

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.

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

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

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.

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.

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.

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.