THE ROLE OF THE DOCTORATE PREPARED NURSE PRACTITIONER IN MEDICAL SURGE POLICY DEVELOPMENT AND REVISION

by

Chelsea Jean Dunshee

A dissertation submitted in partial fulfillment
of the requirements for the degree

of

Doctor of Nursing Practice

in

Family and Individual Health

MONTANA STATE UNIVERSITY
Bozeman, Montana

April 2020

©COPYRIGHT

by

Chelsea Jean Dunshee

2020

All Rights Reserved

ACKNOWLEDGEMENTS

The completion of my DNP scholarly project has been a transformative experience. This undertaking could not have been completed without the support and love of many significant people in my life.

First, thank you to my husband, Christopher Dunshee. You have been a never-ending source of encouragement, support, and unwavering love. Words fail to adequately express my sincere gratitude to you for enduring my sleepless nights, quieting my worries and fears, and doing it all with endless grace, patience, and kindness. With your help, I was able to achieve my dream of completing graduate school.

Second, thank you to my mother, Rebecca D'Amour, for all that you sacrificed so that I could succeed in life. You taught me the meaning of hard work, perseverance, what it means to work for what you want, and how to overcome adversity. I love you. Thank you as well to my brothers, Nathan and Evan. You mean the world to me.

I have sincerely appreciated the support from my mother-in-law and father-in-law Cindy and Rick Dunshee. Your unwavering words of encouragement and love were pivotal in completing not only my project, but also my graduate school endeavor.

Special thanks to my coworkers and friends who rooted me on during this process. I would like to specifically mention Stella Neal, Kim Reynen, and Shannon Wackerman. I could not have done it without you lifting me up along the way.

I wish to express gratitude to my chair Dr. Casey Cole, and my committee members, Dr. Sandra Kuntz, Dr. Jennifer Sofie, and Mary (Mae) Stubbs. You have been instrumental in my success. I am so grateful for your expertise and guidance.

TABLE OF CONTENTS

1. INTRODUCTION 1

Background 2
Statement of the Problem 6
Purpose 6
Inquiry Questions 7
Conceptual Framework 7
Significance of the Study 8
Assumptions 10
Limitations 10

2. REVIEW OF LITERATURE 11

Introduction 11
Search Methods and Results 11
Medical Surge 12
Nurse Practitioner Scope 15
Nurse Practitioner Role in Policy Development 16
Summary 19

3. METHODS 20
Introduction 20
IRB Approval 20
Stakeholders 20
Setting and Population 21
Design Overview 21
Procedures 22
Phase 1: Exploration 22
Awareness and Contracting 22
Phase 2: Planning 23
Diagnosing the Problem 23
Designation of Stakeholder 26
Phase 3: Action 27
Planning the Draft for Change 27
Phase 4: Integration 29
Accepting Change 29
Summary 30

4. RESULTS 32

Policy Outcomes 32
The Role of the DNP 34

TABLE OF CONTENTS CONTINUED

Summary 35

5. DISCUSSION 36

Summary 36
Interpretation 36
Project Barriers 37
Limitations 37
Recommendations for Future Studies 38
Conclusion 38

REFERENCES CITED 40

APPENDICES 46

APPENDIX A: Institutional Review Board 47
APPENDIX B: Emergency Operations Plan 49
APPENDIX C: Emergency Call-Back Roster 54
APPENDIC D: Emergency Patient Surge 56

LIST OF FIGURES

Figure Page

1. RCA After-Action Report Diagram 25

2. Planned Change for Medical Surge Policy Development and Revision 31

ABSTRACT

Disasters and mass casualty events pose significant challenges to healthcare facilities. It is imperative as an organization to have a medical surge policy in place should a sudden influx in patients occur. Proper policy planning is required to ensure the policy in place works sufficiently to meet the healthcare organization's needs. The purpose of this project was to define the role of the Doctorate prepared Nurse Practitioner (DNP) in the medical surge policy development and revision process. This was accomplished by leading a quality and performance improvement project workgroup after performing a review of current literature and a Root Cause Analysis of a recent mass casualty patient surge incident at the organization. The results show that the role of the DNP as it relates to medical surge policy revision are to: (a) analyze policy processes and lead development and implementation of policies, (b) influence policy making process through participation on committees and educating policymakers on nursing processes, policy, and patient outcomes, and (c) act as a change agent and stakeholder. All recommendations made to improve the medical surge policy by the DNP student were accepted and utilized in the acting organizational EOP.

CHAPTER ONE

INTRODUCTION

Disasters and mass patient events pose unique challenges for healthcare facilities. Challenges include the burden on facilities' inherent infrastructure, patient capacity, as well as the overall preparedness for response. A hospital considers activation of a medical surge policy when the ability to provide adequate medical evaluation and care during events exceeds the limits of typical medical infrastructure (United States [U.S.] Department of Health and Human Services, 2012).

A major disaster is defined as:

> …any natural catastrophe (including any hurricane, tornado, storm, high water, wind-driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, or drought), or, regardless of cause, any fire, flood, or explosion, in any part of the United States, which in the determination of the President causes damage of sufficient severity and magnitude to warrant major disaster assistance under this chapter to supplement the efforts and available resources of States, local governments, and disaster relief organizations in alleviating the damage, loss, hardship, or suffering caused thereby. (The Public Health and Welfare Act, 2006, para. 2).

In 2017, the U.S. was impacted by 59 major disasters and 16 separate emergency major disaster events that caused over a billion dollars in damage each (Hijazi, 2018). These major disasters consisted of eight severe thunderstorms across the Midwest, three tropic hurricanes in the southeast, two inland floods in California and Missouri, drought in North Dakota, South Dakota, and Montana, wildfires in the western U.S., and a crop freeze in the upper Midwest. Nearly eight percent, or 25 million people were impacted by these disasters (Hijazi, 2018). In 2017 Montana declared a state of emergency eight

times for wildfires and twice for flooding in 2018 (Federal Emergency Management Agency [FEMA], 2018). Disaster events are not just limited to natural phenomena, however. Hospitals are required to have an Emergency Operations Plan (EOP) in place that describes how the organization will address all hazards that may present, natural or humanmade (Emergency Care Research Institute (ECRI) 2018).

Background

An incident is an occurrence, caused by either human action or natural phenomena that may cause harm, and that may require action (Department of Homeland Security [DHS] Risk Lexicon, 2010). Harm can include human casualties, destruction of property, adverse economic impact, and/or damage to natural resources. An incident has the potential to overwhelm or overburden the routine services of a healthcare facility.

On Sunday, June 18th, 2017, a deck collapsed in Northwest Montana at approximately 1600, injuring 50 individuals ranging in age from young children to seniors. Patients were triaged on site by first responders. Twenty-seven victims were transported to a hospital in North-Western Montana, and nine were transported to its affiliated hospital, 12 miles away. The remaining were transported to surrounding medical centers with two flown to a hospital in Washington state. This incident demonstrated the impact of a disaster not caused by a natural phenomenon and highlighted the need for advanced preparedness planning by a healthcare organization. This healthcare organization was the focus on this project.

The Emergency Severity Index (ESI) levels will be utilized throughout the paper when referencing patient acuity. According to Gilboy, Tanabe, Travers, and Rosenau

(2012), ESI level one is resuscitation and requires immediate life-saving intervention. ESI level two is emergent has a high risk of deterioration and should be seen by a provider within 1-14 minutes. ESI level three patients are stable, will require multiple resources, such as lab and XRAY, to diagnose and treat, and should be seen by a provider within 15-60 minutes. Level four is stable, will require only one resource, such as sutures, to treat, and should be seen by a provider within one to two hours. Level five is stable, requires no resources to manage, and should be seen by a provider within 2-24 hours.

The community of interest (COI) included people of all age ranges and population demographics presenting to the emergency department for care. The targeted facility is located in Northwest, MT, and sees a volume of 32,257 emergency room visits annually. Previous response efforts to events that led to a patient surge in the emergency department caused increased strain on the department. The organization has encountered similar scenarios with two previous deck collapses on August 1st, 2004, injuring 70 and August 2nd, 2016, injuring 11 individuals.

On this incident occurring June 18th, 2017, the sudden influx of patients to the hospital did not initially trigger the organization's emergency policy in place at that time. ESI levels one, two, and three were treated and stabilized for movement out of the emergency department. Patients assigned an ESI level of four and five were sent to the conference room and subsequently waited approximately six to eight hours for treatment after initial triage. This delay before receiving care was due to flaws in the policy that was in place. When the medical surge was ultimately activated, there was no instruction within the plan to call in extra staff to aid in caring for the sudden influx of patient

numbers. This project will demonstrate the flaws that existed in the previous policy as discovered during DNP student's review of the incident After Action Report.

All local primary care clinics and urgent care clinic facilities affiliated with the healthcare organization were closed at the time of the accident as the incident occurred outside of their regular operating hours. There was no guideline in the policy to open these clinics to increase the capacity to aid in the care of the low-level triage patients who were awaiting care in the emergency department or who subsequently presented to the emergency department during the activation of the emergency policy for treatment unrelated to the event. Clinics are often utilized to manage overflow during medical surge activation and treat patients with ESI levels four and five (Office of Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange [ASPR TRACIE], 2018). According to the ESI, patients indicated as a level three, four, and five, are capable of being cared for in an urgent care setting as these patients are considered stable and within the scope of care of a Physician's Assistant (PA) or Nurse Practitioner (NP) (Gilboy, Tanabe, Travers, & Rosenau, 2012).

Policies in Healthcare

Policies in healthcare are part of the day to day operations (Goudreau & Smolenski, 2018, p.4). Policies are pivotal in providing guidance and expectations of procedures, which outline actions to be performed (O'Donnell & Vogenberg, 2012, p. 341). The main reasons policies exist are to:

. . .serve the needs of all members of an organization and to help the organization comply with various regulatory and accreditation demands. Policies provide a course of action

that guides and influences decisions. Policies are driven by laws and regulations, standards of practice or best practices, and institutional executive decisions governing a particular practice. (O'Donnell & Vogenberg, 2012, p. 341).

To change a policy, it must first be decided that the policy needs revision or warrants change (Bullock & Batten, 1985). Awareness the policy requires change usually occurs after a policy is put into action during a real scenario. Only after its utilization are the policy's strengths and weaknesses truly discovered. Once shortfalls are apparent, it is imperative to explore them further to assess for possible remedies and improvements that can be made to update the policy.

