

Minnesota Crisis Standards of Care Framework

GUIDANCE AND STRATEGIES FOR STATE AGENCIES AND LOCAL PARTNERS

Revision Date: 7/20/2018

Minnesota Crisis Standards of Care Framework

Minnesota Department of Health
Center for Emergency Preparedness and Response
PO Box 64975
St. Paul, MN 55164-0975
651-201-5700
health.epr@state.mn.us
www.health.state.mn.us

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

Contents

Minnesota Crisis Standards of Care Framework	i
Letter from Minnesota Department of Health Commissioner	ix
Executive Summary.....	x
Introduction	x
Background	xi
Activation	xi
Attachments.....	xii
CSC Framework.....	1
Introduction	1
Hazard overview	3
Demographic overview	3
Background	4
Historical background	5
Scope.....	6
Planning assumptions	6
Definitions.....	7
Indicators and triggers	14
Notification and communication	18
Threat assessment and reporting to MDH	18
Initial assessment of indicator information.....	19
Framework activation	19
Communications	20
Hotlines	21
Roles and responsibilities	21
Ethical considerations	31
Legal considerations	31
Emergency medical services considerations	33
Hospital medical surge considerations	34
Optimizing resources	34
Alternate care sites	35

CRISIS STANDARDS OF CARE

Alternative prescribing methods 35

Mental and behavioral health considerations..... 36

 Purpose 36

 Responder services 37

 Community..... 37

 Federal resources..... 37

Demobilization and recovery 38

Supporting sections 38

 Implementation 38

 Update and maintenance 39

 Training and exercise 39

Appendix A—Acronym list 40

Appendix B—List of attachments, appendices, figures, and tables 43

Appendix C—Planning and contributing partners 44

Attachment 1—Ethical Guidance for Crisis Standards of Care..... 48

 Introduction 49

 Overview 49

 Process 49

 Purpose and scope..... 50

 Annotated ethical framework..... 50

 Existing ethical guidance and national recommendations..... 50

 Ethical commitments 52

 Ethical objectives 52

 Ethical strategies..... 54

 Conclusion..... 72

Addendum 1.1—CSC ethics framework..... 73

 Ethical commitments for crisis standards of care (CSC) 73

 Ethical objectives for CSC..... 73

 Strategies for the duty to plan..... 74

 Strategies for public understanding, communication and engagement..... 74

 Strategies for duty to care 74

 Strategies for proportionality and equity in freedom limiting interventions..... 76

CRISIS STANDARDS OF CARE

Strategies for addressing health disparities, barriers to access and functional needs 76

Strategies for fairly and consistently stewarding resources (time, task, treater) 77

Strategies for promoting ethical decision-making among private partners 79

Attachment 2—Legal Authority and Environment for Crisis Standards of Care 80

DISCLAIMER..... 80

Background 81

Minnesota emergency management act (MEMA) 83

 The governor’s authority 83

 Disaster declarations..... 83

 Governor’s powers..... 84

 National Guard..... 86

 Staff and resource augmentation 86

 Cross-border licensure 86

 Mutual aid..... 86

 Emergency management assistance compact (EMAC) 88

 Nurses 88

 Commandeering 89

 Liability and other protections in emergencies and disasters..... 89

The Minnesota state tort claims and municipal tort claims acts 92

Legal authorities of the Minnesota Department of Health 93

 Mass dispensing 93

 Minnesota Responds Medical Reserve Corps (MRC) 94

 Isolation and quarantine..... 95

 Practice of medicine 95

Federal laws 95

 Stafford Act 95

 Public Health Services Act (PHSA)..... 96

 Public Readiness and Emergency Preparedness (PREP) Act..... 97

 1135 Waiver 98

Conclusion..... 99

Attachment 3—Surge Operations and Crisis Care for Emergency Medical Services 100

 Preface 101

CRISIS STANDARDS OF CARE

Introduction 102

Crisis care 103

 Key points about crisis care: 105

Roles and responsibilities 105

Surge capacity 106

 Dispatch 108

 Ambulances/transport 109

 Staff 110

 Supplies 111

 Destinations 112

Planning and Implementation – General 112

 Indicators and triggers 112

 Agency policy 113

 Medical direction 114

 Integration with regional operations 114

Planning and implementation - Rural and Urban - Strategies and Tactics 115

 Incident management 116

 Dispatch/911/PSAPs 117

 Treatment 121

 Transport 122

 Transports to hospital in non-ambulance vehicle 123

 Destination 123

Legal and regulatory considerations 124

 Statutes and ordinances 125

 State ambulance requirements suspended during declared disasters 125

 Explanation of specific requirements suspended 126

 Liability 127

 Reimbursement: 1135 Waiver 127

Recovery 128

Conclusion 129

Addendum 3.1—Requests to the State for Additional Ambulance Service Resources 130

Addendum 3.2—Ambulance service surge operations and crisis care matrix 131

Addendum 3.3—Transports to hospital in non-ambulance vehicle.....	133
Addendum 3.4—Pandemic influenza protocols.....	135
Policy context.....	135
Categories for Triage.....	135
Standing Orders	Error! Bookmark not defined.
Attachment 4—Surge Operations and Crisis Care for Hospitals	142
Preface	143
Introduction	143
Crisis care	144
Key points about crisis care:	146
Roles and responsibilities	147
Emergency department space	147
Space – floor space	147
Space – intensive care unit	148
Space – alternative care sites	149
Staff.....	150
Supplies.....	151
Special considerations/capabilities.....	152
Hazardous materials and decontamination.....	152
Pediatrics.....	152
Burns	152
High consequence infectious diseases	153
Planning and Implementation - General.....	153
Indicators and triggers	153
Out-of-hospital plans	154
Hospital plans.....	155
Provider engagement	156
Exercises.....	156
Integration with regional operations.....	156
Triage	160
Framework.....	160
Ethical considerations.....	160

CRISIS STANDARDS OF CARE

Reactive triage 161

Proactive 162

Legal and regulatory considerations..... 163

Statutes and ordinances 164

Liability 164

Reimbursement: 1135 waiver..... 165

Conclusion..... 165

Addendum 4.1 – Sample hospital CSC plan 167

Activation 167

Notifications..... 167

Actions 167

Addendum 4.2—Hospital scarce resource decision-making tree 175

Attachment 5—Public Engagement for Crisis Standards of Care..... 176

Intro..... 177

Purpose 177

Background 177

Scope..... 178

Next Steps 179

Letter from Minnesota Department of Health Commissioner

To Whom It May Concern:

During a pandemic or severe epidemic influenza season, there may not be sufficient resources—such as Intensive Care Unit (ICU) beds or other equipment—available in the United States to care for all patients requiring critical care. As such, the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP), supports Crisis Standard of Care (CSC) planning as it is impossible to predict the timing and severity of a future outbreak and waiting for the disaster to strike would be too late.

The Minnesota Department of Health (MDH) has long recognized the need for this proactive planning. In 2005, the Science Advisory Team (SAT) was established for the purpose of developing initial clinical recommendations for providers of crisis care during scarce resource situations. Those recommendations can be found at [MDH's Strategies for Scarce Resources](#). In 2007, MDH sponsored the [Minnesota Pandemic Ethics Project \(MPEP\)](#), which focused on ethical guidelines for rationing resources after hosting community engagement activities to gain insight from Minnesotans.

The Minnesota CSC Framework addresses specific challenges of a pervasive or catastrophic emergency when demand exceeds available resources warranting a shift from individual patients to the good of the community. The goal of the CSC Framework is to provide planning guidance to health care and public health organizations to successfully manage the transition from conventional to contingency to crisis care, if the need arises. Proactive clinical decision support tools and processes should be in place in order to assure fair and transparent decisions. When these procedures are not in place, agencies and facilities may resort to “on the fly” decisions, which are not ideal. The need for CSC planning is reinforced by the challenging medical decisions providers were forced to make during the aftermath of Hurricane Katrina.

The CSC Framework includes five attachments that have been created to function as stand-alone guidance: Ethical Guidance for CSC, Legal Authority and Environment for CSC, Surge Operations and Crisis Care for Emergency Medical Services (EMS), Surge Operations and Crisis Care for Hospitals, and Public Engagement for CSC. Each attachment includes additional details regarding each subject matter area and should be used by stakeholders for crisis care planning.

If you have any questions or concerns regarding the Framework, please contact Cheryl Petersen-Kroeber, the Director for the Center of Emergency Preparedness and Response, at (651) 201-5700 or Cheryl.Petersen-Kroeber@state.mn.us.

Sincerely,



Jan Malcolm
Commissioner of Health
P.O. Box 64975
St. Paul, MN 55164-0975

Executive Summary

Introduction

The Minnesota Department of Health (MDH) exists to protect, maintain, and improve the health of all Minnesotans. The Crisis Standards of Care (CSC) Framework—referred to as the “CSC Framework” or “the Framework”—addresses specific challenges of a pervasive or catastrophic emergency when demand exceeds available resources in the state, and proactive steps must be taken to coordinate a statewide response for a prolonged period of time to assure the best care possible given resource limitations.

This Framework describes the systems, processes, and procedures that may be implemented within Minnesota to manage a disaster warranting a shift in focus from individual patients to the good of the community. The goal of this Framework is to provide planning guidance to health care and public health organizations to successfully manage the transition from conventional to contingency to crisis care. Though many disasters create temporary and local shortages of resources and addressed through a state, regional or local response, very few disasters, aside from a severe pandemic or epidemic, will require initiation of a formal statewide CSC framework, as adequate assistance can usually be provided at a regional, state, or federal level to meet needs.

Crisis care plans at the agency or health care facility level may be needed anytime and anywhere as extensions of surge capacity plans to address immediate needs when community resources are overwhelmed by a disaster. *Crisis Standard of Care* plans invoke the support of the State and other levels of government to support ongoing, substantial changes in operations and medical care decision-making during a prolonged disaster, when insufficient resources are available, and when the focus of care must shift from the benefit of the individual to the benefit of the community.

In 2012, the National Academies of Sciences, Engineering and Medicine, Institute of Medicine (IOM)—now the National Academies of Medicine (NAM)—(referred to as the IOM/NAM in this document) published national guidance documents for crisis standards of care planning. They recommend the incorporation of key elements into the development of crisis standards of care plans. MDH endorses these key elements of:

- Strong ethical grounding;
- Integrated and ongoing community and provider engagement, education, and communication;
- Assurances regarding legal authority and environment;
- Clear indicators, triggers, and lines of responsibility; and

- Evidenced-based clinical processes and operations.¹

The Minnesota CSC Framework was developed over the course of 2015-2017. MDH established a CSC Steering Group to oversee development of the key elements of the framework noted above. The CSC Steering Group was comprised of representatives from the private and public sectors extending across multiple disciplines of health and government. The CSC Steering Group also oversaw the formation of workgroups consisting of subject matter experts (SMEs) charged with specific components of framework development.

Background

During a pandemic or severe epidemic influenza season, there may not be sufficient resources, such as Intensive Care Unit (ICU) beds and equipment available in the United States to care for all patients requiring critical care. Proactive clinical decision support tools and processes should be in place in order to assure fair and transparent decisions. When they are not in place agencies and facilities may need to resort to adaptive strategies or make “on the fly” decisions, which are not ideal. This need was reinforced by the challenging medical decisions some providers were forced to make during the aftermath of Hurricane Katrina in 2005. After the 2009 H1N1 pandemic, the IOM/NAM developed formal guidance to assist government and the private sector for these types of crises in which the standard of care may need to be altered for the good of the community.

Activation

Minnesota Statutes Chapter 144 grants the Commissioner of MDH (Commissioner of Health) broad authority to protect, maintain, and improve the health of the public. In this role, the CSC Framework may be initiated by the Commissioner of Health during a catastrophic disaster in the State of Minnesota. This plan also falls under the authority of Minnesota Statutes Chapter 12, which assigns the governor and the Department of Public Safety, Division of Homeland Security and Emergency Management (HSEM) the overall responsibility for preparing for and responding to emergencies and disasters. This is accomplished by HSEM through development and maintenance of the comprehensive Minnesota Emergency Operations Plan (MEOP). In accordance with the above statutes, the commissioner shall consult with tribal nations in a timely manner when initiating CSC activities consistent with Executive Order 13-10.

Incident types that may initiate the CSC Framework include but are not limited to a public health emergency, terror attack, a CBRNE (chemical, biological, radiological, nuclear or explosive) incident, weather events, and mass trauma events. These emergencies or disasters can create persistent and substantial resource deficits that cannot be managed through usual all-hazard response activities. Such incidents require specific guidance on allocation of scarce resources or specific regulatory or government support for non-traditional medical response activities.

¹ [“Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report” Report Brief, September 2009](#)

Attachments

In addition to the base CSC Framework, five attachments, which function as stand-alone guidance, have been created for:

- Ethical Guidance for CSC
- Legal Authority and Environment for CSC
- Surge Operations and Crisis Care for Emergency Medical Services (EMS)
- Surge Operations and Crisis Care for Hospitals
- Public Engagement for CSC

The framework document is the base document and the attachments include additional details regarding each subject matter area and should be utilized by stakeholders for crisis care planning.

CSC Framework

Introduction

The Minnesota Department of Health (MDH) exists to protect, maintain, and improve the health of all Minnesotans. The Crisis Standards of Care (CSC) Framework—referred to as the “CSC Framework” or “the Framework”—addresses specific challenges of a pervasive or catastrophic emergency when demand exceeds available resources in the state, and proactive steps must be taken to coordinate a statewide response for a prolonged period of time to assure the best care possible given resource limitations. The goal of this framework is to provide guidance to health care organizations, public health organizations and health care coalition members to successfully manage the transition from conventional to contingency to crisis medical care (Figure 1, p. 22).

Crisis medical care may occur for any Emergency Medical Services (EMS) agency or hospital at any time, and may span a spectrum from drug shortages to the sudden need for many ambulances in a rural area that are simply not available. Agencies and facilities must therefore have plans in place to address these situations as they occur. Most of these situations will be resolved as additional resources arrive. The Crisis Standards of Care Framework is invoked by the Commissioner of Health when the scope of the incident requires proactive State actions and declarations to support non-traditional response strategies or provide resource allocation guidance. Generally, incidents requiring implementation of the Framework are prolonged events. The Framework is intended to assist decision-makers in making the best choices by providing an outline of the governmental support that can be provided during a CSC situation. Guidance for EMS and hospital crisis care planning is available as attachments to this framework.

The Framework was developed over the course of 2015-2017 with input from private and public sectors extending across all disciplines of health and government and tribal nations throughout Metropolitan and greater Minnesota. Partners included representatives from such organizations as:

- Emergency Management – Jurisdictional and Hospital
- Emergency Medicine
- Emergency Medical Services and the Emergency Medical Services Regulatory Board
- Local and Tribal Health
- Medical Examiners
- Minnesota Department of Corrections

- Minnesota Department of Health
- Minnesota Medical Association
- Minnesota Hospital Association
- Non-Profit / Non-Governmental Agencies
- Registered Nurses and Minnesota Nursing Association
- Veterans Health Administration

Please see *Appendix C* for a complete list of planning partners.

In addition to the key elements listed above from the IOM/NAM Report, the IOM/NAM report highlighted that the threat of Mass Casualty Incidents (MCIs) and other incidents generating surges of patients to the nation's hospitals and health care system is always present and many hospitals are already operating at, or over, maximal capacity on a daily basis. Events pushing the system to levels requiring choices about allocation of scarce resources may be driven by demand as well as loss of health care infrastructure. Preparing hospitals, health care systems and their partners to prevent, respond to, and rapidly recover from these threats is critical for protecting and securing the nation's health care system and public health infrastructure.

The CSC Framework provides specific guidance for the unique circumstances imposed in responding to catastrophic public health emergencies. As a part of this response structure, MDH would also rely on the states Regional Health Care Coalitions (HCCs) to enhance the ability of hospitals and health care systems to prepare for, respond to, and recover from these types of events. Additionally, this Framework provides guidance for the health care system, including hospitals and EMS, in the development of their specific crisis standards of care plans.

In the event of a CSC situation, MDH will facilitate equitable access to care through public health recommendations, regulatory guidance, support alternate care mechanisms (e.g., telephone hotlines, alternate care sites), and support public information dissemination in such an event. If the situation required clinical guidance, MDH would promote consistency by activating the MDH Science Advisory Team for Crisis Standards of Care (SAT/CSC) to make recommendations to the Commissioner of Health on best practices. An example of some of these recommendations may include a systematic approach to allocation of scarce resources (select medications, vaccine, or equipment including ambulances) designed to deliver the best care possible given limited resources.

CSC planning is supported by the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP), which has outlined a set of Health Care Preparedness Capabilities to assist with preparedness and response, including but not limited to developing a Crisis Standards of Care Framework.

This Framework is intended to provide support to statewide health care systems response during a catastrophic disaster and is neither prescriptive nor comprehensive. MDH and its

private, local, tribal, state, federal, and non-profit partners will use judgment and discretion at the time of the incident to determine the most appropriate actions.

Hazard overview

The CSC Framework may be initiated during a catastrophic disaster in the state of Minnesota. These incident types are inclusive but not limited to: a public health emergency such as an epidemic or a sudden severe outbreak of infectious disease, major terror attack, a CBRNE (chemical, biological, radiological, nuclear or explosive) incident, weather events such a devastating tornado, and mass trauma events. These emergencies or disasters may overwhelm the health care system and create persistent and substantial resource deficits that typical all-hazard response activities cannot manage. This is a CSC situation and requires a State supported non-traditional medical response and guidance, including resource allocation choices.

Demographic overview

The following table summarizes some demographics pertinent to CSC planning in Minnesota:

Table 1: State of Minnesota Demographics

	Demographics	Comments/References
Population	5,489,594 per 2010 census ² (52% metro, 48% non-metro)	July 1, 2015 estimate based on the U.S. Census Bureau 2010
Ethnic Makeup	85.4% White 6.0% Black/African-American 5.2% Hispanic or Latino 4.9% Asian 1.3% Native American/Alaska Native	July 1, 2015 estimate based on the U.S. Census Bureau 2010
Secondary Languages	3.5% Spanish 1.0% Hmong 0.14 % African Languages ³	Language other than English spoken at home, percent of persons age 5 years+, 2010-2014 is 10.9% ⁴

² Sources: [U.S. Census Bureau, Population Estimates Program \(PEP\), Updated annually. U.S. Census Bureau, 2010 Census of Population, P94-171 Redistricting Data File. Updated every 10 years.](#)

³ Languages spoken at home by ability to speak English for the population 5 years and over: [U.S. Census Bureau, Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over: 2009-2013.](#)

⁴ [US Census Bureau QuickFacts, Selected: Minnesota](#)

	Demographics	Comments/References
With a disability, under age 65 years, percent, 2010-2014	7.0%	2010-2014
Under age 18	23.4%	2015 estimate
Under age 5	6.4%	2015 estimate
Population living below the poverty line	11.5%	July 1, 2015 estimate based on the U.S. Census Bureau 2010
Electricity Dependent Medicare Beneficiaries	30,327	From HHS emPOWER Map, 2016

Demographic groups such as immigrants, seniors, children and people with disabilities may have different and specialized needs following a disaster. Crisis care strategies that are developed by public health and health care system planners should be developed with respect to equity. MDH works with local public health, emergency management, and HCCs to plan for and with these groups on multiple levels. Pre and Post-incident assessments are recommended to determine the needs of affected communities, assist in estimating the number of people who may need specialized services, the types of services they may require, and the type and methods of public outreach that may be needed to reach them. This may be accomplished as part of the state and local CSC planning process.

Background

CSC planning originated nationally about a decade ago with the realization that in a severe pandemic there may be insufficient ventilators and critical care beds available for every patient in need. Furthermore, there was a lack of systems to triage resources, or to provide for alternative methods and sites of medical care. Therefore, development of a framework for decision-making and resource balancing was necessary to provide transparency and consistency, as well as support medical providers making difficult decisions. CSC is defined as a:

“substantial change in the usual [health care] operations and the level of care it is possible to deliver....justified by specific circumstances and....formally declared by a state government in recognition that crisis operations will be in effect for a sustained period” (IOM/NAM, 2009, p. 3)

Crisis care plans may be needed anytime and anywhere as extensions of surge capacity plans to address immediate needs when a community is overwhelmed—but the majority of these situations can be addressed rapidly by providing additional response resources at the local, regional, or state level. *Crisis Standards of Care* plans invoke the support of State and other

levels of government in support of an ongoing, *substantial change in operations and the medical care decision-making* required in a prolonged disaster situation.

The basis for CSC planning in many states has been the 2012 IOM/NAM Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations.⁵ The first recommendation of the IOM/NAM Guidance advises the development of “crisis standards of care protocols that include the key elements:

- A strong ethical grounding;
- Integrated and ongoing community and provider engagement, education, and communication;
- Assurances regarding legal authority and environment;
- Clear indicators, triggers, and lines of responsibility; and
- Evidence-based clinical processes and operations.”⁶

For the purpose of CSC framework development and review in Minnesota, MDH established a CSC Steering Group comprised of representatives from the private and public sectors extending across all disciplines of health and government. To accomplish its charge, the CSC Steering Group assisted the development of the overall plan by acting as planning advocates within their disciplines, as well as monitoring and reviewing the work of CSC workgroups. The workgroups established for the writing of the Crisis Standards of Care Framework were the following:

- Science Advisory Team for Crisis Standards of Care (SAT/CSC)
- Ethics
- Emergency Medical Services (EMS)
- Health Care/Hospitals
- Public Engagement

Historical background

The CSC Framework augments and integrates with many ongoing efforts at MDH. In 2005, the SAT/CSC was established for the purpose of developing initial clinical recommendations for providers of crisis care during scarce resource situations. Those recommendations can be found at [MDH’s Strategies for Scarce Resources](#).

Beginning in 2007, MDH sponsored the [Minnesota Pandemic Ethics Project \(MPEP\)](#)⁷ with funding from the U.S. Centers for Disease Control and Prevention. MDH contracted with ethicists from the Minnesota Center for Health Care Ethics and the University of Minnesota

⁵ Dan Hanfling, Bruce M. Altevogt, Kristin Viswanathan, and Lawrence O.Gostin, Editors; Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations; Institute of Medicine. “Volume 1: Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response” 1-1.

⁶ Ibid, 1-1

⁷ Minnesota Pandemic Ethics Project available at [Minnesota Department of Health Minnesota Pandemic Ethics Project](#).

Center for Bioethics (project team) to develop and lead the project, which involved multiple community engagement sessions to address resource limitations in a pandemic. The project produced two major reports. [*For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic*](#)⁸ provided ethical frameworks for rationing scarce resources in influenza pandemic and [*Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic*](#)⁹ identified and analyzed issues relating to the implementation of those ethical frameworks. The CSC Ethics Team includes members of the MPEP team from the University of Minnesota.

The current CSC Framework builds on these prior efforts to define the scope of State support during a crisis standards of care incident.

Scope

The CSC Framework describes the strategy for health and medical response to a disaster in which a proactive, structured approach is required to provide the best care possible when resource demands far exceed resources available. It also defines MDH actions and role.

MDH's role in a crisis is to assist and support local and regional responses to provide the most consistent, fair, and proportional response possible by balancing resources across the state and coordinating assistance with other state and federal partners. This support assumes that local agencies and health care facilities have developed and implemented their own crisis care plans. Crisis standards of care situations requiring state action are extremely rare (e.g., severe pandemic). More commonly, local disasters may require temporary use of crisis care strategies until adequate resources can arrive to meet the needs. In these short-term situations, initiation of the CSC Framework is not necessary and the jurisdiction would be supported through usual all-hazards response processes.

Planning assumptions

Initiation of the CSC Framework will occur in stages and will be inclusive of a variety of public and private entities. As previously stated, a disaster that occurs at an individual health care facility or regional location requiring short-term crisis care most likely would not require CSC

⁸ Dorothy E. Vawter, J. Eline Garrett, Karen G. Gervais, Angela Witt Prehn, Debra A. DeBruin, Carol A. Tauer, Elizabeth Parilla, Joan Liaschenko and Mary Faith Marshall. [*For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic*](#) 2010. Minnesota Pandemic Ethics Project Report

⁹ DeBruin D, Marshall MF, Parilla E, Liaschenko J, Leider J, Brunquell D, Garrett J, Vawter D. *Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic*. Minneapolis, MN; 2010. Report of the Minnesota Pandemic Ethics Project (deliverable to Minnesota Department of Health) 121 pages is available at [*Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota during Severe Influenza Pandemic*](#).

Framework initiation due to its short duration and limited scope. However, crisis standards of care strategies should be used as extensions of medical surge plans. Statewide initiation of CSC will likely occur only during a widespread catastrophic disaster impacting multiple health care facilities in a large geographical area or densely populated urban area that overwhelms both local and regional capacity. The following criteria describe a situation that will require CSC:

- Resources are scarce and cannot be obtained by health care facilities in time to prevent resource triage.
- Crisis strategies have been invoked by other health care delivery systems and consistency is needed across the state so equitable levels of care are offered.
- Patient transfer is not possible or feasible, at least in the short-term.
- Access to medical countermeasures (vaccine, medications, antidotes, blood products) are limited.
- Available local, regional, state, federal resource caches (e.g., equipment, supplies, medications) have been distributed, and there is no foreseeable short-term resupply of such stocks is.
- Adaptive and alternate strategies have been exhausted or are not appropriate.
- Multiple health care access points within a community or region are impacted.¹⁰

The CSC Framework provides guidance for the State, health care facilities, and EMS in coordinating, establishing, activating, operating and demobilizing a CSC incident. The guidance should be followed as circumstances dictate and as determined by the Minnesota Commissioner of Health, with input from the MDH SAT/CSC. This framework does not supersede or replace the MDH AHRP, nor does it create new authorities or change existing authorities.

Definitions

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
Governor, State of Minnesota	Oversee response and ensure coordination among relevant state agencies	<ul style="list-style-type: none"> ▪ Approves State disaster declaration requests ▪ Requests Federal Emergency or Disaster Declaration ▪ Issues emergency declarations and specific emergency orders to address incident-specific issues ▪ Ultimate authority for State response
Minnesota Department of Health (MDH)-	State lead agency for health-related issues	<ul style="list-style-type: none"> ▪ Facilitate health care resource requests to state/inter-state/federal partners

¹⁰ Crisis Standards of Care, IOM/NAM, p. 1-10, 2012

CRISIS STANDARDS OF CARE FRAMEWORK

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
General Agency Responsibilities		<ul style="list-style-type: none"> ▪ Request State Disaster or Public Health Emergency Declarations and governor’s emergency orders as required from HSEM to support response ▪ Request CMS 1135 waivers as required during response to allow patient billing when usual conditions cannot be met ▪ Convene the clinical SAT/CSC to discuss or develop incident specific medical/resource clinical guidance and triage criteria ▪ Activate other consultative subject matter teams and SMEs as needed (e.g., EMS, Ethics, and Hospitals Surge) help inform specific actions and develop outreach strategies ▪ Provide clinical guidelines/guidance ▪ Request specific emergency orders/actions by the governor’s office ▪ Support HCC information exchange and policy development ▪ Provide treatment and other health related guidance for clinicians, local and tribal public health and community members, based on the nature of the event ▪ MDH’s Public Information Officer (PIO) will develop MDH communications to public and providers on the crisis issues.
Commissioner, MDH	Lead health official; authorizes activation of CSC Framework	<ul style="list-style-type: none"> ▪ Approve implementation of CSC Framework when necessary during a public health emergency/disaster response; ▪ Serve as liaison to the governor’s Office; Issue commissioner’s orders as appropriate to the event to protect the public’s health
Director, Center for Emergency Preparedness and Response, MDH	Guides MDH emergency preparedness and response efforts	<ul style="list-style-type: none"> ▪ Coordinates MDH response; may be given authority by the commissioner to activate CSC Framework components ▪ Key liaison to HCCs in the State

CRISIS STANDARDS OF CARE FRAMEWORK

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
Infectious Disease, Epidemiology, Prevention & Control (IDEPC) Division, MDH	Epidemiology and Infectious Disease Control expertise	Develop impact assessment, provide infection control information, develop public health population-based intervention recommendations based on expert input and CDC guidance
Minnesota Division of Homeland Security and Emergency Management (HSEM), State Emergency Operations Center (SEOC)	State lead for incident coordination	<ul style="list-style-type: none"> ▪ State level coordination of overall disaster response/recovery ▪ Serve as point of contact for resource requests ▪ Request State declaration of emergency ▪ Recommend and request a Federal Disaster Declaration request to governor
EMS Regulatory Board (EMSRB)	State lead agency for EMS disaster issues	<ul style="list-style-type: none"> ▪ Support hospitals by regional and state-level coordination of EMS surge capacity implementation ▪ Carry out duties and responsibilities assigned to the EMSRB in the Minnesota Emergency Operations Plan (MEOP) and the Governor’s Executive Order 15-13 Assigning Emergency Responsibilities to State Agencies. ▪ Deploy Ambulance Strike Teams (AST), MCI buses, additional ground or air ambulances from regions as requested by local EMS agencies through the State Duty Officer or SEOC ▪ Request inter-state (EMAC) or federal (i.e., Federal Ambulance Contract) resources via HSEM ▪ Communicate suspension of selected regulatory statutes/rules to facilitate crisis care activities during declared disaster ▪ Provide support to regional health care coalition/response through regional EMS system program personnel ▪ Support local EMS medical directors by providing guidance on patient care guideline

CRISIS STANDARDS OF CARE FRAMEWORK

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
		<p>development through the State EMS Medical Director and the Medical Director Standing Advisory Committee</p>
<p>Regional Health Care Coalitions (HCCs)</p>	<p>Regional coordination of health/medical response</p>	<ul style="list-style-type: none"> ▪ Information sharing and coordination of activities between public health, hospitals, EMS, and emergency management ▪ May provide/develop regional policies for disaster response/crisis care ▪ Help manage resources between hospitals in the area ▪ May coordinate consistent patient care within the region ▪ May provide single point of contact for patient transfer coordination
<p>Local and Tribal Public Health</p>	<p>Lead agency for public health emergencies at local level</p>	<ul style="list-style-type: none"> ▪ Determine jurisdictional public health activities and interventions and coordinate efforts through HCC partners – especially hospitals and EMS ▪ Supporting agency to hospitals and EMS (local lead agency for pandemic/epidemic situations) ▪ Provide health-related community communications during disasters ▪ Supports alternate care sites as appropriate ▪ Supports/coordinates hotlines ▪ Communicates health alerts and other information to partner agencies ▪ Provides community based interventions (e.g., prophylaxis or vaccination) ▪ Determines need for social distancing and other community infection control measures
<p>Local Emergency Management</p>	<p>Local lead for incident support</p>	<ul style="list-style-type: none"> ▪ Request resources locally and through SEOC ▪ Facilitate local declarations of emergency ▪ Facilitate suspension of ordinances/rules as required to support response ▪ Provide incident information/common operating picture to local and State agencies
<p>Tribal Emergency Management</p>	<p>Tribal lead for incident support</p>	<ul style="list-style-type: none"> ▪ Declare tribal emergency ▪ Request a State or Federal Presidential Disaster Declaration as required

CRISIS STANDARDS OF CARE FRAMEWORK

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
		<ul style="list-style-type: none"> ▪ Tribal level coordination of overall disaster response and recovery ▪ Tribal coordination and utilization of tribal communications, EMS, and tribal first responder resources and tribal public health ▪ Coordinate with Indian Health Service hospitals at Leech and Red Lake and tribal clinics
Regional EMS Programs	Regional coordination EMS response	<ul style="list-style-type: none"> ▪ Information sharing of activities between EMS, hospital, emergency management and local, regional and state emergency operations centers ▪ Assist in coordination of EMS resources and emergency management in collaboration with the State, Regional or Local Emergency Operations Centers ▪ May provide or develop regional procedures for EMS disaster response
Public Safety Answering Point/9-1-1 Dispatch Center	Support agency	<ul style="list-style-type: none"> ▪ Answers 911 calls ▪ Provides emergency medical dispatch support (if equipped, may transfer to secondary center / PSAP or not have this capability) ▪ Determines appropriate response based on situation/algorithms/Standard Operating Procedures ▪ Provides communication point for incident responders ▪ May assign radio talk groups during an incident
Medical Response Unit/First Responders	First response	<ul style="list-style-type: none"> ▪ Frequently the first personnel on scene to assess and report on the situation, provide initial triage and care and help determine what additional resources may be needed ▪ Support and assist arriving ambulance personnel on scene
Local EMS Agency	Emergency response and patient transport	<ul style="list-style-type: none"> ▪ Coordinate patient destination hospitals to the degree possible to avoid overloading a single facility ▪ Develop policies for crisis care situations

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
		<ul style="list-style-type: none"> ▪ Interface with local hospitals and regional health care coalition to share information/status ▪ Adjust response and transport guidelines to reflect the situation at the hospital (e.g., if all hospitals overwhelmed may recommend self-transport to clinic for non-emergent problems)
Health Care Facilities	Acute patient care	<ul style="list-style-type: none"> ▪ Implement surge plans including crisis care plans, implement facility or regional triage/treatment plans as required, coordinate information and resource management with other facilities in the region via their Regional Health Care Coalition (HCC)
Indian Health Service Clinics and Hospitals ¹¹	Acute patient care	<ul style="list-style-type: none"> ▪ Provide clinical support to tribal members ▪ Provide situational awareness to tribal emergency managers and regional health care coalition ▪ Lead for tribal community based interventions (vaccinations, isolation, prophylaxis)

Several terms are utilized throughout this Framework. They are defined here:

Catastrophic Disaster: Disruption severely affecting the population (including mass evacuations), infrastructure, environment, economy, national morale, or government functions in an area...¹²

Contingency care: Provision of functionally equivalent care - care provided is adapted from usual practices; for example, boarding critical care patients in post-anesthesia care areas.¹³

Continuum of care: Medical care that is rendered during a mass casualty event and occurs across 3 phases on a continuum; conventional to contingency to crisis standards of care.¹⁴

¹¹ IHS federally operated hospitals and health centers: Red Lake IHS Hospital, Cass Lake IHS Hospital, White Earth Health Center (main clinic with two clinics operated under White Earth Health Center, Naytahwaush Clinic and Pine Point Clinic).

¹² Congress, U. (2007). Department of Homeland Security Appropriations Act, 2007. *Public Law*, 109-295.

¹³ Hick, J. L., Hanfling, D., & Cantrill, S. V. (2012). Allocating Scarce Resources in Disasters: Emergency Department Principles. *Annals of Emergency Medicine*, 59(3), p 178.

¹⁴ Ibid.

Conventional care: Conventional care: usual resources and level of care provided. The maximal use of the facilities' usual beds, staff, and resources is ensured.¹⁵

Crisis Standards of Care (CSC): A state of being that indicates a substantial change in health care operations and the level of care that can be delivered in a public health emergency, justified by specific circumstances. Medical care delivered during disasters shifts beyond focusing on individuals to promoting the thoughtful stewardship of limited resources intended to result in the best possible health outcomes for the population as a whole.¹⁶

Disaster: "Non-routine events in societies or their larger subdivisions (e.g. regions, communities) that involve social disruption and physical harm. Among the key defining properties of such events are (1) length of forewarning, (2) magnitude of impact, (3) scope of impact, and (4) duration of impact."¹⁷

Emergency: "Any occasion or instance--such as a hurricane, tornado, storm, flood, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, fire, explosion, nuclear accident, or any other natural or man-made catastrophe--that warrants action to save lives and to protect property, public health, and safety."¹⁸

Health disparities: Systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups; they may reflect social disadvantage, but causality need not be established.¹⁹

Mass Casualty Incident (MCI): "...an event which generates more patients at one time than locally available resources can manage using routine procedures. It requires exceptional emergency arrangements and additional or extraordinary assistance."²⁰

Moral Distress: "...an emotion that is expressed when the moral complexity of a situation is not leading to a resolution, thereby having the potential to cause harm to the individual [...] painful feelings and associated mental anguish as a result of being conscious of a morally appropriate action, which, despite every effort, cannot be performed owing to organizational or other constraints."²¹

Palliative Care: "Aggressive management of symptoms and relief of suffering is what generally have come to be called "palliative care." The World Health Organization defines palliative care as 'an approach which improves the quality of life of patients and their families facing life-

¹⁵ Ibid.

¹⁶ IOM 2009

¹⁷ Kreps, G. A. (1998). Disaster as systemic event and social catalyst. *What is a Disaster*, p 34.

¹⁸ Association, F. E. M. (1996). Guide for all-hazard emergency operations planning (state and local guide). *Washington: FEMA*, p GLO-2.

¹⁹ Braveman, P. A., Kumanyika, S., Fielding, J., LaVeist, T., Borrell, L. N., Manderscheid, R., & Troutman, A. (2011). Health disparities and health equity: the issue is justice. *Am J Public Health, 101*(S1), S149-S155

²⁰ WHO (2007). [Mass casualty management systems: strategies and guidelines for building health sector capacity.](#)

²¹ PGCEA, B. (2011). Moral distress and moral courage in everyday nursing practice. *Online journal of issues in nursing, 16*(2), 1B.

threatening illness, through the prevention, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems.”²²

Indicators and triggers

An indicator is a “measurement or predictor of change in demand for health care services or availability of resources” (e.g., a tornado warning, report of several cases of unusual respiratory illness).²³ A trigger is a “decision point about adaptations to health care service delivery” that requires specific action.²⁴ An indicator may identify the need to transition to contingency or crisis care (but requires analysis to determine appropriate actions), while a trigger event dictates action is needed to adapt health care delivery and resources. It is important for organizations to identify indicators and triggers prior to an event due to the “stress, complexity, and uncertainty inherent in a crisis situation.”²⁵

Triggers can be scripted or non-scripted. Scripted triggers are built into Standard Operating Procedures (SOPs) and are automatic ‘if/then.’ Whenever possible, scripted triggers should be developed for front line personnel (e.g., dispatch, first responders, point of entry hospital staff, etc.) so they have actions they can take immediately to prevent delay. Non-scripted triggers require additional analysis and consideration involving management and supervisory staff. These are often part of an incident action planning cycle. The less specific information available, the more difficult it is to apply a scripted trigger. In these cases, an experienced manager, supervisor or Subject Matter Expert (SME) should be involved to process the information and decide on necessary actions.

Figure 1 (below) illustrates the continuum of surge capacity, starting with conventional care, transitioning to contingency care and finally reaching crisis care. During conventional care, maximal routine services are provided (e.g., use of available inpatient beds). In the middle of the continuum is contingency care, where care *functionally equivalent* to routine care is delivered but equipment, medications, and even staff may be used for a different purpose or in a different manner than typical daily use. The demands of most incidents can be met with conventional and contingency care. Crisis care falls at the far end of the spectrum when resources are scarce and the focus changes from delivering individual patient care to delivering the best care for the patient population as a whole.

This shift in focus, which may require adaptations and non-traditional provision of care, which while necessary to maximize the number of lives saved during a catastrophic disaster, increases

²² Phillips, S., & Knebel, A. (2007). Mass medical care with scarce resources: a community planning guide. *Mass medical care with scarce resources: a community planning guide*, p 104.

²³ Dan Hanfling, John Hick, and Clare Stroud, Editors; Committee on Crisis Standards of Care: A Toolkit for indicators and Triggers; Board on Health Sciences Policy; Institute of Medicine, “Crisis Standards of Care: A Toolkit for Indicators and Triggers” (the National Academies Press, 2013) 2

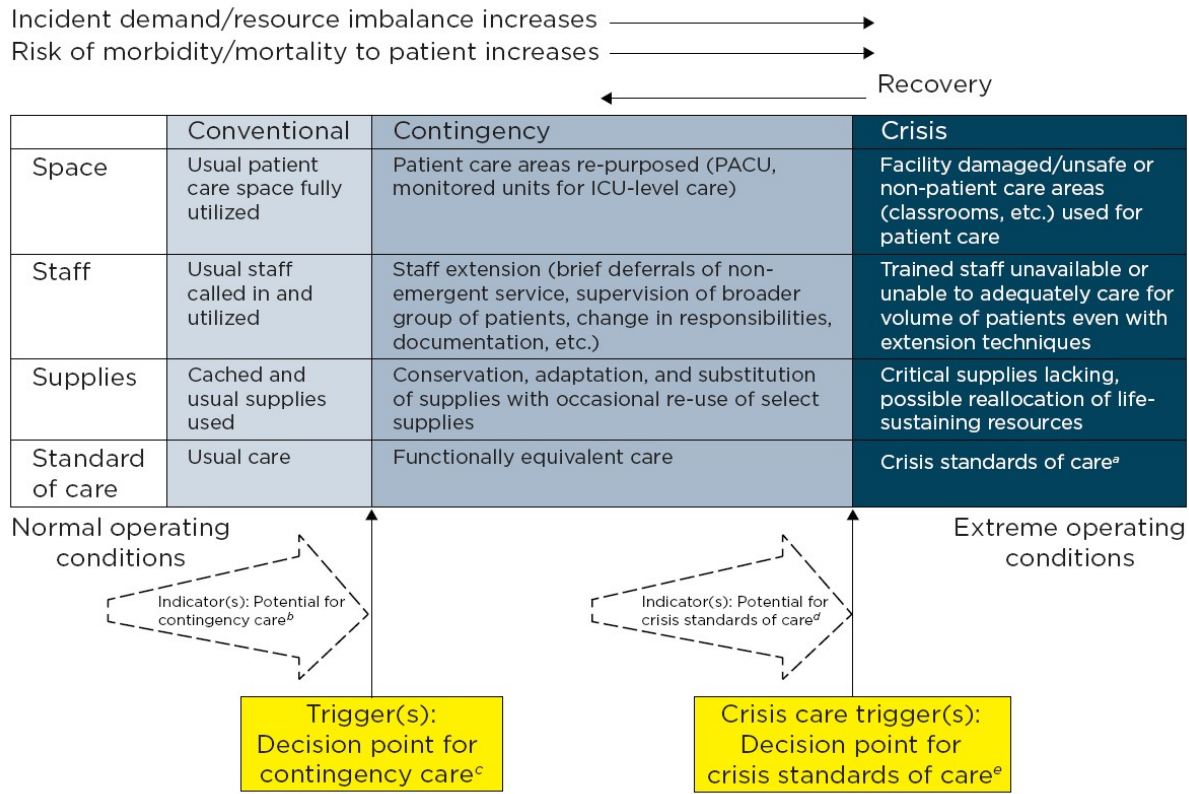
²⁴ Ibid

²⁵ Ibid

the risk to the individual patient of a worse outcome. A single resource (e.g., vaccine) or multiple resources (e.g., critical care beds and staffing) may be affected. Notably, disasters are dynamic, and care moves back and forth along this continuum during an event. The goal is to avoid the crisis state through good contingency planning and implementation, and to recover from the crisis state as soon as possible. For example, a hospital in a crisis situation after a local disaster can usually transfer patients and bring in resources within hours to get back to contingency or conventional status. The initiation of the CSC Framework is at the end of the continuum of surge capacity and would be needed in an extreme prolonged event for a statewide response.

Indicators and triggers aid decision-makers in recognizing when care is moving along this spectrum from conventional to contingency to crisis care and can help prompt requests for assistance. For example, if a hospital is providing cot-based care, that should be an indicator that crisis care is occurring and outside support is needed.

Figure 1: Allocation of specific resources along the care capacity continuum²⁶



The following indicators and triggers may be considered by MDH in the decision to initiate the CSC Framework:²⁷

- Indicators with no associated Trigger (require analysis and decision-making):
 - Disruption of facility or community infrastructure and function (e.g., utility or system failure in health care organizations, more than one hospital affected in the region, more than five hospitals affected, or critical-access hospitals affected in the state);

²⁶ FIGURE 2-2 Allocation of specific resources along the care capacity continuum.

NOTE: ICU = intensive care unit; PACU = post- anesthesia care unit. A) Unless temporary, requires state empowerment, clinical guidance, and protection for triage decisions and authorization for alternate care sites/ techniques. Once situational awareness achieved, triage decisions should be as systematic and integrated into institutional process, review, and documentation as possible. B) Institutions consider impact on the community of resource use (consider “greatest good” versus individual patient needs—e.g., conserve resources when possible), but patient-centered decision making is still the focus. C) Institutions (and providers) must make triage decisions—balancing the availability of resources to others and the individual patient’s needs—shift to community-centered decision making. SOURCE: IOM/NAM, 2009, p. 53.

²⁷ Rear Admiral Ali. S. Khan, M.D., M.P.H., Christine Kosmos, B.S.N., M.S., Christa-Marie Singleton, M.D., M.P.H. “Public Health: Preparedness Capabilities, National Standards for state and Local Planning” (Centers for Disease Control, Office of Public Health Preparedness and Response, March 2011), 93

- Failure of hospital “contingency” surge capacity (i.e., resource-sparing strategies overwhelmed);
 - Availability of material resources;
 - Availability of space for patient care;
 - Pandemic phase / impact
-
- Potential Indicators with associated local Trigger (threshold that ‘triggers’ specific action is specified in agency/facility plans):
 - Unable to answer all EMS calls;
 - More than 12 hours of wait time for emergency department visits;
 - Unable to maintain staffing in ICU;
 - Less than 5 percent of hospital beds available, no beds available;
 - No ICU beds available in the health care organization; or a disaster declaration affects more than one area hospital;
 - Shortage of specific equipment (ventilators) or of medications that have no substitute

It is important to note that ‘triggers’ are more common at the initial levels of response (e.g., report to a hospital of an explosion with 20 casualties, triggers disaster plan activation). At the MDH level it will be much more common that indicators are reviewed and appropriate actions determined based on the problem and potential solutions. For other examples of indicators and triggers, refer to Figure 2 below.

Figure 2: A Toolkit for Indicators and Triggers, IOM/NAM²⁸

Trigger: A decision point that is based on changes in the availability of resources that requires adaptations to health care services delivery along the care continuum (contingency, crisis, and return toward conventional).

Crisis care trigger: The point at which the scarcity of resources requires a transition from contingency care to crisis care, implemented within and across the emergency response system. This marks the transition point at which resource allocation strategies focus on the community rather than the individual.

Steps for Developing Useful Indicators and Triggers

The following four steps should be considered at the threshold from conventional to contingency care, from contingency to crisis care, and in the return to conventional care. They should also be considered for both slow-onset and no-notice incidents.

- 1. Identify key response strategies and actions** that the agency or facility would use to respond to an incident. (Examples include disaster declaration, establishment of an emergency operations center [EOC] and multiagency coordination, establishment of alternate care sites, and surge capacity expansion.)
- 2. Identify and examine potential indicators** that inform the decision to initiate these actions. (Indicators may be comprised of a wide range of data sources, including, for example, bed availability, a 911 call, or witnessing a tornado.)
- 3. Determine trigger points** for taking these actions.
- 4. Determine tactics** that could be implemented at these trigger points.

Note: Specific numeric **“bright line”** thresholds for indicators and triggers are concrete and attractive because they are easily recognized. For certain situations they are relatively easy to develop (e.g., a single case of anthrax). However, for many situations the community/agency actions are not as clear-cut or may require significant data analysis to determine the point at which a reasonable threshold may be established (e.g., multiple cases of diarrheal illness in a community). In these situations, it is important to define who is notified, who analyzes the information, and who can make the decision about when and how to act on it.

