SHAWNEE PREPAREDNESS AND RESPONSE COALITION

REGIONAL RESPONSE AND RECOVERY PLAN:

CRISIS STANDARDS OF CARE ANNEX

MARCH 2021

Signature Page

This Crisis Standards of Care Annex has been reviewed and accepted by the SPARC Executive Board and the coalition member organizations with authority to approve. This plan addresses the domains set forth by the Hospital Preparedness Program (HPP) and is compliant with the principles outlined in the National Incident Management System (NIMS); this plan relies on strong working relationships, and effective networking efforts between all coalition member organizations and partners to manage incidents.

Version 1.0 Approved by the SPARC Executive Board (majority vote) on April 28, 2021.

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Shawnee Preparedness and Response Coalition (SPARC)
Crisis Standards of Care Annex
Version 1.0, April 28, 2021

Record of Revision and Distribution

This document reflects the ongoing work and mission of the Shawnee Preparedness and Response Coalition (SPARC) regional strategies for emergency preparedness and disaster response. This document will be revised annually or as needed after exercises and real-world events to identify and address gaps with a collaborative whole community approach.

Table 1. SPARC Record of Revision

Shawnee Preparedness and Response Coalition **Crisis Standards of Care Annex** **Record of Changes**				
Revision Number	**Section**	**Date of Change**	**Individual Making Change**	**Description of Change**

Table 2. SPARC Record of Distribution

Person/Title/Agency	**Method of Delivery**	**Date**

For information regarding this document, please contact: The Shawnee Preparedness and Response Coalition (SPARC).

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Table Contents

Acronyms/Terms/Definitions

ACS	Alternate Care Site
ARC	American Red Cross
ASPR	Assistant Secretary for Preparedness and Response
EMA	Emergency Management Agency
EMAC	Emergency Management Assistance Compact
EMSC	Emergency Medical Services for Children
EMS	Emergency Medical Services
EMTrack	Commercial electronic multi-functional tracking system
EOC	Emergency Operations Center
ESF	Emergency Support Function
FOA	Funding Opportunity Announcement
FQHC	Federally Qualified Health Centers
HCC	Health Care Coalition
HICS	Hospital Incident Command System
HPP	Hospital Preparedness Program
IDPH	Illinois Department of Public Health
IEMA	Illinois Emergency Management Agency
IMT	Incident Management Team
LHD	Local Health Department
LTC	Long Term Care
MABAS	Mutual Aid Box Alarm System
MAC	Multi-Agency Coordination
MOU	Memorandum of Understanding
MPHMSRR	Marion Public Health and Medical Services Response Region
MRC	Medical Reserve Corps
NIMS	National Incident Management System
RFMR	Request for Medical Resources
RHCC	Regional Hospital Coordinating Center
SME	Subject Matter Expert
SNS	Strategic National Stockpile
TMTS	Temporary Medical Treatment Stations

Capability – The ability to manage patients requiring very specialized medical care.
Capacity – The ability to manage a sudden influx of patients.

Contingency care – Provision of functionally equivalent care – care provided is adapted from usual practices; for example, boarding critical care patients in post-anesthesia care areas.

Continuum of care – Medical care that is rendered during a mass casualty event and occurs across phases on a continuum; conventional to contingency to crisis care.
Indicator – A "measurement or predictor of change in demand for health care services or availability of resources" (e.g., a tornado warning, report of several cases of unusual respiratory illness). An indicator may identify the need to transition to contingency or crisis care (but requires analysis to determine appropriate actions).

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

Summary

During a pandemic or catastrophic event, there may not be sufficient resources – such as Intensive Care Unit (ICU) bed or other equipment – available to care for all patients requiring critical care. As such, the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Program (HPP), supports Crisis Standards of Care (CSC) planning as it is impossible to predict the timing and severity of a future outbreak and waiting for the disaster to strike would be too late.

As a requirement of the 2019-2023 HPP Funding Opportunity Announcement (FOA) HCCs and their members must utilize the Catastrophic Incident Response Annex of IDPH or use the Department developed template for the Healthcare Coalition and its members to inform plans for Crisis Standards of Care for their respective facilities. These plans will be modeled after, and/or integrated with the IDPH Catastrophic Incident Response Annex. Consideration must be given to thresholds/triggers for moving from conventional to contingency standards of care as well as from contingency to crisis standards of care.

The Shawnee Preparedness and Response Coalition is a "whole community" preparedness coalition whose primary purpose is to promote collaboration in disaster and emergency preparedness, mitigation, response, and recovery in Southern Illinois, both for its member organizations and the whole community. Overall resiliency in the event of a disaster or public health emergency is part of the coalition's mission.

Crisis Standards of Care (CSC) are just one aspect of broader disaster planning and response efforts for the coalition; they are a mechanism for responding to situations in which the demand on needed resources far exceeds the resources' availability. A regional tiered system approach to disaster planning and response is therefore required to integrate all of the values and response capabilities necessary to achieve the best outcomes for the community as a whole. It is surge capacity care provided at the end of the surge spectrum that must do the 'greatest good for the greatest number.'

The SPARC Regional Crisis Standards of Care Annex guides the regional level response. It provides guidance for its member organizations and the whole community on the care of patients, including crisis care and resource allocation, during a catastrophic incident that incapacitates the local and regional health care system and prevents the ability to provide conventional and/or contingency care. It defines the role that the coalition plays in CSC, including the integration of the RHCC, local hospitals, emergency medical service providers, local health departments, local emergency management agencies, and other healthcare and non-healthcare response partners.

Primary Coordinating Agency

Shawnee Preparedness and Response Coalition

Primary State Agencies

Illinois Department of Public Health

Illinois Emergency Management Agency

Illinois Law Enforcement Alarm System

Support Agencies, Organizations, and Entities

Regional Hospital Coordinating Center

Hospitals/Healthcare Facilities

EMS Systems

Local Health Departments

Emergency Management Agencies

Mutual Aid Box Alarm System

First Responders

MRC

American Red Cross

Non-Governmental Organizations (NGOs)

Other SPARC Members

Subject Matter Experts

Liaison to SPARC

SIU Heath Services

Marion VA Medical Center

Schools/Universities

Correctional Facilities

1.0 Introduction

Public health emergencies that are large-scaled or prolonged, such as pandemics, earthquakes or other weather-related disasters, or acts of terrorism can overwhelm healthcare systems with critically ill and injured patients and cause shortages of life-saving resources. When medical resources become scarce, healthcare systems need to take actions to conserve resources, and prioritization of may need to be considered.

Crisis Standards of Care is defined 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 crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternat care facility operations. (IOM Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations, 2012).

It should be noted that here could be a localized disaster (particularly one in which there is no-notice) that requires the use of CSC, in which there is no state declaration (i.e., Joplin, MO tornado 2011). All steps and actions taken during the planning and operational phases of the CSC plan activation shall focus on the maximum use of resources to provide rapid access to treatment and care.

During times of crisis care, decisions and strategies involving patient care will be made at the healthcare facility or agency level. This will require coordination and collaboration between providers and incident managers to determine the best use of limited resources, and, to establish modifications of care if necessary when patient care moves from Conventional and Contingency phases, into the Crisis phase when care needs exceed available resources. It is critical that this information be passed on to the Healthcare Coalitions and other response partners. The intent is to effectively integrate regional medical, health and community resources during a large-scale emergency.

1.1 Purpose

1.1.1 The purpose of the SPARC Regional Crisis Standards of Care Annex is to support the SPARC Regional Response and Recovery Plan, by providing a functional annex for all stakeholders involved in an emergency response within the Marion Public Health and Medical Services Response Region (MPHMSRR). SPARC will coordinate information and available resources for its members to maintain conventional surge response. When an emergency overwhelms SPARC's collective resources, SPARC will support the health care delivery system's transition to contingency and crisis surge response and promote a timely return to conventional standards of care as soon as possible. This annex will be integrated with the IDPH Catastrophic Incident Response Annex.

Within disaster response, the three categories in the continuum of care for patients are defined below: See Figure 1.0 for additional information.

- Conventional Care: Patients receive care that is delivered within prevailing standard operating conditions/medical standards of care and the quality of care provided does not differ from usual daily practices.
- Contingency Care: The method of providing care changes (e.g. use of alternate locations, adjustment to staffing patterns and substitutions of selected supplies/equipment), but these temporary alternatives have minimal to no impact on the quality of care provided because they are functionally equivalent alternatives.
- Crisis Care: Standard space, staff, and/or supplies are unavailable and the alternate methods/interventions that are implemented are not sufficient to meet conventional or contingency care. Crisis care is intended to provide sufficient care given the circumstances and resources available.

1.1.2 This annex guides the regional level response and sets incident-specific priorities and guidance for the delivery of healthcare and use of scarce medical resources within the SPARC geographical boundaries. The intent is to effectively integrate regional medical, health and community resources during a large-scale emergency which exceeds the ability of the health care system by coordination of pre-hospital, hospital and contingency alternate care sites, TMTS.

1.1.3 The circumstances associated with the incident results in the inability to maintain healthcare at conventional and contingency levels within SPARC geographical boundaries despite implementation of response efforts such as activating individual facility EOPs. Consequently, crisis care and other measures outlined in this annex need to be implemented to provide a coordinated response necessary to provide the best possible health care.

1.1.4 This annex is intended to support, not replace, any agencies' existing policies or plans by providing coordinated response activities in the case of any type of catastrophic incident.

Table 1 – Allocation of Resources along the Care Capability Continuum

Incident demand / resource imbalance increases →
Risk of morbidity / mortality to patient increases →
← Recovery

	Conventional	Contingency	Crisis
Space	Usual patient care space fully utilized	Patient care areas re-purposed (PACU, monitored units for ICU-level care)	Facility damaged / unsafe or non-patient care areas (classrooms, etc) used for patient care
Staff	Usual staff called in and utilized	Staff extension (brief deferrals of non-emergent service, supervision of broader group of patients, change in responsibilities, documentation, etc)	Trained staff unavailable or unable to adequately cae for volume of patients even with extension techniques
Supplies	Cached and usual supplies used	Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies	Critical supplies lacking, possible re-allocation of life-sustaining resources
Standard of care	Usual care	Functionally equivalent care	Crisis standards of care[1]

Normal operating conditions

Indicator: potential for crisis standards[2]

Trigger: crisis standards of care[3]

Extreme operating conditions

Note: Transitions of individuals along the continuum of care do not always occur abruptly, and they do not necessarily effect facility operations and dimensions of care equally and independently. The level of care that can be delivered may be dynamic and shift rapidly or slowly.

