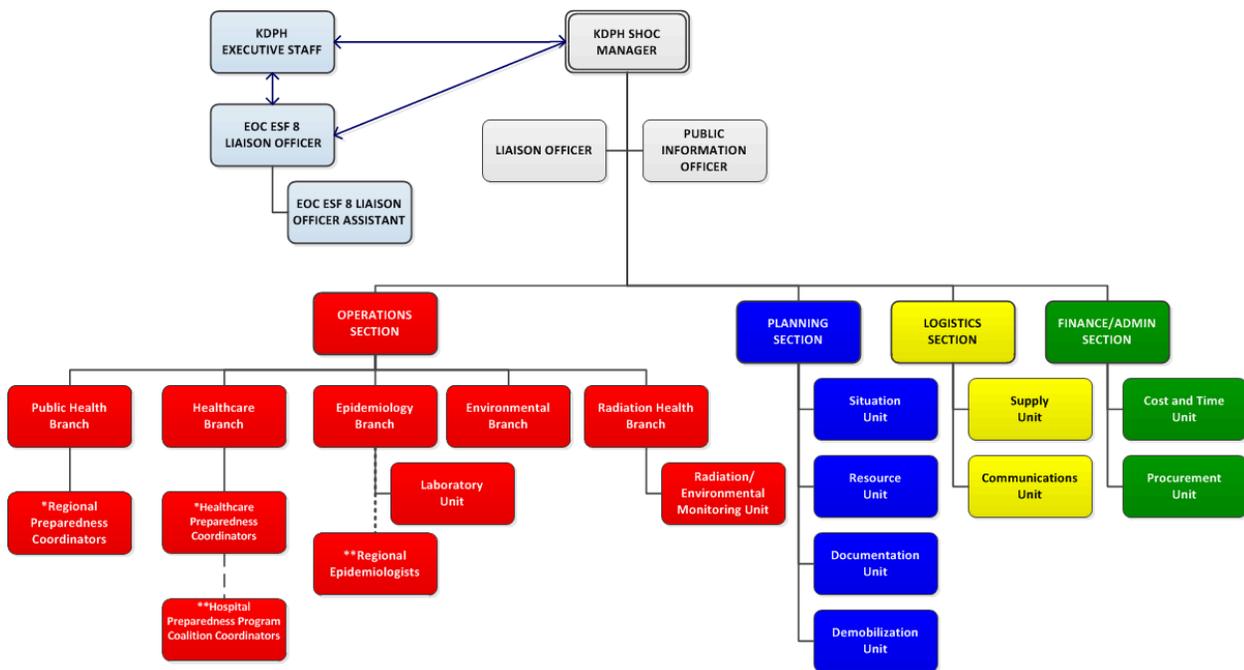
<b>Acronym</b>	<b>Title</b>
AAR/IP	After Action Report/Improvement Plan
AHRQ	Agency for Healthcare Research and Quality
ARC	American Red Cross
ASPR	Office of the Assistant Secretary for Preparedness and Response
BHDID	Behavior Health, Developmental and Intellectual Disabilities
CHFS	Cabinet for Health and Family Services
CJIC	Commonwealth's Joint Information Center
CSC	Crisis Standards of Care
DMORT	Disaster Mortuary Assistance Team
DOSP	Disease Outbreak Support Plan
EI	Essential Elements of Information
EMA	County Emergency Management
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Commonwealth Emergency Operations Center
EOP	Emergency Operation Plan
ESF	Emergency Support Function
FAN	Access and Functional Needs
HHS	Health and Human Services
HAN	Health Alert Network
HCC	Healthcare Coalitions
HIPAA	Health Insurance Portability and Accountability Act
HPC	Healthcare Preparedness Coordinator
HSEEP	Homeland Security Exercise and Evaluation Program
ICS	Incident Command System
JIC	Joint Information Center
KBEMS	Kentucky Board of Emergency Medical Services
KCCRB	Kentucky Community Crisis Response Board
KCCRT	Kentucky Community Crisis Response Team
KDPH	Kentucky Department for Public Health
KEMIS	Kentucky Emergency Medical Services Information System
KHA	Kentucky Hospital Association
KRS	Kentucky Revised Statute
KSP	Kentucky State Police
KYEM	Kentucky Emergency Management
LHD	Local Health Department
MOU	Memorandum of Understanding
MSE	Medical Screening Examination
NIMS	National Incident Management System
OIG	Office of Inspector General

