Scarce Resource Management & Crisis Care Guidance

Front Matter

Drafted for use in Montana in response to the 2020 COVID-19 pandemic emergency

Introduction

The Montana Department of Public Health and Human Services (DPHHS) is the assigned primary agency of Emergency Support Function 8 – Public Health & Medical Services (ESF-8). This assignment is based on the Montana Emergency Response Framework. The purpose of DPHHS is to protect, maintain, and improve the health of all Montanans. The Crisis Standards of Care (CSC) Framework—referred to as the "CSC Framework" or "the Framework"—addresses specific challenges of a pervasive or catastrophic public health event that warrant a change in standard of care, shifting focus from individual patients to the good of the community. In these situations, demand exceeds available resources, warranting proactive steps to coordinate a statewide response for a prolonged period, assuring the best available appropriate care possible despite resource limitations. Montana is facing an emergency public health event, under threat of the novel coronavirus disease known as COVID-19.

In 2012, the National Academies of Sciences, Engineering and Medicine, Institute of Medicine (IOM)—now the National Academies of Medicine (NAM) — (referred to as the IOM/NAM in this document) published national guidance documents for crisis standards of care planning. They recommend the incorporation of key elements into the development of crisis standards of care plans. Key elements of CSC planning include:

- Strong ethical grounding;
- Integrated and ongoing community and provider engagement, education, and communication;
- Assurances regarding legal authority and environment;
- Clear indicators, triggers, and lines of responsibility; and
- Evidence-based clinical processes and operations[1].

Montana DPHHS facilitates equitable access to care through public health recommendations, regulatory guidance, supports alternate care mechanisms (e.g., telephone informational hotlines, alternate care sites, home- and community-based options), and supports public information dissemination in such an event, including the delivery of information in accessible formats. An example of some of these recommendations may include a systematic approach to allocation of scarce resources (e.g., select medications, vaccine, or equipment including ambulances, home care workers and personal assistance support workers) designed to deliver the best available appropriate care possible given limited resources. This document is derived from the Minnesota Crisis Standards of Care Framework *Minnesota Department of Health Concept of Operations* document and the Washington State Department of Health *Scare Resource Management & Crisis Standards of Care* document, explicitly in response to the 2020 COVID-19 emergency.[2,3]

Purpose

The goal of this Framework is to:
- Outline the Montana response during a crisis care situation resulting from the COVID-19 emergency; and
- Provide planning guidance and strategies to health care entities (e.g., hospitals, emergency medical services, home- and community-based providers, aging services, etc.) and public health organizations to manage the transition from conventional to contingency to crisis care during a crisis care situation and develop their own crisis care plans (Figure 1).[4]

Scope

This document was developed in the context of the 2020 emergency COVID-19 declaration. The need to prepare Crisis Care Guidance in the setting of the COVID-19 pandemic is unavoidable. The decision to adopt the Minnesota and Washington State plans was deliberate in an attempt to promote fairness, consistency and transparency in the delivery of medical care to Montanans during the 2020 COVID-19 pandemic, in the event the state ever had to invoke Crisis Care Guidance (CCG). The Montana CCG Framework defines actions and roles during a pervasive or catastrophic public health event that generates a change in standard of care due to scarce resources (e.g., staff, space, supplies). Crisis care plans at the agency or health care facility level may be needed anytime and anywhere as extensions of surge capacity plans to address immediate needs when community resources are overwhelmed by an emergency or disaster. Crisis Care Guidance plans involve the support of the State and other levels of government. The government role is to support ongoing, substantial changes in operations and medical care decision-making during a prolonged emergency, when insufficient resources are available, and when the focus of care must shift from the benefit of the individual to the benefit of the community. Montana DPHHS will also rely on the Montana Hospital Association (MHA) to enhance the ability of hospitals and health care systems to prepare for, respond to, and recover from these types of events as part of this response structure. Crisis care situations requiring state action are extremely rare (e.g., severe pandemic) and assume health care facilities, home- and community-based providers and other local agencies have developed their own plans. Therefore, the CCG Framework also provides planning guidance and strategies for health care facilities, community providers, Emergency Medical Services (EMS), and other local agencies to develop their own crisis care plans. These strategies provide ethically sound, proactive guidance to provide the best and most equitable care possible when demand for resources far exceeds availability. This Crisis Care Guidance provides a framework for decision making but should be seen as flexible and adaptable for local circumstances and changes in understanding about the clinical characteristics of COVID-19.

