3: Toolkit Part 1: Introduction

During a disaster, decision makers, health care providers, responders, and the general public are confronted with novel and urgent situations. Efficient, effective, and rapid operational decision-making approaches are required to help the emergency response system take proactive steps and use resources effectively to provide patients with the best possible care given the circumstances. It is also essential to develop fair, just, and equitable processes for making decisions during catastrophic disasters in which there are not enough resources to provide all patients with the usual level of care. Decision-making approaches should be designed to address a rapidly evolving, dynamic, and often chaotic set of circumstances. Information is often incomplete and contradictory. Agencies and stakeholders need to understand what information is available to support operational decision making in this kind of situation, and what triggers may automatically activate particular responses or may require expert analysis prior to a decision. This toolkit is intended to help agencies and stakeholders have these discussions.

TOOLKIT OBJECTIVE

The objective of this toolkit is to facilitate a series of meetings at multiple tiers (individual agency and organization, coalition, jurisdiction, region, and state) about indicators and triggers that aid decision making about the provision of care in disasters and public health and medical emergencies. Specifically, the toolkit focuses on indicators and triggers that guide transitions along the continuum of care, from *conventional* standards of care to *contingency* surge response and standards of care to *crisis* surge response and standards of care, and back to *conventional* standards of care. The toolkit is intended as an instrument to drive planning and policy for disaster response, as well as to facilitate discussions among stakeholders that will help ensure coordination and resiliency during a response.

Box 3-1 presents descriptions of key terms and concepts. This toolkit (presented in Chapters 3-9 of the report) is designed to be able to stand alone, although interested readers will find additional background information and more nuanced discussion of key concepts related to indicators and triggers in Chapters 1 and 2.

This toolkit focuses on operational planning and the development of indicators and triggers for crisis standards of care. Public engagement is also a key element of crisis standards of care planning; a toolkit for

BOX 3-1
Key Terms and Concepts

Crisis standards of care: "Guidelines developed before disaster strikes to help health care providers decide how to provide the best possible medical care when there are not enough resources to give all patients the level of care they would receive under normal circumstances" (IOM, 2012, p. 6-14).

Continuum of Care: Conventional, Contingency, and Crisis

Conventional capacity: The spaces, staff, and supplies used are consistent with daily practices within the institution. These spaces and practices are used during a major mass casualty incident that triggers activation of the facility emergency operations plan.

Contingency capacity: The spaces, staff, and supplies used are not consistent with daily practices, but provide care that is *functionally equivalent* to usual patient care. These spaces or practices may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources).

Crisis capacity: Adaptive spaces, staff, and supplies are not consistent with usual standards of care, but provide sufficiency of care in the context of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care.

SOURCE: Hick et al., 2009.

Indicators and Triggers

Indicator: A measurement, event, or other data that is a predictor of change in demand for health care service delivery or availability of resources. This may warrant further monitoring, analysis, information sharing, and/or select implementation of emergency response system actions.

community conversations on crisis standards of care is available in the Institute of Medicine's report *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response* (IOM, 2012).

USING THE TOOLKIT

Toolkit Design

The discussion toolkit is structured around two scenarios (one slow-onset and one no-notice), a series of key questions for discussion, and a set of example tables. The example indicators and triggers encompass both clinical and administrative indicators and triggers. The toolkit is designed to facilitate discussion to drive the planning process.

This chapter provides part 1 of the toolkit, which covers material that is relevant to all components of

Trigger: A decision point that is based on changes in the availability of resources that requires adaptations to health care services delivery along the care continuum (contingency, crisis, and return toward conventional).

Crisis care trigger: The point at which the scarcity of resources requires a transition from contingency care to crisis care, implemented within and across the emergency response system. This marks the transition point at which resource allocation strategies focus on the community rather than the individual.

Steps for Developing Useful Indicators and Triggers

The following four steps should be considered at the threshold from conventional to contingency care, from contingency to crisis care, and in the return to conventional care. They should also be considered for both no-notice and slow-onset incidents.

1. **Identify key response strategies and actions** that the agency or facility would use to respond to an incident. (Examples include disaster declaration, establishment of an emergency operations center [EOC] and multiagency coordination, establishment of alternate care sites, and surge capacity expansion.)
2. **Identify and examine potential indicators** that inform the decision to initiate these actions. (Indicators may be comprised of a wide range of data sources, including, for example, bed availability, a 911 call, or witnessing a tornado.)
3. **Determine trigger points** for taking these actions.
4. **Determine tactics** that could be implemented at these trigger points.

Note: Specific numeric **"bright line"** thresholds for indicators and triggers are concrete and attractive because they are easily recognized. For certain situations they are relatively easy to develop (e.g., a single case of anthrax). However, for many situations the community/agency actions are not as clear-cut or may require significant data analysis to determine the point at which a reasonable threshold may be established (e.g., multiple cases of diarrheal illness in a community). In these situations, it is important to define who is notified, who analyzes the information, and who can make the decision about when and how to act on it.

the emergency response system, including the scenarios and a set of overarching questions. Part 2 of the toolkit is provided in Chapters 4-9, which are each aimed at a key component of the emergency response system: emergency management, public health, behavioral health, emergency medical services (EMS), hospitals and acute care facilities, and out-of-hospital and alternate care sites. These chapters provide additional questions intended to help participants drill down on the key issues for their own discipline. These chapters also contain a table that provides example indicators, triggers, and tactics across the continuum of care. This is followed by a blank table for participants to complete.[1] The scenarios, questions, and example table are intended to help facilitate discussion around filling in the blank table.

These scenarios are provided to facilitate discussion and encourage practical thinking, but participants

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[1] The blank table for participants to complete can be downloaded from the project's website: http://iom.edu/Activities/Global/Crisis StandardsofCareToolkit.aspx.

should consider a range of different scenarios—based on their Hazard Vulnerability Analysis—when developing indicators and triggers for their organization, jurisdiction, and/or region. The toolkit provides examples, but does not provide specific indicators and triggers for adoption. This discussion sets a foundation for future policy work, planning, and exercises related to crisis standards of care (CSC) planning and disaster planning in general. The indicators and triggers developed for CSC planning purposes are subject to change over time as planned resources become more or less available or circumstances change. It will be important to regularly review and update CSC plans, including indicators and triggers.

Overarching Key Participants

This toolkit has been designed to be scalable for use at multiple levels. Discussions need to occur at the facility, organization, and agency levels to reflect the level of detail about organizational capabilities that is needed for operational decision making. Discussions also need to occur at higher levels of the emergency response system to ensure regional consistency and integration; it is important to understand the situation in other organizations and components of the emergency response system instead of moving unilaterally to a more limited level of care. Depending on the specific community, these discussions may be initiated at different tiers and may occur in a top-down or bottom-up fashion, but at some point must occur at all tiers reflected in the Medical Surge Capacity and Capability (MSCC) framework shown in Figure 3-1 (repeated here from Chapter 1). The development of indicators and triggers could be used by planners as an opportunity to benchmark their approaches, thus facilitating both intrastate and interstate coordination. This may be particularly valuable to entities operating in multistate locations.

This planning process is important regardless of the size of an agency; local preparedness is a key element of avoiding reaching CSC. Instead of using the MSCC framework and creating another response framework, some states may have existing regional and state infrastructures for inclusive trauma/EMS advisory councils/committees; the points made above about the importance of including all response partners and ensuring horizontal and vertical integration within and across tiers apply equally, regardless of the specific framework used.

The following participants should be considered for these discussions; additional participants may be brought in for the stakeholder-specific discussions and are listed in subsequent chapters:

- State and local public health agencies;
- State disaster medical advisory committee;
- State and local EMS agencies (public and private);
- State and local emergency management agencies;
- Health care coalitions (HCCs) and their representative health care organizations, and where appropriate, U.S. Department of Veterans Affairs Medical Centers and Military Treatment Facilities that are part of those HCCs;
- State associations, including hospital, long-term care, home health, palliative care/hospice, and those that would reach private practitioners;
- State and local law enforcement agencies;
- State and local elected officials;

- State and local behavioral health agencies;
- Legal representatives and ethicists; and
- Nongovernmental organizations that may be impacted by implementation of CSC (AABB, American Red Cross local chapter, etc.).

When Should These Discussions Take Place?