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<b>Acronym</b>	<b>Title</b>
PPD-8	Presidential Policy Directive 8
PPE	Personal Protective Equipment
REC	Regional Emergency Coordinator
RECC	Regional Emergency Coordination Center
RPC	Regional Preparedness Coordinator
RRC	Readiness and Response Coordinator
SHOC	State Health Operations Center
SNS	Strategic National Stockpile
SOFA	Sequential Organ Failure Assessment
UK	University of Kentucky
U of L	University of Louisville
VOAD	Voluntary Organizations Active in Disaster

## ATTACHMENT 2: KDPH’S STATE HEALTH OPERATIONS CENTER (SHOC) INCIDENT COMMAND STRUCTURE FOR ESF #8 OPERATIONS

KDPH’s SHOC will serve as the base of direction, control, and coordination of ESF #8 public health and medical response and recovery activities based upon the type and complexity of event. The incident command structure in Figure 1 will expand or contract to meet the needs of the event. At minimum, an Executive Staff Member and KDPH SHOC Manager will be assigned to coordinate ESF #8 operations. The state’s EOC may or may not be activated when the SHOC is activated. ESF #8 Agency Representatives may provide technical and/or logistical support through assignment to an ICS position.



- *\* RPCs and HPCs are employed by KDPH and will support ESF #8 operations by providing assistance to LHDs, hospitals, long term care facilities and other healthcare agencies in the affected area and maintaining situational awareness through coordination with the SHOC. RPCs and HPCs from unaffected areas may be assigned to work in the SHOC or mobilized to the affected area;*
- *\*\* HPP RRC and Regional Epidemiologists are not employed by KDPH but are preparedness funded through contractual agreements and LHDs. These positions are responsible for coordinating ESF #8 operations, as applicable, within their respective jurisdictions and maintaining situational awareness through coordination with the SHOC. HPP RRCs and Regional Epidemiologists from unaffected areas may be requested to work in the SHOC to support ESF #8 operations.*

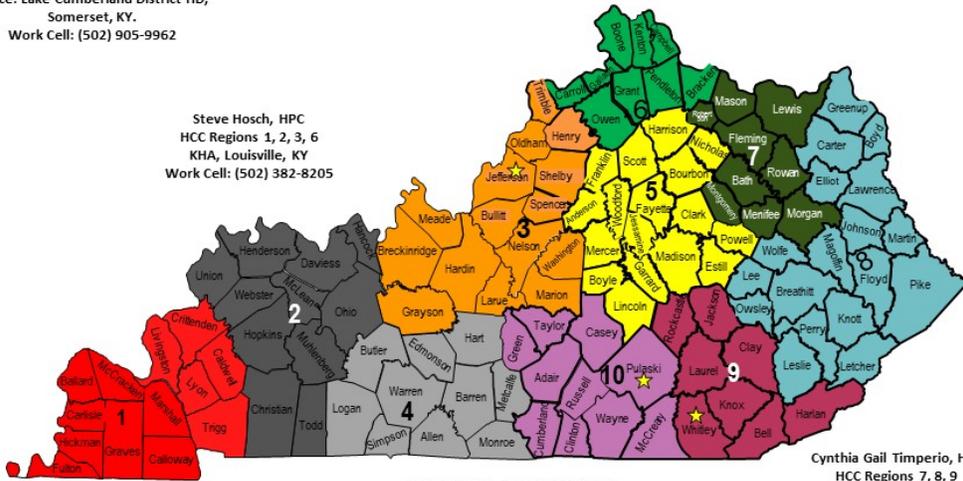
### ATTACHMENT 3: MAP OF KENTUCKY'S ESF #8 REGIONS



