DEPARTMENT OF HEALTH

Minnesota Framework for Contingency Conditions and Crisis Standards of Care

ETHICS

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Minnesota Framework for Contingency Conditions and Crisis Standards of Care: Ethics

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Disclaimer

This document summarizes recommendations to ethically address planning for and responding to pervasive or catastrophic public health events. It does not carry the force of effect of law, and it should not be construed as a statement of legal or regulatory requirements and protections. Significant limitations on resources will affect implementation of these recommendations. The organizations implementing these recommendations will need to determine the priority and process for addressing them, given available resources. Partners should make every effort to implement recommendations presented herein.

Introduction

Overview

Establishing appropriate plans for a pervasive or catastrophic public health event (hereafter, public health event or simply event) requires addressing complex ethical issues. The National Academies of Sciences, Engineering and Medicine, Institute of Medicine (IOM)—now the National Academy of Medicine (NAM)—(referred to as the IOM/NAM in this document) maintains that an ethical framework forms the "bedrock" for event preparedness (Institute of Medicine, 2009). The IOM/NAM outlines a broad ethical framework for such events, 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 healthcare professionals question whether they can maintain core professional values and behaviors in the context of a disaster." (Hanfling, Altevogt, Viswanathan, & Gostin, 2012)*

The IOM/NAM maintains that an ethical framework for preparedness and response must thus include these key features: fairness, the duty to care, the duty to steward resources, transparency, consistency, proportionality, and accountability. The IOM/NAM report offers preliminary analyses of these norms (Hanfling, Altevogt, Viswanathan, & Gostin, 2012).

While discussions about preparedness and response often use the terms "crisis" or "emergency" to refer to all pervasive or catastrophic public health events, it should be noted that those terms also have specific meanings in this context. 'Crisis'—as in crisis conditions or crisis standards of care (CSC)—refers to a particular stage in the continuum of care involved in public health events in which shortages pose a substantial risk to patient outcomes and resource allocation must consider the needs of all, rather than focusing on the individual. 'Emergency' can refer to formal declarations of emergency, with their associated legal powers and authorities. As will be discussed in greater detail below, clarity on these concepts promotes more effective preparedness and response. Thus, this framework will reserve these terms for contexts involving their specific technical meanings and will refer to the broad array of situations requiring preparedness and response as pervasive or catastrophic public health events (or simply, public health events).

Purpose and scope

This guidance applies to preparedness and response activities across public and private organizations, including public health agencies, healthcare systems, emergency services, and other essential service providers. It is intended to support planning and response during public health events, while recognizing that its core ethical commitments and strategies also apply in other organizational contexts.

Public and private systems alike have a duty to plan for public health events, to promote effective and ethically appropriate responses. The framework offers general ethical guidance for a range of public health events—such as pandemics, natural disasters, and bioterrorism—where demand for services may surge and resources become scarce, requiring altered operations and, at times, crisis allocation. Because each event presents unique challenges, context-specific analysis is required. The guidance does not provide medical or operational criteria for triage, but rather ethical direction to inform planning and decision-making alongside scientific evidence and logistical planning.

In addition, certain recommendations—like those associated with triage—depend heavily on medical, logistical, or other factors. This guidance does not seek to address those issues. It offers ethical guidance for how to implement triage when it is needed; it does not offer the medical criteria necessary to predict or prioritize patients based on expected short-term outcomes. Data must be collected and medical/scientific guidelines or best evidence applied to utilize the ethical guidance offered. In general, these ethical considerations are meant to guide the development and implementation of response plans, not to replace operational and logistical planning activities. MDH may issue statewide guidance on management of such shortages, to support a broad community standard and promote collaboration to enable the best care possible for patients. In such cases, organizations should proactively apply these ethical principles to guide contingency or crisis care as needed, even in the absence of a formal emergency declaration.

Framework development

This framework is based on decades of work including national standards (Institute of Medicine, 2009; Hanfling, Altevogt, Viswanathan, & Gostin, 2012; Hick, Hanfling, & Cantrill, 2012; Institutes of Medicine, 2013) (Hanfling, Altevogt, Viswanathan, & Gostin, 2012), literature reviews (Leider, DeBruin, Reynolds, Koch, & Seaberg, 2017), and extensive community engagement conducted as part of the Minnesota Pandemic Ethics Project (www.health.state.mn.us/communities/ep/surge/crisis/panethics.html) (Vawter, et al., 2010; DeBruin, et al., 2010) and additional projects (DeBruin, Negri, Wu, Hick, & Leider, 2025) sponsored by MDH.

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 this ethical framework; they constitute the most basic ethical obligations for public health event planning and response. These ethical commitments largely mirror those embraced by Minnesota Pandemic Ethics Project (www.health.state.mn.us/communities/ep/surge/crisis/panethics.html) (MPEP), given its extensive process of expert analysis, stakeholder consultation, and community engagement (Garrett, et al., 2011). However, while MPEP focused on rationing scarce resources during influenza pandemics, this project aims to develop a broader ethical framework for a variety of public health events.

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") (Hanfling, Altevogt, Viswanathan, & Gostin, 2012).

Ethical objectives

Three (3) equally important and overlapping ethical objectives should be met in all public health event planning and response to honor the fundamental ethical commitments noted above. They are: (1) protect the population's health; (2) respect individuals and groups; and (3) strive for fairness and protect against systematic unfairness.

Protect the population's health

- Minimize mortality and serious morbidity from the public health crisis.
- Minimize mortality and serious morbidity from disruption to basic healthcare, public health, public safety and other critical infrastructure and services.

Planning and response must address the needs of individuals with injuries or illnesses that are directly related to the disaster, as well as health needs related to the impact of the public health event on critical infrastructures. Direct impacts include, for example, injuries related to building collapse or flying debris in tornadoes, cases of anthrax in bioterrorist attacks, or influenza in pandemics. Public health events may have complex impacts on critical infrastructure. For example, an event may overwhelm the healthcare system and significantly complicate the provision of routine care. There may also be public health consequences resulting from the impact of public health events on critical services other than healthcare, including clean water, reliable power, and sanitation services.

Public health protections can include, for example, plans to carefully steward resources when supplies are insufficient to meet needs, and limits on public gatherings to reduce strain on the healthcare system. The goal is to maximize benefits to the population as a whole.

While preparedness and response focuses on protecting human life and health, it should also attend to the risks disasters pose to animals. For example, if evacuation plans do not address needs of animals, owners may refuse to evacuate without their pets or return to care for their animals before it is deemed to be safe, leading to failed evacuations and an increased health

risk for these owners (Blendon, Benson, DesRoches, Lyon-Daniel, & Mitchell, 2007; Glassey & Wilson, 2011; Heath, Voeks, & Glickman, 2001).