One of the methods for discovering issues with policies as recommended by the Centers for Medicaid and Medicare Services (CMS) is to perform a Root Cause Analysis (RCA) via the formation of a cause and effect diagram, also known as a fishbone (CMS, 2019). An RCA is a team process aimed at identifying root causes that resulted in undesired outcomes during an event (CMS, 2019). It is imperative to view the After-Action Report to adequately perform an RCA when attempting to evaluate the efficacy of an organization's EOP as it will identify breakdowns in the policy processes (CMS, 2019).

Medical Surge

Medical surge is defined as "a rapid increase in demand for patient care related to disasters or other significant events that impact the healthcare community" (Koenig & Schultz, 2009). Before 2009, official guidelines for surge capacity planning were limited (Kearns, Cairns, & Cairns, 2014). The Office of the Assistant Secretary of Preparedness

Response (ASPR) provides resources to ensure an organization's medical surge policy meets performance measures as outlined in their 2017-2022 Hospital Preparedness Program (ASPR, 2016). A medical surge occurs when the organization has achieved maximum census for licensed bed levels for either the inpatient or Emergency Department services and requires the healthcare system to declare one of the three Medical Surge Levels, activating the Incident Activation Policy (Barbera & Mcintyre, 2007).

Statement of the Problem

The role of the nurse practitioner as it relates specifically to the development and revision of the medical surge portion of the Northwestern Montana healthcare organization’s EOP is not clearly defined. Additionally, the organization’s acting medication surge policy contained flaws that warranted correction based on review of the After-Action Report.

Purpose

The purpose of this project is to define the role of the Doctorate prepared Nurse Practitioner (DNP) in the medical surge policy development and revision process. A secondary goal included updating and revising the current EOP at the chosen facility in order to improve response to future medical surge incidents.

Inquiry Question

What is the role of the DNP in policy development and revision as it relates to the medical surge portion of a healthcare organization's EOP?

Conceptual Framework

The framework for this project was planned change. Planned change is necessary for healthcare and nursing practice (Mitchell, 2013). Improving disaster response for an organization often requires changes in its policy and procedures (National Research Council, 2007. p. 55). Understanding the need for this change can encourage buy-in from co-workers, physicians, management, and key stakeholders. Kurt Lewin pioneered the change theory in 1951 with the model of unfreezing when change is needed, moving when change is initiated, and refreezing when a new equilibrium has been established (Burnes, 2004). Ronald Lippit (1958), who drew inspiration from Lewin's change theory identified a total of seven phases:

> Becoming more aware of the need for change. Develop a relationship between the system and change agent. Define a change problem. Set change goals and action plans for achievement. Implement the change. Staff accepts the change, stabilization. Redefine the relationship of the change agent with the system. (p. 341)

Bullock and Batten (1985) developed a four-phase organizational development model that was meant to improve upon previously developed change theories. Their model included:

Phase 1: Exploration, which verifies or brings about awareness of the need for change. Establishing contact with resources also occurs at this point.

Phase 2: Planning, requires diagnosing the problem at hand. Diagnosing the problem occurs by gathering information for the purpose of a need's assessment of the organization. Setting a goal for change occurs at this phase with key stakeholders involved.

Phase 3: Action, involves evaluating and implementing feedback for planned change.

Phase 4: Integration happens when the change is made permanent and termination of helping relationship occurs. Changes made are then disseminated to additional areas of the system. (pp. 400-407)

In 1995, Kotter developed a change process with eight steps. These steps included: creating a sense of urgency for change, forming a guiding change team, creating a vision and plan for change, communicating the change vision and plan with stakeholders, removing change barriers, providing short-term wins, building on the change, and making the change stick in the culture. (Appelbaum, Habashy, Malo, & Shafiq, 2012, pp. 775-776). Rogers (2003), went on to further expand Lewin's three phases in five: awareness, interest, evaluation, trial, and adoption. The conceptual framework presented focuses on stages of policy development and its implementation.

Significance to the DNP Role

Natural disasters and emergencies occur in real-time. The time for an organization to be prepared is prior to an incident occurring. A comprehensive medical surge plan can

benefit all healthcare workers caring for patients during the time of activation by allowing them to be prepared with understanding of their roles and the roles of others (Skryabina, Reedy, Amlôt, Jaye, & Riley, 2017). This project serves to clarify the role of the DNP during the development or revision of a medical surge policy. The Essentials of Doctoral Education for Advanced Practice Nursing outlines eight DNP essentials for curricular elements and competencies explicitly required for the DNP (American Association of Colleges of Nursing (AACN), 2006). Essential V: Health Care Policy for Advocacy in Health Care states that the DNP can design, influence, and implement health care policies that frame safety, quality, efficacy, and practice regulations (AACN, 2006). DNP program graduates possess the specific ability to analyze policy processes and engage in politically competent action (AACN, 2006, pp. 13-14). Essential V ensures the DNP graduate has the ability to:

> Critically analyze health policy from the perspective of consumers, nursing, other health professions, and other stakeholders.
>
> Demonstrate leadership in the development and implementation of policies on all levels ranging from institutional to international.
>
> Influence policy makers through active participation on committees, task forces, and boards on all levels to improve healthcare delivery.
>
> Educate others, including policymakers regarding nursing, policy, and patient outcomes related to care.
>
> Develop, evaluate, and provide leadership for a healthcare policy that involves financing, regulation, and delivery of the policy.

Assumption and Limitations

It is impossible to predict if any recommendations made by the DNP during policy development will be included in the policy revision. Furthermore, it is impossible to predict in totality how a policy revision will perform if and when accepted and utilized. Drills can be conducted to attempt to best prepare hospital staff to respond to a large-scale patient event. However, limitations to the policy performance will ultimately be revealed during an actual event that requires medical surge to be activated.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

This comprehensive literature review will serve to state and summarize the knowledge found in available books and journals related to the development and implementation of an organizational policy. Specifically, literature will focus on policy related to patient medical surge due to a disaster or mass casualty scenario. The literature will additionally aim to support the role of the DNP on policy development and revision process.

Search Methods/Results

The literature review utilized systematic methods to identify the most relevant literature. The selection of articles was not limited to specific types of studies but included grey literature, qualitative literature, and peer-reviewed literature. Databases utilized for literature review consisted of MEDLINE, PubMed, DOAJ, Web of Science, and CINAHL. Research librarians from Renee Library at Montana State University assisted with literature searches. Results were limited to search results published January 2001 to April 2019. The project focus was limited to those based in the United States involving patient surge related to mass casualty or disaster. Additional exclusion included studies that were not related to organizational mass casualty or disaster preparedness policies. The researcher reviewed articles. Duplicated articles were excluded. For the

purpose of clarification and understanding, articles related to emergency and disaster preparedness were included.

Topics and keywords of the search included “disaster preparedness,” “disaster planning,” “disaster planning and response,” “medical surge policy,” “hospital surge,” “hospital medical surge policy,” “policy implementation,” “nurse practitioner,” “surge capacity.”

Medical Surge

One of the first of many studies that began to examine medical surge capacity was that of Hick, Hanfling, Burstein, Deatley, Barbisch, Bogdan, and Cantrill (2004). They define surge capacity as the “ability to manage a sudden, unexpected increase in patient volume (i.e. numbers of patients) that would otherwise severely challenge or exceed the current capacity of the health care system.” (Hick et al., 2004, p. 254). Developing a policy for medical surge events requires significant planning on the part of the health care facility. Incident management is imperative for an effective response to sudden patient influx (Hick et al., 2004). Plans must consider numerous factors and develop multiple contingencies that can cater to the underlying precipitating event source ranging from terrorism, contagious outbreak, mass casualty event, to climate events (Hick et al., 2004).

According to Adams (2009), efforts to improve emergency planning have increased in the United States (U.S.) since 2001. Emergency preparedness in healthcare includes the ability to plan for large-scale events; medical surge capacity is one of the crucial areas of emergency preparedness. Medical surge capacity is defined by Adams (2009) as “The ability to obtain adequate staff, supplies and equipment, structures and

systems to provide sufficient care to meet immediate needs of an influx of patients following a large-scale incident or disaster" (p. 6). Adams (2009) goes on to further state that indicators of medical surge include a surge generating event in which a contained event with a distinct geographic location occurs. Medical surge capacity, in a hospital environment, is measured through the number of empty beds immediately available for a surge in an emergency compared to current inpatient occupancy numbers (Adams, 2009). Medical surge capacity can also vary based on the needs of the patients and the ability of the hospital to meet those needs. A hospital only has the ability to care for a finite number of patients that require cardiac telemetry monitoring, for example. Once the organization can no longer accept patients that require cardiac monitoring as all available equipment is being utilized, they are no longer at medical surge and may be advancing to full disaster status due to the inability to handle the particular nature of the event.

According to Kearns, Cairns, and Cairns (2014), the management of medical surge capacity was historically instinctual due to a lack of institutional planning before 2004. In 2007, researchers met to focus on Emergency Mass Critical Care (EMCC) availability and how to leverage staff, equipment, and treatment areas to care for these patients. These researchers continued to collaborate, and by 2009, stratifying surge capacity based on the precipitating events and conditions led to the new standard of care for response. The H1N1 influenza pandemic of 2009 highlighted the need for medical surge capacity policies and procedures for healthcare organizations due to the patient numbers that exceeded not only facility capacity, but also that of available facility ventilators.

Having the capacity to care for patients is mute if the organization does not have the capability in terms of staffing to treat the patients. Kearns, Cairns, and Cairns (2014) divide medical surge into conventional, contingency, and crisis levels. “Convention” is considered a “busy day,” where patients may be held in beds in the hall near the emergency department while waiting for inpatient unit rooms. The standard of care does not differ in these scenarios from any other operational day. “Contingency” surge capacity is that where rooms not traditionally used for patient care is transformed into units, and additional staff must be called in to care for the influx of patients. Supplies and equipment become limited during a contingency medical surge. “Crisis” medical surge overwhelms the capabilities of the healthcare organization. Structures, such as tents, or nontraditional buildings such as fitness centers, are utilized to treat patients, during what is now considered a full disaster. During times of patient surge, clinicians may be asked to care for and manage patients per a traditional standard of care in a non-traditional atmosphere. Policies and procedures must be in place within an organization prior to a medical surge event to ensure proper management of the patient surge event.

