SOP : EMERGENCY PANDEMIC RESPONSE MECHANISM

INTRODUCTION

1. The vacillating COVID-19 Pandemic has gripped the world and our nation since Mar 2020. The rapid spread has been a cause of concern. While the effects of first wave were less severe with a gradual spread over longer period and low fatality ratios, the second wave was intense, overwhelming the healthcare infrastructure in the country with rapid spread and high fatality ratios exposing weaknesses in the response. Despite best efforts of all stakeholders, large number of lives were lost.

2. The veteran community was also affected to a large extent due to their vulnerability and old age. The heavy dependence on empanelled hospitals for treatment exposed the weaknesses of the system and the inevitability of Service Hospitals being the ultimate providers of medical aid to the Ex Servicemen in an emergency came to fore. Notwithstanding the heavy demand on del of service, the org reacted to meet the challenges with the assistance of the fmns. All the three Services were prompt in instituting various measures to tackle the Pandemic and their swift response ensured that the situation was rapidly brought under control without assuming calamitous proportions.

3. The challenges thrown up during the second wave of the pandemic brought out certain lessons. The vacillating nature of the COVID-19 pandemic has raised apprehensions of a possible third wave. Corrective measures and institutionalised response mechanism to rapidly adapt to a dynamically changing sit will ensure better satisfaction among the ECHS beneficiaries. It is therefore intended to formulate a SOP on Emergency Response Mechanism laying down actions to be taken by various stake holder organisations within ECHS to bring in flexibility and mitigate the shortcomings during such pandemic situations.

AIM

4. Aim of this SOP is to lay down an emergency response mechanism by various entities of ECHS including other stake holders such as Stn HQ.

PREVIEW

5. The SOP is laid out as under :-

(a) **Part – I** : Concept & Functioning of ECHS.

(b) **Part – II** : Challenges & Lessons Learnt.

(c) **Part – III** : Response Mechanism.

PART – I : CONCEPT & FUNCTIONING OF ECHS

Overview

6. ECHS aims at providing Quality Healthcare to Ex-servicemen and their dependents through a network of ECHS Polyclinics, Armed Forces medical facilities and private empanelled / government hospitals spread across the Country.

7. The Scheme is structured with Central Organisation at the apex, 29 Regional Centres and 428 Polyclinics geographically spread across the country. The Central Organisation is responsible for policy formulation, technical advice and overall functioning of the ECHS. While the technical support and implementation of policies is supervised by the Regional Centres, the administrative and functional control is exercised by the Station HQ assisted by SEMOs and supervised by the existing chain of command and control of the three Services.

Role & Functions

8. The ECHS polyclinic is a basic unit responsible for delivery of services to the beneficiaries. The polyclinic is responsible for outpatient treatment, basic investigations, provision of medicines and referrals to the Service/Empanelled Hospitals. The beneficiaries look up to the polyclinics for support and advice on medical treatment related matters.

9. The Empanelment of hospitals and the supervision of delivery of services by these empanelled hospitals is the responsibility of Regional Centres.

10. The Station Cdrs are responsible for emp of the polyclinic staff and day to day running of the polyclinics.

Concept of Medical Treatment

11. The concept of medical treatment through ECHS undergoes following cycle :-

(a) Report by the beneficiary to the polyclinic.

(b) Examination by the MO/Specialist, investigation and issue of medicines.

(c) Where further consultations and treatment including inpatient treatment are required, the patients are referred to Service or Empanelled Hospitals.

(d) The OIC Polyclinic is the key functionary who organises and supervises functioning of Polyclinic.

12. In case of an emergency, the patients are entitled to report to any hospital whether empanelled or non empanelled.

Medical Treatment during Pandemic

13. The patients affected by the COVID – 19, require complete isolation and close monitoring. Severely affected patients require hospitalisation. Oxygen support is the key to survival. Psychological support and confidence of assured treatment among the patients are an important part of the patient management.

14. ECHS Polyclinics being the first and the basic place for seeking medical aid, the beneficiaries expect them to solve their medical treatment related problems and provide all assistance.

PART – II : CHALLENGES & LESSONS LEARNT

Challenges

15. The Polyclinics had learnt to function within the Pandemic during the first wave. However, the second wave posed different challenges which were identified as under :-

(a) **Hospital Bed Capacity**. Both Service and Empanelled Hospitals, were not prepared for the unprecedented surge in demand for beds. The numbers of infected patients requiring hospitalisation far exceeded the available capacity in the initial stages. Rapid expansion of capacity by some Service Hospitals resolved the issue. However, denial of admission by empanelled hospitals remained a major challenge during peak periods.

