

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ESF-8 PLAN:
**CATASTROPHIC INCIDENT RESPONSE
ANNEX**

March 2018

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ACRONYMS/TERMS

ACS	Alternate Care Site
APA	American Pharmaceutical Association
ARC	American Red Cross
ASPR	Assistant Secretary of Preparedness and Response
ATS	Alternate Treatment Site
CEMP	Comprehensive Emergency Management Program
CIR	Catastrophic Incident Response
CMS	Centers for Medicare and Medicaid Services
DCFS	Department of Children and Family Services
DHHS	U.S. Department of Health and Human Services
DSCC	Division of Specialized Care for Children
EMA	Emergency Management Agency
EMAC	Emergency Medical Assistance Compact
EMS	Emergency Medical Services
EMTALA	Emergency Medical Treatment and Labor Act
EMTrack	Commercial electronic multi-functional tracking system
EOC	Emergency Operations Center
ESAR-VHP	Emergency System for Advance Registration of Volunteer Health Professionals
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
HAM	Amateur radio
GLHP	Great Lakes Healthcare Partnership
HAv-BED	Hospital Available Beds for Emergencies and Disasters
HCC	Health Care Coalition
HHS	Health and Human Services
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act
HPP	Hospital Preparedness Program
IA	Iowa
IAACCT	Illinois Association of Air and Critical Care Transport
ICAAP	Illinois Chapter of American Academy of Pediatrics
ICAHN	Illinois Critical Access Hospital Network
ICEP	Illinois College of Emergency Physicians
IDPH	Illinois Department of Public Health
IEMA	Illinois Emergency Management Agency
IHA	Illinois Health and Hospital Association
Illinois ENA	Illinois Emergency Nurses Association
Illinois Helps	Illinois ESAR-VHP Program
IMERT	Illinois Medical Emergency Response Team
IMT	Incident Management Team
IN	Indiana
IPA	Illinois Pharmacists Association
IPHMAS	Illinois Public Health Mutual Aid System

ISBE	Illinois State Board of Education
ISMS	Illinois State Medical Society
ITTF	Illinois Terrorism Task Force
KY	Kentucky
KYEM	Kentucky Emergency Management
LHD	Local health department
LTC	Long-term Care
MABAS	Mutual Aid Box Alarm System
MACS	Multiple Agency Command System
MCI	Mass Casualty Incident
MDHSS ERC	Missouri Department of Health and Senior Services Emergency Response Center
MO	Missouri
MOU	Memorandum of Understanding
MRC	Medical Reserve Corp
NIMS	National Incident Management System
OPR	Office of Preparedness and Response
PHEOC	Public Health Emergency Operations Center
PHEP	Public Health Emergency Preparedness
PHMSRR	Public Health and Medical Services Response Regions
PREP	Public Readiness and Emergency Preparedness Act
REMESC	Regional Emergency Medical Services Coordinator
RFMR	Request for Medical Resources
RHCC	Regional Hospital Coordinating Center
SEOC	State Emergency Operations Center
SIREN	State of Illinois Rapid Electronic Notification
SME	Subject Matter Expert
SMOC	St. Louis Medical Operation Center
SNS	Strategic National Stockpile
TMTS	Temporary Medical Treatment Stations
VOAD	Volunteer Organizations Active in Disasters
WI	Wisconsin

RECORD OF REVISIONS

DATE OF CHANGE	SECTION(S) UPDATED	DATE POSTED

PRIMARY AGENCY

Illinois Department of Public Health

SUPPORT AGENCIES, ORGANIZATIONS, AND ENTITIES

Illinois Emergency Management Agency

Regional Hospital Coordinating Centers

Resource Hospitals

All Other Hospitals and Other Health Care Facilities

Health Care Coalitions

EMS Systems/Agencies

Local Health Departments

Public Health Consortia

Illinois Health and Hospital Association

Border States

Illinois Helps

1.0 Introduction**1.1 Purpose**

1.1.1 The purpose of the Catastrophic Incident Response (CIR) Annex is to support the Illinois Department of Public Health (IDPH) ESF-8 Plan, by providing a functional annex for all stakeholders involved in an emergency response within the state of Illinois and/or adjacent states in order to provide crisis care to patients in Illinois during a catastrophic incident. Within disaster response, the three categories in the continuum of care for patients are:

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

1.1.2 This annex guides the state level response and provides local medical services guidance on the care of patients, including crisis care and resource allocation, during a catastrophic incident that incapacitates the local, regional, and/or state health care system and prevents the ability to provide conventional and/or contingency care.

- 1.1.3 The circumstances associated with the incident results in the inability to maintain health care at conventional and contingency levels in the impacted area(s) despite implementation of response strategies such as activating local, regional, and state disaster plans (e.g. IDPH ESF-8 Plan). Consequently, crisis care and other measures outlined in this annex need to be implemented.
- 1.1.4 This annex is intended to support, not replace, any agencies' existing policies or plans by providing coordinated response actions in the case of any type of catastrophic incident.

1.2 Assumptions

- 1.2.1 The IDPH ESF-8 Plan has been fully activated, at the discretion of the IDPH Director.
- 1.2.2 The Public Health and Medical Services Response Regions (PHMSRR) serve as the primary regional geographical organizational structure for the IDPH ESF-8 Plan and the CIR Annex response. In addition, the EMS Regions serve to coordinate day-to-day prehospital/emergency care within Illinois. Although the PHMSRRs and EMS Regions are similar, it is important to recognize the shift in the organizational structure during disasters when the IDPH ESF-8 Plan and this annex are activated. See Attachment 1 for a map that outlines the PHMSRR borders as well as the EMS Regions and the Regional Hospital Coordinating Centers (RHCCs).
- 1.2.3 The local, regional, and/or state health care system has exhausted its capacity to care for patients in such a manner that maintains conventional and/or contingency care.
- 1.2.4 Efforts to implement tactics and strategies (including preparation, conservation, adaptation, and re-use) that are intended to benefit the largest number of patients have been implemented but are insufficient to maintain conventional and/or contingency care
- 1.2.5 Efforts to preserve available resources and balance the delivery of health care services across regions (such that no one region is overwhelmed or taxed to the point of not being able to deliver and sustain medical care at conventional and contingency levels) have become ineffective (e.g. geographic dispersion of patients across multiple regions).
- 1.2.6 Tactics and strategies have been implemented but are ineffective at meeting the needs of the incident. These tactics and strategies include disaster plans on the individual facility/agency, local, regional and state level; supplies from the state and/or federal Strategic National Stockpile (SNS); and established memoranda of understandings (MOUs) and/or mutual aid systems such as Mutual Aid Box Alarm System (MABAS) and Illinois Public Health Mutual Aid System (IPHMAS).

- 1.2.7 Despite attempts to maintain care at conventional and contingency levels, crisis care needs to be implemented in an effort to provide the best care possible for all victims given the circumstances of the catastrophic incident. Every effort will be made to return back to contingency and conventional care from crisis care as soon as possible.
- 1.2.8 A state disaster declaration may have been declared or appears imminent.
- 1.2.9 A federal disaster declaration may have been declared or appears imminent.

1.3 Scope

The CIR Annex is designed to provide the command structure, communication protocols, Request for Medical Resources (RFMR) process, and response processes as related to catastrophic incidents that occur in Illinois. The CIR Annex is designed to:

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

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

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

1.4 Situation

The IDPH ESF-8 Plan and its corresponding annexes are activated when the State Emergency Operations Center (SEOC) is activated and/or at the discretion of the IDPH Director when circumstances dictate and the Public Health Emergency Operations Center (PHEOC) is activated as a result of a catastrophic incident. A catastrophic incident in Illinois is defined as an incident that incapacitates the critical infrastructure and health care system including EMS, hospitals, and other health care facilities (e.g. long term care, dialysis centers, ambulatory care, community based medical groups, etc.), and/or local public health departments, leading to substantial changes in health care operations and level of care capabilities such that both conventional and contingency care cannot be maintained and crisis care is necessary. See Section 2.1.3 for more information.

