



State of New Hampshire
Crisis Standards of Care Guidance

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NH Crisis Standards of Care Guidance

New Hampshire Department of Health and Human Services
Division of Public Health Services, Bureau of Emergency Preparedness, Response and Recovery
129 Pleasant Street, Brown Building
Concord, NH 03301
603-223-3729
EPRR@dhhs.nh.gov
www.dhhs.nh.gov

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Crisis standards of care (CSC) may be needed in times of pervasive or catastrophic natural, human-made, or technological disasters that result in health care systems having sustained resource shortages severe enough to affect the customary ability to deliver health care services. Disasters can stretch many health care systems to the point of restricting services and having to re-allocate scarce resources. The overall goal of crisis care is to provide the best care possible to the largest number of people with the resources available while ensuring equitable access to services for all.

The New Hampshire (NH) *Crisis Standards of Care Guidance* (henceforth referred to as *CSC Guidance*) is document that offers guidance to the Governor of the State of New Hampshire in the event that the Governor is called upon to take control of emergency management.

The NH *CSC Guidance* is founded on strong ethical principles, the rule of law, the importance of community engagement, and the essential responsibilities of health care workers¹ and administrators. Health care organizations across the state are welcome to use this Guidance as a reference when creating their own institutions' CSC plans in conjunction with the NH Department of Safety, Division of Homeland Security and Emergency Management's *State Emergency Operations Plan* (SEOP), Emergency Support Function (ESF) 8 – *Public Health and Medical Annex*, and statewide health care organizations' command centers, emergency operations and medical surge plans. When completed, CSC plans (and subsequent revisions) can be made publicly available to promote transparency and instill public trust. Any plan will be limited and will need to be adjusted as a public health disaster progresses.

The *CSC Guidance* was a joint effort of the hospital and long-term care facility medical and nursing officers, emergency medical services; emergency management authorities; academic and medical ethicists; disability rights advocates; health care and mental health specialist practitioners; hospital, medical, and nursing associations; and legal professionals. Guidance content reflects current medical literature and law combined with references to lessons learned of actual national and international disaster responses e.g., Hurricane Katrina (2006); H1N1 influenza pandemic (2009); Haiti earthquake (2010); Ebola response (2014-2016); Hurricane Maria (2017); and most recently, the 2019 novel coronavirus (SARS-CoV-2) global pandemic, abbreviated as COVID-19. The goal is to update and revise the *CSC Guidance* as frequently as possible to reflect lessons learned during incident response or exercise play.



Lori Shibinette, RN, MBA, NHA
Commissioner, NH Department of Health and
Human Services

6/29/2022

Date

¹According to the U.S. Census Bureau, a healthcare worker is one who delivers care and services to the sick and ailing either directly as doctors and nurses or indirectly as nursing assistants, home health and personal care aides and in other health care support occupations. <https://www.census.gov/library/stories/2021/04/who-are-our-health-care-workers.html>

Executive Summary

The New Hampshire (NH) Department of Health and Human Services (DHHS) is the lead State agency responsible for the Public Health and Medical Emergency Support Function (ESF) 8. As part of that responsibility, this guidance is being issued to provide the planning and response framework used by the Governor for managing strains on the health care systems as the need for care increases during catastrophic or pervasive public health crises with medical surge implications and shortages of resources affecting health care operations.

In response to the 2019 coronavirus called SARS-CoV-2 (COVID-19) global pandemic, the NH DHHS Commissioner sanctioned, in April 2020, a State Disaster Medical Advisory Committee (SDMAC) and State Triage Committee (STC) with representation from health care, emergency medical services (EMS), emergency management, ethical and legal professionals, and other subject matter experts to develop the *NH COVID-19 Crisis Standards of Care Plan* (“*COVID-19 CSC Plan*”) and *NH State Triage Committee Crisis Standards of Care COVID-19 Clinical Guidelines* (“*COVID-19 Clinical Guidelines*”) based in part on the Institute of Medicine (IOM) 2012 Framework². The SDMAC and STC provided recommendations to the DHHS Commissioner on best practices for a systematic approach to allocation of scarce resources (e.g., staff, space, and supplies) designed to deliver the best care possible given limited resources during the COVID-19 global pandemic. The [New Hampshire Crisis Standards of Care State Disaster Medical Advisory Committee \(SDMAC\)](#) webpage is the official location for all state-level CSC documents during the COVID-19 response.

The New Hampshire *Crisis Standards of Care Guidance* (hereafter referred to as *CSC Guidance*) incorporates many sections of the *COVID-19 CSC Plan & Clinical Guidance* and numerous lessons learned from and ongoing, evidence-based research on COVID-19. More importantly, it underpins the critical necessity for an all-hazards approach to crisis standards of care in the event of catastrophic or pervasive public health crises. We have learned that these types of incidents can certainly escalate scarce critical care resources and drive overwhelming patient surges. Experiences over the last two decades has also shown that health care workers who participated in the response to catastrophic natural disasters, and in one pervasive international public health incident, “uniformly highlighted significant moral distress and a lack of ethical guidance for both allocation of scarce resources and CSC—noting that these issues tended to travel together.”³

The *CSC Guidance* was developed, under the leadership of the NH DHHS, Division of Public Health Services (DPHS), Bureau of Emergency Preparedness, Response and Recovery (BEPRR), by a highly committed work group of multidisciplinary professionals spanning health

²IOM 2012. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/13351>.

³Leider J.P., DeBruin D., Reynolds N., Koch A., and Seaberg J. Ethical Guidance for Disaster Response, Specifically Around Crisis Standards of Care: A Systematic Review. *Am J Public Health*. 2017;107:e1-e9. p.e5. <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2017.303882>

care, academics, ethics, emergency management, legal, public health, discipline-specific and community organizations. Several national CSC plans; federal guidance documents; academic research; medical, ethical and legal publications; real world medical surge incident reports; and health care provider perspectives from the field were gathered and reviewed for this *CSC Guidance*.

The *CSC Guidance* outlines a legal framework for government leaders and health care organization professionals to collectively communicate, determine, and rapidly establish clinical guidelines to lessen the possibility of decisions that would place a patient at risk of a poor outcome. Comprehensive CSC plans include the following components:

1. Strong ethical grounding in the principles of justice (fairness and equity), transparency, consistency, proportionality, and accountability, among other values;
2. Foundation in laws and regulations pertaining to disaster response and recovery management;
3. Integrated and ongoing community and health care worker engagement, education, and communication to ensure collective norms, priorities, and values which ensures greater acceptance of the crisis standards care if and when it is activated;⁴
4. Established clear indicators and triggers with lines of responsibility to identify when approaching crisis care and the implementation of mitigating strategies;
5. Application of evidence-based clinical processes and operations;
6. Support health care workers to implement CSC by providing mental health resources with regular training on the provision of care for patients under CSC situations including expectations for how staff will be “stretched” to cover the demand for services as fairly as possible;⁵
7. Define the role of all centralized teams (ethics team, incident command team, legal team, triage team, resource allocation team, etc.) within the health care organization and how the organization interacts with other parts of the health care systems in its geographical region;⁶
8. Transparency of the plans and supplemental information to all who are or may be impacted by the plans. This includes health care workers and other employees, patients, family

⁴IOM 2012. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework*. Washington, DC: The National Academies Press.

⁵Association of American Medical Colleges. COVID-19 Crisis Standards of Care: Frequently Asked Questions for Counsel. December 18, 2020. Available at <https://www.aamc.org/coronavirus/faq-crisis-standards-care>

⁶Ibid

members and the general public. It is recommended that plans be available on the internet and at the location where health care is provided. The plans and/or supplemental documents should be available in all languages regularly spoken by community members, in plain language and in a format that is accessible; and⁷

9. Appeals process. Plans must include a robust appeals process for health care providers and patients to appeal decisions where appropriate. The process to appeal must be provided to providers and patients as needed.

⁷Patrick, Stephanie. Executive Director. Disability Rights Center-NH. <https://drcnh.org/>

Record of Changes

CSC plans should be updated and revised as often to reflect model practices, lessons learned during incident response or exercise play and relevant to the care culture of New Hampshire. *Guidance* is subject to information updates and changes. The use of this Record of Changes helps manage modifications throughout the life of this document.

Description	Date	Completed By
Disease-specific <i>Crisis Standards of Care Plan for Response to COVID-19</i>	April 2020	NH State Disaster Medical Advisory Committee
In accordance with federal Health and Human Services grant requirements, established an all-hazards public health and medical services crisis standards of care guidance/concept of operations to support pervasive or catastrophic mass surge incidents. Title: <i>New Hampshire Crisis Standards of Care Guidance</i> .	June 2022	State Crisis Standards of Care Committee

Abbreviations

ACS	Alternate Care Site
ASPR	U.S. Department of Health and Human Services, Assistant Secretary for Preparedness and Response
BEPRR	Bureau of Emergency Preparedness, Response and Recovery
CBRNE	Chemical, Biological, Radiological, Nuclear, Explosive
CCC	Clinical Care Committee
CMHC	Community Mental Health Care
CMO	Chief Medical Officer
CSC	Crisis Standards of Care
DHHS	NH Department of Health and Human Services
ED	Emergency Department
EDI	Equity, Disability, Inclusion
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Service
EOP	Emergency Operations Plan
ESF	Emergency Support Function
GSHCC	Granite State Health Care Coalition
HAN	Health Alert Network
HCW	Health Care Worker
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program
HTC	Hospital Triage Committee
IAP	Incident Action Plan
IC	Incident Commander
ICS	Incident Command System
IOM	Institute of Medicine
JIC	Joint Information Center
MACE	Multi-Agency Coordinating Entity
MSCC	Medical Surge Capacity and Capability
NAM	National Academy of Medicine
NH	New Hampshire
NHICS	Nursing Home Incident Command System

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NHHA	New Hampshire Hospital Association
NIMS	National Incident Management System
OPLC	Office of Professional Licensure and Certification
PDAFN	Persons with Disabilities and others with Access and Functional Needs
PELOD	Pediatric Logistic Organ Dysfunction
PFA	Psychological First Aid
PIO	Public Information Officer
POLST	Provider Orders for Life Sustaining Treatment
PPE	Personal Protective Equipment
RDHRS	Regional Disaster Health Response System
RPHN	Regional Public Health Network
SDMAC	State Disaster Medical Advisory Committee
SDOH	Social Determinants of Health
SEOC	State Emergency Operations Center
SEOP	State Emergency Operations Plan
SME	Subject Matter Expert
SOFA	Sequential Organ Failure Assessment
SOP	Standard Operating Procedure
STC	State Triage Committee
UC	Unified Command

Glossary

Alternate Care Facility: A temporary site that is not located on hospital property, established to provide patient care. It may provide either ambulatory or non-ambulatory care. It may serve to “decompress” hospitals that are maximally filled, or to bolster community-based triage capabilities. Has also been referred to as an “alternate care site.”⁸

Capability: The ability to manage patients requiring very specialized medical care.⁹

Capacity: The ability to manage a sudden influx of patients.¹⁰

Clinical Care Committee: Composed of clinical and administrative leaders at a health care coalition, healthcare organization, or play the role of the disaster medical advisory committee at the state or regional level (see disaster medical advisory committee). This committee is responsible for making prioritization decisions about the allocation of critical life-sustaining interventions. May appoint a triage team (see triage team) to evaluate case-by-case decisions.¹¹

Contingency Capacity: The spaces, staff, and supplies used are not consistent with daily practices but provide care that is *functionally equivalent* to usual patient care.¹²

Conventional Capacity: The spaces, staff, and supplies used are consistent with *daily practices* within the institution.¹³

Crisis Capacity: Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide *sufficiency* of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available).¹⁴ Crisis care poses a significant risk of a poor outcome to the patient.

Crisis Care Trigger: The point at which the scarcity of resources requires a transition from contingency care to crisis care, implemented within and across the emergency response system. This marks the transition point at which resource allocation strategies focus on the community rather than the individual.¹⁵

⁸IOM (Institute of Medicine). 2009. Guidance for establishing crisis standards of care for use in disaster situations: A letter report. Washington, DC: The National Academies Press. Page 111.

https://www.ncbi.nlm.nih.gov/books/NBK219958/pdf/Bookshelf_NBK219958.pdf

⁹ASPR. 2017-2022 Health Care Preparedness and Response Capabilities. pg. 44

¹⁰ibid, pg. 44

¹¹IOM. 2009. Guidance for establishing crisis standards of care for use in disaster situations: A letter report. Washington, DC: The National Academies Press. Page 111. https://www.ncbi.nlm.nih.gov/books/NBK219958/pdf/Bookshelf_NBK219958.pdf

¹²Institute of Medicine 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework. Washington (DC): National Academies Press. Box 2-4. Section 1-40.

<https://doi.org/10.17226/13351>

¹³ibid

¹⁴ibid

¹⁵IOM 2013. Crisis Standards of Care: A Toolkit for Indicators and Triggers. Washington, DC: The National Academies Press. Box 2-1 Definitions. Page 43. <https://doi.org/10.17226/18338>.

Crisis Standards of Care (CSC): A substantial change in the usual health care operations and the level of care it is possible to deliver, which is made necessary by a pervasive public health emergency (e.g., pandemic influenza) or catastrophic disaster (e.g., earthquake, hurricane), and crisis operations will be in effect for a sustained period of time.¹⁶

Disaster Medical Advisory Committee: Evaluates evidence-based, peer-reviewed critical care and other decision tools and recommends decision-making algorithms to be used when life-sustaining resources become scarce. May also be involved in providing broader recommendations regarding disaster planning and response efforts.¹⁷

Emergency Response System: A formal or informal organization covering a specific geographic area minimally comprised of health care organizations, public health agencies, emergency management agencies, and emergency medical service providers to facilitate regional preparedness planning and response.¹⁸

Functionality Equivalent: Spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources).¹⁹

Health Care Organizations: Any facility or institution, providing patient care. This includes acute care hospitals, community health centers, long-term care institutions, private practices, and skilled nursing facilities.²⁰

Health Care Worker: All paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials. This includes persons not directly involved in patient care, but potentially exposed to infectious agents while working in a healthcare setting.²¹

Health Equity: Health equity is when all members of society enjoy a fair and just opportunity to be as healthy as possible,²² and no one is disadvantaged because of social position or other socially determined circumstances.²³

¹⁶IOM 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework. Washington (DC): National Academies Press. Page 1-1. <https://doi.org/10.17226/13351>

¹⁷IOM (Institute of Medicine). 2009 Guidance for establishing crisis standards of care for use in disaster situations: A letter report. Washington, DC: The National Academies Press. Page 113.

¹⁸Ibid. Page 114.

¹⁹Rhode Island Department of Health. CSC Guidelines. December 4, 2020. Page 5. <https://health.ri.gov/publications/guidelines/crisis-standards-of-care.pdf>

²⁰IOM (Institute of Medicine). 2009 Guidance for establishing crisis standards of care for use in disaster situations: A letter report. Washington, DC: The National Academies Press. Page 114.

²¹U.S. HHS, Centers for Disease Control and Prevention definition, include “essential healthcare workers”.: <https://www.cdc.gov/vaccines/covid-19/categories-essential-workers.html>

²²U.S. Health and Human Services. Centers for Disease Control and Prevention. Health Equity Considerations and Racial and Ethnic Minority Groups. Updated January 25, 2022. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>

²³U.S. Health and Human Services. Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. March 3, 2022.

Indicator: Measurement or predictor that is used to recognize surge capacity and capability problems with the health care system, suggesting that crisis standards of care may become necessary and requiring further analysis or system actions to prevent overload.²⁴

Legal Standard of Care: The minimum amount of care and skill that a health care practitioner must exercise in particular circumstances based on what a reasonable and prudent health care practitioner would do in similar circumstances; during non-emergencies and disasters, they are based on the specific situation.²⁵

Medical Standard of Care: The type and level of medical care required by professional norms, professional requirements, and institutional objectives. These standards vary (1) among types of hospitals, clinics, and alternate care facilities, and (2) based on prevailing circumstances, including emergencies or crisis events.²⁶

Moral Distress: “...an emotion that is expressed when the moral complexity of a situation is not leading to a resolution, thereby having the potential to cause harm to the individual [...] painful feelings and associated mental anguish as a result of being conscious of a morally appropriate action, which despite every effort, cannot be performed owing to organizational or other constraints.”²⁷

Palliative Care: Care provided by an interdisciplinary team to prevent and relieve suffering and to support the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies. Palliative care affirms life by supporting the patient and family’s goals for the future, including their hopes for cure or life prolongation, as well as their hopes for peace and dignity throughout the course of illness, the dying process, and death.²⁸

People with Access and Functional Needs: Individuals who need assistance due to any condition (temporary or permanent) that limits their ability to act. To have access and functional needs does not require that the individual have any kind of diagnosis or specific evaluation.²⁹

Scope of Practice: The extent of a professional’s ability to provide health services pursuant to their competence and license, certification, privileges, or other lawful authority to practice.³⁰

<https://www.cdc.gov/chronicdisease/healthequity/index.htm#:~:text=Health%20equity%20is%20achieved%20when,length%20of%20life%3B%20quality%20of>

²⁴IOM 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 7: Appendixes. Washington, DC: The National Academies Press. Appendix A, page 7-3. <https://doi.org/10.17226/13351>

²⁵ Ibid.

²⁶ Ibid.

²⁷PGCEA, B. (2011). Moral distress and moral courage in everyday nursing practice. *Online journal of issues in nursing*, 16(2), 1B.

²⁸IOM 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 7: Appendixes.

Washington, DC: The National Academies Press. Appendix A, page 7-3. <https://doi.org/10.17226/13351>.

²⁹FEMA Reaches Out to People with Disabilities, Access and Functional Need. January 11, 2021. <https://www.fema.gov/press-release/20210318/fema-reaches-out-people-disabilities-access-and-functional-need#:~:text=Simply%20put%2C%20people%20with%20access,of%20diagnosis%20or%20specific%20evaluation>

³⁰IOM 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 7: Appendixes.

Washington, DC: The National Academies Press. Appendix A, page 7-4. <https://doi.org/10.17226/13351>.

Social Determinants of Health: Conditions in the places where people, live, learn, work, and play that affect a wide range of health and quality-of-life-risks and outcomes.³¹

Triage: The process of sorting patients and allocating aid on the basis of need for or likely benefit from medical treatment. Several types of triage are referenced in this guidance:

- **Primary triage:** The first triage of patients into the medical system (it may occur out of hospital), at which point patients are assigned an acuity level based on the severity of their illness/disease.
- **Secondary triage:** Reevaluation of the patient's condition after initial medical care. This may occur at the hospital following emergency medical service interventions or after initial interventions in the emergency department. This often involves the decision to admit the patient to the hospital.
- **Tertiary triage:** Further reevaluation of the patients' response to treatment after further interventions; this is ongoing during their hospital stay. This is the least practiced and least well-defined type of triage.³²

Triage Team: Appointed by the clinical care committee, uses decision tools appropriate to the event and resource being triaged, making tertiary triage using scarce resource allocation decisions. This is similar in concept to triage teams established to evaluate incoming patients to the emergency department requiring primary or secondary triage, usually in a sudden-onset, no-notice disaster event (e.g., explosive detonation).³³

Trigger: A decision point that is based on changes in the availability of resources that requires adaptations to health care services delivery along the care continuum (contingency, crisis, and return toward conventional).³⁴ Triggers can be scripted or non-scripted.

- **Scripted triggers:** Built into Standard Operating Procedures (SOPs) and are automatic 'if/then' actions.
- **Non-scripted triggers:** Require additional analysis and consideration involving management and supervisory staff.

³¹U.S. Health and Human Services. Centers for Disease Control and Prevention. Social Determinants of Health: Know What Affects Health. <https://www.cdc.gov/socialdeterminants/>

³²IOM 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 7: Appendixes. Washington, DC: The National Academies Press. Appendix A, page 7-5. <https://doi.org/10.17226/13351..>

³³Ibid.

³⁴IOM 2013. Crisis Standards of Care: A Toolkit for Indicators and Triggers. Washington, DC: The National Academies Press. <https://doi.org/10.17226/18338>

Introduction

Purpose

The NH Department of Health and Human Services (DHHS) *Crisis Standards of Care (CSC) Guidance* establishes a framework for the development and promulgation of recommendations statewide during a pervasive or catastrophic public health crisis which requires adapted standards of care and allocation of scarce resources in order to provide effective care to the greatest number of people. In doing so, this framework:

1. Adheres to ethical and legal standards.
2. Ensures equity, fairness, and transparency during public health crisis. Every human being has a right to be treated equally and fairly in the provision of health care services.³⁵
3. Supports health care workers by providing mental health resources with regular training on the provision of care for patients under CSC situations.
4. Provides ongoing community engagement, education, and communication.
5. Provides clear indicators, triggers, and lines of responsibility.
6. Utilizes evidence-based clinical processes and operations.
7. Protects the overall integrity of the health care system.
8. Develops and uses processes that enhance the integration of health care organizations into the community response.

Scope

The *CSC Guidance* defines a process to develop guidance and recommendations to support NH leaders and health care organizations in the context of a pervasive or catastrophic public health crisis. It provides guidance, recommendations, and resources for integrating CSC planning considerations into organization-specific emergency plans. The *CSC Guidance* does not replace the need for individual organizational and/or facility level planning.

The CSC Guidance is an attachment to the State ESF 8 Annex. It may be superseded by any future guidance that may be provided by state or federal public health authorities.

The CSC Guidance aligns with the National Incident Management System (NIMS) and the National Response and Recovery Framework, Fourth Edition (U.S. Department of Homeland

³⁵NRCC Healthcare Resilience Task Force. Crisis Standards of Care and Civil Rights Laws. (2020)
<https://files.asprtracie.hhs.gov/documents/crisis-standards-of-care-and-civil-rights-laws-covid-19.pdf>

Security, October 28, 2019) to facilitate efficient and effective coordination within the State's emergency response system.

Goal

The overall goal of crisis care is to provide the best care possible to the largest number of people with the resources available while ensuring fair and equitable access to services for all.

Assumptions

1. Surge capacity management is dependent on a well-functioning health care entity Incident Command System (ICS) structure and the domains of space, supplies, staff and special considerations (e.g., Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE) incidents).³⁶
2. Contingency or CSC plans developed and issued in accordance with this *CSC Guidance* do not replace the judgment of public health and health care entities' operational management, medical directors, their legal advisors or clinical staff.
3. Contingency and CSC recommendations developed in accordance with this *CSC Guidance* can be adapted by health care entities as support to their organization-specific surge plans in collaboration with health care systems within their geographical region.
4. In no-notice disasters, dissemination of state-level CSC recommendations may be delayed. Any health care organization that experiences a no-notice disaster should utilize all communications necessary to solicit support from other facilities or entities before entering crisis care status independently of other facilities. When necessary, utilize their organizational surge and CSC plans to support clinical decision-making and resource allocation.
5. CSC recommendations developed in accordance with this *CSC Guidance* will only be implemented in response to a catastrophic no-notice disaster (e.g., earthquake, bioterrorism) or a known, pervasive health crisis (e.g., pandemic influenza) that results in:
 - a. Prolonged mismatch between available health care resources and demand for those resources;
 - b. Major disruptions to the health care supply chain or no resupply of resources is foreseeable; and
 - c. Patient transfer to other facilities is no longer feasible, at least in the short-term.

³⁶American College of Emergency Physicians. Health Care System Surge Capacity Recognition, Preparedness, and Response 2018

6. CSC recommendations developed and issued in accordance with this *CSC Guidance* will be triggered for one or more health care organizations when all contingency level of care options have been exhausted by these facilities and there are no acceptable alternatives left.
7. CSC recommendations developed and issued in accordance with this *CSC Guidance* will require the activation of the SEOC and ESFs; Unified Command (UC) with ESF 8 Public Health and Medical leadership; health care entities activating their emergency operations and medical surge plans, and EOCs.
8. Issuance of CSC recommendations developed in accordance with this *CSC Guidance* will only occur when state or federal disaster declarations have been considered or requested (e.g., Stafford Act, Public Health Services Act).
9. Health care organizations will provide crisis standards training to all of their health care workers.

Limitations

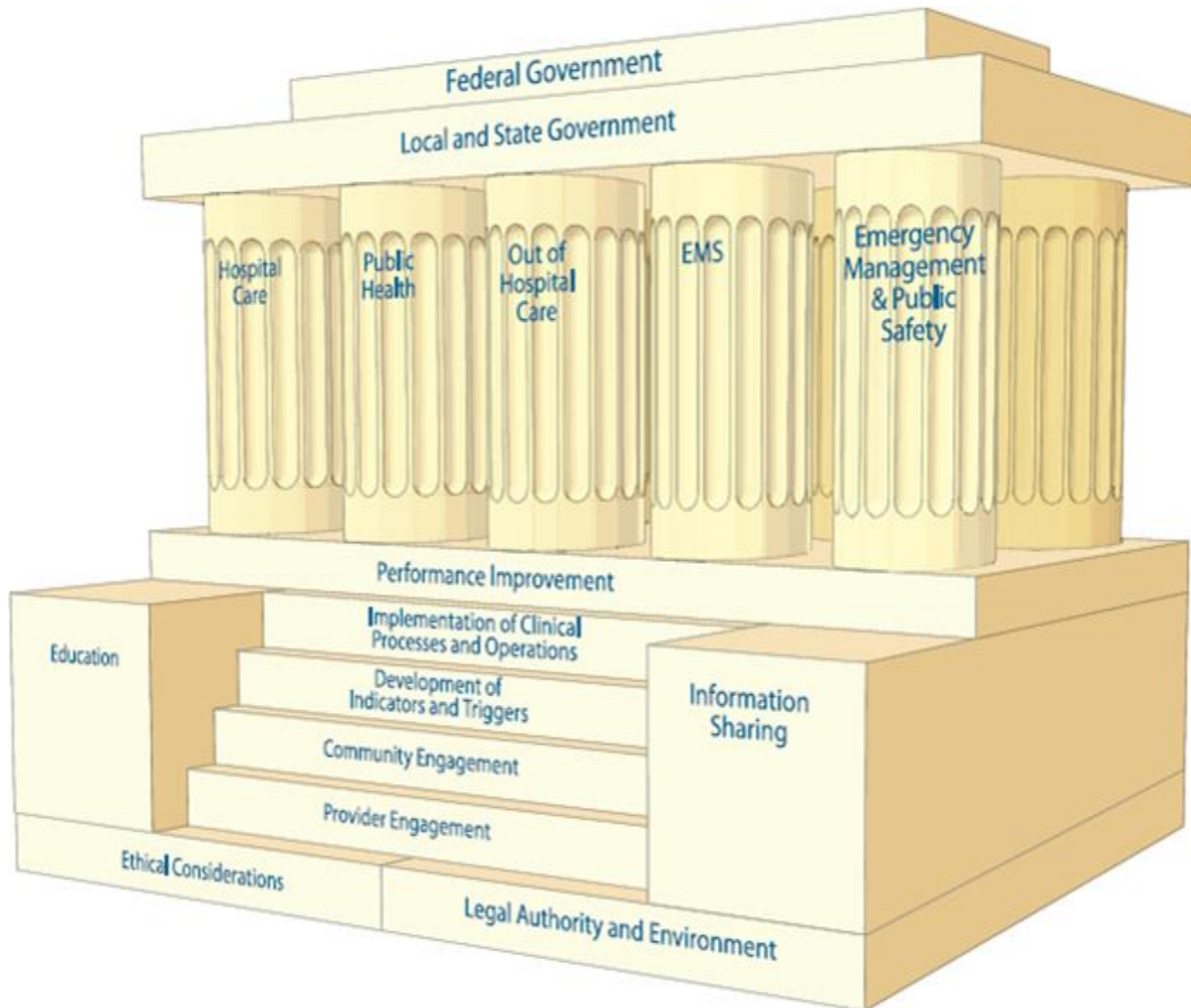
1. No guarantee is implied by this plan of a perfect ICS structure for CSC.
2. As personnel and resources may be overwhelmed, NH DHHS can only endeavor to make every reasonable effort to manage the situation, with the resources and information available at the time.
3. Health care entities or systems implementing strategies identified in this Guidance during crisis situations should assure communications and coordination with the NH DHHS, GSHCC partners, and public safety partners.
4. Recommendations within this document may be superseded by incident specific recommendations by NH DHHS.
5. Web links and resources listed are provided as examples, and may not be the best sources of information available. Their listing does not imply endorsement by NH DHHS.