1.2 Scope

The SPARC Regional CSC Annex is designed to provide the command structure, communication protocols, Request for Medical Resources (RFMR) process, and response processes related to catastrophic incidents in which healthcare needs exceed available resources. Therefore, making it difficult for the healthcare community to maintain conventional and/or contingency care within the MPHMSRR. The SPARC Regional CSC Annex is designed to:

1. Provide support to coalition member organizations related to crisis care and resource allocation decision -making
2. Ensure associated communications processes are in place
3. Provide support on crisis care management
4. Outline strategies and assist with the coordination of resources aimed at supporting transition from crisis care back to contingency care and eventually conventional care.

The Hospital Preparedness Program (HPP) and Public Health Emergency Preparedness (PHEP) domain strategies addressed in this annex include:

1. Strengthen community resilience
2. Strengthen incident management
3. Strengthen information management
4. Strengthen countermeasure and mitigation
5. Strengthen surge management

1.3 Situation

The SPARC Regional Response and Recovery Plan and its corresponding annexes are activated when the Regional Hospital Coordinating Center (RHCC) is activated and/or at the discretion of the SPARC Duty Officer when circumstances dictate as a result of a catastrophic incident. A catastrophic incident in Illinois is defined as an incident that incapacitates the critical infrastructure and health care system including EMS, hospitals, and other health care facilities (e.g. long term care, dialysis centers, ambulatory care, community based medical groups, etc.), and/or local public health departments, leading to substantial changes in health care operations and level of care capabilities such that both conventional and contingency care cannot be maintained and crisis care is necessary.

1.3.1 SPARC Risks and Vulnerabilities

A major epidemic, pandemic, or catastrophic event in the region can overwhelm the capacity of outpatient facilities, emergency departments (EDs), hospitals, and intensive care units, leading to critical shortages of staff, space, and supplies with serious implications for patient outcomes. Such events could compromise the ability of health systems to deliver services meeting established standards of care. The possibility of a pandemic event within the Marion Public Health and Medical Services Response Region (MPHMSRR) has been proven. The current coronavirus pandemic is an ongoing pandemic of coronavirus disease 2019. The risk of Human Pandemic/Highly Consequence Infectious Disease (HCID) is one of SPARC's highest ranking hazards. An Infectious Disease Annex has been developed to improve capacity and capabilities to manage a small number of patients with high-consequence pathogens or a large number or patients during a major epidemic or pandemic.

Numerous known and unforeseen hazards could prompt the activation of the SPARC Regional CSC Annex. These could include (but are not limited to) chemical, biological, radiological, nuclear, and explosive threats (CBRNE), as well as natural disasters, such as flood, wildfires, earthquakes, or severe weather. Man-made disasters such as technological failures, accidents, terrorist attacks, civil unrest, and acts of war are also potential hazards. Hazards that pose the most significant risk to the SPARC region have been identified and prioritized in the hazard vulnerability analysis (HVA). Refer to Attachment H of the SPARC Regional Response and Recovery Plan for a copy of the HVA.

The coalition reviews the HVA on an annual basis or after major incident to identify key concerns as well as potential gaps in response systems and resources in collaboration with Emergency Support Function-8 (ESF-8) lead agency. It is necessary to review the region's capacity to respond to numerous events in order to establish mechanisms for providing care (under the current standards of care) with limited availability of appropriate personal protective equipment to protect not only the individual patient, but the collective need of the community. In light of these threats to public health and the region's experience with both real and potential catastrophic events, this annex offers a guidance to address the issue from an all-hazards perspective.

1.3.2 Preparedness and Response

Disasters and public health emergencies can stress health care systems to the breaking point and disrupt delivery of vital medical services. During such crises, hospitals and other facilities may be without power; trained staff, ambulances, medical supplies and beds could be in short supply; and alternate care facilities may need to be used. Planning for these situations is necessary to provide the best possible health care during a crisis and, if needed, equitably allocate scarce resources.

SPARC is a whole community preparedness coalition dedicated to planning, preparing, responding, and recovering together as a community of organizations and individuals that recognize the necessity of working together to help each other during times of disaster and preparing for those times. SPARC aims to enhance the region's preparedness for disasters and public health emergencies through operational readiness. This is achieved by engaging and empowering all parts of the healthcare community, and by strengthening the existing relationships to understand and meet the actual needs of the whole community.

Planning with community members and stakeholders is key in order to provide a response and recovery framework for catastrophic disasters that enhances community resilience across the regional healthcare system. SPARC offers opportunities for community partners to enhance collaboration through networking, training and exercising together (refer to Section 3.6 Training and Exercise). This effort ensures the needs of the membership and communities in the SPARC region are met.

1.4 Assumptions

The scope of this annex depends fully on assumptions. SPARC will assume some level of response capacity and work toward increasing resilience for its member organizations and the community.

1. The SPARC Regional Response and Recovery Plan has been partially or fully activated, at the discretion of the SPARC Duty Officer.
2. SPARC serves at the primary organization for the coordination of Emergency Support Function 8 (ESF-8) Public Health and Medical Services in the MPHMSRR. The RHCC will activate to coordinate health and emergency response for hospitals in the region and manage surge. See Attachment 1 of this Annex for a map that outlines the geographical boundaries of the coalition.
3. Initiation of the SPARC Regional CSC Annex will occur in stages and will be inclusive of all coalition membership.
4. Health Care Facilities, and other local agencies have developed their own plans and will activate as deem necessary.
5. Hospital partners have implemented Hospital Incident Command System (HICS) due to the pervasive nature of the response.
6. Crisis strategies have been activated by other health care delivery systems and consistency is needed across the region so equitable levels of care are offered.
7. Resources are scarce and cannot be obtained by health care facilities in time to prevent resource triage.
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.
10. The health care system has exhausted its capacity to care for patients in such a manner that maintains conventional and/or contingency care.
11. Efforts to implement tactic and strategies (including preparation, conservation, adaption, and re-use) that are intended to benefit the largest number of patients have been implemented but are insufficient to maintain conventional and/or contingency care.
12. Efforts to preserve available resources and balance the delivery of health care services across hospitals have become ineffective.
13. Despite attempts to maintain care at conventional and contingency levels, crisis care needs to be implemented in an effort to provide the best care possible for all victims given the circumstances of the catastrophic incident. Every effort will be made to return back to contingency and conventional care from crisis care as soon as possible.

14. Most or all of the community's infrastructure has been impacted.
15. Patient transfer not possible or feasible, at least in the short-term.
16. Access to medical countermeasures (vaccines, medications, antidotes, blood products) will likely be limited.

1.5 Authorities

The legal authority and environment support the necessary and appropriate actions in which CSC response can be ethically and optimally implemented. Refer to Attachment 2: Ethical Framework for Providing Crisis Care for further information.

- All requests for health and medical assistance in the care of those in need of services during catastrophic incidents will be routed through the RHCC, local jurisdictional LHD, local jurisdictional EMA and then IEMA as indicated in the Request for Medical Resources (RFMR) process in the SPARC Regional Response and Recovery Plan, Section 2.3.2.5.5 and IDPH ESF-8 Plan, Section 2.4.2. The SPARC Duty Officer will inform the IEMA Duty Officer, IDPH Duty Officer, Regional EMS Coordinator, and the Executive Board that this annex has been activated and crisis care my need to be implemented.
- The RHCC and/or SPARC shall have the authority to coordinate supply/equipment caches and services (other than EMS licensees) as outlined in the approved SPARC Regional Response and Recovery Plan and the IDPH ESF-8 Plan.
- The primary authority within each EMS region for coordinating EMS System licensed providers in response to an emergency medical incident(s) as a result of a disaster or other large scale event rests with the EMS system(s) medical director(s).
- IDPH is the lead agency for all public health and medical response operations in Illinois. IDPH is responsible for coordinating regional, state, and federal health and medical disaster response resources and assets to local operations such as the Illinois Medical Emergency Response Team (IMERT), the Strategic National Stockpile (SNS), temporary medical treatment stations (TMTS), etc.
- Local Health Department is the lead agency for ESF-8 operations in their jurisdiction.
- Local EMA has direct authority for emergency response and recovery in their jurisdiction.
- IEMA is the authority having jurisdiction (AHJ) for the State of Illinois.
- Illinois Compiled Statutes, 210 ILCS 50, Emergency Medical Services (EMS) Systems Act, as amended.
- Illinois Administrative Code, 77 III. Admin. Code 515, Emergency Medical Services and Trauma Code, as amended.

2.0 Concept of Operations

- SPARC functions as a Multi-Agency Coordination Group during incidents. The primary goal of the SPARC during response and recovery is the sharing of information among the membership and the coordination of resources to achieve a combined effort. During a catastrophic incident, decisions made by the Coalition will be transparent to support this functional relationship between member organizations.

- The SPARC Regional CSC Annex will provide the framework throughout the response and recovery periods during and after catastrophic incidents to evaluate and analyze

information regarding medical and public health assistance requests for response; develop and update assessments of medical and public health status in the impact area(s); support crisis care planning to meet anticipated demands as they relate to patients; and outline strategies and support the coordination of resources aimed at transitioning from crisis care back to contingency care and eventually conventional care.

- SPARC will coordinate information and available resources for its members to maintain conventional surge response. When an emergency overwhelms SPARC collective resources, SPARC will support the health care delivery system's transition to contingency and crisis surge response and promote a timely return to conventional standards of care as soon as possible.
- The SPARC Duty Officer will implement the Regional Crisis Standards of Care Annex when all other surge strategies have failed and no other local resources are available.
- SPARC will coordinate with facilities in the region to assure consistency of care and decision making.
- This annex can be partially or fully activated. The result of the incident is the exhaustion. See Attachment 3 for the *Catastrophic Incident Response Annex Activation Pathway*. Circumstances of the incident that lead to the activation of the annex can range from an unexpected, no-notice incident (e.g., earthquake) to a slow, gradually building incident (e.g., epidemic, pandemic). Regardless of the pathway to activate the Annex, the type of incident, or the speed in which resources have become depleted, the health care system would have activated its individual facility/agency disaster plans and resources in order to maintain conventional and/or contingency care. However, due to the devastation caused by circumstances of the catastrophic incident, the capacities and capabilities of caring for patients have been depleted and crisis care is needed.