Respect individuals and groups

- Promote public understanding of, input into, and confidence in public health event planning and response.
- Support a duty to promote the best care possible in contingency and crisis circumstances.
- Ensure burdens imposed by public health event response are minimized and justified by the benefits.

Duties of respect require that individuals and groups receive critical information and provide input on plans that may ultimately affect them. Respect also helps 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.

Strive for fairness and protect against systematic unfairness

- Utilize strategies for public education and public engagement that are inclusive and culturally sensitive.
- Promulgate standardized response protocols that are publicly available, revised regularly, and tailored to specific event responses.
- Ensure that all Minnesotans share the burdens and benefits associated with public health event response fairly.
- Make reasonable efforts to remove barriers to access and address functional needs.
- Steward resources to:
    - Reduce significant group differences in mortality and serious morbidity while maximizing population-level benefits.
    - Appropriately reciprocate to groups accepting high risk in the service of others.
    - Use decision-making processes that consistently apply ethically relevant (non-discriminatory, non-arbitrary) considerations.

Duties of fairness apply at all phases of public health event planning and response and require both fair processes and substantively fair treatment of individuals and groups. Protecting the whole community requires particular attention to the needs of populations with health disparities and/or access and functional needs, since these populations consistently suffer the worst outcomes due to their systemic vulnerabilities. While disproportionate impacts may not be intentional consequences of public health activities, to the extent that they are plausibly avoidable, they nevertheless violate duties of fairness to ensure that all similarly positioned people have similar chances for good outcomes. This framework provides more detail about duties of fairness and those of respect in discussions of ethical strategies below.

Ethical strategies

The final part of this framework presents strategies to achieve the ethical objectives outlined above. Each subsection will list recommended strategies, followed by an explanation of the ethical issues involved.

Duty to plan

Prospective planning

- All organizations with responsibilities related to preparedness and response (hereafter, partners)–including MDH, local/tribal health departments, health systems/facilities, and other partners–should engage in prospective planning for public health events, taking expert stakeholder and community input into account as they do so.
- MDH will make model preparedness and response guidance publicly available to promote transparency, accountability, and public understanding. These model plans will be adaptable to diverse response settings (e.g., large health systems and independent critical access hospitals) and drafted to promote their implementation by overloaded public health and healthcare staff. The model plans will address both (1) processes/procedures for making decisions in public health events (e.g., the Incident Command process), and (2) substantive recommendations regarding principles to follow and actions to take or avoid (e.g., criteria for allocation of scarce resources). Event-specific plans may also be required to respond appropriately to a particular public health event.
- MDH will work with regional partners, including the Regional Healthcare Preparedness Coordinators (RHPCs) where possible, as well as the Minnesota Hospital Association and health systems/facilities to ensure effective dissemination of guidance to appropriate leadership and staff at preparedness and response partners. Guidance to be disseminated includes recommendations from MDH and MDH's Science Advisory Team (SAT), as well as guidance received from federal partners and national professional organizations.
- Partners should tailor guidance to their context so it can be operationalized appropriately. Adapting guidance issued by MDH will promote consistency statewide, where possible, while allowing flexibility for differing contexts. This promotes fairness for partners and for community members/patients.
- Partners are responsible for appropriately informing their staff about guidance so that it can be applied effectively when needed. For example, at health systems/facilities, Incident Command should receive more in-depth training than bedside clinicians, whose training should be tailored to their level of responsibility for implementing guidance.
- Health systems/facilities should engage with their regional partners, including Healthcare Coalitions (HCCs) where possible, to stay up to date in preparedness activities. HCC Clinical Advisors (or similarly positioned personnel) should assist with disseminating guidance and training opportunities.

The duty to plan relates to the position both governmental departments/agencies and private organizations hold in public health event response, and the potential harm to Minnesotans if these organizations elect not to plan prior to an event (Powell, Christ, & Birkhead, 2008).

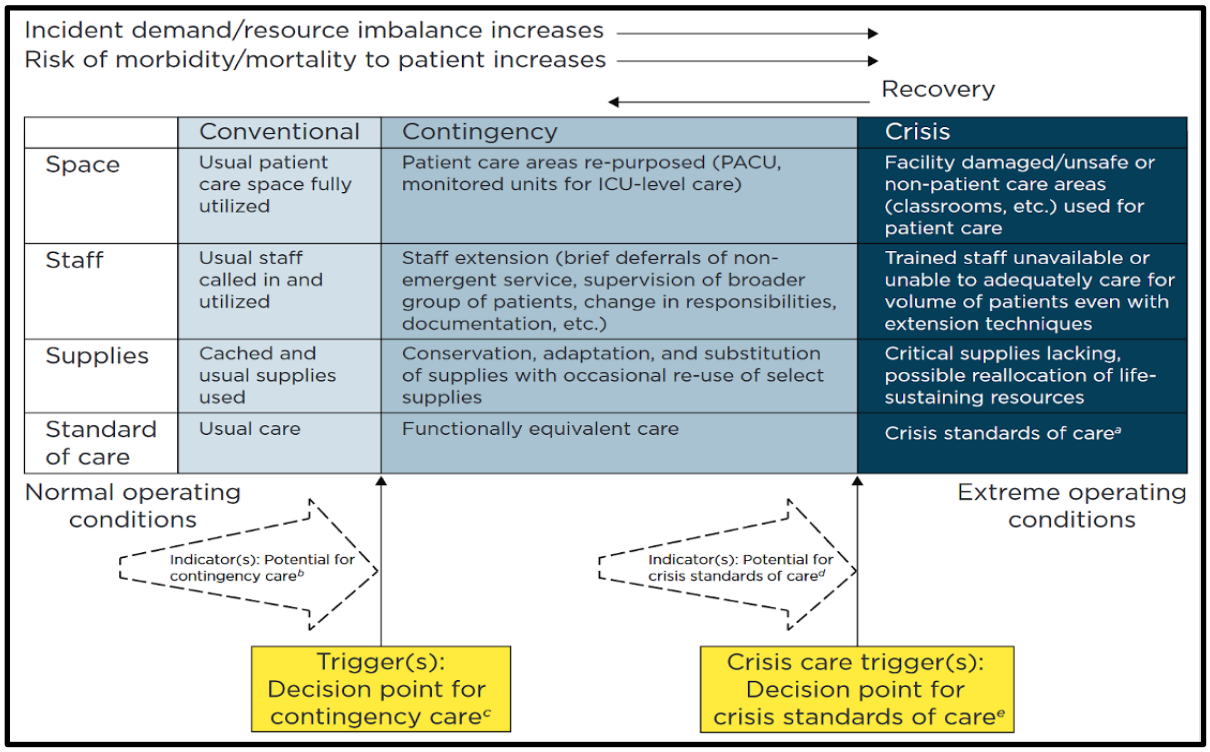
Impromptu decision-making during an event—when resources are tight, demand is high, and other logistical challenges arise—significantly risks undermining the fundamental ethical commitments stated above. State, local, and tribal governments, as well as private health systems/facilities and other partners, must acknowledge a duty to plan for emergencies and disasters, recognizing that plans will periodically need to be reviewed and revised, as well as tailored to the particular circumstances of disasters when they occur. This provides a moral foundation for preparedness and response.

