WISCONSIN DEPARTMENT OF HEALTH SERVICES

Crisis Standards of Care Framework and Allocation of Scarce Resources

(DRAFT) CONCEPT OF OPERATIONS

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ACKNOWLEDGEMENTS

This document was adapted and applied from the following sources:

Institutes of Medicine (IOM) 2009 and 2012 CSC Red Letter Reports

Minnesota Crisis Standards of Care Framework
Minnesota Department of Health Concept of Operations

Developing a Standard of Healthcare During Catastrophic Public Health Emergencies
Nevada Division of Public and Behavioral Health (DPBH)

ARIZONA CRISIS STANDARDS OF CARE PLAN A Comprehensive and Compassionate Response

Crisis Standards of Care - A Guideline for Louisiana's Acute Care Hospitals

All Hazards Internal Emergency Response and Recovery Plan - Colorado Crisis Standards of Care Plan

Michigan Guidelines for Implementation of Crisis Standards of Care and Ethical Allocation of Scarce Medical Resources and Services During Emergencies and Disasters

Alabama Crisis Standards of Care - Managing Modified Care Protocols and The Allocation of Scarce Medical Resources During Healthcare Emergency

National Academies of Science and Medicine (NASAM)
Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response
Washington (DC): National Academies Press (US); 2012 Mar 21.

Duty to Plan: Health Care, Crisis Standards of Care, and Novel Coronavirus SARS-CoV-2 By John L. Hick, Dan Hanfling, Matthew K. Wynia, and Andrew T. Pavia

Bio-Ethics Network of the Upper Midwest (BENUM)

INTRODUCTION

The Institutes of Medicine (IOM) define Crisis Standards of Care (CSC) as a substantial change in usual healthcare operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. The formal declaration that CSC are in operation enables specific legal/regulatory powers and provides some protection for healthcare providers in the necessary tasks of allocating and using allocation of scarce medical resources and implementing alternate care facility operations.

“The primary aim of CSC planning is not to provide a process to make triage decisions such as withholding or reallocating potentially lifesaving resources from one person or group to another who might benefit more. The aim is to have processes in place to manage resources well enough to avoid those situations.” (Hicks, 2020)

CSC is a forced decision and not a choice. This sole purpose of any CSC guidance is to maximize survival for the overall patient population and minimize adverse outcomes.

During crisis, the following circumstances are likely to exist:

- Capacity, even that expanded during surge (also referred to as “contingency”), will not be sufficient to meet ongoing care demands.

- Critical resources are unavailable and must be re-allocated to help as many patients as possible.

- Staffing levels are critically low, and staff present may be operating outside the normal scope of practice.

- Diagnostic tools may be inaccessible, leaving treatment decisions to best clinical judgment. The decision to employ CSC involves recognizing that conventional and contingency standards cannot be maintained to ensure the survival, safety and security of the population at large.

EXECUTIVE SUMMARY

The Wisconsin Guidance for Implementation of Crisis Standards of Care, Ethical Allocation of Scarce Medical Resources and Services for use in public health emergencies (declared/undeclared) and disasters presented in this framework provide suggested guidance for decision-makers to assist in making operational choices concerning resource allocation and prioritization during situations of scarcity that may arise during health emergencies.

These guidelines do not present a rigid or formalized series of instructions, but rather a set of criteria that can be employed by decision-makers in various circumstances during an emergency or disaster that impacts public health, using their best professional discretion.

These guidelines align with the application of accepted Crisis Standards of Care that may arise during emergencies or disasters.

These Guidelines align with the incident management systems such as the Incident Command System (ICS) used by Emergency Management, Public Health, and healthcare facilities incident management (HICS) which are compatible with the National Incident Management System (NIMS).

The CSC Guidelines were originally drafted in 2012 but have been revised in 2021 to incorporate updates and changes reflecting medical resource and service scarcity during the COVID-19 pandemic.

Applicability of these Guidelines

The guidelines incorporate the following understandings that help define their scope and purpose:

- Emergencies and Scarcity - Emergencies and disasters that impact public health give rise to unique challenges that can lead to, and be exacerbated by, scarcity of medical resources and services.

