

Crisis Standards of Care

A Systems Framework for
Catastrophic Disaster Response

State and Local Government

INSTITUTE OF MEDICINE
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Crisis Standards of Care

A Systems Framework for Catastrophic Disaster Response

Volume 2: State and Local Government

Committee on Guidance for Establishing Standards of Care for Use in Disaster Situations

Board on Health Sciences Policy

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Willing is not enough; we must do.”*
—Goethe



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Acronyms

ASPR	Assistant Secretary for Preparedness and Response
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CONOPS	concept of operations
CSC	crisis standards of care
DHS	Department of Homeland Security
DMAT	disaster medical assistance team
DOD	Department of Defense
EMA	emergency management agency
EMAC	Emergency Management Assistance Compact
EMS	emergency medical services
EMTALA	Emergency Medical Treatment and Active Labor Act
EOC	emergency operations center
EOP	emergency operations plan
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FD&C	Food, Drug, and Cosmetic (Act)
FEMA	Federal Emergency Management Agency
FMS	federal medical station
HHS	Department of Health and Human Services
HPP	Hospital Preparedness Program

ICS	incident command system
LHD	local health department
MAC	multiagency coordination
MOU	memorandum of understanding
MRC	Medical Reserve Corps
MSCC	Medical Surge Capacity and Capability
NDMS	National Disaster Medical System
NIMS	National Incident Management System
PHEP	Public Health Emergency Preparedness
PHS	Public Health Service
RDMAC	regional disaster medical advisory committee
REC	regional emergency coordinator
RMCC	regional medical coordinating center
SDMAC	state disaster medical advisory committee
SNS	Strategic National Stockpile
VA	Department of Veterans Affairs

5: State¹ and Local Governments

Because crisis standards of care (CSC) responses will combine the efforts of health care, public health, and emergency management and response systems, they will necessitate interaction between public and private actors and resources and local, state, and federal authorities. While much of the health care component of a CSC response will occur in the private sector (because the health care system comprises largely nongovernmental partners, with some exceptions), government at all levels must play a crucial role in leading and coordinating CSC planning and implementation efforts. Government also is ultimately accountable for CSC activities, with states having “the political and constitutional mandate to prepare for and coordinate the response to disaster situations throughout their state jurisdictions” (IOM, 2009, p. 23). As recommended in the committee’s 2009 letter report, states in particular should lead the development and implementation of CSC protocols “both within the state and through work with neighboring states, in collaboration with their partners in the public and private sectors” (IOM, 2009, p. 4).

Building on existing strengths, authorities, and response structures within states, this chapter outlines the roles and responsibilities of state and local governments in CSC planning and implementation in the overall context of a CSC response system. It focuses on the unique role of the state health department² in leading CSC efforts within states, and on the interplay of local health department, regional, state emergency management, and federal partners in state planning and implementation efforts for CSC incidents. Two templates provide core functions for state and local planners to help guide the development and, when needed, the activation and implementation of CSC plans. In both the text and the templates, the role of local government is highlighted because of the importance of local and state partners working together closely in CSC planning and implementation. Local governments are uniquely positioned in the organizational structure of states to intersect with both state government partners and the communities in their local jurisdiction(s).

Because this chapter focuses primarily on the roles and processes for developing and implementing

¹ For the purposes of this report, the term “states” encompasses states, tribal jurisdictions, and territories.

² As described later in this chapter, there is significant variation in state organizational and reporting structures for public health. For ease of reference, the report uses the term “state health department” to refer to the state department, agency, office, commission, or other entity that is principally and directly responsible for coordinating public health services and programs in the state, whether that entity falls under an umbrella state agency or is an independent, stand-alone state agency. The terms “department” and “agency” are used interchangeably for local government public health entities.

governmental CSC plans, its content should be used in conjunction with the report's other chapters. Those chapters provide detailed guidance on specific CSC topics (e.g., related to legal issues, palliative care, mental health, hospital care, out-of-hospital and alternate care systems) that may be referenced only briefly as planning or implementation considerations in this chapter or the two accompanying templates.

ROLES AND RESPONSIBILITIES OF STATE GOVERNMENT

Emergencies rising to the level of CSC generally are expected to be multijurisdictional, statewide, or even multistate incidents that involve various local, regional, state, and federal roles and authorities. Therefore, considerable state-level coordination with intra- and interstate as well as federal partners is essential. In other words, even though this chapter focuses on the state as being in the best position to take the lead in CSC planning and implementation activities because it can serve as the nexus to link local, regional, state, federal, and private components, the response to this level of crisis requires a comprehensive systems approach (see Chapter 2). In this system, *all* levels of government (from local to federal) and *all* components of emergency response and health care are mobilized as a coordinated, interdependent, and interacting response network.

Depending on the specific nature of the incident, various state agencies, as well as private health care system entities, should be involved in CSC planning and implementation activities because no single agency or health or emergency response entity alone can be expected to handle the challenges presented by a CSC incident. As in most large-scale emergencies, the state emergency management agency (EMA) will likely play an essential coordinating role for the overall state response, such as by establishing the state emergency operations center (EOC) and otherwise supporting the state's emergency response efforts, since parallel response activities will be occurring at the local and regional levels. The involvement of other state government agencies and offices, such as those focused on emergency medical services (EMS) (see Chapter 6) or on at-risk populations, also will be necessary to facilitate specific aspects of a CSC response, depending on the nature of the emergency and patient needs.

In addition to state agencies, political and elected officials in the state can be expected to be involved in various aspects of CSC decision making and implementation. The governor, in particular, is ultimately responsible for his or her state's emergency planning and response actions and for ensuring that effective CSC planning occurs. Variations in state agency structures and authorities often will dictate emergency response leadership roles. Therefore, the guidance presented here is not intended to be prescriptive. Rather, states should have the flexibility to develop the organizational structure for CSC planning and implementation that makes the most sense for them. At the same time, however, recognizing the role of the state health department as Emergency Support Function (ESF)-8 lead and the fact that multiple state agencies and leaders will have pivotal CSC roles, the state health department is fundamentally the most appropriate agency to lead and coordinate CSC planning and implementation efforts at the state level and to advise state leadership on CSC issues.

This section focuses on the attributes of state health departments that make them especially well suited to lead CSC planning and implementation efforts. It also reviews the strengths of the state EMA and the federal government's role in CSC planning and implementation in relation to that of the state.

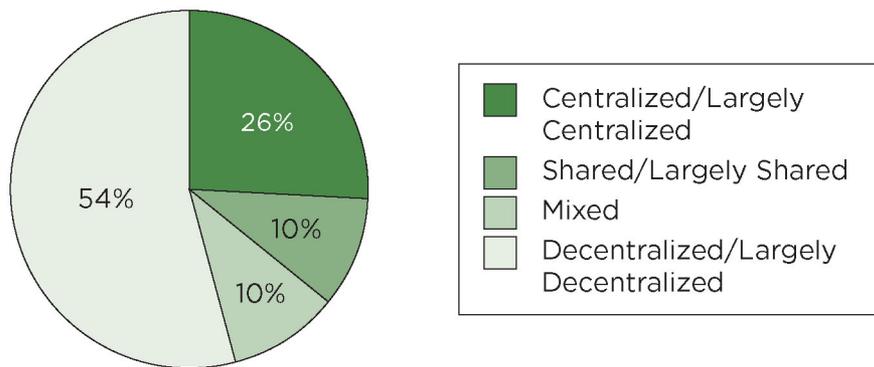


FIGURE 5-1
Organizational structure of public health agencies within states.
SOURCE: ASTHO, 2011, pp. 4, 26-27.

State Health Department

Intrastate partnerships and emergency response systems are essential to effective CSC planning and implementation. However, the state health department is in a unique position to assume the lead role in CSC planning and implementation at the state level (including determining when to implement the state CSC plan) because of its expertise in population-based public health; relationship to the provision of health care; already established local, regional, state, and federal connections with a wide range of stakeholders that may be involved in or affected by a CSC response; legal powers to use public health emergency response authorities; and role in ensuring the representation of appropriate substate (e.g., regional, local) stakeholders.

Structure

Despite considerable differences in the responsibilities, authorities, and structures (e.g., centralized or decentralized, shared governance, or mixed structures)³ of state departments of health (Figure 5-1), each state typically has a single, overarching body (i.e., an independent agency or a component of an umbrella agency)⁴ responsible for protecting the public’s health and overseeing the public health system. More than half of state health agencies “provide all or some of the public health services offered at the community

³ The Association of State and Territorial Health Officials (ASTHO) reported in 2011 that “nearly 30 percent of states (n = 14) have a centralized or largely centralized governance structure where local health units are primarily led by employees of the state and the state retains authority over most decisions relating to budget, public health orders, and the selection of local health officers. Five states have a shared governance system where local health units may be led by state or local government employees. If they are led by state employees, the local government can make fiscal decisions, issue public health orders and/or select local health officials. In shared states where local health departments are led by local employees, the state health agency retains authority over most decisions relating to budget, public health orders, and the selection of local health officials. Over half of states (n = 27) have a decentralized/largely decentralized system where local health units are primarily led by employees of local governments, and the local governments retain authority over certain decisions. Ten percent of states have a mixed governance structure where some local health units are led by state employees and by local government employees. No one arrangement predominates in the state” (ASTHO, 2011, pp. 26-27).

⁴ “State health agency structure describes the placement of a state health agency within the larger departmental/agency organizational structure for the state. For example, in states where the public health agency is part of a larger umbrella agency, the larger agency may also be responsible for Medicaid, services for the aging population, substance abuse or mental health services, or public assistance, in addition to providing public health services. Fifty-five percent of state health agencies are free-standing, independent agencies; the remaining state health agencies are part of a super or umbrella agency. States with medium and large populations more frequently report free-standing, independent agencies (71 percent of medium-sized states and 65 percent of large states). There are no structural differences based on governance classification or U.S. region” (ASTHO, 2011, p. 24).

level” (ASTHO, 2011, pp. 26-27), but “[74] percent of states report an obligation to assume authority when local health agencies cannot perform their duties or when there is no coverage by a local health department. . . . Other reasons for state assumption of authority include emergency response or when issues are cross-jurisdictional. Eighty-five percent of state health agencies report that the obligation is legal while just over 10 percent characterize the obligation as professional” (ASTHO, 2011, p. 30).

Responsibilities

Depending on the state and the structure of its public health system, the state health department typically has a range of public health, health care, and emergency response system responsibilities, such as

- providing oversight of and/or support to local health departments, depending on whether the structure is centralized or decentralized;
- overseeing EMS agencies;
- regulating laboratories;
- licensing health care practitioners (e.g., through professional licensing boards);
- regulating health care;
- monitoring the health status of the population;
- providing prevention services (e.g., HIV, injury control, tobacco control);
- conducting disease surveillance and control;
- overseeing maternal and child health services and medical assistance programs;
- implementing health care reforms;
- providing and regulating mental health services; and
- collaborating on grants and programs with federal health partners (e.g., Department of Health and Human Services [HHS]) (ASTHO, 2011).

State health departments also are actively engaged in public health emergency preparedness (CDC, 2010; TFAH, 2010). For example, often in collaboration with other state agencies, they

- administer Public Health Emergency Preparedness (CDC, 2011a) and Hospital Preparedness Program (ASPR, 2012) cooperative agreements that HHS provides for state, local, and hospital preparedness;
- participate in state-level management of emergencies (e.g., as the state’s lead ESF-8 agency) (MEMA, 2009);
- develop pandemic, medical surge, and other emergency response plans (e.g., mass fatality management and hospital evacuation);
- coordinate state and local components of federal response programs (e.g., Cities Readiness Initiative for mass dispensing of antimicrobials following an anthrax attack) (CDC, 2011b);
- develop and participate in multidisciplinary emergency planning workgroups (Garrett et al., 2011);
- plan for the allocation and prioritization of scarce resources (e.g., vaccines and ventilators) during responses (Garrett et al., 2011);

- coordinate registration and credentialing systems for health care volunteers (e.g., Emergency System for Advance Registration of Volunteer Health Professionals [ESAR-VHP]) and health care response teams (e.g., Medical Reserve Corps [MRC]);
- manage stockpiles of medical countermeasures (e.g., antivirals) and other materiel;
- identify and develop plans for alternate care sites; and
- establish health care emergency communication systems (ASPR, 2011a).

State health departments' linkages to and role in regulating public and private components of the health care system, as well as health care practitioners, also are critical for effective CSC planning and implementation. State health departments "report a high level of collaboration with . . . entities in the health care field" (e.g., hospitals, physician/medical practices, community health centers, health insurers) (ASTHO, 2011, p. 32). Depending on the state, they may also have strong linkages with Department of Veterans Affairs (VA) and Department of Defense (DOD) health care facilities and systems. Given their critical role in the health care system and the large patient base they serve, these facilities and systems are important partners in the overall CSC response system.

