Type of Policy:	**EMERGENCY MANAGEMENT**	Category:	**EMERGENCY OPERATIONS PLANS (EOP'S)**

Title:	***CRISIS (ALTERED) STANDARDS OF CARE/ALLOCATION OF SCARCE RESOURCES PLAN***	Policy #:	
		Replaces #:	
Page:	1 of 16	Developed By:	Clinical Nursing, Pharmacy, Supply Chain Services, Legal, Compliance & Ethics, Emergency Management, Med Staff
Issue Date:	**5/24**	Approved By:	
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I. PURPOSE:

The purpose of this policy is to provide guidelines for <organization name> Hospital Incident Command/Incident Command responders and clinical providers on managing substantial acute or long-term changes to healthcare operations that impact the level of patient care provided.

II. DEFINITIONS:

When used in this policy these terms have the following meanings:

A. Alternate Care Site (ACS): A temporary medical system that can serve various patient types and purposes (e.g. non-acute or acute care). ACS's often handle non-critical patients, those patients triaged as "Green" (minor), patients that are psychological casualties with no physical injury, and other patients that self-refer to the site. An ACS ordinarily allows hospitals to focus on patients with more serious illnesses or injuries that require "in hospital" services.

B. Agency for Health Care Administration (AHCA): The State of Florida's health policy and planning entity, primarily responsible for the state's Medicaid program, licensure of the state's health care facilities and sharing of health care data.

C. AHCA Health Facility Reporting System (HFRS): The State of Florida's online health care facility status reporting system.

D. Authority Having Jurisdiction (AHJ): The organization, office, individual or other statutory authority responsible for approving equipment, materials, and installation, or a procedure.

E. Comfort care patients: Individuals for whom curative therapies are futile, given available resources.

F. Corporate Command Center (CCC): A centralized protected physical site at which Senior <organization name> Executives and key personnel respond during an emergency to coordinate information and resources to support company incident management activities.

G. Clinical Review Committee (CRC): Localized decision-making body for decisions to discontinue life-saving treatment or deploy scarce resources.

H. Contingency Standard of Care: Care involves adjustments to everyday care, but the level of care on an individual patient basis remains functionally equivalent.

I. Conventional Standard of Care: The level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.

J. Crisis Standard of Care: A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic, influenza) or catastrophic (e.g., manmade, hurricane) disaster.

K. Critical Incident Response Team (CIRT): A group of trained <organization name> team members that provide psychological first aid, behavioral crisis intervention, referrals, advocacy, and response assistance to <organization name> personnel in the event of an emergency impacting the organization.

L. Critical Incident Stress Debriefings (CISD): Intervention intended to help small, homogenous groups of 12-20 team members who already have some existing relationship. It is intended to help team members find a way to relate and mitigate the impact of critical incidents. It is not meant to be group therapy or a substitute for therapy and it is best used between 24 to 72 hours of a critical incident. However, it can take place days or even 3-4 weeks after the critical incident.

M. Critical Incident Stress Management (CISM): An adaptive, short-term psychological helping-process that focuses solely on an immediate and identifiable problem. It can include pre-incident preparedness to acute crisis management to post-crisis follow-up.

N. Defusings: Intervention intended to help homogenous (same) groups of 12-15 team members lasting approximately 15-45 minutes. It consists of introduction, brief exploration of the team members' experience, and information on symptoms, coping skills, and resources. This intervention is best used within 8-12 hours of a critical incident.

O. EM Resource: The computer system utilized by the Emergency Medical System (EMS) & hospitals to track real time health and medical updates and emergency situations.

P. Emergency Medical Services (EMS): Emergency Medical Technicians (EMT) and Paramedics from both ambulance services and fire departments.

Q. Emergency Operations Center (EOC): In government, the EOC is a centralized protected physical site at which government representatives respond during an emergency to coordinate information and resources to support incident management activities within their area of responsibility. The Corporate Command Center acts as the EOC for the <organization name> organization.

R. Executive Policy Group: Comprised of senior executives and Board members, the EPG helps with our organizations' overall oversight and responsiveness during major disasters.

S. Hospital Incident Command System (HICS): The HICS; modeled after the Department of Homeland Security's National Incident Management System (NIMS) of Incident Command System (ICS), is designed to manage all routine or planned events as well as emergencies or disasters, of any size or type in a hospital. HICS allows for personnel from different agencies or departments to be integrated into a common structure that may effectively address issues, delegate responsibilities, ensure communication, and eliminate duplication of services.