- Anticipating Scarcity - The likely conditions during emergencies—including conditions of medical resource and service scarcity—may be anticipated even in emergency circumstances that arise from sudden, extraordinary, or temporary events.

- Duty to Plan and Provide Guidance - Emergency planners have an ethical duty to plan for and provide guidance related to the ethical allocation of scarce medical resources and services during emergencies or disasters. The duty to plan includes consideration how plans and their implementation will impact communities that are less resourced and that experience racism and bias.

• Crisis Standards of Care - The guidelines apply to serious emergencies or disasters that impact public health, not everyday scarcity of medical resources and services. Therefore, the guidelines envision allocation decisions being made in circumstances where crisis standards of care are anticipated or have been implemented. The transition between conventional, contingency, and crisis standards of care is rarely well-defined. The need for crisis standards of care can shift as new resources become available or get depleted.

PURPOSE

The goal of this Framework is to:

- Outline the WI Department of Health Services (DHS) operational response during a Crisis Standards of Care situation and

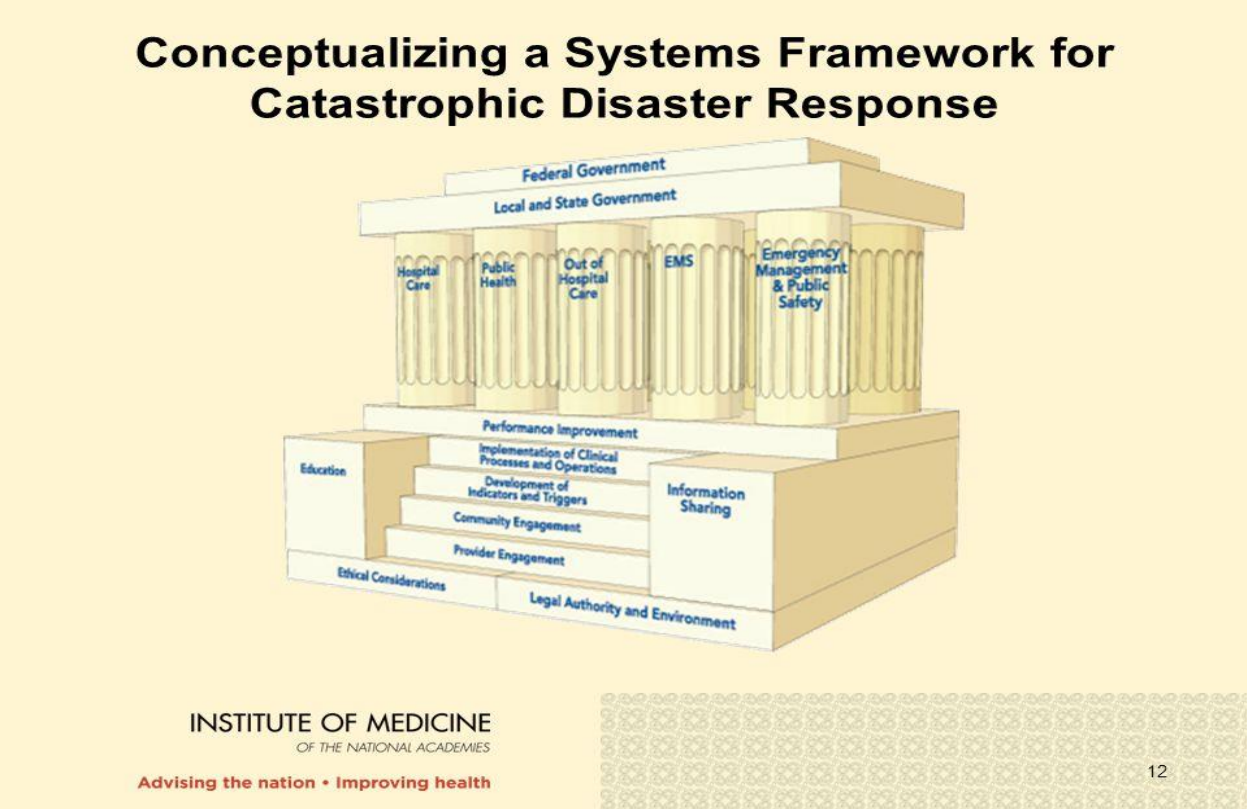
- Provide planning guidance and strategies to health care entities (e.g., public health agencies, hospitals, health care coalitions, emergency medical services, etc.) to manage the transition from conventional to contingency to crisis care during a Crisis Standards of Care situation and develop their own allocation of scare resources plans.

