Central Florida Disaster Medical Coalition

Crisis Standards of Care Guidelines

Approved by CFDMC Board 6-21-22

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RECORD OF CHANGES & DISTRIBUTION

Changes	Distribution
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INTRODUCTION

Crisis Standards of Care are defined as a substantial change in routine healthcare operations and the level of care possible to deliver due to severe shortages of critical resources causing the delivery system to be overwhelmed. Central Florida is regularly exposed to multiple types of hazardous events, from wildfires to hurricanes that could cause the use of crisis standards. Most recently, COVID-19 has shown significant consequences and shortages of personal protective equipment (PPE) and trained personnel for high respiratory distress virus.

Healthcare facilities and agencies will determine decisions and strategies affecting patient care during times of crisis. When care needs exceed available resources, this necessitates coordination and collaboration between providers and incident managers to determine the best use of limited resources and, if necessary, to establish care modifications as care moves from the Conventional and Contingency phases into the Crisis phase. The information must be forwarded to the Healthcare Coalition and other responding partners.

The Healthcare Preparedness Program (HPP) continuously evolved in Florida, and geographic boundaries were set for the healthcare coalitions in Florida. Healthcare facilities utilized the healthcare coalitions for information sharing. Then recently with COVID, it has been more utilized for more than information sharing i.e., resource sharing, communications, coordination of information amongst facilities.

Other occasions in the past include the 2015 Ebola Virus Disease incident, when it was crucial to review how to respond to new or re-emerging infectious disease outbreaks. During this incident, there was the opportunity to establish procedures, resources, equipment, and training to provide care under the current standards of care with a limited supply of appropriate PPE to protect healthcare providers. Considering these threats to public health and our experience with actual and potentially catastrophic events, it was recommended that a more formal review of current best practices be conducted, and a guidance document be developed to address the issue from an all-hazards perspective.

During the Ebola virus event, the State of Florida Department of Health Bureau of Preparedness took the initiative to begin a review of current literature and evidence-based practices relating to the need to respond to a public health emergency in which patients will seek and require medical care. The Florida Infectious Disease Team (FIDTN) was formed and is located throughout Florida.

Central Florida Disaster Medical Coalition (CFDMC) has continued providing training and equipment and conducting exercises for all crisis situations. The coalition developed the CFDMC Trauma MCI Coordination Plan to ensure load-balancing across healthcare facilities and systems so that healthcare facilities can provide the highest possible level of care to all patients who need that care before transitioning hospitals toward crisis measures. The CFDMC Crisis Standards of Care Workgroup drafted the plan based on the concepts outlined in the ASPR Medical Operations Coordination Cells (MOCCs) initiative. The plan focuses on the delivery of healthcare services. It operates as a component of the Emergency Support Function #8, Public Health and Medical Services (ESF-8) activities, bringing the medical aspect of ESF-8 into emergency operations centers (EOCs) to guide the appropriate movement of patients along the care continuum.

CFDMC wishes to recognize the Crisis Standards of Care Workgroup Members

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PURPOSE

The purpose of the CFDMC Crisis Standards of Care (CSC) guidelines is to provide a clinical framework for emergency medical services, healthcare systems, and facilities to plan, prepare for and respond to emergencies that present in resource-limited environments. In addition, this document provides a guide for making informed decisions based on the premise of the CSC which is to do the greatest good for the greatest number of persons. The oversight goal is to achieve the most significant and diverse allocation of patient care during all phases of a public health or medical emergency.

Adaptation of the CFDMC CSC guidelines will empower coalition and regional partners at the point of care during emergencies to allow for more informed decision-making. Members of the coalition include all healthcare partners, county health departments, emergency management, and other agency types identified by CMS to be a part of healthcare coalitions.

BACKGROUND

Florida is bordered to the west by the Gulf of Mexico, to the northwest by Alabama, to the north by Georgia, to the east by the Bahamas and the Atlantic Ocean, and the south by the Straits of Florida and Cuba; it is the only state that borders both the Gulf of Mexico and the Atlantic Ocean. Spanning 65,758 square miles, Florida ranks 22nd in area among the 50 states and, with a population of over 21 million, is the third-most populous.

Florida contains the highest percentage of people over 65 (17%) in the US. There were 186,102 military retirees living in the state in 2008. About two-thirds of the population was born in another state, the second highest in the U.S.

Central Florida is uniquely vulnerable to large-scale disasters. The July 2019 US Census estimates 4.5 million people reside in the nine counties representing East Central Florida (Central Florida Regional Domestic Security Task Force, Region 5 or RDSTF-5). Winter residents dramatically increase this population. In addition, domestic and international tourists flock to Central Florida for golf, shopping, water sports, theme parks and conventions. Orlando is the number one most visited destination in the world. Orlando International Airport was the 10th busiest airport in the nation before the pandemic with approximately 50 million passengers each year and rebounded at twice the average rate of travelers in December 2020. Visitors also arrive in Central Florida via cruises at Port Canaveral, Florida's fastest-growing port and the second busiest port in the world, with more than 5 million travelers annually. There are three large chemical manufacturing plants within the region. Multiple international and commercial airports and freight and passenger railroad services across the region exist.

Since this document was created, the coalition still needs to receive instructions for a state-wide strategy for crisis standards of care. Upon receipt of said guidance the coalition will develop a strategy that lists future activities to promote the development and implementation of the CSC plan. Further, the CFDMC will include recommendations for planning, training, exercising, and distributing the state guidance.