For communities that have already begun to develop CSC plans, this toolkit can be used to specifically develop the indicators and triggers component of the plan. For communities that are in the early phases of the CSC planning process, the use of this toolkit, and the exploration of community-, regional-, and state-derived indicators, triggers, and the process by which actions are then taken, would be an excellent place to start this important work. It provides much of the needed granularity about what it means to transition away from conventional response and toward the delivery of health care that occurs in the contingency arena, or in worst cases, under crisis conditions. For additional guidance on the development of CSC plans, including planning milestones and templates, see the IOM's 2012 report.
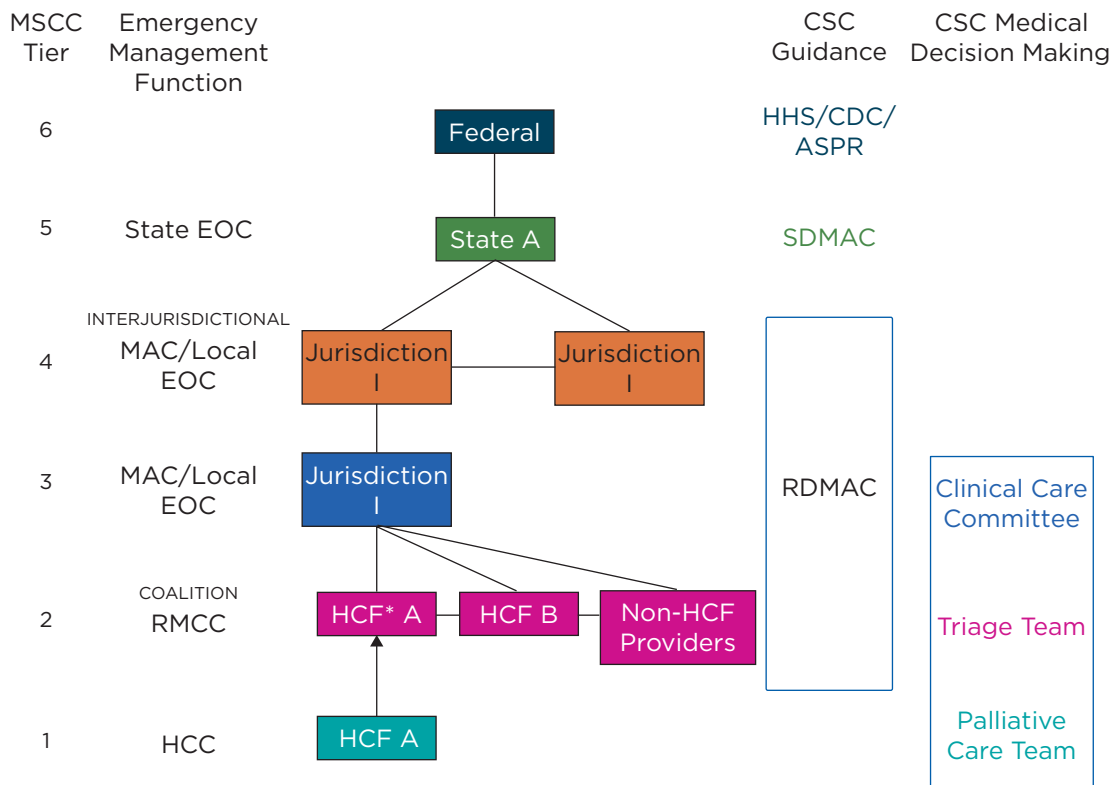

FIGURE 3-1
Integrating crisis standards of care planning into the Medical Surge Capacity and Capability framework.
NOTES: See Table 2-2 in IOM (2012) for further detail and description of the functions of these entities. The clinical care committee, triage team, and palliative care team may be established at MSCC tiers 1, 2, or 3. The RDMAC may be established at MSCC tiers 2, 3, or 4, depending on local agreements. The RMCC is linked to the MAC/Local EOC and is intended to provide regional health and medical information in those communities; it functions at MSCC tiers 2-4. ASPR = Assistant Secretary for Preparedness and Response (Department of Health and Human Services); CDC = Centers for Disease Control and Prevention; CSC = crisis standards of care; EOC = emergency operations center; HCC = health care coalition; HCF = health care facility; HHS = Department of Health and Human Services; MAC = Medical Advisory Committee; RDMAC = Regional Disaster Medical Advisory Committee; RMCC = Regional Medical Coordination Center; SDMAC = State Disaster Medical Advisory Committee.
SOURCE: Adapted from IOM, 2012, p. 1-44.

Suggested Process

As noted above, discussions should occur at multiple tiers of the system. A suggested process is provided in Figure 3-2 for discussions at the level of the health care organization, agency, or a small number of related agencies (e.g., EMS and dispatch).

For discussions at higher tiers of the system (e.g., among organizations, coalitions, and agencies from multiple sectors), additional work by participants in advance would be helpful so they arrive having already given thought to the indicators, triggers, and tactics that their own organization or agency would expect to use. Depending on whether this series of discussions is occurring top-down or bottom-up in a given community, this advance work could be done through convening sector-specific discussions first, as described above, or simply through asking each participant to start thinking about his or her own organization's or agency's likely actions beforehand.

In particular, it is important to highlight that the two government entities, emergency management and public health, should review the other sections and ensure that the activities they have outlined would support the activities described in the other sections. This would solidify the intent that local and state governmental agencies will need to support health care organizations and HCCs during CSC.
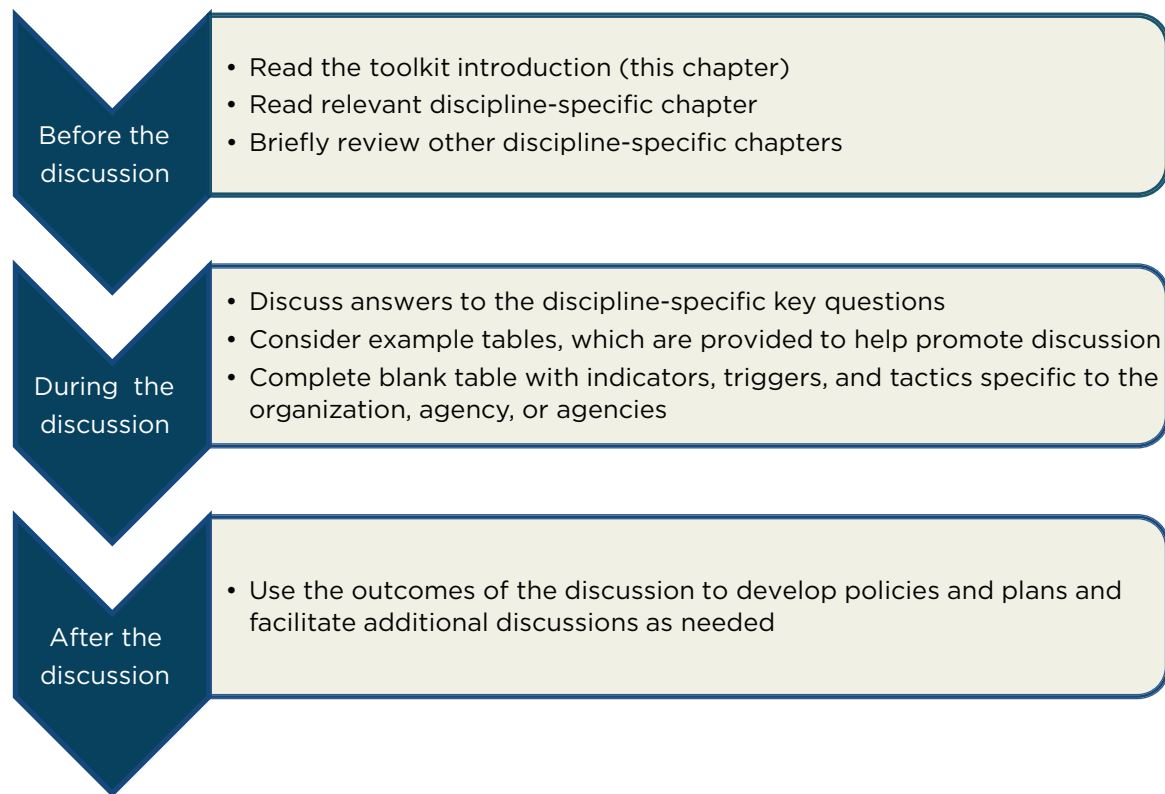
Before the discussion
- Read the toolkit introduction (this chapter)
- Read relevant discipline-specific chapter
- Briefly review other discipline-specific chapters

During the discussion
- Discuss answers to the discipline-specific key questions
- Consider example tables, which are provided to help promote discussion
- Complete blank table with indicators, triggers, and tactics specific to the organization, agency, or agencies

After the discussion
- Use the outcomes of the discussion to develop policies and plans and facilitate additional discussions as needed

FIGURE 3-2
Suggested discussion process.
NOTES: The example tables are provided to help facilitate discussion and provide a sense of the level of detail and concreteness that will be valuable; they are not intended exhaustive or universally-applicable. It is important that participants complete the blank table with key indicators, triggers, and tactics that are specific to their organization, agency, or agencies. Depending on the size of the discussion group, it may be most useful for a subgroup of participants to develop the next steps.

To ensure that this aspect of CSC planning is not done in isolation, it would be helpful if the person(s) leading this initiative has more in-depth knowledge of the IOM's 2012 report, in addition to knowledge about the emergency preparedness program within their facility, agency, and/or jurisdiction.