SCOPE

The Wisconsin CSC Framework helps define DHS or other associated entity actions and roles during any pervasive or catastrophic health event that generates a change in standard of care due to scarce resources (e.g., staff, space, supplies). It does not supersede or replace the DHS All Hazards Response and Recovery Planning or other approved health emergency planning – rather it builds off of that planning. Nor does it create new authorities or change existing authorities. CSC plans at the public health, or private health care facility level may be needed anytime and anywhere as extensions of surge capacity plans to address immediate needs when community resources are overwhelmed by a disaster.

Crisis Standard of Care plans involve the support of the State, other levels of government, key stakeholders and partners, (Figure 1). The government role is to support ongoing, substantial changes in operations and medical care decision-making during a prolonged emergency, when insufficient resources are available and when the focus of care must shift from the benefit of the individual to the benefit of the community. As a part of this response structure, DHS would also rely on the Health Emergency Readiness Coalitions (HERCs) to enhance the ability of hospitals and health care systems to prepare for, respond to, and recover from these types of events.

Figure 1.



Crisis standards of care situations requiring state action are extremely rare (e.g., severe pandemic) and assumes HERCs, health care facilities and other local agencies have developed their own plans. Therefore, the CSC Framework also provides planning guidance and strategies for HERCs, health care facilities, Emergency medical Services (EMS), and other local agencies to develop their own crisis standards of care plans. These strategies provide ethically sound, proactive guidance to provide the best care possible when demand for resources far exceed availability.

AUTHORITY

The primary source of State government's authority to respond to any type of emergency or disaster, including those, which threaten public health, is the Wisconsin Powers and Duties Related to Emergency Management found in the Wisconsin Statue 323.10. Wisconsin's 323 Statutes grant the Secretary of Health broad authority to protect, maintain, and improve the health of the public. In this role, the CSC Framework may be initiated by the Secretary of Health during a pervasive or catastrophic public health event in the State of Wisconsin. DHS will work with the governor's office to determine emergency legal issues that must be addressed in order to facilitate the response. Issues including isolation and social distancing, access to resources, and liability are just a few examples of areas that may require legal interpretation and involvement. If necessary, DHS will work with the Wisconsin Attorney General's office

and the governor's office to provide incident-specific guidance. In some cases, governor's emergency orders may be needed to address the specifics of an incident.

PLANNING ASSUPTIONS

1. Initiation of the CSC Framework will occur in stages and will be inclusive of a variety of public and private entities.

2. Statewide initiation of CSC will likely occur only during a pervasive or catastrophic public health event that overwhelms both local and regional capacity. Initiating CSC is NOT a choice, it is a forced decision.

3. Resources are scarce and cannot be obtained by health care facilities in time to prevent resource triage.

4. Crisis strategies have been activated by other health care delivery systems and consistency is needed across the state so equitable levels of care are offered.

5. Patient transfer is not possible or feasible, at least in the short-term.

6. Access to medical countermeasures (vaccine, medications, antidotes, blood products) are limited.

7. Available local, regional, state, federal resource caches (e.g., equipment, supplies, and medications) have been distributed, and there is no foreseeable short-term resupply of such stock.