Centrality of the continuum of care model in planning and response

- MDH will issue clear, operational guidance on the continuum of care, including updated operational definitions and reminding partners of thresholds for implementation.
- Health systems/facilities should tailor this guidance to their context (including thresholds/triggers and strategies) and disseminate it to their personnel. Health systems/facilities should also ensure that relevant personnel are trained appropriately. Incident command should understand the continuum of care and what actions should be initiated at each point, including the necessity to adapt services and coordinate via regional partners (such as the healthcare coalitions) and with MDH when crisis conditions are identified. Bedside clinicians should also be trained appropriately, relative to their role in implementing plans.

The model of the Continuum of Care is central to understanding responsibilities and strategies for responding to changing conditions and evolving levels of resource scarcity during public health events.

Figure 1: The Continuum of Care (Institutes of Medicine, 2013)



To effectively support event response, plans should explicitly address transitions across the continuum of care, as well as ensure clear roles and responsibilities are assigned to implement CSC when crisis conditions emerge. There should be agreed-upon thresholds for crisis (for example, using non-traditional staff in clinical roles) that prompt the facility to seek regional/MDH assistance to help mitigate the conditions. Moreover, these plans will effectively guide response only if they are appropriately disseminated and all relevant personnel receive training.

Enabling implementation of CSC

- If health systems/facilities meet thresholds and transition from contingency conditions to CSC, this shift in care should be explicit and transparent to state authorities, regional partners such as healthcare coalitions, health system/facility leaders, clinical teams, and the public.
- During a declared peacetime emergency, MDH will work with the governor's office to determine emergency legal and regulatory issues that must be addressed to facilitate the response. This may include:
  - Isolation and social distancing.
  - Access to resources.
  - Exploring authorities to manage transfers and hospital loads to maintain timely and fair access to care.
  - Legal protections for health professionals.

Without formal recognition that clinicians are practicing in crisis conditions, they often do not feel authorized to acknowledge or transition to contingency conditions or CSC, either due to concerns about their fundamental ethical commitments or about legal liability (DeBruin, Negri, Wu, Hick, & Leider, 2025).

Promoting collaboration among partners

Collaborative partnerships and coordinating responsibilities

- Private entities, such as healthcare organizations and faith-based organizations, should continue to partner with MDH and other state agencies (if applicable) in planning for public health events.
- Planning efforts should not unduly burden private partners. Those with greater or unique capabilities should accept proportional responsibilities in response, and MDH and other private partners should support these organizations in doing so.
- During public health events, state agencies should, to the extent in compliance with law and regulation, adapt enforcement, inspection, and oversight activities to accommodate health systems and facilities that are experiencing strain. Health systems and facilities that are making good faith efforts to mitigate or respond to contingency or crisis conditions will likely employ strategies that diverge from usual practices; wherever possible, during events, state agencies should pivot from routine enforcement of normal standards to supporting event response.

Best practice demonstrates collaborations at every level of the public health event response are critical to the success of the response. Organizations at all levels of preparedness and response should work to bolster existing collaborations and build new ones to better prepare for future public health events. Considerations of fairness apply to the involvement of private organizations in disaster response. Private organizations ought to not be unduly burdened nor unfairly privileged or insulated during response or recovery. Health systems/facilities should share relative risks and benefits in line with their capabilities and roles in response. Actions that burden private organizations must be justified by public health interest. Finally, while the government may legislate and enforce regulations on healthcare organizations to promote the general welfare, the government should also recognize that flexibility of regulatory enforcement may be necessary during public health events.

Partnering with tribes

- MDH will engage tribes as equal partners in public health event planning and response.
- MDH will provide support to tribes during public health events when tribes authorize/request assistance from the state in conjunction with support from federal partners.

There are seven Anishinaabe reservations and four Dakota communities within the State of Minnesota (State of Minnesota, n.d.). Tribal governments and lands are recognized as sovereign entities and thus warrant particular attention in public health event response planning. Public health events do not recognize political boundaries. Moreover, Native American populations

are affected by health disparities and access challenges and may be severely impacted by public health events. As part of preparedness 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 public health events. Tribes control their own resources. When tribal members access care outside of tribal facilities—e.g., at MDH vaccine clinics or private health systems/facilities—they should receive equal consideration for access to resources on triage protocols as non-tribal members do. If a tribal government chooses not to engage state or local government in public health event planning, the state should nevertheless plan to offer aid during an event.

Load balancing and patient transfer

- In situations when crisis care is being provided and maximal utilization of inpatient resources is required, health systems/facilities should work together to ensure that a statewide Medical Operations Coordination Center (MOCC) is operational and ensures equal opportunity to access available resources, even if a declaration of emergency is not in effect.
- If necessary, partners like the Minnesota Hospital Association (MHA) should seek additional authorities and protections for MOCC operations. The authority of the MOCC should include the ability to prioritize patients for transfer, and measures should be implemented to ensure timely transfer for patients requiring higher-level care. The MOCC should be operationalized in ways that optimize capacity and promote fair access to care.

A well-functioning MOCC, with the ability to prioritize patients for access to care, is essential to reduce unnecessary health complications and deaths in a public health event. An ethically appropriate event response plan 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. Alternatively, in a widespread public health event such as a pandemic, smaller facilities such as independent critical access hospitals in Greater Minnesota may be overwhelmed by demands for care that exceed capacity either due to numbers of patients or levels of specialization required to treat them appropriately. A well-functioning MOCC will be required to manage load balancing and patient transfers in any of these scenarios, ensuring equal opportunities for access to and maximal utilization of inpatient resources.

Increasing response capabilities and healthcare capacity

- Health systems/facilities and associations should explore options to extend capacity, including expansion of telemedicine, use of out-of-hospital treatments/hospital at home, EMS payment for on-scene treatment and transfers to lower levels of care (e.g., unloading tertiary care centers to smaller hospitals), allowing non-hospital destinations for EMS transport, and other measures to broaden care delivery options to help decompress healthcare capacity.