Because all components of the health care system play such a pivotal role in CSC, this level of collaboration and knowledge is of particular importance in that it makes for optimal engagement in the CSC response system. For example, health agencies' knowledge of health regulations and partners through their regulation of the health care industry, combined with their ability to identify and even operate surge capacity sites through their emergency preparedness roles, is critical for providing oversight of alternate care systems that may be required during CSC implementation. These skills also are important for appropriately regulating the state's health care industry and practitioners during a CSC incident, such as by identifying where it would be most appropriate to relax certain state regulations or requirements (e.g., expanding practitioners' scopes of practice) (Courtney et al., 2010) or by partnering with federal regulators on the appropriate level of compliance with federal health care requirements within the state.

Authorities

State health department officials' legal authorities and powers also are critical to facilitating statewide CSC implementation and identifying resource needs (see Chapter 3). While these authorities and powers vary by state, they may include the authority and capability to authorize certain response actions and provide liability protections for responders; to initiate and facilitate emergency requests for federal (e.g., HHS) health and medical resources, technical assistance, and emergency declarations and waivers and for interstate support (e.g., through the Emergency Management Assistance Compact [EMAC]); to have in-depth access to state, regional, and local health information and resources for providing situational awareness; to establish quarantine and isolation orders; and to modify or provide specific treatment protocols. In terms of lines of authority, "half of state health officials report directly to the governor, and nearly one-third report to the [state's] secretary for health and human services. Other individuals and entities state health officials report to include administrators/directors of an umbrella agency or [the] director of the health division of an umbrella agency. One state health official reports to the governor and the agency director" (ASTHO, 2011, p. 29).

Through each of the above public health, health care, and emergency management system roles, relationships, and authorities, the state department of health often is in the best position to ensure that state, regional, and local CSC planning and implementation efforts are occurring and that they are being conducted systematically—that is, consistently, in a coordinated manner (i.e., within and across state boundaries), and in accordance with applicable state and federal laws and regulations.

State Emergency Management Agency

Each state has a state-level agency or office with responsibility for coordinating the state’s response to emergencies and disasters (e.g., state EMA; state office of emergency management, civil defense, or homeland security) (FEMA, 2012).⁵ While these agencies and offices vary in roles and structures, they often are responsible for a range of preparedness and response actions, such as

- developing and maintaining the state emergency operations plan (EOP);
- ensuring that the ESF functions (e.g., public health and medical services, communications, and transportation) outlined in the state EOP are fulfilled;
- conducting emergency training and exercises;
- managing homeland security and emergency management grant programs;
- establishing and managing the state EOC;
- developing and implementing mitigation strategies;
- ensuring that responses are conducted in accordance with National Incident Management System/ incident command system (ICS) principles and processes;
- coordinating public messaging and emergency communications (e.g., ensuring redundancy and interoperability of communications mechanisms);
- supporting and coordinating with local government and regional responses, including public safety and EMS components;
- collecting data on the emergency and providing situational awareness information to federal, state, regional, and local response partners;
- facilitating requests for and offers and receipt of federal, interstate, and intrastate assistance; and
- developing after-action reports to aid in improving future responses.

Given that CSC incidents are characterized by resource scarcity, the lead role that state EMAs may have in requesting, accepting, and providing mutual aid (e.g., through EMAC) and coordinating resources, including local resources, during a disaster is of particular significance. However, state EMAs and state health partners must work together closely during CSC incidents to ensure that appropriate resource requests and allocations are made, and to coordinate such requests and allocations that may occur through non-EMA channels (e.g., from HHS to the state health agency; interhospital sharing of resources through memorandums of understanding). In addition, coordinated planning with local emergency management programs is critical to ensuring integration into the state CSC plan and the state EOP. State health departments, with their links to local public health agencies and regional medical disaster planning groups, as well as their

⁵ For the purposes of this report, “EMA” is used throughout to refer to these offices and agencies.

possible role as the lead ESF-8 agency for the state, often will have the best awareness of specific health and medical resource needs—and the availability of such resources through its federal and other health and medical partners—during a disaster.

Because of the complex, multidisciplinary nature of CSC incidents and the vital coordinating and collaborating roles of state EMAs in emergency management, these agencies and offices should be directly involved in state-level CSC planning. To support consistency and avoid duplication of effort, the committee encourages state EMAs and state health departments to collaborate closely in CSC planning and implementation efforts. Depending on these entities' response structures and roles, as previously described, the level and type of such collaboration may vary by state. Therefore, state public health and emergency management partners should work together closely to assess and determine the optimal approach for structuring and delineating CSC planning and implementation processes and roles.

State-Federal Government Interaction

States have a number of important linkages to federal partners related to CSC responses. Given the complex nature of CSC incidents, the state health department's relationships with its HHS partners (e.g., Office of the Assistant Secretary for Preparedness and Response [ASPR], Centers for Disease Control and Prevention [CDC], Centers for Medicare & Medicaid Services [CMS]) are of particular significance in terms of emergency authorities, resource requests, and health system regulation. In support of a response requiring the implementation of CSC, for example, ASPR might authorize certain emergency actions or provide CSC guidance; CDC might conduct surveillance, provide medical countermeasures from the Strategic National Stockpile (SNS), and offer treatment and clinical care guidance; HHS agencies might offer response teams; and CMS might relax some of its federal program regulations. The federal government also might utilize state government as a conduit to facilitate information exchange and planning at the regional and local levels. This federal government role becomes even more critical when CSC incidents involve multiple states and interstate regional responses. In such situations, the federal role in facilitating optimal regional collaboration and response is crucial.

Emergency Authorities, Resources, and Regulation

Federal-level emergency declarations (e.g., HHS public health emergency declaration under Section 319 of the Public Health Service Act; HHS declaration of emergency justifying the emergency use of certain medical countermeasures under Section 564 of the federal Food, Drug, and Cosmetic [FD&C] Act) and waivers of federal law (e.g., under the Emergency Medical Treatment and Active Labor Act) can facilitate and support medical and public health responses by authorizing specific emergency actions, providing funding to support response or recovery efforts, or even waiving sanctions for failure to comply with specified federal laws and regulations during a disaster (CMS, 2009).⁶

The federal government also may disseminate (and set conditions on the receipt and use of) critical federal assets, such as the National Disaster Medical System (NDMS), the SNS, and federal medical stations, to support CSC responses at the state, regional, and local levels. States play a key role in receiving

⁶ *Public Health Security and Bioterrorism Preparedness and Response Act of 2002*, 42 U.S.C. § 1320b-5, Public Law 107-188, 107th Cong., 2d sess. (June 12, 2002), <http://www.law.cornell.edu/uscode/text/42/1320b-5> (accessed March 4, 2012).

requests for federal resources from within the state; assessing the need for, requesting, receiving, and allocating these federal resources; and determining the need for and requesting federal declarations and waivers. These activities often must occur within the context of specified lines of authority, in accordance with certain state emergency declarations, and through the governor, state health department leadership, or state EMA officials; pre-established federal processes and requirements may also apply.

HHS Regional Emergency Coordinators

Regional emergency coordinators (RECs) “work closely with state, local, territorial and tribal health officials in each of the country’s 10 disaster planning regions to develop high levels of emergency preparedness and to coordinate disaster response activities” (ASPR, 2011b), thereby serving as “ASPR’s primary representatives throughout the country at the regional level” (ASPR, 2011c). Specifically, RECs work to enhance “cross discipline integration among public health and medical and emergency management partners,” respond to emergencies, provide regional situational awareness information to HHS headquarters, provide command and control for HHS deployed resources, and provide support for exercises (ASPR, 2011d). Their regional positions and state-federal linkages make them important partners in the overall CSC planning and implementation system, putting them in a unique position to link CSC efforts across states and helping to ensure the flow of CSC-related information (e.g., guidance, situational awareness, resource needs) from the state to the federal level (and vice versa).

Consistency with State CSC Response

The state health department also can play a central role in ensuring, to the extent feasible, that the actions of federal health care responders are consistent with the state CSC plan and its implementation during a CSC incident. For example, if health care responder teams (e.g., HHS disaster medical assistance teams) coordinated by the federal government are deployed to a state to supplement local medical care, they should not necessarily be providing care in a substantially different way than nearby local health care facilities that may be operating under CSC protocols in accordance with the state CSC plan. To the extent possible, the approach to patient care under CSC within a state should be coordinated and consistent among local, state, and federal health care responders. Additionally, the state health department, based on its broad, statewide situational awareness of the emergency and knowledge of local and regional health care needs, generally will be in the best position to assess and determine how to allocate federal health and medical response assets.

The availability of assistance (e.g., response teams, medical materiel) to states from the federal government, as well as from other states through mutual-aid agreements (e.g., EMAC), is not always predictable, especially when multiple states are impacted by the same emergency and have shifted to a CSC response. Federal partners also do not have the authority to lead or participate in every aspect of a state-level CSC response. For example, certain critical response tools, such as state emergency declarations or waivers of state law necessary for facilitating the response, rest at the state level and may be activated only by state leaders (e.g., governor or state health secretary) or their designees. The role of the state is heightened because, even with RECs and other HHS regional coordinating entities, it is impractical to expect federal partners to have the detailed knowledge that states have of their available health care and emergency resources; populations and communities; established relationships with local, regional, and interstate partners; and state and local laws, regulations, and emergency authorities.

In addition to federal response assets, many states have VA and DOD health care facilities, which may have significant health care resources and serve large patient populations. For example, the VA is “home to the United States’ largest integrated health care system consisting of 152 medical centers [and] nearly 1,400 community-based outpatient clinics. . . . Together these health care facilities and the more than 53,000 independent licensed health care practitioners who work within them provide comprehensive care to more than 8.3 million veterans each year” (VA, 2011). Planning for disasters and CSC may already be under way at such facilities or in their respective health care systems. The first priority for VA and DOD facilities during a CSC incident will necessarily be the primary patient populations they serve. To the extent feasible, however, their coordination with state and local governments (and health care coalitions) in CSC planning is critical to building the overall CSC response system.

Roles of State Government in Regional Coordination

State-level CSC planning can also facilitate the coordination and linking of regional medical and public health disaster planning efforts, both within and across states. When collaborating and engaging with their local and regional partners, states are in a unique position to facilitate and encourage the intra- and inter-state coordination and consistency necessary for effective CSC planning and implementation. Examples of regional *intrastate* emergency planning structures/alliances include health care coalitions (ASPR, 2011a; Courtney et al., 2009) (which may be across or within jurisdictions), regional medical coordinating centers, and regional disaster medical advisory committees (RDMACs). States may have other regional emergency planning and response bodies, including multiagency coordination (MAC) groups and regional EMS councils that also can be leveraged for intrastate CSC purposes.

The integration of hospital coalition planning and response efforts into the intrastate regional emergency response system is especially important for CSC efforts. Ideally, an overall emergency response system that incorporates public health, health care, public safety, EMS, and emergency management partners and planning groups is needed. In some cases, though, state emergency planning and response efforts also cross state lines because of shared borders and interests, strong relationships, and mutual-aid agreements. Such *interstate* collaboration can be leveraged for coordination of CSC responses in the context of the CSC system and can facilitate resource sharing during an incident. However, a CSC response in any single state, not just those with a history of cross-state emergency collaboration, may necessitate interstate cooperation. In states that do not routinely collaborate with other states for emergency response, federal partners that work at the regional level (e.g., HHS, Department of Homeland Security [DHS]/Federal Emergency Management Agency [FEMA]) can facilitate and link existing state CSC efforts. For example, the HHS RECs are well positioned to support, facilitate, and encourage interstate CSC planning and implementation efforts and communication.

Through its lead role in CSC coordination, the state health department can work with its partners to identify various regional medical and public health disaster planning efforts occurring within the state; to link them so they can form a statewide, interdependent system that supports health and medical responses; and to promote consistency in planning and response among such entities and, when needed, across state lines.

ROLES AND RESPONSIBILITIES OF LOCAL GOVERNMENT

When considering the role of local government in CSC efforts, it is important to remember that vastly different local governmental structures and relationships exist across states nationwide, based on how states are constitutionally and functionally structured. Despite these variations, however, the role of local government in CSC planning and implementation remains crucial. Even though a CSC incident may be widespread and require a systems approach across all levels of government, especially as the geographic area of impact increases, all disasters are truly local. At some point, the state CSC plan will need to be incorporated into or adapted for local planning efforts (e.g., the health and medical annex of the local EOP) and will help guide local activities during a CSC response.

