New Hampshire Department of Health and Human Services

Integrating Crisis Standards of Care Considerations into Existing Organizational Medical Surge Plans

A Planning Checklist

Division of Public Health Services, Bureau of Emergency Preparedness, Response and Recovery

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Integrating Crisis Standards of Care Considerations Into
Existing Organizational Medical Surge Plans: A Planning Checklist

Introduction:

In July 2022, a multi-disciplinary team facilitated by NH DHHS finalized version 1 of the *State of NH Crisis Standards of Care (CSC) Guidance*. The purpose of the guidance to support health care organizations in the implementation of contingency and crisis care strategies in catastrophic or pervasive public health crises where a prolonged mismatch between available health care resources and demand for those resources is expected. NH health care organizations are now asked to integrate protocols for coordinating with state-level CSC actions and operationalizing state-issued recommendations into existing organizational medical surge concept of operations (ConOps) or plan.

Purpose

This checklist is intended to assist with gap identification related to CSC-specific planning elements, and to provide a rationale for and references to support development and integration of elements into health care facility emergency operations and surge plans. It includes CSC planning references that are explicitly required by the Joint Commission and the federal Centers for Medicare and Medicaid (CMS) Emergency Preparedness Rule. Upon completion of the CSC ConOps, health care organizations are encouraged to publicize and engage citizens of diverse backgrounds in discussing the facility's CSC document.

Comments regarding this document can be submitted to the:

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Activation			
Element	**Included in Plan?**	**Rationale**	**Comments / Notes**
1. Do current plans include indicators and triggers that front line staff can use to prompt consultation/request activation of the medical surge plan including CSC?	☐ Yes ☐ No ☐ In Progress	Hick, et al.'s COVID-19 after-action review found that frontline clinicians: • "experienced information deficits… including lack of knowledge of the status of their facility, their roles and responsibilities during a disaster, when and how to seek consultations" • "felt forced to make ad hoc decisions at the bedside" • "[made ad hoc triage decisions that] were not within their usual scope of practice, though clinicians rarely felt they rose to the level of needing to consult a triage team…." • noted that "there was often a disconnect between 'bedside and boardroom,' as senior leaders were not always aware of the decisions clinical staff were being forced to make, while clinical staff were not well integrated into command level decisions and did not receive adequate information about available resources."	
Reference: *Hick, J. L., D. Hanfling, M. Wynia, and E. Toner. 2021. Crisis Standards of Care and COVID-19: What Did We Learn? How Do We Ensure Equity? What Should We Do? NAM Perspectives. Discussion, National Academy of Medicine, Washington, DC.* https://doi.org/10.31478/202108e *(See p. 8)*			

Activation			
Element	**Included in Plan?**	**Rationale**	**Comments / Notes**
2. Do current plans include processes to activate a Clinical Care Committee (CCC) *or equivalent* to recommend strategies to expand/conserve space, staff, supplies to address situation?	☐ Yes ☐ No ☐ In Progress	New Joint Commission standard (EM.12.02.09) includes a requirement that the hospital plan, "describes in writing how it will: ➢ obtain, ➢ allocate, ➢ mobilize, ➢ replenish, and ➢ *conserve* its resources and assets during and after an emergency or disaster incident." This standard places priority on resources known to deplete quickly. The IOM and the *NH CSC Guidance* recommend that that health care organization CSC plans include clear indicators and triggers for when mitigation strategies should be implemented to avert or shorten duration of crisis care status.	
If **Yes**: a. Do current plans name the positions that are members of the CCC?	☐ Yes ☐ No		
b. Does the CCC include a trained ethicist?	☐ Yes ☐ No		
c. Do current plans include ready access to legal expertise?	☐ Yes ☐ No		
d. Do current plans include indicators and triggers for CCC use?	☐ Yes ☐ No		

Activation			
Element	**Included in Plan?**	**Rationale**	**Comments / Notes**
Reference: *Institute 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 *(See pp. 45, 232-233, 255-256); IOM 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/; Minnesota CSC Health Care Facility Framework* https://www.health.state.mn.us/communities/ep/surge/crisis/framework_healthcare.pdf *(See pp. 7, 15); Crisis Standards of Care Guidance for New Hampshire (See pp. 24, 62-66); The Joint Commission. New and Revised Emergency Management Standards. (See p. 33); IOM 2013. Crisis Standards of Care: A Toolkit for Indicators and Triggers. Washington, DC: The National Academies Press.* https://doi.org/10.17226/18338			

Activation			
Element	**Included in Plan?**	**Rationale**	**Comments / Notes**
3. Do current plans include provisions for activation of a Triage Team or Officer (not providing direct patient care) to make clinical resource allocation decisions?	☐ Yes ☐ No ☐ In Progress	Hick, et al. note: • "The availability of rapid expert consultation must be ensured for rationing decisions outside of the provider's normal practice for which there is no practice guideline. This expert or group should have visibility on hospital and regional resources and be able to push the decision and the consequences up to incident command to facilitate both optimal decision making and development of proactive strategies to avoid the ongoing need for triage." • "It is recommended frontline clinicians caring for patients should not be directly involved in the triage process; rather, they should provide clinical	