The Office of the Assistant Secretary for Preparedness and Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) aimed to clarify the role of urgent care centers during the medical surge (ASPR TRACIE, 2018). It was found that urgent care settings have staffing, supplies, equipment, space, and resources to treat low acuity patients to aid in relieving emergency departments during a medical surge. As of March 2018, there were approximately 8,100 urgent care centers across the U.S. capable of treating at least 50 patients with non-life-threatening injuries or

illnesses daily. Sixty percent of the top 20 diagnoses overlap between emergency department and urgent care patients, with at least 13% of all emergency department room visits capable of being cared for in an outpatient urgent care setting, further solidifying that providers working in an urgent care facility are capable of caring for even moderately acute patients during medical surge. Urgent care centers are typically staffed by a combination of at least one physician, mid-level providers such as NPs, nurses, medical assistants, radiology technicians, and front desk staff. In some cases, mid-level providers are the highest-level provider in an urgent care setting. Many urgent care centers have onsite XRAY, Clinical Laboratory Improvement Amendments (CLIA)-waved laboratory tests, the ability to perform suturing to minor lacerations, provide basic fracture care, as well as to assess potentially life-threatening symptoms such as respiratory distress and chest pain and their subsequent stabilization for immediate transfer to higher level of emergency care. "The delivery of unscheduled, episodic treatment for relatively low acuity injuries and illnesses by appropriately trained medical providers suggests that these facilities could be essential partners in providing certain types of care during disasters and emergencies" (ASPR TRACIE, 2018, p. 5).

Nurse Practitioner Scope

The Pennsylvania Coalition of Nurse Practitioners (PCNP) (2016), states:

> …Nurse practitioners (NPs) have graduate-level, advanced education, with master's degrees or doctorates, and are nationally certified in their specialty areas. Among their many services, NPs order, perform and interpret diagnostic tests, diagnose and treat acute and chronic conditions such as diabetes, high blood pressure, infections, and injuries, prescribe medications and other treatments, and manage a patient's care. (para. 7).

NPs provide ninety percent of the services offered by primary care physicians with comparable outcomes and lower malpractice rates (Kraus & DuBois, 2016). It is expected that NPs diagnose, treat, and prescribe medications (Britt, 2012). NPs can treat patients of all ages and are trained to manage acute episodic illness, manage long-term chronic disease, and work in specialties ranging from cardiology, endocrinology, women's health, neurology, and primary care (American Association of Nurse Practitioners, n.d.).

Nurse Practitioner Role in Policy Development

According to Cole (2005), NPs have an expansive scope with training that includes acute and emergent care. NPs can aid in the development of policies as they are a valuable source of information regarding nursing and medical care for a broad population of patients due to their knowledge with various types of medical equipment, medications, and skills such as splinting, suturing, and wound care (Cole, 2005). Furthermore, NPs educated on a doctoral level have core competencies in system-based practice intended to help them shape healthcare policy at local, state, and national levels and thusly are expected to have fundamental skills and knowledge related to engaging in policy advocacy (Xue & Intrator, 2016).

Edmunds (2011) states, "There are increasing opportunities for NPs to move into policy-making roles and assist in the creation of policies that will be fair to NPs and all healthcare providers" (p. 8). NPs on the frontline of patient care possess a unique insight into said patient care. They can share this insight with key stakeholders to initiate the change needed for policy development and reform (Gardenier, 2012). The American

Association of Nurse Practitioners states that NPs have the potential to transform access to healthcare by actively identifying and supporting policy initiatives as well as developing policy resources to cultivate sound healthcare policy (American Association of Nurse Practitioners, n.d.).

Chilton (2015) reported that NPs have clinical expertise in conjunction with an educational background empowering them to be essential advocates for health care policy issues. NPs as nurse leaders can be involved in health policy in a myriad of ways, including, but not limited to, conducting Quality Improvement (QI) projects and using those findings to revise and implement policies in their work environment.

According to Edwards, Coddington, Erler, and Kirkpatrick (2018), the DNP is a driving force for policy changes in healthcare. The DNP is not only informed but also prepared to support healthcare policy development and revision. The DNP core competencies revolving around leadership, organizational systems, informatics, and health policy aid this informed and prepared status. The DNP is qualified to lead projects that improve: quality of care, healthcare systems, and patient outcomes. Approximately eighty percent of DNP peer-reviewed publications are practice-focused, while the remaining twenty percent center around policy development, research, and education (Edwards et al., 2018). Edwards et al. (2018) go on to state that the DNP is well informed, prepared, and empowered to support health care policy development and revision.

Goudreau and Smolenski (2018) define health policy broadly as a course of action that influences health care decisions, and as such, said decisions affect the health of a

society. Health policy can be developed and implemented on an institutional level to address workplace issues as they arise. Graduate-level nursing programs include learning experiences that expose students to aspects of legal and regulatory matters, yet neither clinical practice or formal education adequately equip Advanced Practice Registered Nurses (APRNs), such as the DNP, for effective policy advocacy. The authors state expertise comes from "real-time exposure to the policy-making process" (p. 68). The APRN possesses expert knowledge of healthcare delivery systems and advanced clinical nursing skills that make them exceptionally well-positioned to affect policy. Specifically, the DNP has well developed critical thinking skills with knowledge and experience related to change theory and its application, as well as the principles to effectively lead system transformation. This is due to the fact the DNP has aspects of systems-level analysis and change management incorporated into their educational preparation.

Additionally, Goudreau and Smolenski (2018) reported that the DNP is also prepared educationally to assume leadership roles in the development and implementation of health policy. Furthermore, the DNP can serve as a source of ideas for quality improvement projects in the clinic setting as a starting point for a means to advance their research agenda. Expertise related to leadership in policy development can develop over time by those who seek opportunities to aid in this process (Goudreau & Smolenski, 2018).

Finally, Chism (2019) report that the DNP is considered a terminal degree as it is the highest level of preparation for nursing practice with a curriculum focused on evidence-based practice, organization leadership, information technology, and knowledge

regarding research making them strong healthcare policy advocates. Chism (2019) reported that DNP graduates are prepared to design, implement, and advocate for healthcare policy, making DNPs robust policy influencers. Their practice experiences play a pivotal role in this process. DNP programs prepare students to critically analyze health policies and their related issues from the perspective of a consumer, nurse, and stakeholder. DNPs are also prepared to lead development and implementation of health policy through active participation on committees, boards, or task forces at institutional, local, state, national, and international levels. They are additionally trained to advocate for the nursing profession within policy as well as educate others regarding the health policy and its outcomes.

Summary

In summary, medical surge policy planning is imperative for healthcare organizations to respond to a sudden influx in patients appropriately. NPs are educated to treat all ages of the patient population. They are also trained to treat a broad spectrum of patient presentations ranging from routine, chronic, to urgent care. The DNP is a valuable source of information related to policy development as they receive education specifically regarding analyzing policy processes, leading the development and implementation of policies, influencing policy making through active participation on committees and task forces, and educating other policymakers on nursing, policy, and patient outcomes. The DNP is expected to develop, evaluate, and provide leadership for healthcare policies.

CHAPTER THREE

METHODS

Introduction

The purpose of this project was to define the role of the DNP, by way of developing a planned change, regarding the development and revision of a healthcare organization's medical surge capacity policy and procedures. This chapter will discuss the methodology for the project, which will include the project's design, setting and population, and procedures for implementation.

IRB Approval

IRB approval was granted from the Montana State University IRB (see Appendix A).

Stakeholders

Stakeholders are individuals who have a personal interest in policy outcomes. This interest motivates a stakeholder to attempt to influence policy development (FEMA, n.d.). According to Haller, Fischer, and Frey (2018), expert power stakeholders are described as individuals with superior insight and depth of knowledge in a particular domain. In this case, the expert power stakeholders, i.e. Chief Clinical Officer (CCO), the Chief Nursing Officer (CNO), and the Physician Director of Quality Services, agreed that the policy needed revision given their interest and participation with the medical surge

workgroup during policy development. The final target for buy-in was the referent power stakeholders, the Medical Executive Committee, which includes the organization's Chief Executive Officer (CEO). Their onboarding was imperative for the acceptance of the workgroup's finalized policy, and subsequently, the overall organizational adherence of the policy (Haller, Fischer, & Frey, 2018).

Setting and Population

The setting for this project occurred in a hospital in Northwest Montana. Its focus was to encompass medical surge planning for the hospital, outpatient ambulatory clinics, and urgent care clinics affiliated with the organization. The project serves patients of all ages across the lifespan. These patients would be triggering a medical surge within the hospital due to natural or manmade disasters. For the purpose of the project, no patient subjects or patient information was required.

Design Overview

The project presented is a quality and performance improvement project focused on the role of the DNP in medical surge policy development and revision. This process was accomplished by implementing a planned change as outlined by Bullock and Batten (1985).

Procedures

Phase 1: Exploration

Phase one addresses the awareness for the need for change as well as the need to contract resources that can help aid in a potential change. Awareness occurs when the individual becomes aware of the need for innovation and initiates the sequence of events that will lead to further stages of change (Bullock & Batten, 1985). The reason for the change and who will be involved also occurs (Bullock & Batten, 1985). Organizational change beings at the individual level and these catalysts for change are known as "change agents" (Mannot, 2016).

Awareness and contracting Serving as a change agent, the DNP student, who also works in the capacity as a registered nurse (RN) for the organization in an outpatient urgent care clinic setting, recognized the need for medical surge policy revision after off duty staff members were not notified to respond to aid during the deck collapse. The DNP student initiated a face-to-face meeting with the Director of Nursing (DON) in January 2018. During this meeting, the need for change was made known to the DON, who concurred that medical surge policy change was warranted. The DON provided the DNP student with the contact information of the Emergency Preparedness Program Manager. The DNP student met in person with the Emergency Preparedness Program Manager in March 2018. During this face-to-face meeting, the Emergency Preparedness Program Manager also agreed that medical surge policy revision was needed. After their meeting, the Emergency Preparedness Program Manager met with the CEO, who agreed to allow a medical surge workgroup to be formed. A Process Improvement Team was

formed via email correspondence from the Emergency Preparedness Program Manager in March 2018. This team included the DNP student and 18 other stakeholders and change agents within the organization. These stakeholders were a combination of physicians, nurses, information technology personnel, quality and safety personnel, and organizational leadership.

