[Insert name of healthcare organization]

Crisis Standards of Care ConOps Annex

SAMPLE Template

7-25-2022

Contents

Note to Template Users (for planning consideration only and should be removed): Contingency or Crisis Standards of Care (CSC) plans developed and issued in accordance with the New Hampshire (NH) *CSC Guidance* does not replace the judgment of health care entities' operational management, medical directors, their legal advisors or clinical staff. Recommendations within the *Sample NH Health Care Organization CSC Annex Template* may be superseded by incident specific recommendations from NH Department of Health and Human Services (DHHS). Web links and resources listed are provided as examples. Upon completion of the CSC ConOps, health care organizations are highly encouraged to publicize and engage citizens of diverse backgrounds in discussing the facility's CSC plan.

Note to Template User (for planning consideration only and should be removed).

This section provides:
➢ Sample text for Policy/Reference Number, Goal, Purpose, and Scope.
➢ A placeholder for Template Users to add organization-specific introduction regarding the CSC Annex.

Policy/Reference Number: Click or tap here to enter text.

Approval date:	
Modification date(s):	
Authorizing signature:	

Goal

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

Purpose

To describe the philosophy and operational practice of Click or tap here to enter text. during a catastrophic no-notice disaster (e.g., earthquake, bioterrorism) or a known, pervasive health crisis (e.g., pandemic influenza) that results in:

a. Prolonged mismatch between available health care resources and demand for those resources;
b. Major disruptions to the health care supply chain or no resupply of resources is foreseeable;
c. Patient transfer to other facilities is no longer feasible, at least in the short-term; and
d. Shifting focus from the individual patient to the collective need of the community.

Scope

This is an Annex to the **<NAME OF ORGANIZATION>** Emergency Operations Plan (EOP) and provides additional details relevant to a pervasive or catastrophic natural, human-made, or technological crisis that requires deviation from conventional standards of care. The facility's medical surge plans include provisions regarding measures that can be taken to sustain operations during a surge event (e.g., reduction of non-essential visits, cancelation of elective procedures, emergency staffing protocols, stockpiling and alternative supply contracts, use of alternative health care spaces for the provision of care, etc.).

The **<NAME OF ORGANIZATION>** CSC ConOps Annex describes the ethical and clinical process and procedures the health care leadership and providers will apply to address critical shortages of staffing, space, and medical equipment supplies in any type of catastrophic disaster with prolonged impacts, in which proactive[1] decisions about resource allocation are required. Crisis Care (CC) principles and processes may also be used for isolated issues, such as drug or therapeutic shortages. Public engagement of the CSC ConOps with citizens of diverse backgrounds will inform members of the community about the concept of CSC, when and why the CSC guidelines may become necessary, how they will be applied, and discuss areas of concern.