SCOPE

The CFDMC Crisis Standards of Care Workgroup drafted this CSC document to provide background and planning guidance for developing an approach to understanding the circumstances and triggers that could result in an immediate need to implement altered standards of care, whether the precipitating event is the result of an act of weather, natural disasters, terrorism, public health pandemics, infectious diseases, medical emergencies, mass casualty event (MCE), or inadequate resources available to maintain the current standard of care.

While the CFDMC CSC guidance development included both a hurricane event and an infectious disease pandemic, the guidelines outlined are consistent approaches to catastrophic events of any nature where it would become necessary to allocate scarce resources. Making optimal decisions concerning allocating scarce resources is essential in determining the degree to which healthcare systems continue to function.

GUIDING PRINCIPLES AND ETHICAL CONSIDERATIONS

Public health emergencies raise ethical challenges for healthcare professionals and institutions at every level. The primary role in these cases is to protect the health and welfare of the community, not the individual. During a public health emergency with the threat of high morbidity and mortality, like COVID, demands exceeding capacity for care may result in a situation where the ultimate clinical goal is to do the greatest good for the greatest number of people. Services may not be available in a disaster. It is essential to identify, plan and prepare for making necessary adjustments in medical care standards to ensure that the care provided in response to mass events results in as many saved lives as possible.

The CFDMC is designated as the Region 5 lead health and medical (ESF-8) agency. It is the responsibility of our member organizations and the medical staff at those organizations to provide care. The Coalition aims to equip healthcare practitioners with information and future resources. Principles are formalized and instituted to guide decision makers through public health emergencies and plan for response.

In addition to the ethical framework, several key concepts listed below shaped the guidance for the development process of the Crisis Standards of Care Plan:

1) Promote fairness and consistency in health care during a crisis
If we agree on care strategies and share them broadly before a crisis occurs, healthcare workers will have a standard to guide their actions. The consistent implementation ensures that resources are allocated using the same priorities and principles.
- Duty to care
- Duty to steward resources
- Duty to plan
- Distributive justice
- Transparency

2) Ensure an open process in both development and use of the guidance
The broader healthcare community and the public need to be aware of and involved in crisis care planning. Strategies used to decide who receives what kind of care in a crisis need to be available to the public.

3) Recognize the critical differences in the medical needs of children and adults, including the differences in their care.
Crisis care guidance must address the special needs of children and others with special healthcare needs.

4) Ensure the availability of factual, current information about any crisis
Coordination between agencies, healthcare systems, media, and the public is needed to provide accessible, accurate, and valuable information. In a crisis, it should be clear when people need medical evaluation and when they can be cared for at home or alternative sites.

5) Employ strategies beyond those used in routine care only when and to the degree required by the crisis at hand
Non-routine strategies should be initiated or continued only if the situation warrants them. Coordination is vital for effective healthcare crisis response. Communication among health systems, between healthcare providers--hospital and non-hospital-based--and across jurisdictions enables a community to use resources more efficiently.

PLANNING STRATEGIES

The strategies outlined in this plan may be used at any time prior to the commencement of a crisis to enhance responsiveness. As with the surge capacity and triage strategies, best practices are considered specific to healthcare and other considerations; however, most are broadly applicable:

- Create contingency plans to ensure the continuity of critical functions during a crisis. Identify potential alternate care sites (e.g., long-term care facilities, veterinary hospitals, surgery centers) with suitable infrastructure to support the acute care of ill or injured patients.
- Develop draft requests for Centers for Medicare and Medicaid Services (CMS) to waive specified provisions of the Emergency Medical Treatment and Labor Act (EMTALA) or other federal laws that may present barriers to effective crisis response.
- Develop draft requests to Florida licensing boards for waivers in licensing, documentation, and other requirements that may present barriers to effective crisis response.
- Develop/update memoranda of agreement with potential suppliers, alternate care sites, and other healthcare employers to maximize space, staff, and supplies availability.
- Involve all staff, clinical and non-clinical, in some level of workplace emergency and disaster preparedness, including individual/family preparedness (to allow employees to come to work and/or work non-routine schedules).
- Cross-train staff, as practical, to maximize available staffing for critical healthcare functions.
- Plan periodic exercises to support regional and facility proficiency in implementing key components (e.g., triage and resource allocation) of crisis care response.
- Develop clinical consultation networks for crisis care of children and others with special care needs (e.g., burns, trauma, hazardous exposures).
- Develop subject matter expert networks for behavioral health needs in each county during the crisis.
- Involve clinicians with pediatric and other relevant expertise in crisis care planning.
- Plan with law enforcement to ensure the safety of those using health facilities in a crisis.
- Stock sufficient supplies to maintain care for 96 hours.
- Prioritizing clinical and non-clinical healthcare personnel, including personal protective equipment, relevant vaccines, and other preventive measures to maintain staffing levels
- Create a regional EOP that healthcare facilities can adopt (see appendices)

CONCEPT OF OPERATIONS

When state or federal authorities declare an emergency, the legal environment changes. It enables specific legal and regulatory powers and protections for public health and healthcare providers concerning their actions and omissions associated with allocating and utilizing scarce medical resources and implementing crisis standards of care (CSC). This guidance provides a delineated continuum of care from normal operations to eventual crisis standards. The continuum involves the scarcity of all other resource options until it is no longer feasible to provide routine care, including strategies to utilize and optimize existing resources, and augment existing resources from numerous partners and sources.

Basic medical procedures for immediate care permit some actions during crisis that are unacceptable under ordinary circumstances, such as implementing resource allocation protocols that could preclude the use of certain resources on some patients when others would derive greater benefit from them (i.e., ventilators, ICU beds). Healthcare professionals are always obligated to provide the best care they reasonably can to each patient, including during crises. When resource scarcity reaches catastrophic levels, healthcare entities are ethically justified. They are ethically obligated to use the available resources to sustain life and well-being to the greatest extent possible.