Concepts

Crisis Standards of Care

A CSC framework (Figure 1) is developed with a foundation of legal, environmental and ethical considerations for planning and implementation. The steps are needed to ensure that the development and implementation of CSC plans occur. The pillars are elements of the disaster response system. The more complex a public health incident is, the more important strong and effective coordination and integration among the pillars becomes. Atop the pillars are local, state, and federal government functions. According to the IOM, “Government at all three levels has an overarching responsibility for the development, institution, and proper execution of the CSC plans, policies, protocols, and procedures.”³⁷

Figure 1: CSC Framework

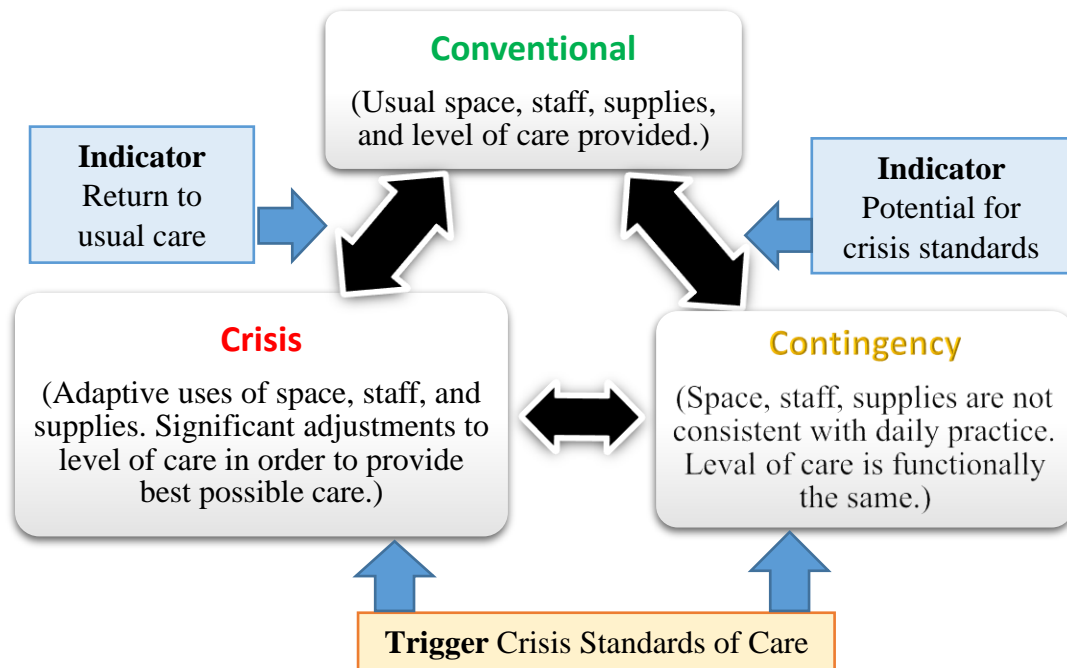


³⁷ Ibid, page 1-4.

Continuum of Care

As described by the National Academies, the need for health care surge capacity in a disaster occurs along a continuum (Figure 2) based on demand for health care services and available resources.

Figure 2: Disaster-Driven Care Continuum



Social Determinants of Health and Its Impact on Crisis Standards of Care

Disasters directly impact the health of the population resulting in physical trauma, acute disease, and emotional trauma that can last for days, months, or years. Identifying and understanding the system of human needs is essential for defining future disaster response and recovery strategies.³⁸ The Social Determinants of Health (SDOH), are internationally recognized as key to any healthy society. SDOH (Figure 3) are the conditions in which people are born, grow, live work and age. Factors include:

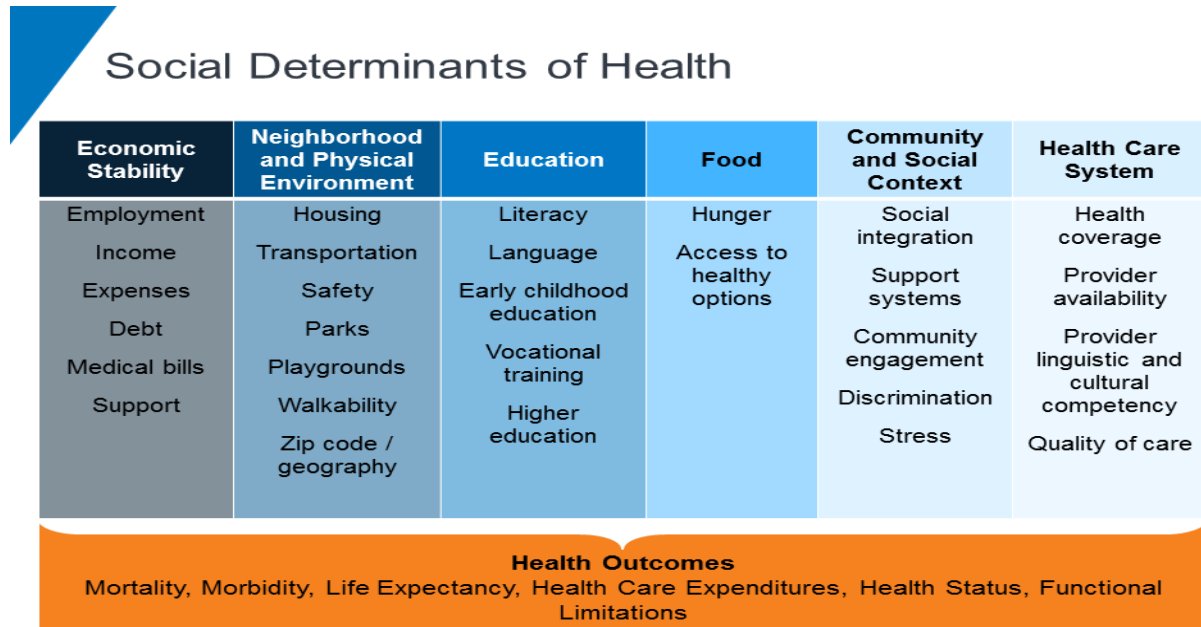
- Socioeconomic status,
- Education access and quality,
- Neighborhood and physical environment,
- Employment,

³⁸Ryan, B., Coppola, D., Canyon, D., Brickhouse, M., & Swienton, R. (2020). COVID-19 Community Stabilization and Sustainability Framework: An Integration of the Maslow Hierarchy of Needs and Social Determinants of Health. *Disaster Medicine and Public Health Preparedness*, 14(5), 623-629. <https://doi.org/10.1017/dmp.2020.109>

- Social support networks,
- Health care access and quality, and
- Political systems.

CSC guidance developers must consider the community and its “historical and contemporary social, health, and healthcare inequities.”³⁹ For CSC to ensure both the fair allocation of resources and promote equitable health outcomes through resource distribution, planners must take into account historical and contemporary social, health, and healthcare inequities.⁴⁰ Community buy-in is essential but should happen in advance (upstream) of a public health crisis to avoid magnification of existing health inequities and possibility of exponential rates of mortality (downstream). Community and health care provider engagement plays a major fundamental role in CSC planning.

Figure 3: Social Determinants of Health⁴¹



³⁹Society for Academic Emergency Medicine. Contributors: Massachusetts Coalition for Health Equity; SAEM ADIEM; SAEM Social EM and Population Health Interest Group; SAEM Ethics Committee; SAEM Palliative Care Interest Group; SAEM Critical Care Medicine Interest Group; Susan Willson, M.S. in Restorative Practices, Together Works Restorative Consulting. Accessed at https://www.saem.org/docs/default-source/saem-documents/equity-in-crisis-standards-of-care-872020.pdf?sfvrsn=c0bd03fd_2

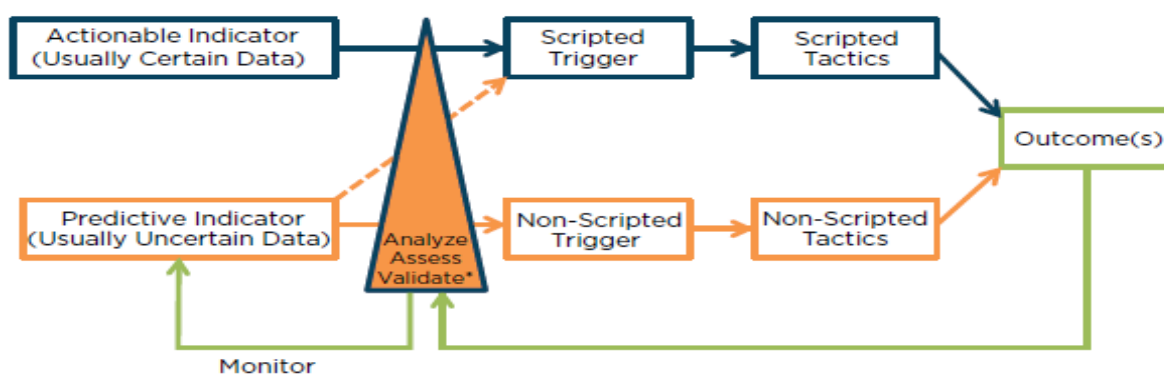
⁴⁰ Ibid

⁴¹ Artiga, S and Hinton, E. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Issue Brief. Kaiser Family Foundation. May 2018. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

Indicators and Triggers

1. Planning for a step-wise degradation of services that is aligned with other hospitals in the area is key to equitable care.⁴²
2. Indicators may identify the need to transition to contingency to crisis care (but requires analysis to determine appropriate actions), while a trigger event dictates action is needed to adapt health care delivery and resources.⁴³
3. It is important for organizations to identify indicators and triggers prior to an incident due to the “stress, complexity, and uncertainty inherent in a crisis situation.”⁴⁴
4. There are two types of triggers (Figure 4):⁴⁵
 - a. *Predetermined (scripted) triggers* that are established during the planning phase and integrated into checklists, job action sheets, and other response procedures; typical ‘if/the’ decisions. Scripted triggers work well with frontline personnel (point of entry, reception, etc.) so they have actions they can take immediately to prevent delay.
 - b. *Non-scripted triggers* require additional analysis involving supervisory staff. These triggers vary with the situation. The less specific the information available, the more difficult it is to apply scripted trigger. Supervisory staff or SMEs will need to be involved to process the information and decide on necessary actions.

Figure 4: Relationship among Indicators, Triggers, and Tactics



⁴² National Academy of Medicine. Crisis Standards of Care. COVID-19 Issue Summary. December 2020.

⁴³ Minnesota Crisis Standards of Care Framework: Health Care Organization Surge Operations and Crisis Care. March 1, 2020. Page 8.

⁴⁴IOM 2013. Crisis standards of care: A toolkit for indicators and triggers. Washington, DC: The National Academies Press. Page 55. <https://www.ncbi.nlm.nih.gov/books/NBK202387/>

⁴⁵Ibid

Resource Allocation

Along the continuum of care, core strategies (Table 1) to maximize health care resources include:

Table 1: Strategies to Maximize Health Care Resources

Core Resource Allocation Strategies					
<p>Prepare</p> <ul style="list-style-type: none"> •Pre-event actions taken to minimize resource scarcity (e.g., stockpile medicines) 	<p>Conserve</p> <ul style="list-style-type: none"> •Use less of a resource by lowering dosage or changing utilization practices (e.g., minimizing use of oxygen driven nebulizers to conserve oxygen). 	<p>Substitute</p> <ul style="list-style-type: none"> •Use an essentially equivalent device, drug, or personnel for one that would usually be available (e.g., morphine for fentanyl) 	<p>Adapt</p> <ul style="list-style-type: none"> •Use a device, drug, or personnel that is not equivalent but that will provide sufficient care (e.g., anesthesia machine for mechanical ventilation) 	<p>Re-Use</p> <ul style="list-style-type: none"> •Re-use (after appropriate disinfection/sterilization) items that would normally be single-use items. 	<p>Re-Allocate</p> <ul style="list-style-type: none"> •Restrict or prioritize use of resources to those patients with a better prognosis or greater need.

Crisis Care Cross-Cutting Strategies

Examples of other fundamental changes that may be considered in conjunction with or prior to implementing CSC plan include, but are not limited to:

1. Implementing measured changes in services provided ensures that the right thing is done clinically for the circumstances and to minimize risks to patients.
2. When the significant risk (i.e., crisis) threshold is not clear, determine regional definitions to facilitate resource allocation/movement decisions—for example, what level of staffing constitutes crisis vs. contingency.
3. Applying principles of field triage and a graded scoring system to determine who gets what kind of care.⁴⁶
4. Determining who receives the use of a limited supply of ventilators or other critical care modalities.⁴⁷

⁴⁶Stanford Health Care, Office of Emergency Management, and Stanford Children’s Health. Interim Crisis Care Plan. January 6, 2021.

⁴⁷ Ibid

5. Creating alternate care sites from area never designed to provide medical care.⁴⁸
6. Changing infection control standards to permit group isolation rather than single person isolation units.⁴⁹
7. Emergency Department access may be reserved for immediate-need patients; ambulatory patients may be diverted to alternate care sites where care can still be provided.⁵⁰

Ethical Standards for CSC

This *CSC Guidance* follows an ethical framework, which values the normative principles of ethical decision-making including a person's right to self-determination and the health care provider's obligations to promote health (beneficence) and avoid harm (non-maleficence). It is intended to facilitate fair health care decision-making. It is vital that these decisions be guided by widely accepted and publicly endorsed ethical principles.⁵¹

Ethical Triage Decisions⁵²

1. **Fairness and Equity** – Every healthcare provider should subscribe to evidence based science, be fair, equitable, and responsive to specific needs of all those who are affected by the public health crisis with a focus on compassion and care, a duty to steward resources, and a goal of maintaining the trust of patients and the community.
2. **Transparency** – In underlying values and priorities and decision-making.
3. **Consistency** – In application across populations and among individuals.
4. **Proportionality** – Public and individual requirements must be commensurate with the scale of the crisis and degree of scarce resources (i.e. the restrictions on care should not be more restrictive than the situation requires – and this may require re-evaluation as more resources become available).
5. **Accountability** – Of individuals making the decisions and of the facilities and governments to support the processes and the providers.

⁴⁸ Ibid

⁴⁹ Ibid

⁵⁰ Ibid

⁵¹University of California Critical Care Bioethics Working Group. Allocation of Scarce Critical Resources under Crisis Standards of Care. Revised June 17, 2020. Page 8.

⁵²IOM 2012. Ethical Framework. <https://doi.org/10.17226/13351>.

Ultimately, when there is a shift to crisis standards of care, it represents not a rejection of ethical principles but their embodiment.

(NAM, Rapid Expert Consultation. March 28, 2020)

Supporting Ethical Principles

These supporting ethical principles have been recognized as central to a just process for allocating limited resources during catastrophic or pervasive public health crises.

1. **Beneficence and Non-Maleficence**⁵³ – A duty to promote health and avoid harm. This general principle has several important repercussions:
 - a. Duty to Care: Health care workers have a duty to care for their patients and should not abandon them. Health care organizations have a reciprocal duty to support and protect health care workers, e.g., provide mental health resources, adequate training, personal protection equipment (PPE), etc.
 - b. Duty to Promote the Public Good: In terms of the whole population, save the greatest number of lives possible during a disaster.
 - c. Duty to Plan: In order to save the population, there need to be plans that can be acted on that mitigate or prevent resource shortages.
 - d. Duty to Steward Scarce Resources: During disasters, it is common to see resource shortages. There is a duty to carefully steward scarce resources in order to save as many lives as possible.

2. **Respect for Persons**⁵⁴ – There is duty to recognize and respect the inherent dignity and worth of each human being. This general principle implies among other things:
 - a. Respect for Autonomy: Respect for persons and their ability to make decisions for themselves may be overridden by decisions for the greater good; however, patients must still be treated with dignity and compassion.
 - b. Protection and Provision for Vulnerable Populations: Health systems should take deliberate, active steps to ensure that vulnerable or marginalized populations receive equal access to scarce resources.

⁵³University of California Critical Care Bioethics Working Group. Allocation of Scarce Critical Resources under Crisis Standards of Care. Revised June 17, 2020. Page 8.

⁵⁴Ibid, page 9.

- c. Disability and Return to Previous State of Health: Triage protocols must either not score individuals on their quality of life after treatment or assess at most how far treatment will return the patient to their own baseline quality of life.⁵⁵
3. **Fairness and Equity** - In addition to the basic five IOM, 2012 ethical requirements, justice has many aspects that should be considered:
 - a. Protection for Populations with Disabilities and Others with Access and Functional Needs: Plans and decisions should take into account the unique health care and social service needs or vulnerabilities of this population.
 - b. Avoid Exacerbating Existing Disparities: Decisions should not be exacerbate existing disparities in health outcomes or access to health care.
 - c. Duty to Collect Information: There is a duty to collect the full range of relevant facts before making decision and to revisit decisions as new information emerges.
 - d. Public Involvement: When feasible, input should be sought from people who stand to benefit from or be harmed by policies. When public participation is not feasible, responsible parties should seek to understand the perspectives of those affected by their decisions, including underrepresented or vulnerable communities.

Legal Standards for CSC

Legal considerations under a crisis standards of care plan may include minimizing liability when medical providers are called upon by the State to provide emergency management services, under conditions where they must:

- a. provide treatment without the required professional licenses;
- b. deviate from the “ordinary” standards of care; and/or
- c. respond under conditions of scarce resources.

Because there is no way to predict with absolute certainty what the next health care crisis will entail, each health care organization should:

⁵⁵Stanford Health Care, Office of Emergency Management, and Stanford Children’s Health. Interim Crisis Care Plan. January 6, 2021.

- a. engage a legal team **before** disaster strikes to help identify potential legal issues that are likely to arise,
- b. identify legal authorities that will need to be considered,
- c. formulate possible solutions to limit liability, and also
- d. plan to engage a legal team to advise it **during** the course of the crisis as issues develop in real time.

This legal section of the NH *CSC Guidance* is provided to identify the different levels of crisis recognized under New Hampshire law and to suggest legal issues that may arise and should be anticipated during these levels of crisis. It is not comprehensive of all possible legal issues as it is impossible to anticipate all scenarios, and it is impossible to predict what orders will be issued by governing bodies to address a crisis. Additionally, the law is constantly evolving through new legislation and case law.

This legal section does not constitute legal advice or legal representation. It is incumbent upon each healthcare organization to consult with its own specific legal counsel for comprehensive, circumstance-specific legal advice.

1. Levels of Crisis

A. State of Emergency

A state of emergency is a condition, situation or set of circumstances that has been deemed to be so extremely hazardous or dangerous to life or property that it is necessary to utilize extraordinary measures to lessen or mitigate possible harm. RSA 21-P:35, VIII (Supp. 2021). The Governor has the power to declare a state of emergency by an executive order. RSA 4:45, I (Supp. 2021). New Hampshire's house and senate also have the power to declare a state of emergency by concurrent resolution. *Id.* A state of emergency may be declared upon the Governor's finding (or the house's and senate's concurrent resolution) that "a natural, technological, or man-made disaster of major proportions is imminent or has occurred within this state, and that the safety and welfare of the inhabitants of this state require an invocation of a state of emergency." *Id.* A declaration of emergency allows the Governor to issue an executive order activating the CSC Plan to address the escalating need for medical care and sharply reduced availability of critical resources resulting from the disaster.

During the existence of a state of emergency, the Governor has the authority to enforce all emergency management laws, rules and regulations, and to assume control of emergency management forces and helpers. RSA 4:45. The Governor's emergency management powers also include:

- A. Selling, leasing, transferring and receiving or delivering materials, or performing “services for emergency management purposes on such terms and conditions as the governor shall prescribe and without regard to the limitations of any existing law;”
- B. Providing for and compelling the evacuation of all or part of the population from any area within the state;
- C. Exercising “such other functions, powers, and duties as are necessary to promote and secure the safety and protection of the civilian population”;
- D. Entering into mutual aid agreements with other states relative to emergency management issues; and/or
- E. Making, amending, suspending and rescinding necessary orders, rules and regulations to carry out the governor’s emergency management authority.

RSA 4:45, III; RSA 4:47, I, III (Supp. 2021).

It is important to be aware that, while the Governor’s powers during a state of emergency are broad under our state’s statutes, the Governor does not have the authority to suspend an individual’s rights under the New Hampshire Constitution. RSA 4:45, III-a. The Governor also does not have the authority to modify or waive an individual’s civil liberties. *Id.* Lastly, the Governor may not suspend the United States Constitution or alter federal law during a state of emergency. *Id.* Accordingly, any executive orders issued by the Governor altering standards concerning federal law will not provide an absolute shield from federal tort claims or legal liability under federal law.

During a state of emergency, the Commissioner of DHHS also has certain powers and duties, under the direction and control of the Governor. RSA 21-P:53 (Supp. 2021). The Commissioner has the authority to:

- A. Carry out all public health activities in collaboration with the New Hampshire, Department of Safety, Division of Homeland Security and Emergency Management;
- B. Purchase and distribute anti-toxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents to be in the interest of public health;
- C. Control and ration use of anti-toxins, serums, vaccines, immunizing agents, antibiotics, and other pharmaceutical agents if there is a shortage or threatened shortage;
- D. Investigate any incident or imminent threat of any disease or health condition that poses a risk of a significant number of human fatalities or incidents of permanent or long-term disability; and

- E. Order a person to undergo medical care as may be necessary to treat or prevent an incident or threat of disease.

Id. The Commissioner’s powers and duties are limited to the specific nature of the emergency, its geographic limits, and the conditions that brought it about, as specified in the declaration of the state of emergency. *Id.*

B. Public Health Incident

A public health incident is a specific incident that the Commissioner of DHHS or the Commissioner of the New Hampshire, Department of Safety has declared in writing to the Governor “poses a threat to the health and safety of the public and demands a response that will require the assistance of agents from outside the state system, but which does not rise to the level that would necessitate the declaration of a state of emergency by the governor under RSA 4:45.”⁵⁶ RSA 508:17-a, II(c). When there is a public health incident, both DHHS and the New Hampshire, Department of Safety have the power to engage agents and volunteers outside of the state workforce to assist in the response to the incident. RSA 508:17-a. During a public health incident, DHHS is also authorized, with the written approval of the Governor, to establish and operate acute care centers to treat people who would normally require admission to an acute care hospital. RSA 141-C:26 (Supp. 2021).

When there is a declared public health incident, health care providers who are authorized to prescribe prescription medication for the treatment or prevention of a communicable disease are permitted to prescribe prescription medication for the treatment or prevention of a communicable disease to a patient that s/he did not evaluate and with whom there is no established health care provider-patient relationship so long as the prescription is issued for a legitimate medical purpose and in accordance with established clinical practice guidelines, when available. RSA 141-C:15-a, I (Supp. 2021).

C. General Emergency Management

Within the New Hampshire, Department of Safety, Division of Homeland Security and Emergency Management, there is a Division of Emergency Services, Communications, and Management that is authorized to cooperate “with the federal government, with other states, and with private agencies in all matters pertaining to the emergency management.” RSA 21-P:34, 37 (Supp. 2021). “‘Emergency management’ means the preparation for and the carrying out of all emergency functions.” RSA 21-P:35, V (Supp. 2021). Emergency management includes but is not limited to emergency response and training functions to prevent, minimize or repair injury or damage resulting from the occurrence or threat of

⁵⁶ A state division of emergency services, communications, and management has been created under the direction of the director of the division of homeland security and emergency management within the New Hampshire, Department of Safety. RSA 21-P:34 (Supp. 2021).

widespread or severe damage, injury or loss of life or property resulting from any natural or human cause. *Id.* In furtherance of its duties, it is authorized to:

- A. Prepare a comprehensive plan and program for the emergency management of the state;
- B. Procure supplies and equipment;
- C. To institute training programs and public information programs;
- D. To study and survey industries, transportation, communication, housing and medical facilities, and resources; and
- E. Subject to the approval of the Governor, to coordinate mutual aid plans between political subdivisions of the state.

RSA 21-P:37 (Supp. 2021). In the event of disaster beyond local control, the Governor is permitted to assume direct operational control over all or any part of these emergency management functions. *Id.*

D. Communicable Diseases

DHHS has specific powers and responsibilities with respect to the prevention and control of communicable diseases. *See* RSA 141-C *et seq.* DHHS has the authority to identify, investigate and test for communicable diseases posing a threat to the state. RSA 141-C:3, I (Supp. 2021). Investigation includes examination of patients in addition to information gathering. RSA 141-C:9, II. DHHS further has a duty to coordinate medical, municipal and other services as may be necessary to control, communicable diseases when they occur. RSA 141-C:3, III. In furtherance of this, the Commissioner has the legal authority to order quarantine and treatment for persons who are or suspected to be carriers of communicable diseases. RSA 141-C:11; RSA 141-C:12; RSA 141-C:1.

