



Minnesota Crisis Standards of Care Framework

MINNESOTA DEPARTMENT OF HEALTH CONCEPT OF OPERATIONS

Updated: 02/25/2020

Minnesota Crisis Standards of Care Framework: Concept of Operations

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

To obtain this information in a different format, call: 651-201-5700. Printed on recycled paper.

Contents

Letter from Minnesota Department of Health Commissioner	iv
Introduction	1
Purpose	2
Scope.....	2
Authority	2
Planning Assumptions.....	3
Definitions.....	3
Background	5
Continuum of Care.....	5
Risk Profile.....	6
Concept of Operations.....	8
Indicators/Triggers.....	8
Threat Assessment.....	8
Communications	9
Roles and Responsibilities.....	12
Triage/Management of Scarce Resources	17
Mental and Behavioral Health Considerations.....	17
Demobilization and Recovery	17
Plan Maintenance and Review	18
Appendix A: Abbreviations and Acronyms	19

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

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 public health event that could generate a change in standard of care by warranting a shift in focus from individual patients to the good of the community. In these situations, demand often exceeds available resources, warranting proactive steps to coordinate a statewide response for a prolonged period, assuring the best care possible despite resource limitations.

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 the 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

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 (SAT) 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.

The [Minnesota Crisis Standards of Care webpage](#) contains multiple resources including information specific for health care facilities, emergency medical services (EMS), public engagement, and overviews of both legal and ethical considerations during a crisis standards of care situation.

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 Plan.

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

Purpose

The goal of this Framework is to:

- Outline the MDH response during a Crisis Standards of Care situation and
- Provide planning guidance and strategies to health care entities (e.g. hospitals, health care coalitions, emergency medical services etc.) and public health organizations to manage the transition from conventional to contingency to crisis care during a Crisis Standards of Care situation and develop their own crisis standards of care plans (Figure 1).

Scope

The Minnesota CSC Framework defines MDH actions and role during a pervasive or catastrophic public health event that generates a change in standard of care due to scarce resources (e.g. staff, space, supplies). It does not supersede or replace the MDH All Hazards Response and Recovery Plan (AHRRP), nor does it create new authorities or change existing authorities.

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 involve the support of the State and other levels of government. The government role is to support ongoing, substantial changes in operations and medical care decision-making during a prolonged emergency, 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. 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. Crisis standards of care situations requiring state action are extremely rare (e.g., severe pandemic) and assumes HCCs, health care facilities, and other local agencies have developed their own plans.

Therefore, the CSC Framework also provides planning guidance and strategies for HCCs, health care facilities, EMS, and other local agencies to develop their own crisis standards of care plans. These strategies provide ethically sound, proactive guidance to provide the best care possible when demand for resources far exceed availability. The planning guidance and strategies are outlined in five attachments. Each attachment includes additional details regarding each subject matter area and should be utilized by stakeholders for their crisis standards of care planning. The five attachments are:

- Ethical Guidance for CSC,
- Legal Authority and Environment for CSC,
- Surge Operations and Crisis Care for EMS,
- Surge Operations and Crisis Care for Hospitals, and
- Public Engagement for CSC.

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 (MEMA).² Minnesota Statutes Chapter 144 grants the 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 pervasive or catastrophic public health event in the State of Minnesota. 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. For more detail, please see [Legal Authority and Environment for CSC](#).

Planning Assumptions

1. Initiation of the CSC Framework will occur in stages and will be inclusive of a variety of public and private entities.
2. Statewide initiation of CSC will likely occur only during a pervasive or catastrophic public health event that overwhelms both local and regional capacity.
3. Resources are scarce and cannot be obtained by health care facilities in time to prevent resource triage.
4. Crisis strategies have been activated by other health care delivery systems and consistency is needed across the state so equitable levels of care are offered.
5. Patient transfer is not possible or feasible, at least in the short-term.
6. Access to medical countermeasures (vaccine, medications, antidotes, blood products) are limited.
7. Available local, regional, state, federal resource caches (e.g., equipment, supplies, and medications) have been distributed, and there is no foreseeable short-term resupply of such stocks is.
8. Adaptive and alternate strategies have been exhausted or are not appropriate.
9. Multiple health care access points within a community or region are impacted.³

Definitions

Several terms used throughout this Framework are defined here:

Capability: The ability to manage patients requiring very specialized medical care.⁴

Capacity: The ability to manage a sudden influx of patients.⁵

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.⁶

² The Minnesota Emergency Management Act is codified at Minn. Stat. ch. 12.