While it is recognized that crisis require extraordinary decisions during high stress situations, implementing CSC must also include a number of patient safeguards, to include but not be limited to, ensuring patients are not treated differently because of their race, nationality, culture, religion, sexual orientation or other factor; ensuring patients with DNRs, Advanced Directives, etc. are not given lesser standards of care.

The final determination as to the applicability of the information contained in the CFDMC CSC planning document is very dynamic by virtue of:

• The event and its variables and circumstances, information available, resources and inventories on hand and availability of adequately trained staff, medical supplies, and equipment for major events

• The locations and structures in which the region's healthcare partners can provide care, i.e., alternate care sites, testing at various locations, shelters, etc.

Implementation of the CFDMC CSC would entail following federal guidance by meeting the following conditions:

• Identification of critically limited resources and infrastructure

• Surge capacity fully employed within the healthcare facility and knowledge of alternate facilities for surge medical patients

• Maximal attempts at allocation, reuse, adaptation, and substitution performed for PPE and other associated equipment

• Patient transfer or use of evacuation equipment (Ambu-bus) if possible or implications to agencies if transfers are started too late and cause impairment to first responders.

• Request for necessary resources made to local and regional health officials through county, state, or regional agency contacts (Emergency Managers, ESF-8, County DOH, State ESF-8, Federal DMAT teams, regional response teams)

• Declared state of emergency, federal declarations, Executive Orders, or other authoritative documentation.

RESPONSE CAPABILITIES

CFDMC's current operational and response capabilities include the following.

INFORMATION SHARING:

The Coalition has redundant communication capabilities with its members, with over 2,000 individuals representing more than 800 organizations. During blue skies, the Coalition uses Constant Contact and the website to share information on meetings, plans, trainings, and exercises with its members. During exercises and grey skies, the Coalition uses the Everbridge health alert network and EMResource to share information with members. In an event, members receive a wealth of information from multiple mechanisms, including the news media and local emergency management. The Coalition's role in information sharing is to monitor communications from local and State ESF-8 and other trusted sources and to share information with member organizations not provided via other sources, such as regional status. For example, during COVID-19, CFDMC generated daily situation reports, including highlights from discipline-specific coordinating calls, regional data, and other resources. The CFDMC situation reports offer quick access to relevant information from local, state, and federal resources.

Any decisions made to alter standards of care must be communicated to the following before being implemented:

- County EMS Medical Director
- Local Emergency Operations Center(s)
- Local ESF-8 and State Department of Health
- AHCA

RESOURCE COORDINATION:

The process for redistribution of available resources during a medical surge event is outlined below.

- If a Coalition member organization needs assistance during a disaster response (staff, equipment, supplies, or other resources), the member organization submits a request to the County Emergency Operations Center (EOC). The county is responsible for trying to fulfill the individual's request. The Coalition member organization may also notify the Coalition that a resource request has been made to the county, so the Coalition can work with other members to try to secure the resource.

- If the County EOC cannot fulfill the request, the County submits requests to the State EOC through WebEOC. Once the State EOC has received a request from a county, it is initially processed by the County Liaison Desk under the direction of the Operations Support Branch, who verifies the information. From there, it is assigned to the proper branch for tasking to the appropriate ESF. If the ESF can meet the provisions of the request, resource information is forwarded to the county EOC. If the ESF cannot provide the requested resources, it is then forwarded to the Logistics Section, who will work with either private vendors or through the Emergency Management Assistance Compact (EMAC) to secure the resources. If the resources are identified from private sources, the vendor information is provided to the county Emergency Operations Center.

- The Coalition monitors all resource requests and attempts to find needed resources from within the region. If a resource requested is readily available locally through the Coalition or other member organizations, the Coalition will notify the State ESF-8 desk and the local requestor of the available local resources. If directed by the State ESF-8 desk, the Coalition will put the requesting organization in touch with the organization providing the resource to arrange the transfer of the resource.

REGIONAL TRAUMA COORDINATION PLAN:

The Region 5 Trauma MCI Coordination Plan seeks to offer load-balancing across healthcare facilities and systems so that healthcare institutions can give the highest degree of treatment feasible to all patients who require it before resorting to crisis measures. The plan is based on the concepts outlined in the ASPR Medical Operations Coordination Cells (MOCCs) initiative. The plan focuses on the delivery of healthcare services and operates as a component of the Emergency Support Function #8, Public Health, and Medical Services (ESF-8) activities, bringing the medical aspect of ESF-8 into emergency operations centers (EOCs) to guide the appropriate movement of patients along the care continuum.

Hospitals are encouraged to notify the Coalition early so the Coalition can assist with resource allocation and stand up the RTCC/MOCC for load-balancing across the region. Each facility should have a plan in place at the facility level.

REGIONAL MEDICAL ASSISTANCE TEAM (RMAT):

The Central Florida Disaster Medical Team (CFDMT) is a Regional Medical Assistance Team (RMAT), a group of volunteer responders whose purpose is to stabilize, treat, and transfer, as appropriate, patients during a disaster or a community-sponsored event such as air shows, marathons, and concerts. The CFDMT comprises trained /credentialed command staff, physicians, physician assistants, nurses, emergency medical technicians, paramedics, and administrative and logistics personnel. Mission types include set-up and operation of alternate care sites and responder rehabilitation. During 2020 and 2021, the CFDMT provided an Incident Management Team (IMT) to assist state operations during the pandemic.