Assumptions

This toolkit assumes that participants have an understanding of baseline resource availability and demand in their agency, jurisdiction, and/or region. The toolkit focuses on detecting movement away from that baseline, and associated decision making.

This toolkit presents common questions, ideas for discussion issues, and example indicators and triggers. Because the availability of resources varies across communities, it is clear that the answers will look very different. That is why this toolkit is a starting point for discussions and is not prescriptive.

Because communities across the nation are at different stages of planning, this toolkit could be used to fill a specific gap in an existing CSC plan, but it also could serve as a first entry point into a larger CSC planning effort.

SLOW-ONSET SCENARIO (PANDEMIC INFLUENZA)[2]

In early fall, a novel influenza virus was detected in the United States. The virus exhibited twice the usual expected influenza mortality rate. As the case numbers increased, a nationwide pandemic was declared. The Centers for Disease Control and Prevention (CDC) identified the at-risk populations as school-aged children, middle-aged asthmatics, all smokers, and individuals greater than age 62 with underlying pulmonary disease. Vaccine for the novel virus is months away.

Emergency Management

Emergency management has been in communication with public health as this outbreak has unfolded, maintaining situational awareness. They have initiated planning with all key stakeholders as soon as the pandemic was recognized. The county emergency operations center (EOC) was activated, first virtually, then partially, and then fully, as cases began to overwhelm the medical and public health systems. Emergency management has been responding to the logistical needs of public health, EMS, and the medical care system and is coordinating information through a Joint Information System. At the request of local EOCs and the State Health Emergency Coordination Center, the State Emergency Operation Center has been activated. The key areas of focus are coordinating volunteers, providing security, maintaining and augmenting communications, and facilitating coordination of efforts in support of the Emergency Support Function (ESF)-8 agencies. The emergency managers maintain the incident planning cycle and assist ESF-8 personnel in writing daily incident action plans and determining resource needs and sources. Private corporations have given significant support, lending personnel to staff points of dispensing sites, providing home meals to those isolated in their homes or on self-quarantine, and providing logistical support to hotlines and

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[2] The two scenarios presented here have been adapted from the two scenarios in Appendix C of IOM (2009). They are provided to encourage discussion and practical thinking, but participants should not confine themselves to the specific details of the scenarios and should consider a range of scenarios based on their Hazard Vulnerability Analysis.

alternate care sites. Later on, when the pandemic winds down, the EOC will help coordinate transition of services toward conventional footing and identify the necessary resources to recovery planning and after-action activities.

Public Health

Local and state public health have been monitoring the status and planning for the pandemic since it was identified through epidemiological data. Multiple health alerts have been issued over the past weeks as conditions or predictions changed and recommendations for targeted use of antiviral medications have been communicated by the State Public Information Officer based on CDC recommendations. Public information campaigns begin, and emergency management and public health convene planning meetings involving key health and medical stakeholders in anticipation of a sustained response. As noted above, vaccine is months away and, when it arrives, may initially be available in only limited quantities. CDC is recommending use of N95 respirators for health care workers. There is an immediate shortfall of N95 respirators in supply chains nationwide and local shortages of antivirals are reported.

Enhanced influenza surveillance has become a standard across the United States and the world. Local health care organizations increased influenza testing and the state laboratory has confirmed the current strain of influenza virus is present in multiple counties statewide. Volume of laboratory testing has increased substantially in local, regional, and state-wide laboratories, which are now looking at current resources and possible modifications to testing protocols.

As the epidemic expands, local and state health EOCs are active 24/7 to support the response. The lead for this incident is the ESF-8, and communications between local and state EOCs in collaboration with the State Health Emergency Coordination Center have been augmented and standardized. Declarations of emergency have been released from the state, including public health emergencies or executive orders consistent with state authorities. Public health and state EMS offices are preparing specific regulatory, legal, and policy guidance in anticipation of the peak impact and subsequent waves. In addition to the activities associated with health, state, and local public health, offices are also addressing other functions, such as human services programs, water quality, food safety, and environmental impact.

EMS

Volumes of calls to 9-1-1 have escalated progressively over time, with high call volumes for individuals complaining of cough and fever. Many high-priority calls cannot be answered during peak hours due to volume. To divert non-emergency calls, hotlines have been established (where available) through which nurses and pharmacists can provide information and prescribe antiviral medications if necessary[3]; auto-answer systems have also been established to direct callers to Internet-based information.

The state EMS office has been contacted and necessary waivers are underway. The physician or physician board providing medical direction for the EMS agency and the EMS agency supervisor have implemented emergency medical dispatch call triage plans and have altered staffing and transport requirements to adjust to the demand. As public health clinics are overflowing with people demanding medical countermeasures (vaccines and antivirals), there have

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[3] See Koonin and Hanfling (2013).

been several reports of violence against health care providers, thefts of N95 respirators from ambulances, and threats against EMS personnel by patients who were informed they do not meet the transport criteria in the disaster protocol.

A recent media report about the sudden death of a 7-year-old child of respiratory failure from a febrile illness has caused significant community concern, sharply escalated the demand on emergency medical dispatch and EMS, and increased workforce attrition throughout the entire emergency response and health care systems.

Hospitals

Hospitals have activated their hospital incident command system and moved from conventional care to contingency care as the pandemic worsens. These modifications have been communicated through their regional health care coalition to their local EOC with anticipated support and possible waivers. As patient volumes escalate to nearly double the usual volume, elective surgeries are reduced, intensive care unit patients are boarded in step-down units, inpatients are boarded in procedure and postanesthesia care, and rapid screening and treatment areas are set up for those who are mildly ill in areas apart from the emergency department (ED). As demand increases, hospital incident commanders are convening their clinical care committees to work with the planning section to prioritize available hospital resources to meet demand, as well as anticipating those resources that may soon be in short supply, including ventilators. Hospitals are sharing ED and inpatient data with the health department. Requests for new epidemiologic and other data have been received. Schools have been dismissed and this, in addition to provider illness, is having a dramatic impact on hospital staffing, as staff who are caregivers are reluctant to use onsite childcare.

Out-of-Hospital

Home care agencies note a significant increase in the acuity and volume of their patient referrals as hospitals attempt "surge discharge" and triage sicker patients within their home. Many home care workers are calling in sick and the agencies are using prioritization systems to determine which clients will be visited on what days. Durable medical equipment across the state providers are starting to identify shortages of home oxygen supplies and devices. Ambulatory care clinics had to clear schedules to accommodate the volume of acute illness. Despite media messages to stay home unless severely ill, many patients are calling their clinics for appointments and information; this is tying up clinic phone lines much of the time. Clinics are struggling to keep infectious and non-infectious patients separated in their facilities. As the epidemic worsened, alternate care facilities are opening to augment care for hospital overflow patients. Hospice patients are being referred to acute care facilities because they can no longer be cared for at home and many do not have their advance directives with them. As the pandemic wanes, many patients who deferred their usual or chronic care during the pandemic now present to clinics and EDs, continuing to stress the outpatient care sector.

Behavioral Health

The pandemic has had a tremendous psychological impact. Nearly everyone is exposed to death and illness, either personally or via the media. Houses of worship and other gathering places where people typically get services and support are closed and people are feeling more isolated. Management of decedents is becoming problematic. Hospital and civil morgues and funeral directors are overwhelmed. Coffins and funeral home supplies are in short supply and there

is difficulty getting more. Families of the deceased are becoming increasingly agitated and assertive, demanding that hospitals, medical examiners/coroners, and health authorities take action. Demonstrations about vaccine delays are occurring at hospitals, clinics, and the local health department. Interstate commerce has been affected as restrictions on travel and transport become more pervasive. This is resulting in a noticeable decline in the availability of goods and services. Police are reporting instances of aggression, especially in grocery stores and at ATMs that have not been resupplied. The local and state Department of Social Services is reporting increased calls regarding substance abuse and domestic violence in homes where families have sheltered in place.

Those with preexisting behavioral health conditions are destabilized and require additional support, and many in the population exhibit features of new mental health problems, including anxiety and posttraumatic stress disorder. Existing psychiatric patients are also exhibiting increased symptoms as they are not able to obtain their medications. Police, health care workers, and community leaders are reporting substantially increased demand on detox services, and hospitals are discharging chemically dependent and psychiatric patients to make room for other types of patients, which is contributing to some of the problems.

Health care workers and public safety personnel are particularly hard hit by stress, especially those who are not prepared mentally for resource triage. Efforts are being made to "immunize" targeted populations with information on normal and abnormal stress responses, and additional screening and crisis support phone lines have been set up. Conventional outpatient crisis care and inpatient psychiatric care are overwhelmed, and faith-based, volunteer, and other support organizations have to take a much more active role supporting those in crisis in the community. That support is increasingly difficult as needs become more pervasive and severe, and face-to-face individual and group support becomes more difficult.

