

**As of: June  
2017**

DEVELOPING A STANDARD OF HEALTHCARE DURING  
CATASTROPHIC PUBLIC HEALTH EMERGENCIES

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**Nevada Division of Public and Behavioral Health (DPBH)**



**Public Health**  
Prevent. Promote. Protect.

# Nevada Crisis Standards of Care (CSC) Plan

NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH (DPBH)

## Nevada Crisis Standards of Care (CSC) Plan

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Nevada Division of Public and Behavioral Health (DPBH)  
Public Health Preparedness (PHP)  
4150 Technology Way • Suite 200  
Carson City, Nevada 89706  
Phone 775.684.3224 • Fax 775.684.5951  
Malinda Southard, CSC Project Manager  
[msouthard@health.nv.gov](mailto:msouthard@health.nv.gov) • 775.684.4039

## DPBH Vision and Mission Statement

The Division of Public and Behavioral Health vision is the foundation for improving Nevada's health. It is the mission of the Division of Public and Behavioral Health to **"protect, promote and improve the physical and behavioral health of the people in Nevada."** Working in partnership with consumers, families, advocacy groups, agencies, and diverse communities, the Division of Public and Behavioral Health provides responsive services and informed leadership to ensure quality outcomes.

## Nevada Crisis Standards of Care Plan Signature Page

The Nevada Crisis Standards of Care Plan is an all-hazards plan that works in conjunction with the Nevada Division of Emergency Management's State Comprehensive Emergency Management Plan (SCEMP) and serves as the framework for supporting the ethical and effective provision of medical care during a catastrophic public health disaster. Public Health Preparedness (PHP) Program employees are required to familiarize themselves with this plan, participate in PHP training and exercises, and be prepared to implement the Nevada Crisis Standards of Care Plan if it is activated during a real event or exercise.

**\*\*Routed for signature on 7/3/17 – signatures will be uploaded once obtained\*\***

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Chad Westom, PAIS Bureau Chief (DPBH)

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Joe Pollock, Deputy Administrator (DPBH)

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Amy Roukie, Administrator (DPBH)

Signed by: \_\_\_\_\_ Date: \_\_\_\_\_  
Dr. John DiMuro, Chief Medical Officer (DPBH)

## Contributors

### PROJECT PLANNING TEAM:

Malinda Southard, Project Manager  
Jeanne Freeman, Project Team Member  
Andrew Lawless, Planning Consultant  
P. Diane Reed, Planning Consultant  
Cari Rioux, Project Team Member

### ADVISORY COMMITTEE MEMBERS:

Karen Allen, Carson City Health and Human Services  
Ihsan Azzam, Nevada Division of Public and Behavioral Health, Nevada Medical Epidemiologist  
John DiMuro, Nevada Division of Public and Behavioral Health, Nevada Chief Medical Officer  
Bill Elliott, Nevada Division of Emergency Management  
Andrea Esp, Washoe County Health District  
Richard (Buck) Fenlason, Nevada Division of Public and Behavioral Health, State EMS Office  
Jeanne Freeman, Carson City Health and Human Services, Quad County Public Health Preparedness  
Dave Fogerson, East Fork Fire District  
Dan Hourihan, Inter-Tribal Emergency Response Commission  
Robert Kidd, Perry Foundation  
Greg Kitchingman, Nevada Division of Public and Behavioral Health  
Christopher Lake, Nevada Hospital Association  
Erin Lynch, Nevada Division of Public and Behavioral Health, Public Health Preparedness  
Major Mario Maxwell, Nellis Air Force Base  
Irene Navis, Clark County Fire Department Emergency Management & Homeland Security  
Rose Park, Nevada Division of Public and Behavioral Health, Southern NV Adult Mental Health System  
Mike Pavlakis, Allison MacKenzie, Ltd.  
Leon Ravin, Nevada Division of Public and Behavioral Health, Statewide Psychiatric Medical Director  
Lois Repass, Nevada Division of Public and Behavioral Health, Disaster Coordinator  
Steve Shell, Desert Parkway Behavioral Healthcare Hospital  
Tina Smith, Nevada Division of Public and Behavioral Health, State EMS Office  
Randall Todd, Washoe County Health District, Director of Epidemiology and Public Health Preparedness  
Jeff Quinn, Southern Nevada Health District, Office of Public Health Preparedness

### WORKGROUP MEMBERS:

Nicki Aaker, Carson City Health and Human Services  
Linda Anderson, Office of the Nevada Attorney General  
Hentjie Apag, Northern Nevada Center of Independent Living

Debra Aschenbrenner, Tahoe Pacific Hospitals  
Mike Barnum, Valley Hospital Medical Center  
Annette Bradley, Southern Nevada Health District  
Jeff Buchanan, Clark County Fire Department  
Kent Choma, Saint Mary's Regional Medical Center  
Deborah Cline, Carrington College  
Curtis Coulter, Law Offices of Curtis Coulter  
Eric Dievendorf, American Medical Response Las Vegas  
Jason Driggars, American Medical Response Las Vegas  
Paul Edwards, Nevada State Board of Pharmacy  
Rachell Ekroos, University of Nevada, Las Vegas  
Temple Fletcher, Regional Emergency Medical Services Authority – Care Flight  
Max Gakh, University of Nevada, Las Vegas  
Katie Grimm, Saint Mary's Regional Medical Center  
Lisa Hathcock, Nellis Air Force Base  
Sally Hardwick, Nevada Physician Order for Life-Sustaining Treatment for Nevada Residents  
Kathryn Harter, Pershing General Hospital  
Shelby Hunt, Northern Nevada Medical Center  
David Johnson, Renown Regional Medical Center Bioethics Committee  
Kathy Johnson, University Medical Center of Southern Nevada  
Robert Kidd, Perry Foundation  
Jon Klassen, Clark County Fire Department  
Scott Lewis, Pahrump Valley Fire Rescue  
Major Mario Maxwell, Nellis Air Force Base  
Sarah McCrea, Las Vegas Fire and Rescue  
Donna Miller, Life Guard International – Flying ICU  
Kim Moore, City of Henderson Fire Department  
Michael Munda, Renown Regional Medical Center  
Irene Navis, Clark County Fire Department Emergency Management & Homeland Security  
Laura Oslund, Partners Allied for Community Excellence Coalition, Elko  
Wendy Pagan, University Medical Center of Southern Nevada  
Russ Park, Seven Hills Behavioral Health Hospital  
Brian Passow, VA Sierra Nevada Health Care System  
Susan Pintar, Carson City Health and Human Services  
Katie Ryan, University Medical Center of Southern Nevada  
Troy Richardson, VHA Office of Emergency Management  
Julia Sbragia, University Medical Center of Southern Nevada  
Damon Schilling, American Medical Response Las Vegas  
Michael Sullivan, Eureka County Emergency Medical Services  
Brian Taylor, Regional Emergency Medical Services Authority  
Troy Tuke, Clark County Fire Department  
Julie Worman, Desert Parkway Behavioral Health Hospital

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## Record of Changes

Change	Date	Part Affected	Date Posted	Who Posted
Original	June 30, 2017			

## Record of Distribution

Plan #	Office/Department	Representative	Signature
1			
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## Introduction

During a catastrophic disaster response, healthcare providers still have the duty to provide ethical and effective medical care despite being overwhelmed by the circumstances. There may not be enough **space** to treat the increased volume of patients, key **supplies** may be exhausted, and **staff** may be unavailable or unable to report to work, resulting in substantial challenges to medical care provision. Despite these challenges, the healthcare system must continue to operate even with limited or inadequate resources to protect the health of the community.

Crisis standards of care (CSC) refer to the level of care possible during a disaster due to limitations in space, staff, supplies, or other factors. CSC may be required during the most extreme statewide disaster circumstances, such as a major earthquake or influenza pandemic. When a mass casualty event occurs, the healthcare system may need to shift from conventional standards of care to contingency standards of care, and finally to CSC in order to meet the overwhelming demand for healthcare services.

According to the Institute of Medicine's (IOM) *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (2012), conventional care is defined as "usual care," whereas contingency care is defined as "functionally equivalent care." The IOM's *Guidance for establishing crisis standards of care for use in disaster situations: A letter report* (2009) describes CSC as "a substantial change in the usual healthcare operations and the level of care it is possible to deliver... justified by specific circumstances and...formally declared by a state government in recognition that crisis operations will be in effect for a sustained period."

As part of CSC operations, a policy group, the Nevada State Disaster Medical Advisory Committee (SDMAC) needs to be established. The SDMAC will be a multidisciplinary group comprised of highly qualified experts in public health, emergency management, healthcare, Emergency Medical Services (EMS), ethics, and law, plus other subject matter experts. Assisting the Division Operations Center (DOC) at the Division of Public and Behavioral Health (DPBH), the SDMAC can be activated during a catastrophic healthcare crisis to develop ongoing recommendations for healthcare and public health stakeholders in Nevada. Additionally, the SDMAC will support the emergency management and incident command system (ICS) established throughout the state. SDMAC recommendations may include but are not limited to the following:

- Guidelines for the provision of EMS;
- Primary, secondary, and tertiary triage guidelines for healthcare facilities;
- Expanding scopes of practice for healthcare professionals, as approved by regulatory authorities;
- Priorities for allocation and utilization of scarce medical resources, including space, staff, and supplies; and
- Guidelines for healthcare access points, including hospitals, out-of-hospital facilities, and alternate care sites.

SDMAC recommendations will be disseminated through existing emergency management and communication channels to healthcare facilities, professional associations, and providers. Healthcare facilities, medical directors, and providers may use these recommendations to adjust standards of care when usual professional practices are not possible.

## Background

DPBH PHP Program collaborated with local and regional public health entities, emergency management, healthcare, EMS, legal professionals, ethical experts, and community stakeholders to develop the *Nevada Crisis Standards of Care Plan* (NV CSC Plan) based on the IOM 2012 Framework. The project included the establishment of a CSC Advisory Committee, CSC Project Team, four workgroups, and an extensive public engagement campaign. The CSC Advisory Committee was made up of stakeholders from across the state. The Committee oversaw the development and execution of the public engagement campaign and reviewed plan content.

Based on the IOM Framework, the CSC Project Team oversaw and facilitated the following four workgroups: 1) EMS, 2) Ethical and Legal, 3) Hospital and Healthcare, and 4) Public Health and Emergency Management. These workgroups were comprised of subject matter experts from across Nevada. Each of the four workgroups met several times to collectively develop and approve content for the NV CSC Plan.

The EMS Workgroup assessed current dispatch function, response time and efficiency, patient assessment and treatment, and patient transportation processes. The workgroup identified possible tactics to adapt practices and standards of care to address the most difficult circumstances, and to the extent possible, ensure consistent care across Nevada.

The Ethical and Legal Workgroup reviewed laws and regulatory issues, examined bioethical concerns, and developed the Nevada CSC Code of Ethics (Appendix C). The Nevada CSC Code of Ethics provides an ethical framework to guide the principles and implementation of CSC during a catastrophic disaster, while focusing on providing the best medical care for the greatest numbers of people. In addition, the workgroup assisted in answering legal questions posed by the members of other workgroups.

The Hospital and Healthcare Workgroup was comprised of healthcare providers and administrators. The workgroup established primary, secondary, and tertiary triage guidelines and parameters for expanded or modified scopes of practice and clinical care. The workgroup addressed the implementation of CSC in multiple types of acute healthcare facilities, including hospitals, out-of-hospital providers, and alternate care sites.

The Public Health and Emergency Management Workgroup developed direction and control guidelines to facilitate communication and coordination among various levels of government agencies and private healthcare organizations. The workgroup ensured that the NV CSC Plan was developed in accordance to

National Incident Management System (NIMS) guidelines and was aligned with ICS standards and practices to facilitate efficient and effective disaster response coordination among government agencies and private organizations.

The public engagement campaign was designed to ensure project transparency and gauge public opinion. The campaign included eight in-person community meetings in urban and rural settings in Northern and Southern Nevada, as well as an online survey. The online survey was conducted in both English and Spanish. A total of 1,200 completed survey responses were collected from community members between April and July 2016. The results were shared with all workgroup members and the CSC Advisory Committee to further direct and guide the development of the NV CSC Plan.

## Purpose

Medical standards of care may need to be modified during a catastrophic public health emergency to meet the increased demand for healthcare and address resource shortages. Disasters may temporarily justify shifting the focus of medical care to emphasize the needs of the community rather than the needs of individuals.

The NV CSC Plan provides a mechanism and process for convening the SDMAC. The plan provides considerations, adaptations, and tools to assist the SDMAC in developing statewide recommendations based on incident specific circumstances. It describes the process for the approval, dissemination, and implementation of SDMAC recommendations. Additionally, it provides a framework of ethical principles including fairness, duty to care, stewardship of resources, transparency, consistency, proportionality, and accountability that should be maintained throughout the public health and medical response.

## Plan Objectives

The NV CSC Plan supports state medical surge capacity and capability planning and provides a mechanism for expanding medical surge operations into CSC. The following objectives have been established for this document:

1. Describe the assumptions for CSC Plan activation;
2. Document the steps for CSC Plan activation including indicators;
3. Establish an ethical framework for CSC operations;
4. Describe the legal authorities and environment for CSC;
5. Describe the roles and responsibilities of the SDMAC members;
6. Define strategies, tactics, and adaptations for clinical processes and operations including EMS, healthcare facilities, healthcare providers, and public health systems;
7. Describe out-of-hospital and alternate care system capabilities;
8. Establish criteria for CSC deactivation;
9. Develop a state health and medical approach to CSC planning that is adaptable at the regional/local level; and

10. Maintain the NV CSC Plan through ongoing training, exercising, evaluation, and planning.

## Applicability

This plan has been developed to support the State Comprehensive Emergency Management Plan (SCEMP) and the Statewide Medical Surge Plan (SWMSP), as well as other incident-specific DPBH plans. The NV CSC Plan is not intended to be activated as a stand-alone plan. It is intended to be activated along with other state emergency response plans based on the nature, causes, severity, duration, magnitude and other disaster-related (incident-specific) circumstances. Table 1 below displays examples of plans that may be co-activated with other local, regional, and state plans, as well as federal guidance.

**Table 1. Nevada Plan Matrix**

Local & Regional Plans	State Plans	Federal Plans and Authorities
Healthcare Organization Plans, Continuity of Operations Plans (COOPs), Emergency Operations Plans (EOPs)/Emergency Response Plans (ERPs), Fatality Management, and Medical Surge	Nevada Crisis Standards of Care Plan (NV CSC Plan)	National Response and Recovery Framework
	Statewide Medical Surge Plan (SWMSP)	The Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288, as amended. (42 U.S.C. §§ 5121-5206)
	Statewide Behavioral Health Emergency Operations Plan	
Municipality Emergency Management Response Plans, EOPs, or ERPs	State Comprehensive Emergency Management Plan (SCEMP) and Emergency Support Function (ESF) support annexes	Public Health Service Act, Section 319 Public Health Emergencies
County Emergency Management Response Plans, EOPs, or ERPs	DPBH Division Operation Center (DOC) Plan	(see Authorities and References section for full list)
Regional Health Authority EOPs or ERPs	DPBH COOP	
	DPBH Public Information and Communication (PIC) Plan	
	Medical Countermeasures and Acquisition and Distribution (MCAD) Plan	
	DPBH Pandemic Influenza Preparedness and Response Plan	
	DPBH Volunteer Management Plan	

## Scope

The NVCSC Plan applies to jurisdictional agencies and organizations that may be impacted by a catastrophic public health emergency. This type of disaster will affect the healthcare system and governmental agencies statewide due to an overwhelming demand for healthcare services when resources (space, staff, and supplies) are insufficient to allow for usual standards of medical care. Agencies and organizations that may be impacted include state, regional, county, municipal, and tribal governments; EMS; hospital, healthcare, and behavioral health organizations; and legal and ethical entities.

The NV CSC Plan describes the role, activation, composition, purpose, and processes for the SDMAC in making CSC recommendations during a statewide catastrophic disaster. This document includes a CSC Code of Ethics that was carefully and thoughtfully developed to address the issues and concerns of the public and healthcare providers in implementing CSC. It supports the five key elements recommended in the IOM 2012 Framework. These elements include:

- A strong ethical grounding that enables a process deemed equitable based on its transparency, consistency, proportionality, and accountability;
- Integrated and ongoing community and provider engagement, education, and communication;
- The necessary legal authority and legal environment in which CSC can be ethically and optimally implemented;
- Clear indicators, triggers, and lines of responsibility; and
- Evidence-based clinical processes and operations.

The NV CSC Plan supports the coordination of public health, emergency management, EMS, and healthcare resources during CSC activation. It is not intended to be an emergency plan for individual agencies or organizations.

## Planning Assumptions

The NV CSC Plan will only be implemented under conditions in which usual standards of care are not possible, multiple healthcare access points are impacted in a region or across the state, and when the demand for healthcare overwhelms available space, staff, or supplies, as determined by the active or acting State Chief Medical Officer. Some or all of the following assumptions must be true for the NV CSC Plan to be activated:

- State and federal (e.g., Stafford Act, Public Health Services Act) disaster declarations have been requested;
- Resources are unavailable or undeliverable to healthcare facilities from elsewhere in the region or state;
- Patient transfer to other facilities is not possible or feasible, at least in the short term;

- Access to medical countermeasures (e.g., vaccines, medications, antidotes, blood products) is limited;
- Trained healthcare staff is unavailable or unable to adequately care for increased volume of patients;
- Available local, regional, state, and federal resource caches (of equipment, supplies, and pharmaceuticals) have already been distributed, and no short-term resupply is foreseeable; and
- There are disruptions to the healthcare supply chain.

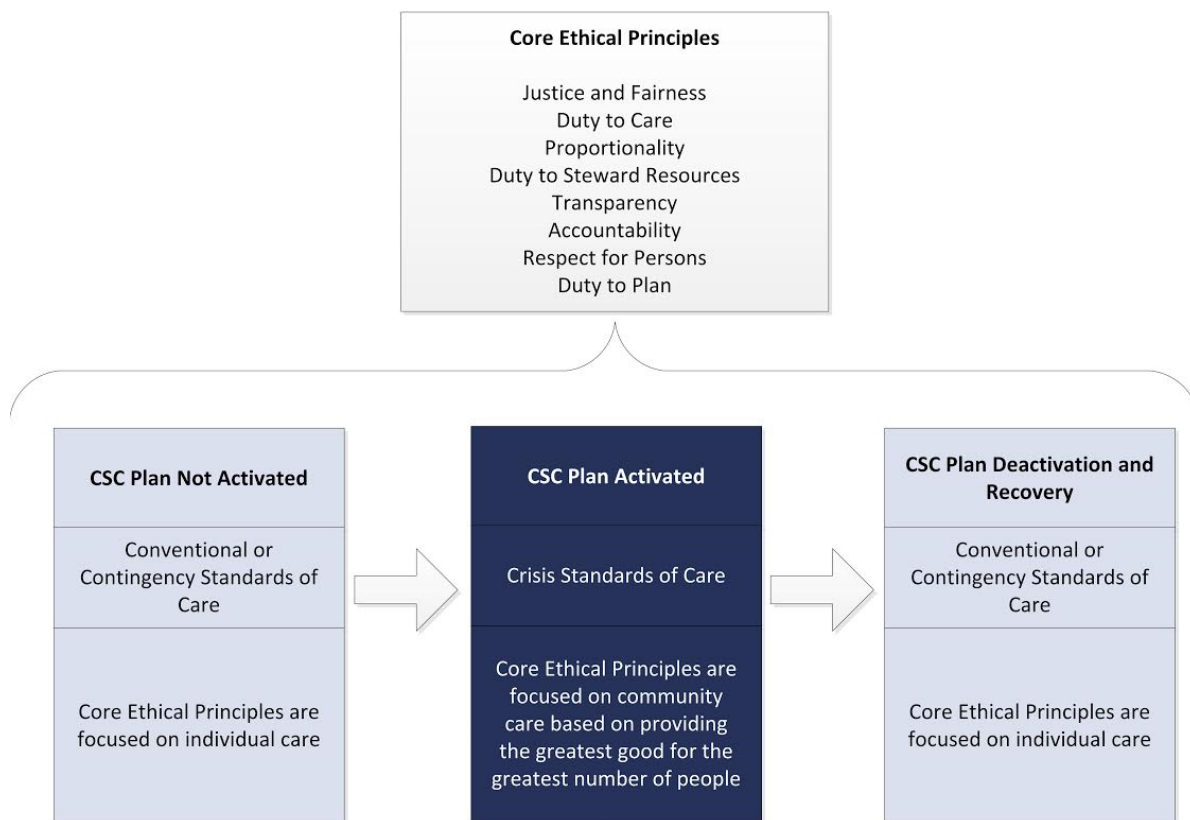
## Ethical Considerations

During CSC, the focus of healthcare will shift from individual care to community care to provide the greatest good for the greatest number of people. In order to achieve this during CSC and maintain continuity with communities' values, it is critical to establish a core ethical framework to provide guidance for decision-makers, medical providers, and medical practitioners. The core ethical guidance for this plan includes justice and fairness, duty to care, proportionality, duty to steward resources, transparency, accountability, respect for persons, and duty to plan.

During CSC, ethical principles do not differ from those applied during normal day-to-day healthcare operations, but their application becomes focused on community healthcare provision instead of on individual healthcare provision. As a catastrophic public health emergency moves through recovery, the focus of care is able to shift back to individual healthcare provision. The figure below shows the maintenance of ethical principles that are most important to Nevada communities (as per the public engagement campaign results) and shows the shift of foci from individual care to community care and back. These guiding ethical principles may be applied to patient care, equitable resource allocation, and professional and legal standards, communications, and other response operations. The NV CSC Code of Ethics is provided in Appendix C.



**Figure 1 - Application of Ethical Principles Across Standards of Care**



## Statewide Concept of Operations

The activation of this Plan will require a coordinated effort between numerous state and local agencies and a number of healthcare organizations, facilities, and providers. As such, a complex systems approach involving indicators and triggers must be utilized to coordinate the development of effective and ethical recommendations and to ensure that information is quickly and accurately delivered to medical professionals. This section includes information on primary, coordinating, and support agencies; roles and responsibilities; direction, control, and coordination; activation; and deactivation.

## Coordinating Agencies List

### Primary Agency

Nevada Department of Health and Human Services (DHHS)

- Division of Public and Behavioral Health (DPBH)
  - Bureau of Preparedness, Assurance, Inspections and Statistics (PAIS)
    - Public Health Preparedness (PHP) Program

### *Coordination Agencies*

Nevada Division of Emergency Management (DEM)  
Regional Emergency Management  
County Emergency Management  
Municipal Emergency Management Agencies

### *Support Agencies*

State agencies and programs  
County public health departments or local public health authorities  
Nevada Healthcare Coalitions  
Emergency Medical Services (EMS)  
Health Provider Organizations:

- Hospitals;
- Healthcare Facilities;
- Long Term Care Agencies;
- Community Health Centers;
- Home Care Agencies;
- Behavioral Health Agencies; and
- Other Healthcare Facilities

### *Federal Agencies*

U.S. Department of Health and Human Services (HHS)

- Office of the Assistant Secretary for Preparedness and Response (ASPR)
  - Regional Emergency Coordinator (REC)
- Centers for Disease Control and Prevention (CDC)

## **Coordinating Agencies Roles and Responsibilities**

Every agency and organization involved in an emergency response brings unique and crucial resources that contribute to the success of the response. Listed below are agency and organization roles and responsibilities. Additional agencies and resources may be involved in incident-specific responses. This list is not intended to be exhaustive, but instead to provide an overview of roles and responsibilities for agencies that are likely to participate in a response involving the need to implement CSC.

