DEPARTMENT OF HEALTH

Minnesota Framework for Contingency Conditions and Crisis Standards of Care

STAKEHOLDER ENGAGEMENT ACTIVITIES AND RECOMMENDATIONS

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Minnesota Framework for Contingency Conditions and Crisis Standards of Care: Stakeholder Engagement Activities and Recommendations

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CONTENTS

Introduction 1
Purpose 1
Background 1
Statewide efforts before the COVID-19 pandemic 2
  Initial engagement 2
  Lunch and learn sessions 2
Statewide efforts after the COVID-19 pandemic 2
  University of Minnesota Center for Bioethics 2
  University of Minnesota Health Emergency Response Office 3
Stakeholder engagement recommendations for health systems and facilities 4
Conclusion 5

Introduction

To ensure planning for contingency conditions and crisis standards of care (CSC) reflects community values and priorities it is necessary to engage and reengage the community in a series of engagement sessions. Community engagement is a process by which citizens engage in dialogue around complex public problems. Rather than confining citizens to a reactionary role, community engagement creates a space where community members may partake in active deliberation and collaborate with officials to create policies that reflect public opinion and values.

Purpose

Community engagement in contingency conditions and CSC is particularly important for several reasons. First, engaging the community in discussions about these situations not only increases understanding of what contingency and crisis standards are and when or why they might be needed, but it also increases awareness of the need for general disaster preparedness. Second, encouraging community participation in crafting plans ensures the plan created reflects the values and priorities of the community thereby both legitimizing the planning process and resulting plan. It also ensures greater public acceptance of the standards should they need to be activated in the future (Hanfling, Altevogt, Viswanathan, & Gostin, 2012).

Background

The Institute of Medicine/National Academies of Medicine (IOM/NAM) identifies public or community engagement as an essential piece of the CSC planning process in its 2012 Crisis Standards of Care Framework and outlines six principles of successful community engagement. They are:

1. Policymakers must be committed to considering and integrating public input into CSC guidance. This means the CSC planning process should not be so far along at the time of community engagement as to leave little room for incorporation of the public's feedback and input.
2. Community engagement sessions should accurately represent the community. All efforts should be made to recruit diverse participation in engagement sessions including those populations that may be considered at-risk or hard-to-reach.
3. Participants are both provided information on CSC, as well as given the opportunity to deliberate and discuss issues.
4. Deliberation should be considered a goal in and of itself. Although consensus may not be reached, active deliberation at the community level helps to "reveal misunderstandings, biases, and areas of deep disagreement" (Hanfling, Altevogt, Viswanathan, & Gostin, 2012).
5. Public input should be given consideration in the CSC decision-making process. Further, ways in which this will happen should be made explicit to participants at the start of all engagement sessions.
6. Strong leadership and top-down support, as well as sufficient resources to complete the process, should be given to community engagement.

Statewide efforts before the COVID-19 pandemic

Initial engagement

The Minnesota Department of Health (MDH) used a modified version of the IOM/NAM community engagement toolkit to conduct ongoing engagement sessions. The first eight sessions hosted by MDH were from June 2017 to January 2019 and ran for two hours and included a presentation on CSC, survey questions, and a patient-ranking activity followed by a facilitated discussion. Topics covered in the facilitated discussions included patient prioritization methods, factors that matter most when you cannot save everyone, fairness in decision-making, and whether certain populations (i.e. healthcare workers) should receive treatment priority. Data from the sessions was collected and analyzed both quantitatively and qualitatively.

Volunteers from local public health and healthcare coalitions assisted with five of the sessions performing tasks such as staffing the sessions, identifying and recruiting participants, and advertising the sessions. Two sessions were co-hosted by a local nonprofit organization. Volunteers from the organization assisted with recruiting participants, securing a location for the sessions, and facilitating the small group discussions. The final session was hosted by the Minnesota Department of Administration's System of Technology to Achieve Results (STAR) Advisory Council and was conducted during a regularly scheduled council meeting.

Lunch and learn sessions

Despite the number of sessions held, the reach of community engagement sessions was limited. To reach more Minnesotans, starting in the winter of 2019 MDH hosted "Lunch and Learn" sessions at state agencies. By condensing the sessions to one-hour increments, although limiting discussions, MDH was able to host more sessions. The hope was to educate the public about the project while at the same time collecting data, fully acknowledging it may not be as robust as previous session.

Statewide efforts after the COVID-19 pandemic

Throughout the COVID-19 pandemic, Minnesota experienced multiple instances of contingency conditions and crisis standards of care. To examine how our MDH can improve responses we contracted with the University of Minnesota to conduct two projects.

University of Minnesota Center for Bioethics

To assess strengths and weaknesses of the COVID-19 response in healthcare, MDH contracted with a project team from the University of Minnesota Center for Bioethics in 2024 to conduct stakeholder engagement activities on lessons learned from the COVID-19 pandemic. The goals of the project were:

1. To solicit input from healthcare stakeholders who worked in acute care settings during the COVID-19 pandemic, including health system/facility leadership, critical care providers, and emergency department (ED) providers; and

2. To identify themes, present in this input and use those themes to develop recommendations for improvements in the state's preparedness and response frameworks.

