Crisis Standards of Care

Public Health Indicators, Triggers, and Tactics for Transitions Along the Continuum of Care in a Slow-Onset Scenario

Indicator Category	*Contingency*	*Crisis*	*Return Towards Conventional*
Surveillance Data	**Indicators:** • Epidemiologic data identify significantly increased or novel activity • Epidemiologic data may identify unusual population affected • Trends over time indicate escalation and/or significant impact on the population and/or highly infectious and transmissible disease **Triggers:** • Health care organizations having difficulties submitting data due to impact of medical surge volumes. The State of Michigan requires healthcare entities to submit data electronically or through their local health departments • An increase of cases in emergency departments, hospital admissions, transmissions in the community, or increased rate of speed of infections **Tactics** • Increase capacity to investigate indicators and collect data that will be transmitted to local health departments to attain improved situational awareness. Additional staff will help to increase efficiency and accuracy of reported data • Work closely with health care coalitions and medical health partners to target data collection to key elements that are required by law or under MDHHS or governor's order • Develop additional data elements based on incident and potential workload impact	**Indicators:** • Epidemiologic data indicate benchmarks and thresholds for critical resources and maximum critical care capacity will be exceeded • Communications from local medical examiner that morgue storage capacity has been exceeded **Crisis Triggers:** • Epidemic curves continue to rise with unclear peak of cases • Hospital data indicates significant shortages in capacity • Surveillance has to be modified to highest priority or impact-only with minimal set of identifiers for future follow-up as identified by public health orders and communicable disease reporting rules **Tactics:** • Executive and MDHHS leadership determines and distributes data capturing requirements for healthcare facilities to provide common operating picture and potential treatment/outcome information • Surveillance data collection narrowed to only automated data streams related to incident unless additional information is needed through medical chart extraction • Required electronic reporting could be modified to include additional data	**Indicators:** • Epidemiologic data indicate sustained decrease in "new" incident-related reports, the outbreak appears to be in the descending part of the peak, and hospital daily census returns to pre-contingency/baseline levels **Triggers:** • Electronic reporting mechanisms indicate return to normal reporting processes by health care organizations **Tactics:** • Public health staff returns to pre-contingency workload and surveillance parameters • Public health staff initiate "catch-up" work to capture health data from the prolonged incident; this is a critical role for public health for future incident response and demand forecasting • Public health entities prepare for next infection peak/wave of pandemic

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Communications Infrastructure **ESF #2 – Communications**	**Indicators:** • Need to communicate with public about potential for high-risk situation **Triggers:** • Communications systems (Health Alert Network [MIHAN], telephone, etc.) disrupted within and external to jurisdiction • Multiple requests for assistance from multiple agencies or jurisdictions • Identified need to establish communication hotlines • Requests for specialized services and needs for broad public communications **Tactics:** • Work with established media and professional organizations to ensure consistent messaging • State health implement statewide plans for nurse triage lines, 211, poison control support for callers related to event • Coordinate risk communication strategies with governmental public information officials	**Indicators:** • Continued need to communicate with public about high-risk, evolving situation **Crisis Triggers:** • Prolonged and widespread communication (cellular, internet) outages render communication difficult **Tactics:** • Use all established resources to coordinate and communicate health messages • Increase availability of coordinated communications for gaps identified • Focused review of communications strategies to identify gaps in targeted populations	**Indicators:** • Decreased requests for messaging • Decreased activity on established hotlines **Triggers:** • Media and health care requests returning to "normal" **Tactics:** • Continue to provide appropriate levels of communication to the media, community, and impacted health care organizations
Community Infrastructure **ESF #1 – Transportation** **ESF #3 – Public Works and Engineering** **ESF #5 – Emergency Management** **ESF #6 – Mass Care, Emergency Assistance, Housing, and Human Services** **ESF #7 – Logistics Management and Resource Support**	**Indicators:** • Potential for disruption of community infrastructure within and external to jurisdiction **Triggers:** • Multiple requests for assistance from multiple agencies or jurisdictions • Interruption or contamination of water supply, food supply, transportation, or utilities **Tactics:** • Coordinate governmental and private sector resources to reduce potential utility disruptions or water supply contamination • Provide access to community infrastructure and services to alleviate shortages	**Indicators:** • Local EOCs and state emergency operation center are fully activated statewide • Water supply contamination • Widespread and sustained utility disruption **Crisis Triggers:** • Reports of disturbances at health care organizations or public shelters, etc. • Prolonged and widespread utilities (power, natural gas) outages **Tactics:** • Coordinate governmental and private sector resources to alleviate utility disruptions or water supply contamination	**Indicators:** • State and local EOCs no longer activated **Triggers:** • Contamination or utility disruption has been resolved and community infrastructure restored **Tactics:** • Continue to provide supportive services as needed for impacted areas and populations