Notification and communication

Threat assessment and reporting to MDH

MDH may receive from information from a variety of sources suggesting a potential public health threat or threat of a potential business interruption. Examples include:²⁹

- The media

²⁸ Dan Hanfling, John Hick, and Clare Stroud, Editors; Committee on Crisis Standards of Care: A Toolkit for indicators and Triggers; Board on Health Sciences Policy; Institute of Medicine, “Crisis Standards of Care: A Toolkit for Indicators and Triggers” (the National Academies Press, 2013) 96

²⁹ Minnesota Department of Health, “All-Hazards Response and Recovery Plan” MDH, Revised Date 4/14/2016, 15

- Reports, alerts, or requests for assistance from local or tribal agencies or other external sources
- MDH staff observations and notification
- Results from surveillance systems or sample analyses
- The Minnesota State Duty Officer
- Homeland Security and Emergency Management (HSEM) and other state agencies
- CDC and other federal agencies

Initial assessment of indicator information

MDH staff that receive indicator information must assess and report their findings according to the standard operating guidelines for their program or division.

Outside of normal business hours, MDH staff notify the appropriate 24/7 point-of-contact to alert their director or designee. The director is responsible for ensuring that an initial assessment is conducted and additional notifications are made including, but not limited to, the Center for Emergency Preparedness and Response (EPR) on-call number, MDH Facilities Management, Human Resources Management, the assistant commissioners for the Health Protection Bureau and the Health Systems Bureau, and the state epidemiologist.³⁰

The director, or designee, who receives the indicator information, will apply the following considerations to conduct the initial assessment:

- Source of the information
- Quality and quantity of the information
- Severity, magnitude, and timelines regarding the potential or actual health threat or threat of business interruption
- Credibility of prior testing done to generate the information for public health threats
- Other intelligence/information to corroborate or support the information
- Anticipated need to provide information to MDH staff, the public, media, or other response partners
- Are there multiple cases of a rare or novel illness, or illnesses with an unknown cause?
- Is the incident occurring in multiple jurisdictions?
- Is the incident causing or likely to cause serious morbidity or mortality?
- Is there an association with a large event?³¹

Framework activation

In the event of a large-scale public health emergency or catastrophic disaster requiring the initiation of strategies discussed in the CSC Framework, the State Emergency Operations Center

³⁰ Ibid.

³¹ Minnesota Department of Health, "All-Hazards Response and Recovery Plan" MDH, Revised Date 4/14/2016, 16

(SEOC) would likely be activated with MDH serving as the lead agency for health and medical response. MDH and HSEM will coordinate with the Minnesota Emergency Medical Services Regulatory Board (EMSRB) and the regional EMS systems. Regional Health Care Coalitions (HCC) should be notified to assist with information coordination and resource sharing among local and tribal health departments, health care facilities, and MDH. CSC Framework initiation can be triggered by various causes, including strained resources and requests for assistance by others (see indicators and triggers section above).

The commissioner of health and the director of the Center for Emergency Preparedness and Response should integrate steps from the MDH All-Hazards Plan into the CSC incident management process.³²

As part of the initiation of this Framework, MDH may activate CSC workgroups or other workgroup members to assist. Examples include but are not limited to EMS, Ethics, SAT/CSC, and Hospital workgroups. Other ad hoc groups may be formed to address issues as they are identified. In particular, the SAT/CSC may be activated for clinical considerations and recommendations on scarce resource allocation and triage in addition to other national guidance relevant to the situation. It may be necessary to request resources from other states or the federal government as available, in accordance with the Minnesota Emergency Operations Plan (MEOP). Additionally, the Minnesota National Guard may be activated by the governor to assist and can provide a variety of assets statewide in response to all-hazards incidents.³³

Communications

Communication is one of the most important components of preparedness, response and recovery operations. Implementation of this framework requires extensive communication, coordination and collaboration among all involved. During response, providing transparency to the public and other stakeholders for situational awareness is just one goal. As the state's lead public health agency, with primary responsibility for policy development and technical expertise regarding public health issues, MDH is responsible under the MEOP for directing and coordinating health-related communications activities during an incident with public health implications.

When the State Emergency Operations Center (SEOC) is active, public/media communications will be directed and coordinated with and through the State Joint Information Center (JIC) via the Lead Public Information Officer (PIO). The Lead Public Health PIO in the SEOC will assume primary responsibility for public health information and messages. When the SEOC is not active, but MDH has activated an incident response structure, the MDH PIO will assume lead responsibility for public communication associated with an emergency or incident.

³² Ibid.

³³ MEOP

Methods and vehicles for communicating both internal and external stakeholders may include:

- Health Alert Network (HAN) messages;
- Minnesota system for Tracking Resources, Alerts and Communications (MNTrac), PIO advisories and guidance documents;
- materials developed in preparation for, or generated in connection with conference calls (e.g., agendas or minutes; individual mass distribution email, including Workspace messages;
- face-to-face conferences or briefings and documents generated in connection with those events; press conferences; and one-on-one contact by phone or in person).

Hotlines

Both MDH and the SEOC have hotlines that can be utilized during an incident response. The SEOC Information Hotline can be activated when the SEOC is in use or the MDH hotline becomes overwhelmed. In situations where both the MDH and SEOC hotlines are activated, the MDH hotline is reserved for public health agencies and health care professionals and the SEOC hotline provides information to the general public about the incident.

Roles and responsibilities

Activation of a State response is detailed in the AHRRP. A brief outline of key roles and responsibilities related to the activation of the CSC Framework is in the table below.

Table 2: Roles and responsibilities

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
Governor, State of Minnesota	Oversee response and ensure coordination among relevant state agencies	<ul style="list-style-type: none"> ▪ Approves State disaster declaration requests ▪ Requests Federal Emergency or Disaster Declaration ▪ Issues emergency declarations and specific emergency orders to address incident-specific issues ▪ Ultimate authority for State response
Minnesota Department of Health (MDH)-General Agency Responsibilities	State lead agency for health-related issues	<ul style="list-style-type: none"> ▪ Facilitate health care resource requests to state/inter-state/federal partners ▪ Request State Disaster or Public Health Emergency Declarations and governor’s emergency orders as required from HSEM to support response

CRISIS STANDARDS OF CARE FRAMEWORK

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
		<ul style="list-style-type: none"> ▪ Request CMS 1135 waivers as required during response to allow patient billing when usual conditions cannot be met ▪ Convene the clinical SAT/CSC to discuss or develop incident specific medical/resource clinical guidance and triage criteria ▪ Activate other consultative subject matter teams and SMEs as needed (e.g., EMS, Ethics, and Hospitals Surge) help inform specific actions and develop outreach strategies ▪ Provide clinical guidelines/guidance ▪ Request specific emergency orders/actions by the governor’s office ▪ Support HCC information exchange and policy development ▪ Provide treatment and other health related guidance for clinicians, local and tribal public health and community members, based on the nature of the event ▪ MDH’s Public Information Officer (PIO) will develop MDH communications to public and providers on the crisis issues.
Commissioner, MDH	Lead health official; authorizes activation of CSC Framework	<ul style="list-style-type: none"> ▪ Approve implementation of CSC Framework when necessary during a public health emergency/disaster response; ▪ Serve as liaison to the governor’s Office; Issue commissioner’s orders as appropriate to the event to protect the public’s health
Director, Center for Emergency Preparedness and Response, MDH	Guides MDH emergency preparedness and response efforts	<ul style="list-style-type: none"> ▪ Coordinates MDH response; may be given authority by the commissioner to activate CSC Framework components ▪ Key liaison to HCCs in the State
Infectious Disease, Epidemiology, Prevention & Control (IDEPC) Division, MDH	Epidemiology and Infectious Disease Control expertise	<ul style="list-style-type: none"> ▪ Develop impact assessment, provide infection control information, develop public health population-based intervention recommendations based on expert input and CDC guidance

CRISIS STANDARDS OF CARE FRAMEWORK

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
Minnesota Division of Homeland Security and Emergency Management (HSEM), State Emergency Operations Center (SEOC)	State lead for incident coordination	<ul style="list-style-type: none"> ▪ State level coordination of overall disaster response/recovery ▪ Serve as point of contact for resource requests ▪ Request State declaration of emergency ▪ Recommend and request a Federal Disaster Declaration request to governor
EMS Regulatory Board (EMSRB)	State lead agency for EMS disaster issues	<ul style="list-style-type: none"> ▪ Support hospitals by regional and state-level coordination of EMS surge capacity implementation ▪ Carry out duties and responsibilities assigned to the EMSRB in the Minnesota Emergency Operations Plan (MEOP) and the Governor’s Executive Order 15-13 Assigning Emergency Responsibilities to State Agencies. ▪ Deploy Ambulance Strike Teams (AST), MCI buses, additional ground or air ambulances from regions as requested by local EMS agencies through the State Duty Officer or SEOC ▪ Request inter-state (EMAC) or federal (i.e., Federal Ambulance Contract) resources via HSEM ▪ Communicate suspension of selected regulatory statutes/rules to facilitate crisis care activities during declared disaster ▪ Provide support to regional health care coalition/response through regional EMS system program personnel ▪ Support local EMS medical directors by providing guidance on patient care guideline development through the State EMS Medical Director and the Medical Director Standing Advisory Committee

CRISIS STANDARDS OF CARE FRAMEWORK

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
Regional Health Care Coalitions (HCCs)	Regional coordination of health/medical response	<ul style="list-style-type: none"> ▪ Information sharing and coordination of activities between public health, hospitals, EMS, and emergency management ▪ May provide/develop regional policies for disaster response/crisis care ▪ Help manage resources between hospitals in the area ▪ May coordinate consistent patient care within the region ▪ May provide single point of contact for patient transfer coordination
Local and Tribal Public Health	Lead agency for public health emergencies at local level	<ul style="list-style-type: none"> ▪ Determine jurisdictional public health activities and interventions and coordinate efforts through HCC partners – especially hospitals and EMS ▪ Supporting agency to hospitals and EMS (local lead agency for pandemic/epidemic situations) ▪ Provide health-related community communications during disasters ▪ Supports alternate care sites as appropriate ▪ Supports/coordinates hotlines ▪ Communicates health alerts and other information to partner agencies ▪ Provides community based interventions (e.g., prophylaxis or vaccination) ▪ Determines need for social distancing and other community infection control measures
Local Emergency Management	Local lead for incident support	<ul style="list-style-type: none"> ▪ Request resources locally and through SEOC ▪ Facilitate local declarations of emergency ▪ Facilitate suspension of ordinances/rules as required to support response ▪ Provide incident information/common operating picture to local and State agencies
Tribal Emergency Management	Tribal lead for incident support	<ul style="list-style-type: none"> ▪ Declare tribal emergency ▪ Request a State or Federal Presidential Disaster Declaration as required

CRISIS STANDARDS OF CARE FRAMEWORK

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
		<ul style="list-style-type: none"> ▪ Tribal level coordination of overall disaster response and recovery ▪ Tribal coordination and utilization of tribal communications, EMS, and tribal first responder resources and tribal public health ▪ Coordinate with Indian Health Service hospitals at Leech and Red Lake and tribal clinics
Regional EMS Programs	Regional coordination EMS response	<ul style="list-style-type: none"> ▪ Information sharing of activities between EMS, hospital, emergency management and local, regional and state emergency operations centers ▪ Assist in coordination of EMS resources and emergency management in collaboration with the State, Regional or Local Emergency Operations Centers ▪ May provide or develop regional procedures for EMS disaster response
Public Safety Answering Point/9-1-1 Dispatch Center	Support agency	<ul style="list-style-type: none"> ▪ Answers 911 calls ▪ Provides emergency medical dispatch support (if equipped, may transfer to secondary center / PSAP or not have this capability) ▪ Determines appropriate response based on situation/algorithms/Standard Operating Procedures ▪ Provides communication point for incident responders ▪ May assign radio talk groups during an incident
Medical Response Unit/First Responders	First response	<ul style="list-style-type: none"> ▪ Frequently the first personnel on scene to assess and report on the situation, provide initial triage and care and help determine what additional resources may be needed ▪ Support and assist arriving ambulance personnel on scene
Local EMS Agency	Emergency response and patient transport	<ul style="list-style-type: none"> ▪ Coordinate patient destination hospitals to the degree possible to avoid overloading a single facility

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
		<ul style="list-style-type: none"> ▪ Develop policies for crisis care situations ▪ Interface with local hospitals and regional health care coalition to share information/status ▪ Adjust response and transport guidelines to reflect the situation at the hospital (e.g., if all hospitals overwhelmed may recommend self-transport to clinic for non-emergent problems)
Health Care Facilities	Acute patient care	<ul style="list-style-type: none"> ▪ Implement surge plans including crisis care plans, implement facility or regional triage/treatment plans as required, coordinate information and resource management with other facilities in the region via their Regional Health Care Coalition (HCC)
Indian Health Service Clinics and Hospitals ³⁴	Acute patient care	<ul style="list-style-type: none"> ▪ Provide clinical support to tribal members ▪ Provide situational awareness to tribal emergency managers and regional health care coalition ▪ Lead for tribal community based interventions (vaccinations, isolation, prophylaxis)
Minnesota Hospital Association (MHA)	Health care facility communication & regulations	<ul style="list-style-type: none"> ▪ Assist in communications and information sharing with hospitals and health care facilities across the state

The following highlighted personnel and groups have critical responsibilities in initiating strategies outlined in the CSC Framework:

Governor

During the initiation of CSC strategies, the Governor of Minnesota (or the Governor’s Authorized Representative in the absence of the governor) is responsible for coordinating response and ensuring an effective coordination between the state and the federal partners. The governor can make specific declarations, such as a State of Emergency declaration. The

³⁴ IHS federally operated hospitals and health centers: Red Lake IHS Hospital, Cass Lake IHS Hospital, White Earth Health Center (main clinic with two clinics operated under White Earth Health Center, Naytahwaush Clinic and Pine Point Clinic).

governor can also request a Federal Emergency or Disaster Declaration (Presidential Declaration of Disaster). For purposes of providing effective CSC, MDH may request a relaxation or suspension of health care and other regulations, as well as potential governor's emergency orders and administrative actions to support the response. In addition, Minnesota may consult with the U.S. Department of Homeland Security, the CDC, and ASPR for federal assistance and with state entities. For example, the Minnesota Board of Medical Practice might be engaged regarding relaxing state physician licensure rules to allow reciprocity with neighboring states.

Science advisory team/crisis standards of care

In the event of a health emergency requiring CSC strategies, the Commissioner can request the advice of the SAT/CSC. The SAT/CSC was established by MDH in the late 1990s to develop operational processes for provision of crisis clinical care and to provide clinical and operational expertise to MDH prior to and during events requiring such input. SAT/CSC is an external advisory group comprised of clinical providers in emergency medicine, critical care, pediatrics, infectious disease, respiratory care, pharmacy, family practice, with liaisons from MDH epidemiology/infectious disease and emergency response sections; it allows broad expert input into crisis care strategies. SAT/CSC also includes members of the Ethics Workgroup to assure ethical decision-making during crises, particularly when allocation of scarce medical resources, including vaccines, antiviral medications, and critical care resources may be required.

The SAT/CSC also advises MDH on ethical and policy considerations and may provide a standardized framework or decision tools to assist regions in determining how to extend resources when the need for specialized equipment and supplies such as ventilators and pharmaceuticals exceeds availability. MDH intends to use the technical expertise of the SAT/CSC to adjust guidance and update recommendations to reflect the needs of the incident. SAT/CSC products and processes are designed to be integrated into regional and hospital level planning.

As it pertains to CSC, key responsibilities of the SAT/CSC include:

- Consultation to MDH regarding overall and detailed patient care strategies for scarce resource situations.
- Advice and assistance to MDH as requested in matters relating to crisis standards of care during public health emergency.
- Consultation to MDH regarding ethical guidance for scarce resource situations.

The SAT/CSC has developed a set of scarce resource cards designed to facilitate resource shortfalls at a health care facility. The cards are a tool to support decision-making during times where standards of care move from conventional to contingency to crisis.³⁵ The Patient Care Strategies for Scarce Resource Situations cards may be accessed at:

<http://www.health.state.mn.us/oep/healthcare/crisis/standards.pdf>.

³⁵ <http://www.health.state.mn.us/oep/healthcare/crisis/standards.pdf>

Local and tribal emergency management/local emergency operations center(s)

In any emergency or disaster, local jurisdictions have the primary responsibility for addressing the immediate health and safety needs of the public. In the event of a multiagency response to a major emergency or disaster, a local jurisdiction's emergency operations center (EOC) will be activated according to local protocols. When local health resources are insufficient, the local jurisdiction formally requests assistance from the State Duty Officer. Tribal Nations, as sovereign entities, may request disaster assistance directly from federal agencies. They can also enlist the support of their regional HCC, local public health departments, or the MDH desk located at the SEOC (if operational): Figure 3 (below) demonstrates these communication pathways. State agencies—like MDH—may provide experts such as Regional Epidemiology staff, infectious disease, and infection control technical and subject matter guidance to support local jurisdictions. If the needs cannot be met rapidly, and the community is already utilizing crisis care strategies, this is an indicator that MDH will consider initiation of CSC Framework strategies. In addition to other state assets, the National Guard may assist with health care surge such as emergency decontamination, medical treatment, and transportation.

Local public health

Local public health agencies provide valuable support to the health care system during an emergency or disaster. When crisis standards of care need to be implemented, the HCC should ensure communication is maintained with local public health agencies. Local public health will share important health information with health care providers through the HAN system and other means. Local public health may be able to assist with community communications and public hotlines, depending on their capacity and other response activities. Additionally, some local public health has staff and/or volunteers that may be available to assist at an alternate care site.

Tribal public health

Tribal nations are independent sovereign nations and though they interface with surrounding jurisdictions they are self-governing and maintain the sovereign authority to make and enforce their own laws and rules. Depending on the nature of the emergency, tribal nations can directly request assistance from the U.S. government through a variety of channels. For a public health response, tribal nations can directly request assistance through the regional Indian Health Services Office within HHS and the Great Lakes Tribal Epidemiology Center. In a natural disaster, tribal nations may directly request assistance under the Stafford Act from the president, although in most cases they will also interface with the State as resources may be available more rapidly through local, regional and state channels.

Tribal nation sovereignty enables the Tribal Chair to declare a local emergency separate from state statutory authority. Under the Minnesota Emergency Management Act (MEMA), the governor or the director of the Minnesota Department of Homeland Security and Emergency Management must consult with Tribal authorities before the governor declares a peacetime emergency if the emergency occurs on tribal lands.

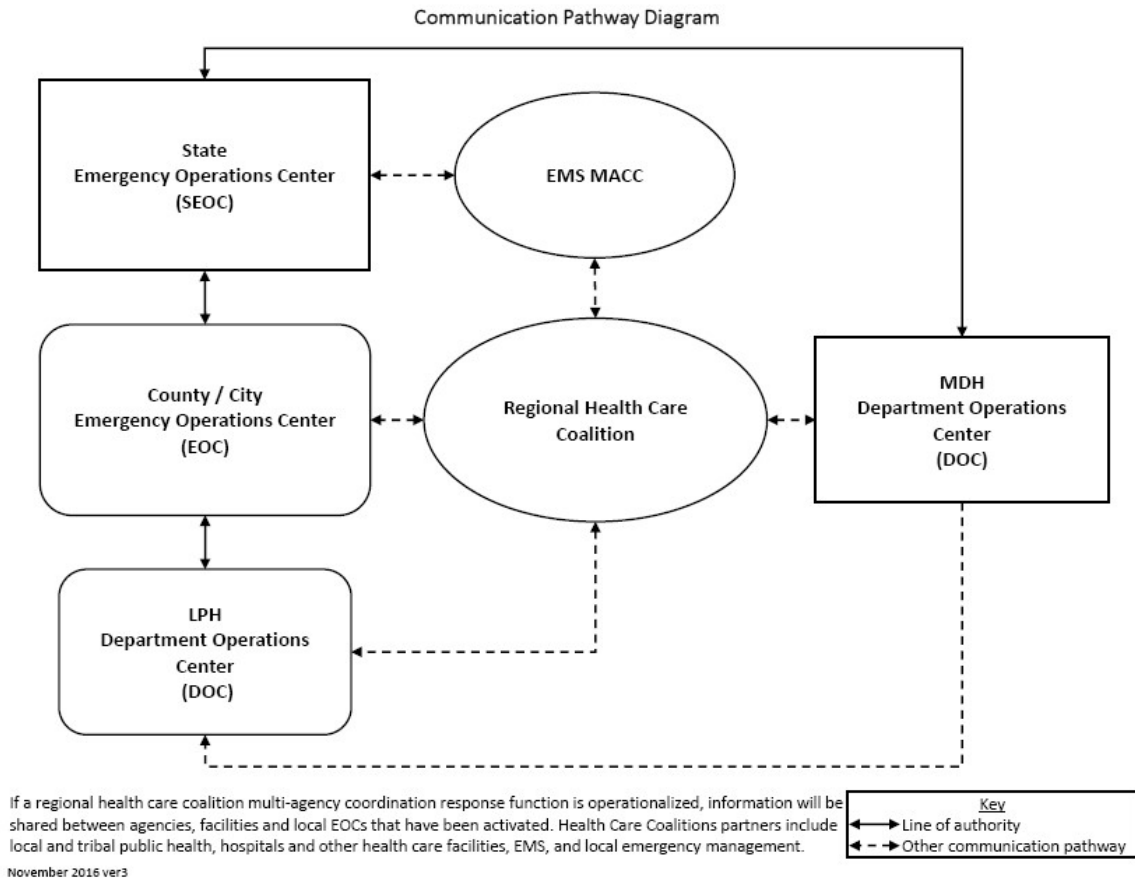
Regional health care coalitions³⁶

Each of the eight public health regions in the state has a health care coalition (HCC) established for health care emergency preparedness and response coordination. HCC membership includes: hospitals and other health care entities, jurisdictional emergency management, local and tribal public health, Emergency Medical Services and additional members such as behavioral health, dialysis centers, federal health facilities and long-term care. The coalitions engage members through regular meetings, training opportunities, exercises and all-hazards planning.

The Regional HCCs are a critical asset during response, providing information sharing, situational awareness, policy development assistance, and resource coordination to promote consistency of response within their geographical area. The eight HCC regions provide a mechanism to coordinate health care information and resource needs with MDH during an event, facilitating a proportional response to the emergency. This provides a means for MDH to assess and analyze the impact of the situation and to determine how best to assist in the allocation of scarce resources. HCCs can also have tremendous value in creating consistent policy for the regional stakeholders where consistency is important both for operations and public messaging, such as common hospital visitor policies, vaccine administration policies, or other issues. Furthermore, in some regions the HCC is responsible for resource allocation including triage activities during a crisis event based upon the specifics of their HCC agreements (e.g., the Metro Health and Medical Coalition). Figure 3 demonstrates the communication pathways involving the HCCs.

³⁶ <http://www.health.state.mn.us/oep/contact/teamsregions.html>

Figure 3: Communication pathway



Health care facilities

Health care facilities should incorporate surge capacity plans that document actions to be taken across the spectrum from conventional to contingency to crisis care as components of their Emergency Operations Plans (EOP). The facility should include a crisis care section or language in their EOP detailing the process when space, staff, and/or resource shortages require crisis care strategies. This includes any proactive triage process that might be required for specific resources. *Attachment 4—Surge Operations and Crisis Care for Hospitals* details the mechanisms by which the hospital and regional HCC will coordinate information and resource requests and how this interfaces with jurisdictional emergency management and the HCC.

At the facility level, crisis care strategies may have to be implemented immediately in response to event demands, and cannot wait for local or state declaration or orders. Having plans in place that are extensions of surge capacity plans, with triggers for notification and other regional actions when crisis care is required, assures more timely mobilization of resources and promotes consistency of response. Official declarations and activation by MDH of the CSC Framework helps provide regulatory and legal support for these activities and may offer additional clinical guidance, but nearly always *follows* actual crisis care decisions (an exception

might be a pandemic) and *supports* activities that are already being conducted. Therefore, though MDH may provide policy or clinical guidance that the hospital can use in their processes it is the hospital, and not MDH, that must assure appropriate response plans are in place.

There are many operational considerations for health care facilities. Please see *Attachment 4—Surge Operations and Crisis Care for Hospitals* for more details.

Ethical considerations

Establishing crisis standards of care requires addressing complex ethical issues. The IOM/NAM asserts that this ethical framework forms the “bedrock” for crisis standards of care preparedness.³⁷ To develop ethical guidance for this CSC Framework MDH contracted with the University of Minnesota Center for Bioethics in 2016. A systematic review of the academic and practice-based literature was conducted. With input from a stakeholder workgroup and in partnership with MDH, CSC ethical guidelines were developed, including supporting analysis and strategies for implementation in disaster scenarios. This ethics guidance is presented in *Attachment 1-Ethical Guidance for Crisis Standards of Care*. The complete Ethical Framework can be referenced in *Addendum 1.1 – CSC Ethics Framework*.

Minnesota’s CSC ethics guidance emphasizes IOM/NAM’s importance of equity and the protection of those who are most vulnerable during disasters.³⁸ This includes groups experiencing health disparities and those with access or functional needs. Minnesota’s CSC ethics guidelines also embraces IOM/NAM’s position about the need for clear guidance for health professionals about how to stay true to their essential ethical commitments in catastrophic contexts.³⁹ Local communities/organizations are encouraged to convene local CSC ethics advisory groups to provide ethically sound guidance on controversial cases and ensure compliance with and consistency in the application of the MDH CSC Ethical Framework. The framework synthesizes the guidance developed in MPEP for stewarding scarce resources in pandemic with that offered by IOM/NAM for CSC.

Minnesota’s ethical guidance outlines fundamental ethical commitments for CSC. It presents the ethical objectives that must be met, so that fundamental ethical commitments can be honored in a time of crisis. Finally, it offers strategies to achieve the stated ethical objectives, and specific case scenarios to illustrate its application.

Legal considerations

³⁷ IOM/NAM 2009, p.5.

³⁸ IOM/NAM 2012, p1-72.

³⁹ Ibid.

Every MCI has the capability of altering not just the operational environment, but the legal environment as well. Any time the response focus shifts from individual to community benefit, there is the potential for multiple legal issues to arise. One major challenge is incorporating legal aspects into emergency planning. Emergency managers and planners should review emergency and response plans with the understanding that it may be difficult, if not impossible, to anticipate all the varying legal issues that may arise in a health-related disaster because emergencies, by their very nature, create unique and often unexpected challenges. Consequently, emergency managers should give some thought to how responders will receive qualified legal advice to address important yet unanticipated legal issues that arise during a surge event.

MDH will work with the governor's office to determine emergency legal issues that must be addressed in order to facilitate the response. Issues including isolation and social distancing, access to resources, and liability are just a few examples of areas that may require legal interpretation and involvement. If necessary, MDH will work with the Minnesota Attorney General's office and the governor's office to provide incident-specific guidance. In some cases, governor's emergency orders may be needed to address the specifics of an incident.

Attachment 2 presents a brief overview of some of the more prominent Minnesota and Federal laws that pertain to emergency preparedness and response, including: authority to declare an emergency and principle declarations and actions, liability mitigation, volunteer protections, staff augmentation, tribal issues, and resource re-allocation. The Attachment also reviews some of the statutory powers of Minnesota's governor to respond to any type of emergency or disaster, the legal authority of the Commissioner of the Minnesota Department of Health to remediate an event that threatens the public health, and the powers of the president and other federal officials. While there is no legal authority that provides complete immunity against all potential liability exposures of health care or public health responders reacting to a crisis situation, the legal authorities highlighted in *Attachment 2*, will provide information that will serve as an asset in evaluating risk, and for future planning purposes.

Liability

Health care responders may have misunderstandings or incorrect assumptions concerning the legal environment during a CSC situation; therefore, legal counsel and ethics advisory support should be engaged in policymaking and planning. In addition, planners should work to identify and discuss potential legal and ethical issues and relevant legal authorities before disaster strikes. Such an analysis should identify the legal protections currently in place for health care and public health workers and volunteers; the existing legal authorities for resource allocation and staff augmentation; and whether current laws are sufficient or in need of change. Although lawsuits resulting from emergency planning or services rendered during an emergency or disaster are rare, responders may nonetheless be comforted in knowing what laws currently exist that afford protections against lawsuits that might be leveled against them for actions undertaken – or not undertaken – during a response.

Having pre-existing operational plans for crisis situations may provide protections for responders, as well as the agencies that employ them. If these plans are reasonable, based on recognized guidance and best practices documents, and approved by the agency (or optimally, by multiple agencies) it will generally be more difficult to find liability if the responder's actions conformed to the expectations of the plan. That said, in some cases a reasonable responder might be required to deviate from the requirements of the operational plan to do the best they could for their patient or community.

'Duty to plan' is not a new concept in risk analysis, but is somewhat new in disaster response. Failure to adequately plan for reasonable foreseeable results of anticipated catastrophic events has served as the legal basis for several successful lawsuits in the United States against private medical care providers and government agencies.

1135 Waiver⁴⁰

The HHS Secretary is authorized to take certain actions during disasters to support the health care response. Section 1135 of the Social Security Act allows the Secretary to temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet patient needs. Within the parameters of the federal disaster declaration, providers might be reimbursed and exempted from sanctions (absent any determination of fraud or abuse) for care provided that would not normally meet the standards but are justified in the circumstances of the disaster.

The 1135 waiver authority applies only to federal, not State, requirements for licensure or conditions of participation in the program. Waivers can be requested by a facility, health system, or MDH for a specific facility or a geographic area. The regional Centers for Medicare and Medicaid Services (CMS) office will review the request and determine whether to grant a waiver and, if so, the effective time period for that waiver.

Emergency medical services considerations

EMS agencies are first responders to nearly all disasters. They also provide the majority of inter-facility transport between hospitals. Effective CSC response relies on EMS to have crisis care plans in place, and to have identified indicators and triggers for activation of these strategies. Any agency operating in crisis mode should reach out for additional resources that may solve the issue through mutual aid, HCC coordination, and/or jurisdictional EOC requests. MDH and EMSRB may provide clinical guidance, EMSRB through the through the Medical Directors

⁴⁰ <https://www.cms.gov/About-CMS/Agency-Information/H1N1/downloads/requestingawaiver101.pdf>

Standing Advisory Committee and the State EMS Medical Director, and the EMSRB will provide regulatory and operational support.

In the spring of 2016, MDH and the EMSRB convened a statewide EMS Crisis Standards of Care (EMS CSC) Workgroup to address and develop CSC recommendations for EMS. *Attachment 3, Surge Operations and Crisis Care for Emergency Medical Services (EMS)* offers a structured approach to address shortfalls in the provision of front line EMS support, response and care by ambulance services, first responders, and public safety answering points (PSAP). The Attachment offers guidance and decision support tools, and assumes incident management and incident command practices have been implemented, and that key personnel are familiar with the ethical frameworks and processes that underlie scarce resource decisions. The Attachment addresses common categories of pre-hospital EMS response, triage, treatment and transport.

Regional HCCs, Minnesota EMSRB designated Regional EMS Systems, PSAP/Dispatch and EMS dispatch centers, first responders, EMS ambulance service personnel, and their medical directors, may determine additional issues and strategies for their specific situation and geographic area. They are key stakeholders in the development and implementation of effective crisis care plans.

Hospital medical surge considerations

Optimizing resources

Health care facilities are responsible for implementing their disaster plans including optimization of surge capacity – freeing additional inpatient and outpatient resources to respond the needs of the incident. In case of resource shortfalls, the hospital should determine which of the following strategies may be relevant and implement them as needed in order to match supply to demand as closely as possible. To ensure success, key personnel are expected to be familiar with the ethical frameworks and processes which underlie scarce resource decisions and provide the best care possible to the community under the circumstances:

- Conservation
- Substitution
- Adaptation
- Re-use
- Re-allocation

The SAT/CSC has created a clinical reference compendium for common resource challenges, called “Patient Care Strategies for Scarce Resource Situations”. This PDF can be found on the [MDH Crisis Standards of Care webpage](#).

These materials may provide helpful clinical guidance for a crisis situation. The health care facility must assure that crisis plans are incorporated into or annexed to their Emergency

Operations Plan and that SMEs have been identified to work with incident command to help prioritize services and resource use in a crisis situation. Further, if the institution provides definitive care or is a referral center, plans should be in place for institutional or regional triage processes in the unlikely event triage of transfers or specific resources becomes necessary.

Whenever a health care facility is operating in crisis conditions, it is obligated to reach out to community emergency management and the HCC to assure that all available resources are applied to ease the demand or address shortages. In cases in which this is not possible, regional coordination of the crisis response with HCC partners and contact with MDH should be implemented.

Alternate care sites

In addition to maximal utilization of usual ambulatory care sites, homecare, and hospitals, alternate systems of care including telehealth services or screening and early treatment sites may be needed to meet the demands of a crisis incident. Alternate Care Sites (ACS) are developed to accommodate overflow hospital capacity. By providing care to less complex inpatients, an ACS can free up hospital capacity for patients in need of more intensive care. During an incident, a hospital may establish an on-site ACS or a community site may be established and work in conjunction with the local health system (via multi-agency coordination) to staff and triage appropriate patients to the facility. Examples of some services available at an ACS may include oxygen, intravenous fluids, medications, and basic laboratory testing. Critical care services are generally not available. Health care services must also be made available at community shelters including resources for those with chronic illness.

Alternative prescribing methods

A 2015 systematic review of medication loss in disasters reported 44% of evacuees and 80% of patients with chronic conditions at shelters required a prescription refill.⁴¹ Access to prescribers and medication is particularly important after disasters, because if survivors do not receive their prescription drugs their conditions can deteriorate rapidly. In situations like this, the National Institute of Health (NIH) suggests providers with prescribing authority be allowed to practice in a jurisdiction they are not licensed, possibly across a state line. They also suggest alternative prescribing methods, such as “e-prescribing” which is a computerized method that allows health care providers to write and send prescriptions to a pharmacy electronically rather than using handwritten or faxed prescriptions.

Additional preparedness details for health care facilities may be found in *Attachment 4—Surge Operations and Crisis Care for Hospitals*.

⁴¹Ochi, Sae, Hoddgson, Susan, et. Al. (February 2015) Retrieved from [Medication Supply for people evacuated during disasters](#)

Mental and behavioral health considerations

In any given disaster, and specifically in a crisis standards of care situation, loss and trauma will directly affect many people and impacts nearly all activities of daily living. Disasters may force people to relocate away from their friends, family, neighbors and other social supports such as church, clinics, childcare, or recreation programs. Work may be disrupted or lost due to business failure, lack of transportation, loss of tools, or a worker's inability to concentrate due to disaster stress. For children, there may be a loss of friends and school relationships due to a potential relocation and/or death. Fatigue and irritability can increase family conflict and undermine family relationships and ties. Social distancing during an epidemic can further exacerbate stressors.

Everyone affected by disaster is, in some sense, a disaster survivor, including responders. In a situation where usual care cannot be offered, providers, patients, and families alike may be severely burdened emotionally by the knowledge that "more could have been done." Feelings of helplessness are strong contributors to development of post-disaster mental health issues. Providing a framework for crisis standards of care may support providers by implementing a structured approach and minimizing the role of individual providers in difficult triage decisions.

Purpose

Community behavioral health support services aim to reduce disaster stress and lessen the impact of trauma risk factors on impacted communities so that they can recover and become more resilient. The activities listed below ensure the readiness of public health, hospital and clinic behavioral health staff, along with community mental health service providers and resources, to respond in the event of a disaster or other emergency in order to ensure the resilience of the personnel responding to an all-hazards incident.

Of major concern during a CSC event is the treatment of existing and emerging mental health and substance abuse disorders related to the incident. The primary focus of the local community mental health response will be on providing services to those with pre-existing and emerging mental health effects, which will reduce stress upon the health care system. In a CSC event access to psychiatric treatment and medications may be severely limited, and staffing levels may be insufficient, creating a shortage of trained mental health providers. Local communities may need to utilize peer support services, telehealth support, and family members to protect and care for their loved one with emotional and mental health disorders in order to meet demand. Novel screening techniques may be needed to assess risk to the community and prioritize access to limited services. The Minnesota Department of Human Services (DHS) is the state agency tasked with assisting their local human service agencies in supporting the care of their individuals with a mental health and substance diagnosis during a disaster.

MDH would focus agency efforts on providing behavioral health support to incident command and responders, facilitate mental/behavioral support services at health care facilities, and support community resilience through messaging and technical assistance.

Responder services

Health care providers may be at higher risk to experience mental health impacts, therefore behavioral health force protection will be critical to ensure that providers are able to manage the psychological trauma of event. Behavioral health force protection refers to “services performed, provided, or arranged to promote, improve, conserve, or restore the mental or physical well-being of personnel” (United States Department of Defense, 2012). Such techniques include:

- Psychological first aid
- Triage and assessment
- Referral to mental health professional, if needed, for more intensive support services (psychiatric care, or one-on-one therapeutic interventions)
- Pre-shift and post-shift support and information about normal and maladaptive stress responses
- Post shift emotional defusing as required
- Provide family support services, as able (assistance with child, elder care, and pet care, as well as psychosocial support services)

Community

- Provide local public health and community support service providers with technical assistance to increase resilience and support the psychosocial health of their community members, including public communication strategies.
- Provide behavioral health intervention services, as available (during a CSC event the Minnesota Behavioral Health MRC volunteers may not be available due to personal or family illness or they may be needed at their workplace so the provision of direct community services may be limited).
- Assist local public health and human services in community mental/behavioral surveillance to assist with determining immediate needs and recovery planning.

Federal resources

In addition to local, tribal, and state means, the federal government has the following mental and behavioral health resources for the public:

- HHS/Substance Abuse and Mental Health Services Administration (SAMHSA) Hotline
 - 1-800-622-HELP (4357)

- 24/7, 365 days a year
- English and Spanish
- Operational and fiscal support for disaster MH response may be available from federal sources depending on the situation and declarations involved.

Demobilization and recovery

Proportionality dictates that the actions taken in response to a crisis be only those required to address the shortfall – that is, restrictions on access should not be more extreme than necessary. Many events will be dynamic and move back-and-forth between conventional and crisis. For example, an EMS agency may be able to provide conventional services at night during a pandemic, but resort to crisis strategies during peak daytime hours.

Therefore, demobilization of assets may be possible without actually entering the recovery phase (e.g., waves of a pandemic). MDH’s role is to assure consistency of response to the degree possible and monitor for opportunities to demobilize resources when it is clear that it is safe to do so. Suspended regulations and emergency orders should not be ended prematurely, but should be scaled back as it is possible to do so.

Recovery planning should start early in the event. MDH will task individuals to a recovery workgroup after an activation of CSC Framework strategies in order to address the demands of reconstituting the health care system, repairing trust as needed, encouraging resilience in the community, tracking return of resources and expenses, and identifying ways the community can “build back better” after the crisis.

The worse the crisis situation, and the more difficult the choices involved, the more prolonged and deep the effects on the community are likely to be. Returning to normal may not be an option, and illustrating a path to a “new normal” will be an important step in the recovery, which MDH will facilitate as it relates to health and medical activities. Formal after-action analysis and corrective action planning is critical to improving future responses and will be conducted by participating agencies and by MDH.

Supporting sections

Implementation

The success of MDH’s response to a CSC situation relies on two major activities:

1. Information sharing and response coordination with the regional health care coalitions enabling rapid identification of potential crisis conditions as well as information to assure resource balancing and consistency of care

2. Operational crisis care planning at the facility and agency level that identifies ways in which MDH can support local response

The development of the CSC Framework and the supporting attachments is a first step. It is imperative that health care facilities, EMS organizations, and other partners use and apply this guidance to their operation plans, and embed crisis care strategies within their own plans for a crisis response to be successful. Much of crisis care planning is intended to minimize the likelihood of a widespread crisis standards of care situation or poor outcomes by early actions at the local and facility level. It is hoped that agencies will see crisis care not as a plan on the shelf, but a natural extension of daily operations to do the greatest good for the greatest number of people in crisis situations.

Update and maintenance

The maintenance of this Framework is the responsibility of MDH. The Framework will be reviewed by MDH on a bi-annual basis. The Framework will also be subject to modification following an exercise, response, or other evaluation as needed. Any substantive changes to the Framework will be reviewed and approved by the CSC Science Advisory Team and MDH. Changes may also be made to this Framework due to information received from state, federal, or other partners. MDH will track and document substantive changes to this Framework.

Training and exercise

Training and exercises will be conducted on an ongoing basis as per the MDH Center for Emergency Preparedness and Response training and exercise schedule with internal and external partners with an emphasis placed on the coordination components within this Framework.

Appendix A—Acronym list

Acronym	Definition
ACS	Alternate Care Site
AED	Automatic External Defibrillator
AHRRP	Minnesota All-Hazard Response and Recovery Plan
ALS	Advanced Life Support
ASPR	U.S. Department of Health and Human Services, Assistant Secretary for Preparedness and Response
AST	Ambulance Strike Team
BLS	Basic Life Support
CBRNE	Chemical, Biological, Radiological, Nuclear or Explosive
CDC	Centers for Disease Control and Prevention
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CSC	Crisis Standards of Care
DHS	Minnesota Department of Human Services
DMAT	Disaster Medical Assistance Team
DOC	Minnesota Department of Health’s Department Operations Center
ED	Emergency Department
EMAC	Emergency Management Assistance Compact
EMD	Emergency Medical Dispatch
EMR	Emergency Medical Responder
EMS	Emergency Medical Services
EMSRB	Emergency Medical Services Regulatory Board
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Labor Act
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
EPR	Minnesota Department of Health Center for Emergency Preparedness and Response
ESF	Emergency Support Function
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Administration
GCS	Glasgow Coma Scale

CRISIS STANDARDS OF CARE FRAMEWORK

Acronym	Definition
HAN	Health Alert Network
HAZMAT	Hazardous materials
HCC	Health Care Coalition
HCMC	Hennepin County Medical Center
HHS	United States Department of Health and Human Services
HICS	Hospital Incident Command System
H-MAC	Health Multi Agency Coordination
H-MACC	Health Multi Agency Coordination Center
HMD	Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine
HPP	Health Care Preparedness Program Cooperative Agreement (HHS/ASPR)
HSEM	Homeland Security and Emergency Management
IAP	Incident Action Plan
IC	Incident Command
ICU	Intensive Care Unit
IMS	Incident Management System
IMT	Incident Management Team
IOM	National Academies of Sciences, Engineering and Medicine, Institute of Medicine
JIC	Joint Information Center
JIS	Joint Information System
MACC	Multi Agency Coordination Center
MCI	Mass casualty incident
MDH	Minnesota Department of Health
MDSAC	Medical Direction Standing Advisory Committee
MEMA	Minnesota Emergency Management Act
MEOP	Minnesota Emergency Operations Plan
MHA	Minnesota Hospital Association
Minn. Stat.	Minnesota Statute
MMT	Mobile Medical Team
MN	Minnesota
MNTrac	Minnesota system for Tracking Resources, Alerts, and Communication
MPEP	Minnesota Pandemic Ethics Project
MRC	Medical Reserve Corps

CRISIS STANDARDS OF CARE FRAMEWORK

Acronym	Definition
MRCC	Medical Resource Control Center
NIMS	National Incident Management System
OSHA	Occupational Health and Safety Administration
PACU	Post anesthesia care Unit
PDD	Presidential Disaster Declaration
PHPC	Public Health Preparedness Consultant
PIO	Public Information Officer
PREP Act	Public Readiness and Preparedness Act of 2005
PSAP	Public Safety Answering Point
RHPC	Regional Health Care Preparedness Coordinator
RHRC	Regional Health Care Resource Center
SALT	Sort, Assess, Lifesaving intervention, Treatment/Transport
SAMHSA	U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration
SAT	Science Advisory Team for the Minnesota Department of Health
SAT/CSC	Science Advisory Team/Crisis Standards of Care
SDO	State Duty Officer
SEOC	State Emergency Operations Center
SME	Subject Matter Expert
SNS	Strategic National Stockpile
SOP	Standard Operating Procedure
START	Simple Triage And Rapid Treatment
STEMI	ST Elevation Myocardial Infarction
Subd.	Subdivision
WC	Wheel Chair

Appendix B—List of attachments, appendices, figures, and tables

- Crisis Standards of Care Base Framework
 - Table 1: Demographics
 - Table 2: Roles and Responsibilities
 - Table 3: Ethical Framework at a Glance
 - Figure 1: Care Capacity Continuum
 - Figure 2: Toolkit Indicators/Triggers
 - Figure 3: Communication Pathway
- Attachment 1—Ethical Guidance for Crisis Standards of Care
 - Addendum 1.1: Ethical Framework IOM/NAM Overlap
- Attachment 2—Legal Authority and Environment for Crisis Standards of Care
- Attachment 3—Medical Surge and Crisis Care for Emergency Medical Services
 - Table 3.1: Roles and Responsibilities
 - Table 3.2: Priority Dispatch
 - Figure 3.1: Care Capacity Continuum
 - Figure 3.2: EMS Dispatch Triage Tree
 - Figure 3.3: Dispatch Algorithm
 - Addendum 3.1: Resource Request to the State for Additional EMS Resources
 - Addendum: 3.2: Matrix
 - Addendum 3.3: Transport to Hospital by Non-Ambulance
 - Addendum 3.4: Pandemic influenza protocols
- Attachment 4—Surge Operations and Crisis Care for Hospitals
 - Table 4.1: Roles and Responsibilities
 - Figure 4.1: Care Capacity Continuum
 - Figure 4.2: Relationships
 - Figure 4.2b: hospital process diagram
 - Figure 4.3: Triage Tree
 - Addendum 4.1: Sample CSC Plan
 - Figure 4.1.1: AHRQ altered standards of care document imagine
 - Addendum 4.2: Hospital scarce resource decision making
- Attachment 5—Public Engagement

Appendix C—Planning and contributing partners

Allina Emergency Medical Services

Allina Health

Altru Health System

American College of Emergency Physicians, Minnesota Chapter

Avera Marshall Regional Medical Center

Beltrami County Sheriff's Office

Brown County Public Health

Carver County

Center for Bioethics, University of Minnesota

CentraCare Health, Monticello

Children's of Minnesota

City of Maple Grove

City of Minneapolis

Emergency, Community, Health and Outreach (ECHO)/ Twin Cities Public Television (TPT)

Emergency Medical Services for Children (EMSC)

Essentia Health

Fairview

Fairview Northland Medical Center

Fairview Pharmacy

Freeborn County Public Health Department

Goodhue County Health and Human Services

Greater Northwest EMS

HealthPartners

Hennepin County

Hennepin County Medical Center (HCMC)

Hennepin County Medical Examiner

Hennepin County Public Health

JP Leider Research and Consulting LLC & Bloomberg School of Public Health

IBM

Kittson Memorial Health Care
Maple Grove Hospital
Mayo Clinic
Metropolitan Emergency Services Board
Mille Lacs Band of Ojibwe, Onamia
Mille Lacs Health System
Minnesota Academy of Family Physicians
Minnesota Ambulance Association
Central Minnesota EMS Region
Minnesota Department of Corrections
Minnesota Department of Health
Minnesota Department of Human Services
Minnesota Disability Law Center
Minnesota EMS Regulatory Board
Minnesota Homeland Security and Emergency Management, St. Paul
Minnesota Hospital Association
Minnesota Medical Association
University of Minnesota Center for Bioethics
University of Minnesota CIDRAP and the Academic Health Center
Veterans Health Administration
Watonwan County Human Services
West Central Minnesota EMS Corp., Alexandria
Winona Health
Minnesota Nurses Association
University of Minnesota, Rochester
Mower County Health and Human Services
Northeast Health Care Preparedness Coalition
North Memorial Ambulance Service
North Memorial Health Care
Otter Tail County Sheriff's Office
Park Nicollet Health Services
Perham Health

CRISIS STANDARDS OF CARE FRAMEWORK

Pine City Medical Center
Rice Memorial Medical center
Riverwood Health Care Center
Sanford Bemidji
Sanford Health
Scott County Public Health
South Central Minnesota EMS Joint Powers Board
South Central Health Care Preparedness Coalition
Southeast EMS System Region
Southwest Minnesota EMS Corp.
St. Benedict's Senior Community
St. Cloud Hospital
St. Louis County Public Health and Human Services
St. Mary's Duluth Clinic Health System
Stearns County
Southwest Health Care Preparedness Coalition
U.S. Army
United Health Care Group
University of Minnesota Health

This Page Left Intentionally Blank.