FRAMEWORK FOR CSC

CFDMC will follow the framework recommended to address the issue of crisis standards of care from state and local public health departments, local and state government representatives, and providers from the healthcare community, including relevant medical disciplines, nursing, emergency medical services, palliative care, hospice, home health care agencies, and healthcare and hospital administrators. Some recommendations and a strategy to modify this CSC plan may include the following.

• Develop crisis standards of care protocols

• Seek community and provider engagement

• Ensure consistency in CSC implementation

The ethical features of the CSC will consist of fairness, a duty to share due to Governmental orders, and forced orders that may be made in emerging situations or crises.

Common Indicators for CSC, for example:

- Situation is causing individual healthcare organizations to consider the initiation of surge protocols
- Healthcare facilities are maximizing surge capacity at their facility and throughout the HCC
- HCC members are working together to utilize and maximize available resources
- HCC members are working together to avoid noncritical use of scarce resources
- Healthcare facilities are using appropriate resources to facilitate the discharge of inpatients and consider or initiate postponing elective procedure surgeries
- When all other options are no longer available
- HCC will make every effort to assist in securing additional resources to reduce the impacts
- HCC members are collecting and responding to information shared

CFDMC member agencies should identify trigger points for activating their plans (see examples below):

Sample Indicators, Triggers, and Tactics by Discipline

Discipline	Indicator	Trigger	Tactic
Emergency management	National Weather Service (NWS) watches/ warnings	NWS forecasts Category 4 hurricane landfall in 96 hours	Issue evacuation/shelter orders, determine likely impact, support hospital evacuations with transportation resources, risk communication to public about event impact
Public health	Epidemiology information	Predicted cases exceed epidemic threshold	Risk communication, consideration of need for medical countermeasures/ alternate care site planning, establish situational awareness and coordination with EMS/hospitals/ long-term care facilities
Emergency medical services (EMS)	911 call	X casualties	Automatic assignment of X ambulances, supervisor, assignment of incident-specific radio talk group
Inpatient	Emergency department (ED) wait times	ED wait times exceed X hours	Increase staffing, diversion of patients to clinics/urgent care, activate inpatient plans to rapidly accommodate pending admissions
Outpatient	Demand forecasting/ epidemiology information	Unable to accommodate number of requests for appointments/ service	Expand hours and clinic staffing, prioritize home care service provision, increase phone support
Behavioral health	Crisis hotline call volume	Unable to accommodate call volume	Activate additional mental health hotline resources, "immunization" via risk communication, implement psychological first aid (PFA) techniques and risk assessment screening in affected areas

Facilities are encouraged to develop a group made up of, but not limited to, the SMEs, who can help with ethical issues concerning how clinical decisions will be made:

- HICS Incident Commander
- HICS Medical Staff Director
- Corporate Incident Commander
- Healthcare Emergency Management
- Chief Medical Officer or designee
- Chief Nursing Officer or designee
- Legal Counsel
- A logistician
- A critical care expert
- A clinical ethics expert
- A social worker
- A chaplain
- A person with a disability
- A Pediatrician (where pediatric patients are involved)
- Chief Quality Officer

PALLIATIVE CARE AND COMFORT CARE

The following definition of palliative and comfort care, followed by the bulleted items, are adapted from the World Health Organization **http://www.who.int/cancer/palliative/en/:**

Palliative and comfort care intend to improve the quality of life for patients and their families facing life-threatening illnesses and injury by preventing and relieving suffering through early identification and treatment of pain and other physical, psychosocial, and spiritual problems.

Palliative and Comfort Care:

- Provide relief from pain and other distressing symptoms
- Affirm life and regard dying as a normal process; it is not intended to either hasten or 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 counseling, 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 is the active total care of the child's body, mind and spirit and involves supporting the family.

Palliative and comfort care begins when illness is diagnosed and continues regardless of whether a child receives treatment directed at the disease.

Healthcare professionals should evaluate and alleviate a child's physical, psychological, and social distress.

Effective comfort care requires a broad multidisciplinary approach that includes the family and uses available community resources; it can be implemented even when resources are limited.

Palliative and comfort care can be provided in acute care facilities, out-of-hospital care, alternate care sites, or children's homes.

Palliative care patients/ Comfort care patients:
Individuals for whom curative therapies are futile, given available resources

Decisions must be taken during CSC to balance the requirement for life-saving care for patients who would likely benefit from treatment versus patients for whom life-saving therapy is likely to prove futile. At a minimum, comfort care services for disaster victims will include relief of severe symptoms and comfort as people face end-of-life decisions.

The delivery of palliative and comfort care will be adapted per the type and severity of the disaster.

PSYCHOSOCIAL SUPPORT

Medical intervention is only one component of palliative and comfort care. During a CSC response with limited clinical resources, psychosocial support may be the only available source of comfort. As with other types of clinicians, behavioral health staff and others qualified to provide psychosocial support in a disaster (e.g., social workers, religious/spiritual advisors, and other responders trained in psychological first aid) will be in short supply. CFDMC will assist in the coordination of available resources.

BEHAVIORAL HEALTH

During a CSC response, CFDMC Leadership will consider four main issues related to behavioral health:

• The behavioral health and psychosocial impact of the disaster on the public

• The behavioral health and psychosocial impact on first responders and medical professionals

- The impact of the disaster on the availability of behavioral health services, including:
    - Availability of CSU and psychiatric hospital beds
    - Availability of detoxification and Addictions Receiving Facility beds
    - Availability of Crisis Response / Mobile Response Teams

• The impact of the disaster on the state's seriously mentally ill population, including a continuation of care.