- Health systems and long-term care facilities should assess and address capacity issues that contribute to ED boarding.
- Evidence-based data collection for understanding and ameliorating conditions should be considered. This data could include, for example, the number of patients boarding, time in the ED (both maximum and average), occupied and available inpatient beds, and other relevant data.
- Health systems/facilities, labor organizations, and regulators should work together to identify and resolve recruitment and retention issues that contribute to workforce shortages with attention to compensation, incentivization, mutual respect, worker safety, and preparing for the expansion of duties beyond the normal scope of practice.
- Health systems/facilities, and labor organizations should work together to identify opportunities to build the nursing workforce in a way that promotes effective patient care, respects and protects nurses, and works within the reasonable constraints of the systems/facilities. These collaborations should also engage with institutions of higher education to promote efforts to train/educate future healthcare professionals.
- Health systems/facilities, and labor organizations should work together to examine surge/strain staffing plans to identify reasonable opportunities for flexible responsibilities or alternate staffing to meet patient needs when there is a shortage of staff.

During a public health event, health systems/facilities may experience bed shortages that not only limit admission from local communities of care but also preclude transfers from around the state, an issue compounded by insufficient EMS transport, workforce shortages, and, in some cases, facilities reserving some beds as “capacity protected” in anticipation of new surges. While capacity extension is necessary to plan for and respond to public health events, it is difficult given that managing health system/facility finances in normal times requires near-capacity patient admits, which leaves minuscule margins to flex resources when conditions deteriorate. Collaborative efforts should be undertaken to implement creative measures to expand capacity and address workforce shortages.

Public engagement, understanding, and communication

Public engagement

- All organizations with responsibilities related to preparedness and response–including MDH, local/tribal health departments, health systems/facilities, and other partners–should reach out to communities, preferably through trusted members of those communities, and not solely rely on a standard public comment period for soliciting feedback on public health event planning.

The fulfillment of the ethical commitments to transparency and accountability necessitates community engagement, open and honest communication, and the promotion of public understanding during both the planning phase and public health event response. This begins with community engagement regarding event planning. Since “groups that are most at risk before a disaster are those most vulnerable during a disaster” (Hanfling, Altevogt, Viswanathan, & Gostin, 2012), fairness demands that these groups be included in public engagement

activities. 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 public health event response. In addition, community engagement activities should 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 is 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 public health event plans; and to ensure the guidance is clear and accessible to all Minnesotans.

Public understanding and communication

- All partners should develop/refine plans for clear, accessible, and transparent evidence-based communication during a public health event, so the public can understand the best available information about the event, why information changes, the impact of the event on the healthcare system, what people can do to keep themselves and others safe, and how to seek appropriate care so their health needs are met.
- All partners should disseminate information regarding a public health event and response plans as widely as possible, in different languages, using a variety of approaches, materials, and venues for distribution of information. These partners should create/continue to refine plans for communication that emphasize and prioritize the involvement of trusted members of local communities. Plans for communications should be developed collaboratively with affected communities, including faith-based communities, cultural communities, and other communities defined by shared risks, values, historical experiences, and social position.
- All partners should develop and implement plans that effectively address mis/disinformation.

During an event, partners have an obligation to provide accessible, clear, and consistent information about the event and response. Communication should be culturally appropriate, offered in the various languages of populations in the state, and consider functional challenges such as unequal access to the internet or other media or the need for interpreters. Plans for public messaging should explicitly address potential misunderstandings or fears about the safety of accessing routine or emergency care. Additionally, mis/disinformation can lead to loss of trust in public health and healthcare, and thus dramatically undermine appropriate response to a public health event and lead to avoidable harms (e.g., threatening behavior directed toward healthcare workers, demands for inappropriate interventions). Therefore, efforts should be made to address mis/disinformation.

Duty to care—obligations to patients

Best care possible

- Health systems/facilities should provide patients with the best care possible given available resources.

- Health systems/facilities should consistently base plans for patient care on their surge capacity and scarce resource plans and explain these plans to patients and their families throughout the process in which decisions concerning care are made.
- Health systems/facilities may not abandon patients and should always strive to relieve pain and suffering.
- Healthcare systems/facilities are obligated to reach out for assistance when crisis conditions are experienced.

Health professionals have a responsibility to provide care in public health events by virtue of their position, training, and professional norms (Hanfling, Altevogt, Viswanathan, & Gostin, 2012; Prehn & Vawter, 2008). Public health events necessitate alterations in usual healthcare operations to adjust to increased patient demand and/or resource shortages, and these alterations may have implications for standards of care. Nevertheless, health professionals have an ethical obligation to provide the best care possible under the circumstances. This includes not only preventive care (such as vaccines in an influenza pandemic) and curative treatment, but also palliative care and mental/behavioral healthcare. Failing to plan to meet these very predictable needs constitutes abandonment of patients. Consistent application of response plans prevents problematic special treatment.

Palliative and hospice care

- Health systems/facilities should ensure that public health event planning addresses how to meet palliative and hospice care needs during an event.

The demand for palliative care in public health events will likely be higher than normal, especially during crisis conditions, and supplies of palliative care resources may be strained. MPEP includes more detailed discussion of planning strategies concerning palliative care needs (DeBruin, et al., 2010). Clinicians should encourage patients to plan ahead, and assist them if desired, by discussing the patient's care preferences and who the patient wishes to serve as their authorized decision-maker (Minnesota Department of Health, 2020).

Mental healthcare

- Health systems/facilities should ensure that public health event plans address how to meet mental/behavioral healthcare needs during an event.
- Health systems/facilities should minimize disruptions in continuity of care during public health events through planning for alternative treatment modalities, e.g., tele-psychiatry.

Health systems/facilities have an obligation to plan to meet mental health needs of health professionals, patients directly affected by event-related injuries or illness, and other members of the public. As with palliative care, the need for mental/behavioral healthcare in public health events is likely to be greater than in conventional circumstances. 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 public health events. The 2012 IOM/NAM report suggests

strategies for mental and behavioral health preparedness (Hanfling, Altevogt, Viswanathan, & Gostin, 2012).

Appropriate care for the dead

- As part of community engagement during public health event planning, MDH will solicit public input regarding expectations for appropriate care for the dead during a pervasive or catastrophic public health event.

Per Minnesota Statute 12.381 (www.revisor.mn.gov/statutes/cite/12.381), subdivision 1, during a declared emergency, 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." (www.revisor.mn.gov/statutes/cite/12.381) 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 public health event. However, accommodation of customs must be balanced with obligations to ensure public health safety, such as with disease transmission, as in the case of Ebola virus disease.