NO-NOTICE SCENARIO (EARTHQUAKE)

An earthquake, 7.2 in magnitude on the Richter scale, occurred at 10:45 a.m. in a metropolitan area. It also affected multiple surrounding counties that are heavily populated. Along with the initial shaking came liquefaction and devastating landslides. This major quake has shut down main highways and roads across the area to the south, disrupted cellular and landline phone service, and left most of the area without power. Several fires are burning out of control in the metropolitan area. As reports are being received, the estimate of injured people has risen to more 8,000. Deaths resulting from the earthquake are unknown at this time, but are estimated to be more than 1,000. Public safety agencies are conducting damage assessments and EMS agencies are mobilizing to address patient care needs. Hospitals and urgent/minor care facilities have been overwhelmed with injured victims. Two community hospitals and an assisted living center report extensive damage. Patients and residents are being relocated to alternate care centers; however, these options are unsuitable for those requiring a higher level of medical support due to lack of potable water and loss of electrical power at several facilities. Outpatient clinics and private medical practices are woefully understaffed or simply closed.

Emergency Management

State, county, and local EOC have been activated. The governor has provided the media with an initial briefing. As outlined in the National Response Framework, they are attempting to coordinate with EOCs in non-impacted

areas and neighboring states, as well as the federal government, in order to mobilize resources to send into affected areas.

Local EOCs in the impacted area are trying to gain situational awareness through damage assessments, communication with stakeholders about utility failures, road access, injuries, and structural damage. EMS and public health have representatives at the EOCs (public health represents the health care sector for the jurisdiction, including liaison to the health care coalition, by prior agreement). Widespread impacts on hospitals will require that those facilities be evacuated, but EMS is taxed by incident-related demands and difficult road access.

Public Health

The state ESF-8 agency has mobilized resources from unaffected areas and is working with the state emergency management agency/state EOC to request assistance via Emergency Management Assistance Compact (EMAC) for vehicles and personnel. The governors of the surrounding states have dispatched medical and search and rescue teams. Public health authorities are inundated with the flow of information and requests for public health and medical assistance coming in to the ESF-8 desk at the local level. The State Health Emergency Coordination Center is fully activated to support the health and public health sectors. Public health authorities are working to initiate "patient tracking" capabilities, and have been asked to support activation of family reunification centers. Health care facilities needing evacuation are calling asking for assistance, including the mobilization of additional personnel resources (e.g., Medical Reserve Corps). Coordinated health and safety messages are providing information pertaining to boil water orders, personal safety measures around gas leaks, downed power lines and active fires, and a description of what resources are being mobilized to respond to this catastrophic disaster event.

EMS and First Responders

Uncontrolled fires have erupted due to broken gas lines. The local fire agencies are unable to respond to all requests for assistance due to broken water lines, difficult access, and the number of fires and damaged structures that have been reported. Only priority structure fires (e.g., fires in or near buildings suspected of containing occupants or hazardous materials) are receiving assistance. Fire departments from counties experiencing less damage are sending whatever assistance they can; however, they are not expected to arrive before evening. Dispatch centers are initiating mutual aid from unaffected counties within the state on request of local and county incident command (IC) through their respective EOCs.

The 9-1-1 emergency lines are inoperable as telephone service has been interrupted by widespread power outages and downed cell towers. The 700 and 800 MHz radios are the most reliable communication because landline and cellular telephone service are inoperative. Many of the injured cannot reach local hospitals due to damaged roads, debris, broken water lines, and power outages that have slowed traffic to a near stand-still. EMS providers report a shortage of staff and vehicles. Air ambulances are temporarily grounded due to foggy and windy conditions, and commercial airports have been closed for an unknown period of time. Unified command has been established and casualty collection points are being identified.

The main freeway is closed due to several collapsed overpasses and road damage, the worst of which has occurred at the freeway interchange. The travel lanes on the overpasses have completely collapsed, trapping at least 12 cars and 2 tourist buses below. The Department of Transportation is assessing structural damage on all freeway overpasses.

The collapse of this segment of the freeway has obstructed or delayed the ability of ambulances and emergency response units to respond to 9-1-1 calls or transport to the local tertiary care facility.

The governor has requested assistance from the Federal Emergency Management Agency (FEMA), including a Presidential Declaration of Disaster. FEMA will initiate a Joint Field Office as a first step to coordinating federal support for this area. State emergency management has requested EMAC assistance for vehicles and personnel. Governors of surrounding states have dispatched medical and search and rescue teams.

Hospital Care

At one of the hospitals, a 300-bed Level 2 trauma center, is occupied at full census, but the administrator activates the Hospital Incident Command System, which opens the hospital command center and activates the disaster response plan. Other area hospitals are also impacted. A damage report reveals that this trauma center is on back-up power and the water supply is disrupted, but there is no major structural damage. Victims are already arriving in the parking lot on foot and by private vehicle as well as by EMS transport. The interhospital radio system is still active, with multiple hospitals reporting significant damage to their hospitals and surrounding routes of access. The administrator recognizes that despite their limitations, they will have to provide stabilizing care to arriving patients. There is no need to imminently evacuate the facility, though appeals for additional staff and a status report are made to the health care coalition coordinating hospitals via radio.

Additional surge care areas are established in the lobby area for ambulatory patients and in an ambulatory procedure area for non-ambulatory patients. Surgeons perform basic "bailout" procedures, but the sterile supply department will have difficulty resterilizing surgical trays with available potable water. The administrator works with established material management departments and hospital staff to take stock of materials that may be in shortage and recommend conservation strategies for oxygen, medications (including antibiotics and tetanus vaccine), and other supplies. Off-shift staff members are having trouble accessing the hospital, and many staff present are not able to reach family members—some have left to go find their families, some have stayed to work extra shifts. Blood supply is limited, with resources already being used for the first cases to arrive. There are limited capabilities to manage burn patients, which are usually transferred to the regional burn center. Health care coalitions in the affected area, as well as neighboring regions, are activated to support response.

Outpatient Care

Ambulatory care clinics, private medical practices, skilled nursing and assisted living facilities, dialysis centers, and home health care services are all significantly impacted by the earthquake. Victims of the earthquake and those patients unaffected directly by the disaster, but in need of ongoing support for their chronic medical care services, are all impacted. Patients requiring regularly scheduled dialysis are unable to receive care at their normal dialysis site. Patients dependent on home ventilators are concerned that their back-up power resources, if any, are not likely to last for more than a few hours. The regional health care coalition hospital coordination center works with public health in the local EOC to identify resources for these patients, including the identification of "shelter" options, but many simply head to the hospital as a safe haven. Health care practitioners and professionals are urgently recruited to assist in the establishment of alternate care sites and shelter environments, which are being set up around the perimeter of

the most severely affected areas. Access to medications at pharmacies is significantly impacted, sending more patients seeking assistance at already overtaxed hospitals. .

Behavioral Health

The behavioral health unit at the impacted hospital or social work department crisis response staff deploys a small team to respond to patient and staff mental health needs as a standard component of the hospital's emergency response plan. The hospital lobby is teeming with people who appear shocked and confused. The hospital sets up an emergency triage and assessment unit for persons with minor injuries and those survivors looking for family members, and initiates behavioral health assessment and psychological first aid, targeting those who appear to be disoriented or distraught.

At the hospital, uninjured citizens begin to arrive in large numbers trying to find their loved ones. The hospital has an incomplete and ever-changing list of those being treated and are challenged in the early hours to provide definitive answers to inquiries. Citizens are becoming more anxious and angry. Hospital personnel are attempting to physically sort and separate family members with loved ones being treated in the hospital, searching families, and families of those in the hospital morgue. The number of deceased patients in the hospital morgue is increasing from deaths related to the incident. In addition, community morgue resources are taxed.

Several people (including children) have experienced severe burns, local capacity has been exceeded, and burn patients have been evacuated to burn centers in neighboring jurisdictions. Searching family members are becoming increasingly agitated and demanding when they are unable to learn the whereabouts of their loved ones and/or be reunited with them. Communications about individuals' locations are being forwarded to governmental support systems such as local and state EOCs, Joint Information Centers, and non-governmental emergency response agencies.

Some hospital personnel are refusing to come to work until and unless they can be assured of their safety in the hospital as well as the proper care and safety of their children (who are no longer in school).

At the request of local EOCs, the state EOC activates six Medical Special Needs Shelters, which are staffed with behavioral health assessment and intervention teams, and activate behavioral health crisis response teams to assist first responders active in rescue and recovery, and evacuation activities. Rumors develop that registered sexual offenders or other "risky persons" are among those residing in shelters.

