

# Long-term Care Contingency Staffing Plan (TEMPLATE)

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**DISCLAIMER: This is a template that has been created for facilities to leverage and incorporate into their existing Emergency Operations Plans.**

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## Purpose

In collaboration with local, regional, and state partners, we developed this plan to assist long-term care (LTC) facilities to coordinate strategies to ensure continuity of operations. The plan takes an all-hazards approach that addresses natural, manmade, and technological hazards. Implementation of an organization’s continuity plan will be based on the needs of the incident and resources available.

### Objectives

* Reduce the overall impact of an emergency/disaster on employees, patients/residents, partners, and stakeholders.
* Decrease the time it takes to restore full operational capacity.

## Background

During a disaster, the organization may face staffing shortages for a variety of reasons—staff may not be able to get in to work, may be ill, or may need to take care of their own families during the emergency.

***This plan cannot work without additional supporting plans, guidelines, and policies, including the following:***

* A communication plan to notify staff about the emergency and for calling in off-duty staff, which could include group text, calling tree, and/or mass notification software.
* A policy supporting families of staff to encourage staff to come to work. Consider including:
  + Daycare support for dependents.
  + Sleeping accommodations at the facility to minimize travel time and limit exposure of vulnerable family members, or providing local hotel reimbursement.
  + Sheltering at the facility and/or evacuating with the facility for family members.
* A training plan to cross-train staff to fulfill different roles in case the primary person responsible for a given function is not available.
* Disaster credentialing and privileging policy - including degree of supervision required, clinical scope of practice, mentoring and orientation, electronic medical record access, and verification of credentials.
* Participate with regional healthcare coalition and sign mutual aid agreements with other organizations.
* Encourage employee preparedness planning:
  + <CDC: Emergency Preparedness and Response: Protect Yourself and Your Loved Ones (https://www.emergency.cdc.gov/protect.asp)>
  + [MDH: Individual and Family Health (https://www.health.state.mn.us/people/index.html)](https://www.health.state.mn.us/people/index.html)
  + [Office of Homeland Security: Ready (www.ready.gov)](http://www.ready.gov/)
* Cache adequate personal protective equipment (PPE) and support supplies.

When determining critical functions in the next section, consider whether external staffing support could fulfill some staff functions in the event of a severe staffing shortage, and develop guidelines specifying which tasks this external staff can and cannot do. Training or on-the-job guide sheets should be developed for any tasks that could be completed by staff members from a different facility.

## Critical Functions

Critical functions are the job functions that your organization does on a normal, daily basis to deliver your primary purpose/mission (e.g., patient/resident care, registration/admissions, billing, critical administrative support functions, etc.). Delivery of these services must continue without interruption or resume quickly following a disruption. Ensure you address all areas within the organization such as clinical care, food services, building operations, housekeeping, administrative operations, and any other function that can’t be postponed or delayed. Please add lines as appropriate to provide more specificity.

| Critical Function | Loss of Function Impact[[1]](#footnote-2) | Maximum Tolerable Downtime[[2]](#footnote-3) |
| --- | --- | --- |
| [enter description of the function] | Choose an item. | Choose an item. |
|  | Choose an item. | Choose an item. |
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|  | Choose an item. | Choose an item. |
|  | Choose an item. | Choose an item. |

(See [Figure 1](#Fig1) in guidance for example)

## Delegation of Authority/Order of Succession

The positions listed below will succeed to the key position in the order listed, in any emergency/disaster situation in which the key individuals are unavailable to perform their duties.

| Key Position | Successor 1[[3]](#footnote-4) | Successor 2 | Successor 3 |
| --- | --- | --- | --- |
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(See [Figure 2](#Fig2) for guidance)

Delegation of authority begins when established channels of direction are disrupted and ends when these established channels have resumed. All persons (by position) listed will have authority to operate in the position they are assuming to the fullest extent possible until they are relieved by the next-highest-ranking individual.