Attachment 1—Ethical Guidance for Crisis Standards of Care

PLANNING AND RESPONSE GUIDELINES

Introduction

Overview

The Minnesota Department of Health (MDH) exists to protect, maintain, and improve the health of all Minnesotans. The Crisis Standards of Care (CSC) Framework—referred to as “CSC Framework” or “this Framework”—addresses specific challenges of a catastrophic emergency when demand exceeds available resources in the state and proactive steps must be taken to coordinate a statewide response for a prolonged period of time to assure the best care possible given resource limitations.

This Framework describes the systems, processes, and procedures implemented to manage a disaster warranting a shift in focus from individual patients to the good of the community. This Framework aims to provide guidance to health care and public health organizations to successfully manage the transition from conventional to contingency to crisis care.

This Attachment presents an Ethical Framework for CSC, explains the guidance offered, and applies the framework to three case scenarios to illustrate its implementation (See *Addendum 1.1—Case Scenarios* for detail). The Framework outlines fundamental Ethical Commitments and goes beyond general analysis of abstract values and principles that should guide CSC. It also presents Ethical Objectives to be met so the Ethical Commitments can be honored in a time of crisis. Finally, the Framework offers select strategies to achieve the stated Ethical Objectives.

Process

The CSC Ethics Team was contracted by MDH to develop this Attachment during the summer and fall of 2016. First, the CSC Ethics Team conducted a systematic review of academic and practice-based literature, focusing on documents released after the 2012 Institute of Medicine’s (IOM)—now the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine (HMD)—(referred to as the IOM/NAM in this document) landmark report on CSC. Highlighted in the literature review ([available here](#)), are ethical issues CSC plans ought to address and that guide the development of the ethical framework for CSC and this Attachment.

Next, MDH, in partnership with the CSC Ethics Team, convened a CSC Ethics Workgroup, a multidisciplinary group of stakeholders including ethicists, emergency regional coordinators, health care professionals, health systems administrators, clergy, advocates for populations with access and functional needs, tribal coordinators, and other subject matter experts (SMEs). The CSC Ethics Workgroup was tasked with providing input on the ethical framework. The Ethics Team led a series of meetings during which the Workgroup offered feedback on the structure and content of the proposed framework, as well as on questions about its implementation. The Ethics Team also presented the proposed framework to MDH’s Science Advisory Team (SAT) and CSC Steering Committee for their input. Finally, the Ethics Team engaged in ongoing

consultation with MDH, and conferred with SMEs (e.g., scientific or legal advisors) as needed during the plan development.

Purpose and scope

The ethical framework provides the ethical foundation for the CSC Framework, which the Attachment explains in detail. This guidance may be useful to both public and private providers, such as health care systems, ambulatory care centers, clinics and others, in planning for disasters and times of critical resource shortages. In some communities and organizations, local ethics advisory groups may be established (ad hoc or proactively) to also serve as a resource in guiding ethically sound decisions on controversial cases. The MDH CSC Ethical Framework aims to support these varied groups during the planning and response phases in a crisis standards of care disaster.

Public and private systems alike have a duty to plan for CSC, to minimize the risk for moral distress and ad hoc decision-making during a crisis and to fulfill the duty to provide the best care possible within context. Leaders should then tailor their plans to the specific circumstances of the event. Thus, context-specific analysis will be required to implement the ethical framework during a disaster.

In addition, certain recommendations—like those associated with triage—depend heavily on medical, logistical, or other factors. This Attachment does not seek to address those issues. This Attachment offers ethical guidance for how to implement triage when it is needed; it does not offer the medical criteria necessary to prognosticate or prioritize patients based on expected short-term outcome. Data must be collected and medical/scientific guidelines or best evidence applied to utilize ethical guidance offered in this Attachment. In general, the ethical considerations offered are meant to guide implementation of the CSC Framework, not usurp operational and logistical planning activities, nor that of other public or private health care systems.

Annotated ethical framework

Existing ethical guidance and national recommendations

The ethical guidance offered in this Attachment builds upon [the Minnesota Pandemic Ethics Project \(MPEP\)](#). The CSC Ethics Team includes members of the MPEP team from the University of Minnesota. MPEP developed ethical guidance for rationing scarce resources in a severe influenza pandemic through a complex process involving extensive expert analysis, stakeholder consultation and community engagement. The project produced two major reports that offered substantial, operational ethical guidance for an influenza pandemic. They are:

- [*For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic*](#),⁴² which presented ethical frameworks for rationing, and
- [*Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic*](#),⁴³ which identified and analyzed issues relating to the implementation of those ethical frameworks.

Of course, Minnesotans may face other disasters that pose serious threats to public health and safety (e.g., acts of bioterrorism, tornadoes, etc.). The 2012 IOM/NAM report on crisis standards of care emphasizes a duty to plan for implementing CSC under catastrophic conditions. The IOM/NAM outlines a broad ethical framework for CSC, based on two key concepts:

*“First, groups that are most at risk before a disaster are those most vulnerable during a disaster. Ethically and clinically sound planning will aim to secure equivalent resources and fair protections for these at-risk groups. Second, some health care professionals question whether they can maintain core professional values and behaviors in the context of a disaster.”*⁴⁴

The IOM/NAM maintains that an ethical framework for CSC must thus include these key features: fairness, the duty to care, the duty to steward resources, transparency, consistency, proportionality, and accountability. The report offers preliminary analyses of these norms.⁴⁵

Minnesota’s CSC ethics framework emphasizes the IOM/NAM’s stance about the fundamental importance of equity and the protection of those who are most vulnerable during disasters. This includes groups experiencing health disparities, as well as those confronting barriers to access or with functional needs. Public health systems have an obligation to “ensure that the basic resources and conditions necessary for health are accessible to all.”⁴⁶ Minnesota’s CSC ethics framework also embraces the IOM/NAM’s position about the need for clear guidance for health professionals about how to stay true to their essential ethical commitments in catastrophic contexts. A demonstration of how the IOM/NAM’s key features are infused throughout Minnesota’s CSC ethics framework can be found in Addendum 1.2. - Overlap of IOM/NAM CSC Ethics Framework. The review of the literature completed during this project greatly informed the ethical framework and analysis in this annex.

⁴² Vawter, DE. (2010) Retrieved from [For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic](#)

⁴³ Debra A. DeBruin, Mary Faith Marshall, Elizabeth Parilla, Joan Liaschenko, J.P. Leider, Donald J. Brunquell, J. Eline Garrett, Dorothy E. Vawter (2010) Retrieved from [Implementing Ethical Frameworks for Rationing Scarce Resources in Minnesota during Severe Influenza Pandemic](#).

⁴⁴ Dan Hanfling, Bruce M. Altevogt, Kristin Viswanathan, and Lawrence O. Gostin, Editors; Committee on Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations; Institute of Medicine. “Volume 1: Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response” p. 1-72

⁴⁵ Ibid.

⁴⁶ Dan Hanfling et al., Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response (National Academies Press, 2012).

Each section of the framework is explained in detail below. The complete Ethical Framework can be referenced in *Addendum 1.3 – CSC Ethics Framework*.

Ethical commitments

Pursue Minnesotans’ common good in ways that:

- **Are accountable, transparent and worthy of trust;**
- **Promote solidarity and mutual responsibility;**
- **Respond to needs respectfully, fairly, effectively and efficiently.**

These fundamental ethical commitments ground the ethical framework for CSC; they constitute the most basic ethical obligations for disaster planning and response. These ethical commitments largely mirror those embraced by MPEP given its extensive process of expert analysis, stakeholder consultation and community engagement.⁴⁷ However, while MPEP focused on rationing scarce resources during influenza pandemic, this project aims to develop a broader ethical framework for crisis care situations.

These commitments also reflect the most fundamental of the key features in the IOM/NAM’s ethical framework: transparency, accountability, fairness and consistency (characterized by the IOM/NAM as “one way of promoting fairness” because it requires “treating like groups alike”⁴⁸). The other key ethics features outlined by the IOM/NAM—the duty to care, the duty to steward resources, and proportionality – constitute ethical objectives in this ethical framework, as noted below. Finally, the commitments in this CSC ethics framework give rise to a duty to plan for disasters. IOM/NAM maintains that both government and private providers have such a duty, which will be explained in more detail in the strategies section of this framework.

Ethical objectives

This section of the framework identifies the ethical objectives that should be met in CSC planning and response to honor the fundamental ethical commitments noted above.

Promote Minnesotans’ common good by balancing three (3) equally important and overlapping ethical objectives.

Protect the population’s health by:

- **Reducing mortality and serious morbidity from the public health crisis; and**

⁴⁷ Garrett, J. E., D. E. Vawter, K. G. Gervais, A. W. Prehn, D. A. DeBruin, F. Livingston, A. M. Morley, L. Liaschenko, and R. Lynfield. "The Minnesota Pandemic Ethics Project: sequenced, robust public engagement processes." *J Particip Med* 3 (2011).

⁴⁸ Hanfling et al., *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*, p 1-75.

- **Reducing mortality and serious morbidity from disruption to basis health care, public health, public safety and other critical infrastructures.**

Respect individuals and groups by:

- Promoting public understand of, input into, and confidence in CSC planning and response;
- Supporting a duty to promote the best care possible in crisis circumstances; and
- Ensuring burdens imposed by crisis response are minimized and justified by the benefits gained.

Strive for fairness and protect against systematic unfairness by:

- Utilizing strategies for public education and public engagement that are inclusive and culturally sensitive;
- Promulgating standardized crisis standards of care response protocols that are publicly available, revised regularly, and become tailored to specific crisis responses;
- Ensuring that burdens and benefits associated with crisis response are equitable;
- Making reasonable efforts to remove barriers to access and address functional needs;
- Stewarding resources to:
 - Reduce significant group differences in mortality and serious morbidity; and
 - Appropriately reciprocate to groups accepting high risk in the service of others;
- Using decision-making processes that consistently apply only ethically relevant (non-discriminatory, non-arbitrary) considerations.

To meet the objective concerning protection of the public's health, planning must address the needs of individuals in the communities with injuries or illnesses that are directly related to the disaster: e.g., injuries related to building collapse or flying debris in tornado, cases of anthrax or influenza in bioterrorist attacks or pandemics. Planning must also attend to health needs related to the impact of the disaster on critical infrastructures as well as consideration of how to fairly and effectively manage more routine health care needs in the context of a disaster that overwhelms the health care system. These related needs also include concerns about public health consequences of disaster on critical services other than health care, including clean water, reliable power, sanitation services, etc.

While emergency and disaster preparedness focuses on protecting human life and health, planning should also attend to risks disasters pose to animals. For example, if disaster evacuation plans do not address needs of animals, owners may refuse to evacuate without

their pets or return to care for their pets before it is deemed to be safe, leading to failed evacuations and an increased health risk for these owners.^{49, 50, 51}

The CSC ethical framework reflects the commitment to respect individuals and groups. Duties of respect require that individuals and groups receive critical information and provide input on plans that may ultimately affect them. Duties of respect also help ground the duty to care, which honors both those whose health is affected by disaster and those who provide care. Finally, duties of respect protect individuals and groups when public health interventions may restrict their rights and liberties.

Duties of fairness apply at all phases of disaster planning and response, and require both fair processes and substantively fair treatment of individuals and groups. Public health ethics demands a focus on the needs of populations with health disparities and/or access and functional needs, since these populations consistently suffer the worst public health outcomes. While disproportionate impacts may not be intentional consequences of public health activities, they are nevertheless inequitable, and thus violate duties of fairness. This attachment provides more detail about duties of fairness and those of respect in discussions of ethical strategies below.

Ethical strategies

This section of the CSC ethical framework focuses on strategies to implement to achieve the ethical objectives outlined above. It includes considerations regarding the duty to plan; public understanding, public communication and public engagement; the duty to care; proportionality and equity in liberty-limiting interventions; removing barriers to access; fairly and consistently stewarding resources; and promoting ethical decision-making among private partners. With two exceptions, these strategies follow directly from the components of the ethical objectives above, and offer guidance about how to accomplish those objectives. The two exceptions involve strategies for the duty to plan and promoting ethical decision-making among private partners. Those strategies affect achievement of all of the objectives because they address the planning and coordination required for ethically appropriate of disaster response.

Duty to plan

- **Prospective planning**
 - MDH, local/tribal health departments, private providers and other partners should engage in prospective planning for CSC, taking expert stakeholder and community input into account as they do so.

⁴⁹ Blendon, R. J., Benson, J. M., DesRoches, C. M., Lyon-Daniel, K., Mitchell, E. W., & Pollard, W. E. (2007). The public's preparedness for hurricanes in four affected regions. *Public Health Reports*, 167-176.

⁵⁰ Glassey, S., & Wilson, T. (2011). Animal welfare impact following the 4 September 2010 Canterbury (Darfield) earthquake.

⁵¹ Heath, S. E., Voeks, S. K., & Glickman, L. T. (2001). Epidemiologic features of pet evacuation failure in a rapid-onset disaster. *Journal of the American Veterinary Medical Association*, 218(12), 1898-1904.

- Standardized CSC response protocols should be made publically available to promote transparency, accountability and public understanding.
- **Process for review and tailoring**
 - Processes should be developed to periodically review and revise CSC plans, as well as to tailor them to the specific context of particular disasters encountered.
 - Consultation with the state and/or local CSC ethics support teams may be sought to support these processes.

The duty to plan relates to the position both governments and private providers hold in disaster and emergency response, and the potential harm to individuals if these organizations elect not to plan prior to an emergency or disaster.⁵² Ad hoc decision-making during a disaster—when resources are tight, demand is high, and other logistical challenges arise—significantly risks undermining the fundamental ethical commitments embraced by this framework. State, local, and tribal governments, as well as private providers and other partners, must acknowledge a duty to plan for emergencies and disasters, recognizing plans will periodically need to be reviewed and revised, as well as tailored to the particular circumstances of disasters when they occur. This ethical framework provides a moral foundation for CSC planning and response.

Public Engagement, understanding, and communication

- **Public engagement**
 - Initiatives should reach out to communities and not rely on a standard public comment period for soliciting feedback on the proposed framework.
 - Reasonable efforts should be made to consult with populations with health disparities as well as those with access and functional needs. Input should be gathered on culturally appropriate planning and how to minimize the impact of health disparities, access barriers and functional needs in the context of crisis response.
- **Public understanding and communication**
 - Strong communication is critical to an ethically appropriate disaster response.
 - Information regarding an MCI and crisis response plans should be disseminated as widely as possible, in different languages, using a variety of approaches, materials, and venues for distribution of information.
 - Care should be taken to adequately inform the public without creating fear and to avoid dissemination of misinformation.

The fulfillment of the ethical commitments to transparency and accountability necessitate a strong focus on community engagement, open and honest communication, and the promotion of public understanding during both the CSC planning phase and crisis response. This begins with community engagement regarding this CSC Framework, including the ethical guidance in this Attachment. MDH will work with private provider systems, nonprofits, and other stakeholders to accomplish this task of seeking input from lay community members, including

⁵² Powell, T., Christ, K. C., & Birkhead, G. S. (2008). Allocation of ventilators in a public health disaster. *Disaster Med Public Health Prep*, 2(01), 20-26.

members of populations with health disparities and those with access and functional needs. Since, as the IOM/NAM contends, “groups that are most at risk before a disaster are those most vulnerable during a disaster”⁵³ fairness demands that these groups be included in public engagement activities. In addition, community engagement activities will address questions about how to make plans culturally appropriate, as well as potential limits to cultural accommodation given demands of fairness across groups and the limits of what can be possible in the challenging context of disaster response. Community engagement activities have two goals: to gather input to assess the acceptability of the norms and standards proposed in this CSC Framework; and to ensure the guidance is as clear and accessible as possible to all Minnesotans.

The state will offer educational campaigns concerning crisis standards of care plans. Once plans have been developed, prior to a crisis, information about the plan will be publicized to promote transparency and public understanding. During a crisis, MDH has an obligation to be accessible and provide clear, consistent information about the incident and response. Communication should be culturally appropriate, offered in the diverse languages of populations in the state, and take into account functional challenges such as unequal access to the internet or other media or the need for interpreters. While dissemination of information should occur within communities, such as at neighborhood “hubs,” the media also merits special attention as it will play an important role in disclosure of information to the public.

Duty to Care—obligations to patients

- **Best care possible**
 - Fundamental norms of good care carry over from conventional care standards during a crisis situation. Patients should be provided the best care possible given available resources.
 - The plan for care should be based upon the CSC plan and explained to patients and their families throughout the process in which decisions concerning care are made.
 - Patients should not be abandoned.
- **Palliative and hospice care**
 - CSC planning should address how to meet palliative and hospice care needs during an MCI, including:
 - Recommendations for stockpiling;
 - Distributing and securely storing palliative care resources;
 - Promulgating symptom management protocols and algorithms;
 - Developing caregiver educational programs for laypersons and clinicians;
 - Developing a process for ongoing community engagement and communication;
 - Planning for support of the dying and their caregivers.
- **Mental and behavioral health care**

⁵³ Dan Hanfling et al., *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (National Academies Press, 2012), p 1-72.

CRISIS STANDARDS OF CARE FRAMEWORK
ETHICAL GUIDANCE

- CSC plans should address how to meet mental/behavioral health care needs during an MCI, including:
 - Identifying disaster mental health providers and means of access (local and national mechanisms)
 - Incorporating disaster mental health into crisis planning and response processes;
 - Assuring triage protocols fairly triage patients suffering from both mental and somatic ailments;
 - Creating a parallel triage protocol for those requiring mental health resources if rationing is required;
- Providers should minimize disruptions in continuity of care during disasters through planning for alternative treatment modalities, e.g., tele-psychiatry.
- **Appropriate care for the dead**
 - As part of community engagement during CSC planning, solicit public input regarding expectations for appropriate care for the dead during an MCI. Special efforts should focus on Minnesota’s major immigrant populations, tribal communities and faith communities.

Health professionals have a responsibility to provide care in crisis circumstances by virtue of their position and training, benefits they have received previously, and professional norms.^{54, 55} Disasters triggering CSC strategies activation, by definition, involve “substantial change in the usual health care operations and the level of care it is possible to deliver...”⁵⁶ Nevertheless, providers have an ethical obligation to provide the best care possible under the circumstances. This includes not only preventive care (such as vaccines in influenza pandemic) and curative treatment, but also palliative care and mental/behavioral health care. Failing to plan to meet these very predictable needs constitutes abandonment of patients.

The demand for palliative care in crisis circumstances will be much higher than in conventional or contingency care. This means that both the state and private providers including hospital systems and physician practices should have adequate supplies of palliative care medications. This must be done with the recognition that stockpiling opioid or other types of painkillers poses risks in the current environment of prescription and other drug abuse and may have operational storage and management constraints. Safeguards must be taken when creating stockpiles. However, these drugs are relatively inexpensive, have a considerable shelf life, and will be critical to crisis response. A mechanism for distributing comfort care kits for home and alternative site use should also be considered. MPEP includes more detailed discussion of planning strategies concerning palliative care needs.⁵⁷

⁵⁴ [IOM 2012](#), p 1-73.

⁵⁵ Prehn, A. W., & Vawter, D. E. (2008). Ethical guidance for rationing scarce health-related resources in a severe influenza pandemic: Literature and plan review: Minneapolis, MN: Minnesota Center for Health Care Ethics and University of Minnesota Center for Bioethics.

⁵⁶ IOM 2009, p 3

⁵⁷ DeBruin, D. A., Marshall, M. F., Parilla, E., Liaschenko, J., Leider, J., Brunquell, D., . . . Vawter, D. E. (2010). Implementing ethical frameworks for rationing scarce health resources in minnesota during severe influenza pandemic. *Minneapolis, MN*, 121.

Similarly, officials charged with CSC planning and preparedness have an obligation to plan to meet mental health needs of health professionals, patients directly affected by disaster-related injuries or illness, and other members of the public. As with palliative care, the need for mental/behavioral health care in crisis circumstances is greater than during conventional or contingent care. This need poses significant planning challenges, given that some communities routinely experience shortages of some mental/behavioral health resources, especially inpatient beds. Thus, careful planning is required to meet the duty to care in CSC. The 2012 IOM/NAM report suggests strategies for mental and behavioral health preparedness.⁵⁸

Per Minnesota Statute, during declared disasters, the governor is permitted to take direct measures to ensure safe disposition of dead human bodies including “transportation, preparation, temporary mass burial, and other interment, disinterment, and cremation of dead human bodies.”⁵⁹ The statute states that the governor is encouraged to respect cultural customs, family wishes, religious rites, and pre-death directives to the extent possible in a disaster. The statute also outlines the process required for identification of bodies. The aftermath of Hurricane Katrina provides ample evidence of the strong moral and cultural importance of the respectful treatment of the dead, given intense community reaction when these norms were violated during that crisis by, for example, cremating remains without permission of next of kin. Given the potential for overwhelming circumstances during an MCI, community engagement on this issue during the planning phase is critical, especially with Minnesota’s major immigrant populations, tribes and religious communities.

Duty to care—support for health professionals

- **Ethically appropriate liability protections**
 - Should be drafted by legal advisors working in partnership with their ethics support team.
 - Providers who act in good faith to meet crisis standards of care must be protected, but even in the highly challenging context of an MCI, providers should not be fully immunized from liability. There must be safeguards and protections for patients as well as for providers (for example, review/appeals processes).
- **Reciprocity**
 - Fairness requires society protect those who take on risk on behalf of the public, and such protections are indexed to level of risk taken by the professionals.
 - CSC plans should include provisions for promoting safety of these professionals (e.g., appropriate personal protective equipment and training, as well as procedures for protection of staff when faced with threats such as active shooter attacks or flooding of facilities).
 - Providers’ duty to care for patients may be limited in situations posing imminent danger to providers.

⁵⁸ [IOM 2012](#), Ch4

⁵⁹ [Minn. Stat. § 12.381 subd. 1](#)

CRISIS STANDARDS OF CARE FRAMEWORK
ETHICAL GUIDANCE

- In some circumstances key workers should be prioritized for access to resources when illness or injury is related to provision of care in disaster or would result in maintaining their health and ability to serve.
- Plans should also make provisions for mental/behavioral health care for professionals given the stress/trauma of working in disasters.
- **Mandates to provide service**
 - Where possible, CSC plans should use incentives rather than mandates for health professionals to provide services in MCIs.
 - Rather than relying upon state power to mandate provision of services, employers should create emergency plans with their employees prior to a disaster in order to best address issues such as absenteeism (e.g., due to illness or family obligations) and reasonable expectations about length of work shifts.
- **Process for triage/rationing decisions**
 - Separate triage/rationing decisions from bedside care by using a triage team to allow clinicians to advocate for their patients while still following CSC plans for triage/rationing.
 - It may be necessary to construct regional triage teams for greater Minnesota, depending on the nature of the disaster and given the strain on available staff.
 - Best practices should be used in a consistent manner – these may originate from MDH SAT/CSC team, national specialty societies, or agencies such as the Centers for Disease Control and Prevention (CDC).
- **Ethics support**
 - MDH will propose a system for ethics support at the state level, and require and facilitate development of ethics support mechanisms at local/regional levels as required. The primary functions of the ethics support process are to facilitate application of ethical frameworks for CSC and to help manage moral distress.
 - MDH CSC/SAT may:
 1. Provide prospective education to Local CSC ethics advisory groups regarding state and federal guidance concerning ethical frameworks, and
 2. Review of issues/challenges regarding the ethics framework.
 - Local CSC ethics advisory groups would provide support (during planning and response) when those attempting to resolve an ethical problem need prospective guidance in decision-making. The advisory group may assist with a retrospective review of policies and practices to ensure compliance with and consistency in the application of the ethical framework and to advise MDH on measures to alter or improve policies/practices.

Given that health professionals have a duty to care in crises, public health authorities and health care organizations have a corresponding duty to support those professionals in the discharge of their duty. This section of the framework outlines several strategies for supporting health professionals.

Discussions of CSC often note health professionals may be apprehensive about implementing CSC plans due to liability concerns. In MPEP, this discussion primarily focused on controversial interventions such as the removal of ventilator support from one patient to reallocate the

ventilator to another in accordance with rationing protocols. However, concerns regarding liability go well beyond these particular procedures, and relate to “difficulties with providing care at alternative care sites, the challenges of asking personnel to perform duties outside their normal scope of practice when the system is overwhelmed, and the need to implement interventions based on limited information as the crisis evolves.”⁶⁰ Thus it is critical that CSC plans include ethically appropriate liability protections for health professionals. For additional information on legal authority and environment in relation to CSC please reference *Attachment 2—Legal Authority and Environment for Crisis Standards of Care* of this Plan.

Furthermore, fairness requires society to protect those who take on risk on behalf of the public; this framework outlines strategies for meeting these duties of reciprocity. CSC plans should include provisions for promoting safety for health professionals, such as appropriate personal protective equipment and training. In addition, CSC plans should recognize that while the duty to care holds—even in the face of increased risk to the provider’s safety—limits do exist to the duty. Providers may take reasonable steps to protect themselves. In the face of life-threatening imminent harm such as an active shooter in their immediate work area (not just any part of the facility), providers may take reasonable steps to protect themselves (e.g., leaving patient to seek a safe environment). Generally, however, a duty to care means providers may not abandon patients under their direct care.

Health professionals have additional obligations that may conflict with their duty to care, including family obligations and—especially for volunteer professionals such as many EMS workers—other work duties. CSC plans should address these conflicting obligations.⁶¹ While Minnesota law allows the governor or state director of emergency management (Minnesota Department of Public Safety, Division of Homeland Security and Emergency Management) to mandate that health professionals perform services for emergency management purposes,⁶² implementing such mandates may be inadvisable. First, unless they are implemented in a context of additional support for health professionals’ conflicting obligations, such mandates may infringe upon the moral legitimacy of those conflicting obligations. Second, mandates may be enforced by withdrawal of the health professionals’ clinical privileges, but this enforcement mechanism may be counterproductive given strains on the health workforce in a crisis.⁶³

When health professionals report for work in CSC, they encounter conditions characterized by a shift “in the balance of ethical concerns to emphasize the needs of the community rather than the needs of individuals.”⁶⁴ Some providers may perceive this shift to be a betrayal of their fundamental ethical obligations to their patients. To alleviate their moral distress, hospitals, health systems, or regions may establish triage teams, separating the bedside clinician from high-level allocation decision-making. This approach has the additional advantage of preserving

⁶⁰ [DeBruin et al 2010, 56](#)

⁶¹ IOM 2012, p 1-73

⁶² [Minnesota Statute §12.34 subdivision 1](#)

⁶³ [DeBruin et al 2010, 60](#)

⁶⁴ Dan Hanfling et al., *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (National Academies Press, 2012)1-1

the bedside clinician's advocacy for their patients, thus protecting against abandonment concerns. However, the bedside clinician is expected to follow the directives of the triage team to fulfill duties to ethically steward scarce resources. Clinicians who believe they cannot practice in accordance with CSC may be transferred to support or non-clinical roles to ensure consistency of response. Local ethics advisory groups may provide invaluable guidance to facilitate communication and ethically appropriate decision making in resource allocation and patient care, and to alleviate providers' moral distress. This ethics framework joins other guidance in recommending a time limited, simple process for real time reviews of decisions that raise concerns for providers, performed by the Ethics Support Teams described in this attachment.^{65, 66}

While CSC requires health care providers to provide the best care possible, this may be considerably different than achievable levels of care in non-crisis situations. For example, modifications to scope of practice, the use of triage protocols, and the potential for resource withdrawal for reallocation, all represent deviations from conventional practice. Ethics Support Teams should be established at the state and local level to facilitate application of the ethical frameworks for CSC in challenging circumstances and to help manage health professionals' moral distress. Such an Ethics Support process is critical for public health authorities and health professionals to respond to a broad range of evolving ethics issues that will inevitably arise in crises. MPEP offers detailed recommendations about how to implement Ethics Support processes.⁶⁷

Proportionality and equity in liberty-limiting interventions

- **Social distancing techniques**
 - May be justified when public health interests of society outweigh the burdens and harms brought to affected individuals or groups. Evaluation of burdens must consider the impact of these techniques on non-health aspects of well-being, including economic and financial, of those impacted.
 - Decisions to implement restrictive interventions must be evidence-based, and should be made using a fair, transparent process of consultation with public health leaders and an Ethics Support Team to avoid the influence of political agendas.
- **Proportionality**
 - Requires the use of the least restrictive interventions possible to achieve the outcome of interest.
 - Appropriate limits may become unfair as the context changes (e.g., further resources arrive or demand decreases).
 - Response plans should be flexible and able to adapt to the situation.

⁶⁵ James C Thomas et al., "A Code of Ethics for Public Health," *American Journal of Public Health* 92, no. 7 (2002).

⁶⁶ Hick, J.L., L. Rubinson, D.T. O'Laughlin, and J. C. Farmer. 2007. Clinical review: Allocating ventilators during large-scale disasters—problems, planning, and process. *Crit Care* 11(3):217.

⁶⁷ DeBruin et al., "Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic." (2010). p. 93-108

- **Equity**
 - Liberty-limiting interventions should not disproportionately impact populations with health disparities as well as those with access and functional needs.

Proportionality fundamentally concerns the balance of benefits and burdens. While benefits in the context of disaster response tend to be straightforward, typically related to health, safety, or continued societal functioning, burdens may be harder to fully identify. For example, isolation, quarantine, and other social distancing techniques are critical in many disaster responses; their use is legally protected in state and federal law. However, such techniques may adversely impact the population in significant ways. Closing schools affects families given challenges arranging appropriate child care and may disproportionately impact families who rely on school meals programs for nutritional support for children. Closure of public spaces adversely affects business and may disproportionately impact low-wage workers. Isolation and quarantine may have serious personal and economic consequences for individuals, and may also have disproportionate impact on low-wage workers who may risk job loss and who have few if any resources to help cushion the economic blow they experience. Closure of public transport inconveniences some but disproportionately impacts those who have no other means of travel or getting to work. Beyond the risks to social or economic well-being, individual liberties—such as the freedoms of movement and association—are important goods in and of themselves. As such, they should be impinged upon only when necessary, and to the smallest extent possible that allows for effective and efficient disaster response.

A commitment to equity requires special attention to socially vulnerable groups to ensure liberty-limiting interventions do not disproportionately impact them. Moreover, decisions to implement restrictive interventions must be evidence-based, and should be made using a fair, transparent process of consultation with public health leaders, MDH’s Science Advisory Team for CSC (SAT/CSC) to avoid the influence of political agendas, and promote trustworthiness and accountability.

Health disparities, barriers to access and functional needs

- **Health disparities, barriers to access and functional needs**
 - CSC plans at all levels should focus on alleviating health disparities, reducing access barriers, and meeting functional needs.
- **Partnerships to promote equity**
 - Planning regarding these issues should be conducted in partnerships across systems to best inform and implement relevant interventions.
- **Public engagement**
 - Activities should address challenges regarding health disparities, access barriers and functional needs.
- **Distribution of resources**
 - Efforts should be made to provide free or low cost services to those with greatest financial need.
 - Distribution of resources should ensure those at highest priority—including health disparities populations—have best access to resources.

- **Tribes**
 - MDH will engage tribes as equal partners in CSC planning and response.
 - If requested, MDH will aid tribes during emergencies and disasters.
- **Immigrants**
 - Immigration authorities should not be present or involved in the allocation of resources during an MCI, and CSC protocols should not be crafted to allow only legal residents of the state of Minnesota access to scarce resources in the state.
- **Consultation with the state and/or local CSC ethics support teams may be sought to support planning and response on issues of equity.**

Within the United States, Minnesota has one of the lowest percentage of people living below the poverty level⁶⁸ and ranks among the healthiest of states.⁶⁹ However, “Minnesota has some of the greatest health disparities in the country between whites and people of color and American Indians.”⁷⁰ Since people of color and lower income populations are often most vulnerable during disasters⁷¹ Minnesota should aggressively plan to address health disparities and access barriers in a CSC situation.

Health equity means achieving conditions in which all people have the opportunity to attain their highest possible level of health, without limits imposed by structural inequities. No ethical framework for public health preparedness can, on its own, redress existing health disparities or inequities of access to health care for the people in Minnesota.^{72,73} Rather, this ethics framework requires that CSC plans “reduce significant group differences in mortality and serious morbidity” and to “make reasonable efforts to remove barriers to fair access and address functional needs.” These objectives promote MDH’s mission to protect, maintain, and improve the health of all Minnesotans. They also honor the key commitments espoused by the IOM/NAM and the Bellagio Statement of Principles which emphasize health equity in public health emergency preparedness.^{74, 75} This section of the CSC ethics framework offers strategies for achieving these objectives.

The objective relating to significant group differences in mortality and serious morbidity addresses health disparities. Substantial evidence documents these inequities in health status related to race, ethnicity, socioeconomic status and other characteristics associated with social disadvantage. A complex combination of factors—referred to as social determinants of

⁶⁸ World Atlas. [US Poverty Level By State.](#)

⁶⁹ Minnesota Department of Health Report to the Minnesota Legislature 2016. (January 15, 2016). Retrieved from [Eliminating Health Disparities Initiative.](#)

⁷⁰ Minnesota Department of Health Report to the Minnesota Legislature 2016. (January 15, 2016). Retrieved from [Eliminating Health Disparities Initiative.](#)

⁷¹ IOM 2012, 1-72

⁷² Vawter et al., “*For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic*”, (2010).

⁷³ DeBruin et al., “*Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic.*” (2010).

⁷⁴ Dan Hanfling et al., *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (National Academies Press, 2012)

⁷⁵ [Bellagio Group 2006, The Bellagio Meeting on social Justice and Influenza.](#)

health—influence health disparities, including experiences of discrimination or social exclusion, lack of convenient access to healthy foods, lack of safe options for exercise and recreation, unsafe housing conditions, and many others. Disparities cannot simply be attributed to barriers in access to care or functional needs. Consider the example of influenza pandemics. Members of socially disadvantaged groups tend to be less able to protect themselves from exposure to illness (e.g., they may lack resources that would allow them to avoid public transportation, or the employment flexibility to allow telecommuting to work, and thus be unable to adopt recommended social distancing strategies). Socially disadvantaged groups also tend to be more vulnerable to illness given their higher rates of co-morbid chronic conditions that increase influenza risks. In addition, those who are socially disadvantaged may have poorer access to care.^{76,77} Disparities in morbidity and mortality during public health crises are thus more generally linked to other health disparities and social inequalities.⁷⁸

Partnerships between MDH, the State Community Health Services Advisory Committee, regional coordinators, tribal health departments and local health departments (LHDs) throughout the state should attend specifically to health disparities, access barriers and functional needs. These partnerships will be critical to the promotion of equity given the special expertise of each of the partners. Equity will be further promoted through collaboration between LHDs and social service agencies, home care providers, community health centers, community organizations, faith-based communities that serve low income people and other populations with health disparities as well as those with access and functional needs. These organizations are vital as they are well-positioned to know what MCI response strategies will be useful to their constituents and to bear witness to their needs.

Regional health care disaster response plans (including homecare, outpatient, and inpatient care) should also attend specifically to efforts to alleviate health disparities, reduce access barriers and address functional needs. Working toward strong, collaborative relationships between these entities will facilitate patient care. All facilities and agencies should be open to accepting patients who typically confront access barriers that can block or delay care. Further, implementation of alternate strategies for care must consider access issues for those with disabilities, limited English language skills and other groups with functional needs.

Public engagement efforts of the CSC Framework should also specifically address equity concerns. MPEP's public engagement process asked participants to identify barriers to access in their communities and suggest strategies to reduce these barriers. These discussions yielded significant input to recommendations regarding equity. Participants offered suggestions about culturally appropriate educational campaigns and how they might be structured to address

⁷⁶ Blumenshine, Philip, Arthur Reingold, Susan Egerter, Robin Mockenhaupt, Paula Braveman, and James Marks. "Pandemic influenza planning in the United States from a health disparities perspective." *Emerg Infect Dis* 14, no. 5 (2008).

⁷⁷ Quinn, Sandra Crouse, Supriya Kumar, Vicki S. Freimuth, Donald Musa, Nestor Casteneda-Angarita, and Kelley Kidwell. "Racial disparities in exposure, susceptibility, and access to health care in the US H1N1 influenza pandemic." *American journal of public health* 101, no. 2 (2011): 285-293.

⁷⁸ DeBruin et al., "Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic." (2010).

functional needs, ways to address barriers in access to care, and strategies to improve trust in public health response initiatives, among others.⁷⁹

To promote access to resources for those at highest priority, including health disparities populations, distribution of resources throughout the state should follow the geographic distribution of target groups. That is, more resources should be sent to communities with greater numbers of prioritized recipients, so that those at highest priority have best access to the resources. In contrast, if resources are shipped throughout the state in amounts proportional to area population as opposed to population in need, priority groups may not be reached efficiently. To further promote equitable distribution of resources, CSC plans should strive to make free or low cost resources available to those who face financial barriers to access. For example, resources from the Strategic National Stockpile could be provided at no or low cost to those with greatest financial need, while individuals with insurance coverage or other ability to pay could access resources through private providers.

It should also be noted that significant urban-rural disparities exist between the twin cities and greater Minnesota. While most of the state's population and hospital facilities reside in the Twin Cities metro area (as well as outlying areas in the seven-county metro area), over two million Minnesotans live and work outside the metro area. As such, facilities in these areas are critical to state-level disaster response and implementation of CSC. However, some facilities have relatively few health care providers, and some lack critical care resources. This significantly complicates disaster response under CSC, as transporting patients in need of critical care may become a limiting factor during response.

One important consequence of the ethical commitments outlined in this Attachment is that all Minnesotans, regardless of geography, have equal claim to resources if triage protocols prioritize them equally. This means someone in rural Minnesota would have as much claim to a ventilator as someone living in the twin cities if they are triaged to an equally priority. Allocation decisions would include resource considerations involved in the transport of the rural individual. Beyond infrastructure issues, some facilities in rural Minnesota may not have the necessary expertise to fully provide all needed services in a disaster response. MDH will work with private providers, through regional coalition partnerships, to maximize preparedness across urban-rural boundaries.

There are seven Anishinaabe reservations and four Dakota communities within the state of Minnesota. Tribal governments and lands are recognized as sovereign entities and thus warrant particular attention in CSC planning. Disasters do not recognize political boundaries. Moreover, Native American populations are affected by health disparities and so may be severely impacted by disasters. As part of disaster planning and response, the state should continue to engage tribes as equal partners to protect the health of all Minnesotans. The state must include tribal populations in risk analyses and resource allocation plans while recognizing and respecting the authority of tribal governments to decide how they will respond to disasters.

⁷⁹ DeBruin et al., *Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic.* (2010). p. 43-45

Tribes control their own resources. When tribal members access care outside of tribal facilities – e.g., at MDH vaccine clinics or private providers following MDH’s CSC plan – they should receive equal consideration for access to resources on this plan’s triage protocols as non-tribal members do. If a tribal government chooses not to engage state or local government in disaster planning, the state should nevertheless plan to offer aid during a disaster.

Immigrants must also be included in CSC planning and response. This CSC ethics framework echoes MPEP guidance that response protocols should not be crafted only to allow legal residents of the state of Minnesota access to scarce resources. First, in infectious disease outbreaks, withholding preventive or treatment resources from certain groups like immigrants can impede efforts to slow or reduce rates of infection. Second, all life has value and all rights must be respected, regardless of residency or citizenship. Third, any plan that recommends or requires verification of citizenship status to determine who is eligible to receive resources may result in denial of treatment for citizens who lack, or simply do not have handy, requisite forms of identification. Finally, those without proper identification may disproportionately be members of socially disadvantaged groups such as individuals with physical or psychological disabilities, thus compounding the unfairness of withholding resources on this basis. Further, immigration officials ought not be present during crisis response.⁸⁰ Experience from response efforts to the Flint, MI water contamination crisis validates the concerns here:

The sight of uniformed state troopers and National Guardsmen entering neighborhoods in convoys with flashing lights frightened many who did not open their doors to accept filter or water distributions. Initial requirements for identification scared many families away from distribution sites.⁸¹

Requirements for identification or involvement of law enforcement personnel can impede the effectiveness of response interventions for groups that are particularly socially vulnerable.

Fairly and consistently stewarding resources

- **Coordination**
 - Equitably distributing of resources across jurisdictions is required to assure consistency of care and equity of access. Therefore, coordination of response activities and sharing of impact/demand data is critical to a successful response. Regional coordinators, health care coalitions (HCCs) and emergency management have critical obligations to ensure the ability to share information and manage resources to allow this balancing to occur.
- **General considerations for rationing/triage**
 - Extend supplies and conserve resources before implementing triage or rationing; use triage and ration as a last resort.

⁸⁰ DeBruin et al., “Implementing Ethical Frameworks for Rationing Scarce Health Resources in Minnesota During Severe Influenza Pandemic.” (2010). P. 49-50

⁸¹ Force, Flint Water Advisory Task. "Flint water advisory task force final report." *Lansing, Michigan* (2016). p. 56

CRISIS STANDARDS OF CARE FRAMEWORK
ETHICAL GUIDANCE

- Expand providers' scope of practice to provide the best care possible in context of the need associated with the mass casualty event.
- Scale rationing strategies to different levels of scarcity.
- Generally, de-prioritize people who are unlikely to benefit from the resource.
- **Processes to promote accountability**
 - Triage/rationing decisions should be reviewed and revised as needed, consistent with this ethics framework.
- **Data**
 - Care must be taken in gathering data that reflects risk across populations in the state, since the State of Minnesota can implement recommendations regarding health disparities only to the extent that it works taking into account these risks.
- **Health records as a basis for decision-making**
 - Patients' self-reports about their health should be accepted as guiding triage/allocation decisions where possible.
- **Key workers**
 - When threats to societal functioning or disaster response are present, prioritize key workers who become ill or injured working in disaster response on either a separate track or in parallel with a track for the general public, recognizing that in some circumstances a two-track approach might not be justified.
 - Two reasons to potentially justify prioritizing key workers:
 - Fairness requires that society protect those who take on risk to protect the public; this obligation is referred to as reciprocity.
 - If societal functioning is at risk in a crisis, it may be appropriate to create a separate priority track for key workers to maintain societal functioning. This priority is justified to support professionals' ability to provide services during the MCI, or that the key worker would be able to return to work and continue to provide key services during the MCI.
 - Ethics Support Teams should work with incident command to determine when and to what extent considerations regarding societal functioning and/or reciprocity justify prioritizing key workers for access to resources, especially given that prioritizing them may affect the general public's fair access to resources. Decisions should consider the professionals' level of risk, the importance of their services, and their ability to benefit from the resources in question.
 - The decision about which workers to identify as key is an event-dependent one, and should consider the role of volunteers.
 - The two-track approach must reflect a commitment to strive for balance between prioritizing key workers and prioritizing those groups in the general public who are at greatest risk for morbidity and mortality.
- **Rationing**
 - Do not ration based on:
 - Race, gender, religion or citizenship;
 - Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication);

CRISIS STANDARDS OF CARE FRAMEWORK
ETHICAL GUIDANCE

- Ability to pay;
- First-come, first-served;
- Judgments that some people have greater quality of life than others;
- Predictions about baseline life expectancy (i.e. life expectancy if the patient were not facing MCI related health crisis), unless the patient is imminently and irreversibly dying, because rationing based on such baseline predictions would exacerbate health disparities;
- Judgments that some people have greater “social value” than others.
- Ration resources based on the following:
 - Risk of mortality and serious morbidity;
 - Likelihood of good or acceptable response to resource;
 - Risk of transmitting infection;
 - Irreplaceability of key workers.
- When the supply is inadequate to serve all similarly prioritized people then use a random process to allocate materials.

CSC becomes necessary in crisis situations involving scarcity of resources; thus, guidance about stewardship of scarce resources is central to an ethical framework for CSC. While rationing and triage are inevitable features of CSC, efforts should be made to extend supplies and conserve resources before implementing triage or rationing. While Minnesota law permits the state to commandeer resources from private organizations to support public health emergency response,⁸² previous guidance notes this possibility creates perverse incentives for private organizations to refuse to stockpile resources, given the risk that they will be commandeered. Thus, it may best promote preparedness for the state to reassure private partners that it prefers to avoid commandeering of resources.⁸³ There are, of course, other ways to extend supplies or capacity to respond in a crisis. In a disaster of relatively local impact, supplies or personnel may be transported from unaffected jurisdictions. Some medications may be safe and effective beyond their recommended shelf life, or it may be possible to reuse N95 respirators. Expanding scope of practice for personnel may ease staffing pressures.

Once plans for rationing or triage are implemented, resources must be balanced across jurisdictions to ensure consistency of care and equity of access. Public health authorities should pay explicit attention to the types of data that will be required to reflect risk across populations in the state and thus guide rationing decisions. Certain sources of data may fail to adequately reflect the burden of disease in populations with health disparities as well as those with access and functional needs. For example, data gathered from hospitalizations or on personal health care records may not capture rates of morbidity and mortality in populations lacking good access to care. When treating individual patients, providers should accept patient self-reports about health status and co-morbid conditions. In crisis circumstances, health records may not be readily available, and delays in seeking information will only hamper response capacities.

⁸² [Minnesota Statute §12.34 subdivision 1](#)

⁸³ DeBruin et al 2010, 62-63

Perhaps most importantly, processes should be implemented to routinely review and revise triage/rationing decisions and processes. This is true at the level of individual patients and the systems level. For individual patients, there may be changes in their status that would alter initial triage/rationing decisions. Individuals who initially were deprioritized for access to resources may become prioritized. Individuals who were granted access to resources—for example, a trial on a mechanical ventilator—may not be responding well to that resource, and if it is needed by others, it may be withdrawn and reallocated to someone at higher priority. At a systems level—e.g., a health care organization—decisions about allocation of resources should be monitored to ensure that they are made in as principled and effective way as possible, and changes made as needed. Ethics Support Teams may provide helpful guidance for institutional or systems-level reviews of triage/rationing decision-making.

The framework's strategies also endorse specific decision-making criteria for triage/rationing. These include a number of considerations that ought not to be taken into account—ability to pay, first-come first served, judgments about quality of life, predictions about extending life, race, gender, religion, citizenship, judgments about social value, amount of resources to be allocated to patient, or the duration of resource use per patient. These considerations introduce systematic unfairness into triage/rationing decisions.⁸⁴

The framework also advises against using age as a criterion for triage/rationing. This recommendation does not prohibit using age as a factor in clinical assessment of risk or prognosis for particular individuals or groups of individuals. For example, evidence may indicate certain antibiotics are not safe and effective in infants, or that morbidity and mortality risks for influenza are especially high for the elderly. It is morally appropriate for allocation decisions to take into account information about health risks and prognoses faced by members of certain age groups. These are clinically based decisions, not age based decisions. The guidance in this framework relates specifically to age as a criterion for rationing distinct from its correlation to health considerations such as risk and prognosis.