Appropriate local representation in statewide CSC planning efforts provides the opportunity for true state-local partnership and allows those involved to act as a conduit for information from the local to the state level and vice versa. Local political (e.g., mayor, county executive) and agency leadership also will be involved in local response decision making and resource requests during a CSC emergency. Thus, local CSC coordination, consistent with state planning and response actions, is critical to achieving the envisioned systems-based CSC response described in Chapter 2. Similarly, the local health department often is in the best position to coordinate CSC planning and implementation at the local level given its close linkages to the state, neighboring regional partners, the community, the health care system, and emergency management and response partners.

Local Health Department

While “the relationship between state health agencies and regional/local public health agencies differs across states” (ASTHO, 2011, p. 26), local health departments serve a unique and essential role in CSC planning and implementation. They typically represent the smallest form of government in a state and, where they exist, are well positioned to interface not only with the state government structure but also with community stakeholders and health systems within their own jurisdiction. Since local health departments are located within a local jurisdiction (e.g., city, county, or county-city), they are uniquely positioned to appreciate the needs and interests of their local populations; what resources are available and what planning efforts are under way (e.g., local health care coalitions); and how best to achieve CSC planning objectives (e.g., through implementation of the state CSC plan at the local level).

Structure and Authorities

Although state government bears the primary constitutional responsibility and authority for public health activities within a state, local health agencies were created to address a myriad of health conditions and to manage a variety of ongoing health threats facing populations in local communities. Local health departments often are considered the front line of public health agencies, generally providing direct public health services to the communities and populations they serve. Depending on how the term “local health department” is defined, they number from 2,500 to 3,000 throughout the United States (CDC, 2001; IOM, 1988, 2003; NACCHO, 2010). In addition to the sheer number of local health departments, “the organization and authority granted to . . . local public health agencies vary substantially across the country” (IOM, 2003, p. 108; see also IOM, 1988; see also Figure 5-1 presented earlier). In some states (e.g., Florida, Missouri),

there is a more centralized organizational structure in which state government has direct control of and/or authority for oversight of local health departments (IOM, 2003; NACCHO, 2010). Other states (e.g., California, Texas, Ohio) have a less centralized structure, with independent local health departments being run by local government structures and systems (IOM, 2003; NACCHO, 2010). CSC planning and potential implementation will need to take into account these varying structures and relationships in states and localities throughout the United States.

Responsibilities

While their specific roles, sizes, and structures vary across and within states, local health departments often have unique on-the-ground knowledge and relationships, including with local response agencies (e.g., emergency management, EMS, and other public safety agencies and offices), health care practitioners and facilities, communities, at-risk populations, academic institutions, and private-sector partners. Local health departments often have defined local public health emergency response roles (e.g., conducting biosurveillance activities, mass dispensing medical countermeasures directly to their constituents) and participate in established local and regional emergency preparedness partnerships (e.g., health care coalitions) (Courtney et al., 2009; Toner et al., 2009) through which they conduct joint planning with response partners (e.g., developing contracts to share resources and establishing shared communications systems) (ASPR, 2011a). The ability of local health departments to assess and provide local and regional jurisdictional information (e.g., demographic data, emergency and resource needs) is essential to the overall statewide situational awareness for emergency response.

Local Emergency Management Agency

Many local jurisdictions have their own EMA or emergency management office that is a component of their state's emergency management system. During a statewide emergency, for example, the local EMA would provide local situational awareness, establish forums for collaboration, or make resource requests through the state EMA. Local health agencies' relationships with local EMAs vary; some have strong working relationships (including by partnering with them in local health care coalitions), while others are less actively engaged.

Where local EMAs exist and where local health departments have the authority to collaborate with their local EMA, joint planning for CSC is encouraged as part of the overall CSC response system. In addition, these agencies or offices can help support the management of response issues not directly related to the public health, EMS, and health care components of a CSC incident (e.g., critical infrastructure, resource requests, public safety), enabling health agencies and the health care system to focus on the health-related aspects of the emergency. The level of collaboration and support that local EMAs, when available, can provide to local health agencies cannot be overstated. Such collaborative relationships are similar to the relationships of state EMAs with their state health department counterparts.

Local-State Government Interaction

The recommendation for state departments of health to assume the lead role in CSC planning and implementation in a state in no way undermines the unique and integral roles of local and regional stakeholders,

as applicable. Ultimately, during a CSC catastrophic disaster, state and local collaboration and coordination will be essential and may also help mitigate “forum shopping” (i.e., members of the public going to another hospital or jurisdiction where they perceive that a different or better level of care is being provided) and perceptions of inequity.

Local government is particularly crucial in CSC outreach and engagement at the community level, and these activities should be undertaken in partnership with appropriate planning and response partners. The state health department’s role in such outreach and engagement will depend largely on the structure of the state’s public health system. In some cases, it may be optimal for local health departments to take the lead role for CSC efforts with respect to public and stakeholder engagement in their communities. The nature of this type of state-local dynamic concerning engagement is dependent on the ongoing working relationships between the two levels of government, as well as the local community context. Regardless of whether the state or local health department, or both, take the lead in public engagement, it should be done consistently and not with cross purposes or intent.

Either way, the answer to the question of which entity should take the lead in such engagement depends on which health agencies—whether at the state or local level—have the optimal relationship with and trust of the community. In states with limited numbers of local health departments and in the approximately one-third of states in which the state health department assumes responsibility for providing local public health services (ASTHO, 2011), the state may need to take a more active role in ensuring appropriate local stakeholder representation in state-level CSC planning, as well as in furthering community and provider engagement. This includes local health departments having the opportunity to participate in the state disaster medical advisory committee (SDMAC), as described later, and to comment on the draft state CSC plan. Local health departments can, in turn, identify and engage appropriate local stakeholders as CSC planning proceeds.

It is clear that some local health departments (especially those representing large jurisdictions and communities) may be farther along the spectrum of CSC planning compared with their state counterparts. In these cases, states should give due consideration to such planning efforts already under way and leverage the good work that has been accomplished to best achieve the goal of optimizing CSC planning. At some point, state government will need to be involved in CSC planning and implementation given the roles and authorities that lie only at the state level. However, if such involvement has not already occurred and local jurisdictions in these instances have already taken significant steps forward in CSC planning, it would be prudent for states to build upon the local work already begun rather than start anew.

OPERATIONAL CONSIDERATIONS

In planning for CSC incidents and in implementing CSC plans in response to a catastrophic disaster, state and local governments should be aware of certain operational considerations that may affect their interactions with one another and with the entire CSC system. Three such considerations are the level of state engagement in the state’s CSC planning process, the level of consistency in CSC planning and implementation, and the level of consistency in care.

Level of State Engagement in CSC Planning

As noted, states are in varying stages of CSC planning (AHRQ, 2012; GAO, 2008). Some have been engaged in such planning for several years and have established multidisciplinary CSC advisory committees or conducted community engagement activities (Levin et al., 2009; Ohio Department of Health and Ohio Hospital Association, 2011). In other states, individual health care facilities or public health departments in large cities have initiated CSC planning, including the development of CSC protocols or the conduct of community engagement activities (Public Health-Seattle and King County, 2009; Shah, 2012). In some cases, such planning has occurred even when the state has not taken the lead role in, or even commenced, CSC planning. In other cases, regional planning efforts may be occurring (Inova Hospital Group, 2007). Even in states that are or plan to be actively involved, CSC efforts can be expected to occur outside of the state government context and formal planning structures (e.g., in local jurisdictions or in private health care facilities or systems).

The importance of comprehensive state CSC planning cannot be overemphasized. States that have engaged in no or only very limited CSC planning may have additional federal and interstate resource needs during an actual CSC emergency compared with those states that have planned for such an incident. Since resources (e.g., federal responders and materiel) may need to be diverted to a state that needs more support as a result of insufficient planning, a state's failure to plan could have a negative impact on responses in those states that *have* planned for CSC, in addition to the negative impact on its own response efforts. State agencies also should be cognizant of the fact that—depending on the scale of the disaster and associated needs—personnel, space, and supplies from federal and interstate sources may be limited or altogether unavailable. These and other factors reinforce the imperative for state-level CSC planning and coordination. The overall success of the state's CSC response will rest not on an assemblage of independently occurring efforts of local jurisdictions and health care entities but on a well-coordinated, interdependent, and transparent CSC system that is possible only through early, inclusive, and truly collaborative planning and partnership.

States with More Active Engagement

If a state health department has moved forward in CSC planning and done so in the spirit of true collaboration with local and regional partners, the process of ensuring that CSC planning occurs is best left to this multilevel collaborative process already under way and led by the state. By leveraging ongoing relationships, such a process enables CSC planning to occur in a more organized and methodical manner, taking into account the critical issues involved in a CSC response well in advance of a crisis. This collaborative approach also allows for the continual coordination and ongoing communication that are key to the success of CSC planning.

Once a crisis has begun to unfold and the decision has been made to implement the state CSC plan, the same collaborative relationships and protocols already utilized during the planning process will be essential to the success of implementation efforts. Building on this pre-established systems-based, collaborative approach will help ensure a common operating picture and a systematic, rather than piecemeal, response. The importance of these agency relationships cannot be overstated as they—along with sound assessment and communication processes—ensure that critical decisions during a crisis are made with a collaborative understanding of what the issues are and how they should be addressed.

The role for local health departments during the planning process can be twofold: (1) to ensure that statewide planning is inclusive of individual jurisdictional differences with respect to variations in systems, populations, roles, and resources at the local level; and (2) to help communicate the complex and challenging issues inherent in CSC planning to local community entities, whether institutions or lay members of the public. Even with strong state leadership and planning for CSC, defined local roles not only are encouraged, but also are necessary to ensure the penetration of state guidance at all levels of community within a state. These roles include but are not limited to establishing or engaging health care coalitions, providing linkages to health care facilities and/or practitioners, developing plans to implement state CSC planning efforts at the local level, and assisting with identifying and implementing CSC indicators and/or triggers relevant for the local context. Thus, state inclusion of local and regional players in CSC planning in an honest and transparent manner is critical to the success of CSC efforts within a given state.

Ultimately, the role of local health departments should not be viewed as a passive one, but as an active one that ensures optimal CSC planning and, in turn, appropriate incorporation of local perspectives and issues into the planning process. This active role will be furthered by providing for effective community and provider engagement, and by working with local and other partners to ensure that CSC planning efforts are understood at the local level and that local considerations are understood at the state level. Depending on the context of the crisis and the robustness of work already accomplished, the local role thus remains central to optimizing CSC planning.

Once CSC efforts have transitioned from the planning to the implementation phase, local health departments (and their local government partners) continue to play an important role in serving as the conduit for two-way communication between state government and what is occurring within the local community (and vice versa). This communication can further situational awareness and provide a means to monitor appropriate metrics (indicators and/or triggers) in both the activation and deactivation of CSC. Through routine monitoring and reporting mechanisms to establish local, regional, and state normative levels of seasonal and incident-based demand, resources, capacity (e.g., beds), and staffing, this communication can also further situational awareness and provide a means to monitor the most appropriate metrics (whether indicators and/or triggers) in both the activation and deactivation of CSC with essential real-world benchmarks. Close collaboration at the local health department level thus is key to achieving consistency during the implementation phase, as well as furthering community resilience once the crisis has passed. In the end, once the crisis has passed, the community as a whole will be looking to government entities, especially at the local level, with respect to how the CSC response was accomplished. There undoubtedly will be keen interest in how issues of accountability and fairness, as well as effectiveness and efficiency, played out in the response. As noted earlier, given the importance of working with communities, states that are actively engaged in but may still be only in the earlier stages of CSC planning should assess the work that is already occurring at the regional, local, and health system levels instead of initiating a de novo state-led process without these considerations in mind. In states that have conducted limited CSC planning and in which planning may be further developed in a region or local jurisdiction (e.g., a large city or even a health system), the state should consider leveraging, to the extent practical and appropriate, that ongoing work. States should consider actively engaging such partners in state-level planning efforts, as they may have useful expertise, resources, relationships, and lessons learned from their own CSC planning processes. This engagement also can help save duplication of effort, especially important at a time of increasingly limited resources.

States with Less Active Engagement

Where the state health department has not moved forward significantly in CSC planning, or has moved forward but without engaging its local and regional partners in a true partnership, the importance of the local health department's role cannot be overemphasized. In addition to the roles described earlier, this role may involve local health departments having to work in a strategic and deliberative manner with state government partners to raise awareness of the overall importance of engaging in CSC work—including by potentially highlighting planning efforts from across the nation or in neighboring states—and the critical role of the contribution of local government to the CSC planning process.

Some local government agencies may be required to take a more active role in driving state efforts to initiate or to further CSC work. In these cases, local health departments—especially those with sufficient capacity to do so—may need to take the lead in advancing CSC planning in partnership with their other local and regional partners.