As noted in the Minnesota plan, medical malpractice and other forms of civil liability are situational.[5] During an emergency or disaster, as in conventional operations, responders are held to the standard of care that a "reasonable responder" would have given in that same or similar situation accounting for the availability of resources.[5] One factor in determining whether the "reasonable responder" standard was met is whether the responder was following previously-adopted operating plans or guidance.[5] Having pre-existing operational plans for crisis situations may provide protections for responders, as well as the agencies that employ them.[5] If these plans are reasonable, based on recognized guidance and best practices documents, and approved by the agency or, optimally, by multiple agencies it may be, in most situations, difficult to find liability if the responder's actions conformed to the expectations of the plan.[5] That said, in some cases a reasonable responder might be required to deviate from the requirements of the operational plan to do the best they could for their patient or community.[5] Because the legal standard of care is a flexible and fact-specific concept that ordinarily takes into account the circumstances under which care was provided, courts evaluating the conduct of a health care provider should take into account the particular circumstances surrounding an emergency event where resources may be scarce and health care systems and providers may be overwhelmed.[5]

During the timeframe of the COVID-19 emergency, the guidance outlined here applies to all patient care, in the event the state ever had to invoke Crisis Care Guidance (e.g., COVID-19 patient management and non-COVID-19 patient management). Upon resolution of the current COVID-19 emergency, hospital emergency planning teams may initiate a revision of the current document or creation of a new document, including incorporation of more extensive Montana-specific stakeholder engagement. Before adoption of the Washington plan, Montana DPHHS and MHA convened a *Crisis Care Guidance Workgroup* to ensure that the document content and triage algorithms reflected Montana-specific resource and population matters.

Authority

Montana DPHHS will work with the Governor's office to provide incident-specific guidance. On March 15, 2020, Governor Bullock issued executive orders 2-2020 and 3-2020, declaring a state of emergency in Montana due to the global outbreak of COVID-19 novel coronavirus. On March 26, 2020, Governor Bullock issued a Stay at Home Directive to "curtail the spread of the COVID-19 pandemic in Montana, and to protect the health and economic wellbeing of all Montanans." DPHHS will work with the Governor's office to determine emergency legal issues that must be addressed in order to facilitate the response. Issues including isolation and social distancing, equal access to resources, the accessibility of resources to people with disabilities, and liability are just a few examples of areas that may require legal interpretation and involvement.

Planning Assumptions

1. Initiation of the CCG Framework will occur in stages and will be inclusive of a variety of public and private entities.
2. Initiation of CCG will occur only during a pervasive or catastrophic public health event that overwhelms both local and in-state regional capacity.
3. Resources are scarce and cannot be obtained by health care facilities in time to prevent resource triage. Adaptive and alternate strategies have been exhausted or are not appropriate.
4. Crisis strategies have been activated by other health care delivery systems and consistency is needed across the state so equitable levels of care are offered and standardized processes are used.
5. There are circumstances where regional clinical triage teams or committees will transfer patients with a better chance of survival to an institution that can provide a higher level of care. As the emergency situation evolves, this ability to transfer patients may become impossible, at least in the short term.
6. Access to medical countermeasures (e.g., vaccines, medications, antidotes, ventilators, intensive care beds, hospital beds, blood products, etc.) are limited.
7. Available local, regional, state, federal resource caches (e.g., equipment, supplies, and medications) have been distributed, and there is no foreseeable short-term resupply of such stock. A facility may enter a brief period of crisis for a particular resource, with resolution upon replenishment of that resource.
8. Multiple health care access points within a community or region are impacted.[1]

Methodology

Although the rapidly evolving circumstances associated with the 2020 COVID-19 pandemic precluded the ideal deliberative and participatory CCG planning with substantial involvement of local public and private entities, every effort was made to involve interested and expert stakeholders on an accelerated timeline. The source documents used here and created by the Minnesota Department of Health and the Washington State Department of Health have been vetted by their respective stakeholders.