8. Adaptive and alternate strategies have been exhausted or are not appropriate.

9. Multiple health care access points within a community or region are impacted

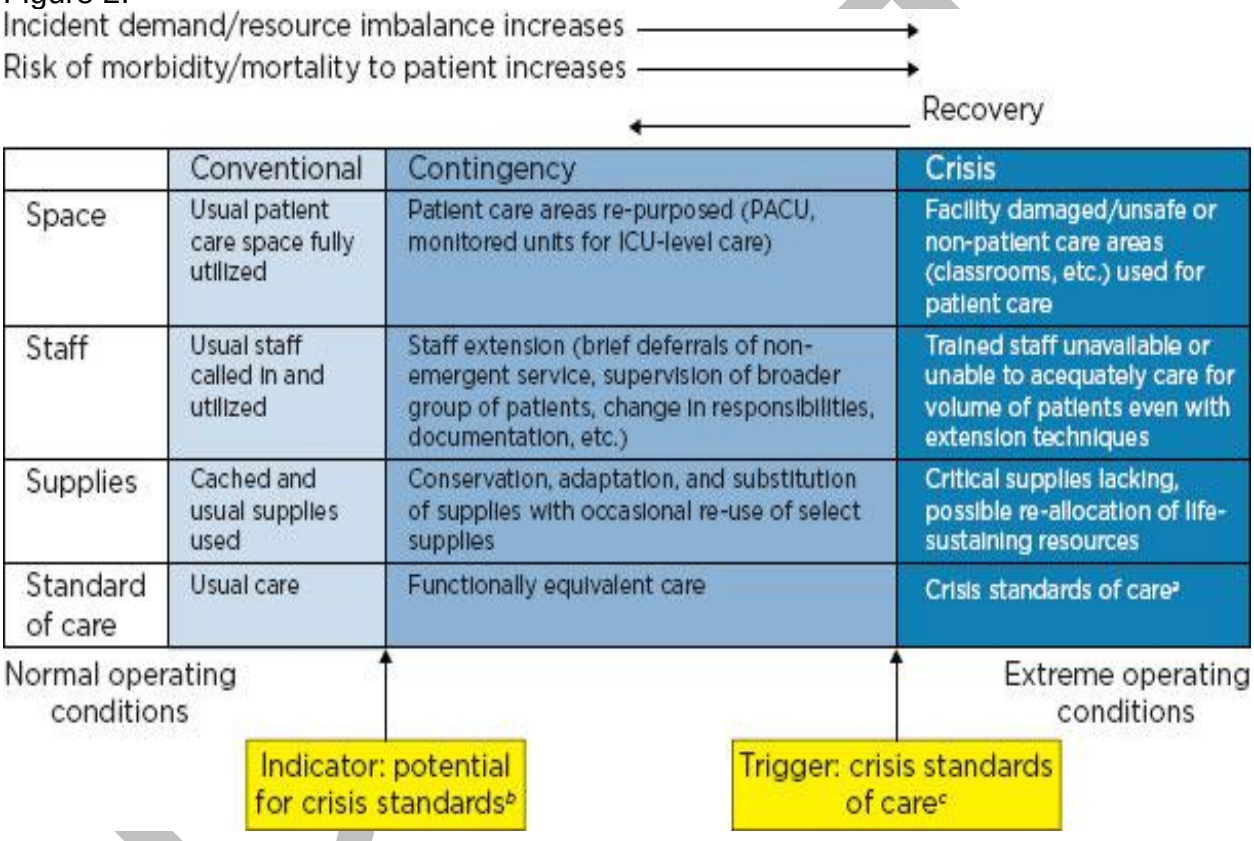
CONTINUM OF CARE BACKGROUND

The goal is to avoid the crisis state through good contingency planning and implementation, and to recover from the crisis state as soon as possible.
Figure 2. (below) illustrates the continuum of care, from conventional care, transitioning to contingency care and finally crisis care.

- During conventional care, customary routine services are provided with no issues (e.g., use of available inpatient beds).
- During contingency care, care provided is functionally equivalent to routine care but equipment, medications, and even staff may be used for a different purpose or in a different manner than typical daily use (e.g., substituting one antibiotic for another that covers the same classification). The demands of most incidents can be met with conventional and contingency care.

- Crisis care falls at the far end of the spectrum when resources are scarce and the focus changes from delivering individual patient care to delivering the best care for the patient population as a whole. This shift in focus, may require adaptations and non-traditional provision of care, which while necessary to maximize the number of lives saved during a pervasive or catastrophic public health event, increases the risk to the individual patient. A single resource (e.g., vaccine) or multiple resources (e.g. critical care beds and staffing) may be affected. Notably, emergencies are dynamic and care moves back and forth along this continuum during an incident.