³ Crisis Standards of Care, IOM/NAM, p. 1-10, 2012

⁴ ASPR. *2017-2022 Health Care Preparedness and Response Capabilities*. pg. 44

⁵ ASPR. *2017-2022 Health Care Preparedness and Response Capabilities*. pg. 44

⁶ 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.

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 care.⁷

Conventional care: Usual resources and level of care provided. The maximal use of the facilities' usual beds, staff, and resources is ensured.⁸

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 event, 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.⁹

Health disparities: Systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups; they may reflect social disadvantage, but causality need not be established.¹⁰

Indicator: 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). An indicator may identify the need to transition to contingency or crisis care (but requires analysis to determine appropriate actions).¹¹

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.”¹²

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-threatening illness, through the prevention, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems.’”¹³

Trigger: A “decision point about adaptations to health care service delivery” that requires specific action. A trigger event dictates action is needed to adapt health care delivery and resources. Triggers can be scripted or non-scripted. Scripted triggers are built into Standard

⁷ 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.

⁸ 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.

⁹ IOM 2009.

¹⁰ 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

¹¹ 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

¹² PGCEA, B. (2011). Moral distress and moral courage in everyday nursing practice. *Online journal of issues in nursing*, 16(2), 1B.

¹³ 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.

Operating Procedures (SOPs) and are automatic ‘if/then’ actions. Non-scripted triggers require additional analysis and consideration involving management and supervisory staff.¹⁴

Background

Continuum of Care

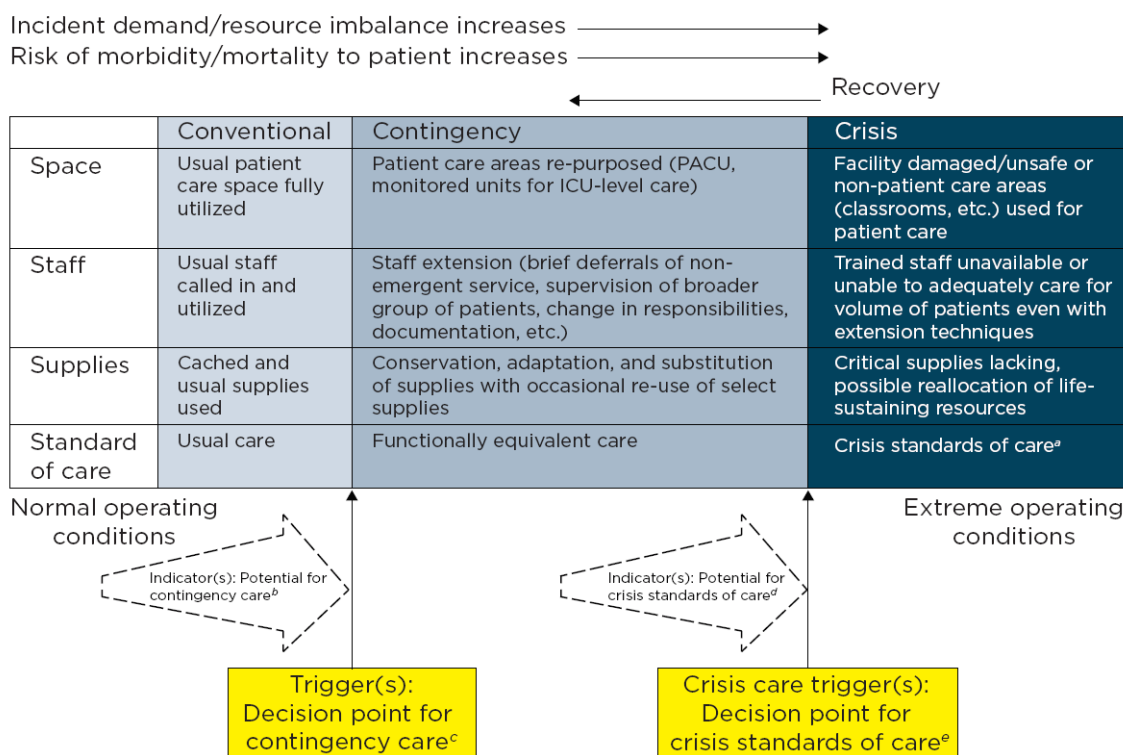
Figure 1 (below) illustrates the continuum of care, from conventional care, transitioning to contingency care and finally crisis care. During conventional care, customary routine services are provided with no issues (e.g. use of available inpatient beds). During contingency care, care provided is *functionally equivalent* to routine care but equipment, medications, and even staff may be used for a different purpose or in a different manner than typical daily use (e.g. substituting one antibiotic for another that covers the same classification). 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 pervasive or catastrophic public health event, increases 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, emergencies are dynamic, and care moves back and forth along this continuum during an incident. 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 after a local emergency can usually transfer patients and bring in resources within hours to get back to contingency or conventional status. In this example, a State response is not warranted. The activation of a State response is at the end of the continuum of care and is only utilized 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, this indicates crisis care is occurring and outside support is needed.