T. Hub-and-spoke approach: This model provides a means of resource control that relies on a central location (the hub) and a number of hospitals (the spokes) leading out from that hub.

U. Incident Command System (ICS): The emergency management system used during an emergency situation in a non-hospital facility.

V. Medical Gas: Oxygen, medical air, nitrogen, nitrous oxide, carbon dioxide or vacuum system.

W. Palliative care patients: Individuals who may benefit from available curative therapies meant to enhance a person's current care by focusing on quality of life.

X. PBX (Private Branch Exchange) Operator: The team member staffing the private telephone system used at <organization name>.

Y. PBX (Private Branch Exchange): A private telephone system used in a company. The system has several outside lines which users can share for making outside phone calls. A PBX also connects the phones within the company to each other and also connects them to outside lines.

Z. Scarce Resource Allocation Committee (SRAC): Executive committee to oversee resource allocation across the system, identify trigger points, triage protocols, and appoint Triage Officers; and Clinical Review Committee members.

III. POLICY:

It is the policy of <organization name> to:

A. Rapidly identify and communicate internally any situation that creates, or has the potential to create, a substantial change in usual healthcare operations and the subsequent levels of patient care being delivered.
B. Assess and stabilize patients affected by any such situation; assess operations and make adjustments where necessary; continue essential operations where possible and alter or discontinue certain services if the safety of patients cannot be ensured.
C. Communicate and collaborate with local, regional, state and federal authorities to address any areas of need that are beyond <organization name>'s control, as required.
D. Consider all forms of assistance, including non-conventional support and services, to ensure the continued wellbeing of patients.
E. Make informed, compassionate decisions to do the greatest good for the greatest number of persons during austere conditions.

IV. PROCEDURE:

A. Implementation of Crisis Standard of Care measures within <organization name> must align with clinical realities. Situational awareness of patient volumes, and resource availability is critical to supporting patient care decision-making for triage or allocation of life-sustaining care. Specific physician and clinician guidance about the scope of any such declaration, such as which resources or processes it applies to, must be made and communicated to physician and clinical personnel.
B. Strategies:
    1. Activation of CCC/HICS:
        a. Once it is recognized that a Crisis Standard of Care situation exists or is understood to take effect in the near future within <organization name> (or at a regional level), <organization name> shall immediately activate the CCC and HICS at all facilities to begin addressing the issue at a system level, ensuring all locations are in sync regarding resources and care. Utilizing a hub-and-spoke approach where information is distributed from a central location (the hub) to <organization name> facilities (the spokes) will help reduce the potential that one location implements a triage processes when others may have resources available.
        b. The site HICS Medical Staff Director shall work closely with providers and all clinicians to be certain that all are aware of clinical needs and available resources.
        c. The CCC/HICS shall begin to implement strategies to prevent critical shortages which helps with organizational oversight and responsiveness towards crisis, major emergencies, or disasters.
    2. Activation of the <organization name> Executive Policy Group:
        a. Activating the Executive Policy Group shall be required to assist the CCC with decision making.
        b. The Executive Policy Group has the authority to make decisions, commit resources, obligate funds, and provide the resources necessary to support <organization name>'s patients, staff, and facilities.
    3. Activation of a Scarce Resource Allocation Committee:
        a. The <organization name> Executive Policy Group shall approve the CCC to form a Scarce Resource Allocation Committee and process.

b. The CCC shall convene the Scarce Resource Allocation Committee who report directly back with any findings, changes, and/or recommendations.

c. The Scarce Resource Allocation Committee identifies activation triggers and medical triage protocols, then identifies:

1. Members to form a Clinical Review Committee, which serves as site-specific decision-making bodies for clinical triage decisions in cooperation with the Triage Officers;.
2. Triage Officers, assigned to oversee triage decisions for an inpatient unit, in conjunction with clinical staff;
3. Each <organization name> hospital HICS shall delegate two team members (e.g., an ethicist and a clinician) as the extension of the Scarce Resource Allocation Committee to provide oversight at their respective sites.

4. Government Affairs:

a. Any disaster impacting <organization name>'s area of operations is likely to affect other hospital/healthcare systems ability to operate normally.

b. To support an effective response the CCC Incident Commander shall, where considered necessary, authorize <organization name> Government Affairs to:

1) Request Centers for Medicare and Medicaid Services (CMS) to waive specified provisions of the Emergency Medical Treatment and Labor Act (EMTALA) or other federal laws that may present barriers to effective crisis response.
2) Request the Florida licensing boards waiver licensing, documentation, and other requirements that may present barriers to effective crisis response.
3) Work with regional regulatory bodies to identify where <organization name> may be able to provide material support to other non-<organization name> hospitals/healthcare systems, and track the organization's requests.