The CFDMC has developed a Disaster Behavioral Health Plan to provide guidance to mitigate the adverse effects of disaster-related trauma by promoting and restoring psychological well-being and daily life functioning of affected individuals and communities.

INSTITUTE OF MEDICINE (IOM) AND CENTERS FOR DISEASE CONTROL (CDC)

The IOM in 2009 defined "crisis standards of care" as;

A substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations.

FS 765.101(4) (http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0765/0765.html) uses this standard to identify (in)effectiveness of a treatment, i.e., "end-stage condition" is defined as "an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective." That probability concept is sometimes known as the "standard of medical reasonableness."

Ethics Subcommittee of the Advisory Committee to the Director, Centers for Disease Control and Prevention (CDC), proposed to aid in decision making regarding the field of all-hazard public health emergency preparedness and response. "Ethical Guidance for Public Health Emergency Preparedness and Response: Highlighting Ethics and Values in a Vital Public Health Servicepdf icon,"

EXPANDING SCOPES OF PRACTICE

The scope of clinical practice is defined as the extent of a licensed healthcare professional's ability to provide services consistent with their competence, license, certification, and privileges. Most healthcare professionals' scopes of practice are delineated by rules and regulations describing a range of responsibilities, including the extent and limits of procedures, actions, and processes that a healthcare provider may undertake in keeping with the terms of their professional license, including requirements for training and continuing education. CFDMC will support local, state, and agency efforts by expanding the scope of practice for clinical care and comfort practice.

LEGAL AUTHORITY

The Crisis Standards of Care Plan does not alter the existing authorities of Federal, State, or local agencies or Tribal governments. The Plan provides a collective interoperability framework for emergency response action, including response and recovery activities during and after an emergency incident response requiring activation of Crisis Standards of Care.

This CSC Plan and its components may be used in conjunction with other Federal, State, Tribal, and local incident management and All Hazards Emergency Operations Plans developed under these and other authorities as well as Memorandums of Understanding (MOU's) or Memorandums of Agreement (MOA's) among various Federal and State agencies.

The need for crisis standards is justified by specific circumstances and may or may not be triggered by a formal declaration of emergency, disaster, or public health emergency (with input from state, regional or federal authorities), in recognition that crisis operations will be in effect for a sustained period.

These CFDMC CSC planning materials are not intended to be official policy but rather to present options for healthcare professionals and facilities to consider when preparing their reaction to an event in which the decision to allocate scarce resources in a manner that is different from ordinary circumstances but appropriate to the scenario is made.

Emergency declarations precipitate different authorities that facilitate response efforts and processes of public, private, and volunteer organizations. Emergency declarations trigger an array of non-traditional powers that are designed to facilitate response efforts through the public and private sectors that are critical to responding to complex incidents across the continuum of care.

Emergency Laws may:

- Provide government with sufficient flexibility to respond
- Mobilize central commands and infrastructures
- Encourage response efforts by limiting liability
- Authorize interstate recognition of healthcare licenses and certifications
- Allocate healthcare personnel and resources
- Help to change medical standards of care and scope of practice

The CFDMC CSC Framework (2012) identifies the following legal issues for healthcare practitioners and entities responsible for emergency preparedness:

- Personnel
- Access to treatment
- Coordination of health services
- Patient's interest
- Resource allocation
- Liability
- Reimbursement

- Inter-jurisdictional cooperation
- Activation of alternate care sites by facilities

APPENDICES AND LINKS

Region 5 Mass Casualty Incident (MCI) Trauma Coordination Plan
https://www.centralfladisaster.org/resources

CFDMC Fatality Management Plan
https://www.centralfladisaster.org/resources

CFDMC Behavioral Health Response Plan
https://www.centralfladisaster.org/resources

Crisis Standards of Care Resources
https://www.nationalacademies.org/events

Florida Bioethics Network information
https://fbn.miami.edu/

Hospital Tool Kit
http://www.nationalacademies.org/hmd/%7E/media/Files/Report%20Files/2013/CSC-Triggers/HospitalandAcuteCareToolkit.pdf

Framework for Catastrophic Disaster Response: Volume 1
https://www.nap.edu/catalog/13351/crisis-standards-of-care-a-systems-framework-for-catastrophic-disaster

American Society of Law, Medicine & Ethics
https://aslme.org

World Health Organization
http://www.who.int/cancer/palliative/en/

Florida Statute
FS 765.101(4) (http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&URL=0700- 0799/0765/0765.html)
CDC Guidance

Hospital Crisis Standards of Care Policy Template (attached)

Hospital Crisis Standards of Care Policy Template

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

Title:	**CRISIS STANDARDS OF CARE**	Policy #:	
		Replaces #:	
Page:	16 of 11	Developed By:	Clinical Nursing, Pharmacy, Supply Chain Services, Legal, Compliance & Ethics, Emergency Management
Issue Date:	**XX**	Approved By:	
Revision Dates:			

I. PURPOSE:

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

II. DEFINITIONS:

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

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

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

C. Authority Having Jurisdiction (AHJ) is the organization, office, individual or other statutory authority responsible for approving equipment, materials, installation, or a procedure.

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

E. Corporate Command Center (CCC): A centralized protected physical site at which senior organization executives and key personnel respond during an emergency to coordinate information and resources to support company incident management activities.

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

G. Critical Incident Stress Debriefings (CISD): Intervention intended to help small, homogenous groups of 12-20 team members who already have some existing relationship. It is intended to help team members find a way to relate and mitigate the impact of critical incidents. It is not meant to be group therapy or a substitute for therapy and it is best used between 24 to 72 hours of a critical incident. However, it can take days or even 3-4 weeks after the critical incident. Critical Incident Stress Management (CISM): An adaptive, short-term psychological helping process that focuses solely on an immediate and identifiable problem. It can include pre-incident preparedness to acute crisis management to post-crisis follow-up.