(b) **Lack of Oxygen Cylinders and Concentrators**. Requirement of Oxygen to the affected patients was the key to survival. Availability of cylinders and oxygen concentrators assumed a major role in the treatment of COVID-19. However, availability could not match the requirement, particularly in the initial devp of the second wave.

(c) **Information Void**. The rapid surge in cases and high infectious spread coupled with greater fatalities caused considerable panic and anxiety amongst the veterans as it took some time for systemic information channels to become utilitarian.

(d) **Home Care Solutions**. Since bed capacity in hospitals was short of demand, many Veterans had to undergo home treatment/ isolation/ quarantine. An organised institutionalised mechanism for providing monitoring support and ready medical advice was lacking in the initial stages.

(e) **Manpower Constraints**. There were expectations of availability of round the clock services and medical attention in Polyclinics, especially those with high dependencies. The available contractual manpower was not adequate to stretch the working hours continuously to a 24 hour cycle throughout the Pandemic.

(f) **Transport Facilities for Patients**. Availability of single ambulance vehicle in a polyclinic was inadequate to meet the raised demands for transportation to a service or an empanelled hospital.

(g) **Data Base Mgt**. There was a clear gap in the availability of required data in the desired format in real time. This posed challenges towards a thorough and solution inducing analysis.

(h) **Ability to Influence Empanelled Hospitals**. Empanelled Hospitals fell short of expectations and despite adequate provisions in the MoA, these hospitals could not be influenced or coerced into raising the admission numbers of ECHS beneficiaries to the desired levels.

Lessons Learnt

16. **Inevitable Heavy Dependence on Service Hospitals**. The inherent trust and familiarity associated with Service Hospitals coupled with denial of admission by empanelled hospitals brought high numbers of Veterans to the Service Hospitals which were already under heavy patient load of serving personnel and their dependents. This pattern is likely to be encountered in the future too.

17. **Inadequacies of Empanelled Hospitals Exposed**. A huge surge in the pandemic affected cases coupled with shortages of oxygen stretched the available resources in the empanelled hospitals to the limits leading to denial of services in these hospitals. Even bigger and well known hospitals were no exception. In the absence adequate leverages, insufficient pressures and inadequate personal contact in some cases, no solution could be offered. This needs to be corrected.

18. **Requirement of Additional Manpower**. ECHS Polyclinics are manned by contractual staff authorised to each Polyclinic in accordance with MoA signed as approved by the MoD. This staff functions six days a week for eight hours daily. Their non availability beyond the working hours became conspicuous in emergency situations. Service Hospitals also were in dire need of additional manpower owing to the increasing load of Veterans and their dependents. ECHS employees, thus, have to be prepared to be employed 24x7 in emergency conditions.

19. **Outreach Limitations of Polyclinics**. An ECHS beneficiary expects the Polyclinic to be able to support him in resolution of all problems related to his health and medical condition. The OsICs of majority of the polyclinics were proactive in formulating outreach mechanism, however, in some Polyclinics the response was inadequate. Lack of empathy and concern caused disquiet among the Veterans. Another issue was the lack of data on affected beneficiaries. This aspect needs particular attn since a Veteran accustomed to dedicated medical advice and care, expects the same during such situations.

20. **Coordination Deficit**. A well established coordination mechanism of ECHS entities at various levels with Service and Empanelled Hospitals and State Health Authorities would have ensured a better flow of information and further dissemination to the beneficiaries.

21. **Business Orientation of Empanelled Hospitals**. It was apparent that few empanelled hospitals prioritised admission based on better financial returns from non ECHS patients. This resulted in ECHS beneficiaries being placed on waiting lists for prolonged periods. Adequate leverages and pressures have to be formulated to address this tendency.

PART – III : RESPONSE MECHANISM

22. A number of initiatives were undertaken by ECHS after onset of the Pandemic; both in the first and second waves. List of these initiatives is att as **Appx** A. Future response mechanism will need to be a progression of these initiatives.