Note: "Utilizing a crisis standard of care may not be optional, as it could be a forced choice based on the emerging situation. Under such circumstance, failing to make substantive adjustments to healthcare operations, this is; not to adopt crisis standards can result in increased morbidity and mortality." (Hospital Preparedness Program, Capability 10).

2.1 Indicators/Triggers to Activate

Implementing CSC in a hospital setting should be a last resort and should be activated only when all other surge strategies are exhausted, and no other regional resources are available. The hospital IC will notify the SPARC Duty Officer when the hospital has activated CSC.

The need to implement CSC in response to a catastrophic event at the regional level may be influenced by the extent to which a community within the SPARC region can adjust to care for a significantly larger patient population; **when numbers of seriously ill patients greatly surpass the capability of available care capacity and normal standards of care can no longer be maintained**.

2.2 Notifications

Once the decision to activate the SPARC Regional CSC Annex is made, coalition member organizations and response partners will be notified through communications systems outlined in the IDPH ESF-8 Plan and the SPARC Regional Response and Recovery Plan Section 2.3.2.2.

The SPARC Duty Officer will send notifications to IEMA Duty Officer, IDPH Duty Officer, and the Executive Board regarding the Plan's activation. The Duty Officer will notify:

- IDPH Regional EMS Coordinator
- IDPH Regional ERC
- IEMA Regional Coordinator
- RHCC Staff, if needed
- Additional members and response partners

2.2.1 Upon activation of this annex, the Catastrophic Medical Incident Report Form (See Attachment 4) will utilized to communicate necessary information about the annex activation with all affected entities and those entities that may be called upon to assist during the incident unless otherwise indicated by the SPARC Duty Officer at the time of the incident. This form may be sent and received via any available communication method. When the *Catastrophic Medical Incident Report Form* is utilized during an incident, the communication method that will be utilized for stakeholders to reply will be indicated on the form in the "Reply/Action required" section.

2.2.2 Transparent communication is important during any incident. Communication pathways shall be fluid between SPARC partners. Affected entities and those entities that may be called upon to assist during the incident must have the ability to communicate pertinent information internally and externally from their facility. Information should be shared in the preferred and usual method. However, during a catastrophic incident, the typical alert and messaging systems may not be available and alternate communication methods will be required to communicate. Some of the possible established methods for communication that can be used include:

1. Telephone (landline)
2. Telephone (cellular)
3. Voice over Internet Protocol (VOIP)
4. Electronic mail (e-mail)
5. Facsimile (fax)
6. Radio (Direct and/or Relay, Starcom21, Ham/Amateur)
7. Satellite Radio and Communications
8. Short Message Service (SMS)
9. Homeland Security Information Network (HSIN)
10. EMTrack
11. State of Illinois Rapid Electronic Notification (SIREN) alert
12. Human Runners
13. Public Information Officer (PIO)
14. Scheduled Meetings
15. SIREN
16. HAN (Health Alert Network)

17. EMResource (includes Illinois' HAv-BED Tracking and Notification System)
18. WebEOC
19. Social media recognized/maintained by the jurisdictional authority
20. Comprehensive Emergency Management Program (CEMP) (for information sharing including access to documents and resources)

2.2.3 The *Catastrophic Medical Incident Report Form* should be utilized by all stakeholders to assist with ensuring consistent communication between stakeholders, provide a mechanism to request patient resources, and identify availability of resources at a facility. Listed below are facilities/agencies/entities that either play a role in caring for patients or may be part of the incident response and should be notified and receive ongoing communications from the time the SPARC Regional CSC Annex is activated until normal operations resume. The *Catastrophic Incident Communication Pathway* (Attachment 5) outlines which stakeholders will typically communicate and share information with each other when the annex is activated. This communication process is similar to daily communication processes and other types of disasters. This same communication process is also outlined in the SPARC Regional Response and Recovery Plan, Attachment M, and IDPH ESF-8 Plan, Attachment 13. The *Catastrophic Incident Communication Pathway* is different from the RFMR process, although there is some overlap. The following list is not inclusive, nor are entities listed in any priority order. Depending on the type of incident, additional stakeholders should be included in the information sharing process as needed and appropriate

1. Hospitals
    a. Resource Hospitals
    b. Associate Hospitals
    c. Participating Hospitals
1. Other health care facilities such as LTC facilities, Rural Health Clinics, FQHCs
2. County emergency management agencies (EMA)
3. Local EMS agencies
4. LHDs
5. IDPH Regional Emergency Medical Services Coordinator (REMSC)
6. IEMA
7. Illinois Law Enforcement Alarm System (ILEAS)
8. Mutual Aid Box Alarm System (MABAS)
9. America Red Cross (ARC)
10. Local Law Enforcement
11. Local Fire Departments
12. Non-Governmental Organizations (NGOs – Salvation Army, Faith-based organizations)
13. Mental Health Agencies
14. Professional medical organizations
    a. Medical Response Corp (MRC)
15. Any alternate treatment sites (ATS), alternate care sites (ACS) and/or TMTS established during the incident

3.0 Roles and Responsibilities

Hospital, EMS, and LHDs all should have a protocol/plan in place, outlining how they will provide crisis care and work to return to contingency and conventional levels are quickly as possible. Roles and Responsibilities for SPARC member organizations and response partners will be activated during CSC in order to continue to provide care to patients and the SPARC community as a whole.

3.1 Primary Coordinating Agency

3.1.1 Shawnee Preparedness and Response Coalition (SPARC)

1. Collaborate hospital and other health care facilities, and agency partners to:
    a. Receive and disseminate information vital to a common operating picture
    b. Maintain situational awareness
    c. Assist with resource identification, location, and procurement for coalition members, as applicable
2. Implement regional response plans and assist members by supporting crisis care and resource allocation when resources are exhausted and/or pre-identified triggers are reached
3. SPARC will remain a resource throughout the response and recovery processes.

3.2 Lead State Agency

3.2.1 Illinois Department of Public Health (IDPH)

1. IDPH is the lead agency for ESF-8 Public Health and Medical Services.
2. Assist with the communication between stakeholders (e.g., hospitals, other health care facilities, LHDs, EMS agencies, etc.) during an incident.
3. IDPH communicates with the RHCC for intelligence gathering, information dissemination, additional resource request, and coordination of efforts during an incident.
4. Coordinate state and federal health and medical disaster resources to support local operations such as the Strategic National Stockpile (SNS), temporary medical treatment stations (TMTS), etc.

3.3 Other State Agencies

3.3.1 Illinois Emergency Management Agency (IEMA)

1. Coordinate the collection, receipt, compilation, and development of situational reports on damage impacts to services, facilities, sites, and programs at the federal, state, and local levels.
2. Collaborate with IDPH on the RFMR process.
3. Collaborate with IDPH to coordinate the activation of medical mobile support teams.
4. Request disaster declaration (state and federal) as indicated.
5. Facilitate EMAC requests as indicated.
6. Collaborate with IDPH to ensure consistent communication and messaging occurs with the public regarding the need for crisis care and resource allocation.

3.3.2 Illinois Law Enforcement Alarm System (ILEAS)

1. ILEAS is a consortium of over 900 local governments. ILEAS will meet the needs of local law enforcement throughout the State of Illinois in matters of mutual aid, emergency response and the combining of resources for public safety and terrorism prevention and response.

3.4 Lead County Agency

3.4.1 Local Health Departments (LHDs)

1. Implement LHD's medical disaster preparedness and response plan that should contain response components/processes/considerations related to a catastrophic incident and provide crisis care and resource allocation when resources are exhausted and/or pre-identified triggers are reached (Attachment 6 of this Annex: *Crisis Care and Resource Allocation Tactics for Local Health Departments during Catastrophic Incidents* may be a resource that can provide additional guidance.).
2. Maintain communication and provide situational awareness updates to hospitals, other health care facilities, local emergency response partners, IDPH, and the community as indicated; Situational awareness updates should be closely aligned with county and/or jurisdictional EMA partners.
3. Develop and disseminate internal and external communication and risk messaging with stakeholders (e.g. media, public service announcements).
4. Collaborate and coordinate with local and/or regional HCCs, when applicable, to ensure coordinated processes are activated for medical countermeasure distribution and dispensing, fatality management, treatment and reporting protocols, and general situational awareness updates.
5. Assist hospitals and other health care facilities in obtaining supplies from the Strategic National Stockpile (SNS), as requested, through the processes that are currently identified and incorporated into their existing plans and the RFMR process outlined in the IDPH ESF-8 Plan (Section 2.4.2).
6. Coordinate with local assets (i.e. schools, voluntary organizations active in disasters [VOADs], medical reserve corps [MRCs], faith based organizations, other volunteer organizations) during community based response.
7. Provide infection control, surveillance, laboratory testing, and general treatment guidance and information to hospitals, other health care facilities (e.g. LTC, dialysis centers), community health centers, other clinical outlets as applicable based on services offered at the LHD.
8. Provide situational awareness updates, counseling, and other mental health services, education, and other resources as applicable based on services offered at the LHD.

3.5 Lead Support Agency

3.5.1 Emergency Management Agency

1. Process local resource requests locally.
2. Facilitate local declarations of emergency.
3. Provide incident information/common operating picture to local and state agencies.

3.6 Other Support Agencies/Facilities/Organizations/Entities

3.6.1 Regional Hospital Coordinating Center (RHCC)

1. Provide necessary situational awareness communications to/from the affected and/or assisting hospital(s) and partners within the region and to/from IDPH and the regional HCC
2. Communicate with other RHCCs in order to assess resource availabilities and conduct additional response activities, as warranted.
3. Inform IDPH, as appropriate, when catastrophic response components of the regional medical disaster preparedness and response plan have been activated.
4. Assist with the communication and RFMR as indicated in this annex and the SPARC Regional Response and Recovery Plan.
5. Assist hospitals in its region with accessing Illinois Helps as applicable.