Once CSC planning efforts are moving forward and gaining momentum, other partners, including state entities, are likely to see the advantage of becoming part of the process, even if it originated as a more locally or regionally driven effort. Eventually, the overall success of CSC planning will require the involvement of all levels of government within a state. Regardless of how state government becomes engaged—whether by taking the lead itself or by having local/regional partners assert leadership, followed by state involvement—state-level involvement eventually will become necessary, especially during the CSC implementation phase (e.g., to authorize certain response actions through state legal authorities, to formally request resources from federal and other state partners).

The transition from a locally or regionally driven CSC planning process to a state-led process is important to ensure consistency across various jurisdictions within a state. This transition ideally should occur as early as possible in the CSC planning process and certainly in advance of an actual crisis. As stated previously, the failure to plan for a CSC emergency within a state means that state's response during a CSC incident may be compromised, which in turn may needlessly endanger the health and well-being of the state's residents.

While CSC planning and implementation efforts should be coordinated at the state level, it is true partnership and collaboration with local entities that will ensure the success of CSC planning and, eventually, implementation within each state and across the nation during a catastrophic disaster. As noted earlier, for a variety of reasons, local and/or regional entities may need to take the lead at times when CSC efforts are not occurring adequately within a state. Ultimately, however, the engagement of all government players—with their inherent roles and responsibilities—will be necessary to ensure an appropriate response to an emergency of the magnitude that would require CSC implementation.

Consistency in CSC Planning and Implementation

While effective CSC planning and implementation require active local stakeholder participation, the state's lead coordinating role for CSC is essential in promoting consistency in intrastate (and, as needed and appropriate, interstate) planning, response, and recovery activities. But to what extent should CSC planning and implementation be consistent across local jurisdictions and regions?

Some level of *local* variation may be valid to address jurisdictional emergency needs, structures, and

resources. In fact, some level of local variation is inherent even under noncrisis conditions when resources are not so constrained. However, both local efforts that occur independently and are not coordinated within the overall context of the state-level CSC plan and state efforts that occur without adequate local involvement may in fact compromise the public's health, the public's trust, and ultimately the public's perceptions of fairness in resource allocation decisions and the rationale for varying approaches—especially when significant—to patient care. Such inconsistency (or even perceptions thereof) may also lead to forum shopping among those seeking medical care, evoke concerns about transparency from various responding authorities and agencies, and lead to liability claims.

Similar to what occurs at the local level under noncrisis conditions, some degree of *regional* (both within the state and across states) variation in CSC planning also may be necessary to address jurisdictional realities. However, if regional efforts are disjointed and/or undertaken independently and outside of the context of state-level and other regional and local CSC planning efforts, public health outcomes and trust may be compromised or eroded. Such disparate efforts also will make it difficult for federal, state, and local government partners to manage resource allocations appropriately and efficiently (both factors being of significant concern in a CSC incident when, by definition, resources are limited). As stated earlier, significant numbers of individuals can then also be expected to engage in forum shopping. While some forum shopping may be expected in limited forms during a CSC response, substantial forum shopping can lead to chaotic and disjointed levels of care across jurisdictions and regional and interstate lines.

Consistency in Care

In noncrisis situations, it is considered normal for the level of care provided in a state to vary depending on the levels and types of resources that are available to jurisdictions and, more specifically, to the health care organizations within jurisdictions. This is then referred to as the community “standard of care.” In some cases, especially in large jurisdictions with unequal distribution of resources, this standard may vary within a community. Absent significant resource inequalities, however, the standard of care ideally should be more or less the same within any one community.

For example, an academic health care center in a large urban area will likely have access to resources and expertise that may not be available to a practitioner in a rural health clinic or hospital in the same state (Baldwin et al., 2004; Escarce and Kapur, 2009). Therefore, a certain level of care may be provided in that urban facility that would not be possible for the rural facility, even after taking into consideration differences in demand or need for services, for instance. This differential can be seen, for example, in the case of an individual patient presenting to an emergency department for an acute myocardial infarction. Depending on the resources available to that facility, there may be a difference in access to invasive cardiac services. In a more resource-rich environment (e.g., a tertiary care center), the patient may be taken immediately to cardiac catheterization for revascularization; where such services are not available (e.g., a more rural critical access hospital), the patient may instead receive a less comprehensive level of care (e.g., acute thrombolytic therapy instead of immediate cardiac catheterization) (Andersen et al., 2003; Baron and Giugliano, 2011; Claeys et al., 2011; McNamara et al., 1987). While outcomes in both instances may be the same for some patients, in other cases the differences between receiving and not receiving timely cardiac catheterization may lead to significantly different outcomes, especially in those patients considered at higher risk (Andersen et al., 2003;

Claeys et al., 2011). The case of acute myocardial infarction exemplifies this point, but similar differences in care can be seen for other conditions (e.g., heart failure, pneumonia) (Joynt et al., 2011; Lutfiyya et al., 2007).

Thus, even in noncrisis conditions or when CSC do not need to be implemented, differences in the standard of care that is possible in one community versus another may exist based on a variety of factors, including the allocation and availability of relevant health care resources (and the ratio of these resources to the health care needs of individuals requiring them). If the ratio between needed and available health care resources increases, the level of care that can be provided in a community (or even institution) may vary accordingly, especially in comparison with a setting where resource needs and demand are better balanced.

As available resources begin to decrease across entire communities, as they will during a CSC incident, the impact on the level of care that can be provided across various communities becomes greater. As a result, differential levels of care may be provided in different communities during the incident, as well as compared with the same community operating in a time of conventional care (Figure 5-2).

Consistent processes or standards of care can help mitigate dramatic inconsistencies in provided services that may lead to forum shopping, since similar types of care will be provided across various settings as resources become less available (as is the case in situations requiring the implementation of CSC). Thus, it is important not to be overly prescriptive as to what types of care should be provided, but to encourage some flexibility across the system—especially in various communities and institutions therein—to meet state/local needs (but without promoting forum shopping).

The committee emphasizes that “consistent is not the same” and that such variations happen under both crisis and noncrisis conditions. The goal is to incorporate consistency into planning processes and the underlying tenets or principles used in planning. In fact, it is possible that input from the public engagement processes within communities may lead to additional variations in how care will be delivered in some communities. Again, coordination of CSC planning through a state-led process may help minimize variations not necessitated by the factors discussed above. More important, without consistent planning in communities across the state in advance of a crisis and consistent implementation of CSC during such an incident, these expected variations will be further accentuated when CSC are required. Thus the ideal way to maximize the consistency of service provision in a crisis situation is to engage in CSC planning in advance of a crisis and not when a crisis is already at hand.

TEMPLATE DESCRIPTIONS

Building on the five key elements of and milestones for developing state-level CSC plans, as described in Chapters 1 and 2, respectively, and as outlined in detail in the committee’s letter report (IOM, 2009), the two core function-based templates that follow are intended primarily to provide detailed steps and structure to aid states in

- establishing the planning structure for and developing a CSC plan within the state (Template 5.1); and
- after its development, implementing the CSC plan within the state in response to a disaster (Template 5.2).

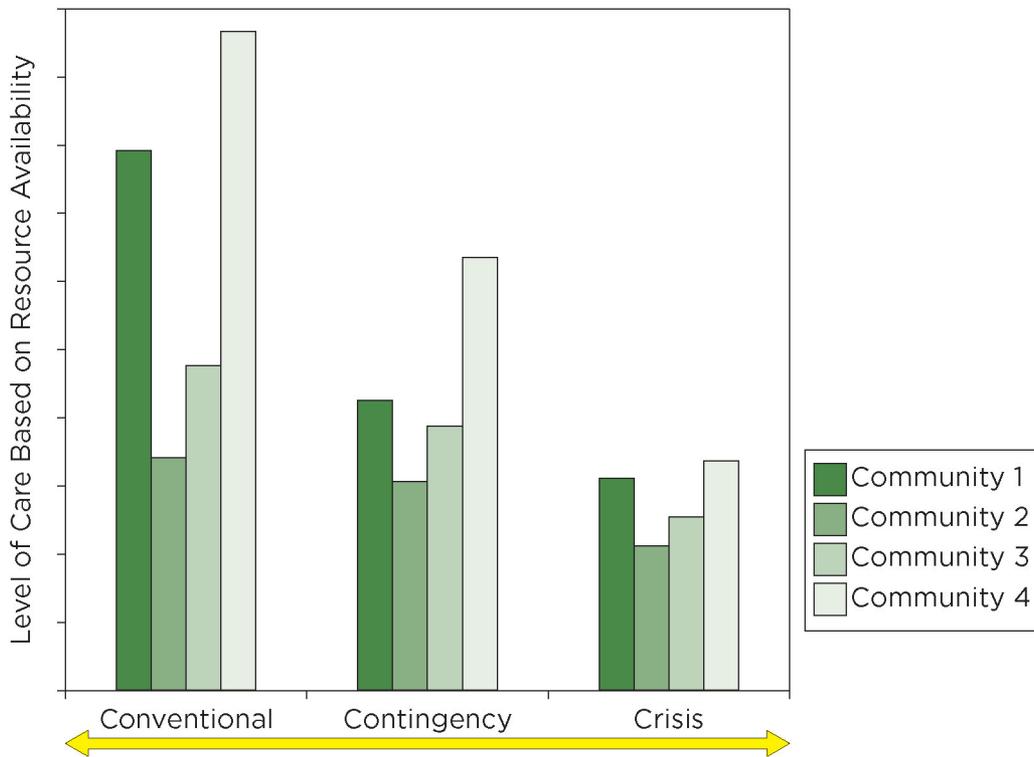


FIGURE 5-2 Model illustrating cross-community variability in the level of care based on resource availability. In this model, the bars that correspond to conventional care illustrate the potential—and normal—variation in the community standard of care (due to such differences as resource availability and patient demand for services) within states at routine times. As the availability of resources (supplies, space, and staff) decreases and demand for health care services increases during the shift from contingency to crisis care, this variability may become less distinct, particularly as resources are fairly and appropriately allocated through the CSC response system.

These templates were developed to provide guidance for states that are already engaged in CSC planning (so they can assess their planning efforts and identify any gaps), and to provide guidance and a roadmap for states that have not yet initiated or are in the earlier stages of planning.

These two templates can help define local roles and processes for CSC incidents when the state is actively engaged in CSC efforts (as described earlier in this chapter). Following local government efforts to partner with the state (also as described earlier in this chapter), if the state is not actively engaged in CSC preparedness, the templates can also be used to help guide local government agencies and/or regional planning and response activities. However, local government partners should understand that, as it unfolds, a CSC incident will necessitate state involvement and authorities. Therefore, not all components of the CSC planning and implementation templates will apply directly to local government disaster efforts.

To further support CSC planning and implementation efforts, other chapters of this report provide additional detail on critical planning components, including legal issues (Chapter 3); cross-cutting ethical, palliative care, and mental health issues (Chapter 4); EMS/prehospital care (Chapter 6), hospitals and acute care (Chapter 7); out-of-hospital and alternate care systems (Chapter 8); and public engagement (Chapter 9). Therefore, planners should use this chapter together with those other chapters, referring to them for specific details.

Template 5.1. Core Functions for CSC Plan Development Within States

This template outlines the recommended core functions for states in their CSC planning efforts (see also Figure 5-3). The template also provides the optimal tasks associated with achieving each function. While the state health department should be the lead coordinating agency for CSC planning and response in each state, a multidisciplinary group of experts from within the state—with appropriate representation of local governments and other non-state-level partners—should be convened to develop the state-level CSC plan.

Function 1. Establishment of CSC Planning Committee. The state health department, as the lead state agency for CSC planning and implementation, should establish and staff at the state level a multidisciplinary (i.e., representing public health, EMS, emergency management, the health care system, community-based practitioners, public safety, and other partners) and transparent state disaster medical advisory committee (SDMAC), with an appropriate balance of local, regional, and state representation, to draft the state CSC plan. An SDMAC or similar committee may already exist in the state. If so, that existing committee, depending on its size and composition, can be expanded or adapted to include the appropriate range of stakeholders for conducting CSC planning.

The development of the CSC plan should ultimately be driven by stakeholders, with the state serving the lead coordinating role in moving the CSC efforts forward and linking various partners. Neither the state, a local government, nor a hospital alone can effectively plan for or respond to catastrophic disasters. Effective CSC planning requires true collaboration at all levels of government, from the local through the state (and even federal) levels, and with the full range of nongovernment stakeholders (e.g., the health care system).