2. Professional Licensing

Various healthcare professions require a person to be licensed to be able to provide medical care within the scope of that specific profession, and it is unlawful and grounds for discipline for a person to provide medical care without a license, or for a professional to provide medical care outside the profession for which s/he is licensed. Such requirements for a license to practice any professional skill, however, may not apply if the practitioner is an “authorized emergency management worker who shall, in the course of performing his or her duties as such, practice such professional...skill during an emergency.” RSA 21-P:41, II (Supp. 2021). Emergency management workers who are performing emergency management duties during an emergency are exempt from the requirement of needing a license to practice a professional skill that would normally require such a license. *Id.* “Emergency management workers” are broadly defined to include not just paid employees of the State, but also

volunteers and employees of other states, territories, possessions, and governments. *Id.* Emergency management workers may even be private corporations or organizations. *Id.* To be considered an emergency management worker, however, one must be performing emergency management services in New Hampshire, and must be “subject to the order or control of, or pursuant to a request of, the state government or any of its political subdivisions.” *Id.* RSA 21-P:41 specifically identifies dentists, registered nurses, student nurses undergoing training at a licensed hospital in this state and emergency medical care providers who are licensed in New Hampshire as “authorized emergency management workers” “in any emergency” and are authorized to administer anesthetics, perform minor surgery, perform intravenous, subcutaneous, and intramuscular procedures and administer oral and topical medication under the general supervision of a member of the medical staff of a legally incorporated and licensed hospital of this state. *Id.*

3. Tort Liability

A. Immunity

In New Hampshire, the State and its departments are immune from being sued unless there is a statute that specifically waives the State’s immunity. *See N. H. Atty. Gen. Op. No. 2020-01, Avery v. Comm’r, New Hampshire Dep’t of Corr.*, 173 N.H. 726, 730 (2020) and *XTL-NH, Inc. v. N.H. State Liquor Comm’n*, 170 N.H. 653, 656 (2018). Any such statutory waiver will be limited to that which is articulated within the statute. *See N. H. Atty. Gen. Op. No. 2020-01, Avery*, 173 N.H. at 730 and *XTL-NH, Inc.*, 170 N.H. at 656. Simply put, “New Hampshire courts lack subject matter jurisdiction over an action against the State ‘unless the legislature has prescribed the terms and conditions on which it consents to be sued, and the manner in which the suit shall be conducted.’” *N. H. Atty. Gen. Op. No. 2020-01, Avery*, 173 N.H. at 731 *quoting XTL-NH, Inc.*, 170 N.H. at 656. The legislature has not waived sovereign immunity with respect to emergency management activities, so the State and its departments are immune from being sued for such activities. *N. H. Atty. Gen. Op. No. 2020-01*. In addition, the legislature has specifically declared all emergency management activities to be governmental functions. *Id.*, *citing RSA 21-P:41, I*. “As a result, these functions are cloaked with sovereign immunity.” *N.H. Atty. Gen. Op. No. 2020-01 citing XTL-NH, Inc.*, 170 N.H. at 656.

When private corporations, organizations, agencies and/or emergency management workers are required to engage in emergency management activities under a state of emergency, these private workers are justifiably concerned about the potential liability when a patient becomes injured as a result of receiving aid. Private corporations, organizations, agencies and/or emergency management workers may be entitled to immunity from liability due to injury, death or property damage while performing emergency management activities if these private actors are complying with, or reasonably attempting to comply with, laws regarding emergency management, or the orders, rules or regulations promulgated pursuant to said laws. *See RSA 21-P:41, I and N. H. Atty. Gen. Op. No. 2004-01*.

In addition, any person who acts as an agent of DHHS or the Department of Safety during a public health incident is immune from claims and civil actions arising from acts committed within the scope of his or her official duty to the same extent as state officers, trustees, officials, employees, and members of the general court under RSA 99-D. RSA 508:17-a, I. This immunity is contingent on the DHHS or the Department of Safety designating the person to act as its agent, the person must act in good faith, within the scope of his or her official functions and duties, and the damage or injury must not be caused by willful, wanton, or grossly negligent misconduct by the agent. RSA 508:17-a, II(c).

B. Professional-Specific Exemptions from Liability

Licensed physicians, registered nurses and hospitals who provide remote advice or orders to emergency medical providers under emergency conditions and in good faith before the patient arrives at the health care facility may be exempt from liability for negligence. RSA 508:12-b, I (Supp. 2021). Reciprocally, the emergency medical care provider who relies on this remote advice in good faith may also be exempt from liability for damages so long as the act or omission made within the level of his or her training and certification. RSA 508:12-b, II.

C. The Good Samaritan

New Hampshire law also provides some protection for those who, in good faith, render emergency assistance without compensation at an emergency or accident. RSA 508:12. The emergency care can be to the victim of an, accident, crime or delinquent act. *Id.* The aid can be provided at the scene of the incident, or while in transit in an ambulance or rescue vehicle. *Id.* The victim must be in urgent need of care as a result of the incident. *Id.* The acts of care must be made without willful or wanton negligence, and so as long as the actor receives no direct compensation for the care from the victim or on behalf of the victim. *Id.* Those who render such emergency care have a duty to place the injured person under the care of a physician, nurse, or other person qualified to care for such person as soon as possible and to obey the instructions of such qualified person. *Id.*

4. Privacy of Patient Information

Medical privacy is a fundamental concern of Congress, the New Hampshire legislature and society in general. *Hidalgo-Semlek v. Hansa Med., Inc.*, 498 F. Supp. 3d 236, 251 (D.N.H. 2020). The protections afforded to medical privacy are not minimized or waived during emergency conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects confidential patient information by requiring strict adherence to rules concerning when release of patient information is appropriate. 42 U.S.C.A. 320d *et seq.* (Supp. 2021); 45 C.F.R. Part 164 (2022). HIPAA does allow for disclosure of protected medical information for treatment purposes, public health purposes, and certain disclosures to disaster relief organizations. *See* 45 CFR 164.510(b). Additionally, the Secretary of the United States, Department of Health and Human Services, has the authority to put in place modification or waivers altering the HIPAA Privacy Rule standards during a declared

emergency under section 1135(b)(7) of the Social Security Act. New Hampshire has a state law equivalent to HIPAA. *See* RSA § 332-I, *et seq.* New Hampshire law also permits disclosure of protected medical information by a health care provider for purposes of treatment and care coordination. RSA § 332-I:3.

The broad powers of the State to investigate communicable diseases are balanced by privacy considerations protected by both federal and state laws, and exercised in the context of disclosures limited to the minimum necessary. As such, medical providers must be prepared to respect patients' health information privacy even in an emergency.

5. Civil Liberties

When resources are inadequate to meet demand, health care providers may need to change practices to accomplish the “greatest good for the greatest number.”⁵⁷ Federal and New Hampshire laws, however, prohibit discrimination in the provision of health care services, even during a crisis. Laws and regulations prohibit discrimination on the basis of race, color, national origin, religion, disability, age and sex, including in the provision of health care services during a health care emergency. On the federal level, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and Section 1557 of the Affordable Care Act prohibit discrimination in health programs or activities funded by the U. S. Department of Health and Human Services. New Hampshire state law protects individuals from being denied equal access to public accommodations, such as hospitals, and any services of a public accommodation because of age, sex, sexual orientation, gender identity, race, creed, color, marital status, physical or mental disability or national origin. *See* RSA 354-A: 17. These laws remain in effect during a crisis.

It can be confusing which factors can and cannot be used legally to make CSC decisions regarding who is to receive treatment when need exceeds resources. In September of 2021, the Network for Public Health Law attempted to outline information on legal decision factors in CSC decision-making. While specific legal bases for critical decisions directly impacting patient outcomes are fact specific and vary across jurisdictions, the following have been identified as factors or criteria generally interpreted or viewed as “unlawful” for purposes of CSC decision-making:

- Race / Color
- Ethnicity
- National Origin
- Sex
- Gender
- Age (as a purely categorical factor)
- Disability – Physical or Mental
- Quality of Life
- Individual’s Relative Worth
- Inequitable Clinical Assessment Scores
- Resource Intensity Due to Disability /Age
- Duration of Need Due to Disability / Age

⁵⁷ Hick JL, Hanfling D, and Cantrill SV. Allocating Scarce Resources in Disasters: Emergency Department Principles.” *Annals of Emergency Medicine*. August 22, 2011. <https://doi.org/10.1016/j.annemergmed.2011.06.012>.

- Veteran Status
- Marital Status
- Religion / Exercise of Conscience
- Long-term Mortality or Life Expectancy⁵⁸
- Income
- Ability to Pay
- Limited English Proficiency
- Stereotypes

Objective medical evidence, equitable clinical assessments, individualized patient assessments, patient consent and short term survival are recognized as some of the lawful bases for which CSC decisions may be lawfully made.⁵⁹

Notification and Activation of Crisis Standards of Care Guidance

Situational Awareness Indicators

1. Monitoring of ongoing regional, national, and global events for possible threats to New Hampshire—if an event is “noticed” or “no-notice”;
2. Status of national supply chain resources, transportation;
3. Environmental sources of information: reports regarding weather, air, and water quality, etc.;
4. State and local/regional infrastructure: facility environment of care and community infrastructure (power, telecommunications, road systems, etc.);
5. Status of health care and public health critical infrastructure (cyber connectivity, medical devices, etc.);
6. Health care systems information: syndromic surveillance, epidemiological monitoring of illness and injury, national pharmacy data, 911 dispatch, call centers, poison control centers, mortuary data, veterinary data, emergency department visits/status, and regional hospital operational and diversion status; and
7. Transportation: mass transit, air transport, port authorities, and information about EMS transportation capabilities, including rotor-wing and ground units.

⁵⁸ Hodge, James G., Jr., J.D., L.L.M., Piatt, Jennifer L., J.D. and Wells, Nora, J.D., “Crisis Standards of Care: Legal Decision Factors.” *The Network for Public Health Law*. September 7, 2021. <https://www.networkforphl.org/wp-content/uploads/2021/09/Western-Region-Memo-CSC-Legal-Factors-1.pdf>.

⁵⁹ Used here with permission from James G. Hodge, Jr. JD, LLM.


Health Care Triggers

1. Activation of local hospital and nursing home incident command (HIC/NHIC), the facility’s emergency operations plan (EOP) and annexes (e.g., Mass Casualty, Medical Surge, Mass Fatality, etc.) to address demand for health care services and status of available resources.
2. One or more health care organizations’ space, staff, and supplies for contingency level of care have been exhausted, see Table 2 for additional triggers.


Declaration of Emergency and/or Public Health Incident

Emergency declarations can arise a host of powers and protections that may impact the delivery of health care services depending, in part, on real-time legal interpretations.


Table 2: Sample CSC Implementation Chart

	Possible Triggers	State-level Action
Escalation within Contingency Care 	<ul style="list-style-type: none"> ➤ One or more hospitals or health care entities activate incident emergency operations center. ➤ One or more hospitals or health care entities initiate resource requests and/or mutual aid. ➤ Infrastructure of one or more facilities severely compromised. ➤ Abnormally high percentage of hospitals on diversion for EMS. ➤ Patient transfer across all or part of the state limited. ➤ Major disruptions to health care supply chain. ➤ Medical countermeasure availability declining. ➤ Marked increase in number of patients critically ill and unlikely to survive. ➤ Forecasting data suggesting surge in excess of resources. 	<ul style="list-style-type: none"> ➤ NH DHHS Commissioner, in consultation with the DHHS Chief Medical Officer (CMO), convenes State Disaster Medical Advisory Committee (SDMAC). ➤ Recommendation made to the DHHS Commissioner, or the Commissioner of the Department of Safety (DOS), for State of Emergency or Public Health Incident Declaration (if not previously done). ➤ Maintain regular communications with: <ul style="list-style-type: none"> ○ SEOC ESF-8 and GSHCC ○ State Joint Information Center (JIC) / health care organization Public Information Officers (PIOs) regarding media and public notification of the emergency situation and risk communication strategies that include coping mechanisms ○ DHHS, in collaboration with DOS JIC, issues Health Alert Network (HAN) and/or press releases announcing the existence of CSC in the state.

NH Crisis Standards of Care Guidance

	Possible Triggers	State-level Action
		<ul style="list-style-type: none"> ➤ SDMAC assesses the situation and recommend: <ul style="list-style-type: none"> ○ Implementation of interstate and intrastate mutual-aid agreements to substitute, conserve, and adapt staffing, transportation, patient triage, and destinations. ○ Develop recommendations to support NH health care organizations with contingency. ○ Develop recommendations for approval by DHHS Commissioner and Governor to equitably and fairly deliver health care services if CSC is required.
Escalation to Crisis Care and Recommending Crisis Standards of Care 	<ul style="list-style-type: none"> ➤ All identified contingency strategies fully executed at one or more health and health care systems; affected organizations must shift to crisis level of care. The situation may include: <ul style="list-style-type: none"> ○ Multiple health care access points impacted. ○ Multiple health care entities experiencing crisis level shortages of space, staff, and/or supplies. ○ Trained health care personnel unavailable/unable to adequately care the volume of patients. ○ Available local, regional, state, and federal caches (of equipment, supplies, pharmaceuticals) already exhausted and no resupply is foreseeable. ○ Patient transfers insufficient or impossible for affected 	<ul style="list-style-type: none"> ➤ SDMAC develops recommendations for approval by DHHS Commissioner and Governor to equitably and fairly deliver health care services (if not previously done). ➤ Recommendation made to the DHHS Commissioner for State of Emergency or Public Health Incident Declaration (if not previously done). ➤ DOS Homeland Security and Emergency Management (HSEM) requests resource support through EMAC (if not previously done) and possibly IEMAC. ➤ Recommendation made to Governor to declare State of Emergency and approve SDMAC recommendations, if not already underway. ➤ DHHS, in collaboration with DOS JIC, issues Health Alert Network (HAN) and/or press releases announcing the existence of CSC in the state.

NH Crisis Standards of Care Guidance

	Possible Triggers	State-level Action
	<p style="text-align: center;">health care organizations.</p> <ul style="list-style-type: none"> ○ Request to open alternate care sites from health care organizations. ○ Medical countermeasures depleted. 	
<p>Crisis Standards of Care Implementation</p> 	<ul style="list-style-type: none"> ➤ Governor declares State of Emergency or DHHS Commissioner declares a Public Health Incident and approves SDMAC CSC recommendations, if not already declared. 	<ul style="list-style-type: none"> ➤ SDMAC CSC recommendations disseminated to health care system partners for their use. ➤ DHHS/SDMAC: <ul style="list-style-type: none"> ○ Monitor resource supply chains ○ Support unmet needs requests ○ Monitor CSC implementation actions and impacts across the state’s health care system ○ Receive requests from health care facilities Clinical Care Committee and/or Ethics Committee for guidance on ethical questions related to facility-level CSC implementation and/or resolution of appeals regarding CSC decisions <ul style="list-style-type: none"> ○ Maintain regular communications with: <ul style="list-style-type: none"> ▪ SEOC ESF-8 and GSHCC ▪ State JIC / health care organization PIOs on risk communication strategies that include coping mechanisms ▪ DHHS, in collaboration with DOS JIC, issues Health Alert Network (HAN) and / or press releases announcing the existence of CSC in the state and emphasizes: <ul style="list-style-type: none"> • Clear mitigation measures for localized crisis conditions and

NH Crisis Standards of Care Guidance

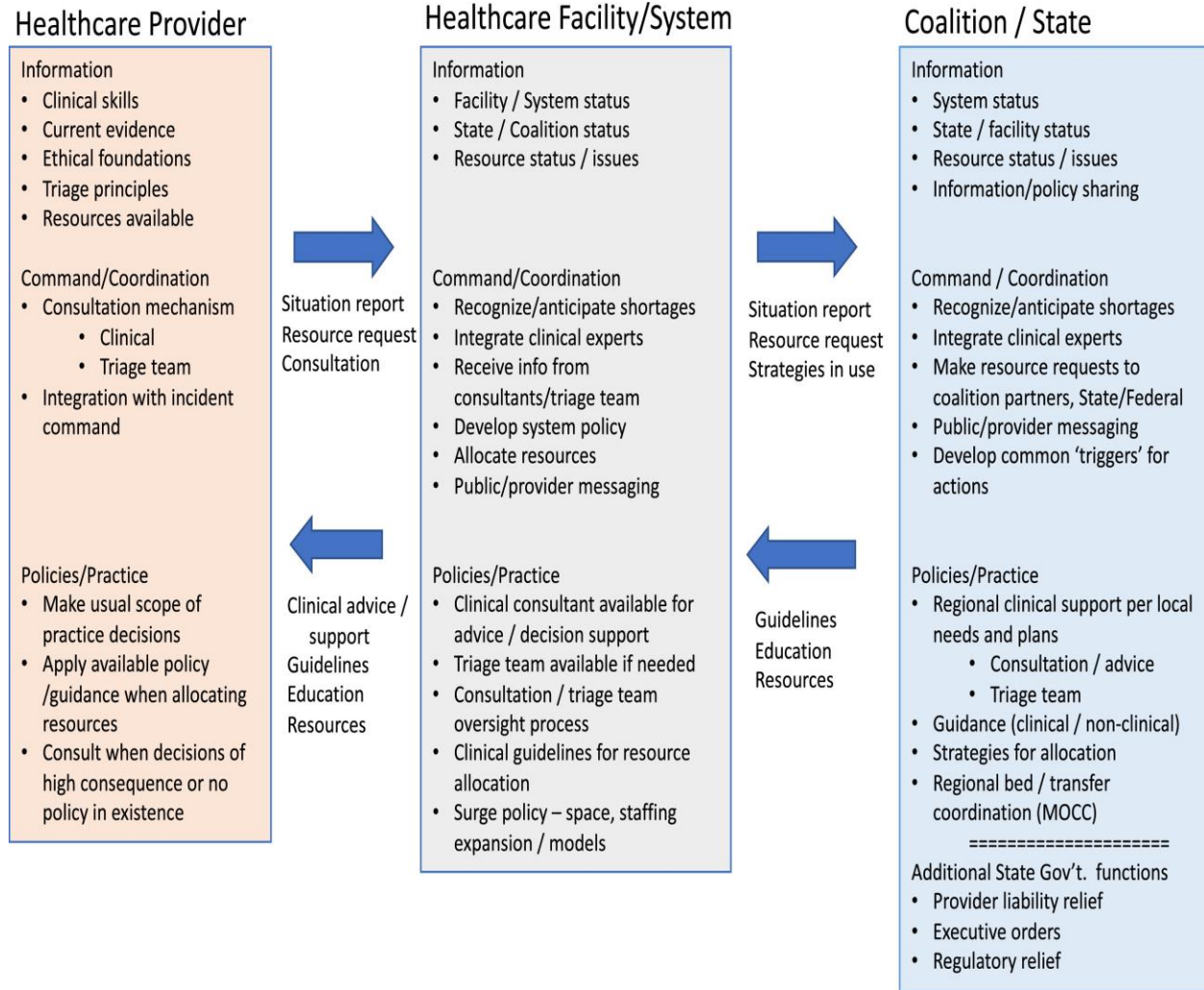
	Possible Triggers	State-level Action
		<ul style="list-style-type: none"> • Assisting facilities that are disproportionately impacted.⁶⁰
De-Escalation and De-Activation of CSC	<ul style="list-style-type: none"> ➤ All impacted health care entities are projected to be able to meet patient demand using conventional level or contingency level standards of care. ➤ Patient transfer or evacuation becomes a feasible tactic to alleviate crisis-level surge at affected health care facilities. 	<ul style="list-style-type: none"> ➤ DHHS/SDMAC: <ul style="list-style-type: none"> ○ Assess status of the State’s health care system ○ Work with individual health care facilities to solve space, staff, and/or supply shortages; movement of patients ○ Identify opportunities for controlled de-escalation / demobilization of CSC ○ Make recommendation to Governor and DHHS Commissioner on controlled deactivation of CSC ○ Maintain regular communications with: <ul style="list-style-type: none"> ▪ SEOC ESF-8 and GSHCC ▪ State JIC / health care organization PIOs on continued posting of risk communication strategies that include coping mechanisms and statewide health care systems’ de-activation/de-mobilization strategies <ul style="list-style-type: none"> ▪ DHHS, in collaboration with DOS JIC, issues Health Alert Network (HAN) and/or press releases announcing the termination of CSC in the state. ○ Conduct debrief sessions to update plans

⁶⁰ASPR TRACIE. Crisis Standards of Care during COVID-19: Summary of State Actions. March 2022. Page 3. <https://files.asprtracie.hhs.gov/documents/csc-actions-by-states-summary.pdf>

Organization and Assignment of Responsibilities

Figure 5⁶¹ provides an example at the provider, facility/system, and coalition / state levels and reflect an integrated system when CSC is required.

Figure 5: CSC Roles and Responsibilities



The New Hampshire Governor through established legal authorities can call stakeholders to action for the purpose of implementing crisis standards of care. A brief outline of key partnerships, roles and responsibilities related the activation of CSC are listed in Table 3.

⁶¹Hick, J.L., D. Hanfling, M. Wynia, and E. Toner. 2021. Crisis Standards of Care and COVID-19: What did we learn? How do we ensure equity? What should we do? NAM Perspectives. Discussion, National Academy of Medicine, Washington, DC. <https://doi.org/10.31478/202108e>

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Table 3: NH CSC Response Partners – Roles and Responsibilities

NH Response Partners	Role	Responsibilities
Granite State Health Care Coalition (GSHCC)	Regional coordination of health / medical information and resource management	<ul style="list-style-type: none"> • Serves as a direct support to the State ESF 8 Public Health and Medical • Maintain situational awareness, share information, and coordinate coalition disaster response activities between public health and the health care system in the state • May help manage resources between hospitals in the area, e.g., patient transfer coordination • Share information of the effects of the disaster in the community including mental health and substance misuse
NH Hospital Association (NHHA)	Hospital communications and regulations	<ul style="list-style-type: none"> • Assist DHHS and GSHCC in communicating pertinent information with hospitals and health care systems across the state
NH Health Care Association	Long-term care provider communications and regulations	<ul style="list-style-type: none"> • Assist DHHS in communicating pertinent information with long-term care providers across the state.
NH Chapter – National Alliance on Mental Illness	Support, education and advocacy regarding mental illness and suicide	<ul style="list-style-type: none"> • Assist DHHS in communicating with mental health care providers across the state.
Health Care Facilities	Patient Care	<ul style="list-style-type: none"> • Establish facility Clinical Care Committee (CCC) <i>or equivalent</i> and Triage Team (depending upon the size and role of the organization). • Activate Ethics Committee (or include ethicist in CCC, or process for tele-consult with a medical ethicist depending upon the size of the organization). • Implement surge plans including crisis care plans and organization or regional triage/treatment plans as required, • Coordinate information and resource management with other facilities in the region. • Coordinate information and resource management with other organizations in the geographical region via GSHCC

NH Crisis Standards of Care Guidance

NH Response Partners	Role	Responsibilities
Health Care Provider and Hospital Networks	In-Network coordination of health / medical response	<ul style="list-style-type: none"> • Facilitate communication among network affiliates • Facilitate resource allocation among network affiliates • Facilitate patient care and surge coordination among network affiliates • Facilitate financial management and coordination among network affiliates • Coordinate information and resource management with other organizations in the geographical region via GSHCC
Office of Professional Licensure and Certification	State lead office for professional licensure and certification	<ul style="list-style-type: none"> • Provides administrative support to over 40 professional licensing boards, commissions and councils responsible for licensing and regulating their professions within the State of New Hampshire
NH DHHS – Health Facilities Administration	State lead office for oversight and enforcement of health care facilities	<ul style="list-style-type: none"> • The contract survey agency for the NH Medicaid Office and the US Centers for Medicare and Medicaid Services (CMS). The Health Facility Certification Unit certifies and inspects health facilities, nursing facilities and nonresidential health care providers that participate in the Medicare/Medicaid programs <ul style="list-style-type: none"> ○ Request CMS 1135 waivers as required during response to allow patient billing when usual conditions cannot be met
NH DOS – <ul style="list-style-type: none"> • Division of Homeland Security and Emergency Management (HSEM) 	<ul style="list-style-type: none"> • State lead agency for planning, preparation, response to, recovery from, and mitigation of all emergencies and disasters. 	<ul style="list-style-type: none"> • Mission and resource coordination • Federal Public Assistance and Individual Assistance funding coordination

NH Crisis Standards of Care Guidance

NH Response Partners	Role	Responsibilities
NH DOS – <ul style="list-style-type: none"> • Division of Fire Standards and Training & Emergency Medical Services (FSTEMS) 	<ul style="list-style-type: none"> • State lead agency for EMS disaster issues 	<ul style="list-style-type: none"> • Support hospitals by regional and state-level coordination of EMS surge capacity implementation • Deploy Ambulance Strike Teams (AST), MCI buses, additional ground or air ambulances from regions as requested by local EMS agencies through the SEOC • Communicate suspension of selected regulatory statutes / rules to facilitate crisis care activities during declared disaster • Support local EMS medical branch directors by providing guidance on patient care guideline development through the State EMS Medical Director

Interstate Response Partner	Role	Responsibilities
Region 1 Regional Disaster Health Response System (RDHRS)	Regional coordination of health / medical response, support agency	<ul style="list-style-type: none"> • Large-scale interstate coordination, integration, and mutual aid • Collect and convey key information related to operational / functional status of the regional health care system

Federal Response Partners	Role	Responsibilities
Region 1 US Health and Human Services (HHS)	Regional coordination of health / medical response, support agency	<ul style="list-style-type: none"> • Coordinate regional resource management • Provide response management personnel • Coordinate communication between state and federal partners
Federal Emergency Management Administration (FEMA)	Response and recovery coordination and assistance	<ul style="list-style-type: none"> • Assist response efforts providing resources and response management personnel • Assist recovery efforts providing resources, funding and recovery management personnel

Direction, Control and Coordination

State Level

1. During a declared public health incident, the SEOC Director may assume a Unified Command (UC) for a multi-agency / single jurisdiction (Figure 6) or a multi-agency / multi-jurisdiction (Figure 7).