The project team solicited input during listening sessions with 35 individuals. These individuals broadly represented the Minnesota healthcare system. They worked in the Twin Cities metro area (19) or greater Minnesota (15) during the pandemic with experience ranging from 1-5 years to over 20 years in their professions. They represented different roles including leadership, incident command, critical care, and emergency department and they represented different facility trauma level designations including tribal health.

Depending on participant preference and availability, listening sessions involved either individual interviews or small group discussions. Almost all listening sessions were held virtually. Sessions followed a semi-structured interview guide developed by the project team in collaboration with MDH. Participants were asked open-ended questions related to:

- What crisis/crisis conditions/crisis standards of care meant to them.
- Whether they worked in crisis conditions during the pandemic.
- Whether crisis conditions impacted their ability to work in accordance with their ethical and professional commitments.
- If acknowledgments of the crisis were seen as a failure of health systems/facilities.
- Best practices they implemented or observed in pandemic response.
- Guidance or training resources/opportunities to support their work during the response.
- What contingency/contingency conditions meant to them.
- Collaborations that were valuable for managing the pandemic response.
- A "wish list" of changes they would want to see to better prepare/protect healthcare organizations, providers, patients, and their families for future emergencies.

Ample time was dedicated throughout the sessions to ask follow-up questions, promote discussion, and allow participants to raise issues of importance to them. Although there was some variation, listening sessions typically lasted for approximately 90 minutes.

The final report and recommendations from these sessions tied personal narratives to disaster response and healthcare crises, striving to pinpoint actionable change for improving preparedness and response in future emergencies.

University of Minnesota Health Emergency Response Office

To more broadly assess strengths and weaknesses of the COVID-19 response throughout Minnesota's healthcare system, inclusive of public health, the University of Minnesota's Health Emergency Response Office (HERO), conducted statewide engagement and identified gaps and opportunities for future preparation for large-scale, ongoing emergencies. This project was called Project Alliance. The goals of the project were:

1. Identify gaps in coordination and communications in preparedness plans.

2. Strengthen understanding of equity and access within healthcare systems during a disaster.
3. Document successful processes during the COVID-19 response.

The project team's work was unfortunately cut short due to funding, however from January to March 2025 they were able to interview 23 individuals. The interview format was a "Nine Things Survey" as follows:

"Thinking about public health partnering with healthcare during the pandemic, and from your experience and in your opinion,

- What three things do you think were most successful? These are things that should be documented, celebrated, and repeated during the next disaster."
- What three things, that could realistically be changed, were a problem or a challenge? These are things that public health and healthcare partners might consider for review in anticipation of the next disaster."
- What three things were a challenge that cannot realistically be changed? These are things that should be acknowledged early to ensure a shared understanding and ease frustrations among public health and healthcare partners."

The report outlined the most successful practices which should be repeated in the next disaster, items that realistically could be changed but were a challenge or a problem, and things that were a challenge and cannot be realistically changed but should be acknowledged early to ensure a shared understanding, ease frustrations, and build resiliency among partners.

As funding allows, MDH will work with the University of Minnesota's Health Ethics Response Office to share Project Alliance's lessons learned with healthcare systems.

Stakeholder engagement recommendations for health systems and facilities

Frontline community engagement should have a two-pronged approach. First, health systems/facilities should engage their patient population to ensure plans and policies reflect the values and priorities of the community they serve. The University of Minnesota Center for Bioethics 2024-2025 project gave one recommendation for health systems/facilities to create or refine plans, specifically for communications, that emphasize and prioritize the involvement of trusted members of local communities. Plans for communications and public health event management 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. By doing this, health systems establish trust with the community, which may result in better understanding and adherence to recommended public health and healthcare policies in these situations.

Second, health systems/facilities should engage their own staff in education and planning for contingency conditions and crisis standards of care. The frontline healthcare and emergency medical services staff are the people who will provide altered standards of care to patients. It is vital these staff members are educated and well versed in the facility or agency plans and decision-making process. Additionally, the University of Minnesota Center for Bioethics

recommend 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. Health systems/facilities should also implement protections against retaliation for "speaking up" or being labeled a "troublemaker" when voicing concerns about matters related to the event response and patient safety. Another recommendation for health systems/facilities, which would involve engagement of both the local community they serve, and their employees is they should use processes for decision-making and the development of guidance that involve the perspectives of all relevant stakeholders and affected groups. All guidance should include explicit consideration of protections for all Minnesotans, including those affected by disparities and challenges with access to care.

MDH does not expect all health systems/facilities and ambulance services to conduct widespread community engagement sessions. However, MDH encourages them to review the reports MDH has developed from statewide community engagement sessions available on the CSC Community Engagement website and ensure plans align with the values Minnesotans described. Additionally, MDH does expect health systems/facilities and ambulance services to engage their staff appropriately as mentioned above.

Conclusion

The importance of community and stakeholder engagement has been demonstrated over the years during planning and response. It is important for all public health partners to ensure their contingency conditions and crisis standards of care plans align with Minnesotans' values and that their staff are educated on them.