An inpatient forensic psychiatric unit has been damaged and deemed unsafe. Following hospital response plans, arrangements are attempted to move patients to a comparable facility in another county/state. Difficulties are encountered in arranging appropriate transport and the receiving hospital reports very limited bed availability.

The chaos associated with the incident has increased the public's anxiety that people will die from their injuries while awaiting emergency transport. Risk/crisis communication talking points are disseminated to local officials and the media as to where behavioral health assistance is available.

OVERARCHING KEY QUESTIONS

The following questions reflect overarching common themes that apply to all stakeholder discussions. The discipline-specific portions of the toolkit (Chapters 4-9) include questions that are customized for these disciplines; the overarching questions are included here to facilitate shared understanding of the common issues under discussion by each discipline.

- What information is accessible?
- How would this information drive actions?
- What additional information *could* be accessed during an emergency and how would this drive actions?
- What actions would be taken? What other options exist?
- What actions would be taken when X happens, where X is a threshold that would signal a transition point in care (e.g., can't transport all patients, run out of ventilators, can't visit all the sickest home care patients).
- Do the identified indicators, triggers, and actions follow appropriate ethical principles for crisis standards of care? What legal issues should be considered?[4]

WORKER FUNCTIONAL CAPACITY

It is important to highlight understanding and attending to the sometimes unique needs of those whose roles include administration of and response to an extreme incident. If their health (including behavioral health) is adversely impacted in ways that impact role function, the entire response can become compromised and, in extreme cases, fail. Preparedness activities should include detailed planning that anticipates and addresses behavioral health consequences for both decision makers and responders. Preparedness activities should address strategies for monitoring the responder population, identifying potential sources of psychological distress, and available interventions, including those geared toward stress reduction and management as well as resilience promotion among these responders. During a response, proactive monitoring is needed of the "temperature" of staff by supervisory personnel, with reports back to the IC, and aggressive measures to maintain morale, manage fatigue, and manage home-related issues for staff.

Table 3-1 below outlines indicators, triggers, and tactics related to worker functional capacity and workforce behavioral health protection. It has the same format as the tables included in the discipline-specific chapters that follow this one. These chapters provide tables with examples of discipline-specific indicators, triggers, and tactics; this is not an exhaustive list. The examples are provided here because this is a crosscutting issue that should be addressed by all sectors to improve the quality of decisions and quantity of available staff. The discipline-specific chapters also discuss strategies to address worker shortages.

Given the focus of this toolkit on decision making, the examples in the table are focused primarily on behavioral health and human factors. It is important to recognize that other areas of workforce protection, such as physical health and safety (including fatigue management), are also critical and should be considered during disaster planning processes. A comparable discussion should take place about other health and medical elements of force protection. In addition, the examples provided here are general approaches to worker functional capacity; for more details on individual topic areas, see the discipline-specific chapter and, in particular, the behavioral health chapter (Chapter 6).

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[4] Ethical considerations are a foundational component that should underlie all crisis standards of care planning and implementation. The Institute of Medicine's 2009 and 2012 reports provide extensive discussion of ethical principles and considerations. Considerations of legal authority and environment are also a foundational component to CSC planning and implementation. Certain indicators and triggers related to legal issues are included in this toolkit in Chapters 4-9; for additional discussion, see the 2009 and 2012 reports.

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TABLE 3-1
Example Worker Functional Capacity Indicators, Triggers, and Tactics for Transitions along the Continuum of Care

Indicator Category	Contingency	Crisis	Return Toward Conventional
Worker functional capacity	**Indicators:** • Employees routinely working more than 150% of usual shift duration • Patient/public complaints increase • Worker complaints about coworkers increase (attitude, decision making, etc.) • Workers begin to exhibit increased signs of stress (physiological, psychological, emotional, behavioral, social) (unit supervisors should be passing on reports to the command center) • Increased sick calls • Coworker perception of excessive fatigue or maladaptive behaviors (inability to make decisions, increased anger, etc.) • Increases in role conflict issues (relative priorities of home/family well-being and job function) reported by unit supervisors or implied by infrastructure damage, school closings, or communications systems failures • Workplace accidents increase • Workers express doubts/problems with their perceived safety or education/training for current tasks • Negative media coverage /public perception of facility/agency response **Triggers:** • Worker signs of stress or fatigue (physiological, psychological, emotional, behavioral, social) become commonplace • Productivity/function begins to decrease to the extent that supervisory personnel must intervene • X% increase in errors/incidents reported formally or informally to command center • Increases in role conflict (relative priorities of home/family well-being and job function) results in increased difficulty covering shifts/key roles	**Indicators:** • Productivity declines further • Errors/incidents increase rate and severity (patients/public are harmed and/or die as a result of errors) • Facility policies and actions cause negative public/media attention or compromised function of operations/relationships • Role conflict (relative priorities of home/family well-being and job function) increasingly problematic • Workplace accidents continue to increase • Workers decline to assume responsibilities they deem to be high risk **Crisis triggers:** • Productivity/function problems due to personnel issues cause service disruption • Role conflict (relative priorities of home/family well-being and job function) results reach a point where units are unable to maintain staffing, patients are transferred to other facilities, personnel refuse to come to work • Unable to give workers time off between shifts, at least equal to shift length • Workers are noted to be falling asleep on the job or exhibiting other unsafe behaviors **Tactics:** • Intensify stress management/resilience promotion training and activities (e.g., psychological first aid) • Continue regular and accurate surveillance of stress-related issues • Continue integration of various stakeholders in strategy development and implementation (e.g., direct care leadership, administration, HR, general counsel, EAP, etc.)	**Indicators:** • Workers begin to exhibit decreased signs of stress (physiological, psychological, emotional, behavioral, social) • Productivity/function begins to increase • Errors, incident reports, complaints decrease • Decreases in role conflict (relative priorities of home/family well-being and job function) • Workplace accidents decrease **Triggers:** • Productivity/function return to baseline • Errors/incident reports return to baseline • Shift schedules and responsibilities return toward baseline **Tactics:** • Stress management/resilience promotion training and activities (e.g., psychological first aid) become routine part of organizational practices • Evaluate, enhance, and continue regular and accurate surveillance of stress-related issues • Continue integration of various stakeholders in strategy development and implementation (e.g., direct care leadership, administration, HR, general counsel, EAP, etc.) with focus on rewarding staff, memorialization where appropriate, appreciation activities • Scale back or discontinue specialized consultation from content experts in workplace stress • Review, evaluate, and appropriately modify personnel policies and practices • Deactivate mutual aid and other supplemental human resources

Tactics:

- Implement stress management/resilience promotion training and activities (e.g., psychological first aid)
- Implement fatigue management policies
- Ensure adequate staffing ratios or provide additional personnel support for non-expert duties (lower levels of trained personnel, etc.)
- Ensure incident information flow to staff (situational awareness) is maintained, including operational briefings and opportunity for staff to provide input and comment
- Liaison/discussions with collective bargaining representatives to avoid conflicts arising from disaster-related staffing changes
- Provide support for the staff's family needs (access to phone lines to call home, providing basic shelter to family members, childcare, pet care, etc.)
- Provide appropriate nutrition support, including expanded hours of services
- Restrict non-essential duties (meetings, etc.)
- Ensure regular and accurate surveillance of stress and fatigue-related issues by management/supervisory staff
- Ensure integration of various stakeholders in strategy development and implementation (e.g., clinical care leadership, administration, human resources [HR], legal counsel, employee assistance programs [EAPs], etc.)
- Initiate staff appreciation activities
- Explore specialized consultation from content experts in workplace stress in extreme situations
- Review personnel policies and practices to explore ways in which stress on workers may be reduced, including rotations through other areas of the facility or variable responsibilities
- Review and update plans for mutual aid or other means of supplementing human resources

- Explore specialized consultation from content experts in workplace stress in extreme situations
- Implement changes in personnel policies and practices
- Activate plans for mutual aid or other means of supplementing human resources, including use of support personnel for all non-critical tasks

6: Toolkit Part 2: Behavioral Health

INTRODUCTION

This chapter presents a discussion and decision-support tool to facilitate the development of indicators and triggers that help guide decision making about behavioral health (BH) during a disaster. Because integrated planning across the emergency response system is critical for a coordinated response, it is important to first read the introduction to the toolkit and material relevant to the entire emergency response system in Chapter 3. Reviewing the toolkit chapters focused on other stakeholders would also be helpful.

"Behavioral health" is a term encompassing many topics. While there is growing use and consensus on the term's application and meaning, there is also some inconsistency in its use and meaning. For the purposes of this document, behavioral health is intended to include factors related to overall psychological, psychiatric, and psychosocial healthiness and well-being. It also refers to specific psychiatric and substance abuse disorders.

Behavioral health is a pervasive factor affecting the response capabilities of decision makers and response personnel. It also affects the survival capabilities of the general public and those persons who require either acute or longer term behavioral health treatment. Each of these groups faces common challenges in extreme events as well as unique stressors and intervention needs and opportunities.