Figure 2.



For example: a hospital in a crisis after a local emergency can usually transfer patients and bring in resources within hours to get back to contingency or conventional status. In this example, a State response is not warranted. The activation of a State response is at the end of the continuum of care and is only utilized in an extreme prolonged event for a statewide response. Indicators and triggers aid decision-makers in recognizing when care is moving along this spectrum from conventional to contingency to crisis care and can help prompt requests for assistance. For example, if a hospital is providing cot-based care, this indicates crisis care is occurring and outside support is needed.

ETHICS

Principles for Ethical Decision Making

CSC does not imply a lower standard of care or patient abandonment. To the contrary, it assumes plans for palliative or comfort care are in place. CSC strives to preserve equity and fairness and is intended to minimize adverse outcomes that would otherwise occur due to the crisis situation. CSC ensures that decisions are made in accordance with the following ethical principles:

- Fairness – processes are equitable for all patients
- Respect – information is shared truthfully and candidly; honors patient's autonomy, dignity and privacy
- Stewardship – preserving the effectiveness and impact of available resources
- Transparency – providing open access to available information and the decision-making process
- Justice – decisions are made without regard for social positions or relationships
- Proportionality – decisions are proportional to the scope and severity of the circumstances
- Accountability – health care workers act responsibly, in accordance with professional standards

RISK PROFILE

Demographic groups such as marginalized populations, immigrants, seniors, children and people with disabilities may have different and specialized needs following a disaster.

Crisis care strategies should be developed with respect to equity. DHS works with ethicists, local public health, emergency management, and HERCs to plan for and with these groups on multiple levels.

Pre- and post-incident assessments are recommended to determine the needs of affected communities, assist in estimating the number of people who may need specialized services, the types of services they may require, and the type and methods of public outreach that may be needed to reach them. This may be accomplished as part of the state and local CSC planning process.

DUTY TO PLAN

Hospitals must develop plans for moving from Conventional to Contingency to Crisis Capacity. During a disaster or declared emergency, the goal is to remain in Contingency status to the extent possible and avoid moving to CSC.

Strategies for remaining in Contingency Capacity may include:

- Canceling elective procedures and surgeries to increase capacity.
- Early discharge or transfer of appropriate patients to home or less acute levels of care.
- Transferring less acute patients from medical surgical units to alternate care sites, with the assistance of case managers and discharge planners.
- Transferring post-acute and behavioral health patients from acute settings into other appropriate settings.
- Expanding critical care capacity into areas such as post-anesthesia care units, surgical suites, and outpatient care units.
- Expanding patient care areas to include hallways and private rooms.
- Expediting admissions to move patients from the emergency department to patient care units.
- Utilizing EMTALA compliant screening of individuals seeking care, in coordination with EMS or other medical direction, to determine the most appropriate setting for care including an established alternate care site for less acute patients.

CONCEPT OF OPERATIONS

Possible Indicators/Triggers

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

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

- Failure of hospital “contingency” surge capacity (i.e. resource-sparing strategies overwhelmed);
- Availability of material resources;
- Availability of space for patient care;
- Pandemic phase/impact.

- Potential Indicators with associated local Trigger (threshold that ‘triggers’ specific action is specified in agency/facility plans):
  - Unable to answer all EMS calls;
  - More than 12 hours of wait time for emergency department visits;
  - Unable to maintain staffing in ICU;
  - Shortage of hospital beds available, no beds available;
  - No ICU beds available in the health care organization; or a disaster declaration affects more than one area hospital;
  - Shortage of specific equipment (ventilators) or of medications that have no substitute.

It is important to note that ‘triggers’ are more common at the initial levels of response.

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

Threat Assessment

Per the Wisconsin Department of Health All-Hazards Response, DHS may receive information that suggests or indicates a potential or actual public health threat or business interruption from a variety of sources. In a crisis standards of care situation, the indicators will most likely come from hospitals, health care coalitions or other health care entities. DHS staff that receive threat warning information must assess and report their findings according to the standard operating guidelines for their program or division.