As described by the National Academies, the need for health care surge capacity in a disaster occurs along a continuum (**Figure 1**) based on demand for health care services and available resources.
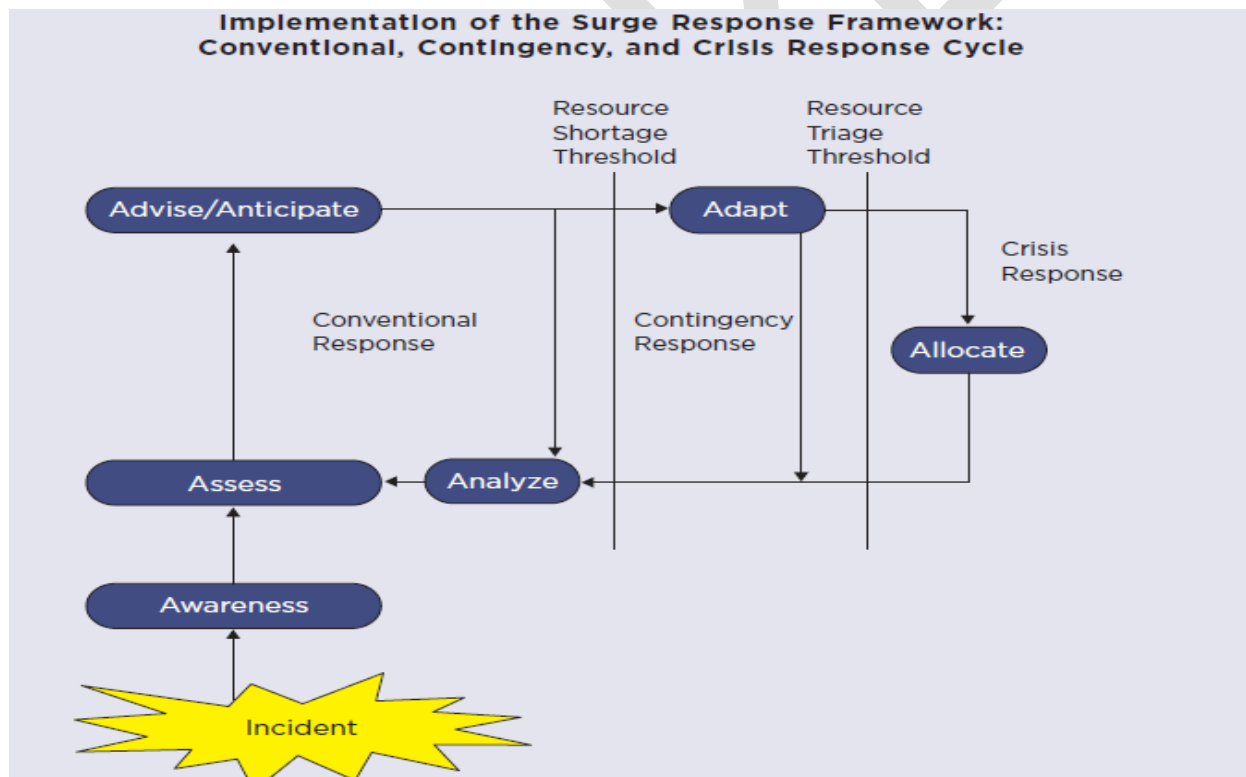
Figure 1: Disaster-Driven Care Continuum

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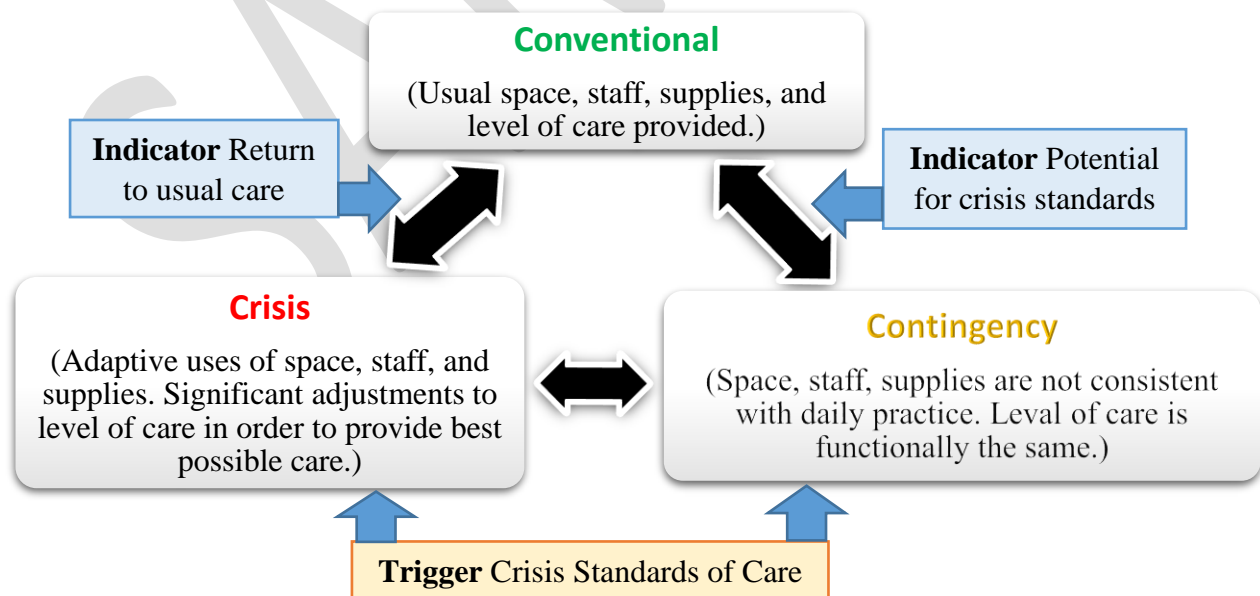
[1]"A proactive approach to patient triage and resource allocation [is] a structured, systems approach that weighs demand against resource availability." *Institute of Medicine (IOM). (2012). Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response. Retrieved from NAP.edu.* https://doi.org/10.17226/13351. P. 49