Is there a special obligation to provide first for children when not all can be given resources? Should younger adults be prioritized over older adults, on the grounds the latter have already had more of an opportunity to live a fuller life? This framework recommends against the use of age based rationing for two reasons. First, the IOM/NAM recommends that age be used to guide triage/rationing decisions only if its use clearly reflects community values.⁸⁵ MPEP's community engagement activities demonstrated lack of consensus about how age should factor into decision-making.⁸⁶ Second, age based rationing raises implementation issues concerning the possible violation of age discrimination law.⁸⁷ For example, the Federal Age Discrimination Act of 1975 prohibits age discrimination in programs or activities that receive financial

⁸⁴ [Vawter et al 2010, 19](#)

⁸⁵ [IOM 2012, 1-77](#)

⁸⁶ Dorothy E. Vawter, J. Eline Garrett, Karen G. Gervais, Angela Witt Prehn, Debra A. DeBruin, Carol A. Tauer, Elizabeth Parilla, Joan Liaschenko and Mary Faith Marshall. For the Good of Us All: Ethically Rationing Health Resources in Minnesota in a Severe Influenza Pandemic 2010. Available at [Minnesota Pandemic Ethics Project Report](#).

⁸⁷ DeBruin 2010, 72-76

assistance from the federal government. Given the federal support involved in the Strategic National Stockpile program, the Age Discrimination Act may apply to state guidelines for rationing resources during a pandemic or other MCI when federal resources are used. Medicare and Medicaid providers must also comply with the Age Discrimination Act.⁸⁸

Moreover, it does not appear that the governor can set aside the protections of the Age Discrimination Act under state emergency powers. The IOM/NAM also notes that: “Some liability protections will not apply – even during emergencies – to acts of discrimination. Specific limitations on liability or indemnity protections focused on willful or wanton misconduct should be interpreted to include unlawful acts of discrimination.”⁸⁹ Thus, given difficulties in crafting triage/rationing protocols using age in a way that genuinely reflects community values, and concerns about the violation of age discrimination laws if such protocols were implemented, this CSC ethics framework recommends against age based triage/rationing.

The framework recommends prioritizing key workers for access to certain resources in at least some circumstances. Doing so does not depend upon a judgment—prohibited by this framework—that such individuals have more social value than other individuals. Rather, the permissibility of prioritizing them flows from their role in preserving vital infrastructures that serve to benefit and protect the public’s health and safety, and from fairness considerations given these personnel are placed at risk because of their work to protect the public. When it is justifiable to prioritize key workers for access to resources, they should be assessed for triage/rationing on a separate track from the general public. Ethics Support Teams should work with incident command to determine when key workers should receive prioritized access in this way, given the realities of a particular crisis. Which workers should be seen as “key” should also be an event dependent decision.

Promoting ethical decision-making among private partners

- **Partnerships**
 - MDH will continue to treat private entities, such as health care organizations, as partners in planning disaster response, recognizing the shared planning and response roles of private providers and health care systems as necessary to effective response.
 - MDH will continue to work with other governmental entities and engage non-health private partners (e.g., faith-based organizations or nonprofit service providers) in planning for a disaster.
- **Coordinating responsibilities**
 - Planning efforts should not unduly burden private partners. Those with greater or unique capabilities should accept equivalent responsibilities in response, and MDH and other private partners should support these organizations in doing so.
- **Patient transfer and care transition plans**

⁸⁸ 29 U.S.C. §§ 621-634

⁸⁹ [IOM 2012, p. 51](#)

CRISIS STANDARDS OF CARE FRAMEWORK
ETHICAL GUIDANCE

- The health care sector should work with MDH to create patient transfer and care transition plans and maps for disaster response.
- These plans should allow lower levels of care to occur outside of the hospital setting so as to minimize the burden on hospital services, especially critical care.
- Scope of practice should be expanded so the majority of care may be shifted to community clinics, primary care or specialty offices, and other providers.
- State and local government should be prepared to support these non-traditional responses both from a financial and regulatory standpoint.
- **Increasing response capabilities**
 - MDH will support public and private actions aimed at increasing capabilities of health care providers who do not have the infrastructure to meet their accepted roles in disaster response. This may include offering technical support, increasing the availability of telemedicine, and creating helplines for private actors during disaster response and recovery.

Private entities such as health care organizations benefit from government efforts in disaster planning and response. These organizations thus have an obligation to contribute to a societal response. Health care organizations, in particular, have deeper obligations, including the duty to care and duty to plan. These obligations exist due to benefits accrued to these organizations by virtue of their place in society, special training and capacities housed within these organizations, and because everyday obligations of the duty to care do not evaporate when a disaster occurs.⁹⁰⁹¹ Minnesota is fortunate to have robust engagement of health care provider communities in disaster planning and response. Non-health private organizations may be critical to response, as well. These include logistically useful sectors like transportation. Large employers and small businesses may also be necessary to a broader response, depending on the disaster and should therefore be considered during planning efforts. At the same time, the government and its citizenry must recognize private organizations have additional obligations—to their owners, directors or shareholders—that justifiably drive different incentives and priorities.

Considerations of equity apply to the involvement of private organizations in disaster response. Private organizations ought not to be unduly burdened during response or recovery. Health care systems should share relative risks and benefits in line with their capabilities and roles in response. As with infringing on individual liberties among the public, governmental entities have an obligation to use the least restrictive means of responding to a disaster. For corporate entities, this translates to minimally impinging on their financial, economic, or other interests during disaster. Moreover, as with individuals, actions that do burden private organization must be justified by public health interest.

⁹⁰ Prehn, Angela W., and Dorothy E. Vawter. *Ethical guidance for rationing scarce health-related resources in a severe influenza pandemic: Literature and plan review.* (2008).

⁹¹ ["Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report"](#) Report Brief. September 2009, p.3

An ethically appropriate CSC framework requires coordination of responsibilities and collaboration in patient transfer and care transition plans across private organizations in the state. Large systems tend to have greater staff capacity, specializations, and offer higher levels of care than smaller systems or individual facilities. However, in the event higher-level hospitals become overburdened or must be evacuated, patient care may need to be dramatically reorganized. Transports and transfers to other similar level facilities is a reasonable first step. However, obligations to patient care may not be satisfied without transitioning patients to lower level providers and expanding their scope of practice. Disaster response may call on other types of providers to accept less acute or complex patients. This may require response from community health centers, but also private general practice and specialty providers that would not typically be involved in emergency response. MDH, as well as private provider systems, will engage in planning for patient and care transition in the event major facilities (e.g., Level 1 Trauma) are overburdened or unavailable.

Disasters take many forms. It may not be practical for smaller or more rural organizations to maintain the staffing or technical expertise necessary to respond to disasters. As part of the duty to plan, these organizations have an obligation to maximize their readiness and competency for disaster response. This is tempered by other obligations, e.g., fiduciary obligations to shareholders. MDH, then, will support these organizations in planning for disaster response. This largely occurs through planning for technical assistance provision or logistical support within their coalition or by request to jurisdictional emergency management. This may include offering technical support, increasing the availability of telemedicine, and creating helplines for private actors during disaster response and recovery.

MDH will treat private organizations as partners in planning disaster response, recognizing the shared planning and response roles private providers and health care systems play are necessary to effective response.

Conclusion

This Attachment presents a foundational ethical framework for CSC planning and response. Should a significant disaster occur that overwhelms public health and health care systems, the analysis herein would help guide an ethically appropriate response. However, as clinicians and scholars have noted, there are circumstances every day across the US where rationing occurs, where there is not enough of a particular resource to attend to all the patients needing it. In these circumstances, contingency standards of care will be attempted first, but sometimes crisis principles must be the de facto means of operation due to the levels of scarcity. The reality may be that even supply shortages or small disasters could necessitate application of these principles. For example, if there are insufficient ambulances to transport patients after a large traffic incident, triage must occur. It is our hope that the framework and supporting analysis in this attachment may ground lessons for all applications of resource triage and not just in mid- or large-scale disasters.

Addendum 1.1—CSC ethics framework

Ethical commitments for crisis standards of care (CSC)

Pursue Minnesotans' common good in ways that:

- Are accountable, transparent and worthy of trust;
- Promote solidarity and mutual responsibility;
- Respond to needs respectfully, fairly, effectively and efficiently.

Ethical objectives for CSC

Promote Minnesotans' common good by balancing three equally important and overlapping ethical objectives.

- **Protect the population's health** by reducing mortality and serious morbidity from:
 - The public health crisis; and
 - Disruption to health care, public health, public safety, other critical infrastructures.
- **Respect individuals and groups** by:
 - Promoting public understanding, input, and confidence in CSC plan/ response;
 - Supporting a duty to promote the best care possible in crisis circumstances;
 - Ensuring that burdens of CSC response are minimized and justified by benefits.
- **Strive for fairness and protect against systematic unfairness** by:
 - Utilizing strategies for public education and public engagement that are inclusive and culturally sensitive;
 - Promulgating standardized crisis standards of care response protocols that are publicly available, revised regularly, and tailored to specific crisis responses;
 - Ensuring that burdens and benefits associated with crisis response are equitable;
 - Making reasonable efforts to remove access barriers and address functional needs;
 - Stewarding resources to:
 - Reduce significant group differences in mortality and serious morbidity; and
 - Appropriately reciprocate to groups accepting high risk in service of others;
 - Using decision-making processes that consistently apply only ethically relevant (non-discriminatory, non-arbitrary) considerations.

Strategies for the duty to plan

Prospective Planning: MDH, local/tribal health departments, private providers and other partners should plan for CSC, taking expert stakeholder and community input into account. Standardized CSC response protocols should be made available to the public to promote transparency, accountability and understanding.

Process for review and tailoring: Processes should be developed to periodically review and revise CSC plans, as well as to tailor them to the specific context of particular disasters encountered. Consultation with State and/or Local CSC Ethics Support Teams should be sought to support these processes.

Strategies for public understanding, communication and engagement

Public engagement: Initiatives should reach out to communities and not rely on a standard public comment period for soliciting feedback on the proposed plan. Reasonable efforts should be made to consult with populations with health disparities as well as those with access and functional needs. Input should be gathered on culturally appropriate planning and how to minimize impact of health disparities, access barriers and functional needs in the context of crisis response.

Public Understanding and Communication: Strong communication is critical to an ethically appropriate disaster response. Information regarding an MCI and crisis response plans should be disseminated as widely as possible, in different languages, using a variety of approaches, materials, and venues for distribution of information. Care should be taken to adequately inform the public without creating fear and to avoid dissemination of misinformation.

Strategies for duty to care

Obligations to patients:

- **Best care possible:** In CSC, fundamental norms of good care carry over from conventional care standards. Patients should be provided the best care possible given available resources. The plan for care should be based upon the CSC plan and explained to patients and their families throughout the process in which decisions concerning care are made. Patients should not be abandoned.
- **Palliative and hospice care:** CSC plans should address how to meet palliative and hospice care needs during an MCI, including recommendations for stockpiling; distributing and securely storing palliative care resources; promulgating symptom management protocols and algorithms; developing caregiver educational programs for laypersons and clinicians; developing a process for ongoing community engagement and communication; and planning for support of the dying and their caregivers.

- **Mental health care:** CSC plans should address how to meet mental health care needs during an MCI, including identifying disaster mental health providers, both local and electronic; incorporating disaster mental health response into crisis planning and response processes; assuring that protocols fairly triage patients suffering from both mental and somatic ailments; creating a parallel triage protocol for those requiring mental health resources if rationing is required; minimizing disruptions in continuity of care during disasters through planning for alternative treatment modalities (e.g., tele-psychiatry).
- **Appropriate care for the dead:** As part of community engagement during CSC planning, solicit public input regarding expectations for appropriate care for the dead during an MCI. Special efforts should focus on Minnesota's major immigrant populations, tribal communities and faith communities.

Support for health professionals:

- **Ethically appropriate liability protections** for providers should be drafted by legal advisors in partnership with the State Ethics Support Team. Providers who act in good faith to meet crisis standards of care must be protected, but even in the highly challenging context of an MCI, providers should not be fully immunized from liability. There must be safeguards and protections for patients as well as for providers (for example, review/appeals processes).
- **Reciprocity:** Fairness requires that society protect those who take on risk on behalf of the public, and that such protections are indexed to level of risk taken by the professionals. CSC plans should include provisions for promoting safety of these professionals (e.g., appropriate personal protective equipment and training, procedures for protection of staff when posed with threats such as active shooter attacks or flooding of facilities). Providers' duty to care for patients may be limited in situations posing imminent danger to providers. In some circumstances, key workers should be prioritized for access to resources when illness or injury is related to provision of care in disaster. Plans should make provisions for mental/behavioral health care for professionals given the stress/trauma of working in disasters.
- **Mandates to provide service:** Where possible, CSC plans should use incentives rather than mandates for health professionals to provide services in mass casualty incidents rather than relying upon state power to mandate provision of services, employers should create emergency plans with employees prior to a disaster to best address issues such as absenteeism (e.g., due to illness or family obligations) and reasonable expectations about length of work shifts.
- **Process for triage/rationing decisions:** Separate triage/rationing decisions from bedside care by using a triage team, to allow clinicians to advocate for patients while following CSC plans for triage/rationing. It may be necessary to construct regional triage teams for Greater Minnesota, depending on the nature of the disaster and given the strain on available staff.
- **Ethics support:** Implement and administer a system for ethics support at the state level, and require and facilitate development of ethics support mechanisms at local levels. The

primary functions of the ethics support process are to facilitate application of ethical frameworks for CSC and to help manage moral distress.

- **State CSC Ethics Support Team** would be responsible for:
 - Providing education to Local CSC Ethics Support Teams regarding state and federal guidance concerning ethical frameworks
 - Review of requests for guidance from Local CSC Ethics Support Teams relative to fair application of ethical frameworks, and
 - Review of systemic issues/challenges regarding the ethics frameworks that arise at the local or state level.
- **Local CSC Ethics Support Teams** would provide support when those attempting to resolve an ethical problem need prospective guidance in decision-making or real time review of a controversial decision, in addition to retrospective review of policies and practices to ensure compliance with and consistency in the application of the ethical framework and to advise MDH on measures to alter or improve policies/practices.

Strategies for proportionality and equity in freedom limiting interventions

Social distancing techniques, including isolation and quarantine, may be justified when public health interests outweigh the burdens to affected individuals or groups. Evaluation of burdens must consider the impact of these techniques on non-health aspects of well-being, including economic and financial. Decisions to implement restrictive interventions must be evidence-based, and should be made using a fair, transparent process of consultation with public health leaders and the State CSC Ethics Support Team to avoid the influence of political agendas.

Proportionality requires the use of the least restrictive interventions possible to achieve the outcome of interest. Appropriate limits may become unfair as the context changes (for example, further resources arrive or demand decreases). Response plans should be flexible and able to adapt to the situation.

Equity: Liberty-limiting interventions should not disproportionately impact populations with health disparities as well as those with access and functional needs.

Strategies for addressing health disparities, barriers to access and functional needs

Health Disparities, barriers to access and functional needs: CSC plans at all levels should attend to alleviating health disparities, reducing access barriers, and meeting functional needs. Partnerships to promote equity: planning regarding these issues should be conducted in partnerships across systems to best inform and implement relevant interventions.

Public engagement activities for CSC plans should address challenges regarding health disparities, access barriers and functional needs.

Distribution of Resources: Efforts should be made to provide free or low cost services to those with greatest financial need. Distribution of resources that those at highest priority—including health disparities populations—have best access to the resources. Distribution decisions should also take into account availability of infrastructure and trained staff to support use of specialized resources such as ventilators.

Tribes: MDH will engage tribes as equal partners in CSC planning and response and upon request aid tribes during disaster.

Immigrants: Immigration authorities should not be present during allocation of resources in MCI. CSC protocols should not be crafted to allow only legal residents of the state of Minnesota access to scarce resources in the state.

Consultation with the State and/or Local CSC Ethics Support Teams may be sought to support planning and response on issues of equity.

Strategies for fairly and consistently stewarding resources (time, task, treater)

Coordination: Balancing of resources across jurisdictions is required to assure consistency of care and equity of access. Therefore, coordination of response activities and sharing of impact/demand data is critical to a successful response. Regional coordinators, health care coalitions and emergency management must ensure the ability to share information and manage resources to allow this balancing to occur.

General considerations for rationing/triage: Extend supplies and conserve resources before implementing triage or rationing; triage/ration only as a last resort. Expand providers' scope of practice to provide the best care possible in context of the need associated with the mass casualty event. Scale rationing strategies to different levels of scarcity. Generally, de-prioritize people who are unlikely to benefit from the resource.

Processes to promote accountability: Triage/rationing decisions should be reviewed and revised as needed, consistent with this ethics framework.

Data: Care must be given to gathering data to reflect risk across populations in the state, since the state can implement recommendations regarding health disparities only to the extent that it works to understand risks confronting these populations.

Health records as a basis for decision-making: Patients' self-reports about their health should be accepted as guiding triage/allocation decisions where possible.

Key workers: When threats to societal functioning or disaster response are present, prioritize key workers who become ill or injured working in disaster response on a separate track in

parallel with a track for the general public, recognizing that in some circumstances a two-track approach might not be justified.

- Two reasons potentially justify prioritizing key workers: First, if societal functioning is at risk in a crisis, it may be appropriate to create a separate priority track for key workers to maintain societal functioning. This reason may justify priority for preventive resources to support professionals' ability to provide services during the MCI, or for treatment resources if they offer a reasonable prospect that the key worker would be able to return to work and so continue to provide key services during the MCI. Second, fairness requires that society protect those who take on risk to protect the public; this obligation is referred to as reciprocity.
- Ethics Support Teams should work with incident command to determine when and to what extent considerations regarding societal functioning and/or reciprocity justify prioritizing key workers for access to resources, especially given that prioritizing them may affect the general public's fair access to resources. Decisions should consider the professionals' level of risk, the importance of their services, and their ability to benefit from the resources in question.
- The decision about which workers to identify as key is an event-dependent one, and should consider the role of volunteers.
- The two-track approach must reflect a commitment to strive for balance between prioritizing key workers and prioritizing those groups in the general public who are at greatest risk for morbidity and mortality.

Do not ration based on:

- Ability to pay;
- First-come, first-served;
- Judgments that some people have greater quality of life than others;
- Predictions about baseline life expectancy (i.e. life expectancy if the patient were not facing MCI related health crisis), unless the patient is imminently and irreversibly dying, because rationing based on such baseline predictions would exacerbate health disparities;
- Race, gender, religion or citizenship;
- Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication);
- Judgments that some people have greater "social value" than others.

Ration resources based on the following considerations:

- Risk of MCI-related mortality and serious morbidity (due to greater exposure (occupational exposure for key workers) to risk or greater risk given exposure related to co-morbid conditions, etc);

- Good or acceptable response to resource;
- Risk of transmitting MCI-related infection.
- Irreplaceability of key workers

Allocating within priority groups: When the supply is inadequate to serve all similarly prioritized people then use a random process.

Strategies for promoting ethical decision-making among private partners

Partnerships: MDH will continue to treat private entities such as health care organizations as partners in planning disaster response, recognizing the shared planning and response roles of private providers and health care systems as necessary to effective response. MDH will work with other governmental entities and engage non-health private partners (e.g., faith-based organizations or nonprofit service providers) in planning for a disaster.

Coordinating responsibilities: Planning efforts should not unduly burden private partners. Those with greater or unique capabilities should accept concomitant responsibilities in response, and MDH and other private partners should support these organizations in doing so.

Patient transfer and care transition plans: The health care sector should work with MDH to create patient transfer and care transition maps for disaster response. These plans should allow lower levels of care to occur outside of the hospital setting so as to minimize the burden on hospital services, especially critical care. Scope of practice should be expanded so the majority of care may be shifted to community clinics, primary care or specialty offices, and other providers. State and local government should be prepared to support these non-traditional responses both from a financial and regulatory standpoint.

Increasing response capabilities: MDH will support public and private systems aimed at increasing capabilities of health care providers that do not have the infrastructure to meet their accepted roles in disaster response. This may include offering technical support, increasing the availability of telemedicine, and creating helplines for private actors during disaster response and recovery.

Attachment 2—Legal Authority and Environment for Crisis Standards of Care

THE MINNESOTA LEGAL FRAMEWORK: AN OVERVIEW⁹²

DISCLAIMER

The information contained in this Attachment does not constitute any official position of the Minnesota Department of Health (MDH). This Attachment is designed only as very brief, superficial, cursory information on complicated legal subjects; it is not intended, nor should it be construed as, legal advice. Legal advice on the issues pertaining to emergency preparedness and response, and in particular mass casualty surge events, is necessarily fact-specific and varies depending upon specific laws and specific circumstances. For legal advice, readers are encouraged to consult with an attorney of their choice.

This Attachment will illuminate some Minnesota state and U.S. federal laws potentially applicable to the subjects of liability protection and resource allocation; it is beyond the scope of this Attachment and this Framework to conduct an exhaustive review of all State or federal laws that may be applicable in an emergency or disaster. There is no Minnesota statute that directly relieves health care providers responding to a disaster of liability for injury or death resulting from the delivery or withholding of health care;⁹³ likewise, MDH is not vested with the legal authority to alter medical practice standards whether in a medical surge event or otherwise. The purpose of this Attachment is to provide a brief overview of some potentially applicable laws to give emergency management officials basic background information to assist when dealing with their own attorneys in emergency planning and response.

⁹² BY: Arden Fritz, Legal Affairs Coordinator, Minnesota Department of Health; (2015).

⁹³ For example, a Virginia statute provides: In the absence of gross negligence or willful misconduct, any health care provider who responds to a disaster shall not be liable for any injury or wrongful death of any person arising from the delivery or withholding of health care when: (1) a state or local emergency has been or is subsequently declared in response to such disaster; and (2) the emergency and subsequent conditions cause a lack of resources, attributable to the disaster, rendering the health care provider unable to provide the level or manner of care that otherwise would have been required in the absence of the emergency and which resulted in the injury or wrongful death at issue.

Background

Public health preparedness is an ongoing priority for state and local public health agencies, health professionals, and others who may find themselves responding to a mass casualty event (MCI) with public health implications. These incidents have the capability of altering, not just the operational environment, but the legal environment as well. Any time that the focus shifts from individual to community benefit there is the potential for multiple legal issues to arise. One important consideration of public health preparedness is whether public health authorities are legally empowered to respond in the desired manners. This is important because of the potentially wide-ranging and unprecedented impacts of MCIs and their potential to cross-jurisdictional borders.

As with emergency preparedness in general, legal preparedness activities may not anticipate all of the varying legal issues that might arise in a health-related disaster because emergencies, by their very nature, create unique and sometimes unexpected challenges. For example, the Minnesota governor is granted the legal authority to make an emergency declaration that could change the legal environment for the duration of the incident. Such a declaration may grant state government officials a wide range of expanded powers which can facilitate rapid response efforts. Even with this ability to invoke extraordinary powers, existing law may, nonetheless, create gaps and challenges. The role of the attorney representing emergency management is to address the challenges and ambiguities that arise in this altered legal environment.

One major challenge is convincing emergency planners to incorporate legal aspects into planning. Emergency managers should review emergency and response plans and give thought to how responders will receive qualified legal advice to address the important yet unanticipated legal issues that will inevitably arise during a surge event.

Addressing the challenges and ambiguities that arise in the altered legal environment during a catastrophic disaster entails the practice of “legal triage,” which may be defined as the efforts of practitioners to prioritize legal issues in real-time and provide solutions that facilitate response efforts. This practice incorporates the concept that legal practitioners and others must be prepared to respond to those facets of emergencies:

That are not easily anticipated by existing legal structures, or

For which existing statutes or other laws provide only flexible guidance, but not concrete authority or direction. In an altered legal environment during any type of surge event, innovative, coordinated, and real-time response are all prerequisites to legal preparedness. Aspects of legal crisis standards of care may include:

1. Establishing and implementing standards of care that apply in disaster situations under conditions of scarce resources;
2. Modification of the standards of professional care delivered in a catastrophic disaster; and
3. Liability concerns when practitioners deviate from the “ordinary” standards of care.

Therefore, the role of the attorney in emergency response may be described as working with their clients to prioritize legal issues and provide solutions in real-time that facilitate legitimate public health responses. In so doing, the lawyer must recognize that existing statutes or other laws may provide only flexible guidance, as opposed to concrete authority or direction. In an altered legal environment innovative, coordinated, and real-time responses are all prerequisites to legal preparedness.

Of primary concern to many health care and public health professionals is their potential exposure to legal liabilities when extreme service demands, coupled with constrained supplies, prevents them from the degree and type of services and care they would otherwise provide.⁹⁴ This, in turn, raises complex questions about responsibility, causation, and justice that are particularly difficult in the context of emergency situations.⁹⁵ Although lawsuits resulting from emergency planning or services rendered during a catastrophic emergency or disaster are rare, responders may be comforted in knowing what laws afford protections against lawsuits for death, personal injuries, or property damage that might be leveled against them for actions undertaken – or not undertaken – during a response;⁹⁶ as well as how they and their families will receive compensation if they are injured or killed during a response.⁹⁷

Emergency planners should work with their attorneys to identify and discuss potential legal issues and legal authorities before disaster strikes. To assist in that conversation, this Attachment will briefly review current liability protections and the ability to re-direct resources under current Minnesota law, and other laws that may apply in any event posing a threat to the public health will also be briefly discussed.

⁹⁴ Civil liability refers to the potential responsibility that an individual or entity owes for actions (or failures to act) that harm others. Civil liability may arise from a person's actions that breach or deviate from statutory, regulatory, or judicial requirements, or contractual obligations or policy statements. In other instances, a person's failure to act may injure others. In either scenario, if an aggrieved person can prove their case (in court or otherwise), the opposing party may be liable to provide monetary compensation for physical or mental injuries, property losses, or other damages.

⁹⁵ Common questions raised by emergency responders concerning potential liability exposures resulting from emergency response activities include who may be liable; under what specific circumstances may civil liability be imposed; what protections from liability may exist, and whether liability protections under existing law apply during training exercises and other response situations in which a formal emergency declaration has not been issued.

⁹⁶ For example, the elements of a negligence claim are (1) the defendant (the party sued) owed the plaintiff (the person bringing the claim) a duty of care; the defendant breached that duty; the plaintiff suffered injuries, and the defendant's breach of duty was the proximate cause of plaintiff's injuries. In like regard, a medical malpractice case may be simply described as a breach of the medical standard of care, which is defined as the type and level of medical care required in a specific circumstance, based upon the reasonable and common practice usually exercised by an ordinary member of the profession in good standing in a same or similar locality under same or similar circumstances. Because the legal standard of care is a flexible and fact-specific concept that ordinarily takes into account the circumstances under which care was provided, courts evaluating the conduct of a health care provider should take into account the particular circumstances surrounding an emergency event where resources may be scarce and health care systems and providers may be overwhelmed.

⁹⁷ As will be demonstrated, often responders are considered employees of state or local government for purposes of workers' compensation benefits.

Minnesota emergency management act (MEMA)

The governor's authority

The primary source of State government's authority to respond to any type of emergency or disaster, including those which threaten public health, is the Minnesota Emergency Management Act, or MEMA.⁹⁸ The emergency powers provided by MEMA are purposefully broad so that they may be applied in any possible catastrophic situation. MEMA created the Division of Homeland Security and Emergency Management (HSEM) within the Minnesota Department of Public Safety.⁹⁹ MEMA grants the governor widespread direction and control of emergency management within Minnesota,¹⁰⁰ and provides the governor, other State officials, and emergency managers exemplary powers to prepare for, and respond to, an emergency or disaster.¹⁰¹

Disaster declarations

Some, but not all, of the powers expressly provided by MEMA may only be exercised if the governor has issued a disaster declaration. MEMA provides the governor the authority to issue two types of emergency declarations. The first is a national security emergency, which the governor may declare when a major disaster from enemy sabotage or other hostile action within the United States or Minnesota is imminent.¹⁰² Otherwise, the governor may declare a peacetime emergency when any act of nature, technological failure or malfunction, terrorist incident, industrial accident, hazardous materials accident, or civil disturbance endangers life or

⁹⁸ The Minnesota Emergency Management Act is codified at Minn. Stat. ch. 12.

⁹⁹ Minn. Stat. §12.09. The duties of the Division of Homeland Security and Emergency Management (HSEM) under MEMA include coordinating State preparedness; developing and maintaining a comprehensive State emergency plan; providing guidance, information, and training to cities, counties, and townships; and coordinating volunteer resources. Under §12.351, HSEM may activate deployment of specialized emergency response teams.

¹⁰⁰ Minn. Stat. §12.21, Subd. 1. MEMA defines "emergency management" as the preparation for and carrying out of emergency functions to prevent, minimize, and repair injury and damage from disaster including, without limitation... medical and health services... emergency human service... and other functions related to civilian protection, together with all other activities necessary or incidental to preparing for and carrying out these functions. *See* Minn. Stat. §12.03, Subd. 4 (emphasis added).

¹⁰¹ Under MEMA, a "disaster" is defined as a situation that creates an actual or imminent serious threat to the health and safety of persons, or a situation that has resulted or is likely to result in catastrophic loss to property or the environment, and for which traditional sources of relief and assistance within the affected area are unable to repair or prevent the injury or loss. Likewise, MEMA defines an "emergency" as an unforeseen combination of circumstances that calls for immediate action to prevent a disaster from developing or occurring. *See* Minn. Stat. §12.03, Subds. 2 and 3.

¹⁰² Minn. Stat. §12.31, Subd. 1. A declaration of a national security emergency lasts for a period of 30 days.

property; and local government resources are inadequate to handle the situation.¹⁰³ Thus, unlike federal law,¹⁰⁴ Minnesota law does not expressly recognize the declaration of a “public health emergency,”¹⁰⁵ although the broad definition of a peacetime emergency would very likely include any event which would typically be considered a public health emergency.

The governor typically declares an emergency by issuing an executive order.¹⁰⁶ An executive order issued pursuant to the governor’s expressed authority under MEMA, or any other emergency executive order issued to protect persons from an imminent threat to health and safety, is immediately effective.¹⁰⁷

MEMA also authorizes a mayor or county board chair to declare a local emergency.¹⁰⁸ The length the declaration is 3 days, unless a longer period is approved by the governing body. The effect of declaring a local emergency is “invokes necessary portions of the response and recovery aspects of applicable local or inter-jurisdictional disaster plans, and may authorize aid and assistance under those plans.”¹⁰⁹ MEMA also requires all political subdivisions in Minnesota to establish a local emergency management organization to perform emergency management functions, and counties are required to coordinate emergency management activities within their jurisdiction.¹¹⁰ MEMA specifically grants political subdivisions the authority to levy additional property taxes to pay expenditures incurred for emergency management purposes.¹¹¹

Governor’s powers

MEMA grants the governor many broad powers to plan for or respond to an emergency or disaster; only some are highlighted in this Section. For example:

¹⁰³ Minn. Stat. §12.31, Subd. 2. A declaration of a peacetime emergency must not continue for more than 5 days unless extended by resolution of the State Executive Council, which may extend the declaration up to 30 days. Extending the declaration beyond 30 days requires legislative approval.

¹⁰⁴ As will be discussed later, §319 of the Public Health Services Act, 42 U.S.C. §247d(a)(2009), authorizes the Secretary of the United States Department of Health and Human Services (HHS) to declare a public health emergency if the Secretary determines that a disease or disorder presents a public health emergency otherwise exists.

¹⁰⁵ Minn. Rule 4735.0110(1987) authorizes MDH to enter agreements with local boards of health to specify shared responsibility for collecting data and information pertaining to communicable diseases, and authorizes MDH to suspend such agreements in the event of a public health emergency. Minn. Rule 4735.0100 (1987) defines a “public health emergency,” only for purposes of Rule 4735.0110, as “an unanticipated and temporary condition threatening the health of a specific population such that the resources of one or more local boards of health cannot reasonably be considered adequate to respond to the emergency needs of the affected population.”

¹⁰⁶ Governor executive orders are expressly authorized by Minn. Stat. §4.035.

¹⁰⁷ Minn. Stat. §4.035, Subd. 2. By comparison, other Governor executive orders are effective 15 days after the order is filed with the Secretary of State and published in the State Register.

¹⁰⁸ Minn. Stat. §12.29, Subd. 1.

¹⁰⁹ Minn. Stat. §12.29.

¹¹⁰ Minn. Stat. §12.25.

¹¹¹ Minn. Stat. §12.26.

CRISIS STANDARDS OF CARE FRAMEWORK
LEGAL AUTHORITY

- The governor is authorized to make, amend, and rescind necessary orders and rules to carry out MEMA’s provisions, within the limits of authority conferred by MEMA.112
- All emergency management organizations within the State are required to execute and enforce the governor’s orders and rules made pursuant to MEMA’s authority.113
- Orders and rules promulgated by the governor when approved by the Executive Council and filed with the Secretary of State have, during a national security, peacetime, or energy supply emergency, the full force and effect of law.114
- The governor may procure supplies, equipment, and facilities.115
- The governor may cooperate with the federal government, and other states, in matters pertaining to emergency management including accepting gifts and grants of services, equipment, or funds.116
- The governor may disconnect utility services, order evacuations, order people into shelters, control traffic and other movements of persons and vehicles, and cancel public meetings and events.117
- During emergency or disaster, the governor may enter contracts, incur obligations, and exercise powers in light of the exigencies without compliance with time-consuming procedures and formalities prescribed by laws pertaining to contract, employment, purchasing supplies and equipment, or budgeting.118
- The governor may alter working hours of State employees, and transfer the personnel and functions of State agencies to perform or facilitate response and recovery activities.119
- The governor may authorize the Commissioner of Education to close schools.120
- The governor may cooperate with the president and federal agencies in matters pertaining to emergency management.121
- The governor may take possession of fatalities and provide for their safe disposition including mass burial.122

¹¹² Minn. Stat. §12.21, Subd. 3(1).

¹¹³ Minn. Stat. §12.28.

¹¹⁴ Minn. Stat. §12.32.

¹¹⁵ Minn. Stat. §12.21, Subd. 3(3).

¹¹⁶ Minn. Stat. §§12.21, Subd. 3(7) and 12.22, Subd. 1.

¹¹⁷ Minn. Stat. §12.21, Subd. 3(7) (iv) – (vi) and (9).

¹¹⁸ Minn. Stat. §12.36. Minn. Stat. §12.37 provides the same authority to political subdivisions during emergencies or disasters.

¹¹⁹ Minn. Stat. §12.21, Subd. 3(10) and (12).

¹²⁰ Minn. Stat. §12.21, Subd. 3(11).

¹²¹ Minn. Stat. §12.21, Subd. 3(7).

¹²² Minn. Stat. §12.381, Subd. 1.

National Guard

The Minnesota Constitution also designates the governor as commander in chief of the State's military force, the National Guard.¹²³ The governor may employ the National Guard for defense or relief of Minnesota, or any other state; and to enforce laws and protect persons and property.¹²⁴ Additionally, National Guard members may be called into temporary active service in case of emergency or as otherwise authorized by the Governor.¹²⁵ Thus, the Governor has legal authority to deploy the Minnesota National Guard in response to an emergency or disaster.

Staff and resource augmentation

Professional licensing requirements for health care professionals establish minimum competencies and prerequisites for entry into each health profession, create mechanisms to grant licenses to qualified persons, and establish the scope of practice for each profession. Such licensing requirements are a function of state laws, and the qualifications and procedural requirements necessary for obtaining and retaining professional licenses varies from state to state. Typically, licensed health professionals may practice their professions anywhere within the state which issued their license,¹²⁶ but those who practice without a license issued by the state in which they are rendering services may be subject to civil or criminal penalties.

Cross-border licensure

Prolonged responses to an emergency or disaster create staffing shortages for responding agencies, which may be alleviated by allowing licensed professionals from other states and Canada to practice in Minnesota. MEMA authorizes the Governor, during a declared emergency, to authorize any person who holds a license, certificate, or other permit issued by another state, the District of Columbia, or a Canadian province for professional, mechanical, or other skills, to render aid involving those skills in Minnesota when such aid is needed to meet the needs of the emergency.¹²⁷ The license, certificate, or other permit of the person, while rendering aid, has the same force and effect as if issued in Minnesota, subject to whatever limitations and conditions as the Governor may prescribe.

Mutual aid

One tool commonly employed to establish parameters of the legal landscape are mutual aid agreements. The flow of personnel and supplies into areas impacted by a mass casualty event is

¹²³ Minn. Const. Art. V, Sec. 3.

¹²⁴ Minn. Stat. §190.02.

¹²⁵ Minn. Stat. §190.08, Subd. 4.

¹²⁶ For example, under Minn. Stat. §148.234 a nurse in Minnesota may perform patient care procedures and techniques on a patient in Minnesota at the direction of a physician licensed in another state provided that physician examined the patient in the State in which she or he is licensed.

¹²⁷ Minn. Stat. §12.42.

often facilitated by pre-existing agreements for inter-jurisdictional assistance, and MEMA addresses this subject as well. For example, MEMA authorizes mutual aid agreements between local emergency management organizations; between local emergency management or HSEM and emergency management in other states; and even between HSEM and emergency management organizations in Canadian provinces.¹²⁸ Additionally, the Governor is granted specific authority to enter into mutual aid or other cooperative agreements with other states, tribal governments, and Canadian provinces.¹²⁹ Finally, under MEMA the Governor, upon request of another state, may dispatch Minnesota equipment and personnel to that state as deemed necessary to respond to an emergency or disaster.¹³⁰

Even if no mutual aid agreement is in place, MEMA contains several provisions specific to the sharing of response equipment and personnel. The Governor has authority to direct the personnel, equipment, and supplies of police, fire-fighting, health, or other forces of one political subdivision to assist another in an imminent emergency.¹³¹ In fact, MEMA dictates in carrying out its provisions, the Governor and the governing bodies of cities, counties, and towns shall utilize the services, equipment, supplies, and facilities of existing departments, offices, and agencies of the State and of political subdivisions “to the maximum extent practical.”¹³²

If the Governor makes such a directive, the personnel from the sending jurisdiction are considered to be acting within the scope of their regular employment for that jurisdiction. Additionally, the receiving jurisdiction is obligated to reimburse the sending jurisdiction for supplies and personnel expenses, but the State will reimburse the sending jurisdiction for equipment loss or damage.¹³³ During an emergency, if one political subdivision requests assistance from another, the employees of the sending jurisdiction considered to be acting within their scope of employment for the sending jurisdiction for purposes of worker’s compensation;¹³⁴ in contrast those same responders are considered employees of the receiving jurisdiction for purposes of tort claim defense, indemnity, and immunity.¹³⁵ The sending jurisdiction is financially liable for damage to its equipment¹³⁶, while the receiving jurisdiction must reimburse the sending jurisdiction for supplies used and compensation for the personnel sent to assist.¹³⁷

¹²⁸ Minn. Stat. 12.27, Subds. 1, 2, and 2a.

¹²⁹ Minn. Stat. §12.21, Subd. 3(5). Mutual aid agreements between states and Canadian provinces is the subject of the International Emergency Management Assistance Compact (EMAC), which provides legal protections to emergency management workers utilized by party states, in accordance with its provisions. Retrieved from [International Emergency Management Assistance Memorandum of Understanding](#) (July 18, 2000).

¹³⁰ Minn. Stat. §12.27, Subd. 4.

¹³¹ Minn. Stat. §12.33, Subd. 1.

¹³² Minn. Stat. §12.23.

¹³³ Minn. Stat. §12.33, Subds. 3 and 4.

¹³⁴ Minn. Stat. §12.331, Subds. 1 and 2(a) and (b).

¹³⁵ Minn. Stat. §12.331, Subd. 2(b).

¹³⁶ Minn. Stat. §12.331, Subd. 2(d).

¹³⁷ Minn. Stat. §12.331. Subd. 2(e).

Emergency management assistance compact (EMAC)

Another law that assists stricken jurisdictions in receiving necessary personnel, equipment, and supplies is the Federal Emergency Management Assistance Compact, or EMAC.¹³⁸ EMAC is an interstate mutual aid assistance agreement administered by the National Emergency Management Association (NEMA). When activated, EMAC provides for mutual assistance between states in managing any declared emergency or disaster.

When intra-state resources are insufficient, EMAC provides an avenue to deploy personnel and/or resources to the impacted states to ensure an efficient and effective response when the governor of the stricken state declares a state of emergency and requests aid. EMAC provides legally-binding arrangements for reimbursement, liability protections, compensation for responders injured or killed, and recognition of professional licenses and certificates. All fifty states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands have ratified EMAC. The Minnesota Interstate Emergency Management Assistance Compact is codified at Minn. Stat. §192.89.

For example, to facilitate interstate sharing of health care personnel EMAC authorizes a requesting state to recognize out-of-state medical or other licenses for purposes of rendering aid during a declared emergency or disaster, subject to limitations imposed by the requesting state's governing body. Persons holding an out-of-state license, certificate, or permit are "deemed licensed, certified, or permitted by the state requesting assistance" when deployed through EMAC.¹³⁹ The state-to-state assistance under EMAC includes the loan and delivery of state owned or controlled material, as well as personnel such as state or local government employees and health-related professionals. Thus, EMAC provides another legal basis for other states to augment Minnesota responders during an emergency or disaster in Minnesota, and also provides Minnesota responders called to serve in other stricken states protections against lawsuits and injuries received during the response. All EMAC requests are requested and go through MN HSEM.

Nurses

Minnesota law specifically provides that the provisions of the Minnesota Nurse Practice Act "shall not prohibit the furnishing of nursing assistance in an emergency."¹⁴⁰ Licensed nurses may practice across state lines under the Nurse Licensure Compact Act, a model law currently adopted by 25 states. For states that have entered the Compact, a license to practice registered nursing issued by a home state to a resident in that state will be recognized by other Compact-member state as authorizing a multistate licensure privilege to practice as a registered nurse in that state.¹⁴¹ Minnesota has not yet adopted the Compact.

¹³⁸ Public Law 104.321, effective 1996. Retrieved from [The Emergency Management Assistance Compact](#)

¹³⁹ EMAC Article V.

¹⁴⁰ Minn. Stat. §148.271(1).

¹⁴¹ More information regarding the Nurse Licensure Compact may be found at [National Council of State Boards of Nursing](#).

Commandeering

Under MEMA, any abled-bodied person may be required by the Governor, or State or local emergency management, to perform emergency management services under threat of criminal prosecution.¹⁴² The Act also provides that, when necessary to save life, property, or the environment during a declared emergency, the Governor, or state or local emergency management designated by the Governor, may commandeer motor vehicles, tools, appliances, medical supplies, personal property, or facilities.¹⁴³ In this regard; however, MEMA defines “medical supplies” as medication, durable medical equipment, instruments, linens, and other materials a health care provider deems not essential for the continued operation of the provider’s practice or facility. It specifically excludes medication, equipment, or materials that is personal property used by individuals or borrowed, leased, or rented by individuals for purposes of treatment or care.¹⁴⁴ Thus, under MEMA emergency management is prohibited from commandeering medical supplies in use by individuals for purposes of medical care. Additionally, the State or local jurisdiction must pay the owners of commandeered property “just compensation” for its use and for any resulting damages.¹⁴⁵

Liability and other protections in emergencies and disasters

Liability

Medical malpractice and other forms of civil liability are situational. During a disaster, as in conventional operations, responders are held to the standard of care that a “reasonable responder” would have given in that same or similar situation accounting for the availability of resources. One factor in determining whether the “reasonable responder” standard was met is whether the responder was following previously-adopted operating plans or guidance. Having pre-existing operational plans for crisis situations may provide protections for responders, as well as the agencies that employ them. If these plans are reasonable, based on recognized guidance and best practices documents, and approved by the agency or, optimally, by multiple agencies it may be, in most situations, difficult to find liability if the responder’s actions conformed to the expectations of the plan. That said, in some cases a reasonable responder might be required to deviate from the requirements of the operational plan to do the best they could for their patient or community.

This also raises the issue of “duty to plan”. This is not a new concept in risk analysis, but is somewhat new in disaster response. The failure to adequately plan for reasonable foreseeable results of anticipated catastrophic events has served as the legal basis for several successful lawsuits throughout the United States against both private medical care providers and government agencies.

¹⁴² Minn. Stat. §12.34, Subds. 1(1) and 3. Any abled-bodies person who refuses to perform the required services is guilty of a misdemeanor and must serve a minimum of 10 days in jail.

¹⁴³ Minn. Stat. §12.34, Subd. 1(2).

¹⁴⁴ Minn. Stat. §12.03, Subd. 6a.

¹⁴⁵ Minn. Stat. §12.34, Subd. 2.

Individual volunteer protections

MEMA specifically provides several forms of liability protections for individuals and organizations who respond to an emergency or disaster. Regarding individual volunteers, MEMA states that persons will be considered employees of the State or the local government for purposes of workers' compensation and tort claim defense and indemnification if those persons:

- Volunteer to assist the State or a local government;
- During an emergency or disaster (not necessarily a declared one);
- Register with the State or local government; and
- Act under the direction and control of the State or a local unit of government.¹⁴⁶

Entity liability protections

Apart from protecting individual volunteers, MEMA's liability protections also extends to entities such as corporations, associations, businesses, nonprofits, and charitable organizations. Any entity, or an agent acting on its behalf who (1) volunteers without compensation; (2) to assist the State or a local jurisdiction; (3) during an emergency or disaster; who (4) previously registered with the State or local jurisdiction; and (5) acts under direction and control of the State or local jurisdiction; is not liable for civil damages or administrative sanctions as a result of good-faith acts or omissions by that entity or agent in rendering emergency care, advice, or assistance.¹⁴⁷

Temporary care facilities

Sometimes a flood or other natural disaster will require the residents and patients of a health care facility in harm's way to be relocated to another facility, on a temporary basis, in another part of the State unaffected by the calamity. In that situation, MEMA provides that the Governor, during a declared emergency, may issue an emergency executive order when number of ill or injured in hospital region exceeds the hospital or transport capacities in that region.¹⁴⁸ Most importantly, that statute also specifically provides that during the effective period of the executive order, responders in impacted regions acting consistent with emergency plans are not liable for civil damages or administrative sanctions resulting from good-faith acts or omissions in rendering emergency care, advice or assistance.¹⁴⁹ The scope and reach of this statutory liability protection; however, is subject to debate.

¹⁴⁶ Minn. Stat. §12.22.

¹⁴⁷ Minn. Stat. §12.22, Subd. 2b. For purposes of this statute, "entity" is defined by Minn. Stat. §12.03, Subd. 4e as including a firm, corporation, association, limited liability company, partnership, limited liability partnership, nonprofit organization, or other business, religious, or charitable organization.

¹⁴⁸ Minn. Stat. 12.61, Subd. 2(a).

¹⁴⁹ *Ibid.*, Subd. 2(b).