Phase 2: Planning

Diagnosing the problem The DNP student developed a cause and effect diagram after reviewing the after-action reports from the deck collapse to identify a root cause for the need for medical surge policy revision. An After Action Report (AAR) is a document generated in accordance with recommendations set forth by the Federal Emergency Management Agency (FEMA) and Homeland Security Exercise and Evaluation Program (HSEEP) with the intention to capture observations made during an exercise with the purpose for recommendations and post-exercise improvement (Savoia, Agboola, & Biddinger, 2012). Suggestions made by this report can then influence the need for policy revision. The Centers for Medicaid and Medicare Services recommend performing an RCA to identify undesired outcomes that occurred during an event (CMS, 2019).

Some issues discovered during review of the after-action reports exceed the scope of a medical surge workgroup and would exceed the time constraints of the project. Medical surge is only a particular portion of an organization's EOP. Issues discovered during RCA, but not within the scope of the medical surge workgroup included assigning patients “Disaster names” in place of their legal name, no master list of patients vs. their “disaster name” was kept, family was unable to find where patients were located due to

lack of name association, no hospital personnel were assigned to the family room to check them in address their questions or concerns, and there were no directions in place for arriving family members to locate the family room. While these issues were included in the RCA diagram for the sake of thoroughness, only those that could be addressed by the DNP student in a medical surge workgroup will be discussed in this paper.

The overarching issue discovered that pushed the need for medical surge policy revision was the breakdown in communication. Only the hospital supervisor and administration on-call were made aware that a medical surge was occurring. The acting emergency notification system was known to be nonfunctional per the after-action report, and no staff was notified of the impending medical surge. As a result, no employees on or off shift at the time, outside of those working directly in the emergency room, were unaware the event was occurring. There was a clear need for the means to deliver mass communication to all staff that a medical surge was activated to allocate all available resources to care for the influx of patients.

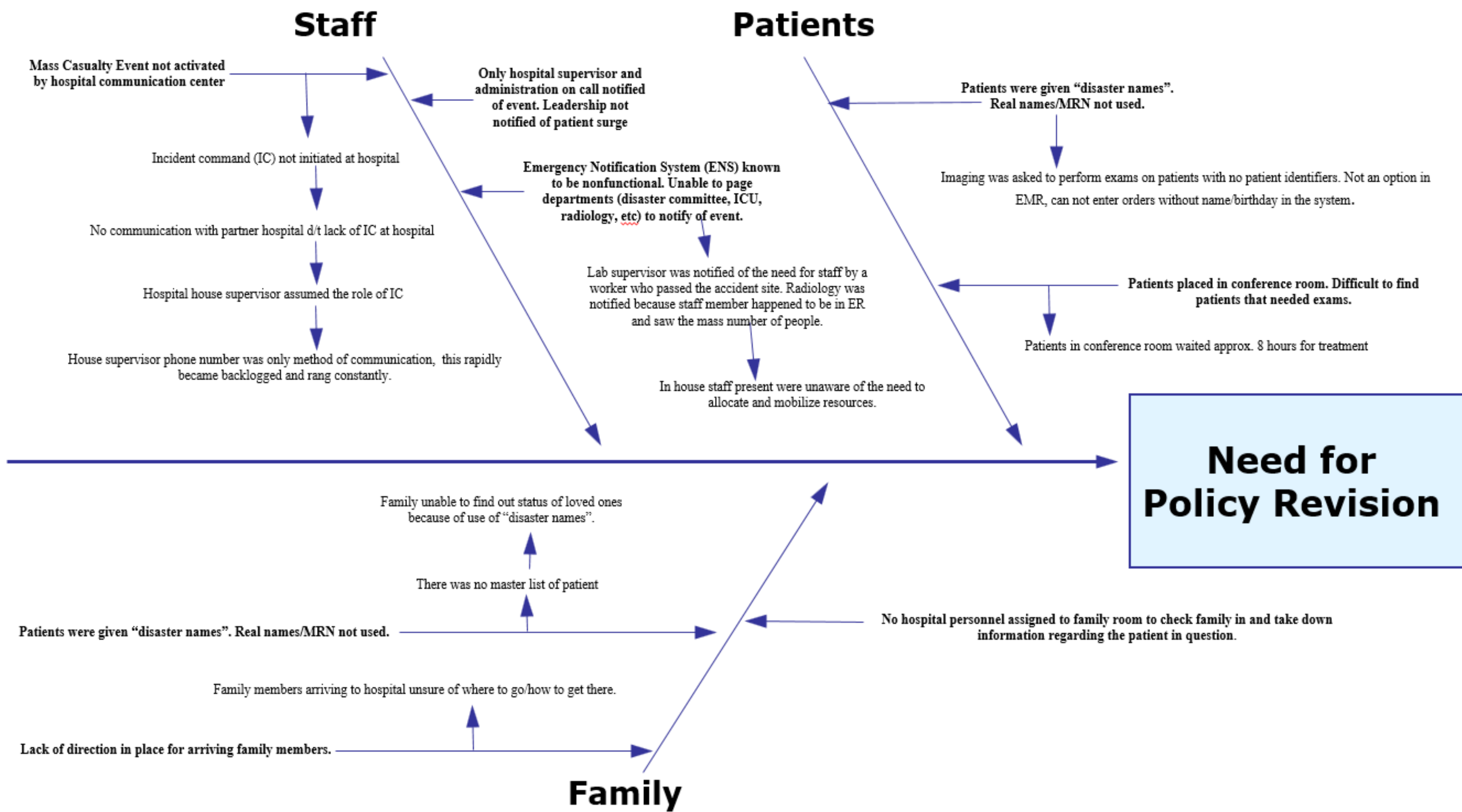

Figure 1. RCA After-Action Report Diagram

For clarification of abbreviations in Figure 1, Incident Commander is:

> …the individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site. (FEMA, 2008, pp.9, para. 7).

Designating roles of stakeholders At the initial meeting, additional roles for change agents in the workgroup were finalized. In addition to being part of the Process Improvement Team, the DNP student was designated a Project Leader in conjunction with the Emergency Preparedness Program Manager, as well as a Core Team member. Core Teams consist of members who are involved with direct care of patients (Agency for Healthcare Research and Quality, 2014). Core Teams should be small enough to ensure that they can direct unfiltered communication between members (AHRQ, 2014). The Core Team, comprised of the DNP student, Emergency Preparedness Program Manager, a data analyst for Quality and Safety Services, and a Performance Improvement Coordinator for Quality Management, was responsible for ensuring that the project remained on task.

For this project, the DNP student served as the sole representative and resource regarding aspects of medical surge policy development related to all outpatient ambulatory family practice and urgent care clinic settings. As the only workgroup member enrolled in a DNP program, and with no practicing NPs serving on the workgroup, the DNP student also served as the primary resource regarding the training, capability, and scope of the NP in aiding in a medical surge response. All individuals on the Process Improvement Team agreed to be members based on their mutual recognition for the need of medical surge policy revisions.

Phase 3: Action

Planning the draft for change The setting for the meetings occurred in the emergency room conference room. Meetings were 60 minutes in length and occurred twice monthly from March 2018 to July 2018. Based on findings from the RCA, the DNP Student notified the workgroup that the ambulatory clinics had not been included in the medical surge policy. Lack of inclusion of the clinics was a significant oversight, and underuse of available staff and resources, particularly because clinics are considered one of the primary sites for point-of-care or hands-on medical evaluation and treatment during a patient medical surge (ASPR, 2013). As the sole representative for the outpatient setting, the DNP student was responsible for educating and counseling the workgroup regarding the capabilities and capacity of the local ambulatory clinics to care for patients in the event a medical surge occurs. The need to include the ambulatory clinics in the medical surge policy as a resource for services was strengthened after notifying the workgroup that two of the outpatient clinics can manage approximately 15 to 30, ESI level 3 to 5 patients, at any given time. These clinics can suture lacerations, perform XRAY, splint and cast fractures, perform EKG's, as well as place IV catheters, IV infusion, and perform limited lab testing in-house, including Point of Care INR and blood glucose, urinalysis, influenza, RSV, rapid streptococcus antigen A, cardiac enzymes, HGC, mono spot, CMP, and CBC without differentials. In totality, the ambulatory clinics within the organization can each effectively manage 60-125 patients each, within a standard 10-hour operating shift. The clinics are staffed with a combination of Physicians, Nurse Practitioners (NPs), Physician Assistants (PAs), Registered Nurses (RNs), Medical Assistants (MAs), Radiology Technicians (RTs), and Laboratory

Technicians. Collectively, all workgroup members present at the March 2018 meeting, agreed that wording to include the use of the ambulatory clinics in the revised medical surge policy was needed based on this information.

Guided by the RCA, the next recommendation for the medical surge policy made by the DNP student was the need for an active staff call-back roster. During the deck collapse, no off-duty staff was notified of the need for assistance. During this meeting, due to her status within the organization authorizing her the ability to collect employee information, the DON agreed to take on the task of developing a means to collect employee data for a call-back roster. Collectively, all in attendance at the meeting in April 2018 agreed that the need to contact and notify staff that a medical surge was occurring and that their services were needed, was warranted.

Third, the DNP student counseled the workgroup of the need for education for all staff regarding medical surge activation. Performing two disaster drills annually, with one specifically related to sudden patient influx, or medical surge, is a Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirement (The Institute of Medicine of National Academies, 2007). Drills are proven effective for training staff, but also for identifying gaps in the current policy (Skryabina, Reedy, Amlôt , Jaye, & Riley, 2017). Previous disaster drills only included the hospital and ER. Drills failed to provide any education to ambulatory clinic staff. Developing education specifically for a policy required the revised medial surge policy be approved and, ultimately, organizationally implemented. The task of developing education and drills for medical surge fell outside the timeline of the workgroup. Collectively, the workgroup agreed that this suggestion

was also justified. The task of developing educational material was delegated to the clinical educator on the medical surge workgroup. The development of educational material was to be resumed if and when the medical surge policy was amended in accordance with the medical surge workgroup's revisions.