To eliminate delays, the **<NAME OF ORGANIZATION>** has incorporated a flexible surge response framework linked to the conventional-contingency-crisis care continuum (**Figure 2**). "After an incident occurs, the first priority is to develop situational **Awareness**, and then to **Assess** the situation relative to the available resources. The incident commander, along with relevant technical experts and/or the clinical care committee (in a proactive response/longer-term incident) **Advises** on strategies and **Anticipates** any resource deficits (and recommends obtaining necessary supplies, staffing, etc.). If a resource is scarce, **Adaptive** strategies (such conservation, substitution, adaptation, and reuse) should be implemented. In a crisis, a deliberate triage decision to **Allocate/reallocate** resources may be necessary. In all cases, the response and any strategies should be **Analyzed** at regular intervals as part of the disaster response planning cycle, and the elements repeated until the incident concludes."[2] This reflects a greater level of health care system preparedness with a common operating picture and accepted indicators for the need of contingency and crisis response.

Figure 2: Implementation of the Surge Response Framework for CSC

Implementation of the Surge Response Framework: Conventional, Contingency, and Crisis Response Cycle

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

Planning Assumptions

> ***Note to Template User*** *(for planning consideration only and should be removed).*
>
> This section provides sample text and describes:
> ➢ Suggestions on assumptions that will be true when finalizing the organizational CSC Annex, some of which are linked directly to assumptions included in the *NH CSC Guidance.*
> ➢ Suggestions on assumptions that will be true when activating the organizational CSC Annex.
> ➢ A placeholder for Template Users to add organization-specific assumptions regarding CSC Annex development, activation, operations, and demobilization.
>
> ➢ **Resource:** For more information on medical surge related requirements that should be addressed in organizational EOPs, see (for hospitals) *The Joint Commission. New and Revised Emergency Management Standards.* https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-emergency-management-standards/ and; the surge planning considerations contained in *CMS Updated Guidance for Emergency Preparedness-Appendix Z of the State Operations Manual (SOM) https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and-memos-states-and/updated-guidance-emergency-preparedness-appendix-z-state-operations-manual-som*

1. Surge capacity management is dependent on a well-functioning health care entity Incident Command System (ICS) structure and the domains of space, supplies, staff and special considerations (e.g., Chemical, Biological, Radiological, Nuclear, Explosive (CBRNE) incidents).[3]

2. The **<NAME OF ORGANIZATION>** CSC ConOps Annex supplements the existing organizational medical surge plans and protocols that are a part of the EOP.

3. Publication and community listening sessions of the facility's CSC ConOps Annex, in accessible formats, provide opportunities to engage citizens of diverse backgrounds for their considerations on why and how the CSC guidelines would be activated. It ensures that the guidance reflects the values and priorities of community members.

4. This ConOps Annex will be activated when:
   a. Resources and/or infrastructure are critically limited (e.g. inadequate staff or equipment).
   b. Maximum efforts to conserve, substitute, adapt and reuse materials are insufficient to meet needs and require ongoing, proactive planning.

5. When this ConOps Annex is activated, our organization will:
   c. Have activated a NIMS-compatible incident management system (e.g., Hospital Incident Command System (HICS)).
   d. Be sharing information and coordinating resource requests within our health care system, the Granite State Health Care Coalition (GSHCC) and ESF-8.
   e. Have implemented short term strategies to increase organizational capacity outlined in our EOP.

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

  f. Have requested declaration of a public health incident or state of emergency (if not already in place).

6. CSC recommendations will be provided by NH DHHS only in response to a catastrophic no-notice disaster (e.g., earthquake, bioterrorism) or a known, pervasive health crisis (e.g., pandemic influenza) that results in:

  a. Prolonged mismatch between available health care resources and demand for those resources;

  b. Major disruptions to the health care supply chain or no resupply of resources is foreseeable; and

  c. Patient transfer to other facilities is no longer feasible, at least in the short-term.

7. Contingency and CSC recommendations provided by NH DHHS may be adapted by health care entity Crisis Care Committees (CCC) **<or equivalent>** in light of their specific contexts.