5. Secondary Review Group:

a. Consideration shall be given to the creation of a secondary group of clinicians.

b. This group shall review the decisions made by the Clinical Review Committee/Scarce Resource Allocation Committee with a view to ensuring all possible solutions have been outlined.

C. Resources:

1. To maintain centralized knowledge and coordination of resources across the system, the CCC shall be the central repository for all resource utilization information. The system hospital capacity response and medical triage protocol activation shall also be centralized within the CCC. Where necessary, the CCC can utilize the EPG for high level issues and requests for support.
2. Additional resources shall be considered:

a. Staffing:

1) The CCC/HICS must consider applying non-typical, regional support processes to help offset hospital/healthcare system stressors.
2) These include, but are not limited to:

a) Use family members/lay volunteers to provide basic patient hygiene and feeding, releasing staff for other duties.

b) Utilizing staff from other <organization name> areas.

c) Have specialty staff oversee larger numbers of less-specialized staff and patients (for example, a critical care nurse oversees the intensive care issues of nine patients while three medical/surgical nurses provide basic nursing care to three patients each.)

d) Expanding scope of practice: Scope of clinical practice is defined as the extent of a licensed healthcare professional's ability to provide services consistent with their competence, license, certification, and privileges. Most healthcare professionals' scopes of practice are delineated by rules and regulations describing range of responsibility, including extent and limits of procedures, actions, and processes, that a healthcare provider may undertake in keeping with the terms of their professional license, including requirements for training and continuing education.

e) Canceling all learning and development training courses, conferences, and meeting with clinicians to allow them to go back into service and care for patients.

f) Regional workforce talent sharing: Where an <organization name> facility is looking at implementing crisis standards of care due to a staffing shortage and resources are not available within the organization, consideration must be given to requesting support from facilities outside of the system. Area hospitals contacted must agree on the minimum standards required for clinical personnel to work at their facility, and ways this information can be quickly verified.

b. Limiting Patient Volumes and Expanding Surge Spaces:

1) <Organization name> shall work closely with local and regional partners, such as EMS, to help load balance patient care as required and able. Load-balancing ordinarily involves prehospital distribution of patients among area healthcare facilities, transferring patients from overwhelmed healthcare facilities within <organization name> facilities and then once at full capacity to ones outside our network to those that we already have transfer agreements with, or moving resources to support an overwhelmed facility.

2) Requesting assistance from the Florida Region V Regional Trauma Coordination Center, which acts as a traffic control center to support regional load-balancing across healthcare facilities and systems. This furthers the highest possible level of care that can be provided to all patients who need care. This consistent approach includes beds, staffing, key resources and strategies for care.

3) Identifying potential alternate care sites (e.g., long-term care facilities, surgery centers) with suitable infrastructure to support acute care of ill or injured patients.

c. Patient Triage Decisions:

1) Patient triage decisions, in many circumstances, cannot wait for a committee structure. Rapid decision processes must be developed that involve the treating physician, as well as other physicians. Clinicians, reasonably, are unlikely to be

comfortable making crisis standard of care decisions. To support the most appropriate, ethical decisions being made education must be provided to those clinicians and physicians making such decisions, and a process developed to help them engage with experts in the field as rapidly as possible. This can include, but not be limited to:

a) Identifying consultation networks for crisis care of children and others with special care needs (e.g., burns, trauma, hazardous exposures).
b) Involving clinicians and/or physicians with pediatric and other relevant expertise in crisis care decisions.

2) Clinicians and/or physicians shall be advised that Crisis Standard of Care involves making the best decision they can when in an unfamiliar situation that involves risk to the patient or provider; it is not necessarily limited to ventilator triage or a formal triage process.
3) Consideration must be given to whether the adoption of crisis standards of care is dependent on any formal government declaration. Formal declarations may not be forthcoming, so the rapid communication of issues is critical. Ideally, the information on anticipated changes in care shall be escalated as soon as reasonably possible and, where possible, in advance of impact to the organization.
   a) This includes the movement of potential indicators from the patient bedside up through the hospital, city/county level, through the regional healthcare coalition and state level.
   b) Where shortfalls cannot be managed by load balancing and regional support, the state shall be contacted for assistance through policy changes.
4) Clinicians and/or physicians and their legal advisors must resolve differences in understanding of the legal aspects of Crisis Standard of Care.
5) Any Crisis Standard of Care decisions must factor in that a timely declaration may not be made, and include how to proceed without it.
6) The three levels of patient care standards are:
   a) Conventional Standard of Care: The level at which the average, prudent provider in a given community would practice. It is how similarly qualified practitioners would have managed the patient's care under the same or similar circumstances.
   b) Contingency Standard of Care: Care involves adjustments to everyday care, but the level of care on an individual patient basis remains functionally equivalent.
   c) Crisis Standard of Care: A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic, influenza) or catastrophic (e.g., manmade, hurricane) disaster.