## Staffing Contingency Plan

For the critical functions listed above, identify alternative processes that can minimize dependence on normal staffing numbers.

| Critical Function  (from list above) | Alternatives if personnel are unavailable (Temporarily suspend the function, alternate staffing models, closure of certain areas and reallocation of staff, reduce the frequency of the action, etc.) |
| --- | --- |
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(See [Critical Function](#CriticalFunctions) from list above)

During an emergency or disaster, personnel resources may be limited. The following table identifies the minimum personnel required to maintain critical functions. Please also consider contractors in your area.

| Position Title | Shift | # of staff required during normal conditions | Minimum # of staff required during crisis | Skills, certification required for the position |
| --- | --- | --- | --- | --- |
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(See [Figure 3.1](#Fig3_1) & [Figure 3.2](#Fig3_2) for guidance)

## Response

During an emergency the following procedures will be used to help maintain the minimum staffing listed above.

This response will cover the continuum of care, from conventional care, transitioning to contingency care, and finally crisis care. For more detail on this concept of operations see [MDH Crisis Standards of Care CONOPS (PDF)](https://www.health.state.mn.us/communities/ep/surge/crisis/conops.pdf).

Department leadership will be notified of any anticipated shortage and will determine when and which parts of this plan to activate.

### Conventional

This phase includes activation of the facility’s normal day-to-day protocols to fill staffing gaps, including utilizing on-call staff and leveraging resources from facility partners. The quality of care provided to the residents is the highest practicable level of care to meet the needs of the residents.

Development of the proactive steps and ideas listed below needs to occur before a crisis occurs and will help to minimize the risk of having to move to crisis staffing.

We recommend that the facility form a workgroup to include, but not be limited to, facility administration, HR, and facility leads.

* Maintain emergency contact numbers for:
  + All staff
  + System and/or sister facilities as applicable
  + Staffing agencies
  + Other local emergency staffing resources
  + Family members in those cases where a patient/resident could be cared for at home as a temporary measure
* Routinely share information with staff about the current situation and the steps the organization has put into place for staff safety.
* Identify potential risks to staffing specific to that facility. These might include current staffing challenges, knowledge gaps for patient/resident management for potential threats, high patient census, and feelings of isolation from local and regional support.
* Develop contingency staffing and resident placement plans with neighboring facilities.
* Create and share the list of staff requirements for external personnel working at your facility with any “supplemental nurse staffing agencies” (e.g.,. basic life support, vaccinations, etc.) so they can cross reference staff requirements.
* Develop just-in-time training that can be provided to supplemental staff for emergency orientation to ensure they understand their roles, policies, and procedures.
* Contact staffing agencies/supplemental nurse staffing agencies (SNSA) for assistance. These agencies have a variety of healthcare staff that can provide needed coverage. Sign a contract with at least one, preferably more than one.
* Develop an on-boarding and off-boarding process for emergent staffing:
  + Credential process
  + Understanding role
  + Chain of command/report to
  + PPE available for incident or job tasks
* Ask what the ability is for these agencies to provide last-minute coverage. Check on how this availability changes during a crisis.
* Find an SNSA list at: [MDH Health Care Provider Directory (https:/www.health.state.mn.us/facilities/regulation/directory/providerselect.html)](https://www.health.state.mn.us/facilities/regulation/directory/providerselect.html).   
  It is recommended that you choose “select all” under “Step 2” to get a complete list.

### Contingency

This phase occurs when local resources are exhausted.   
It may include canceling events or activities to balance workloads; readjusting facility schedules to allow for maximization of in-house staff; adding incentives or bonuses for staff who take on additional shifts; bringing on additional staff from outside of the facility (i.e., supplemental staff);   
and using volunteers to serve nonclinical roles to assist with critical daily tasks.