3.6.2 Resource Hospitals

1. Implement hospital's (and corporate entity as applicable) medical disaster preparedness response plan that should contain response components/processes/considerations related to a catastrophic incident, and provide crisis care and resource allocation when resources are exhausted and/or pre-identified triggers are reached.
2. Inform IDPH, as appropriate, when the hospital's catastrophic incident response plan is activated and crisis care is provided via the *Catastrophic Medical Incident Report Form*
3. Complete and submit the CMS 1135 Waiver for its hospital as applicable when providing crisis care.
4. Provide care for patients who arrive at the facility to the best of the facility and practitioners' ability utilizing crisis care (Attachment 7 of this Annex: *Crisis Care and Resource Allocation Tactics for Health Care Facilities during Catastrophic Incidents* and Attachment 8 of this Annex: *Crisis Care and Resource Allocation Tactics for the Pediatric and Neonatal Population during Catastrophic Incidents* may be resources that can provide additional guidance.)
5. Provide patient family members at its facility with information about the event and education about components of the response that may involve a family member's care (e.g., rationale for implementation of crisis care, how care changes when CSC annex is activated)
6. Assist with the communication and RFMRs as indicated in the regional medical disaster preparedness and response plan, the SPARC Regional Response and Recovery Plan, the IDPH ESF-8 Plan, and in this annex.
7. Function as a liaison between the EMS associate and participating hospitals within its system and the RHCC.
8. Assist with the communication with EMS providers within its EMS system.

3.6.3 All Other Hospitals and Health Care Facilities (including: LTC, Rural Health Clinics, FQHCs)

1. Implement hospital's/health care facility's (and corporate entity as applicable) medical disaster preparedness and response plan that should contain response components/processes/considerations related to a catastrophic incident, and provide

crisis care and resource allocation when resources are exhausted and/or pre-identified triggers are reached.

2. Inform IDPH, as appropriate, when the hospital or other health care facilities' catastrophic incident response plan is activated and crisis care is provided via the *Catastrophic Medical Incident Report Form.*
3. Complete and submit the CMS 1135 Waiver for its hospital or health care facility as applicable when providing crisis care.
4. Provide care for patients who arrive at the facility to the best of the facility and practitioners' ability utilizing crisis care (Attachment 7 of this Annex: *Crisis Care and Resource Allocation Tactics for Health Care Facilities during Catastrophic Incidents* and Attachment 8 of this Annex: *Crisis Care and Resource Allocation Tactics for the Pediatric and Neonatal Population during Catastrophic Incidents* may be resources that can provide additional guidance.).
5. Provide patient family members at its facility with information about the event and education about components of the response that may involve a family member's care (e.g., rationale for implementation of crisis care, how care changes when this annex is activated).
6. Communicate and submit RFMR for resources as necessary as indicated in the regional medical disaster preparedness and response plan, the SPARC Regional Response and Recovery Plan, the IDPH ESF-8 Plan, and in this annex.

3.6.4 EMS Systems/Agencies

1. Implement system medical disaster preparedness and response plan that should contain response protocols related to a catastrophic incident and provide crisis care and resource allocation for EMS agencies and emergency medical dispatch centers when resources are exhausted and/or pre-identified triggers.
2. EMS providers will provide care for patients, including palliative care utilizing crisis care methods as directed by their EMS Medical Director and system protocols. (Attachment 9 of this Annex: *Crisis Care and Resource Allocation Tactics for EMS Systems/Agencies during Catastrophic Incidents* may be a resource that can provide additional guidance.).
3. EMS providers may utilize a variety of response/transport/destination options as directed by their EMS Medical Director and system protocols which may be approved by IDPH as a result of catastrophic conditions, including but not limited to: prioritization of calls for response/transport, transport to alternate care locations (i.e. ATS, ACS, TMTS), and/or expanded scope of practice.
4. EMS providers will maintain communication and provide situational awareness updates to their EMS system resource hospital as indicated.
5. EMS System Coordinators will maintain communication and provide situational awareness updates to EMS providers/agencies, their RHCC, and IDPH as indicated.
6. Inform IDPH, as appropriate, when the catastrophic incident response plan is activated and crisis care is provided, including staffing and expanded scope of practice waivers via the *Catastrophic Medical Incident Report Form.*
7. Request a waiver from IDPH to modify the staffing configuration of ambulances.

3.6.5 First Responders (Law Enforcement, Fire)

1. First on scene to assess and report on the situation.
2. Provide initial triage and care and help determine what additional resources may be needed.
3. Support and assist arriving ambulance personnel on scene.
4. Maintain public safety within the community.

3.6.6 Mutual Aid Box Alarm System (MABAS)

1. MABAS provides a 24-hour mechanism to mobilize emergency response and EMS resources to any given location within the State through coordination with IEMA and IDPH/EMS. MABAS assets include fire engines, ladder trucks, heavy rescue squads, ambulances, emergency medical technicians (EMTs) and hazardous material teams.

3.6.7 Non-Governmental Organizations (NGOs)

1. Upon request, NGOs, such as faith-based organizations, may provide shelter, food, clothing and other basic needs of survival during an incident or emergency.

3.6.8 American Red Cross

1. Support role for ESF-6 Mass Care (i.e., sheltering, feeding, distribution of emergency supplies and reunification services) establishing and running emergency shelters within the affected area(s).
2. Provide basic health support services at Red Cross facilities.
3. Provide disaster related mental health and psychological first aid for the affected population and disaster workers.
4. Facilitate the dissemination of public information, messaging and education for the affected population.
5. Provide blood and blood products through Red Cross regional blood centers as needed and requested.
6. Coordinate the provision of blood and blood products through the American Association of Blood Banks Disaster Task Force as requested.
7. Coordinate with hospitals and coroners to provide appropriate casualty and/or patient information for purposes of family reunification.
8. Coordinate with the affected jurisdiction for potential Multi-Agency Resource Center (MARC) operations.

3.6.9 Liaison to SPARC

SIU Health Services, Marion VA Medical Center, Schools/Universities “but not limited to”

1. Support role, if needed.

3.7 Management of Scarce Resources

When the health care delivery system is stressed beyond its maximum surge capacity, crisis care strategies may be employed and planned well in advance.

- SPARC will implement this annex and assist members with providing crisis care with resource allocation when resources are exhausted and/or pre-identified triggers are reached.

- Each hospital, EMS system, and LHD will determine what resource allocation strategies/tactics may be implemented during a catastrophic incident based on their facility's capacity and capabilities.
- As outlined in the IDPH Catastrophic Incident Response Annex, these strategies/tactics are not meant to be all inclusive, replace any existing policies and/or procedures (**refer to Attachments 6-9 of this Annex for the Crisis Care and Resource Allocation Tactics for Catastrophic Incidents**).

It is everyone's responsibility to assure stability of their supply chain and prepare for supply chain interruption. Hospitals in Region V rely on some of the same suppliers, resulting in resource shortfalls in a disaster or catastrophic incident.

- SPARC will consider the following strategies when supporting a scarce resource situation in order to facilitate the coordination of incident response activities for hospital partners and the community so that strategies and actions support the healthcare response:

  Prepare – e.g., anticipate challenges, develop plans, stockpile materials
  Conserve – implement conservation strategies for supplies in shortage or anticipated shortage to ensure the minimum impact/compromise possible (e.g., determining "at-risk" groups with priority for therapies in shortage and overall strategies to conserve use of oxygen delivery devices or personal protective equipment)
  Substitute – provide an equivalent or near equivalent medication or delivery device
  Adapt – use of equipment for alternative purposes (e.g., anesthesia machine as a ventilator)
  Re-use – plan to re-use a wide variety of materials after appropriate disinfection or sterilization (may include oxygen delivery devices, for example)
  Re-allocate – if no alternatives, remove a resource from one area/patient and allocate to another who has a higher likelihood of benefit (e.g., triage of scarce resources such as Extra-Corporeal Membrane Oxygenation [ECMO] or ventilators.

3.7.1 Resource Coordination and Support

The SPARC MAC Group will assist local jurisdictions and member organizations with resource coordination activities prior to, during and/or following a catastrophic incident that results in scarce resources in the face of demand and changes in practice. Member organizations currently have existing memoranda of understanding (MOU) from member to member or member to other agency. These MOUs may be of assistance to the region upon need, provided all involved parties agree.

- Member organizations are expected to utilize their traditional and pre-established agreements for resources prior to making a request. The requesting entities will need to complete the **ICS 213RR form (Attachment 10)** and submit it through the RFMR process as outlined in the SPARC Regional Response and Recovery Plan Section 2.3.2.5.5 or the IDPH ESF-8 Plan Attachment 8 and 10.

- The RHCC maintains a small supply cache designed to augment the emergency response and recovery capabilities of coalition member organizations during major incidents and disasters.

- The RHCC will coordinate the movement of resources with IDPH and IEMA upon request. Below is a listing (not all inclusive) of the HPP resources. Refer to the SPARC Regional Response and Recovery Plan Attachment R for complete listing of HPP Resources:
    - Basic medical supplies
    - Personal Protective Equipment (PPE)
    - Emergency electrical power generator
    - Communication equipment
    - Morgue Trailer
    - Decon Trailer
    - Field Hospital

Note: During a crisis event, local and regional resources and processes may become exhausted. Hospitals will contact the LHD within its jurisdiction to assist in acquiring supplies from the strategic national stockpile (SNS) as requested. Hospitals should follow processes identified and incorporated into their existing plans. If there is not a LHD within its jurisdiction, the affected hospital will contact their local EMA coordinator.

3.8 At-Risk Populations

It is essential that plans for the delivery of health and medical care in a large-scale disaster or emergency address how the special needs of several groups within the general population will be met. These groups include:

- FAN (Functional and Access Needs)
- Children (refer to State Pediatric and Neonatal Plan or EMSC Pediatric Disaster Preparedness Guidelines for Hospitals
- Person with physical or cognitive disabilities
- Non-English speaker
- Persons with preexisting mental health and/or substance abuse problems
- Those in congregate living facilities

During an incident that involves emergency response and recovery as well as CSC Annex activation, resources will likely be scarce. SPARC response activities will take into account the behavioral health, and the medical needs of at-risk populations.

- SPARC will coordinate with Centerstone, American Red Cross (ARC), and Faith-Based Organizations to identify behavioral and health care resources that meet the needs of the most at-risk and marginalized people within the region. Addition response assistance may include communication, medical care, maintaining independence, transportation or supervision. **Refer to the SPARC Regional Response and Recovery Plan Appendices Section 4 for a list of identified resources to assist each unique entity.**

3.9 Demobilization/Return to Conventional Care

- As supply of resources increase and demand for services decrease, SPARC will begin to monitor hospital partners and regional healthcare facilities for indicators that the region can return to the higher practice environment of contingency and move back toward conventional care status.

- All healthcare facilities should be prepared for taking incremental steps in this return with the possibility of reversing decisions.