## *Primary Agency*

### **Nevada Department of Health and Human Services (DHHS), Division of Public and Behavioral Health (DPBH)**

- Provide Chief Medical Officer staff to the Nevada State Emergency Operations Center (SEOC);
- Provide staff and financial and administrative support to the DPBH DOC;
- Provide public information support to the DPBH DOC; and
- Participate in DEM After-Action Conference (AAC) and Improvement Plan (IP) development

#### **Bureau of Preparedness, Assurance, Inspections, and Statistics (PAIS), Public Health Preparedness (PHP) Program**

- Activate and maintain the DPBH DOC;
- Provide public health support to the Nevada State Emergency Operations Center, ESF-8: Public Health and Medical Services;
- Maintain and coordinate updates of the NV CSC Plan;
- Develop DPBH After-Action Reports (AARs) and Improvement Plans (IPs) following exercises or real incidents; and
- Conduct the DPBH AAC and make recommendations for implementing corrective actions based on the DPBH AAC.

## *Coordination Agencies*

### **Nevada Division of Emergency Management (DEM)**

- Activate emergency and recovery support functions within the SCEMP;
- Activate and maintain the Nevada SEOC and Joint Information Center (JIC);
- Through the SEOC:
  - Coordinate ESF-8: Public Health and Medical Services;
  - Coordinate county and regional Emergency Operations Center (EOC) requests for resources and requests for federal assets;
  - Advise the Governor about situational status and make recommendations;
  - Coordinate alternate care site information with regional and county partners;
  - Manage and coordinate communications with response partners;
  - Communicate information, plans, requirements, and strategies with county and regional EOCs;
  - Acquire and manage resources (including voluntary), supplies, and services from core capability service providers via contracts, mission assignments, interagency agreements, and donations; and
  - Activate mutual aid agreements for additional resources.
- Provide DPBH with AAR/IP.

### *Regional and County Emergency Management Agencies*

- Activate the appropriate county or regional Emergency Operations Plan Annexes and Appendices;
- Activate and maintain county or regional EOCs and support public information needs;
- Through the EOCs:
  - Coordinate Public Health and Medical Services;
  - Coordinate county and regional EOC resource requests with the Nevada SEOC;
  - Maintain county or regional EOC activation and maintain liaison with other jurisdictional EOCs, DOCs, Incident Command Posts (ICPs), or agencies, as necessary;
  - Advise county or regional officials about situational status and make recommendations;
  - Manage and coordinate communications with response partners;
  - Communicate information, plans, requirements, and strategies to the Nevada and municipal EOCs;
  - Acquire and manage resources (including voluntary), supplies, and services from core capability service providers via contracts, mission assignments, interagency agreements, and donations;
  - Activate and coordinate deployment with DEM of any needed ancillary operations and/or facilities (e.g., alternate care sites); and
  - Activate mutual aid agreements for additional resources.

### *Municipal Emergency Management Agencies*

- Activate the applicable Emergency Operations Plan (EOP) Annexes and Appendices;
- Activate and maintain jurisdictional EOCs and support public information needs; and
- Through the EOCs:
  - Coordinate Public Health and Medical Services;
  - Coordinate resource requests with the county or regional EOC;
  - Maintain EOC activation and maintain liaison with other jurisdictional EOCs, DOCs, ICPs, or agencies;
  - Advise jurisdictional officials about situational status and make recommendations;
  - Manage and coordinate communications with response partners;
  - Communicate information, plans, requirements, and strategies to the county or regional EOCs;
  - Acquire and manage resources (including voluntary), supplies, and services from core capability service providers via contracts, mission assignments, interagency agreements, and donations; and
  - Activate mutual aid agreements for additional resources.

## *Support Agencies*

### **Other State Agencies and Programs**

- Provide subject matter experts to DOC or SDMAC, as needed;
- Provide staff to DOC;
- Make recommendations for implementing corrective action; and
- Participate in AACs and IP development.

### **County or Regional Public Health Authorities**

- Provide Health Officer or other staff to the local EOC;
- Provide expertise to the SDMAC;
- Activate and maintain the local public health emergency operations;
- Provide staff, financial, and administrative support to the local EOC as requested;
- Provide public information support to the local EOC;
- In the local EOC (if activated or available):
  - Collaborate and coordinate with Nevada DHHS DPBH;
  - Provide public health situational reports to the Nevada SEOC ESF-8: Public Health and Medical Services; and
  - Facilitate implementation of CSC recommendations.
- Develop AARs and IPs following exercises or real incidents; and
- Make recommendations for implementing corrective actions.

### **Emergency Medical Services (EMS)**

- Provide patient assessment and initial medical treatment services;
- Implement CSC recommendations (as approved by agency Medical Directors) during emergency medical services provision; and
- Provide transport to hospital or alternate medical facilities, as recommended.

### **Hospitals, Healthcare Facilities, Long-Term Care Agencies, Community Health Centers**

- Activate facility or agency EOPs or protocols;
- Implement CSC recommendations (as approved by agency Medical Directors or Chief Medical Officers);
- Provide healthcare facility situational assessments and information to jurisdictional EOCs, as needed;
- Coordinate and implement patient movement, if necessary;
- Coordinate public information with jurisdictional public information activities;

- Request needed resources that are beyond the capacity of the healthcare organization through the jurisdictional EOC;
- Participate in planning efforts to mitigate the effects of future disaster/emergency incidents; and
- Participate in local or regional after-action planning or IP development or corrective action planning.

#### **Home Care Agencies**

- Activate agency EOPs;
- Implement CSC recommendations (as approved by agency Medical Directors or Chief Medical Officers);
- Provide situational assessments and information to jurisdictional EOCs, as needed;
- Coordinate public information with jurisdictional public information activities;
- Request needed resources that are beyond the capacity of the agencies through the jurisdictional EOC; and
- Participate in planning efforts to mitigate the effects of future disaster/emergency incidents.

#### **Behavioral Health Agencies**

- Provide behavioral healthcare services and treatment programs for adults and children;
- Provide Critical Incident Stress Management (CISM) services to emergency responders and their families, as needed;
- Provide crisis intervention services to disaster victims through established clinics or mental health stations at disaster sites; and
- Provide mobile teams to assess mental and behavioral health needs and either stabilize individuals in the community or refer individuals to an appropriate level of care as necessary.

#### **Nevada Healthcare Coalitions**

- Coordinate with county and regional emergency management;
- Assist in information sharing with county and regional emergency management; and
- Advise county or regional officials about situational status and make recommendations.

## *Federal Resources*

### **United States Department of Health and Human Services (HHS)**

- Upon DPBH request, support may include:
  - Training;
  - Funding;
  - Grant opportunities;
  - Guidance; and
  - Research and reports.

### **Office of the Assistant Secretary for Preparedness and Response (ASPR)**

- The Regional Emergency Coordinator (REC):
  - Serves as ASPR's primary representative;
  - Consults and makes recommendations to DPBH;
  - Provides situational awareness to ASPR; and
  - Provides command and control for deployed HHS resources.

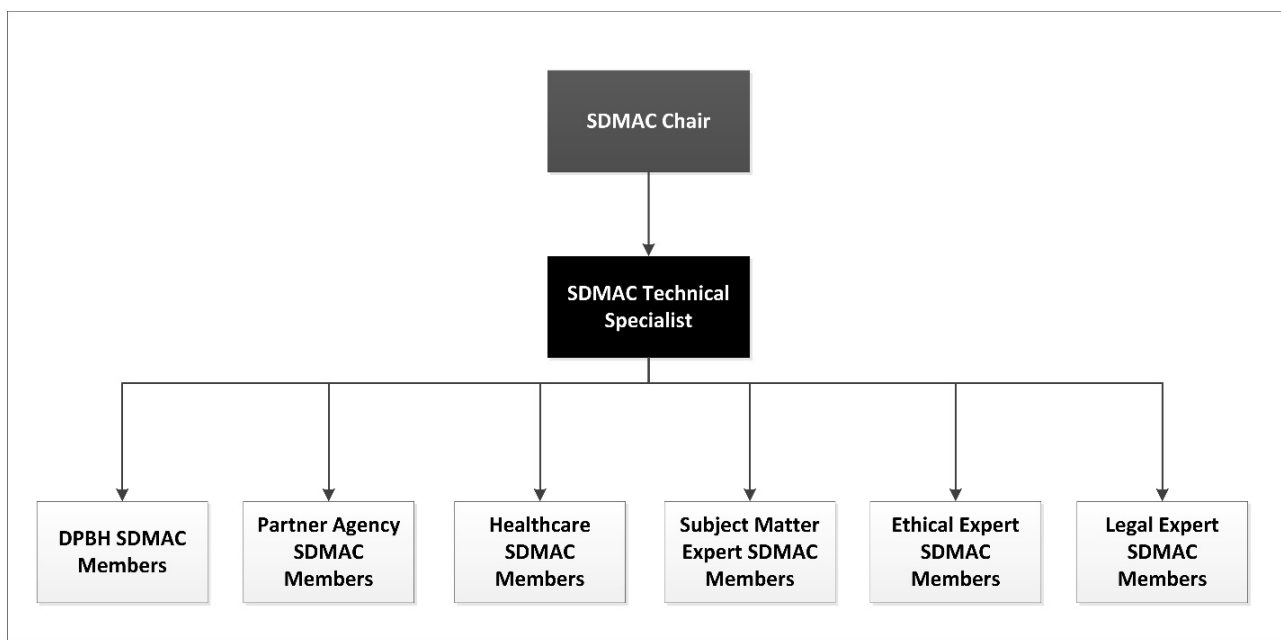
### **Centers for Disease Control and Prevention (CDC)**

- Upon DPBH request, support may include:
  - Funding;
  - Disease surveillance;
  - Disease control assistance;
  - Behavioral health recommendations;
  - Pharmaceuticals;
  - Medical countermeasures;
  - Equipment and supplies; and
  - Subject matter expertise.

## State Disaster Medical Advisory Committee (SDMAC) Roles and Responsibilities

A wide variety of highly qualified experts, medical professionals, and decision makers will be required to staff the SDMAC. Detailed job descriptions for the SDMAC positions have been created to assist with the staffing process (see Appendix B). In keeping with ICS concepts of scalability and flexibility, the exact composition of the SDMAC will be incident-specific and will be determined at the time of CSC activation. DPBH is in the process of registering medical professionals in their newly developed Emergency Providers Organization of Nevada (EPON) system. EPON registrants will help to provide a pool of potential SDMAC members and direct care providers at the time of CSC activation. However, *at a minimum*, the following SDMAC positions should be filled to help ensure the development of effective and ethical recommendations. Figure 2 below illustrates SDMAC organization.

**Figure 2. State Disaster Medical Advisory Committee (SDMAC) organization chart**



SDMAC Position responsibilities include:

- **The SDMAC Chair** will be responsible for overseeing the SDMAC and the development and dissemination of recommendations;
- **The SDMAC Technical Specialist** will report to the SDMAC Chair and will coordinate the development of timely, incident-specific recommendations;
- **DPBH SDMAC Members** will coordinate and advise on CSC recommendations from their assigned program areas;



- **Partner Agency SDMAC Members** will contribute to the development and implementation of CSC recommendations and interface between their respective partner agencies and the SDMAC;
- **Healthcare SDMAC Members** will contribute to the development and implementation of CSC recommendations and interface between their respective facilities or agencies and the SDMAC;
- **Subject Matter Expert SDMAC Members** will provide and interpret technical information and data related to the response and contribute to the development and implementation of CSC recommendations statewide;
- **Ethics Expert SDMAC Members** will advise on ethical healthcare-related issues related to the response and contribute to the development and implementation of CSC recommendations; and
- **Legal Expert SDMAC Members** will advise on legal issues related to the response and contribute to the development of CSC recommendations.

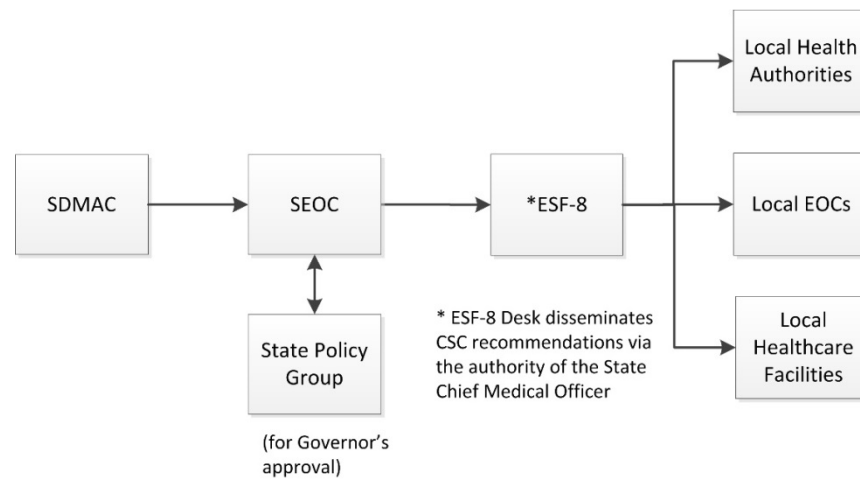
## Direction, Control, and Coordination

Effective coordination among government and healthcare organizations is critical during CSC activation to provide the best medical care possible to the community when usual standards of care are not feasible due to statewide catastrophic conditions complicated by insufficient resources. Nevada DPBH utilizes ICS, in compliance with NIMS, for operational management and coordination during disasters and emergency situations.

DPBH is the state coordinating agency for ESF-8: Public Health and Medical Services and provides staff to Nevada SEOC ESF-8. ESF-8 provides the mechanism for coordinated resource requests, resource allocation, and healthcare related information flow in situations where public health and healthcare systems are impacted. ESF-8 relies on DEM for non-healthcare partner support.

The SDMAC is a policy group in the DPBH DOC. SDMAC CSC recommendations flow through the SEOC via ESF-8 to local health authorities, local EOCs, and local healthcare facilities. Figure 3 illustrates the SDMAC recommendation flow during NV CSC Plan activation.

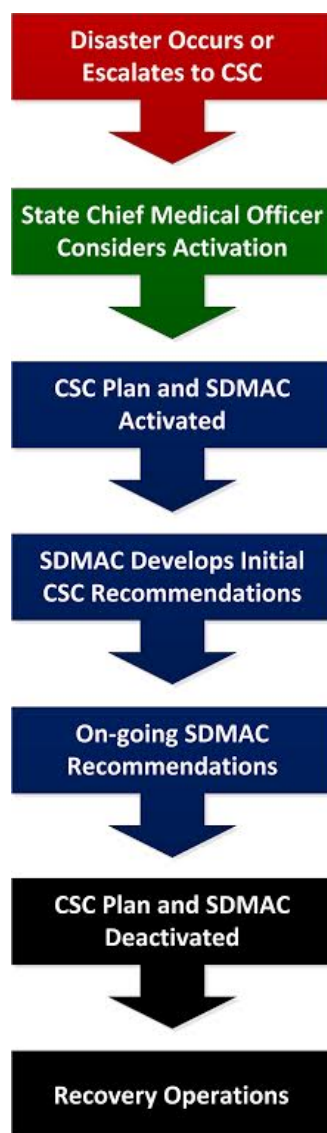
**Figure 3. SDMAC Recommendation Flow:**



### Plan Activation

NV CSC Plan activation may occur suddenly as a result of a no-notice incident such as a catastrophic earthquake, or it may occur gradually during a pervasive response such as an influenza pandemic. In either case, the NV CSC Plan will support the timely activation, ongoing implementation, and deactivation of CSC. Some responses may suddenly escalate to CSC, while others may slowly transition from conventional standards of care, to contingency standards of care, and finally to CSC. Figure 4 provides an overview of CSC Activation and Deactivation.

**Figure 4. NV CSC Plan Activation and Deactivation**



The State Chief Medical Officer, in consultation with the Governor's Office, the Attorney General's Office, local health officials, and DEM, has the authority to activate the NV CSC Plan and convene the SDMAC. Before or concurrently with the activation of the NV CSC Plan, DPBH will consult with DEM to ensure that applicable local and state emergency or disaster declarations are in place or requested. DPBH and DEM will also coordinate with federal partners to ensure that appropriate federal declarations have been requested or instated as appropriate.

Once the NV CSC Plan is officially activated, the State Chief Medical Officer will work with DPBH and DEM staff to identify and notify appropriate personnel to staff the SDMAC. 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. The State Chief Medical Officer or designee will identify the most appropriate individuals for the SDMAC and request their participation.

After the SDMAC participants have been notified, they will confirm their availability to serve on the SDMAC. The SDMAC will meet initially to receive a situation briefing from the State Chief Medical Officer or designee. This meeting can be held in-person, via conference call, or a combination thereof. Following the initial situation briefing, the SDMAC will begin the process of developing recommendations for the practical application and proper implementation of CSC. SDMAC recommendations may include the following:

- Establishing guidelines for the provision of EMS;
- Developing primary, secondary, and tertiary triage guidelines for healthcare facilities;
- Advising on expanding scopes of practice for healthcare professionals, as approved by legal or regulatory authorities;
- Developing priorities for the allocation and utilization of scarce medical resources including space, staff, and supplies; and
- Establishing clear guidelines for healthcare access points, including hospitals, out-of-hospital facilities, and alternate care sites.

The SDMAC will send the recommendations to the SEOC. The SEOC will then send the recommendations to the State Policy Group for the Governor's approval. Once approved, the SEOC will send the recommendations to ESF-8 for dissemination to local public health authorities, EOCs, and healthcare facilities.

At the healthcare facility level, a Clinical Care Committee (CCC) will receive the CSC recommendations and work with healthcare professionals to implement the recommendations. Each CCC will work under its hospital's or healthcare facility's Incident Command (IC). The main functions of the CCC are to interpret the recommendations for its healthcare facility, implement triage standards, and make resource allocation decisions, thereby allowing clinicians to focus on patient care. This facilitates the transition from individual to population-based care.

## **Plan Deactivation**

In most cases, deactivation will start with a move from CSC to contingency standards of care, followed by reinstatement of conventional standards of care. As with plan activation, the NV CSC Plan may be deactivated quickly or may be gradually deactivated over a sustained period of time. The State Chief Medical Officer, based on SDMAC recommendations, and in consultation with the DHHS Director and the Governor's Office, the Attorney General's Office, local health officials, and DEM, has the authority to deactivate the NV CSC Plan. Deactivation will only occur when all healthcare facilities are able to return

to contingency or conventional standards of care. The following steps will help ensure consistent deactivation of CSC statewide:

- The SDMAC will maintain situational awareness of impacted healthcare;
- When a significant number of facilities, as determined by the SDMAC, may be able to return to conventional or contingency standards of care, the SDMAC will inform the State Chief Medical Officer that deactivation is anticipated;
- The State Chief Medical Officer will work with the SEOC State Policy Group to evaluate the situation and obtain consensus for deactivation of CSC;
- Upon approval of the State Chief Medical Officer, the SDMAC will work with the SEOC ESF-8 to prepare messaging for deactivation; and
- The SEOC ESF-8 disseminates deactivation messaging to local and regional public health authorities, emergency operation centers, and healthcare facilities.

## **Clinical Concept of Operations**

This section includes indicators for the various standards of care, strategies for healthcare resource maximization, resources for various types of triage, adaptations for emergency medical services, and considerations for healthcare providers and alternate care sites. Additional topics include palliative and comfort care, access and functional needs considerations, and behavioral health.

## **Indicators for Conventional, Contingency, and Crisis Standards of Care**

The NV CSC Hospital and Healthcare Workgroup identified multiple indicators for recognizing the change in the demand for medical care and limited resources within healthcare facilities. These indicators follow the continuum of care, from conventional standards of care, to contingency standards of care, and finally to crisis standards of care. Tables 2 – 4 below list these indicators according to space, staff, supplies, and emergency operations for each standard of care. These indicators can help healthcare facility staff and emergency response agencies identify increasing levels of patient surge during and following a disaster and coordinate with response partners accordingly.

The conventional indicators listed for space, staff, supplies, and emergency operations are consistent with daily practices within a healthcare facility. For example, the patient care areas (i.e., space) and practices listed in Table 2 are representative of patient surge levels found during seasonal influenza or minor mass casualty incidents. Hospital Incident Command System (HICS) would not typically be activated during conventional surge conditions.

**Table 2: Conventional Indicators for Healthcare**

Category	Indicators
Space	<ul style="list-style-type: none"> <li>Usual patient care space fully utilized</li> </ul>
Staff	<ul style="list-style-type: none"> <li>Usual staff called in and utilized</li> </ul>
Supplies	<ul style="list-style-type: none"> <li>Cached and usual supplies being used</li> </ul>
Emergency Operations	<ul style="list-style-type: none"> <li>HICS not activated</li> </ul>

Contingency indicators for space, staff, supplies, and emergency operations are not consistent with daily practices but describe an operating environment that is functionally equivalent in providing usual patient care. The patient care areas and practices listed in Table 3 may be used during an atypical surge in patients when the demands of the incident exceed facility resources. During a contingency response, local and state resources are able to support the healthcare system.

**Table 3: Contingency Indicators for Healthcare**

Category	Indicators
Space	<ul style="list-style-type: none"> <li>Patient care areas re-purposed (e.g., post anesthesia care unit [PACU] or monitored unit used for intensive care unit [ICU] level care)</li> <li>Facility needs to transfer patients out to maintain standard of care</li> </ul>
Staff	<ul style="list-style-type: none"> <li>Staff extension in place (brief deferrals of non-emergency care, supervising broader groups of patients, etc.) beyond normal operations</li> <li>Absenteeism of staff that moderately impacts healthcare operations</li> </ul>
Supplies	<ul style="list-style-type: none"> <li>Conservation, adaptation, and substitution of supplies with selective re-use of supplies for an individual patient</li> </ul>
Emergency Operations	<ul style="list-style-type: none"> <li>HICS activated</li> <li>Communication with emergency management</li> </ul>

Crisis indicators for space, staff, supplies, and emergency operations are not consistent with provision of usual standards of care, but provide sufficiency of care in the context of a catastrophic disaster (i.e., the best possible care given the circumstances and available resources). The patient care areas and practices listed in Table 4 would be used during a severe (higher than usual mortality or morbidity) influenza pandemic or other catastrophic disaster severely impacting the healthcare system (i.e., multiple healthcare access points within a region or the State).