The Minnesota Department of Health engaged a diverse cross section of stakeholders including tribal health and advocates for people with disabilities to address three overlapping goals when developing CSC plans. Minnesota's ethical objectives outlined below demonstrate their commitment to developing a sound CSC plan and this informed Montana's decision to repurpose parts of the Minnesota plan as a Montana document for use during the timeframe of the COVID-19 emergency.[6] The underlying goals of Minnesota's process included:

- Protecting population health by reducing mortality and serious morbidity from:
  - The public health crisis; and
  - Disruption to health care, public health, public safety, and other critical infrastructure.
- Respecting individuals and groups by:

- o Promoting public understanding, input, and confidence in the CSC plan/response;
- o Supporting a duty to promote the best care possible in crisis circumstances;
- o Ensuring the burdens of CSC response are minimized and justified by benefits.
- Striving for fairness and protecting against systemic unfairness by:
  - o Utilizing strategies for public education and public engagement that are inclusive and culturally sensitive;
  - o Promulgating standardized crisis standards of care response protocols that are publicly available, revised regularly, and tailored to specific crisis responses;
  - o Ensuring that burdens and benefits associated with crisis response are equitable;
  - o Making reasonable efforts to remove access barriers and address functional needs;
  - o Stewarding resources to:
    - ▪ Reduce significant group differences in mortality and serious morbidity and
    - ▪ Appropriately reciprocating to groups accepting high risk service of others;
  - o Using decision-making processes that consistently apply only ethically relevant (non-discriminatory, non-arbitrary) considerations.

This document was created under an emergency declaration. The need to prepare Crisis Care Guidance in the setting of the COVID-19 pandemic is unavoidable. The decision to adopt the Minnesota and Washington State plans is deliberate to facilitate the timely development of a CCG that promotes fairness, consistency and transparency in the delivery of medical care during the COVID-19 emergency.

Definitions
Several terms used throughout this Framework are defined here:
- **Capability**: The ability to manage patients requiring very specialized medical care.[7]
- **Capacity:** A hospital's maximum ability to serve patients including the availability of qualified staff, beds and equipment that accommodate the needs of the whole community, including people with disabilities.
- **Contingency care:** Provision of functionally equivalent care - care provided is adapted from usual practices; for example, boarding critical care patients in post-anesthesia care areas.[8]
- **Continuum of care:** Medical care that is rendered during a mass casualty incident or declared emergency and occurs across 3 phases on a continuum; conventional to contingency to crisis care.[8]
- **Conventional care:** Usual resources and level of care provided. The maximal use of the facilities' usual beds, staff, and resources is ensured.[8]
- **Crisis Standards of Care (CSC):** A state of being that indicates a substantial change in health care operations and the level of care that can be delivered in a public health event, justified by specific circumstances. Medical care delivered during disasters shifts beyond focusing on individuals to promoting the thoughtful and equitable stewardship of limited resources intended to result in the best possible health outcomes for the population as a whole. Crisis capacity activation constitutes a significant adjustment to standards of care.[4] Crisis care is distinguished from contingency care by an inability to adhere to the accepted standard of care.
- **Health disparities:** Systematic, plausibly avoidable health differences adversely affecting socially disadvantaged groups and/or people with disabilities; they may reflect social disadvantage, but causality need not be established.[9,10]
- **Indicator:** A "measurement or predictor of change in demand for health care services or availability of resources" (e.g., a tornado warning, report of several cases of unusual respiratory

illness). An indicator may identify the need to transition to contingency or crisis care (but requires analysis to determine appropriate actions).[11]

- **Moral Distress:** "...an emotion that is expressed when the moral complexity of a situation is not leading to a resolution, thereby having the potential to cause harm to the individual [...] painful feelings and associated mental anguish as a result of being conscious of a morally appropriate action, which, despite every effort, cannot be performed owing to organizational or other constraints (such as resource scarcity)."[12]

- **Palliative Care:** "Aggressive management of symptoms and relief of suffering" is what generally have come to be called "palliative care." The World Health Organization defines palliative care as "an approach which improves the quality of life of patients and their families facing life threatening illness, through the prevention, assessment, and treatment of pain and other physical, psychosocial, and spiritual problems."[13]

- **Resource triage threshold:** Denotes "triggers" that demonstrate that specific resources are in short supply or are altogether unavailable. As a result, an allocation schema must be implemented and access to a specific care resource must be triaged because of demand. The triage decision involves an assessment of need, benefit, and duration of use.[1]

- **Trigger:** A "decision point about adaptations to health care service delivery" that requires specific action. A trigger event dictates action is needed to adapt health care delivery and resources. Triggers can be scripted or non-scripted. Scripted triggers are built into Standard Operating Procedures (SOPs) and are automatic 'if/then' actions. Non-scripted triggers require additional analysis and consideration involving management and supervisory staff.[11]

Background
Continuum of Care

Figure 1 (below) illustrates the continuum of care, from conventional care, transitioning to contingency care and finally crisis care.