1.5 Authorities

- 1.5.1 Within Illinois, the overall authority for direction and control of the response to an emergency medical incident rests with the Governor (Article V, Section 6, of the Illinois Constitution of 1970). The Governor is assisted in the exercise of direction and control activities by his/her staff and in the coordination of the activities by Illinois Emergency Management Agency (IEMA). The State Emergency Operations Center (SEOC) is the strategic direction and control point for Illinois response to an emergency medical incident.
- 1.5.2 IDPH is the lead agency for all public health and medical response operations in Illinois. IDPH is responsible for coordinating regional, state, and federal health and medical disaster response resources and assets to local operations such as the Illinois Medical Emergency Response Team (IMERT), the Strategic National Stockpile (SNS), temporary medical treatment stations (TMTS), etc. Additional resources may be available on the local and regional levels to assist (e.g. Regional Medical Emergency Response Teams [RMERT]).
- 1.5.3 In the event of a catastrophic incident in which the local or regional health care system capabilities are overwhelmed or incapacitated, the Governor may grant authority to the IDPH Director for establishment of temporary medical treatment stations (TMTS). IDPH will assist local health departments (LHDs), emergency management, and RHCCs. Refer to the IDPH ESF-8 Plan, Section 3.1.1 for more information.
- 1.5.4 All requests for health and medical assistance in the care of those in need of services during catastrophic incidents will be routed through the State Emergency Operations Center (SEOC) and IEMA as indicated in the Request for Medical Resources (RFMR) process in the IDPH ESF-8 Plan, Section 2.4.2. The IDPH SEOC liaison will inform the SEOC manager that this annex has been activated and crisis care may need to be implemented.
- 1.5.5 The overall authority for direction and control of IDPH resources and licensees to respond to a catastrophic medical incident rests with the IDPH Director. The line of succession at IDPH extends from the Director to the Assistant Director, then to the appropriate Deputy Directors of the IDPH Offices.
- 1.5.6 The primary authority within each EMS Region for coordinating EMS System licensees in response to an emergency medical incident(s) as a result of a disaster or other large scale events rests with the EMS system medical director(s) or designee(s).
- 1.5.7 The RHCC and/or regional Health Care Coalition (HCC) shall have the authority to coordinate supply/equipment caches and services (other than EMS licensees) as outlined in the IDPH approved regional disaster preparedness plan and within the scope of the IDPH HPP program.

- 1.5.8 During times when crisis care is implemented, essential personnel and health care facilities may be reluctant to provide care due to fear of legal repercussions. Applicable laws and regulations which may need to be altered or suspended during an emergency include: EMTALA, HIPAA, the Federal Volunteer Protection Act, and the Good Samaritan Law. The decision to alter or suspend these laws and regulations rests with the corresponding responsible government entity under which the law/regulations fall. The providers' care should follow a standard of reasonable practice based on public health principles during crisis care. See Attachment 2: *Ethical Framework for Providing Crisis Care*.
- 1.5.9 The Public Readiness and Emergency Preparedness (PREP) Act authorizes the Secretary of the Department of Health and Human Services (Secretary) to issue a declaration (PREP Act declaration) that provides immunity from liability (except for willful misconduct) for claims of loss caused, arising out of, relating to, or resulting from administration or use of countermeasures to diseases, threats, and conditions determined by the Secretary to constitute a present, or credible risk of a future, public health emergency to entities and individuals involved in the development, manufacture, testing, distribution, administration, and use of such countermeasures. A PREP Act declaration is specifically for the purpose of providing immunity from liability, and is different from, and not dependent on, other emergency declarations.
- 1.5.10 Centers for Medicare and Medicaid Services (CMS) 1135 Waiver
- 1.5.10.1 When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the Health and Human Services (HHS) Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to her regular authorities. Examples of these 1135 waivers or modifications include:
1. Conditions of participation or other certification requirements
 2. Preapproval requirements
 3. Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State
 4. Emergency Medical Treatment and Labor Act (EMTALA)
 5. Stark self-referral sanctions
 6. Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers
- 1.5.10.2 Individual hospitals, health care facilities, and/or health departments are responsible for completing their own 1135 waiver as applicable. For additional information on the 1135 waiver process, waiver application, and current CMS guidelines/requirements for the waiver process, hospitals, health care facilities, and/or health departments should visit the

CMS website or contact the CMS regional office for the Midwest consortium.

2.0 Concept of Operations

2.1 General

- 2.1.1 The IDPH ESF-8 Plan: Catastrophic Incident Response (CIR) Annex will provide the framework throughout the response and recovery periods during and after catastrophic incidents to evaluate and analyze information regarding medical and public health assistance requests for response; develop and update assessments of medical and public health status in the impact area(s); provide crisis care planning to meet anticipated demands as they relate to patients; and outline strategies and assist with the coordination of resources aimed at transitioning from crisis care back to contingency care and eventually conventional care.
- 2.1.2 The IDPH Incident Management Team (IMT) will call upon medical, legal, and ethical expertise throughout the state to advise and/or direct operations as it pertains to resource allocation and crisis care within the context of the Incident Command System (ICS) structure when an incident occurs that meets the definition of a catastrophic incident (See Sections 1.4, 2.1.4 & 2.1.5). These subject matter experts (SMEs) will provide oversight to ongoing efforts associated with the implementation of crisis care in Illinois and work together with experts on the local level.
- 2.1.3 A catastrophic incident in Illinois is defined as an incident that incapacitates the critical infrastructure and health care system including hospitals and other health care facilities (e.g. long term care, dialysis centers, ambulatory care centers, community based medical groups, etc.), public health departments, and/or EMS, leading to substantial changes in health care operations and level of care capabilities such that neither conventional nor contingency care can be maintained and crisis care is required.
- 2.1.4 This annex can be partially or fully activated during Type 1 Health and Medical Emergency Events. The result of the incident is the exhaustion of resources to care for the casualties at the local, regional, and/or state level. See Attachment 3 for the *Catastrophic Incident Response Annex Activation Pathway*. Circumstances of the incident that lead to the activation of the annex can range from an unexpected, no-notice incident (e.g., earthquake) to a slow, gradually building incident (e.g., epidemic, pandemic). Regardless of the pathway to activate the Annex, the type of incident, or the speed in which resources have become depleted, the health care system would have activated its individual facility/agency, local, regional, and/or state disaster plans and resources in order to maintain conventional and/or contingency care. However, due to the devastation caused by circumstances of the catastrophic incident, the capacities and capabilities of caring for patients have been depleted and crisis care is needed.

2.1.5 Conditions and/or incidents on the local, regional, and/or state level that may lead to a catastrophic incident and prompt the activation of the CIR Annex include, but are not limited to:

1. Capacity and capability to care for patients with conventional and contingency care has been exceeded despite activation of local, regional, and state ESF-8 plans
2. Inadequate health care resources (e.g., patient care spaces including inpatient monitored beds, ventilators, equipment, and/or supplies) to meet the patient demands despite implementation of individual facility/agency, local, regional, and/or state disaster plans, MOUs, and mutual aid agreements
3. Severe damage or threats to multiple hospitals and/or other health care facilities, and/or critical infrastructure including essential services (e.g., EMS) that incapacitates the health care system
4. Crisis level staffing limitations (e.g., lack of qualified and trained staff to care for patients) despite implementation of individual facility, local, regional, and/or state disaster plans, MOUs, mutual aid agreements, and volunteer resources (e.g. Illinois Helps)
5. Critical infrastructure(s) (e.g. electricity, water) has failed and causes the health care system to function in austere conditions
6. Possible loss of local and/or state governance or oversight

See Attachment 3: *Catastrophic Incident Response Annex Activation Pathway*.

2.1.6 Within the IDPH ESF-8 Plan, multiple annexes exist that address the needs of specialty populations or types of incidents (e.g., pediatric and neonatal patients, burn mass casualty incidents, pandemic influenza). During a catastrophic incident, multiple annexes or components within multiple annexes may already have been activated in an effort to thoroughly address the specific needs of the victims (e.g., pediatric burn patients). Efforts have been made to ensure consistency between all annexes that address the needs of specialty populations. It is the recommendation that the subject matter experts that are outlined in each of the annexes for the different specialty populations involved in the catastrophic incident work together to address any potential conflicts that may arise.

2.2 Notification

2.2.1 Upon the activation of the CIR Annex, the *Catastrophic Medical Incident Report Form* (See Attachment 4) will be utilized to communicate necessary information about the annex activation with all affected entities and those entities that may be called upon to assist during the incident unless otherwise indicated by IDPH and IEMA at the time of the incident. See Section 2.2.4 for a listing of possible stakeholders that should be notified during the activation of the CIR Annex. This form may be sent and received via any available communication method. When the *Catastrophic Medical Incident Report Form* is utilized during an incident, the communication method that will be utilized for stakeholders to reply will be indicated on the form in the “Reply/Action required” section.