It is important to highlight the centrality of understanding and attending to the sometimes unique needs of those whose roles include administration of, and response to, an extreme event. If the health of those involved (including BH) is impacted in ways that adversely impact role function, the entire response can become compromised and, in extreme cases, fail. Preparedness activities must include detailed and strategic planning, which anticipates and addresses behavioral health consequences for both decision makers and responders. Preparedness activities should address issues such as strategies for identification, monitoring, and interventions geared toward stress reduction and management, as well as post-recovery resilience promotion and mitigation of post-traumatic stress disorder.

During an emergency communities are confronted with a surge in demand and need for behavioral health intervention in health care facilities, sheltering sites, at numerous public and private outpatient care venues, and through risk and crisis messaging and communications. When local health care capacity is being stretched beyond conventional care standards, the need for BH alternative care strategies becomes essential

either as an adjunct to general health care treatment or as a primary intervention for major behavioral health conditions (including substance abuse and addictive disorders).

Nobody who experiences a crisis (e.g., one described by scenarios provided) is unaffected by its psychosocial impact. The individual and collective impact will introduce considerable variability in people's ability to function. Behavioral health sequelae will impact the function of leaders, providers, and victims on both individual and collective levels. Understanding, anticipating, and specifically planning for these impacts is central to protection and promotion of the public's health and successful event and recovery management.

Discussions within local communities that include the widest array of stakeholders with the goal of planning alternatives to conventional care and preparing for the eventuality of providing only crisis care can mitigate the premature and/or inappropriate movement to this level of care through a proactive planning and resource allocation process. The recognition and inclusion of behavioral health stakeholders and factors in these complex decisions is an essential component of sound preparedness, response, and recovery.

Roles and Responsibilities

In the broadest sense, nearly every organization and system and every governmental level has a stake in ensuring efficacious response to behavioral health factors in large-scale emergencies and disasters. Addressing adverse impacts of stress, suggesting actions, and implementing strategies that promote resilience, and ensuring efforts that provide appropriate care of those with BH disorders, is in everybody's best interest. Additional discussion about behavioral health in planning for and implementing crisis standards of care is available in the IOM's 2012 report, *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response.*

Special Circumstances

All extreme events require understanding of, and adaptation to, new and complex challenges. All of these challenges have behavioral health (as defined earlier in this chapter) elements. While all extreme events are stressful and demanding, some are especially difficult and complex. In these types of events, it is especially important that planners and incident leaders/managers understand the special psychosocial sequelae involved and ensure that behavioral health content experts are fully integrated into both decision making and response implementation. These include

- *Situations where a transition must be made in the fair and just allocation of resources and care when circumstances will not allow for the optimal level of care for all:* These are among the most difficult challenges that health care professionals can face. These are extraordinarily complex and difficult decisions that not only involve ethical and legal factors, but also have major psychological impact on those involved in these actions and choices. Planners are strongly encouraged to involve behavioral health professionals in preparing for and implementing these difficult transitions. Integrating behavioral health consultation and services into this process will enhance the probability that adverse psychological consequences for those involved can be reduced.

- *Situations resulting in large-scale incapacitation or death of health care workers:* These situations not only degrade the capacity and capability of the health care system, they often bring grief and bereavement to remaining colleagues and coworkers. The result may increase the need for support services (including behavioral health) and result in performance problems in workers.
- *Events producing extremely large numbers of fatalities:* These events (especially with special circumstances; e.g., contaminated, partial, unidentifiable, or difficult-to- retrieve remains) create special challenges. Although these regrettable circumstances may actually result in low use of prehospital and hospital care, they frequently result in a significant expansion of behavioral health issues and needs.
- *Events resulting in potential long-term or unknown health consequences:* Events resulting in these types of health consequences can have a long-term impact on not only the medical status, but the psychosocial well-being of both workers and the general population.
- *Death or incapacity of key leaders and/or decision makers:* Sound disaster and emergency preparedness and response rely heavily on capable and trusted leadership. In the event these leaders are unable to play their important roles, the entire response will likely be compromised. In preparing for these events it is critical that strategies be developed and implemented that anticipate absent and/or impaired (including psychological) leadership.
- *Events evoking extreme emotions:* While all disasters provoke significant emotional responses in many, if not most, of those who experience them, some events evoke extreme emotions in large numbers of people. These reactions can have a significant impact on the health system (including behavioral health). As an example, some types of events can produce widespread rage. These events may include terrorism, violence disproportionately impacting the most vulnerable (e.g., children), and perceived social injustice. Planners should include these types of events and their impact on the public's health in their preparedness activities.

Because panic is so widely misunderstood, a brief discussion about it may be helpful. Panic is defined as behavior in which individuals and groups engage in actions that are motivated exclusively by self-preservation, even at the expense of the health, safety, and lives of others. Issues about panic in extreme events are often not well understood. Inaccurate assumptions sometimes lead to compromised preparedness and response efforts. While panic does occur, it is extremely rare. Several conditions are typically present in those rare instances where panic does appear. These include imminent threat to life, novelty of the situation, absence of leadership and/or authority, and extremely limited or non-existent behavioral options. Planners should challenge assumptions that panic is a common, widespread, and easily triggered phenomenon. Planning should include strategies to address conditions where panic may occur, but recognize that if is far less common than is often assumed.

DISCUSSION AND DECISION-SUPPORT TOOL

Building on the scenarios and overarching key questions presented in Chapter 3, this tool contains additional questions to help participants drill down on the key issues and details for behavioral health. It also contains a chart that provides example behavioral health indicators, triggers, and tactics, and a blank chart

for participants to complete. The scenarios, questions, and example chart are intended to provoke discussion that will help participants fill in the blank chart for their own situation.[1] Participants may choose to complete a single, general blank chart, or one each for various scenarios from their Hazard Vulnerability Analysis.

Discussion Participants and Key Stakeholders

Suggested participants and key stakeholders for a discussion focused on behavioral health are listed below.

- State and local public health agencies;
- State disaster medical advisory committee;
- State and local emergency medical services agencies;
- State and local emergency management agencies;
- Health care coalitions (HCCs), and where appropriate, Department of Veterans Affairs Medical Centers (VAMCs) and military treatment facilities (MTFs) that are part of those HCCs;
- State associations, including hospital, long-term care, home health, palliative care/hospice, and those that would reach private practitioners and other community-based providers;
- State and local law enforcement agencies;
- State and local elected officials;
- Representatives of key systems and stakeholders where changes in medical and public health (including behavioral health) status might present (e.g., large employers, primary and secondary schools, colleges and universities), law enforcement;
- Senior agency representatives for at-risk and vulnerable populations, such as persons with developmental disabilities, elder affairs, children and families, persons with acute and chronic behavioral health disorders, and developmental disabilities;
- Behavioral health practitioner associations and related licensing and regulatory boards;
- Members of the faith-based sheltering network and representatives of the BH advocacy community, including, for example, Mental Health America and National Alliance on Mental Health, child/family advocacy groups, and the addiction recovery community;
- Behavioral health crisis response agencies tasked with operating various aspects of the community crisis response operations: (1) crisis lines, (2) mobile crisis teams that conduct face-to-face assessments, and (3) non-hospital-based crisis stabilization programs; and
- Additional non-governmental agencies that could include chemical dependency recovery programs, methadone clinics, domestic abuse/sheltering agencies, and certified psychological first aid provider agencies.

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[1] The blank table for participants to complete can be downloaded from the project's website: http://iom.edu/Activities/Global/Crisis StandardsofCareToolkit.aspx.

Key Questions: Slow-Onset Scenario

The questions below focus on the slow-onset influenza pandemic scenario presented in Chapter 3.[2]

Assumptions for Responding to a Slow-Onset Event

The gradual-onset pandemic scenario presents a complex set of behavioral health issues. The preevent readiness planning process activated preparedness structures addressing ethical, legal, public health emergency management, and public stakeholder/advocacy concerns and responsibilities. The medical advisory committee (critical care, emergency department physicians, infectious disease and pediatric specialists) established guidelines (indicators and triggers) necessary to ethically and legally move from conventional standards of care to contingency and ultimately to crisis standards of care. Each developing phase of the pandemic, starting with preevent planning, the onset of the event, the initiation of emergency operations, monitoring of the event features, and ongoing situational awareness, is accompanied by a corresponding degree of behavioral health assessment and intervention. The emerging discrepancy between behavioral health response capabilities and increasing demand from providers, patients/families, and the general public correspond directly with the intensity and complexity of the disaster event. The behavioral health discussion will need to address the crosscutting issues and population needs before, during, and after the event. The five key elements of ethical grounding, community and provider involvement, legal authority, clearly specified indicators, triggers and lines of responsibility, and the provision of evidence-based interventions, are applicable to the development of crisis standards of care for behavioral health.