Demobilization of assets may be possible without actually entering into the recovery phases depending on the dynamics of the events, such events could possibly move back and forth between conventional and crisis. **SPARC's role is to assure consistency of response to the degree possible and monitor for opportunities to demobilize resources when it clear that it is safe to do so.** Similar to have pre-identified trigger points to implement principles of CSC, it is important to continually assess and re-assess the situation as more resources arrive. Facilities want to return to contingency and conventional care as quickly as possible. When it is determined that the situation is contained, through IDPH, local EM or on-scene IC/UC, the SPARC Duty Officer will rely pertinent information to the membership that the situation has been contained and the region has returned to a normal. The may occur on a county by county basis.

- SPARC shall track activities and expenses and submit them to the SPARC Duty Officer at the end of the operational period or deployment. SPARC will provide copies of those activities and expenses to the appropriate Coalition member's and local jurisdictions when requested. SPARC will not be financially responsible in the event should any part of the plan be activated.

Recovery planning will start early in the event and should follow the continuity and recovery processes outline in the IDPH ESF-8 Plan, Section 6.0 and the SPARC Regional Response and Recovery Plan, Sections 2.3.2.5.8, 2.3.2.5.9, 2.4. The intent of this annex and the primary focus of recovery efforts are to eliminate the need for crisis care and return to contingency and conventional care as quickly as possible.

- Hospital partners shall refer to their organization's continuity of operations plan (COOP) for direction and guidance.

3.10 Education, Training, and Exercise

Training and exercise requirements are outlined by the Assistant Secretary for Preparedness and Response (ASPR). SPARC leadership will support the response by ensuring partners and stakeholders are familiar with their roles and responsibilities prior to any disaster or emergency in the MPHMSRR. SPARC provides the opportunity for its member organizations and the community to plan, train, and exercise together. Training is crucial to sustain regional disaster and emergency preparedness.

Crisis surge planning is an integral part of overall surge capacity planning. Emergency Operation Plans, training, and exercises will reflect the continuity of care along the continuum. Hospitals can cross-train clinical personnel or provide "just-in time training" of non-clinical staff to assist in care during a large-scale emergency. As a requirement outlined by ASPR, SPARC will incorporate and validate the State Crisis Standards of Care ConOps in an HCC-level exercise. Principle focus will be on policy and resource coordination.

Refer to 2021-2024 Illinois EMS Region V Multi-Year Training and Exercise Plan (MYTEP) for regional opportunities or coalition membership can visit www.sparccoalition.com for upcoming training resources/events.

3.11 Plan Maintenance and Review

The Crisis Standards of Care Annex is a living document. The SPARC Executive Board or designee will update the plan annually or as needed after exercises, planned events and real-world incidents to identify gaps and to define strategies to address gaps with a collaborative whole community approach.

The revised plan will be distributed to each coalition partner and posted on the SPARC website www.sparccoalition.com.

4.0 Appendices

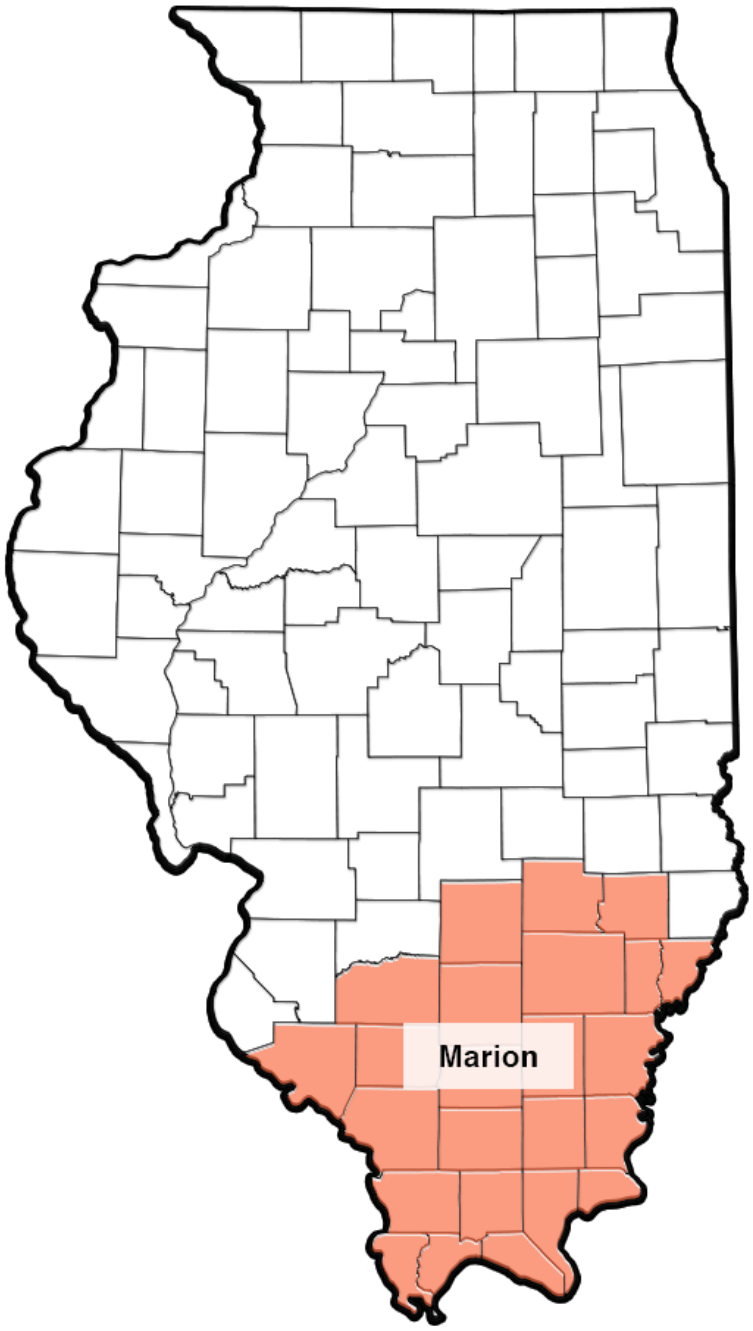
4.1 References

4.1.1 Crisis Standards of Care, IOM/NAM, p. 1-10, 2012
4.1.2 ASPR. *2017-2022 Health Care Preparedness and Response Capabilities.* pg. 44
4.1.3 IDPH Catastrophic Incident Response Annex
4.1.4 SPARC Regional Response and Recovery Plan
4.1.5 SPARC Regional Infectious Disease Annex
4.1.6 SPARC Medical Surge Plan

4.2 Attachments

1. SPARC Coverage Area Map
2. Ethic Framework for Providing Crisis Care
3. Catastrophic Incident Activation Pathway
4. Catastrophic Incident Report Form
5. Catastrophic Incident Communication Pathway
6. Crisis Care and Resource Allocation Tactics for Local Health Departments During Catastrophic Incidents
7. Crisis Care and Resource Allocation Tactics for Health Care Facilities During Catastrophic Incidents
8. Crisis Care and Resource Allocation Tactics for the Pediatric Neonatal Populations During Catastrophic Incidents
9. Crisis Care and Resource Allocation Tactics for EMS System/Agencies During Catastrophic Incidents
10. Region V ICS 213 RR Form

Attachment 1: SPARC Coverage Area Map



Attachment 2: Ethical Framework for Providing Crisis Care

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 2: ETHICAL FRAMEWORK FOR PROVIDING CRISIS CARE

Purpose: Provide guidance to practitioners and responders during a catastrophic incident when implementing crisis care
Instructions: These guidelines should be used as a reference by practitioners and responders when providing crisis care to patients in order to ensure the resource allocation strategies being implemented follow an ethical approach.
Disclaimer: This information is not meant to be all inclusive. Individual health care facilities and agencies should work to develop ethical strategies that guide their allocation of resources and services decisions during a catastrophic incident by consulting their internal ethics committee. In addition, when this annex is activated, medical, ethical, and legal experts for crisis care and resource allocation may also be available to assist.

Ethical Objectives in Times of Crisis

Steward scarce resources to promote the common good of the people in Illinois by balancing these equally important and overlapping ethical objectives:

1. Protect the population's health by:
    a. Reducing mortality and serious morbidity;
    b. Minimizing disruption to basic health care and public health;
    c. Recognizing health is holistic and more than just the physical needs of people.
2. Protect public safety and civil order by:
    a. Minimizing disruption to public safety and other critical infrastructures.
3. Enhance community resilience by:
    a. Promoting public understanding about and confidence in resource distribution;
    b. Incorporate community input on planning and response process
4. Strive for fairness/protect against systematic unfairness by:
    a. Rejecting strategies that are discriminatory or exacerbate health disparities;
    b. Reducing significant group differences in mortality and serious morbidity;
    c. Making reasonable efforts to remove barriers to access;
    d. Making reasonable efforts to reciprocate to groups accepting high risk in the service of others.

General Ethical Strategies for Crisis Care Response Planning

1. Different components must be viewed as interrelated components of a single system
2. Specific methods should be employed to achieve and maintain the overarching system
3. Strive to implement consistent strategies across the state; incorporate methods to continuously gather and assess information for quality improvement at every level of function
4. Continuously assess impact of response plans during and after the event
5. Review and adjust strategies in light of new information
6. Establish and share best practices

Allocation of Resources and Services

1. Assess the probability that a scarcity of resources may occur and plan in advance how to address such scarcity.
    a. Scarcity of resources and services during a crisis may take many forms, and plans should address the anticipated nature, duration, and severity of the scarcity.
    b. At all levels of planning, efforts should be made to acquire, stockpile, and/or prepare for sufficient levels of resources and services to alleviate, as much as possible, the need to allocate these resources and services during a crisis.
    c. Extend supplies and conserve resources before reallocating; reallocate only as a last resort.
    d. Scale reallocating strategies to different levels of scarcity.

