SDAHO Trustees Resource Center

The Trustee Quarterly

For South Dakota Association of Healthcare Organization Board of Trustee Members Fall 2021

BOARDROOM BASICS

Disaster Planning: Thinking Ahead for the "What If?"

When category four Hurricane Ida made landfall in Louisiana in August 2021, it hit hospitals that were already overwhelmed with a surge in COVID-19 cases. Hospitals and other health care facilities lost power, sustained roof damage, and experienced water inside facilities. As disaster plans kicked in, generators turned on, and patient transfers were executed, patient lives relied on each facility having a successful disaster preparedness plan.

The importance of disaster planning was already escalating in significance before 2020 due to the increase in wildfires, hurricanes, and other natural disasters, as well as the growth in man-made tragedies including mass shootings and terrorist attacks. That was before COVID-19. When hospitals were inundated with COVID-19 patients in 2020, the presence of a well-designed disaster plan meant life and death not only in the short-term but in the years to come as well.

Board Requirements for Disaster Planning

While it's not the board's responsibility to create and implement the organization's disaster plan, it is the board's fiduciary responsibility to ensure that the administration has a clear disaster plan in place, with the funding and resources necessary to carry it out. In addition to ensuring that their organization is fully prepared in the event of a disaster, disaster planning is also an opportunity for hospitals and health systems to:

- Improve the quality of service provided to the community;
- Strengthen community relationships; and
- Build lasting community trust and partnerships that benefit hospitals and health systems in many ways.

In addition, the Affordable Care Act (ACA) and Joint Commission accreditation have specific requirements for disaster preparedness.

Requirements Included in the Affordable Care Act. The ACA includes a requirement that charitable hospitals have a written Emergency Medical Care policy in place that requires the provision of emergency care regardless of eligibility under the financial assistance policy. This means that hospitals must be prepared financially to handle the initial cost and long-term financial implications of caring for patients during an emergency.

Joint Commission Requirements. Joint Commission accreditation includes specific requirements relating to the development of a written Emergency Operations Plan. This includes conducting a hazard

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Our Perspective

Disaster Planning: Yesterday, Today and Tomorrow

Disaster planning has been part of SDAHO's ongoing conversations with our members for years, so when the COVID-19 pandemic reached South Dakota, the SDAHO team was ready to update a plan that was already in place. The most recent plan called The *South Dakota Crisis Standards of Care Plan* is almost finalized and expected to be ready by late October of 2021. The revised plan will take work already created and adopt new provisions to allow for consistency and collaboration across the state of South Dakota. To understand the revised plan, it's important to know the history of the conversations and the organizations involved.

In 2009, the South Dakota Department of Health and LifeCircle South Dakota (formerly known as the Sioux Falls Bioethics Network), worked together during the H1N1 pandemic to create a draft policy of the South Dakota Pandemic Guidelines. The guidelines follow a clinical framework for responding to a crisis and treating patients when resources are limited.

In 2021, LifeCircle South Dakota, with facilitation from SDAHO and collaboration with the South Dakota Department of Health, created a legal and medical workgroup to update the 2009 plan and unify South Dakota hospitals on how to prioritize critical care resources during a public health emergency with the overall goal of saving as many lives as possible. The SD Crisis Standards of Care Plan helps to reduce clinician burden by providing an ethically sound, clinically objective, practical, non-discriminatory, and transparent triage guideline for allocation of limited medical resources in the event of a mass critical care situation during which the demand for hospital and critical care services exceeds capacity.

Education and training for hospitals, providers and key stakeholders will take place in November 2021 to update everyone on the purpose and revisions to the plan and develop policies and procedures at a local level.

Today's Emergencies Need Long Term Solutions:

Workforce shortages continue to impact healthcare communities across South Dakota, especially in rural areas. For the facilities that reside in those smaller communities, they know firsthand the disaster they are potentially facing if solutions are not found. Finding quality healthcare professionals to fill open slots is a need for today, but it's only a short-term fix if that position is filled by a temp agency, which we are seeing in both large and small facilities. Long term solutions are needed and that is where SDAHO is focusing some of its resources and energy. One project is focusing on the recruitment of healthcare students at our state and public universities and colleges.