H. Defusings: Intervention intended to help homogenous (same) groups of 12-15 team members lasting approximately 15-45 minutes. It consists of introduction, brief exploration of the team members' experience,

and information on symptoms, coping skills, and resources. This intervention is best used within 8-12 hours of a critical incident.

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

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

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

L. Everbridge: The use of a corporation-wide mass communication system to alert, through various formats, all organization team members for emergency contact purposes. Hospital Incident Command System (HICS): Designed to handle any routine or scheduled events, catastrophes, or disasters of any size or type in a hospital. HICS is based on the Incident Command System's National Incident Management System (NIMS) from the Department of Homeland Security (ICS). HICS allows for personnel from different agencies or departments to be integrated into a standard structure that effectively addresses issues, delegates responsibilities, ensures communication, and eliminates duplication of services.

M. Health Facility Reporting System (HFRS): AHCA's online health care facility status reporting system.

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

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

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

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

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

III. POLICY:

It is the policy of the organization to:

A. Rapidly identify and communicate internally any situation that creates, or has the potential to create, a substantial change in everyday healthcare operations and the level of patient care delivered. Assess and stabilize patients affected by any such situation; assess operations and make adjustments where necessary; continue essential operations where possible and alter or discontinue certain services if the safety of patients cannot be ensured.

B. Communicate and collaborate with local, regional, state and federal authorities to address any areas of need that are beyond the organization's control, as required.

C. Consider all forms of assistance, including non-conventional support and services, to ensure the continued wellbeing of patients.

D. Make informed, compassionate decisions to do the greatest good for the greatest number of persons during austere conditions.

IV. PROCEDURE:

A. Moving away from the normal standards of patient care can become necessary because of the austere conditions that follow a catastrophic disaster. In such a situation, a clear declaration is needed that a Crisis Standard of Care context exists within the organization, supporting physician and hospital leadership's situational awareness of patient loads, limited resources, and changing guidance and policies. Situational awareness of patient load, staffing, and resource availability is critical to supporting clinician decision-making for triage or allocation of life-sustaining care. Implementation of Crisis Standard of Care measures within the organization must align with clinical realities. Specific clinical guidance about the scope of any

such declaration, such as which resources or processes it applies to, must be made and communicated to clinical personnel.

B. Strategies:
   1. Activation of CCC/HICS:
      B. When the organization (or a region) determines that a Crisis Standard of Care context exists, it must immediately activate the CCC and HICS at all institutions to start addressing the problem at a systemic level and ensure that all sites are coordinated in terms of resources and care. This approach will reduce the potential for one location to implement triage processes when others may have available resources.
         a. The site HICS shall work closely with providers and all clinicians to be certain that all are aware of clinical needs and available resources.
         b. The CCC/HICS shall begin to implement strategies to prevent critical shortages. These shall consist of, but not be limited to internal and external messaging, staffing, expanding surge spaces, patient triage decisions, supplies and medication adjustment strategies.
   1. Activation of the organization Executive Policy Group:
      a. Activating the Executive Policy Group shall be considered to assist the CCC with decision making.
      b. The Executive Policy Group has the authority to make decisions, commit resources, obligate funds, and provide the resources necessary to support the organization's patients, staff, and facilities.
   2. Government Affairs:
      a. Any disaster impacting the organization's area of operations is likely to affect other hospital/healthcare system's ability to operate normally.
      b. To support an effective response the CCC Incident Commander shall, where considered necessary, authorize the organization's Government Affairs to:
         1) Request Centers for Medicare and Medicaid Services (CMS) to waive specified provisions of the Emergency Medical Treatment and Labor Act (EMTALA) or other federal laws that may present barriers to effective crisis response.
         2) Request the Florida licensing boards waiver licensing, documentation, and other requirements that may present barriers to effective crisis response.

C. Messaging:
   1. The organization's Internal Communications shall work with the Chief Medical Officer and their designee(s) to create clear messaging for providers and clinicians.
   2. Messaging must clearly state the situation that created the austere conditions, how this is/has impacted the organization and how the organization is responding.
   3.

The messaging must provide clarity on the difference between triage decisions that are made daily versus triage decisions that are involved during a crisis.

D. Resources:
   1. Additional resources shall be considered, as per Attachments A and B.
      a. Staffing:
         1) The CCC/HICS must consider applying non-typical, regional support processes to help offset hospital/healthcare system stressors.
         2) Staffing may be categorized to accommodate for changing nurse to patient ratios, which varies depending on the acuity of the patients and any needed adjustments, as outlined in Attachment B.
         3) These can include, but are not limited to:
            a) Use family members/lay volunteers to provide basic patient hygiene and feeding, releasing staff for other duties.
            b) Utilizing staff from other organizational areas.
            c) Have specialty staff oversee larger numbers of less-specialized staff and patients (for example, a critical care nurse oversees the intensive care issues of nine patients while three medical/surgical nurses provide basic

nursing care to three patients each.)

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

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

b. Limiting Patient Volumes and Expanding Surge Spaces:

1) Our organization shall work closely with local and regional partners, such as EMS, to help load balance patient care as required and able. Load-balancing ordinarily involves prehospital distribution of patients among area healthcare facilities, transferring patients from overwhelmed healthcare facilities to ones with more capacity, or moving resources to support an overwhelmed facility.