8. In no-notice disasters, dissemination of state-level CSC recommendations may be delayed. Any health care organization that experiences a no-notice disaster should utilize all communications necessary to solicit support from other facilities or entities (e.g., GSHCC) before entering crisis care status independently of other facilities. When necessary, organizations will utilize their organizational surge and CSC ConOps Annexes to support clinical decision-making and resource allocation.

9. *Insert any other planning assumptions here*

Concept of Operations

Note to Template User *(for planning consideration only and should be removed)*

This section provides suggested text and describes:
- ➢ How a potential need to activate the Annex will be recognized by staff and communicated to organizational leadership/Incident Command;
- ➢ Who has the authority to activate the Annex for the organization (e.g., CMO, CNO, etc.);
- ➢ The process for assessing the need to activate and to activate the Annex;
- ➢ How the organization coordinates with the GSHCC, State EOC and ESF 8 Coordinator, and other health care organizations in the region.
- ➢ Identification of a Clinical Care Committee **<or its equivalent>** within the facility.
- ➢ Note that new Joint Commission standard (EM.12.02.09) includes a requirement that the hospital plan, "describes in writing how it will obtain, allocate, mobilize, replenish, and conserve its resources and assets during and after an emergency or disaster incident."

- ➢ **Resources:**
  - *Implementation of the Surge Response Framework: Conventional, Contingency, and Crisis Response Cycle (IOM, 2012, pp. 1-48 – 1-50)*
  - *Hick, J. L., D. Hanfling, M. Wynia, and E. Toner. 2021. Crisis Standards of Care and COVID-19: What Did We Learn? How Do We Ensure Equity? What Should We Do? NAM Perspectives. Discussion, National Academy of Medicine, Washington, DC.* https://doi.org/10.31478/202108e *(See p. 8)*

- *Thomasian NM, Madad S, Hick JL, Ranney ML, Biddinger PD (2021). Hospital Surge Preparedness and Response Index. Disaster Med Public Health Prep 15:398–401 doi: https://doi.org/10.1017/dmp.2021.190.*
- *The Joint Commission. New and Revised Emergency Management Standards.* https://www.jointcommission.org/standards/prepublication-standards/new-and-revised-emergency-management-standards/ *(See p. 33)*

Organizational Situational Awareness

Activation of this ConOps Annex is contingent upon having processes in place to assess the adequacy of available resources to meet the demand for those resources at the organizational level. This includes processes to understand clinical decisions made based on available resources at the point of care.

To ensure that organizational leadership/Incident Command is aware of current or impending rationing decisions at the point of care, **<NAME OF ORGANIZATION>** encourages all staff to share information via **<LIST MEANS>** to **<LIST POSITION(S) OR ENTITY PROVIDING CONSULT>**. Staff should report instances in which constrained resources are causing providers to make decisions that potentially constitute an implicit triage decision (i.e., decisions outside current evidence and best practice that providers would not normally make due to perceived or real resource constraints).[4] The goal is to remove ad hoc decision making at the bedside and move from a reactive decision to a proactive decision at the facility, coalition and state level.

Internal Notifications

If organizational Incident Command is not activated:

On receipt of situational awareness information that indicates a potential need to **<LIST POSITION(S) OR ENTITY PROVIDING CONSULT>** will utilize the procedures outlined in the organizational EOP to alert organization leadership of the situation. Organizational leadership **<LIST POSITIONS>** uses the process outlined in the EOP to make a determination regarding the need to activate organizational Incident Command and activate the Clinical Care Committee **<or equivalent>**. Leadership assesses current or anticipated resource shortfalls and the likely impact of existing strategies to mitigate these shortfalls.[5] The decision to activate Incident Command and the Clinical Care Committee **<or equivalent>** is largely predicated on the complexity and expected duration of the resource constraint and the likelihood that existing mitigation strategies will be effective in the short term. While in some cases a single or several

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[4] CDC. Clinician Outreach and Communication Activity. Making Practical Decisions for Crisis Standards of Care at the Bedside During the COVID-19 Pandemic. December 17, 2020.
https://emergency.cdc.gov/coca/calls/2020/callinfo_121720.asp
[5] IOM, 2012, pp.1- 48-1-50.