SDAHO recently launched *The Student Athlete Recruitment Project*, which highlights some of South Dakota's most talented collegiate athletes that are pursuing a career in healthcare and plan to stay in South Dakota. SDAHO is collaborating with the universities and colleges to connect with some of these students to highlight them through video testimonials. These short video stories will be shared on social media, in high schools and more, to the next generation of college students. These potential students will hear from some of their favorite South Dakota athletes why they are excited to move from a hero on the court or football field to the next generation of healthcare heroes. The end mission is to attract more of today's youth to consider a degree and career in healthcare, leading to more healthcare professionals in the future.

Spotlight Sponsors

SDAHO Enterprises

SDAHO Enterprise was developed to pursue valued services and increase non-dues revenue. Overall goals and objectives of providing revenue to supplement SDAHO strategies and providing support and benefit to members.

Upcoming Education

Nov. 11th 340B Drug Pricing Program: Overview, Impact & Update: 12pm CST – 1pm CST

Presenters:

- Jesse Breidenbach, Senior Executive Director, Pharmacy – Sanford Health
- Melissa Goff, Vice President of Outpatient Pharmacy – Avera
- Scott Peterson, Senior Director of Ambulatory and Pharmacy Operations, Monument Health

Nov. 16th – How to Retain and Reward Top Talent in Today's Healthcare Industry: 1pm CST – 2pm CST

Presenters:

- Ryan Millman, Managing Partner, Modern Capital
- Alexander Yaffe, Managing Director, Pearl Meyer

Nov. 23rd. – End of Life Series: Final Days (Part 3): 11:00am CST – 12pm CST

Presenters:

- Lores J. Vlaminck, MA, BSN, RN, CHPN, LALD, Principal, Lores Consulting, LLC.

The SDAHO Learning Hub

Are you looking for continuing education hours for nursing home administrators or social workers? Are you searching for content to provide to your team on leadership topics such as team culture, difficult conversations, or ways to effectively communicate? SDAHO's Learning Hub is a collection of recently recorded webinars on content areas including, leadership, regulatory, patient/ resident care, human resources, governance and the legalization of medical marijuana. Visit the Learning Hub today.

SAVE THE DATE:

Post-Acute Partners in Care Conference
April 13-14, 2022 in Sioux Falls at the Sioux Falls Convention Center

Rural Health Leaders Conference
June 2022 – Pierre, SD – Details coming soon!

SDAHO Annual Convention
September 21-23, 2022 in Sioux Falls at the Sioux Falls Convention Center

NYU Langone Health: Lessons from the Front Lines

In September 2021 American Hospital Association Board Chair Rod Hochman, M.D., discussed emergency preparedness with Fritz Francois, M.D., chief medical officer and patient safety officer at New York University Langone Health. NYU Langone Health has experienced a breadth of public emergencies in the last 20 years, including the 9/11 terrorist attacks, Hurricane Sandy, a fire on campus, and the COVID-19 pandemic. The organization conducts tabletop exercises twice a year, and in the fall of 2019 had already selected the emergence of a deadly virus for their 2020 exercise. Their plan was quickly activated once COVID-19 made its way to the U.S.

Initial Lessons Learned: In the first few months of the COVID-19 pandemic in New York City, NYU Langone Health learned:

- **They hadn't anticipated the speed with which things would change.** They had a plan in place for extending the number of beds for COVID-19 patients, but rather than a few beds every single floor had to be converted to care for COVID-19 patients.
- **The ability to pivot quickly was essential.** They still regularly ask: "how quickly can we get up to speed?"
- **Staff fatigue needed to be constantly assessed** and reassessed as the disaster response continued.
- **Staff was responsible for caring for families too,** because patient families couldn't be at the bedside.

Building Staff Resiliency: The health system's advice for supporting staff through a tumultuous period includes:

- **Celebrate wins**, like discharges of severe cases and letters from grateful patients.
- **Communicate a lot** with staff and leaders about what's going on, and what's going to happen.
- **Put the experience in perspective,** communicating what's happening locally compared to the rest of the country.
- **Expand staff resources for mental health and wellness,** using feedback from staff about what's important to them.

The full interview is available at www.aha.org/leadership-rounds.

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vulnerability analysis, working with community partners, ensuring a communication plan is in place, and conducting annual drills. The Joint Commission has a dedicated website for hospital Emergency Management Resources, available at: http://www.jointcommission.org/emergency_management.aspx.

What Boards Should Be Doing Now

Every organization should have a robust disaster plan in place. These plans should not be created or practiced in a vacuum. Disaster preparations require collaborative work with local and regional community organizations, including potential competitors, to ensure a comprehensive plan is in place.