Figure 6: Sample CSC State-Level Unified Command Multi-Agency / *Single Jurisdiction* Organizational Chart

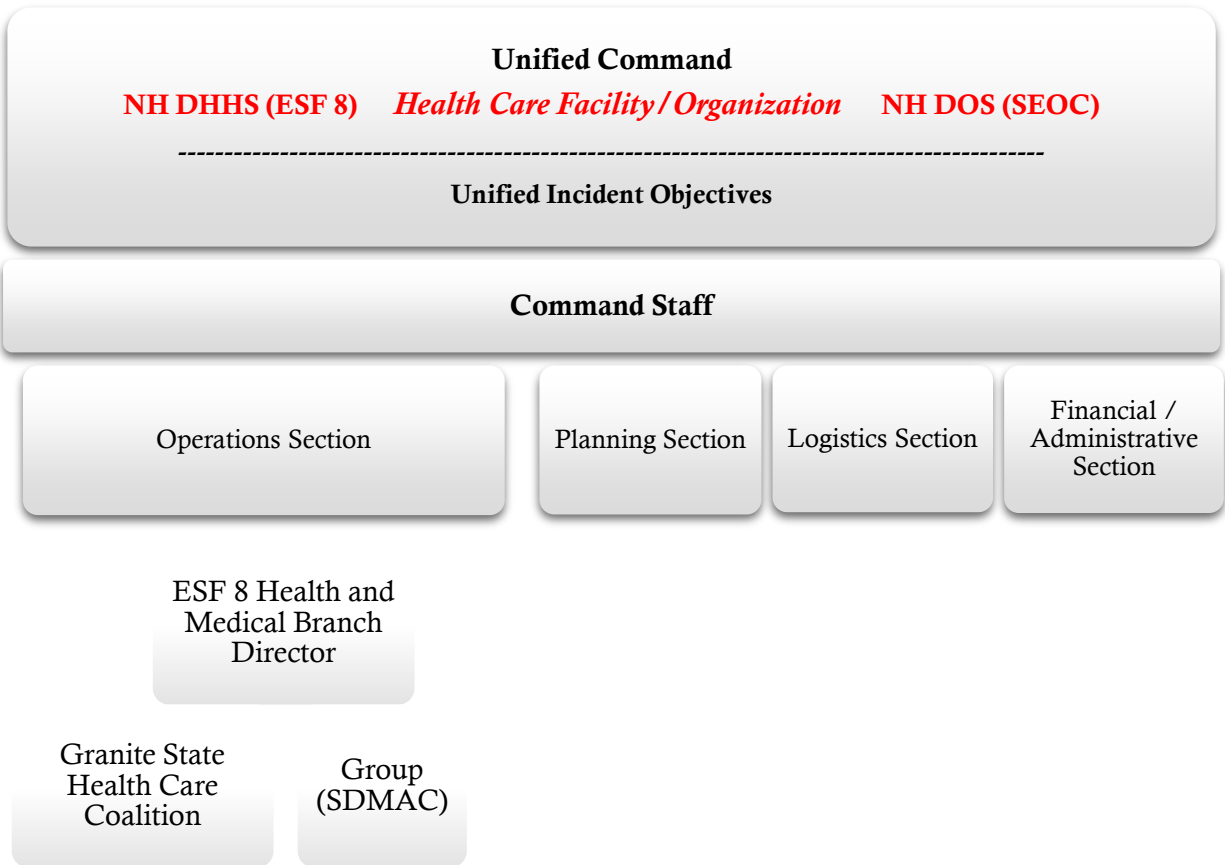
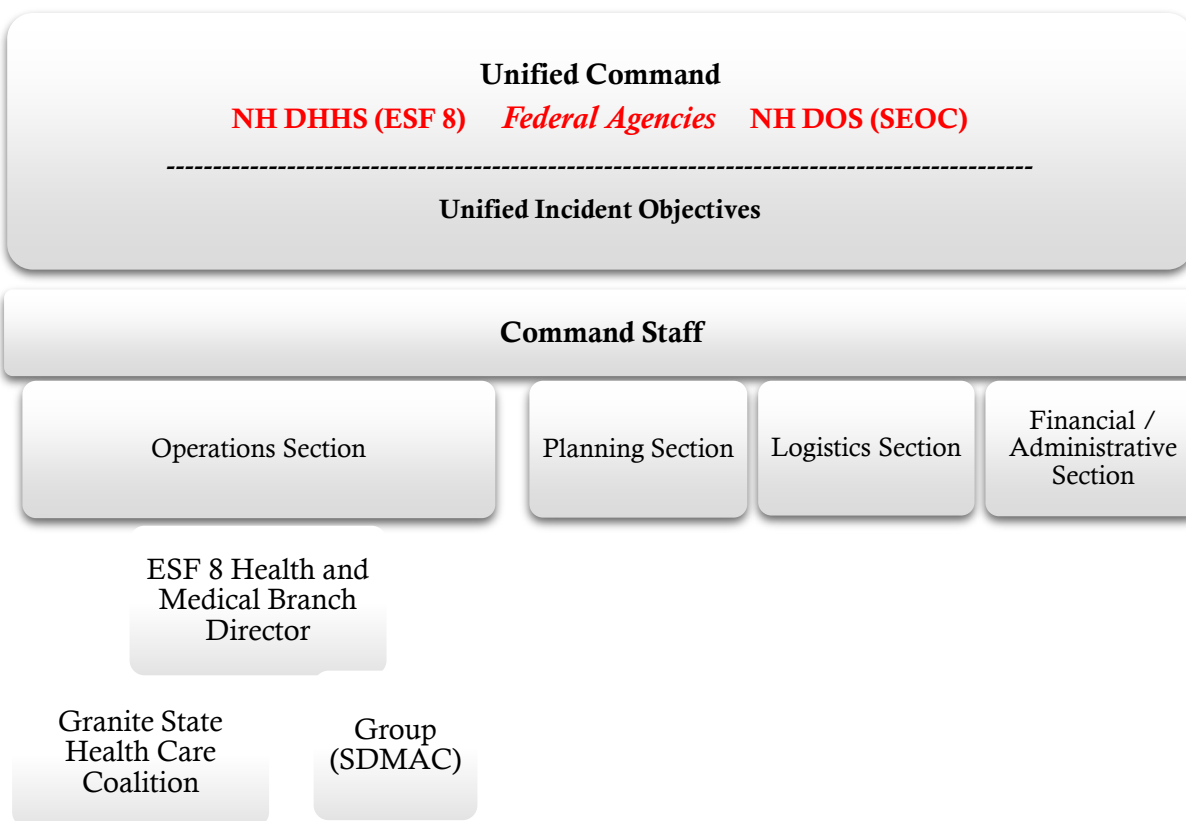


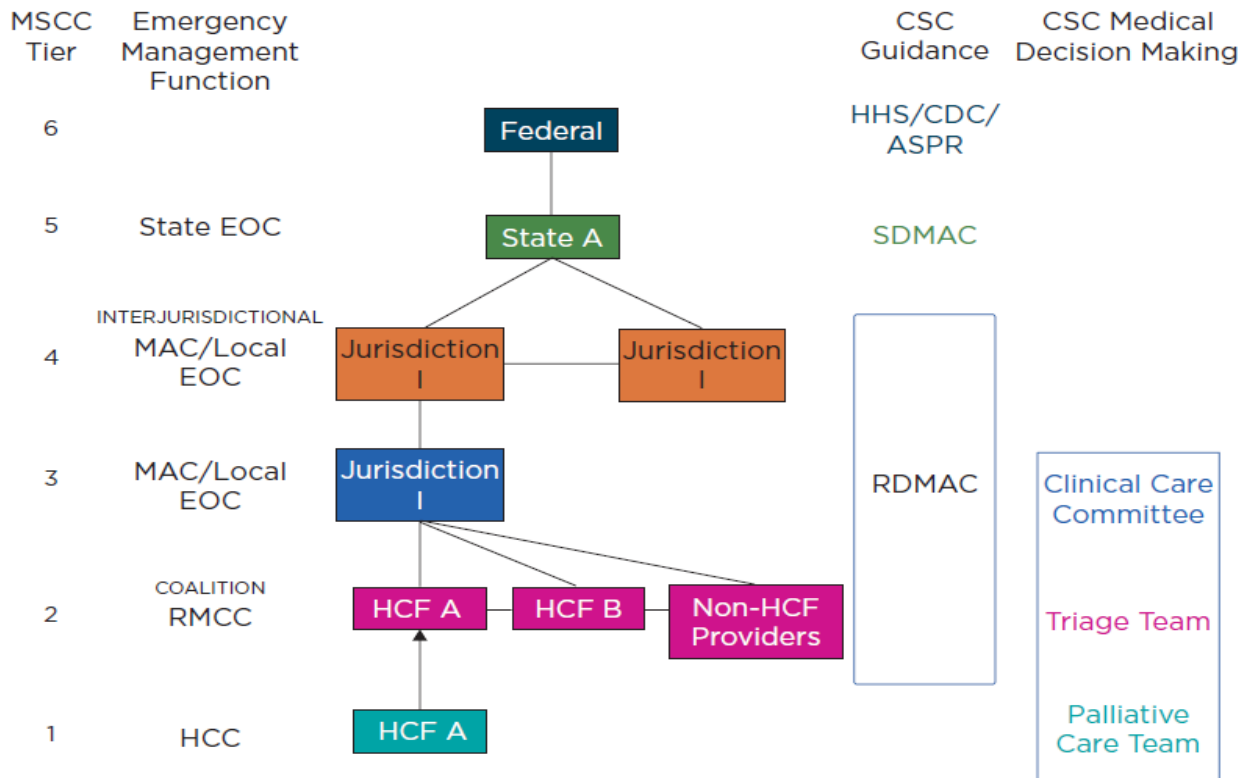
Figure 7: Sample CSC State-Level Unified Command Multi-Agency / Multi-Jurisdiction Organizational Chart



1. Within the SEOC, activated ESFs will organize activities to support response efforts based on their specific missions.
2. The SEOC ESF 8 Desk Coordinator, in collaboration with subject matter experts (SMEs), will determine Essential Elements of Information (EIs) e.g., patient loads, acuity, staffing adaptations, etc., and communicate those requirements to GSHCC and other partner health care organizations.
3. The State and Regional Public Health Networks (RPHNs) have incorporated the *Medical Surge Capacity and Capability*⁶² (MSCC) framework, which outlines integrated planning within and across a tiered system of relationships among individual health care organizations, health care coalitions, and local, state, and federal governments, into their Medical Surge Plans. The 2012 IOM report integrates CSC planning and implementation into this framework (Figure 8). The State does not have a MAC or RDMCC.

⁶²U.S. Department of Health and Human Services. *Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies*. Second Edition. September 2007. <https://www.phe.gov/preparedness/planning/mscc/handbook/documents/mscc080626.pdf>

Figure 8: Integrating CSC Planning into the MSCC Framework



Terminology: ASPR=Assistant Secretary for Preparedness and Response; CDC=Centers for Disease Control and Prevention; CSC=Crisis Standards of Care; EOC=Emergency Operations Center; HCC=Health Care Coalition; HCF=Health Care Facility; HHS=Health and Human Services; MAC=Medical Advisory Committee; RDMCC=Regional Disaster Medical Coordination Center; SDMAC=State Disaster Medical Advisory Committee⁶³

State Disaster Medical Advisory Committee

1. During contingency level of care status, the NH DHHS Commissioner, in consultation with the DHHS Chief Medical Officer (CMO), will consider activating the State Disaster Medical Advisory Committee (SDMAC) to monitor and prepare for crisis level of care if needed.
2. The State CMO will work with the State CSC Committee to identify appropriate personnel to staff the SDMAC. The list of recommended members will be reviewed and finalized by the DHHS Commissioner. Each type of response (e.g., pandemic, earthquake, terrorist attack) will require a different set of medical professionals, public health staff, and subject matter experts.
3. Table 4 lists the various disciplines that may constitute the SDMAC. Final selection of members will be appointed by the NH DHHS Commissioner.

⁶³Adapted from IOM 2012, p.1-44.

Table 4: SDMAC Membership

• State government officials	• Legal and medical professionals
• GSHCC	• Medical ethicists or Chair of Ethics Committee
• Risk management professionals	• Community representative (if possible)
• EMS	• Hospital representatives
• Representatives of nursing, medical societies, hospitals, primary care, palliative care, long-term care, home care, mental health, substance misuse, and persons with disabilities and others with access and functional needs	

4. Activation of the *CSC Guidance* itself does not necessarily constitute implementation of triage resource allocation but allows for assembly of the State Ethics Committee (SEC) and creation of a State Triage Committee (STC).
5. After the SDMAC members have been notified, they will confirm their availability to serve on the SDMAC. The SDMAC will meet (in-person, virtually, or hybrid) to receive a situation briefing from the CMO and DHHS Commissioner or designee.
6. Following the initial situation briefing, the SDMAC will begin the process of establishing a State Triage Committee (STC).

SDMAC Actions

1. Continually assess the situation, including whether the *NH CSC Guidance* should remain activated.
2. Evaluate evidence-based, peer-reviewed critical care and other decision tools.
3. Establish clinical protocols for crisis standards of care e.g., ventilator use, consistent with the guiding principles.
4. Recommend decision-making algorithms for allocation of medical resources when life-sustaining resources become scarce.
5. Provide broader recommendations regarding disaster health care planning and response efforts and make recommendations to the Governor and SEOC Director during the incident.
6. Recommend intrastate and interstate mutual-aid agreements (if not yet implemented) to substitute, conserve, and adapt staffing, transportation, patient triage, and destinations if not already implemented.

7. Develop recommendations to support NH health care organizations with contingency strategies such as but not but not limited to:
 - a. Adaptions of EMS systems under disaster response conditions,
 - b. Routine and crisis monitoring / reporting mechanisms for documenting and analyzing normative levels of seasonal and incident-based health care demand, resources, capacity, and staffing at local, RPHNs, and state levels,
 - c. Integration of palliative care planning and resource / knowledge assessment into planning and educational processes,
 - d. Addressing the needs of Persons with Disabilities and others with Access and Functional Needs (PDAFN); responder and their families,
 - e. Advising when public alternate care sites are needed.

State Triage Committee

1. The SDMAC will solicit key subject matter experts (SMEs) to form a STC, a subcommittee of the SDMAC, who will be appointed by the Commissioner of NH DHHS with membership relevant to the crisis at hand to develop clinical guidelines.
2. The STC may include physicians who are content-matter experts in areas relevant to the crisis, practicing clinicians in the NH, and other specialist as listed in Table 5.
3. NH DHHS encourages broad understanding of Equity, Diversity, and Inclusiveness (EDI).

Table 5: STC Membership

Members	Additional Specialty Clinicians
• Medical ethicist	• Internal medicine
• Health care attorney	• Emergency medicine
• State Chief Medical Officer (CMO)	• Pulmonary
• State emergency management representative	• Anesthesia
• Critical care nurse	• Surgical
• Pharmacist	• Pediatric
• Risk management representative	• Mental health and SUDs representatives

STC Actions

1. Develop the CSC clinical guidelines, which will establish recommendations for the triage of critical health care resources and provide guidance to hospital triage officers/committees and the SDMAC.
2. Consult and collaborate with hospital triage committees, ethics committees, and additional experts at their discretion.
3. The STC may solicit and use guidelines developed at stakeholder hospitals to inform state recommendations.
4. The STC will address top priority issues that the SDMAC deems highly consequential and broadly applicable for all health care partners, and for which alignment of criteria between health care facilities, especially hospitals, is critically necessary.
5. While hospitals and other care facilities may have EOPs and CSC that may have slight variation, any significant variation in top priority issues will require coordination and standardization by the state and its partners.
6. Crisis standards of care clinical guidelines developed by the SDMAC and STC will:
 - a. Be tailored to the crisis (i.e., public health incident) and the availability of space, staff, and supplies.
 - b. Be grounded in a common ethical framework to guide allocation of critical care resources across the state to promote fairness and equity.
 - c. Be fair and transparent in establishing processes for the equitable allocation of resources both within and between health care facilities.
 - d. Be informed by applicable legal statutes, with integration of state and federal emergency orders, and waivers to expand access to medically necessary services.
 - e. Primarily consider survivability and benefit from treatment in order to provide the most benefit for the population.
 - f. Be widely disseminated to the public, who will be given the opportunity to provide feedback.
 - g. Be accountable in the duty to support health care workers, including but not limited to: communicating clearly about scarcity and plans for addressing it; designating

leaders authorized to address questions about how to adapt care to evolving conditions; protecting workers with adequate personal protective equipment (PPE); and addressing their psychological and moral distress.⁶⁴

Modifications of Crisis Standards of Care While Activated

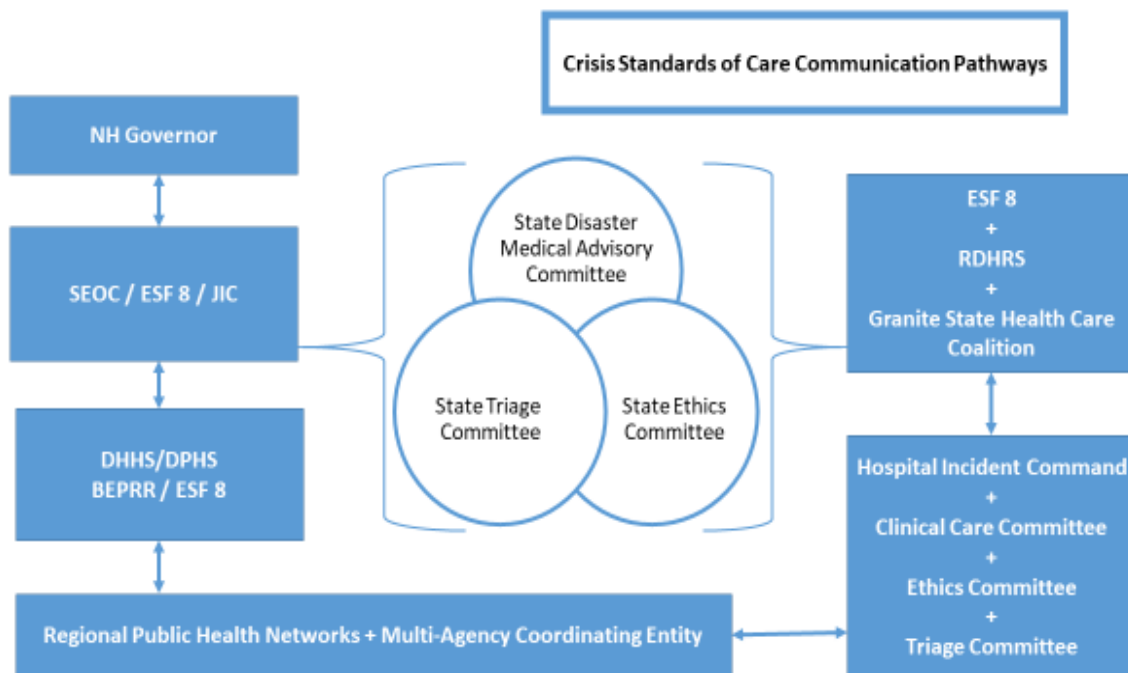
1. Managing catastrophic or pervasive disasters may require rapid adjustments to these crisis standards of care. When the *NH CSC Guidance* is authorized by the Governor through Executive Order and activated by the NH DHHS CMO, these crisis standards of care may be modified while they are activated.
2. The SDMAC/STC may recommend to the DHHS Commissioner and State Governor modifications to these crisis standards of care, including modifying or terminating an existing standard or adding a new standard.
3. Upon adoption of the SDMAC/STC's recommendation by the DHHS Commissioner and the Governor, the modification shall become part of these crisis standards of care with the full effect of the rest of this plan, its authorization, and its activation.

Communication between Health Care Organizations and SDMAC

1. Direct and indirect lines of communication from DHHS and the SDMAC (and STC) to health care organizations should be established and maintained during activation of the CSC for the purposes of information sharing and communication of standards of care. Figure 9 demonstrates a basic communication structure for the flow of information.
2. Hospital incident command (HIC) groups will nominate two liaisons to the SDMAC through which urgent communications and feedback can be given.
 - a. Regional Multi-Agency Coordinating Entities (MACEs) will work with participating HICs to develop plans for regional "temporary acute care centers".
 - b. HIC groups will share summary data regarding triage decisions with the SDMAC, to the extent deemed necessary to assure general crisis standard alignment and flag patterns of significant wide scale deviation that may indicate a need to update guidelines. The STC will not review individual HTC decisions unless requested under the appeals process.

⁶⁴Ethical Framework for Transitions Between Conventional, Contingency, and Crisis Conditions in Pervasive or Catastrophic Public Health Events with Medical Surge Implications. Minnesota Crisis Standards of Care. November 24, 2021. https://www.health.state.mn.us/communities/ep/surge/crisis/framework_transitions.pdf

Figure 9 Communication Pathways



3. The SDMAC will designate a SDMAC Liaison to facilitate communications and be the primary point of contact for health care facilities and the GSHCC for concerns pertinent to CSC planning.
4. Crisis standards of care clinical guidelines will be disseminated to all HTC, NHICs and to the GSHCC.
 - a. The GSHCC will serve as the indirect point of contact between hospitals, nursing homes, skilled health care facilities, and the SDMAC and will maintain up-to-date clinical crisis care guidelines for dissemination to partner health care organizations in the state.
 - b. Guidelines or recommendations related to Emergency Medical Services (EMS) care will be disseminated through the Division of Fire Standards and Training & Emergency Medical Services to the State EOC and other EMS service leaders.
5. Additional lines of communication to other response organizations and health care facilities (e.g. home care agencies, long-term care facilities, hospice facilities, etc.) will be established and maintained by the BEPRR and ESF 8 with relevant feedback passed to the SDMAC, and relevant recommendations from the SDMAC disseminated to those entities.

State Level Health Care Coalition

1. New Hampshire has one state-level health care coalition (HCC) the Granite State Health Care Coalition. It is a statewide network of key representatives from public and private health and safety organizations that help communities prepare, respond, and recover from incidents impacting the New Hampshire health care system. The existence of a HCC is a federal requirement for health care emergency operational funding.
2. The GSHCC may also convene workgroups during planning or a response to help develop regional tactics (e.g., to support alternate care sites or processes during a response) with health care systems, public health and emergency management partners in the state and within the New England six state region. The GSHCC works closely with the Regional Disaster Health Response System (RDHRS).

Local Level

It is expected that all health care organizations' comprehensive crisis standards of care plans include the following components:

1. Strong ethical grounding in the principles of fairness and equity, transparency, consistency, proportionality, and accountability, among other values.
2. Foundation in laws and regulations pertaining to disaster response and recovery management.
3. Integrated and ongoing community and health care worker engagement, education, and communication to ensure their collective norms, priorities, and value which ensures greater acceptance of the crisis standards care if and when it is activated.⁶⁵
4. Established clear indicators and triggers with lines of responsibility to identify when approaching crisis care and implementation of mitigating strategies.
5. Application of evidence-based clinical processes and operations.
6. Support health care workers to implement CSC by providing mental health resources with regular training on the provision of care for patients under CSC situations including expectations for how staff will be “stretched” to cover the demand for services as fairly as possible.⁶⁶

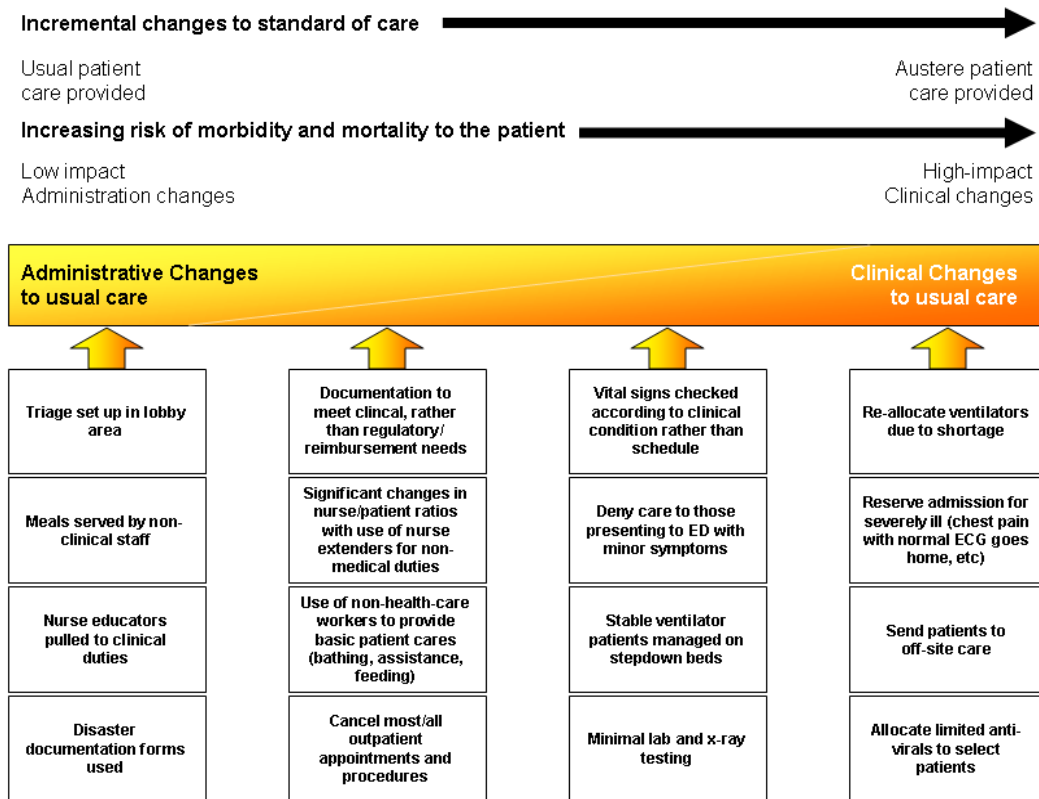
⁶⁵ IOM 2012. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/13351>.

⁶⁶ Association of American Medical Colleges. COVID-19 Crisis Standards of Care: Frequently Asked Questions for Counsel. December 18, 2020. Available at <https://www.aamc.org/coronavirus/faq-crisis-standards-care>

- Define the role of any centralized teams (ethics team, incident command team, legal team, triage resource allocation team, etc.) within the health care organization and how the organization interacts with other parts of the health care systems in its geographical region.⁶⁷

Incident Commanders (IC) at health care organizations are advised to incorporate a structured assessment of their facilities services and resources on a daily basis as part of their Incident Action Plan (IAP). Examine the administrative and clinical adaptations needed each operational period based on the incident demands. Administrative, rather than clinical adaptations should be emphasized until no longer possible. Figure 10 below shows strategies from least to most aggressive.

Figure 10: Catastrophic Disaster Response⁶⁸



⁶⁷Ibid

⁶⁸IOM 2012. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/13351>.

Regional Level

New England Regional Disaster Health Response System

1. RDHRS is a federally funded system located in the Massachusetts General Hospital designed to support optimal health care disaster planning, offer SMEs, and enhance clinical surge capabilities within the Regional health care community through the following goals:
 - a. Identify and further develop highly specialized clinical capabilities,
 - b. Improve organization and coordination,
 - c. Improve situational awareness, and
 - d. Increase health care coalition participation.
2. NH DHHS and the GSHCC participate in RDHR Partnership activities.
3. RDHR is available for consultation and/or CSC response efforts when contacted by the NH DHHS ESF 8 Coordinator; and for non-emergent activities by the GSHCC Director.

Assistance from Other States and Canada

1. The Governor has the authority to seek assistance from other states through the Emergency Management Assistance Compact (EMAC) and internationally e.g., Canada and its provinces and territories.
2. New Hampshire's professional licensing boards, such as nursing and the Board of Medicine, have inter-state compacts that may have provisions offering guidance in emergencies allowing for inter-jurisdictional aid and services.