- 2.2.2 Affected entities and those entities that may be called upon to assist during the incident must have the ability to communicate pertinent information internally and externally from their facility. Information should be shared in the preferred and usual method. However, during a catastrophic incident, the typical alert and messaging systems may not be available and alternate communication methods will be required to communicate. Some of the possible established methods for communication that can be used include:
1. Telephone (landline)
 2. Telephone (cellular)
 3. Facsimile
 4. Radio systems (StarCom, HAM/Amateur, MERCI, telemetry)
 5. E-mail
 6. Electronic emergency management systems
 7. SIREN
 8. EMResource (includes Illinois' HAv-BED Tracking and Notification System)
 9. WebEOC[®]
 10. Social media recognized/maintained by the jurisdictional authority
 11. Comprehensive Emergency Management Program (CEMP) (for information sharing including access to documents and resources)
 12. Other, as applicable and available (e.g. CDC EpiX)
- 2.2.3 While appropriate and established communication and/or notification processes during an incident are important, during a catastrophic incident, these processes may not be available. Providing emergency care, including crisis care, initially takes priority over requests for approval to execute any external bed authorization, communication, waiver, and EMS expanded scope of practice requests, and/or notification processes. Once the incident and patients become more stabilized, health care facilities must communicate with IDPH to relay what processes (e.g., increased bed capacity beyond licensure) occurred as indicated by hospital licensing and in the IDPH ESF-8 Plan. These notifications should be made via the *Catastrophic Medical Incident Report Form* unless otherwise indicated by IDPH.
- 2.2.4 The *Catastrophic Medical Incident Report Form* should be utilized by all stakeholders to assist with ensuring consistent communication between stakeholders, provide a mechanism to request patient resources, and identify availability of resources at a facility. Listed below are facilities/agencies/entities that either play a role in caring for patients or may be part of the incident response and should be notified and receive ongoing communications from the time the CIR Annex is activated until normal operations resume. The *Catastrophic Incident Communication Pathway* (Attachment 5) outlines which stakeholders will typically communicate and share information with each other when the annex is activated. This communication process is similar to daily communication processes and other types of disasters. This same communication process is also outlined in the IDPH ESF-8 Plan, Attachment 13. The *Catastrophic Incident Communication Pathway* is different from the RFMR process, although there is some overlap. The following

list is not inclusive, nor are entities listed in any priority order. Depending on the type of incident, additional stakeholders should be included in the information sharing process as needed and appropriate.

1. Hospitals
 - a. Acute care hospitals
 - b. EMS resource hospitals
 - c. Psychiatric hospitals
 - d. Rehabilitation hospitals
2. Other health care facilities such as long term care facilities (LTC), dialysis centers, ambulatory care centers, community based medical groups, etc.
3. RHCCs
4. Regional HCCs
5. County emergency management agencies (EMA)
6. Local EMS agencies
7. LHDs
8. Public Health Consortiums
9. IDPH Regional Emergency Medical Services Coordinator (REMSC)
10. IDPH
11. IEMA
12. Professional medical organizations
 - a. Illinois Health and Hospital Association
 - b. Illinois College of Emergency Physicians (ICEP)
 - c. Illinois State Medical Society (ISMS)
 - d. American Pharmaceutical Association (APA)
 - e. Illinois Pharmacists Association (IPA)
 - f. Illinois Emergency Nurses Association (ENA)
 - g. Illinois Chapter of the American College of Surgeons
 - h. Illinois Chapter of the American Academy of Pediatrics (ICAAP)
13. Illinois Critical Access Hospital Network
14. Border state agencies (Refer to Section 2.3.4 and 3.4.11 for specific notification details)
 - a. Great Lakes Healthcare Partnership (includes Illinois, Indiana, Michigan, Minnesota, Ohio and Wisconsin) through the Minnesota Department of Health, Office of Emergency Preparedness
 - b. Iowa - Iowa Department of Public Health duty officer
 - c. Kentucky - Duty officer in the Commonwealth Emergency Operations Center
 - d. Missouri – Missouri Department of Health and Senior Services’ Emergency Response Center (MDHSS ERC) as Missouri ESF-8 Lead
 - i. For incidents that occur in Illinois counties served by St Louis Medical Operations Center (SMOC) (specifically, Madison, Monroe and St Clair counties), the SMOC should secondarily be contacted.
15. Any alternate treatment sites (ATS), alternate care sites (ACS), and/or TMTS established during the incident. Refer to IDPH ESF-8 Plan, Attachment 20 for definitions of these terms.

2.3 Organization

2.3.1 Local Response Structure

2.3.1.1 EMS System Response Structure

1. During a catastrophic incident, demands on EMS systems will be extreme and the infrastructure will become incapacitated, but there is a need to continue to provide care to patients. Therefore, EMS systems should have a protocol/plan in place, outlining how they will provide crisis care and work to return to contingency and conventional levels as quickly as possible.
2. See Section 3.2.7 for Roles and Responsibilities of EMS Systems/Agencies when this annex is activated during a catastrophic incident.
3. See Attachment 6 for *Crisis Care and Resource Allocation Strategies/Tactics for EMS during Catastrophic Incidents* that outlines key components to be considered by EMS systems/agencies in their catastrophic incident/crisis care protocols/plans.

2.3.1.2 Hospital and Other Health Care Facilities Response Structure

1. During a catastrophic incident, resources at hospitals and/or other health care facilities will become exhausted but there is a need to continue to provide care to patients. Therefore, hospitals and/or other health care facilities should have a system/plan in place, outlining how they will provide crisis care and work to return to contingency and conventional levels as quickly as possible.
2. See Sections 3.2.3, 3.2.4, 3.2.5, and 3.2.6 for Roles and Responsibilities of Hospitals and Other Health Care Facilities when this annex is activated during a catastrophic incident.
3. See Attachment 7 for *Crisis Care and Resource Allocation Strategies/Tactics for Health Care Facilities during Catastrophic Incidents* that outlines key components to be considered in hospitals and other health care facilities' catastrophic incident/crisis care plans.

2.3.1.3 Local Health Department Response Structure

1. During a catastrophic incident, resources at LHDs will become exhausted but there is a need to continue to provide services or care to clients or patients and assist with resource requests for hospitals and other health care facilities. Therefore, LHDs should have a system/plan in place, outlining how they will provide crisis care and work to return to contingency and conventional levels as quickly as possible.
2. See Section 3.2.8 for Roles and Responsibilities of LHDs.
3. Some areas of the state have Public Health Consortia that may be able to provide assistance when this annex is activated during a catastrophic incident. See section 3.2.9 for additional information.

4. See Attachment 8 for *Crisis Care and Resource Allocation Strategies/Tactics for Local Health Departments during Catastrophic Incidents* that outlines key components that should be considered in LHD catastrophic incident/crisis care plans.

2.3.2 Regional Response Structure

Each region will respond as indicated within its regional medical disaster preparedness and response plan that should contain response components/processes/considerations related to a catastrophic incident.

2.3.3 State Response Structure

1. State emergency management officials will activate the SEOC to coordinate state and/or federal support to local jurisdictions. The PHEOC will be activated by IDPH. RFMR will be processed in accordance with the IDPH ESF-8 Plan (Section 2.4.2).
2. Upon determining (based on situational awareness information) that the available medical resources are incapable of maintaining conventional and contingency levels of care, the IDPH SEOC liaison will notify the SEOC manager that the IDPH Director has activated the CIR Annex.
3. During activation of this annex, the IDPH IMT will utilize SME guidance and ensure appropriate, coordinated, and timely response to the needs of patients.
4. When this annex is activated, the request for medical resources by an ATS (hospital or regionally based), ACS (hospital or regionally based), and/or state TMTS will continue to follow the same pathway outlined in the IDPH ESF-8 Plan (Section 2.4.2), unless otherwise indicated by IDPH and IEMA at the time of the incident.
5. The IDPH REMSC(s) will assist with the communication between IDPH and the RHCCs. The REMSC(s) should be involved in the situational awareness briefings throughout the incident. The REMSC should then relay this information to their RHCC to ensure loop closure and awareness of the response activities within their region.
6. The IDPH ERC(s) will assist with the communication between IDPH and LHDs. The ERC(s) should be involved in the situational awareness briefings throughout the incident. The ERC should then relay this information to their LHDs to ensure loop closure and awareness of the response activities within their region. They may also share information as appropriate with the Public Health Consortia in their regions. In some areas of the state, communication with the LHDs may be routed through a Public Health Consortium.

2.3.4 Multi-State Response Structure

The incident may require accessing resources that exist outside the border of Illinois. The PHEOC, in collaboration with the SEOC, may consider requesting out-of-state resources through normal request patterns, methods indicated within this annex and the IDPH ESF-8 Plan, and/or interstate mutual aid agreements, including Emergency Management Assistance Compact (EMAC). The following border states

will be contacted as indicated in the IDPH ESF-8 Plan by the PHEOC to identify resource availability and share situational awareness updates about the incident.