**Table 4: Crisis Indicators for Healthcare**

Category	Indicators
Space	<ul style="list-style-type: none"><li>• State of facility is severely impacting hospital operations</li><li>• Non-patient care areas (classrooms, etc.) used for patient care</li></ul>
Staff	<ul style="list-style-type: none"><li>• Staff unavailable or unable to adequately care for volume of patients even with extension techniques</li><li>• Absenteeism of staff that severely impacts healthcare operations</li></ul>
Supplies	<ul style="list-style-type: none"><li>• Critical supplies lacking and no resupply is foreseeable for at least 96 hours</li><li>• Possible reallocation or redistribution of life-sustaining resources</li></ul>
Emergency Operations	<ul style="list-style-type: none"><li>• Ongoing coordination between HICS and local emergency management with utilization of external resources.</li></ul>

## Healthcare Resource Maximization

During a CSC response, the use of healthcare resources (i.e., space, staff, and supplies) may have to be limited to do the greatest good for the greatest number of people. The strategies listed in Box 1 below may be used by the SDMAC to develop incident-specific recommendations for healthcare facilities and professionals. These strategies may be progressive, meaning that substitution might be used before adaptation or conservation. Because of this, SDMAC recommendations may initially focus on resource substitution, but eventually involve resource allocation as the response escalates.

### Box 1: Strategies for Maximizing Healthcare Resources

- **SUBSTITUTE:** Use an essentially equivalent facility, professional, drug, or device for one that would usually be available.
- **ADAPT:** Use a facility, professional, drug, or device that is not equivalent, but provides the best possible care.
- **CONSERVE:** Use lower dosages or change practices, e.g., minimize use of oxygen by using air for nebulizers, when possible.
- **REUSE:** Only after appropriate disinfection or sterilization, use single use items again.
- **OPTIMIZE ALLOCATION:** Allocate resources to patients whose prognosis is more likely to result in a positive outcome with limited resources.

Adapted from *The Guidelines for Use of Modified Healthcare Protocols in Acute Care Hospitals During Public Health Emergencies*, September 2013, Kansas Department of Health and Environment

## Triage

During a CSC response, the SDMAC will likely develop recommendations for healthcare professionals performing triage. This may include recommendations for primary, secondary, and tertiary triage. Due to the scope and scale of a CSC response, healthcare providers and facilities that do not normally perform disaster triage may be required to do so. The following descriptions and methodologies will serve as a basis for the development of incident-specific triage recommendations and guidance.

The triage and treatment of pediatric patients will pose substantial challenges during a CSC response, especially with younger, non-verbal children. In addition to challenges associated with space, staff, and supplies for pediatric patients, a number of other issues exist including communication, behavioral health, evacuation and transfer, and family reunification.

### Primary Triage

Primary triage is the first medical evaluation given to a patient. It typically occurs before any medical care is administered. EMS providers routinely use triage methodologies based on the immediate, delayed, minimal, and expectant (IDME) classifications. This system categorizes patients into one of four color codes. Patients in need of immediate lifesaving interventions are color coded as “red.” Patients in serious condition, but whose treatment may be delayed are color coded as “yellow.” Patients with minimal injury or illness are color coded as “green,” and patients that are expectant are color coded as “black.”

During CSC, the SDMAC may recommend that all healthcare facilities and professionals use the same criteria to sort patients into these four categories. These criteria will be incident specific and based on available resources throughout the healthcare system. See Table 5 below for additional information regarding the IDME color coding system.

The IDME Triage Colors listed in Table 5 are also used to prioritize pediatric patients. Instead of the Simple Triage and Rapid Treatment (START) or Sort, Assess, Lifesaving intervention, Treatment/Transport (SALT) systems used for adult patients, the JumpSTART® system is often used for pediatric patients during mass casualty incidents. JumpSTART® addresses the difference between adult and pediatric physiologic parameters. This methodology is intended for the triage of children with acute injuries and may not be appropriate for the triage of children with medical illness (e.g., influenza).



**Table 5: IDME Triage Colors**

Status	Color Code	Characteristics
Immediate	RED	<ul style="list-style-type: none"><li>• Life threatening illness or injury</li><li>• Lifesaving intervention required</li><li>• First to treat</li></ul>
Delayed	YELLOW	<ul style="list-style-type: none"><li>• Serious but not life threatening illness or injury</li><li>• Delaying treatment will not affect outcome</li><li>• Second to treat</li></ul>
Minimal	GREEN	<ul style="list-style-type: none"><li>• Minor illness or injury</li><li>• Walking wounded</li><li>• Third to treat</li></ul>
Expectant	BLACK	<ul style="list-style-type: none"><li>• Not expected to survive</li><li>• Will receive comfort care</li><li>• May be upgraded to red if new resources permit treatment</li></ul>

## Secondary Triage

Secondary triage occurs after primary triage and may occur after initial medical interventions. During CSC, secondary triage may occur in any area where medical treatment is delivered. It involves continuing reassessment of patients by medical personnel throughout the medical intervention process to sort those patients who may most benefit from scarce medical resources. Based on standard practices, hospitals may employ additional triage tools such as the Emergency Severity Index (ESI), which was developed by the ESI Research Team working with the Agency for Healthcare Research and Quality (AHRQ). The ESI is a five-level triage system based on the estimated number of resources that will be used by individual patients. A brief description of the five levels is provided in Table 6. The SDMAC may recommend the use of ESI or other secondary triage methodologies as needed throughout the CSC response. Pediatric secondary triage is typically performed using the ESI levels mentioned above. The ESI system has some specific considerations and parameters for pediatric patients. See the *Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4. Implementation Handbook 2012 Edition* for more information.

**Table 6: Emergency Severity Index (ESI) Levels**

Level	Name	Description
1	Resuscitation	Immediate, life-saving intervention required without delay
2	Emergent	High risk of deterioration, or signs of time-critical problem
3	Urgent	Stable, with multiple types of resources needed to investigate or treat (such as lab tests plus X-ray imaging)
4	Less Urgent	Stable, with only one type of resource anticipated (such as only X-ray, or only sutures)
5	Nonurgent	Stable, with no resources anticipated except oral or topical medications, or prescriptions

Gilboy N, Tanabe T, Travers D, Rosenau AM (2011, November). *Emergency Severity Index (ESI): A Triage Tool for Emergency Department Care, Version 4. Implementation Handbook 2012 Edition*. AHRQ Publication No. 12-0014. Rockville, MD. Agency for Healthcare Research and Quality.

## Tertiary Triage

Tertiary triage is performed in a hospital setting, typically by a triage officer. Many tools are available for tertiary triage; the following tools do not represent an exhaustive list of resources. During CSC, the purpose of tertiary triage is to determine priority for ICU level care. It may not be possible to admit all patients that need intensive care into the ICU. Therefore, recommendations may need to be developed by the SDMAC to support and guide triage officers during the tertiary triage process.

As with adults, pediatric tertiary triage is typically performed in a hospital setting by a triage officer. During CSC, the purpose of pediatric tertiary triage is to determine priority for ICU-level care. It may not be possible to admit all children that need intensive care into the pediatric intensive care unit (PICU) or neonatal intensive care unit (NICU); therefore, tertiary triage recommendations may need to be developed by the SDMAC to support and guide triage officers and intensivists during the pediatric tertiary triage process.

Table 7 lists criteria for ICU-level care for adult and pediatric patients that may be used by triage officers during CSC. The SDMAC may recommend that these criteria or other incident-specific criteria be used or modified to determine priority for adult or pediatric ICU-level care based on available resources.

**Table 7: CSC Criteria for ICU-Level Care for Adult and Pediatric Patients**

<b>Requirement for invasive ventilatory support</b>	<ul style="list-style-type: none"><li>• Refractory hypoxemia (SpO2 &lt; 90% on a non-rebreather mask or an FIO2 &gt; 0.85)</li><li>• Respiratory acidosis (pH &lt; 7.2)</li><li>• Clinical evidence of impending respiratory failure</li><li>• Inability to protect or maintain airway</li></ul>
OR	
<b>Hypotension* with clinical evidence of shock**refractory to volume resuscitation, and requiring vasopressor or inotrope support that cannot be managed in a ward setting</b>	<ul style="list-style-type: none"><li>• *Hypotension = Systolic blood pressure (SBP) &lt; 90 mm Hg for patients age &gt; 10 years old, &lt; 70 + (2 x age in years) for patients ages 1 to 10, &lt; 60 for infants &lt; 1 year old, or relative hypotension</li><li>• **Clinical evidence of shock = altered level of consciousness, decreased urine output, or other evidence of end-stage organ failure</li></ul>

Christian MD, Hawryluck L, Wax RS, et al. (2006). *Development of a triage protocol for critical care during an influenza pandemic*. CMAJ, 175 (11): 1377-1381.

### **Sequential Organ Failure Assessments**

There are a variety of methodologies and tools commonly used to track a patient's progress in the ICU. During a CSC response, some of these tools might be used to make decisions about the reallocation of lifesaving resources. They may also be used during ongoing patient reevaluation and continuing considerations for resource prioritization. These tools include the sequential organ failure assessment (SOFA) score, the Modified SOFA (mSOFA) score, and the Quick SOFA (qSOFA) score.

The SOFA Score requires three laboratory tests, the mSOFA Score requires only one laboratory test, and the qSOFA Score does not require laboratory tests. The use of one or more of these tools during CSC may be based on laboratory capacity and capability at the time of the disaster. It is important to note that qSOFA is mainly used as a sepsis identification tool and should only be used to determine priority for ICU admission when it is not possible to perform laboratory testing for creatinine in urine.

The SOFA Scoring Tool in Table 8 may be used by physicians during CSC to compare patient status and prioritize resources for patients with the greatest chance of a positive outcome. Scores can range from 0 to 24. Low scores indicate a greater likelihood of positive outcome in comparison to patients with high scores (greater than 11). See Table 10 for more information on scoring.

**Table 8: SOFA Scoring Tool**

Organ System	0 Points	1 Point	2 Points	3 Points	4 Points
Respiratory PaO <sub>2</sub> /FiO <sub>2</sub> , mmHg	>400	≤400	≤300	≤200	≤100
Coagulation Platelets x10 <sup>3</sup> /μL	>150	≤150	≤100	≤50	≤20
Liver Bilirubin, mg/dL	<1.2	1.2-1.9	2.0-5.9	6.0-11.9	>12.0
Cardiovascular, hypotension	No hypo- tension	MAP <70 mm Hg	dopamine≤5 or dobutamine any dose	dopamine>5 epinephrine≤0.1 norepinephrine≤0.1	dopamine>15 epinephrine>0.1 norepinephrine>0.1
CNS, Glasgow Coma Score	15	13-14	10-12	6-9	<6
Renal, Creatinine mg/dL urine output mL/d	<1.2	1.2-1.9	2.0-3.4	3.5-4.9 or urine <500 mL/d	>5.0 or urine<200 mL/d

Vincent JL, Moreno R, et al. (1996, July) *The SOFA (Sepsis-related Organ Failure Assessment) score to describe organ dysfunction/failure*. Intensive Care Med, 22 (7): 707-10.

The mSOFA Scoring Tool in Table 9 can be used to compare probable patient outcomes and prioritize scarce healthcare resources during CSC. Because the mSOFA score only requires one laboratory test versus the three laboratory tests required for SOFA, mSOFA may be a more viable option during CSC when laboratory resources are limited.

**Table 9: mSOFA Scoring Tool**

Organ System	0 Points	1 Point	2 Points	3 Points	4 Points
Respiratory SpO <sub>2</sub> /FiO <sub>2</sub>	>400	≤400	≤315	≤235	≤150
Liver	No scleral icterus or jaundice			Scleral icterus or jaundice	
Cardiovascular, hypotension	No hypo- tension	MAP <70 mm Hg	dopamine≤5 or dobutamine any dose	dopamine>5 epinephrine≤0.1 norepinephrine≤0.1	dopamine>15 epinephrine>0.1 norepinephrine>0.1
CNS, Glasgow Coma Score	15	13-14	10-12	6-9	<6
Renal, Creatinine mg/dL urine output mL/d	<1.2	1.2-1.9	2.0-3.4	3.5-4.9 or urine <500 mL/d	>5.0 or urine<200 mL/d

Grissom CK, Brown SM, et al. (2010, December) *A Modified Sequential Organ Failure Assessment Score for Critical Care Triage*. Disaster Med Public Health Prep, 4 (4): 10.1001/dmp.2010.40.

Once the SOFA or mSOFA score is calculated using one of the tools above (Table 8 or 9), the SOFA and mSOFA triage tool for prioritizing ICU-level care (Table 10) can be used. During CSC, the SDMAC may recommend the use of this tool to prioritize admission for ICU-level care or to reallocate scarce medical resources.

**Table 10: SOFA and mSOFA Triage Tool for Prioritizing ICU-Level Care**

SOFA Triage Color Score	Criteria	ICU-Level Care Priority
Red	SOFA score ≤ 7 or single organ failure	Highest priority for ICU
Yellow	SOFA score 8 through 11	Intermediate priority for ICU
Blue	SOFA Score > 11	Lowest priority for ICU with palliative care as needed
Green	No significant organ failure	No need for ICU

Christian MD, Hawryluck L, Wax RS, et al. (2006) *Development of a triage protocol for critical care during an influenza pandemic*. CMAJ, 175 (11): 1377-1381.

The qSOFA Scoring Tool is documented in Table 11 below. A qSOFA score is a bedside prompt that may identify patients with suspected infection who are at greater risk of a poor outcome outside the ICU. It uses three criteria, assigning one point for low blood pressure (SBP≤100 mmHg), high respiratory rate (≥22 breaths per min), or altered mentation (Glasgow coma scale<15)

The score ranges from 0 to 3 points. The presence of 2 or more qSOFA points near the onset of infection is associated with a greater risk of death or prolonged intensive care unit stay. These are outcomes that are more common in infected patients who may be septic than those with uncomplicated infection.

**Table 11: qSOFA Scoring Tool**

Assessment	qSOFA score
Low blood pressure (SBP ≤ 100 mmHg)	1
High respiratory rate (≥ 22 breaths/min)	1
Altered mentation (GCS < 15)	1

Seymour, Liu, Iwashyna, Brunkhorst, Rea, Scherag, Rubenfeld, Kahn, Shankar-Hari, Singer, Deutschman, Escobar, and Angus. (2017) *qSOFA, What is qSOFA*. [www.qsofa.org](http://www.qsofa.org). Retrieved 03-19-17

The Revised Trauma Score (RTS) Calculation Tool is depicted in Table 12 below. During a catastrophic public health emergency involving an overwhelming number of trauma injuries, the RTS may be a more valuable tool than one of the SOFA scoring methodologies. Scores range from 0 to 7.8408. This scoring methodology correlates well with the probability of survival. The scores are heavily weighted towards the Glasgow Coma Score to compensate for head injuries without multi-system injury or major physiological changes.

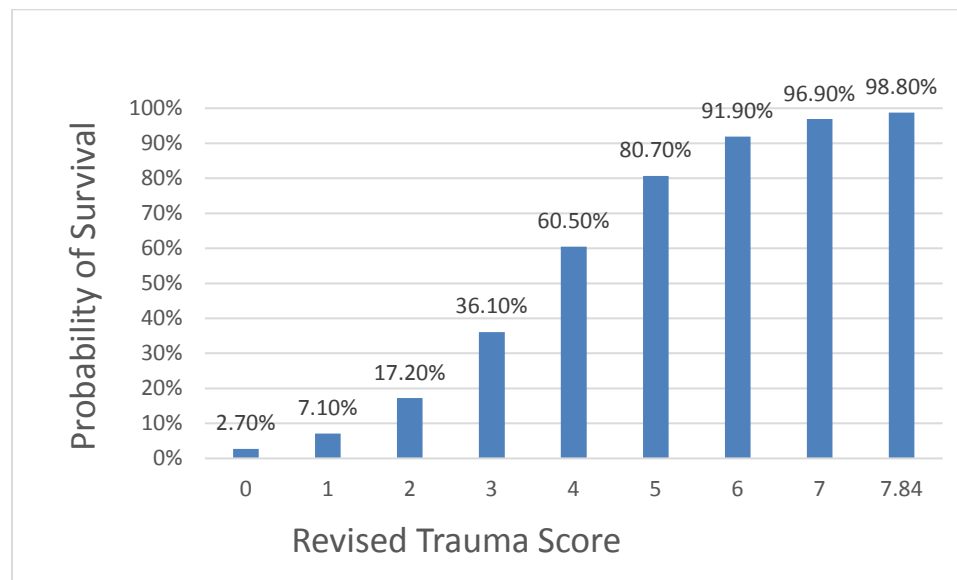
**Table 12: Revised Trauma Score Calculation Tool**

Criteria	Score	Coded Value	Weighting	Adjusted Score
Glasgow Coma Score	3	0	X 0.9368	<hr/>
	4 – 5	1		
	6 – 8	2		
	9 – 12	3		
	13 – 15	4		
Systolic Blood Pressure (SBP)	0	0	X 0.7326	<hr/>
	1 – 49	1		
	50 – 75	2		
	76 – 89	3		
	>89	4		
Respiratory Rate (RR) in breaths per minute (BPR)	0	0	X 0.2908	<hr/>
	1 to 5	1		
	6 to 9	2		
	>29	3		
	10 to 29	4		
Revised Trauma Score (add three adjusted scores)				

Champion HR, Sacco WJ, et al. (May 1989). *A revision of the Trauma Score*. The Journal of Trauma. May 1989; 29 (5): 623–9.

Once a RTS has been calculated for a patient or a group of patients, the score can be compared to the data in Figure 5 below to establish priority for treatment based on available resources. The SDMAC may recommend the RTS be used to triage and prioritize patients during a mass casualty incident.

**Figure 5: Revised Trauma Score and Probability of Survival**



Champion HR, Sacco WJ, et al. (May 1989). *A revision of the Trauma Score*. The Journal of Trauma. May 1989; 29 (5): 623–629.

## Burn Triage

Throughout Nevada, the number of burn beds in hospitals is limited. A disaster with a substantial number of burn patients will require out-of-state transport. Table 13 may be used by the SDMAC or clinicians during a disaster involving high numbers of burn patients to establish priority for treatment. The table groups patients into the following categories:

- **Outpatient:** Survival and good outcome expected, without requiring initial admission;
- **Very high:** Survival and good outcome expected with limited/short-term initial admission and resource allocation (straightforward resuscitation, length of stay (LOS) <14-21 days, 1-2 surgical procedures);
- **High:** Survival and good outcome expected (survival >90%) with aggressive and comprehensive resource allocation, including aggressive fluid resuscitation, admission >14-21 days, multiple surgeries, prolonged rehabilitation;
- **Medium:** Survival 50-90% and/or aggressive care and comprehensive resource allocation required, including aggressive resuscitation, initial admission >14-21 days, multiple surgeries and prolonged rehabilitation;
- **Low:** Survival <50% even with long-term aggressive treatment and resource allocation; and
- **Expectant:** Predicted survival <10% even with unlimited aggressive treatment.



**Table 13: Triage Decision Table for Burn Victims**

Age (yrs)	Burn Size (% of total body surface area)									
	0 – 10%	11 – 20%	21 – 30%	31 – 40%	41 – 50%	51 – 60%	61 – 70%	71 – 80%	81 – 90%	91% +
0-1.9	Very high	Very high	Very high	High	Medium	Medium	Medium	Low	Low	Low/Expectant
2.0-4.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Low	Low
5.0-19.9	Outpatient	Very high	Very high	High	High	High	Medium	Medium	Medium	Low
20.0-29.9	Outpatient	Very high	Very high	High	High	Medium	Medium	Medium	Low	Low
30.0-39.9	Outpatient	Very high	Very high	High	Medium	Medium	Medium	Medium	Low	Low
40.0-49.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Medium	Low	Low	Low
50.0-59.9	Outpatient	Very high	Very high	Medium	Medium	Medium	Low	Low	Low/Expectant	Low/Expectant
60.0-69.9	Very High	Very high	Medium	Medium	Low	Low	Low	Low/Expectant	Low/Expectant	Low/Expectant
70.0 +	Very High	Medium	Medium	Low	Low	Low/Expectant	Expectant	Expectant	Expectant	Expectant

Palmieri TL et al., Triage/Resource Table for a Burn Disaster, Developed from the American Burn Association National Burn Repository

## Healthcare Sector Adaptations and Considerations

The following sections list adaptations (tactics) for EMS as well as considerations for various components of the healthcare system including hospitals, outpatient providers, and alternate care sites. The SDMAC may use these adaptations and considerations in developing recommendations for different sectors of the healthcare system during a CSC response.

### Emergency Medical Services (EMS)

EMS agencies are the primary providers of out-of-hospital acute care and patient transport. EMS is critical in managing medical surge, especially during CSC response operations. EMS agencies are frequently the initial medical care providers for patients, assessing the need for emergency care, evaluating injury and/or illness status, providing the first medically supervised care for victims of natural or human-caused emergency incidents, and transporting patients to appropriate medical facilities. EMS agencies may provide transport to alternative locations such as mental health facilities and alcohol and drug treatment facilities. EMS providers may be the primary source of healthcare services during both emergency and non-emergency situations, especially in rural areas.

During an emergency, EMS providers are the critical link between the public safety response at an incident scene and medical care at a healthcare facility. EMS provides crucial continuity of care from initial patient assessment and primary triage following an emergency incident through transport to a medical facility for definitive care. EMS providers also provide a valuable reservoir of knowledge and expertise during medical surge and CSC implementation.

For emergencies occurring over a widespread geographical area or over an extended period of time, such as public health emergencies involving pandemics, disease outbreaks or intentional releases of biological pathogens, EMS providers may be the initial medical care contact for much of the public. Because of their front-line role during these types of emergencies, EMS providers must implement infection control and decontamination procedures during incident-specific response activities to ensure their continued capability to provide initial assessment, treatment, and transport of large numbers of patients to hospital or other healthcare access points.

In Nevada, EMS resources are comprised of a complex system of public, private, and volunteer EMS providers, regulated by state or regional public health authorities. EMS providers fall into the following classifications, based on national standards and specific training:

- Emergency Medical Dispatcher (EMD);
- Emergency Medical Responder (EMR);
- Emergency Medical Technician (EMT);
- Advanced Emergency Medical Technician (AEMT);
- Emergency Medical Technician Paramedic (EMT-P);
- Critical Care Emergency Medical Technician - Paramedic (CCEMT-P); and
- Emergency Medical Services Registered Nurse (EMS RN).

EMS providers in urban areas are more likely to have access to greater numbers of qualified staff in various classifications. Rural EMS providers may only have access to staff in limited classification categories. For example, a rural area EMS provider may have EMR, EMT, and AEMT staff and fewer personnel overall, limiting response capabilities even under conventional circumstances. As a result, rural areas are more vulnerable to staffing shortages and have less flexibility in staffing unit configurations.

Rural areas face additional challenges, including fewer mutual aid resources, coverage of large geographical regions, inconsistent communications coverage, medical facility availability, extreme weather conditions, and long response times. During emergencies, some rural EMS agencies may be supported by private mining EMS resources, including EMR, EMT, and AEMT staff, as well as rescue and hazardous materials teams.