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

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

c. Patient Triage Decisions:

a) Patient triage decisions, in many circumstances, must act before a committee structure. Rapid decision-making systems involve the treating physician and other physicians. Reasonably speaking, clinicians are likely to feel uneasy when deciding on a crisis standard of care. Clinicians making these decisions must be educated, and a framework must be devised to assist them in connecting with subject-matter specialists as soon as possible to support the most ethical and suitable decisions. Identifying consultation networks for crisis care of children and others with special care needs (e.g., burns, trauma, hazardous exposures).

b) Involving clinicians with pediatric and other relevant expertise in crisis care decisions.

1) Clinicians shall be advised that Crisis Standard of Care involves making the best decision they can when in an unfamiliar situation that involves risk to the patient or provider; it is not necessarily limited to ventilator triage or a formal triage process.

2) Consideration must be given to whether the adoption of crisis standards of care is dependent on any formal government declaration. Formal declarations may not be forthcoming, so the rapid communication of issues is critical. This includes the movement of potential indicators from the patient bedside up through the hospital, city/county level, through the healthcare coalition and state level. Where shortfalls cannot be managed by load balancing and regional support, the state may provide some assistance through policy changes.

3) Clinicians and their legal advisors must resolve differences in understanding of the legal aspects of Crisis Standard of Care.

4) Any Crisis Standard of Care decisions must factor in that a timely declaration may not be made and include how to proceed without it.

5) The three levels of patient care standards are:

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

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

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

d. Supplies:

1) Recommendations for the redistribution of available resources in the event of a medical surge event are outlined below:

a) Sharing resources between our facilities.

b) Requesting supplies from other healthcare systems and considering non-typical, regional support processes such as cross-healthcare system sterilization or equipment transportation.

2) Supply Chain Services must update memoranda of agreement with potential suppliers, alternate care sites, and other healthcare employers to maximize availability of space, staff, and supplies.

3) Where volumes are limited/unavailable, the CCC Liaison Officer will contact the following for support:

a) Central Florida Disaster Medical Coalition (CFDMC): The CFDMC assists with the availability of staff, equipment, supplies, or other resources. The CFDMC effectively acts as an Area Command and creates a resource triage system where area hospitals can identify if they have the item(s). The CFDMC acts as an intermediary and works on getting the critical resources to those locations that are most needy.

b) City/county Emergency Operations Center (EOC).

(1) Where the city/county is unable to fulfill the request, they will submit requests to the State EOC, where it is processed by the County Liaison Desk under the direction of the Operations Support Branch. From there, it is assigned to the proper branch for tasking to the appropriate Emergency Support Function (ESF).

(2) If the ESF cannot provide the requested resources, it is forwarded to the Logistics Section who will work with either private vendors or through an Emergency Management Assistance Compact (EMAC) to secure the resources.

e. Medication Adjustment Strategies:

1) Pharmacy personnel will provide additional input

2) CFC CHEMPAKs are available within the region

f. Standards of Care Triggers:

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

2) Dependent on the scope of the incident, there is the possibility that standards of care may need to be temporarily altered to provide the greatest amount of care possible to the greatest number of people possible.

3) Special consideration must be given to any circumstance where crisis standards of care may be needed. Ethical issues concerning how decisions will be made in the event healthcare be done in consultation with:
   a) A chaplain
   b) A clinical ethics expert
   c) A critical care expert
   d) A person with a disability
   e) A social worker
   f) CCC Incident Commander
   g) Chief Medical Officer or designee
   h) Chief Nursing Officer or designee
   i) Chief Quality Officer
   j) Corporate Emergency Management
   k) HICS Medical Staff Director for the subject site
   l) Hospital Incident Commander
   m) Legal Counsel
   n) Pediatrician (where pediatric patients are involved)
4) None of the consulting team members identified as part of the ethics decision team shall be directly involved in the care of any patient(s) being evaluated by the team. Any decisions made by the team to adjust standards of care shall be communicated to:
   a) County EMS Medical Director
   b) Local Emergency Operations Center(s)
   c) Local and State Department of Health
   d) AHCA
5) Crisis Standard of Care Activation Triggers:
   a) Conventional standard of care:
      (1) Facility is at (TBI)% above minor surge capabilities.
      (2) Facility looks internally to streamline patient care lines, move resources such as equipment and staffing within the system as needed to better manage the heightened volumes.
   b) Moving from Conventional to Contingency Standards of Care:
      (1) Facility is at TBI% above moderate surge capabilities.
      (2) The decision is made to move into contingency care. Patient care involves some deviation from everyday care, but the level of care on an individual patient basis remains functionally equivalent. All efforts are made to return to conventional care levels as quickly and safely as possible.
      (3) Where little progress is made returning to normal operations, a notification is made from the CCC to the Regional Trauma Coordination Center.
   c) Moving from Contingency to Crisis Standards of Care
      (1) Facility is at TBI% above major surge capabilities.
      (2) The organization notifies regional partners to request immediate, additional support.

E. Triage Triggers:
1. The CCC/HICS activates a Pre-Triage Trigger, which informs our facilities that triage is imminent, to include moving patients and resources to optimize occupancy. The process works as outlined below.
2. Prior to any triage trigger activation, there must be communication at a regional level to ensure that all possible opportunities for support have been activated and/or exhausted before triage triggers have been initiated.
3. Facilities identify current ICU patients who meet Level 1 criteria and prepare to withdraw life support if triage is initiated.
   a. Level 1 Triage:
      1) CCC/HICS notifies hospitals to apply Level 1 Triage criteria.