Key Questions[3]

1. Has the specificity of the Concept of BH Operations integrated into command and response structures been tested?
2. What are the specific capabilities and capacities required for patients and families?
3. What are the specific capabilities and capacities required for providers?
4. What are the specific capabilities and capacities required for the general public?
5. What is necessary for rapid triage assessment and self-assessment BH triage?
6. What is the continuum of acute BH interventions needed?
7. What is the continuum of acute BH interventions available?
8. What is the BH risk/crisis communications strategic plan for each phase of the event?
9. What is the plan for postevent gap analysis to determine short-term strategies to meet additional BH demand for services?
10. What is the strategy for building and sustaining health care provider resilience for all phases of the event?
11. What epidemiological surveillance capabilities and indicators require monitoring of BH factors?

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[2] These questions are provided to help start discussion; additional important questions may arise during the course of discussion. The questions are aimed at raising issues related to indicators and triggers, and are not comprehensive of all important questions related to disaster preparedness and response.

[3] Some of these questions are derived from Box 4-4 of IOM (2012, p. 1-90).

Key Questions: No-Notice Scenario

The questions below focus on the no-notice earthquake scenario presented in Chapter 3.

Assumptions for Responding to a Rapid-Onset Event

A rapid-onset event assumes immediate and massive destruction of the physical infrastructure and significant injury and loss of life to the general population within the incident area. The BH impact is immediate and pervasive throughout the general population and the immediate responder community (also part of the general population). No-notice catastrophic events require strategies for addressing immediate loss of preevent treatment capacity and accommodating to mass fatalities and injury throughout the general population. Postincident trauma involves acute traumatic stress reactions throughout the responder and general population affecting all response capacity in the community. Activation and reassignment of behavioral health staff from non-impacted areas should be an integral feature of any initial (72-hour) response plan.

Key Questions

1. What BH response strategy/resources can be deployed immediately and in 24-hour increments for the initial 72-hour postincident response period?
2. What specific actions should a hospital take to manage a surge involving both injured and uninjured (seeking information/bereaved) citizens?
3. Is/how is assessment of first responder capacity and fitness for duty (both physical and behavioral health) occurring?
4. Are triage strategies for the general population and delivery of low-level calming interventions in place?
5. What are the strategies for inpatient and residential BH population evacuation? Are these strategies integrated with strategies of other required systems? What considerations have been made for the evacuation of the BH population that receives care from community providers?
6. How is the first responder stress management cadre staffed and deployed?
7. How is surveillance of alternate care and sheltering sites for surge in demand for BH intervention accomplished?
8. What are the strategies for treating widespread addiction/withdrawal?
9. What is the continuum of acute BH interventions needed?
10. Is a BH risk/crisis communications strategic plan in place for each phase of the event? Is there a strategy to have BH input into risk/crisis communications of other stakeholders (e.g., public health, political leadership)?
11. What is the plan for postevent gap analysis to determine short-term strategies to meet additional BH demand for services?
12. What is the strategy for building and sustaining health care provider resilience for all phases of the event?
13. What epidemiological surveillance capabilities and indicators require monitoring?
14. Has a disaster crisis line been activated and contact information published through traditional and other social media outlets?

Decision-Support Tool: Example Table

The indicators, triggers, and tactics shown in Table 6-1 are examples to help promote discussion and provide a sense of the level of detail and concreteness that is needed to develop useful indicators and triggers for a specific organization/agency/jurisdiction; they are not intended exhaustive or universally applicable. Prompted by discussion of the key questions above, discussion participants should fill out a blank table, focusing on key system indicators and triggers that will drive actions in their own organizations, agencies, and jurisdictions. As a reminder, *indicators* are measures or predictors of changes in demand and/or resource availability; *triggers* are decision points (refer back to the toolkit introduction [Chapter 3] for key definitions and concepts).

The example triggers shown in the table mainly are ones in which a "bright line" distinguishes functionally different levels of care (conventional, contingency, crisis). Because of their nature, this type of trigger can be described more concretely and included in a bulleted list. It is important to recognize, however, that expert analysis of one or more indicators may also trigger implementation of key response plans, actions, and tactics. This may be particularly true in a slow-onset scenario. In all cases, but particularly in the absence of bright lines, decisions may need to be made to *anticipate* upcoming problems and the implementation of tactics and to *lean forward* by implementing certain tactics before reaching the bright line or when no such line exists. These decision points vary according to the situation and are based on analysis, multiple inputs, recommendations, and, in certain circumstances, previous experience. Discussions about these tables should cover *how* such decisions would be made, even if the specifics cannot be included in a bulleted list in advance.

Note: (NN) designates indicators, triggers, and tactics that are most relevant to no-notice scenarios, and (SO) designates indicators, triggers, and tactics that are most relevant to slow-onset scenarios. Indicators, triggers, and tactics without such a marking are relevant to both no-notice and slow-onset scenarios.

TABLE 6-1
Example Behavioral Health Indicators, Triggers, and Tactics for Transitions Along the Continuum of Care

BH Indicator Category	Contingency	Crisis	Return Toward Conventional
Surveillance data: Community indicators	**Indicators** • Widespread acute anxiety and agitation increases presentations for treatment to and beyond normal limits • Hospitals experience a surge of not only medical patients, but searching family members; increased calls to hospitals as more people search for missing family members (NN) • Police, social services, schools, and others report increasing incidents of disruptive/anxiety-driven behaviors (e.g., civil unrest and domestic violence, driving under the influence, etc.) • Increased psychiatric presentations in emergency department (ED) • Increased calls to behavioral health- (BH-) related crisis lines (e.g., suicide, domestic abuse, etc.) • Increased waiting list for appointments in BH providers • Hospitals begin to prematurely discharge BH patients (e.g., psychiatric, detox) **Triggers:** • X% increase in law enforcement/social services reports • Jail and alternative diversion programs are at capacity • X% increased psychiatric presentations in ED • X% increased calls to BH crisis lines • X% increased waiting list for appointments in BH providers • X% of BH providers report seeing only emergency cases **Tactics:** • Implement and expand early BH intervention strategies (e.g., psychological first aid, or PFA) • Implement/expand strategies to enhance crisis leadership • Increase overtime shifts for existing staff • Appropriately adjust and implement comprehensive risk/crisis communication strategies	**Indicators** • All data indicate continuing and increasing demand for BH-related services • Hospital services become increasingly compromised as a result of demands of searching family members (NN) • BH service providers are at capacity and refuse to take on new cases • Increased public presentation of BH casualties (e.g., overtly psychotic citizens, people ill from detox, increased drug-related crimes, etc.) • Widespread acute anxiety, agitation, and demand for care threaten integrity of treatment systems/sites • Alternative care/diversion programs (e.g., domestic violence shelters) are at capacity and cannot admit more • Jails are at capacity **Crisis Triggers:** • HCOs report that they can no longer admit patients exhibiting acute anxiety and agitation • Roads become impassable as a result of citizens evacuating and searching for members (NN) • EDs threaten closure because of inability to manage BH-related cases (e.g., no beds, no referral options) **Tactics:** • Implement a variety of local mutual aid agreements and federal disaster medical assistance teams and National Disaster Medical System resources (NN) • Diversion of psychiatric patients • Seek funding and other resources including government and refer to DMRUs and medical special needs shelters • Route calls searching for missing family members to disaster hotline	**Indicators** • Decline in demands for services • Reduction of waiting lists to preevent levels • Number and severity of "new" cases declines • Reduced reports from police, social services, schools, and others regarding BH issues **Triggers:** • X% decline in demands for services • Reduction of waiting lists to preevent levels • X% decline in number and severity of "new" cases • X% reduction in reports from law enforcement, social services, schools, and others regarding BH issues • Preevent BH service capacity reestablished **Tactics:** • Continue and enhance monitoring of BH issues and service needs • Identify areas and/or populations with different patterns of recovery

- Seek and expand temporary employment of workers (including retirees, former employees, etc.)
- Implement health care organization (HCO) plan to cope with surge, sort BH and other health issues, and support staff and searching family members (NN)
- Route calls searching for missing family members to disaster hotline
- Transfer patients to alternative psychiatric and correctional sites designated for disaster response (SO)
- Expand sheltering and treatment capacity of state hospitals for civil and forensic patients (SO)

Community and communications infrastructure

Indicators:
- Families cannot find their loved ones (NN)
- Family members are separated (e.g., in different locations at time of earthquake or transported to different treatment sites) (NN)
- As a result of building damage, transportation system degradation, and communications systems failure, the population is unable to gather for support and ceremonies (NN)
- Communication mechanisms are degraded or non-existent (NN)
- Other utilities (e.g., water, electricity) are degraded or non-existent (NN)
- Roads and systems are becoming overloaded as a result of families trying to find their members (NN)
- Road congestion is complicated by arriving emergency vehicles from other jurisdictions (NN)
- General services are compromised and goods are in short supply, causing increased anxiety and agitation
- BH providers report delays and short supplies of prescription medication (e.g., antipsychotic, methadone, antidepression) because of supply line disruption
- Agitation increases as many/most basic community services are compromised
- Workplaces and schools close; status of persons in those structures unknown (NN)
- Work and school logistics become increasingly complex as schedules adapt to impact of event (causing increased fatigue and agitation) (SO)