EMS can be divided into four main functions: dispatch, response, patient assessment and treatment, and transportation. Dispatch centers are the public safety answering points (PSAPs) that dispatch EMS and other public safety agencies. Some dispatch centers may have access to EMDs who can collect and assess caller information to determine response priorities, dispatch appropriate EMS units, and provide pre-arrival instructions to callers. Dispatch is localized in many rural areas. For example, 911 calls may be answered by the Sheriff's Office dispatch center and there may not be access to EMD resources.

Response involves the types and configurations of EMS units responding to an emergency scene. Ambulance units are classified on their life support levels based on defined numbers and classifications of personnel and equipment. For example, units may be classified as Basic Life Support (BLS), Intermediate Life Support (ILS), Advanced Life Support (ALS), and Critical Care Transport (CCT).

Patient assessment and treatment involves the initial on-scene assessment and triage of patients according to established guidelines. During CSC and upon approval of their medical directors, EMS personnel may need to change their usual triage procedures to disaster protocols that are focused on saving the greatest number of individuals. Disaster triage systems may include START, SALT, or other protocols that may be recommended by the SDMAC.

Transportation involves the movement of patients using ground or air ambulances. During normal operations with conventional levels of care, patients are typically transported to hospitals or between hospitals. CSC operations may require changes to normal transportation procedures, such as batch transports, self-transport by families of non-critical patients, and transport to non-hospital facilities or alternate care sites.

Statewide coordination of EMS services is critical in implementing CSC guidelines. During CSC activation, the SDMAC will consider and recommend strategies and tactics to provide the most effective EMS response for incident-specific situations. Tables 14 through 17 list possible tactics identified by the EMS Working Group for dispatch centers and EMS providers to use in conventional, contingency, and crisis care circumstances. Many of these adaptations will require approval from EMS agency medical directors prior to implementation.

**Table 14: Dispatch Tactics**

	Conventional	Contingency	Crisis
Dispatch	<ul style="list-style-type: none"> <li>Consider initial auto-answer during times of high call volume for medical emergencies</li> <li>Utilize other regional EMD regulated dispatch centers to assist with increased call load</li> </ul>	<ul style="list-style-type: none"> <li>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 PSAPs)</li> <li>Utilize non-medically trained dispatch personnel to handle incoming non-emergent calls</li> <li>Decline response to, and refer low acuity, non-emergent calls to nurse triage line for referral to appropriate primary/secondary medical care</li> </ul>	<ul style="list-style-type: none"> <li>Decline response to calls without evident potential threat to life (also requires medically trained dispatcher and dispatch protocol changes at the regulatory level)</li> <li>Place additional staff in Emergency Back-Up Communications Center (EBUCC) and regional EOC (if available)</li> <li>Decline response to unknown problem/unknown injury incidents until known illness/injury can be confirmed</li> </ul>

**Table 15: Response Tactics**

	Conventional	Contingency	Crisis
Response	<ul style="list-style-type: none"> <li>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)</li> </ul>	<ul style="list-style-type: none"> <li>Modify resource assignments to a greater extent</li> <li>Change EMS assignments to closest available unit rather than ALS/BLS</li> <li>Consider staffing configuration changes (e.g., from two paramedics to one paramedic plus one EMT)</li> <li>Consider requests for disaster assistance, including mutual aid assistance from surrounding areas</li> <li>Request EMS units from emergency management</li> <li>Consider use of National Guard ambulances or other assets</li> <li>Leave low acuity calls pending, to be handled by BLS and ILS capable units, when available. Note: Not every EMS system has ALS units</li> <li>Initiate a single provider, quick response vehicle (non-ambulance)</li> <li>Use non-emergency medical transport for low acuity responses</li> <li>Coordinate with hospital/ healthcare facility to achieve faster turnaround (off load) times</li> <li>Establish receiving centers (e.g., alternate care sites, casualty collection points, triage centers) for off-loading patients quickly</li> </ul>	<ul style="list-style-type: none"> <li>Utilize scheduled BLS providers to answer emergency calls</li> <li>Change staffing to one medical provider, one driver</li> <li>Further modify resource assignments as possible</li> </ul>

**Table 16: Patient Assessment and Treatment Tactics**

	Conventional	Contingency	Crisis
Patient Assessment and Treatment	<ul style="list-style-type: none"> <li>Patients with very minor injuries may self-transport</li> <li>Treat as appropriate and approved by the medical director when resources are available</li> </ul>	<ul style="list-style-type: none"> <li>Encourage patients with minor injury/illness to self-transport to a designated facility</li> <li>Treat as appropriate and approved by the medical director when resources are available</li> </ul>	<ul style="list-style-type: none"> <li>Assess patients and decline to transport those without significant injury/illness (according to guidance from EMS medical director)</li> <li>Provide alternative resources/destination/transportation to definitive care dependent on the crisis occurring</li> <li>Treat and triage as appropriate given the circumstances and approved by the medical director as recommended by the State Disaster Medical Advisory Committee</li> </ul>

**Table 17: Patient Transportation Tactics**

	Conventional	Contingency	Crisis
Patient Transportation	<ul style="list-style-type: none"> <li>• Transport patients to the appropriate designated facility (rather than the facility of the patient's choice)</li> </ul>	<ul style="list-style-type: none"> <li>• Allow transport to urgent care or clinics for minor injury and illness</li> <li>• Consider batch transportation resources, such as school buses and public transit buses</li> <li>• Consider use of air resources for critical patients (rotor and fixed wing)</li> </ul>	<ul style="list-style-type: none"> <li>• Continue to assess patients and decline to transport those without significant injury/illness (according to guidance from EMS medical director)</li> <li>• Employ batch transports, as needed</li> <li>• Request all available air resources (i.e., rotor, fixed wing, National Guard, Navy) for critical patients</li> <li>• Transport will be based on triage guidelines and bed availability, as established based on the crisis</li> <li>• Allow the combining of resources from different agencies (e.g., staff from one agency paired with equipment from another agency)</li> </ul>

## Hospitals

Hospitals and acute care facilities will be at the front line of the healthcare response during a CSC. These facilities will be immediately impacted with injured or ill patients, family members, and the worried well. In addition to a major surge in patient volume from EMS, facilities will be inundated with walk-in patients. To keep up with the demand for healthcare, hospitals and acute care facilities must implement CSC strategies, perform initial and ongoing triage of patients, and prioritize hospital resources based on SDMAC guidance and clinical assessments.

Intensive Care Unit (ICU) suites are licensed and regulated through the Nevada Bureau of Healthcare Quality and Compliance (HCQC). Numbers of ICU suites reported come directly from the ICU suites licensed to healthcare facilities in each zone. Operating Rooms (ORs) and ventilators are not licensed or regulated through any state agency. Therefore, numbers of ORs and ventilators are based upon all potential resources available in each zone; numbers of ORs and ventilators can change based upon equipment and staffing availability. See Appendix E for a map of ICUs and ventilators by region.

SDMAC Considerations for <b>Hospitals and Acute  Care Facilities</b>	<ol style="list-style-type: none"> <li>1) Maintain situational awareness of hospitals and acute care facilities to assess demand for healthcare and resource availability.</li> <li>2) Evaluate and recommend primary, secondary, and tertiary triage strategies for hospital implementation.</li> <li>3) Consider recommending the adaptation of space, staff, and supplies.</li> <li>4) Make recommendations for therapeutic treatments based on incident-specific requirements.</li> </ol>
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In addition to the considerations above, a variety of healthcare facility resource strategies exist. One such resource is the Minnesota *Patient Care Strategies for Scarce Resource Situations* (2013). It lists numerous strategies for dealing with shortages in space, supplies, and staff. The document provides core clinical strategies for oxygen, staffing, nutritional support, medication administration, hemodynamic support and IV fluids, mechanical ventilation and external oxygenation, and blood products. The resource reference and triage cards address unique system response issues required by specific patient groups (renal replacement therapy, burn therapy, pediatrics, and palliative care). It may be accessed at: <http://www.health.state.mn.us/oep/healthcare/crisis/standards.pdf>.

### Out-of-Hospital Care Providers

All types of healthcare facilities and providers may be impacted during a CSC response. As hospitals become inundated with patients, people will look for care at other healthcare settings. Out-of-hospital care providers may play a key role during CSC operations by expanding hours of operations and repurposing infrastructure and equipment. As a part of the overall CSC response, the SDMAC will provide recommendations to out-of-hospital care providers to coordinate care across the state in non-hospital settings. Out-of-hospital care providers include the following types of healthcare:

- Outpatient providers;
- Clinics;
- Surgical centers;
- Long-term care facilities;
- Group homes and congregate environments;
- Home care and durable medical equipment vendors; and
- Family-based care.

### Outpatient Providers

This category includes physicians and advanced practice nurses in solo or group practice settings. Many of these providers do not normally treat patients in need of emergency or urgent care, but may be called upon to contribute to a CSC response in the following ways:

- **Medical skills** may be used in their usual practice environment or in alternate care settings (e.g., Medical Reserve Corps (MRC), answering patient hotlines, or even in their own neighborhoods after a disaster that isolates people in their own communities); and
- **Infrastructure and practice environments** may be adjusted to meet the demands of an overwhelming response. For example, hours of operation may be expanded or practice environments may be repurposed (e.g., physicians who do not normally see patients with infectious diseases could be called upon to do so).

SDMAC Considerations for <b>Outpatient Providers</b>	<ol style="list-style-type: none"> <li>1) Maintain situational awareness with all types of providers to assess demand for healthcare and resource availability.</li> <li>2) Develop messaging on referring and routing higher acuity patients to available healthcare access points.</li> <li>3) Develop incident-specific recommendations for various outpatient provider types.</li> </ol>
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## Clinics

This category comprises a wide variety of practice settings including urgent care centers, federally qualified health clinics (FQHCs), multi-specialty clinics, and clinics located in retail stores and pharmacies. Per IOM guidance, this category also includes nontraditional care such as veterinarians and dentists, who may be called upon to support surge operations under extreme circumstances. Most of these practices and associated infrastructure are privately owned, although there are some publicly operated clinics. Most hospital-affiliated clinics are already designated as alternate care sites for their parent hospitals.

SDMAC Considerations for <b>Clinics</b>	<ol style="list-style-type: none"> <li>1) Maintain situational awareness with all types of clinics through medial boards, associations, local health authorities, and healthcare coalition partners.</li> <li>2) Develop CSC recommendations for clinics to expand hours of operation and repurpose space, staff, and supplies as appropriate.</li> </ol>
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## Surgical and Procedure Centers

These facilities may be repurposed to provide acute care, non-ambulatory hospital overflow care, or elective surgeries not possible at hospitals due to the scale of the disaster (e.g., during pandemic influenza). The repurposing of these facilities will depend on the demands of the incident, the specifics of the facility, and the needs of the community. As with clinics, many of these facilities are privately owned and some are affiliated with hospitals and already serve as alternate care sites in hospital disaster plans. Therefore, coordination with these facilities will require a multifaceted approach.

SDMAC Considerations for <b>Surgical and Procedure Centers</b>	<ol style="list-style-type: none"> <li>1) Maintain situational awareness with all types of surgery and procedure centers through medical boards and associations and healthcare coalition partners.</li> <li>2) Develop CSC recommendations for surgical and procedure centers to expand hours of operation and repurpose space, staff, and supplies as appropriate.</li> <li>3) Coordinate with hospitals to determine types of cases that can be sent to specialty surgical centers.</li> </ol>
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### Long-Term Care Facilities

This category encompasses many types of facilities providing a wide range of care. Most long-term care facilities have limited surge capacity to accommodate hospital discharges, and many of these facilities already have agreements with hospitals to take these patients. However, these facilities should not be overlooked as a resource during a CSC response. Some hospital-affiliated long-term care facilities (e.g., in rural areas) may not operate at full capacity and may serve as a resource for hospital overflow. Additionally, long-term care facilities may be disproportionately impacted by some disasters (e.g., pandemic influenza) and may be a key part of the public health response.

SDMAC Considerations for <b>Long-Term Care Facilities</b>	<ol style="list-style-type: none"> <li>1) Maintain situational awareness with all types of long-term care facilities through medical boards and associations, and healthcare coalition partners.</li> <li>2) Develop CSC recommendations for long-term care facilities.</li> <li>3) Consult with SEOC and medical licensing for Part 1135 waivers to be in place allowing for waiver of Medicare regulations, which will facilitate the admission of new patients not requiring long-term care.</li> </ol>
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### Group Homes and Congregate Environments

This type of facility (e.g., group home, school, university, business) may need to provide sheltering or isolation for residents, students, or staff and may even need to conduct referral and routing of patients during a CSC response. Organizations with on-site medical care can serve as dispensing or vaccination points (i.e., closed points of dispensing [PODs]) in conjunction with local and state mass prophylaxis/vaccination efforts.

SDMAC Considerations for <b>Group Homes and Congregate Environments</b>	<ol style="list-style-type: none"> <li>1) Establish and maintain situational awareness with various types of group homes and congregate environments in coordination with medical licensing and other partners.</li> <li>2) Develop CSC recommendations for group homes and congregate environments.</li> </ol>
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## Home Care and Durable Medical Equipment Vendors

Home care providers and durable medical equipment vendors may play a major role in a CSC response, especially in an infectious disease outbreak where isolation is a key community mitigation strategy. Device-dependent individuals should have a care plan in place with their care providers and equipment vendors to ensure continuity of care during a power outage or other emergency. This is especially important during a CSC response because these individuals will likely seek care at hospital emergency departments, which will already be over capacity.

SDMAC Considerations for <b>Home Care and Durable Medical Equipment Vendors</b>	<ol style="list-style-type: none"><li>1) Establish and maintain situational awareness with home care providers and durable medical equipment vendors</li><li>2) Develop CSC recommendations for home care providers and durable medical equipment vendors.</li><li>3) Consider consolidation to single point of distribution for durable medical equipment.</li></ol>
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## Family-Based Care

Home care provided by family members can play a key role in alleviating overcrowding at hospitals and other healthcare access points. Throughout Nevada, family members, domestic partners, friends, and cohabitants provide a variety of care to individuals with behavioral health conditions, chronic diseases, end-of-life conditions, developmental disabilities, and traumatic injuries. During a CSC response, these non-clinical care-givers can play a substantial role in preventing medical surge by helping limit unnecessary visits to healthcare providers and ensuring that at-risk individuals receive the most appropriate care available. To effectively reach these care-givers, public messaging must be developed and disseminated to inform the public of available healthcare resources for homebound people and other at-risk groups. Family-based care-givers should be prepared for additional responsibilities during a catastrophic public health emergency.

SDMAC Considerations for <b>Family-Based Care</b>	<ol style="list-style-type: none"><li>1) Develop public messaging for family members and friends providing home-based care.</li><li>2) Develop considerations for commonly used medications points of dispensing (PODs)</li><li>3) Increase coordination with local pharmacies to promote effective distribution of commonly used medications.</li></ol>
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## Alternate Care Sites

When a disaster overwhelms both hospitals and out-of-hospital providers, it may be necessary to activate alternate care sites to help mitigate the demand for medical services. Alternate care sites are not a part of the regular healthcare system, but are established and activated (i.e., made operational) during a disaster to help alleviate overcrowding at traditional healthcare access points. Each type of alternate care site, such as ambulatory, non-ambulatory, shelter-based, emergency care, surgical, and intensive care, provides for the needs of specific patient groups. Alternate care sites require a certain amount of time to set up, and different types may be more appropriate in certain types of disasters (e.g., an evolving epidemic versus a no-notice mass casualty incident). The following categories of alternate care sites are addressed in the sections below:

- Electronic alternate care systems;
- Ambulatory care facilities;
- Shelter-based care;
- Non-ambulatory care/hospital overflow;
- Emergency care replacement/overflow; and
- Surgical/intensive care or inpatient replacement/overflow.

### Electronic Alternate Care Systems

Electronic systems (e.g., telephone, call centers, web-based) can be used to communicate basic medical information and direct the general public to the most appropriate type of care. During infectious disease outbreaks, telephone and web-based systems can be used to assess patients and even prescribe medications while limiting in-person contact. Electronic alternate care also includes telemedicine, which can be an important asset during a mass casualty incident or other response requiring remote diagnosis or medical consultations (e.g., rash identification during an infectious disease response). Electronic systems may also help assess patient behavioral and emotional health and provide information to help alleviate anxiety for people who are asymptomatic.

SDMAC Considerations for <b>Electronic Alternate Care Systems</b>	<ol style="list-style-type: none"><li>1) Coordinate with SEOC staff and public information personnel to identify existing and alternate electronic care providers and resources across the state.</li><li>2) Establish and maintain situational awareness with electronic alternate care resources.</li><li>3) Develop recommendations for electronic care to promote consistent electronic triage, messaging, and prescribing across the state.</li></ol>
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## Ambulatory Care Facilities

These facilities (e.g., casualty collection points or influenza centers) are intended to serve the minimally ill or injured who cannot be accommodated during a catastrophic public health emergency by the pre-existing healthcare infrastructure. The use of these facilities will vary based on the type of response and the availability of space, staff, and supplies required to operate them.

Healthcare facilities can coordinate with licensing authorities to temporarily activate and operate ambulatory care facilities on hospital properties. Public sites may also be utilized if the capacity of the healthcare system is severely impacted or if selected populations are disproportionately affected. Public sites may be activated in nontraditional locations (e.g., schools, universities, convention center facilities, dental clinics, veterinary clinics). Ambulatory care facilities, whether located on private or public property, must coordinate with licensing authorities to obtain appropriate permissions and waivers for medical service operations.

SDMAC Considerations for <b>Ambulatory Care Facilities</b>	<ol style="list-style-type: none"><li>1) Establish and maintain situational awareness with healthcare entities considering activation of ambulatory care facilities.</li><li>2) Develop recommendations for the activation, operation, and demobilization of temporary ambulatory care facilities.</li></ol>
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## Shelter-Based Care

Evacuations and mass sheltering may be required during a CSC response. The healthcare needs of evacuees may be extensive and some may require shelter-based care. Current recommendations are to avoid the use of special shelters for those with medical, physical, and functional needs. These recommendations are based on the potential for discrimination because of failure to prepare for individuals with access and functional needs in general population shelters. As a result, shelter operators must be prepared for a wide variety of evacuees with diverse needs including oxygen dependent patients, people with behavioral healthcare needs, and people requiring dialysis. Shelter operators must work closely with jurisdictional public health authorities to request medical resources needed to provide appropriate care at shelter facilities.

SDMAC Considerations for <b>Shelter-Based Care</b>	<ol style="list-style-type: none"><li>1) Establish and maintain situational awareness with shelter operations through local public health, local health authorities, and healthcare coalition partners.</li><li>2) Work with ESF 6 and ESF 8 agencies to identify medical capabilities and equipment needs at shelter locations.</li><li>3) Coordinate with Nevada Board of Pharmacy to obtain waiver for managing medications for shelter populations.</li><li>4) Develop and implement statewide medical recommendations for shelters.</li></ol>
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## Non-ambulatory Care/Hospital Overflow

These facilities are typically set up in large, flat-space areas (i.e. convention centers, gymnasiums, and sporting venues) and provide overflow for patients that are non-ambulatory but have less intensive healthcare needs than hospitalized patients. One type of non-ambulatory care/hospital overflow is a Federal Medical Station. These 250-bed units are designed to provide basic non-ambulatory care to hospital overflow patients with minimal medical needs or to shelter patients with more advanced outpatient needs. Federal Medical Stations may be requested by the SEOC during a CSC response. It is important to note that during a multi-state catastrophic public health emergency, the availability of Federal Medical Stations is likely to be limited. Set up for these facilities can require several days.

SDMAC Considerations for <b>Non-Ambulatory Care/Hospital Overflow</b>	<ol style="list-style-type: none"><li>1) Coordinate with local health authorities, healthcare coalitions, and emergency management to assess need for non-ambulatory care.</li><li>2) Coordinate with DPBH DOC to determine optimal locations for Federal Medical Stations based on location of demand for medical services and location of disaster.</li><li>3) Develop statewide recommendations for non-ambulatory care/hospital overflow.</li></ol>
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## Emergency Care Replacement/Overflow

Usually provided in a specialty trailer or temporary specialty structure, emergency care replacement or overflow sites provide replacement capacity for damaged emergency departments. They also can provide temporary increased capacity for a single facility or area during a major disaster, particularly one involving healthcare or transportation infrastructure damage that limits access to emergency care. The level of care provided often can be equal to that provided in a hospital environment.

SDMAC Considerations for <b>Emergency Care Replacement/ Overflow</b>	<ol style="list-style-type: none"><li>1) Identify availability of emergency care replacement/overflow resources in the state.</li><li>2) Conduct assessment to determine optimal locations for emergency care replacement overflow based on location of disaster and demand for healthcare services.</li></ol>
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## Surgical/Intensive Care or Inpatient Replacement/Overflow

As with the emergency care replacement/overflow, these temporary facilities are typically housed in a trailer or specialty structure and provide services in areas where healthcare facilities are damaged or otherwise inadequate. These facilities may have significant infrastructure and specialty staffing

requirements. Federal assets such as Expeditionary Medical Facilities (EMF) may fall into this category of alternate care sites. The deployment of an EMF can be requested through the Region IX Emergency Coordinator contacted through the ESF 8 Desk at the SEOC.

SDMAC Considerations for <b>Surgical/Intensive  Care or Inpatient  Replacement/  Overflow</b>	<ol style="list-style-type: none"> <li>1) Identify availability of these resources in the state.</li> <li>2) Conduct assessment to determine optimal locations for these facilities based on location of disaster and demand for healthcare services.</li> </ol>
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The healthcare and public health sectors must work together during a CSC response to effectively manage resources and maximize care for people that need it most. To accomplish this, each sector must contribute to the response through collaboration and coordination. The public sector cannot simply dictate that private healthcare organizations expand or modify their operations, and private healthcare cannot assume that public health can provide all the resources needed to establish effective alternate care systems. Table 18 below outlines some of the functions that healthcare and public health can undertake to develop an integrated alternate care system.