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Staff	**Indicators:** • Increasing absenteeism among public health staff; increased demand for staffing for community-based interventions, etc. **Triggers:** • Community-based interventions required (e.g., vaccine, countermeasure distribution, "flu centers") **Tactics:** • Eliminate routine or non-life safety laboratory testing, surveillance of community organizations, etc. • Initiate Continuity of Operations planning to ensure that essential functions for local and state public health are implemented to support health care organization response • Identify services to put on "pause" as personnel resources continue to decline • Activate mutual aid/support plans from other agencies, disciplines, predesignated volunteer sources as required • Off-load tasks onto technology as possible (e.g., hotlines rather than face-to-face assessments) • Change staffing patterns and hours	**Indicators:** • Increasing absenteeism and inability to fulfill critical missions to community • Increased demand for resources **Crisis Triggers:** • Unable to fulfill critical missions (e.g., support alternate care sites) with appropriate staff **Tactics:** • Eliminate all non-essential functions to support local and state response to the incident • Reallocate any health professionals whose training allows them a more active role to support health care organizations • Work with LARA to expedite licensing for out of state healthcare professionals • Assist if needed in coordination of health volunteers to support public health and medical functions identified • Triage personnel resources to services of most benefit (community vaccination, etc.) • Use just-in-time recruiting and training as required to fulfill missions • Obtain regulatory relief as required to facilitate facility crisis responses (e.g., who may administer vaccinations) • Recall retired personnel to assist • Cancel non-critical procedures and re-allocate personnel for critical missions	**Indicators:** • Impact of incident decreasing • Personnel absenteeism is decreasing • Personnel communicating need to initiate activities to "return to normal operations" **Triggers:** • Missions able to be completed with adequate staffing **Tactics:** • Review and prioritize key services for reimplementation at the local and state levels • Initiate data analysis of impact of CSC implementation on personnel • Revert to normal staffing patterns/hours/duties

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Space/Infrastructure	**Indicators:** • Health care organizations are unable to meet demands with traditional bed capacity with all surge strategies implemented • Local and state public health-initiated strategies to authorize alternate care site initiation; including assurances related to governmental waivers (e.g., 1135 waivers) **Triggers:** • Space expansion is required for community-based interventions (e.g., vaccination campaign, etc.) • Recognition of the need to open alternate care sites for screening clinics/early treatment **Tactics:** • Requests are made for waivers to authorize alternate care sites for care delivery • Work with LARA and local Fire Marshall's office for permissions to utilize additional needed space for patient care • Local public health departments work with their local health care organizations and regional Healthcare Coalitions to ensure that inpatient sites, including skilled nursing facilities, are prioritized for support • Public health provides risk communication and coordination like 211, clinical and public hotlines and websites, etc. for advising when to seek care, etc.	**Indicators:** • Health care organizations have narrowed admission criteria to maximize available resources • Hospitals re-purposing care areas such as pre- and post-op, recovery, etc. **Crisis Triggers:** • Health care organizations have implemented all medical surge strategies and should seek alternate care site locations for inpatient care overflow **Tactics:** • Supply or support mobilization of deployment of volunteer health professionals • Implementation of governmental waivers to establish alternate care sites • State emergency operation centers and health emergency coordination centers work with state and federal agencies to establish declarations and emergency order rules specific to the necessary tactics to respond to the incident • State public health to communicate with state disaster medical advisory committee to review status of CSC guidelines and distribute to impacted health care organizations	**Indicators:** • Surveillance indicates declining new infections • Health care organizations are able to broaden admission based on available resources • Hospital care areas return to routine functions **Triggers:** • Decreasing census in alternate care sites within jurisdiction • State observes multiple health care coalitions readying for demobilization of alternate care sites **Tactics:** • Support health care alternate care site demobilization strategies • Patient records, resources, and supplies should be accounted for and returned as required; local and state public health departments mobilize resources to assist as available • State public health works with local partners and non-governmental organizations to communicate plans to return to conventional care