During *conventional care*, customary routine services are provided with no issues (e.g., use of available inpatient beds). During *contingency care*, care provided is functionally equivalent to routine care but equipment, medications, and even staff may be used for a different purpose or in a different manner than typical daily use (e.g., substituting one antibiotic for another that covers the same classification). The demands of most incidents can be met with conventional and contingency care. Pursuant to federal and state laws, contingency care does not mean that persons with disabilities may be treated in long term care facilities instead of hospitals as would be available to their family, friends, and other community members. Nor do contingency care plans supplant the rights of persons with disabilities to receive services in the least restrictive setting (e.g., community). *Crisis care* falls at the far end of the spectrum when resources are scarce and the focus changes from delivering the best available appropriate care for each individual patient to delivering the best available appropriate care for the patient population as a whole. This shift in focus, which may require adaptations and non-traditional provision of care, which while necessary to maximize the number of lives saved during a pervasive or catastrophic public health event, increases the risk to the individual patient of a worse outcome. A single resource (e.g., vaccine) or multiple resources (e.g., critical care beds and staffing) may be affected. In crisis delivery of care, all will receive medical care based on an array of objective medical standards including consideration of those most likely to benefit and those least likely to benefit. No patient will be abandoned. With limited resources, some persons will receive fuller, medically indicated treatment(s), some persons will receive limited medical treatment(s), and some persons will receive palliative treatment(s) based on objective medical standards.

Notably, emergencies are dynamic, and care moves back and forth along this continuum during an incident. The goal is to avoid the crisis state through good contingency planning and implementation, and to recover from the crisis state as soon as possible. For example, a hospital in a crisis after a local emergency can usually transfer patients and bring in resources within hours to get back to contingency or conventional status. Indicators and triggers aid decision-makers in recognizing when care is moving along this spectrum from conventional to contingency to crisis care and can help prompt requests for assistance. For example, if a hospital is providing cot-based care, this indicates crisis care is occurring and outside support is needed.
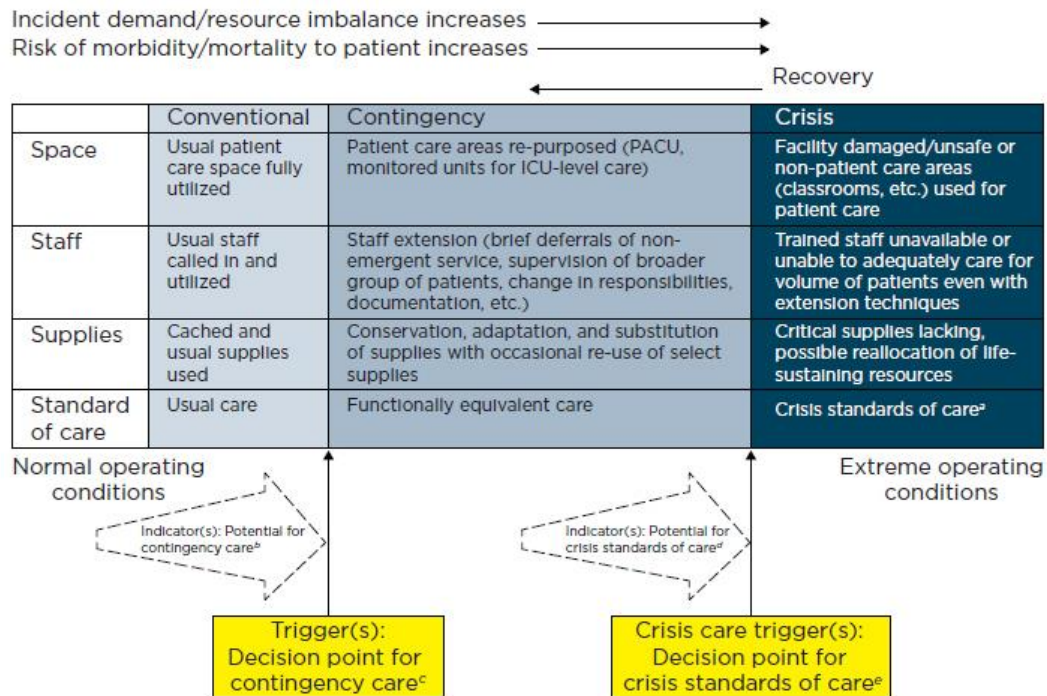