**Table 18: Healthcare and Public Health Sector Functions During a CSC Response**

Function	Healthcare Sector	Public Health Sector
Overall	Providers, private infrastructure, medical materiel support, medical care and decision making, clinical policy development/technical expertise	Organizational support, situational awareness, liaison to emergency management and state/local government (including legal authorities and regulatory, policy, and logistical support [e.g., sites for care])
Electronic care: telephone triage, expanded patient hotlines, web-based assessment and prescribing, tele-medicine	Augment and unify telephone advice and prescribing systems; update and modify consistent advice (i.e., single source for information with many outlets)	Set up public lines/resources when demand exceeds available augmented resources; provide mechanisms for backup to 911 and other call centers; facilitate phone script coordination; address prescribing and practice regulatory issues
Ambulatory alternate care sites (e.g., flu centers or minor trauma care sites)	Augment existing clinics, and open new clinics in other spaces; assist in staffing public health clinics	Set up clinics in high incidence/impact areas where healthcare resources are inadequate; provide site and logistics support (and potential staffing from MRC and other public sources); address prescribing and practice regulatory issues
Non-ambulatory alternate care sites (hospital overflow; may include medical shelter for non-ambulatory patients)	Provide policy, medical direction, staffing, and special medical materiel support to site	Provide site and logistical support in conjunction with emergency management; legal/regulatory protections
Population-based interventions	Provide vaccinations and prophylaxis in conjunction with public health policy and directives (may include closed points of dispensing)	Coordinate overall provision of interventions, including public sites and their staffing

## Palliative Care and Comfort Care

The delivery of consistent, compassionate, and equitable palliative and comfort care across Nevada is a critical component of this plan. This applies to casualties of the CSC disaster, as well as patients facing end-of-life decisions from other illnesses and injuries. The delivery of palliative and comfort care will be modified based on incident specific circumstances and severity.

Palliative care focuses on providing patients with relief of pain and symptoms following a serious diagnosis. Palliative care may be offered to patients who may benefit from available curative resources at any stage of an illness or medical condition. Palliative care can be provided along with curative treatment and does not depend on prognosis. Palliative care may be administered at a hospital, out-of-

hospital facility, or at home. Palliative care provides available medical, social, emotional and practical support.

Comfort care is focused on patients who will not benefit from available curative resources. Comfort care helps to prevent and relieve suffering for persons who are dying, while still respecting their wishes. Comfort care can include as possible relieving physical discomfort, helping manage mental and emotional distress, addressing spiritual needs, and provision of practical tasks.

During CSC, lifesaving care for those in triage categories who will likely benefit from treatment must be balanced with provision of comfort care for those who are not likely to benefit from treatment. At a minimum, comfort care for persons unlikely to benefit from treatment will include available pain and severe symptom relief and other available support as people and their families face end-of-life decisions.

The SDMAC may develop recommendations for healthcare facilities and personnel, community responders, and other caregivers based on the scope and type of response. This includes EMS personnel who may initially triage a patient at a higher priority than expectant, followed by the patient being re-triaged as expectant, based on their condition deteriorating or depletion of resources.

The intent of palliative and comfort care is to improve the quality of life for patients and their families who face life-threatening illnesses and injury by preventing and relieving suffering, by means of early identification and treatment of pain and other, physical, psychosocial, and spiritual problems (World Health Organization).

Palliative and comfort care may include:

- Provide relief from pain and other distressing symptoms;
- Affirm life and regard dying as a normal process;
- Intend neither to hasten nor postpone death;
- Integrate the psychological and spiritual aspects of patient care;
- Offer a support system to help patients live as actively as possible until death;
- Offer a support system to help the family cope during the patient's illness and the family's bereavement;
- When possible, uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- Enhance the quality of life and may positively influence the course of the illness or injury;
- Palliative and comfort care for children represent a special, albeit closely related field to adult comfort care. In addition to the above considerations, the following apply to pediatric patients:
  - Palliative and comfort care for children are the active total care of the child's body, mind and spirit, and also involves giving support to the family;
  - Palliative and comfort care begin when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease;

- Healthcare professionals should evaluate and alleviate a child’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; and
- Palliative and comfort care can be provided in acute care facilities, out-of-hospital care settings, alternate care sites, or in children’s homes.

SDMAC recommendations for delivering and continuing palliative and comfort care in a consistent and equitable manner across the state will take into account the number of people needing comfort care and the number of disaster casualties needing curative therapies or treatments. The SDMAC may need to give consideration to available baseline pre-disaster numbers of persons receiving comfort care or lifesaving treatments prior to the disaster and available inventory assessments of comfort care medications in developing recommendations for allocation of scarce resources for palliative and comfort care patients. Because disaster situations may be dynamic, the SDMAC may need to reassess and reissue recommendations based on changing situational information.

### **Palliative and Comfort Care in Hospitals and Acute Care Facilities**

Hospitals and acute care facilities may optimize their resources by transferring patients requiring palliative or comfort care to out-of-hospital facilities. Many types of healthcare facilities may be able to assist with a surge of palliative or comfort care patients, including out-of-hospital settings such as skilled nursing facilities, clinics, and alternate care sites. Hospice service providers may be able to provide comfort kits for home-based comfort care, as well as comfort care information and support for families of patients.

During a CSC response, local EOCs will coordinate with triage officers, and emergency management staff at healthcare facilities to facilitate transfer of palliative and comfort care patients from acute care to other healthcare facilities or home healthcare settings. This will require coordination with regional or state health authorities and the SEOC.

### **Palliative and Comfort Care at Out-of-Hospital Facilities**

Depending on the type and scope of the response, the SDMAC may develop recommendations for comfort care in non-hospital settings that do not normally provide care to acute medical surge patients. Long-term care facilities, which are very familiar with providing palliative and comfort care, may be able to expand operations and admit patients requiring comfort care from other healthcare facilities.

To facilitate this, local EOCs and the SEOC will coordinate with healthcare authorities and partners based on assessments of available beds and the ability to expand operations at long-term care and other healthcare facilities. Assessments should include information as available on existing, licensed in-patient beds, as well as non-licensed emergency beds at alternate care sites.



## **Palliative and Comfort Care at Alternate Care Sites and Systems**

The SDMAC may consider activated alternate care sites, such as casualty collection points, shelter-based care, and federal medical stations, in recommendations involving palliative and comfort care support strategies. These resources, if available, will require additional coordination with local EOCs and regional health authorities and with the SEOC for coordination with federal agencies.

### **Just-in-Time Training for Palliative and Comfort Care**

Based on available resources, the SDMAC may consider the development of just-in-time training recommendations for palliative and comfort care. These recommendations may address strategies to maximize medical resources, including substitution, adaptation, conservation, reuse, and allocation of key resources. Under extreme conditions, these training recommendations may address the use within facilities of non-medical personnel in the delivery of comfort care, including helping a patient take their own medications. Hospice agencies may provide a resource in providing comfort care advice and instruction to family members of patients that have been discharged to home healthcare settings.

### **Psychosocial Support for Palliative and Comfort Care**

Palliative and comfort care also include components of social, emotional, and spiritual care in addition to medical intervention, as described in the sections above. During a CSC response with limited clinical resources, psychosocial support may be the only available source of comfort. As with other types of resources, there may be few available behavioral health professionals, social workers, spiritual/religious advisors, or other personnel to provide psychosocial support in a disaster. Although family members and friends often provide psychosocial support to patients receiving palliative or comfort care, they may be also impacted by disasters or unable to be present with disaster victims due to incident specific circumstances. The SDMAC may develop additional recommendations to address the psychosocial needs of palliative and comfort care patients to help alleviate symptoms of distress and isolation.

<b>SDMAC Considerations for Palliative and Comfort Care</b>	<ol style="list-style-type: none"><li>1. Transfer of expectant patients to out-of-hospital facilities or home healthcare settings.</li><li>2. Available inventories, caches, and stockpiles of palliative and comfort care medications and allocation of scarce resources to palliative and comfort care patients.</li><li>3. Leverage of medical support at out-of-hospital healthcare facilities, such as long-term care facilities, surgical centers, and clinics.</li><li>4. Utilization of alternate care sites such as shelters and federal medical stations.</li><li>5. Development of recommendations for just-in-time training for medical and non-medical personnel at healthcare access points.</li><li>6. Provision of behavioral health, spiritual, and psychosocial support for casualties and providers.</li><li>7. Palliative and comfort care recommendations for hospital triage officers and/or emergency responders.</li></ol>
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## Access and Functional Needs Considerations

During a CSC response, many individuals with access and functional needs (AFN) will be impacted by the disaster and may require additional support. Per the CDC document *Planning for an Emergency: Strategies for Identifying and Engaging At-Risk Groups* (2015), an AFN population is defined as a population that might require physical, program, or effective communication access. They might have additional needs before, during, or after an incident in functional areas, including but not limited to independence, communication, transportation, and health maintenance.

Where possible, CSC recommendations should consider the unique circumstances of individuals. These individuals may require special consideration with respect to risk communication, transportation, treatment, equipment, and supplies.

### Children with AFN

CSC recommendations should consider the needs of children with AFN which may include children with developmental, physical, emotional, or behavioral conditions. These children often require a substantial amount of care not normally needed by the general population. As with adults, children with AFN may have multiple disabilities resulting in extensive healthcare and supervisory requirements. It is important to note that some children may have unseen disabilities that are not easily noticeable.

The SDMAC should consider the following challenges, space/staff/supply considerations, and triage issues for both adults and children.

<b>AFN Populations</b>	<b>Challenges</b> <ul style="list-style-type: none"><li>• Access to information and notification of catastrophic public health emergency</li><li>• Transportation to healthcare facilities</li><li>• Access to medications, refrigeration, and back-up power</li><li>• Access to mobility devices or service animals</li></ul>
	<b>Space/Staff/Supply Considerations</b> <ul style="list-style-type: none"><li>• Space to accommodate mobility devices and service animals</li><li>• Staff communication with non-verbal, deaf, and hearing impaired patients</li><li>• Supplies (e.g., medications, oxygen, durable medical equipment, etc.) with patients</li></ul>
	<b>Triage Issues</b> <ul style="list-style-type: none"><li>• Keeping patients, family members, care givers, and service animals together during triage and transport</li><li>• Pre-hospital triage for non-verbal, deaf, and hearing impaired patients</li><li>• Transporting mobility devices, durable medical equipment, and medications</li><li>• Knowledge of AFN physical disabilities</li></ul>

## Behavioral Health

For the purposes of this document, behavioral health includes overall psychological, psychiatric, and psychosocial well-being, including psychiatric and substance abuse disorders. Behavioral health affects the survival capabilities of the general public and people who need acute and long-term behavioral health treatment following a crisis. Behavioral health can affect the response capabilities of decision makers and response personnel, impacting their ability to perform their functions during and after the CSC response.

During a CSC response, the SDMAC should consider three main issues related to behavioral health in developing recommendations:

1. The behavioral health and psychosocial impact of the disaster on the general public;
2. The behavioral health and psychosocial impact on first responders and medical professionals;  
and
3. The impact of the disaster on the state’s seriously mentally ill population, including continuation of care.

The SDMAC will develop behavioral health strategies in coordination with behavioral health experts during CSC.

SDMAC Considerations for <b>Behavioral Health</b>	<ol style="list-style-type: none"><li>1. Public messaging and recommendations for healthcare and behavioral health practitioners regarding the behavioral impact on the general population.</li><li>2. Behavioral health impact on the responder and healthcare provider community.</li><li>3. Continuation of care for persons with serious mental illnesses and individuals receiving treatment (including medication) for substance dependency.</li></ol>
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## **Behavioral Health Impact on the General Population**

During a CSC incident, when health care facilities are experiencing severe medical surge conditions, the need for behavioral health care strategies becomes a critical adjunct to patients requiring medical treatment for physical illness or injury, as well as for primary care assessment and treatment of behavioral health conditions. Many people may require behavioral health services to manage grief and post-traumatic stress symptoms. The impact of a crisis will result in a substantial range of variability in the ability of people to respond and function during the crisis. Community resilience strategies that encourage family and neighborhood outreach may be beneficial in enhancing social support systems and reducing stress associated with an emergency incident.

## **Behavioral Health and Pediatric Populations**

Children are an especially vulnerable population to mental health risks following a disaster. Common markers of potential mental health-related issues based on the child's age include:

- Refusal to return to school and clinging behavior;
- Persistent fears related to the catastrophe;
- Sleep disturbances persisting more than several days after the event, such as nightmares, screaming during sleep, and bed wetting;
- Loss of concentration and irritability;
- Jumpiness or startling easily;
- Behavior problems, such as misbehaving in ways that are not typical for the child.
- Physical complaints with no physical cause; and
- Withdrawal from family and friends, sadness, listlessness, decreased activity, and preoccupation with the events of the disaster.

## **Behavioral Health and Public Information**

Incident specific public communication strategies should be developed and disseminated to help people manage stress, clarify the incident situation, and direct listeners and viewers to additional resources as necessary. During CSC, the SDMAC should fully integrate behavioral health content experts in decision making and response implementation. This is especially important during situations where:

- A transition must be made in the fair and just allocation of resources and care when circumstances will not allow for the optimal level of care for all;
- There are situations resulting in large-scale incapacitation or death of health care workers.
- Events produce extremely large numbers of fatalities;
- Events result in potential long-term or unknown health consequences;
- There are deaths or incapacity of key leaders or decision-makers; and

- There are events that evoke extreme emotions, such as terrorism or violence that impacts the most vulnerable populations, e.g. children.

## **Mental Health Triage**

Research indicates that between 30 and 40 percent of people directly impacted by a major disaster are at risk of developing new clinically diagnosable mental illness, such as depression or post-traumatic stress disorder. Early triage, intervention, and referral to services can reduce the risk of mental health disorders in disaster victims. An important component of managing medical surge following a major disaster is the ability to identify people at high risk for development of mental health conditions and managing the demand for mental health services by people who are experiencing a mental health crisis.

One strategy that may be considered by the SDMAC is the recommendation of a mental health triage system such as PsySTART (Psychological Simple Triage and Rapid Treatment), Fast Mental Health Triage Tool (FMHT), and the Alsept-Price Mental Health Scale (APMHS). Mental health triage systems are useful in identifying individuals experiencing a mental health crisis or at risk for chronic mental health disorders and triaging them to the correct mental health services.

Psychological First Aid is designed to reduce the initial distress caused by a traumatic event and to foster short and long term adaptive functioning and coping. Psychological First Aid is based on the understanding that individuals affected by traumatic events will experience a wide range of initial reactions that may cause enough distress to interfere with coping. Psychological First Aid is designed to be used in the immediate aftermath of a traumatic event. Psychological First Aid's basic objective are to establish connection in a compassionate and non-intrusive manner, enhance immediate and ongoing safety and provide physical and emotional comfort, calm and orient emotionally overwhelmed and distraught survivors, identify the survivors immediate needs and concerns, offer practical assistance to help survivors address immediate needs, connect survivors to social support networks and family, support adaptive coping, provide information, be clear about availability and link survivor to another team or recovery support system. Psychological First Aid Counselors are available in Southern Nevada by contacting the Southern Nevada Regional Behavioral Health Coordinator; and a similar resource: Crisis Counselors are available in Northern and Rural Nevada by contacting the Statewide Behavioral Health Coordinator.

## **Behavioral Health Impact on Responders and Medical Providers**

Behavioral health strategies should consider the unique impacts and behavioral health consequences of catastrophic public health emergencies on responders and healthcare providers. Responders and healthcare providers may be especially prone to post traumatic stress and other psychosocial impacts. Strategies for addressing the behavioral health needs of these groups should consider the identification, monitoring, and intervention systems tailored toward stress reduction, stress management, and mitigation of posttraumatic stress disorder. Peer-to-peer support, counseling, and other behavioral health support services, such as CISM, may be useful for responders and providers.

## **Impact on the Seriously Mentally Ill Population and Continuation of Care**

People with serious mental illness (SMI) will likely be among disaster victims, including the injured or ill, or experience emotional crises related to the disaster. Many people require ongoing behavioral health treatment or services due to SMI or other behavioral health conditions. Ongoing treatment or services may be disrupted during a disaster, leaving people with difficulties in managing their conditions or obtaining needed prescription medications. As behavioral health providers and social workers address the needs of disaster victims, including palliative and comfort care patients, there will be an impact on the overall availability of resources for behavioral healthcare within the state.

The SDMAC should consider the ongoing treatment and service needs of the SMI population and the additional emotional and behavioral issues this group may experience as a result of the disaster. Behavioral health recommendations should also address the continuation of substance dependency treatment, including the availability and administration of medications.

## **Public Information**

The efficient release of timely and accurate information to the public is one of the most important components of a CSC response. Effective public information strategies can help direct people to available healthcare resources and reduce overcrowding at hospitals that are already over capacity. Public information can also ease people's fears and help correct misinformation.

During a CSC response, all available methods of communicating with the public should be employed. Based on incident-specific circumstances and time constraints, communication methods may include but are not limited to, press conferences, media releases, websites, social media, public service announcements (radio and television), call centers, and print media. In addition, it is important to identify spokespersons that can establish trust with the public and become consistent voices for the response.

During CSC, public information will flow from the SDMAC to the SEOC and then to the Joint Information Center (JIC). Communication experts in the JIC will help ensure that messaging is ongoing and ideally developed at a fifth-grade reading level. JIC staff will work with community partners and contracted resources to ensure that messaging is translated into appropriate languages and that hard-to-reach and vulnerable populations are considered during message development and dissemination.

## **Communications Plans and Protocols**

Additional communication protocols are described in the SCEMP and the DPBH Public Information and Communications (PIC) Plan.

## Legal Considerations

Emergency declarations precipitate different authorities that facilitate response efforts and processes of public, private, and volunteer organizations. Emergency laws may (1) provide government with sufficient flexibility to respond; (2) mobilize central commands and infrastructures; (3) encourage response efforts by limiting liability; (4) authorize interstate recognition of healthcare licenses and certifications; (5) allocate healthcare personnel and resources; and (6) help to change medical standards of care and scope of practice.

The following identified issues, organization of personnel, coordination of health services, patients' interests, resource allocation, liability, reimbursement, and Nevada authorities, provide information on legal topics derived from the IOM Crisis Standards of Care Framework (2012) and from discussion points posed by the NV CSC Ethical and Legal Workgroup. Additional legal references and links to additional information are provided in Appendix D.

For the purposes of this section, emergency means a declared state of emergency. According to Nevada Revised Statute (NRS) 414.070, the existence of such an emergency or disaster may be proclaimed by the Governor or by resolution of the Legislature if the Governor in his or her proclamation, or the Legislature in its resolution, finds that an attack upon the United States has occurred or is anticipated in the immediate future, or that a natural, technological or man-made emergency or disaster of major proportions has actually occurred within this State, and that the safety and welfare of the inhabitants of this State require an invocation of the provisions of this section. Any such emergency or disaster, whether proclaimed by the Governor or by the Legislature, terminates upon the proclamation of the termination thereof by the Governor, or the passage by the Legislature of a resolution terminating the emergency or disaster.

Further, NRS 414 provides that the Governor may direct any state agency to exercise its authority and utilize its resources accordingly. Response by state departments and agencies providing lifesaving and life protecting activities under this plan takes precedence over other state activities, except where national security implications are determined to be of a higher priority by the Governor or the President. The Governor has delegated authority to the Department of Public Safety, Nevada Division of Emergency Management (DEM) for emergency management. The Governor does not have to declare an emergency to request additional medical countermeasures from the Centers for Disease Control Prevention (CDC).

The following legal issues have been identified by the IOM Crisis Standards of Care Framework (2012), the Ethical and Legal Workgroup, other Nevada CSC Workgroups, and the Nevada CSC Advisory Committee for healthcare practitioners, healthcare providers, and other entities involved in emergency preparedness and response activities. Questions include topics concerning Nevada authority for activation of the NV CSC Plan, organization of state personnel, coordination of health services, patients' interests, resource allocation, liability, and reimbursement.

## **Nevada Authority for Activation of the NV CSC Plan:**

- 1. Is there legal authority for DPBH to activate the NV CSC Plan and convene a SDMAC for the purpose of developing recommendations?**

Although activation of the NV CSC Plan is not statutorily mandated, activation of the plan and convening the SDMAC is consistent with and in furtherance of the broad scope of the DHHS' authority under NRS 439.150. This authority includes "the preservation of the health and lives of citizens of this State."

## **Organization of State Personnel**

- 1. How are employees, independent contractors, and volunteers legally distinguished for the purpose of coordinating services and benefits during an emergency?**

In a declared disaster, federal and state laws protect the actions of employees and volunteers. NRS 414.110 provides recognition of immunity and exemption for governmental workers relating to emergency management, except in the case of willful misconduct, gross negligence, or bad faith. It also may waive requirements for a license to practice any professional, mechanical or other skill for any authorized worker who in the course of performing his or her duties as such, practices that professional mechanical or other skill during an emergency or disaster. As used in this section, "worker" includes, without limitation, any full-time or part-time paid, volunteer or auxiliary employee of this State, of any political subdivision thereof, of other states, territories, possessions or the District of Columbia, of the Federal Government, of any neighboring country, or of any political subdivision thereof, or of any agency or organization, performing services for emergency management at any place in this State subject to the order or control of, or pursuant to a request of, the State Government or any political subdivision thereof.

The federal Volunteer Protection Act (VPA) applies to uncompensated, individual volunteers of nonprofit organizations or governmental entities. Volunteers shall not be liable for harm caused by their acts or omissions on behalf of the organization or entity so long as they are: (1) acting within the scope of the volunteer's responsibilities; (2) properly licensed, certified, or authorized by the appropriate authorities as required by law in the state in which the harm occurred; (3) have not engaged in willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual(s) harmed by the volunteer; and (4) have not caused the harm by operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires its operator to possess an operator's license or maintain insurance. The State Emergency Registry of Volunteers – Nevada (SERV-NV) system is a state volunteer registry that also provides liability protection for volunteers deployed for public health events or responses.



Medical practitioners from other states may be allowed to practice in Nevada due to the Uniform Emergency Volunteer Health Practitioners Act (UEVHPA). The UEVHPA allows state governments during a declared emergency to give reciprocity to other states' licensees on emergency services providers so that covered individuals may provide services without meeting the disaster state's licensing requirements. Nevada is among the states that have enacted this Act as identified in NRS 415A. NRS 415A, Emergency Volunteer Health Practitioners (Uniform Act) describes volunteer health practitioner definition, applicability, regulation, registration systems, qualifications, practice, immunity, and benefits for death or injury.

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Secretary of the federal Department of Health and Human Services to extend liability protections to entities and individuals for injuries resulting from the distribution of "covered countermeasures". Liability protections extend to any "covered persons" under the PREP Act which includes any manufacturer of countermeasures; distributor of countermeasures; program planners of countermeasures; qualified persons who prescribe, administer, or dispense countermeasures; and officials, agents, and employees of any of these entities or persons, barring any willful misconduct. A person includes an individual, partnership, corporation, association, entity, or public or private corporation, including a Federal, State, or local government agency or department.

**2. Do existing labor contracts or union requirements affect the ability of the state entity and its personnel to respond to an emergency?**

Existing Nevada state job announcements and work performance standards describe expected job duties including other duties as assigned. However, unless an employee is specifically designated as a situationally essential employee, it is unlikely that employees would be legally required to report to work during an emergency, i.e. the state would not seek legal action against an employee as the result of that employee not reporting to work during an emergency.

Various NRS regulate the conditions for local government employers in negotiating with employee organizations, setting pay plans, and determining work hours and overtime pay. NRS 288.150 describes the mandatory subjects of bargaining and conditions that every local government employer shall negotiate with the representatives of the recognized employee organization. NRS 284.180 outlines the pay plan to set official rates applicable to all positions in classified service, including overtime, the workweek for certain firefighters, innovative workweeks, existing contracts of employment, and payment for working on holiday. NRS 284.181 discusses agreements concerning provision of compensatory vacation time instead of monetary payment for overtime.