Phase 4: Integration

Accepting change The decision to ultimately adopt policy change recommendations occurred in July 2018 at the final medical surge workgroup meeting. During this meeting, all workgroup members agreed to keep the recommendations made by the DNP student in the medical surge policy revision draft, which was to be finalized by the Emergency Preparedness Program Manager. These recommendations were the need for a means to notify all staff members that a medical surge was occurring to allocate available resources, the need to utilize ambulatory clinics during medical surge activation, and the need for organization-wide education regarding the medical surge policy. This policy was drafted to be in accordance with American College of Emergency Physicians recommendations for response to a mass casualty incident (American College of Emergency Physicians, 2017). The Emergency Preparedness Program Manager would present the finalized policy draft to referent organizational stakeholders for possible implementation per her corporate designation. The workgroup was dissolved after this meeting, and consequently, termination of helping relationships occurred. Subsequently, the medical surge workgroup's policy draft was accepted and implemented as the acting policy for the organization by referent stakeholders in January 2019.

Summary

Determining the need for change, organizing a workgroup, developing policy revisions, and finalizing a policy to submit to referent stakeholders was a tedious process that involved many dedicated individuals who all had an inherent belief that the organization's medical surge policy could be improved upon to benefit the greater good. All recommendations made by the DNP student regarding revisions for the medical surge policy were accepted and included in the final draft presented to referent stakeholders. These recommendations included the need for a means to notify all staff members that a medical surge was occurring to allocate available resources, the need to utilize ambulatory clinics during medical surge activation, and the need for organization-wide education regarding the medical surge policy. Figure 2 outlines Bullock and Batten's (1985) stages of planned change in relation to the process of the medical surge policy development and revision process.

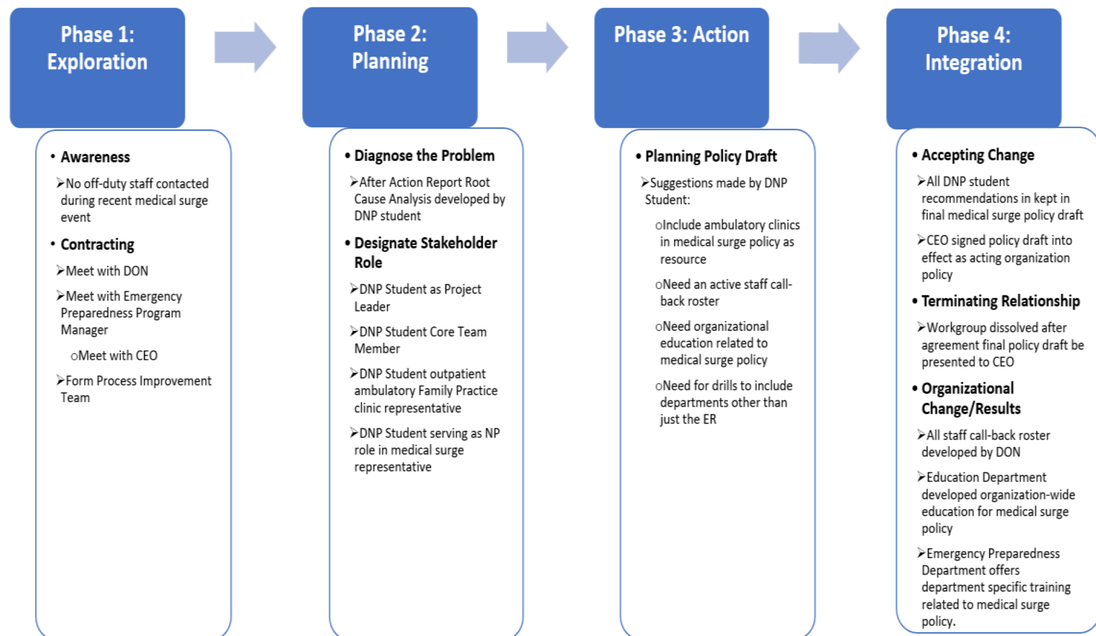

Figure 2. Planned Change for Medical Surge Policy Development and Revision.

CHAPTER FOUR

RESULTS

The purpose of this study was to explore the role of the DNP in the development and revision of a healthcare organization's medical surge policy. During the workgroup meetings, recommendations made by the DNP student were applied to the final medical surge policy draft. These recommendations were meant to address and correct weaknesses and oversights recognized during root cause analysis. Recommendations included the need for a means to notify all staff members that a medical surge was occurring to allocate available resources, the need to utilize ambulatory clinics during medical surge activation as a resource, and the need for organization-wide education regarding the medical surge policy should the policy be approved. The CEO ultimately approved the policy draft as an official organizational policy in January 2019. As a direct result of the DNP student involvement in the process of the medical surge policy revision and development, the following changes were implemented.

Policy Outcomes

The need for a means to contact all staff was addressed by the organization's Director of Nursing (DON). The collection of employee information was outside the authority of the DNP student's position within the medical surge workgroup as well as outside the DNP student's organizational employment standing as an RN. Additionally, collection of employee information was outside the IRB approval of the project, hence the need to request this task be completed the DON. The DON sent out a survey via

organization email to all active staff requesting their cell phone numbers to generate a staff call-back roster in July 2018. Subsequently, this call-back roster was tested Fall 2019 due to the need to alert all staff of a power outage affecting a neighboring county's hospital. Staff was notified via text message of the possible inbound medical surge should the power outage continue to impact that hospital. This recommendation for a call-back roster was mandated as an appendix to the organizations Emergency Operations Plan. (See Appendix C).

Second, the need to include outpatient clinics and urgent care facilities associated with the organization was added as an appendix to the organizations EOP under the Emergency Patient Surge policy as it relates specifically to medical surge. Located under Procedures: item 2: Mitigation Strategies: section C, utilization of clinical staff from non-inpatient departments, including clinics, will occur to increase staffing ratios should a patient surge occur. (See Appendix D).

Third, the organization's education department addressed the DNP student's recommendation for organization-wide knowledge deficit related to the medical surge portion of the EOP. In spring 2019, mandatory online education was assigned to all staff regarding emergency preparedness and risk planning. This requirement is located in the EOP under Procedures: section 2: Training and Exercises. (See Appendix B). Hazard Vulnerability and Analysis was included in this, which included the topic of a medical surge as a rationale for activation of the organization's EOP. In late summer 2019, the organization's Quality and Safety department started performing in-person audits of

information related to the online education to assess for any possible knowledge deficits that would prompt the need for additional education.

Finally, the need for departmental training related to their role during a medical surge activation made by the DNP student was addressed by the organization's Emergency Preparedness Department. Completion of this recommendation was delegated to their department as it was to be completed after the workgroup dissolved and was contingent upon the policy revisions being accepted as the new current organization policy by referent stakeholders. Employees can request via an online form under the organization's Emergency Preparedness webpage for training specific to their department. Between May and November 2019, six drills had been run at the emergency room within the organization.

The Role of the DNP

The role of the DNP in policy development covers a wide range of duties. This first role is that of initiating change by way of becoming a change agent on an individual level (Mannot, 2016). Due to their education and experience, DNPs are valuable sources of information and share their insights with stakeholders to help initiate policy development and revision (Gardenier, 2012). Part of the required DNP education prepares them to assume leadership roles in development and revision of health policy (Smolenski, 2018). The DNP is an advocate for policy change and is essential for QI projects to revise policies in their work environment (Chilton, 2015). As a driving force for policy change, the DNP possesses expert knowledge of the healthcare delivery system (Edwards, Coddington, Erler, & Kirkpatrick, 2018). This positions the DNP well to affect

policy as they possess well-developed knowledge and experience related to change theories and their application (Edwards, Coddington, Erler, & Kirkpatrick, 2018).

Translating these roles to the medical surge policy development and revision process, the DNP student acted as a change agent and approached senior leadership with the concerns for the need for change when awareness occurred that off-duty staff was not contacted to aid in a medical surge activation. Working for the organization as an RN positioned the DNP student in a manner that allowed her to contact potential key stakeholders to gain approval and backing for the need for policy change. Acting as a project leader and core team member on the QI project for the medical surge policy revision workgroup, the DNP student was able to share insight related to ambulatory clinics and educational needs within the organization related to the medical surge policy. Utilizing and appropriately applying change theories allowed the medical surge policy development and revision workgroup to progress towards accomplishing the end goal of successfully finalizing a revised medical surge policy for organizational submission.

Summary

The role of the DNP in medical surge policy development and revision is to act not only as a change agent, but also a leader, and educator, and stakeholder during this process. After the resolution of the medical sure revision workgroup, the policy was brought to referent stakeholders for evaluation of the medical surge policy final draft. This draft of the policy was ultimately approved and has since been organizationally implemented and includes the recommendations set forth by the DNP student during medical surge policy development and revision process.

CHAPTER FIVE

DISCUSSION

Summary

The purpose of this scholarly project intended to explore the role of the DNP in a healthcare organization's medical surge policy revision. Large scale events leading to medical surge will continue to pose challenges, such as patient capacity and organizational preparedness to respond, to healthcare facilities in the future. It is imperative to address issues related to adequate staffing during medical surge policy development (Adams, 2009).

Additionally, the utilization of urgent care clinics is essential to help alleviate the load on the ER. Urgent care clinics are capable of accommodating an average of 50 patients with non-life-threatening illness or injury and clinics are considered one of the primary sites for hands-on medical evaluation and treatment during a patient medical surge (ASPR TRACIE, 2018, p. 5; ASPR, 2013). Nurse Practitioners, especially those who are trained on a doctoral level, possess the competencies develop and shape the healthcare policies that guide the treatment of patients on organization, local, state, and national levels.

Interpretation

Members of the medical surge workgroup ultimately considered recommendations made by the DNP student regarding policy revision to be warranted

and relevant as they were kept in the final draft of the policy that was brought before referent stakeholders for review. I would consider this project to be successful as not only were recommendations included in the final policy draft but also remained in what is now the organizations acting policy after referent stakeholder approval.

Project Barriers

During this project, the most significant barrier that occurred was a massive redesign of the organization's staff across all levels, including leadership and administration. This redesign resulted in many of those who were both directly and indirectly involved in the workgroup and the completion of the medical surge revision, subsequently dissolving their relationship with the organization. After this organizational redesign, all workgroups and councils were terminated for the foreseeable future. The redesign effectively dissolved all connections the DNP student had made within the organization to follow up on any long-term policy progress.