Appropriate management of visitation

- Health systems/facilities should tailor and implement any MDH guidance provided regarding social distancing/visitation to their context, so it can be operationalized appropriately. Adapting guidance issued by MDH will promote consistency statewide, where possible, while allowing flexibility for differing contexts.
- Health systems/facilities should adopt effective, Health Insurance Portability and Accountability Act (HIPAA)-compliant technologies for virtual communication with patients' loved ones and for telehealth consultation.

During public health events, a patient's rights to visitation and association may be constrained to prevent further harm from hazards such as the spread of infectious disease or to preserve operational effectiveness of overloaded health systems/facilities. Restrictions on patient visitation and association should be balanced and fair. Restrictions should be tailored to be the least restrictive necessary to prevent avoidable harms (including emotional harm, a detrimental impact on trust in healthcare, and impaired clinical care and shared decision-making). Harms may vary across contexts, as restrictions will affect some patients more significantly than others. Restrictions should be implemented fairly; any exceptions should be principled and not ad hoc. Appropriate technology should be identified to promote visitation when restrictions are needed.

Duty to care—support for health professionals

Given that health professionals have a duty to care in crises, public health authorities and healthcare 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.

Ethically appropriate liability protections

- MDH will support licensing boards, professional associations, and private practice groups, to improve opportunities for clinicians to obtain education regarding professional duties and liabilities during public health events.
- A coalition of key stakeholders—such as the Minnesota Medical Association (MMA), the Minnesota Nurses Association (MNA), and other professional societies—should examine current state and federal liability protections for healthcare professionals during declared emergencies and other situations where resource shortages require them to systematically and continuously adapt or deviate from usual approaches to care. If appropriate, this group of stakeholders should advance policy to protect health professionals who provide care or advice that is reasonable in the context.

Discussions of preparedness and response often note health professionals may refuse to implement, or be apprehensive about implementing, public health event plans—especially CSC plans—due to litigation and liability concerns. This discussion often focuses on controversial interventions, such as removing ventilator support from one patient to reallocate it to another in accordance with rationing protocols. However, concerns regarding litigation and liability go well beyond these particular procedures, including, for example, challenges with treating patients at alternative care sites, working outside one's normal scope of practice, and providing specialty medical advice to clinicians at facilities outside one's own health system to support patient care when transfers are not possible (DeBruin, et al., 2010; DeBruin, Negri, Wu, Hick, & Leider, 2025). Additionally, conversations demonstrated a lack of knowledge among healthcare providers regarding current protections (DeBruin, Negri, Wu, Hick, & Leider, 2025).

Reciprocity

- Fairness requires society to protect those who take on risk on behalf of the public, and such protections should be indexed to the level of risk taken by the professionals.
- Health systems/facilities, and other private partners should ensure that their preparedness and response plans 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).
- Health system/facility guidance should acknowledge that healthcare professionals' duty to care for patients may be limited in situations that pose imminent danger to these professionals.
- Other partners' guidance should reflect that, in some circumstances, key workers who serve in high risk contexts should be prioritized for access to resources when illness or injury is related to provision of care in a public health event, or when resources are needed to prevent/recover from health impairments that would undermine their ability to provide critical services (e.g. priority access to vaccines).
- Health systems/facilities should also make provisions for mental/behavioral healthcare for professionals, given the stress/trauma of working in public health events. They should also

implement additional support for their staff, specifically to promote resiliency, and prevent and address burnout and cases of suspected (or diagnosed) Post Traumatic Stress Disorder (PTSD).

Fairness requires society to protect those who take on risk on behalf of the public. Public health event plans should include provisions for promoting safety for health professionals, such as appropriate personal protective equipment and training, or consideration of offering priority allocation of scarce medical resources to frontline staff to prevent or treat illness or injury. In addition, public health event plans should recognize that while the duty to care holds—even in the face of increased risk to the health professionals' safety—limits do exist to the duty. Health professionals 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). Generally, however, a duty to care means clinicians may not abandon patients under their direct care.

Personal protective equipment (PPE)

- Where possible, health systems/facilities should implement plans for reasonable stockpiling of PPE.
- Like MDH, other state agencies should consider maintaining a cache of PPE to promote fair access to these critical supplies, given that not all facilities are equally positioned to effectively stockpile PPE.

PPE scarcity negatively affects clinicians and other healthcare staff, increasing not only their physical risk but also engendering psychological and moral distress. Duties of reciprocity require concerted efforts to prevent/mitigate PPE shortages so that health professionals are protected from undue risk as they work to protect the public. Provision of appropriate PPE will require cooperative planning efforts. Such shortages also negatively impact patients and the community. PPE stockpiling can alleviate shortages, but not all health systems/facilities are equally able to stockpile.

Mandates to provide service

- Where possible, health systems/facilities' plans should use incentives rather than mandates for health professionals to provide services during a pervasive or catastrophic public health event.
- Rather than relying upon state power to mandate provision or restriction of services, employers should create plans with their employees prior to a public health event to best address issues such as absenteeism (e.g., due to illness or family obligations) and reasonable expectations about length of work shifts.

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. Plans should address these conflicting obligations (Hanfling, Altevogt, Viswanathan, & Gostin, 2012). 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 (Minnesota Statutes 12.34 subdivision 1), 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 impose undue burdens on the professionals, their families, and/or their other employers. 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 public health event (DeBruin, et al., 2010).

Process for triage/rationing decisions

- Health systems/facilities should develop/implement ethical processes for making alterations to care practices in both contingency and crisis conditions. In the absence of specific guidance on the management of a scarce resource, ad hoc alterations in care practices should not be made by individual clinicians at the bedside without consultation with unit, facility, or system leadership. If, in contingency conditions, the bedside clinician must make a very time-sensitive decision about patient care that they do not routinely make, the clinician should consult with at least one other professional with relevant expertise, if possible, and then notify leadership about the resource shortage and the decision that was made to promote awareness of shortages and permit development and implementation of a plan for response. Changes to care practices that may significantly compromise patient outcomes should be avoided if possible. When such changes are necessary, health systems/facilities should separate triage/rationing decisions from bedside care by using a triage officer or team to allow clinicians to advocate for their patients while still following CSC plans. This prevents role conflict and associated moral distress, while ensuring a degree of impartiality, consistency, and due process (Minnesota Department of Health, 2021; Minnesota Department of Health, 2021).
- Health systems/facilities should collaborate with MDH or regional partners such as their Regional Healthcare Preparedness Coordinators to convene statewide or regional triage officers/teams, if necessary, depending on the resource in question (e.g., ECMO), the nature of the public health event, and the strain on available staff.
- Health systems/facilities should develop practices and policies for regular, transparent, and bidirectional communication with all staff. Communications during public health events should include information about scarcity, other hazards, available resources, changes or adaptations to event response, and increased risk to patients associated with the conditions and/or the response to the conditions.