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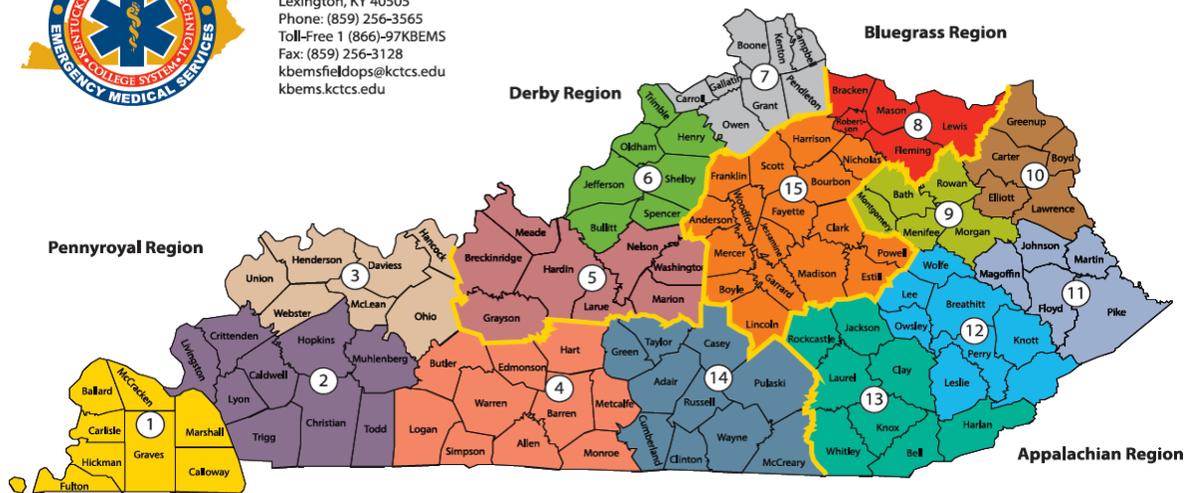
★ Office Locations