¹⁴ 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

Figure 1: Allocation of specific resources along the care capacity continuum¹⁵



Risk Profile

Demographic groups such as immigrants, seniors, children and people with disabilities may have different and specialized needs following a disaster. Crisis care strategies 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. The following table summarizes some demographics pertinent to CSC planning in Minnesota:

¹⁵ FIGURE 2-2 Allocation of specific resources along the care capacity continuum.

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 needs—shift to community-centered decision making. SOURCE: IOM/NAM, 2009, p. 53.

Table 1: State of Minnesota Demographics

Category	Demographic	Number or Percent
Population ¹⁶	Total	5,611,179
	Under 5 years	6.3%
	Under 18 years	23.2%
	Over 65 years	15.9%
	Foreign born persons (2013-2017)	8.2%
Race and Hispanic Origin ¹⁷	White	84.1%
	Black/African-American	6.8%
	Hispanic or Latino	5.5%
	Asian	5.1%
	American Indian/Alaska Native/Native Hawaiian	1.5%
Household Makeup ¹⁸	Persons per household (2013-2017)	2.49
	English other than English spoken at home (% of persons 5 years +)	11.3%
	Secondary Languages (percent of total population) ¹⁹	3.4% Spanish 3.1% Hmong 1.15% African Languages 0.11% North American Native Languages
	Median household income (2013-2017, 2017 dollars)	\$65,699
	Persons in poverty	9.5%
	Health ²⁰	With a disability, under 65 years
	With a disability, under 18 year	0.9%
	With a disability, under 5	0.7%
	Persons without health insurance, under 65 years	5.1%
	Electricity-Dependent Medicare Beneficiaries ²¹	34,300

¹⁶ U.S. Census Bureau. QuickFacts. July 2018 estimates.

¹⁷ U.S. Census Bureau. QuickFacts. July 2018 estimates.

¹⁸ U.S. Census Bureau. QuickFacts. July 2018 estimates.

¹⁹ 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.](#)

²⁰ U.S. Census Bureau. QuickFacts. July 2018 estimates.

²¹ U.S. Department of Health and Human Services. emPOWER Map. August 2019.

Concept of Operations

Indicators/Triggers

MDH might consider the following indicators and triggers to activate a Crisis Standards of Care response:²²

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);
- 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. At the State level it will be much more common that indicators are reviewed and appropriate actions determined based on the problem and potential solutions.

Threat Assessment

Per the Minnesota Department of Health All-Hazards Response and Recovery Base Plan (AHRRP), MDH may receive information that suggests or indicates a potential or actual public health threat or business interruption from a variety of sources. In a crisis standards of care situation, the indicators will most likely come from hospitals, health care coalitions or other health care entities.

MDH staff that receive threat warning information must assess and report their findings according to the standard operating guidelines for their program or division. For more details, please see the MDH AHRRP, Section IV, Figure 2.a. and Appendix A (Version 2019).