	• ESF-8 lead to keep each local emergency operations center aware of impact and contingency care implemented • State public health works with all health care coalitions to support implementation of statewide medical surge strategies • State Community Health Emergency Coordination Center (CHECC) to keep each local health department aware of impact and	• MDHHS and governor to initiate process for implementing executive orders for to protect public health	

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Supplies	**Indicators:** • Local and state monitoring of supplies and inventory data indicate shortage/potential shortage • Benchmark supply availability to disease reporting and mortality data • Anticipate challenges with medical supply chain based on expanding incident; review communications from each health care coalition for the impact to their health care organizations **Triggers:** • Decreased availability of critical medical resources anticipated • Requests to health care coalition medical coordination center for allocation of regional cache supplies **Tactics:** • Prioritize resource allocation by urgency of need and risk • Determine time frame and availability from other vendors/sources • Review and update risk communication strategies specific to users of critical resources and community	**Indicators:** • Demand forecasting/projections exceed available critical resources • No national source of specific supplies available • New MCM, such as medications and vaccines, are available but not in sufficient amounts for widespread access **Crisis Triggers:** • Shortages of critical equipment, medications, or vaccine present significant risk to persons who cannot receive them • National guidance on rationing distributed **Tactics:** • Focus allocation of scarce resources to maintaining critical social/ public safety function (civil order maintenance) • Coordinate risk communication strategies • Use government purchasing powers to support critical medical supplies	**Indicators:** • Vaccine manufacturers have increased supply chain so targeted groups for vaccination is expanded based on disease trends and ethical guidelines • Additional resources are obtained • Demand for resources (e.g., ventilators) is declining as event wanes **Triggers:** • Critical medical supplies are sufficient to meet the needs of the patients requiring them **Tactics:** • Continued, coordinated risk communication. • Assessment if transition is temporary or likely to be permanent • Local public health should augment Points of Dispensing plans to meet

	• CHECC work with each health care coalition to allocate regional cache contents and other resources • CHECC initiates procurement of MCM from the Strategic National Stockpile • CHECC initiates internal mechanisms to move anticipated Medical Counter Measures (MCM) materiel requests received in the state EOC	• Maintain communications with federal SNS program • State and regional disaster medical advisory committees review triage guidance available and propose recommendations • State public health circulates guidelines on allocation of resources • Legal, regulatory, and emergency powers invoked as required to facilitate fair,	demands when vaccination is expanded as vaccine is available • Demobilization of SNS or state-allocated resources • State public health to review CSC guidelines for possible revision based on resource availability

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Fatality Management	**Indicators:** • Rising death toll • Rate of deaths projected to exceed local capabilities **Triggers:** • Health care organizations are reporting an inability to manage the number of decedents within facilities • Local medical examiners are unable to meet the demands of their jurisdiction with usual processing • Communications to local public health on fatality management shortages **Tactics:** • Local public health works with medical examiners/coroners to determine if the bottleneck is processing (medical examiner caseload) or body management • Local public health contacts funeral home, mortuaries, morgues, or crematoriums to assess current impact on capacity and expansion capacity • Local governmental agencies should identify potential cultural barriers to modifications in	**Indicators:** • Funeral homes communicating limited resources to conduct funeral services • Rate of deaths projected to exceed regional/surge capabilities **Crisis Triggers:** • With disaster plans implemented, fatality processing demand exceeds available resources and threat of civil unrest is real • Local funeral homes unable to meet fatality management within their community **Tactics:** • Risk communication strategies coordinated at local and state levels • Activation of all available mortuary resources, including response teams and expanded cremation and processing operations • Governor declaration for expedited burials and/or temporary interment upon state public health recommendation. NOTE: Requires extensive planning with multiple	**Indicators:** • Number of deaths are stabilizing or in a sustained decline **Triggers:** • Decedent processing is able to be accommodated within surge or conventional systems • Local funeral homes return to normal operations **Tactics:** • Risk communication on decedent management • Local and state public health, in conjunction with medical examiners/coroners, resume normal processes, which include funerals and traditional burials • Alterations that had occurred should be addressed to return to normal state, recognizing the complexity associated