7-1-19

### Map of Kentucky's EMS Regions

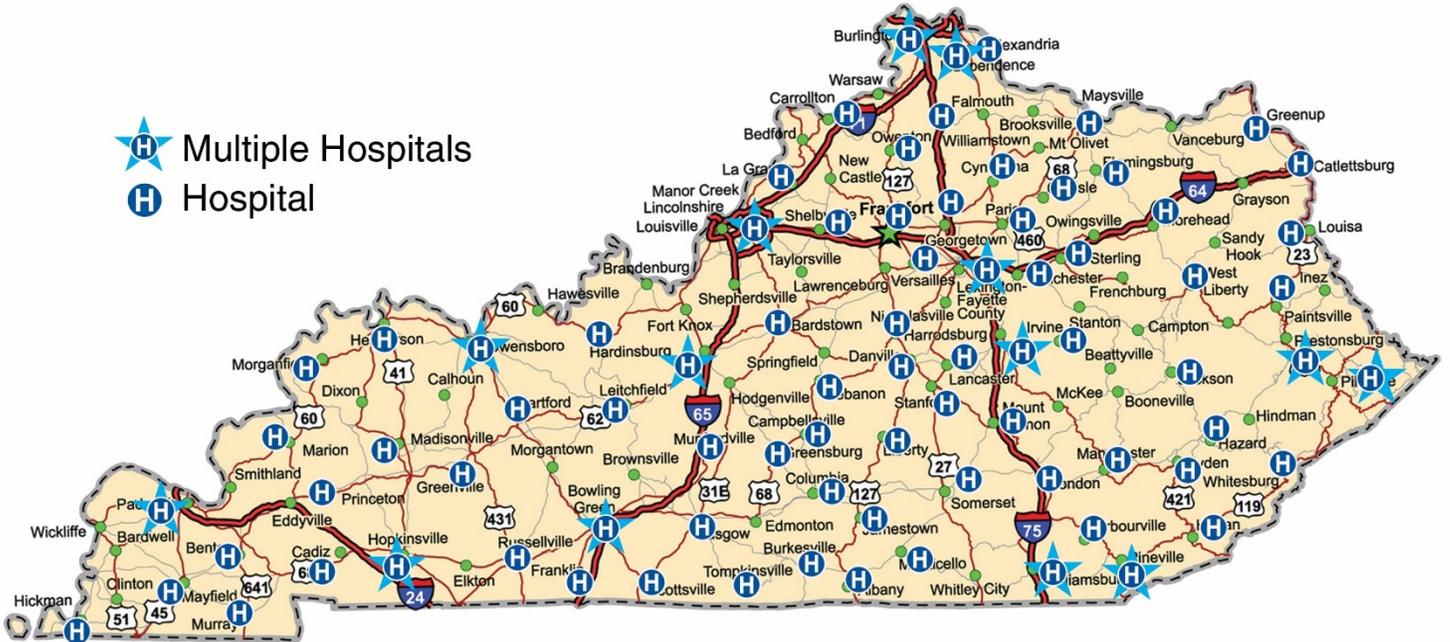


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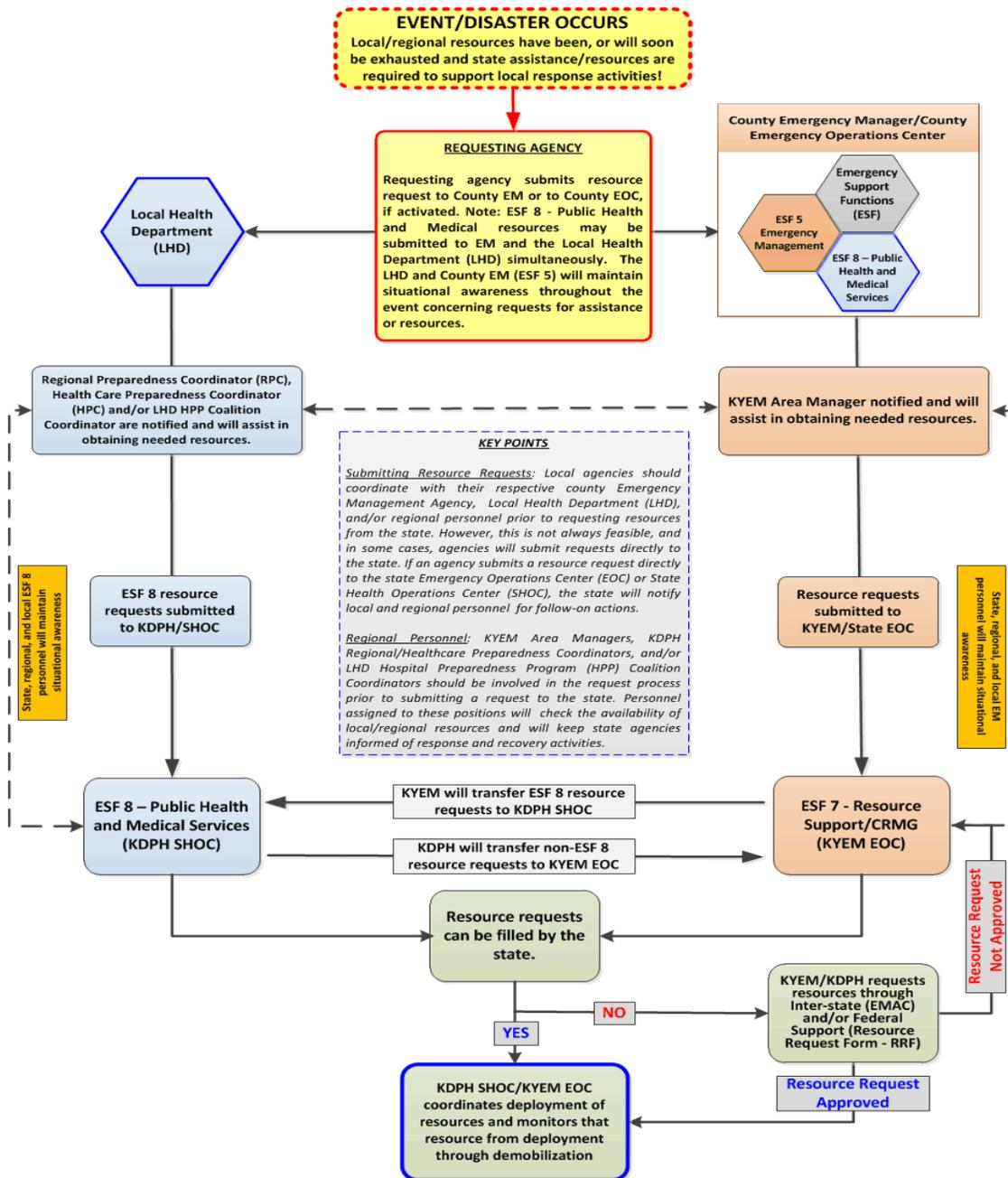
## ATTACHMENT 4: MAP OF KENTUCKY'S HOSPITALS

Map of Kentucky's Hospitals



## ATTACHMENT 5: KENTUCKY'S ESF #8 RESOURCE REQUEST FLOWCHART

### Kentucky's ESF #8 Resource Request Flowchart



## ATTACHMENT 6: INITIAL TRIAGE FOR PANDEMIC INFLUENZA

**Purpose:** Initial triage is intended to help patients who are concerned about influenza determine whether or not they should seek medical help.