Communications

As the state’s lead public health agency, with primary responsibility for policy development and technical expertise regarding public health issues, DHS is responsible under the Wisconsin Emergency Plan (WERP) for directing and coordinating health-related communications activities during an incident with public health implications. A

crisis standards of care situation will require extensive communication, coordination and collaboration among all involved so messaging is clear and consistent statewide.

DHS Office of Preparedness for Emergency Health Care (OPEHC) staff will send notifications to appropriate response partners including, HERCs, the Wisconsin Hospital Association (WHA), health care organizations, local and tribal health departments, and others. Response partners maintain their 24/7 contact information in the DHS EMResource system.

Activation

An activation may require the activation of other state agencies and the State Emergency Operations Center (SEOC). DHS is the lead agency for health and medical response in the SEOC and the DHS Department Operations Center (DOC) would work in conjunction with the SEOC.

Depending on circumstances, DHS OPEHC may advise the Secretary of Health to activate the State Disaster Medical Advisory Committee (SDMAC) to provide clinical considerations and recommendations on scarce resource allocation, triage, and other national guidance relevant to the situation. The SDMAC Advisor and DHS Medical Director maintain contact with the SEOC and the Secretary of Health for ongoing recommendations and serve as liaisons for activated agencies and partners.

On-Going Communication

During a crisis standards of care situation, transparent communication is of the utmost importance. Communication between state agencies, local agencies, and HERCs for both internal and external communications to stakeholders will be critical. And may include:

- WISCOM;
- Health Alert Network messages;
- Wisconsin System for Tracking Resources, Alerts and Communications (EMResource);
- Public Information Officer (PIO) advisories and guidance documents;

Public Information

Under the WERP, DHS is responsible for directing and coordinating health-related communications activities during an incident with public health implications. When the SEOC is active, public/media communications are coordinated through the State Joint Information Center (JIC) via the Lead PIO. The Lead Public Health PIO in the SEOC will assume primary responsibility for public health information and messages. When the SEOC is not active, but DHS has activated an incident response structure, the DHS PIO

will assume lead responsibility for public communication associated with an emergency or incident.

Both DHS and the SEOC have hotlines that can be utilized during an incident response. The SEOC Information Hotline can be activated when the SEOC is in use or the DHS hotline becomes overwhelmed.

In situations where both the DHS and SEOC hotlines are activated, the DHS hotline is reserved for public health agencies and health care professionals and the SEOC hotline provides information to the public about the incident.

Roles and Responsibilities

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

Principle	Role	Responsibilities
Governor	Oversee response and ensure coordination among relevant state agencies	▪ Approves State disaster declaration requests. ▪ Requests Federal Emergency or Disaster Declaration. ▪ Issues emergency declarations and specific emergency orders to address incident-specific issues. ▪ Ultimate authority for State response.
Wisconsin Department of Health Services (DHS)	State lead agency for health-related issues	▪ Facilitate health care resource requests to state/inter-state/federal partners. ▪ Request State Disaster or Public Health event Declarations and governor's emergency orders as required to support response. ▪ Request CMS 1135 waivers as required during response to allow

		patient billing when usual conditions cannot be met. ▪ Convene the SDMAC to discuss or develop incident specific medical/resource clinical guidance and triage criteria. ▪ Activate other subject matter experts (SMEs) as needed (e.g., EMS, Ethics, and Hospitals Surge) to help inform specific actions and develop outreach strategies. ▪ Provide clinical guidelines/guidance. ▪ Request specific emergency orders/actions by the governor's office. ▪ Support HERC information exchange and policy development. ▪ Provide treatment and other health related guidance for clinicians, local and tribal public health, and community members based on the nature of the event. ▪ DHS's PIO will develop DHS communications to public and providers on the crisis issues.
Wisconsin Secretary of Health	DHS Lead Health Official	▪ When necessary approve implementation of CSC Framework when necessary during a public health event/disaster response. ▪ Authorizes activation of CSC Framework