Good Samaritan act

The Minnesota “Good Samaritan” statute requires persons at an emergency scene to stop and render reasonable assistance, which includes attempting to obtain help from law enforcement or medical personnel, if such reasonable assistance can be rendered without subjecting the person to danger or peril.¹⁵⁰ Any person who renders emergency care, advice, or assistance at the scene of an emergency or during transit to a location where medical care can be received is not liable for any civil damages as a result of acts or omissions by that person in rendering the emergency care, advice, or assistance unless the person acts in a willful and wanton or reckless manner.¹⁵¹ The protections under this law; however, are not available to anyone who receives compensation or has an expectation of compensation for rendering the assistance, or who otherwise renders emergency care during their course of regular employment.¹⁵² With that restriction, Minnesota’s Good Samaritan Act likely has limited applicability to many volunteer health professionals responding to an emergency or disaster.

Workers’ compensation

Workers compensation laws provide a method by which employees are compensated for medical expenses, lost wages during recovery, retraining, and beneficiary death benefits for injuries received while on the job without regard to fault for the injuries.¹⁵³ With regard to workers’ compensation benefits, the definition of “employee” under Minnesota law includes a voluntary uncompensated worker engaged in emergency management who is registered with the state or political subdivision and acting under the direction and control of, and within the scope of duties approved by, the state or political subdivision;¹⁵⁴ a volunteer uncompensated worker while volunteering services as a first responder or a law enforcement assistance organization acting under the supervision and authority of a political subdivision;¹⁵⁵ and a Minnesota Responds Medical Reserve Corps (MRC) volunteer responding at the request of or engaged in training conducted by MDH.¹⁵⁶

¹⁵⁰ Minn. Stat. §604A.01, Subd. 1. A person who violates the law by failing to give reasonable assistance at the scene of an emergency is guilty of a petty misdemeanor.

¹⁵¹ Minn. Stat. §604.01, Subd. 2(a).

¹⁵² *Ibid.*

¹⁵³ Workers’ compensation laws provide the method by which employees are compensated for medical expenses, lost wages, retraining, and beneficiary death benefits for injuries received while on the job without regard as to fault for causing the injuries. Minn. Stat. §176.021(1) provides employers are liable to pay compensation in every case of personal injury or death for an employee arising out of and in the course of employment.

¹⁵⁴ Minn. Stat. §176.011, Subd. 9(9); the definition of “emergency management” includes the “preparation for” and the “carrying out” of emergency functions including medical and health functions. See Minn. Stat. §12.03, Subd. 4.

¹⁵⁵ Minn. Stat. §176.011, Subd. 9(23).

¹⁵⁶ Minn. Stat. §176.011, Subd. 9(25).

The Minnesota state tort claims and municipal tort claims acts

Volunteers responding to an emergency or disaster may, under certain circumstances, be considered “employees” of a State governmental agency or of a municipality and may enjoy the liability protections and workers’ compensation benefits normally afforded government employees. Under Minnesota law, employees of the state and municipalities are provided protections against lawsuits arising from events that occur while acting within the scope of employment. The Minnesota Tort Claims Act¹⁵⁷ provides the State will compensate anyone who suffers injury to or loss of personal property, personal injury, or death caused by an act or omission of a State employee acting within the scope of their employment,¹⁵⁸ subject to certain exclusions.

One of the liability exclusions under the State Tort Claims Act is immunity. The Act specifically provides the State and its employees are not liable for losses caused by the employee performing or failing to perform a discretionary duty.¹⁵⁹ In addition, the Act requires the State to defend, save harmless, and indemnify any employee in connection with any civil claim incurred by employee acting within scope of employment.¹⁶⁰ The Act also caps the total liability of the State and its employees on any tort claim to \$500,000.00 per person and \$1,500,000.00 for all claims arising from a single occurrence.¹⁶¹ Employee of the State, for purposes of the State Tort Claims Act, includes all present or former employees or persons acting on behalf of the State in an official capacity, temporarily or permanently, with or without compensation.¹⁶²

The Municipal Tort Claims Act,¹⁶³ provides employees of a “municipality” immunity, indemnification, and tort liability limit protections similar to those under the State Tort Claims

¹⁵⁷ Minn. Stat. §3.732 and §3.736. The doctrine of sovereign immunity precludes litigation against the State unless the State has consented to being sued, and the Minnesota Tort Claims Act describes the circumstances under which the Minnesota Legislature intended to waive sovereign immunity.

¹⁵⁸ Minn. Stat. §3.736, Subd. 1

¹⁵⁹ Minn. Stat. §3.736, Subd. 3(b). A “discretionary duty” is defined as one that involves “individual professional judgment that necessarily reflects the professional goals and factors of a situation.” In contrast, the Tort Claims Act generally does not afford protections against liability for ministerial acts, which are defined as a duty that is “absolute, certain, and imperative, involving merely the execution of a specific duty arising from fixed and designated facts.” See generally *Shariss v. City of Bloomington*, 852 N.W.2d 278, 281-82 (Minn. Ct. App. 2014), (citations omitted).

¹⁶⁰ Minn. Stat. §3.736, Subd. 9. Indemnification is the right of a person to be restored, in whole or in part, by another for a loss through payment, repair, or replacement. Thus, under the State Tort Claims Act, the State would step in and pay and damages an individual State employee would be court-ordered to pay if the employee was found liable for a claim that arose against the employee while she or he was acting in the scope of their employment.

¹⁶¹ Minn. Stat. §3.736, Subd. 4(c) and (g).

¹⁶² Minn. Stat. §3.732, Subd. 1(2).

¹⁶³ The Minnesota Municipal Tort Claims Act is codified at Minn. Stat. ch. 466.

Act. For purposes of this statute, a “municipality” includes cities, counties, towns, public authorities, school districts, joint powers boards, and other political subdivisions.¹⁶⁴

MEMA provides that “nothing in this chapter shall be construed to remove any immunity from, defense to, or limitation on liability provided by the Minnesota Tort Claims Act, the Municipal Tort Claims Act, or other law.”¹⁶⁵

Legal authorities of the Minnesota Department of Health

The commissioner is directed by statute to take necessary steps to remediate the effects of a natural disaster to ensure public health is maintained.¹⁶⁶ In communities affected by a natural disaster, MDH may provide for the necessary assessment and evaluation of the current state of health care access, mental health concerns and needs, infectious disease concerns, indoor environmental quality, food safety, the safety of food, pools, and lodging, and public and private drinking water systems.¹⁶⁷

Mass dispensing

Minnesota law grants specific powers to the Commissioner of Health to respond to mass events that negatively impact the public’s health. The exercise of these powers by the commissioner does not depend upon a Governor’s emergency declaration. For example, the commissioner may prescribe a legend drug by protocol for mass dispensing purposes if such action is necessary to protect public health and safety, and if (1) a local emergency was declared; (2) the Governor declared an emergency; (3) community health board requested assistance responding to a public health threat; or (4) a pandemic influenza, other life threatening disease, or other events require urgent treatment or prophylactic measures.¹⁶⁸ When a legend drug or vaccine has been predetermined and delegated by a licensed physician, a registered nurse may implement that protocol and prescribe a legend drug or administer a vaccine when caring for a patient whose condition falls within the protocol and when that protocol specifies the circumstances under which that legend drug or vaccine may be administered or prescribed.¹⁶⁹

The Commissioner of Health may modify state drug labeling requirements, medical screening criteria and documentation where time is critical and such measures are most likely to ensure

¹⁶⁴ Minn. Stat. §466.01, Subd. 1.

¹⁶⁵ Minn. Stat. §12.22, Subd. 4.

¹⁶⁶ Minn. Stat. §12A.08, Subd. 2.

¹⁶⁷ Minn. Stat. §12A.08, Subd. 1.

¹⁶⁸ Minn. Stat. §151.37, Subd. 2(b). This authority to prescribed legend drugs by protocol applies to the Commissioner of Health if the commissioner is a licensed practitioner, or otherwise to a licensed practitioner designated by the commissioner.

¹⁶⁹ Minn. Stat. §148.235, Subds. 8 and 9.

legend drugs reach the maximum number of persons in a timely fashion.¹⁷⁰ The Commissioner of Health may purchase, store and distribute vaccines, antitoxins, serums, immunization agents, antibiotics, antivirals, antidotes, pharmaceutical agents, and medical supplies to treat and prevent communicable disease.¹⁷¹

In response to Governor's declared emergency, declared local emergency, or request from a community health board to assist with event threatening public health, the Commissioner of Health may authorize any person to administer vaccinations or dispense legend drugs if necessary to protect public health and safety.¹⁷² This Authorization must be in writing and designate the category of persons authorized to distribute or dispense, state the required training and supervision of these new administrators and dispensers, and set forth the duration of the authorization. Any person so authorized by commissioner is not subject to criminal liability, administrative penalty, professional discipline, or other sanction for good faith performance of the assigned vaccination or drug dispensing duties.¹⁷³

In response to some incidents, the best way to protect the public health is to vaccinate as many people as quickly as possible. The Commissioner of Health may designate persons and entities to expedite legend drug dispensing when pandemic influenza, or other life-threatening disease or event, requires urgent treatment or prophylactic measures.¹⁷⁴ Alternative and expedited mass dispensing methods under this statute include distributing to household representatives, door-to-door distribution by the United States Postal Services, distribution by closed points of dispensing which distribute only to a limited; defined group, as well as by "any method the commissioner deems warranted."¹⁷⁵ Any person or entity acting as a closed point of dispensing acting in good faith under an approved dispensing plan is not liable for civil damages or administrative sanctions for causing death, injury, or property damage.¹⁷⁶

Minnesota Responds Medical Reserve Corps (MRC)

Under Minnesota law, the Commissioner of Health may accept grants from HHS to implement and operate the emergency system for the advanced registration of volunteer health professionals, otherwise known as ESAR-VHP, in Minnesota.¹⁷⁷ The ESAR-VHP Program in Minnesota is known as the Minnesota Responds Medical Reserve Corps. The purpose of the MRC is to pre-identify, train, and organize volunteer medical and public health professionals to render services in conjunction with local emergency response programs. The Commissioner of Health may dispatch Minnesota Responds MRC volunteers from outside the jurisdiction of a community health board if the prevention, mitigation, response to, or recovery from, an actual or threatened public health event or emergency exceeds the capacity of the community health

¹⁷⁰ Minn. Stat. §151.37, Subd. 2(b).

¹⁷¹ Minn. Stat. §151.37, Subd. 10.

¹⁷² Minn. Stat. §144.4197.

¹⁷³ Ibid.

¹⁷⁴ Minn. Stat. §144.4198, Subd. 2(a).

¹⁷⁵ Ibid.

¹⁷⁶ Minn. Stat. §144.4198, Subd. 3.

¹⁷⁷ Minn. Stat. §145A.06, Subd. 6(b). ESAR-VHP was established by U.S.C. Title 42, §247d-7b.

board.¹⁷⁸ The commissioner may also request Minnesota Responds MRC volunteers to respond to a request from another state through EMAC or a Canadian Province, a tribal government, or the federal government if the commissioner determines such a deployment is in the public interest.¹⁷⁹ A Minnesota Responds MRC volunteer responding to a request for assistance or training at the call of the commissioner must be deemed a State employee for purposes of workers' compensation, as well as tort claim defense and indemnification under the State Tort Claims Act.¹⁸⁰

Isolation and quarantine

MDH is also vested with the legal authority to isolate and quarantine persons with a communicable disease if isolation or quarantine is both effective and the least restrictive alternative to protect the public health.¹⁸¹

Practice of medicine

While MDH does have regulatory authority over hospitals and certain health care facilities, MDH does not regulate the practice of medicine in Minnesota. Therefore, with the exception of the limited circumstances noted, the Commissioner of Health does not have the authority to alter medical practice standards, whether in a mass surge event or otherwise.

Federal laws

Stafford Act

Perhaps the primary federal law pertaining to emergency response is the Robert T. Stafford Disaster Relief and Emergency Assistance Act.¹⁸² First enacted in 1988, the Stafford Act is the primary federal law providing authority to the federal government to support state and local disaster response and recovery efforts. Federal assistance, which may include personnel, equipment, technical support, coordination of disaster relief efforts, and financial disaster relief is triggered by a presidential declaration of an emergency or a major disaster.¹⁸³ The Stafford Act allows the president to provide any kind of federal assistance to protect and save lives, property, and public health and safety. Under the Homeland Security Act of 2002, as

¹⁷⁸ Minn. Stat. §145A.04, Subd. 6c.

¹⁷⁹ Minn. Stat. §145A.06, Subd. 7.

¹⁸⁰ Minn. Stat. §145A.06, subd. 7(f)(1).

¹⁸¹ Minn. Stat. §§144419-.4196.

¹⁸² 42 U.S.C. §§5121-5206.

¹⁸³ Prerequisites to a presidential declaration include a state governor requesting the declaration, certifying federal assistance is necessary because state and local resources are insufficient, and activating the state's emergency operations plan. Otherwise, the president may issue a declaration if accelerated federal assistance is required or the event primarily impacts areas of federal responsibility such as Tribal lands or military installations.

amended,¹⁸⁴ The Federal Emergency Management Agency (FEMA) is generally responsible for providing the federal response to major disasters including implementing relief available under the Stafford Act.

Public Health Services Act (PHSA)

Under the PHSA, as amended by the Pandemic and All-Hazards Preparedness Act, the Secretary of HHS has broad discretion to declare a “public health emergency” if the Secretary determines that a disease or disorder presents a public health emergency; or that a public health emergency, including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists.¹⁸⁵ If the Secretary declares a Public Health Emergency, the PHSA grants the Secretary authority to take such actions that may be appropriate to respond to the public health emergency such as making grants, providing awards for expenses, entering contracts, and conducting and supporting investigations into the cause, treatment, or prevention of the disease or disorder causing the public health emergency.¹⁸⁶

A Public Health Emergency declaration is a necessary step for the Secretary to take a variety of discretionary actions in response to the public health emergency. For example, after a public health emergency is declared the Secretary may (1) issue a “1135 waiver”;¹⁸⁷ (2) waive certain sanctions under the Health Insurance Portability and Accountability Act (HIPAA) for 72 hours;¹⁸⁸ and (3) waive certain requirements under the Emergency Medical Treatment and Active Labor Act (EMTALA).¹⁸⁹ Declaring a public health emergency may also serve as the basis for the Food and Drug Administration to issue an Emergency Use Authorization allowing the special use of drugs and other medical products, either allowing the use of unapproved medical products or the unapproved use of medical products, during an emergency.¹⁹⁰

The PHSA, however, also grants HHS broad authority to assist states during an emergency even in the absence of a Public Health Emergency declaration. For example, HHS may, at the request of a state, extend temporary assistance including deploying approved medical countermeasures from the Strategic National Stockpile (SNS); deploying National Disaster Medical System teams; conduct research, surveillance, and investigations; and exercising federal isolation and quarantine authority.¹⁹¹

¹⁸⁴ P.L. 109-295; 6 U.S.C. §§311-321(j).

¹⁸⁵ Section 319 of the PHSA, 42 U.S.C. §247d. The Secretary is required to consult with various public health officials before making this determination.

¹⁸⁶ 42 U.S.C. §247(d)(a).

¹⁸⁷ 1135 waivers are discussed later in this Annex.

¹⁸⁸ The HIPAA sanctions and penalties the Secretary may waive include those pertaining to patient consent required for the disclosure of the patient’s s protected health information under certain circumstances.

¹⁸⁹ EMTALA is otherwise known as the “anti-patient-dumping law.” Following a Public Health Emergency declaration, HHS may waive EMTALA sanctions for re-directing a patient to another health care facility if the transfer is pursuant to a state emergency plan or if necessitate by the circumstances of the emergency.

¹⁹⁰ 21 U.S.C. §360bbb-03.

¹⁹¹ See *generally* §§301, 311, and 2812 of the PHSA (42 U.S.C. §§241, 243, and 300hh-11).

Public Readiness and Emergency Preparedness (PREP) Act

This federal law provides immunity for liability claims related to the administration and use of certain designated medical countermeasures.¹⁹² The PREP Act authorizes the Secretary of HHS to issue a declaration if the Secretary determines that a disease, condition, or public health threat constitutes a public health emergency, or poses a credible threat of a future public health emergency, and finds that the development and use of a medical countermeasure is desirable.¹⁹³ The Secretary would then issue a PREP Act declaration setting forth:

1. The medical countermeasures covered by the declaration;
2. The activities covered by the declaration, such as the manufacturing, testing, distribution, and administration of the covered countermeasures;
3. Categories of diseases, health conditions, or health threats for which administration of the covered countermeasures is recommended;
4. The effective time period of the declaration;
5. The populations of individuals and geographic areas to which the declaration applies;
6. Any limitations on the means of distributing the covered countermeasures; and
7. Persons identified as qualified to prescribe, dispense, or administer the covered countermeasures and thus subject to the PREP Act's liability protections; this could include manufacturers, distributors, program planners,¹⁹⁴ and those qualified persons who prescribe, administer, or dispense the covered countermeasures.

The PREP Act provides immunity for the persons and activities identified in the PREP Act Declaration against tort claims of loss caused, arising out of, relating to, or resulting from the administration or use of the covered countermeasures. The very broad PREP Act immunities apply to claims of death; physical, mental, or emotional injuries; illness; disability; medical monitoring; and loss or damage to property that have any type of causal relationship to the development, distribution, administration, or use of a covered countermeasure. The liabilities under the PREP Act also preclude any claims directly related to the administration or use of a covered countermeasure based on state law. Public health workers and volunteers could receive immunity for liability claims related to the administration and use of covered countermeasures covered under a PREP Act declarations if they are a covered person and their activities fall inside the scope of the declaration. PREP Act protections are limited to tort claims; and do not apply in cases of willful misconduct. The PREP Act also established a fund to provide

¹⁹² Public Readiness and Emergency Preparedness Act. Pub. Law No. 109-148.

¹⁹³ A separate public health emergency declaration by HHS, a presidential declaration under the Stafford Act, or an emergency declaration by a state governor are not required for the liability protections under the PREP Act to become effective.

¹⁹⁴ Program planners include individuals, government agencies, private sector employees, and community groups and entities who supervise or administer a program to administer, dispense, distribute, provide, or use a covered countermeasure. Protected activities include establishing requirements, providing policy guidance, supplying scientific or technical assistance, or providing a facility for distribution.

financial compensation for injuries directly caused by administration or use of a covered countermeasure.

1135 Waiver¹⁹⁵

When the president declares a disaster or emergency under the Stafford Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions. For example, under section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the patient needs¹⁹⁶. Within the parameters of the emergency declaration, providers may be exempted from sanctions (absent any determination of fraud or abuse) for care provided that would not normally meet program standards but are justified in the circumstances. Examples of these 1135 waivers or modifications include:

- Conditions of participation or other certification requirements (such as requirements for inpatient care);
- Program participation and similar requirements;
- Preapproval requirements;
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State;
- Emergency Medical Treatment and Labor Act (EMTALA) waivers for pre-planned referrals in pandemics or infectious disease events;
- Sanctions for certain physician self-referral violations as determined by Centers for Medicare and Medicaid Services (CMS) (“Stark Law”)¹⁹⁷;
- Performance deadlines and timetables may be adjusted (but not waived); and
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers.

The 1135 waiver authority applies only to federal program requirements and does not apply to State requirements for licensure or conditions of participation. A health care facility should consider requesting an 1135 waiver any time that facility feels they are providing the best care possible but cannot comply with specific CMS requirements. Waivers can be requested by a facility, health system, or MDH for a specific facility or a geographic area. The request is made

¹⁹⁵ <https://www.cms.gov/About-CMS/Agency-Information/H1N1/downloads/requestingawaiver101.pdf>

¹⁹⁶ 42 U.S.C. §1320b-5. The requirements that may be waived include conditions of participation, pre-approval requirements for health care services, or the requirement that health care providers be licensed in the state in which they provide services.

¹⁹⁷ Centers for Medicare and Medicaid Services. (2015, January 5) Retrieved from [Physician Self Referral](#).

to the regional CMS office who will review the situation and determine whether to grant a waiver and the effective time.

In addition to the 1135 waiver authority, Section 1812(f) of the Social Security Act authorizes the HHS Secretary to provide for skilled nursing facility coverage in the absence of a qualifying hospital stay, as long as this action does not increase overall program payments and does not alter the benefit's "acute care nature" (that is, its orientation toward relatively short-term and intensive care).

Providers must resume compliance with normal rules and regulations as soon as they are able to do so, and in any event the waivers or modifications a provider was operating under are no longer available after the termination of the emergency period.

Federally certified/approved providers must operate under normal rules and regulations, unless they have sought and have been granted modifications under the waiver authority from specific requirements.

Further information on the 1135 Waiver process can be found at [TRACIE: Healthcare Emergency Preparedness Information Gateway, Healthcare-Related Disaster Legal/Regulatory/Federal Policy](#), topic collections (3/14/2016).

Conclusion

This Attachment provided examples of some Minnesota and federal laws potentially applicable to issues such as liability protection, resource allocation, and staff augmentation that could be anticipated to arise during a MCI. Again, it is beyond the scope of this Attachment and this Framework to conduct an exhaustive review of all state or federal laws that may be applicable in an emergency or disaster. The purpose of this Attachment is to provide a brief overview of some potentially applicable laws to give emergency management officials basic background information to assist when dealing with their own attorneys in emergency planning and response.

Attachment 3—Surge Operations and Crisis Care for Emergency Medical Services

PLANNING AND IMPLEMENTATION GUIDANCE

Preface

The Medical Surge Operations and Crisis Care for Emergency Medical Services (EMS) Attachment represents a thoughtful, proactive consideration and structured approach to shortfalls in the provision of front line response and care by ambulance services, first responders and public safety answering points (PSAP) who are often the lead agencies for disaster response. This Attachment is a decision support tool and assumes incident management and incident command practices are implemented and key personnel are familiar with the ethical frameworks and processes, which underlie scarce resource decisions.

In a Crisis Standards of Care situation each ambulance service licensee and medical director for each licensee will have to determine the most appropriate steps and actions for their agency/agencies based on their environment, hazards, and resources in concert with MDH and this Framework. Since pre-planned actions are always preferred to ad hoc decisions, pre-event familiarization with the contents of this Attachment and development of regional and local crisis standards of care plans is recommended to aid with event preparedness, response and in anticipation of specific resource shortfalls. This Attachment addresses common categories of pre-hospital EMS response, triage, treatment and transport. Regional health care coalitions, Minnesota Emergency Medical Services Regulatory Board (EMSRB) designated Regional EMS Systems, PSAP/Dispatch and EMS dispatch centers, first responders, ambulance service personnel and their medical directors may determine additional issues and strategies for their specific situation in addition to those outlined in this Attachment and in the overall context of the State of Minnesota Crisis Standards of Care Framework.

The Minnesota Department of Health (MDH) and the Minnesota EMS Regulatory Board (EMSRB) convened a statewide EMS Crisis Standards of Care Workgroup in the spring of 2016 to provide input on crisis care issues and solutions for EMS, which drove the development of this consensus document. This Attachment would not have been possible without the diverse and practical input provided by the Workgroup; their efforts will benefit the citizens of the State. This workgroup and resulting guidance is part of a larger process by MDH to document Crisis Standards of Care policy recommendations as well as engage the public in discussions about the ethics and principles of crisis care.

This Attachment constitutes the consensus recommendations of the Workgroup but does not represent policy of MDH or the MN EMSRB. Ambulance service providers and their medical directors, PSAP/dispatch center leadership or first responders implementing these strategies in crisis situations should assure communication of this to their public safety, health care providers and local and tribal public health partners and emergency management to assure the invocation of appropriate legal and regulatory protections as appropriate in accord with State and federal laws. This Attachment may be superseded by incident specific recommendations by MDH or MN EMSRB. Web links and resources listed are provided as examples, and may not be the best sources of information available. Their listing does not imply endorsement by MDH or MN EMSRB. This Attachment does not replace the judgement of the EMS operational management, medical directors, their legal advisors or clinical staff and consideration of other relevant variables and options during an event.

“In a crisis standards of care event the focus changes from individual to population needs. The evolution from conventional » contingency » crisis modes isn’t simply an operational shift, this is a legal shift as well involving changes in the applicable standards used to determine whether the duty of care was met for those who required assistance to the best degree possible given the circumstances.”¹⁹⁸

Introduction

The Minnesota EMS system has a long-standing history of providing exemplary service to the people of Minnesota, both visitors and residents alike. It serves as a vital link to the health care system statewide, especially in rural areas of the state where access to medical care is less readily available.

Comprised of both private and public (paid, partial paid and volunteer) ambulance services, Minnesota’s EMS system runs the gamut from a volunteer ambulance service that may respond to 20 calls a year to busy urban services responding to 200 calls a day. Volunteer ambulance service agencies are generally located in the more rural areas, and paid ambulance service agencies are generally found in the higher population centers (e.g., Duluth, Rochester, St. Cloud, Marshall, Mankato, Moorhead, East Grand Forks) of greater Minnesota, as well as in the twin cities metropolitan area of Minneapolis – St. Paul. The total population of Minnesota in 2014, based on Minnesota State Demographic Center estimates is 5,453,218.

Minnesota ambulance service providers are faced with a variety of actual and potential large-scale incidents that could quickly exhaust the resources of local ambulance service agencies. There is a significant risk for natural, man-made and terrorism-related disasters throughout the state. Influenza pandemics can have an impact on ambulance services statewide. Minnesota borders Canada in some of the most rural portions of the state creating cross-border issues, in addition to multiple international ports of entry on Lake Superior that serve oceangoing vessels. Highways and railways crisscrossing the state present substantial risk of hazardous materials and other transportation-related incidents. Minnesota also has two (2) nuclear power plants, both located outside of the twin cities metropolitan area that could potentially impact ambulance resources in the event of a radiological release at one of these plants.

Unfortunately, the risk of terrorist attacks on targets small and large in Minnesota is substantial and must be planned for by all ambulance service agencies.

To respond to disasters, local ambulance services would, in most cases, rely on mutual aid response from neighboring agencies to fill the resource and equipment gaps necessary to meet the pre-hospital care and transportation needs of patients. Development of well trained, equipped and ready to respond EMS systems has enhanced capabilities and reduced gaps in

¹⁹⁸ IOM/NAM, *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*©

ambulance response and resource availability for all types of disasters that may occur in Minnesota.

However, the threats mentioned above may easily generate an incident where over an extended period of time demand is so great that responding agencies are not able to provide usual services and reach a point where they need to do the “greatest good for the greatest number” by implementing crisis care protocols. It is often standard for EMS systems to operate near or at this threshold for short to moderate periods of time, but a more robust structured planning is required for situations where demand exceeds resources for a period of time that could result in poor outcomes for patients unless crisis strategies are implemented.

This Attachment provides an overview of crisis care operational considerations for ambulance service providers, and PSAP/dispatchers. In-depth discussion of the framework, ethics, and practical applications of crisis standards of care may be found in the 2012 National Academies of Sciences, Engineering and Medicine, Institute of Medicine (IOM) (now known as the National Academies of Medicine, Health and Medicine Division [HMD]—referred to as IOM/NAM throughout this Attachment) report including a specific section on EMS care, [Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response](#). An additional document that may be of assistance to EMS are the [Patient Care Strategies for Scarce Resource Situations](#) (staff, medications, etc.) developed by the MDH Science Advisory Team/Crisis Standards of Care (SAT/CSC).

Rural ambulance services may face greater and more frequent challenges than urban systems due to difficulties in maintaining adequate staffing, limited vehicle availability, prolonged resupply times and long response times that can be exacerbated in a disaster. In urban areas, increases in demand during major incidents, pandemics, or epidemics can also rapidly stress and exhaust available resources. The goal of this Attachment is to provide background on these issues and practical strategies across the continuum of EMS response that can be implemented at the regional and local level. This Attachment is aimed at the EMS agencies themselves and though it does detail the supporting role of State agencies it is the responsibility of the ambulance service agency to apply this guidance with the help of their management team and medical director to ensure operational plans are in place. The Attachment also provides considerations for PSAPs and ambulance dispatch centers as well as first responders.

Crisis care

Most ambulance service agencies are familiar with the concept of surge capacity—the ability to increase services to match demand. Surge capability is slightly different—it requires specialized equipment or training to meet the patient’s needs. A few examples are patients who are contaminated with hazardous materials or those with a highly infectious disease. This guidance is focused on capacity, but services should remember specialized patients (pediatric, highly infectious disease, special needs, etc.) can push services into crisis care as well, even with a single patient (e.g., suspect Ebola case when the crew has inadequate protective equipment).

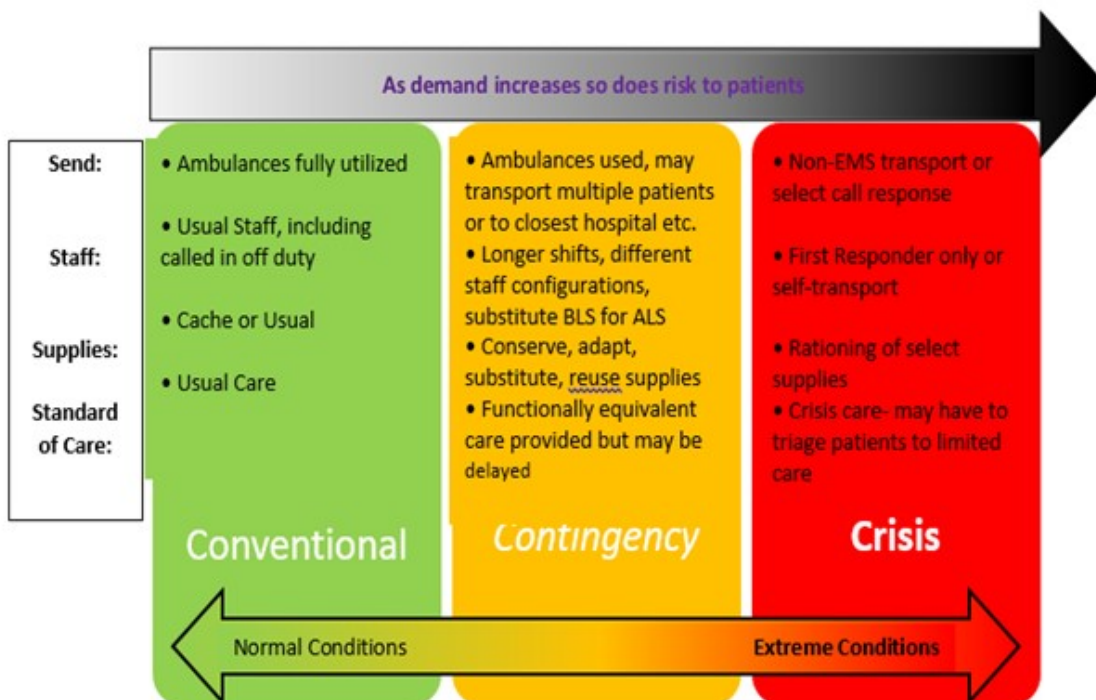
Adequate supplies, training, and regional policies are just as important for capability as well as overall capacity.

Surge capacity strategies are not all equal. Some can be accomplished with minimal risk (mutual aid) and some carry significant risk (not responding to some 911 calls due to overwhelming demand). Maximizing the potential benefits of surge capacity strategies to mitigate the crisis while minimizing the risks associated with deviations from routine operations is the goal. Strategies need to be identified and selected that are most appropriate to the situation and offer the least risk to the patient and EMS personnel, proceeding to riskier strategies as demand increases and options decrease.

Surge capacity is therefore divided into three categories across a spectrum (Figure 3.1):

- **Conventional** – usual strategies and resources (e.g., dispatch of additional ambulances, mutual aid, extending staff shifts for a few hours)
- **Contingency** – uncommon strategies and resources that incur a small risk to patients such as staffing ambulances with less personnel or a lower level of response delayed or single agency response (police, fire, rescue)
- **Crisis** – disaster strategies used when demand forces choices that pose a significant risk to patients but is the best that can be offered under the circumstances (e.g., recommending self-transport, medical personnel accompanying patient in a private vehicle)

Figure 3.1: Examples of EMS Conventional, Contingency, and Crisis Care (modified from IOM/NAM 201)



This Attachment will refer to crisis care as a component of the surge capacity plan that must be invoked when demand forces the agency to make decisions that may place the patient at a higher risk of a poor outcome, but are the best that can be offered given the circumstances. Most of these situations are quickly resolved with arrival of additional resources. The balance of risk and time is the essential consideration; all segments of the health care delivery system need to exercise their best judgment for providing care in these circumstances.

The term “Crisis Standards of Care” (CSC) refers to a longer-term and more pervasive situation where adequate resources to meet the needs are not available and therefore a systematic approach is required. In these situations, State agencies provide necessary legal and regulatory support and clinical guidance to support the crisis care actions being taken. This may include but is not limited to dispatch and triage decisions, alternate care sites, alternate care systems, and treatment recommendations or suspension of regulations (Attachment 2). A key example of an incident requiring formal CSC would be a pandemic.

Key points about crisis care:

- Crisis care is not a separate plan on a shelf for responders—the strategies are extensions of all-hazards response plans.
- Ambulance service agencies will not have an option to await State or other agency action before implementing crisis care decisions in a no-notice event, demand will drive options and choices.
- If strategies are not thought out ahead of time, they likely will not be considered and/or cannot be implemented.
- Strategies should be proportional to the resources available—that is, as more resources arrive, you should revert to lower risk strategies (and therefore, back to contingency and eventually conventional status).

Crisis care planning must be integrated into all-hazards plans at all levels of health care planning. Local, tribal and State governments (including agencies such as the EMSRB and MDH) support those actions through declarations and legal and regulatory mechanisms (Attachment 2), which may include care guidelines or declarations of CSC.

Roles and responsibilities

Activation of a State response is detailed in the AHRRP. A brief outline of key roles and responsibilities as related to the initiation of the CSC Framework is in the [Roles and Responsibilities Table 2](#). The primary focus of this guidance is on the operational strategies for EMS responders during crisis care, EMS should be supported by regional health care coalitions (partnerships between local and tribal public health, EMS, hospitals and emergency management) that provide planning and response coordination in each of eight regions of the state and with State of Minnesota and local government agencies.

Table 3.1 Roles and Responsibilities

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
Public Safety Answering Point/9-1-1 Dispatch Center	Support agency	<ul style="list-style-type: none"> ▪ Answers 911 calls ▪ Provides emergency medical dispatch support (if equipped, may transfer to secondary center/ PSAP or not have this capability) ▪ Determines appropriate response based on situation/algorithms/Standard Operating Procedures ▪ Provides communication point for incident responders <p>May assign radio talk groups during an incident</p>
Medical Response Unit/First Responders	First response	<ul style="list-style-type: none"> ▪ "Medical Response Unit" is an organized service recognized by a local political subdivision whose primary responsibility is to respond to medical emergencies to provide initial medical care before the arrival of a licensed ambulance service ▪ "Emergency Medical Responder Group" is a group of certified or registered personnel who respond to medical emergencies and have a medical director ▪ Personnel with "Emergency Response Units" and First Responder Groups are typically educated at the Emergency Medical Responder or EMT levels, but may include Paramedics, Nurses, Doctors, other health care professionals or the general public that may be trained in emergency care at some level ▪ Frequently the first personnel on scene to assess and report on the situation, provide initial triage and care and help determine what additional resources may be needed ▪ Support and assist arriving ambulance personnel on scene as needed
Local EMS Agency	Emergency response and patient transport	<ul style="list-style-type: none"> ▪ Coordinate patient destination hospitals to the degree possible to avoid overloading a single facility ▪ Develop policies for crisis care situations

CRISIS STANDARDS OF CARE FRAMEWORK
EMS GUIDANCE

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
		<ul style="list-style-type: none"> ▪ Interface with local hospitals and regional health care coalition to share information/status ▪ Adjust response and transport guidelines to reflect the situation at the hospital (e.g., if all hospitals overwhelmed may recommend self-transport to clinic for non-emergent problems)
Health Care Facilities	Acute patient care	<ul style="list-style-type: none"> ▪ Implement surge plans including crisis care plans, implement facility or regional triage/treatment plans as required, coordinate information and resource management with other facilities in the region via their Regional Health Care Coalition (HCC)
Indian Health Service Clinics and Hospitals	Acute patient care	<ul style="list-style-type: none"> ▪ Provide clinical support to tribal members ▪ Provide situational awareness to tribal emergency managers and regional health care coalition ▪ Lead for tribal community based interventions (vaccinations, isolation, prophylaxis)
Minnesota Hospital Association (MHA)	Health care facility communication & regulations	<ul style="list-style-type: none"> ▪ Assist in communications and information sharing with hospitals and health care facilities across the state
Local EMS Agency	Emergency response and patient transport	<ul style="list-style-type: none"> ▪ Coordinate patient destination hospitals to the degree possible to avoid overloading a single facility ▪ Develop policies for crisis care situations ▪ Interface with local hospitals and regional health care coalition to share information/status ▪ Adjust response and transport guidelines to reflect the situation at the hospital (e.g., if all hospitals overwhelmed may recommend self-transport to clinic for non-emergent problems)

Surge capacity

EMS must plan for surge capacity across multiple functions (dispatch, response, treatment, transport). The resources available must be utilized to their maximal capacity and additional resources obtained from known sources via pre-existing mechanisms (e.g., mutual aid agreement, request to local emergency manager, through the State Duty Officer, etc.). These include 'Send' (dispatch and response assets), 'Staff' (personnel), and 'Supplies' (resources and materials including medications) and may include alternative transport and patient disposition destinations as resources. This step involves assessing current or potential available and alternative assets, and is *not* about policy development which is the focus of the planning and Implementation sections that follow.

Dispatch

Ambulance service agencies are dispatched by PSAPs. PSAPs may be primary (single point of answer/dispatch) or secondary (receives PSAP routed calls for post-dispatch, ambulance service dispatch, or pre-arrival instructions and is able to receive 911 calls routed to it from a PSAP when the PSAP is unable to receive or answer 911 calls). Sometimes, ambulance request calls are transferred to an Emergency Medical Dispatcher (EMD). EMDs are trained to perform caller questioning to collect critical information and provide pre-arrival instructions to responders, assign different priorities to calls based on the acuity, dispatch appropriate ambulance/fire/law enforcement resources and then give pre-arrival instructions to the caller to provide basic medical care while awaiting ambulance arrival. PSAPs in rural areas often do not have these resources or training. Ambulance service agencies should examine their dispatch process and determine:

- Are there options for adding supplemental staff and dispatchers to support additional communications call volumes?
- Is there a technical capability to automatically rollover calls to other dispatch centers or PSAPs if call volumes exceed pre-determined call wait times?
- Is there a phone system 'auto-answer' capability which can be activated to divert calls related to a particular event to a hotline or recording rather than a dispatcher (water contamination, pandemic influenza, etc.)?
- Is there a capability to develop arrangements, policy and procedures to transfer calls to a clinical provider that could help prioritize the need for an ambulance in areas where EMD's are not normally available (this could be hospital based personnel, call transfer to another dispatch center with EMD capability, use of a medical director, etc.)?
- Could a call taker/dispatcher ambulance response algorithm, policy and protocol be utilized to assist non-medically trained dispatchers in determining the need for an ambulance (see Figure 3.2—Disaster dispatch algorithm to prioritize pending ambulance request calls under Planning and Implementation – Rural and Urban – Strategies and Tactics).

Ambulances/transport

Ambulance service agencies generally do not have significant additional ambulance capacity available, and should account for the following in their plans:

- Maximal use of existing ambulances
- Mutual aid from surrounding agencies (including knowledge of capacity, special capabilities, and response times) or from a parent health system. This should include area agencies providing non-emergency transportation where applicable.
- A request to the State Duty Officer (SDO) for deployment and use of Ambulance Strike Teams (AST). The request will be processed through the EMSRB on-call staff (Addendum 3.1). An AST consists of five ambulances, either Basic Life Support (BLS) or Advanced Life Support (ALS) or a Task Force which is a combination of ALS/BLS, plus one Strike Team Leader. These teams can provide support within hours that can help the community augment 911 responses and/or provide inter-hospital transfers for victims from an overloaded community hospital to referral centers or potentially assist in other clinical missions such as alternate care sites.
- Request and use of mass casualty incident buses – two buses in the metro (Minneapolis Fire and Metropolitan Emergency Services Board), and one in Fargo (F-M Ambulance). These resources can move many patients at a time to assist evacuating a hospital or long-term care facility. Plans should include guidance for when it is appropriate and how to request these assets.
- Mutual aid including ambulances from neighboring states may be obtained via request to the State EOC via the Emergency Management Assistance Compact (EMAC). Significant aid would be limited to state-declared disasters.
- Federal ambulance contracts can provide hundreds of ambulances but requires a federal declaration of disaster, in addition to a request, and time to get the ambulances to the disaster location. Therefore, at minimum 24-48 hours would be required to see significant contributions from these contractors.
- Scheduled BLS provider engagement – if the service area has scheduled BLS providers those resources may contribute substantially during a disaster. Their capabilities and contact information should be available and the point at which they become involved should be predefined.
- Wheelchair (WC) vans – local WC or stretcher service providers may be a helpful asset particularly with long-term care evacuations, though they may contribute to other responses as well.
- Buses - school buses or public transit buses that are climate controlled and capable of assisting with mass movements or batched transports.
- Private transport – use of private vehicles, with or without medical personnel may need to be used to augment ambulance services. In general, it is better to get a patient to the

hospital faster rather than wait long periods of time for an ambulance. Prioritizing ambulatory and other selected patients to private transport can significantly reduce burden on ambulance service agencies. The threshold for recommending private transport should be specified at the dispatch level (see Planning and Implementation section).

- Military – in particular, National Guard ambulances and potentially airlift capacity could contribute to patient movement if activated by the State during a declared disaster. Military airlift assets could also be used to move patients via the National Disaster Medical System if required during a federally declared disaster.

Ambulance service agency plans should include guidance for when and how to request these additional assets including the threshold to engage community emergency management and HCC partners.

Staff

Flexibility of staffing often correlates with run volumes (small volume volunteer services often have less flexibility than large urban services) though exceptions occur. During a pandemic or epidemic, ambulance service agency staff could be severely and disproportionately affected, dramatically reducing staffing options. Agencies should examine the following possibilities when planning for surge situations:

- Maximal utilization of current staff – consider extending shifts and changing schedules
- Mutual aid from nearby services – though current mutual aid focuses on ambulances, in some cases it may also be possible to share staff across services to maximize the use of the vehicles available. Also, services that are part of a health system may obtain staff from other areas if the event affects a single area/jurisdiction.
- Change in crew configuration – for example, 1 Paramedic/Emergency Medical Technician (EMT) rather than 2 Paramedics or 1 Emergency Medical Responder (EMR)/1 EMT rather than 2 EMT's (note that some areas of the state are already doing this)
- Use of direct response by staff in personal vehicles – this could involve community paramedics, or simply a first responder that can respond to provide assessment and basic care if an ambulance is not available
- Medical Reserve Corps (MRC) – depending on the community, MRC members may have qualifications that would enable them to contribute to EMS operations if this was a priority for their use. MRC can be activated by the local or tribal public health or State (MDH) on request during a disaster
- MN Mobile Medical Team (MMT) – the MMT has a broad array of providers and could be used to supplement EMS and emergency service personnel or used to staff an alternate care site to relieve the burden on EMS personnel. MMT may be requested by a local jurisdiction through the SDO or SEOC.

- Disaster Medical Assistance Team (DMAT) – DMAT teams are federal versions of the MMT and may provide emergency and alternate care site medical services. DMAT teams are available during federally declared disasters and are operational within 48 – 72 hours. DMAT teams do not staff ambulances directly but can provide support in many areas where EMS personnel might otherwise be requested to assist. A DMAT is requested through the SEOC or HSEM. More information about DMAT teams can be found at U.S. Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response, Public Health Emergency, Disaster Medical Assistant Team.

Supplies

Current supply chain models rely on “just-in-time” inventory processes with minimal stock or “par” levels. Few ambulance services are able to maintain significant contingency stocks of disposable supplies. Services should identify key supplies required in a disaster and attempt to assure adequate supplies are available by increasing par levels and rotating those items through existing stock. These key supplies may include:

- Hemorrhage control – particularly tourniquets and dressings
- Backboards (helpful for transferring multiple patients, and for short carries over uneven terrain)
- Medications – particularly pain medication and IV fluids
- Triage tags/tagging system
- General personal protective equipment
- Specialty supplies for pediatrics, burn (in particular, airway, pain management, IV access and fluids and burn sheets/dressings) and potentially chemical (auto-injectors) and general personal protective equipment

The vast majority of disaster medical care focuses on basic life support skills, with the predominant ALS contribution of narcotic pain medications (and occasionally airway management and chest decompression). Many ambulance services cache disaster supplies in trailers. Caches can be problematic for two reasons: 1) Supplies may become outdated or compromised without a system of checks, and 2) Staff have to retrieve the cache from its storage location, which takes time and resources.

Ambulance service agencies should understand their supply chain – where things come from, what is available within the region - recognizing that the supply chain could be compromised during and immediately following an incident when attempting to replenish stocks. Drug shortages recently have become routine and serve as a good reminder of how fragile the supply chain is even without the pressures of a disaster. Adaptations and substitutions may need to occur when usual supplies are not available. These ‘routine’ shortages are useful opportunities to engage medical directors, managers or leadership in creating new SOPs that contribute to familiarity with the process and options during a crisis and are consistent with crisis care frameworks—see [IOM/NAM 2012 for additional information](#).

Federal stockpiles contain significant quantities of medications, specialized incident supplies, and prophylactic antibiotics (e.g. the Strategic National Stockpile). These can be accessed during a federally declared disaster through the State Duty Officer (SDO) if sufficient supplies are unavailable locally. Regional health care coalition and state options should be exhausted, or clearly inadequate, prior to requesting SNS assets. SNS assets should be available within 12 hours of a request.

Destinations

Destinations are included under “resources” as it is critical that ambulance services have the ability to safely off-load patients, freeing ambulances for additional calls. In general, hospitals are the default destination. During disasters, the closest hospitals to the scene usually receive a significant number of walk-in casualties, therefore a conscious decision should be made early in response to distribute casualties across several hospitals rather than overly burden a single hospital when possible. Ambulance service personnel should understand the trauma and other capabilities of the hospitals in the area and be able to obtain capacity information for local hospitals rapidly via radio, phone, or Minnesota system for Tracking Resources, Alerts and Communications (MNTrac). This information should be utilized to distribute patients/casualties among receiving hospitals when more than one destination is available.

In prolonged events—such as a pandemic—or an event where the local hospital is damaged and not operational, alternate destinations for care may have to be used. Clinics, urgent care centers, or temporary care sites (e.g., a ‘field hospital’ or site where an MMT or DMAT is operational) or even an influenza screening center may be appropriate sites depending on the situation. However, these are generally event-dependent options for the ambulance service medical directors, managers or leadership to consider, develop event-specific policy, and communicate appropriate destinations to the crews. 1135 waivers to local ordinances and Centers for Medicare and Medicaid Services (CMS) may be needed to facilitate these changes or reimbursements, more information may be found at [Requesting an 1135 Waiver](#).

Planning and Implementation – General

Indicators and triggers

An “indicator” is a predictor of a possible event (e.g., a tornado warning, report of several cases of unusual respiratory illness) that requires gathering of additional information or analysis to decide if a “trigger point” has been reached to take action.