- a. Great Lakes Healthcare Partnership (GLHP)
- b. Iowa
- c. Kentucky
- d. Missouri

2.3.5 Federal Response Structure

When response to a disaster or emergency incident exceeds the resources and capabilities of Illinois to manage, IEMA will notify officials at FEMA Region V of the Governor's forthcoming request for federal assistance and a presidential disaster declaration. FEMA authorities will deploy a FEMA liaison officer to the SEOC when a presidential disaster declaration appears imminent. IDPH will notify the U.S. Department of Health and Human Services (DHHS) Emergency Coordinator and the Assistant Secretary of Preparedness and Response (ASPR) Field Officer for resource requests, as appropriate, and to provide situational awareness updates about the incident.

3.0 Roles, Responsibilities, and Resource Requirements

3.1 Primary Agency

3.1.1 Illinois Department of Public Health (IDPH)

1. Provide leadership in directing, coordinating, and integrating overall state efforts to provide public health and medical assistance to affected areas and the populations within those areas
2. Assist with the communication between stakeholders (e.g., hospitals, other health care facilities, LHDs, EMS agencies, border states, GLHP) during an incident
3. Coordinate the activation of medical mobile support teams in collaboration with IEMA
4. Coordinate and direct the activation and deployment of this CIR Annex as part of the IDPH ESF-8 Plan either partially or in its entirety as indicated by the ability to adequately meet the resource needs following a catastrophic incident
5. Direct the activation and deployment of TMTS
6. Collaborate with IEMA on the RFMR process
7. Collaborate with IEMA to ensure consistent communication and messaging occurs with the public regarding the need for crisis care and resource allocation
8. Coordinate medical, ethical, and legal subject matter experts to advise and/or direct operations as it pertains to resource allocation and crisis care

3.2 Support Agencies/Facilities/Organizations/Entities

3.2.1 Illinois Emergency Management Agency (IEMA)

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

3.2.2 Regional Hospital Coordinating Center (RHCC)

1. Implement hospital's (and corporate entity as applicable) medical disaster preparedness and response plan that should contain response components/processes/considerations related to a catastrophic incident, and provide crisis care and resource allocation when resources are exhausted and/or pre-identified triggers are reached
2. Inform IDPH, as appropriate, when the hospital's catastrophic incident response plan is activated and crisis care is provided via the *Catastrophic Medical Incident Report Form*
3. Complete and submit the CMS 1135 Waiver for its hospital as applicable when providing crisis care
4. Provide care for patients who arrive at its facility to the best of the facility and practitioners' ability utilizing crisis care (Attachment 7: *Crisis Care and Resource Allocation Tactics for Health Care Facilities during Catastrophic Incidents* and Attachment 9: *Crisis Care and Resource Allocation Tactics for the Pediatric and Neonatal Population during Catastrophic Incidents* may be resources that can provide additional guidance.)
5. Provide patient family members at its facility with information about the incident and education about components of the response that may involve a family member's care (e.g., rationale for implementation of crisis care, how care changes when CIR annex is activated)
6. Provide necessary situational awareness communications to/from the affected and/or assisting hospital(s) and partners within the region and to/from IDPH and the regional HCC
7. Communicate with other RHCCs in order to assess resource availabilities and conduct additional response activities, as warranted
8. Inform IDPH, as appropriate, when catastrophic response components of the regional medical disaster preparedness and response plan have been activated
9. Assist with the communication and RFMR as indicated in this annex
10. Assist hospitals in its region with accessing Illinois Helps as applicable and as their role is outlined in the regional medical disaster preparedness and response plan (See Section 3.2.12)

11. Function as a liaison between IDPH, IEMA, and hospitals and EMS providers within its region

3.2.3 Resource Hospitals

1. Implement hospital's (and corporate entity as applicable) medical disaster preparedness and response plan that should contain response components/processes/considerations related to a catastrophic incident, and provide crisis care and resource allocation when resources are exhausted and/or pre-identified triggers are reached
2. Inform IDPH, as appropriate, when the hospital's catastrophic incident response plan is activated and crisis care is provided via the *Catastrophic Medical Incident Report Form*
3. Complete and submit the CMS 1135 Waiver for its hospital as applicable when providing crisis care
4. Provide care for patients who arrive at the facility to the best of the facility and practitioners' ability utilizing crisis care (Attachment 7: *Crisis Care and Resource Allocation Tactics for Health Care Facilities during Catastrophic Incidents* and Attachment 9: *Crisis Care and Resource Allocation Tactics for the Pediatric and Neonatal Population during Catastrophic Incidents* may be resources that can provide additional guidance.)
5. Provide patient family members at its facility with information about the event and education about components of the response that may involve a family member's care (e.g., rationale for implementation of crisis care, how care changes when CIR annex is activated)
6. Assist with the communication and RFMRs as indicated in the regional medical disaster preparedness and response plan, the IDPH ESF-8 Plan, and in this annex
7. Function as a liaison between the EMS associate and participating hospitals within its system and the RHCC
8. Assist with the communication with EMS providers within its EMS system

3.2.4 All Other Hospitals and Health Care Facilities

1. Implement hospital's/health care facility's (and corporate entity as applicable) medical disaster preparedness and response plan that should contain response components/processes/considerations related to a catastrophic incident, and provide crisis care and resource allocation when resources are exhausted and/or pre-identified triggers are reached
2. Inform IDPH, as appropriate, when the hospital or other health care facilities' catastrophic incident response plan is activated and crisis care is provided via the *Catastrophic Medical Incident Report Form*
3. Complete and submit the CMS 1135 Waiver for its hospital or health care facility as applicable when providing crisis care
4. Provide care for patients who arrive at the facility to the best of the facility and practitioners' ability utilizing crisis care (Attachment 7: *Crisis Care and Resource Allocation Tactics for Health Care Facilities during Catastrophic Incidents* and Attachment 9: *Crisis Care and Resource Allocation Tactics for*

the Pediatric and Neonatal Population during Catastrophic Incidents may be resources that can provide additional guidance.)

5. Provide patient family members at its facility with information about the event and education about components of the response that may involve a family member's care (e.g., rationale for implementation of crisis care, how care changes when CIR annex is activated)
6. Communicate and submit RFMR for resources as necessary as indicated in the regional medical disaster preparedness and response plan, the IDPH ESF-8 Plan, and in this annex

3.2.5 Health Care Coalitions (HCCs)

1. The list of regional HCCs and contact information can be found in the IDPH ESF- 8 Plan.
2. Collaborate with the state, regional, and local hospital and other health care facilities, and agency partners to:
 - a. Receive and disseminate information vital to a common operating picture
 - b. Maintain situational awareness
 - c. Assist with resource identification, location, and procurement for coalition members, as applicable.
3. Implement HCC's catastrophic incident response plan and assist members with providing crisis care with resource allocation when resources are exhausted and/or pre-identified triggers are reached

3.2.6 EMS Systems/Agencies

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

6. Inform IDPH, as appropriate, when the catastrophic incident response plan is activated and crisis care is provided, including staffing and expanded scope of practice waivers via the *Catastrophic Medical Incident Report Form*
7. Request a waiver from IDPH to modify the staffing configuration of ambulances

3.2.7 Local Health Departments (LHDs)

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

3.2.8 Public Health Consortia

Some areas within the state have Public Health Consortia. These Public Health Consortia may be able to assist with information sharing and communication when this annex is activated. The capabilities of each Public Health Consortium varies. LHDs and their Public Health Consortium should work together prior to an incident to identify how they may be able to assist during a catastrophic incident.

3.2.9 Illinois Health and Hospital Association (IHA)

IHA will disseminate situational updates and other incident information to IHA members.