Information Management

1. As indicated in hospitals' and other health care organizations Medical Surge Plans, the hospitals provide daily status reports on bed availability, morgue capacity, oxygen availability, and ventilator status. Other elements can easily be added to Juvare, the state's public health and health care WebEOC incident management software.
2. The manner with which such a system can reallocate resources across a region or facilitate transfers between hospitals to maximize resource utilization and equity is a priority focus of the SEOC's ESF 8 use of Juvare.
3. The State ESF 8 Coordinator, working with the GSHCC staff, will be able to identify where resources may be available to make more rapid decisions about transferring patients between hospitals.

4. The BEPRR and GSHCC staff will monitor organization status and help coordinate sharing of resources. The use of Juvare also provides a method to document information related to the incident and serve as an indicator of contingency levels of care that could escalate to CSC.
5. As local jurisdictions' EOCs work through managing an incident, they should follow the State EOC mission request process to ESF 8 as described in WebEOC.
6. As health care organizations continue to adjust their response to an increasing patient surge incident, it is crucial that they maintain open lines of communication with each other through their HIC/NHIC and with the GSHCC.
7. When resource allocation decision making is conducted over a prolonged time period, the institution should take steps to develop and deploy, in a timely way, a method of tracking the implementation of their CSC policy, defining and describing quality performance of triage teams, and longitudinally analyzing their performance.
8. Copies of the *NH CSC Guidance* and *CSC Clinical Guidelines* will be kept in the State EOC ESF 8 position file library and posted on the DHHS website.

Communication

1. It is important that the public be provided with a clear understanding of CSC concepts such as triage of resources. Public information and messaging must be consistent and timely and be culturally and linguistically accessible to ensure that information reaches individuals who are deaf or hard of hearing, are blind, or have low vision, or have, limited English proficiency.
2. Clear, unified messaging promotes the ethical principles of transparency and accountability, relies on the alignment of CSC clinical and scarce resource triage process and procedures applied by all health care organizations in the state. Proactive communication regarding activation and implementation of CSC is critical for maintaining that trust.
3. Rapid and reliable communication among the health care organizations Public Information Officers (PIOs), GSHCC, SDMAC, and the State Joint Information Center (JIC) will promote this alignment, which in turn will support strong and consistent messaging at all levels of the response.

Public Communications

1. Public communications regarding the CSC and their application will be handled primarily by health care organizations communications staff/PIOs and the NH DHHS PIOs in coordination with the SEOC - JIC.
2. Like implementation of the crisis standards, communications to the public regarding their purpose and notifications regarding their use should be proactive and transparent; provided in a format that is accessible to people with disabilities and people who speak languages other than English.
3. It is highly recommend that health care organizations and NH DHHS conduct regular virtual town halls to gather community feedback.
4. Stakeholders and members of the community may submit feedback regarding the standards to the DHHS Commissioner to be considered by the SDMAC during the iterative process.

Logistics

Patient Movement

1. During the contingency stage of medical surge incidents, frequent health care partner collaboration conference calls or virtual meetings help to promote a consistent standard of care across a region.
2. These calls or virtual meeting can be initiated by DHHS, GSHCC, or other partners can facilitate patient movement (referred here as load-balancing, Box 1), health care staffing, and life-saving resource allocation.

Box 1: Key Principles of Load-Balancing

1. Any health care organization can request load-balancing based on voluntary cooperation of the others subject to available beds.
2. Patient considerations for load balancing across the impacted region of the state. This could include changes to staffing that are more dire than those taken at other facilities (e.g., using non-traditional staff in intensive care units) or involves a percentage of occupancy of beds beyond capacity that is more than X% different from others in the area. (add...hospitals to other providers)
3. Load-balancing assumes that usual surge capacity actions have taken place and that non-emergency procedures are postponed to free up space and staff.

Transporting Patients to Other Facilities

1. Evacuation and/or transfer procedures must be initiated by HICS at impacted health care facilities. If in-state capacity to evacuate/transfer patients is completely exhausted, transfer to facilities in other states should be considered.
2. The health care organization requesting transfer must contact GSHCC to apprise them of the situation. The GSHCC may:
 - a. Intervene in bed management and inter-facility transfer if it becomes apparent that the system is not able to account for a discrepancy in bed availability.
 - b. Work closely with the SEOC ESF 8 and the RDHRS, to arrange resources/staff or local/interregional patient transfers sufficient to deescalate contingency care operations and/or activate alternate care sites, without overwhelming a secondary region.
3. When needed, all health care organizations must:
 - a. Identify patients for possible transfer and prioritize patients for evacuation based on the situation, and
 - b. Create transfer patient lists for regional/federal use.
4. Patient transfer decisions should be made irrespective to patient insurance status and other nonclinical factors and should be based on patient loads and clinical needs only.⁶⁹

Although health care facilities likely have established referral patterns, other options should be examined prior to crisis. It should be understood that in a pervasive or catastrophic public health crisis, the ability to transfer patients could be limited or temporarily not an option.

CSC De-Mobilization / Return to Conventional Care

1. Continually assess and re-assess the situation as more resources arrive.
2. The SEOC ESF 8 Desk Coordinator, GSHCC will continue to communicate with federal and state partners (directly with HICs and NHICs only if needed) to ensure accurate information gathering about the situation.

⁶⁹Hick JL, Hanfling D, Wynia M, and Toner E. Crisis Standards of Care and COVID-19: What Did We Learn? How Do We Ensure Equity? What Should We Do? Discussion Paper. August 30, 2021. Page 13.

3. HICs and NHICs are expected to relay pertinent information to their Clinical Care Committee, Ethics Team, and/or Triage Teams.
4. NH DHHS Senior Leadership Team, in consultation with the Governor's Office and the SDMAC, will de-activate CSC when health care organizations are no longer operating at a crisis level.
5. This de-activation will occur when all impacted health care organizations can meet patient demand using:
 - a. Contingency-level surge standards,
 - b. When patient transfer or evacuation becomes a feasible tactic to alleviate crisis-level surge, or
 - c. Return to conventional-level of care at affected health care facilities.
6. The Governor's Office will issue a declaration terminating the CSC Executive Order.
7. Health care organizations impacted by institution of the CSC clinical guidelines are encouraged to host formal crisis debriefings to assist in recovery, identify areas of improvement, and provide institutional feedback.
8. In the case of a severe resource shortage prompting CSC, de-activation may occur when supply levels become sufficient to meet health care system demands. The following procedures will be employed to ensure a coordinated de-activation of CSC standards across the state:
 - a. Throughout the response, SEOC, NH DHHS Commissioner, and health care organization staff will review their indicators and analyze situation reports (SitReps), bed capacities, and updates from health care system partners to determine the continued need for crisis-level care across the state.
 - b. When impacted facilities (facilities at crisis-level) have initiated transition back to contingency surge, conventional surge, or normal operations, GSHCC and SDMAC should be notified.
 - c. The SDMAC will inform NH DHHS Commissioner who will consult with the Governor regarding de-activating the CSC Executive Order across the state.

- d. The SDMAC will coordinate with the JIC to prepare health alert and public messaging to prepare for CSC de-mobilization. These messages will be sent to the GSHCC for dissemination to the health care organizations in advance of release to the public.
- e. It is important to note that the de-activation of CSC Executive Order does not stop emergency operations at the state, local, or organization level. Emergency operations and declarations may still be in place even though CSC has ended.
- f. The SDMAC, GSHCC, and ESF 8 will conduct crisis debriefings as soon as possible or at least one month after CSC de-mobilization.

Clinical Concepts of Operations

Surge Capacity and Continuum of Care

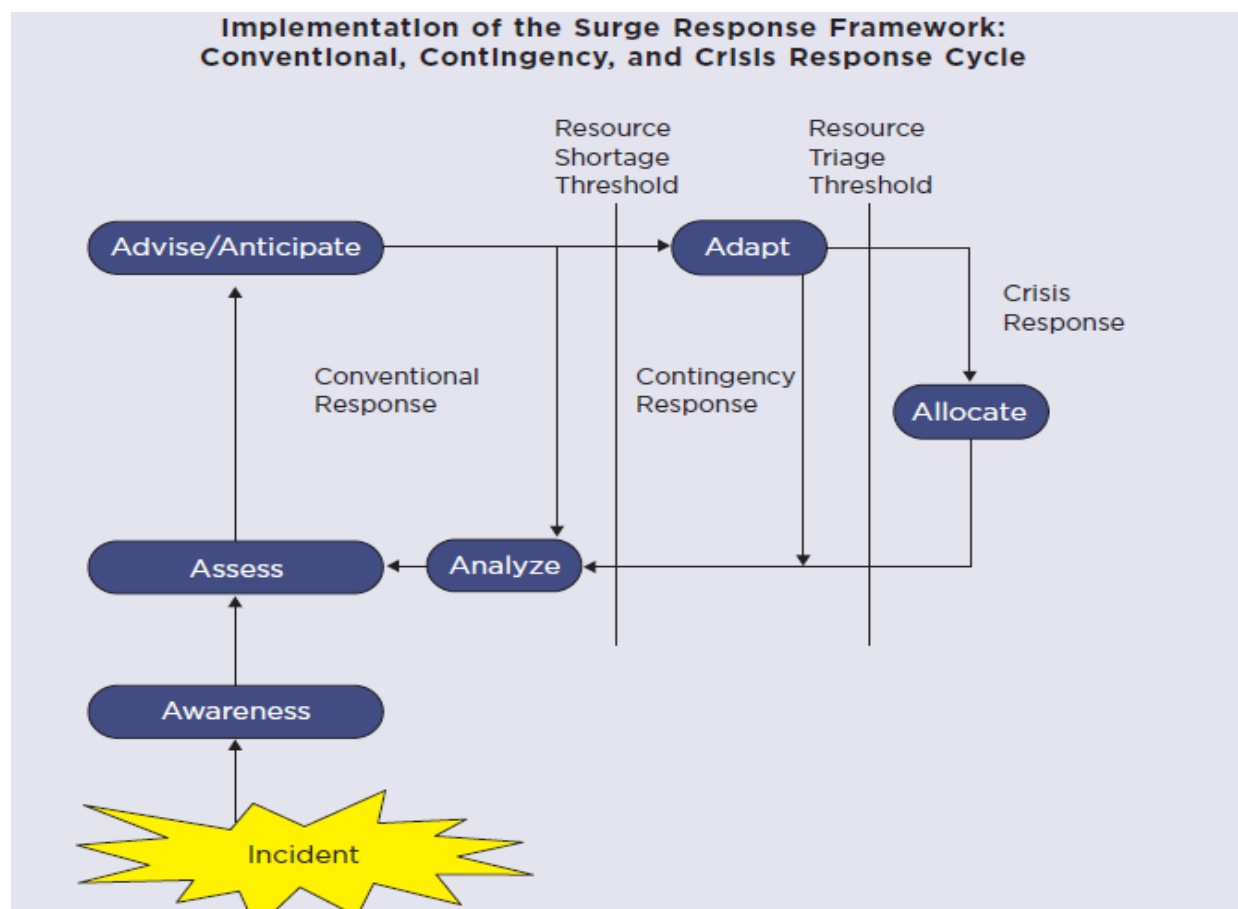
1. Surge capacity is a measurable representation of ability to manage a sudden influx of patients. It is dependent on a well-functioning HICS/NHICS structure that includes concrete plans for expanding surge capacity (space, supplies, and staff) and adequate training of all health care personnel.
2. Continuum of care is simply the essence of good patient care.⁷⁰ An integrated system of care that provides a comprehensive range of health services that evolve with the patient over time. It comprises services (e.g., extended care, acute hospital care, ambulatory care, home care, outreach, wellness, and housing) and integrating mechanisms (e.g., planning and management, care coordination, case-based financing, and integrated information systems).
3. A health care system will translate these broad principles into *standards of care* that focus on the safety, dignity, well-being and quality of life of service users –the community.
4. When the community is faced with a pervasive or catastrophic public health crisis, it will be marked by a sudden or gradual increase in demand for all types of health care resources and services. Delays in attaining situational awareness, anticipating resource shortfalls, or making appropriate requests for assistance can result in a crisis situation.⁷¹
5. To eliminate delays, all health care system partners are highly encouraged to incorporate a flexible surge response framework linked to the conventional-contingency-crisis care continuum (Figure 11). “After an incident occurs, the first priority is to develop situational

⁷⁰Evashwick CJ. Creating a Continuum. The goal is to provide an integrated system of care. Health Prog. 1989 Jun;70(5):36-9,56. Accessed 10.29.21 at <https://pubmed.ncbi.nlm.nih.gov/10293328/>

⁷¹IOM 2012. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework*. Washington, DC: The National Academies Press. Page: 1-41-42. <https://doi.org/10.17226/13351>.

Awareness, and then to **Assess** the situation relative to the available resources. The incident commander, along with relevant technical experts and/or the clinical care committee (in a proactive response/longer-term incident) **Advises** on strategies and **Anticipates** any resource deficits (and recommends obtaining necessary supplies, staffing, etc.). If a resource is scarce, **Adaptive** strategies (such as conservation, substitution, adaptation, and reuse) should be implemented. In a crisis, a deliberate triage decision to **Allocate/reallocate** resources may be necessary. In all cases, the response and any strategies should be **Analyzed** at regular intervals as part of the disaster response planning cycle, and the elements repeated until the incident concludes.⁷² This reflects a greater level of health care system preparedness with a common operating picture and accepted indicators for the need of contingency and crisis response.

Figure 11: Implementation of the Flexible Surge Response Framework



⁷²Institute of Medicine (IOM) 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response. Retrieved from NAP.edu. <https://doi.org/10.17226/13351>. Page 1-48.

Clinical Care Committee

1. The HIC/NHIC commander recognizes that systematic clinical changes and/or allocation of scarce clinical resources to those most likely to benefit is required.
2. Planning chief gathers any guidelines, epidemiologic information, resource information, and regional health care facility information and schedules meeting or conference call with Incident commander and designees to clinical care committee.
3. Clinical Care Committee (CCC)⁷³ or equivalent is convened by the incident commander—membership (Table 6) may vary depending on the type of facility, incident, and resources. Detailed information about the membership and function of the Clinical Care Committee is available in the IOM 2012 document.

Table 6: CCC Membership

Members	
• Health care administrator	• Chief Medical Officer (CMO)
• Chair of Ethics Committee	• Chief Nursing Officer (CNO)
• Health care attorney (if possible)	• Emergency medicine
• Community representative (if possible)	• Critical care
• Ambulatory care (clinics)	• Pediatrics
• Infectious Disease (for infectious incident)	• Respiratory care
• Palliative care	• Other specialty care

4. Clinical care committee reviews situation, state and federal guidance, and regional/state health care facility efforts and determines:
 - a. Methods to meet patient care needs e.g., use of non-invasive ventilation techniques, changes in medication administration techniques, use of oral medication and fluids instead of intravenous, etc. These will generally be of limited value in correcting large demand/resource deficits, however. Apply *MDH Patient Care Strategies for Scarce Resource Situations*, see Attachment D.
 - b. Additional changes in staff responsibilities to allow specialized staff to re-distribute workload (for example, floor nurses provide basic ICU patient care while critical care nurses oversee these nurses and their patients) or would incorporate other health care

⁷³This may be done at a system or facility level. Please reference the [Minnesota Crisis Standards of Care Framework: Health Care Facility Surge Operations and Crisis Care](#) for more guidance.

providers, lay providers, or family members to provide assistance based on their skillset.

- c. Mechanism for reassessment of local and regional health care facility efforts and strategies (e.g., assignment of liaison officer and establishment of regular communications loop with the SDMAC and any regional entities).
- d. Mechanism to summarize recommendations and changes and circulate to all staff and patients/families (concrete guidelines are important to provide clarity and reduce decision-making based upon emotional or subjective factors).

5. Committee reviews options for:

- i. Location of care (triage of patients to critical care, floor care, off-site care, home-based on disease severity).
- ii. Assignment of resources (which patients will receive resources in limited supply – ventilators, anti-toxin, etc., or which will not be offered such interventions when there are competing demands).

6. Committee summarizes recommendations for care for next operational period and determines meeting and review cycles for subsequent periods (e.g.: daily meeting, twice daily conference call, etc.) assuring that regional efforts at the GSHCC level are integrated into facility process/timelines.

- i. Incident commander approves recommendations and integration into Incident Action Plan (IAP). Section chiefs and Command Staff briefed and Public Information Officer (PIO) or designee assures communications to all staff.
- ii. Information is disseminated to inpatient services, outpatient services, and the GSHCC. Daily conference calls with GSHCC and ESF 8 involving critical care, infectious disease, and command staff, as indicated by circumstances.

Triage

- 1. The triage *process* is far more important than the specific clinical decision tools, which may vary based on the event. The HTC/SMEs must provide a process and agree on indicators for treatment (e.g. specific medications) or approve decision tools for triage of ICU and other resources. The *Health Care Facility Scarce Resource Decision-Making Tree* in Attachment B could be used during a CSC situation.

2. Triage prioritizes patients for care on the basis of some set of criteria, typically grounded in medical status and likely triage prioritizes patients for care on the basis of some set of criteria, typically grounded in medical status and likely outcome.⁷⁴ Although there are four basic types of triage, the first three are explained in more detail pertaining to crisis standards of care.⁷⁵
 - a. *Primary triage* performed at first assessment and prior to any interventions: in the out-of-hospital setting, on Emergency Medical Services (EMS) arrival at the scene, emergency departments, clinics or other healthcare access points.
 - b. *Secondary triage* performed after additional assessments and initial interventions (e.g. administration of intravenous fluid or airway management). Secondary triage is used to determine priority for the operating room, imaging, etc. Decisions during this phase rely on the best clinical judgment of providers based on their knowledge of the incident and patients' conditions (usually trauma, burns, or chemical exposures).
 - c. *Tertiary triage* involves assessment of the value of ongoing resource commitment during delivery of definitive care (e.g., deciding about continued medical treatments, tests, etc.).
 - d. *Reverse triage* may be utilized while CSC are in effect. During catastrophic or pervasive public health incidents, frequently reviewing the acuity and needs of current inpatients may be safely triaged for early discharge from health care facilities. Discharging noncritical patients can be an effective way to increase a hospital's capacity for emergency admission during a public health incident.⁷⁶

Reactive triage

Reactive triage occurs in the early phases of the incident when less information regarding the incident is available to providers. Physicians and nurses make triage decisions based on their best judgment.

1. Factors to consider:
 - a. Time required to perform treatment,
 - b. Clinical skill requirements (i.e. how much physician/nursing expertise is required),
 - c. Treatment requirements (what are the resource requirements),

⁷⁴Leider et al. AJPH September 2017, Vol 107, No. 9. P.e5-e6.

⁷⁵Hick et al. 2011; IOM/NAM 2009

⁷⁶Kelen GD, Kraus CK, McCarthy ML, Bass E, Hsu EB, Li G, Scheulen JJ, Shahan JB, Brill JD, Green GB. Inpatient disposition classification for the creation of hospital surge capacity: a multiphase study. Lancet. 2006 Dec 2;368(9551):1984-90.

- d. Prognosis of the injury.
 - a. In general, as the number of victims increases, the triage process should prioritize the moderately injured that require lifesaving interventions that can be performed rapidly (e.g. chest tube, airway management, and tourniquet).
- 2. It is critical to re-evaluate patients as more resources arrive.
 - a. Triage is a central issue in crisis standards of care, as is the notion of “repeat triage.”⁷⁷
 - b. During a disaster situation, a health care provider (and patient) may be asked to reassess the clinical and resource conditions.
 - c. In some cases, this reassessment leads to **re-allocation** of clinical interventions and/or resources.

Proactive (tertiary) triage

Proactive triage may be required later in an incident that continues to overwhelm the health care system after initial stabilization and delivery of available resources. This occurs when the situation and resources have been established. Decisions revolve around whether resources can continue to be deployed given patient prognosis and availability of resources.

Before implementing proactive or tertiary triage, facilities must have firmly established triage processes and plans that take into consideration available evidence, resources, and has administrative backing of the organization (and where applicable, the SDMAC).

- a. Anticipation of the need for tertiary triage is an indicator for activation of the *NH CSC Guidance* and development of clinical crisis care strategies by the State Disaster Medical Advisory Committee (SDMAC) and the State Triage Committee (STC).
- b. Proactive triage of resources should only occur when the following conditions are met and unless specified otherwise, the patient should continue to receive all other means of support e.g., equitable access to medications to control pain and suffering to the degree given the circumstances.⁷⁸

⁷⁷Ibid, p.e6.

⁷⁸IOM/NAM Crisis Standards of Care (2009) table 4-14.

Proactive
Triage
Conditions
to Meet

1. Critically limited resource(s) and infrastructure are identified.
2. Surge capacity is fully employed within health care facilities (and regionally) if capacity / space is the limited resource.
3. Maximum efforts to conserve, substitute, adapt, and re-use are insufficient if supplies are the limited resource.
4. Patient transfer or resource importation is not possible or will occur too late for bridging therapies (such as bag-valve ventilation or other temporizing measures) to be considered.
5. Necessary resources have been requested from local and regional health officials (as applicable).
6. A state of emergency has been declared, or other health powers (as applicable) have been activated.
7. Regional, state, and federal resources are insufficient or cannot meet demand.

Triage Committee / Triage Officer

The SDMAC reaffirms that decisions regarding triage and allocation of scarce resources, when possible, should not be made by bedside clinicians.

1. Each hospital should appoint a Triage Committee that works with the HICS (Hospital Incident Command System) and the State Triage Committee to develop and implement criteria for the triage of critical resources.
2. If forming a Triage Committee is not feasible, institutions should assign a willing medical expert, such as an emergency physician, intensivist, or trauma surgeon, as the Triage Officer.
3. During CSC activation, the Triage Officer's sole responsibility is triage. He / She should not perform patient care while performing triage duties.⁷⁹
4. Each hospital should appoint a Triage Committee (or at minimum a Triage Officer), typically formed of two physicians from the affected discipline (usually two critical care or one critical care and one relevant specialty physician – infectious disease, burn surgeon, etc.). Inclusion of a critical care nurse or a non-clinician provider (e.g., a respiratory therapist) with relevant expertise is suggested.

⁷⁹ ⁷⁹Minnesota Crisis Standards of Care. Ethical Framework for Transitions between Conventional, Contingency, and Crisis Conditions in Pervasive or Catastrophic Public Health Events with Medical Surge Implications. Updated 11.24.2021. Page 11. https://www.health.state.mn.us/communities/ep/surge/crisis/framework_transitions.pdf

5. The standards used by all triage committees in the state should be aligned in criteria and application to minimize disparities in the delivery of care, while accounting for differences in the available resources at facilities.
6. The triage team should ask for and receive whatever patient information is necessary to make a decision but should NOT consider subjective assessments of the quality of the patient's life or value to society. (The treating physician should assure that the patient/family/surrogate wishes to use the ventilator or other resources if they are available prior to asking the triage team for an opinion).
7. Triage team should pass recommendations to the inpatient unit leader and document decision-making on templates in the affected patient(s) medical charts/records.
8. Summary data on triage decisions **must** be gathered and reported to the State Triage Committee via established data sharing pathways (e.g. Juvare).
9. Note that in some situations health care facility staff may participate on regional triage team on rotating basis.
10. Health care organizations implementing triage of resources should have a process for concurrent and retrospective appeals of resource allocation decisions.

Communication of Triage Resource Allocation to Patients and their Surrogates

1. The Triage Officer/Team and attending physician of record (or other licensed health care worker) involved in the care of the patient should collaborate to determine how best to communicate the results to the patient, family, caregiver, or surrogate.
2. The optimal method of communication may vary depending on an attending physician's relationship with the affected person(s), the workload of the treatment team or triage team, and other factors. *It is highly recommended that social work, spiritual care, and palliative care services be available to assist patients, families, caregivers, or surrogates in this process.*
3. A written, plain language explanation of the triage and appeals process should be provided to the patient and/or surrogate(s). Decisions should also be verbally explained clearly with supporting medical information in the patient or surrogate's native language, using medical interpreters as necessary.⁸⁰ These patient and/or surrogate(s) communications should include an explanation of:

⁸⁰University of California Critical Care Bioethics Working Group. Allocation of Scarce Critical Resources under Crisis Standards of Care. Revised June 17, 2020. Page 16. <https://www.ucop.edu/uc-health/reports-resources/uc-critical-care-bioethics-working-group-report-rev-6-17-20.pdf>

- a. How the triage decision was made and the limited appeals process,
- b. The medical facts supporting this decision in plain language,
- c. What could happen to the patient without critical care support,
- d. The options available for ongoing treatment, including palliative care services,
- e. Referral for support services, including social work and spiritual care.

Appeals Process

1. It is possible that patients, families, caregivers, surrogates, or clinicians will challenge individual triage decisions. Procedural fairness requires the availability of an appeals mechanism to resolve such disputes.
2. On practical grounds, different appeals mechanisms are needed for the initial decision to allocate a scarce resource among individuals, none of whom are currently using the resource, and the decision whether to withdraw a scarce resource from a patient who is clearly not benefiting from that resource.⁸¹ This is because initial triage decisions for patients awaiting the scarce resource will likely be made in highly time-pressured circumstances.
3. Every allocation decision (including initial assessment and reassessment) for an unrepresented patient (i.e. an individual who lacks decisional capacity and for whom there is no appropriate surrogate) should automatically be reviewed by the Triage Committee prior to assignment to an allocation level.⁸²
4. Similarly, every case where a ventilator or other scarce resource is to be reallocated should automatically be reviewed by the Triage Committee prior to reallocation. Personal equipment (at home ventilator, wheelchair) will never be removed from a person with a disability to be given to someone else because of a crisis.
5. During a crisis, bedside clinicians should be provided a mechanism to appeal a triage decision in real time to the HTC if the initial decision was:
 - a. Based on incorrect information,

⁸¹Santa Clara Valley Medical Center. Crisis Standards of Care During a Public Health Emergency. 12.9.20. Page12-13. <https://och.sccgov.org/sites/g/files/exjcpb906/files/12092020%20Crisis%20Standards%20of%20Care%20During%20a%20Public%20Health%20Emergency.pdf>

⁸²University of California Critical Care Bioethics Working Group. Allocation of Scarce Critical Resources under Crisis Standards of Care. Revised June 17, 2020. Page 17. <https://www.ucop.edu/uc-health/reports-resources/uc-critical-care-bioethics-working-group-report-rev-6-17-20.pdf>

- b. A change in patient condition, or
 - c. New clinical information is available.
6. The HTC may consult the STC if needed for clarification or assistance in applying the CSC clinical guidelines.
 7. The appeals process therefore starts at the local/institutional level. If a satisfactory decision cannot be determined at the local level, the STC should be engaged for secondary review.
 8. Treating clinician or Triage Officer should be prepared to explain the calculation, in plain language, to the patient, family, caregiver, or legal guardian on request.