		▪ Serve as liaison to the Governor's Office. ▪ Issues orders as appropriate for the event to protect the public's health
Medical Director	Guides DHS emergency preparedness and response efforts	▪ Coordinates DHS response; may be given authority by the commissioner to activate CSC Framework components. ▪ Key liaison to HERCs in the State
Infectious and Disease, Epidemiology, DHS	Epidemiology and Infectious Disease Control expertise	▪ Develop impact assessment, provide infection control information, develop public health population-based intervention recommendations based on expert input and Centers for Disease Control (CDC) guidance.
Wisconsin Department of Military Affairs – Wisconsin Emergency Management, Or State Emergency Operations Center (SEOC)	State lead for incident coordination	▪ State level coordination of overall disaster response/recovery. ▪ Serve as point of contact for resource requests. ▪ Request State declaration of emergency. ▪ Recommend and request a Federal Disaster Declaration to governor.
Health Emergency Readiness Coalitions (HERCs)	Lead for regional coordination of planning and response to health care emergencies	▪ Coordinate overall regional emergency response and recovery ▪ Facilitate communication, information and resource sharing ▪ Maximize how existing resources are used and obtain needed items ▪ Support the Regional Medical Coordinating Centers (RMCC)

		▪ Support community medical surge capacity and capabilities
EMS Regulatory Board (EMSRB)	State lead agency for EMS disaster issues	▪ Support hospitals by regional and state-level coordination of EMS surge capacity implementation. ▪ Carry out duties and responsibilities assigned by the Governor's Executive Order ▪ Deploy ambulance teams, mass casualty incident buses, additional ground or air ambulances from regions as requested by local EMS agencies through the State Duty Officer or SEOC. ▪ Request inter-state (EMAC) or federal (i.e. Federal Ambulance Contract) resources via HSEM. ▪ Communicate suspension of selected regulatory statutes/rules to facilitate crisis care activities during declared disaster. ▪ Provide support to regional health care coalition/response through regional EMS system program personnel. ▪ Support local EMS medical directors by providing guidance on patient care guidelines and the Medical Director Standing Advisory Committee.
State Disaster Medical Advisory Committee (SDMAC)	Subject Matter Experts	▪ Provide ethical clinical, operational and policy expertise to WI Secretary of Health during a pervasive or catastrophic public health event.

		▪ Develop ethical crisis care strategies for health care providers prior to and during a response requiring scarce resource allocation. ▪ Assist with disseminating information regarding altered standards of care.
County Public Health Departments	Lead agency for public health events at local level Determine jurisdictional public health activities and interventions and coordinate efforts with HERC partners.	▪ Support hospitals and EMS (local lead for pandemic/epidemic situations). ▪ Provide health-related community communications during disasters. ▪ Support alternate care sites as appropriate. ▪ Support/coordinate local hotlines. ▪ Communicate health alerts and other information to partner agencies. ▪ Provide/coordinate community-based interventions (e.g., prophylaxis or vaccination).
Local and Tribal Public Health	Lead agency for public health events at local level	▪ Supporting agency to hospitals and EMS (local lead agency for pandemic/epidemic situations). ▪ Provide health-related community communications during disasters. ▪ Supports alternate care sites as appropriate. ▪ Supports/coordinates local hotlines.

	Determine jurisdictional public health activities and interventions and coordinate efforts with HERC partners Tribal lead for incident support	▪ Communicates health alerts and other information to partner agencies. ▪ Provides community-based interventions (e.g., prophylaxis or vaccination). ▪ Request a State or Federal Presidential Disaster Declaration as required. ▪ Tribal level coordination of overall disaster response and recovery. ▪ Tribal coordination and utilization of tribal communications, EMS, and tribal first responder resources and tribal public health. ▪ Coordinate with Great Lakes Inter-Tribal Council
Regional EMS Programs	Regional Coordination EMS response	▪ Assist in coordination of EMS resources and emergency management in collaboration with the State, Regional or Local Emergency Operations Centers. ▪ May provide or develop regional procedures for EMS disaster response
Local Emergency Management	Local lead for incident support	▪ Request resources locally and through SEOC. ▪ Facilitate local declarations of emergency. ▪ Facilitate suspension of ordinances/rules as required to support response.