* Notify organization staff of the staffing shortage and ask staff to work additional hours (not to exceed \_\_ hours per day or \_\_ hours per week).
  + Be sure to allow adequate rest and recuperation time for staff members between shifts.
  + Ask staff not to take voluntary time off during the incident. [Consider suspending the cap on vacation so staff can continue to accrue vacation even if they cannot spend it down at this time].
  + Consider offering bonuses or overtime pay for critical shortages while mindful of staff health and burnout.
  + Consider offering other perks for taking extra shift (such as child care support).
  + Consider shift changes such as implementing 12-hour shifts.
  + Institute additional support for staff where issues like transportation or housing (e.g., if a staff member lives with vulnerable individuals) might prevent them from reporting to work.
  + Review essential functions and create a prioritized list. Postpone or stop all nonessential functions and reassign those staff to critical functions. If staffing continues to be a challenge, defer other lower priority functions.
* Focus staff time on core clinical duties (conserve).
  + Minimize meetings and relieve staff of administrative responsibilities not related to incident.
  + Consider options for cohorting residents to conserve PPE and conserve/reuse PPE based on guidance.
  + Personnel with specific critical skills should concentrate on those skills; specify job duties that can be safely performed by other medical professionals using alternatives listed above in Staffing Contingency Plan section.
* Adapt clinical needs (conserve).
  + Consider changes to staffing ratios and management oversight.
  + Implement technology for virtual and telemedicine options to address care by providers, hospice, and consultations as available.
  + Restrict elective appointments and procedures.
* Consider use of supplemental staff (substitute).
  + Develop/implement emergent credentialing criteria.
  + Bring in equally trained staff (supplemental staff, retired nurses, and others as identified).
  + Shift equally trained staff from administrative positions.
  + Adjust personnel work schedules (longer but less frequent shifts, etc.) if this will not result in skill/PPE compliance deterioration.
  + Use family members/lay volunteers or staff in other roles (PT, OT, RT, SLP, administrative support staff) to provide basic resident hygiene and feeding – releasing staff for other duties as appropriate within restricted access guidelines.
  + Consider corporate staff sharing.
  + Create memoranda of understanding (MOU) with other community health care organizations.
* Use alternative personnel to minimize changes to standard of care (adapt).
  + Use other health care workers, trainees, or volunteers with appropriate mentoring and just-in-time education.
  + Use other health care workers, trainees, or volunteers to take over portions of skilled staff workload for which they have been trained, providing just-in-time training for specific skills.
* Ask for staff support assistance from:
  + Sister facility or system.
  + Local staffing agencies.
  + Other nearby health care facilities, partners, or local university/college health career centers.
  + Trade association to assist in procuring staff:
    - [LeadingAge of MN (www.leadingagemn.org)](http://www.leadingagemn.org/)
    - [Care Providers of MN (www.careproviders.org)](http://www.careproviders.org/)
* Notify local emergency management/public health agencies directly or through the local operations/regional healthcare coordination centers, if activated, of the situation including:
  + Overview of the situation causing the need.
  + Details about what staffing assistance is needed:
    - The type and number/FTE of requested staff including licensure/certification requirements.
    - An estimate of how quickly the requested staff is needed.
    - Information regarding parking, entry, where and to whom to report, contacts’ information at LTC facility while working there, and any other pertinent details needed.
    - An estimate of how long the staff will be needed.
* Provide appropriate PPE for any staff sent to assist.
* Vet any staff that offers assistance to ensure they can meet the need and the facility’s requirements. The facility will also be responsible for paying these staff members either directly or by reimbursing the sending facility.

### Crisis

This phase occurs when there are significant staffing shortages, and consists of implementing  
 large-scale changes to the way the facility provides care and conducts business.   
Activities include leveraging statewide and federal resources. Staff must consider altered standards and do the best they can with the resources available.

* Ask for staff support assistance from:
  + Organizations with which you have an MOU as part of your emergency preparedness planning.
  + Other local health care facilities.
* Contact families that have agreed to care for residents/patients at home during crisis times. Use known resources to assist with patient transport as needed.
* If additional staffing is needed, ask for assistance from:
  + Local government emergency operations centers/local public health agencies.. Inform these agencies of: The type and number/FTE of requested staff including licensure/certification requirements.
  + An estimate of how quickly the requested staff is needed.
  + Information regarding parking, entry, where and to whom to report, contacts’ information at LTC facility, and any other pertinent details needed.
  + An estimate of how long the staff will be needed.