Retrospective Appeals

1. During or after a crisis, clinicians, patients, caregivers, or surrogates should be given the opportunity to submit retrospective appeals to help determine if triage guidelines were incorrectly applied during the crisis.
2. Processes should be established at health care facilities/systems to conduct periodic retrospective review of all triage and rationing policies and decisions, to promote fairness and equity.⁸³ This process would not be able to:
 - a. Change decisions in real time,
 - b. Constitute binding legal determinations, or be
 - c. Used in any way for liability.
3. Outcomes of the retrospective appeals process can be sent to the STC for adjudication if indicated but otherwise offer:
 - a. Information in plain language to the patient, family, caregiver, or surrogate.
 - b. Lessons learned that may be applicable in future crises.
4. Retrospective appeals made after crisis de-escalation and dissolution of crisis response teams at the local and state level should be:
 - a. Heard in the hospital's ethics committee.
 - b. Directed to NH DHHS when assistance is required.

⁸³Minnesota Crisis Standards of Care. Ethical Framework for Transitions between Conventional, Contingency, and Crisis Conditions in Pervasive or Catastrophic Public Health Events with Medical Surge Implications. Updated 11.24.2021. Page 12. https://www.health.state.mn.us/communities/ep/surge/crisis/framework_transitions.pdf

Clinical Guidelines

1. Depending upon the scope and duration of a disaster, health care organizations are encouraged to focus on developing and promulgating tools for managing specific resources that may be in extreme shortage (e.g., PPE, dialysis, oxygen, sedatives) rather than seeking an overarching declaration of crisis conditions.⁸⁴
2. During a CSC response, the SDMAC and other SMEs will develop clinical guidelines that will include application of health care resources (i.e., space, staff, and supplies) which may have to be limited to do the greatest good for the greatest number of people.
3. It is presumed that emergency response agencies and other entities will adapt approaches and strategies to fit the circumstances of their specific organization and, when needed, use their professional training and discretion to guide allocation decisions. *It is recommended that all health care organizations consider the Strategies for Maximizing Health Care Resources (see Table 1, page 30).*
4. The State of New Hampshire governing body and the health care organization community will do everything in their power to avoid needing this *CSC Guidance* and its attachments.
5. The NH DHHS Commissioner **must** be notified when implementation of crisis standards are required. It is expected that all health care organizations:
 - a. Activating crisis standards of care **will** document the prioritization and allocation of all remaining resources provided to patients in their medical records.⁸⁵
 - b. Staff involved in the implementation of CSC triage teams to maintain current training.
 - c. Utilize resource allocation strategies.⁸⁶
6. *It is highly recommended that education be provided to clinicians about the circumstances under which life-saving resources may be ethically withheld from patients without patient or surrogate consent, and these processes must have the support of the providers as well as the state.*
7. *In the event the State enacts CSC, NH DHHS recommends compliance with the adapted Minnesota Department of Health (MDH) Patient Care Strategies for Scarce Resource Situations (Attachment D). Stipulating strategies for health care providers and other entities*

⁸⁴Ibid, Page 6-7.

⁸⁵Washington State Crisis Standards of Care Triage Team Operational Guidebook. October 2021.

<https://doh.wa.gov/sites/default/files/2022-02/821-151-CSC-TT-guidebook.PDF>

⁸⁶IOM 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response: Volume 1: Introduction and CSC Framework. Washington, DC: The National Academies Press.

to utilize in disaster/emergency situations will minimize their role in difficult triage decisions and preserve mental wellbeing.⁸⁷

4-Stage Priority Scoring of Patients for Resource Allocation

1. The allocation of scarce resources in a catastrophic or pervasive public health incident necessitates the creation of a priority scoring system to determine who will receive a particular resource should demand overwhelm supply.
2. Alignment of priority score criteria among hospitals in New Hampshire is essential for maintenance of the public trust that all persons will receive fair and equitable treatment regardless of where they receive their care.
3. All crisis standards of care guidelines should embody the following overarching **recommendations**.

Stage I: Inclusion Criteria

The Committee recommends against the use of exclusion criteria at any point during the triage process.

1. The first step in allocating a resource is determining who requires it. Using a framework in which all patients are eligible and worthy of care is most in keeping with the ethical framework of the *NH CSC Guidance*.

The Committee does recommend the use of inclusion criteria to determine the need for prioritization.

2. Inclusion criteria must be clinically relevant to the resource being allocated. The allocation framework must be applied equitably to all patients in need of a resource.
3. Implementation of crisis standards of care and a triage scoring system does *not* preclude clinical decisions (with patient, family, or legal guardian involvement) about the appropriateness of pursuing aggressive therapy that would take place under routine circumstances.

Stage II: Assignment of a Priority Score

The Committee recommends the use of the Sequential Organ Failure Assessment (SOFA) or modified SOFA (mSOFA) for assessment of short-term survival in adults, and the Pediatric Logistic Organ Dysfunction-2 score (PELOD-2) in children. Patients with lower primary priority scores are prioritized for the allocation of resources.

⁸⁷Minnesota Crisis Standards of Care Framework. Minnesota Department of Health Concept of Operations. February 25, 2020. Page 17.

1. Assignment of a priority score would determine the order in which patients receive a limited resource. Resources should be allocated using a priority score that assesses the likelihood of a patient to benefit from the resource based on objective measures of short-term and near-term survival. A priority score should allow for meaningful access for all patients and incorporate individualized clinical assessment based on objective evidence.
2. The assessment of near-term survival should be based on objective clinician assessment for the presence of severe life limiting conditions with predicted survival of less than one year. Assessment of comorbidities with the goal of predicting long-term survival carries the risk of unwarranted discrimination on the basis of age, race, disability, and socioeconomic status, etc., and is not recommended. Assessment of survival and assignment of a priority score should not include subjective assessments such as quality-of-life or intrinsic worth.
3. Care should be taken if primary priority scores are further divided into color coded priority groups. Usage of color groups may limit the ability to assess dynamic changes in priority scores and may not translate well to other institutions.
4. A sample of a Tiered Priority Scoring System can be found at the end of Stage IV: Periodic Reassessment and Possible Reassignment of Resources.

Stage III: Application of Secondary Criteria

If the priority score between two or more patients in need of the same resource is a tie, secondary criteria should be considered.

The Committee recommends the following secondary criteria:

Pregnancy: In the event of a tie between a pregnant woman and another non-pregnant patient, a fetal evaluation of fetal heart tones and fetal viability should be performed. If normal, priority should be given to the pregnant woman.

Age less than 18: Children under the age of 18 may be prioritized, especially if transfer to a pediatric hospital with resources reserved for this population is possible.

The Committee recommends against consideration of stage of life or age in-and-of itself as a criterion.

1. Use of the stages of life explicitly treats age as a triage consideration separate from its prognostic significance, which conflicts with the ethical framework set out in the NH CSC Plan. ***Prioritization of children is the one exception to this recommendation.***

The Committee recommends against giving priority to health care workers at this time, until a framework for such determinations can be agreed upon by appropriate stakeholders.

2. While the prioritization of front-line health care workers and first responders is ethically justifiable, doing so in a fair, transparent, and accountable way is operationally difficult at best.

If there remains a tie after consideration of secondary criteria, the Committee recommends the random allocation of the resource using a validated random allocation method.

1. A first-come first-served method is not recommended as it may disadvantage rural and other vulnerable populations with less access to care.
2. Objective medical evidence, equitable clinical assessments, individualized patient assessments, patient consent and short term survival are recognized as some of the bases for which CSC decisions may be made.⁸⁸

Stage IV: Periodic Reassessment and Possible Reassignment of Resources

The Committee recommends that reassessments should occur at regular intervals for as long as a resource continues to require allocation.

1. Reassessment of patients who have received a scarce resource is necessary for the ethical allocation of resources in a crisis. Patients should be given a therapeutic trial of a duration specific and proportional to their individual disease process, as determined by the individual hospital's triage committee. The duration of a therapeutic trial should be established based on existing clinical data and modified as new data becomes available.
2. In the event of considerable clinical deterioration or highly morbid complication, or other clear indication that a patient will not benefit from ongoing utilization of a resource, the hospital triage committee may decide to end a therapeutic trial and withdraw the resource so that it may benefit another patient.
3. This process will necessitate the exercise of clinical judgment and should be carried out objectively.
4. Withdrawal of resource decisions made by the hospital triage committee should be transparent to the patient, family, and/or legal guardian prior to discontinuation.
5. All patients, their families, and/or legal guardians who are considered for the allocation of a resource should be notified in advance of the possibility of resource withdrawal.

⁸⁸Hodge, James G., Jr., J.D., L.L.M., Piatt, Jennifer L., J.D. and Wells, Nora, J.D., "Crisis Standards of Care: Legal Decision Factors." *The Network for Public Health Law*. September 7, 2021. <https://www.networkforphl.org/wp-content/uploads/2021/09/Western-Region-Memo-CSC-Legal-Factors-1.pdf>. Used here with permission from James G. Hodge, Jr. JD, LLM.

6. Notification and disclosure should be a collaborative process between the triage committee and the bedside physician.
7. All patients who are unable to receive needed critical care resources or have them withdrawn shall receive comprehensive palliative care for symptom management and psychosocial support to the fullest extent possible.

Limitations on Resuscitative Care during a Crisis

The Committee believes it is unethical to deny patients cardiopulmonary resuscitation based solely on arbitrary factors (e.g. all patients with COVID-19) that are out of line with the patient’s wishes, advanced directives, or Provider Orders for Life Sustaining Treatment (POLST).

- However, in resource scarce situations, patients with unwitnessed cardiac arrest, recurrent cardiac arrest, or who are unresponsive to a reasonable trial of Advanced Cardiac Life Support (ACLS) care with defibrillation, may have care withdrawn if continued resuscitation attempts would draw resources and care from other patients.

Palliative and Hospice Care

1. In a public health incident where there is a high number of patients and a limited supply of resources, health care professionals have an obligation to provide patients clinical care for symptom management and comfort during the incident.
2. Palliative care is designed to holistically provide care for patients with serious illness and hospice care continues that care when it is determined that a patient terminally ill and not likely to survive.
3. In the IOM’s 2009 report about CSC, the IOM committee stated that, “palliative care should be available to all people affected by a disaster. The key services include comfort, compassion, and maintenance of dignity—services that can be provided with essentially no physical resources other than the presence of another human being”.⁸⁹
4. Normally, palliative care complements medical care by focusing on provision of comfort through symptom management for an individual with a serious or life-threatening illness. In a catastrophic or pervasive public health incident, palliative care would focus on aggressive and compassionate management of symptoms and the relief of suffering of patients likely to die which could be physical, emotional, psychosocial, or spiritual.

⁸⁹Gostin, L. O., Hanfling, D., Hanson, S. L., Stroud, C., & Altevogt, B. M. (Eds.). (2009). Guidance for establishing crisis standards of care for use in disaster situations: A letter report. National Academies Press.

2. It is important for palliative and hospice care providers to form partnerships with acute care providers as a step during emergency preparedness and during an emergency response.
3. Palliative and hospice care providers are positioned as a resource for patients in need of this type of care and to serve as clinical consultants to acute facility staff if transfer to palliative or hospice care is not an option.⁹⁰
4. Hospice care clinicians are skilled in identifying transition indicators in a patient's physical and behavioral status which helps prepare the patient and family for the end of life.
5. Integrating palliative and hospice resources for individuals who are not likely to survive is a viable service option for responders and triage clinicians.⁹¹
6. Palliative and hospice care providers should prepare for their role and patient surge capacity in no-notice events (local mass casualties) or other noticed events (pandemic).
7. Individuals who are at risk of dying during an emergency event include not only people who were previously healthy and became ill or injured related to the event, but also those with a pre-existing or life-threatening illness. Categories of patients who are at risk include individuals:
 - a. With pre-existing life-threatening illnesses who are highly dependent on medical care (i.e. dialysis);
 - b. Receiving palliative or hospice care;
 - c. With chronic illnesses or comorbidities who require medical care; and
 - d. With a poor prognosis for whom the focus of care may be palliative in the setting of limited resources in an emergency event.⁹²

Behavioral and Mental Health

During crisis, behavioral health services will be an important component of health care that will be needed by many to cope with new and emerging psychosocial stressors. While Psychological First Aid (PFA) and social support and assistance will play a large role in addressing these issues, incident specific risk communication strategies should be developed and disseminated to

⁹⁰IOM 2012. Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response. Washington (DC): National Academies Press (US). Cross-Cutting Themes. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK201082/>

⁹¹Matzo M. L. Palliative care: Prognostication and the chronically ill. American Journal of Nursing. 2004;104(9):40–50. <https://pubmed.ncbi.nlm.nih.gov/15365339/>

⁹²Nouvet, E., Sivaram, M., Bezanson, K. et al. Palliative care in humanitarian crises: a review of the literature. Int J Humanitarian Action 3, 5 (2018). <https://doi.org/10.1186/s41018-018-0033-8>

help those affected manage the stress of crisis and also direct those affected to additional resources as necessary.

Health care organizations, including acute care hospitals and community mental health centers (CMHCs), will be a vital piece of the state's response to crisis. Depending on the crisis, criteria for behavioral health inpatient admission and capacity of inpatient behavioral health care units are likely to change. Furthermore, community resilience programs encouraging neighbor-to-neighbor and family-to-family outreach will need to be supported.

In a time of crisis when CSC are activated, the psychosocial impact of a crisis as well as the behavioral health of the public, emergency personnel, medical professionals, and those with serious mental illness must be considered. Efforts must be made to continue to provide quality and timely mental health care for all affected populations.

Criteria for Behavioral Health Admission

During activation of CSC, criteria for inpatient behavioral health admission should be revisited in order to determine whether criteria for admission should become stricter. Strict admission criteria would necessitate better coordination between hospitals and community mental health centers in order to manage those with less acute mental health needs by using community mental health care.

In the event of an outbreak of disease transmissible through proximity (such as an epidemic of an infectious disease), inpatient behavioral health units could be a site of transmission and morbidity. In this case, hospitals should consider reducing capacity of behavioral health units and limiting on-unit group sessions in order to accommodate social distancing. Discharge of patients should be coordinated with community mental health centers.

Capacity of Inpatient Behavioral Health Treatment Units

In times of crisis, the capacity of inpatient behavioral health treatment units may be reduced. In these scenarios, patients discharged from inpatient behavioral health treatment units or ED should be offered timely outpatient follow-up. To ensure that follow-up can be timely, hospitals, CMHCs, and outpatient mental health providers should consider using telephone or video-enabled devices to conduct these visits.

Community and Outpatient Mental Health

During events necessitating activation of CSC, outpatient mental health services and community mental health centers will be important resources serving the needs of those living in our state. Outpatient mental health providers should be proactive in providing information for the crisis lines of the state community mental health centers. Those taking crisis calls will be instrumental in triaging, steering those in most acute need towards the nearest ED and coordinating services for those with less acute needs. Outpatient mental health providers and hospitals should coordinate services with the community mental health center in their region.

Key Points

- Public messaging and guidelines for health care and behavioral health practitioners regarding the behavioral impact on the general population should be developed
- Guidelines for health care workers, behavioral health practitioners, and first responders regarding the behavioral health impact on the responder community should be developed
- Mental health care for people with serious mental illness and individuals receiving treatment (including medication) for substance dependency should be continued, guidelines should be developed to support this continuing care
- Psychological first aid adapted specifically for community resilience/social support enhancement in a CSC context should be deployed for use by the general public, health care workers, and those involved in the disaster response
- Criteria for inpatient behavioral health admission should be revisited during times when CSC is activated, and discharges should be coordinated with community mental health centers
- Outpatient mental health services and hospitals should coordinate with community mental health centers who can be instrumental in the triaging of patients in need of mental health care

Sources: IOM 2009/2012; Minnesota Framework for Healthcare Facilities; and Arizona CSC

Emergency Medical Services

1. During activation of crisis standards of care (CSC), Emergency Medical Services (EMS) maintain their focus to deliver appropriate care to patients while maintaining the safety of providers.
2. The NH Department of Safety, Division of Fire Standards and Training & Emergency Medical Services Emergency Medical Services (EMS) will play a major role during a CSC response, linking patients in the outpatient environment to hospitals and the delivery of care.
3. In a CSC response within NH, EMS providers will have to adapt practices and standards of care to address the most difficult circumstances. The process by which they are developed and applied must also adhere to the ethical principles within the *NH CSC Guidance* be transparent and accountable.
4. Tables 10-13, provide information for EMS and SDMAC to consider across the health care standard of care continuum (conventional, contingency, and crisis).

Table 10: Considerations for EMS Dispatch

Conventional	Contingency	Crisis
<p>1. Consider initial auto-answer during times of high call volume for medical emergencies.</p> <p>2. Utilize other regional regulated emergency medical dispatch centers to assist with increased calls.</p>	<p>1. Prioritize calls according to potential threat to life; “pend” apparently non-life-threatening calls (note this requires a medically trained dispatcher, not available at many public safety answering points (PSAPs).</p> <p>2. Utilize non-medically trained dispatch personnel to handle incoming non-emergent calls.</p> <p>3. Decline response to, and refer low acuity, non-emergent calls to nurse triage line for referral to appropriate primary/secondary medical care.</p>	<p>1. Utilize non-certified dispatch personnel to handle incoming emergent calls.</p> <p>2. Decline response to calls without evident potential threat to life (requires certified dispatcher and medical dispatch protocol).</p> <p>3. Decline or delay response and consider telephone triage recommendations to self-transport for potential life-threatening conditions.</p>

Table 11: Considerations for EMS Response

Conventional	Contingency	Crisis
<p>1. Modify resource assignments (e.g., only fire/rescue dispatched to motor vehicle crashes unless EMS are clearly required, single agency EMS responses if fire agencies are overtaxed).</p>	<p>1. Modify resource assignments to meet system demands.</p> <p>2. Change EMS response assignments to BLS versus ALS as resources necessitate.</p> <p>3. Consider requests for disaster assistance, including mutual aid assistance from surrounding areas.</p> <p>4. Use non-emergency medical transport for low acuity responses.</p> <p>5. PPE conservation activities (i.e. one person with PPE goes into residence and implement other PPE conservation activities as necessity dictates).</p>	<p>1. Utilize scheduled BLS providers to staff ambulance in ALS system.</p> <p>2. Request EMS units from emergency management.</p> <p>3. Further modify resource assignments as possible.</p> <p>4. Response resources may be delayed or incapable of response due to surge capacity or system demands.</p>

Table 12: Considerations for EMS Patient Assessment and Treatment

Conventional	Contingency	Crisis
<p>1. Recommend that patients with very minor injuries self-transport.</p> <p>2. Treat as appropriate and approved by the medical director when resources are available.</p>	<p>1. Encourage patients with minor injury/ illness to self-transport to a designated facility.</p> <p>2. Assess patients and determine transport necessity for those without significant injury/illness (according to guidance from local EMS Medical Director).</p> <p>3. Utilize CHEMS agencies/units in screening, providing instructions, and following up with patients and their primary care providers or alternative treatment facility as appropriate.</p> <p>4. Minimize aerosol-producing procedures or non-invasive airway support measures (CPAP/BiPAP).</p>	<p>1. Provide alternative resources /destination/ transportation to definitive care dependent on the crisis occurring.</p> <p>2. Consider critical care guidance modification allowing an experienced critical care Paramedic or RN be the sole provider versus a three-person team if they are comfortable providing that care based on patient needs.</p> <p>3. Treat and triage appropriately given the circumstances and as approved by the medical director.</p>

Table 13: Considerations for EMS Transportation

Conventional	Contingency	Crisis
<p>1. Transport patients to the appropriate designated facility.</p>	<p>1. Allow transport to urgent care or clinics for minor injury and illness.</p> <p>2. Continue to assess patients and decline to transport those without significant injury/illness (according to guidance from EMS medical director).</p> <p>3. Consider batch transportation resources, such as school buses and public transit buses.</p> <p>4. Ensure proper PPE doffing areas are set up and maintained at the receiving destination as well as possible decontamination area.</p>	<p>1. Employ batch transports, as needed.</p> <p>2. Transport and destination will be based on triage guidance and bed availability, as established based on the crisis.</p> <p>3. Allow combining of resources from different agencies (e.g., staff from one agency paired with equipment from another agency).</p>

Out-of-Hospital Care

1. During the CSC response, health care access points across the state will need to adapt their practices to the overwhelming number of patients seeking care.
2. Out-of-hospital care will be an important part and will naturally expand operations to meet demand.
3. Out of hospital care refers to the following types of health care access points
 - Outpatient Providers
 - Ambulatory Clinics
 - Surgical Centers
 - Long-Term Care Facilities
 - Group Homes and Congregate Settings
 - Home Care
 - Family-Based Care Systems

Outpatient Providers

1. During the CSC response, to ensure consistent care, the SDMAC will need to coordinate with hospital incident command groups and GSHCC to implement standards and to:
 - a. Maintain situational awareness with all varieties of out-of-hospital providers.
 - b. Understand guideline creation will be an interactive and dynamic process with the provider community.
2. The specific medical skills and the infrastructure and equipment available to out-of-hospital providers will be considered during a CSC response:
 - a. Medical skills—may be used in their usual practice environment; in alternate care systems/ assignments (e.g., serving as members of the Medical Reserve Corps (MRC), answering patient hotlines); and perhaps even in their neighborhood/community settings.
 - b. Infrastructure—practice environments may be adjusted to help meet the demands of an overwhelming incident. For example, clinic functions may be:
 - i. Expanded—using expanded hours, modifying care practices, and adjusting schedules to accommodate increased acute care (e.g., deferring elective appointments)
 - ii. Repurposed—outpatient infrastructure may be repurposed during an incident as, for example, when a subspecialty clinic adjusts its hours or closes to enable the space to be used for acute care

- c. Referral and Routing—outpatient providers will stay informed of existing healthcare access points and can refer or route patients to higher acuity care as appropriate during a CSC response (IOM, 2012).

3. During a CSC response, the SDMAC will coordinate with the local and state health departments, and the GSHCC to:

- a. Maintain situational awareness, through medical boards and associations, with all types of providers to assess demand for healthcare and resource availability.
- b. Develop guidance and messaging on referring and routing higher acuity patients to available healthcare access points.
- c. Develop and implement guidance for various types of outpatient providers.

Ambulatory Clinics

1. During the CSC response, this category will include a wide variety of health care access points. These will include facilities licensed under [RSA 151:2](#) and those governed by Office of Professional Licensure and Certification ([OPLC](#)). Clinics may include:

- Urgent care centers
- Federally qualified health clinics,
- Multi-specialty clinics
- Independently operated healthcare practitioners
- Clinics located in retail stores
- Pharmacies that provide basic medical screening
- Non-traditional providers: dentists, veterinarians, and others

2. During a CSC response, the SDMAC will coordinate with the local and state health departments, and the GSHCC to:

- a. Maintain situational awareness with all types of clinics through medical boards, NH Medical Association, OPLC and DHHS.
- b. Develop and implement CSC guidelines for clinics to expand hours of operation and repurpose space, staff, and supplies as appropriate.

Surgical Centers

1. Free standing and hospital-based ambulatory surgical centers may be repurposed to provide:

- a. Acute care
- b. Non ambulatory hospital overflow care, or
- c. Elective surgeries not possible at hospitals (during infectious disease incidents)

2. The specific mode of repurposing can be based on:
 - a. Demands of the incident,
 - b. Specifics of the facility, and
 - c. Needs of the community.
3. The need for modified regulatory and licensure standards (e.g. changes in the scope of care) will need to be addressed in advance in the event that federal, state, or local government entities (such as public health) authorize the delivery of triaged care in these facilities.
4. During a CSC response, the SDMAC will coordinate with the local and state health departments, and the GSHCC to:
 - a. Maintain situational awareness with all types of surgery and procedure centers through medical association partners.
 - b. Develop and implement CSC guidelines for surgery and procedure centers.

Long-Term Care Facilities

1. Many long-term care facilities have limited surge capacity to accommodate hospital discharges, although they should not be overlooked as a resource.
2. During CSC response long-term care facilities can:
 - a. Implement Nursing Home Incident Command System (NHICS),
 - b. Prepare to shelter in place (including without power) during a major incident,
 - c. Consolidate placement of current residents to create surge capacity centers, clusters within centers and/or facilitate efficient delivery of care.
 - d. Modify patient care and referral policies
3. During a CSC response, the SDMAC will coordinate with the GSHCC to:
 - a. Maintain situational awareness with all types of long-term care facilities through medical association partners.
 - b. Implement and/or develop CSC guidelines for long-term care.
 - c. Consult with NH DHHS Health Care Facilities Unit for Part 1135 waivers to be in place for waiver of Medicare regulations, which will facilitate the admission of new patients not necessarily requiring long-term care.

4. Table 14 provides information for Long-Term Care Agencies and SDMAC to consider across the health care standard of care continuum (conventional, contingency, and crisis).

Table 14: Considerations for Long-Term Care

Conventional	Contingency	Crisis
<p>1. Coordinate with state public health, local health departments, and designated coalitions to maintain situational awareness.</p> <p>2. Consider limiting face-to-face visits as indicated by transmissible illness and incorporating telehealth visits and video communication as appropriate, provide basic care and evaluate whether a higher level of care indicated.</p> <p>3. Establish objective criteria of illness/injury severity to determine treatment venue.</p> <p>4. Identify surge capacity and associated needs.</p>	<p>1. Coordinate with hospitals and ambulatory care to determine appropriate admits and dispositions.</p> <p>2. Consult with medical licensing for Part 1135 waivers to be in place for waiver of CMS regulations, which will facilitate the admission of new patients not necessarily requiring long-term care.</p> <p>3. Form coalitions with other facilities to establish “contagious” and “non-contagious” facilities to limit unnecessary exposures.</p> <p>4. Form coalitions with other facilities to coordinate effective utilization of resources and supplies.</p> <p>5. Implement emergency operations plans as appropriate to support patient care delivery.</p>	<p>1. Use objective inclusion criteria to evaluate patients needing higher or lower level of care.</p> <p>2. Provide comfort care per patient request and for those triaged to comfort care measures only by triage protocols approved by the SDMAC.</p> <p>3. Expand scope of illnesses and injuries monitored and cared for through services in the facility.</p> <p>4. If unable to transfer contagious/non-contagious to appropriate facility, ensure patients are separated to the greatest degree possible.</p> <p>5. Implement Extended Use protocols to conserve supplies as appropriate.</p>

Group Homes and Congregate Settings

1. These include:
 - a. Large business operations,
 - b. Group homes,
 - c. Schools,
 - d. Universities

2. During CSC response group homes and congregate setting can:
 - a. Support dispensing or vaccination/prophylaxis services in conjunction with the local health department
 - b. Provide shelter or isolation for residents/students/staff

- c. Conduct referral and routing of patients
- 3. During a CSC response, the SDMAC will coordinate with the local and state health departments, and the GSHCC to:
 - a. Establish and maintain situational awareness with group homes and congregate settings.
 - b. Develop and implement CSC guidelines for group homes and congregate settings.