3.2.10 Border States

1. Great Lakes Healthcare Partnership (GLHP) (FEMA/DHHS Region V)
Assist with communication and resource assistance in the first 24-72 hours of the catastrophic incident.
2. Iowa
Assist with the identification of resource availability in hospitals, transport services and EMS, and assist with communication with Iowa hospitals/agencies
3. Kentucky
Assist with the identification and coordination of available resources in Kentucky (i.e., hospital and transport)
4. Missouri
Contact the appropriate personnel for response and coordination including contact with the St. Louis Medical Operations Center (SMOC) as appropriate, sending information to Missouri hospitals and assisting with coordination of resources

3.2.11 Illinois Helps Volunteer Management System

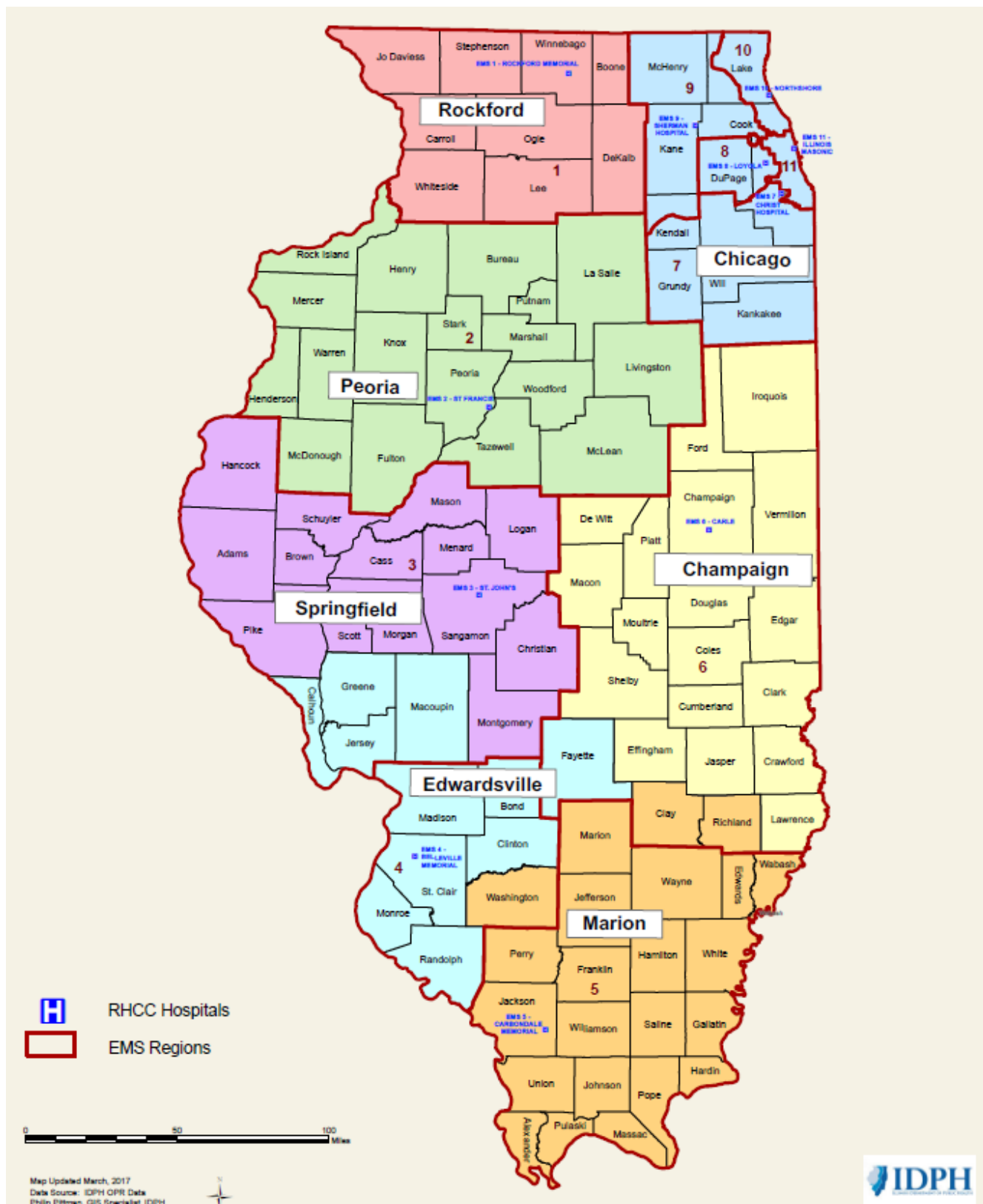
The Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP) system for Illinois (Illinois HELPS) supports the pre-registration, management, and mobilization of clinical and non-clinical volunteers to help in responding to all types of disasters. The volunteer management system is part of a nationwide effort to ensure volunteer professionals can be quickly identified and their credentials checked so they can be properly utilized in a disaster response.

1. Illinois HELPS provides a method to track credentials, qualifications, certifications, contact information, and training of health care providers throughout the state.
2. During a catastrophic incident, Illinois Helps is available to conduct credentialing and vetting of spontaneous volunteers. The entity utilizing Illinois Helps will contact the state coordinator to request background checks be performed. Note that only the state coordinator can perform background checks.

4.0 Recovery

The recovery process following a catastrophic incident may require a significant amount of time and should follow the continuity and recovery processes outlined in the IDPH ESF-8 Plan, Section 6.0. The intent of this annex and the primary focus of recovery efforts are to eliminate the need for crisis care and return to contingency and conventional care as quickly as possible.

ATTACHMENT 1: PUBLIC HEALTH AND MEDICAL SERVICE RESPONSE REGIONS MAP



ATTACHMENT 2: ETHICAL FRAMEWORK FOR PROVIDING CRISIS CARE

Purpose: Provide guidance to practitioners and responders during a catastrophic incident when implementing crisis care

Instructions: These guidelines should be used as a reference by practitioners and responders when providing crisis care to patients in order to ensure the resource allocation strategies being implemented follow an ethical approach.

Disclaimer: This information is not meant to be all inclusive. Individual health care facilities and agencies should work to develop ethical strategies that guide their allocation of resources and services decisions during a catastrophic incident by consulting their internal ethics committee. In addition, when this annex is activated, medical, ethical, and legal experts for crisis care and resource allocation may also be available to assist.

Ethical Objectives in Times of Crisis

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

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

General Ethical Strategies for Crisis Care Response Planning

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

Allocation of Resources and Services

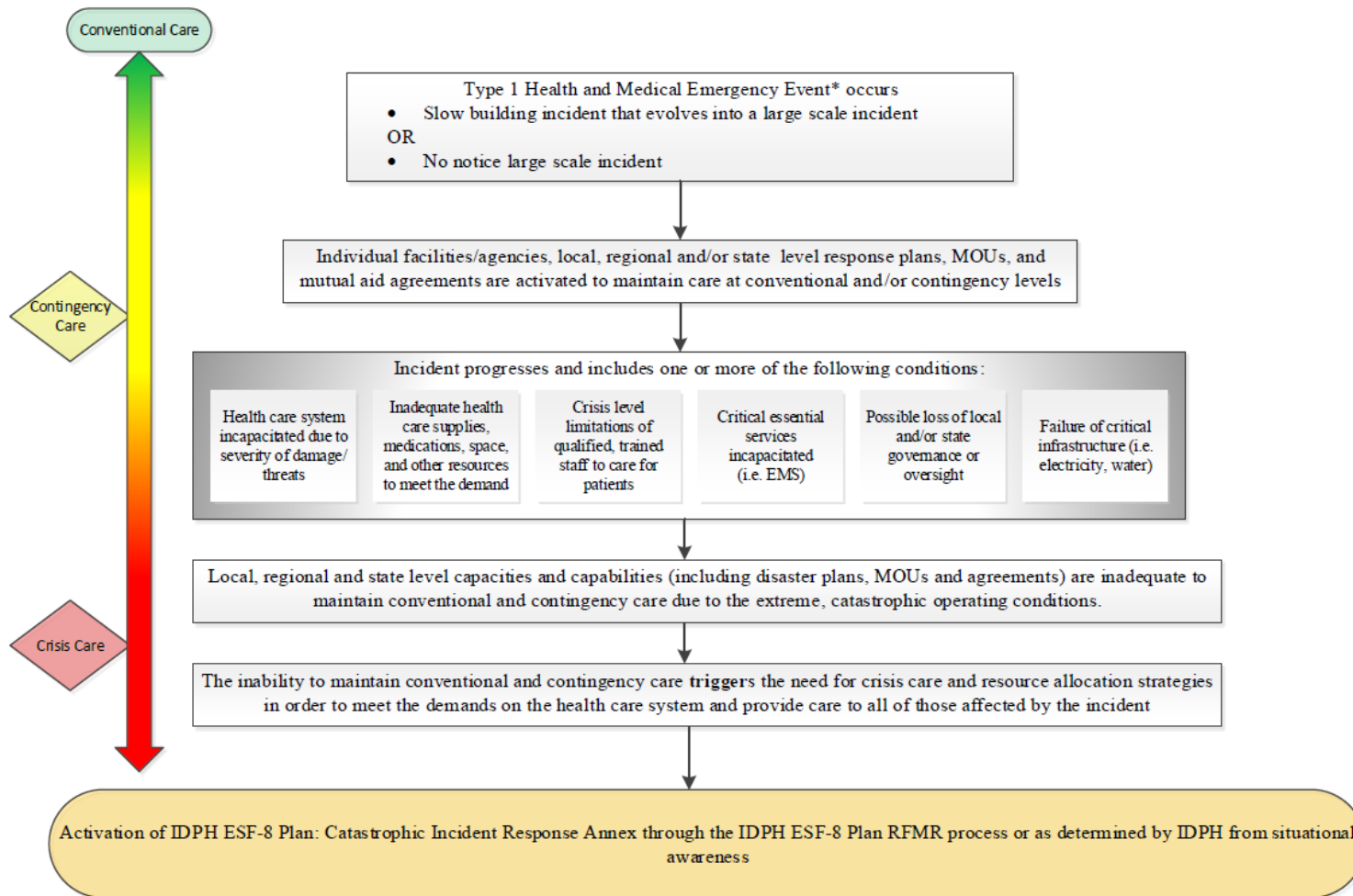
1. Assess the probability that a scarcity of resources may occur and plan in advance how to address such scarcity.
 - a. Scarcity of resources and services during a crisis may take many forms, and plans should address the anticipated nature, duration, and severity of the scarcity.
 - b. At all levels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