*Note: If your facility is a member of a regional coalition, follow the provisions of their response plans outlining procedures and information regarding reimbursement processes of sending agencies. If not a member, an agreement should be made with the sending facility before staff are sent about reimbursement, liability, and workman’s compensation issues.*

* + If activated, use the State Healthcare Coordination Center Minnesota Healthcare Resource Call Center at 1-833-454-0149 (toll free) or 651-201-3970 (local).
* Vet any staff that offers to assist to ensure they can meet the need and the facility’s requirements. The facility will also be responsible for paying these staff members either directly or by reimbursing the sending facility.
  + Provide just-in-time training to staff sent to assist to ensure they understand their roles, policies, and procedures. This will maximize efficiency of operations and reduce workplace safety risks. It is essential that workers receive training prior to participating in operations in the facility regarding infection control procedures, including the donning, doffing, usage, and disposal of the PPE they will wear.
  + Provide appropriate PPE for any staff sent to assist.
* Review your facility Return to Work policy. Staff returning to work will be prioritized based upon several factors, including who is nearest to their return date. Additionally, employees returning to work will follow current PPE guidelines.

## Additional Resources

* CMS Appendix Z: [CMS: Emergency Preparedness Rule (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule)](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule)
* [CDC: Strategies to Mitigate Healthcare Personnel Shortages (https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html" \t "_top)
* [MDH Long-term Care Toolkit Appendix C Emergency Staffing Progression & Planning Worksheet (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)](https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
* [Responding to and Monitoring COVID-19 Exposures in Health Care Settings (https://www.health.state.mn.us/diseases/coronavirus/hcp/response.pdf)](https://www.health.state.mn.us/diseases/coronavirus/hcp/response.pdf" \t "_top)

Additional considerations include:

* If normal tasks are altered for staff, consider what notifications should be made to human resources, managers, union representatives, and other key personnel as to status and plan implementation.
* Assess union considerations surrounding overtime issues and disaster support/sharing of responsibilities among workers.
* Identify work options available through “telecommuting” or other off-site possibilities.
* Assess flexible leave options that would allow employees to address family needs while continuing to support the organization through a flexible work plan where feasible.
* Evaluate potential health and safety issues that may arise through diversion of staff to new job roles and loss of critical staff in various operational positions.

# 

## Appendix 1: Guidance

This appendix can be deleted from the completed plan and is intended only to provide examples and descriptions of what each section is meant to contain.

### Scope

Each organization is structured differently. After looking through the template, each organization must assess the most logical approach for their area. For some organizations, many of the sections of the plan will be the same from work area to work area. In those cases, it might make sense to have one overarching plan; just make sure to include all work areas in respective appendixes. For other areas, completing the template at the organization level would result in a template that is too broad and high level to be of value or too large a document to be functional so it would make sense to have multiple area-specific continuity plans within the same organization.

If you choose to complete the plan at the work-area level, please include the location of the work areas covered. If you are completing the template at the department or division level, list the appropriate buildings/campuses in the location section.

### Critical Functions

Figure 1: Critical Function Guidance

| Critical Function (General Service Transport/Escort) | Loss of Function Impact | Maximum Tolerable Downtime |
| --- | --- | --- |
| Resident Transport | **Catastrophic** | **2 hours** |
| Resident Dietary Support | **Critical** | **2 hours** |
| Medication Administration | **Catastrophic** | **2 hours** |
| Resident Activities | **Marginal** | **96 Hours** |

When identifying critical functions, the idea is not to capture a list of individual tasks, but rather general categories of activities. For example, putting “patient care” as a critical function is likely too broad, whereas stating “unwrapping the syringe to administer medication” is too specific. Charting, patient monitoring, administering medications, etc., would be good examples of critical functions for a patient care area. It may work best to identify your list of critical functions before moving on to the other columns in the table.

#### Impact for loss or impairment of critical function

* Catastrophic: Loss of critical function results in death, total departmental mission loss, or severe infrastructure damage
* Critical: Loss of critical function results in severe injury/illness, major mission loss, or major infrastructure damage
* Marginal: Loss of critical function results in minor injury/illness, minor mission loss, or minor infrastructure damage
* Negligible: Loss of critical function results in less than minor injury/illness, less than minor mission loss, and less than minor infrastructure damage

Maximum Tolerable Downtime: “The maximum length of time (in hours or days) that a critical function can be discontinued without causing irreparable harm to people (staff, patients, visitors) or operations.”