d. Supplies:

1) Recommendations for the redistribution of available resources in the event of a medical surge incident are outlined below:
   a) Sharing resources between <organization name> facilities and the wider organization.
   b) Requesting supplies from other healthcare systems and considering non-typical, regional support processes such as cross-healthcare system equipment sterilization or transportation services.
2) Supply Chain Services must update memoranda of agreement with potential suppliers, alternate care sites, and other healthcare employers to maximize availability of space, staff, and supplies.
3) Where volumes are limited/unavailable, the CCC Liaison Officer shall contact the following for support:
   a) City/county Emergency Operations Center (EOC).
      (1) City/County EOCs shall be contacted a formal request for assistance.
      (2) The local/regional Department of Health shall be contacted with a formal request for assistance.
      (3) Where the city/county/Department of Health is unable to fulfill the request, <organization name> shall ask that they submit requests to the State EOC, where it is processed by the County Liaison Desk under the direction of the Operations Support Branch. From there, it is assigned to the proper branch for tasking to the appropriate Emergency Support Function (ESF).
      (4) If the ESF cannot provide the requested resources, it is forwarded to the Logistics Section who will work with either private vendors or through an Emergency Management Assistance Compact (EMAC) to secure the resources.
   b) Central Florida Disaster Medical Coalition (CFDMC): The CFDMC assists with the availability of staff, equipment, supplies, or other resources. The CFDMC effectively act as an Area Command and create a resource triage system where area hospitals can identify if they have the item(s). The CFDMC acts as an intermediary and works on getting the critical resources to those locations that are most needy.

e. Space requirements:
   1) The CCC shall conduct a forward-look review of non-traditional spaces that can be used to support patient care.
   2) Location options may include, but not be limited to:
      a) Medical office buildings
      b) Conference rooms
      c) Classrooms
      d) PACU

3) Other options shall be explored, such as increasing the use of virtual healthcare visits and Healthcare At Home.

f. Medication Adjustment Strategies:

1) There are two categories of drugs/medications that need to be considered in any situation that creates resource scarcity include, but may not be limited to:

a) Disaster drugs – These include medications commonly used in the emergency department on a daily basis, such as:

(1) IV fluids
(2) Antibiotics
(3) Formulas
(4) Pain medications (analgesics)
(5) Rapid Sequence Intubation (RSI) kits
(6) Burn therapies
(7) Crush injury therapies
(8) Tetanus Prophylaxis

b) Medical Countermeasures/Antidotes – These include:

(1) Atropine, pralidoxime, benzodiazepines used in a nerve agent attack or serious organophosphate pesticide incident.
(2) Calcium salts (gluconate, chloride) for situations involving hydrofluoric acid
(3) Hydroxocobalamin, (or sodium nitrite, sodium thiosulfate) for cyanide victims
(4) Methylene blue to treat victims with methemoglobinemia
(5) Potassium iodine for protection of the thyroid gland after radiation exposure
(6) Pyridoxime HCl for exposure to hydrazine (rocket fuel)
(7) Sodium bicarbonate may be used as an aerosol in patients with chlorine gas inhalation.

2) Factors considered in the medication supply chain:

a) Inventory – Medications available to administer.
b) Acquisition – Turnaround needed to acquire medications (typically 3-5 days).
c) Days on hand – Assessment of inventory in relation to its use per 24 hours. Example:

(1) 100 units of drug
(2) Hospital's use = 20 units per 24 hours
(3) Example result = 5 days on-hand

d) Formulas – Medications that can be made to meet the need.

3) Breakpoints needed for therapy considerations are:

a) Green – Days on hand > 14 days: no issues with inventory or acquisition able to support service lines without issue.

b) Yellow – Days on hand 7 to 14 days: inventory suspect and acquisition will need to be assessed for alternative modes to support current use and support of service lines. Conservation strategies are needed.

c) Red – Days on hand less than 7 days: inventory is critically low and acquisition is untenable to support current clinical use.