Limitations

Limitations to the suggestions made and implemented as a result of recommendations can only adequately be assessed when they are utilized during an activation of the medical surge policy. Time constraints for this project, as well as the barriers described related to the continuation of the workgroup, also limit the ability to follow up on success of the recommendations.

Recommendations

Employees who were new to the organization after the initial call-back roster survey had been sent out are not on the current call-back roster as they did not receive text notification during the Fall 2019 medical surge alert. Future recommendations would include ensuring a call-back roster survey was emailed to staff annually to capture new employees. Additionally, the need for organization-wide drills related to medial surge activation should be carried out by the organization to ensure all employees receive active training.

Further work related to the number of DNPs that are actively involved in health care policy development and revision on organization, local, state, and national levels is also warranted. Additionally, it would be wise to explore barriers, hesitancies, and limitations to DNP participation in medical surge policy development and revision.

Conclusion

The role of the DNP in medical surge policy development and revision is to be a change agent, leader, and educator during the process. The DNP possesses the knowledge, experience, and education to actively engage in the development and revision of all forms of healthcare policy, not just that related to medical surge policy. It is imperative that the DNP decide to be involved in an area of interest and then decide on the amount of time and the level of energy the DNP can devote to involvement. A great starting point for the DNP who wants to get involved in policy development and revision is to serve as a

source of ideas for quality improvement in the clinical setting. Hopefully this project will encourage future DNPs to be the advocate for change.

REFERENCES CITED

Adams, L. (2009). Exploring the Concept of Surge Capacity. *Online Journal of Issues in Nursing, 14*(2), 1F.

Agency for Healthcare Research and Quality (AHRQ). (2014, March 01). TeamSTEPPS Fundamentals Course: Module 2. Team Structure. Retrieved from https://www.ahrq.gov/teamstepps/instructor/fundamentals/module2/igteamstruct.html

American Association of Colleges of Nurses (AACN). (2017). Common Advanced Practice Registered Nurse Doctoral-Level Competencies October 2017. Retrieved from https://www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Common-APRN-Doctoral-Competencies.pdf

American Association of Colleges of Nursing (AACN). (2006). The Essentials of Doctoral Education for Advanced Nursing Practice. Retrieved from https://www.aacnnursing.org/Portals/42/Publications/DNPEssentials.pdf.

American Association of Nurse Practitioners (AANP). (n.d.). State Advocacy. Retrieved from https://www.aanp.org/advocacy/state

American Association of Nurse Practitioners (AANP). (n.d.). What's a Nurse Practitioner (NP)? Retrieved from https://www.aanp.org/about/all-about-nps/whats-a-nurse-practitioner

American College of Emergency Physicians. (2017, October). Health Care System Surge Capacity Recognition, Preparedness, and Response. Retrieved from https://www.acep.org/globalassets/new-pdfs/policy-statements/health-care-system-surge-capacity-rec-preparedness-response.pdf.

Appelbaum, S. H., Habashy, S., Malo, J.-L., & Shafiq, H. (2012). Back to the future: revisiting Kotter's 1996 change model. *Journal of Management Development, 31*(8), 764-782. doi:10.1108/02621711211253231

Barbera, J. A., & Macintyre, A. G. (2007, September). *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies*[PDF]. The CNA Corporation Institute for Public Research.

Britt, D. (2012). Family Nurse Practitioner's Role in Primary Care. *South Source,*(23). Retrieved from http://source.southuniversity.edu/family-nurse-practitioners-role-in-primary-care-110820.aspx

Brotman, R., Lippitt, R., Watson, J., & Westley, B. (1958). The Dynamics of Planned Change. *American Sociological Review, 23*(3), 341-342.

Bullock, R. J., & Batten, D. (1985). It's Just a Phase We're Going Through: A Review and Synthesis of OD Phase Analysis. *Group & Organization Studies*, *10*(4), 383–412. https://doi.org/10.1177/105960118501000403

Burnes, B. (2004). Kurt Lewin and the Planned Approach to Change: A Re-appraisal. *Journal of Management Studies, 41*(6), 977-1002. doi:10.1111/j.1467-6486.2004.00463.x

Chilton, L. (2015). Nurse Practitioners Have an Essential Role in Health Policy. *The Journal for Nurse Practitioners, 11*(2), A19. doi:10.1016/j.nurpra.2014.10.009

Chism, L. A. (2019). *The Doctor of nursing practice: a guidebook for role development and professional issues* (4th ed.). Burlington, MA: Jones & Bartlett Learning.

Centers for Medicare and Medicaid Services (CMS). (2019). Guidance for Performing Root Cause Analysis (RCA) with PIPs. Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf

Centers for Medicare and Medicaid Services CMS. (2019). How to Use the Fishbone Tool for Root Cause Analysis. Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/FishboneRevised.pdf

Cole, F. L. (2005). The role of the nurse practitioner in disaster planning and response. *Nursing Clinics of North America, 40*(3), 511-521, ix. doi:10.1016/j.cnur.2005.04.007

Department of Homeland Security [DHS] Risk Lexicon. (2010, September). Retrieved from https://www.dhs.gov/xlibrary/assets/dhs-risk-lexicon-2010.pdf

ECRI Institute. (2018, November 27). Emergency Preparedness: Planning and Mitigation. Retrieved from https://www.ecri.org/components/HRC/Pages/SafSec6.aspx?tab=2

Edmunds, M. W. (2011). Policy-Making Opportunities Increase for Nurse Practitioner Leaders. *The Journal for Nurse Practitioners, 7*(1), 8. doi:10.1016/j.nurpra.2010.11.017

Edwards, N., Coddington, J., Erler, C., & Kirkpatrick, J. (2018). The Impact of the Role of Doctor of Nursing Practice Nurses on Healthcare and Leadership. *Medical Research Archives, 6*(4). doi:10.18103/mra.v6i4.1734

Federal Emergency Management Agency (FEMA). (2018). Disaster Declarations by Year. Retrieved from

https://www.fema.gov/disasters/year/2017?field_dv2_declaration_type_value=All &page=1

Federal Emergency Management Agency (FEMA). (n.d.). Chapter 2/Emergency Management Stakeholders. In (pp. 33-59). Retrieved from https://training.fema.gov/hiedu/docs/fem/chapter 2 - emergency stakeholders.doc.

Gardenier, D. (2012). Can Clinical Nurse Practitioners Be Involved in Policy Making? The Journal for Nurse Practitioners, 8(3), 198-199.

Gilboy, N., Tanabe, P., Travers, D., & Rosenau, A. (2012). Emergency Severity Index (ESI) A Triage Tool for Emergency Department Care. Retrieved from https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/esi/esihandbk.pdf

Goudreau, K. A., & Smolenski, M. C. (2018). *Health policy and advanced practice nursing: impact and implications* (2nd ed.). New York, NY: Springer Publishing Company, LLC.

Haller, D. K., Fischer, P., & Frey, D. (2018). The Power of Good: A Leader's Personal Power as a Mediator of the Ethical Leadership-Follower Outcomes Link. *Frontiers in psychology*, *9*, 1094. doi:10.3389/fpsyg.2018.01094

Hick, J. L., Hanfling, D., Burstein, J. L., Deatley, C., Barbisch, D., Bogdan, G. M., & Cantrill, S. (2004). Health care facility and community strategies for patient care surge capacity. *Annals of Emergency Medicine, 44*(3), 253-261. doi:10.1016/j.annemergmed.2004.04.011

Hijazi, J. (2018, January 18). The 16 "Billion-Dollar Disasters" That Happened in 2017. Retrieved from https://www.scientificamerican.com/article/the-16-ldquo-billion-dollar-disasters-rdquo-that-happened-in-2017/

Jarvis P. R. (2016). Improving emergency department patient flow. *Clinical and experimental emergency medicine*, *3*(2), 63–68. doi:10.15441/ceem.16.127

Kearns, R. D., Cairns, B. A., & Cairns, C. B. (2014). Surge Capacity and Capability. A Review of the History and Where the Science is Today Regarding Surge Capacity during a Mass Casualty Disaster. *Frontiers in public health*, *2*, 29. doi:10.3389/fpubh.2014.00029

Koenig, K. L., & Schultz, C. H. (2009). *Koenig and Schultz's Disaster Medicine : Comprehensive Principles and Practices*. New York, UNITED STATES: Cambridge University Press.

Kraus, E., & DuBois, J. M. (2016). Knowing Your Limits: A Qualitative Study of Physician and Nurse Practitioner Perspectives on NP Independence in Primary

Care. *Journal of general internal medicine*, *32*(3), 284–290. doi:10.1007/s11606-016-3896-7

Mitchell, G. (2013). Selecting the best theory to implement planned change. *Nursing Management*, *20*(1), 32–37. doi: 10.7748/nm2013.04.20.1.32.e1013

Monnot, M. J. (2016). Organizational Change Agent Influence: A Conditional Process Model of Key Individual Psychological Resources. *Journal of Change Management*, *17*(3), 268–295. doi: 10.1080/14697017.2016.1237534

National Research Council. (2007). Successful Response Starts with a Map. *The National Academies of Science Engineering Medicine*, 47–86. doi: 10.17226/11793

O'Donnell, J., & Vogenberg, F. R. (2012). Policies and Procedures: Enhancing Pharmacy Practice and Limiting Risk. In *P T* (Vol. 37, pp. 341-344).

Office of Assistant Secretary for Preparedness and Response (ASPR). (2016, November). 2017-2022 Health Care Preparedness and Response Capabilities. Retrieved from https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/2017-2022-healthcare-pr-capablities.pdf

Office of Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange (ASPR TRACIE). (2018, March). Medical Surge and the Role of Urgent Care Centers. Retrieved from https://asprtracie.s3.amazonaws.com/documents/aspr-tracie-medical-surge-and-the-role-of-urgent-care-centers.pdf

Office of Assistant Secretary for Preparedness and Response Technical Resources, Assistance Center, and Information Exchange (ASPR TRACIE). (2018, October). Medical Surge and the Role of Health Clinics. Retrieved from https://files.asprtracie.hhs.gov/documents/aspr-tracie-health-clinics-survey-report-508.pdf.

Office of the Assistant Secretary for Preparedness and Response (ASPR). (2013, May 14). Management of Individual Healthcare Assets (Tier 1). Retrieved from https://www.phe.gov/Preparedness/planning/mscc/handbook/chapter2/Pages/default.aspx.