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		knowledge to the decision-making body who will make determinations of care. Facilities should have a Clinical Care Committee and/or Triage Team available for consultation."	
Reference: *IOM 2012. (See p. 45); Hick, J. L., D. Hanfling, M. Wynia, and E. Toner. (2021). (See pp. 13, 256-257); Minnesota CSC Health Care Facility Framework (See pp. 7, 15); Crisis Standards of Care Guidance for New Hampshire (pp.66-74).*			

Operations			
Element	**Included in Plan?**	**Rationale**	**Comments / Notes**
1. Do current plans detail the ethical framework that will be used in developing and implementing CSC recommendations to ensure fairness?	☐ Yes ☐ No ☐ In Progress	The IOM (2012) and the *NH CSC Guidance*, stress the importance of defining an ethical framework to ensure fairness in resource allocation. Hick, et al. note: • "COVID-19 laid bare the structural inequities of our current health care system that made [ensuring unbiased, fair, and consistent triage decisions] largely unachievable."	
2. Do current plans include a process to integrate state-provided contingency and CSC guidance into organizational decision making?	☐ Yes ☐ No ☐ In Progress	The IOM notes: • "The clinical care committee should provide any required modifications to guidelines and triage tools that are available from other sources, including regional and state disaster medical advisory committees."	
Reference: *IOM 2012. (See pp. 1-6, 4-30); Crisis Standards of Care Guidance for New Hampshire (pp. 26-27, 51-53, 71-74, 106-107); Hick, et. al, 2021 (See p. 2).*			

Operations			
Element	**Included in Plan?**	**Rationale**	**Comments / Notes**
3. Do current plans include redundant processes to notify staff in real-time regarding resource availability and the need to triage specific resources?	☐ Yes ☐ No ☐ In Progress	Hick, et al. note: • "All clinicians should receive real-time information that is sufficient to understand whether or not they should be triaging specific resources." • CMS Appendix Z states that facilities should have policies in place to provide additional emergency preparedness procedures to staff.	
Reference: *Hick, J. L., D. Hanfling, M. Wynia, and E. Toner. (2021). (See p. 9); CMS Updated Guidance for Emergency Preparedness-Appendix Z of the State Operations Manual (SOM) (See p.30).*			

Operations			
Element	**Included in Plan?**	**Rationale**	**Comments / Notes**
4. Do current plans incorporate an appeals process for triage decisions?	☐ Yes ☐ No ☐ In Progress	Hick, et al. note: • "Health care facilities should define the situations in which an appeals process may be reasonable and develop a different model to ensure that bias [explicit and implicit] is avoided when time-sensitive decisions are needed—particularly if multiple appeals are occurring simultaneously. Ensure appropriate documentation to support quality assurance review, including by the consulting provider."	
Reference: *Hick, J. L., D. Hanfling, M. Wynia, and E. Toner. (2021). (See p. 12); IOM 2012.(See p. 258); Crisis Standards of Care Guidance for New Hampshire (pp. 67-69).*			

Operations			
Element	**Included in Plan?**	**Rationale**	**Comments / Notes**
5. Current plans include provisions to expand / conserve space, staff, and supplies? If **Yes:** a. Do plans include capabilities specific to trauma care, critical care, HAZMAT, infectious disease, burn, and pediatrics? b. Do plans include strategies for managing resources more likely to be in extreme shortage?	☐ Yes ☐ No ☐ In Progress ☐ Yes ☐ No ☐ Yes ☐ No	New Joint Commission standard (EM.12.02.09) includes a requirement that the hospital plan, "describes in writing how it will: ➢ obtain, ➢ allocate, ➢ mobilize, ➢ replenish, and ➢ *conserve* its resources and assets during and after an emergency or disaster incident."	
Reference: *The Joint Commission. New and Revised Emergency Management Standards. (See p. 33); Minnesota CSC Health Care Facility Framework (See pp. 7, 15); Crisis Standards of Care Guidance for New Hampshire (pp. 74-92, 106 and 110).*			

Deactivation			
Element	**Included in Plan?**	**Rationale**	**Comments / Notes**
1. Do current plans include decision-making strategies and processes to determine how and when CSC may be discontinued?	☐ Yes ☐ No ☐ In Progress	CMS Appendix Z encourages facilities to assess when use of a Section 1135 waiver may no longer be needed, in spite of an ongoing public health emergency.	
Crisis Standards of Care Guidance for New Hampshire (pp. 58-59); CMS Updated Guidance for Emergency Preparedness-Appendix Z of the State Operations Manual (SOM) (See p.57).			