4) Medications on shortage are immediately Red breakpoints.

5) Additional consideration should be given to utilizing the Centers for Disease Control and Prevention (CDC) CHEMPAK/SNS. This must only be accessed in times of terrorism or if we have no other supply. Permission must be granted by the CDC prior to opening.

g. Messaging:

1) Internal:

a) <organization name> Internal Communications shall work with the Chief Medical Officer and/or their designee(s) to create clear messaging for providers and clinicians.

b) Messaging must clearly state the situation that created the austere conditions, how this is/has impacted <organization name>, estimated time until impact, expected duration of the incident and how the organization is responding.

c) The messaging must provide clarity on the difference between triage decisions that hospital clinicians make on busy days and the shift in thinking and practice that is involved in Crisis Standard of Care, and how long these conditions are expected to last.

2) External:

a) <Organization name> Media Relations shall create clear statements, with consideration given to:

(1) Media press releases.

(2) Website updates.

(3) Social Media posts/rumors.

b) All messaging shall be cleared through the CCC Incident Commander before being released external to <organization name>.

h. Standards of Care Triggers:

1) While it is recognized that crisis situations require extraordinary decisions during high stress situations, implementing Crisis Standard of Care must also include a number of patient safeguards, to include but not be limited to, ensuring patients are not treated differently because of their race, nationality, culture, religion, sexual orientation or other factor; and ensuring patients with orders such as Allow Natural Death, Do Not Resuscitate, Advanced Directives, etc. are not given lesser standards of care.

2) Dependent on the scope of the incident, there is the possibility that the standard of care may need to be temporarily altered to provide the greatest amount of care

possible to the greatest number of people possible. Consideration shall be given to patient volumes and available supplies vs. incident trajectory (see Attachment B).

3) Special considerations must be given to any circumstance where crisis standards of care may be needed. Ethical issues concerning how decisions will be made in the event healthcare be done in consultation with:
   - a) A Chaplain
   - b) A Chief of Staff for Medical Staff Services
   - c) A Clinical Ethics Experts
   - d) A Critical Care Expert
   - e) A person with a special need (disability)
   - f) A Respiratory Therapist
   - g) A Social Worker
   - h) An Emergency Department Senior Physician
   - i) CCC Incident Commander
   - j) Chief Medical Officer or designee
   - k) Chief Nursing Officer or designee
   - l) Chief Quality Officer
   - m) Corporate Bioethics Committee co-chair
   - n) Corporate Compliance and Ethics
   - o) Corporate Emergency Management
   - p) Corporate Risk Management
   - q) HICS Medical Staff Director for the subject site
   - r) Hospital Incident Commander
   - s) Legal Counsel
   - t) Pediatrician (where pediatric patients are involved)
   - u) Pharmacy
   - v) Supply Chain Services
4) None of the consulting team members identified as part of the ethics decision team shall be directly involved in the care of any patient(s) being evaluated by the team. Any decisions made by the team to adjust standards of care shall be communicated to:
   - a) County EMS Medical Director
   - b) Local Emergency Operations Center(s)
   - c) Local and State Department of Health
   - d) AHCA
5) Crisis Standard of Care Activation Triggers (see Attachment B):
   - a) Conventional standard of care:
     - (1) Facility is at 30% below minimum surge capabilities.
     - (2) Facility looks internally to streamline patient care lines, move resources such as equipment and staffing within the system as needed to better manage the heightened volumes.
   - b) Moving from Conventional to Contingency Standards of Care:

(1) Facility is at 30% above moderate surge capabilities.
(2) The decision is made to move in to contingency care. Patient care involves some deviation from everyday care, but the level of care on an individual patient basis remains functionally equivalent. All efforts are made to return to conventional care levels as quickly and safely as possible.
(3) Where little progress is made returning to normal operations, a notification is made from the CCC to the Regional Trauma Coordination Center.

c) Moving from Contingency to Crisis Standards of Care
(1) Facility is at 30% above major surge capabilities.
(2) <organization name> notifies regional partners to request immediate, additional support.