		▪ Provide incident information/common operating picture to local and State agencies.
Local EMS Agencies	Emergency response and patient transport	▪ Coordinate patient destination hospitals to the degree possible to avoid overloading a single facility. ▪ Develop policies for crisis care situations. ▪ Interface with local hospitals and regional health care coalition to share information/status. ▪ Adjust response and transport guidelines to reflect the situation at the hospital (e.g. if all hospitals overwhelmed may recommend self-transport to clinic for non-emergent problems).
Medical Response Unit/First Responders	First response	▪ Frequently the first personnel on scene to assess and report on the situation, provide initial triage and help determine what additional resources may be needed. ▪ Support and assist arriving ambulance personnel on scene.
Health Care Facilities	Acute patient care	▪ Implement surge plans including crisis care plans. ▪ Implement facility or regional triage/treatment plans as required. ▪ Coordinate information and resource management with other

		facilities in the region via their regional HERC. ▪ Consider alternate care sites (ACS) to maintain appropriate level of medical care
Public Safety Answering Point	9-1-1 Dispatch Center Support Agency	▪ Answers 9-1-1 calls. ▪ Provides emergency medical dispatch support (if equipped, may transfer to secondary center). ▪ Determines appropriate response based on situation/algorithms/SOPs. ▪ Provides communication point for incident responders. May assign radio talk groups during an incident.
Wisconsin Hospital Association (WHA) Rural Wisconsin Health Cooperative (WRHC) Wisconsin Association of Local Health Departments and Boards (WALHDAB)	Health care facility communication & regulations	Assist DHS in communicating pertinent information with hospitals and public health care facilities across the state.

Management of Scarce Resources

During a pervasive or catastrophic public health event, DHS will suggest reliance on the core strategies of crisis care when altering the standard of care is required. They are:

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

DHS will disseminate Patient Care Strategies (PCS) as suggested by the SDMAC in the event the State enacts Crisis Standards of Care. In doing so, affording as many protections to medical and other health professionals and a basis for the ethical allocation of scarce resources.

These strategies, created by the SDMAC, are ethically grounded and approved strategies that if followed, provide legal protections to medical providers. Additionally, this would apply to any other material, protocols, strategies, etc. the SDMAC may recommend during the incident.

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

Behavioral Health Considerations

In a Crisis Standards of Care situation, loss and trauma will directly affect many people and will impact nearly all activities of daily living. In a situation where, usual care cannot be offered, providers, patients, and families alike may be severely burdened emotionally by the knowledge that more could have been done. Feelings of helplessness are strong contributors to development of post-disaster mental health issues.

DHS may wish to include agency efforts on providing behavioral health support to incident command and responders, facilitate mental/behavioral support services at health care facilities, and support community resilience through messaging and technical assistance.

Demobilization and Recovery

Proportionality dictates that the actions taken in response to a crisis be only those required to address the shortfall, that is, restrictions on access should not be more than necessary. Many events will be dynamic and move back-and-forth between conventional and crisis.

For example, an EMS agency may be able to provide conventional services at night during a pandemic, but resort to crisis strategies during peak daytime hours. Therefore, demobilization of assets may be possible without actually entering the recovery phase (e.g. waves of a pandemic).

DHS's role is to assure consistency of response to the degree possible and monitor for opportunities to demobilize resources when it is clear that it is safe to do so. Suspended regulations and emergency orders should not end prematurely, but should be scaled back as it is possible to do so.

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

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

Plan Maintenance and Review

The maintenance of this Framework is the responsibility of DHS. The Framework will be reviewed by DHS on a bi-annual basis.

The Framework will also be subject to modification following an exercise, response, or other evaluation as needed. Any substantive changes to the Framework will be reviewed and approved by the DHS, SDMAC and additional SMEs within DHS as appropriate.

Changes may also be made to this Framework due to information received from state, federal, or other partners. DHS will track and document substantive changes to this Framework. Training and exercises with an emphasis placed on the coordination

components within this Framework will be conducted on an ongoing basis as per the DHS training and exercise schedule with internal and external partners.

APPENDIX

Supplement Incident Specific State Emergency Plans To Be Added At A Later Date