Office of the Assistant Secretary for Preparedness and Response (ASPR). (2017). 2017-2022 Hospital Preparedness Program Performance Measures Implementation Guidance. Retrieved from https://www.phe.gov/Preparedness/planning/hpp/reports/Documents/hpp-pmi-guidance-2017.pdf.

Pennsylvania Coalition of Nurse Practitioners (PCNP). (2016, March 1). Five New Studies: Nurse Practitioners Expand Access to Health Care, Lower Costs,

Improve Outcomes. Retrieved from https://www.pacnp.org/news/277542/Five-New-Studies-Nurse-Practitioners-Expand-Access-to-Health-Care-Lower-Costs-Improve-Outcomes.htm

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed. ed.). New York: New York: Free Press.

Savoia, E., Agboola, F., & Biddinger, P. D. (2012). Use of After Action Reports (AARs) to Promote Organizational and Systems Learning in Emergency Preparedness. *International Journal of Environmental Research and Public Health, 9*(8), 2949-2963. doi:10.3390/ijerph9082949

Skryabina, E., Reedy, G., Amlôt, R., Jaye, P., & Riley, P. (2017). What is the value of health emergency preparedness exercises? A scoping review study. *International Journal of Disaster Risk Reduction,21*, 274-283. doi:10.1016/j.ijdrr.2016.12.010

The Institute of Medicine of National Academies. (2007). *Emergency care for children: growing pains*. Washington, D.C.: National Academies Press. Retrieved from https://www.nap.edu/read/11655/chapter/1#ii

The Public Health and Welfare Act, 42 U.S.C. §§ 5122 (2006).

Xue, Y., & Intrator, O. (2016). Cultivating the Role of Nurse Practitioners in Providing Primary Care to Vulnerable Populations in an Era of Health-Care Reform. *Policy, Politics, & Nursing Practice, 17*(1), 24-31. doi:10.1177/1527154416645539

APPENDICES

APPENDIX A

INSTITUTIONAL REVIEW BOARD

INSTITUTIONAL REVIEW BOARD
For the Protection of Human Subjects
FWA 00000165

2155 Analysis Drive
c/o Microbiology & Immunology
Montana State University
Bozeman, MT 59718
Telephone: 406-994-4706
FAX: 406-994-4303
E-mail: cherylj@montana.edu

Chair: Mark Quinn
406-994-4707
mquinn@montana.edu
Administrator:
Cheryl Johnson
406-994-4706
cherylj@montana.edu

MEMORANDUM

TO: Chelsea Dunshee and Casey Cole

FROM: Mark Quinn *Mark Quinn CJ*
Chair, Institutional Review Board for the Protection of Human Subjects

DATE: October 11, 2019

RE: *"The Role of the Doctoral Prepared NP in Medical Surge Policy Development" [CD101119-EX]*

The above research, described in your submission of October 11, 2019, is exempt from the requirement of review by the Institutional Review Board in accordance with the Code of Federal regulations, Part 46, section 101. The specific paragraph which applies to your research is:

____ (b) (1) Research conducted in established or commonly accepted educational settings, involving normal educational practices such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

____ (b) (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation; and (iii) the information obtained is recorded by the investigator in such a manner that the identity of the human subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by section 16.111(a)(7).

____ (b) (3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if: (i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

_X_ (b) (4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available, or if the information is recorded by the investigator in such a manner that the subjects cannot be identified, directly or through identifiers linked to the subjects.

____ (b) (5) Research and demonstration projects, which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.

____ (b) (6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed, or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the FDA, or approved by the EPA, or the Food Safety and Inspection Service of the USDA.

Although review by the Institutional Review Board is not required for the above research, the Committee will be glad to review it. If you wish a review and committee approval, please submit 3 copies of the usual application form and it will be processed by expedited review.

APPENDIX B

EMERGENCY OPERATIONS PLAN

Current Status: *Active* **PolicyStat ID:** *5875576*

Origination:	*01/2019*
Effective:	*01/2019*
Last Approved:	*01/2019*
Last Revised:	*01/2019*
Next Review:	*01/2021*
Owner:	*Emergency Preparedness Manager*
Area:	*Environment of Care Emergency Preparedness*
References:	
Applicability:	

Emergency Operations Plan, A792

Purpose

- To reduce the impact on life, property and environment during a hazardous incident.
- To provide guidance and a foundation for developing following healthcare preparedness capabilities:
  - Healthcare System Preparedness
  - Emergency Operations Coordination
  - Medical Surge
  - Information Sharing
  - Volunteer Management
  - Healthcare System Recovery

COPY

Policy

( ) uses an all-hazards approach to coordinating incident mitigation, preparedness, response and recovery for all of its facilities (see *Attachment 1 – Facility List*). Emergency preparedness planning will be in coordination with the County Office of Emergency Services, the City-County Health Department, and the Western Region Healthcare Coalition.

utilizes the Incident Command System (**ICS**) at and ( ) to manage incidents involving one or more facilities. ICS facilitates a flexible "all hazards" approach to emergency management that can be adapted to respond to a variety of incidents.

Procedures

1. **Hazard Vulnerability Analysis**
   A. The hazard vulnerability analysis (**HVA**) is used to identify the probability of all types of hazards and assess the healthcare system's vulnerability to each hazard.
   B. The HVA will be updated annually by the Unified Emergency Preparedness Committee (**UEPC**).
2. **Training and Exercise**
   A. All training on the Incident Command System is based on the National Incident Management Systems (**NIMS**) model and different members of the team are expected to train at various predetermined levels determined by the UEPC.

1. **Health Stream EOP Training** – All Staff
2. **Health Stream & Classroom ICS Training** – House Supervisor/Coordinators, Administrators On-call, Emergency Preparedness Committee Members, Department Directors, & Clinic Managers
3. **FEMA Independent Study (IS) courses 100HC, 200HC, 700, 800 & 808** – Emergency Preparedness Committee Members

B. facilities will utilize the Homeland Security Exercise and Evaluation Program (**HSEEP**) when planning and executing training of the EOP and ICS.

C. The Unified Emergency Preparedness Committee will plan and coordinate multi-facility and multi-agency drills and exercises; whereas, the hospital specific Emergency Preparedness Committees will plan and coordinate internal drills and exercises.

D. Each facility will participate in both a tabletop exercise and a full-scale exercise on a yearly basis.

3. **Incident Command Activation:** the Incident Activation policy outlines how to activate Incident Command.

4. **Notification**

A. Staff Roster

1. Each facility or department will manage a staff roster, which list employee names and their contact information.
2. The roster is a single source document, which should be printed and place it in a secure location that can be accessed during an incident.
3. The Staff Call-Back Roster should be updated quarterly due to changes in staffing and contact information.

B. Emergency Notification System

1. The Emergency Notification System (**ENS**) will be used to send text, email or phone messages to alert staff to potential and actual hazards.
2. ENS can also be used to verify the safety of staff and/or recall staff during an emergency.
3. The Emergency Preparedness Program Manager can assist in identifying who to notify.
4. Facilities not fully utilizing MediTech to store staff contact information will not have access to ENS; therefore, those facilities will rely on staff rosters and/or phone trees.

5. **Roles and Responsibilities**

A. **Hospital Incident Management Team**

a. Both and will develop and train an Incident Management Team (**IMT**). IMT members will be familiar with the following:

i. This policy and its attachments

ii. Other Emergency Preparedness Policies

iii. ICS

b. If both IMTs are activated, the IMT will manage the overall incident.

B. **Emergency Preparedness Program Manager:**

COPY

a. Will act as liaison between all facilities;

b. Coordinate with community partners when necessary; and

c. Fill other ICS roles as assigned by the Incident Commander (e.g. Planning Section Chief).

6. **Coordination and Communication**

A. Determine the appropriate people to notify and coordinate with to improve response during all incidents.

B. The Emergency Preparedness Program Manager will maintain relationships with County emergency response agencies (e.g. City-County Health Department and County Officer of Emergency Services).

C. Public Information & Warning

1. has a Public Information Officer (**PIO**) on-call 24/7.

2. The PIO is responsible for developing public messaging during an incident.

3. The Marketing & Communication Department will maintain a Crisis Communication Policy, which will be updated it annually.

D. Redundant Communication

1. All facilities will maintain two or more forms of communication to mitigate against communication failures during incidents.

2. Health Information Technology/System (**HIT/HIS**) will help maintain a Telecommunication plan or policy, which will be updated annually.

7. **Volunteer Management:** The Emergency Preparedness Program will maintain a Emergency Volunteer Management policy, which will be updated annually.

8. **Vulnerable Populations**

A. All hazard and emergency capability specific policies will annotate special considerations for the following populations:

1. Individuals with disabilities

2. Individuals will access and functional needs

3. Children and infants

4. Home Health and Hospice

9. **Recovery**

A. Demobilization procedures will be listed in incident response policies.

B. Business Continuity Plans will be developed and maintained for all in-patient facilities.

C. Reconstitution and reoccupancy procedures will be included in facility evacuation policies.

10. **Policy Development and Maintenance**

A. The program elements will be evaluated on an ongoing basis to ensure they meet Patient Care, Safety and Risk Management needs.

B. Process improvement measures will be identified through the training and exercise program.

C. Emergency preparedness oversight committees will track and manage the improvement plan.

COPY

Attachments

1. Facility List
2. Incident Management Team Organizational Chart

Definitions

1. **Incident:** occurrence, caused by either human action or natural phenomena that may cause harm and that may require action. Harm can include human casualties, destruction of property, adverse economic impact, and/or damage to natural resources. Has the potential to overwhelm or overburden the normal routine services.
2. **Incident Commander (IC):** the individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources. The IC has overall authority and responsibility for conducting incident operations and is responsible for the management of all incident operations at the incident site. The IC role can be transferred due to qualifications or operational period. The IC will assign Incident Management Team roles and incident objectives.
3. **Incident Command System (ICS):** ICS is the combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure, designed to aid in the management of resources during incidents.
4. **Incident Management Team (IMT):** the Incident Commander and appropriate Command and General Staff personnel assigned to an incident. IMTs are scalable relative to the incident type and size. Each role has a Job Action Sheet, which acts as a checklist and guide for each position (see *Attachment 2 – Incident Management Team Organizational Chart*).
5. **Incident Activation:** the activation of this plan, an IMT, and related policies/procedures.
6. **Incident Command Post (ICP):** The specified location at which the primary tactical-level, on-scene incident command functions are performed. For example, when incident command elements are activated at a specific department or field location directly addressing the incident.
7. **Emergency Operations Center (EOC):** a physical location for multi-departmental or multi-facility coordination of information and resources to support a domestic incident.