D. Triage Triggers:

1. The CCC/HICS activates a Pre-Triage Trigger, which informs <organization name> facilities that triage is imminent, with consideration given to moving patients and resources to optimize occupancy. The process works as outlined below. Possible triggers may include:
   a. Unable to answer all EMS calls.
   b. More than 12 hours of wait time for emergency department visits.
   c. Unable to maintain staffing in ICU.
   d. Less than 5 percent of hospital beds available, no beds available.
   e. No ICU beds available.
   f. A disaster declaration affects more than one area hospital.
   g. Shortage of specific equipment (e.g., ventilators) or of medications that have no substitute.
2. Prior to any triage trigger activation, there must be communication at a local, regional and state level to ensure that all possible opportunities for support have been requested, activated and/or exhausted before any triage triggers have been initiated.
3. Facilities review current patient census and apply the following methodology based on resource levels:
   a. Conventional Standards of Care Triage (Level 1):
      1) CCC/HICS notifies hospitals to apply conventional standards of care triage criteria.
      2) Hospital triage officers apply conventional standards of care triage criteria to both new and current patients.
      3) Facilities preserve bed capacity by:
         a) Considering delaying/cancelling any elective surgery that would require postoperative hospitalization.
         b) Preserving oxygen capacity by:
            (1) Phasing out all non-acute hyperbaric medicine treatments.
            (2) Ensuring that all liquid oxygen tanks are full.
         c) Improving patient care capacity by transitioning space in ICUs to accommodate more patients

d) Controlling infection by limiting visitation.

b. Contingency Standards of Care Triage (Level 2):
   1) CCC/HICS notifies hospitals to apply contingency standards of care triage criteria.
   2) Hospital triage officers apply contingency standards of care triage criteria to both new and current patients.
   3) Facilities preserve bed capacity by:
      a) Delaying/cancelling certain elective surgeries unless necessary to facilitate hospital discharge.
      b) Improving patient care capacity by implementing altered standards of care regarding nurse/patient ratios and expanding capacity by adding patients to occupied hospital rooms.
      c) Instituting a supportive and/or palliative care team to provide symptom management, counseling and care coordination for patients, and support for families of patients who do not receive intensive care unit services

c. Crisis Standards of Care Triage (Level 3):
   1) CCC/HICS notifies hospitals to apply Crisis Standards of Care triage criteria.
   2) Hospital triage officers apply Crisis Standards of Care triage criteria to both new and current patients.
   3) Crisis Standards of Care are implemented to allocate scarce resources.
   4) Sites preserve bed capacity by limiting surgeries to patients whose clinical condition is a serious threat to life or limb, or to patients for whom surgery may be needed to facilitate discharge from the hospital.
   5) Long-term care patients are no longer accepted if they meet Crisis Standards of Care criteria.

d. Downgrading Triage:
   1) CCC/HICS notifies hospitals of downgrade.
   2) Triage officers review patients previously excluded from intensive care at higher triage levels, and reapply Triage Decision Algorithm. Triage levels may fluctuate throughout the life of the incident based on the availability of staff, space and equipment.

4. See Attachment A for an example of the movement from standard care through crisis standards of care.

E. Palliative and comfort care:
1. This level of care begin when illness is diagnosed and continues regardless of whether the patient receives treatment directed at the disease. During Crisis Standards of Care, decisions must be made to balance needs for lifesaving care for those in triage categories who will likely benefit from treatment, while providing comfort care to those for whom lifesaving care is likely futile. At a minimum, comfort care services for disaster victims will include relief of severe symptoms and providing comfort as people face end-of-life decisions.
2. Healthcare professionals should evaluate and alleviate the patient's physical, psychological, and social distress. When possible, effective comfort care requires a broad multidisciplinary approach

that includes the family and makes use of available community resources; it can be implemented, even when resources are limited. Palliative and comfort care can be provided in acute care facilities, out-of-hospital care, alternate care sites or in the patient's home.

F. Psychosocial Support:
   1. During a Crisis Standards of Care response with limited clinical resources, psychosocial support may be the only available source of comfort for many patients.
   2. Healthcare workers are likely be to be profoundly psychologically affected by dealing with Crisis Standard of Care issues amid the extraordinary surge. The Critical Incident Response Team shall be activated in accordance with Reference E.
   3. As with other types of clinicians, behavioral health staff and others qualified to provide psychosocial support in a disaster (e.g., social workers, religious/spiritual advisors, and other responders trained in psychological first aid) may be in short supply and consideration must be given to locating support from non-typical areas (such as military, etc.).

G. Termination/Recovery:
   1. When the CCC receives information from all responding facilities that they have returned to Conventional Standards of Care and there are no indicators of a move to Contingency Standards of Care over a predetermined number of hours, the Crisis Standards of Care response period shall be considered over.
   2. Responding facilities shall take steps to return their facilities and inventories back to normal status.
   3. Responding team members must return to their departments, where applicable.
   4. The Hospital Incident Command System/Incident Command System must be deactivated when it is no longer needed in response to the incident.
   5. An Emergency Incident Critique of the incident must be completed to determine areas for improvement and submitted to the Site Emergency Management Council Chair within three (3) days.