Once the initial plan development has been completed (i.e., after each core function in this template has been completed), the SDMAC can contract to a smaller, technical committee of CSC experts that assumes operational responsibility during CSC incidents or is otherwise available during routine times to inform and advise the state health department, state leadership, and other stakeholders on CSC plan development/improvement, implementation, and recovery issues. The technical committee of CSC experts can also assist regional disaster medical advisory committees and/or regional health care coalitions in engaging in CSC planning. The smaller SDMAC group should identify and have access to a range of other experts (e.g., critical care, burn, radiation injury, pediatrics) during a CSC response to ensure that a comprehensive range of expertise is available.

During this phase of planning, it may also be necessary to promote the importance of a disaster response framework for the state among elected officials and senior (i.e., cabinet-level) state and local government leadership.

Function 2. Plan Drafting. Plan drafting should occur once there is solid state agency and stakeholder (at all levels, from local to state) investment in the CSC planning process and when the state and its stakeholder partners have sufficient background to develop the state plan. The SDMAC should first assess the existing CSC literature and CSC planning efforts (e.g., at the local or health care system level) already occurring within the state and in neighboring jurisdictions, and consult and coordinate with various stakeholders to promote and ensure consistency in intrastate and interstate CSC planning and

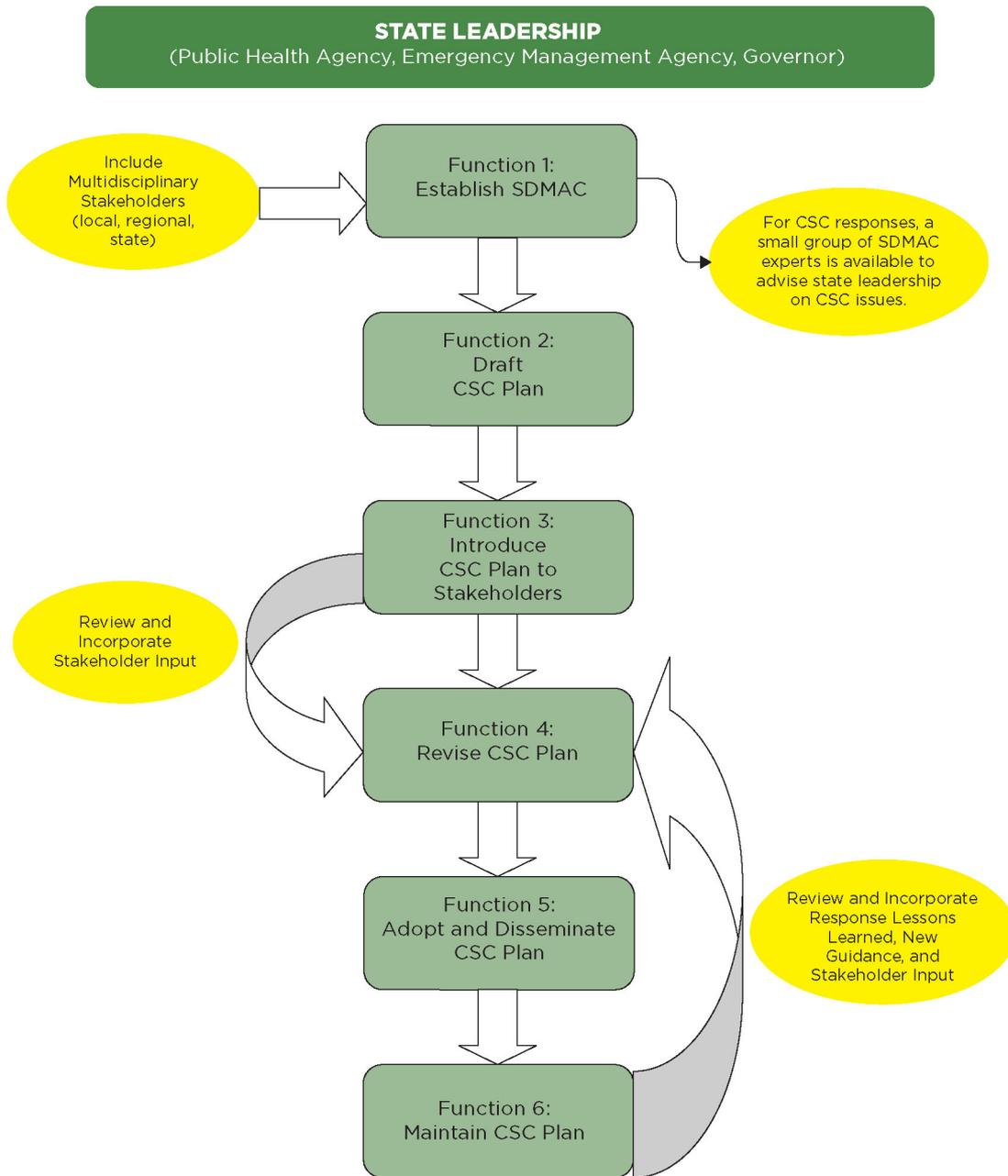


FIGURE 5-3
Core functions for CSC plan development within states.
NOTE: SDMAC = state disaster medical advisory committee.

implementation. The SDMAC should also consult with the state health department general counsel or attorney general’s office, as applicable, to conduct a CSC legal assessment and ensure the development of a legal framework for CSC implementation in the state.

The SDMAC should then begin drafting the CSC plan. The plan should be based on the vision, key elements, and recommendations outlined in the committee’s 2009 letter report and summarized in

Chapter 1 of this report, as well as on the specific recommendations, guidance, and functions set forth in this report. Once the draft plan has been developed, state health department leadership (and other state and local leadership, as applicable) should review the plan and collaborate with the SDMAC on any needed revisions.

Function 3. Plan Introduction and Review—Stakeholder and Public Engagement. As described in detail in Chapter 9, public and stakeholder review of the state CSC plan (or key planning concepts or components of the plan) is critical. Following the state health department’s review of the plan and any needed revisions, the state health department, with the support of the SDMAC, should coordinate the introduction of the draft CSC plan to stakeholders and the public for review and comment.

State health agencies should determine which agency or agencies will assume responsibility for conducting such activities (e.g., state health department or local health departments). Given that such engagement activities will involve community members—whether stakeholders or the lay public—local health departments should be involved as early as possible in the engagement planning process. States also should coordinate with local health departments on the importance of CSC planning and on the planning roles at the state, regional, and local levels; with health care stakeholders (including out-of-hospital practitioners and practitioners affiliated with hospitals, institutions, and coalitions) so they understand their roles and state roles in CSC planning and implementation; and with the public (in particular, at-risk populations).

The state should ensure that findings resulting from state- and locally led public engagement activities are shared with local health departments and other state, regional, and local planning partners, as appropriate, and are used to help inform the state-level CSC planning process and any corresponding regional and local planning efforts. Further, the state health department, with support of the SDMAC, should brief public officials within the state regarding the CSC plan, their roles in a CSC response, and the types of decisions they may need to make during such an incident.

During this review phase, the plan also should be reviewed closely by state legal counsel (e.g., state health department counsel) to ensure that it describes legal authorities appropriately and that recommended actions therein are undertaken in accordance with applicable federal, state, and local laws and regulations (see Chapter 3).

Function 4. Plan Revision. After all public engagement and state (and local, as appropriate) review activities have been completed, the state health department and the SDMAC should carefully review stakeholder input and make appropriate changes before finalizing the CSC plan. Following this review, they should revise the draft plan as needed and should consult with stakeholders about any clarifications or concerns. Where needed, substantive changes should also be reviewed and approved by state officials (e.g., legal counsel should confirm any revisions related to legal authorities).

Function 5. Plan Adoption, Notification, and Dissemination. After the appropriate revisions (based on stakeholder input as described in Function 3 above) have been incorporated into the CSC plan, the plan should be approved and adopted by state health department leadership (and other state leadership, if necessary, depending on the state’s lines of authority). While the state CSC plan will be developed in

collaboration with stakeholders to address and balance the range of state, regional, and local planning needs and issues, the plan itself should be housed and maintained at the state level to ensure that it is accessible to all relevant parties.

For example, the state health department, which is best positioned to maintain the CSC plan, should work with the state EMA to integrate the plan, as applicable, into the state EOP (e.g., in the ESF-8 public health and medical annex), state surge capacity plan or annex, or other appropriate state emergency response plan(s). State health officials should, as appropriate, also provide notice to public officials in the state and other stakeholders (including interstate and federal) about the adoption of the state CSC plan and its processes. In particular, state officials and the SDMAC should ensure that their regional partners (e.g., the RDMAC) and local health agency/local government partners promptly receive the plan for incorporation into regional and/or local CSC planning efforts (e.g., as part of the health and medical annex of the local jurisdiction's EOP). A public version of the plan should be made available on the state health department or other appropriate state agency website.

Function 6. Plan Maintenance. The state health department and the SDMAC will be responsible for ensuring that the state CSC plan is operational and ready for activation through such activities as reviewing and updating the plan on a regular or as-needed basis (e.g., following a CSC or other health emergency to incorporate lessons learned, the issuance of new guidance, and stakeholder input); conducting ongoing education with the public and stakeholders at all levels (local, state, and federal as necessary) and ongoing engagement with public officials at all levels of government about the plan and its implementation; tracking developments in CSC planning and guidance (within and external to the state); conducting workshops, tabletop exercises, and functional exercises involving the state CSC plan at the state, regional, and local levels in conjunction with EMA, public health, and hospital and health care coalition exercises, when possible; soliciting input from stakeholders and the public about the plan, including continuing to conduct public engagement activities, as needed; and notifying stakeholders and the public, as necessary, of any substantive plan updates. The state health department legal counsel (or, as applicable, others at the state level) also should work to revise state legal and regulatory authorities to address CSC needs if necessary.

Template 5.2. Core Functions for Implementing CSC Plans in States During CSC Incidents

This template outlines the recommended functions and tasks associated with implementing the state CSC plan during a catastrophic disaster. It is not intended to provide an exhaustive list of all local, regional, and state emergency management and public health emergency response processes, actions, and requirements. Rather, it focuses on the core functions that encompass the full range of a CSC-level response, from alerting and activation through demobilization of the plan and recovery.

While the full SDMAC will have a pivotal role during the state CSC planning phase (Template 5.1), the authorities and responsibilities of the state health department and other state (and local, as applicable) agencies and leadership include assuming the lead in the response to a CSC incident. However, a pre-established technical subgroup of the SDMAC should be available throughout the incident to advise state leadership on CSC response issues.

Function 1. Alerting and Activation. The state health department and state EMA should be able to receive and manage emergency alerts and requests from stakeholders (in particular, from local health department/local government, health care, and emergency management partners) that may trigger activation of the state CSC plan. If the state receives emergency information that indicates the need to activate its CSC plan, the state health department, as the lead state agency for CSC, should activate and, throughout the emergency, consult with the technical subgroup of the SDMAC, as well as with applicable state (e.g., governor, state EMA) and local (e.g., mayor, county executive, local health department) leadership, to assess the emergency and make an informed decision about activation of the state-level CSC plan.

Plan activation and response actions should follow established emergency management processes, including ensuring that the appropriate state and local emergency declarations (e.g., public health emergency, catastrophic health emergency, state of emergency, or civil defense emergency, depending on the jurisdiction) are made or requested. The state health department should activate components of the state CSC plan based on the above assessment and on the ethical principles and indicators and triggers outlined in the plan (see Figure 5-4).

Concurrently with activation of the state CSC plan, the state health department and state EMA should support and work closely with local and regional partners to activate local and/or regional emergency planning and response committees, EOCs, emergency plans (including any local CSC response plans based on the state plan), and mutual-aid agreements, as applicable. State legal counsel also should be consulted closely on a range of legal issues, including the use of response authorities, various response actions, existing or needed liability protections, and regulatory requirements (or waivers thereof) (see Chapter 3).

Function 2. Notification. It is the responsibility of the state health department and state EMA to provide immediate notification—through pre-established, redundant, and interoperable communication systems—of activation of the state CSC plan and any related emergency declarations, and to provide access to the plan (e.g., via the state health department and state EMA websites) to applicable local, regional, state, federal, and private-sector stakeholders (e.g., state and local public officials, state health department and EMA staff, local health departments, local EMAs, health care entities, interstate and federal partners). In turn, these stakeholders should collaborate closely with their response partners to ensure full and prompt awareness of plan implementation.

The state health department, or other state agency as appropriate, also should provide timely and consistent notification to the media and the public about the emergency situation and CSC plan activation. Risk communication should focus on sustaining and building the public's trust by clearly addressing what the problem is; what is being done; what is the expected duration/solution; where they can go (or should not go) to receive health care; what emergency declarations have been issued; how public safety, health services, and public health will be affected; and what is not currently known (see also Function 4 below).