Figure 1: Allocation of specific resources along the care capacity continuum.

a) Unless temporary, requires state empowerment, clinical guidance, and protection for triage decisions and authorization for alternate care sites/ techniques. Once situational awareness achieved, triage decisions should be as systematic and integrated into institutional process, review, and documentation as possible.

b) Institutions consider impact on the community of resource use (consider "greatest good" versus individual patient needs— e.g., conserve resources when possible), but patient-centered decision-making is still the focus.

c) Institutions (and providers) must make triage decisions—balancing the availability of resources to others and the individual patient needs—shift to community-centered decision making.[4]

Risk Profile

Demographic groups such as immigrants, indigenous peoples, seniors, children and people with disabilities may have different and specialized needs following a disaster. Crisis care strategies should be developed with respect to equity. Montana DPHHS works with local public health, emergency management, disability rights and service organizations and MHA to plan for, and with, these groups on multiple levels. Under normal circumstances, pre- and post-incident assessments are recommended to determine the needs of affected communities, assist in estimating the number of people who may need

specialized services, the types of services they may require, and the type and methods of public outreach that may be needed to reach them. Along the continuum of care, the civil rights of persons with disabilities must be protected. In the event of emergency and disaster situations, this means that persons with disabilities living in the community will be supported with community resources. Special populations treatment and sheltering practices are not allowed. According to federal and state laws, people with disabilities must be supported in the least restrictive environments. These environments support self-determination and control and afford access to a person's informal and paid community living support and resources for planning, preparedness, response and recovery. Additionally, many community members rely on persons with disabilities as neighbors, family members, friends, employers, co-workers, students, and volunteers.

Based on national survey data collected prior to the COVID-19 pandemic (National Survey of Children's Health 2017/2018), Montana children will have needs for health care and community support that can be described in several ways. Protecting and strengthening community support for managing these issues (e.g., home visiting, case management, and child welfare checks modified for frequency, content and social distancing) is one strategy for preventing emergent health care events and added pressure on the health care systems. Some of the conditions experienced by children may make them more vulnerable to COVID-19, warranting review and updates of health care goals and plans within the child's medical home. Note that some children may be in one or more of the following needs categories, so percentages should not be totaled across categories. Nearly 1 in 5 Montana children (19.1%) has more than two current or lifelong health conditions (e.g., allergies, asthma, cerebral palsy). A similar number of children in Montana meets national criteria for having a *special health care need,* resulting from a medical or other health condition with a duration or expected duration of the condition that is 12 months or longer. More than one in six Montana children at any point during the year (17.3%), will have limitations in one of twelve areas of functioning (e.g., breathing, digesting food, physical pain, walking or climbing stairs, concentrating, and hearing). Finally, half of Montana children (51.2%) will have health conditions that consistently and often greatly affect their daily activities during the past 12 months. The rates of these pediatric needs among children should be considered in critical care planning in Montana.[14]

There are eight federally recognized Tribal Reservations and five Urban Indian Centers located in Montana. Approximately 65,000 American Indians live in Montana with roughly 70% of them living on a reservation.[15] These reservations are located in very rural or frontier areas where access to care is limited, and the distance to a major medical facility is over an hour away. Historical trauma, ongoing discrimination, socioeconomic disparities (e.g., income, housing, transportation, health care), and the burden of certain chronic disease (e.g., cardiovascular disease, asthma, diabetes mellitus, etc.) among American Indians create disproportionate vulnerability for this population. Thirty-five percent of American Indian residents reported they did not have a person they regarded as their usual health care provider.[16] According to the 2016 American Community Survey, 7% of Montana American Indians were aged 65 years or older. According to the 2017 Montana State Health Assessment, the prevalence among Montana American Indian adults of chronic conditions associated with an increased risk for severe illness from COVID-19 were: asthma (13%), chronic obstructive lung disease (8%), cardiovascular disease (10%), diabetes (17%), kidney disease (5%), and obesity (32%). In 2018, 17.2% of American Indian/Alaska Natives in Montana reported a diagnosis of diabetes compared to 8.7% of white, non-Hispanics.[17] The negative impacts of COVID-19 also may be greater among American Indians in Montana with jobs that do not have paid leave or opportunities to take leave to recover from illness or provide care to others who are ill. These factors may influence how COVID-19 impacts on American Indians and tribal communities, and it is critical that ongoing CCG planning efforts include this perspective.[18]