ATTACHMENT 2: ETHICAL FRAMEWORK FOR PROVIDING CRISIS CARE

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

ATTACHMENT 3: Catastrophic Incident Response Annex Activation Pathway

Purpose: Outline the types of incidents that prompt the activation of the Catastrophic Incident Response Annex
Instructions: All stakeholders should use this pathway as a reference guide for the different avenues and types of Health and Medical Emergency Events that can trigger the activation of the Annex



* = See IDPH ESF-8 Plan for definitions of each type of Health and Medical Emergency Event

ATTACHMENT 4: CATASTROPHIC MEDICAL INCIDENT REPORT FORM

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

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

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

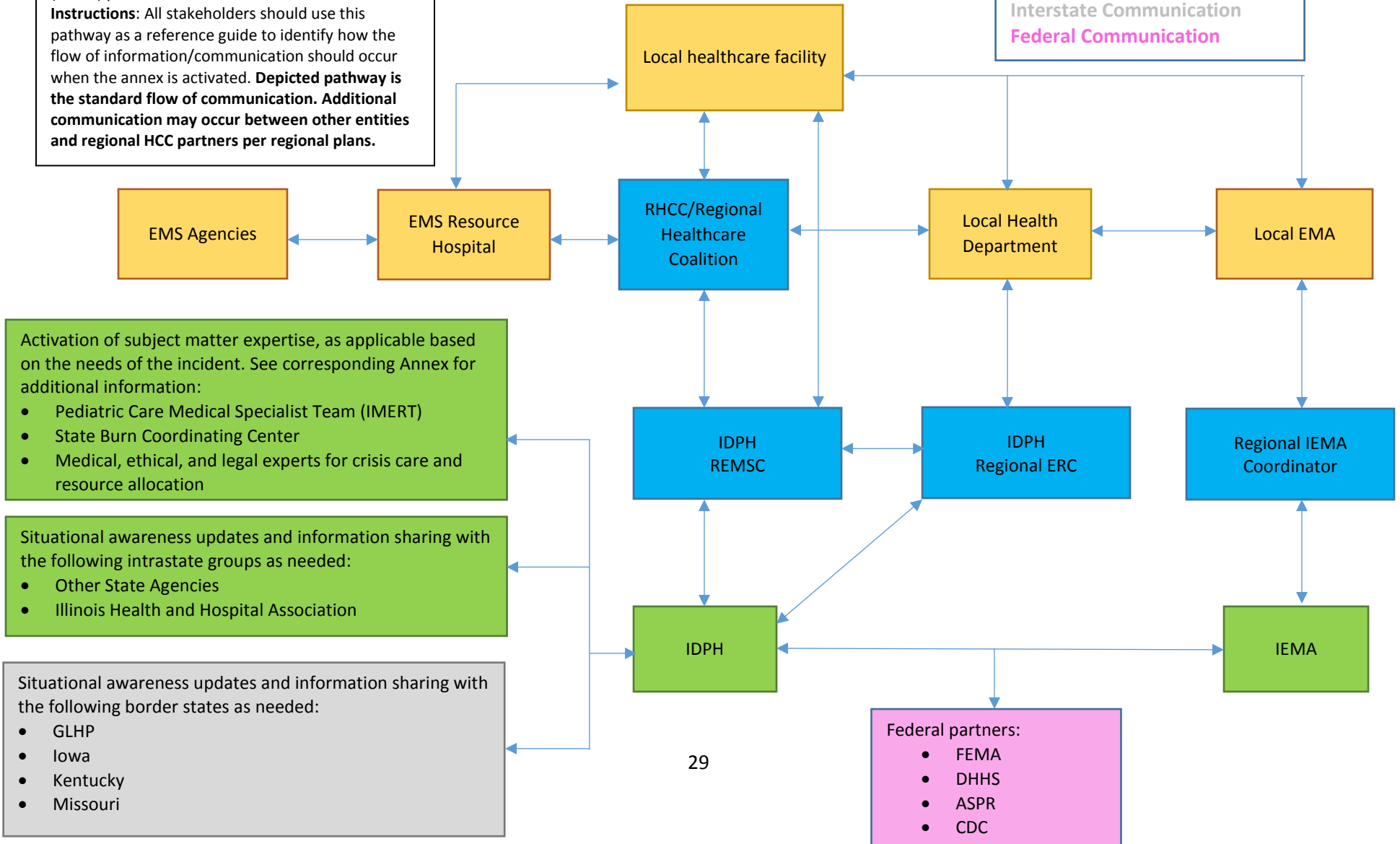
** See Attachments 6, 7, 8 and 9 for crisis care and resource allocation tactics and strategies for EMS, health care facilities, and local health departments

Attachment 5: Catastrophic Incident Communication Pathway

Purpose: Outline which stakeholders will typically communicate and share information with each other when the plan is activated. Although there is some overlap, this Communication Pathway is different from the Request for Medical Resources (RFMR) process.

Instructions: All stakeholders should use this pathway as a reference guide to identify how the flow of information/communication should occur when the annex is activated. **Depicted pathway is the standard flow of communication. Additional communication may occur between other entities and regional HCC partners per regional plans.**

Local communication
 Regional Communication
 State Communication
 Interstate Communication
 Federal Communication



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

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

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

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

Resource Type	Indicators	Crisis Care Tactics
Systems: Command and Control	Incident causes mass casualties and disruption or failure of health care system resulting in inability for EMS to utilize routine operations	<ul style="list-style-type: none"> • Conduct briefings with staff and other stakeholders; establish regular schedule for briefing every operational period • Modify ambulance staffing configurations (e.g. change staffing patterns, 1-BLS and 1 ALS provider vs. 2 ALS providers)
Systems: Communication and Coordination	Incident causes disruption in normal communication pathways	<ul style="list-style-type: none"> • Use MERCI, Satellite phones, emails, texts, HAM/CB radios • Implement “runner” messaging system
Systems: Emergency Dispatch	Emergency medical dispatch overwhelmed by call volumes and unable to answer all calls	<ul style="list-style-type: none"> • Use pre-recorded messaging to filter calls that require direct emergency medical dispatch staff contact • Consider implementation of hotlines or nurse call triage lines to mitigate requests for EMS transports • Implement call triage models to target highest priority calls for response • Maximize frequent use of emergency broadcast system and media outlets for community messaging
Systems: Triage	Incident results in catastrophic number of patients	<ul style="list-style-type: none"> • Utilization of mass casualty triage protocols • May have to devise impromptu triage tags or marking system • Track all patient contacts with whatever means available • Treat and release minor injuries
Systems: Triage	Acuity level of patients may be so severe that comfort care measures will be required	<ul style="list-style-type: none"> • Contact medical control for treatment protocols if possible • When possible provide separate area for privacy • Provide comfort measures
Systems: Transport	Incident causes substantial change in routine patient transport operations	<ul style="list-style-type: none"> • Use alternate transportation (e.g. buses, other municipal vehicles, personal vehicles, helicopters, and other air transport resources)