V. DOCUMENTATION:

A. Event Report.
B. Emergency Incident Critique Form.

VI. REFERENCES:

A. Center for Medicare and Medicaid Services (CMS), Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule, *Policies and Procedures*. Federal Register: Vol. 81, No. 180, § 482.15(b).
B. Emergency Management Policy and Procedure #1120, *AMTS/ACS Plan.*
C. Emergency Management Policy and Procedure #1516, *Relocation Plan.*
D. Emergency Management Policy and Procedure #1810, *Hospital Incident Command System (HICS) and Incident Command Locations.*
E. Emergency Management Policy and Procedure #1960, *Critical Incident Response Protocol (CIRP) and Team (CIRT).*
F. Environment of Care (EC) Utilities Response Matrix, located within the Comprehensive Emergency Management Plan (CEMP) and the Corporate Engineering Office.

G. Illinois Department of Public Health, Guidelines on Emergency Preparedness for Hospitals During COVID-19.

H. Spectrum Health, Scarce Resource Protocol.

I. The Maryland framework for the allocation of scarce life-sustaining medical resources in a catastrophic public health emergency (2017)

J. The Joint Commission (2024). 2024 Hospital accreditation standards. EM.12.02.01, EM.12.02.03, EM.12.02.05, EM.12.02.07, EM.12.02.09. Oakbrook Terrace, IL: Joint Commission Resources.

K. University of Michigan Health System Emergency Management Operations Committee Ethics Team's *Guidelines for Allocation of Life Saving Or Critical Resources in a Pandemic* (2014)

VII. ATTACHMENTS:

A. Framework for surge response (example), one page.

B. Scarce Resource Allocation Committee (SRAC) Operational Structure, one page.

C. Quick Response Checklist, one page.

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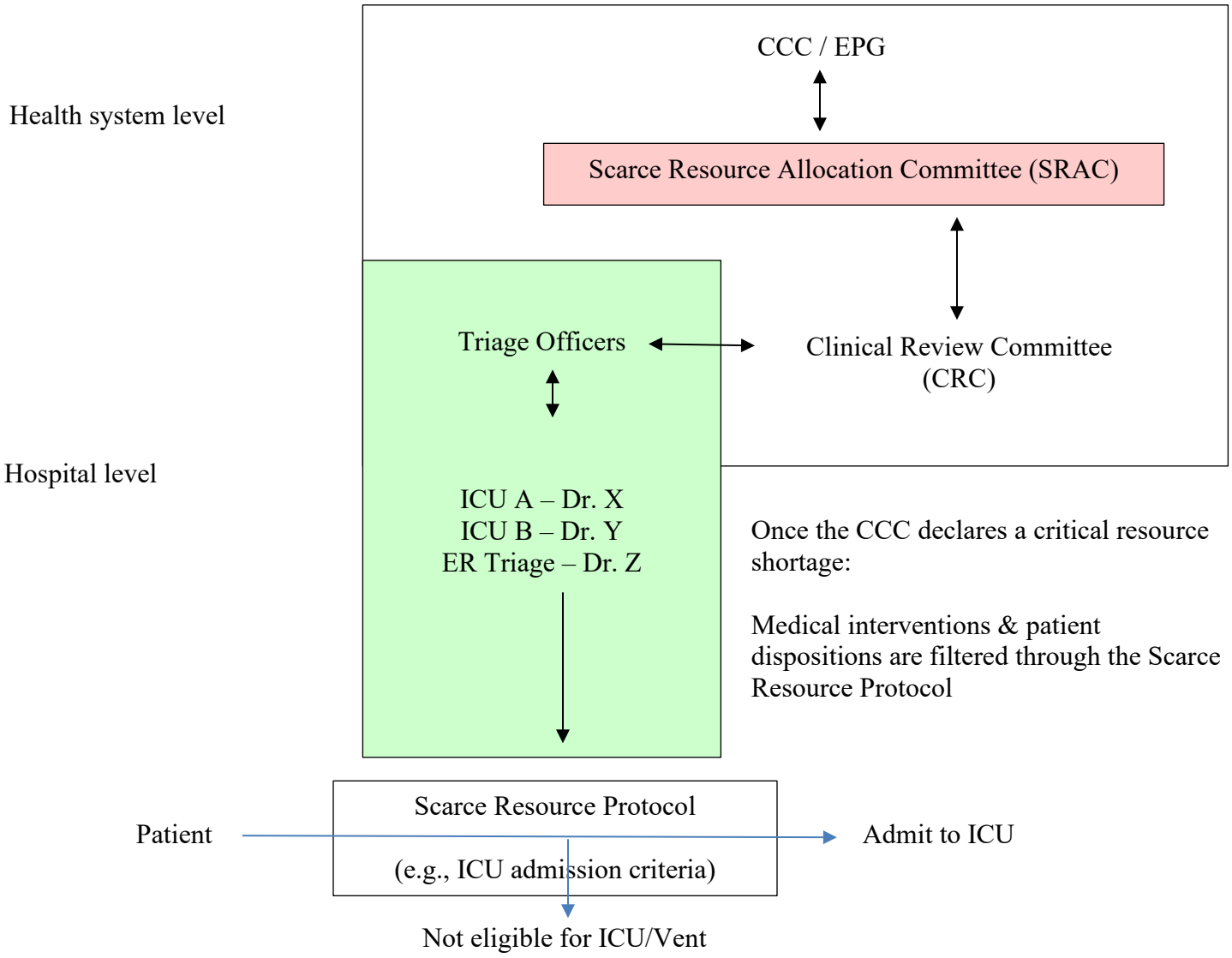
Attachment A – Framework for surge responses (example)