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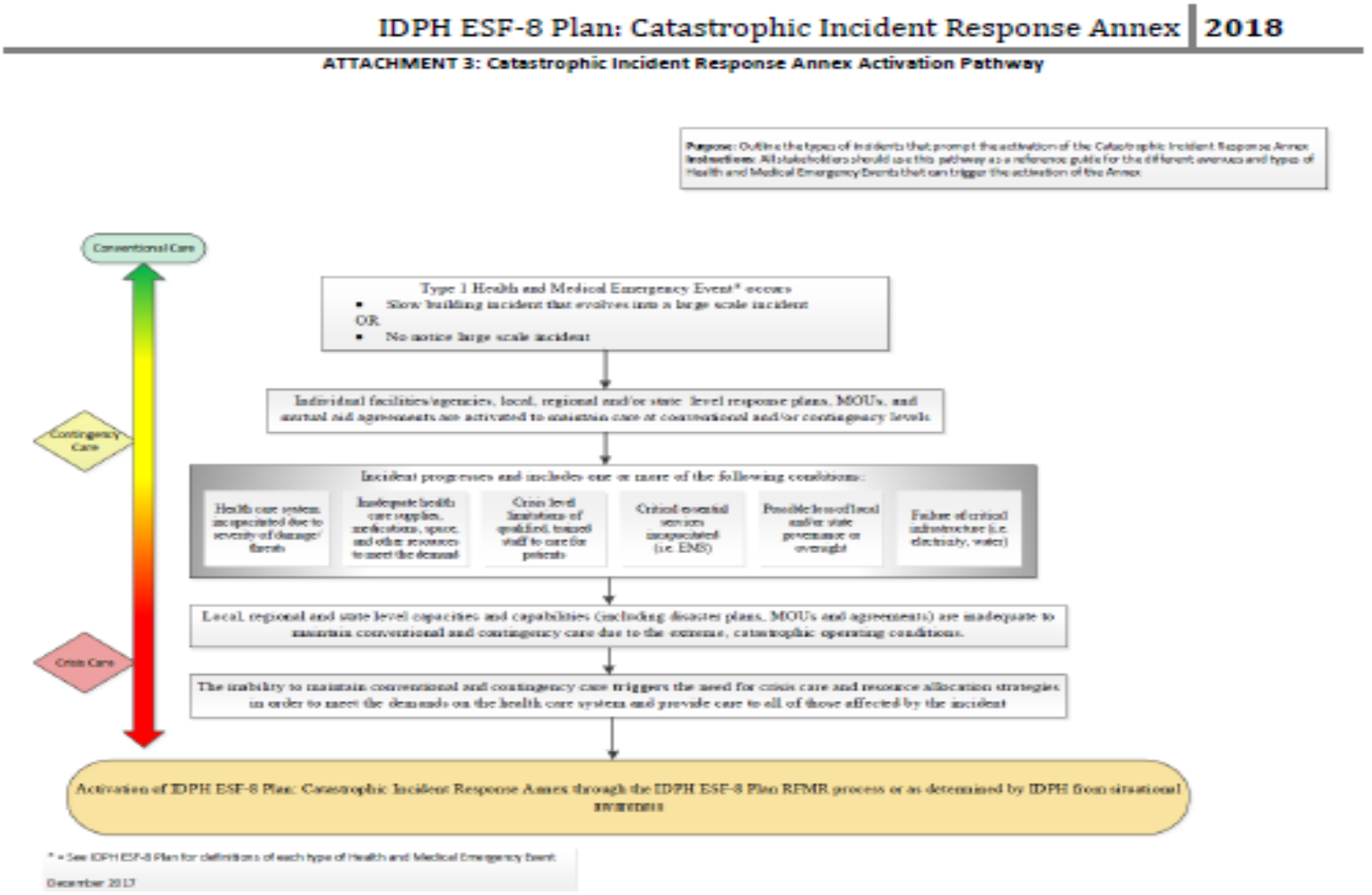
Attachment 2: Ethical Framework for Providing Crisis Care

ATTACHMENT 2: ETHICAL FRAMEWORK FOR PROVIDING CRISIS CARE

2. Whenever possible, avoid making definitive decisions (such as who to treat/not to treat or triaging to palliative care) alone, instead rely on pre-defined processes and/or team-based decisions.
    a. Conditions of over-whelming scarcity limit autonomous choices for both recipients and providers regarding the allocation of scarce resources, but do not permit actions that violate ethical norms.
3. Do NOT reallocate based on:
    a. Race, gender, age, religion, citizenship, sexual orientation, pre-existing physical or mental disability unrelated to the medical diagnosis or need, or socioeconomic status (including ability to pay)
    b. Judgments that some people have greater quality of life than others
    c. Judgments that some people have greater "social value" than others
4. Generally, de-prioritize persons unlikely to benefit from the resource.
    a. Access to palliative care resources and services should be provided to these persons in order to minimize pain and suffering.
5. When necessary, prioritize essential or key workers to support critical infrastructures and the health of the population.
    a. Prioritizing groups based on key worker status is only justified when it clearly supports critical infrastructures and the health of the population. Therefore, key workers are not always prioritized ahead of the general population and not all key workers are at highest priority to receive all of the resources.
6. Reallocate different resources to reduce overall mortality and morbidity (rather than resort to random processes from the start).
7. For the general public, consider:
    a. Medical need and urgency of treatment
    b. Adequacy of available resources to meet the need
    c. Anticipated good or acceptable response to available resources
8. When appropriate to prioritize essential workers separately from the general public, consider:
    a. Risk of occupational exposure as a result of the catastrophic incident
    b. Irreplaceability in the critical infrastructure workforce
    c. Anticipated good or acceptable response to available resources

Attachment 3: Catastrophic Incident Activation Pathway



Attachment 4: Catastrophic Incident Report Form

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 4: CATASTROPHIC MEDICAL INCIDENT REPORT FORM

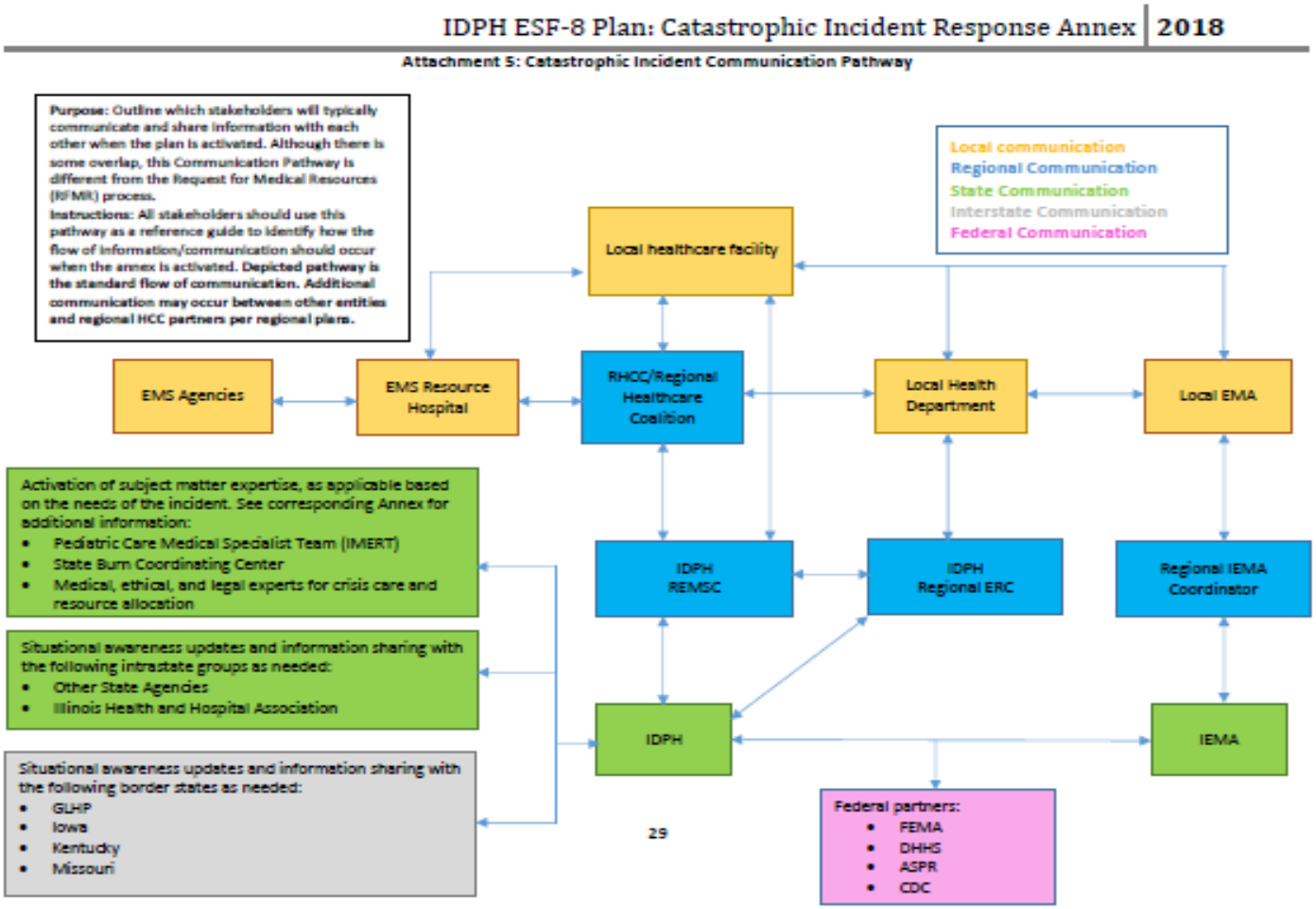
Purpose: Assist with ensuring consistent communication between stakeholders and provide a mechanism to report medical resources status and shortages, request for temporary modifications in care (including implementing crisis care), and provide updates on what crisis care is in progress

Instructions: When the annex is activated, this form will be utilized by **all** stakeholders (e.g. EMS systems, health care facilities, LHDs, IDPH) to communicate necessary information about the incident, annex activation, status of resources, implementation of crisis care and return to conventional and/or contingency care during a catastrophic incident.