Once plans are in place, practice is needed to ensure that all key players know what they should be doing and are comfortable with their role before they are placed in a high-pressure situation. Hospitals must be proactive in forming the necessary partnerships and conducting drills to ensure their community is prepared. Three key steps are outlined below.

Step 1: Identify Logical, Likely Threats. Every hospital or health system should begin its disaster preparedness plan by conducting a "hazard vulnerability analysis" to determine the types of emergencies most likely to occur. For example, while hospitals along the Gulf Coast face a risk of hurricanes, those in the West will be concerned about earthquakes and wildfires. Hospitals in the Midwest may be concerned about flooding or severe winter storms, and those near chemical plants will focus on hazardous materials spills, burns and injuries from inhalation of fumes.

All hospitals also need to be prepared for the emergence of new diseases like COVID-19, SARS, and Ebola. In

addition, hospitals and health systems need to be prepared for the threat of "active shooter" situations, bombings, and terrorist attacks in the facility or in the community.

It is also essential that hospitals and health systems plan for cybersecurity threats, including considering attacks on electronic health records, internet-enabled medical devices, and databases for clinical, financial, and administrative operations.

Step 2: Assess Threats and Create an Action Plan. Once potential hazards have been determined, organizations must develop plans to address each emergency. The process should include all key players within the hospital family and the surrounding community. Working across departmental and agency boundaries will help to strengthen communication among all segments of the hospital and its community.

Hospitals and health systems must also ensure their facilities and equipment are prepared to withstand the effects of disasters such as wildfires, hurricanes, earthquakes, and floods.

Step 3: Simulate the Disaster, Practice the Response. An emergency plan will not successfully prepare a hospital or community unless it is practiced. Simulating a disaster helps key players understand their roles in the emergency plan and helps identify flaws in the plan, which can be amended before a real disaster strikes. Performing at least two practice drills a year is a requirement of Joint Commission accredited hospitals.

Community-Wide Planning

A coordinated response from local and regional community organizations is essential in ensuring the most efficient and effective response to an emergency. Community-wide emergency planning is stressed in The Joint Commission's standards, a concept that helps to ensure services aren't duplicated and resources are maximized in an emergency.

Ideally, when a disaster occurs community partnerships are already well-established and the organizations are prepared to work together in a collaborative manner. Hospitals and health systems have the opportunity to:

Disaster Planning: Board vs. Administration Roles

Board members and hospital leaders must work together to emphasize the importance of planning for potential emergencies, but they each have distinct roles.

The Board's Role

- Focus on policy and strategy, familiarizing themselves with the issues and implications.
- Ensure the proper plans are in place.
- Ensure appropriate funding and resources to plan, test, and implement.
- Ensure that drills and simulations take place, and engage in discussions about adequacy of response, planning, and coordination as well as next steps needed.

The Administration's Role

- Develop or update the emergency plan.
- Order the equipment, supplies, and other materials necessary to carry out the plan.
- Arrange and coordinate both internal drills and community-wide disaster simulations.

- Leverage existing community partnerships and build new partnerships.
- Be part of community-wide disaster planning efforts, including emergency operations centers that help coordinate responses to emergencies.
- Be part of a shared community-wide crisis communication plan, which often begins with a task force of community leaders.
- Build relationships with community partners that may start with disaster planning, but provide opportunities for lasting relationships with community organizations, governmental agencies, and individual leaders in the community that can help strengthen community trust and support for the hospital in the long term.

Learning from Your Successes and Failures: Conducting a Post-Emergency Assessment

The board's role in a disaster does not end once the disaster has passed. When things are beginning to "return to normal," the board should be actively involved in assessing the hospital's response to the disaster. As with any crisis, some things will have gone according to plan, and some will not. The board should work with senior leaders to weigh what additional resources are needed to aid the hospital as it updates and upgrades its disaster readiness plan, and seek ways to adequately fund these necessities.

Board Review of the Disaster Plan

In reviewing the disaster readiness plan, board members should look for three key elements:

- Threat identification, or hazard vulnerability analysis
- Detailed action plan to address each threat
- Adequate simulation drills