In contingency conditions, consultation between bedside clinicians and unit, facility, or system leadership will promote shared understanding of the resource shortages impacting care delivery, as well as fair and effective plans for response to those shortages. When health professionals report for work in crisis conditions, they encounter conditions characterized as requiring a shift "in the balance of ethical concerns to emphasize the needs of the community rather than the needs of individuals" (Hanfling, Altevogt, Viswanathan, & Gostin, 2012). Some health professionals 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 officers or teams, separating the bedside clinician from high-level

allocation decision-making. This approach has the additional advantage of preserving 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 officer/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. Ethics support personnel may provide invaluable guidance to facilitate communication and ethically appropriate decision making in resource allocation and patient care, and to alleviate health professionals' moral distress. Finally, regular review of triage/rationing decisions should be conducted, both to ensure that individual patients are triaged appropriately and to promote systematic fairness of triage/rationing processes.

Ethics support

- Partners at the regional and local levels—including health systems/facilities—should develop processes for incorporating ethics support personnel into their preparedness and response activities. In addition, health systems/facilities should adopt clear protocols for requesting ethics consults for cases involving conflicts over treatment plans and goals of care, as well as real-time support for decision-making and moral distress debriefs. The primary functions of the ethics support process at the regional and local levels are to facilitate development and application of ethical frameworks for public health event response, to resolve values-based disputes in clinical care, and to help manage moral distress. Ethics support personnel may also 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 on measures to alter or improve policies/practices.

While healthcare professionals are required to provide the best care possible in public health events, this may be considerably different than achievable levels of care in conventional conditions. 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 should be established at the state and local level to help create and facilitate the application of ethical frameworks 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 public health events. MPEP offers detailed recommendations about how to implement ethics support processes (DeBruin, et al., 2010).

Support for sharing best practices

- If funding is available, MDH will work with regional partners such as the Regional Healthcare Preparedness Coordinators to convene statewide groups of relevant health professionals (e.g., emergency clinicians) to provide a forum for sharing best practices and providing collegial support.

The establishment of venues for sharing best practices and providing collegial support across health systems/facilities will also help health professionals to provide the best care possible in challenging circumstances. During the COVID-19 pandemic, the statewide Critical Care work group provided such a venue for critical care clinicians. Other groups may benefit from this type

of support, geared toward their own challenges. MDH will work with the regional partners such as the RHPCs to convene statewide groups to promote this type of collaboration, when desired by relevant groups of health professionals.

Promoting health professional resiliency

- If funding is available, MDH will partner with regional personnel, such as the RHPCs, to convene a statewide group of health systems/facilities to share best practices for promoting staff resiliency. MDH also provides disaster behavioral health resources that may be helpful (Minnesota Department of Health, 2025).
- Health systems/facilities should enact plans, tailored to their context, to provide appropriate support to augment and preserve staff resiliency.
- Health systems/facilities should regularly solicit input from clinicians and other staff on the types of support they require while providing services during a public health event. Additionally, health systems/facilities should implement protections against retaliation for "speaking up" or being labeled a "troublemaker" when voicing concerns about matters related to event response and patient safety. This may include anonymous reporting systems for employee concerns.

Additional supports may be needed to promote the resilience of health professionals working in public health event response. In these challenging circumstances, overwhelming demands and moral distress can be pervasive problems that erode staff resilience. Appropriate supports are best identified through collaborative processes between and within health systems/facilities. Promoting resilience will protect health professionals and the patients and communities they serve.

Protecting health workers from threats

- Health systems/facilities must protect healthcare workers and affiliated staff from abusive behavior, mistreatment, and threats of violence by patients and other community members. Health systems/facilities should implement/improve clear procedures that address inappropriate patient and family behavior and ensure the safety and interests of healthcare personnel and other patients, including up to administrative discharges.
- Health systems/facilities should implement/improve procedures and resources to ensure healthcare workers' security and safety on-site, in the community, or online. This includes systems for documenting and tracking incidents involving threats, violence, or other abusive behavior by patients and people related to patients.
- Health systems/facilities should implement/improve programs to provide support for staff who have been targeted with threats, abuse, and/or violence by patients and their families. This includes, for example, codes of conduct, adaptive security capacity and presence across the hospital setting (including in EDs, floors, and parking lots), and adaptive staffing capacity and ratios to allow for improved coverage and support while providing clinical care to challenging patients.

Health systems/facilities must protect staff members from harassment, threats, and abusive or violent behavior. These harmful behaviors are increasing in frequency (Zhang, et al., 2023), violate workers' rights to safety, have significant and enduring effects on staff, and may prompt individuals to leave health professions. As a result, they also have a wider impact on care of patients and communities.

Fairly and consistently stewarding resources

Data gathering

- The state should continue to gather data that reflects risk across populations in the state, since state agencies need data to understand risks and disparities in risk, and to implement recommendations regarding risk mitigation and amelioration of disparities.

During response, state agencies pay attention to the types of data required to reflect risk across populations in the state and thus guide decisions regarding the distribution and allocation of resources. 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 healthcare records may not capture rates of morbidity and mortality in populations lacking good access to care.

Distribution of resources

- Where MDH has a role in distribution of state and/or federal assets and the circumstances allow, strong consideration will be given to ensure those at highest priority have the best access to resources. Given common recommendations to prioritize patients at highest risk of poor outcomes if they are not allocated resources, distribution of resources should consider the needs of populations facing health disparities and access barriers.

To promote access to resources for those at highest priority, 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 morally appropriate distribution of resources, event response 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 health systems/facilities.

General considerations for rationing/triage

- If appropriate, MDH might issue model guidance on scarce resource allocation. This may include updates to general guidance (e.g., Patient Care Strategies for Scarce Resource Situations (www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf)) or event-specific guidance. Health systems/facilities should adapt this guidance to their context and

implement it transparently and in a way that promotes fairness for all patients. This guidance should specify that:

  - Supplies should be extended and resources conserved before implementing triage or rationing, triage and ration are a last resort.
  - Rationing strategies should be scaled to different levels of scarcity.

- Health systems/facilities should implement processes to routinely review and revise triage/rationing decisions. For individual patients, there may be changes in their status that would alter initial triage/rationing decisions. Routine retrospective review of rationing decisions should also be conducted, to ensure that the ethical framework for allocation is applied fairly and consistently, decisions are made without bias, and that no groups are being disproportionately impacted in a way that leads to systematic disadvantage or worsens existing disparities.
- Health systems/facilities and clinicians should accept patients' self-reports (or information from their surrogates) about their health as guiding triage/allocation decisions when records cannot be accessed in a timely manner.