INCIDENT NAME		**DATE/TIME PREPARED**
OPERATIONAL PERIOD		**REPORT RECEIVED VIA** ◻ Phone ◻ Radio ◻ Fax ◻ Other
FROM (SENDER)	**TO (RECEIVER)**	**REPLY/ACTION REQUIRED?** ◻ YES ◻ NO If YES, *include detailed sending information* below **REPLY TO:** ◻ **Phone** ◻ **Radio** ◻ **Fax** ◻ **Other (List number)**
PRIORITY: ◻ Urgent/High ◻ Non-urgent/Medium ◻ Informational/Low		
DATE/TIME PHEOC ACTIVATED		**REASON FOR PHEOC ACTIVATION**
DATE/TIME ANNEX ACTIVATED		**REASON FOR ANNEX ACTIVATION**
ACTIVATION LEVEL ◻ Local ◻ Regional ◻ State		
CURRENT INCIDENT INFORMATION		
IMPACTED FACILITY/AGENCY/DEPARTMENT/SYSTEM:		
SCARCE RESOURCE SITUATION DESCRIPTION:		
1. GENERAL SITUATION		
2. PATIENT NUMBERS AND SPECIFIC CARE NEEDS		
3. TYPES OF INADEQUATE RESOURCES NEEDED FOR PATIENT CARE		
4. SPECIFIC SUBSTITUTE/MODIFIED METHODS USED TO MAINTAIN CONVENTIONAL AND/OR CONTINGENCY CARE LEVELS		
CRISIS CARE INFORMATION		
1. DATE/TIME CRISIS CARE INITIATED		
2. PROJECTED TIME TO REMAIN IN CRISIS CARE MODE		
3. CRISIS CARE METHODS REQUESTED **		
4. CRISIS CARE METHODS IMPLEMENTED **		
5. DATE/TIME RETURNED TO CONVENTIONAL AND/OR CONTINGENCY CARE LEVEL		
REQUIRED/REQUESTED ACTIONS AT THIS TIME		
COMMENTS		

** See Attachments 6, 7, 8 and 9 for crisis care and resource allocation tactics and strategies for EMS, health care facilities, and local health departments

Attachment 5: Catastrophic Incident Communication Pathway



Attachment 6: Crisis Care and Resource Allocation Tactics for Local Health Departments During Catastrophic Incidents

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 8: Crisis Care and Resource Allocation Tactics for Local Health Departments During Catastrophic Incidents

Purpose: Provide public health practitioners with crisis care and resource allocation strategies/tactics that may be implemented during catastrophic incidents
Instructions: When the annex is activated, this document should be used to guide public health practitioners when providing crisis care to patients.
Disclaimer: These strategies/tactics are not meant to be all inclusive, replace an existing policy and procedure, or substitute for clinical judgment. These guidelines may be modified at the discretion of the public health practitioner.

Resource Type	Indicators	Crisis Care Tactics
Systems: Surveillance systems	• Increased case reports of unusual levels of illness from hospitals • Epidemiology surveillance data indicates surge in cases could exceed staffing and resource availability • Multiple or increasing case fatality rates	• Increase surveillance activity to active status • Provide treatment and containment measures to hospitals and health care facilities • Activate local containment, isolation, and quarantine plans • Coordinate with local public safety officials in preparation for need for additional assistance • Coordinate with state and federal authorities (i.e. IDPH, CDC) • Monitor information in EMResource and coordinate with local health care facility partners and IDPH to use EMResource as a data repository for ease in reporting
Systems: Command and Control	• Disparate and incomplete information received from multiple partners • Increased communication needs and/or media requests	• Facilitate situational awareness to local authorities (e.g. hospitals, EMA, other public safety officials, elected officials) • Increased situational awareness reporting to hospitals and other response partners • Conduct regular briefings with public health staff and other stakeholders, establishing a regular briefing schedule for each operational period. • Increase press conferences for key leadership and active media releases • Development of streamlined public communications messages
Systems: Communications Systems	• Communication system failures occur and are persistent (e.g. HAN, Epi-X, WebEOC, EMResource)	• Utilize alternate communication mechanisms

Attachment 6: Crisis Care and Resource Allocation Tactics for Local Health Departments During Catastrophic Incidents

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 8: Crisis Care and Resource Allocation Tactics for Local Health Departments During Catastrophic Incidents

Resource Type	Indicators	Crisis Care Tactics
Systems: Situational Awareness/ EOC Coordination	• Disparate and incomplete information received from multiple partners • Increased communication needs and/or media requests	• Communicate with public health EOC (PHEOC) for streamlined communications and situational awareness • Facilitate situational awareness to local authorities (e.g. hospitals, EMA, other public safety officials, elected officials) • Staff local EOC, if applicable
Supplies	• Demands on supplies begin to exceed available supplies • Hospitals and other health care facilities report resource scarcity and increase resource requests	• Mobilize stockpiled assets under health department control • In coordination with the local EMA, prioritize stockpile assets for dissemination to hospitals and other types of health care facilities • Assist with the request for medical resource (RFMR) process in accordance with the IDPH ESF-8 Plan • Assist with local requests for supplies from the Strategic National Stockpile (SNS) • Identify alternate methods of transporting and receiving additional supplies (e.g. drones, aircraft, horses) in conjunction with the local EMA
Space	• Space capacity exceeded in hospitals and other health care facilities • Hospitals and health care facilities are incapacitated	• Coordinate off-loading of patients to skilled nursing facilities and long-term care facilities that are not impacted in conjunction with the local EMA • Collaborate with RHCC and local EMA on the selection, establishment, and operation of the TMTS in their jurisdiction
Staff	• Increasing staff absenteeism due to illness or injury • Leadership shortages (local/state)	• Develop and disseminate recommendations for non-pharmaceutical interventions • Re-allocation of staff to other roles • Activate IPHMAS or other mutual aid agreements as applicable • Activate MRCs, IL Helps for volunteer staff resources • Implement plans for staff and volunteer credentialing

Attachment 7: Crisis Care and Resource Allocation Tactics for Health Care Facilities During Catastrophic Incidents

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 7: Crisis Care and Resource Allocation Tactics for Health Care Facilities During Catastrophic Incidents

Purpose: Provide practitioners with crisis care and resource allocation strategies/tactics that may be implemented during catastrophic incidents
Instructions: When the annex is activated, this document should be used to guide health care providers when providing crisis care to patients.
Disclaimer: These strategies/tactics are not meant to be all inclusive, replace an existing policy and procedure, or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.

Resource Type	Indicators	Crisis Care Tactics
Systems: Surveillance Data	• Epidemiology surveillance data shows more cases than local hospital system staffing and resources can safely manage • IDPH and IEMA projections indicate local hospital system exceeding available resources after accounting for contingency plans	• Activate state and/or federal plans • Coordinate via multi-agency ICS coordination • Activate local plans for limited distribution of medication, PPE, and patient care

Systems: Communications and Community Infrastructure	• Widespread or total loss of communications and/or infrastructure; loss of redundancies
	• Inability for local hospital system and EMS to:
	  ○ Communicate with outside entities or with employees
	  ○ Unable to transport patients
	  ○ Loss of utility that limits ability to care
	  ○ Electrical grid shutdown or loss of generator for power
		• Use social media or other media outlets
		• Instruct staff to self-report
		• Use HAM Radios
		• Switch to non-powered equipment
		• Assist other facilities and agencies
		• Use runners for internal written communications
		• Assign one non-medical staff on each floor of the hospital to assist with communication and share situational awareness updates with staff

Systems: Documentation	• Unable to maintain electronic medical record (Need to move from electronic records to paper documentation if key functions are not connected or if internet fails)	• Use alternate methods for documentation • If there is a suspicion of criminal activity (cyber-attack, etc.), collect what evidence you can and notify law enforcement
Systems: Security	• Exponential increase in security needs; inability to maintain proper access control and security related to the increase in people	• Increase patrolling of available security personnel • Enlist non-security personnel to assist in security role • Contact and request assistance from outside security agencies • Limit public access to hospital • Maintain lockdown procedures in response to specific types of incidents • Use transport coordinator; barricades; traffic control plan
Systems: Sheltering	• Increased number of first responders, volunteers, public/community, employees' families seeking shelter	• Access psych and social support; secure separate area for special needs • Utilize partner agencies to help decompress shelter needs

Attachment 7: Crisis Care and Resource Allocation Tactics for Health Care Facilities During Catastrophic Incidents

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 7: Crisis Care and Resource Allocation Tactics for Health Care Facilities During Catastrophic Incidents

Resource Type	Indicators	Crisis Care Tactics
Systems: Fatality management	• Fatality management needs to increase and morgue is overwhelmed	• Use alternative sites and/or cold storage areas • Be aware of alternate cooling facilities/ capabilities within the community (e.g. refrigerator trucks, funeral homes, warehouses with walk in freezers and ice rinks)
Systems: Patient transport	• Air and/or ground transportation overwhelmed beyond current ability to manage safely with no means to transport in/out	• Use transport coordinator • Use unconventional patient transportation
Supplies	• Essential supplies are limited • Unable to replenish ongoing demands for supplies and/or anticipate supply needs for the next several days • Patient need far greater than what supply inventory can handle or inability to access critical supplies • Appropriate protective gear unavailable for specific events • Multiple hospitals have MOUs with same vendor	• Need to contact local, regional, state, and/or national partners regarding stockpiles; need to implement MOUs with area hospitals and community businesses for food, medications, infection control gear, water, linens, etc. for basic care needs • Go beyond usual vendors; utilize local grocery or drug stores for supplies • Identify alternate methods of transporting and receiving additional supplies (e.g. drones, aircraft, horses) • Monitor inventories more frequently • Request donations • Reuse certain items or disposables if needed (instruments, just in time cleaning) • Initiate a blood drive • Use an outside courier to bring in lab testing supplies • Ration or withhold as a last resort • Boil water for use by staff and patients • Consider alternative uses for available items (e.g. bedsheets or belts as tourniquets) • Utilize staff and family members to manually ventilate patients with BVM if ventilators are not available
Space	• Experience and/or anticipate more casualties or critically ill cases than the local hospital system space can safely accommodate immediately or in immediate future • Triage, emergency department, hospital inpatient units, intensive care, obstetrics are stressed	• Consider external patient areas such as clinics, gyms, community partner buildings • Discharge early and work with outpatient providers for at home care • Use nontraditional areas for care • Create warm boxes out of drawers with heat lamps to warm newborns

Attachment 8: Crisis Care and Resource Allocation Tactics for the Pediatric and Neonatal Populations During Catastrophic Incidents

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 9: Crisis Care and Resource Allocation Tactics for the Pediatric and Neonatal Populations During Catastrophic Incidents

Purpose: Provide health care practitioners with crisis care and resource allocation strategies/tactics specific to children that may be implemented during catastrophic incidents
Instructions: When the annex is activated, this document should be used to guide health care practitioners when providing crisis care to patients.
Disclaimer: These strategies/tactics are not meant to be all inclusive, replace an existing policy and procedure, or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care practitioner.