Questions for Boards: Disaster Readiness Checklist

- Has your hospital or health system conducted a "hazard vulnerability analysis" to determine what types of emergencies are most likely to occur and should be included in your disaster plan?
- Does your disaster preparedness plan focus on a general "all-hazards" approach, providing an adaptable framework for a variety of crisis situations?
- Have community health care leaders convened for disaster preparedness discussions?
- Has your organization determined the scope and resources necessary for the emergency management plan and its implementation?
- Does your hospital or health system have a separate crisis communications plan in place? Has it been developed in collaboration with other local community leaders?
- Does your hospital have backup communications capabilities in place in the event that traditional forms of communication are either slowed or not functioning?
- Do you have plans in place to rapidly expand clinical and non-clinical staff in the event of a disaster?
- Is there a plan for supporting the families of staff members working during a disaster? Does the plan cover assurances that family members are safe, including child care, elder care, and pet care?
- Has your organization determined how critical supplies will be obtained and allocated in the event of an emergency?
- Is your hospital prepared to potentially be "on its own" for up to 96 hours, as required by The Joint Commission?
- Does your hospital have a simplified patient registration procedure in the event of a large number of patients and/or casualties?

GOVENRANCE INSIGHTS

Crisis Standards of Care: What It Is, and Why It Matters to Your Board

At the beginning of the COVID-19 pandemic in the U.S., patient care had to be rationed in the hardest-hit areas. In other areas, resources were rationed even without a declared "crisis standards of care." As the delta variant has brought a new wave of COVID infections, some hospitals are again pushed to the limit, forcing questions about prioritization of care.

Hospitals across the country are not only experiencing challenges in caring for the increase in COVID-19 patients, but they are also warning communities about limited resources impacting their ability to care for patients with non-COVID-related health care needs. This includes emergency patients, elective surgeries, cancer care, and more. For organizations experiencing shortages of staff and resources, this poses a serious dilemma: *What should hospital leaders do when there isn't enough space, staff, medication, or equipment?*

According to the National Academy of Medicine (formerly the Institute of Medicine), crisis standards of care (CSC) "occur when the degree of resource shortage requires decisions that place a patient or provider at risk of a poor outcome."[1] As a part of disaster planning discussions, boards of hospitals and health systems must understand how clinical and hospital leaders will proceed if the need to invoke crisis standards of care occurs.

The Current State of Care Rationing in the U.S.

In the early stages of the 2020 COVID pandemic, the potential need to ration care for both COVID and non-COVID patients was a prominent discussion. While Arizona and New Mexico were the only states to declare crisis standards of care at that time, experts agree that other states and providers still rationed care and resources.[2]

Moving to crisis standards of care should be a last resort.

In the fall of 2021, as cases rose again, a few states activated statewide crisis standards of care and others issued statements about hospital capacity and concerns about the potential need to ration care.

In September 2021, Alaska and Idaho activated the CSC framework, which allows hospitals and health systems to prioritize patient care or even deny treatment based on their likelihood of survival.[2] Washington also announced that hospital capacity was stretched, and according to the Washington Department of Health's September 2021 statement, the state's partners had "undertaken a number of strategies to stretch resources and mitigate current challenges." If further action is needed, the state has adopted and plans to use the ethical framework developed by the National Academy of Medicine.[3]

Determining Criteria for Crisis Standards of Care

The transition to crisis standards of care requires prioritizing the community above individual patients' needs. Moving to crisis standards of care should be a last resort.

Plans Should Be Developed in Advance. All hospitals and health systems should have clearly defined protocols and guidelines for providing care when it must be rationed well before the process ever needs to be used. Defining the process can be controversial, invoke ethical dilemmas, and have long-term consequences. It should not be rushed or determined "in the moment."

During an emergency, hospitals may face difficult decisions about the triage and management of patients who may be competing for scarce resources such as hospital emergency admissions, ventilators, equipment, medications, and intensive care resources.

The norms in medical care do not change during disasters – health care professionals are always obligated to provide the best care they reasonably can under given circumstances.

These critical, ethical, and legal decisions should not be made by one person or even just a few people. Instead, the criteria used to make these decisions should be created in advance, formally adopted by the medical staff and hospital leadership, and approved by the board.

Ethical Implications. The COVID-19 pandemic highlighted inequalities that already existed related to lack of access to care and services in the health care system. For leaders developing the standards to be used, ethical issues will be the greatest challenge in determining how to transition from providing a patient-centered approach of providing the best care for individuals to providing resources fairly to the overall public.