Home Care

- 1. During CSC, the SDMAC should coordinate with home care / durable medical equipment vendors to prioritize their services based on the nature of an incident and be able to adjust plans as the incident changes over time.
- 2. These plans also should cover clients that are quarantined, isolated, or sheltering-in-place because of weather or other hazards / threats.
- 3. All persons served by home agencies should have a personal emergency plan in case a crisis delays care delivery.
- 4. Device-dependent persons should have a care plan in case of a system failure or power outage.
- 5. Table 15 provides information for NH Home Health Care Agencies and SDMAC to consider across the health care standard of care continuum (conventional, contingency, and crisis).

Table 15: Considerations for Home Health

Conventional	Contingency	Crisis
<p>1. Train home health staff and other potential care providers for care of transmissible illness, trauma, or other prevalent conditions.</p> <p>2. Use a variety of strategies including hotlines, internet sites, and social networking tools to share information about prevalent conditions, when they can be self-managed, when they require medical evaluation, and where to go for evaluation.</p>	<p>1. Consider limiting home visits as indicated by transmissible illness and incorporating telehealth visits as appropriate, serve as educational resource for patients home bound, provide basic care and evaluate whether a higher level of care indicated.</p> <p>2. Coordinate with hospitals to identify patients discharged and provide needed at-home follow-up.</p>	<p>1. Use objective inclusion criteria to evaluate patients needing higher or lower level of care.</p> <p>2. Provide comfort care per patient request and for those triaged to comfort care measures only by triage protocols approved by the SDMAC.</p> <p>3. Expand scope of illnesses and injuries monitored and cared for through services in the home.</p> <p>4. Explore alternative care sites / arrangements for patients as indicated due to spread of transmissible illness to caregivers.</p>

Family-Based Care Systems

1. Care is often provided by family members, domestic partners, or cohabitants.
2. Friends and family members provide basic care to people with a wide variety of conditions including:
 - a. Behavioral health issues,
 - b. Chronic diseases,
 - c. End-of-life,
 - d. Developmental disabilities, and
 - e. Traumatic injuries
3. These non-clinical caregivers can play a key role in preventing the medical system from being overloaded by helping limit unnecessary visits to healthcare providers and ensuring at-risk people receive the most appropriate available care.
4. Public information messages should be disseminated statewide to inform the general public of available healthcare resources for homebound persons and other at-risk groups. Families and friends should be prepared for expanded responsibilities during a catastrophic incident.

5. The NH Choices for Independence waiver (CFI) provides home health care, home support and personal care, case management and assisted living services to seniors and adults with disabilities who meet eligibility requirements for placement in a nursing facility. Services also include adult medical day services, home health aide, homemaker, personal care, respite, supported employment, financial management services, adult family care, adult in-home services, and community. Utilization of this and other long term supports and services (LTSS) to offload the medical system should be considered.
6. Home and Community Based Services agencies such as the Bureau of Developmental Services' Area Agencies, Elderly and Adult Services Case Management Agencies, and Community Mental Health Centers should develop contingency plans in coordination with their supervisory entities to prepare for augmentation and possible expansion of roles during a crisis.
7. During a CSC response, the SDMAC will coordinate with the local and state health departments and the GSHCC to:
 - Develop public messaging for family/surrogate/friend caregivers and coordinate dissemination with public information staff.

Pediatric and Burn Patients

1. Considerations for the SDMAC and Hospitals:
 - a. Communication: Messaging and communication will need to be modified for pediatric patients, especially those who are non-verbal.
 - b. Personal Protective Equipment (PPE): Masks, gloves, gowns, and other PPE may frighten pediatric patients. Pediatric sizes of masks and other types of PPE should also be available.
 - c. Decontamination: Children may need to be decontaminated with or by adult family members/caregivers. Tepid (98.6o F) water will be needed because children are more prone to hypothermia.
 - d. Mental Health: Children have unique psychological needs and may be prone to fear and panic.
 - e. Evacuation/Transfer: Please refer to the Transfer Guidelines portion of the In-Hospital Care section above. Out-of-state transfer will be a last resort.
 - f. Reunification: Hospital reception sites will be set up at hospitals to assist families seeking information about missing loved ones.

- g. Pediatric Space, Staff, and Supplies: When possible, pediatric patients should be brought to pediatric acute healthcare facilities. If evacuation or transfer is not possible, healthcare professionals will have to use available
- 2. Pediatric and burn mass casualty incidents require planning for specific surge capabilities in order to ensure the best possible patient care outcomes.
- 3. The Western Regional Alliance for Pediatric Emergency Management Reference Table provide conventional, contingency, and crisis triggers, sample activation requirements, institutional tactics, and agency / policy / systems considerations. https://wrap-em.org/images/WRAP-EM_CSC_Template_Final.pdf
- 4. Table 16 provides information for pediatric and burn center clinicians and SDMAC to consider.⁹³

Table 16: Considerations for Pediatric and Burn Patients

	Pediatric	Burn
Stabilization	Pediatric equipment, including guides for weight-based equipment selection and drug dosing (liquid medications), and appropriately trained providers must be available at <i>all</i> emergency departments to stabilize patients, with emphasis on those <8 years of age.	Basic dressings, analgesia, fluid support, and airway management should be available at <i>all</i> emergency departments. Providers should be trained in initial stabilization and management of burn victims in order to avoid critical errors in resuscitation.
Surge capacity	Specific spaces that are safe and appropriate for pediatric care must be identified, as well as the requisite equipment and staff with pediatric expertise necessary for appropriate care. Increased staffing ratios are required to safely care for children. Strategies for adaptation of equipment or medications in adults may not be applicable to the pediatric population. Specific support and safety issues must be addressed—a pediatric safe area, nutrition (including infant formula), psychological support, etc. Non-pediatric hospitals may have to provide inpatient care for pediatric patients during epidemic or mass casualty incidents.	Major burn patients require large amounts of intravenous fluids and narcotic analgesia. Burn unit beds are in critically short supply in the United States and in mass casualty incidents non-burn unit hospitals may have to manage burn victims for at least the first few days. Will need tiered triage to transport those most likely to benefit from care at a burn center over time.
Tracking	Reunification of children with their caregivers is a critical focus of pediatric planning. Policies and processes need to be in place prior to an incident. Information on transfers must be easily shared between organizations to facilitate this process.	Information on number of victims, condition, and transfers must be easily shared among organizations to facilitate appropriate transfers and reunification, especially when regional transfers are required.
Coordination	Incident demand must be balanced across coalition facilities that provide (or can provide) pediatric care and other networks of children’s hospitals. Pediatric subject matter experts or pediatric health care coalitions should be integrated into the transfer framework to provide input on appropriate destinations and use of available beds for specific patients.	Incident demand must be balanced across coalition facilities that provide (or can provide) burn care and burn center networks. Subject matter experts should be integrated into the transfer framework to provide input on appropriate destinations and use of available beds for specific patients so debridement and interventions can be appropriately timed.
Consultation	Must be available for hospitals that have to manage pediatric patients that do not normally do so. Telemedicine, telephone, and other methods of consultation are imperative, and these may need to be set up with national pediatric centers or with pediatric health care coalitions if the local/regional centers of expertise are too overwhelmed to provide such support.	Must be available for hospitals that have to manage burn patients that do not normally do so. Telemedicine, telephone, and other methods of consultation are imperative—and these may need to be set up with national burn centers if the local/regional centers of expertise are too overwhelmed to provide such support.
Transportation	Pediatric patients may have specific transport needs (bassinets, car seats, other safety restraints, appropriate pediatric-sized equipment for en-route care, e.g., IV pumps).	Burn patients need to be protected against hypothermia during transport, and adequate analgesia, fluids, and airway equipment are required for safe transfer.]

⁹³IOM, 2012.

Clinical Resource Management

Staff - Health Care Workforce

Scope of Practice

1. Scope of clinical practice is defined as the extent of a licensed healthcare professional's ability to provide service consistent with their competence, license, certification, and privileges. Most healthcare professional's scopes of practice are delineated by rules and regulations describing range of responsibilities. During disasters and emergencies, modification of the scope of practice for health professionals to meet increased demand for service is expected.
2. In the setting of a health care crisis, facility disaster plans should optimize the availability of all health care professions, particularly those serving in front-line roles. The use of reserve staff or sharing health care workers with other institutions may also be necessary at times.
3. While health care workers (HCWs) should not be asked to perform outside their scope of practice (e.g. a nurse would not be asked to perform surgery), workers should be prepared to be assigned to additional roles outside their normal everyday duties.
2. Workers being assigned to new duties or roles may still require additional training or refresher instruction if they do not regularly perform this activity. If a modified scope of practice is required, the facility needs to offer appropriate training prior to the worker performing these duties. Just-in-time training can be used in this circumstance to ensure workers have the appropriate skills in these settings.

Trainees and Supervision

1. Ensuring ongoing patient safety during a crisis through trainee supervision remains important. However, considerations to allow for trainees in any health profession to play a larger role in crisis response efforts can be made. As an example, medical and nursing students can be given additional responsibilities based on their training prior to the crisis commencing.
2. For trainee physicians, additional responsibilities can be delegated to them, if sufficient supervision by an attending physician occurs. Trainees may also be able to practice at other facilities, while still receiving supervision from a physician at that facility. Advanced practice providers such as APRNs and PAs, as well as pharmacists, can also be given additional responsibilities, in line with the scope of practice issues discussed previously.
3. Licensed RNs who have met requirements to perform procedures defined by the state's nursing board may be able to perform these in facilities where they have privileges.

Staff Support

1. Staff shortages are expected to be a challenge during a crisis. Provision of support to help enable staff to continue to perform their clinical duties is important. Some key areas to address include ensuring access to childcare, ensuring staff are protected with appropriate person protection equipment (PPE), and providing housing if needed for on-duty staff.
2. Efforts should be made to reduce the risk of staff burnout. All staff should have access to information on contingency plans for managing the crisis, to allow staff to assess how this will impact them. Shifts should be scheduled with appropriate redundancy in a way that avoids fatigue, especially if a crisis continues over a prolonged period. Supports should be made available to staff who are experiencing burnout.
3. Table 17 is an example of how staffing may be categorized. The example should not be interpreted as policy or recommendations of the State or any specific health care system. The safety of nurse-to-patient ratios may vary depending on the acuity of the patients and require adjustments. Examples provide a consistent level of adaptations and care across facilities.⁹⁴

Table 17: Considerations for Health Care Workforce Staffing

Conventional	Contingency	Crisis
1. Usual staff on Units / Wards. 2. Usual nurse to patient ratios. 3. No tiered staffing. 4. No volunteer / government providers utilized for direct patient care.	1. “Step Over Staff” with consistent training from other Units / Wards. 2. Ratio increase less than or equal to 150% of usual example: From 1:6 up to 1:9. 3. No tiered staffing. 4. No volunteer / government providers utilized for direct patient care. 5. Attempt to address social factors that might prevent HCW from reporting to work, such as need for transportation or housing that allows for physical distancing, particularly if HCW live with individuals with	1. “Step Up Staff” that do not usually care for patients of current acuity. Example: Intermediate or tele RNs to ICU. 2. Ratio increase > 150%. 3. Implement tiered staffing. 4. Implement volunteer / government providers utilized for direct patient care. 5. Implement regional plans to transfer patients impacted by the incident to designated health care facilities, or alternate care sites with adequate staffing. ⁹⁸ 6. If shortages continue despite other mitigation strategies, as a

⁹⁴Minnesota Department of Health. Crisis Continuum Staffing Definitions. <https://www.health.state.mn.us/communities/ep/surge/crisis/continuum.pdf>

⁹⁸Ibid

Conventional	Contingency	Crisis
	<p>underlying medical conditions or older adults. Consider that these social factors disproportionately affect persons from some racial and ethnic groups, who are also disproportionately affected by the incident.⁹⁵</p> <p>6. Identify additional HCW to work in the facility. Be aware of state-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCW.⁹⁶</p> <p>7. As appropriate, request that HCW postpone elective time off from work. However, there should be consideration for the mental health benefits of time off and that care-taking responsibilities may differ substantially among staff⁹⁷.</p>	<p>last resort consider allowing HCW to work even if they have suspected or confirm infection, if they are well enough and willing to work, even if they have not met all Return to Work criteria.</p>

Supplies

1. The US supply chain has minimal ability to rapidly surge production, resulting in challenges to meeting the large or unexpected increases in demand that might occur during public health events. Therefore, without proper planning shortages of supplies are likely. When supplies are inadequate, the six core strategies discussed above should be employed and health care facilities should work with GSHCC to share supplies if possible.
2. Health care facilities should not operate in a silo and implement extreme (e.g. re-use, reallocation) strategies without consulting external partners (e.g. health system, GSHCC, state).
3. For most hospitals, concentrating on inexpensive but commonly needed supplies such as intravenous fluids, airway supplies, wound care supplies, and medications for analgesia and sedation will provide the highest return on investment when planning for disasters.

⁹⁵U.S. Health and Human Services. Centers for Disease Control and Prevention. Strategies to Mitigate Healthcare Personnel Staffing Shortages during COVID-19. Updated January 21, 2022. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

⁹⁶Ibid

⁹⁷ Ibid

4. Increasing par levels of selected medications and supplies can be critical to accommodate a surge in demand. Consideration should be given to placing beds, monitors, and ventilators that are going out of service into storage rather than selling them whenever possible, as these high-cost items are not likely to be available from vendors during an emergency or disaster. Depending on the institution, purchase of some of these items may be possible.
3. Medication shortages are common occurrences and allow health care facilities to practice crisis care strategies by using incident management frameworks and engaging SMEs (physicians in the specialty area, pharmacy staff, administration, and nursing) in the decision-making process as they cope with dynamic and multiple medication shortages.
4. When levels of supplies are inadequate, and the supply chain and GSHCC partners cannot provide relief, the health care facility's ICS Planning Section should convene appropriate SMEs to look at existing guidance and develop facility recommendations (note that this can also be done at the health system and regional level as needed).
5. If broader resource challenges are present, the Planning Section or hospital Incident Commander may ask a Clinical Care Committee or equivalent to convene in order to assist with addressing service, supply, and staff practices. They can help to focus the facility resources on patient care and make recommendations for any necessary triage of services. For example, such a committee can assist with decisions like discontinuing provision of high-intensity services such as extracorporeal membrane oxygenation (ECMO) when the resource commitment is unsustainable.
6. In an extreme situation, re-allocation of resources may be necessary (i.e. taking a resource from one patient to give to another).

Space – In-Hospital Care

1. Tables 18 and 19 provides information for Hospital Wards, Surgical Units, and the SDMAC to consider across the health care standard of care continuum (conventional, contingency, and crisis).

Table 18: Considerations for Hospital Wards

Conventional	Contingency	Crisis
<ol style="list-style-type: none"> 1. Screen all scheduled elective admissions 24 hours in advance, with cancellation for anyone with influenza-like illness or other relevant symptoms. 2. Inventory and order needed supplies and equipment. 3. Isolate caring for influenza patients in areas separated from non-influenza patients. 	<ol style="list-style-type: none"> 1. Discharge patients not requiring acute in-patient care. 2. Use alternate care sites/systems. 3. Modify nurse-to-patient ratios. 4. Change documentation practices to increase numbers of patients who can safely be cared for. 	<ol style="list-style-type: none"> 1. Triage services to maximize overall lives saved. 2. Continue bed/resource capacity reporting. 3. Cancel all job duties considered non-essential and reassign personnel as appropriate. 4. Move patients who cannot be discharged but who are stable to alternate facilities experiencing less surge. 5. Ensure availability of high-quality palliative care and symptom management services to all patients through a prearranged palliative care team consisting of physicians, nurses, clergy, and lay volunteers.

Table 19: Considerations for Hospital Surgical Units

Conventional	Contingency	Crisis
<p>1. Consider deferring elective surgeries for patients with influenza-like illness or other relevant symptoms in a pandemic setting.</p>	<p>1. Defer surgeries unless the situation is emergent or, in the judgment of the surgeon, the operation is medically required within the next 14 days.</p> <p>2. Free staff and operating rooms to care for injured in a mass trauma setting.</p> <p>3. Free staff for alternate duties, makes post-anesthetic recovery space available for acute care in a pandemic setting.</p>	<p>1. Defer surgeries not essential to preserve life and limb or not needed to facilitate discharge from hospital. Triage services to maximize overall lives saved.</p> <p>2. In mass trauma settings, pull staff with surgical experience from other areas of hospital to support trauma response capacity.</p> <p>3. Have surgical staff assist in other units of the hospital as needed in a pandemic setting.</p> <p>4. Maintain a 24/7 call schedule for emergency lifesaving surgery, with back-up staff identified to address staff illness.</p>

Intensive care units (ICU)

4. For planning purposes, ICU services should include the ability to provide cardiac monitoring, invasive monitoring, mechanical ventilation, and hemodynamic management.
5. Many facilities do not provide these services, although at a minimum, facilities should be able to provide initial resuscitation and management while awaiting transfer to another facility.
6. In certain situations, a health care facility that normally refers critically ill patients to other facilities may have to continue to provide care for hours to days longer than usual or may elect to provide ongoing critical care using transport ventilators and other resources. In these cases, critical care consultation should be obtained via phone or telemedicine to provide expert input on the care provided until transfer can be arranged or critical care is no longer required.
7. The American College of Chest Physicians has provided guidance documents on ICU surge published in 2014. The executive summary with all the suggestions can be found at [Introduction and Executive Summary Care of the Critically Ill and Injured during Pandemics](#)

[and Disasters: CHEST Consensus Statement](#). Each of the sections has a supporting article (e.g. surge capacity logistics) with further details.

8. According to the key recommendations made by the American College of Chest Physicians, hospitals that provide inpatient critical care should be able to:
 - a. Surge 20% of usual ICU capacity within hours of an incident;
 - b. Surge 100% of usual ICU capacity within 24 hours using facility or regional HCC assets; and
 - c. Surge 200% of usual ICU capacity within days using regional HCC, state, or federal assets.
9. In order to accomplish this, health care facilities providing ICU services should determine the additional space that can be used for ICU level care. Procedural and surgical areas including pre- and post-op care areas are likely targets as they may already have the monitoring equipment necessary for critical care. Health care facilities may wish to create a grid for an ICU surge indicating the sequence/preference and numbers of beds (as well as additional supplies needed for those areas) to be used.
10. Though planning for a 200% surge is daunting, most facilities will find adequate space that can be repurposed. Facilities should also document the specific additional logistical (staff and supply) needs that may be requested if required. This would primarily occur in a pandemic event, but also potentially in other scenarios where the health care facility cannot off-load patients rapidly (e.g. large-scale attack involving anthrax or botulinum, etc.) Few hospitals will have the ventilator and cardiac monitor resources to achieve a 100-200% surge, but understanding the needs and planning for them is critical to the ability to request the necessary assets in a timely manner from regional and Federal sources.
11. Inherent within the ICU surge plan is an understanding that the overall acuity at each respective healthcare facility will increase markedly and lower acuity patients may need to be discharged to outpatient care or referred to homecare, long-term care, or an alternate care site. This may necessitate changes in discharge protocols and health care facility policies about which types of patients can be cared for on which types of units.
12. Table 20 provides information for ICUs and SDMAC to consider across the health care standard of care continuum (conventional, contingency, and crisis).

Table 20: Considerations for Hospital ICUs

Conventional	Contingency	Crisis
<p>1. Stress use of infection control practices appropriate to the situation.</p> <p>2. Cohort patients (to the extent possible) who have the same severe, transmissible infections.</p>	<p>1. Recommend strategies to increase the number of patients who can receive critical care services, including:</p> <p>a. Increase numbers of available critical care beds.</p> <p>b. Use non-ICU settings for care of ventilated patients.</p> <p>c. Modify nurse-to-patient ratios.</p> <p>d. Change documentation practices.</p> <p>e. Expand services provided by nurses and other staff.</p> <p>2. Develop and use guidance for early discharge from ICU to free bed capacity.</p>	<p>1. Triage services using objective criteria to maximize lives saved (See Attachment D: Patient Care Strategies for Scarce Resource Situations Annex).</p> <p>2. Conduct periodic reassessments, using objective criteria, to determine if critical care should be continued.</p> <p>3. Identify a Triage Officer (group or individual not involved in patient care) to make triage decisions, if possible.</p> <p>4. Implement "family/surrogate support teams" (where possible) to provide information and comfort to families/surrogates of patients receiving on-going critical care services as well as to patients triaged to comfort care.</p> <p>5. Continue bed/resource capacity reporting.</p>

Emergency Departments (ED)

1. A location, staff, and basic supplies (ideally packed in bins, pre-event) for overflow care of people with minor wounds, as well as one for family reunification should be planned.
2. Additionally, if there are clinics, supervised living facilities or nursing homes connected to or close to the health care facility, they should be included within the surge capacity plan. Upon activation of the EOP, the ED should be cleared to the degree possible by discharging, moving patients to inpatient beds, moving patients to observation areas, and moving stable patients back out to triage as rapidly as possible depending on available space. Inpatient units should be ready to accept patients to decompress the ED, bypassing usual processes.

3. Transfer of patients to other facilities can also assist with space creation. This may occur by ground or air and by many transportation options (ambulance, bus, private vehicle) as warranted by the situation. Although the hospital likely has established referral patterns, other options should be examined in a crisis and it should be understood that in a pervasive or catastrophic public health event, the ability to transfer patients could be limited.
4. Table 21 provides information for EDs and SDMAC to consider across the health care standard of care continuum (conventional, contingency, and crisis).

Table 21: Considerations for ED Admissions

Conventional	Contingency	Crisis
<ol style="list-style-type: none"> 1. Cohort patients with suspected severe transmissible conditions (e.g. influenza). 2. Implement a regionally coordinated phone information line to encourage symptom or injury management at home as appropriate. In mass trauma settings, this would promote most effective use of trauma care resources. In a pandemic setting, it would decrease exposure of those not ill to others who are infected. 	<ol style="list-style-type: none"> 1. Recommend aggressive triage/discharge of patients with non-life or limb threatening conditions to an appropriate, less stressed ambulatory setting. Coordinate expectations with these clinics. 2. Use "drive-through" triage area or related strategies to reduce emergency department patient load. 3. Use alternative emergency department waiting areas and care sites for patients with influenza-like illness or other severe transmissible diseases. 	<ol style="list-style-type: none"> 1. Triage services to maximize overall lives saved, based on objective criteria. (See Attachment D: Patient Care Strategies for Scarce Resource Situations for more information).

Medical Surge Floor

1. Conventional beds should be filled and staffed to capacity. Health care facilities should identify which single rooms can accommodate an additional bed and keep adequate beds in supply to the degree possible to allow for double rooming.
2. Adequate headers (oxygen, suction, electrical) and privacy curtains are important considerations when planning to double rooms.
3. Additional observation beds, procedure areas, and flat spaces may be used.

4. Health care facilities should maintain adequate cots (with egg-crate or other mattresses) to use in flat-space areas for crisis care (also helpful for staff during blizzards and other situations).
5. Patients should be carefully evaluated before being moved to these areas (normal mental status, low risk for pressure ulcers, not in isolation for infection control purposes etc.).
6. A rapid discharge process should occur as soon as the EOP is activated.
7. Charge nurses should identify patients that are appropriate for early discharge and move them to a discharge holding area or the hallway/unit waiting area for physician review. This can increase the availability of rooms rapidly.
8. If not appropriate for discharge, the patients moved may be appropriate for cot-based care. When not needed for intensive care unit (ICU)-level care, pre- and post-op areas may be used for floor care as well if available.
9. If use of surge areas or cot-based care are anticipated beyond the first 24 hours for inpatient care, GSHCC partners should be engaged to assist with accepting transfers and other support.
10. If other health care facilities are also in a similar situation, the request for a [Centers for Medicare and Medicaid Services \(CMS\) 1135 waiver](#) should be considered to allow billing for patient care in these areas.

Plan Development and Maintenance

Plan Development through Community and Provider Engagement

1. This *CSC Guidance* is intended to be a public document, subject to public feedback to more fully align with the needs and interests of all residents of New Hampshire.
2. Involving community members in the development of crisis standards of care is important because the values of ordinary citizens should inform the actions of professionals, especially when there are no reliable ways to predict survival that help providers make decisions.
3. Meaningful community engagement is helpful for successful development, dissemination, and implementation of crisis standards of care. Facilities should have a plan to distribute documents / information pertaining to CSC in accessible formats including alternate languages.
4. Community conversations should take place before a disaster strikes for the purpose of enabling participants to understand each other's perspectives while tackling complex issues associated with allocating scarce medical resources and appeals process.⁹⁹
5. *It is recommended that health care facilities and systems engage with their community members as part of its overall disaster preparedness and response planning.*

Goals of Community Engagement

Community conversations on crisis standards of care are designed to:

1. Inform members of the public about the concept of crisis standards of care and why they are necessary;
2. Ensure broad participation and ensure that vulnerable, hard-to-reach populations are represented;
3. Increase awareness and understanding about the development of a crisis standards of care plan or an existing draft plan; and
4. Gather input on the considerations and priorities that should be the basis of a crisis standards of care plan or that are included in a draft crisis standards of care plan under review.

Application of the Community's Input

1. Community conversations help medical and public health officials understand what values are important to individuals and to the entire group, and on what issues people differ.

⁹⁹IOM 2012. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*. Washington, DC: The National Academies Press.

2. The goal is not to reach consensus or agreement, or to take a vote. Instead, the opinions and concerns raised in discussions will ensure that crisis standards of care guidelines accurately reflect, as much as possible, the views of the community about what is as fair and ethical as possible.
3. Upon completion of community engagement sessions, it is highly recommended that health care organizations develop and distribute educational material for both health care providers and the public on:
 - a. What crisis standards of care are;
 - b. When and how they would be implemented;
 - c. What facilities and the State are doing to avoid their use; and
 - d. What the public can do to help.

Plan Maintenance

1. Information brought forth as a result of these crisis debriefings will be considered at biennial NH State Crisis Standards of Care Committee meetings and incorporated in the plan maintenance process.
2. NH DHHS/DPHS/BEPRR is responsible for the overall coordination and maintenance of the NH *CSC Guidance* with participation from health care system stakeholders.
3. All users of this NH *CSC Guide* should review it at least annually or when referenced in a real-world incident, as part of after action incident reporting, and submit changes to BEPRR.