There are two types of triggers, scripted and non-scripted. Scripted triggers are built into SOPs and are automatic if/then decisions. Whenever possible, scripted triggers should be developed for front line personnel so they have actions they can take immediately to prevent delay. Non-scripted triggers require additional analysis and consideration involving management and

supervisory staff. These are often part of an incident action planning cycle. The less specific the information available, the more difficult it is to apply a scripted trigger and the more likely an experienced manager, supervisor or SME will be involved to process the information and decide on necessary actions. Responder and dispatch personnel should have a low threshold for passing indicator information along to supervisors for situational awareness and potential action.

Rather than focus on indicators and triggers in isolation, the ambulance service agency should determine what strategies or options it may employ in a disaster and then decide on indicators that might be available and a trigger point for staff to take tactical action. Though this may sound complex, it is all about establishing thresholds for action. A tornado warning, while an indicator, does not trigger disaster related actions. A report to a dispatcher of a tornado touchdown in a populated area *should* generate specific pre-planned actions by dispatch staff just as a report of a fire in a building or “gun shots fired” would.

Standard operating procedures (guidelines/policies) and algorithms for frontline personnel should specify *when* to take certain actions and *what* those actions should be. This is critical to the success of crisis response plans. Unfortunately, delays in decision-making can occur in unfamiliar situations and with unclear authority when the decisions could have been automatic if they were pre-planned. Worse, providers under stress may continue to delay procedures or try to invent solutions that are sub-optimal without clear guidance.

Triggers are important at every level of response from local to regional to state to federal and the thresholds may vary (e.g., the threshold for a local disaster declaration is different than for a Federal declaration). Detailed information on indicators and triggers (including templates for EMS) is available in the [2015 IOM/NAM report](#).

Agency policy

Ambulance service agencies should first look at their resources (staff, ambulances, equipment and supplies) and determine which policy and procedure options best apply to their service across the surge capacity spectrum from conventional to crisis care. This should be a joint effort involving management or leadership, medical directors, and responder/dispatcher staff and potentially members of the regional health care coalition and the designated regional EMS system. Indicator and trigger thresholds should be determined. These will vary by service, for example in a very rural area a response time of 30 minutes for an ambulance may be normal, and in an urban area could prompt implementation of call triage and recommendations for private transport for stable patients.

Once the indicators and triggers have been determined, ambulance service agency policy should be developed to give personnel clear expectations of what they will do and when they will do it, as well as the notifications that should occur to supervisors and surrounding agencies when these triggers are activated. Delegating authority to the responders and dispatchers

should be done when possible, as the adoption of clear policies helps facilitate decisions and provides accountability.

Education, training, and exercising should be conducted to ensure successful policy implementation. During an event that lasts longer than one day, the agency should review and modify their procedures as needed. Plans should be flexible and not “lock in” disaster response protocols for the duration of an incident, but rather allow transition back to conventional care as more resources arrive or demand falls, or both. For example, do not keep recommending private transport once ambulances are available.

Medical direction

Crisis strategies and tactics balance community versus individual needs. Risk to the individual patients must be balanced against the demand. Therefore, involvement of medical directors is critical to the success of the plans, strategies and tactics. Local ambulance service agency medical directors should know the area and resources and be engaged with neighboring agencies in these planning discussions. Optimally, the medical director should have a role during the crisis situation providing subject matter expertise, while acting as a liaison between the hospital and ambulance service. However, the engagement level of ambulance service medical directors varies widely across the state, and the ambulance service agency and medical director will need to agree on an appropriate level of participation. If needed, individual ambulance service medical directors may need to collaborate at a regional level to serve as an organized resource or provide guidance.

Medical directors must also approve of triage strategies used by their service, including baseline strategies such as Simple Triage And Rapid Treatment (START) or Sort, Assess, Lifesaving intervention, Treatment/Transport (SALT) as well as any incident-specific guidance that allows ambulance personnel to make decisions to leave patients at the scene or transport to alternate destinations. Since the medical director is ultimately responsible for the care provided, any change to usual SOPs will require physician input and approval.

Ambulance service medical direction in Minnesota occurs at the local level; however, the Medical Direction Standing Advisory Committee (MDSAC) of the EMSRB through the State EMS Medical Director may support individual local medical directors by providing resource documents including sample patient care guidelines. In situations with unique clinical circumstances such as pandemics the MDSAC is a resource that can offer guidance on clinical circumstances from physicians with EMS expertise.

Integration with regional operations

Minnesota has eight health care coalitions covering the geography of the state. Each regional Health Care Coalition (HCC) consists of members from hospitals, EMS, local and tribal public health, and local and tribal emergency management. There are also eight EMSRB designated

regional emergency medical services systems in the State which are in most regions identical to the coalition boundaries. The EMSRB designated regional EMS system is usually the EMS coordinating entity in collaboration with EMSRB staff (EMS Specialist) assigned to each designated regional EMS System. Each HCC also has at least one full-time equivalent Regional Health Care Preparedness Coordinator (RHPC) to coordinate information sharing, situational awareness and resource coordination among members for surge events affecting the health care system. The HCCs have mechanisms in place to communicate with MDH and the EMSRB.

It is critical that ambulance service agencies do *not* work on EMS CSC plans in isolation, but do so in concert with their regional framework and partners. Consistency of plans and knowing what others in the region (and adjacent regions) are planning is critical to success. Surge strategies and SOPs do not have to be identical, but if they are similar or complementary, it will help greatly in education, training, and mutual aid response. During a response, the HCC assures information sharing between partners and support for and between disciplines in the area. The local HCC can also engage with the neighboring HCC and the State (MDH and EMSRB) to coordinate information and policies. Members of HCCs also interface with their local jurisdictional response structure to assure that resource requests are processed and a common operating picture is maintained. HCCs may also convene members during planning or a response to help develop regional tactics (e.g., to discuss hotline/virtual support/common EMS practices in the area during a response).

The key to EMS crisis strategies is to only implement them when planned assistance from regional partners is inadequate (either too little or too late). This prevents inappropriate implementation of crisis care strategies when resources are available to address the demand. Coordination with regional partners *must* be achieved as soon as possible when a crisis situation develops so the services can return to conventional operations as soon as possible. The sooner a crisis situation is recognized (indicators) and pre-planned resources and coordinating mechanisms are activated (triggers), the shorter the crisis period will be.

Planning and implementation - Rural and Urban - Strategies and Tactics

This section offers strategies and tactics for rural and urban settings. However, the diversity of services in rural areas or their proximity to urban areas may require adaptation. For rural ambulance services this guidance is generally directed toward a volunteer service dispatched by a PSAP with no EMD capability. Rural ambulance services with EMD support may wish to refer to the “Urban” strategies highlighted in this section. Note that an EMS Surge Operations and Crisis Care Matrix summary of issues, strategic and tactical considerations is presented in Addendum 3.2.

Incident management

The critical role of the regional HCC is to maintain consistency and communications across the region—one area should not be in conventional status while others are in crisis. Therefore, information sharing about system demand and the ability to facilitate mutual aid to load balance are key activities the HCC must be prepared to provide or support. Disaster situations are dynamic and require frequent monitoring.

The use of an incident management system (IMS) during an event is extremely important. Use of the National Incident Management System (NIMS) is required by EMS, but incident action plans (IAP's) - (management by objectives) are seldom used due to the short duration of most events. In longer-term events, use of the "Planning P" and the IAP cycle greatly facilitates development of common goals and identifies, obtains, and documents use of resources. All agencies should be comfortable using incident action planning processes. Incident Management Teams (IMT) are an additional appropriate resource to augment local incident management personnel when the incident is expanding, extends across multiple regions or jurisdictions, involves massive number of victims, or continues through multiple operational periods. In order to request an IMT, contact the SDO or the State EOC. The request for an IMT will be processed through a State coordinating group who will determine the appropriate IMT level, either a Type II or a Type III team. The HCC or an EMS multi-agency coordinating function can also provide assistance. (For additional information on IAP see [FEMA Incident Action Planning Guide](#).)

All ambulance service agencies should know their lead regional EMS contacts (EMSRB and designated regional EMS system) and plans for the regional health care coalition multi-agency coordination function and capability during an event to help coordinate overall health care response efforts across the geographic area during a disaster. Due to the distances in many rural Coalition regions, health care coalition multi-agency coordination and engagement often is virtual, involving conference calls and electronic coordination platforms such as MNTrac rather than a specific physical location. The regional HCCs can assist local agencies with resource issues (in conjunction with local emergency management), policy development, and joint incident action plans.

Urban ambulance service agencies benefit from close mutual aid relationships and more resources compared to rural environments, but can easily enter crisis mode during a very large or prolonged event (e.g., pandemic with tripled call volumes). In urban settings, such as the twin cities metro area, if an incident affects a single jurisdiction the ambulance service agency responsible for the primary service area should be represented at the jurisdictional EOC. In a large event, the affected agency or agencies may request regional assistance.

The Metropolitan Emergency Services Board (the Metro Regional EMS System) provides a virtual or physical location of the EMS Multi-Agency Coordination Center (EMSMACC) acts as a base for the Metro AST assets and serves as the first-responder pharmaceutical cache distribution point. The EMSMACC assists the SDO or State EOC processes in a metro-wide

emergency by assisting with facilitating EMS resource requests, tracking assets and costs, assisting requesting agencies by providing operational period planning, situational awareness and updates, and providing local/regional/state EMS incident management assistance upon request. The EMSMACC partners with the Metro region health care coalition's Regional Health Care Resource Center (RHRC) to coordinate acute care as required. The EMSMACC may assist other HCCs, designated regional EMS systems, emergency management or other ambulance service providers upon request as presented in Addendum 3.1.

Dispatch/911/PSAPs

Part of the goal during a crisis is to decrease the call volume at the PSAP. This may be accomplished using a variety of methods:

- Work with emergency management, local and tribal public health, health care coalitions and local media to communicate to the public the stress on the system and to only call 911 for life-threatening emergencies.
- Keep the public up-to-date with incident information to reduce non-emergency 911 calls. Frequently updated information provision to the community through the Public Information Officer (PIO) or Joint Information System (JIS) can be very helpful at reducing call volumes.
- Activate an “auto-answer” that may be as simple as “Due to extreme demands on our 911 system please stay on the line only if you have a life-threatening emergency” or may involve options to route a caller to a hotline if they have questions about influenza symptoms, toxin exposure, or family reunification depending on the event. Auto-answer systems should be available to PSAPs if possible and optimally should be activated whenever the dispatcher cannot answer the phone right away. Some dispatch centers have roll-over capability to other PSAPs or secondary PSAPs when they cannot answer by a certain number of rings. In this case, a trigger for use of the auto-answer should be determined and the dispatcher empowered to activate the system.

During a crisis, once a request for ambulance response is received by the PSAP/Dispatch, the goal is to provide the most appropriate services available:

Rural ambulance service dispatch considerations

Given the long response and transport times in some rural areas, and the lack of medically trained dispatchers in many communities, determining the best services to match a request can be difficult. A possible dispatcher algorithm for consideration is presented in Fig. 3.2. Dispatchers should be trained and empowered to use an algorithm such as this whenever the situation occurs, with a trigger to notify supervisory personnel whenever mutual aid is not available in a timely manner (the number of minutes should be specified by local decision based on usually available resources). The algorithms which can be used by the dispatcher and what other actions must be taken at the time they are implemented (triggers) should be clearly spelled out in policy, education and drills to reinforce the agency policies and procedures.

Dispatch centers should have authority to use crisis dispatch algorithms and must immediately notify supervisory staff. Unless the situation is clearly limited to a few hours, the supervisor should notify the regional points of contact for the EMS multi-agency coordination center.

The use of private non-ambulance transport may seem unusual to EMS providers, but may represent the best practice when ambulance response and care would otherwise be substantially delayed. The community may have first responders that are not currently on the ambulance(s) and can respond to subsequent calls for assistance directly to the scene to help the patient determine the best option for transport. In these situations, maintaining the minimum staff on the ambulance may help conserve responders, allowing remaining staff to be available.

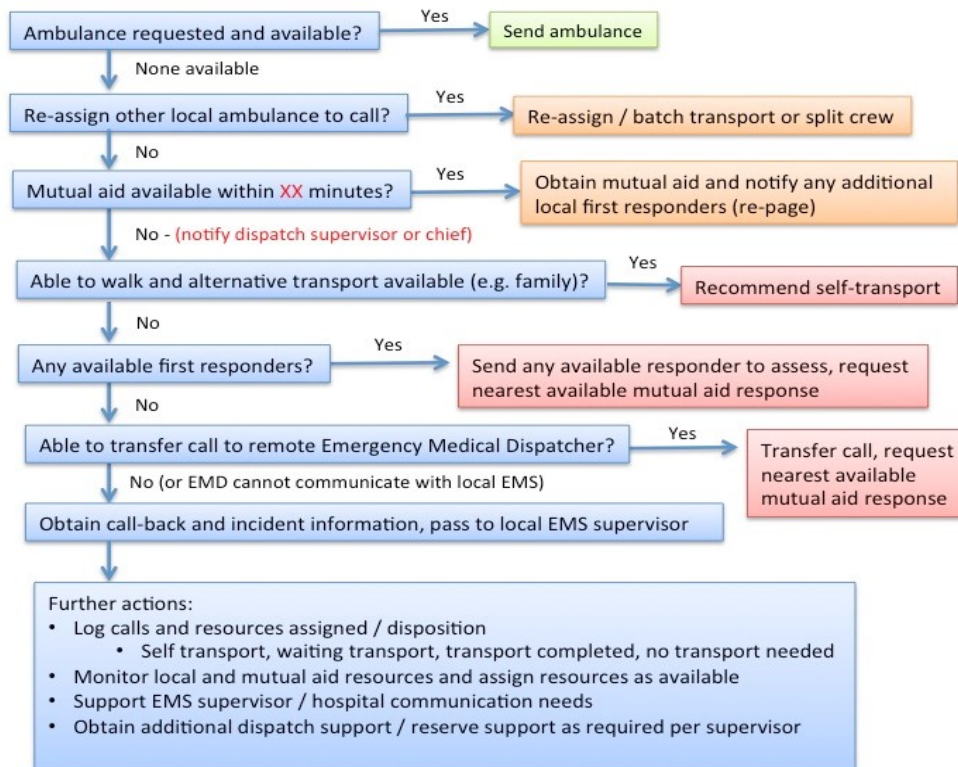
When possible, it may be very helpful to screen calls using a medical provider if available. This approach has been utilized following prior major disasters in some communities. Call screening could involve a partnership with an ambulance service agency medical director within the designated regional EMS system, the area hospital, or a dispatch center with EMD capability. During a pandemic even tripled call volumes in a rural area may not cause severe stress on available ambulance resources if they are spaced out in time. More likely is a no-notice mass casualty incident that overwhelms a rural community PSAP and ambulance resources for a short period of time. Crew members may have to assist in prioritizing the response to calls that are pending if no supervisor or medical director is available to provide input. PSAP/dispatch should always have contact information for an available ambulance service operations manager, supervisor or operations chief as well as the designated regional EMS system point of contact.

Figure 3.2: EMS dispatch-triage tree

CRISIS STANDARDS OF CARE FRAMEWORK
EMS GUIDANCE

EMS Dispatch - Triage Tree

v. April 28, 2016



Notes:

- Assumes non-EMD PSAP - for EMD PSAP triage calls based on priority dispatch levels and in conjunction with medical direction
- Supervisors for EMS and public safety should be notified when any 'red box' / 4th level is used
- Dispatcher should have authority, process, and contact numbers for activating this algorithm
- Dispatcher should have contact information for regional ground and rotor-wing resources
- Identify support mechanism for call triage decisions (EMS supervisor / lead medic, hospital personnel and document responsibilities / contact information prior to event)
- Identify role of EMS supervisor / medical director in this process
- First responders without an ambulance should coordinate appropriate care with receiving hospital / EMS supervisor
- Consider *not* sending EMS initially on calls for potential injury accidents until confirmed significant injuries.
- Consider other call type triage based on local system and dispatcher training

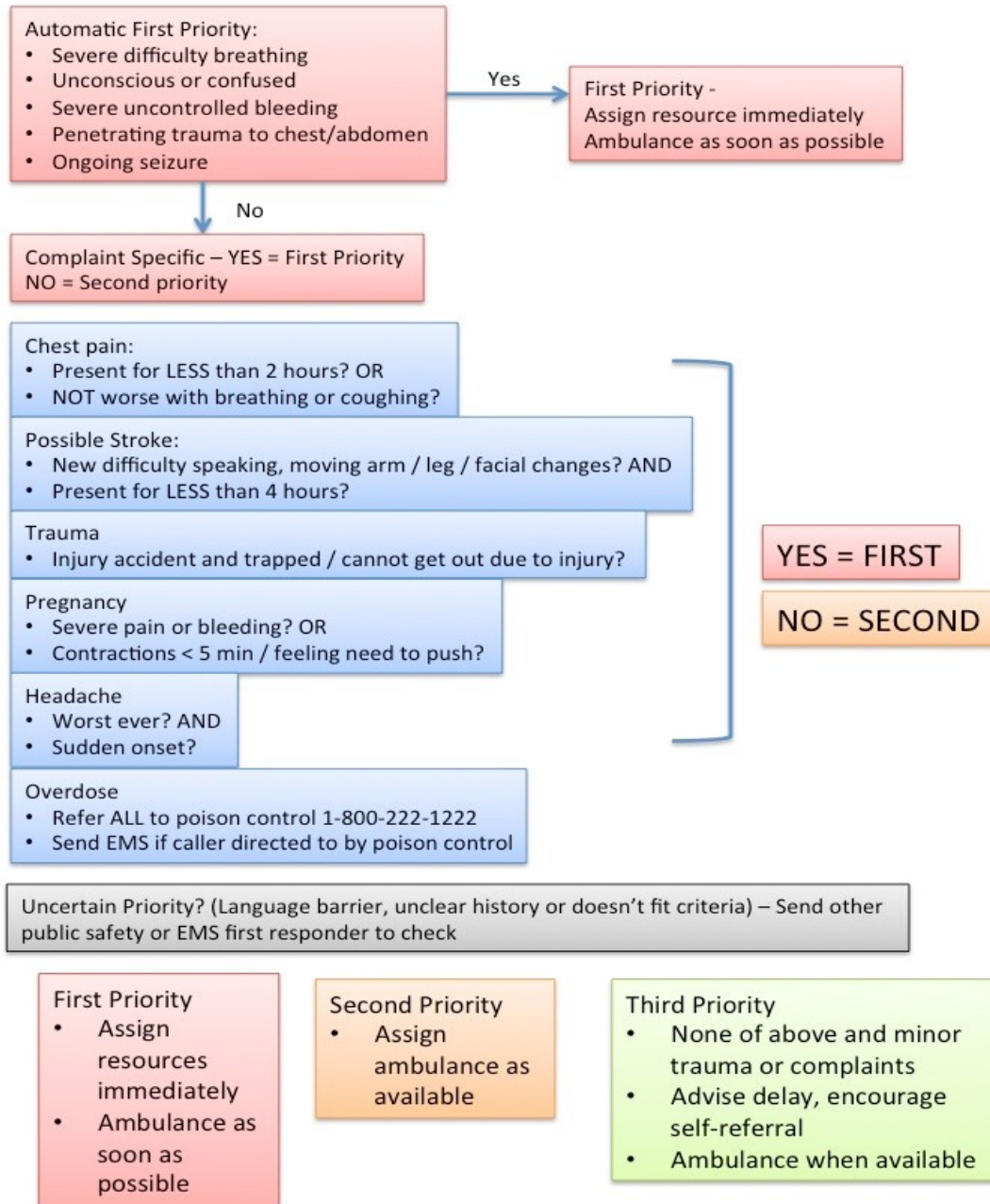
Additionally, if the PSAP does not use an emergency medical dispatch system the service may wish to authorize the use of an algorithm by non-medically trained personnel to prioritize ambulance dispatches during a disaster as shown below in Figure 3.3. Note that this algorithm does not cover all circumstances and should not substitute for good judgment of the dispatcher.

Figure 3.3: Disaster dispatch algorithm to prioritize pending EMS calls

CRISIS STANDARDS OF CARE FRAMEWORK
EMS GUIDANCE

EMS Crisis Care Dispatch Aid

Draft May 8, 2016



Urban ambulance service dispatch considerations

Medical priority dispatch is very helpful in prioritizing pending calls and is widely available to urban PSAPs or EMS agencies serving as secondary PSAPs. A log should be kept of calls that are pending or were referred to self-transport. The following adaptations should be considered during a crisis when calls are pending and no ALS or BLS ambulance is available:

- No ambulance response or only a first responder with automatic external defibrillator (AED) to cardiac arrest calls (recommend use of on-site AED if one is available)
- First responder (fire, rescue or police) only on the following until clear that ambulance transport is required:
 - Motor vehicle crashes
 - Assaults
 - Intoxication
 - Slumper or “one-down” calls (unknown medical victim in a vehicle or on the ground)
 - Fall (without other priority 1 complaints)
- Continue emergency medical priority dispatch (i.e., maintain response to priority 1 (echo, delta, bravo) calls for as long as possible, recommending private transport when available based on current wait times for ambulance (e.g., recommend to priority 3 (omega and alpha). See Table 3.2:

Table 3.2: Emergency Medical Priority Dispatch

Type	Capability	Response Time
Alpha	BLS—Minor emergency	Cold (no lights and siren) single unit
Bravo	BLS—Life threatening emergency	Hot (with lights and siren) multiple units
Charlie	ALS—Minor emergency	Cold single unit
Delta	ALS—Life threatening emergency	Hot multiple units
Echo	ALS & special units—Life threatening emergency	Hot multiple units
Omega	Referral or Alternate Care	None—no EMS response

Treatment

During no-notice or unpredicted disasters, care should focus on BLS measures with rapid transport to the hospital. Providers should understand what automatic changes to SOPs may be invoked during a disaster (for example, some ambulance services do not require calling in for online physician verbal orders during a disaster and allow the ambulance personnel to work

within the full scope of their SOP for a medical complaint). During no-notice or prolonged disasters, such as a pandemic, the medical director and ambulance service agency leadership may also approve broader discretion for patients being left at scene by the ambulance service crew (if the condition is not emergent and appropriate follow-up and/or transportation can be arranged). This should **only** be invoked when additional 911 calls are pending in the system and **only** for conditions and circumstances that the medical director approves via SOP or online medical control (see Addendum 5 as an example of pre-developed and approved SOPs prepared for medical director authorization for use – Hennepin County ALS Pandemic Protocols – Triage/Treatment).

During a prolonged event, printed information may be available for EMS to distribute to persons seeking care for pandemic or other conditions.

Transport

Ambulance crews may be authorized the discretion to leave patients at the scene as discussed in the Treatment section and with pre-established SOPs as authorized for a specific situation by the ambulance service medical director. Crews may “batch transport” or transport more than one victim from a single scene or may respond to calls sequentially when their first patient is stable and another call is pending in the same general area.

Mass casualty buses (two in the metro area) or less traditional transport (scheduled BLS, self-transport by family, public transport, wheelchair van) may all be utilized as appropriate. The ambulance service agency should know how and when to request and use these resources if they will help relieve stress on the emergency response system.

Inter-facility/Inter-hospital transfers can take essential local ambulance resources out of the service area for hours at a time particularly in rural areas. Careful consideration should be given for decisions regarding the use of ambulance resources for inter-facility transport during a crisis of care event. The use of ASTs (See Addendum 3.1), EMS units from the receiving facility/community, or more aggressive use of rotor-wing aircraft transfer may be of substantial benefit to preserve community response assets in rural areas and scheduled BLS and wheelchair transports may help to reduce the burden of these transports in more urban settings. In some situations, the hospital may need to board patients they wish to have transferred while EMS continues to respond to high volumes of 911 calls. The hospital should understand this dual priority ahead of time and ambulance service leadership, supervisory staff and medical directors may need to be involved in these discussions and negotiations.

Use of online medical control if available or contact with an ambulance service supervisor may be helpful to resolve specific medical or logistical questions; a mechanism for crews and dispatch to contact these individuals should be available at all times.

Transports to hospital in non-ambulance vehicle

In a crisis, ambulance resources may be severely limited and alternate transport options may need to be considered and utilized. One option would be transport of patients via a motor vehicle that is not an ambulance with or without EMS providers administering care in the vehicle during transport. If necessary, minivans with a flat cargo area offer lower loading height as well as a protected environment compared to pickup trucks. Pickups may offer an advantage in rescue situations for getting patients to roadways from remote areas that require a high-clearance four-wheel drive vehicle. Addendum 3.3 provides specific considerations and guidance to be when the option of non-ambulance transport is considered. Dispatch and the receiving hospital should always be notified when private transports are occurring and an abbreviated patient report given to the receiving hospital when feasible.

Destination

Ambulance units almost universally transport to hospitals since they are usually not reimbursed for non-hospital transports. A crisis care event may require changes to this standard practice.

Rural ambulance service destination considerations:

Rural ambulance services usually transport patients to a single hospital in rural response areas, with occasional exceptions.

During a disaster, the closest hospital can quickly become overwhelmed with patients self-presenting as well as ambulance transported patients. In these cases it may be appropriate to change protocols. These changes should be considered and developed ahead of an event. It will usually require a supervisor or manager to approve transport to non-hospital facilities, but a crew may have to decide on the most appropriate destination hospital and should be empowered to do so.

The disadvantage of spreading patient transports between other and more distant hospitals or facilities is distance equals time. The time the crew takes to transport the patient to a farther facility is time they could be spending responding to requests for ambulance service. Time can be reduced with lights-siren transport to the hospital though this increases provider and patient risk as well as risk to other drivers. However, when an incident is in an area where the transport time is not significantly longer or when the facility may be larger or offer a higher level of trauma or burn care it is appropriate to try to balance transports between hospital facilities rather than risk overloading one particular hospital. Patient tracking becomes important in this situation.

In some events where there are many patients that have mild symptoms (pandemic or a hazardous materials release—for example chlorine) the hospital may set up a screening site for those with mild symptoms so they can focus on the sickest individuals. Alternate patient dispositions could include a clinic, alternate care site or other community venue. It is

appropriate for ambulance service personnel to transport to those locations provided they are open, appropriately staffed, and the patient does not have any severe symptoms.

Ambulance services may be requested to provide on-site response and transport support for these facilities, as well as to shelters, and to support fire personnel at fire rescue or suppression scenes during a disaster. Unless there is an active need for transport, these support or stand-by roles must be declined if the service is in a crisis situation and having difficulty answering all their requests for service.

Urban ambulance service destination considerations:

Urban ambulance services should seek to avoid overloading a single hospital with victims from a no-notice event. In the metro area, the East and West Metro Medical Resource Control Centers (MRCC) maintain lists on MNTrac of the “first wave” patient assignments for hospitals based on their trauma level. MRCC can assist ambulances with hospital assignments based on the triage category of their patient and capacity reported by individual hospitals via the MNTrac system. In general, critical trauma should go to a Level 1 trauma center and burns to a designated Burn Center unless these centers are over capacity otherwise, the closest appropriate hospital should be chosen. Critical medical patients may need to be diverted away from Level 1 trauma centers to allow those facilities to focus their resources on trauma patients. Though patient preference is usually honored when choosing a destination hospital, during a crisis situation the closest appropriate hospital should be chosen to allow the ambulance crew to return to service as quickly as possible (similar to blizzard and other situations that require exceptions).

In cases such as a pandemic, it is possible that flu lines, caller screening, alternate care sites, or designated clinics or urgent care facilities may be appropriate options or destinations for ambulance units.

Legal and regulatory considerations

Crisis care actions that occur during major disasters or for a prolonged period should be undertaken with consideration for the impact of legal and regulatory standards. Responders, in evaluating which laws may apply to any crisis situation, need to seek legal advice from their attorneys. Legal advice from qualified attorneys is a critical an element of emergency planning and response activities, equally as important as the guidance and support from local, tribal and Federal governments, and State agencies such as MDH and EMSRB. In a prolonged event, systematic regional or statewide CSC activities such as structured triage of resources and specific emergency orders may be issued.

The ability of the Governor of Minnesota and the President of the United States to issue emergency declarations and promulgate enforceable orders and rules to address the contingencies created by a mass casualty event are provided by law. Some of the more important state and federal laws that may apply to the preparedness for, response to, and

recovery from an emergency or disaster are summarized in *Attachment 2—Legal Authority and Environment for Crisis Standards of Care*.

Tribal and territorial areas are independent legal entities and though they interface with surrounding jurisdictions they are self-governing and have the ability to make and enforce their own laws and rules. Tribes are also allowed to directly seek federal assistance, though in most cases they will also interface with the State, as resources are often available more rapidly through those channels.

Statutes and ordinances

Agencies that issue rules obtain their authorities and enforcement abilities by statute (law). Laws are more difficult to modify, even in times of emergency unless the Governor promulgates a rule suspending the statute. Rules, on the other hand, are more easily suspended. EMSRB is the lead agency for ambulance response and coordination as designated by state law and in the Minnesota Emergency Operations Plan (MEOP). During a surge event, EMSRB will interface with the State Emergency Operations Center (SEOC) and regional EMS program coordinators to provide information and support for ambulance operations and resource requests. Under Minn. Stat. §144E.266 during a Governor declared disaster certain state ambulance statutes may be suspended (see below for more detail). Additionally, certain administrative rules pertaining to ambulance services may also be suspended, even in the absence of a Governor’s emergency declaration, in time of disaster, mass casualty, or other public emergency. Note that even during these periods, resources may be available that allow the usual requirements to be met, and at those times, ambulance responders should continue to meet those standards.

Additionally, it is critical ambulance service agencies know if there are local ordinances that may apply to them. These cannot be in conflict with state laws and rules, but could be more proscriptive. For example, Hennepin County specifies a response time standard and staffing standards for ambulance services. These ordinances may need to be relaxed in a crisis, and ambulance service agencies should work with local Emergency Management to determine how this would happen.

State ambulance requirements suspended during declared disasters

As part of disaster preparedness planning, the State recognizes the need to allow suspension of certain ambulance requirements during legally declared disasters. Minnesota Statute, section 144E.266 enables this by suspending the following:¹⁹⁹

The requirements (see below for explanation) of sections [144E.10](#); 144E.101, subdivisions 1, 2, 3, 6, 7, 8, 9, 10, 11, and 13 ; [144E.103](#); [144E.12](#); [144E.121](#); [144E.123](#); [144E.127](#); and [144E.15](#), are suspended:

¹⁹⁹ Minn. Stat. 144E.266, available at [Emergency Suspension of Ambulance Service Requirement](#).

- Throughout the state during a national security emergency declared under section [12.31](#);
- In the geographic areas of the state affected during a peacetime emergency declared under section [12.31](#); and
- In the geographic areas of the state affected during a local emergency declared under section [12.29](#).

For purposes of this section, the geographic areas of the state affected shall include areas where one or more ambulance services are providing requested mutual aid to the site of the emergency.

Explanation of specific requirements suspended

- [144E.10](#): license required to operate an ambulance service;
 - [144E.101 subd. 1](#): requires certified personnel and staffing appropriate to the level of service on ambulance; also requires ambulance service to have medical director;
 - [144E.101, subd. 2](#): requires at least one ambulance attendant in patient compartment and Paramedic in patient compartment if ALS care provided.
 - [144E.101, subd.3](#): requires ambulance service to offer continual service (24 hours a day, every day of the year);
 - [144E.101, subd. 6](#): basic life support staffing and care requirements;
 - [144E.101, subd. 7](#): advanced life support staffing and care requirements;
 - [144E.101, subd. 8](#): part-time advanced life support staffing and care requirements;
 - [144E.101, subd. 9](#): specific requirements for specialized life support ambulances;
 - [144E.101, subd. 10](#): requires driver of ambulance to have driver's license and emergency driving course;
 - [144E.101, subd. 11](#): requires on-call schedule, documentation of personnel qualifications, and statement signed by medical director accepting responsibilities;
 - [144E.101, subd. 13](#): limits ambulance to assigned PSA, except when called for mutual aid or requested by transferring physician;
 - [144E.103](#): equipment and safety restraints requirements; requires drugs approved by medical director for ALS;
 - [144E.12](#): licensure of air ambulances;
 - [144E,121](#): requirements for air ambulance;
 - [144E.123](#): requires pre-hospital care data be collected and submitted to Board on every response; requires copy of patient care report to be left at hospital;
 - [144E.127](#): allows substitution of physician, RN, or PA for one of required ambulance attendants on inter-hospital transfer;

- 144E.15: requires board approval for relocating base of operations within PSA.

Liability

A catastrophic disaster which causes initiation of the CSC Framework may raise legal and liability concerns among health care and public health professionals due to their potential liability risk when extreme service demands, coupled with constrained supplies and diminished personnel, prevent provision of usual services and care expected by the community. Although lawsuits resulting from emergency planning or services rendered during an emergency or disaster are rare, responders may nonetheless be comforted in knowing what laws currently exist that might afford protections against lawsuits that might be leveled against them for actions undertaken – or not undertaken – during a response. For a more comprehensive review of Minnesota laws pertaining to emergency responders please see *Attachment 2—Legal Authority and Environment for Crisis Standards of Care* for more detail.

Having pre-existing operational plans for crisis situations may provide protections for responders, as well as the agencies that employ them. If these plans are reasonable, based on recognized guidance and best practices documents, and approved by the agency (or optimally, by multiple agencies and the jurisdiction), it will be, in most situations, difficult to find liability if the responder’s actions conformed to the expectations of the plan. This raises the issue of “duty to plan”. The failure to adequately plan for reasonable foreseeable results of anticipated catastrophic events has served as the legal basis for several successful lawsuits throughout the United States against both private medical care providers and government agencies.

Additionally, many government agencies including the Occupational Health and Safety Administration (OSHA) can hold employers liable when a “commonly recognized” risk was not sufficiently mitigated. Thus, because any ambulance service agency could experience a crisis situation, not having a plan to address the situation could result in liability for the agency in case of worker injury/illness.

Reimbursement: 1135 Waiver

Finally, there may be insurance/payer issues that need to be addressed during a mass casualty event. Generally, if a patient is not taken to a hospital, Centers for Medicare and Medicaid Services (CMS) and private insurance will not pay for ambulance transport. However, if the nearest hospital is not operating because it was damaged or destroyed in the disaster, or the hospital is overwhelmed, it may be more appropriate to transport the patient to a clinic or some type of alternate care site. During an emergency or disaster, the HHS Secretary may authorize a Section 1135 Waiver, which enables reimbursement under specific circumstances. A Federal declaration must be obtained prior to the Secretary issuing a Section 1135 Waiver, and information justifying why the actions are in the patients’ best interest must be supplied to the regional CMS office. MDH may make Section 1135 Waiver requests to CMS on behalf of EMS or hospitals in the affected area.

Additionally, non-ambulance transport generally cannot be billed to insurance, though the hours the personnel worked and supplies used *may* be reimbursable with proper documentation if patients were not billed for the disaster-related activities. Agencies should keep careful records and work with local Emergency Management on all administrative and financial issues. For additional information on 1135 Waivers please see [Requesting an 1135 Waiver](#).

Recovery

Ambulance service agencies should conduct a thorough review and quality assurance process whenever crisis care strategies are implemented. This should include a hot wash with involved personnel after the incident, drill or exercise to determine successes and opportunities as well as provide a common understanding of the sequence of events and decision-making. A formal after-action report may be generated depending on the scope of the incident. A corrective action plan should be generated for all incidents in which a practice was identified that can be improved.

Planning for recovery should begin while the event is ongoing. Recovery is the restoration of services to their pre-existing state (or optimized conventional state). The basic philosophy of recovery is to “build back better” after an incident.

However, because of the dynamic nature of crisis conditions (particularly during long events such as pandemics) a return to conventional care may be temporary, and does *not* mean the recovery phase has truly begun, as recovery is a stable state. Ambulance service agencies should assure they are prepared to be flexible across the surge spectrum and be certain the situation has concluded prior to ending the response. For example, ambulance services may be able to operate in conventional status during the night in a pandemic, but during daytime hours may remain in crisis mode due to call volumes.

During recovery, there are multiple priorities including debris removal, strategic re-building of damaged infrastructure, mental health support, and more. Some priorities for ambulance services specifically include:

- Final documentation of supply and time costs for potential reimbursement
- Return of borrowed equipment
- Restoration of equipment to usual state
- Replacement of supplies
- Provision of mental health support to affected staff (psychological first aid or more specific strategies depending on the situation)
- Support for provider families affected by the incident
- After-action reviews of the event and development of a corrective action plan for future similar events

Ambulance services may need to provide ongoing support to other agencies as they continue body recovery and other operations. Ambulance service agencies should also confirm with local Emergency Management there are no other functions required of them and participate in community recovery planning and after-action analysis.

Conclusion

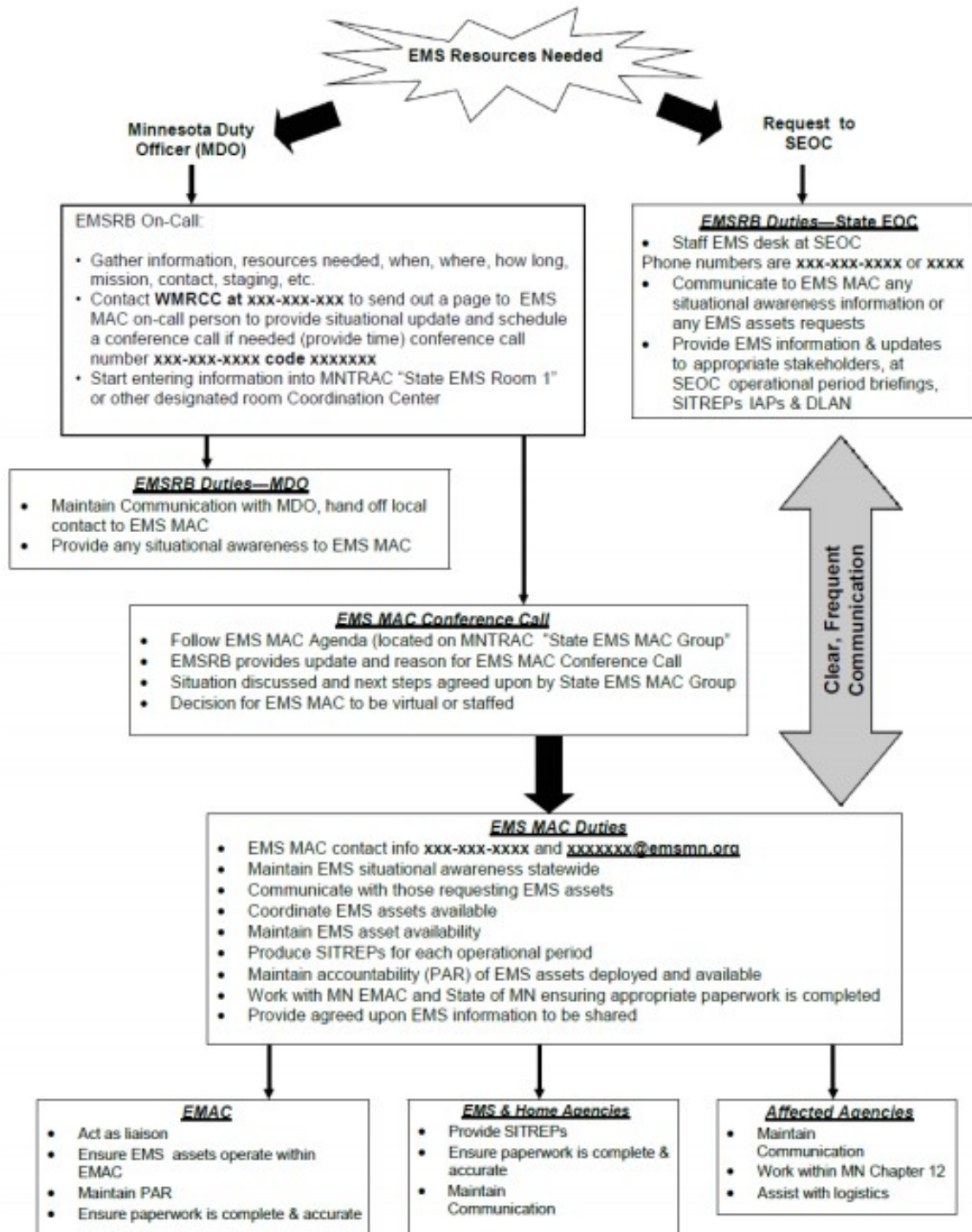
Ambulance service agencies in Minnesota are diverse, but all are at risk of situations where demand exceeds available resources and require adaptive strategies. All agencies have a duty to plan for such situations and should empower EMS providers through training and standard operating procedures to make good choices that truly do the “greatest good for the greatest number” while assuring available additional resources are requested in a timely manner. Though these situations are rare, ad hoc decisions in novel conditions are often sub-optimal; the unique risks of these situations to patients requires deliberate planning.

This Attachment should provide a framework on which ambulance service agencies, working with their HPP Coalition and designated regional EMS system partners, can modify their operational plans to incorporate crisis care conditions.

The key planning steps for each ambulance service agency following review of the document are:

- Convene a planning group with leadership or supervisory staff and medical director
- Identify resources and resource limitations (‘send’, ‘staff’, and ‘supplies’)
- Determine limitations and options, then resource and policy needs, then develop indicators and triggers in the following areas:
 - Dispatch
 - Response
 - Treatment
 - Transport
 - Destination/Patient Disposition
 - Develop formal written policy
- Discuss policy with surrounding agencies, regional HPP Coalition, Regional EMS System Program and receiving hospitals
- Educate and exercise new policies and procedures

Addendum 3.1—Requests to the State for Additional Ambulance Service Resources



Addendum 3.2—Ambulance service surge operations and crisis care matrix

	Conventional	Contingency	Crisis
Public Messaging	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Limit calls to 911 	<ul style="list-style-type: none"> Limit calls to 911 – risk to others if not true emergency
PSAP/EMS Dispatch	<ul style="list-style-type: none"> Priority dispatch Standard dispatch procedures or protocols 	<ul style="list-style-type: none"> Mutual aid as required and normally requested Priority dispatch but pend calls of non-emergent nature (A) (1) Consider adjusted response assignments (e.g., no EMS until injuries confirmed at MVC) (A,C) (2) 	<ul style="list-style-type: none"> Auto-answer with diversion of non-emergency calls to health care provider health line/311/other source (A) Medical screening for necessity – decline or refer callers to other transportation options (taxi, bus, special transportation, etc.) (A, possible C, S for liability issues?) or to prescribing line (S) (3) Priority dispatch of emergency calls only (A,C) Adjusted response assignments as per Contingency (A,C)
Response	<ul style="list-style-type: none"> Usual resources and response standards 	<ul style="list-style-type: none"> Mutual aid Consider additional use of BLS or alternate transport (A) Consider alternate staffing and shift patterns 	<ul style="list-style-type: none"> Additional mutual aid, EMS strike teams or MCI bus? (A,C, possible S) Non-medical vehicle drivers (A,C, possible S) Alternate response – BLS, wheel chair/special transportation, school or public transit buses, other (A,C,S) Additional trained staff unavailable or unable to respond to volume of requests even with extension techniques (A,C,S)
Treatment – Standard of Care	<ul style="list-style-type: none"> Assess and treat per usual Standard Operating Procedures (SOP) and standard of care 	<ul style="list-style-type: none"> Assess and treat per SOP, radio control for unusual situations; functionally equivalent care (ALS, BLS) Conservation, adaption and substitution of supplies with occasional re-use of selected supplies 	<ul style="list-style-type: none"> Broaden discretion of ambulance service personnel to leave patient at scene according to crisis plan or radio contact with MD/RN (A,C, possible S) and/or refer to alternate transport options (4) Critical supplies lacking, possible re-allocation of personnel and life sustaining resources (A,C,S) Broaden on-scene treatment options (A,C, possible S) Crisis Standard of Care – incident specific patient care guidelines from MDH or other source (A, C, S)

CRISIS STANDARDS OF CARE FRAMEWORK
EMS GUIDANCE

Transport	<ul style="list-style-type: none"> ▪ Transport to destination hospital of choice 	<ul style="list-style-type: none"> ▪ Transport to closest appropriate hospital (A,C) 	<ul style="list-style-type: none"> ▪ ‘Batch’ transports of multiple patients, private or public vehicle, buses, special transportation (A,C) (5) ▪ Transport to closest appropriate facility (A,C) ▪ Transport to alternate care facility, i.e., clinic, specialty clinics, field medical station, alternate care site, other non-traditional patient disposition facilities (A,C, S) ▪ Use of non-ambulance vehicles (private, wheel chair, buses, vans, police/fire vehicles) (A,C,S) (5)
------------------	---	---	---

Notes:

A = Agency policy/SOP adjustment needed – operational policy development, ambulance service and medical director approval

C = County or City/ community ordinance may require exemption/waiver

S = State regulatory or other action needed (EMSRB, etc.)

Requires Emergency Medical Dispatch (EMD) for 911 public safety answering points (PSAP) without medically trained dispatchers will require algorithm and/or referral to EMS EMD-providing service. Algorithms would need to be approved by local gov’t entity and potential liability relief from locality.

- Will require pre-scripting of changes to response assignments on paper or in computer aided dispatch (CAD) for dispatch to use – requires trigger for use approved by agency and medical director.
- Medical screening may be carried out by dispatcher, or by medical provider (RN or MD) – staffing and scripting should be pre-planned and approved by agency
- Left at scene discretion should be developed by agency policy (e.g., Hennepin County EMS System Pandemic Influenza Plan) and clear approval by agency, medical directors, and triggers for use should be described
- Trigger and approval by agency supervisor/medical director should be described in policy

Addendum 3.3—Transports to hospital in non-ambulance vehicle

In a crisis, ambulance resources may be severely limited and alternate transport options may need to be considered. One option would be transport of patients via a motor vehicle that is not an ambulance, including the following options:

- Family members or others transporting stable patient in private vehicle without escort/attendant (e.g., arm laceration with bleeding controlled by dressing)
- Family members or others transporting patient in vehicle with EMS personnel following in another vehicle (stable but with potential for deterioration)
- Others transporting in private vehicle with EMS personnel in the vehicle with them monitoring or providing care (unstable – highest risk to patient and provider)
- Non-ambulance public safety vehicle (fire or police) transporting patient (professional driver and marked vehicle but limited ability to provide any medical care in usual squad vs. private vehicle such as mini-van)

Ambulance service agencies should develop clear policies on when these options may be exercised, as this may be an option in many situations where ambulance transport is severely limited (e.g., multi-victim accident in rural community with one ambulance unit available). Transports by non-ambulance vehicles should be reviewed retrospectively in a hotwash or otherwise by ambulance service management and medical directors for appropriateness.

Ambulance service providers need to weigh the risks and benefits of patient transport in a non-traditional vehicle versus the risks and benefits of waiting for an ambulance to arrive. This may involve consultation with a physician or supervisor to assist with the assessment of the risks/benefits of the two options. Some considerations that should be taken into account:

- **Time sensitivity** – Does the patient have a time sensitive condition that can only be stabilized at a hospital and that is likely to continue to deteriorate until hospital arrival? This could include conditions such as ST elevation myocardial infarction (STEMI), acute stroke, sepsis, shock or multisystem trauma.
- **Decreased time to treatment** – Does the time to the hospital by a non-ambulance decrease the time to hospital arrival and increase the chances of the patient having a successful outcome?
- **Stabilization needed** – Can the patient be appropriately stabilized on-scene while awaiting arrival of an ambulance? Patients requiring spinal immobilization will need to be supine and may not be adequately restrained in a supine position in vehicles other than an ambulance.
- **Existing medical conditions** – Are there medical conditions present which will make transport by a non-ambulance more difficult? Many patients transported by a non-ambulance will need to be able to tolerate a seated position.