technical experts may be required, in more complex situations the full Clinical Care Committee **<or equivalent>** will be needed.[6]

If organizational Incident Command is activated:

On receipt of situational awareness information that indicates a potential need to **<LIST POSITION(S) OR ENTITY PROVIDING CONSULT>** will utilize the procedures outlined in the organizational EOP to alert incident command of the situation. Incident Command will make a determination regarding the need to activate the Clinical Care Committee **<or equivalent>** (if not already activated). The Incident Commander assesses current or anticipated resource shortfalls and the likely impact of existing strategies to mitigate these shortfalls. The decision to activate the Clinical Care Committee **<or equivalent>** is largely predicated on the expected duration of the resource constraint and the likelihood that existing mitigation strategies will be effective in the short term.

Convening of the Clinical Care Committee <or equivalent>

- *Insert the process that Incident Command will use to convene the CCC <or equivalent> here, or refer to existing processes contained in the organizational EOP.*

When activated, the Clinical Care Committee **<or equivalent>** is a technical unit within the Planning Section (see **Figure 3**).

Figure 3: Location of technical specialist(s) and Technical Units within Incident Command Framework[7]

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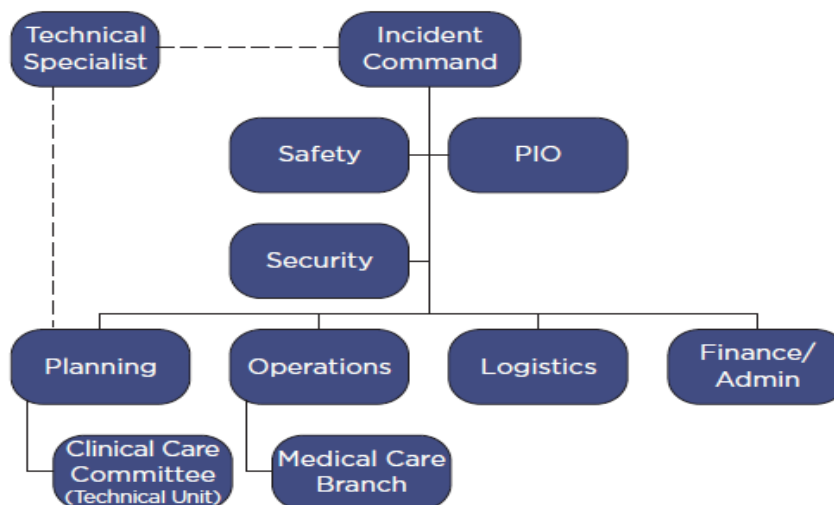
[6] IOM, 2012, pp. 4-25 – 4-26
[7] IOM, 2012, p. 4-26.

Pre-Identified Indicators and Trigger Points

> ***Note to Template User*** *(for planning consideration only and should be removed)*
>
> ➢ Based on IOM recommendations, NH *CSC Guidance* expects that health care organization CSC plans include clear indicators and triggers for when mitigation strategies should be implemented to avert or shorten duration of crisis care status.
> ➢ The Joint Commission's New and Revised Emergency Management Standards emphasize documentation of strategies to obtain, allocate, mobilize, replenish and conserve resources, with priority placed on resources known to deplete quickly.
> ➢ The tables below are adapted from NM Thomasian et al. They include example indicators, triggers, and action items that can be adapted to your organizational context, vulnerabilities, and priority resources.
> ➢ Organization-specific action items included in current plans can be referenced, or be integrated into the table or listed below it.
>
> ➢ **Resources:**
>   • *NH CSC Guidance (local level expectations pg 58)*
>   • *IOM 2013. Crisis Standards of Care: A Toolkit for Indicators and Triggers. Washington, DC: The National Academies Press. https://doi.org/10.17226/18338*
>   • *The Joint Commission. New and Revised Emergency Management Standards. (See p. 33)*
>   • *Thomasian NM, Madad S,Hick JL, Ranney ML, Biddinger PD (2021).Hospital Surge Preparedness and Response Index. Disaster Med Public Health Prep 15:398–401 doi: https://doi.org/10.1017/dmp.2021.190.*

Indicators are measures or predictors of changes in demand and/or resource availability; triggers are decision points. Indicators and triggers guide transitions along the continuum of care, from conventional to contingency to crisis and in the return to conventional (IOM, 2013).