References

Incident Activation Policy, EC350

Emergency Call-back Roster Policy, EC352

Emergency Notification System Policy, EC353

Attachments:	Attachment 1 Facility List.docx Attachment 2 Incident Management Team.pdf Emergency Call-Back Roster- EC352.pdf Emergency Notification System- EC353.pdf Incident Activation- EC350.pdf

COPY

APPENDIX C

EMERGENCY CALL-BACK ROSTER

Current Status: *Active* — **PolicyStat ID:** *5440060*

Origination:	*01/2003*
Effective:	*09/2018*
Last Approved:	*09/2018*
Last Revised:	*09/2018*
Next Review:	*09/2020*
Owner:	*Emergency Preparedness Manager*
Area:	*Environment of Care Emergency Preparedness*
References:	
Applicability:	

Emergency Call-Back Roster, EC352

PURPOSE

1. Facilitate the call-back of personnel in the event of an emergency.
2. Provide additional personnel resources at the department level on an "as needed" basis during an emergency.

COPY

POLICY

All departments within the system will update and maintain a call-back roster in order to meet staff requirements during an emergency.

PROCEDURE

1. Responsibilities of Department Managers
   - A. Complete the emergency Call-Back Roster form, see attached. *Note: Some departments use the "telephone tree" as part of their call-back process. If completing a telephone tree, the Call-Back Roster form must also be completed.*
   - B. Maintain an updated physical copy within the department's Environment of Care (Safety) Manual, under the department-specific section.
   - C. Ensure the Call-Back Roster form and its contents are updated each September.
   - D. Send a completed copy (physical or electronic) to the Emergency Preparedness Program Manager in Quality and Safety Services, for master list purposes.
2. Responsibilities of the Emergency Preparedness Program Manager and Quality and Safety Services
   - A. Maintain the master electronic Call-Back Roster Form (in Excel format).
   - B. Provide Human Resources/Incident Command Labor Pool with an updated master list on an annual basis.

APPENDIX D

EMERGENCY PATIENT SURGE

Current Status: *Active* | **PolicyStat ID:** *6273023*

Origination:	*08/2018*
Effective:	*06/2019*
Last Approved:	*06/2019*
Last Revised:	*06/2019*
Next Review:	*06/2021*
Owner:	*Emergency Preparedness Manager*
Area:	*Environment of Care Emergency Preparedness*
References:	
Applicability:	

Emergency Patient Surge, A791

PURPOSE

1. To assess, plan and implement operational strategies to respond to emergent surge events.
2. Sustain the healthcare system's ability to manage a sudden influx of patients.

POLICY

COPY

will develop and maintain procedures to mitigate and respond to emergent patient surge events as required by Montana and federal laws. Crisis Standards of Care may be adopted if the incident is associated with a disaster declaration by the Governor of Montana and/or the President of the United States. Levels of patient surge are as follows. For more procedures for High and Maximum Census refer to policy *High Census Action Plan, A793.*

1. **High Census:** when House Census is between 95-99%.
2. **Maximum Census:** when the House Census equals or exceeds 100%.
3. **Level I Surge:** when has filled all licensed inpatient beds, a surge event overwhelms the healthcare system and additional county resources are required.
4. **Level II Surge:** when a surge event causes to surpass Level I Surge and state resources are required/requested.
5. **Level III Surge:** when a surge event causes to surpass surge Levels I-II and federal resources are required.

PROCEDURE

1. **Determine Size & Scope**
   A. The House Supervisor/Coordinator (**HS/HC)** and the Administrator On-Call (**AOC**) will determine the level of surge by completing an assessment of the potential operational impact on the facility.
   B. Emergency Department (**ED**) leadership will determine whether to activate Medical Control Communications.
2. **Mitigation Strategies**

A. Utilizing the ED and/or other areas as holding areas, providing space is available. Reschedule elective surgeries and procedures.

B. Balance the surgery schedule throughout the week.

C. Utilize clinical staff from non-inpatient departments (e.g. clinics, education, etc.) to increase staffing resources.

D. Flex patient/staff ratio.

3. **Activation**

A. The IC will coordinate with the Emergency Preparedness Coordinator (**EPC**) to determine whether to activate the Emergency Operations Center (**EOC**).

B. An urgent needs assessment will be conducted to prioritize staffing and to clarify roles.

C. The IC will develop an Incident Action Plan (**IAP**), assign the Incident Management Team (**IMT**) positions and activate staff call-back rosters as necessary (see Incident Activation policy).

4. **Internal Notifications**

A. ED will notify IC when Medical Control is activated.

B. The HS/HC will notify the following departments of surge level:

1. Communications Center
2. Emergency Department
3. Surgical Services
4. Pre-/Post Anesthesia Care Unit (**PACU**)
5. Pharmacy
6. Hospitalists
7. Case Management
8. North Valley Hospital

COPY

C. The Communications Center will notify the following groups set-up in the Emergency Notification System of surge level:

1. Incident Management Team
2. High Census Alert

5. **Bed Capacity**

A. The HS/HC will update Charge Nurses, Emergency Department and Administration of bed status at 2-4 hour intervals.

B. Available gurneys shall be brought to the ED by Plant Operations, Environmental Services, **or** Logistics Section designee.

C. The HS/HC or EPC shall request a state-wide bed-status report from Montana Department Public Health and Human Services (**DPHHS**).

D. IC and appropriate Incident Management Team (**IMT**) staff will review the state-wide bed-status report and contact neighboring county hospitals to confirm bed availability.

E. Transfer Center will transfer appropriate patients to healthcare facilities with bed availability.

6. **Emergency Department & Inpatient Directors**
    A. Communicate all changes in bed availability and staffing changes to HS/HC.
    B. Assist with care delivery on units.
    C. If requesting additional staff, communicate skills needed to staffing office so the Staffing Office and/ or Labor Pool can assign staff appropriately. Examples are as follows:
        1. Request a scribe or someone to assume administrative tasks.
        2. Requests someone who can take vitals.
    D. The Operating Room Director may need to contact surgeons to discharge appropriate patients prior to starting surgery.
    E. PACU or holding room manager may need to prepare units to keep admitted patients.
7. **Emergency Preparedness Coordinator**
    A. Notify the County Office of Emergency Services (**OES**) when this policy is activated.
    B. Send resource and capability requests to the Montana State Department of Emergency Services (**DES**) Coordinator at OES.
    C. Facilitate state-wide bed-status requests as needed throughout operational period(s).
    D. Coordinate with the Western Region Healthcare Coalition and/or the Montana State DPHHS for any additional resource requests as appropriate.
8. **Disaster Declaration & Crisis Standards of Care**
    A. Upon a Governor may adopt Crisis Standards of Care in accordance with Montana Code "Medical Services during declared emergency or disaster, limitation of liability, administrative disciplinary sanctions (10-3-103110).
    B. See policy A780 – Adapting Standards of Care for Extreme Conditions
    C. If the following declarations occur during the emergency, will review the necessity of submitting an 1135 waiver to the Center for Medicare & Medicaid (**CMS**) Regional Office in order to temporarily waive certain Conditions of Participation such as licensure for physicians or others to provide services, Medicare Advantage out of network providers, and/or the requirements of the Health Insurance Portability and Accountability Act:
        1. The President declares a disaster or emergency under the Stafford Act or National Emergencies Act; **AND**
        2. The HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act.
9. **Downgrade to Max or High Census**
    1. Max Census:
    2. High Census: once House Census decreases to between 95-99% Net Beds, the House Supervisor shall prompt the Communication Center to issue a "Max Census downgraded to High Census Alert" notification through the ENS to the same individuals in Section 2, Max Census Alert Distribution.
10. **Demobilization**
    A. From the initial activation of this policy, the Planning Chief and/or Demobilization Unit Leader will coordinate with the IC to identify milestones towards demobilizing.

COPY

B. The Business Continuity Branch (if activated) should also coordinate demobilization planning with the Planning Section.

C. The purpose of the Demobilization Unit is to focus on how to return the organization to day-to-day operations.

D. Termination of Crisis Standards of patient Care will be determined by Incident Command in conjunction with representatives of the Medical Executive Committee and Administration and will be communicated to the healthcare team.

DEFINITIONS

1. **Bed Capacity:** total number of licensed inpatient beds within a healthcare facility.
2. **Emergency Operations Center:** a physical location for a multi-facility or multiagency coordination of information and resources to support a domestic incident.
3. **Incident:** an occurrence, caused by either human action or natural phenomena that may cause harm and that may require action. Harm can include human casualties, destruction of property, adverse economic impact, and/or damage to natural resources. An Incident has the potential to overwhelm or overburden normal routine services.
4. **Incident Commander:** the individual responsible for all incident activities, including the development of strategies and tactics and the ordering and the release of resources.
5. **Incident Management Team (IMT):** the Incident Commander and appropriate command and general staff personnel assigned to an incident. IMTs are scalable relative to the incident type and size.
6. **House Census:** House Census shall be determined using the following formula: Net Available Beds = (Available Beds+Discharges)-(Surgeries+Transfers). Available Beds include HealthCenter inpatient beds and the following Kalispell Regional Medical Center inpatient units:
   A. Intensive Care
   B. Intermediate Care
   C. Medical
   D. Surgical
   E. Oncology
7. **Non-conventional Beds:** when assigning patients to beds in units that do not typically treat the demographics or patient type (e.g. placing an adult in a pediatric bed).
8. **Surge Capacity:** a measurable representation of a healthcare system's ability to manage a sudden or rapidly progressive influx of patients within the currently available resources at a given point in time. *Defined by the American College of Emergency Physicians.*

COPY

REFERENCES

1. American College of Emergency Physicians. (2017). Health Care System Surge Capacity Recognition, Preparedness, and Response. Retrieved on June 25, 2018, from https://www.acep.org/patient-care/policy-statements/health-care-system-surge-capacity-recognition-preparedness-and-response/#sm.001paq9q1cxld2r100d1nw4z1u04w
2. County Office of Emergency Services. (2010). Mass Casualty Annex to the County Comprehensive Emergency Operations Plan.