- **Spinal immobilization** (other transport available) - If a patient is to be transported supine in a vehicle other than an ambulance are there other marked emergency vehicles that can provide an escort for the transport? Are there other variables that can be adjusted to increase the safety of a supine transport in a non-ambulance like speed, route of travel, and immobilization methods?
- **Patient restraints** – Although not always possible, patients and any attendants being transported to a hospital in a non-ambulance should have appropriate patient restraints while the vehicle is in motion whenever possible; this will necessitate the patient is able to sit upright for appropriate safety belt use while the vehicle is in motion. Vehicle collisions are one of the most common causes of death for patients and first responders even in well-marked emergency vehicles with lights and sirens.
- **Driver distractions** – The provision of patient care by EMS personnel will be a distraction to the driver of the vehicle and the driver should be specifically cautioned about this.
- **Car seats** – Children in car seats may be transported in a non-ambulance safely if the car seat is appropriately installed in the vehicle.

Transporting a patient in a non-ambulance can be a stressful decision that could require the involved parties to operate outside their standard motor vehicle operating procedures regarding restraints. The private vehicle will likely not be equipped with lights/sirens so all speed limits and traffic laws must be obeyed for safety. The most experienced driver available should drive the vehicle. Public safety vehicle drivers (e.g., police) may not be used to driving with medical care en route and should minimize speed in favor of safe transport.

Addendum 3.4—Pandemic influenza protocols

Protocols developed and approved by Hennepin County EMS Council (April 9, 2009) for use in the Hennepin County EMS System and included here to serve as a guide for other EMS agencies.

Policy context

These standing orders will be used to provide the best pre-hospital care to the greatest number of people during an extreme situation. They will only be put into place when resources are defined by the system as “Level Red,” which means EMS services are pending or not answering calls for which there is a significant risk of death for the patient. They do not supersede other protocols. You will be notified when this status is in effect.

Our ethical commitments are:

Limitation of individual autonomy: The fair and just rationing of scarce resources requires public health decisions based on objective factors, rather than on the choice of individual leaders, providers, or patients. All individuals should receive the highest level of care given the resources available at the time.

Transparency: Governments and institutions have an ethical obligation to plan allocation through a process that is transparent, open, and publicly debated. Governmental honesty about the need to ration medical care justifies institutional and professional actions of withholding and withdrawing support from individual patients. These restrictive policies must be understood and supported by medical providers and the public, ideally with reassurances that institutions and providers will be acting in good faith and legally protected in their efforts.

Justice/fairness: The proposed triage process relies on the principle of maximization of benefit to the population served. The triage process treats patients equally based on objective, physiologic criteria, and when these criteria do not clearly favor a particular patient, “first come, first serve” rules will apply.

Assurance: In order to ensure “procedural justice,” EMS triage processes will be regularly evaluated to assure that the process has been followed fairly and consistently.

Documentation: MNTrac records will include policy notations including the times the “Level Red” was in effect.

Categories for Triage

When an ambulance arrives on scene during “Level Red” status, instead of automatically offering transport to an emergency department, as under normal practice, you will assess the patient’s objective condition and triage him/her into the following categories:

CRISIS STANDARDS OF CARE FRAMEWORK
EMS GUIDANCE

INFO	Provide homecare information
CLINIC	Refer to a clinic or other medical destination
ALT TRANS	Refer to use of alternate transportation to a hospital, clinic or other medical destination
LE	Transport by (and at the discretion of) law enforcement
EMS	Transport by ambulance to a hospital or other medical destination

Standing Orders

1. A. If the patient’s complaint or symptoms are not listed in this Appendix, Paramedic’s discretion is advised as long as the decision is not in conflict with SOP.
2. B. When resources during a Pandemic are “Level Red,” automatically offer to transport patients with the following presentations:

EMS	1. Paramedic discretion – suspicion of critical illness/injury
EMS	2. Altered vital signs (or age-specific abnormal vital signs), including any one of these: <ul style="list-style-type: none"> • SBP < 90+ • SpO2 < 92% • RR > 30 (or respiratory distress) • HR > 120, or delayed capillary refill
EMS	3. Breathing: <ul style="list-style-type: none"> • Respiratory distress • Cyanosis, or pallor/ashen skin
EMS	4. Circulation/Shock: <ul style="list-style-type: none"> • Signs or symptoms of shock • Severe/uncontrollable bleeding • Large amounts of blood (or suspected blood) in emesis or stool
EMS	5. Neurologic: <ul style="list-style-type: none"> • Unconscious or altered level of consciousness • New focal neurologic signs (CVA, etc.) • Status, multiple or new-onset seizure • Severe headaches – especially sudden onset or accompanied with neck pain/stiffness • Head injuries with more than brief loss of consciousness or continued neck pain, dizziness, vision disturbances, ongoing amnesia or headache, and/or nausea and vomiting
EMS	6. Trauma: <ul style="list-style-type: none"> • Significant trauma with chest/spinal/abdominal/neurologic injury deemed unstable or potentially unstable • Suspected fractures or dislocations that cannot be safely transported by private vehicle

When resources during a Pandemic are “Level Red,” consider patients with the following presentations for:

- **Transportation by ambulance:** - Note that many ‘transport by ambulance’ patients will not require emergency transport to the hospital – in which case, the crew may answer additional calls until the ambulance is full, or a critical patient is picked up, depending on system call volumes.
- **Transportation by alternate means:** Private vehicle or police to clinic or hospital. Except in very limited cases, the patient should NOT self-transport to the hospital/clinic, but could be driven by someone else.
- **Homecare:** Give patient the Homecare form for their complaint and advise to contact personal medical doctor if symptoms persist or worsen. The form will have information pertaining to their complaint and list ways of caring for themselves, as well as what to look for that would prompt self-transport to a clinic or hospital, or transport via ambulance to the hospital. Advise the patient that this does not restrict them from seeking care at a clinic or hospital on their own, should they desire.

1. ABDOMINAL PAIN:

EMS	<ul style="list-style-type: none"> • Pulsating mass • Marked tenderness/guarding • Pain radiating into back and/or groin/inner thighs • Recurrent severe vomiting not associated with diarrhea
ALT.TRANS/CLINIC	<ul style="list-style-type: none"> • Recurrent severe vomiting associated with diarrhea – to emergency if associated with signs/symptoms of dehydration, to urgent care or clinic if no dizziness nor vital sign changes and normal exam
INFO	<ul style="list-style-type: none"> • Intermittent vomiting and diarrhea without blood or evidence of dehydration

2. ANAPHYLAXIS/STINGS:

EMS	<ul style="list-style-type: none"> • Patients who have had epinephrine administered for symptoms • Patients experiencing airway, hypotension or respiratory symptoms, after an allergy exposure
INFO/ALT. TRANS./CLINIC	<ul style="list-style-type: none"> • Patients with itching after exposure – if rapid onset of symptoms, may require EMS transport; if delayed > 1hour, safe for private transport. All patients with history of anaphylaxis should be seen in emergency room if possible. Others may be seen in clinic or urgent care. EMS may administer diphenhydramine prior to clearing scene, up to 1mg/kg.

3. BACK PAIN

EMS	<ul style="list-style-type: none"> • Acute trauma with midline bony spinal tenderness • New onset of extremity weakness, sensory deficits, other neurological changes, incontinence of urine or bowel, urinary retention, or bloody urine • Concern for abdominal aortic aneurysm • Pain radiating into abdomen, or groin/inner thighs
-----	--

CRISIS STANDARDS OF CARE FRAMEWORK
EMS GUIDANCE

INFO/ALT. TRANS.	<ul style="list-style-type: none"> • Inability to ambulate/care for self
INFO	<ul style="list-style-type: none"> • Concern for kidney stone, bloody urine

4. BEHAVIORAL

EMS	<ul style="list-style-type: none"> • Uncontrolled agitation requiring sedation by EMS
EMS/LE/ ALT. TRANS	<ul style="list-style-type: none"> • Suicidal ideation – must be left with a responsible party
INFO/ALT. TRANS	<ul style="list-style-type: none"> • Other emotionally disturbed patients may be transported at law enforcement’s discretion or by other means

5. BLEEDING (LACERATIONS, ABRASIONS, OR AVULSIONS):

EMS	<ul style="list-style-type: none"> • Patient is on Coumadin or other blood thinner with significant ongoing bleeding or large hematoma
ALT.TRANS/ CLINIC	<ul style="list-style-type: none"> • Significant lacerations after bandaging – heavily contaminated, bite-related, likely to involve foreign body, deep structure injury, sensory/motor deficit – to emergency room • Lacerations requiring simple repair – consider self-transport to physician’s office or urgent care center (however, some offices do not do procedures; patient will need to call ahead)
INFO	<ul style="list-style-type: none"> • Abrasions or avulsions not requiring suturing or repair, no significant contamination. • Minor lacerations that do not require sutures

6. Burns

EMS	<ul style="list-style-type: none"> • All chemical or electrical burns • Suspected inhalant burn • Significant third degree burns • Second degree burns to ≥5% of body area • Second degree burns to face, mouth • Severe pain • Circumferential burns
ALT. TRANS	<ul style="list-style-type: none"> • Second degree burns to hands or feet, or to other location 1%-5% body surface area (size of patient’s palmar surface)
INFO	<ul style="list-style-type: none"> • Second degree burns < 1% body surface area, non-critical location • First degree burns

7. CARDIAC ARREST

EMS	<ul style="list-style-type: none"> • Witnessed down time ≤ 10 minutes – follow usual resuscitation protocols
INFO	<ul style="list-style-type: none"> • All others – report death to dispatch and return to service; do not wait for law enforcement or medical examiner arrival

8. CHEST PAIN

EMS	<ul style="list-style-type: none"> Chest pain or other signs or symptoms suspicious for cardiac ischemia, pulmonary embolus, or other life threat
INFO/ALT. TRANS/ CLINIC	<ul style="list-style-type: none"> Chest pain ongoing for >12 hours and a normal ECG Pleuritic chest pain without hypoxia Chest pain reproducible on physical exam to palpation is generally NOT concerning; unless ECG changes or known cardiac disease, unlikely to require treatment for acute coronary syndrome

9. DIABETIC

EMS/ALT. TRANS	<ul style="list-style-type: none"> Any patient on oral diabetes medications with low blood glucose – if transported by private vehicle must NOT drive self Critical high glucose or signs of Diabetic Ketoacidosis/dehydration
INFO	<ul style="list-style-type: none"> Patients with typical hypoglycemia and explanation for low sugar (did not eat, etc.) can be left without medical control contact as long as family/friend is present and patient is eating

10. ENVIRONMENTAL

EMS	<ul style="list-style-type: none"> Heat-related illness with any alteration in mental status (confusion, decreased LOC) Frozen extremity Hypothermia with AMS
EMS/ ALT. TRANS.	<ul style="list-style-type: none"> Frostbite to face, hands, feet, other location suspected deeper injury, blisters, or frozen to touch
INFO	<ul style="list-style-type: none"> Heat-related illness without alteration in mental status – initiate external cooling at home under supervision of friends/family Minor frostbite with tissues now soft, pink, no blisters, and NOT involving digits

11. ETOH/SUBSTANCE ABUSE

EMS	<ul style="list-style-type: none"> Very decreased LOC or other confounding issues (head injury, suspicion of aspiration)
LE	<ul style="list-style-type: none"> Otherwise may be transported at law enforcement’s discretion
INFO	<ul style="list-style-type: none"> Patient may be left with a responsible individual who can assist the patient Able to ambulate safely without assistance

12. EYE PAIN

EMS	<ul style="list-style-type: none"> Impaled objects or possible penetrating injury to eye, or globe rupture Chemical exposures (alkaline) after decontamination and initial rinsing
EMS/ALT. TRANS/ CLINIC	<ul style="list-style-type: none"> Eye pain and/or acute changes to vision should receive transport for urgent evaluation to emergency department or other qualified clinic (e.g. eye clinic)

CRISIS STANDARDS OF CARE FRAMEWORK
EMS GUIDANCE

	<ul style="list-style-type: none"> • Chemical exposures (non-alkaline) – consult poison control for instructions; transport if symptoms/dangerous exposure
INFO	<ul style="list-style-type: none"> • Chemical exposures (non-alkaline) – consult poison control for instructions; if no symptoms and limited toxicity likely, give instruction sheet

13. FEVER

EMS	<ul style="list-style-type: none"> • Fever plus altered mental status including confusion • Fever plus severe symptoms by paramedic assessment • Fever plus seizures, lethargy, still neck, rash, or blistering
EMS/ALT. TRANS/ CLINIC	<ul style="list-style-type: none"> • ≤ 3 months with fever estimated a 100.5°F → emergency room or clinic urgently • > 3 months with fever that does not reduce with anti-pyretics, or fever lasting more than 5 days → emergency room, urgent care, or clinic

14. HEADACHE

EMS	<ul style="list-style-type: none"> • With vision deficit, lethargy, or page 1 qualifiers (fever, etc.)
ALT. TRANS	<ul style="list-style-type: none"> • New headaches for patient require assessment • Usual headaches for patient may require treatment

15. MUSCULOSKELETAL INJURIES (ISOLATED)

EMS	<ul style="list-style-type: none"> • Loss of distal pulses • Unable to effectively splint the affected part • Neurological changes or deficits • Open fractures • Displaced fractures or pain requiring injectable narcotics
ALT. TRANS	<ul style="list-style-type: none"> • Suspected fractures that are stable and do not require injected analgesia may be splinted appropriately and transported by private vehicle
INFO OR ALT. TRANS.	<ul style="list-style-type: none"> • Neck pain and back pain after MVC, that is delayed in onset and not associated with midline tenderness or neurologic symptoms

16. NOSEBLEED

EMS	<ul style="list-style-type: none"> • Signs of hypovolemia or dizziness upon standing • Patient is on blood thinners (Coumadin, lovenox, clopidogrel, etc.)
INFO	<ul style="list-style-type: none"> • All other

17. OB/PREGNANCY

EMS	<ul style="list-style-type: none"> • Imminent delivery • Pain in abdomen or back • Profuse vaginal bleeding • Third trimester (>24 weeks) bleeding • Pre/eclampsia – syncope, seizure, altered mental status, SBP≥140
-----	---

CRISIS STANDARDS OF CARE FRAMEWORK
EMS GUIDANCE

INFO	<ul style="list-style-type: none"> • All other
------	---

18. SWALLOWING PROBLEM

EMS	<ul style="list-style-type: none"> • Patient unable to manage own secretions due to pain or obstruction
INFO	<ul style="list-style-type: none"> • All other

19. HEART DISEASE

EMS	<ul style="list-style-type: none"> • History of coronary disease or heart failure • Age =>55 • Pregnant • Chest pain, headache, or shortness of breath (or other symptoms concerning to paramedics)
INFO/ALT. TRANS./CLINIC	<ul style="list-style-type: none"> • Likely dehydration, with dizziness preceding the syncope • Other underlying medical conditions

20. TOXICOLOGIC

EMS/INFO/ALT. TRANS./CLINIC	<ul style="list-style-type: none"> • Overdose or other toxic exposure → contact Poison Control and/or online medical control • If intentional, see Behavioral Health in this Appendix
--------------------------------	---

VULNERABLE PERSON IN POTENTIAL DANGER

EMS/ALT. TRANS./CLINIC	<ul style="list-style-type: none"> • EMS should assure person will not be left in dangerous environment • If safe disposition and transport can be arranged and the injuries do not otherwise require medical evaluation, other transport may be appropriate
---------------------------	--

Attachment 4—Surge Operations and Crisis Care for Hospitals

PLANNING AND IMPLEMENTATION GUIDANCE

Preface

The Surge Operations and Crisis Care for Health Care Facilities Attachment is a guidance document designed to help health care facilities plan for shortfalls in the health care system during a surge incident. This guidance assumes incident management and incident command practices are implemented and key personnel are familiar with the ethical frameworks and processes which underlie scarce resource decisions as outlined in the State of Minnesota Crisis Standards of Care Framework.

During a Surge Operations and/or Crisis Care situation each health care facility or health care system will have to determine the most appropriate steps and actions for their entity based on their environment, hazards, and resources. Since pre-planned actions are always preferred to ad hoc decisions, pre-event familiarity with the contents of this Attachment and development of regional and local crisis standards of care plans is recommended to aid with event preparedness, response and in anticipation of specific resource shortfalls. This Attachment addresses common categories of health care delivery, triage, staff and space. Regional health care coalitions (HCCs), Minnesota Hospital Association (MHA), health care systems, and health care personnel may determine additional issues and strategies for their specific situation in addition to those outlined in this Attachment.

The Minnesota Department of Health (MDH) formed a Crisis Standards of Care Health Care Surge Workgroup in the fall of 2016 to review and provide input on crisis care issues and solutions for the wide range of Minnesota health care facilities. This Attachment would not have been possible without the diverse and practical input provided by the reviewers and advisors to this process; their efforts will benefit the citizens of the state. This Attachment is part of a larger process by MDH to document Crisis Standards of Care policies as well as engage the public in discussions about the ethics and principles of crisis care.

This Attachment constitutes the consensus recommendations of the Workgroup but does not represent policy of the MDH. Health care facilities or systems implementing these strategies in crisis situations should assure communication and coordination with their public safety, health care providers and local and tribal public health partners and emergency management to assure the invocation of appropriate legal and regulatory protections as appropriate in accord with state and federal laws. Recommendations within this Attachment may be superseded by incident specific recommendations by MDH. Web links and resources listed are provided as examples, and may not be the best sources of information available. Their listing does not imply endorsement by MDH.

This Attachment does not replace the judgment of the health care facilities' operational management, medical directors, their legal advisors or clinical staff and consideration of other relevant variables and options during an event.

Introduction

Minnesota has over 130 hospitals ranging from critical access health care facilities with 25 beds to large academic medical centers with more than 1000 beds. These hospitals may be the only health care resource for many miles, providing necessary emergency and general inpatient services to their community or may be mere blocks away from another major tertiary medical center. As health care systems consolidate, services and available beds continue to shrink, thereby capacity within the system to respond flexibly to surges in demand.

Minnesota hospitals and other health care facilities are faced with a wide variety of potential large-scale incidents that could quickly tax or exhaust their resources. In some situations, the event may damage the health care facility itself, with major impact on the ability to maintain operations and serve the community. There is a significant risk for natural, man-made and terrorism-related disasters throughout the state. Pandemics such as H1N1 flu virus can have an impact on health care services statewide. Minnesota borders Canada in some of the most rural portions of the state creating cross-border issues, in addition to multiple international ports of entry on Lake Superior that serve oceangoing vessels. Highways and railways crisscrossing the state present substantial risk of hazardous materials and other transportation-related incidents. Minnesota also has two nuclear power plants, both located outside of the twin cities metropolitan area, which could potentially affect health care systems in the event of a radiological release at one of these plants. Unfortunately, the risk of terrorist attacks on targets small and large in Minnesota is substantial and must be planned for by all health care systems.

This document provides an overview of surge capacity and crisis care operational considerations for health care facilities with an emphasis on hospitals. In-depth discussion of the framework, ethics, and practical applications of crisis standards of care may be found in the 2012 Institute of Medicine (IOM) (now known as the National Academies of Medicine, Health and Medicine Division [HMD])—referred to as IOM/NAM throughout this Attachment) report including a specific section on Hospital care are available at The National Academies of Science, Engineering and Medicine, [Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response](#). An additional document that may be of assistance is a card set designed for scarce resource situations (e.g., shortages of staff, medications) developed by the MDH Science Advisory Team (SAT) which is available at the [Minnesota Department of Health, Patient Strategies for Scarce Resources Situations](#).

This Attachment is aimed at hospital operations and though it does detail the supporting role of state agencies it is the responsibility of the facility to apply this guidance with the help of their management team and medical staff to ensure operational plans are in place.

Crisis care

Most health care facilities are familiar with the concept of surge capacity, the ability to increase services to match demand. Surge capability is slightly different in that it requires specialized equipment or training to meet a patient's specific needs – an example might be a contaminated patient or one with a highly infectious disease. This Attachment focuses on capacity, but a short section provides some basic guidance on specialty situations (pediatric, high consequence

infectious diseases) that can push health care facilities into crisis care as well. Adequate supplies, training, and regional policies are just as important for capability as well as overall capacity.

For purposes of this Attachment, crisis care refers to the care and strategies at the facility level when demand acutely exceeds supply of resources and usual medical practices cannot be maintained. Crisis care situations can occur without warning when a no-notice event affects any health care facility, but usually can be addressed within hours by bringing in additional resources or transferring patients to other facilities.

Crisis Standards of Care refers to systematic support (including governmental) for non-traditional health care operations during a prolonged and widespread event that require declarations of disaster, legal and regulatory support, and issuance of clinical care guidelines (potentially including triage criteria) by state agencies recognizing the need for consistent statewide implementation of patient care strategies. Crisis Standards of Care would typically involve an extremely unusual and widespread event such as a severe pandemic.

In order to achieve a successful response, health care facilities must utilize an incident management system and attempt to move as rapidly as possible from a reactive posture (relying on frontline personnel utilizing job aids and applying their training) to a proactive posture (managing the event by objectives using an incident action plan). The Incident Management System (usually the Hospital Incident Command System [HICS]) must have the ability to integrate the appropriate medical/technical experts into the planning process and to inform the hospital Incident Commander (IC) about the specific needs of the event.

For example, critical care physicians or a clinical care committee to propose modifications to medical services provided and any necessary triage decision processes. The IC and administration should bear responsibility for assuring that they have obtained the appropriate expert advice (e.g., infectious disease input for Ebola protocols) and approve the policies and modifications to clinical practice whenever possible. They should not allow it to fall to the individual clinician to make such decisions.

Coordination with other health care facilities both internally and externally within the regional HCC is *critical* to assure that patients and resources are distributed to balance the demands of the event across as many facilities as possible and thereby diffuse the impact. Health care facilities should attempt to mitigate any crisis situation as soon as possible by transferring patients or bringing in resources. This should be done in coordination with HCC partners. Hospitals should be very familiar with the plans of their local coalition for response coordination and resource management.

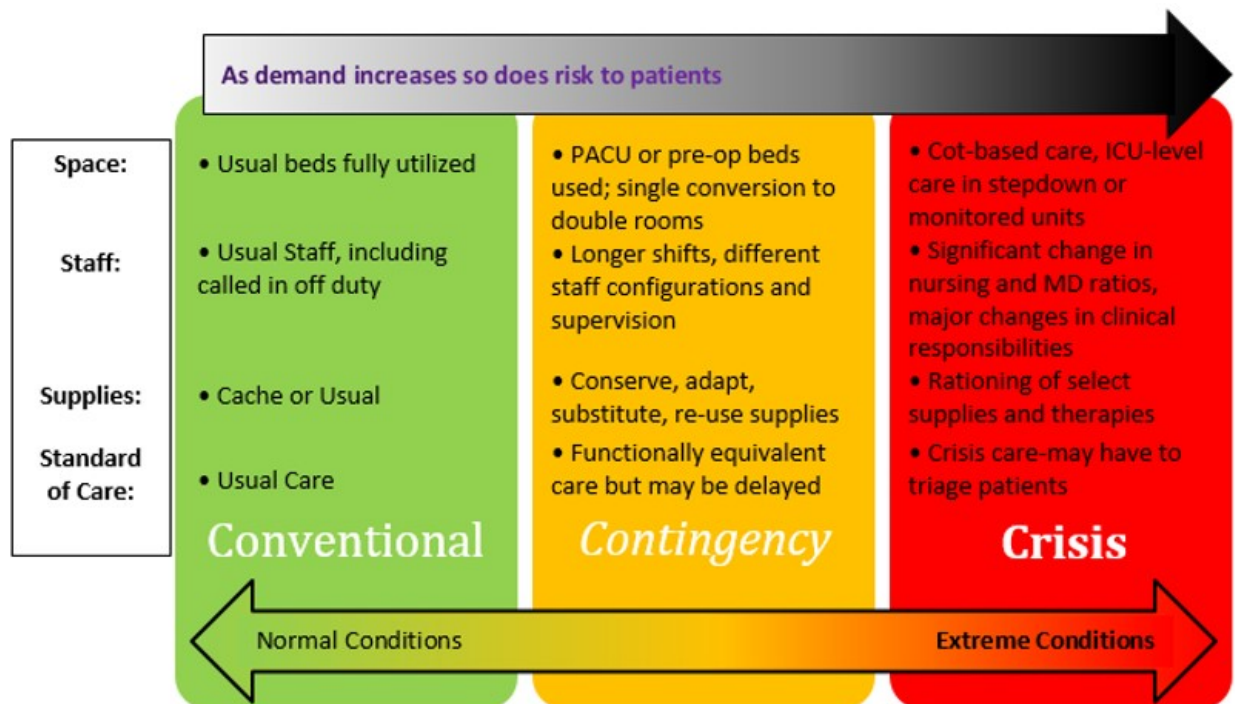
Surge capacity strategies are not all equal. For example, some can be accomplished with minimal risk (e.g., using post-anesthesia care beds for temporary inpatient care) and some carry significant risk (e.g., providing cot-based care in flat-space areas such as classrooms). Maximizing surge capacity strategies that mitigate the crisis while minimizing the risks associated with deviations from conventional care is the goal. Choosing the strategies that are most appropriate to the situation and pose the least risk to the patient and provider, and then

proceeding to riskier strategies as demand increases and options decrease is the preferred path.

Surge capacity is therefore divided into three categories across a spectrum (Figure 3.1):

- **Conventional** – usual strategies and resources – e.g., maximizing bed occupancy, calling in additional staff to assist
- **Contingency** – strategies and resources that may incur a small risk to patients but provide functionally equivalent care (e.g., using post-anesthesia care unit (PACU) beds for patient care using less traditional but appropriate resources).
- **Crisis** – disaster strategies used when demand forces choices that pose a significant risk to patients but is the best that can be offered under the circumstances – e.g., cot-based care, severe staffing restrictions, or restrictions on use of certain medications or other resources.

Figure 4.1: Examples of health care facility conventional, contingency, and crisis care (modified from IOM/NAM 2012)



Key points about crisis care:

- Crisis care is not a separate triage plan; these strategies are extensions of surge capacity plans.
- Crisis care may occur during long-term events such as pandemics when no reasonable help is expected, or during short-term, no-notice events where help will arrive, but too late to solve an acute resource shortfall.

- Health care facilities will not have an option to defer caring for patients in a crisis situation; demand will drive the choices that have to be made.
- If strategies are not planned for ahead of time, they likely will not be considered and/or will be difficult to implement.
- Strategies should be proportional to the resources available; as more resources arrive, you should move back toward lower risk strategies (and therefore, back toward contingency and eventually conventional status).

It is MDH's view that crisis care planning must be integrated into all-hazards plans at all levels of health care planning. Local and state government, including agencies such as MDH, support those responses through declarations and legal and regulatory mechanisms. These may include care guidelines or declarations of Crisis Standards of Care, as required.

Roles and responsibilities

Though the primary focus of this guidance is on the operational strategies for health care facilities during crisis, health care facilities should be supported by local health care coalitions and state and local government agencies. Health care coalitions includes partnerships between local public health, EMS, health care facilities, and emergency management that provide planning and response coordination in each of eight regions of the State. A brief outline of key roles and responsibilities as related to the initiation of the CSC Framework is in the [Roles and Responsibilities Table 2. Surge Capacity](#)

Emergency department space

A location, staff, and basic supplies (ideally packed in bins, pre-event) for overflow care of people with minor wounds, as well as one for family reunification should be planned. Additionally, if there are clinics, supervised living facilities or nursing homes connected to or close to the health care facility, they should be part of the surge capacity plan. Upon activation of the disaster plan, the ED should be cleared to the degree possible by discharging, moving patients to inpatient beds, moving patients to observation areas, and moving stable patients back out to triage as rapidly as possible depending on available space. Inpatient units should be ready to accept patients to decompress the ED, bypassing usual processes. Transfer of patients to other hospitals can also assist with space creation. This may occur by ground or air and by many transportation options (ambulance, bus, private vehicle) as the situation warrants. Although the hospital likely has established referral patterns, other options should be examined in a crisis.

Space – floor space

Conventional beds should be filled and staffed to capacity. The health care facility should know which single rooms can accommodate an additional bed and keep adequate beds in supply to

the degree possible to allow for double rooming. Adequate headers (oxygen, suction, electrical) and privacy curtains are important considerations when planning to double rooms. Additional observation beds, procedure areas, and flat spaces may be used. The health care facility should maintain adequate cots (with egg-crate or other mattresses) to use in flat-space areas for crisis care (also helpful for staff during blizzards and other situations). Patients should be carefully evaluated before being moved to these areas (normal mental status, low risk for pressure ulcers, not in isolation for infection control purposes etc.)

A “surge discharge” process should occur as soon as the EOP is activated. Charge nurses should identify patients that are appropriate for early discharge and move them to a discharge holding area or the hallway/unit waiting area for physician review. This can open up rooms rapidly. If not appropriate for discharge, the patients moved may be appropriate for cot-based care.

When not needed for intensive care unit (ICU)-level care, pre and post-op (i.e., PACU) areas may be used for floor care as well if available. If use of surge areas such as PACU or cot-based care are anticipated beyond the first 24 hours for inpatient care, HCC partners should be engaged to assist with accepting transfers and other support. If other area’s health care facilities are in the same situation, the request of a Centers for Medicare and Medicaid Services (CMS) 1135 waiver should be considered to allow billing for patient care in these areas (see Legal section below).

The health care facility surge plan should include a grid that demonstrates the strategies/areas that will be used for conventional, contingency, and crisis care for quick reference. An example is available in [Table 7-2 of the 2012 IOM Crisis Standards of Care Report](#).

Space – intensive care unit

For planning purposes, ICU services should include the ability to provide cardiac monitoring, invasive monitoring, mechanical ventilation, and hemodynamic management (e.g., pressor medications). Many facilities do not provide these services, although at a minimum, they should be able to provide initial resuscitation and management awaiting transfer to another facility. In certain situations, due to capacity or weather, a health care facility that normally refers critically ill patients may have to continue to provide care for hours to days longer than usual or may elect to provide ongoing critical care using transport ventilators and other resources. In these cases, critical care consultation should be obtained via phone or telemedicine to provide expert input on the care provided until transfer can be arranged or critical care is no longer required.

The American College of Chest Physicians has guidance documents on ICU surge published in 2014. The executive summary with all the suggestions can be found at [Introduction and Executive Summary Care of the Critically Ill and Injured during Pandemics and Disasters: CHEST Consensus Statement](#). Each of the sections has a supporting article (e.g., surge capacity logistics) with further details.

According to the key recommendations made by the American College of Chest Physicians, hospitals that provide inpatient critical care should be able to:

- Surge 20% of usual ICU capacity within hours;
- Surge 100% of usual ICU capacity within 24 hours using facility or regional HCC assets; and
- Surge 200% of usual ICU capacity within days using regional HCC, state, or federal assets.

In order to accomplish this, health care facilities that provide ICU services should determine the spaces of the hospital that could be used for ICU level care. In particular, procedural and surgical areas including pre and post-op care areas are likely targets as they may already have the monitoring equipment necessary for critical care. The health care facility may wish to create a grid for ICU surge similar to that for floor beds indicating the sequence/preference and numbers of beds (as well as additional supplies needed for those areas) to be used. Additional information on planning for ICU surge has been published in *Chest* including principles²⁰⁰ and logistics.²⁰¹

Though planning for a 200% surge is daunting, most facilities will find they have adequate space, and can document the specific additional logistical (staff and supply) needs that may be requested if required. This would primarily occur in a pandemic event, but potentially in other scenarios where the health care facility cannot off-load patients rapidly (e.g., large scale anthrax or botulism attack). Few hospitals will have the ventilator and may not have the cardiac monitor resources to achieve a 100-200% surge, but understanding the needs and planning for it is critical to being able to request the necessary assets in a timely manner from regional and Federal sources.

Inherent in the ICU surge plan is an understanding that the overall acuity at the health care facility will increase markedly, and that lower acuity patients may need to be discharged to outpatient care referred to homecare, long-term care, or provided care at an alternate care site. This may necessitate changes in discharge protocols and health care facility policies about what patients will be cared for on what units.

Space – alternative care sites

In addition to maximal utilization of usual ambulatory care sites, homecare, and hospitals alternate systems of care including telehealth services or screening and early treatment sites may be needed to meet the demands of a crisis incident. Alternate Care Sites (ACS) are developed to accommodate overflow hospital capacity. By providing care to less complex inpatients, an ACS can free up hospital capacity for patients in need of more intensive care. During an incident, a hospital may establish an on-site ACS or a community site may be

²⁰⁰ John L. Hick, Sharon Einav, MD, Dan Hanfling, MD, Niranjana Kissoon, MBBS, FRCPC, Jeffrey R. Dichter, MD, Asha V. Devereaux, MD, MPH, FCCP, Michael D. Christian, MD, FRCPC, FCCP on behalf of the Task Force for Mass Critical Care (2014, October) [Surge Capabilities Principles](#), Volume 146 (Issue 4), Supplement, Pages e1S-e16S.

²⁰¹ Sharon Einav, MD'Correspondence information about the author MD Sharon EinavEmail the author MD Sharon Einav, John L. Hick, MD, Dan Hanfling, MD, Brian L. Erstad, PharmD, Eric S. Toner, MD, Richard D. Branson, MSc, RRT, Robert K. Kanter, MD, Niranjana Kissoon, MBBS, FRCPC, Jeffrey R. Dichter, MD, Asha V. Devereaux, MD, MPH, FCCP, Michael D. Christian, MD, FRCPC, FCCP on behalf of the Task Force for Mass Critical Care (October 2014) [Surge Capacity Logistics. CHEST Journal](#), Volume 146 (Issue 4) Pages e17S-e43s.

established and work in conjunction with the local health system (via multi-agency coordination) to staff and triage appropriate patients to the facility. Examples of some services available at an ACS may include oxygen, intravenous fluids, medications, and basic laboratory testing. Critical care services are generally not available. Health care services must also be made available at community shelters including resources for those with chronic illness.

Alternate systems of care should be implemented by health care coalition partners as part of a regional strategy to address incident demands and may include virtual as well as physical patient contact and interventions.

Staff

Availability of appropriately trained staff is a key limiting factor in disaster response. Health care facilities should have plans and mechanisms to notify and call back their staff, as required, during an incident. In most no-notice scenarios, a brief period of inadequate staffing is followed by too many available staff.

Longer events, such as pandemics, where staff are taxed for long periods of time and absenteeism may be high due to personal or family illness are of particular concern. The Incident Commander should direct the hospital ICS Planning Section to engage appropriate experts to determine what services will be prioritized and direct appropriate staff to provide those services. This could include the use of a multi-disciplinary Clinical Care Committee if resources allow; see [IOM/NAM report 2012 section 4-5](#). For example, clinics may be cancelled to allow staff to participate in inpatient care, specialty clinics might be cancelled to allow additional rooms to see ill ambulatory patients and decrease ED volumes.

Such decisions require careful balancing of the usual medical needs of the community and the demands of the incident, so that patients with acute conditions unrelated to the incident can still be seen and evaluated and issues that do not absolutely require a patient visit (e.g., medication refills) can be addressed using alternative means. Further, staff and others may be asked to contribute to patient care in novel ways (e.g., office staff or family members may provide non-medical care and feeding to the patient, allowing nurses to focus their expertise on medication administration and other patient management, clinic hours may be extended, and electronic visits may substitute for in-person visits).

In some cases, just-in-time training may be used to broaden staff skills, but tasks still need to be delegated appropriately and within scope of practice. For example, staff most able to manage ventilators are registered respiratory therapists. In order to alleviate respiratory therapist workload and allow them to focus on ventilator management, nurses can administer nebulized medications and perform other respiratory care duties within their scope of usual practice. Additional guidance on staff shortages may be found in the SAT Scarce Resource card set can be found at [Patient Care Strategies for Scarce Resources Situations](#).

Supplies

A wide range of supplies may be needed during an emergency or disaster depending on the type and duration of the incident. Due to current just-in-time supply policies, shortages of supplies are likely without proper planning. Increasing par levels of selected medications and supplies can be critical to accommodate a surge in demand. Consideration should be given to placing beds, monitors, and ventilators that are going out of service into storage rather than selling them whenever possible, as these high-cost items are not likely to be available from vendors during an emergency or disaster. Depending on the institution, purchase of some of these items may be possible.

For most hospitals, concentrating on inexpensive but commonly needed supplies such as intravenous fluids, airway supplies, wound care supplies, and medications for analgesia and sedation will provide the highest return on investment when planning for disasters. Additional information on medication, IV fluid, oxygen, and other supplies is available in the [SAT Scarce Resource card set](#).

When supplies are inadequate, a structured approach should be used involving:

- Conservation
- Substitution
- Adaptation
- Re-use
- Re-allocation

Medication shortages are common occurrences and allow health care facilities to practice crisis care strategies by using incident management frameworks and engaging SMEs (physicians in the specialty area, pharmacy staff, administration, nursing) in the decision-making process as they cope with dynamic and multiple medication shortages.

During an incident, when levels of supplies (e.g., PPE) or medications are inadequate, and the supply chain and HCC partners cannot provide relief, the facility's ICS Planning Section should convene appropriate SMEs to look at existing guidance and develop facility recommendations (note that this can also be done at the health system and regional level as needed). If broader resource challenges are present, the Planning Section or hospital Incident Commander, may ask a Clinical Care Committee to convene in order to assist with addressing service, supply, and staff practices. They can help to focus the facility resources on patient care and make recommendations for any necessary triage of services. For example, discontinuing provision of high-intensity services such as extra-corporeal membrane oxygenation (ECMO) when the resource commitment is unsustainable. Detailed information about the membership and function of the Clinical Care Committee is available in the [IOM/NAM 2012 document referenced above and in the template Crisis Care Facility Plan in Appendix 4.1](#).

In an extreme situation, re-allocation of resources may be necessary (i.e. taking a resource from one patient to give to another). In this case, the gravity and complexity of the situation is

markedly increased and the health care facility should have a formal Crisis Care Triage Plan to refer to (see Appendices 4.1 and 4.2 for examples). Note as ECMO is used more frequently, the available capacity is very limited and may have to be triaged, even during significant seasonal influenza years.

Special considerations/capabilities

Certain populations or categories of illness and injury require specialized responses. The health care facility should have appropriate equipment to initially assess and manage emergent needs while awaiting transfer or admission during a surge incident. There are many categories, but a few are worth highlighting, as an unprepared facility poses a risk to both providers and patients. Regional planning, training, and exercising for these specialty situations is strongly encouraged. During an event, HCC support for affected facilities can be critical to avoiding or reducing crisis care situations.

Hazardous materials and decontamination

Hospitals should be prepared to provide decontamination services to arriving patients including wet and “dry” decontamination (dry decontamination = disrobing with redress kits). Dry decontamination may be supplemented by skin wiping (see PRISM guidance at MedicalCountermeasures.gov, [Decontamination Guidance for Chemical Incidents](#)). Provider PPE and training should conform to [OSHA Best Practices for Hospital Based First Receivers of victims from Mass Casualty Incidents Involving the Release of Hazardous Substances](#). Health care facilities should be prepared for large numbers of patients with inhalational exposures following transportation and fixed-facility incidents that may, at minimum, require dry decontamination.

Pediatrics

Every acute care health care facility should have trained personnel and equipment available to manage pediatric emergencies. Additionally, HCCs should have pediatric plans in place that the facility should be aware of. Plans for a pediatric safe area, patient tracking, and on-site surge or transportation plans should be in place. In some situations, the facility may have to hospitalize pediatric patients due to pandemic or weather-related events. The [Minnesota Pediatric Surge Primer and Template Plan](#) provides templates and specific planning information for pediatric mass casualty events.

Burns

Every acute care hospital should have trained personnel and equipment available to provide initial management to burn patients. Health care facilities should plan to stock analgesia and basic dressings according to their size and the HCC expectations and should notify their RHPC as well as their usual burn center partner immediately of a mass burn event. The Metro Mass Burn

and Minnesota State Burn Surge Plan may need to be activated when Hennepin County Medical Center and Regions Hospital Burn Centers²⁰² exceed capacity in which case excess burn casualties may be boarded at Burn Surge Facilities. Burn Surge Facilities are usually regional trauma centers. Additional burn educational and planning materials are available from MDH's Center for Emergency Preparedness and Response (EPR) [Minnesota Burn Surge](#).

High consequence infectious diseases

Health care facilities should have a screening process for fever and international travel that can be updated for domestic exposures and specific countries as required by current epidemics/pandemics. All hospitals should have a plan to provide airborne isolation to suspect cases of tuberculosis (TB), Severe Acute Respiratory Syndrome (SARS)/Middle East Respiratory Syndrome (MERS), variant influenza, and more "usual" diseases, such as measles. Appropriate stocks of N95 masks and barrier precautions should be available with regional strategies for larger events. A regional plan should be in place for initial transportation, screening, and referral to further evaluation for any patient with suspect Viral Hemorrhagic Fever (e.g., Lassa fever, Ebola virus disease) symptoms. The PPE and training for these cases is intensive and requires ongoing commitment to assure provider and patient safety. The biggest danger with suspect viral hemorrhagic fever cases is that a patient with possible symptoms - but without the disease - gets inadequate care and has a poor outcome due to provider reluctance to give care. Health care facilities should assure that appropriate mechanisms are in place to provide initial screening and stabilization care and referral as required based on the level of suspicion. EMS should have protocols on the safe transport and identified destination facilities for suspect cases. For further reference, please see Minnesota Collaborative for Health Care Response to Ebola Conceptual Framework and Collaborative Charter.

Planning and Implementation - General

Indicators and triggers

An "indicator" is a predictor of a possible surge event (e.g., a tornado warning, report of several cases of unusual respiratory illness) that requires gathering of additional information or analysis to decide if a "trigger point" (threshold) has been reached to take action.

There are two types of triggers. Scripted triggers are built into standard operating procedures and are automatic "if/then" decisions. Whenever possible, scripted triggers should be developed for frontline personnel (e.g., point of entry health care facility staff, reception, etc.) so they have actions they can take immediately to prevent delay. Non-scripted triggers require additional analysis and consideration involving supervisory staff. These are often part of an incident action planning cycle. The less specific the information available, the more difficult it is

²⁰² Minnesota state burn centers

to apply a scripted trigger and the more likely an experienced supervisor or subject matter expert (SME) will be involved to process the information and decide on necessary actions. Front line personnel —like an Emergency Department nurse—should have a low threshold for passing indicator information along to supervisors for situational awareness and potential decision-making.

Rather than focus on indicators and triggers in isolation, the facilities should determine what response strategies or options it may employ in a disaster. Then the facilities should decide on indicators that might be available and a trigger point for staff to take action. Though this may sound complex, it is simply establishing thresholds. A tornado warning, while an indicator, does not trigger disaster related actions. A report of a tornado touchdown in a populated area with multiple injuries *should* generate specific actions by hospital staff (disaster plan activation).

Standard Operating Procedures (SOPs) should specify *when* personnel take certain actions (e.g., activate disaster plan for event likely to generate >10 casualties). This is critical to the success of the response. Delays in decision-making occur in unfamiliar situations and with unclear authority. If a clear SOP is in place, the trigger will be automatic.

Triggers are important at every level of response from local to state to federal and the thresholds may vary (e.g., the threshold for a local disaster declaration is different than for a Federal declaration). Detailed information on indicators and triggers (including templates for health care facilities in Table 8-1) is available in the [2015 IOM/NAM report](#).

Out-of-hospital plans

Clinics and ambulatory care centers can provide critical outpatient capacity during pandemics, epidemics, and may be called upon to broaden their scope of care during other protracted events or when health care infrastructure is damaged in the community. These activities should be coordinated with local hospitals and the health care coalition to promote consistency and coordination of care. Clinics should examine their resources and determine potential contingencies such as:

- Extended hours
- Conversion of space and staff from specialty care to primary care duties
- Changes to charting and administration to enhance flow (template charts and prescriptions for the event)
- Changes to scheduling (e.g., cancel or re-schedule elective procedures and appointments)
- Enhanced use of tele-medicine or telephone prescribing
- Adjust clinic flow to avoid exposing well persons to ill persons
- Communicate and implement guidance on scarce resources (e.g. guidelines for prescribing anti-viral medications or administering vaccine)

Homecare and hospice agencies may need to accommodate much sicker patients who have been discharged from hospitals that are concentrating efforts on critical care. These agencies

will need to prioritize patients and caregivers, considering whether certain patient needs can be met with less skilled personnel, fewer visits, or less intensive support in order to successfully manage workload. The use of volunteers to provide check-in and other services may be helpful, as may telephone and other contact with clients. Agencies may not be able to spare workforce to assist with vaccination campaigns and alternative providers may need to be trained to provide the vaccinations, freeing homecare personnel for other, more specialized duties. Coordination with health care coalition planning and response activities can help balance staff and resource demands and promote consistency of response across multiple agencies.

Hospital plans

Hospitals should look at their resources (space, staff, supplies—described in more detail below) and determine their strategy options across the surge capacity continuum from conventional to crisis care as well as looking at specific capabilities in trauma care, critical care, HAZMAT, infectious disease, burn, and pediatrics to meet their objectives. This should be a joint effort involving nursing, administration, emergency management, emergency services, support services (e.g., lab, radiology, respiratory therapy, pharmacy) and physician personnel (as well as surgery and critical care if provided by the institution). Members of the HCC and regional EMS program should be involved to vet the plan when possible, ideally when still in draft form. Indicator and trigger thresholds for crisis care should be determined whenever possible (e.g., crisis status exists when any cot-based care is provided or any ICU care is provided outside usual intermediate and pre/post op areas). These triggers will vary by facility depending on size and resources. Additionally, the institution should decide, based on its role in the community and the presence or absence of other health care facilities in the area what number of general or specialty mass casualty patients will be planned for based on suspected hazards. For example, a critical access hospital might prepare for up to 10 total casualties with up to 5 being small children, whereas an urban Level 1 trauma center might prepare for up to 100 significantly injured patients, with up to 20 small children.

Once the indicators and triggers have been determined, the surge capacity information (including crisis care) should be written into the health care facility emergency operations plan (EOP) to give personnel clear expectations of what they will do and when they will do it. It should also include the notifications to supervisors and partner agencies that need to occur when these triggers are activated. Delegating authority to activate the disaster plan to Emergency Department staff or nursing supervisors'/charge nurses should be done when possible to facilitate rapid action. The adoption of clear policies helps facilitate decisions as well as provides accountability.

Education, training, and exercising should be conducted to assure successful implementation of the plan. Job aids such as brief task cards should be widely used to help front line personnel with initial decisions and actions. During an event response, the facility should review and modify their procedures as needed as part of the incident action planning process. Plans should be flexible to not “lock in” disaster response protocols for the duration of an incident but allow flexibility and transition toward conventional care as more resources arrive or demand falls, or both (i.e., do not keep triaging resources when you have enough available).