The federal Department of Labor (DOL) administers mandates and regulations that cover workplace activities for employers and workers. The Fair Labor Standards Act (FLSA) prescribes

standards for wages and overtime pay, which affects most private and public employment and can be accessed at <https://www.dol.gov/general/aboutdol/majorlaws#workerscomp>.

**3. Have appropriate contractual or other mechanisms been executed to facilitate the delivery of services by employed or volunteer personnel, ensure worker safety, or ensure the availability of workers' compensation or other benefits during an emergency?**

NRS 415A, Emergency Volunteer Health Practitioners (Uniform Act) describes volunteer health practitioner definition, applicability, regulation, registration systems, qualifications, practice, immunity, and benefits for death or injury.

NRS 288.150 describes the mandatory subjects of bargaining and conditions that every local government employer shall negotiate with the representatives of the recognized employee organization. These include, among other mandatory subjects, sick leave, insurance benefits, and employee safety.

In addition to regulations included in the NRS, the state has developed training plans and protocols for volunteers and employees. The *State Volunteer Management Plan* details the just-in-time training protocols and programs for volunteers and employees.

The Occupational Safety and Health (OSH) Act is administered by the Occupational Safety and Health Administration (OSHA). OSHA regulates the safety and health conditions in most private industries and OSHA-approved state programs which cover public sector employers.

The Employee Retirement Income Security Act (ERISA) regulates employers who offer pension or welfare benefit plans for their employees. Title I of ERISA is administered by the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration) and imposes a wide range of fiduciary, disclosure and reporting requirements on fiduciaries of pension and welfare benefit plans and on others having dealings with these plans. These provisions preempt many similar state laws. Under Title IV, certain employers and plan administrators must fund an insurance system to protect certain kinds of retirement benefits, with premiums paid to the federal government's Pension Benefit Guaranty Corporation (PBGC). EBSA also administers reporting requirements for continuation of health-care provisions, required under the Comprehensive Omnibus Budget Reconciliation Act of 1985 (COBRA) and the health care portability requirements on group plans under the Health Insurance Portability and Accountability Act (HIPAA).

## **Coordination of Health Services**

**1. Are there legal ramifications for healthcare personnel related to expanding scope of practice during CSC as approved and recommended by the Governor?**

The Governor has broad discretion in modifying licensing laws that apply in crisis standards of care scenario. Licensing boards are appointed by the Governor and are subject to any orders or recommendations from the Governor once they are received. The licensing board members may provide valuable information and expertise to the SDMAC when creating CSC recommendations.

There should be recognition that licensing standards may not be enforced. This is dependent on the different licensing boards (e.g. nursing or physician). Some licensing boards have limited temporary authority allowing actions in an emergency that might otherwise not be allowed by regulation under non-emergency circumstances. In an emergency, those boards (usually the Executive Director) could authorize the board's licensees to act differently and on a limited basis to accommodate the emergency.

## **Patients' Interests**

### **1. Can patients with physical or behavioral disabilities be accommodated during the emergency consistent with disability protection laws?**

A CSC incident will result in challenges for many patients, but particularly for patients who are "at risk" and patients with access and functional needs. An emergency does not void or eliminate the requirements to follow the Americans with Disabilities Act (ADA) or HIPAA. During an emergency, all providers should continue to apply ADA and HIPAA requirements to the best of their ability. Providers should pursue due-diligence during an emergency. While an emergency does not void ADA or HIPAA requirements, the emergency situation would be considered in consequential lawsuits.

### **2. Will federal HIPAA waivers apply to patient information relayed over dispatch channels or other CSC circumstances?**

Agencies should continue to comply with all state and federal regulations to the best of their ability. However, under the federal Social Security Act (SSA), Section 1135 (42 U.S.C. § 1320b-5), when the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and the Health and Human Services (HHS) Secretary declares a public health emergency, the Secretary is authorized to, among other things, waive or modify certain Medicare, Medicaid, Children's Health Insurance Program (CHIP) and HIPAA requirements as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals enrolled in SSA programs and that providers of such services in good faith who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse. It should be noted that each provider needs to apply for 1135 waivers individually.

## Resource Allocation

1. **Does Nevada government have the authority to allocate resources among private medical facilities in a CSC scenario? If so, how can the government exercise this authority? What types of resources are covered? What types of facilities are covered?**

Legal authorization is generally required to shift the provision of care and allocate resources during emergencies. The Chief Medical Officer statute (Chapter 439 of the NRS) is very broad and would encompass allocation of resources in a CSC scenario. In addition, NRS 414 provides that the Governor may direct any state agency to exercise its authority and utilize its resources accordingly. Response by state departments and agencies providing lifesaving and life protecting activities under this plan takes precedence over other state activities, except where national security implications are determined to be of a higher priority by the Governor or the President. The Governor has delegated authority to the Department of Public Safety, DEM for emergency management. The Governor does not have to declare an emergency to request additional medical countermeasures from the CDC.

Additionally, memoranda of understanding (MOU) and mutual aid agreements assist in the sharing of scarce resources during emergencies. The Emergency Management Assistance Compact (EMAC) provides for mutual assistance among all 50 states and the District of Columbia in managing an emergency duly declared by the Governor of the affected state, whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspects of resources shortages, community disorders, insurgency, or enemy attack.

## Liability

1. **What are the consequences if medical providers do not adhere to SDMAC recommendations during CSC activation? Can a licensed Emergency Medical Technician (EMT), paramedic, physician, nurse, etc. be sued for not following established standards of care which are approved by the SDMAC, State Policy Group, and the Governor during a crisis if their Medical Director does not establish crisis protocols in response to CSC recommendations?**

Healthcare providers should always act within their scope of practice and for the good of the patient. SDMAC recommendations are meant as guidance and the provider has the ultimate responsibility of doing what is best for the patient. No current laws would hold medical providers accountable in this situation unless the licensed health care provider is practicing outside their scope AND outside the SDMAC recommendations AND outside licensing board recommendations. Medical providers adhering to SDMAC recommendations during CSC activation will strengthen defenses available and will lead to a better response for recovery.

2. **Is there current legal recognition in the NRS or Nevada Administrative Code (NAC) that conventional standards of care may not be followed by EMS, EMS dispatch, hospitals, and other healthcare providers when the NV CSC Plan is activated and the SDMAC has disseminated recommendations?**

No, there is no specific language in the NRS or NAC regarding the NV CSC Plan. However, there are various federal and Nevada laws that provide specific liability protections. The federal PREP Act authorizes the Secretary of HHS to extend liability protections to entities and individuals for injuries resulting from the distribution of “covered countermeasures”. Liability protections extend to any “covered persons” under the PREP Act which includes any manufacturer of countermeasures; distributor of countermeasures; program planners of countermeasures; qualified persons who prescribe, administer, or dispense countermeasures; and officials, agents, and employees of any of these entities or persons, barring any willful misconduct. A person includes an individual, partnership, corporation, association, entity, or public or private corporation, including a Federal, State, or local government agency or department.

NRS 414.110 describes immunity and exemption for activities involving governmental functions relating to emergency management activities. It states that:

1. All functions under this chapter and all other activities relating to emergency management are hereby declared to be governmental functions. Neither the State nor any political subdivision thereof nor other agencies of the State or political subdivision thereof, nor except in cases of willful misconduct, gross negligence, or bad faith, any worker complying with or reasonably attempting to comply with this chapter, or any order or regulation adopted pursuant to the provisions of this chapter, or pursuant to any ordinance relating to any necessary emergency procedures or other precautionary measures enacted by any political subdivision of the State, is liable for the death of or injury to persons, or for damage to property, as a result of any such activity. The provisions of this section do not affect the right of any person to receive benefits to which he or she would otherwise be entitled under this chapter, or under the provisions of chapters 616A to 616D, inclusive, or chapter 617 of NRS, or under any pension law, nor the right of any such person to receive any benefits or compensation pursuant to any act of Congress.
2. Any requirement for a license to practice any professional, mechanical or other skill does not apply to any authorized worker who, in the course of performing his or her duties as such, practices that professional, mechanical or other skill during an emergency or disaster.
3. As used in this section, “worker” includes, without limitation, any full-time or part-time paid, volunteer or auxiliary employee of this State, of any political subdivision thereof, of other states, territories, possessions or the District of Columbia, of the Federal Government, of any neighboring country, or of any political subdivision thereof, or of any agency or organization, performing services for emergency management at any place in

this State subject to the order or control of, or pursuant to a request of, the State Government or any political subdivision thereof.

Additionally, NRS 414A, Nevada Intrastate Mutual Aid System, NRS 414A.180 describes immunity and tort liability for activities performed by an emergency responder of an assisting participant. All activities performed pursuant to this chapter are deemed to be governmental functions for which immunity is provided under the provisions of NRS 414.110.

**3. Does Nevada law require providers to adhere to SDMAC recommendations instead of conventional standards of care during a CSC scenario? If providers adhere to SDMAC recommendations, are they immune from liability in a lawsuit? Are they protected from any licensure implications?**

There should be recognition that licensing standards may not be enforced. This is dependent on the different licensing boards (e.g. nursing or physician). Some licensing boards have limited temporary authority allowing actions in an emergency that might otherwise not be allowed by regulation under non-emergency circumstances. In an emergency, those boards (usually the Executive Director) could authorize the board's licensees to act differently and on a limited basis to accommodate the emergency.

NRS 41.500–507 describes the liability of persons who render emergency care and gratuitous care. NRS 41.500 states that except as otherwise provided in NRS 41.505, any person in this State who renders emergency care or assistance in an emergency, gratuitously and in good faith, except for a person who is performing community service as a result of disciplinary action pursuant to any provision in title 54 of NRS, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering the emergency care or assistance or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured person. NRS 41.503 describes the limited liability for providing medical care and assistance necessitated by traumatic injury. NRS 41.504 provides liability information for physicians, physician assistants, and registered nurses who give instructions or provide supervision to emergency medical attendants during emergencies. In addition, it provides information on liability for emergency medical attendants, physician assistants and nurses who obey instruction given by physician, physician assistant or nurse during an emergency. NRS 41.505 and NRS 41.506 further describe liability limitations for physicians, physician assistants, nurses, and dentists. NRS 41.507 describes liability protections for volunteer emergency medical dispatchers and volunteer medical directors of agencies which employ emergency medical dispatchers.

**4. Where is telemedicine written into the NRS or NAC?**

Telemedicine was specifically authorized in several chapters of the NRS through Senate Bill (SB)

327 (2013). Nevada law authorizes Nevada-licensed practitioners to practice via telemedicine within the scope of practice for their profession. In summary, any person who provides such services through telehealth to a patient located in this State: (1) is subject to the laws, including regulations, and jurisdiction of this State; and (2) is required to comply with all federal and state laws that would apply if the person were providing services from a location in this State (NRS 630.020, 630.261, 630.275, 632.237, 633.165, 639.0727, 639.235).

**5. Is it abandonment for an EMS unit to leave a patient at an overwhelmed hospital or treatment center in order to keep the EMS unit in service?**

While there is no specific NRS language addressing abandonment by EMS units as asked in this question, EMS agencies should continue to comply with all state and federal regulations to the best of their ability during emergencies. NRS 450B.795 requires the State Board of Health to collect data concerning the waiting times for the provision of emergency services and care to each person who is in need of such services and care and who is transported to a hospital by a provider of emergency medical services. This data is reviewed at least quarterly each year. Incidents in which persons transferred to appropriate places in hospitals to receive emergency services and care more than thirty (30) minutes after arrival at the hospitals are reviewed. Findings reporting the circumstances surrounding the wait times are reported to the State Board of Health.

**6. Are SDMAC members immune from any potential liability for developing CSC recommendations in good faith? If not, how can such immunity be extended to the SDMAC members?**

While there is no specific immunity language currently in the NRS, SDMAC members who are volunteers should register with the State Emergency Registry of Volunteers – Nevada (SERV-NV) system, which is a state volunteer registry providing liability protection for volunteers deployed for public health events. Liability protections for governmental workers serving on the SDMAC are described in NRS 414.

## **Reimbursement**

**1. Are there state or federal laws that alter payer-provider relationships in a catastrophic public health emergency? Are there any special obligations/requirements regarding payment for patient health services that apply to insurers in a catastrophic public health emergency that do not apply under non-catastrophic conditions?**

Yes, 42 U.S. Code § 300hh–11 subparagraph (A) states that the HHS Secretary may activate the National Disaster Medical System (NDMS) to (i) provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the

needs of victims of a public health emergency, including at-risk individuals as applicable (whether or not determined to be a public health emergency under section 247d of Title 42); or (ii) be present at locations, and for limited periods of time, specified by the Secretary on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified. Subparagraph (D) states that the HHS Secretary may determine and pay claims for reimbursement for services under subparagraph (A) directly or through contracts that provide for payment in advance or by way of reimbursement.

Hospitals that have signed the NDMS Memorandum of Agreement (MOA) for Definitive Medical Care during a disaster in which NDMS is activated will be reimbursed according to the schedule detailed in the MOA. Reimbursements, subject to the availability of appropriations, will be limited to care provided for: injuries or illnesses resulting directly from a specified public health emergency; injuries, illnesses and conditions requiring essential medical services necessary to maintain a reasonable level of health temporarily not available as a result of the public health emergency; or injuries or illnesses affecting authorized emergency response and disaster relief personnel responding to the public health emergency. HHS will define what constitutes a “NDMS patient”.

Currently there are no Nevada Revised Statutes that would alter payer-provider relationships in a catastrophic public health emergency. The Nevada Division of Insurance regulates small and individual group plans (serving a maximum of 200 thousand people) but not large employer insurance groups. Centers for Medicare and Medicaid Services (CMS) regulates medical payments for about 600 thousand people in Nevada. NRS Title 57 Chapter 679A lists the general provisions of the Nevada Insurance Code.

## **Plan Development and Maintenance**

This NV CSC Plan is a living document that will be updated as situations change, problems are identified, and gaps become apparent. It must be adapted to remain useful and up-to-date. The NV CSC Plan will be tested during exercises and real responses. Improvements and corrective actions will be incorporated into document changes and revisions.

DHHS, DPBH, PHP Program will maintain this document and coordinate reviews, revisions, and changes with partner agencies. The NV CSC Plan will be reviewed and updated biennially. The date of the NV CSC Plan will be determined by the most recent signature date.

A document change involves making specific changes to a limited number of pages to update the document. A document revision is a complete rewriting of the existing NV CSC Plan. Revisions are advisable when numerous pages of the document are updated, major portions of the document are deleted, or substantial text needs to be added. Changes or revisions will be made to the NV CSC Plan when it is no longer current. Changes or revisions in the plan may be needed when:



- Hazard consequences or risk areas change;
- The concept of operations changes;
- Departments, agencies, or groups which perform emergency or recovery functions are reorganized or can no longer perform tasks laid out in this plan;
- Warning and communications systems are upgraded;
- Additional emergency or recovery resources are obtained through acquisition or agreement, the disposition of existing resources changes, or anticipated emergency or recovery resources are no longer available;
- A training, exercise, or actual emergency reveals significant deficiencies in the existing NV CSC Plan; or
- State or federal planning standards are revised.

Updated versions of this document will be distributed by DPBH PHP to partner agencies. Directors of partner agencies and stakeholders are responsible for maintaining their internal plans, standard operating procedures (SOPs), and resource data to ensure timely and effective responses to emergencies and disasters.

## Appendix A – Resource Challenges by Disaster Type

<b>BLAST/ CRUSH</b>	<b>Hazard-Specific Challenges</b> <ul style="list-style-type: none"> <li>• Triage – education on blast/crush injuries may be lacking</li> <li>• Intravenous fluids and medications may be limited</li> <li>• Surgical bottlenecks</li> <li>• Dialysis capacity may be challenged, especially if healthcare infrastructure is damaged</li> </ul>
	<b>Space/Staff/Supply Considerations</b> <ul style="list-style-type: none"> <li>• Common medications (sodium bicarbonate, narcotic analgesia, antibiotics)</li> <li>• Supplies such as tourniquets, major procedure trays, external fixators and ortho trays, additional suture trays, ocular trays, ENT trays</li> <li>• Just-in-time education on crush injury and other specific syndromes</li> <li>• Dialysis capacity</li> </ul>
	<b>Triage Issues</b> <ul style="list-style-type: none"> <li>• Triage based on knowledge of injuries and medical assessment</li> <li>• Assess carefully for subtle penetrating injury and compartment syndrome</li> <li>• Provide temporizing treatments such as hemorrhage control (including tourniquets when tissue destruction is significant) and analgesia initially</li> </ul>

<b>BURN</b>	<b>Hazard-Specific Challenges</b> <ul style="list-style-type: none"> <li>• Lack of burn beds and burn centers</li> <li>• Educational background often lacking for burn resuscitation and management</li> <li>• Intravenous fluids, dressings, and analgesics limited</li> <li>• Limited number of burn surgeons and nurses</li> </ul>
	<b>Space/Staff/Supply Considerations</b> <ul style="list-style-type: none"> <li>• Supplies for large-scale burn incidents, including adequate analgesia</li> <li>• Critical burn patient distribution to out of state burn centers</li> <li>• Just-in-time education for staff</li> <li>• Burn technical expert availability (telemedicine or telephone consult – consider experts from another unaffected area) to facilities that have to manage patients out of their usual range of expertise</li> </ul>
	<b>Triage Issues</b> <ul style="list-style-type: none"> <li>• Use knowledge of contributing injuries, inhalational injury, age, and extent of burns when triaging burn patients</li> <li>• Provide palliative care to those who cannot be offered definitive interventions</li> <li>• Provide temporizing measures such as escharotomy and airway management while deferring formal burn dressings initially in favor of sterile sheets and towels</li> </ul>

<b>CHEMICAL</b>	<b>Hazard-Specific Challenges</b> <ul style="list-style-type: none"> <li>• Mass airway management and ventilatory therapy</li> <li>• Antidotal treatment (atropine, pralidoxime particularly)</li> <li>• Mass decontamination</li> </ul>
	<b>Space/Staff/Supply Considerations</b> <ul style="list-style-type: none"> <li>• Intubation equipment</li> <li>• Antidotes (onsite and community/Strategic National Stockpile (SNS))</li> <li>• Critical care equipment</li> <li>• “Dry decontamination” kits (redressing kits)</li> <li>• Chemical Personal Protective Equipment (PPE) and Hazardous Materials (HAZMAT) training for staff</li> </ul>
	<b>Triage Issues</b> <ul style="list-style-type: none"> <li>• Temporizing (bag-valve, other) therapies reasonable while awaiting outside resources</li> <li>• May still have good outcomes in cardiac arrest in organophosphate poisoning, but in mass casualty situation may have to prioritize care to those prior to respiratory arrest</li> </ul>

<b>NUCLEAR</b>	<b>Hazard-Specific Challenges</b> <ul style="list-style-type: none"> <li>• Overwhelming acute trauma for hospitals near incident</li> <li>• Overwhelming numbers of acute radiation syndrome (ARS) casualties in subsequent days/weeks</li> <li>• Identification/categorization of ARS casualties – difficulty accessing lab testing or results</li> <li>• Shortages of cytokines and blood products (especially platelets during bone marrow failure phase)</li> <li>• Large number of expectant patients from initial trauma, radiation, or combined injury</li> </ul>
	<b>Space/Staff/Supply Considerations</b> <ul style="list-style-type: none"> <li>• Evacuation of patients in latent phase of ARS to other jurisdictions with intact infrastructure</li> <li>• Areas for alternate ambulatory triage sites</li> <li>• Equipment and medications for triage areas (tourniquets, bandages, antiemetics and antidiarrheals)</li> <li>• Sources of radiation illness information</li> </ul>
	<b>Triage Issues</b> <ul style="list-style-type: none"> <li>• Vomiting in early hours is non-specific and can be due to many causes</li> <li>• Absolute lymphocyte count (ALC) is optimal for assessment of ARS, but may not be easily available</li> <li>• Victim information (proximity, particulate debris) and symptoms can allow rough classification within a few days after the incident</li> <li>• Patient decontamination</li> </ul>

<b>PANDEMIC</b>	<b>Hazard-Specific Challenges</b> <ul style="list-style-type: none"> <li>• PPE use and type required</li> <li>• Vaccine, antiviral, antibiotic supply and use</li> <li>• Alternate care site establishment (early treatment-influenza centers)</li> <li>• Mechanical ventilation capacity</li> <li>• Extracorporeal membrane oxygenation (ECMO) criteria and capacity</li> </ul>
	<b>Space/Staff/Supply Considerations</b> <ul style="list-style-type: none"> <li>• PPE supplies, particularly N95 masks if required</li> <li>• Medications including antivirals, antibiotics, analgesics, paralytics</li> <li>• Outpatient and inpatient care spaces may be insufficient and require alternate care sites</li> <li>• Ventilators, ECMO supplies, and equipment and staffing plans</li> <li>• Staff illness, family obligations, or reluctance to report may contribute to difficulty with adequate staffing</li> </ul>
	<b>Triage Issues</b> <ul style="list-style-type: none"> <li>• Contingency plans for PPE and medication shortages</li> <li>• Outpatient referral/triage plans (hotlines, phone prescribing, etc.)</li> <li>• Triage criteria and process for life-saving interventions</li> <li>• Triage criteria for emergency care (vs. referral to “influenza center”)</li> </ul>

<b>PEDIATRIC MASS CASUALTY</b>	<b>Hazard-Specific Challenges</b> <ul style="list-style-type: none"> <li>• Age-specific sizes of equipment, airway, intravenous access, catheters, operative equipment</li> <li>• Educational background often lacking for pediatric-specific resuscitation and management</li> </ul>
	<b>Space/Staff/Supply Considerations</b> <ul style="list-style-type: none"> <li>• Concentration of critical patients and those 5 years or less at pediatric facilities</li> <li>• Just-in-time education for staff, initial treatment resources</li> <li>• Pediatric technical expert availability (telemedicine or telephone consult-preferably to experts outside affected area) for facilities that are managing patients out of their usual range of expertise</li> <li>• Management of unaccompanied children and their needs for support</li> <li>• Family assistance centers may experience large volume</li> </ul>
	<b>Triage Issues</b> <ul style="list-style-type: none"> <li>• Assessment may be difficult due to verbal skills and fear</li> <li>• Physiologic compensation may mask “usual” signs of shock until advanced</li> <li>• Keeping families together when possible (e.g., transporting critically injured child to pediatric center along with parents with minor injuries)</li> </ul>

<b>TRAUMA</b>	<b>Hazard-Specific Challenges</b> <ul style="list-style-type: none"> <li>• Triage bottlenecks</li> <li>• Airway and initial interventions</li> <li>• CT and imaging bottlenecks</li> <li>• Operative bottlenecks</li> <li>• Surgical and trauma supplies</li> </ul>
	<b>Space/Staff/Supply Considerations</b> <ul style="list-style-type: none"> <li>• Operative supplies (especially major procedure, chest tube, orthopedic trays)</li> <li>• Selective use of CT and other imaging methods</li> </ul>
	<b>Triage Issues</b> <ul style="list-style-type: none"> <li>• Basic trauma triage including knowledge of impact of GCS, age, and multisystem trauma on prognosis</li> <li>• Palliative care for those who cannot be offered definitive interventions</li> <li>• The larger the event, the higher the concentration on targeted, brief interventions with high impact (hemorrhage control, pneumothorax decompression, airway management)</li> <li>• Limiting definitive imaging and procedures (e.g., limit CT to cranial for decreased level of consciousness, perform bailout surgical procedures with temporary closures)</li> <li>• Ultrasound may contribute to rapid assessments of casualties</li> </ul>

Adapted from the Institute of Medicine (2012). *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*. Washington, DC: The National Academies Press.