2) Hospital triage officers apply Level 1 Triage criteria to both new and current patients.
3) Hospital triage officers identify current ICU patients who meet Level 2 criteria and prepare to withdraw life support if triage initiated.
4) Long-term care patients are no longer accepted if they meet Level 1 criteria.

b. Level 2 Triage:
1) CCC/HICS notifies hospitals to apply Level 2 Triage criteria.
2) Hospital triage officers apply Level 2 Triage criteria to both new and current patients.
3) Hospital triage officers identify current ICU patients who meet Level 3 criteria and prepare to withdraw life support if triage initiated.
4) Long-term care patients are no longer accepted if they meet Level 2 criteria.

c. Level 3 Triage:
1) CCC/HICS notifies hospitals to apply Level 3 Triage criteria.
2) Hospital triage officers apply Level 3 Triage criteria to both new and current patients.
3) Hospital triage officers identify current ICU patients who meet Level 3 criteria and prepare to withdraw life support if triage initiated.
4) Long-term care patients are no longer accepted if they meet Level 2 criteria.

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

4. See Attachment A for an example of the movement from standard care through Level 3 Triage.

F. Palliative and comfort care:
1. This level of care begins when illness is diagnosed and continues regardless of whether the patient receives treatment directed at the disease. During Crisis Standards of Care, decisions must be made to balance needs for lifesaving care for those in triage categories who will likely benefit from treatment, while providing comfort care to those for whom lifesaving care is likely futile. At a minimum, comfort care services for disaster victims will include relief of severe symptoms and providing comfort as people face end-of-life decisions.
2. Healthcare professionals should evaluate and alleviate the patient's physical, psychological, and social distress. When possible, effective comfort care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be implemented, even when resources are limited. Palliative and comfort care can be provided in acute care facilities, out-of-hospital care, alternate care sites or in the patient's home.

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

H. Termination/Recovery:
1. Identify facility recovery plan/process
2. Provide behavioral health support to workforce

V. DOCUMENTATION:

A. Event Report.

B. Emergency Incident Critique Form.

VI. REFERENCES:

A. Center for Medicare and Medicaid Services (CMS), Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers Final Rule, *Policies and Procedures*. Federal Register: Vol. 81, No. 180, § 482.15(b).

B. Crisis Communications Response Plan.

C. Crisis Standards of Care: A Toolkit For Indicators And Triggers. Nationality Center for Biotechnology Information. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/24872980/

D. Emergency Management Policy and Procedure #1960, *Critical Incident Response Protocol (CIRP) and Team (CIRT).*

E. Emergency Management Policy and Procedure #1516, *Relocation Plan.*

F. Emergency Management Policy and Procedure #1810, *Hospital Incident Command System (HICS) and Incident Command Locations.*

G. Environment of Care (EC) Utilities Response Matrix, located within the Comprehensive Emergency Management Plan (CEMP) and the Corporate Engineering Office.

H. Minnesota Department of Health (2020), Crisis Continuum Staffing Definitions. Taken from: https://www.health.state.mn.us/communities/ep/surge/crisis/continuum.pdf

I. Minnesota Department of Health (2021), Patient Care: Strategies For Scarce Resource Situations. Taken from https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf

J. The Joint Commission (2023). 2023 Hospital accreditation standards. EM.12.02.01, EM.12.02.03, EM.12.02.05, EM.12.02.07, EM.12.02.09, EM.12.02.11 and EM.14.01.01. Oakbrook Terrace, IL: Joint Commission Resources.

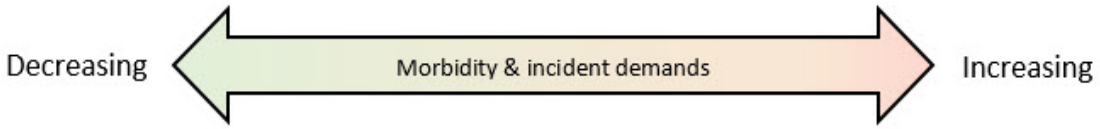
VII. ATTACHMENTS:

A. Framework for surge response

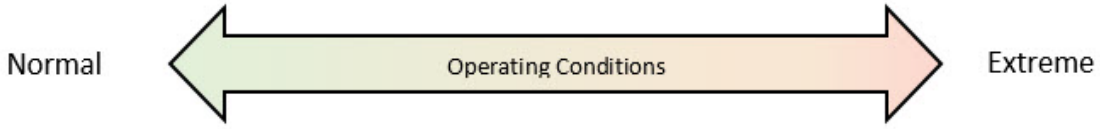
B. Staffing Categories Example

C. Quick Response Checklist

Attachment A: Framework for surge response



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



Attachment B: Staffing Category Examples

The table below represents an example of how staffing may be categorized. The safety of nurse-to-patient ratios may vary depending on the acuity of the patients and require adjustments.

This example provides a consistent level of adaptations and care across facilities.

Category	Conventional	Contingency	Crisis
Staff Used	Usual staff on units	"Step Over" staff with consistent training from other units. Example: PACU RNs to ICU; nurse educators at bedside	"Step Up" staff that do not usually care for patients of current acuity. Example: Intermediate or tele RNs to ICU.
Staffing Ratios	Usual RN to Patient ratio	Ratio increase ≤ 150% of usual. Example: From 1:6 up to 1:9	Ratio increase > 150%
Tired Staffing	No	No	Yes
Volunteer/Government providers utilized for direct patient care	No	No	Yes

Attachment C: Quick Response Checklist

Hospital	Non-Hospital	Freestanding ED
☐ ☐	☐	☐ ☐ ☐
☐ ☐	☐ ☐	☐ ☐
☐ ☐	☐	☐
☐ ☐ ☐ ☐		