Provider engagement

Health care providers must clearly understand the rationale for crisis care planning, the ethical principles underlying triage decisions, and the specific plans of the institution. Staff should be divided into tiers for education (e.g., knowledge, competency, proficiency) about the specifics of the crisis care plans based on their role in the response. For example, a floor nurse should understand how the surge plans affect their unit, including use of cots and changes in staffing). A nursing supervisor should understand when to activate crisis care plans, and who to notify that this is occurring. Staff who are fulfilling incident command roles should understand the interface with the health care coalition, where to get help or expertise, and be prepared to adopt proactive crisis care strategies with input from subject matter experts. It is critical that providers who may be called upon to make reactive triage decisions (e.g., emergency medicine physicians, trauma surgeons) understand not only the ethical principles, but which criteria may be ethically considered when making triage decisions. Examples of criteria to consider may include, prognosis, duration of use, the amount of resources likely to be used, and the duration of benefit. For more detail on ethical decision-making during a crisis care situation or initiation of the Minnesota CSC Framework, please reference *Attachment 1—Ethical Guidance for Crisis Standards of Care*.

Exercises

Though it is difficult to fully exercise crisis care situations, providing table-top and other opportunities to walk through the process will help administrators and clinical staff become more comfortable with their roles and responsibilities relative to crisis care and will help drive modifications of existing plans. Exercises should also test the interface with the regional health care coalition to emphasize that under no circumstances should a health care facility be providing crisis care without reaching out for assistance from partner facilities.

Integration with regional operations

Minnesota is divided into eight health care preparedness program (HPP) regions, each of which has a health care coalition (HCC) consisting of leadership from health care facilities, EMS, public health, and emergency management. Each region has a Regional Health Care Preparedness Coordinator (RHPC) who works primarily with the health care facilities and EMS, and a corresponding Public Health Preparedness Consultant (PHPC) who works with local and tribal public health agencies. The RHPCs and PHPCs have direct communication with the State Health Department. For information on your local coalition please reference the map and contact information at: <http://www.health.state.mn.us/oep/healthcare/coalitions/index.html>.

It is critical that health care facilities do *not* work on surge and crisis care plans in isolation, but in concert with their regional partners and with their parent health systems, as applicable. Consistency of plans and knowing what other health care facilities in the region are planning is critical to success. Surge strategies and standard procedures do not have to be identical, but if they are similar, it will help greatly in education, training, and mutual aid response. HCCs help

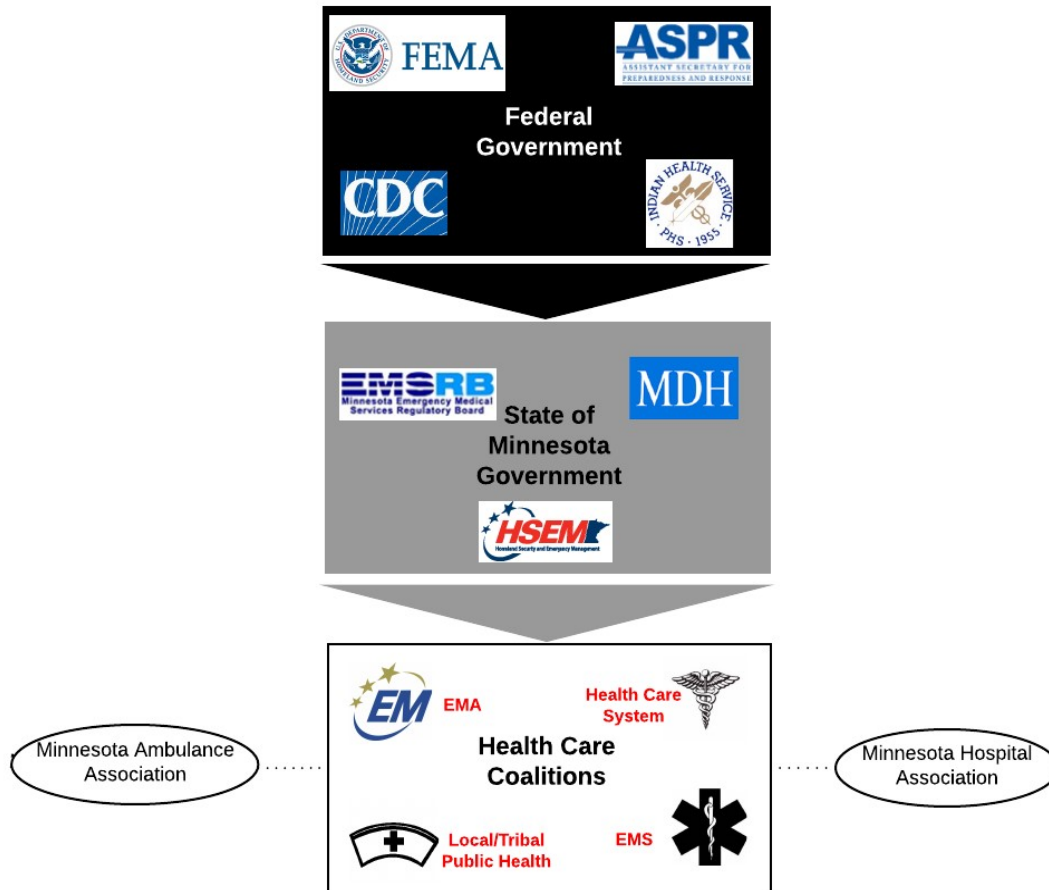
coordinate not only planning, but also response activities. During a response, the HCC assures information sharing between health care facilities, EMS, and public health and provides support for and between disciplines in the area including resource management support (e.g., facilitating resource requests for staff or supplies between health care facilities). They can also engage with neighboring coalitions and the State (MDH/EMSRB) to coordinate information and strategies. HCC members interface with emergency management to assure that resource requests are met through established processes and a common operating picture is maintained. They may also convene workgroups during planning or a response to help develop regional tactics (e.g., to support alternate care sites or processes during a response or develop common policies such use and conservation of N95 masks).

The key is to **only implement crisis strategies when assistance from regional partners is inadequate (either too little or too late) and no “bridging” therapies or patient transfers can address the need**. Assuring regional coordination and leveraging of available resources prevents inappropriate transition to crisis standards of care. Coordination with the regional partners *must* be achieved as soon as possible when a crisis situation develops so patient care can return to conventional operations as soon as possible. The sooner a crisis situation is recognized (indicators), pre-planned resources and coordinating mechanisms are activated (triggers), and then the shorter the crisis period will be. The goal of emergency planning, and having good surge capacity plans is to *avoid* provision of crisis care. Detailed information about hospital surge capacity planning is beyond the scope of this Attachment but some key areas connected to crisis care are highlighted below.

Figure 4.2: Relationships

Figure 4.2a demonstrates the relationships between the Health Care Coalitions, health care, EMS, public health, tribal health, government, and non-governmental partners.

CRISIS STANDARDS OF CARE FRAMEWORK
HOSPITAL GUIDANCE



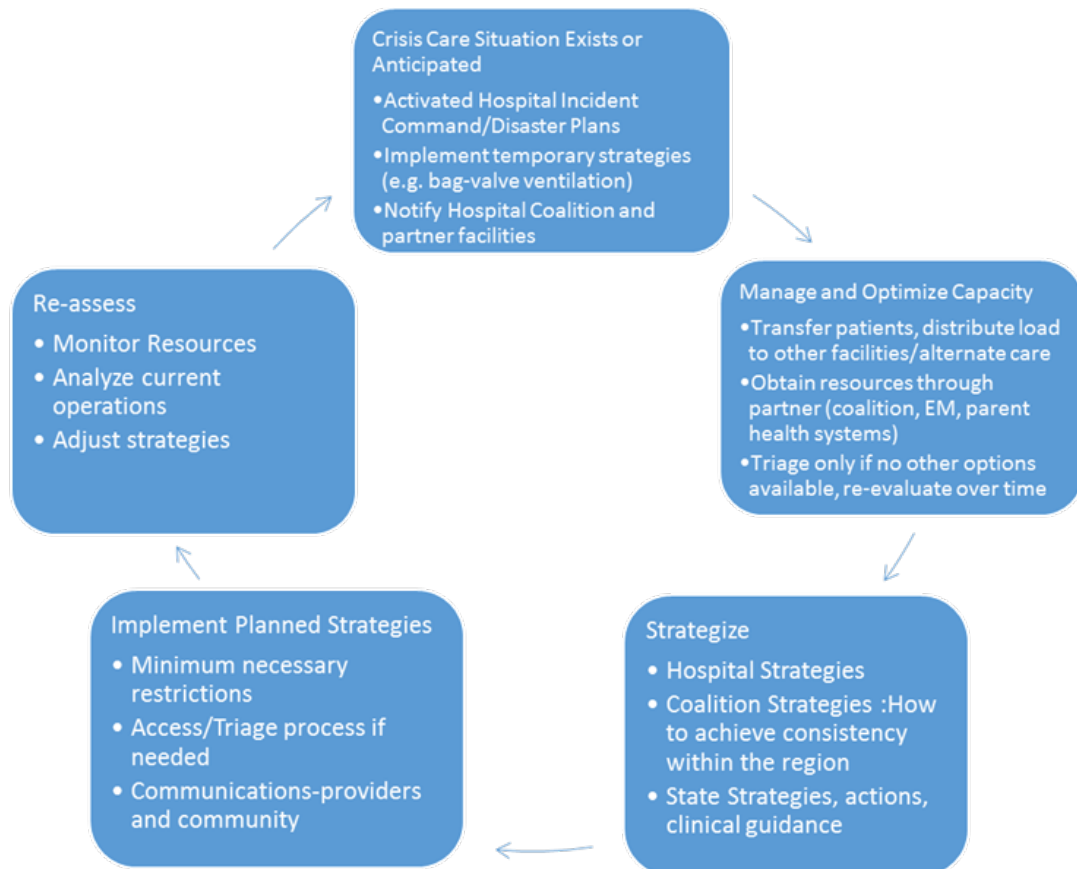
As for the MDH All Hazards Plan, MDH will use the National Incident Management System (NIMS) as a basis for supporting, responding to, and managing Plan activities. Incidents and events are managed at the lowest possible geographic, organizational, and jurisdictional level using NIMS. A key element of NIMS is the Incident Command System (ICS). ICS is a fundamental standardized form of management that provides a common organizational structure. Here at MDH, we organize our responses to an incident or event using ICS.

NIMS also stipulates that all disasters are local. On this note, all disasters will first be addressed on a local level with local/Tribal Public Health, the local EMS, the local Emergency Management Agency (EMA), the local health care systems, and finally the regional health care coalition (HCC). Each of the eight public health regions in the state has a health care coalition established for health care emergency preparedness and response coordination. HCC membership includes hospitals and other health care entities, jurisdictional emergency management, local and tribal public health, Emergency Medical Services and additional members such as behavioral health, dialysis centers, federal health facilities and long-term care. The coalitions engage members through regular meetings, training opportunities, exercises and all-hazards planning.

When resources and capacity are reached at a local level, response entities will go to the State and when State capacity and resources are reached the federal government will become involved. Federal resources and assistance will all be coordinated through the state. The only caveat to this is that Tribal Nations, as sovereign entities may request disaster assistance directly from the federal government.

Figure 4.2b: Hospital process diagram

Figure 4.2b is a hospital process diagram that facilities would use in a crisis standards of care situation much like the planning P used in ICS to help guide the process and steps involved in responding to an incident.



Triage

Framework

Triage generally refers to prioritization for care or resources. For example, emergency department patients are triaged for placement in the department based on their acuity. In rare situations, a lack of resources may require a more difficult type of triage that requires re-allocation or denial of a specific treatment, which may be prioritized based on prognosis or risk. For example, a patient without risk factors for complicated influenza may not qualify for antiviral medication. Or, in a more extreme event, a patient might not be able to receive critical care due to their poor prognosis. This type of triage, performed after initial stabilization or during ongoing care (and in comparison to others that need the resource) is termed tertiary triage.” Frameworks are available for this type of burn and critical care triage and in the [MDH Scarce Resource Card set](#) noted prior.

More important than any clinical frameworks are the plans and process for tertiary triage decisions at the facility level. A triage plan should involve SMEs informing the Incident Commander and Planning Chief, likely through a Clinical Care Committee. This is mainly an issue at larger facilities providing ICU care. In situations where this type of triage is required during a protracted incident, MDH will provide guidance and convene the Science Advisory Team (SAT) to provide recommendations. The SAT/CSC is an expert group of clinicians that provide clinical recommendations to the commissioner regarding resource allocation and triage. For example, they were convened to work on re-use and conservation protocols for N95 masks during the H1N1 pandemic.²⁰³

Ethical considerations

The accompanying Ethics Attachment (see *Attachment 1—Ethical Guidance for Crisis Standards of Care*) to the Minnesota Crisis Standards of Care Framework provides a comprehensive overview of considerations for providers. Providers and health care administrators should be familiar with that document and potential resulting conflicts and pitfalls that can be made. In general, triage decisions must meet the five basic requirements outlined in the IOM/NAM 2012 publication:

1. **Fairness**—process recognized as fair, equitable, evidence based, and responsive to specific needs of individuals and the population focused on a duty of compassion and care, a duty to steward resources, and a goal of maintaining the trust of patients and the community.

²⁰³ Insert web link citation to the card set

2. **Transparency**—in design and decision making
3. **Consistency**—in application across populations and among individuals
4. **Proportionality**—public and individual requirements must be commensurate with the scale of the emergency and degree of scarce resources (i.e. the restrictions on care should not be more restrictive than the situation requires – and this may require re-evaluation as more resources become available).
5. **Accountability**—of individuals making the decisions and of the facilities and governments to support the processes and the providers.

Reactive triage

Reactive triage occurs in the early phases of the incident where the situation and information are fluid and the physicians and nurses will have to prioritize access to care and treatments based on their best judgment.

Mass casualty triage after a no-notice event is reactive, as it is performed based on limited information about the event, in a dynamic resource environment, and is usually performed by a single experienced provider. Generally, patients with altered mental status, signs of shock, penetrating torso injury, uncontrolled bleeding, and respiratory distress are highest priority. It is rare to have to categorize patients during this process as expectant (and therefore to receive palliative care as their only intervention) but this is possible in an overwhelming situation.

Factors to consider:

- Time required to perform treatment
- Treater requirements (i.e., how much physician/nursing expertise is required)
- Treatment requirements (what are the resource requirements)
- Prognosis of the injury—for example, elderly patients with massive burns, patients in severe traumatic shock with torso injuries at a hospital that does not provide surgical services, patients with severe coma (e.g. GCS = 3)²⁰⁴ immediately after trauma at a center that does not provide neurosurgery should take lower priority than patients with more favorable injuries/illness.

In general, the more victims there are, the more that the triage process should prioritize the moderately injured that require interventions (e.g. chest tube, airway management, and tourniquet) that will save their life and can be rapidly performed. It is always critical to re-evaluate patients as more resources arrive, however, as patients should always receive resources when they are able to. Finally, if multiple patients present with identical prognosis to

²⁰⁴ The Glasgow Coma Scale (GCS) is a neurological scale commonly used in medical care. A score of 3 is the lowest possible score a patient can receive.

a hospital that has minimal resources, a first-come, first-served or lottery strategy may have to be implemented.

Proactive

Proactive triage may be required later in an incident that continues to overwhelm the health care system after initial stabilization and delivery of available resources. The situation and resources are now known. Decisions revolve around whether resources can continue to be expended given the patient prognosis. A systematic approach should be taken that considers available evidence, resources, and has administrative backing of the facility.

Proactive triage of resources should only occur when the following conditions are met and unless specified otherwise, the patient should continue to receive all other means of support. The patient should always have equitable access to medications to control pain and suffering to the degree possible given the circumstances:²⁰⁵

Proactive triage conditions to meet:

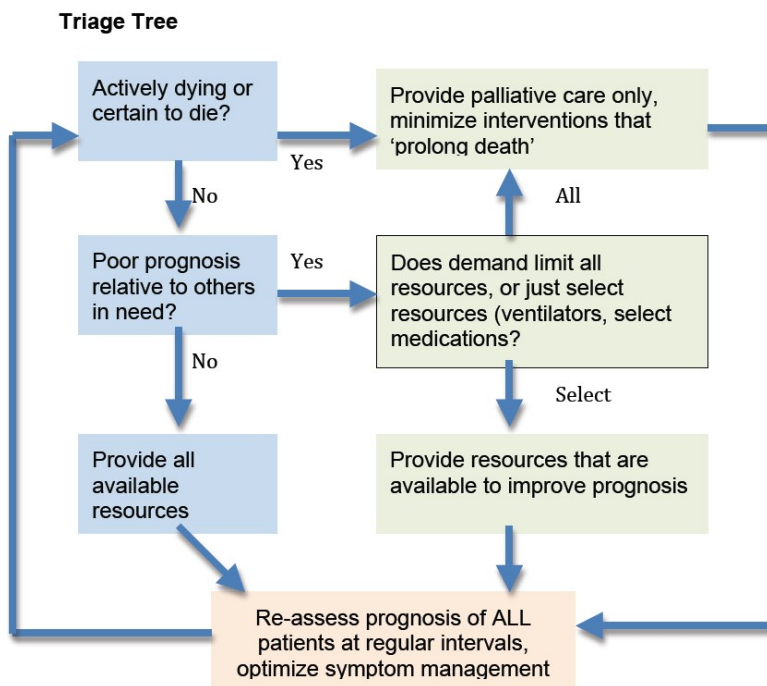
- Critically limited resource(s) and infrastructure are identified.
- Surge capacity is fully employed within health care facilities (and regionally) if capacity/space is the limited resource.
- Maximal efforts to conserve, substitute, adapt, and reuse are insufficient if supplies are the limited resource.
- Regional, state, and federal resources are insufficient or cannot meet demand.
- Patient transfer or resource importation is not possible or will occur too late for bridging therapies (such as bag-valve ventilation or other temporizing measures) to be considered.
- Necessary resources have been requested from local and regional health officials (as applicable).
- A state of emergency has been declared, or other health powers (as applicable) have been activated.

Once a proactive triage situation is recognized (trigger) or anticipated (indicator) the facility should assure that a triage process is in place. The triage *process* is far more important than the specific clinical decision tools, which may vary based on the event. The facility can expect to receive guidance on decision tools from MDH during an emergency in which proactive resource allocation would be required on a large scale. The Clinical Care Committee/SMEs must provide a process and agree on indications for treatment (e.g., specific medications) or approve decision tools for triage of ICU and other resources.

²⁰⁵ IOM/NAM Crisis Standards of Care (2009) table 4-14

If required, a triage team (usually clinicians *not* directly responsible for the care of the patient) should be available for consultation. This function may be provided regionally and remotely depending on the regional plan. For example, health systems may provide this function for all their health care facilities and the same team may provide assistance to outside health care facilities that wish to refer patients or do not have the resources to effectively make triage decisions. This would be a very unusual situation mainly limited to a severe pandemic though limitations on interventions like ECMO could be subject to regional shortages on a more frequent basis and may require similar processes – optimally implemented on a regional basis by those institutions providing these services.

Figure 4.3: Triage tree example



An additional, more detailed example of a triage plan can be found in *Addendum 4.2*. HCC activities during crisis care event will be robust, as the goal is to maintain a consistent level of clinical care within the region. Resource allocation, alternate care strategies, policy development, and agreeing on regional decision tools are all roles for the health care coalition members during an event.

Legal and regulatory considerations

Local, state, and federal agencies can provide support for crisis operations through a variety of mechanisms in addition to obtaining resources and providing guidance and policy directives for responders. A variety of legal and regulatory actions can be implemented during disasters that can facilitate payment, reduce liability, and permit response activities that would not normally be allowed without a disaster declaration. The ability of the Governor of Minnesota and the

President of the United States to issue emergency declarations and promulgate enforceable orders and rules to address the contingencies created by a mass casualty event are provided by law. Some of the more important State and Federal laws that may apply to the preparedness for, response to, and recovery from an emergency or disaster are summarized in *Attachment 2—Legal Authority and Environment for Crisis Standards of Care*.

Tribal and territorial areas are independent legal entities, and though they interface with surrounding jurisdictions, they are self-governing and have the ability to make and enforce their own laws and rules. Tribes are also allowed to directly seek Federal assistance though in most cases they will also interface with the State as resources are often available more rapidly through local and State channels than Federal.

Statutes and ordinances

Agencies that issue rules, such as the [Minnesota Department of Health and the EMS Regulatory Board](#)²⁰⁶ have their authorities and some enforcement actions in statute (law). Laws are more difficult to modify, even in times of emergency. Rules, on the other hand, are more easily suspended. In relation to health care facilities, the Commissioner of Health maintains authority to implement provisions of Minnesota’s mass dispensing laws (Minn. Stat. §151.37, Subd. 2(b)) if the commissioner finds such action necessary to protect the public health and safety and provides for broad authority and protections in the types, use and administration of those medical interventions. It is possible a health care facility, or other acute care setting might be utilized as a point of distribution (POD) in an emergency and health care facility personnel, including emergency managers, lawyers, and staff will need to know what their role will be in this situation. Additionally, specific State rules and regulations governing hospital operations may be waived if the suspension of these would facilitate crisis care strategies. Provider licensing requirements may be adjusted or suspended, by the respective boards, to allow out-of-state and other providers to practice, or to allow an expansion of scope of practice. For example, prescribing exemptions or allowances for providers to administer vaccinations they are not normally licensed to provide.

Liability

A catastrophic disaster which causes initiation of the CSC Framework may raise legal and liability concerns among health care and public health professionals due to their potential liability risk when extreme service demands, coupled with constrained supplies and diminished personnel, prevent provision of usual services and care expected by the community. Although lawsuits resulting from emergency planning or services rendered during an emergency or disaster are rare, responders may nonetheless be comforted in knowing what laws currently exist that might afford protections against lawsuits that might be leveled against them for actions undertaken – or not undertaken – during a response.

There are four major areas of protection to keep in mind:

1. If a responder is not going to receive any substantial reimbursement for the care, the Good Samaritan laws protect that responder from liability unless it is “willful and wanton” misconduct. However, the Good Samaritan law does *not* apply to providers within a health care facility in Minnesota, though it would apply at aid stations and other non-health care facility locations.
2. Responders acting on behalf of the State (e.g., Medical Reserve Corps, MN Mobile Medical Team) have broad liability protections and damage caps from the State
3. Responders that are working in alternate care sites approved by the State have broad protections regardless of whether they are paid to be there
4. Medical malpractice is situational. Just as a critical access hospital cannot be held liable for not having a trauma surgeon on a daily basis, in a disaster you are held to the standard of care that a “reasonable provider” would have given in that situation with those resources. Therefore, if you are following plans or guidance developed by reasonable providers prior to the incident it would be very hard to obtain a legal judgment.

For a comprehensive review of Minnesota laws providing liability protections to emergency responders please see *Attachment 2—Legal Authority and Environment for Crisis Standards of Care*.

Reimbursement: 1135 waiver

Finally, there may be insurance/payor issues that need to be addressed during crisis care. Generally, the Centers for Medicare and Medicaid Services (CMS) and private insurance has very specific care requirements for inpatient care. However, if the health care facility is not operating normally (tornado) or the facility is overwhelmed and the patient must be cared for in a non-traditional fashion because of lack of alternatives, the Secretary of HHS may authorize an 1135 waiver that can allow reimbursement under specific disaster codes. A Federal declaration must be obtained prior to seeking an 1135 waiver and information justifying why the actions are in the patients’ best interest must be supplied to the regional CMS office. MDH may make 1135 waiver requests on behalf of EMS or health care facilities. For additional information please see Requesting an 1135 Waiver at [cms.gov](https://www.cms.gov) or *Attachment 2—Legal Authority and Environment for Crisis Standards of Care*.

Facilities should keep careful records and work with local Emergency Management on these administrative and financial issues. In general, private health care facilities are not eligible for reimbursement of costs of providing care under the Stafford Act though there are exceptions and there is eligibility in case of facility damage, etc.

Conclusion

Effective crisis care planning for health care facilities depends on multiple factors including the following:

- Crisis conditions may be caused by severe increases in demand and/or facility damage and require immediate facility and regional response, with State actions (including declarations and legal and regulatory action) following and supporting the response strategies.
- Most crisis care situations can be resolved within or between coalitions by diffusing initial impact from one facility to multiple facilities and thus broaden the supply of resources to meet the demand.
- Crisis of care plans should be an extension of hospital surge capacity plans. Integration into the facility all-hazards Emergency Operations Plan is important for seamless response. Formal resource allocation and triage processes may be written into a separate appendix or Attachment.
- Crisis conditions should prompt coalition and, when necessary, prompt State actions to assure that resources are obtained to move care back to contingency and then conventional status as soon as possible.
- Having a process to involve SMEs at the facility in the Incident Command process (including creation of a Clinical Care Committee when feasible based on facility/health system size) is critical to assure fairness and best clinical practices given the limitations of the situation.
- Having a triage process in place is much more important than specific triage decision support tools – incident specific guidance if required will be made available by the MDH, specialty societies, the CDC or HHS/ASPR. General guidance is available on the scarce resource card set from the MDH Science Advisory Team.

Addendum 4.1 – Sample hospital CSC plan

Activation

A disaster has occurred that overwhelms X health care facility. Resources are inadequate to provide a usual standard of care. Resources are not rapidly available, and systematic adaptations must be made to provide the best care possible under the circumstances. Examples include:

- Surge capacity is overwhelmed and patient care is being provided on cots or inadequate qualified staff are available
- ICU capacity is overwhelmed due to a pandemic
- Burn unit capacity is overwhelmed due to a massive fire/blast incident

Notifications

- Hospital IC (Incident Commander) will notify Regional Health Care Preparedness Coordinator (RHPC) or on-call of situation (xxx) xxx-xxxx and attempt to obtain needed resources
- If needs cannot be met in the region the RHPC will:
 - Notify Minnesota Department of Health (MDH) Center for Emergency Preparedness and Response
 - Notify other health care facilities in the X Regional Coalition of situation
 - Notify jurisdictional emergency management and public health
 - Establish Multi-Agency Coordination (MAC) including the above agencies to determine policy and information needs

Actions

Short-Term strategies: Short-term strategies to increase health care facility capacity should have been implemented. If the resource shortages can be quickly addressed (e.g., within hours to days) by these strategies crisis care may not be necessary or may be very brief:

- Rapid discharge of emergency department and outpatients that can safely continue their care at home.
- Rapid assessment and early discharge of inpatients (surge discharge)
- Transfer of patients to other institutions in metro/state/adjoining states

CRISIS STANDARDS OF CARE FRAMEWORK
HOSPITAL GUIDANCE

- Transfer of patients to alternate facilities (if they are available)—these may be permanent (long-term care facility) or temporary (alternate care site), or usual health care facilities in an adjacent region/state.
- Cancellation of elective surgeries and procedures, with re-assignment of surgical staff and space (e.g., post-anesthesia care area, endoscopy suites).
- Reduction of usual use of elective imaging, laboratory testing and other ancillary services.
- Expansion of critical care capacity by placing select ventilated patients on monitored/stepdown beds, using pulse oximetry (with high/low rate alarms) in lieu of cardiac monitors, or relying on ventilator alarms (which should alert for disconnect, high pressure, and apnea) for ventilated patients, with spot oximetry checks.
- Call-in of appropriate staff.
- Changes in staff scheduling (e.g., may elect to change duration of shifts or alter staffing ratios – however, longer shift duration during an infectious event may be detrimental to staff who may not adhere to PPE recommendations when fatigued), or changes in staff assignments (all nurse educators work clinical shifts, etc.).
- Changes in documentation requirements and release from administrative, teaching, and other responsibilities.
- Request for supplemental staff from partner hospitals, clinics.
- Conversion of single rooms to double rooms or double rooms to triple rooms if possible.
- Designation of wards or areas of the facility that can be converted to negative pressure/isolated from rest of ventilation system for coalescing contagious patients.
- Use of cots and beds in flat space areas (classrooms, gymnasiums, lobbies) within the health care facility for non-critical patient care.
- Communication with staff and public, educate staff about specifics of incident and provide just-in-time training on specialty patient care (e.g., burns, highly contagious infections, toxic exposures). Develop web-based modes of communication and education for staff.
- Provision of behavioral health support for patients and family members.
- Provision of staff support including feeding, behavioral health support, family/pet support and access to supplies (gas, groceries, etc.).

Long term strategies: These are usually employed in a >24h incident which will continue to require a crisis standard of care due to pervasive region-wide demands on resources. A State declaration of emergency should occur; planning cycles will be implemented by the hospital incident commander. Strategies may include:

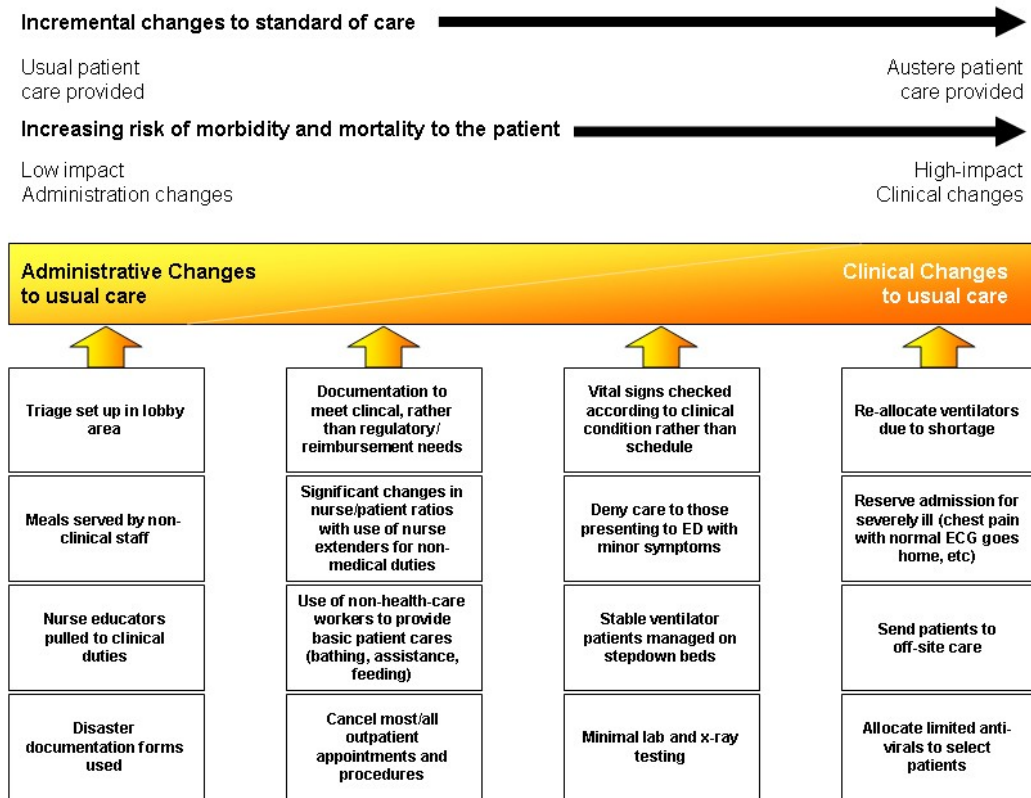
- Staffing: in addition to usual staff sharing, medical reserve corps, Federal personnel, public health, and other personnel may be used as needed.
 - Determine need for non-employee assistance in the facility (e.g., provision of non-medical responsibilities, supervision by health care facility staff mentor, etc.).

CRISIS STANDARDS OF CARE FRAMEWORK
HOSPITAL GUIDANCE

- Determine a preference list of providers (e.g., facility staff first, followed by local hospital staff, followed by clinic staff, out-of-state licensed staff, retired staff, EMS personnel, medical reserve corps, trainees, non-health care organization staff, military personnel assigned to the response, or lay volunteers that might assist the facility during an incident).
- Determine need to use family members to provide patient care/feeding duties
- Facilitation of home-based care for a larger proportion of patients in cooperation with public health and homecare agencies.
- Establish mobile or temporary evaluation and treatment facilities in the community to supplement usual clinic locations. These locations may also be used to screen those with mild symptoms when medications (e.g., anti-virals) are available for treatment.
- Establish guidelines and public messaging directing potential patients how to evaluate symptoms and care for themselves at home, indications for seeking medical evaluation and treatment, whether evaluation and treatment for some conditions can safely be delayed, and locations of available care.

At this point, the IC must incorporate a structured assessment of health care facilities services and resources on a daily basis as part of the Incident Action Plan. The IC should examine the administrative and clinical adaptations needed each operational period based on the incident demands. Administrative, rather than clinical adaptations should be emphasized until no longer possible.

Figure 4.1.1: Altered Standard of Care Document Image²⁰⁷



Process for implementing crisis standard of care (see flowchart addendum 4.3)

1. Incident commander recognizes that systematic clinical changes will be required to allocate scarce resources to those most likely to benefit.
2. Planning chief gathers any guidelines, epidemiologic information, resource information, and regional health care facility information and schedules meeting or conference call with IC and designees to clinical care committee.
3. Clinical care committee is convened by IC – membership may vary depending on incident and facility resources:
 - A. Health care administrator
 - B. Medical Director (Medical Care Director)

²⁰⁷ Altered Standards of Care in a Mass Casualty Event (Current as of April 2005), Retrieved from Agency for Healthcare Research and Quality, Available at [Appendix A, Expert Meeting on Mass Casualty Medical Care Participant List](#).

CRISIS STANDARDS OF CARE FRAMEWORK
HOSPITAL GUIDANCE

- 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. Community representative (if possible – similar to Institutional Review Board role)
 - M. Ambulatory care (clinics)
 - N. Other – may include lab, radiology, bioelectronics, pharmacy, palliative care, burn staff, etc.
4. Clinical care committee reviews situation, outside guidance, and regional/state health care facility efforts and determines:
- A. Methods to meet patient care needs (for example, use of non-invasive ventilation techniques, changes in medication administration techniques, use of oral medications and fluids instead of intravenous, etc.). These will generally be of limited value in correcting large demand/resource deficits, however. Use MDH scarce resource guidance (see Patient Care Strategies for Scarce Resource Situations).
 - B. Additional changes in staff responsibilities to allow specialized staff to re-distribute workload (for example, floor nurses provide basic ICU patient care while critical care nurses oversee these nurses and their patients) or would incorporate other health care providers, lay providers, or family members to provide assistance based on their skillset.
 - C. Mechanism for reassessment of local and regional health care facility efforts and strategies (e.g., assignment of liaison officer and establishment of regular communications loop with state Science Advisory Team and any regional entities).
 - D. 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).
5. Committee reviews options for:
- A. Location of care (triage of patients to critical care, floor care, off-site care, home based on disease severity)

- B. Assignment of resources (which patients will receive resources in limited supply – ventilators, anti-toxin, etc., or which will not be offered such interventions when there are competing demands).
6. Committee summarizes recommendations for care for next operational period and determines meeting and review cycles for subsequent periods (e.g.: daily meeting, twice daily conference call, etc.) assuring that regional efforts at the MAC level or RHPC level are integrated into facility process/timelines.
- A. Incident commander approves recommendations and integration into Incident Action Plan (IAP). Section chiefs and Command Staff briefed and PIO assures communications to all staff.
 - B. Information is disseminated to inpatient services, outpatient services, RHPC. Daily conference calls with RHPC involving critical care, infectious disease, command staff, as indicated by circumstances

Re-allocation of ventilators or other critical care or limited resources

1. Current inpatients, patients presenting to the health care facility, and their family members are given verbal and printed information - by the triage nurse in the ED with reinforcement by physician - explaining the situation and explaining that resources may have to be restricted or re-allocated, even once assigned, in order to provide the care to those that will most benefit. A contact point (phone extension) for responding to patient/family questions and concerns should also be included, as should spiritual support contact information.
2. Access controls should be implemented appropriate to the situation.
3. Assure behavioral health resources and appoint palliative care unit leader if needed.
4. Triage plan for each operational period:
 - A. Emergency department/Outpatient screening of patients (and denial of service to patients either too sick or too well to be benefited by evaluation/admission) based on current regional resources and regional/MDH guidance as well as facility resources.
 - B. Triage team – Two physicians from the affected discipline (usually two critical care or one critical care and one relevant specialty physician - infectious disease, burn surgeon, etc.) consider ventilator and other resource allocation decisions acting on data supplied by units/teams in concordance with MDH strategies (see appendix) and other evidence. (If ECMO is the resource in question one of the physicians should have ECMO expertise).
 - a. When two patients have essentially equal levels of illness/prognosis, a “first-come, first-served” policy should be used.
 - b. When, according to guidelines or the triage team’s clinical experience, the prognosis is not equal, the patient with a substantially more favorable prognosis shall receive the resource.

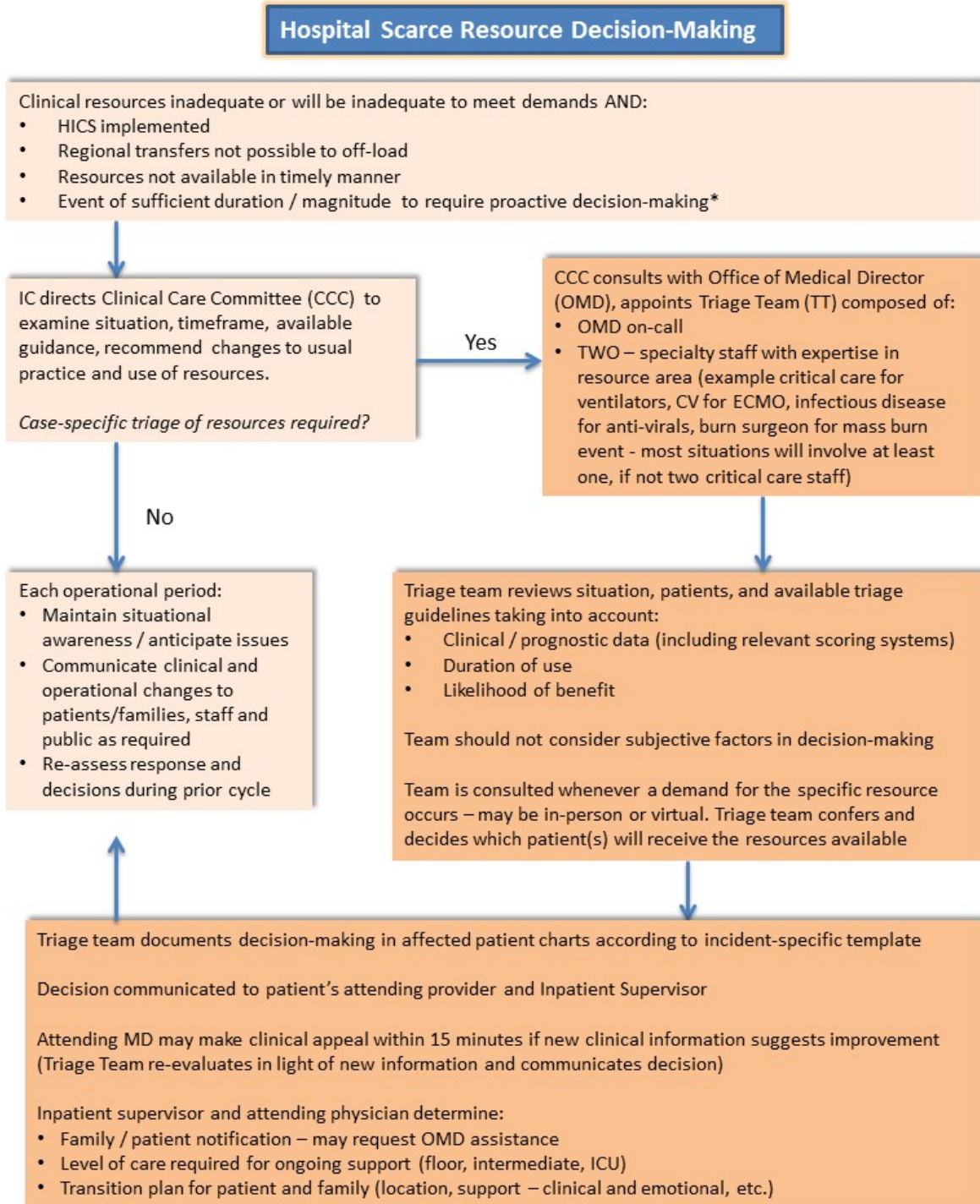
CRISIS STANDARDS OF CARE FRAMEWORK
HOSPITAL GUIDANCE

- c. The triage team should ask for and receive whatever patient information is necessary to make a decision but should NOT consider subjective assessments of the quality of the patient's life or value to society. (The treating physician should assure that the patient/family wishes to use the ventilator or other resources if they are available prior to asking the triage team for an opinion).
 - d. Triage team should pass recommendations to the inpatient unit leader and document decision-making on templates in the affected patient(s) charts
 - e. Note that in some situations health care facility staff may participate on regional triage team on rotating basis.
5. The inpatient unit leader should maintain situational awareness of the facility. This individual should have access to:
 - A. ED and other outpatients waiting for beds (both floor and critical care units)
 - B. Inpatient bed status including pending transfers into/out of critical care areas.
 - C. Clinical status of patients by unit (i.e., improving: able to move to floor status or discharge or worsening: may require critical care or may not be eligible for continued treatment). This requires ongoing contact between the inpatient unit leader and the clinical units to assure that information is up to date and accurate so that good decisions can be made. The leader will work closely with the Triage Team to determine the best use of beds available.
6. The process and rationale for resource assignment should be provided to the attending physician and family: Office of the Medical Director staff may act as messenger to the family as desired/necessary):
 - A. Grounds for the decision
 - B. An appeals process that allows a period of time (appropriate to the intervention being allocated – for ventilators 15 minutes) for the attending physician to request re-consideration of the decision if there is new objective information available that that patient's prognosis is more favorable than determined by the triage team.
 - C. The resource allocation protocol and decisions should be reviewed by the clinical care committee and additional oversight physicians at set periods (e.g., every 24-48 hours) and as needed to assure the best evidence available is being used and that the decisions and the system are operating justly.
 - D. The inpatient areas supervisor and the attending physician will agree on the level of care required for the patient after the allocation decision is made – floor, intermediate, or ICU
 - E. **Note:** in most cases all means of available support should continue to be offered aside from the resource triaged, and should the patient improve or more resources become available they may re-qualify for a resource, unless decision expected to result in a non-survivable state (e.g., ventilator re-allocation).

CRISIS STANDARDS OF CARE FRAMEWORK
HOSPITAL GUIDANCE

7. Assure adequate symptom relief and comfort for all patients as possible based on the available resources.

Addendum 4.2—Hospital scarce resource decision-making tree



*Algorithm and plan does not apply to immediate, reactive triage decisions in the early phase of a disaster (e.g. ED, trauma surgery) or to non-emergency circumstances (specialty providers will engage colleagues in decision-making). This algorithm is a summary of select actions in the HCMC Crisis Care Annex which should be referred to for further details

Attachment 5—Public Engagement for Crisis Standards of Care

STRATEGY AND REPORT

Intro

In order to ensure the Crisis Standards of Care (CSC) Framework reflects community values and priorities from around the state, Minnesota engaged in a series of public engagement sessions during 2017 and 2018. Public engagement is a process by which citizens engage in dialogue around “complex public problems”.²⁰⁸ Rather than confining citizens to a reactionary role, public engagement creates a space where community members may partake in active deliberation and collaborate with officials to create policies that reflect public opinion and values.

Purpose

Public engagement in crisis standards of care (CSC) is particularly important for several reasons. First, engaging the public in discussions around CSC not only increases understanding of what these standards are and when or why they might be enacted, but it also increases awareness of the need for general disaster preparedness. Second, encouraging public participation in crafting CSC ensures that the plan created reflects community values and priorities thereby both legitimizing the CSC planning process and resulting Framework as well as ensuring greater public acceptance of the standards should they need to be activated in the future.²⁰⁹

Background

The Institute of Medicine/National Academies of Medicine (IOM/NAM) identifies public engagement as an essential piece of the CSC planning process in its 2012 Crisis Standards of Care Framework and outlines six principles of successful public engagement:

1. Policymakers must be committed to considering and integrating public input into CSC guidance. This means that the CSC planning process should not be so far along at the time of public engagement as to leave little room for incorporation of the public’s feedback and input.
2. Public engagement sessions should accurately represent the community. All efforts should be made to recruit diverse participation in engagement sessions including those populations that may be considered at-risk or hard-to-reach.
3. Participants are both provided information on CSC as well as given the opportunity to deliberate and discuss issues surrounding CSC.

²⁰⁸ Public Engagement: A Primer from Public Agenda (2008, January 1). Retrieved from <https://www.publicagenda.org/media/public-engagement>

²⁰⁹ IOM (Institute of Medicine). 2012. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*. Washington, DC: The National Academies Press.

4. To this end, deliberation should be considered a goal in and of itself. Although consensus may not be reached, active deliberation at the community level helps to “reveal misunderstandings, biases, and areas of deep disagreement”.²¹⁰
5. Public input should be given consideration in the CSC decision-making process. Further, ways in which this will happen should be made explicit to participants at the start of all engagement sessions.
6. Finally, strong leadership and top-down support, as well as sufficient resources to complete the process, should be given to public engagement.

Scope

The IOM/NAM offers a public engagement toolkit that organizations may use to structure their public engagement sessions. The Minnesota Department of Health (MDH) used a modified version of this toolkit to conduct its CSC public engagement sessions. The following strategies were used:

- Seven engagement sessions took place across the state of Minnesota from spring 2017 through spring of 2018. A draft of the CSC Framework was available and ready for public feedback during this time.
- Volunteers from local public health and health care coalitions assisted with five of the sessions performing tasks such as staffing the sessions, identifying and recruiting participants, and advertising the sessions.
- Two of the sessions were co-hosted by a local nonprofit organization. Volunteers from the organization assisted with recruiting participants, securing a location for the sessions, and facilitating the small group discussions.
- All sessions ran for two hours and included a presentation on CSC and MDH’s work thus far.
- Feedback was gathered from participants through electronic polling, a patient-ranking exercise, and small group facilitated discussions.
- Topics covered in the facilitated discussions included patient prioritization methods, factors that matter most when you cannot save everyone, fairness in decision-making, and whether certain populations (i.e. health care workers) should receive treatment priority.
- Data from the sessions was collected and analyzed both quantitatively and qualitatively and a summary report from the sessions can be found on the MDH website. Session participants were provided a copy of this summary report.

²¹⁰ IOM (Institute of Medicine). 2012. *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*. Washington, DC: The National Academies Press.

Next Steps

In order to promote broad public dissemination of the CSC Framework, as well as ensure feedback collected comes from community members who are demographically representative of the state, MDH will continue conducting engagement sessions throughout the next several years. MDH will strive to engage community members, representative of the diverse demographics of the state with an eye towards health equity.

In order to ensure equity, efforts will be made to engage groups that have been historically marginalized, including individuals with access and functional needs (such as the disability community) and immigrant and refugee populations. MDH will seek the help and consultation of community leaders and/or liaisons to these groups and will seek the following assistance from these community experts:

- Strategies for effectively engaging the specific population
- Identification of potential community partnerships and other recruitment strategies
- Recommendations on effective agenda development, facilitation and other considerations related to the engagement process

In addition to the above groups, MDH will continue to engage participants from the general population as well as recruit participants from the faith-based community, the elderly, tribal nations, rural and urban communities, and Minnesota's primary immigrant populations including East and West Africans, Hispanic/Latino, Hmong, and Karen peoples.

Data from future sessions will continue to be collected, analyzed, summarized, shared with participants, and posted publically. Major themes and considerations from the engagement sessions will be incorporated annually into the CSC Framework and MDH operations to ensure the recommendations therein reflect the values and priorities of Minnesotans.