<NAME OF ORGANIZATION> has defined the following organization-specific indicators and triggers that will be used by organizational leadership/Incident Command/and the CCC **<or equivalent>** to assist with determining actions to be taken in the event of resource shortages in the categories of staffing, space and supplies.

> ***Note to Template User (for planning consideration only and should be removed)***
> ➢ The three EXAMPLES below were adapted from NM Thomasian et al.'s *Hospital Surge and Preparedness Index*. Add or delete as necessary.

Staffing

	Trigger	Response Actions
Conventional	• Can meet routine staffing protocol	• Maintain usual staffing assignments • Use routine staffing to acuity • Isolate/quarantine infected/exposed staff per public health guidelines • Familiarize staff with disaster protocols

Contingency	• Cannot meet routine staffing protocol but can provide staffing alternatives to meet patient medical needs	• **Notify ESF8/GSHCC**
		• Determine shortage etiology
		• Consistent with functionally equivalent care and in light of any NH DHHS guidance:
		  • Cross-cover with similarly trained staff
		  • Adjust staff ratios or acuity
		  • Adjust admissions criteria
		  • Leverage existing MOUs
		  • Obtain contract staff

Crisis	• Cannot meet all patient medical needs with available staffing options	• **Notify ESF8/GSHCC**
		• Considering any NH DHHS guidance:
		  • Cross-train staff to fill unfamiliar roles ("step-up-staffing)
		  • Use a tiered staffing model
		  • Further adjust staff ratios or acuity
		  • Begin structured onboarding of volunteers, students, etc.

EXAMPLE - Indicator 1: Ability to meet routine staffing protocol

Space

EXAMPLE - Indicator 1: Facility occupancy*		
	Trigger	**Response Actions**
Conventional	• Facility operating at normal census	• Use regular patient care areas • Review and drill plans for surge space creation

Contingency	• Occupancy of one or more units (including morgue) exceeds or is expected to exceed conventional capacity by x%	• **Notify ESF8/GSHCC**
		• Consistent with functionally equivalent care and in light of any NH DHHS CSC guidance:
		  • Reverse triage/discharge patients/residents
		  • Double existing single rooms considering infection control requirements
		  • Create additional surge space for specific purposes (e.g., ICU – PACU, dedicated COVID isolation wings)
		  • Reduce non-emergency admissions, advocate for changes to criteria for EMS transport
		  • Prepare adjacent alternate care/triage areas
		  • Load balance across health care organizations/coalition (considering the role of LTC, primary care, home care, etc.)
		  • Consider alternative morgue sites

Crisis	• Occupancy of one or more units (including morgue) exceeds or is expected to exceed conventional capacity by x%	• **Notify ESF8/GSHCC**
		• Considering any NH DHHS CSC guidance:
		  • Use space not generally used to provide care
		  • Prepare community-based alternate care sites
		  • Continue to reduce admissions; change criteria for admission for inpatient care, transport.
		  • Continue other contingency strategies mentioned above

*Other indicators might include ED surge, availability of usual patient care space (e.g., after facility damage)

Supplies

EXAMPLE - Indicator 1: Sufficiency of supplies** to meet care needs		
	Trigger	**Response Actions**
Conventional	• Supplies and equipment sufficient to meet care needs	• Leverage alternative supply chains • Create collaborative for distribution of scarce resources • Develop new supply chains

Contingency	• Ongoing or impending shortages negatively impact care but functional alternatives available	• **Notify ESF8/GSHCC**
		• Consistent with functionally equivalent care and in light of any NH DHHS CSC guidance:
		  • Conserve
		  • Substitute
		  • Adapt/repurpose
		  • Extend use
		  • Limited re-use/decontaminate
		• Consider alternatives to standard supplies

Crisis	• Cannot meet all patient medical needs with available staffing options	• **Notify ESF8/GSHCC**
		• Use more aggressive conservation, adaptation, substitution strategies, considering any NH DHHS CSC guidance
		  • Reuse
		  • Reallocate
		  • Ration

****Per the Joint Commission, priority supplies include resources that are known to deplete quickly and are extremely competitive to receive and replenish (these include fuel, oxygen, PPE, ventilators, IV fluids, antiviral medications). Health care organizations of all types should identify relevant supplies that meet the "known to deplete quickly and competitive to receive and replenish criteria" in their contexts.