Resource Type	Indicators	Crisis Care Tactics
Systems: Command, Control, Communication, and Coordination	Tracking systems and processes are unavailable due to the incident	• Utilize tools from the Pediatric and Neonatal Surge Annex to facilitate care and tracking of pediatric patients (e.g., Pediatric Identification Tracking Form)
Systems: Transport	Inability to communicate and organize transfer with tertiary care centers or obtain transport resources to transfer patients	• Admit pediatric patient if transport resources unavailable; utilize pediatric care guidelines and medical consultation via Pediatric Care Medical Specialist to assist with care
Supplies: IV Fluids and Hemodynamic Support	Medical resources are no longer available at the facility and no means to obtain additional supplies via MOUs or RFMR process	• Reuse nasogastric (NG) tubes after appropriate disinfection • Utilize expired equipment if sterile packaging intact • Use alternate preparation methods for medications (e.g., Rule of 6's, [which is not typically recommended], should be considered for utilization in a catastrophic incident when the standard infusion concentrations are not available)
Supplies: Respiratory Support: Mechanical Ventilation and Oxygen	Medical resources are no longer available at the facility and no means to obtain additional supplies via MOUs or RFMR process	• Reuse vent circuits and other oxygen supplies after appropriate cleaning/disinfection • Implement re-allocation techniques/triage processes for re-allocation of oxygen, ventilators, and other respiratory support resources

Supplies: Medications	Medications are no longer available at the facility and no means to obtain additional medications via MOUs or RFMR process	• Allocation of select medications:
		  ○ Allocate limited stocks of anti-viral medications with consideration of regional/state guidance and available epidemiological information
		  ○ Utilize re-allocation decision making methods for medications
		  ○ Unit dose or sealed medications from patients.
		• Consider use of veterinary medications when alternative treatments are not available

Attachment 8: Crisis Care and Resource Allocation Tactics for the Pediatric and Neonatal Populations During Catastrophic Incidents

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 9: Crisis Care and Resource Allocation Tactics for the Pediatric and Neonatal Population During Catastrophic Incidents

Resource Type	Indicators	Crisis Care Tactics
Supplies: Nutrition	Medical resources are no longer available at the facility and no means to obtain additional supplies via MOUs or RFMR process	• Eliminate or modify specialty diets temporarily • Re-use NG tubes and other feeding equipment with appropriate disinfection
Space	• Traditional surge areas are beyond capacity or no longer available to care for patients • Inability to communicate and organize transfer with tertiary care centers or obtain transport resources to transfer patients	• Initiate system decompression within the state of Illinois and border states as indicated in the IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex • Utilize holding areas while patients are waiting for transport to other facilities • Decompress/transfer non-critical pediatric and neonatal patients from tertiary care centers to pre-determined appropriate facilities • Create warm boxes out of drawers with heat lamps to warm newborns • Triage of critically ill/injured pediatric patients to tertiary care center through consultation with Pediatric Care Medical Specialist (PCMS) (see Pediatric Triage Criteria Form within the Pediatric and Neonatal Surge Annex)
Staff	• Staffing resources are exhausted and the ability to obtain additional staff (e.g. Illinois Helps, medical mobile assets) is not available • Inability to communicate and organize transfer with tertiary care centers or obtain transport resources to transfer patients	• Divert staff to emergency response • Cancel all non-emergent procedures including surgeries, laboratory and radiographic studies, and reassign staff to perform emergency duties • Admit and care for pediatric patients in non-pediatric facilities • Work with PCMS as part of IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex and utilize the *Pediatric and Neonatal Care Guidelines* to assist in caring for pediatric and neonatal patients while waiting transfer to another facility for higher level for pediatric/neonatal care

Attachment 9: Crisis Care and Resource Allocation Tactics for EMS System/Agencies During Catastrophic Incidents

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 6: Crisis Care and Resource Allocation Tactics for EMS Systems/Agencies During Catastrophic Incidents

Purpose: Provide EMS systems/agencies/providers with crisis care and resource allocation strategies/tactics that may be implemented during catastrophic incidents

Instructions: When the annex is activated, this document should be used to guide EMS systems/agencies/providers when providing crisis care to patients.

Disclaimer: These strategies/tactics are not meant to be all inclusive, replace any existing policies and/or procedures (e.g. staffing, transportation, treatment modalities) within an EMS System, or substitute for clinical judgment. These guidelines may be modified at the discretion of the EMS System and Medical Director.

Resource Type	Indicators	Crisis Care Tactics
Systems: Command and Control	Incident causes mass casualties and disruption or failure of health care system resulting in inability for EMS to utilize routine operations	• Conduct briefings with staff and other stakeholders; establish regular schedule for briefing every operational period • Modify ambulance staffing configurations (e.g. change staffing patterns, 1-BLS and 1 ALS provider vs. 2 ALS providers)
Systems: Communication and Coordination	Incident causes disruption in normal communication pathways	• Use MERCI, Satellite phones, emails, texts, HAM/CB radios • Implement "runner" messaging system
Systems: Emergency Dispatch	Emergency medical dispatch overwhelmed by call volumes and unable to answer all calls	• Use pre-recorded messaging to filter calls that require direct emergency medical dispatch staff contact • Consider implementation of hotlines or nurse call triage lines to mitigate requests for EMS transports • Implement call triage models to target highest priority calls for response • Maximize frequent use of emergency broadcast system and media outlets for community messaging
Systems: Triage	Incident results in catastrophic number of patients	• Utilization of mass casualty triage protocols • May have to devise impromptu triage tags or marking system • Track all patient contacts with whatever means available • Treat and release minor injuries
Systems: Triage	Acuity level of patients may be so severe that comfort care measures will be required	• Contact medical control for treatment protocols if possible • When possible provide separate area for privacy • Provide comfort measures
Systems: Transport	Incident causes substantial change in routine patient transport operations	• Use alternate transportation (e.g. buses, other municipal vehicles, personal vehicles, helicopters, and other air transport resources)

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Attachment 9: Crisis Care and Resource Allocation Tactics for EMS System/Agencies During Catastrophic Incidents

ATTACHMENT 6: Crisis Care and Resource Allocation Tactics for EMS Systems/Agencies During Catastrophic Incidents

Resource Type	Indicators	Crisis Care Tactics
		• Establish rally points with other transport resources if significant transport time is required to keep resources in community
	Patient destinations may be to clinics or other non-traditional sites	• Consider batched transports; move multiple patients at one time
	EMS may need to provide direct patient care for multiple patients for a longer period of time	• Contact Medical Control for prolonged treatment protocols • Use best clinical judgment if Medical Control is not available
	Incident causes need to suspend rules for field to hospital radio calls and potential modification of record keeping requirements	• Request modification from EMS medical director for radio report and patient care documentation • Transport patients and provide face to face report upon arrival to destination
Supplies: Consumables, First Aid stabilization, and comfort supplies (dressings, slings, tourniquets etc.)	Shortage/limited or non-existent resupply	• Contact local hospital or RHCC for resupply or access to regional/national stockpiles • Seek guidance from EMS medical director/ Medical Control to develop just-in-time tactics for: substitution, conservation, adaptation, and improvised use of IV fluids and other hemodynamic support equipment and supplies (e.g. only use IV fluid for hemodynamically unstable patients) • Reuse, repurpose, and improvise first aid and stabilization supplies (e.g. make slings and dressings out of clean sheets, pillow cases etc.)
Space	Incident has resulted in the inability to access local hospitals resulting in EMS needing to provide prolonged care at casualty collections sites	• Coordinate with local Incident Command and EMS medical director when possible, to identify health care facility sites for non-traditional EMS transport destinations (e.g. local clinics, surgical centers and other outpatient providers) • Coordinate with local Incident Command and EMS medical director to identify and establish casualty collection points to begin providing care when there is a delay in transport • Alternate treatment modalities and destinations should be requested from the EMS medical director • Coordinate with local medical sources to request assistance (e.g. local physicians and other health care providers)

Attachment 9: Crisis Care and Resource Allocation Tactics for EMS System/Agencies During Catastrophic Incidents

IDPH ESF-8 Plan: Catastrophic Incident Response Annex | 2018

ATTACHMENT 6: Crisis Care and Resource Allocation Tactics for EMS Systems/Agencies During Catastrophic Incidents

Resource Type	Indicators	Crisis Care Tactics
Space: Mass fatality	Morgues at the city and county level as well as at hospitals are at capacity	• Work with local medical examiner, coroners, and law enforcement under the direction of the EMS medical director for fatality management • Be aware of alternate cooling facilities/ capabilities within the community (e.g. refrigerator trucks, funeral homes, warehouses with walk in freezers and ice rinks)
Staff: Resources	Staffing resources are exhausted and likelihood of timely mutual aid may not be available	• Request additional assistance through official methods; identify members of the community who can be of assistance with basic patient care • Consider coordination with MRCs, CERT, Illinois Helps, and other organizations to provide credentialed trained volunteers • Request non-medical personnel to drive the ambulance to increase the number of first responders available to provide direct patient care
Staff: Family communication	First Responders have concerns about the welfare of themselves and of their own family	• Establish method for responders to stay in touch with family or develop message relay capacity (e.g. designate email or text line for families and responders to exchange messages)
Staff	First responders are physically and mentally exhausted	• Monitor and assist responders; ensure responders are provided an opportunity for: rest, sleep, nutrition, hydration, contact with family, and opportunity for debriefing • Provide responders with information on how to recognize normal and abnormal stress responses and how to access support for themselves • Find additional community resources to assist: trained mental health providers, counsellors, local faith based groups, therapy animals, etc.
Staff	Emergency dispatch staff unable to get to work	• Use pre-recorded messaging to filter calls that require direct emergency medical dispatch staff contact • Consider implementation of hotlines or nurse call triage lines to mitigate requests for EMS transports • Implement call triage models to target highest priority calls for response • Maximize frequent use of emergency broadcast system and media outlets for community messaging

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Attachment 10: Region V ICS 213 RR Form

RESOURCE REQUEST REGION V RHCC (ICS 213RR)

1. Hospital Name:				**2. Date/Time**		**3. Resource Request Number:**		
Requestor	**4. Order** (Use additional forms when requesting different resource sources of supply.):							
	Qty.	Kind	Type	Detailed Item Description: (Vital characteristics, brand, specs, experience, size, etc.)	Arrival Date and Time		Cost	
					Requested	Estimated		
	5. Requested Delivery/Reporting Location:							
	6. Suitable Substitutes and/or Suggested Sources:							
	7. Requested by Name/Position:			**8. Priority:** ☐ Urgent ☐ Routine ☐ Low		**9. Section Chief Approval:**		
Logistics	**10. Logistics Order Number:**					**11. Supplier Phone/Fax/Email:**		
	12. Name of Supplier/POC:							
	13. Notes:							
	14. Approval Signature of Auth Logistics Rep:					**15. Date/Time:**		
	16. Order placed by (check box): ☐ SPUL ☐ PROC							
Finance	**17. Reply/Comments from Finance:**							
	18. Finance Section Signature:					**19. Date/Time:**		
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