**Ask these initial questions**

1. **Within the past 10 days** has the patient been **exposed to someone with influenza**?
2. Did the patient **get sick fairly quickly**, over 1-2 days?
3. Does the patient have a **fever over 101° F** or 38° C?
4. Does the patient have a **sore throat**?
5. Does the patient have a **cough**?
6. Does the patient have **severe muscle aches**?

**YES to 4 or more  
of the above**

**YES to 3  
of the above**

**Patient is NOT likely to have influenza  
and should contact his/her usual source  
of medical care**

**Patient IS likely to have influenza. CONTINUE with the following questions.**

1. Is the patient **struggling to breathe** or **breathing very rapidly**?
2. Is the **breathing very shallow, slow, or weak**? (respiratory suppression)
3. Are the **lips, tongue, or face blue**? (cyanosis)
4. Has it been **more than 12 hours since the patient last urinated**? (dehydration)
5. Is the patient **too weak to walk to the bathroom** or **not moving around in bed** AND/OR is the **skin pale and cool to the touch**? (shock)
6. Is the patient an **infant younger than 2 months** with a fever, feeding poorly, or with fewer than 3 wet diapers within a 24-hour period?

**YES to 4 or more  
of the above**

**YES to 3 or fewer  
of the above**

**Patient should be  
evaluated by a private  
physician, urgent care  
facility, or hospital  
triage area**

- Advise patient to be evaluated if any of the above occurs in the near future
- Reassure patient that the illness is not severe and can be treated at home
- Provide information about self-care
- If available, offer Tamiflu if within 48 hours of illness onset

## ATTACHMENT 7: SOFA SCORE

### The SOFA Score\*

Organ System, Measurement	SOFA Scale				
	0	1	2	3	4
Respiration PaO <sub>2</sub> /FiO <sub>2</sub> mmHg	Normal	<400	<300	<200 (with respiratory support)	<100 (with respiratory Support)
Coagulation Platelets X10 <sup>3</sup> /mm <sup>3</sup>	Normal	<150	<100	<50	<20
Liver Bilirubin, mg/dL (μmol/l)	Normal	1.2-1.9 (20-32)	2.0-5.9 (33-101)	6.0-11.0 (102-204)	>12.0 (>204)
Cardiovascular Hypotension	Normal	MAP<70 mmHg	Dopamine≤5 or Dobutamine (any dose)**	Dopamine >5 or Epinephrine ≤0.1 or Norepinephrine ≤0.1	Dopamine >15 or Epinephrine >0.1 or Norepinephrine >0.1
Central Nervous System Glasgow Coma Score	Normal	13-14	10-12	6-9	<6
Renal Creatinine Mg/dL (μmol/l) Or Urine output	Normal	1.0-1.9 (110-170)	2.0-3.4 (171-299)	3.5-4.9 (300-440) Or <500 mL/day	>5.0 (>440) Or <200 mL/day

\*Source: Vincent et al., (1996) The SOFA (Sepsis-related Organ Failure Assessment) score to describe organ dysfunction/failure. Intensive Care Med 22: 707-710

\*\*Adrenergic agents administered for at least 1 hour (doses given are in mcg/kg/min).

It is important to remember that SOFA is a single criteria, and other patient factors (e.g., underlying diseases and current response to treatment) should be taken into account when making triage decisions. Disease-specific predictive factors may also need to be accounted for and included in the triage decision-making. Assuring that the triage team members are experienced critical care providers that have access to the relevant patient information, guidance, and are part of a defined, structured process for triage whenever possible is critical to making fair, accountable, transparent decisions about resource allocation.

**ATTACHMENT 8: DISASTER PATIENT TRACKING FORM**

<b>HICS 254 - DISASTER VICTIM/PATIENT TRACKING FORM</b>								
<b>1. INCIDENT NAME</b>			<b>2. DATE/TIME PREPARED</b>			<b>3. OPERATIONAL PERIOD DATE/TIME</b>		
<b>4. TRIAGE AREAS (Immediate, Delayed, Expectant, Minor, Morgue)</b>								
MR#/ Triage #	Name	Sex	DOB/ Age	Area Triage to	Location/Time of Diagnostic Procedures (x-ray, angio, CT, etc.)	Time sent to Surgery	Disposition (home, admit, morgue, transfer)	Time of Disposition
<b>5. SUBMITTED BY</b>				<b>6. AREA ASSIGNED TO</b>			<b>7. DATE/TIME SUBMITTED</b>	
<b>8. FACILITY NAME</b>								