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

Resource Type	Indicators	Crisis Care Tactics
	<p>Patient destinations may be to clinics or other non-traditional sites</p> <p>EMS may need to provide direct patient care for multiple patients for a longer period of time</p> <p>Incident causes need to suspend rules for field to hospital radio calls and potential modification of record keeping requirements</p>	<ul style="list-style-type: none"> Establish rally points with other transport resources if significant transport time is required to keep resources in community Consider batched transports; move multiple patients at one time Contact Medical Control for prolonged treatment protocols Use best clinical judgment if Medical Control is not available Request modification from EMS medical director for radio report and patient care documentation Transport patients and provide face to face report upon arrival to destination
<p>Supplies: Consumables, First Aid stabilization, and comfort supplies (dressings, slings, tourniquets etc.)</p>	<p>Shortage/limited or non-existent resupply</p>	<ul style="list-style-type: none"> Contact local hospital or RHCC for resupply or access to regional/national stockpiles Seek guidance from EMS medical director/ Medical Control to develop just-in-time tactics for: substitution, conservation, adaptation, and improvised use of IV fluids and other hemodynamic support equipment and supplies (e.g. only use IV fluid for hemodynamically unstable patients) Reuse, repurpose, and improvise first aid and stabilization supplies (e.g. make slings and dressings out of clean sheets, pillow cases etc.)
<p>Space</p>	<p>Incident has resulted in the inability to access local hospitals resulting in EMS needing to provide prolonged care at casualty collections sites</p>	<ul style="list-style-type: none"> Coordinate with local Incident Command and EMS medical director when possible, to identify health care facility sites for non-traditional EMS transport destinations (e.g. local clinics, surgical centers and other outpatient providers) Coordinate with local Incident Command and EMS medical director to identify and establish casualty collection points to begin providing care when there is a delay in transport Alternate treatment modalities and destinations should be requested from the EMS medical director Coordinate with local medical sources to request assistance (e.g. local physicians and other health care providers)

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

Resource Type	Indicators	Crisis Care Tactics
Space: Mass fatality	Morgues at the city and county level as well as at hospitals are at capacity	<ul style="list-style-type: none"> • Work with local medical examiner, coroners, and law enforcement under the direction of the EMS medical director for fatality management • Be aware of alternate cooling facilities/ capabilities within the community (e.g. refrigerator trucks, funeral homes, warehouses with walk in freezers and ice rinks)
Staff: Resources	Staffing resources are exhausted and likelihood of timely mutual aid may not be available	<ul style="list-style-type: none"> • Request additional assistance through official methods; identify members of the community who can be of assistance with basic patient care • Consider coordination with MRCs, CERT, Illinois Helps, and other organizations to provide credentialed trained volunteers • Request non-medical personnel to drive the ambulance to increase the number of first responders available to provide direct patient care
Staff: Family communication	First Responders have concerns about the welfare of themselves and of their own family	<ul style="list-style-type: none"> • Establish method for responders to stay in touch with family or develop message relay capacity (e.g. designate email or text line for families and responders to exchange messages)
Staff	First responders are physically and mentally exhausted	<ul style="list-style-type: none"> • Monitor and assist responders; ensure responders are provided an opportunity for: rest, sleep, nutrition, hydration, contact with family, and opportunity for debriefing • Provide responders with information on how to recognize normal and abnormal stress responses and how to access support for themselves • Find additional community resources to assist: trained mental health providers, counsellors, local faith based groups, therapy animals, etc.
Staff	Emergency dispatch staff unable to get to work	<ul style="list-style-type: none"> • Use pre-recorded messaging to filter calls that require direct emergency medical dispatch staff contact • Consider implementation of hotlines or nurse call triage lines to mitigate requests for EMS transports • Implement call triage models to target highest priority calls for response • Maximize frequent use of emergency broadcast system and media outlets for community messaging

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

Purpose: Provide practitioners with crisis care and resource allocation strategies/tactics that may be implemented during catastrophic incidents

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

Disclaimer: These strategies/tactics are not meant to be all inclusive, replace an existing policy and procedure, or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care provider.

Resource Type	Indicators	Crisis Care Tactics
Systems: Surveillance Data	<ul style="list-style-type: none"> Epidemiology surveillance data shows more cases than local hospital system staffing and resources can safely manage IDPH and IEMA projections indicate local hospital system exceeding available resources after accounting for contingency plans 	<ul style="list-style-type: none"> Activate state and/or federal plans Coordinate via multi-agency ICS coordination Activate local plans for limited distribution of medication, PPE, and patient care
Systems: Communications and Community Infrastructure	<ul style="list-style-type: none"> Widespread or total loss of communications and/or infrastructure; loss of redundancies Inability for local hospital system and EMS to: <ul style="list-style-type: none"> Communicate with outside entities or with employees Unable to transport patients Loss of utility that limits ability to care Electrical grid shutdown or loss of generator for power 	<ul style="list-style-type: none"> Use social media or other media outlets Instruct staff to self-report Use HAM Radios Switch to non-powered equipment Assist other facilities and agencies Use runners for internal written communications Assign one non-medical staff on each floor of the hospital to assist with communication and share situational awareness updates with staff
Systems: Documentation	<ul style="list-style-type: none"> Unable to maintain electronic medical record (Need to move from electronic records to paper documentation if key functions are not connected or if internet fails) 	<ul style="list-style-type: none"> Use alternate methods for documentation If there is a suspicion of criminal activity (cyber-attack, etc.), collect what evidence you can and notify law enforcement
Systems: Security	<ul style="list-style-type: none"> Exponential increase in security needs; inability to maintain proper access control and security related to the increase in people 	<ul style="list-style-type: none"> Increase patrolling of available security personnel Enlist non-security personnel to assist in security role Contact and request assistance from outside security agencies Limit public access to hospital Maintain lockdown procedures in response to specific types of incidents Use transport coordinator; barricades; traffic control plan
Systems: Sheltering	<ul style="list-style-type: none"> Increased number of first responders, volunteers, public/community, employees' families seeking shelter 	<ul style="list-style-type: none"> Access psych and social support; secure separate area for special needs Utilize partner agencies to help decompress shelter needs

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

Resource Type	Indicators	Crisis Care Tactics
Systems: Fatality management	<ul style="list-style-type: none"> Fatality management needs to increase and morgue is overwhelmed 	<ul style="list-style-type: none"> Use alternative sites and/or cold storage areas Be aware of alternate cooling facilities/capabilities within the community (e.g. refrigerator trucks, funeral homes, warehouses with walk in freezers and ice rinks)
Systems: Patient transport	<ul style="list-style-type: none"> Air and/or ground transportation overwhelmed beyond current ability to manage safely with no means to transport in/out 	<ul style="list-style-type: none"> Use transport coordinator Use unconventional patient transportation
Supplies	<ul style="list-style-type: none"> Essential supplies are limited Unable to replenish ongoing demands for supplies and/or anticipate supply needs for the next several days Patient need far greater than what supply inventory can handle or inability to access critical supplies Appropriate protective gear unavailable for specific events Multiple hospitals have MOUs with same vendor 	<ul style="list-style-type: none"> Need to contact local, regional, state, and/or national partners regarding stockpiles; need to implement MOUs with area hospitals and community businesses for food, medications, infection control gear, water, linens, etc. for basic care needs Go beyond usual vendors; utilize local grocery or drug stores for supplies Identify alternate methods of transporting and receiving additional supplies (e.g. drones, aircraft, horses) Monitor inventories more frequently Request donations Reuse certain items or disposables if needed (instruments, just in time cleaning) Initiate a blood drive Use an outside courier to bring in lab testing supplies Ration or withhold as a last resort Boil water for use by staff and patients Consider alternative uses for available items (e.g. bedsheets or belts as tourniquets) Utilize staff and family members to manually ventilate patients with BVM if ventilators are not available
Space	<ul style="list-style-type: none"> Experience and/or anticipate more casualties or critically ill cases than the local hospital system space can safely accommodate immediately or in immediate future Triage, emergency department, hospital inpatient units, intensive care, obstetrics are stressed 	<ul style="list-style-type: none"> Consider external patient areas such as clinics, gyms, community partner buildings Discharge early and work with outpatient providers for at home care Use nontraditional areas for care Create warm boxes out of drawers with heat lamps to warm newborns

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

Resource Type	Indicators	Crisis Care Tactics
	<ul style="list-style-type: none"> Hospital has exhausted space contingencies Non-patient care areas no longer handle excess patients safely Exhaustion of contingencies at hospital and/or system Inability to discharge in timely manner Inability to transport discharged patients out of hospital 	
Staff	<ul style="list-style-type: none"> Immediate and ongoing patient care needs beyond all available resources; not enough care givers and medical providers Unable to safely manage and/or increase patient to staff ratio 	<ul style="list-style-type: none"> Need to obtain outside care givers and providers to support or identify ways to transport Seek caregivers such as nurses, care technicians, and medical providers from the community Assign a hospital coordinator to track influx of outside staff and reassignment of internal staff and providers, and check credentials Initiate Memoranda of Understanding (MOUs) with neighboring organizations for support staff Delegate primary care to other areas such as schools or public buildings Consider bypass and closing hospital to additional cases Transfer or move to alternate treatment sites (ATS), alternative care sites (ACS), and or temporary medical treatment stations (TMTS) Use volunteer resources such as IL HELPS Call upon system staff support Utilize family members to provide care or as volunteers for non-care focused needs
Other: Triage Protocol	<ul style="list-style-type: none"> Reached internal capacity but patients are either still coming or patient level is overwhelming 	<ul style="list-style-type: none"> Utilize second-level internal triage Just-in-time training for providing care beyond regular scope of practice or for non-clinical staff and individuals Incident Commander, in conjunction with Operations Chief and CMO (or ranking Clinical staff member), may need to make triage decisions Use of ethical consult or pre-established guidelines for resource allocation in care of patients

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

Purpose: Provide public health practitioners with crisis care and resource allocation strategies/tactics that may be implemented during catastrophic incidents

Instructions: When the annex is activated, this document should be used to guide public health practitioners when providing crisis care to patients.