Exercises and Training

Exercises

1. The federal Healthcare Preparedness Program (HPP) requires all funded health care entities to develop, train, and exercise their emergency operations plans and supporting guidance documents as specified in annual federal funding opportunity notices.
2. The CSC plan should be incorporated in to the facilities EOP, and as such, exercised together via a workshop or tabletop exercise.
3. *It is recommended that the concepts of CSC be incorporated into annual exercises.*

Training

1. *It is recommend that each health care entity provide training on their CSC Guide.*
2. It is recommended that health care personnel be educated on CSC by the following tiers¹⁰⁰:
 - a. **Knowledge:** awareness of the plan;
 - b. **Competency:** the ability to do something successfully or efficiently in relationship to the plan; and
 - c. **Proficiency:** a high degree of competence or expertise.
3. All of the following groups must be integrated into CSC planning and response: ¹⁰¹
 - a. **Frontline employees:** Awareness—actions should be scripted at specific thresholds and be made as concrete as possible (e.g., activate EMS disaster plan for MCI involving >10 victims). Awareness may also be an appropriate goal for elected officials and executive officers.
 - b. **Supervisors:** Knowledge—initial triggers and tactics should be scripted, but with some flexible interpretation of the trigger threshold (disaster declaration for hospital by nursing supervisor or ED physician) and perhaps simple, phased-response options.
 - c. **Managers/directors:** Proficiency—trigger should be scripted for notification and activation of incident management process, but tactics can be non-scripted and based on expert analysis of the situation with subject matter expert input. This often requires regional/coalition consistency and coordination (e.g., decisions about how to manage limited availability of N95 masks).

¹⁰⁰Minnesota Crisis Standards of Care Framework: Health Care Facility Surge Operations and Crisis Care. Updated 03/01/2020. Page 12. https://www.health.state.mn.us/communities/ep/surge/crisis/framework_healthcare.pdf

¹⁰¹IOM 2013. Crisis standards of care: A toolkit for indicators and triggers. Washington, DC: The National Academies Press. Page 55.

Authorities and References

In addition to the federal and state authorities referenced within the document, this section elaborates on specific federal emergency powers and statutes.

Federal

[National Emergencies Act \(1976\)](#)

[Robert T. Stafford Disaster Relief and Emergency Assistance Act \(1988\)](#)

[Public Health Services Act \(1994\)](#)

[Public Readiness and Emergency Preparedness Act \(2005\)](#)

[Pandemic and All-Hazards Preparedness Act \(2006\)](#)

New Hampshire State Statutes

NH Statutes (<https://www.gencourt.state.nh.us/rsa/html/nhtoc.htm>) support the legal and regulatory actions that may be taken for the provision of health care strategies during crisis care conditions.

References

References comprise a variety of sources ranging from State plans, Federal Resources, and medical literature that were of major significance in the creation of this guidance.

State Plans

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12. Washington State Crisis Standards of Care Triage Team Operational Guidebook. October 2021. <https://doh.wa.gov/sites/default/files/2022-02/821-151-CSC-TT-guidebook.PDF>

Federal Resources

1. Altered Standards of Care in a Mass Casualty Event (Current as of April 2005), Retrieved from Healthcare Research and Quality, Available at [Appendix A, Expert Meeting on Mass Casualty Medical Care Participant List](#).
2. Association of State and Territorial Health Officials. ASTHO Scope of Practice Toolkit: Scope of Practice Issues in Public Health Emergencies.
<https://www.astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Scope-of-Practice-Toolkit/Scope-of-Practice-Issues-in-Public-Health-Emergencies-Fact-Sheet/>
3. ASPR TRACIE (2020). Crisis Standards of Care and COVID-19: What’s Working and What Isn’t. <https://asprtracie.hhs.gov/technical-resources/resource/9414/crisis-standards-of-care-and-covid-19-whats-working-and-what-isnt-webinar>
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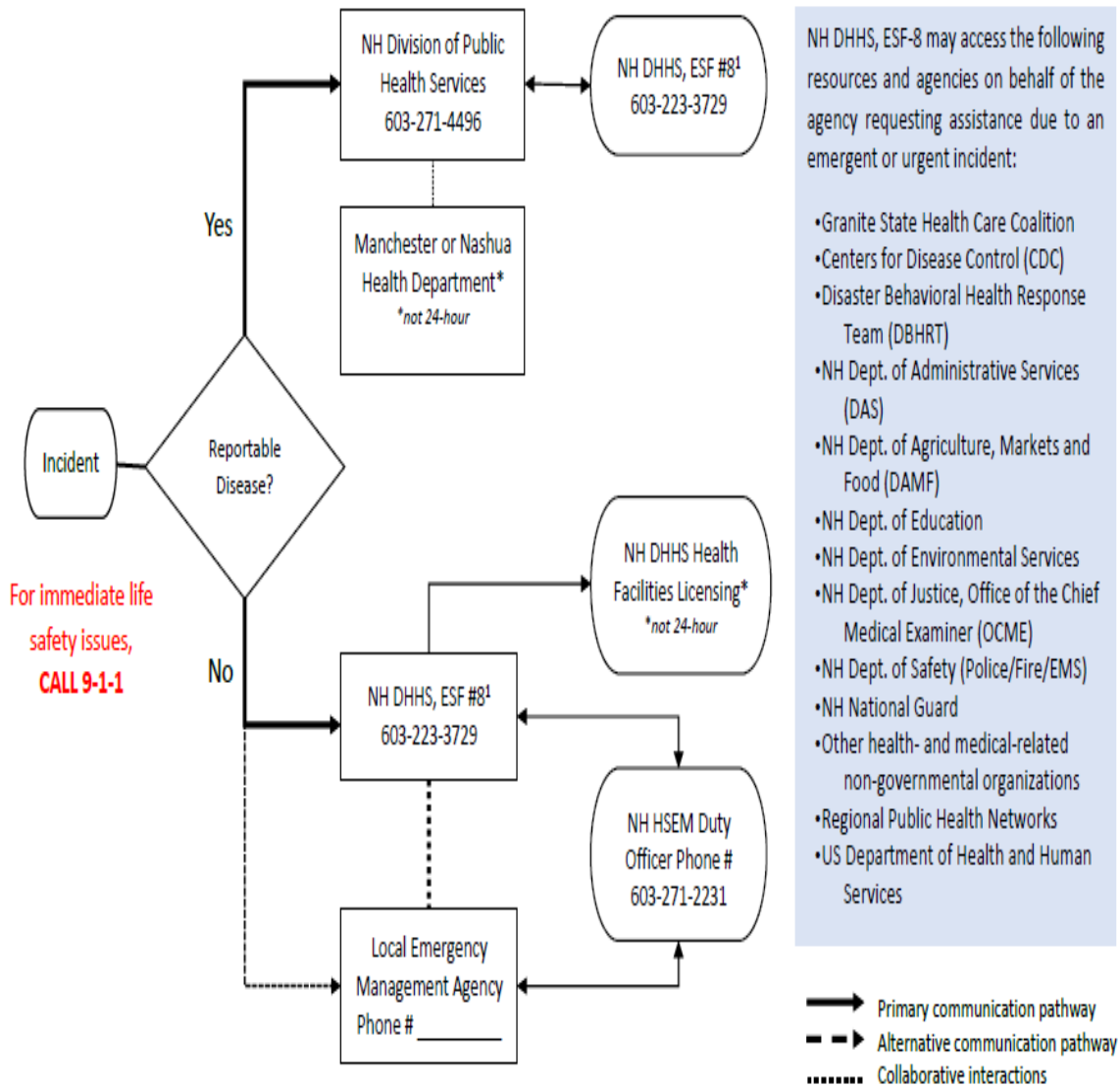
Other Resources

National Hospice and Palliative Care Organization. *Crisis Standards of Care in Hospice and Palliative Care Emergency Management*. November 2020. <https://www.nhpc.org/>

NH State Crisis Standards of Care Committee – Member Agencies

- Concord Hospital
- Dartmouth Hitchcock Medical Center
- Elliot Hospital
- Hillsborough County Nursing Home
- Lake Sunapee Region VNA & Hospice
- NH Disability Rights Center
- NH Fire Chiefs Association
- NH Granite State Health Care Coalition
- Granite State Independent Living
- New Hampshire Hospital Association
- New Hampshire Medical Society
- New Hampshire National Alliance on Mental Illness
- New Hampshire Nursing Association
- New Hampshire Senator
- Portsmouth Regional Hospital
- Southern NH Medical Center
- Tilton-Northfield Fire and EMS
- Wentworth Douglas Hospital
- Community Health Institute / JSI Research & Training Institute, Inc.
- MedEthics Consulting
- Dartmouth College, Geisel School of Medicine
- University of New Hampshire: Department of Health Management and Policy; Franklin Pierce School of Law, Institute for Health Policy and Practice
- State Department of Health and Human Services, Division of Public Health Services
- State Department of Justice, Office of the Attorney General
- State Department of Safety, Division of Homeland Security and Emergency Management; Division of Fire Standards and Training & EMS

Attachment A – Initial Notification of Incident from Health Care Agency to State / Local Support Agencies



¹The Bureau of Emergency Preparedness, Response, and Recovery coordinates the NH Department of Health and Human Services' (DHHS) disaster emergency response efforts under the direction of the Commissioner or designee. This Bureau is responsible for managing the Department's emergency supplies, supporting technologies used during disasters, and fulfilling the Emergency Support Function (ESF) 8 - Health & Medical Services and ESF 6-Mass Care & Sheltering needs of the citizens of NH during a disaster.

Updated 05/25/2021

This document serves as a reference and will not address all situations.

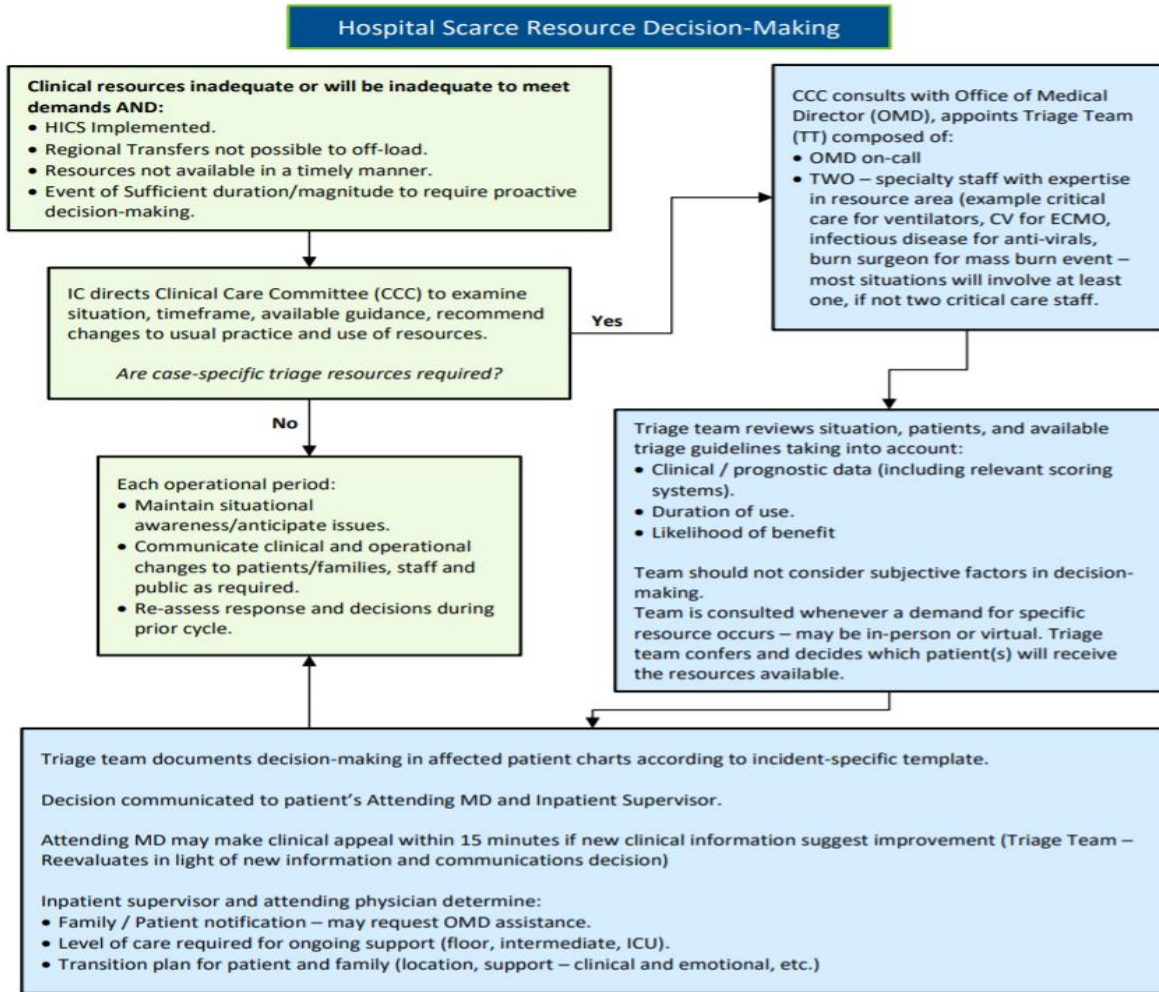
Phone numbers available 24 hours a day.

Attachment B – Health Care Facility Scarce Resource Decision-Making Tree



Health Care Facility Scarce Resource Decision-Making Tree

Health care facilities could utilize this more detailed triage plan during a Crisis Standards of Care situation.



*Algorithm and plan does not apply to immediate, reactive triage decisions in the early phase of a disaster (e.g. ED, trauma surgery) or to non-emergency circumstances (specialty providers will engage colleagues in decision-making). This algorithm is a summary of select actions in the HCMC Crisis Care Annex which should be referred to for further details.

March, 2020

Source: <https://www.health.state.mn.us/communities/ep/surge/crisis/decisiontree.pdf>

Image used with permission.

Attachment C – Sample Tier Priority Scoring System

According to the Colorado Crisis Standards of Care Plan, their Triage Scoring System involves a multi-tiered system to determine which patients will receive scarce resources and which patients may have their resources re-allocated to other patients. The first tier involves calculation of an objective CSC Triage Score. In the event of a CSC Triage Score tie between 2 or more patients in need of the same resource, the CSC Triage Team will sequentially consider tiers 2, 3 and 4 as necessary. The tiered system is meant for allocation of resources (Figure 1). When considering re-allocation of ventilators or other critical care resources, the CSC Triage Score will be reassessed and additional information may be considered including trajectory (improving, stable, worsening) and likelihood of recovery.

Tier One: CSC Triage Score

- The first tier of the triage framework is an objective scoring system based on severity of acute and chronic illness, to assess likelihood of short (30-day/hospital) and near-term (1-year) survival.
- No perfect scoring system exists, so the development and implementation of any triage score is based on the principle of using the best-available clinical information at the time.
- For pediatric patients >1 and <17 years, consultation with a pediatrician, dedicated pediatric hospitals, and pediatric critical care specialists should be considered if triaging pediatric patients becomes necessary.
- Specific scoring systems and approaches to triaging of neonatal patients (infants <12 months) is beyond the scope of the state guidelines. Consult with neonatal critical care specialists.
- What constitutes a tie in the CSC Triage Score for Tier 1 will depend on the heterogeneity of the patient population at a given institution. Individual institutions can define a tie as the same CSC Triage Score or +/- 1 point difference. The definition of a tie may also shift as the specific demands and needs in a crisis evolve.

Tier Two: Pediatrics, Health care Workers, and First Responders as Tiebreakers

- Given the societal worth ascribed to children and the life-cycle principle, we recommend that pediatric patients be given consideration in Tier 2 should there be a tie in Tier 1.
- Neonatal patients are a separate special consideration and consultation with a neonatal critical care specialist should guide any neonatal triage decision.
- Health care workers and first responders (EMS, firefighters, and law enforcement including correctional officers) have the potential to save and protect other lives should they recover (multiplier effect) and they are at increased risk of exposure to a potentially lethal infection by virtue of being on the front lines of the COVID-19 response.
- We recommend healthcare workers and first responders with a role in the COVID-19 response receive a scarce resource over individuals not in one of these categories if all have the same initial Tier 1 CSC Triage Score.¹⁰²

Tier Three: Special Considerations as Tiebreakers

¹⁰²We recommend that “healthcare workers” be defined as any individual who has a direct role in caring for patients with COVID-19 in a healthcare setting. This would broadly include physicians, advanced practice providers, nurses, medical assistants, respiratory therapists, medical technicians, chaplains, phlebotomists, housekeepers, etc. if they work in a COVID-19 areas. Each institution should carefully decide how they want to define healthcare workers and use a consistent definition throughout a crisis.

Based on expert and community engagement, several other factors should be considered when a patient has a tie for both Tier 1 and 2 (e.g., a nurse and a firefighter, both with a CSC Triage score of 6). In no particular order these include:

- Essential workers – Essential workers with direct interaction with the public (e.g. grocery store workers, teachers and school staff, childcare workers, public transportation workers, etc.) or who work in high density environments with evidence of high transmission rates (e.g. meat packing workers, agricultural workers, etc.) are at increased risk of exposure due to the essential function they provide to society.¹⁰³ There is also ample evidence that front-line essential workers have over representation of members of communities of color which workers should receive some consideration as a Tier 3 tie-breaker from the perspective of reciprocity and equity. Not all essential workers should receive this consideration. It should be reserved specifically for those essential workers with increased risk of exposure directly through their work.
- Pregnancy – priority for a scarce resource may be given to a patient with a confirmed pregnancy over a non-pregnant patient.
- Life Years Saved - priority for a scarce resource can be given to a patient with more near and intermediate (1-5 years) life years to be saved. The life-years principle is NOT a categorical age exclusion criterion as a 35 year old and 70 year old patient could have similar 1-year survival predictions. The life-years saved principle is the place where more disease-specific prediction models could be used to provide greater insight on near and intermediate-term mortality (1-5 years).¹⁰⁴ For example, even with the same CSC Triage Score (Tier 1), some consideration may be given to a 35 year old patient with no comorbidities over an 80 year old with metastatic pancreatic cancer. Similarly, a 70 year old with no comorbidities may receive consideration over a 40 year old with end stage liver disease with an extremely high Model for End-Stage Liver Disease (MELD) score.
- Multiplier Effect - priority for a scarce resource may be given to patients who are the sole caregiver to a dependent child or dependent adult.

Each institutional CSC Triage Team will have to decide how they wish to prioritize Tier 3 considerations but consistency across cases, accurate and complete record keeping and transparency in the decision-making process are required.

Tier Four: Random Allocation as Tiebreaker

- In the event of a tie at Tiers 1, 2, and 3, we recommend the use of random allocation to decide which patient should receive a scarce resource.
- For patients who are triaged not to receive a scarce resource such as a full ventilator, alternative treatment considerations including early palliative care consultation should be provided.

¹⁰³There is no strict rigid definition of essential worker that would qualify as a Tier 3 tie-breaker. Importantly, not all essential workers fall into this prioritization category. Essential workers who do not interact with the public (e.g. those that can work remotely or work in a private office setting) should not receive prioritization. The principle of reciprocity dictates that only those essential workers with interaction with the public (e.g. grocery store workers, public transportation personnel, teachers and school staff, childcare workers, etc.) and those who work in high density settings should receive consideration. Each triage team will have to interpret this category individually but could use Colorado’s COVID-19 vaccination plan for guidance.

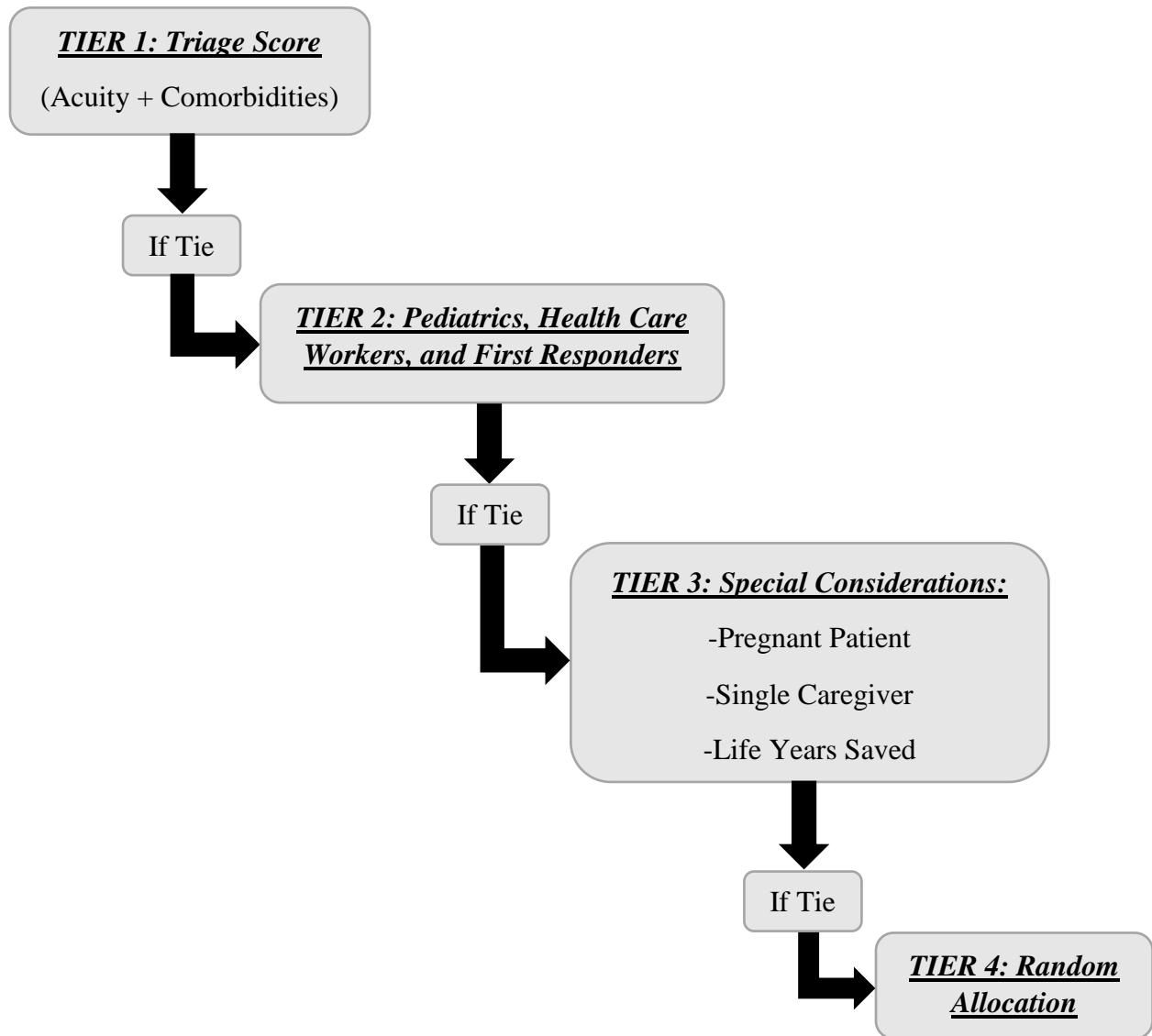
(https://drive.google.com/file/d/1LRUAZxfr_jR756_O41jnVsG7Lu4l-5gg/view)

¹⁰⁴Some of examples of disease specific models include the Modified End-Stage Liver Disease (MELD) score, BODE Index for COPD, cancer survival curves, etc. could be used for specific patients. The use of disease-specific models is a suggestion is not mandatory but can be used by triage teams.

In sum, the tiered process is designed to focus initially on calculating a clinical score to assess each patient’s likelihood of experiencing acute or near-term survival, and then to address the possibility of 2 or more patients having the same clinical prognosis (i.e. a tie).

Figure 1: Crisis Standards of care Triage Framework for Scarce Resources

This is a 4 Tiered process to allocate scarce resources. In the event of a tie within a Tier, the triage team should move to the next Tier of considerations until they reach Tier 4 which calls for a random lottery.



Attachment D – Scarce Resource Strategies for Healthcare Systems

How to use this Attachment:

1. Recognize or anticipate shortfall(s).
2. Implement appropriate incident management system and plans; assign subject matter experts (technical specialist to problem).
3. Determine degree of shortfall(s), expected demand, and duration; assess ability to obtain needed resources via local, regional, or national vendors or partners.
4. Find category of resource on *Minnesota Healthcare System Preparedness Program Strategies for Scarce Resource Situations*¹⁰⁵ index.
5. Refer to specific recommendations.
6. Apply *Core Resource Allocation Strategies*.
7. Decide which strategies to implement and/or develop additional strategies appropriate for the facility and situation.
8. Assure consistent regional approach by informing public health authorities and other facilities if contingency or crisis strategies will continue beyond 24 hours and no regional options exist for re-supply or patient transfer; activate regional scarce resource coordination plans as appropriate.
9. Review strategies every operational period or as availability (supply/demand) changes.

PATIENT CARE STRATEGIES FOR SCARCE RESOURCE SITUATIONS

MINNESOTA HEALTH CARE PREPAREDNESS PROGRAM

Table of Contents

Core Clinical Strategies for Scarce Resource Situations <small>Core clinical categories are practices and resources that form the basis for medical and critical care.</small>	Resource Reference and Triage Cards <small>Resource cards address the unique system response issues required by specific patient groups during a major incident. Some of this information is specific to the State of Minnesota's resources and processes.</small>
Summary Card	Renal Replacement Therapy Resource Cards
Oxygen	Burn Therapy Resource Cards
Staffing	Burn Therapy Triage Card
Nutritional Support	Pediatrics Resource Cards
Medication Administration	Pediatrics Triage Card
Hemodynamic Support and IV Fluids	Palliative Resource Cards
Mechanical Ventilation	ECMO Resource Card
Blood Products	

Ethical Values For Scarce Resource Situations

All facilities and/or agencies utilizing these strategies are encouraged to review the Ethical Considerations for Crisis Standards of Care website: <https://www.health.state.mn.us/communities/ep/surge/crisis/ethical.html>. Efforts should be made to extend supplies and conserve resources. Organizations should triage/re-allocate resources only as a last resort. Patients should receive supportive care and treatment to manage symptoms, including palliative care; this applies to all patients, including those who are not prioritized to receive specific resources. Allocating scarce life saving resources should NOT be based upon:

- Race, ethnicity, gender, gender identity, sexual orientation or preference, religion, citizenship or immigration status, or socioeconomic status;
- Ability to pay;
- Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication of likelihood of short term survival);
- Disability status or comorbid condition(s) as a criterion in and of itself (this does not limit consideration of a patient's physical condition in clinical prognostication of likelihood of short term survival);
- Predictions about baseline life expectancy beyond the current episode of care (i.e., life expectancy if the patient were not facing the current crisis), unless the patient is imminently and irreversibly dying or terminally ill with life expectancy under 6 months (e.g., eligible for admission to hospice);
- Judgements that some people have greater "quality of life" than others;
- Judgements that some people have greater "social value" than others.

¹⁰⁵Minnesota Healthcare System Preparedness Program Strategies for Scarce Resource Situations, August 2021. <https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf>

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