## Appendix B– NV CSC SDMAC Job Descriptions

The following job descriptions for the NV CSC SDMAC are included in this appendix.

- SDMAC Chair;
- SDMAC Technical Specialist;
- DPBH SDMAC Members;
- Partner Agency SDMAC Members;
- Healthcare SDMAC Members;
- Subject Matter Expert SDMAC Members;
- Ethical Expert SDMAC Members; and
- Legal Expert SDMAC Members.

## **Crisis Standards of Care Job Description**

**Position: SDMAC Chair (DHHS/DPBH staff)**

### **Qualifications and Training**

- The Nevada Department of Health and Human Services (DHHS) Director, Division of Public and Behavioral Health (DPBH) Chief Medical Officer, or designated representative
- A thorough understanding of Division Operations Center (DOC) procedures and plans, the State Comprehensive Emergency Management Plan (SCEMP), and the Nevada Crisis Standards of Care (CSC) Plan

### **Overall Responsibilities**

- Oversee the State Disaster Medical Advisory Committee (SDMAC)
- Supervise the development and dissemination of CSC recommendations by the SDMAC
- Communicate with DOC Public Information Officer, officials, policy makers, and stakeholders during the implementation of statewide CSC recommendations

### **Activation**

- Consult with the Governor's Office, State Attorney General, and Nevada Division of Emergency Management (DEM) to activate the NV CSC Plan
- Identify SDMAC members in consultation with the SDMAC Technical Specialist
- Direct the DOC staff to convene the SDMAC by notifying SDMAC members and providing necessary logistical support through the SDMAC Liaison to the DOC
- Oversee the SDMAC and the development of incident-specific goals, objectives, and tactics

### **CSC Operations Ongoing**

- Oversee the development and recommendation of incident-specific tactics
- Oversee the implementation of statewide CSC recommendations
- Maintain situational awareness during CSC response through participation in meetings and conference calls

### **CSC Deactivation and Recovery**

- Monitor situation and identify when all healthcare facilities can return to contingency or conventional standards of care
- Consult with the Governor's Office, State Attorney General, and DEM to deactivate CSC
- Work with the DOC and SEOC recovery staff and healthcare system partners to identify long-term impacts to the healthcare system
- Participate in ongoing healthcare recovery efforts with local, state, and tribal public health and emergency management partners

## **Crisis Standards of Care Job Description**

### **Position: SDMAC Technical Specialist**

#### **Qualifications and Training**

- Experienced Division of Public and Behavioral Health (DPBH) staff member such as a Public Health Preparedness Manager
- A thorough understanding of Division Operations Center (DOC) procedures and plans, the State Comprehensive Emergency Management Plan (SCEMP), and the Nevada Crisis Standards of Care (CSC) Plan

#### **Overall Responsibilities**

- Report to the State Disaster Medical Advisory Committee (SDMAC) Chair or designee
- Under the direction of the SDMAC Chair, coordinate SDMAC operations
- Coordinate with the DOC, Emergency Support Function 8 (ESF-8) in the State Emergency Operations Center (SEOC), and DPBH Public Information Officer (PIO)
- Coordinate the development of timely, statewide CSC incident-specific recommendations

#### **Activation**

- Assist the SDMAC Chair in identifying SDMAC members
- Work with DOC Incident Commander to notify SDMAC members and request their participation in the SDMAC
- Meet (in person or virtually) with the SDMAC Chair, Command Staff, DPBH Public Information Officer, and other Command Staff to establish goals and objectives for SDMAC operations
- Conduct initial meeting(s) with SDMAC members to develop initial CSC recommendations to guide priorities for treatment and allocation of scarce medical resources
- Coordinate with DOC to verify that initial recommendations have been disseminated to public health and healthcare system partners
- Coordinate with DOC to verify that initial public information has been distributed via the SEOC Joint Information Center (JIC)

#### **CSC Operations Ongoing**

- Coordinate with DOC to monitor and track the dissemination and implementation of CSC recommendations across the statewide healthcare system
- Update and coordinate dissemination of CSC recommendations as needed throughout the response
- Organize and facilitate ongoing SDMAC meetings and conference calls

#### **CSC Deactivation and Recovery**

- Work with SDMAC Chair to monitor situation and identify when all healthcare facilities can return to contingency or conventional standards of care
- Under the direction of the SDMAC Chair, work with the DOC and SEOC recovery staff and healthcare system partners to identify long term impacts to the healthcare system
- Participate in ongoing healthcare recovery efforts under the supervision of the SDMAC Chair with local, state, and tribal public health and emergency management partners



## **Crisis Standards of Care Job Description**

### **Position: DPBH SDMAC Members**

#### **Qualifications and Training**

- Division of Public and Behavioral Health (DPBH) senior staff, managers, and personnel
- A thorough understanding of Division Operations Center (DOC) procedures and plans, the State Comprehensive Emergency Management Plan (SCEMP), and the Nevada Crisis Standards of Care (CSC) Plan

#### **Overall Responsibilities**

- Report to the SDMAC Technical Specialist
- Coordinate and advise on CSC recommendations in assigned program areas
- Provide situational awareness updates in assigned program areas and areas of expertise
- Contribute to the timely development of CSC recommendations for public health and healthcare system stakeholders

#### **Activation**

- Participate in meeting(s) with other SDMAC members to develop initial CSC recommendations to guide priorities for treatment and allocation of scarce medical resources
- Provide situational awareness update in specified program areas and area of expertise

#### **CSC Operations – Ongoing**

- Under direction of the SDMAC Technical Specialist, monitor and track the dissemination and implementation of CSC recommendations for assigned program areas
- Assist with updating and revising CSC recommendations as needed throughout the response
- Continue to provide situational awareness updates in specified program areas and area of expertise to the SDMAC Technical Specialist through participation in meetings and conference calls

#### **CSC Deactivation and Recovery**

- Work with SDMAC Technical Specialist to monitor situation and identify when all healthcare facilities can return to contingency or conventional standards of care
- Under the direction of the SDMAC Technical Specialist, work with the DOC and SEOC recovery staff and healthcare system partners to identify long term impacts to the healthcare system related to area(s) of expertise
- As requested by the SDMAC Technical Specialist, participate in ongoing healthcare recovery efforts with local, state, and tribal public health and emergency management partners

## **Crisis Standards of Care Job Description**

### **Position: Partner Agency SDMAC Members**

#### **Qualifications and Training**

- Staff member from a partner agency such as the Governor's Office, state medical board, healthcare association, county health officer, tribal administration, or other representative deemed necessary by the SDMAC Chair
- Knowledge of the Nevada Crisis Standards of Care (CSC) Plan

#### **Overall Responsibilities**

- Contribute to the development and implementation of statewide CSC recommendations
- Interface between respective partner agency and the SDMAC

#### **CSC Activation**

- Confirm receipt of notification message from the DOC requesting participation in the SDMAC
- Participate in initial meeting or conference call
- Assist with information gathering and situational awareness from local/regional jurisdictions and healthcare facilities
- Contribute to the development of initial status report, meeting minutes, and other documentation, as required
- Under the direction of the SDMAC Technical Specialist, collaborate with other SDMAC members to develop initial CSC recommendations

#### **CSC Operations – Ongoing**

- Continue to gather information and provide situational awareness from local/regional jurisdiction and healthcare facilities through participation in meetings and conference calls
- Contribute to the development of ongoing status reports, meeting minutes, and other documentation as required
- Work collectively with other SDMAC members to evaluate and update CSC recommendations as needed throughout the response

#### **CSC Deactivation and Recovery**

- Work with SDMAC Technical Specialist to monitor situation and identify when all healthcare facilities can return to contingency or conventional standards of care
- Work with partner agencies and healthcare facilities to establish priorities for healthcare systems recovery
- As requested by the SDMAC Technical Specialist, participate in ongoing healthcare recovery efforts with local, state, and tribal public health and emergency management partners

## **Crisis Standards of Care Job Description**

### **Position: Healthcare SDMAC Members**

#### **Qualifications and Training**

- Stakeholder from healthcare facilities (such as: academic medical center, community clinic, dialysis center, surgery center, hospitals, skilled nursing facility, long term care facility, or behavioral healthcare facility), EMS agency, healthcare coalition or insurance agency (minimum one from each region)
- Knowledge of healthcare system, public health emergency preparedness, emergency management, or medical surge
- Knowledge of the Nevada Crisis Standards of Care (CSC) Plan

#### **Overall Responsibilities**

- Contribute to the development and implementation of statewide CSC recommendations
- Interface between respective home facility or agency and the SDMAC

#### **CSC Activation**

- Confirm receipt of notification message from the DOC requesting participation in the SDMAC
- Participate in initial meeting or conference call
- Assist with information gathering and situational awareness from healthcare facilities and organizations
- Contribute to the development of initial status report, meeting minutes, and other documentation, as required
- Under the direction of the SDMAC Technical Specialist, collaborate with other SDMAC members to develop initial CSC recommendations

#### **CSC Operations – Ongoing**

- Continue to gather information and provide situational awareness from healthcare facilities and organizations through participation in meetings and conference calls
- Contribute to the development of ongoing status reports, meeting minutes, and other documentation as required
- Work collectively with other SDMAC members to evaluate and update CSC recommendations as needed throughout the response

#### **CSC Deactivation and Recovery**

- Work with SDMAC Technical Specialist to monitor situation and identify when all healthcare facilities can return to contingency or conventional standards of care
- Work with partner agencies and facilities to establish priorities for healthcare systems recovery
- Participate in ongoing healthcare recovery efforts with local, state, and tribal public health and emergency management partners

## **Crisis Standards of Care Job Description**

### **Position: Subject Matter Expert SDMAC Members**

#### **Qualifications and Training**

- Expert knowledge in one or more response areas such as chemical, biological, explosive, radiological, nuclear, infectious disease, tribal or other area deemed necessary by the SDMAC Chair
- Knowledge of the Nevada Crisis Standards of Care (CSC) Plan or emergency preparedness in the area of subject matter expertise

#### **Overall Responsibilities**

- Provide and interpret technical information and data related to the response
- Contribute to the development and implementation of statewide CSC recommendations

#### **CSC Activation**

- Confirm receipt of notification message from the DOC requesting participation in the SDMAC
- Participate in initial meeting or conference call
- Assist with information gathering and situational awareness related to areas of expertise
- Contribute to the development of initial status report, meeting minutes, and other documentation as required
- Under the direction of the SDMAC Technical Specialist, collaborate with other SDMAC members to develop initial CSC recommendations

#### **CSC Operations – Ongoing**

- Serve as a subject matter expert for the SDMAC as necessary
- Interpret technical information into commonly understood language
- Continue to gather information and provide situational awareness from other technical experts on the field
- Contribute to the development of ongoing status reports, meeting minutes, and other documentation as required through participation in meetings and conference calls
- Work collectively with other SDMAC members to evaluate and update CSC recommendations as needed throughout the response

#### **CSC Deactivation and Recovery**

- Work with SDMAC Technical Specialist to monitor situation and identify when all healthcare facilities can return to contingency or conventional standards of care

## **Crisis Standards of Care Job Description**

### **Position: Ethical Expert SDMAC Members**

#### **Qualifications and Training**

- Staff member from a state recognized agency or university program such as the Nevada Physical Order for Life Sustaining Treatment (POLST)

#### **Overall Responsibilities**

- Advise on ethical issues related to the response
- Contribute to the development and implementation of statewide CSC recommendations

#### **CSC Activation**

- Confirm receipt of notification message from the DOC requesting participation in the SDMAC
- Participate in initial meeting or conference call
- Assist with information gathering and situational awareness related to areas of expertise
- Contribute to the development of initial status report, meeting minutes, and other documentation as required
- Under the direction of the SDMAC Technical Specialist, collaborate with other SDMAC members to develop initial CSC recommendations

#### **CSC Operations – Ongoing**

- Serve as an ethical subject matter expert for the SDMAC
- Interpret complex ethical issues into commonly understood language
- Contribute to the development of ongoing status reports, meeting minutes, and other documentation as required through participation in meetings and conference calls
- Work collectively with other SDMAC members to evaluate and update CSC recommendations as needed throughout the response

#### **CSC Deactivation and Recovery**

- Work with partner agency to identify ethical priorities for healthcare systems recovery
- As requested by the SDMAC Technical Specialist, participate in ongoing healthcare recovery efforts with local, state, and tribal public health and emergency management partners

## **Crisis Standards of Care Job Description**

### **Position: Legal Expert SDMAC Members**

#### **Qualifications and Training**

- Staff member from a legal partner agency such as the Governor's Office or Attorney General

#### **Overall Responsibilities**

- Advise on legal issues related to the response
- Contribute to the development and implementation of statewide CSC recommendations

#### **CSC Activation**

- Confirm receipt of notification message from the DOC requesting participation in the SDMAC
- Participate in initial meeting or conference call
- Assist with information gathering and situational awareness related to areas of expertise
- Contribute to the development of initial status report, meeting minutes, and other documentation as required
- Under the direction of the SDMAC Technical Specialist, collaborate with other SDMAC members to develop initial CSC recommendations

#### **CSC Operations – Ongoing**

- Serve as a legal subject matter expert for the SDMAC
- Interpret complex legal issues into commonly understood language
- Contribute to the development of ongoing status reports, meeting minutes, and other documentation as required through participation in meetings and conference calls
- Work collectively with other SDMAC members to evaluate and update CSC recommendations as needed throughout the response

#### **CSC Deactivation and Recovery**

- Work with partner agency to identify legal priorities for healthcare systems recovery
- As requested by the SDMAC Technical Specialist, participate in ongoing healthcare recovery efforts with local, state, and tribal public health and emergency management partners

## Appendix C – Nevada Crisis Standards of Care Code of Ethics

### Overview

The NV CSC Code of Ethics was developed to assist decision-makers, healthcare providers, and health care practitioners in ethical decision-making processes during catastrophic public health emergencies. This code of ethics is not intended to apply to localized emergency incidents of limited duration, emergencies not impacting population health, or emergencies where critical medical resource allocation decisions are not required to protect the population's health.

The ethical principles and code language outlined below were developed by the NV CSC Ethical and Legal Workgroup for application during catastrophic public health emergencies. The workgroup carefully considered public health ethical principles, community values obtained from feedback during the public engagement campaign, and information collected from several states during the development of the NV CSC Code of Ethics.

### Application

During a catastrophic public health emergency in which the NV CSC Plan is activated, the SDMAC may develop CSC recommendations for dissemination to the public health agencies, healthcare providers, and healthcare practitioner network. The NV CSC Code of Ethics is provided to help guide decision-making and implementation processes. The NV CSC Code of Ethics is intended to supplement, not supplant, relevant existing codes of ethics for public health practitioners, healthcare facilities, healthcare providers, emergency medical services, and other entities involved in CSC responses.

### Definitions of Key Terms

- **Decision-makers:** Persons tasked with making decisions regarding emergency responses or the allocation of scarce resources during a public health emergency on behalf of governmental bodies (e.g., federal, state, tribal, or local) or private sector entities (e.g., emergency response organizations, hospitals, health care providers, health insurance companies, or pharmaceutical companies).
- **Healthcare practitioner:** A person that furnishes healthcare or public health services.
- **Healthcare provider:** An organization or institution that provides healthcare or public health services.
- **Public health emergency:** Either (1) a declared state of emergency or public health emergency in which the health of the public is at risk; or (2) circumstances that require implementing a crisis standard of care as defined by IOM.

## Format

The Nevada CSC Code of Ethics includes core ethical guidelines (numbers 1.0, 2.0, 3.0 . . .) together with code language (1.1, 2.1 . . .) that reflects or is consistent with the corresponding core ethical guideline. Please note that the numbered order of the core ethical guidelines below is not intended to reflect priority. These ethical principles should be used to guide the delivery of healthcare across the state. The intent is to ultimately achieve the greatest good for the greatest number of persons.

## Core Ethical Guidelines:

- 1.0 **Justice and Fairness.** Justice and fairness are the moral and social principles that attempt to allocate scarce medical resources and services which are consistent, equitable, and non-discriminatory.
  - 1.1 While the focus is on saving the greatest number of individuals for the benefit of the community instead of the individual, responses to disaster must not exacerbate disparities or access to care. The level of service to any one individual should be consistent with the above focus.
  - 1.2 Persons critical to protecting the health and safety infrastructure may receive additional support to provide their services.
  - 1.3 Distinctions among patients ought to be based on medical assessment and probable success of treatment.
  - 1.4 The timing and content of a just system ought not to fall to individual healthcare providers.
  - 1.5 The needs of particularly vulnerable groups should be addressed to ensure that a greater burden does not fall to those groups.
  - 1.6 No prevailing treatment will establish the right to receive treatment. All treatment decisions ought to be based on resource availability and the best information available.
- 2.0 **Duty to care.** Healthcare practitioners have an ethical obligation to provide care during a response to a catastrophic public health emergency.
  - 2.1 The care provided by healthcare practitioners will necessarily differ from the care they provide under conventional conditions.
  - 2.2 Circumstances may require traditional patient-provider relationships be limited or altered.
  - 2.3 To the extent possible, patients will not be abandoned.
  - 2.4 Government and healthcare institutions should support healthcare practitioners in meeting conflicting duties or obligations.
  - 2.5 Healthcare practitioners may face disproportionate burdens or greater risks for the benefit of the community. Healthcare professionals may be prioritized for support and services to enable them to provide continued service to the community.



- 2.6 During a catastrophic public health emergency, patients may not receive all levels of care.
  - 2.7 Patients who are unable to receive conventional care or contingency care because capacities are overwhelmed should receive alternative forms of treatment or care, which may include palliative or comfort care if possible.
- 3.0 **Proportionality.** Burdensome requirements, (e.g., social distancing or school closures), should be commensurate with the scale of the catastrophic public health emergency and promise clear benefits that outweigh the burdens.
- 3.1 Government authorities should not overburden the public with restrictions. Restrictions should be as narrow as possible to address the needs of the community.
  - 3.2 Restrictive measures will be utilized only when essential to the response.
- 4.0 **Duty to steward resources.** Decision-makers at all levels should allocate scarce resources and services to preserve their effectiveness and impact.
- 4.1 To the extent possible, scarce resources must be managed during a catastrophic public health emergency to minimize morbidity and mortality.
  - 4.2 When resources are scarce, the patient who is most likely to medically benefit from the use of resources should be given priority.
- 5.0 **Transparency.** Officials should provide planning information to the community prior to a catastrophic public health emergency to facilitate public input. During such an event, officials should maintain clear communications with the community to provide situational and policy decision information.
- 5.1 During planning phases, officials should communicate clearly plans currently in place. Decisions should be open to public input and justifications for those decisions clearly explained.
  - 5.2 Planning activities should be characterized by consideration of community values and priorities, response to public comment, commitment to ongoing revision of policy based on dialogue and data, and accountability for support and implementation.
  - 5.3 During a catastrophic public health emergency, officials have an obligation to communicate to the community the decisions that have been made and the justification for those decisions.
- 6.0 **Accountability.** Agencies, healthcare practitioners, and healthcare providers at all levels of the healthcare system should accept and act upon their responsibilities.
- 6.1 Decision-makers and those responding to catastrophic public health emergencies, including healthcare practitioners and healthcare providers, are responsible for their actions (including failure to act).

6.2 The practitioner duty to care obligation is not absolute and practitioners may face conflicting ethical obligations, such as family obligations, performing procedures outside of a practitioner's scope of practice, or endangerment by caring for patients.

7.0 **Respect for persons.** To the extent possible, basic respect of a person's autonomy, dignity, privacy, and bodily integrity must be maintained, including honoring a patient's wishes.

7.1 In communication with the patient and family, healthcare practitioners and healthcare provider staff should be truthful and candid about a person's condition.

**Duty to plan**

8.0 **Duty to plan.** Government, healthcare providers, and the healthcare system have a responsibility to plan to the best of their abilities for catastrophic public health emergencies.

## Appendix D – Legal Authorities and References List

The list below includes, but is not exhaustive, federal and state authorities and references that apply to the NV CSC Plan. A brief explanation is provided for each authority and the Uniform Resource Locator (URL) is included for convenience in locating additional information.

### Federal Authorities

#### **Centers for Medicare and Medicaid Services (CMS) Emergency Medical Treatment and Labor Act (EMTALA)**

Congress enacted the Emergency Medical Treatment & Labor Act (EMTALA) to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare-participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html>

#### **Employee Retirement Income Security Act (ERISA)**

The ERISA regulates employers who offer pension or welfare benefit plans for their employees. Title I of ERISA is administered by the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration) and imposes a wide range of fiduciary, disclosure and reporting requirements on fiduciaries of pension and welfare benefit plans and on others having dealings with these plans. These provisions preempt many similar state laws. Under Title IV, certain employers and plan administrators must fund an insurance system to protect certain kinds of retirement benefits, with premiums paid to the federal government's Pension Benefit Guaranty Corporation (PBGC). EBSA also administers reporting requirements for continuation of health-care provisions, required under the Comprehensive Omnibus Budget Reconciliation Act of 1985 (COBRA) and the health care portability requirements on group plans under the Health Insurance Portability and Accountability Act (HIPAA).

<https://www.dol.gov/general/aboutdol/majorlaws#workerscomp>

#### **Fair Labor Standards Act (FLSA)**

The FLSA prescribes standards for wages and overtime pay, which affect most private and public employment. The act is administered by the Wage and Hour Division.

<https://www.dol.gov/general/aboutdol/majorlaws#workerscomp>

***Federal Continuity Directive 1 (FCD 1), Federal Executive Branch National Continuity Program and Requirements***, October 2012.

This Federal Continuity Directive (FCD) provides direction to the Federal Executive Branch for developing continuity plans and programs. The ultimate goal of continuity in the executive branch is the continuation of National Essential Functions (NEFs).

[https://www.fema.gov/media-library-data/20130726-1903-25045-0080/fcd\\_1\\_october\\_2012.pdf](https://www.fema.gov/media-library-data/20130726-1903-25045-0080/fcd_1_october_2012.pdf)

**Federal Food, Drug, and Cosmetic Act (FD&C Act), Section 564**

The FDA Commissioner may allow unapproved medical products or unapproved uses of approved medical products to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions caused by CBRN threat agents when there are no adequate, approved, and available alternatives. Section 564 of the FD&C Act was amended by the Project Bioshield Act of 2004 and the Pandemic and All-Hazards Preparedness Reauthorization Act of 2013 (PAHPRA), which was enacted in March 2013.