	death processes and prepare strategies to address these • Initiate strategies to expedite the completion of death certificates/investigations • State public health considers modifications to laws, regulations, etc., for dealing with decedents • Governmental authorities initiate planning for possible alternate storage strategies • Consider federal or state disaster mortuary team resources • Consider temporary storage facilities implementation plan	state agencies to identify a location, tracking, and personnel support to implement such a response to manage mass fatality incident • Consider transfer of decedents to other locations for processing if required	with variation in cultural and societal death routines
Indicator Category	***Contingency***	***Crisis***	***Return Towards Conventional***
Congregate Gatherings	**Indicators:** • Epidemiologic models indicate person-to-person spread is prevalent • Multiple jurisdictions reporting that large gatherings implicated in outbreak investigations • Outbreaks linked to funeral services **Triggers:** • Epidemiologic data indicate increasing outbreaks directly related to known congregate gatherings in more than one jurisdiction **Tactics:** • Local and state review immediate and future large-scale venues for anticipated cancellation • Local and state recommendations on modifications to school activities or school closures • State public health readies social distancing guidelines working with governor's office	**Indicators:** • Statewide indication of high transmission in congregate gathering settings **Crisis Triggers:** • Social separation is required to prevent spread of dangerous pathogen **Tactics:** • Executive order or governor's declaration to prohibit or limit the size of congregate gatherings • Social distancing or quarantine orders implemented as indicated • Governmental agencies collaborate to enforce congregate-gathering bans	**Indicators:** • Decrease in evidence for person-to-person trends • Criteria for identifying "super spreaders" as individuals allows targeted interventions **Triggers:** • Sustained decrease in disease transmission trends **Tactics:** • Governor rescinds gathering orders and other mitigation strategies • Initiate public gatherings • Local and state continue close monitoring of epidemiologic data to ensure continued decline and are prepared to reinstate mitigation strategies if cases increase

	• State and local public health implement other infectious control and mitigation measures (masking, distancing requirements, etc.)		

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Surveillance Data	**Indicators:** • Collection of information indicates disruption of services that impact local public health and health care organizations within jurisdiction • Local health department identifies specific population health surveillance data impacted by incident • Impacted persons are being taken to multiple health care organizations through traditional and non-traditional methods • Forecast temperature extremes **Triggers:** • Communications from health care organizations to their health care coalitions that many facilities have infrastructure damage	**Indicators:** • Scope of incident indicates need to focus surveillance on key elements to support medical and public health operations • Communications indicate emergency management and/or American Red Cross or other nongovernmental organization establishing multiple sheltering operations • Incident-related injuries necessitate modification of surveillance strategies • Shelters established, need for augmented surveillance to protect shelter population **Crisis Triggers:**	**Indicators:** • Focused surveillance indicates diminishing impact of incident **Triggers:** • No additional victims being entered into system

	• Communications from local emergency operations centers (EOCs) to state EOC (SEOC) that medical and public health have significant impact to service delivery • Incident disrupts medical supply chain; anticipate shortages • Unable to locate or track all patients impacted by incident. **Tactics:** • Data collection to local and state EOC's • CHECC queries all health care coalitions to identify statewide impact to service delivery and plan response strategies (patient and resource movement) • Local health department implements focused assessments and modification specific to impact	• Health care organization capacity is overwhelmed based on casualty counts and impact on health care infrastructure **Tactics:** • Collection of key information only to maximize/distribute resources or reunite families • Continue established patient tracking system and allow access by nongovernmental and other organizations as required to facilitate	• Decreasing numbers in shelters and consolidation of sheltering services **Tactics:** • Return to routine surveillance activities • Extensive review of incident specific surveillance data to determine long-term follow-up or further focused surveillance • Archiving of patient tracking from event