	Conventional	Contingency	Crisis
Space	Usual patient care spaces maximized	Patient care areas re-purposed (e.g., PACU, monitored units for ICU-level care)	Non-traditional areas used for critical care or facility damage does not permit usual critical care
Staff	Additional staff called in as needed	Staff extension (supervision of larger number of patients, changes in responsibilities, documentation, etc.)	Insufficient ICU-trained staff available/unable to care for volume of patients, care team model required & expanded scope
Supplies	Cached/on-hand supplies	Conservation, adaptation and substitution of supplies with selected re-use of supplies when safe	Critical supplies lacking, possible allocation/reallocation of lifesaving resources
Standard of Care	Usual care	Minimal impact on usual patient care practices	Not consistent with usual standards of care (Mass Critical Care)
ICU expansion goal	x 1.2 usual capacity (20%)	x 2 usual capacity (100%)	x 3 usual capacity (200%)
Resources	Local	Regional/State	State/National

Title: ***CRISIS (ALTERED) STANDARDS OF CARE/ALLOCATION OF SCARCE RESOURCES PLAN*** Policy #:

Attachment B – Scarce Resource Allocation Committee (SRAC) Operational Structure



Title: ***CRISIS (ALTERED) STANDARDS OF CARE/ALLOCATION OF SCARCE RESOURCES PLAN***

Policy #:

Attachment C – Quick Response Checklist

Hospital	Non-Hospital	Freestanding ED
☐ Administrative Supervisor notifies the Administrator On Call of the potential for a change from Conventional to Contingency standards of care. ☐ Hospital Incident Command System (HICS) is activated to identify areas of need and establish response teams. ☐ The HICS Operations Chief notifies the Corporate Emergency Management on-call duty officer – Tel: (***) ***-****.	☐ Facility Senior Leader notifies their leadership of the potential for a change from Conventional to Contingency standards of care. ☐ Incident Command System (ICS) is activated to identify areas of need and establish response teams. ☐ The ICS Operations Chief notifies the Corporate Emergency Management on-call duty officer – Tel: (***) ***-****.	☐ Facility Senior Nursing Leader notifies the parent hospital's Administrative Supervisor of the potential for a change from Conventional to Contingency standards of care. ☐ Hospital Incident Command System (HICS) is activated to identify areas of need and establish response teams. ☐ The HICS Operations Chief notifies the Corporate Emergency Management on-call duty officer – Tel: (***) ***-****.
☐ Corporate Emergency Management notify the CCC Incident Commander of a possible Crisis Standards of Care situation. ☐ Based on the information provided, the CCC Incident Commander may activate the Corporate Command Center and Executive Policy Group.	☐ Corporate Emergency Management notify the CCC Incident Commander of a possible Crisis Standards of Care situation. ☐ Based on the information provided, the CCC Incident Commander may activate the Corporate Command Center and Executive Policy Group.	☐ Corporate Emergency Management notify the CCC Incident Commander of a possible Crisis Standards of Care situation. ☐ Based on the information provided, the CCC Incident Commander may activate the Corporate Command Center and Executive Policy Group.

☐ The Scarce Resource Allocation Committee (SCAC) is formed.

☐ SRAC identifies activation triggers and medical triage protocols