Table 1: State of Montana Demographics – US Census		
Category	**Demographics**	**Number or Percent**
Population[19]	Total	1,062,305
	Under 5 years	5.9%
	Under 18 years	21.6%
	Over 65 years	18.7%
	Foreign born persons (2014-2018)	2.2%
	With a disability, under age 65 years (2014-2018)	9.2%
Race and Hispanic Origin[19]	White	89.0%
	American Indian/ Alaska Native alone	6.6%
	Hispanic or Latino	4.0%
	Asian alone	0.9%
	Black/African American alone	0.6%
	Native Hawaiian/ other Pacific Islander alone	0.1%
Household Information[19]	Person per household (2014-2018)	2.39
	Median household income (2014-2018)	$52,559
	Persons in poverty[20]	13.0%
	Households with computer (2014-2018)	87.3%
Health[19]	Persons without health insurance, under age 65 years[20]	10.0%

[19] U.S. Census Bureau. QuickFacts. July 1, 2018 estimates
[20] 2018 American Community Survey 1-year estimates
https://www.census.gov/quickfacts/fact/table/MT#

Table 2: State of Montana Demographics – American Community Survey 5-year estimates		
Category	**Demographics**	**Number (Percent)**
Population[21]	Total civilian noninstitutionalized population	1,026,586
	Total with a disability	139,635 (13.6%)
	Total under 18 years	226,630
	Total with a disability	9,196 (4.1%)
	Total 18 to 64 years	620,841
	Total with a disability	69,062 (11.1%)
	Total 65 years and over	179,115
	Total with a disability	61,377 (34.3%)

[21] American Community Survey 2018 5-year estimate data profiles
https://data.census.gov/cedsci/table?d=ACS%205-
Year%20Estimates%20Data%20Profiles&table=DP05&tid=ACSDP5Y2018.DP02&g=0400000US30&hidePreview=false&vintage=2018&layer=V
T_2018_040_00_PY_D1&cid=DP05_0001E

Skilled nursing facilities (SNF), assisted living facilities (ALF), and other congregate settings-- particularly those that involve multiple support personnel and direct care workers moving in and out of the facilities (e.g., group homes, intermediate care facilities, jails, and prisons), are particularly vulnerable to the spread of infection.[22] These settings have limited resources for implementing infection control measures. Staffing shortages are among these limitations and have been exacerbated by the pandemic. In addition to the

infection control vulnerabilities inherent in congregate settings, threats to self-determination and personal liberties experienced by persons with disabilities and seniors are more difficult to minimize in these settings compared to less restrictive community living arrangements. These threats also place residents in congregate settings at additional risk for neglect, abuse, and discrimination. Finally, the majority SNF and ALF residents, along with many residents of group homes, jails, and prisons, have underlying health conditions placing them at higher risk for infection and for needed medical treatment. Residents of congregate settings also are more likely to be at higher risk for negative outcomes related to COVID-19 infection. Assuring equal access to preventative and treatment resources requires concerted focus and the coordination of national, state, and local strategies, activities, and resources.

Montana DPHHS tracks and reports COVID-19 cases and deaths with information related to outbreaks for congregate care settings in its dashboard.[23] On October 30, 2020, the state reported:

> *A total of 2,974 cases can be attributed to outbreaks at congregate setting, most of them are residents, meaning people who reside at these locations (i.e. residents, inmates, students) versus staff, who frequent these settings as employees (i.e. nursing staff, jailors, teachers) [sic]. Seventy-one persons with COVID-19 have died as part of outbreaks associated with congregate settings, about one third of all COVID-19 reported deaths in the state. Most of those deaths (94%) occurred at ALFs and long-term care facilities (LTCFs).*

Montana DPHHS also provides specific SNF and ALF numbers for residents and staff in a separate report.[24] On October 30, 2020, more than three-quarters (76%) of SNF and nearly a half (46%) of ALF had reported COVID-19 cases for residents and/or staff. Additionally, the majority of Montana counties—49 of Montana's 56 counties, had reported at least one congregate setting with a COVID-19 outbreak. As community and health care resources become more scare, many of these risk factors could be further exacerbated. Utilizing ombudsman, guardianship and other protection and advocacy resources within COVID-19 mitigation procedures presents new access challenges and barriers that must be addressed (e.g., Montana Governor's guidance on safe visitation in nursing homes).[25] Additionally, the impacts of COVID-19 in the community are constraining local resources available to assist people living and working in congregate care settings.