23. A well coordinated response mechanism in a Pandemic situation will, therefore, entail simultaneous, progressive and evolving actions by all ECHS entities and chain of command in the formations. Immediately on identifying the threat of a spread of pandemic, a series of actions will be undertaken by all entities within the ECHS to respond to the evolving situation. The Central Org, Regional Centres and Stn HQ in consultation with their chain of comd will closely monitor the situation. The Regional

Centres and Station HQ will recommend declaration of an emergency situation to the Cenral Org. The Central Org in conjunction with the Medical Branch will pass executive instrs for Pandemic Response to commence the Emergency Response Mechanism and take actions as given out in succeeding paras.

ECHS Polyclinics.

24. Polyclinics are the first port of call for all beneficiaries to report and hence it is imperative that expected assistance and immediate care is readily available. Following will be ensured at each Polyclinic by OIC Polyclinic on declaration of Pandemic Response :-

(a) **Enhanced Functional Efficiency**.

(i) Activation of 24 x 7 helpline.

(ii) Creation of WhatsApp Groups and other social media to coordinate actions and disseminate real time information.

(iii) Generate confidence among beneficiaries through outreach and personal interaction by nominated staff.

(iv) Enable emergency medical assistance beyond working hours by working in shifts.

(v) Ensure smooth delivery of services to beneficiaries not affected by pandemic.

(v) Ensure ready availability of requisite medicines, equipment, stores and serviceability of ambulances with assistance from SEMO and Stn HQ.

(vi) Maintain a record of all known pandemic affected beneficiaries

(b) **Medicare and Hospital Admissions**.

(i) Enable establishing of testing/ sample collection facilities within premises to the extent feasible.

(ii) Provide/ coordinate ambulances for transporting beneficiaries to hospitals.

(iii) Assist the beneficiaries in securing admission to hospitals, both Service and Empanelled.

(iv) Establish functional coordination with State Health Authorities controlling allotment of beds in civil private and Govt hospitals.

(c) **Home Care and Counselling**.

(i) Medical Officers will be assigned for providing tele consultation directly to the beneficiaries as also through e-SeHAT OPD. Ensure periodic monitoring of the vital parameters.

(ii) Keeping the functional requirements of the Polyclinic in mind, assign Medical Officers and Paramedical staff to attend the home isolated patients at home, duly observing relevant protocols.

(iii) Prepare medicine kits with essential reqmts as per **Appx B** att (COVID related) for home isolated patients and endeavour to deliver these at home.

(iv) Provide domiciliary equipment at home to the affected beneficiaries.

(v) Provide feedback to RCs and Central Org ECHS.

(d) **Maintain Database**.

(i) Number of ECHS beneficiaries affected and their status.

(ii) Bed availability in the empanelled hospitals.

(iii) Ambulance service providers in the jurisdiction with contract details.

(iv) Home care service providers incl nursing services.

(v) Funeral services providers.

(e) **Processing of Claims**. Timely processing of claims post treatment.

ECHS Regional Centres

25. Regional Centres are the direct interface with the Empanelled Hospitals and the Director Regional Centre acts as an advisor on ECHS matters to the GOC Sub Area/ Area. Actions to be taken by the Director Regional Centre on declaration of Pandemic will be as under:-

(a) **Ensure Accessibility**.

(i) Ensure a functional 24 x 7 dedicated helpline in Polyclinics and within Regional Centre.

(ii) Create Crisis Management Cell to function as a nodal agency within the Regional Centre.

(iii) Maint a two way 24x7 communication with Central Org ECHS.

(b) **Treatment**.

(i) Ensure 24x7 accessibility and functioning of polyclinics.

(ii) Ensure empanelled hospitals nominate a nodal representative for services to ECHS beneficiaries. Obtain data transparency on availability of beds, medicines, oxygen etc with Empanelled Hospitals.

(iii) Establish an uninterruptible communication and coordination channel with the nodal officer of hospitals to secure admissions and relay of timely data.

(iv) Coordinate medical attention and admission in Service Hospitals either directly or through HQ Sub Area/ Area.

(v) Ensure liaison and coordination with Col Veteran of the Sub Area/Area.

(c) **Execution of Policy and Outreach**.

(i) Expediency in dissemination of policies and provisions.

(ii) Establish/ rejuvenate contact with ESM organisations to obtain feedback and gain information.

(iii) Pursue hiring of additional contractual staff, when allotted, with Station HQ.

(iv) Establish liaison with State Health Authorities under the aegis of HQ Sub Area/Area.

(d) **Database**.

(i) Availability of domiciliary equipment especially Oxygen Concentrators with service providers.