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Communications Infrastructure **ESF #2 – Communications**	**Indicators:** • Initial and subsequent damage reports indicate substantial loss of 911 or other communications **Triggers:** • Requests from multiple health care organizations and health care coalitions for governmental assistance due to communication infrastructure damage • Local EOCs getting queries from health care organizations about utility restoration **Tactics:** • Local public information officials work with media on health-related risk communication strategies • State public information officials working with other state agency and local public information officials for coordinated risk communications	**Indicators:** • Widespread loss of critical communications (cellular, Internet, public safety radio, etc.) **Crisis triggers:** • Incident unfolding with health care coalitions communicating significant communications infrastructure damage • Inability for multiple hospitals to communicate with other healthcare entities/911/Healthcare Coalitions **Tactics:** • Continued need for risk communications to community	**Indicators:** • Public safety communications back online **Triggers:** • Emergency communications systems reestablished **Tactics:** • Communicate de-escalation of incident to community through established methods and using risk communication strategies

		• Identify needs of health care organizations in collaboration with Healthcare Coalitions • State public information officials working with other state agency and local public information officials for coordinated risk communications	

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Community Infrastructure **ESF #1 – Transportation** **ESF #3 – Public Works and Engineering** **ESF #5 – Emergency Management** **ESF #6 – Mass Care, Emergency Assistance, Housing, and Human Services**	**Indicators** • Initial and subsequent damage reports indicate substantial loss of health care or residential infrastructure • Numbers of persons are missing and the pressure families are putting on 911 and other systems to find them • Disruption of roads impact ability to meet the needs of patient movement **Triggers:** • Requests from multiple health care organizations and health care coalitions for governmental assistance due to infrastructure damage	**Indicators:** • Local EOCs and state emergency operation center are fully activated statewide to respond to catastrophic incident • Widespread loss of utilities **Crisis triggers:** • Incident unfolding with health care coalitions communicating facilities with significant infrastructure damage that impacts health care for the community	**Indicators:** • Repairs to health care organizations provide the ability to repopulate or resume previous level of service • Local EOCs no longer activated **Triggers:** • Need for shelters has decreased to pre-emergency levels • Infrastructure and utility damage have been repaired and/or functioning of essential systems have been restored

ESF #7 – Logistics Management and Resource Support **ESF #8 – Public Health and Medical Services**	• Significant reports of safety issues that could impact community, thus indicating a need for coordinated risk communication strategies • Local EOCs getting queries from health care organizations about utility restoration **Tactics:** • Support requests from health care organizations through health care coalition • Prioritize key public health activities to support critical jurisdictional needs and health care organization service delivery • Local EOCs establishing mechanisms to implement family reunification systems	• Inability for multiple hospitals to remain in their current building without significant support • Multiple health care facilities require evacuation and inadequate transport resources to accomplish this • Local emergency management indicates a need to establish multiple shelters, including functional needs **Tactics:** • Identify needs of health care organizations in collaboration with health care coalitions • Local health departments should identify staff, including volunteers, to assist with public health issues in shelters, including those targeted to functional needs • State working with locals to ensure that family reunification systems can meet	**Tactics:** • Continue to provide supportive services as needed for impacted areas and populations • Local and state public health assist with assessments or surveys to clear impacted health care organizations for repopulation or resume suspended services

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Staff	**Indicators:** • Personnel availability impacted by access, family obligations, injury/direct effects **Triggers:** • Request for additional medical or public health personnel to support operations	**Indicators:** • Personnel availability impacted widely by access, family obligations, injury/direct effects • Local infrastructure damage will prevent mutual aid in a timely manner • Alternate care sites and shelters initiated **Crisis triggers:** • Multiple organizations requesting medical staff support and inadequate availability of staff via usual programs (MI Volunteer Registry, etc.)	**Indicators:** • Decreasing use of alternate care sites • Decreasing requests for staff support **Triggers:** • Health care organizations releasing volunteer and other supplemental staff • Alternate care sites demobilizing