In Montana, there are 72 licensed skilled nursing facilities (SNF) and 210 licensed assisted living facilities (ALF). SNF and ALF residents number nearly 10,000 in Montana (5,924 in SNF and 3,624 in ALF), and the average numbers of SNF residents and ALF residents per facility are 98 and 145 residents, respectively (ranges = 13 to 155 residents/SNF; 4 to 181 residents/ALF). Most Montana counties have at least one SNF (n = 37 counties), and most counties have at least one ALF (n = 41 counties). The numbers of facilities in these Montana counties range from one to seven SNF facilities, and from one to thirty-nine ALF facilities per county, respectively. Nearly half of the SNF residential population (47.10%) is in one of ten counties comprising Montana's seven Metropolitan Statistical Areas (MSA) (Billings, Missoula, Bozeman, Kalispell, Helena, Great Falls, Butte-Silver Bow), and the other half of the SNF population is in a county not in an MSA. The ALF residential population is more concentrated, with seven of eight ALF residents living in

Montana MSA counties (87.20%) and the smaller percentage living in non-MSA counties (12.80%) (See Table 3 and Table 4 for further descriptions of the size and geographic distribution of these facilities).

All Montana counties need support to mitigate COVID-19 in these facilities and to support the health of SNF/ALF residents. SNF/ALF residents, administrators, facility staff, protection and advocacy staff, guardians and families, and other stakeholders will need specific communications and supports related to CCG implementation to assure equal access to needed medical care among residents. Non-MSA counties will have additional needs, including access to additional public health, protection and advocacy, and medical professionals to support the care of COVID-19 patients, including transitions to medical centers. While similar numbers are not available for group homes, intermediate care facilities, jails and prisons, these efforts should extend to protect the rights and health of residents and workers in those congregate care settings as well.

Additional Montanans at risk in these settings during COVID-19 are the workers, especially when a positive case exists in a facility. These essential health care workers need support to make ethical and legal decisions regarding the care and treatment of residents and to coordinate these decisions with medical experts using direct observations and current clinical assessments of residents' health. A critical condition for ethical and legal decision making and quality care delivery is an unstressed, healthy, and robust workforce. These facilities may need to expand the labor force and their staff and make environmental changes to implement quarantine, isolation, and other staffing strategies related to COVID-19 mitigation procedures. In those settings, additional attention is needed to provide for care routines within COVID-19 guidelines (e.g., CDC guidance for direct service providers), to accessing needed medical care, and to protecting civil rights and equal opportunities for adequate preventative resources and medical care.[26] Providing these alternate options reduces the demands on facilities and affords greater capacity to implement social distancing and staffing routines in the congregate settings.

Table 3. Numbers of Montana Licensed Skilled Nursing and Assisted Living Facilities and Residents, by Counties in Montana Metropolitan Statistical Areas (MSA), with Totals for Non-MSA counties (data source: Montana DPHHS Communicable Diseases Bureau, 2020).

County	No. SNF[2]/ county	No. of SNF residents	Percent of state SNF residents	No. of ALF[3]/ county	No. of Residents in ALF	Percent of state AFN residents
Carbon County	1	45	1.24%	2	35	0.59%
Cascade	3	359	9.91%	22	665	11.25%
Flathead	6	429	11.84%	17	621	10.50%
Gallatin County	3	154	4.25%	17	1269	21.46%
Jefferson County	1	56	1.55%	5	62	1.05%
Lewis and Clark County	3	120	3.31%	16	455	7.70%
Missoula	4	92	2.54%	17	519	8.79%
Silver Bow	3	176	4.86%	6	240	4.60%
Stillwater County	1	43	1.19%	2	25	0.42%
Yellowstone County	7	406	11.20%	39	1299	21.98%
Total for MSA Counties[1]	32	1474	47.90%	134	5155	87.20%
Total for Non-MSA (rural) Counties	40	2150	52.10%	76	757	12.80%
Total for all counties	72	3624	100%	210	5912	100%

[1]MSA counties = Metropolitan Statistical Area counties, and Montana MSAs include Billings (Carbon, Stillwater, and Yellowstone Counties), Missoula (Missoula County), Bozeman (Gallatin County), Helena (Jefferson and Lewis and Clark Counties); Kalispell (Flathead County); Great Falls (Cascade County); Butte-Silver Bow (Silver Bow County). [2] SNF = Licensed Skilled Nursing Facilities; [3] ALF = Licensed Assisted Living Facilities

Table 4. Additional descriptions of Montana Skilled Nursing Facilities and Assisted Living Facilities (data source: Montana DPHHS Communicable Diseases Bureau, 2020).