(ii) Status of bed occupancy and availability with hospitals, both Service and Empanelled.

(iii) Number of beneficiaries affected, hospitalized and status.

(iv) Sharing of data with Central Org ECHS as required.

Central Org ECHS

26. Central Org ECHS being the apex body is responsible for ensuring uninterrupted smooth delivery of service to all beneficiaries. It will be responsible for liaison and coordination with MoD, Med Dtes Gen of Services HQs and other stake holders to issue executive instrs for implementation of enabling provisions immediately on declaration of the Pandemic.

27. Based on the lessons learnt, important enabling provisions that have been obtained and to be pursued are as under :-

(a) Insertion of suitable clauses in the Memorandum of Agreement with empanelled hospitals assurance of service to ECHS beneficiaries.

(b) Promulgation of duration specific sanction for hiring additional contractual manpower for identified high pressure Polyclinics well in time.

(c) Allow Station Commanders to optimize ECHS contractual staff from Polyclinics with reduced footfall to augment capacity of Service Hospitals.

(d) Ab-initio establishment of testing and sample collection facility in the Polyclinics through empanelled facilities.

(e) Assistance in creation of oxygen cylinder and concentrator banks at Stn level.

(f) Provision of essential equipment from ECHS funds to establish adhoc COVID Care Centres for ECHS beneficiaries.

28. Various actions required to be taken by Central Org are as under:-

(a) Establish a Crisis Management Cell to function 24 x 7 which will coordinate facilitative measures with all stake holders.

(b) Augment the existing 24 x 7 helpline and ensure its utilitarian value.

(c) Collect and collate data received from Regional Centres for analysis.

(d) Effect budgetary allocations.

(e) Coordinate with DGAFMS and DGMS (Army), (Navy) and (Air) to ensure smooth flow of medicines, med stores and eqpt to the Polyclinics.

(f) Pursue requirement based cases with MoD for emergent requirements.

Station HQs and Area/ Sub Area HQs.

29. Involvement of the Formation HQs is of utmost importance in ensuring delivery of services to ECHS beneficiaries. Following will be ensured by Stn HQ and the chain of comd :-

(a) Est of 24 x 7 Crisis Management Cells at Sub Area/ Area HQ level under a Nodal officer.

(b) Synergy between Veteran Cells and ECHS staff in Station/ Formation HQ.

(c) Planning, procurement and distribution of critical pandemic medical stores.

(d) Establish and maint coord with State Govt hlth authorities and CMOs at district level.

(e) Coordinate actions at Polyclinics, Regional Centres and Formation HQ to ensure optimal utilisation of resources.

(f) Timely hiring of additional manpower as and when allotted.

(g) Enable provisioning of additional ambulances at Polyclinics with drivers and amb staff.

(h) Beneficiaries are not unwarrantedly inconvenienced for investigations, unlisted procedures and waivers/ sanctions.

(j) ECHS beneficiaries are not denied treatment in Service Hospitals and are assured of treatment protocols without discrimination.

CONCLUSION

30. The COVID – 19 Pandemic is unlikely to recede in the short foreseeable future. The shortcomings noticed and the lessons learnt are important to ensure a well coordinated and rapid response mechanism so that the ECHS beneficiaries are provided with the expected service.

31. A rejuvenated drive to comprehensively improve the response to the pandemic affected is necessary to save lives and instil confidence among the beneficiaries. It is necessary to remain relentless in our efforts through our proactive measures to meet the challenges of any further wave of COVID-19 Pandemic with resolute preparedness and matching infrastructure.

32. The SOP is a basic guideline to design a response mechanism and various entities providing services to the veterans should modify their responses to suit the local conditions.

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Adjutant General's Branch
IHQ of MoD (Army), Thimayya Marg.
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Case File No : B/49701-PR/AG/ECHS/2021

Dated : 16 Jul 2021

(Rajesh Dogra)
Col
Dir (Ops & Coord)
for MD ECHS

Distr:-

All Regional Centers ECHS

Copy to:-

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HQ Central Command (A/ECHS)
HQ Northern Command (A/ECHS)
HQ South Western Command (A/ECHS)
HQ Andaman & Nicobar Command (A/ECHS)

Internal

All Secs

Appx A
(Refers to Para 22 of the SOP)

COVID-19 PANDEMIC POLICIES AND ADVISORIES BY ECHS

1. **Cashless COVID-19 Testing**. Advisory issued to Empanelled HCOs under ECHS for cashless COVID testing for ECHS beneficiaries vide CO ECHS letter No B/49770/AG/ECHS/Treatment/Policy dt 14 May 2020.