Function 3. Command and Control, Communications, and Coordination. For *command and control*, the state EMA (with, as applicable, support of the state health department as the lead state agency for

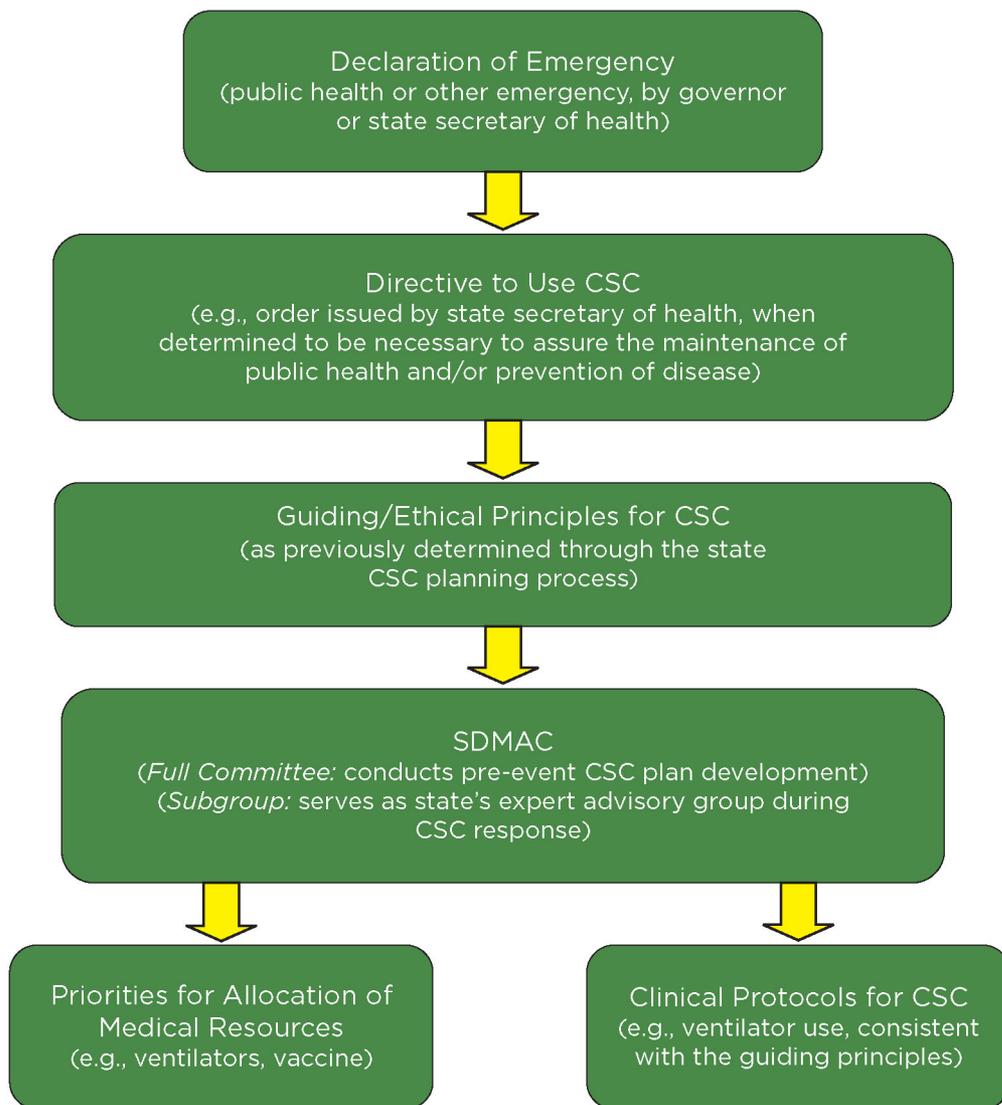


FIGURE 5-4
Example algorithm to frame state CSC implementation actions and decisions.
SOURCE: Levin et al., 2009.

CSC) implements/expands the ICS consistent with incident-driven demands and activates the state EOC at a level appropriate to the situation. The state EMA provides support and makes recommendations, as needed, to local and regional EMAs on activation of local and regional EOCs and response plans. The state EMA and state health department also ensure that command staff are trained in CSC plan components and response and understand their roles, as well as the roles of local, regional, state, and federal stakeholders, in the state's CSC response. States and local jurisdictions that have public health department EOCs should activate and ensure appropriate operation of such operations centers (including providing notification of EOC activation to response partners).

For *communications*, the state should have established policies and procedures for providing, receiv-

ing, and maintaining information that enables situational awareness throughout the CSC response and for communicating that information to stakeholders at all levels (e.g., through health alert networks, e-mail, text messaging, paging, telephone, amateur radio, satellite telephone, fax, social media). It is critical that the state have the ability to maintain proactive and transparent bidirectional communications throughout the CSC incident with the public, media, and stakeholders at the local through the state level.

For *coordination*, the state EMA and command staff, in collaboration with the state health agency, should be capable of serving as the interface for resource requests and managing the acquisition or donation process (as well as any existing plans for resource triage/allocation) (e.g., through the EMAC) with response partners. In addition, many substate regional health care coalitions that have established their Medical Surge Capacity and Capability Tier 2 support Medical Advisory Committees can use them to assist in the coordination of medical resources, including beds, supplies, and situational awareness. All response partners in the state also should be able to document response actions, including the tracking of resources, expenses, and lessons learned. States and local jurisdictions with public health department EOCs that are integrated into the state's or local jurisdiction's overall emergency management system should coordinate, as applicable, health care resource requests and allocations.

Function 4. Public Information. Because of its lead CSC role and expertise in public health and medical issues, the state health department should be responsible for overseeing the development of public and risk communication messaging at the state level. To facilitate timely and consistent risk communication during a CSC emergency, the state health department and state EMA should leverage pre-existing relationships with applicable media partners and communication processes and mechanisms (e.g., websites, calling programs, e-mail, social media). The state EMA and/or state health department (depending on pre-established risk communication roles in the state) should coordinate the dissemination of risk communication messages and participate in joint information system and joint information center activities. Independent local health departments (e.g., an independent health department for a large city), other local health departments (as applicable, based on the public health department structure within the state), or local government agencies also should be responsible for public and risk communication messaging for their jurisdictions in coordination with state messaging (and vice versa). Given the critical need for communication processes to be coordinated, state agencies should make every effort to work with local and other partners to ensure that messaging is appropriate, consistent, and effective.

Function 5. Operations. CSC operations occurring within a state should be considered in the context of the continuum of care (i.e., from conventional to contingency to crisis) (Figure 5-5; see also Chapter 2). For *conventional care* situations, government response partners should understand the roles and authorities of health care sector partners in augmenting emergency medical care through medically approved triage, treatment, and transport protocols and in using normal modes of transportation, staffing, and equipment, including mutual-aid agreements. Government response partners also should coordinate and provide guidance on the delivery of care for health care providers, as applicable.

For *contingency care* situations, government response partners should understand how to implement

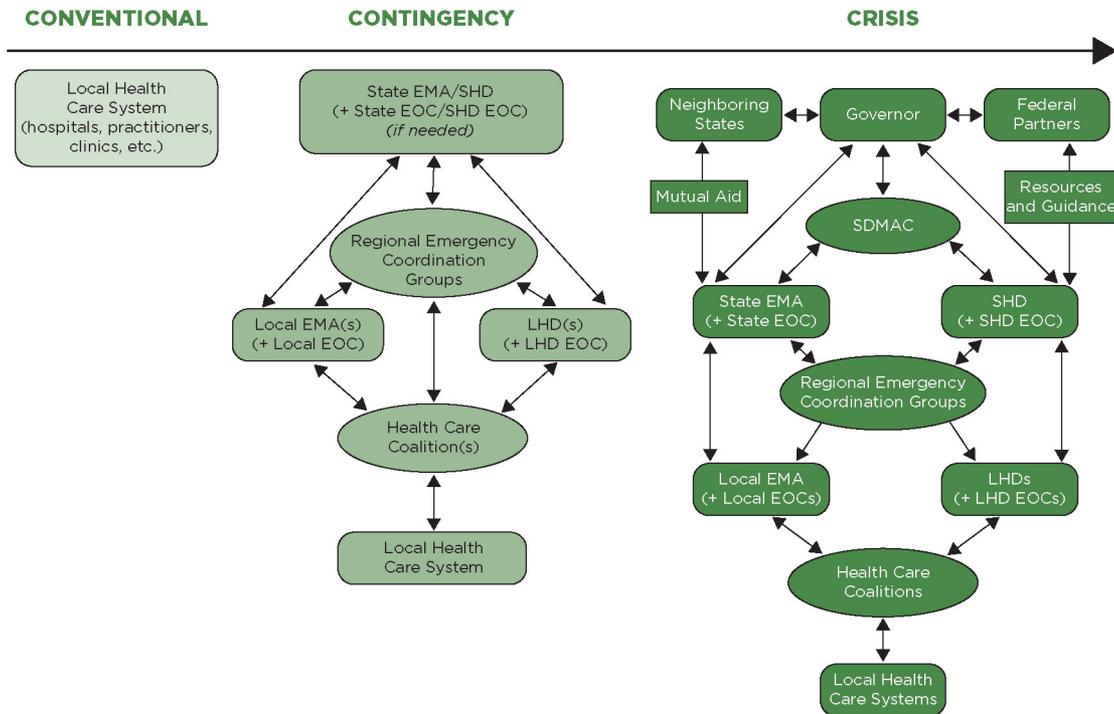


FIGURE 5-5

State response structure along the continuum of care: Conventional to crisis.

NOTE: EMA = emergency management agency; EOC = emergency operations center; LHD = local health department; SHD = state health department; SDMAC = state disaster medical advisory committee.

response plans and intrastate and interstate mutual-aid agreements to substitute, conserve, and adapt staffing, transportation, patient triage, and destinations. They also should coordinate and provide guidance on the delivery of care for health care providers, as applicable.

For *crisis care* situations, government response partners should understand how to execute mass casualty, surge capacity, and CSC plans to maximize resources for meeting broad public health needs; should coordinate and provide guidance on the delivery of care under CSC for health care providers; and, as appropriate, should be able to link to and coordinate with federal and interstate response partners. Given the critical need for operations to be coordinated, state agencies should make every effort to work with local, regional, and other relevant partners to ensure that operations are appropriate and effective.

Although *mental health* resources are limited in many jurisdictions, mental health care under CSC will require specific competencies among mental health, social services, and health care staff (discussed in detail in the mental health section of Chapter 4). Simultaneously, efforts should be made to enhance community resilience through “neighbor-to-neighbor, family-to-family” support systems (such as by applying certain psychological first aid models specifically created for use by community members) as needed. The resilience of the health care workforce, including those in emergency medical services (EMS), is paramount to the success of the state’s CSC strategy.

One-time, one-size-fits-all approaches, such as some stress debriefing once common in EMS settings, no longer are recommended and may result in exacerbating the mental health problems of those most affected by a crisis (Bisson et al., 1997, 2007; IASC, 2007; McNally et al., 2003; NIMH, 2002). Those approaches have been replaced by more integrated preparedness efforts to enhance the resilience of the workforce specifically around mass casualty events, as part of CSC preparedness, by addressing their needs during response and recovery (Schreiber and Shields, 2012).

Integrated mental health operations should be a part of EMS incident command operations within overall ICS/EOC and medical/health operations. Recent models developed for Los Angeles County, Seattle/King County, the American Red Cross's National Operations Center/Disaster Mental Health, and a national prototype specifically for children utilize real-time situational awareness of triage for mental health risk among patients and disaster victims and responders (including health care workers, EMS workers, and their families). This includes situational awareness across various disaster systems of care (e.g., hospitals, schools, shelters, public health settings) to guide mental health operations within the ICS (Schreiber et al., in press). Also recommended is a common operating picture of

- population-level mental health risks (traumatic loss, multiple traumatic losses), using a common rapid mental health triage system across disaster systems of care, including EMS;
- mental health risks among EMS and health care workers; and
- mental health resources, including the use of emerging national models of Internet-based intervention (Ruggiero et al., 2006).

Addressing the social and psychological challenges of CSC requires the use of the triage-driven mental health incident management system, as well as community resilience efforts based on community engagement during the CSC planning phase (see Chapter 9). Also required are basic “neighbor-to-neighbor, family-to-family” psychological first aid competencies that leverage community members, responders, and family members as the first line of psychosocial support (see the American Red Cross’s “Coping in Times of Crises” and the “Listen, Protect and Connect” psychological first aid models).

The state CSC response also should address *palliative care* for all patients. The response should encompass palliative care principles and triage tools, supply issues for patients (including those who will not receive other treatment modalities), and recommendations for management of fatalities (see the palliative care section of Chapter 4). It is the state’s responsibility to provide information on palliative care training (including just-in-time training) to stakeholders and public information on palliative care (including the management of at-home deaths) during the response. In addition, the state needs to work with partners to ensure that appropriate palliative care is available during a CSC response.