Skilled Nursing Facility (SNF)		Assisted Living Facility (ALF)	
Mean number of county residents[1] in Montana skilled nursing facilities	97.95 residents	**Mean number of county residents[1] in Montana assisted living facilities**	144.93
Mean number SNF Residents (range)	51.04 (range 13-155 residents/SNF)	**Mean number of MT ALF Residents (range)**	28.30 (range 4-181 residents/ALF)
Counties with at least one SNF	37	**Counties with at least one ALF**	41
Range number of SNF/County	1 to 7	**Range number of ALF/County**	1 to 39

[1]Calulated for counties with at least one facility

Concept of Operations
Indicators/Triggers

Montana DPHHS might consider the following indicators and triggers to activate a Crisis Care Guidance response:[27]

Indicators with no associated Trigger (require analysis and decision-making):

- Disruption of facility or community infrastructure and function (e.g., utility or system failure in health care organizations, more than one hospital affected in the region, more than five hospitals affected, or critical-access hospitals affected in the state);
- Failure of hospital "contingency" surge capacity (i.e., resource-sparing strategies overwhelmed);
- Availability of material resources;
- Availability of space for patient care;
- Shortage of community resources to support patient discharge and care coordination;
- Pandemic phase/impact.

Potential Indicators with associated local Trigger (threshold that 'triggers' specific action is specified in agency/facility plans):
- Unable to answer all EMS calls;
- More than 12 hours of wait time for emergency department visits;
- Unable to maintain staffing in the Intensive Care Unit (ICU);
- Fewer than 5 percent of hospital beds available, no beds available;
- No ICU beds available in the healthcare organization; or a disaster declaration affects more than one area hospital;
- Shortage of specific equipment (ventilators) or of medications that have no substitute.

It is important to note that 'triggers' are more common at the initial levels of response. At the State level it will be much more common that indicators are reviewed, and appropriate actions determined based on the problem and potential solutions.

Communications
A Crisis Care Guidance situation will require extensive communication, coordination and collaboration among all response partners, so messaging is clear and consistent statewide. All communication materials should be available in accessible alternative formats.

On-Going Communication
During a crisis care situation, transparent communication is of the utmost importance. DPHHS Public Health Emergency Preparedness (PHEP) follows the principles of the National Incident Management System (NIMS) and will conduct its operations under the structure of the Incident Command System (ICS). Activities in this annex are based on established relationships and partnerships with the public, stakeholders and partners, and contributing agencies, including local, state, and federal entities. Methods for communicating both internal and external stakeholders may include:

- Health Alert Network (HAN) messages; and
- Public Information Officer (PIO) advisories and guidance documents

Public Information
DPHHS is responsible for directing and coordinating health-related communications activities during an incident with public health implications. During states of emergency, public/media communications are coordinated through the State Joint Information Center (JIC) via the Lead Public Information Officer (PIO). The Lead Public Health PIO will assume primary responsibility once DPHHS has activated an incident response structure. The DPHHS PIO will assume lead responsibility for public communication associated with an emergency or incident (see the DPHHS Public Health Crisis and Emergency Risk Communication Annex). The Federal Emergency Management Agency (FEMA) is committed to providing accessible

Information and Communication Technology to individuals with disabilities, including members of the public, disaster survivors and federal employees, by meeting or exceeding the requirements of Section 508 of the Rehabilitation Act (29 U.S.C. 794d). The availability of communications in accessible formats is required.[28]

Maintenance

Although the rapidly evolving circumstances associated with the 2020 COVID-19 pandemic precluded the ideal deliberative and participatory CCG planning with substantial involvement of local public and private entities, every effort was made to involve interested and expert stakeholders on an accelerated timeline. The source documents used here and created by the Minnesota Department of Health and the Washington State Department of Health have been vetted by their respective stakeholders. Minnesota's ethical objectives outlined under *Planning Assumptions* above demonstrate their ethical commitment to developing a sound CSC plan and this informed Montana's decision to repurpose their plan as a Montana document for use during the timeframe of the COVID-19 emergency, in the event the state ever had to invoke Crisis Care Guidance. Upon resolution of the current COVID-19 emergency, hospital emergency planning teams will initiate a revision of the current document or creation of a new document, including incorporation of more extensive Montana-specific stakeholder engagement.

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