²² 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

Communications

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 Minnesota Emergency Operations Plan (MEOP) for directing and coordinating health-related communications activities during an incident with public health implications. A crisis standards of care situation will require extensive communication, coordination and collaboration among all involved so messaging is clear and consistent statewide.

MDH Internal Notification

A crisis standard of care situation should result in a threat assessment level of "Orange-Be Ready" or "Red-Take Action".²³ Internal notifications of MDH staff and actions will follow the MDH AHRRP.

Notification of External Partners

MDH Center for Emergency Preparedness and Response (CEPR) staff will send notifications to appropriate response partners including, HCCs, the Minnesota Hospital Association (MHA), health care organizations, local and tribal health departments, and others. Response partners maintain their 24/7 contact information in the MDH PartnerLink system.

Activation

Per the MDH AHRRP, MDH will activate at an activation level (Levels 1-4). An activation at Level 3 or 4 may require the activation of other state agencies and the State Emergency Operations Center (SEOC). MDH is the lead agency for health and medical response in the SEOC and the MDH Department Operations Center (DOC) would work in conjunction with the SEOC.

Depending on circumstances, MDH-CEPR may advise the Commissioner of Health to activate the Science Advisory Team (SAT) to provide clinical considerations and recommendations on scarce resource allocation, triage, and other national guidance relevant to the situation. The SAT project manager (MDH-CEPR staff) maintains the membership's 24/7 contact information in the MDH PartnerLink system.

On-Going Communication

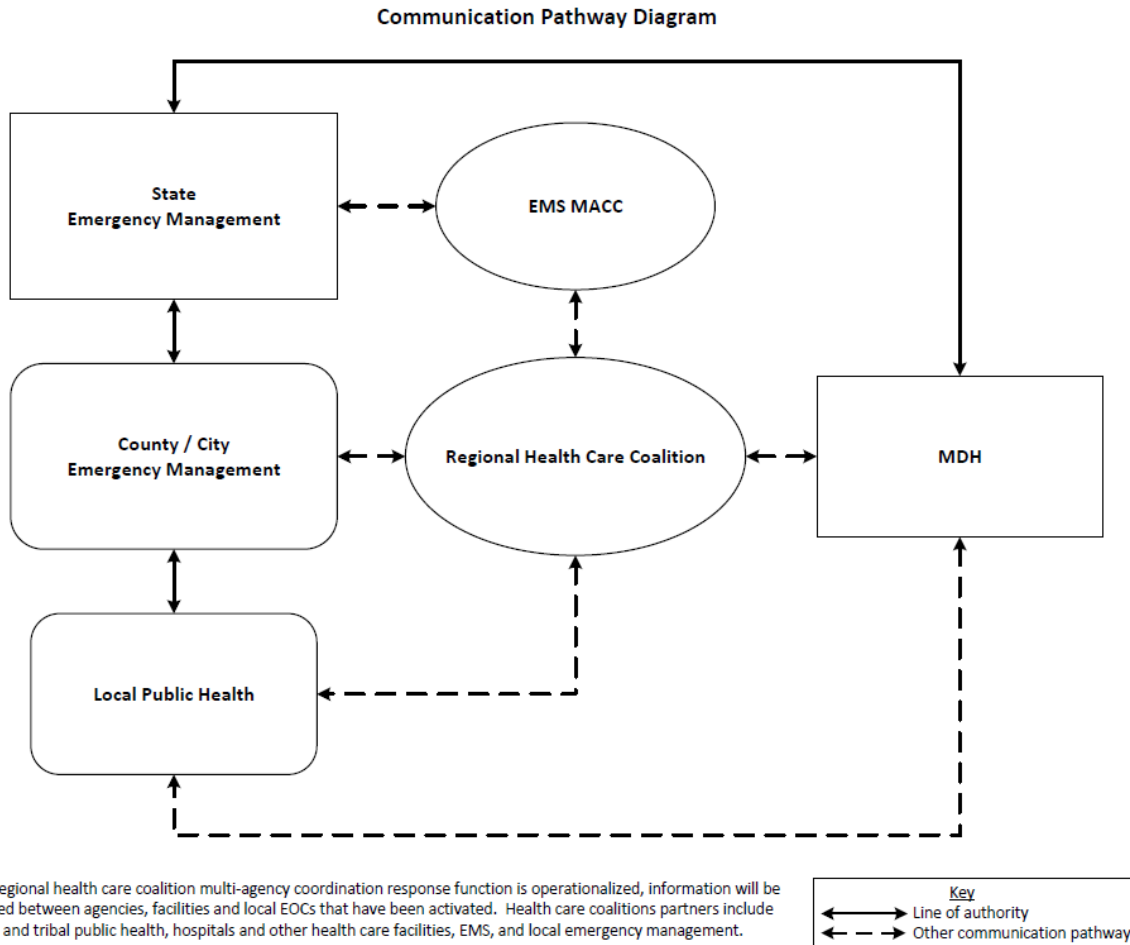
During a crisis standards of care situation, transparent communication is of the utmost importance. Figure 2 below demonstrates the communication pathways between state agencies, local agencies, and HCCs. Methods for communicating both internal and external stakeholders may include:

- Health Alert Network (HAN) messages; Minnesota system for Tracking Resources, Alerts and Communications (MNTrac);
- Public Information Officer (PIO) advisories and guidance documents;

²³ MDH All-Hazards Response and Recovery Base Plan, Version 2019,
<https://www.health.state.mn.us/communities/ep/plans/allhazardsbase.pdf>

- Materials developed in preparation for, or generated in connection with conference calls (e.g. agendas or minutes).

Figure 2: Communication Pathway Diagram



Public Information

Under the MEOP, MDH is responsible for directing and coordinating health-related communications activities during an incident with public health implications. When the SEOC is active, public/media communications are coordinated through the State Joint Information Center (JIC) via the Lead 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.

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

CRISIS STANDARDS OF CARE

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 public about the incident.

Roles and Responsibilities

A brief outline of key roles and responsibilities related to the activation of the CSC Framework is in the table below.

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
Governor	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 event 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 to discuss or develop incident specific medical/resource clinical guidance and triage criteria. Activate other subject matter experts (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 PIO will develop MDH communications to public and providers on the crisis issues.
Commissioner, MDH	Lead health official;	<ul style="list-style-type: none"> Approve implementation of CSC Framework when necessary during a public health event/disaster response.

CRISIS STANDARDS OF CARE

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
	authorizes activation of CSC Framework	<ul style="list-style-type: none"> ▪ 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 Centers for Disease Control (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 MEOP and the Governor’s Executive Order 15-13 Assigning Emergency Responsibilities to State Agencies. ▪ Deploy Ambulance Strike Teams (AST), mass casualty incident buses, additional ground or air ambulances from regions as requested by local EMS agencies through the State Duty Officer or SEOC.

CRISIS STANDARDS OF CARE

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
		<ul style="list-style-type: none"> ▪ 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 guidelines through the State EMS Medical Director and the Medical Director Standing Advisory Committee.
Science Advisory Team (SAT)	Subject Matter Experts	<ul style="list-style-type: none"> ▪ Provide ethical clinical, operational and policy expertise to MDH Commissioner of Health during a pervasive or catastrophic public health event. ▪ Develop ethical crisis care strategies for health care providers prior to and during a response requiring scarce resource allocation. ▪ Assist with disseminating information regarding altered standards of care.
Regional Health Care Coalitions (HCCs)	Regional coordination of health/medical response	<ul style="list-style-type: none"> ▪ Information sharing and coordination of activities among coalition members (e.g. public health, hospitals, EMS, and emergency management). ▪ May provide/develop regional policies for disaster response/crisis care. ▪ Help manage resources between health care facilities 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 events at local level	<ul style="list-style-type: none"> ▪ Determine jurisdictional public health activities and interventions and coordinate efforts with HCC partners. ▪ 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 local hotlines. ▪ Communicates health alerts and other information to partner agencies. ▪ Provides community based interventions (e.g., prophylaxis or vaccination).

CRISIS STANDARDS OF CARE

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
		<ul style="list-style-type: none"> Implements social distancing and other community-based infection control measures as applicable.
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. 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"> 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 (PSAP)/9-1-1 Dispatch Center	Support agency	<ul style="list-style-type: none"> Answers 9-1-1 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/SOPs. 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.