Finally, the state CSC response should include working in close collaboration with local agencies to identify and address the functional needs of *at-risk populations*, including certain patient groups (e.g., pediatric, maternal, burn, elderly), as well as specific linguistic, cultural, ethnic, and other groups (Andrulis et al., 2007, 2011; Drexel University Center for Health Equality, 2008) that may require special consideration with respect to risk communication, transportation, treatment, equipment, and supplies. To ensure that such needs are appropriately met, the state should conduct a preliminary needs

assessment at the outset of the CSC incident and continually monitor, assess, and provide support for the needs of these populations throughout the response in collaboration with local and regional partners.

Function 6. Logistics. Logistics for a CSC response can be organized around staff, supplies, and space. Given the critical need for logistics to be coordinated, state agencies should make every effort to work with local, regional, and other partners (including the private sector) to ensure that logistics are appropriate and effective.

For *staff*, government response partners should have a clear understanding of the available staffing resources and needs within the state and utilize a resource monitoring system to track those resources. When staffing resources are needed, government response partners should understand when to activate mutual-aid agreements and utilize established legal processes for supplementing and allocating the workforce (e.g., through the Medical Reserve Corps, the ESAR-VHP, state strike teams, NDMS teams, scope-of-practice expansions). Government response partners also should help ensure the safety of their staff and of responders and their family members by providing personal preparedness training.

For *supplies*, government response partners should understand the types and locations of applicable resources (e.g., stockpiles of medical countermeasures, equipment trailers) available within the state and whether such resources fall under mutual-aid agreements. They also should know the processes for appropriately requesting, accepting, and utilizing resources from other jurisdictions (e.g., through EMAC) and from federal partners (e.g., SNS assets, NDMS teams), as well as how to donate resources to other jurisdictions. For highly at-risk supplies, government response partners can identify and share with applicable stakeholders strategies for their appropriate substitution, conservation, adaptation, reuse, and reallocation, and also utilize resource tracking methods to monitor the availability of applicable resources during the CSC response.

For *space*, government response partners should have awareness of the types and locations of applicable space resources related to CSC and the alternate care system in the state (see Chapter 8). They also should have systems for tracking available beds and alternate patient care space (e.g., beds in storage, cots, beds for lease, and other potential sources); be capable of accepting requests for such space; and develop plans for maximizing available space and converting non-patient care areas to patient care, as necessary. Government response partners, particularly at the state level, should be capable of making the necessary legal and regulatory changes (and coordinating with federal health care facility regulators, as applicable) to authorize the use of alternate patient care space during a CSC incident.

Consistent with broader surge capacity planning, the development of an outpatient capability will be important in helping to defray the patient surge at hospitals, thereby reducing the likelihood that, if not simply the time within which, a community must transition from conventional to contingency and to crisis response. The planning and execution of the development of alternate care system functions should be government driven and involve the coordination and collaboration of both public and private health care and non-health care partners. Preferential use of municipal buildings may help expedite the planning. Coordination with the private health care sector will be necessary, particularly in supporting staffing needs and the development of medical care protocols and related medical expertise.

Function 7. Termination, Demobilization, Recovery, and Evaluation. With support of the SDMAC, the state health department and state EMA, as well as local government response partners, should understand when to deactivate or scale down the state CSC plan and what their roles in deactivation are. Through established communication systems, they will need to notify stakeholders, media, and the public of the rationale for deactivating the state CSC plan and shifting back to contingency or conventional care, and what such deactivation means. If possible, health care stakeholders should receive advance notice of deactivation so they can plan appropriately for the shift to contingency or conventional care. Given the critical need for demobilization efforts to be coordinated, state agencies should make every effort to work with local and other partners to ensure that demobilization activities are appropriate and effective.

To document response efforts and improve future disaster responses, government response partners in the state, with support of the SDMAC, should coordinate a comprehensive evaluation of the response, including developing an after-action report and implementing improvement plan items. This documentation should be coordinated with appropriate other players in the response, including regional partners and local government, as well as health care and other partners. Government response partners also should understand their roles in the recovery phase, including ongoing mental health operations for the public and for health care practitioners.

Template 5.1. Core Functions for CSC Plan Development (Within States)

Function 1. Establishment of CSC Planning Committee

Notes and Resources

Task 1

State public health agency is identified as the lead state agency for CSC planning and implementation.

Task 2

State health department establishes and staffs a state-level, multidisciplinary, and transparent state disaster medical advisory committee (SDMAC) to draft the state CSC plan. During a CSC response, a smaller, technical subgroup of the SDMAC is available to serve as an operational, expert advisory body to inform and advise the state health department, state leadership, and other stakeholders on CSC plan development, implementation, and recovery issues.

Full SDMAC meets as needed. Full SDMAC CSC plan drafting group includes a broad range of stakeholders, such as

- state health department;
- local health departments and other local government agencies;
- state emergency management agency (EMA);
- state homeland security office;
- health care (including SDMAC members if such a committee already exists, regional medical coordination centers or regional DMACs [RDMACs], health care coalitions, private practitioners, hospitals, health care systems, specialty hospitals, professional boards and associations, and emergency medical services [EMS]);
- medical examiner;
- ethics experts;
- attorneys;
- academics;
- community members;
- representatives of at-risk populations (e.g., pediatric, mental health);
- governor's office;
- National Guard;
- Department of Veterans Affairs (VA) health care facilities (if located within the state);
- Department of Defense (DOD) health care facilities (if located within the state); and
- others as applicable (including federal partners, such as Department of Health and Human Services [HHS] regional emergency coordinators [RECs]).

An SDMAC or similar committee may already exist in the state. If so, that existing committee can be adapted to conduct CSC planning, ensuring that its membership includes the appropriate range of stakeholders. After the planning phase, the SDMAC can contract to a smaller, technical subgroup that assumes operational responsibility for advising the state during CSC incidents.

Task 3

SDMAC recommends to the state the CSC response structure that would work best in the state (e.g., based on existing structures,

strengths, and authorities of public health, emergency management, and health systems within the state).

Function 2. Plan Drafting

Notes and Resources

Task 1

SDMAC assesses existing CSC literature, plans, guidance, and planning efforts, including CSC efforts already occurring within the state (e.g., led by local jurisdictions or health care facilities/systems) and in neighboring jurisdictions.

Task 2

SDMAC consults and coordinates, as applicable, with stakeholders involved in existing health care facility, local, and regional (including regional medical coordination center or RDMAC) CSC planning efforts within the state—and in neighboring states—to promote and ensure consistency in intrastate and interstate CSC planning and implementation processes. State health department (and the SDMAC, as applicable) engages with local health departments on the importance of—and their role in—CSC planning and implementation.

Task 3

SDMAC consults and coordinates with the state health department general counsel/attorney general's office, as applicable, to conduct a CSC legal assessment by identifying and developing an inventory of applicable federal, state, and local legal authorities and regulations (and identifying areas that need strengthening) applicable to CSC, including those related to the following (see also Chapter 3):

- emergency declarations,
- sources of liability,
- liability protections,
- licensing and credentialing,
- mutual aid agreements,
- scopes of practice,
- regulation of the state's health care facilities and practitioners (including regarding care provided at alternate care sites during CSC conditions), and
- dispute resolution regarding CSC decisions.

Task 4

Following state agency and stakeholder investment in the CSC planning process, and when the state has sufficient background to develop the plan, SDMAC drafts the state CSC plan. At all levels, the CSC plan should include the following key elements:

- ethical considerations;
- community and provider engagement, education, and communication;
- legal authority and environment;
- indicators and triggers; and
- clinical processes and operations.

More detail is provided about each of the five key elements in the chapters indicated below:

- Ethical considerations—Chapter 4
- Community and provider engagement, education, and

Specifically, the plan should

- establish lines of authority and clear roles and responsibilities of stakeholders (e.g., state health department, local health departments, state EMA, local EMAs, EMS, health care, federal partners);
- identify clinical and administrative triggers for activating and terminating state CSC plan components (e.g., following local health department or local EMA reports of specific indicators of health care surge, critical infrastructure disruption, failure of contingency surge capacity; following a formal declaration of emergency by the governor and activation of the state CSC plan by the state health department), and identify indicators to prompt consideration of plan activation;
- establish connectivity and uniformity, as applicable, with local, regional, interstate, and federal CSC planning efforts to ensure consistency in CSC planning and implementation;
- identify, in collaboration with state and local EMAs, communication systems for ensuring connectivity during a CSC incident;
- incorporate risk communication strategies specific to catastrophic disaster response that include coping messages;
- identify processes for coordinating and facilitating resource requests and allocations (e.g., define role of state EMA in managing requests and allocations within and across states and with federal assets);
- ensure that local and state response plans include clear provisions that permit adaptations of EMS systems under disaster response conditions, including changes in protocols, practices, and personnel;
- establish routine and crisis monitoring/reporting mechanisms for documenting and analyzing normative levels of seasonal and incident-based health care demand, resources, capacity, and staffing at local, regional, and state levels;
- acknowledge the state role in determining when public alternate care sites are needed, and provide the leadership to support their opening and operation (see Chapter 8);
- promote collaboration with federal partners (e.g., HHS/Office of the Assistant Secretary for Preparedness and Response [ASPR], HHS RECs) and consistency in scope of care for federally deployed Emergency Support Function (ESF)-8 assets (i.e., across federal teams and with the state and local entities these federal teams support);
- integrate palliative care planning and resource/knowledge assessment into planning and educational processes (see Chapter 4); and
- address the needs of at-risk populations (e.g., mental health patients including responders and their families; pediatric populations) (see Chapter 4) through specific concept of operations (CONOPS) components, and include a “responder resilience” system for all responders.

communication—
Chapter 9

- Legal authority and environment—
Chapter 3
- Indicators and triggers—Chapter 7
- Clinical processes and operations—
Chapter 7

Task 5

State health department leadership reviews the state CSC plan and collaborates with the SDMAC on revising the plan, if needed, prior to

its introduction and stakeholder/public engagement (as outlined in Function 3).

Function 3. Plan Introduction and Review—Stakeholder and Public Engagement

Task 1

State health department, with the support of the SDMAC, continues to engage regularly with local health departments on CSC planning. Local health departments

- understand their role in CSC planning and response;
- understand the role of local health care stakeholders in CSC planning and response;
- understand state CSC processes;
- understand applicable federal, state, and local legal authorities and existing mutual aid agreements and processes; and
- have the opportunity to review and provide comments on the draft state CSC plan.

Task 2

State health department, with the support of the SDMAC, continues to engage with health care stakeholders (including practitioners, institutions, and coalitions) on CSC planning. Health care stakeholders

- understand their role in CSC planning and response,
- understand state and local CSC planning and response roles and processes, and
- have the opportunity to review and provide comments on the draft state CSC plan.

Task 3

To engage the public (including at-risk populations), state health department, with support of the SDMAC (see Chapter 9),

- determines when to conduct, and which agency or agencies will assume responsibility for coordinating and conducting, public engagement activities (i.e., state health department or local health departments);
- ensures that meaningful public engagement activities occur;
- applies public engagement findings to help inform the state CSC plan;
- shares public engagement findings with local health departments throughout the state to help inform local and regional CSC planning efforts; and
- makes a summary of the draft state CSC plan available for public review and comment.

Task 4

State health department, with support of the SDMAC, briefs applicable public officials within the state on the CSC plan and their roles in a CSC response.

Task 5

State CSC plan is reviewed by state legal counsel (e.g., state health

department counsel) to ensure that the plan describes legal authorities appropriately and that recommended actions in the plan are undertaken in accordance with applicable federal, state, and local laws and regulations (see Chapter 3).

Task 6

State health department and the SDMAC review input from Function 3 actions and update the draft state CSC plan as needed.

Function 4. Plan Revision

Task 1

State health department and the SDMAC carefully review the input of stakeholders, the public, and legal counsel before finalizing the state CSC plan.

Task 2

Following this review, state health department and the SDMAC revise the draft plan as needed and, as appropriate, consult with stakeholders about any clarifications or concerns. Where needed, substantive changes are reviewed and approved by the appropriate state officials.

Function 5. Plan Adoption, Notification, and Dissemination

Task 1

State health department leadership approves and adopts the CSC plan, and works with the state EMA to integrate it into the state emergency operations plan (EOP) (ESF-8 public health and medical annex) and state surge capacity plan/annex or other state emergency response plan(s), as applicable.