<https://www.fda.gov/regulatoryinformation/lawsenforcedbyfda/federalfooddrugandcosmeticactfdact/default.htm>

**Federal Volunteer Protection Act (VPA).**

Applies to uncompensated, individual volunteers of nonprofit organizations or governmental entities. Volunteers shall not be liable for harm caused by their acts or omissions on behalf of the organization or entity so long as they are: (1) acting within the scope of the volunteer's responsibilities; (2) properly licensed, certified, or authorized by the appropriate authorities as required by law in the state in which the harm occurred; (3) have not engaged in willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual(s) harmed by the volunteer; and (4) have not caused the harm by operating a motor vehicle, vessel, aircraft, or other vehicle for which the state requires its operator to possess an operator's license or maintain insurance.

<https://www.gpo.gov/fdsys/pkg/PLAW-105publ19/pdf/PLAW-105publ19.pdf>

***National Security Presidential Directive (NSPD) 15/Homeland Security Presidential Directive (HSPD) 20***, May 9, 2007

This directive establishes a comprehensive national policy on the continuity of Federal Government structures and operations and a single National Continuity Coordinator responsible for coordinating the development and implementation of Federal continuity policies.

<https://fas.org/irp/offdocs/nspd/nspd-51.htm>

**National Disaster Medical System (42 U.S. Code § 300hh–11)**

Regarding reimbursement for medical care:

(A) In general

The Secretary may activate the National Disaster Medical System to—

(i) provide health services, health-related social services, other appropriate human services, and appropriate auxiliary services to respond to the needs of victims of a public health emergency, including

at-risk individuals as applicable (whether or not determined to be a public health emergency under section [247d](#) of this title); or

(ii) be present at locations, and for limited periods of time, specified by the Secretary on the basis that the Secretary has determined that a location is at risk of a public health emergency during the time specified.

(D) Administration

The Secretary may determine and pay claims for reimbursement for services under subparagraph (A) directly or through contracts that provide for payment in advance or by way of reimbursement.

[http://uscode.house.gov/view.xhtml?req=\(title:42%20section:300hh-11%20edition:prelim\)](http://uscode.house.gov/view.xhtml?req=(title:42%20section:300hh-11%20edition:prelim))

### **Occupational Safety and Health (OSH) Act**

The OSH Act is administered by the Occupational Safety and Health Administration (OSHA). Safety and health conditions in most private industries are regulated by OSHA or OSHA-approved state programs, which also cover public sector employers.

<https://www.dol.gov/general/aboutdol/majorlaws#workerscomp>

### **Public Health Service Act (PHSA), Section 319. Public Health Emergencies.**

Section 319 provides the legal authority for the Department of Health and Human Services (HHS), among other things, to respond to public health emergencies.

[http://www.astho.org/uploadedFiles/Programs/Preparedness/Public\\_Health\\_Emergency\\_Law/Emergency\\_Authority\\_and\\_Immunity\\_Toolkit/12-PH%20Srv%20Act%20FS%20Final%203-12.pdf](http://www.astho.org/uploadedFiles/Programs/Preparedness/Public_Health_Emergency_Law/Emergency_Authority_and_Immunity_Toolkit/12-PH%20Srv%20Act%20FS%20Final%203-12.pdf)

### **Public Law 104-321. Emergency Management Assistance Compact (EMAC).**

The purpose of this compact is to provide for mutual assistance between the states entering into this compact in managing any emergency disaster that is duly declared by the Governor of the affected state, whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspects of resources shortages, community disorders, insurgency, or enemy attack.

<https://www.gpo.gov/fdsys/pkg/PLAW-104publ321/html/PLAW-104publ321.htm>

### **Public Readiness and Emergency Preparedness Act**

The Public Readiness and Emergency Preparedness Act (PREP Act) authorizes the Secretary of the Department of Health and Human Services (Secretary) to issue a declaration (PREP Act declaration) that provides immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats and conditions determined by the Secretary to constitute a present, or credible risk of a future public health emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. A PREP Act declaration is specifically for the purpose of providing immunity from liability, and is different from, and not dependent on, other emergency declarations.

<https://phe.gov/preparedness/legal/prepact/pages/default.aspx>

[https://www.hrsa.gov/getthehealthcare/conditions/countermeasurescomp/covered\\_countermeasures\\_and\\_prep\\_act.pdf](https://www.hrsa.gov/getthehealthcare/conditions/countermeasurescomp/covered_countermeasures_and_prep_act.pdf)

**Robert T. Stafford Disaster Relief and Emergency Assistance Act, As Amended, April 2013.**

The Stafford Act constitutes the statutory authority for most Federal disaster response activities especially as they pertain to the Federal Emergency Management Agency (FEMA) and FEMA programs.

<https://www.fema.gov/library/viewRecord.do?fromSearch=fromsearch&id=3564>

**Social Security Act, Section 1135 (42 U.S.C. § 1320b-5).**

When the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency, the Secretary is authorized to, among other things, waive or modify certain Medicare, Medicaid, Children's Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) requirements as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act (SSA) programs and that providers of such services in good faith who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse.

[https://www.ssa.gov/OP\\_Home/ssact/title11/1135.htm](https://www.ssa.gov/OP_Home/ssact/title11/1135.htm)

<https://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx>

**Uniform Emergency Volunteer Health Practitioners Act (UEVHPA)**

The UEVHPA, promulgated by the Uniform Law Commission (ULC) in 2006 and amended in 2007 allows state governments during a declared emergency to give reciprocity to other states' licensees on emergency services providers so that covered individuals may provide services without meeting the disaster state's licensing requirements. Nevada is among the states that have enacted this Act.

UEVHPA establishes a system whereby health professionals may register either in advance of or during an emergency to provide volunteer services in an enacting state. Registration may occur in any state using either governmentally established registration systems, such as the federally funded "ESAR VHP" or Medical Reserve Corps programs, or with registration systems established by disaster relief organizations, licensing boards or national or multi-state systems established by associations of licensing boards or health professionals.

<http://uniformlaws.org/LegislativeFactSheet.aspx?title=Emergency%20Volunteer%20Health%20Practitioners>

<http://uniformlaws.org/ActSummary.aspx?title=Emergency%20Volunteer%20Health%20Practitioners>

**42 U.S.C. § 247d-6d. Targeted liability protections for pandemic and epidemic products and security countermeasures.**

Subject to the other provisions of this section, a covered person shall be immune from suit and liability under Federal and State law with respect to all claims for loss caused by, arising out of, relating to, or resulting from the administration to or the use by an individual of a covered countermeasure if a declaration under subsection (b) has been issued with respect to such countermeasure.

<https://www.gpo.gov/fdsys/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap6A-subchapII-partB-sec247d-6d.htm>

## Nevada Authorities

**NRS 41.500–507** describes the liability of persons who render emergency care or gratuitous care. NRS 41.500 states that except as otherwise provided in NRS 41.505, any person in this State who renders emergency care or assistance in an emergency, gratuitously and in good faith, except for a person who is performing community service as a result of disciplinary action pursuant to any provision in title 54 of NRS, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by that person in rendering the emergency care or assistance or as a result of any act or failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured person. NRS 41.503 describes the limited liability for providing medical care and assistance necessitated by traumatic injury. NRS 41.504 provides liability information for physicians, physician assistants, and registered nurses who give instructions or provide supervision to emergency medical attendants during emergencies. In addition it provides information on liability for emergency medical attendants, physician assistants and nurses who obey instruction given by physician, physician assistant or nurse during an emergency. NRS 41.505 and NRS 41.506 further describe liability limitations for physicians, physician assistants, nurses, and dentists. NRS 41.507 describes liability protections for volunteer emergency medical dispatchers and volunteer medical directors of agencies which employ emergency medical dispatchers.

<https://www.leg.state.nv.us/NRS>

**NRS 239C.260**, Plan for continuation of state and local governmental operations in event of catastrophic emergency.

<http://www.leg.state.nv.us/Nrs/NRS-239c.html>

**NRS 284.180** Pay plan to set official rates applicable to all positions in classified service; overtime; workweek for certain firefighters; innovative workweeks; existing contracts of employment; payment for working on holiday.

<https://www.leg.state.nv.us/NRS/NRS-284.html#NRS284Sec180>

**NRS 284.181** Agreements concerning provision of compensatory vacation time instead of monetary payment for overtime.

<https://www.leg.state.nv.us/NRS/NRS-284.html#NRS284Sec181>

### **Chapter 414 of the NRS: Emergency Management**

The Governor may direct any state agency to exercise its authority and utilize its resources accordingly. Response by state departments and agencies providing lifesaving and life protecting activities under this plan takes precedence over other state activities, except where national security implications are determined to be of a higher priority by the Governor or the President. The Governor has delegated authority to the Department of Public Safety, Division of Emergency Management (DEM) for emergency management. Note: The Governor does not have to declare an emergency to request additional medical countermeasures from the CDC.

<http://www.leg.state.nv.us/Nrs/NRS-414.html>

In **NRS 414A**, Nevada Intrastate Mutual Aid System, NRS 414A.180 describes immunity and tort liability for activities performed by an emergency responder of an assisting participant. All activities performed pursuant to this chapter are deemed to be governmental functions for which immunity is provided under the provisions of NRS 414.110.

<https://www.leg.state.nv.us/NRS/NRS-414A.html>

**NRS 414.110** Immunity and exemption.

1. All functions under this chapter and all other activities relating to emergency management are hereby declared to be governmental functions. Neither the State nor any political subdivision thereof nor other agencies of the State or political subdivision thereof, nor except in cases of willful misconduct, gross negligence, or bad faith, any worker complying with or reasonably attempting to comply with this chapter, or any order or regulation adopted pursuant to the provisions of this chapter, or pursuant to any ordinance relating to any necessary emergency procedures or other precautionary measures enacted by any political subdivision of the State, is liable for the death of or injury to persons, or for damage to property, as a result of any such activity. The provisions of this section do not affect the right of any person to receive benefits to which he or she would otherwise be entitled under this chapter, or under the provisions of [chapters 616A to 616D](#), inclusive, or chapter [617](#) of NRS, or under any pension law, nor the right of any such person to receive any benefits or compensation pursuant to any act of Congress.

2. Any requirement for a license to practice any professional, mechanical or other skill does not apply to any authorized worker who, in the course of performing his or her duties as such, practices that professional, mechanical or other skill during an emergency or disaster.

3. As used in this section, “worker” includes, without limitation, any full-time or part-time paid, volunteer or auxiliary employee of this State, of any political subdivision thereof, of other states, territories, possessions or the District of Columbia, of the Federal Government, of any neighboring country, or of any political subdivision thereof, or of any agency or organization, performing services for emergency management at any place in this State subject to the order or control of, or pursuant to a request of, the State Government or any political subdivision thereof.

<https://www.leg.state.nv.us/NRS/NRS-414.html#NRS414Sec060>

**Chapter 415 of the NRS:** Emergency Management Assistance Compact

The purpose of this Compact is to provide for mutual assistance between the States entering into this Compact in managing any emergency or disaster that is duly declared by the Governor of the affected State(s), whether arising from natural disaster, technological hazard, man-made disaster, civil emergency aspects of resources shortages, community disorders, insurgency, or enemy attack.

Mutual assistance in this Compact may include the use of the States’ National Guard forces, either in accordance with the National Guard Mutual Assistance Compact or by mutual agreement between States.

<http://www.leg.state.nv.us/Nrs/NRS-415.html>



### **Chapter 439 of the NRS: Administration of Public Health**

The Nevada Division of Public & Behavioral Health (DPBH) is the state agency responsible to “protect, promote, and improve the physical and behavioral health of Nevadans”. It is established by the Nevada Legislature in Chapter 439 of the NRS, as amended.

<http://www.leg.state.nv.us/Nrs/NRS-439.html>

### **NRS 450B.795** Collection of data concerning wait times for provision of emergency services.

The State Board of Health collects data concerning waiting time for provision of emergency services to certain persons. Hospitals and providers of emergency services in certain counties are required to participate in collecting this data. Data is reviewed quarterly by an advisory committee which reports its findings to the State Board of Health.

<http://www.leg.state.nv.us/Nrs/NRS-450B.html#NRS450BSec795>

### **NRS Title 57 Chapter 679A** General Provisions (Nevada Insurance Code)

The purposes of this Code are to

- (a) Protect policyholders and all having an interest under insurance policies;
- (b) Implement the public interest in the business of insurance;
- (c) Provide adequate standards of solidity of insurers, and of integrity and competence in conduct of their affairs in the home offices and in the field;
- (d) Improve and thereby preserve state regulation of insurance;
- (e) Insure that policyholders, claimants and insurers are treated fairly and equitably;
- (f) Encourage full cooperation of the office of Commissioner with other regulatory bodies, both of this and other states and of the Federal Government;
- (g) Insure that the State has an adequate and healthy insurance market characterized by competitive conditions and the exercise of initiative;
- (h) Prevent misleading, unfair and monopolistic practices in insurance operations; and
- (i) Continue to provide the State of Nevada with a comprehensive, modern and adequate body of law, in response to the McCarran Act (Public Law 15, 79th Congress, 15 U.S.C. §§ 1011 to 1015, inclusive), for the effective regulation and supervision of insurance business transacted within, or affecting interests of the people of this state.

<https://www.leg.state.nv.us/NRS/NRS-679A.html>

### **NRS 630.020, 630.261, 630.275, 632.237, 633.165, 639.0727, 639.235.** Telemedicine

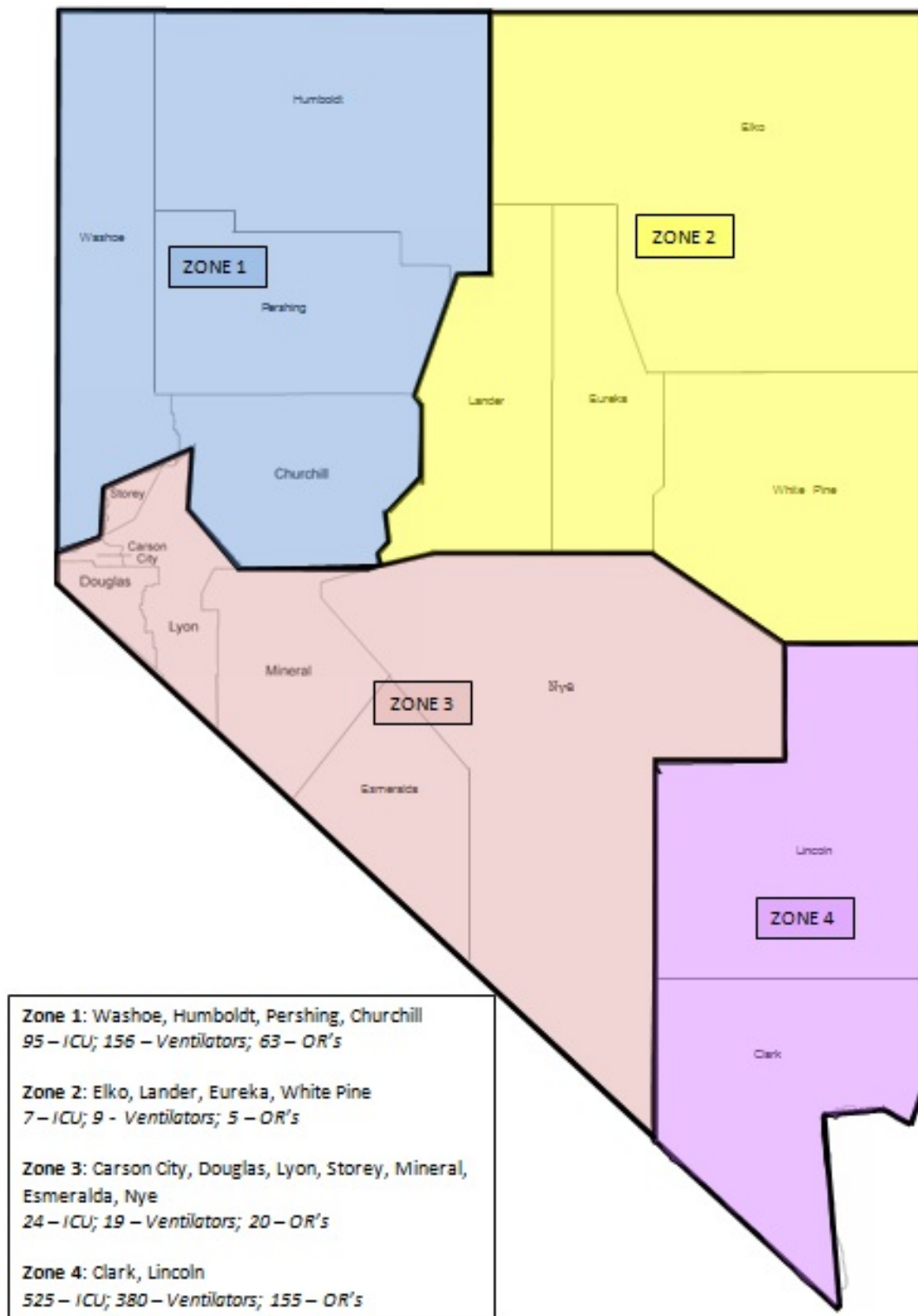
Telemedicine was specifically authorized in several chapters of the NRS through Senate Bill (SB) 327 (2013). Nevada law authorizes Nevada-licensed practitioners to practice via telemedicine within the scope of practice for their profession. In summary, any person who provides such services through telehealth to a patient located in this State: (1) is subject to the laws, including regulations, and jurisdiction of this State; and (2) is required to comply with all federal and state laws that would apply if the person were providing services from a location in this State

<https://www.leg.state.nv.us/NRS>

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## Appendix E – CSC Zone Map



\* Numbers reviewed annually, Ventilators and OR's can fluctuate based on equipment and staffing

## Appendix F – Acronym List

AAC	After-Action Conference
AAR	After-Action Report
ADA	Americans with Disabilities Act
AEMT	Advanced Emergency Medical Technician
AFN	Access and functional needs
AHRQ	Agency for Healthcare Research and Quality
ALC	Acute lymphocyte count
ALS	Advanced Life Support
APMHS	Alsept-Price Mental Health Scale
ARS	Acute radiation syndrome
ASPR	Office of the Assistant Secretary for Preparedness and Response
BLS	Basic Life Support
CBRN	Chemical, biological, radiological, and nuclear
CCC	Clinical Care Committee
CCEMT	Critical Care Emergency Medical Technician - Paramedic
CCT	Critical Care Transport
CDC	Centers for Disease Control and Prevention
CHIP	Children’s Health Insurance Program
CISM	Critical Incident Stress Management
CMS	Centers for Medicare and Medicaid Services
CNS	Central Nervous System
COBRA	Comprehensive Omnibus Budget Reconciliation Act
COOP	Continuity of Operations Plan
CSC	Crisis Standards of Care
CT	Computed tomography
DEM	Nevada Division of Emergency Management
DHHS	Department of Health and Human Services
DOC	Division or Department Operations Center
DOL	Department of Labor
DPBH	Division of Public and Behavioral Health
EBSA	Employee Benefit Security Administration
EBUCC	Emergency Back-Up Communications Center
ECMO	Extracorporeal membrane oxygenation
EMAC	Emergency Management Assistance Compact
EMC	Emergency Medical Condition
EMD	Emergency Medical Dispatcher

EMF	Expeditionary Medical Facilities
EMTALA	Emergency Medical Treatment and Labor Act
EMT-P	Emergency Medical Technician - Paramedic
EMR	Emergency Medical Responder
EMS	Emergency Medical Services
EMS RN	Emergency Medical Services Registered Nurse
EMT	Emergency Medical Technician
ENT	Ear, Nose, Throat
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EPON	Emergency Providers Organization of Nevada
ERISA	Employee Retirement Income Security Act
ERP	Emergency Response Plan
ESAR-VHP	Emergency System for Advance Registration of Healthcare Professionals
ESF	Emergency Support Function
ESI	Emergency Severity Index
FCD	Federal Continuity Directive
FD&C Act	Federal Food, Drug, and Cosmetic Act
FEMA	Federal Emergency Management Agency
FiO2	Fraction or percentage of oxygen in the space being measured
FLSA	Fair Labor Standards Act
FMHT	Fast Mental Health Triage Tool
FQHC	Federally qualified health clinic
GCS	Glasgow Coma Score
HAZMAT	Hazardous Materials
HHS	United States Department of Health and Human Services
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
HSPD	Homeland Security Presidential Directive
IC	Incident Command
ICP	Incident Command Post
ICS	Incident Command System
ICU	Intensive care unit
IDME	Immediate, delayed, minimal, and expectant
ILS	Intermediate Life Support

IOM	Institute of Medicine
IP	Improvement Plan
IV	Intravenous
JIC	Joint Information Center
MAP	Mean Arterial Pressure
MCAD	Medical Countermeasures Acquisition and Distribution
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MRC	Medical Reserve Corps
mSOFA	Modified Sequential Organ Failure Assessment
NAC	Nevada Administrative Code
NEF	National Essential Function
NICU	Neonatal intensive care unit
NIMS	National Incident Management System
NRS	Nevada Revised Statute
NSPD	National Security Presidential Directive
NV	Nevada
OSH	Occupational Safety and Health
OSHA	Occupational Safety and Health Administration
PACU	Post-anesthesia care unit
PAHPRA	Pandemic and All-Hazards Preparedness Reauthorization Act
PAIS	Bureau of Preparedness, Assurance, Inspections and Statistics
PaO2	Partial pressure of oxygen in arterial blood
PBGC	Pension Benefit Guaranty Corporation
PHP	Public Health Preparedness
PIC	Public Information and Communications
PICU	Pediatric intensive care unit
POD	Point of dispensing
PPE	Personal protective equipment
PREP Act	Public Readiness and Emergency Preparedness Act
PSAP	Public Safety Answering Point
PsySTART	Psychological Simple Triage and Rapid Treatment
qSOFA	Quick Sequential Organ Failure Assessment
REC	Regional Emergency Coordinator
RTS	Revised Trauma Score

SALT	Sort, Assess, Lifesaving intervention, Treatment/Transport
SB	Senate Bill
SBP	Systolic Blood Pressure
SDMAC	State Disaster Medical Advisory Committee
SCEMP	State Comprehensive Emergency Management Plan
SEOC	State Emergency Operations Center
SERV-NV	State Emergency Registry of Volunteers - Nevada
SMI	Serious mental illness
SNS	Strategic National Stockpile
SOFA	Sequential Organ Failure Assessment
SOP	Standard Operating Procedure
SpO2	Peripheral capillary oxygen saturation
SSA	Social Security Act
START	Simple Triage and Rapid Treatment
SWMSP	Statewide Medical Surge Plan
ULC	Uniform Law Commission
URL	Uniform Resource Locator
UEVHPA	Uniform Emergency Volunteer Health Practitioners Act
VPA	Volunteer Protection Act