2. **Revision of Rates for RT PCR Test**. Guidelines issued to all Regional Centres regarding revision of rates for RT PCR TEST for COVID-19 vide CO ECHS letter No B/49770/AG/ECHS/Treatment dt 15 Jun 2020.

3. **Reimbursement of Cost of Pulse Oximeter**. Advisory issued on reimbursement of cost of Pulse Oximeter for the family of COVID positive ECHS beneficiary for their home care vide CO ECHS letter No B/49770/AG/ECHS/ Treatment dt 13 Jul 2020.

4. **Tele Consultancy through SeHAT OPD**. Advisory on integration of Medical Officers of ECHS Polyclinics in online consultancy through SeHAT OPD issued vide Central Org ECHS letter No B/49762/AG/ECHS/2021 dated 12 Apr 2021.

5. **Purchase of Medicines Directly from Market**. Sanction for ECHS beneficiaries having life style /chronic ailments / diseases on long treatment to purchase medicines till 31 Jul 2021 in one go or month wise based on prescription held irrespective of NA or otherwise and claim reimbursement issued vide Central Org ECHS letter No B/49761/AG/ECHS dated 16 Apr 2021.

6. **Home Isolation Service Package**. This initiative has been introduced for COVID-19 Positive ECHS beneficiaries undergoing home quarantine/isolation which, among others facilities, allows home visit by a doctor twice a week, visit by nursing staff to record parameters and render advice as well as trg to the kin of the COVID patient. Expenditure upto Rs 1000/- per day for 14 days from the date of prescription of advice of home isolation is permissible for reimbursement. Details are available in Central Org ECHS letter Number B/49761/AG/ECHS dated 27 April 2021.

7. **Augmentation of Service Hospitals with ECHS Contractual Manpower**. Advisory on allowing Stn Cdrs to utilise contractual manpower of ECHS Polyclinics to augment the manpower resources of AFH to handle the incr patient load issued vide Central Org ECHS letter No B/49760/AG/ECHS/R/2021 dt 27 Apr 21.

8. **Additional Contractual Staff for High Pressure Polyclinics**. Sanction for temp emp of addl contractual staff over and above auth for high pressure Polyclinics issued vide Central Org ECHS letter No B/49760/AG/ECHS/R/2021 dt 27 Apr 2021.

9. **Reimbursement of Cost of Negative RT PCR Tests**. Guidelines for claiming of Medical Bills for Symptomatic ECHS Beneficiaries who are RT PCR/Rat Negative issued vide Central Org ECHS letter No B/49761/AG/ECHS dt 06 May 2021.

10. **Tele Consultancy by ECHS Medical Officers**. Advisory to all ECHS Regional Centres to ensure Med Offrs of Polyclinics provide daily tele advice to known COVID–19 positive cases among ECHS beneficiaries under home isolation /quarantine issued vide Central Org ECHS letter No B/49760/AG/ECHS/R/2021 dt 24 May 2021.

11. **ECHS Polyclinics Designated as COVID Vaccination Centres**. Sanction to all Regionals Centres to ECHS Polyclinics to be utilised as GCVCs (Govt COVID Vaccination Centres) issued vide Central Org ECHS letter No B/49761/AG/ECHS/ Med/2021 dated 04 Jun 2021.

Appx B
(Refers to Para 24 (c) (iii) of the SOP)

COVID KIT

Ser No	Nomenclature	Str	Use per day	Total days	Qty
1.	Tab Dolo (Paracetamol)	650 mg	Three times a day	05 days	15 Tabs
2.	Tab Azithromycin	500 mg	Once in a day	05 days	05 Tabs
3.	Tab Ivermectin	12 mg	Once in a day	05 days	05 Tabs
4.	Tab Fabiflu	800 mg	Day 1-1800 mg BD Day 2-7-800 mg BD	07 days	16 x 800 mg 02 x 200 mg
5.	Tab Levocet M	-	Once in a day	10 days	10 Tabs
6.	Tab Limcee (Chewable)	-	Once in a day	30 days	30 Tabs
7.	Tab zinc	-	Once in a day	30 days	30 Tabs
8.	Tab B complex	-	Once in a day	30 days	30 Tabs
9.	Thermometer	-	Qty 01		