Task 2

State health department notifies public officials of plan adoption; state health department informs applicable stakeholders (including interstate and federal) about plan adoption and processes. In particular, local health departments and local EMAs are informed of the plan's adoption and are provided the plan so they can incorporate it into local emergency planning efforts (e.g., local EOP health and medical annex or surge plan for local implementation of the state CSC plan) and inform their local response partners (especially the health care community). Legal issues related to CSC are disseminated to legal partners (e.g., the judicial system through bench books; hospital legal counsel).

Task 3

State and local health departments support health care facility and system surge capacity and planning efforts, including by developing protocols and plans for allocation of scarce resources so these plans can coalesce at the regional hospital coalition level.

Task 4

State health department makes a public version of the state CSC plan available on the state health department website for public access.

Function 6. Plan Maintenance

Task 1

State health department and the SDMAC ensure that the state CSC plan is operational and ready for activation by

- conducting ongoing education with stakeholders, public officials, and the public about the plan and its implementation;
- tracking developments in CSC planning and guidance (within and external to the state), developing a process for continuous assessment of routine and catastrophic disaster response capabilities based on existing information and knowledge management platforms, and creating a mechanism for ensuring that CSC milestones are being achieved;
- conducting annual workshops, tabletop exercises, and functional exercises involving the state CSC plan at the interstate, state, regional, and local levels in conjunction with state/local EMA, public health, hospital, and federal exercises and partners, when feasible;
- reviewing and updating the plan on a regular basis or as needed (using information gained through provider and community engagement and through exercises and actual emergencies) as elements of a disaster planning process improvement cycle;
- soliciting input from stakeholders and the public about the plan, including continuing to conduct public engagement activities, as needed; and
- notifying stakeholders and the public, as necessary, of any substantive plan updates.

Task 2

State health department general counsel (or others at the state level) work to revise state legal and regulatory authorities to address CSC needs if necessary (see Chapter 3).

Template 5.2. Core Functions for Implementing CSC Plans in States During CSC Incidents

Function 1. Alerting and Activation

Task 1

State health department and the state emergency management agency (EMA) are able to receive and manage emergency alerts that may trigger activation of the state CSC plan from stakeholders, including local public health, health care, and emergency management partners.

Task 2

Upon receiving emergency information suggesting the need for activation of the state CSC plan, state health department (as the lead state agency for CSC) activates and consults with the state disaster medical advisory committee (SDMAC), and also consults with applicable state (e.g., governor, EMA) and local (e.g., mayor, local health department) leadership to assess the situation and make a determination on activation of the state CSC plan. Routine and crisis monitoring and reporting mechanisms are developed to establish local, regional, and state normative levels of seasonal/incident-based demand, resources, capacity (beds), and staffing.

Task 3

Before or concurrently with health department activation of the state CSC plan, state health department ensures that applicable state and local emergency declarations (e.g., public health emergency, catastrophic health emergency, state of emergency, or civil defense emergency, depending on the jurisdiction) are made or requested; the state also understands applicable federal, state, and local legal authorities and regulations (see Chapter 3).

Task 4

State health department activates components of the state CSC plan based on indicators and triggers outlined in the plan and on the assessment performed under Task 2 above; the state health department and state EMA also work with state, regional, and local partners to activate local and/or regional CSC or other emergency plans and mutual aid agreements, as applicable.

Task 5

Throughout the emergency, SDMAC members are available to the state for consultation, and the state health department and SDMAC are able to continually assess the situation, including whether the state CSC plan should remain activated.

Function 2. Notification

Task 1

State health department and the state EMA provide immediate notification through pre-established communication systems

of activation of the state CSC plan (and any related emergency declarations). They also provide access to the plan (e.g., via the state health department website) to applicable local, regional, state, federal, and private-sector stakeholders, including

- public officials;
- state health department staff;
- state EMA staff;
- local health departments and other local government agencies;
- local EMAs;
- health care entities (e.g., regional medical coordination centers or regional DMACs, local clinical care committee[s] and triage team[s], health care coalitions, private practitioners, hospitals, health care systems, specialty hospitals, mental health agencies, professional boards and associations, and emergency medical services [EMS]);
- interstate partners (e.g., neighboring states); and
- federal partners (e.g., Department of Health and Human Services [HHS] regional emergency coordinators [RECs]).

Task 2

State health department (or other state agency, as appropriate) notifies media and the public of the emergency situation and CSC plan activation, including what the problem is; what is being done; what is the expected duration/solution; what emergency declarations have been issued; and how public safety, health services, and public health will be affected.

Task 3

State EMA and the state health department ensure that notification mechanisms account for redundancy and interoperability in the event the disaster affects usual means of contact.

Function 3. Command and Control, Communications, and Coordination

Command and Control

Task 1

State EMA (with, as applicable, support of the state health department as the lead state agency for CSC) implements/expands the incident command system (ICS) consistent with event-driven demands and activates the state emergency operations center (EOC) at a level appropriate to the situation. The state EMA makes recommendations, as needed, to local EMAs on activation of local EOCs and response plans (see Chapter 6).

Task 2

State EMA and the state health department ensure that command staff

- are trained in CSC plan components and response;
- understand their roles, as well as the roles of local, regional, state, and federal stakeholders, in the state CSC response;
- are well versed in incident action planning during longer-term events;

- have access to appropriate resources (e.g., job aids) to guide decision making; and
- understand the role of the SDMAC and any regional medical coordination centers or regional DMACs, as well as the means by which information is received by or communicated to these bodies.

Communications

Task 3

State has policies and procedures in place for providing, receiving, and maintaining information that enables situational awareness throughout the response and for communicating information to stakeholders through a range of communication systems (e.g., Internet, radio, social media).

Task 4

State should have the ability to maintain proactive and transparent communications throughout the CSC incident with the public, media, and stakeholders, including

- state agencies and leadership;
- local health departments;
- local EMAs;
- the health care system (e.g., regional medical coordination centers or regional DMACs, local clinical care committees and triage teams, health care coalitions, private practitioners, hospitals, health care systems, specialty hospitals, professional boards and associations, and EMS);
- interstate partners (e.g., neighboring states); and
- federal partners (e.g., HHS RECs)

Task 5

State EMA and the state health department ensure that communication systems account for redundancy and interoperability in the event the disaster affects usual means of contact.

Coordination

Task 6

State EMA and command staff, in collaboration with the state health department, are capable of serving as the interface for resource requests and managing the acquisition or donation process (as well as any existing plans for resource triage/allocation) (e.g., through the Emergency Management Assistance Compact [EMAC]) with

- local health departments and local EMAs;
- local/regional health care coalitions;
- other intrastate and regional partners, as well as interstate partners; and
- federal partners (e.g., HHS).

Task 7

State health department, the state EMA, and other state agencies, as applicable, are capable of documenting response actions, including tracking of resources and expenses.

Function 4. Public Information

Task 1

State health department and the state EMA implement (and adapt as needed for the emergency) pre-established risk communication plans for routine and catastrophic disaster response.

Task 2

State health department and the state EMA leverage pre-existing relationships with applicable media partners to facilitate risk communication during the emergency.

Task 3

State health department and the state EMA have processes and mechanisms in place to ensure appropriate and timely risk communication and consistent messaging to the public via the media (e.g., websites, calling programs, e-mail, social media).

Task 4

State health department coordinates the development of messaging for public information/risk communication efforts (including where to direct those interested in volunteering for the response).

Task 5

State EMA and/or the state health department (depending on pre-established risk communication roles in the state) coordinate risk communication and participate in joint information system and joint information center activities.

Function 5. Operations

Conventional Operations

Task 1

For conventional care situations, state understands the roles and authorities of health care sector partners in augmenting emergency medical care through medically approved triage, treatment, and transport protocols and in using normal modes of transportation, staffing, and equipment, including mutual aid agreements. The state also coordinates and provides guidance on the delivery of care for health care providers, as applicable. Sharing of resources through mutual aid agreements and mechanisms is encouraged/promoted.

Contingency Operations

Task 2

For contingency care situations, state understands how to implement various applicable emergency response plans and intrastate and interstate mutual aid agreements to substitute, conserve, and adapt staffing, transportation, patient triage, and destinations. The state also coordinates and provides guidance on the delivery of care for health care providers, as applicable. Sharing of resources through mutual aid agreements and mechanisms is encouraged/promoted.

Notes and Resources

See Chapter 2 of this report and the committee's 2009 letter report for additional detail on conventional, contingency, and crisis care.

Crisis Operations

Task 3

For crisis care situations, state understands how to execute mass casualty, surge capacity, and CSC plans to maximize resources for meeting broad public health needs (including the institution and authorization of alternate care systems). The state also coordinates and provides guidance on the delivery of care under CSC for health care providers. To the extent feasible, sharing of resources through mutual aid agreements and mechanisms is encouraged/promoted.

Mental Health

Task 4

State utilizes a disaster mental health concept of operations, including the following features:

- provides a rapid mental health triage/incident management system linking local, regional, and state disaster systems of care, including health care facilities and mental health resources, in incident command operations;
- provides for access to a continuum of evidence-based interventions for adults and children;
- provides training in basic “neighbor-to-neighbor, family-to-family” psychological first aid with triage for the general public and health care workers;
- provides CSC-specific behavioral coping components for risk communications;
- completes a CSC gap analysis with a plan for enhancing local disaster mental health and spiritual care capacities and capabilities; and
- develops a health care worker resilience system with integrated triage and referral components.

Mental Health section of Chapter 4 of the report provides a more detailed discussion and examples.

Palliative Care

Task 5

State CSC response addresses palliative care for all patients, including palliative care principles and triage tools, supply issues for patients (including those who will not receive other treatment modalities), and planning for management of in-home deaths as part of the state mass fatality plan.

Task 6

State provides information on palliative care training (including just-in-time training) to stakeholders during the response.

Task 7

State provides public information on palliative care, including management of at-home deaths, during the response.

At-Risk Populations

Task 8

State CSC response identifies and addresses patient groups (e.g., pediatric, maternal, burn, elderly, non-English-speaking) requiring

special consideration for risk communication, transportation, treatment, equipment, and supplies.

Task 9

State conducts a preliminary assessment of needs of at-risk populations at the outset of the CSC incident, and continually monitors, assesses, and provides support for these populations' needs throughout the response in conjunction with local resources.

Function 6. Logistics

Staffing

Task 1

State understands available staffing resources and needs within the state (including for alternate care sites) and utilizes resource monitoring system(s), as available, to track staffing resources.

Task 2

State understands when to activate mutual-aid agreements and utilizes established legal processes for supplementing and allocating the workforce, including for appropriate use in alternate care sites.

Task 3

State ensures that agency call-back criteria and policies are in place and maintains current and accurate employee contact information.

Task 4

State ensures that staff receive personal preparedness training to assist with family needs and are prepared for on-site accommodation of staff and family members, as appropriate.

Notes and Resources

Task 2 examples include the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), state strike teams, National Disaster Medical System (NDMS) teams, and scope of practice expansions.

Supplies

Task 5

State understands the types and locations of applicable resources (e.g., medication caches, equipment trailers) available within the state (and whether such resources fall under mutual-aid agreements). The state also understands how to appropriately request, accept, and utilize resources from other jurisdictions (e.g., through EMAC) and from federal partners (e.g., Strategic National Stockpile [SNS] assets).

Task 6

State assesses and identifies, in collaboration with its local and regional partners, key potential scarce resources based on the type of event and the availability of stockpiled or identified alternative sources for these supplies.

Task 7

State identifies and shares with applicable stakeholders strategies for appropriate substitution, conservation, adaptation, reuse, and reallocation of highly at-risk supplies.

Task 8

State utilizes a resource tracking method to monitor the availability of applicable resources for the CSC response.

Space

Task 9

State understands the types and locations of applicable space resources related to CSC/alternate care sites in the state, including sites that may be established on the premises of a health care facility (see Chapter 8).

Task 10

State and local health departments track available beds and alternate patient care space (e.g., beds in storage, cots, space for lease, and other potential sources); accept requests for such space; and develop plans to maximize available space in patient care locations and convert non-patient care areas to patient care, as necessary (see Chapter 8).

Task 11

State makes appropriate legal and regulatory changes, as needed, to authorize use of alternate care sites during the CSC incident (see Chapter 3).

Function 7. Termination, Demobilization, Recovery, and Evaluation

Task 1

State health department and the state EMA, with support of the SDMAC, understand when to deactivate the state CSC plan and what their roles in deactivation are.

Task 2

State health department and the state EMA, with support of the SDMAC, notify stakeholders, media, and the public of reasons for deactivation of the state CSC plan and what such deactivation means through established communication systems.

Task 3

State health department and the state EMA, with support of the SDMAC, coordinate response evaluation, development of an after-action report, and implementation of improvement plan items so there is a continuous feedback loop for strengthening the state CSC plan.

Task 4

State health department and the state EMA, with support of the SDMAC, understand their roles in CSC recovery, including ongoing mental health operations.

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