When resources become so scarce that usual standards of care can no longer be maintained despite efforts to mitigate scarcity, CSC should be implemented, and rationing becomes a core feature of event response. While rationing and triage are inevitable features of CSC, transparent, systematic efforts should be made to build capacity, extend supplies, and conserve resources before implementing triage or rationing. MDH's Patient Care Strategies for Scarce Resource Situations (www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf) recommends ways to extend supplies or capacity for a variety of resources. Once rationing becomes necessary, health system/facility plans should be implemented to promote the best care possible in these circumstances. The US Department of Health and Human Services Administration for Strategic Preparedness and Response Technical Resources, Assistance Center and Information Exchange (ASPR TRACIE) offers additional planning resources (ASPR TRACIE, 2025), including a template for hospital CSC resource allocation planning (ASPR TRACIE, 2024).

Perhaps most importantly, as able, 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 healthcare organization—decisions about allocation of resources should be monitored and routinely reviewed to ensure that they are made in as principled and effective a way as possible, and changes made as needed. Ethics support personnel may provide helpful guidance for institutional or systems-level reviews of triage/rationing decision-making.

Criteria for triage/rationing

- All partners should ensure that they **do not ration based on:**
  - Race, ethnicity, gender, gender identity, sexual orientation or preference, religion, citizenship or immigration status, disability status, carceral status or socioeconomic status.
  - Age as a criterion in and of itself (this does not limit consideration of a patient's age in clinical prognostication).
  - 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 the pervasive or catastrophic public health event-related health crisis—sometimes referred to as life years saved), 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.
- All partners **should ration resources based on:**
  - Risk of mortality and serious morbidity—prioritize patients at highest risk of poor outcomes if they do not receive the resource.
  - Likelihood of good or acceptable response to resource (e.g., immune response to vaccine, prognosis regarding survival to hospital discharge for critical care resources).
  - Risk of transmitting infection.
  - Obligations to key workers.
- When the supply is inadequate to serve all similarly prioritized people, then all partners should use a random process to allocate resources.
- All partners should deprioritize people who are unlikely to benefit from the resource when making allocation decisions.
  - Futile interventions should be withdrawn or not started.
  - Providers of care should have preemptive conversations with patients and/or their families regarding end of life preferences (e.g. do not resuscitate orders).
  - Interventions that are non-beneficial or potentially inappropriate may be withheld or withdrawn following due process involving patients and families (Minnesota Department of Health, 2021; Wu, DeBruin, Wolf, Klemond, & DeMartino, 2021; Kon, et al., 2016; Bosslet, et al., 2015).

Specific decision-making criteria for triage/rationing should reflect this ethical framework's fundamental ethical commitment and objectives. Recommendations regarding criteria broadly outline the types of criteria that should guide decision-making. They also 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 (Vawter, et al., 2010).

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 consider information about health risks and prognoses faced by members of certain age groups. These are clinically based decisions, not age-based decisions per se. 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.

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 (Hanfling, Altevogt, Viswanathan, & Gostin, 2012). MPEP's community engagement activities demonstrated a lack of consensus about how age should factor into decision-making (Vawter, et al., 2010). Second, age-based rationing raises implementation issues concerning the possible violation of age discrimination law (DeBruin, et al., 2010).

Special priority for key workers who serve in high-risk contexts

If appropriate, MDH might issue response-specific guidance concerning the implementation of special priorities for key workers who serve in high-risk contexts. This guidance recognizes two reasons to potentially justify prioritizing these 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 or weighting for key workers to maintain societal functioning. This priority is justified to support professionals' ability to provide services during the pervasive or catastrophic public health event, either to prevent illness or injury, or to allow the key worker to return to work after being injured or infected, to continue to provide critical services during the event.

As MDH develops response-specific guidance, careful consideration will be given to when and 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 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.

- A two-track approach may be used to reflect a commitment to strive for balance between prioritizing key workers and prioritizing those groups in the public who are at greatest risk for morbidity and mortality.

The framework recommends prioritizing certain key workers for access to certain resources in at least some circumstances. Doing so does not depend upon a judgment that such individuals have more social value than other individuals; this framework prohibits making triage/rationing decisions based on perceived social value. 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, prioritization may be operationalized on a separate track from the public (i.e., in parallel with a track for the public), recognizing that in some circumstances a two-track approach might not be justified/relevant. MDH guidance should carefully analyze when key workers should receive prioritized access, given the realities of a particular public health event and considerations regarding particular scarce resources. Which workers should be seen as "key" should also be an event-dependent decision.

The morally appropriate use of liberty-limiting interventions

Justifying interventions that limit liberties

- Health systems/facilities should implement temporary interventions that place limits on personal autonomy when identified thresholds are met. For example, requiring staff mask in patient care areas when absenteeism meets a threshold during respiratory season. There are situations in which public health considerations may lead to measures that affect individual freedoms, particularly when the anticipated societal benefits are greater than the potential harms.
- Health systems/facilities' decisions to implement restrictive interventions should be evidence-based, where possible, and should be made using a fair, transparent process of consultation with public health experts and ethics support personnel to avoid the influence of political agendas.
- Health systems/facilities should endeavor to use well-targeted, effective, and 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.
- Health systems/facilities should ensure that liberty-limiting interventions do not disproportionately impact populations with health disparities, as well as those with access and functional needs.

While the benefits of liberty-limiting interventions in the context of public health event response tend to be straightforward—typically related to health, safety, or continued societal functioning—burdens may be harder to fully identify. The ethical justification for such

interventions will require careful analysis of their benefits and burdens. A commitment to ethical protections for all Minnesotans requires special attention to socially vulnerable groups to ensure liberty-limiting interventions do not disproportionately impact them. Burdens may be offset by provision of social supports for affected individuals or organizations.

In addition, decisions to implement restrictive interventions should be evidence-based, if possible, and made using a fair, transparent process of consultation with public health leaders, relevant subject matter experts, and ethics support personnel to avoid the influence of political agendas and promote trustworthiness and accountability.

Health disparities, barriers to access, and functional needs

Planning to address disparities, access, and functional needs

- Partners at all levels of preparedness and response should, when developing plans, include explicit consideration of alleviating health disparities, reducing access barriers, and meeting functional needs. Planning regarding these issues should be conducted in partnerships across organizations to best inform and implement relevant interventions.
- Partners at all levels of preparedness and response should use inclusive processes for decision-making and the development of guidance. Activities should address challenges regarding health disparities, access barriers, and functional needs.
- Partners at all levels of preparedness and response should consult with state and/or local ethics support personnel to support planning and response on issues of disparities, access, and functional needs.