Disclaimer: These strategies/tactics are not meant to be all inclusive, replace an existing policy and procedure, or substitute for clinical judgment. These guidelines may be modified at the discretion of the public health practitioner.

Resource Type	Indicators	Crisis Care Tactics
Systems: Surveillance systems	<ul style="list-style-type: none"> • Increased case reports of unusual levels of illness from hospitals • Epidemiology surveillance data indicates surge in cases could exceed staffing and resource availability • Multiple or increasing case fatality rates 	<ul style="list-style-type: none"> • Increase surveillance activity to active status • Provide treatment and containment measures to hospitals and health care facilities • Activate local containment, isolation, and quarantine plans • Coordinate with local public safety officials in preparation for need for additional assistance • Coordinate with state and federal authorities (i.e. IDPH, CDC) • Monitor information in EMResource and coordinate with local health care facility partners and IDPH to use EMResource as a data repository for ease in reporting
Systems: Command and Control	<ul style="list-style-type: none"> • Disparate and incomplete information received from multiple partners • Increased communication needs and/or media requests 	<ul style="list-style-type: none"> • Facilitate situational awareness to local authorities (e.g. hospitals, EMA, other public safety officials, elected officials) • Increased situational awareness reporting to hospitals and other response partners • Conduct regular briefings with public health staff and other stakeholders, establishing a regular briefing schedule for each operational period. • Increase press conferences for key leadership and active media releases • Development of streamlined public communications messages
Systems: Communications Systems	<ul style="list-style-type: none"> • Communication system failures occur and are persistent (e.g. HAN, Epi-X, WebEOC, EMResource) 	<ul style="list-style-type: none"> • Utilize alternate communication mechanisms

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

Resource Type	Indicators	Crisis Care Tactics
Systems: Situational Awareness/ EOC Coordination	<ul style="list-style-type: none"> Disparate and incomplete information received from multiple partners Increased communication needs and/or media requests 	<ul style="list-style-type: none"> Communicate with public health EOC (PHEOC) for streamlined communications and situational awareness Facilitate situational awareness to local authorities (e.g. hospitals, EMA, other public safety officials, elected officials) Staff local EOC, if applicable
Supplies	<ul style="list-style-type: none"> Demands on supplies begin to exceed available supplies Hospitals and other health care facilities report resource scarcity and increase resource requests 	<ul style="list-style-type: none"> Mobilize stockpiled assets under health department control In coordination with the local EMA, prioritize stockpile assets for dissemination to hospitals and other types of health care facilities Assist with the request for medical resource (RFMR) process in accordance with the IDPH ESF-8 Plan Assist with local requests for supplies from the Strategic National Stockpile (SNS) Identify alternate methods of transporting and receiving additional supplies (e.g. drones, aircraft, horses) in conjunction with the local EMA
Space	<ul style="list-style-type: none"> Space capacity exceeded in hospitals and other health care facilities Hospitals and health care facilities are incapacitated 	<ul style="list-style-type: none"> Coordinate off-loading of patients to skilled nursing facilities and long-term care facilities that are not impacted in conjunction with the local EMA Collaborate with RHCC and local EMA on the selection, establishment, and operation of the TMTS in their jurisdiction
Staff	<ul style="list-style-type: none"> Increasing staff absenteeism due to illness or injury Leadership shortages (local/state) 	<ul style="list-style-type: none"> Develop and disseminate recommendations for non-pharmaceutical interventions Re-allocation of staff to other roles Activate IPHMAS or other mutual aid agreements as applicable Activate MRCs, IL Helps for volunteer staff resources Implement plans for staff and volunteer credentialing

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

Purpose: Provide health care practitioners with crisis care and resource allocation strategies/tactics specific to children that may be implemented during catastrophic incidents

Instructions: When the annex is activated, this document should be used to guide health care practitioners when providing crisis care to patients.

Disclaimer: These strategies/tactics are not meant to be all inclusive, replace an existing policy and procedure, or substitute for clinical judgment. These guidelines may be modified at the discretion of the health care practitioner.

Resource Type	Indicators	Crisis Care Tactics
Systems: Command, Control, Communication, and Coordination	Tracking systems and processes are unavailable due to the incident	<ul style="list-style-type: none"> Utilize tools from the Pediatric and Neonatal Surge Annex to facilitate care and tracking of pediatric patients (e.g., Pediatric Identification Tracking Form)
Systems: Transport	Inability to communicate and organize transfer with tertiary care centers or obtain transport resources to transfer patients	<ul style="list-style-type: none"> Admit pediatric patient if transport resources unavailable; utilize pediatric care guidelines and medical consultation via Pediatric Care Medical Specialist to assist with care
Supplies: IV Fluids and Hemodynamic Support	Medical resources are no longer available at the facility and no means to obtain additional supplies via MOUs or RFMR process	<ul style="list-style-type: none"> Reuse nasogastric (NG) tubes after appropriate disinfection Utilize expired equipment if sterile packaging intact Use alternate preparation methods for medications (e.g., Rule of 6's, [which is not typically recommended], should be considered for utilization in a catastrophic incident when the standard infusion concentrations are not available)
Supplies: Respiratory Support: Mechanical Ventilation and Oxygen	Medical resources are no longer available at the facility and no means to obtain additional supplies via MOUs or RFMR process	<ul style="list-style-type: none"> Reuse vent circuits and other oxygen supplies after appropriate cleaning/disinfection Implement re-allocation techniques/triage processes for re-allocation of oxygen, ventilators, and other respiratory support resources
Supplies: Medications	Medications are no longer available at the facility and no means to obtain additional medications via MOUs or RFMR process	<ul style="list-style-type: none"> Allocation of select medications: <ul style="list-style-type: none"> Allocate limited stocks of anti-viral medications with consideration of regional/state guidance and available epidemiological information Utilize re-allocation decision making methods for medications Unit dose or sealed medications from patients. Consider use of veterinary medications when alternative treatments are not available

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

Resource Type	Indicators	Crisis Care Tactics
Supplies: Nutrition	<p>Medical resources are no longer available at the facility and no means to obtain additional supplies via MOUs or RFMR process</p>	<ul style="list-style-type: none"> • Eliminate or modify specialty diets temporarily • Re-use NG tubes and other feeding equipment with appropriate disinfection
Space	<ul style="list-style-type: none"> • Traditional surge areas are beyond capacity or no longer available to care for patients • Inability to communicate and organize transfer with tertiary care centers or obtain transport resources to transfer patients 	<ul style="list-style-type: none"> • Initiate system decompression within the state of Illinois and border states as indicated in the IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex • Utilize holding areas while patients are waiting for transport to other facilities • Decompress/transfer non-critical pediatric and neonatal patients from tertiary care centers to pre-determined appropriate facilities • Create warm boxes out of drawers with heat lamps to warm newborns • Triage of critically ill/injured pediatric patients to tertiary care center through consultation with Pediatric Care Medical Specialist (PCMS) (see Pediatric Triage Criteria Form within the Pediatric and Neonatal Surge Annex)
Staff	<ul style="list-style-type: none"> • Staffing resources are exhausted and the ability to obtain additional staff (e.g. Illinois Helps, medical mobile assets) is not available • Inability to communicate and organize transfer with tertiary care centers or obtain transport resources to transfer patients 	<ul style="list-style-type: none"> • Divert staff to emergency response • Cancel all non-emergent procedures including surgeries, laboratory and radiographic studies, and reassign staff to perform emergency duties • Admit and care for pediatric patients in non-pediatric facilities • Work with PCMS as part of IDPH ESF-8 Plan: Pediatric and Neonatal Surge Annex and utilize the <i>Pediatric and Neonatal Care Guidelines</i> to assist in caring for pediatric and neonatal patients while waiting transfer to another facility for higher level for pediatric/neonatal care