External Notifications

When organizational leadership/the Incident Commander determines that the organization is functioning in a contingency or crisis status, they will notify ESF8/GSHCC to provide a situational update, request resources and/or mutual aid.

Roles and Responsibilities

> ***Note to Template User*** *(for planning consideration only and should be removed)*
>
> This section provides sample text and describes:
>
> ➢ The CSC-specific roles of the health care organization leadership and other personnel (for example, department/unit leadership), teams and committees (e.g., the Ethics Committee)
> ➢ The roles and members of CSC-specific teams (e.g., Clinical Care Committee, Triage Team)

Health Care Organization Leadership CSC Roles

- *Insert the organizational leadership position(s) and their CSC-specific roles (e.g., "Use the process outlined in the EOP to make a determination regarding the need to activate organizational Incident Command and the Clinical Care Committee.")*

Other CSC Roles

- *Name relevant position(s) and their CSC-specific roles (e.g., "Attend daily briefings and provide a situational update to unit staff including changes in resource availability, procedures, etc. at the beginning of shift")*

Role of the Clinical Care Committee[8]

- Work with clinical departments / Medical Care Branch Director to determine what services the organization can provide and how and where to provide them.
- Recommend to the Incident Commander ,for inclusion in the Incident Action Plan, courses of action for coping with the scarce resource situation, including:
  - Development and dissemination of care protocols for alternative, functionally equivalent care and for conserving resources in short supply that take into account current facility/regional/state resource availability that are based on current regional resources and NH DHHS-issued guidance (see, for example, MDH Patient Care Strategies for Scarce Resource Situations).
  - Determining crisis clinical guidelines for the organization (e.g., proactive triage criteria, staffing strategy, intake criteria, rationing criteria, use of adjunct space) in collaboration with clinical departments/Medical Care Branch Director, Incident Command, and in light of any recommendations issued by DHHS.
- Establish an appeals process for triage decisions.
- Develop a Triage Plan for each operational period, if needed, for inclusion in the Incident Action Plan.
- Appoint a Triage Team for each operational period, if needed.

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[8] IOM, 2012, pp. 4-29 – 4-31.

- Establish a mechanism to summarize recommendations and changes and circulate to all staff and patients/families (concrete guidelines are important to provide clarity and reduce decision-making based upon emotional or subjective factors).
- Conduct quality assurance of allocation and triage decisions, including review of the decisions and related documentation and discussion with clinical staff and Triage Team members about pending process modifications that might aid their performance.
- Review any process appeals (that is, any challenge to a triage decision) and either address them or refer them to a regional appeals committee (if established).
- Make recommendations to Incident Command regarding interventions to and timelines for a shift to contingency and/or conventional care at the organizational level, taking into account current facility/regional/state resource availability and NH DHHS-issued guidance.

- *Insert additional CCC roles here*

Clinical Care Committee Membership

Note to Template User *(for planning consideration only and should be removed)*

Clinical Care Committee or equivalent membership will vary depending on facility type, facility resources, and incident-specific requirements. CCCs may be implemented at the facility or the health care system level. The following is a list of potential positions to include on an hospital CCC:

a. Health Care Administrator

b. Medical Director (Medical Care Director)

c. Health care attorney (if possible)

d. Infection Control (for infectious incident)

e. Infectious Disease (for infectious incident)

f. Critical care

g. Emergency medicine

h. Pediatrics

i. Nursing supervisor

j. Respiratory care supervisor

k. Chair of Ethics Committee

l. Ambulatory care (clinics)

m. Community representative (if possible)

n. Other – may include lab, radiology, bioelectronics, pharmacy, palliative care, burn staff, etc.

➢ **Resources:**
- *Minnesota Crisis Standards of Care Framework: Health Care Facility Surge Operations and Crisis Care* *https://www.health.state.mn.us/communities/ep/surge/crisis/index.html*

- *Insert CCC member position titles here*

Role of the Triage Team[9]

- Make determinations regarding the allocation of scarce, potentially life-saving interventions (e.g., mechanical ventilation, ECMO) by reviewing objective evidence for the patients requiring the intervention given available resources and in concordance with the ethical principles in the NH DHHS-issued CSC guidance.
- Document allocation decisions made.
- Re-evaluate patients to ensure continued consideration for resources as the incident and their conditions evolve.