CRISIS STANDARDS OF CARE

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
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).
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 HCC. Consider alternate care sites (ACS) for austere medical care.
Indian Health Service Clinics and Hospitals²⁴	Acute patient care	<ul style="list-style-type: none"> Provide clinical support to tribal members. Provide situational awareness to tribal emergency managers and regional HCC. 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 MDH in communicating pertinent information with hospitals and health care facilities across the state.

²⁴ 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).

Triage/Management of Scarce Resources

During a pervasive or catastrophic public health event, MDH will rely on the core strategies of crisis care when altering the standard of care. They are:

- **Prepare:** Pre-event actions taken to minimize resource scarcity.
- **Substitute:** Use an essentially equivalent device, drug, or personnel for one that would usually be available.
- **Adapt:** Use a device, drug, or personnel that are not equivalent but that will provide sufficient care.
- **Conserve:** Use less of a resource by lowering dosage or changing utilization practices.
- **Re-use:** Re-use (after appropriate disinfection/sterilization) items that would normally be single-use items.
- **Re-allocate:** Restrict or prioritize use of resources to those patients with a better prognosis or greater need.

In the event the State enacts Crisis Standards of Care to afford protections to medical professionals, MDH will recommend statewide compliance with the [MDH Patient Care Strategies for Scarce Resource Situations](#). These strategies—created by the SAT—are ethically grounded and approved strategies that if followed, provide legal protections to medical providers. Additionally, this would apply to any other material, protocols, strategies, etc. the SAT may recommend during the incident.

It is the responsibility of health care facilities, EMS agencies, and other entities to include crisis care strategies—including optimization of surge capacity, triage and resource allocation—in their respective emergency operations plans (EOP). MDH recommends incorporating the [Patient Care Strategies for Scarce Resource Situations](#) directly into these plans. Stipulating strategies for health care providers to utilize in these situations will minimize their role in difficult triage decisions and preserve mental wellbeing.

Mental and Behavioral Health Considerations

In a Crisis Standards of Care situation, loss and trauma will directly affect many people and will impact nearly all activities of daily living. 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.

MDH will 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. Specific resources are located on the [MDH Behavioral Health and Emergency Preparedness](#) website.

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 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 end 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.

Plan Maintenance and Review

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 MDH SAT and additional SMEs within MDH as appropriate. 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 exercises will be conducted on an ongoing basis as per the MDH-CEPR training and exercise schedule with internal and external partners with an emphasis placed on the coordination components within this Framework.

Appendix A: Abbreviations and Acronyms

Abbreviation or Acronym	Definition
AHRRP	Minnesota All-Hazard Response and Recovery Plan
ASPR	U.S. Department of Health and Human Services, Assistant Secretary for Preparedness and Response
AST	Ambulance Strike Teams
CDC	Centers for Disease Control and Prevention
CEPR	Minnesota Department of Health, Center for Emergency Preparedness and Response
CSC	Crisis Standards of Care
DOC	Department Operations Center
EMAC	Emergency Management Assistance Compact
EMS	Emergency Medical Services
EMSRB	Minnesota Emergency Medical Services Regulatory Board
EOP	Emergency Operations Plan
HAN	Health Alert Network
HCC	Health Care Coalition
HHS	U.S. Department of Health and Human Services
HPP	Hospital Preparedness Program
HSEM	Minnesota Department of Homeland Security and Emergency Management
ICU	Intensive Care Unit
IDEPC	Minnesota Department of Health Infectious Disease, Epidemiology, and Prevention Control
IOM	Institute of Medicine
JIC	Joint Information Center
MDH	Minnesota Department of Health
MEOP	Minnesota Emergency Operations Plan
MHA	Minnesota Hospital Association
MNTrac	Minnesota system for Tracking Resources, Alerts and Communication
MPEP	Minnesota Pandemic Ethics Project
NAM	National Academy of Medicine

CRISIS STANDARDS OF CARE

Abbreviation or Acronym	Definition
PIO	Public Information Officer
PSAP	Public Safety Answering Point
SAT	MDH Science Advisory Team
SEOC	State Emergency Operations Center
SME	Subject Matter Expert
SOP	Standard Operating Procedure