Within the United States, Minnesota has one of the lowest percentages of people living below the poverty level (9.3%) (US Census Bureau, 2024) and ranks among the healthiest of states (Minnesota Department of Health, 2023). However, “Minnesota is also home to some of the most significant health disparities in the country between white residents and people of color, and American Indians” (Minnesota Department of Health, 2023). Since “groups that are most at risk before a disaster are those most vulnerable during a disaster” (Hanfling, Altevogt, Viswanathan, & Gostin, 2012), Minnesota should aggressively plan to address health disparities and access barriers both prior to and during a public health event.

Our fundamental ethical commitments require action to promote conditions in which all people have the opportunity to attain their highest possible level of health, without limits imposed by structural disparities, access barriers, or functional needs. No ethical framework for public health preparedness can, on its own, redress existing health disparities or access barriers for the people in Minnesota, or meet all of their functional needs (Vawter, et al., 2010; DeBruin, et al., 2010). Rather, this ethics framework requires that response plans “reduce significant group differences in mortality and serious morbidity” and “make reasonable efforts to remove barriers to fair access and address functional needs.” These objectives promote MDH’s mission (www.health.state.mn.us/about/mission.html) of “protecting, maintaining, and improving the health of all Minnesotans.” They also honor the key commitments espoused by the IOM/NAM (Hanfling, Altevogt, Viswanathan, & Gostin, 2012).

The objective relating to significant group differences in mortality and serious morbidity addresses health disparities. Substantial evidence documents these disparities 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 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 infectious disease 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 comorbid chronic conditions that increase infectious disease risks. In addition, those who are socially disadvantaged may have poorer access to care (Quinn, et al., 2011; Blumenshine, et al., 2008). Disparities in morbidity and mortality during public health events are thus linked to other health disparities and access barriers (DeBruin, et al., 2010).

Morality requires equal opportunity for access to care. All health systems/facilities should be open to accepting patients who typically confront access barriers that can block or delay care; health systems/facilities should care for patients based on their needs, not their health system affiliation. 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 regarding public health event response plans should also specifically address concerns regarding disparities, access, and functional needs. 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 for recommendations regarding these concerns. Participants offered suggestions about culturally appropriate educational campaigns and how they might be structured to address functional needs, ways to address barriers in access to care, and strategies to improve trust in public health response initiatives, among others (DeBruin, et al., 2010).

Geographic disparities and access barriers

- In partnership with EMS and the Medical Resource Control Center (MRCC), health systems/facilities should ensure the use of a statewide transfer and load-balancing mechanism (i.e., Medical Operations Coordination Center/MOCC) that prioritizes transfers to ensure fair access to advanced care, particularly for patients in Greater Minnesota facilities.
- Health systems and facilities should proactively strengthen EMS capacity through coordination with peer organizations and the Minnesota Office of EMS, with attention to longer-term sustainability and resource alignment.

- Health systems/facilities should establish processes to facilitate specialty consults between health systems/facilities to support smaller facilities, especially hospitals in Greater Minnesota.
- When MDH creates training opportunities and guidance, it will consult with personnel from Greater Minnesota health systems/facilities so that the training and guidance can be tailored to their needs and structure.

It should also be noted that significant urban-rural disparities exist between the Twin Cities metro area and Greater Minnesota. While most of the state's population and available inpatient beds reside in the Twin Cities metro area (including 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 public health event response. However, some facilities have relatively few clinicians, and some lack critical care resources. This significantly complicates public health event response, 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 ethical framework 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 equal 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 provide all needed services in a public health event response. When able MDH will work with private organizations, through regional partnerships, to maximize preparedness across urban-rural boundaries. Further, MDH will promote the use of a MOCC to facilitate load-balancing and patient transfers. To promote fair access to care, the MOCC should have the resources (expertise and needed guidance) to prioritize patients and connect them with care based on their priority levels. When patients are not able to be transferred, health systems/facilities should establish processes for specialty consults across health systems/facilities to support patient care in facilities without needed clinical expertise. As noted above, implementation of appropriate liability protections must extend to this process of advice/consultation. Since inadequate EMS capacity can pose a barrier to needed transports, health systems/facilities should collaborate with relevant partners to enhance this critical capacity.

Immigrants/Refugees

- Immigrants/refugees should be included in public health event planning and response. This ethics framework echoes MPEP guidance that response protocols should not discriminate based on immigration status or citizenship.
- Partners should consider the trust level of immigrants when receiving services at their sites. This should include vetted translators, signage, and attire of staff or others on-site.

In infectious disease outbreaks, withholding preventive or treatment resources from certain groups, like immigrants, can impede efforts to slow or reduce rates of infection. 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 readily available,

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 (DeBruin, et al., 2010). Requirements for identification or involvement of law enforcement personnel can impede the effectiveness of response interventions for groups that are particularly socially vulnerable.

Definitions

Several terms used throughout this Framework are defined here:

Capability: The ability to manage patients requiring very specialized medical care (Administration for Strategic Preparedness & Response, 2016).

Capacity: The ability to manage a sudden influx of patients (Administration for Strategic Preparedness & Response, 2016).

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 (Hick, Hanfling, & Cantrill, 2012).

Continuum of care: Medical care that is rendered during a mass casualty incident and occurs across 3 phases on a continuum; conventional to contingency to crisis care (Hick, Hanfling, & Cantrill, 2012).

Conventional care: Usual resources and level of care provided. The maximal use of the facilities' usual beds, staff, and resources is ensured (Hick, Hanfling, & Cantrill, 2012).

Crisis Standards of Care (CSC): "A state of being that indicates a substantial change in healthcare 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" (Institute of Medicine, 2009).

Functional equivalence: Despite alterations in care practices to manage/mitigate scarcity of resources, care is functionally equivalent to usual (conventional) care if (a) outcomes of care are expected to be substantially similar to those in usual circumstances (death or serious adverse outcomes should not be expected because of altered care delivery for patients or staff), and (b) care continues to be primarily focused on the well-being of the individual patient (Minnesota Department of Health, 2021).

Health disparities: Systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups; they may reflect social disadvantage, but causality need not be established (Braverman, et al., 2011).

Indicator: A "measurement or predictor of change in demand for healthcare 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) (Institutes of Medicine, 2013).

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" (Gallagher, 2011).

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" (Phillips & Knebel, 2007).

Trigger: A "decision point about adaptations to healthcare service delivery" that requires specific action. A trigger event dictates action is needed to adapt healthcare delivery and resources. Triggers can be scripted or non-scripted. Scripted triggers are built into Standard Operating Procedures (SOPs) and are automatic 'if/then' actions. Non-scripted triggers require additional analysis and consideration involving management and supervisory staff (Institutes of Medicine, 2013).

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