Triage Team Members

> **Note to Template User** (for planning consideration only and should be removed)
>
> ➢ Triage Teams are needed in situations in which proactive decisions regarding the allocation of a scarce, life-saving resource must be made. This role may not be relevant to all healthcare organizations.
> ➢ Triage Teams may be facility-, healthcare system-, or regionally-based.
> ➢ Triage Teams should be made up of at least two physicians trained in critical care or with substantial expertise in critical care decision making (or in the specialty area within which the allocation decisions are being made); may be supported by other technical or ethics personnel.
> ➢ Triage Team members should not be the clinical care providers for patients that are being considered to receive a scarce resource.
>
> ➢ **Resources:**
> IOM (2012), 4-30 – 4-31

- *Insert positions who will serve as members of the triage team and have been oriented to this role here.*

Triage Decision Appeals

> **Note to Template User** (for planning consideration only and should be removed)
>
> This section describes:
>
> ➢ The process the organization will implement to facilitate elevation of appeals of Triage Team triage decisions by treating physicians or next-of-kin when there is new objective information available that may impact the decision of the Triage Team.
> ➢ The process the organization will implement to resolve appeals and "ties" in priority scores/categories between patients.
>
> ➢ **Resources:**
> IOM (2012), 4-31

- *Insert the process for appealing a Triage Team decision.*

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[9] IOM, 2012, pp. 4-30 – 4-31.

Demobilization/Return to Conventional Care

> **Note to Template User** *(for planning consideration only and should be removed)*
>
> This section provides sample text and describes:
>
> ➢ How the organization will determine the feasibility and timeline for returning to contingency or conventional care.
> ➢ How the organization will coordinate with ESF-8 to inform the deactivation of CSC.
>
> Note that CMS Appendix Z encourages facilities to assess when use of a Section 1135 waiver may no longer be needed, in spite of an ongoing public health emergency.

Similar to having pre-identified trigger points to implement principles of CSC, it is important to continually assess and re-assess the situation as resource imbalances dissipate. The goal of this organization is to move from crisis to contingency and conventional care as quickly as possible.

In order to do so, Incident Command will collect:

- Collect internal information on pre-identified indicators and other situational awareness information.
- Communicate with external partners (HCC, state, federal partners) for situational awareness.
- Relay this information Clinical Care Committee **<or equivalent>**, Ethics Team, and Triage Team.

The CCC will make recommendations to Incident Command regarding interventions to and timelines for a shift to contingency and/or conventional care at the organizational level, taking into account current facility/regional/state resource availability and NH DHHS-issued guidance.

Education, Training, and Exercise

> **Note to Template User** *(for planning consideration only and should be removed)*
>
> This section provides sample text and describes:
>
> ➢ Education, training, and exercise
> ➢ of the CSC ConOps Annex to staff.

Health care staff will be educated on this plan by the following tiers:

Knowledge: awareness of the plan;
Competency: the ability to do something successfully or efficiently in relationship to the plan; and
Proficiency: a high degree of competence or expertise.
A list of which staff positions are trained to which level can be found in Attachment A.

Concepts of CSC will be incorporated into annual exercises as appropriate to include involvement from the Click or tap here to enter text.

Authorities & References

- *Insert applicable authorities and references here.*

Attachment A: Education Tiers by Staff Position

Knowledge

- Hospital Executives, not in an incident command role

- Nursing staff

- Respiratory staff

- Security staff

- Click or tap here to enter text.

- Click or tap here to enter text.

Competency

- Unit Medical Directors

- Nursing Supervisors

- Respiratory Therapist Supervisors

- Click or tap here to enter text.

- Click or tap here to enter text.

 Proficient

Hospital Emergency Manager

All staff (three deep) in incident command roles. This includes:

- Incident Commander: Click or tap here to enter text.

- Planning Chief: Click or tap here to enter text.

- Operations Chief: Click or tap here to enter text.

- Logistics Chief: Click or tap here to enter text.

- Finance: Click or tap here to enter text.

- Communications: Click or tap here to enter text.

Members of the Facility Ethics Board, Triage Team, and/or Clinical Care Committee **<or equivalent>**

- Click or tap here to enter text.

- Click or tap here to enter text.

- Click or tap here to enter text.