### Delegation of Authority/Order of Succession

Figure 2: Delegation of Authority/Order of Succession Guidance

| Key Position | Successor 1 | Successor 2 | Successor 3 |
| --- | --- | --- | --- |
| Supervisor for Resident Activities | Alternate Supervisor | Assistant Supervisor | Most senior RN |
| Operations Manager | Operations Coordinator | Supervisor | Assistant Supervisor |

It is important to note that the order of succession does not need to follow the hierarchical structure; but rather, successors should be identified who possess the functional skillsets necessary to accomplish the critical functions of the department/work area. If the organization’s delegation of authority and order of succession exist in a different document, this section of the template can reference that document.

### Staffing Contingency Plan

Figure 3.1: Staffing Contingency Plan Guidance

| Critical Function | Loss of Function Impact | Alternatives if staff are unavailable (Temporarily suspend, alternate staffing models, closure of certain locations and reallocation of staff, etc.) |
| --- | --- | --- |
| Administering Medication | Catastrophic | Must be completed. Use alternate staffing model to ensure completion. |
| Changing patient linen | Marginal | Suspend for up to 24 hours unless visibly soiled. |
| Patient billing | Negligible | Close certain locations and reallocate staff to locations that remain open. |

Figure 3.2: Staffing Contingency Plan Guidance

| Alternatives if staff are unavailable  Examples: Critical functions that can be temporarily discontinued, alternate staffing models, closure of certain locations and reallocation of staff, etc. |
| --- |
| Prioritize staffing based on highest volume and criticality of activity. Shift staff between locations as necessary. Utilize supplemental staff as appropriate. |
| Consider temporarily suspending operations for all critical functions designed as Type 3&4 and marginal/minimal as appropriate and reallocate staff. |

## 

### Communications

This section should also contain contact information for everyone who needs to be notified during a continuity situation. This information may be in the form of organization calling trees or other communication plans. Additionally, this section addresses back-up methods of communication.   
Example table:

| Dependency | Service Description | Actions if Dependency is Unavailable |
| --- | --- | --- |
| Carry Phone (Internal System Telephone) | Internal department communication | Utilize alternate phones, emergency phone, email, runners, pagers. |
| Email | Internal and external communication | If email is down, utilize phones or runners. |
| Emergency phone | Communication when primary phone is down | Utilize runners or email. |
| Internet (External sites) | Weather monitoring | Listen for weather alerts via radio and overhead announcements. |
| Intranet (Internal sites) | Department webpage | Refer to paper copy of plans. |
| Mobile Phone | Staff notification | Use land lines if applicable, use local radio stations to communicate with staff, etc. |
| Network Devices (Rover or tablets) | Medication scanning, documentation, staff communication | Use PCs for scanning and documentation. |
| Pagers | Code Teams | Use overhead announcement system to page necessary teams. |
| Radios | Internal communication | Communicate via telephone. |
| Traditional Telephone | Internal and external communication | Initiate telecommunications downtime procedure. Utilize emergency phones located (insert location here). |

### Alternate Locations

If your organization has multiple work areas, complete the Primary and Alternate Location section for each work area where critical functions cannot be deferred or suspended.

Estimated Time Required to Relocate

For this section, please estimate how long it would take to relocate all necessary, staff, supplies, and residents (if applicable) to your alternate location and reestablish critical functions. For the purposes of this estimate, envision a developing situation that has not yet reached a point where immediate evacuation is necessary and allows time to gather what you need.

Primary Operating Location (Building/Room Number)

Please document your current operating locations in this section.

Alternate Location/Back-up Alternate Location

When filling in alternate locations consider what “buddy units/facilities” might already have the equipment and staff skill level needed to serve your patient population.

If your alternate location is not available, it is prudent to have a backup in mind. Your backup should be in a building that is not connected to your primary operating location.