	Tactics: • Identify cross-trained personnel to support services linked to incident • Modifications to services will be based on staff available • Plan to support response with volunteer health professionals (MI Volunteer Registry, Medical Reserve Corps [MRC], coalition, etc.) • Work with LARA to expedite licensing for out of state healthcare professionals	• Specialty consultation unavailable to hospitals boarding burn, pediatric, or other patients due to demands or communication issues at referral centers **Tactics:** • Use available staff and provide support for non-specialized tasks to maximize response • Limit services to those related to life/safety issues only • Facilitate out-of-area specialty consultation as applicable • Use volunteer health professionals if available • State to seek additional personnel resources through federal programs (Department of Health and Human Services, Department of Defense, etc.) • Expand contractual staffing if available	**Tactics:** • Initiate processes to return staff to routine positions • Implement demobilizations strategies if volunteers were used

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Space/infrastructure	**Indicators:** • Emergency management has initiated shelters • Emergency medical services (EMS) reporting evacuations of long-term care (LTC) and similar facilities • Hospital data indicate capacity exceeded at multiple facilities despite surge capacity plan activation	**Indicators:** • Communications indicate demand exceeds patient transport supply • Hospitals have inadequate space for patients	**Indicators:** • EMS indicates return to normal dispatch and transport protocols • Alternate care sites no longer required/use diminishing

	Triggers: • Local requests for assistance with patient movement • Inadequate EMS resources to accommodate demands **Tactics:** • Need anticipated to modify EMS transport protocols statewide and suspend specific staffing and other response requirements • Local EOCs work with regional health care coalitions to identify and prioritize transport resources • State Community Health Emergency Coordination Center to work on statewide available resources through health care coalition structure • State public health and SEOC identify additional resources through Mutual Aid Agreements or Emergency Management Assistance Compact (EMAC)	**Crisis triggers:** • Requests to modify EMS transport protocols • Requests for alternate care sites for inpatient overflow **Tactics:** • State ESF-8 works to implement protocol waivers to support modified transport plans • State public information official communicates efforts to all medical health entities • State coordination of alternate care sites and patient transportation assets from state, EMAC, and federal sources	**Triggers:** • System data indicate returning to baseline transport status **Tactics:** • Support efforts to return EMS to normal operations and regulations • Support demobilization of alternate care sites and shelter medical support • Local and state public health staff gather all after-action reports, meet with key stakeholders to identify challenges, and plan to support future operations
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Supplies	**Indicators:** • Interruption in supply chain impacts resource availability • Local use of resources exceeds supply (e.g., blood products, surgical supplies) **Triggers:** • Resource shortages reported, including medical material and pharmaceuticals	**Indicators:** • Critical medical supplies are unavailable **Crisis triggers:**	**Indicators:** • Mobilization of equipment, supplies, and resources to meet demand **Triggers:** • Decreasing requests for additional supplies to support response

	• Local request for Strategic National Stockpile (SNS) or cache materiel **Tactics:** • Local health care organizations work with their Healthcare Coalition to distribute regional resources, including obtaining resources from Healthcare Coalitions that are not impacted by the incident • State ESF-8 should identify possible waivers, including the reuse of equipment and supplies within health care organizations • Initiate process to request SNS or other materiel through state EOC	• Unable to locate additional medical supplies to support medical care, presenting a life/safety risk **Tactics:** • Local and state public health should continue to identify resources to support organizational response; this would include implementing MAA and EMAC requests for services and supplies needed to deliver care • Executive orders or public health/ emergency declaration if needed to support altering the use of equipment, supplies, or human resources • Public health guidance on allocation of specific scarce resources may be required, with input from state disaster medical advisory committee	**Tactics:** • Data collection and financial accountability to assess impact of incident and plan for remediation of gaps • Continue situational monitoring to determine if this a temporary or sustained improvement