Categories of Care

The National Academy of Medicine defines the continuum of care during health care surges as:[1]

- **Conventional Care:** Usual resources and level of care provided through maximal use of the facilities' usual beds, staff, and resources.
- **Contingency Care:** Provision of functionally equivalent care—care provided is adapted from usual practices (such as boarding critical care patients in post-anesthesia care areas).
- **Crisis Care:** Inadequate resources are available to provide equivalent care—care is provided to the level possible given the resource gap. ***Increased risk of morbidity and mortality defines the care provided in this phase—this risk can be minimized by implementing consistent proactive resource use strategies.***

National Guidance

The National Academy of Medicine (formerly the Institute of Medicine), first published guidance on crisis standards of care during the H1N1 pandemic in 2009 for hospitals in serious disaster situations. This guidance was updated in 2020, providing a framework and toolkit with indicators for hospitals to use when confronted with these dire circumstances.

The guidance suggests that hospitals use the following considerations when determining if crisis standards of care are necessary:

- Whether essential infrastructure (such as beds, utilities, and transportation) are critically compromised;
- Absence or a serious lack of human, equipment, and supply resources; and
- Consistent information which prevents transferring patients to other hospitals.

A Shift in Focus. The transition to crisis standards of care is a difficult decision for physicians and senior leaders. It requires a shift in focus moving along a continuum, ranging from:

- "conventional" everyday standards of care with efforts devoted to caring for individual patients, to
- "contingency" standards of care using adapted practices, to
- the worst-case of "crisis" care, where care is rationed, bringing increased risk of morbidity and mortality.

Hospital and health system boards and leaders have a duty to create plans and written guidelines in advance that can be called upon if this emergency situation occurs. Organizations such as the National Academy of Medicine, the American Medical Association (AMA), and the American Hospital Association (AHA) provide tools and resources to ensure ethically sound crisis standards of care are used. For

example, the AMA guidelines specify that triage protocols are applied fairly and consistently to all patients. The AMA also defines how limited resources should be allocated, such as "based on criteria related to medical need, not on non-medical criteria such as patients' social worth."[4]

The Heart of Medical Care Doesn't Change. The Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations noted in their recommendations to the Institute of Medicine that the norms in medical care do not change during disasters – health care professionals are always obligated to provide the best care they reasonably can under given circumstances.

The Decision to Transition to Crisis Standards of Care

Before it's needed, boards should understand and evaluate the organization's criteria for when to transition to crisis standards of care. According to governWell, a leading national health care governance consulting firm, the decision should include:

- Legal assurances that the federal and state authorities' emergency declarations and statutes have authority for hospitals to use crisis standards of care.
- Clear definitions of evidence-based clinical processes, operations, and treatment—including detailed indicators, triggers to move to the next stage, and responsibility and authority for decision-making.
- Strong ethical guidelines on the use of available resources to sustain life for the "greatest good."
- A documented plan for communication, including transparency with the hospital staff and community.

Ensuring a Crisis Communications Plan

If crisis standards of care are required, hospital and health system leaders should be prepared with a "crisis communications plan." governWell recommends that the communications plan includes:

- Defining the official spokesperson for the hospital or health system responsible for media updates and answering questions.
- Communicating what approvals have been secured.
- Communicating the proactive measures the organization has already taken to try to avoid the crisis.
- Explaining how the community will know when the crisis is resolved. For example, sharing clearly defined measures that will indicate the crisis standards of care are no longer needed.

Questions for Boards

Your board is ultimately responsible for ensuring your hospital or health system is prepared in the event that resources must be limited. A written and well-understood plan that addresses crisis standards of care is part of this planning process. To be prepared, your board must:

- Understand what "crisis standards of care" means.
- Ensure a written plan is in place that defines how your organization defines crisis standards of care and when it should be invoked.
- Engage in a robust dialogue about your organization's policy, asking questions such as: Does our plan align with the National Academy of Medicine's guidance? Is our plan consistent with the rest of the state? How does our plan address inequities in care?
- Ensure a crisis communications plan is determined in advance if crisis standards of care is necessary.

Content for this article was contributed by governWell, www.governwell.net. Additional resources are included below.

Sources and More Information

1. Hick, J. L., D. Hanfling, M. Wynia, and E. Toner. 2021. Crisis Standards of Care and COVID-19: What Did We Learn? How Do We Ensure Equity? What Should We Do? NAM Perspectives. Discussion, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/202108e.
2. Knowles, Hannah. Hospitals Overwhelmed by Covid are Turning to 'Crisis Standards of Care.' What Does That Mean? *The Washington Post*. September 22, 2021.
3. Statement on Hospital Capacity and Crisis Standards of Care. News Release. Washington State Department of Health. September 8, 2021. www.doh.wa.gov/Newsroom.
4. Crisis Standards of Care: Guidance from the AMA Code of Medical Ethics. American Medical Association. Updated April 5, 2020.