When filling in the “Supplies/Equipment Needed” column, consider what supplies and equipment you would need to set up operations in this unit/facility. What supplies and equipment are available to be shared in your alternate location or could be requested? What needs to be brought during the move to support critical functions? What role will be assigned to bring the supplies/equipment and how will it be moved?

| Alternate locations: Building/Room # | Supply/Equipment Needed |
| --- | --- |
| Alternate Location  Building and Room Number | Supplies/equipment that need to be brought from impacted unit, if safe to do so:   * Patient/resident belongings – Nurse or PCA * IV Pumps - Nurse * Special forms - HUC * Equipment or supplies unique to your unit (that your buddy unit doesn’t have and are transportable) |
| Supplies/equipment that will need to be brought in by other departments/vendors:   * Equipment that isn’t easily transportable * Items routinely supplied by a different department (e.g., linen and pharmaceuticals) |
| Back-up Alternate Location | Supplies/equipment that need to be brought from impacted unit, if safe to do so |
| Telework | Supplies/equipment needed for employees to telework for an extended period of time |

*If telework is not a viable option to complete your department/work area’s critical functions, you may delete the telework row from the template.*

### Supply/Equipment Contingency Plan

Adequate supplies and equipment are essential for maintaining critical functions. It would be appropriate to assign the assessment of the department/work area’s essential equipment and supplies to someone in the department who is familiar with this task.

Please use the first two tables in this section to document the essential equipment and supplies your department/work area receives from internal Supply Chain Management.

When considering essential equipment, also consider what other pieces of equipment they might rely on to function.

Essential Equipment

| Description (Item, brand, size, etc.) | Manufacturer | Point of Contact | 24/7 Phone No. | Criticality Score | Alternative |
| --- | --- | --- | --- | --- | --- |
| Motorized Wheelchairs | Alco | John Doe | XXX-XXX-XXXX | 3 | Transport via non-motorized wheelchairs or stretchers |
| Dose Calibrator | Captintec | Customer Service Line | XXX-XXX-XXXX | 1 | Use Dose Calibrator from alternate site. |
| C-Arm | Siemens and Philips | HTM | XXX-XXX-XXXX | 1 | Use C-Arm in different room, suspend operations if no C-Arms available. |

Essential Supplies

| Description (Item, brand, size, etc.) | Manufacturer | Point of Contact | 24/7 Phone No. | Criticality Score | Alternative |
| --- | --- | --- | --- | --- | --- |
| Nitrile Gloves | Kimberly-Clark | Terry Dactyl | XXX-XXX-XXXX | 2 | PCS clear plastic gloves |
| Oxivir wipes | Diversey | Jane Smith | XXX-XXX-XXXX | 3 | Other disinfectant wipes or a bleach cleaning solution. |
| Evac Vial | DuoPross | Customer Service Line | XXX-XXX-XXXX | 1 | Self-prepare Evac Vials. |
| Central Lines | Varies | Jane Doe | XXX-XXX-XXXX | 1 | Prioritize patient criticality if supply is limited. Consider alternative line. |

When determining the criticality score for each item, the following guidelines should be used:

* 1 = Without this resource, the department/work area is unable to complete its critical functions.
* 2 = Department/work area has identified an alternate process or supply item, and can continue critical functions for a period of time with **major** impact to staffing or other considerations (e.g., waste, training, availability of alternate supplies)
* 3 = Department/work area has identified an alternate process or supply item, and can continue critical functions for a period of time with **minimal** impact to staffing or other considerations (e.g., waste, training, availability of alternate supplies)

In the “Alternative” columns, indicate if there are any alternate procedures or conservation measures identified for the identified equipment or supplies. In the absence of essential equipment and supplies, discontinuation of critical functions may be used as an alternative.

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Contact [health.communications@state.mn.us](mailto:health.communications@state.mn.us) to request an alternate format.

7/24/2020

1. Departmental Impact for Loss or Impairment of Critical Function

   Catastrophic: Loss of critical function results in death, total departmental mission loss, or severe infrastructure damage

   Critical: Loss of critical function results in severe injury/illness, major mission loss, or major infrastructure damage

   Marginal: Loss of critical function results in minor injury/illness, minor mission loss, or minor infrastructure damage

   Negligible: Loss of critical function results in less than minor injury/illness, less than minor mission loss, and less than minor infrastructure damage [↑](#footnote-ref-2)
2. Maximum Tolerable Downtime “the maximum length of time (in hours or days) that a critical function can be discontinued without causing irreparable harm to people (staff, patients, visitors) or operations.” [↑](#footnote-ref-3)
3. List successors by position title rather than name if possible. [↑](#footnote-ref-4)