Indicators:
- Road congestion becomes increasingly acute (NN)
- All data indicate continuing and increasing demand for BH-related services
- BH service providers are at capacity or have compromised facilities and refuse to take on new cases
- Increased public presentation of BH casualties (e.g., overtly psychotic citizens, people ill from detox, increased drug-related crimes, etc.)
- X% of workplaces and schools are closed (NN)
- Workplaces and schools report X% increases in lateness/absenteeism and decreases in productivity resulting from infrastructure degradation (SO)

Crisis triggers:
- HCOs report that they can no longer admit patients exhibiting acute anxiety and agitation
- Alternative care/diversion programs (e.g., domestic violence shelters) are at capacity and cannot admit more
- BH providers report they can no longer provide prescription medication (e.g., antipsychotic, methadone, antidepression) because of supply line disruption
- Widespread acute anxiety, agitation, and demand for care threaten integrity of treatment systems/sites

Indicators:
- Restoration of public services

Triggers:
- Acute anxiety, agitation, and demand for care no longer threaten integrity of treatment systems/sites

Tactics:
- Continue and enhance monitoring of BH issues and service needs
- Identify areas of infrastructure improvement and degradation
- Identify populations with different patterns of recovery and different infrastructure challenges

TABLE 6-1
Continued

BH Indicator Category	Contingency	Crisis	Return Toward Conventional
Community and communications infrastructure (continued)	• Agitation increases as mail is delayed, automated teller machines are not replenished, etc. **Triggers:** • HCOs report that they can no longer admit patients exhibiting acute anxiety and agitation • Alternative care resources and diversion-receiving facilities are at capacity and cannot admit more • EDs threaten closure because of inability to manage BH-related cases (e.g., no beds, not referral options) • Jails are damaged and/or at capacity • Crisis phone lines and hotlines are disrupted • Forensic psychiatric unit is severely damaged; there is an immediate need to treat injured patients and evacuate others (NN) • Treatment facilities are damaged; extent of damage and continued use is unclear (NN) **Tactics:** • Implement risk/crisis communications strategies to inform, comfort, and reassure the public • Implement strategies for alternative sources for, and reallocation of, prescription medications • Monitor and prioritize infrastructure and supply degradation for early identification and anticipatory response • Identify regional facilities or temporary facilities that can provide capacity	**Tactics:** • Expand mutual aid arrangements for BH medications and staff • Expand work-from-home programs (SO) • Seek funding and other resources, including government • Implement alternative internal and response-related communication protocols (NN)	
Staff *[Refer also to the worker functional capacity table in Toolkit Part 1 (Table 3-1)]*	**Indicators:** • Staff are also earthquake victims; their ability to report to work is unclear (NN) • Requests for evaluations and services from BH staff increase • Requests from ED for BH specialty care (e.g., children, etc.) begin to increase • Increased frequency of psychological stress responses among health workforce (e.g., distractibility, hostility, hypervigilance, emotional extremes, interpersonal conflicts, etc.) • Increased absenteeism/presenteeism of critical staff persons	**Indicators:** • Requests to BH staff for patient evaluations and services approach capacity • Requests for BH specialty care (e.g., children, etc.) approach capacity • Frequency and severity of psychological stress responses among health workforce (e.g., distractibility, hostility, hypervigilance, emotional extremes, interpersonal conflicts, etc.) compromise patient care • Frequency and severity of psychological stress responses among health workforce compromise relationships among staff at any or all levels within the organization	**Indicators:** • BH staff become more able to provide patient evaluations and services • Availability of BH specialty care (e.g., children, etc.) begins to return toward baseline • Staff resources increase and exhausted staff are able to rotate out of deployment

- Increased demands on employee assistance programs (EAPs); private BH practitioners are not readily available (SO)
- Increases in requests for psychological fitness for duty assessments of staff
- Increased reports of stress-related sequelae in other systems (e.g., law enforcement, social services, faith organizations, etc.)

Triggers:
- Requests to BH staff for patient evaluations and services increase by X%
- Requests for BH specialty care (e.g., children, etc.) increase by X%
- X% increase in staff absenteeism (NN)/presenteeism (SO)
- X% increases in frequency of psychological stress responses among health workforce (e.g., distractibility, hostility, hypervigilance, emotional extremes, interpersonal conflicts, unscheduled time away from duty station, increased demand for stress management support, etc.)
- X% increase in demands on EAPs
- X% increases in requests for psychological fitness for duty assessments of staff
- X% increase in informal personnel complaints

Tactics:
- Implement and expand early BH intervention strategies (e.g., PFA)
- Implement/expand strategies to enhance crisis leadership
- Implement expanded and alternative ways to establish and maintain contact with staff (NN)
- If possible explore and establish a means for staff families to be housed and supported at HCO (NN)
- Appropriately adjust and implement comprehensive risk/crisis communication strategies
- Expand temporary employment of workers (including retired, former employees, etc.)
- Review and appropriately modify personnel policies and practices where possible
- Assess the potential to obtain or enhance specialized consultation in areas of workplace stress and disaster BH
- Mobilize stress management team for responders and staff

- Absenteeism/presenteeism compromises patient care and/or organizational function EAP resources approach capacity
- Requests for psychological fitness for duty assessments of staff approach capacity to process
- Increasing reports of stress-related sequelae in other systems (e.g., law enforcement, social services, faith organizations, etc.), school, employers (SO)

Crisis triggers:
- Requests to BH staff for patient evaluations and services reach capacity and no additional service can be provided
- Existing services cannot be maintained
- Requests for BH specialty care (e.g., children, etc.) can no longer be fulfilled
- Absenteeism/presenteeism causes shutdown of services
- EAPs can no longer accept new referrals and/or manage existing caseloads
- Requests for psychological fitness for duty assessments of staff increase to a level where they cannot be processed in a timely/quality manner
- Increase in formal personnel complaints cannot be processed in a timely/quality manner

Tactics:
- Implement and expand early BH intervention strategies (e.g., PFA)
- Implement or expand strategies to support leadership
- Appropriately adjust and implement comprehensive risk/crisis communication strategies
- Seek to expand temporary employment of workers (including retired, former employees, etc.)
- Review and appropriately modify personnel policies and practices where possible
- Assess the potential to obtain or enhance specialized consultation in areas of workplace stress and disaster BH
- Implement mutual aid and other resource enhancement strategies
- Mobilize stress management team for responders and staff (NN)

- Frequency and severity of psychological stress responses among health workforce allows for resumption of routine staffing ratios
- Absenteeism/presenteeism declines
- Requests for psychological fitness-for-duty assessments of staff decline
- Reports of stress-related sequelae in other systems (e.g., law enforcement, schools, employers, etc.) decline

Triggers:
- BH staff are able to meet needs for patient evaluations and services
- Reduction in absenteeism/presenteeism to level where services begin functioning
- EAPs begin to accept new referrals and/or can now manage existing caseloads
- Requests for psychological fitness for duty assessments of staff decrease to baseline and can be processed in a timely/quality manner
- Decrease in formal personnel complaints/litigation to baseline and can be processed in a timely/quality manner

TABLE 6-1
Continued

BH Indicator Category	Contingency	Crisis	Return Toward Conventional
Space/infrastructure	**Indicators:** • Specialty psychiatric units experience increased use • Specialty psychiatric units experience damage and must treat injured and/or consider evacuation (NN) • Hospital triage results in BH (e.g., psychiatric, detox) patients being discharged before scheduled • Health care facilities initiate alternative space use plans to accommodate additional beds and space for families • Increases in service provision/ consultation in ways other than face to face • Social distancing reduces support for patients, families, community (SO) **Triggers:** • Specialty psychiatric units exceed capacity • Hospital triage results in BH patients being discharged before scheduled **Tactics:** • Increase alternate care sites/services for BH patients • Increase surveillance of BH needs and resources across systems • Update mutual aid strategies/plans • Update plans and strategies for obtaining outside BH or other help • Refer to Disaster Medical Response Units (DMRUs) and medical special needs shelters (NN)	**Indicators:** • Specialty psychiatric units exceed capacity • Specialty psychiatric units experience damage and must treat injured and/or the decision is made to evacuate (NN) • Hospital triage results in reduction of BH (e.g., psychiatric, detox) patients admitted • Increased numbers of BH patients being maintained in ED or general medical treatment areas • Very heavy use of service provision/ consultation in ways other than face to face • BH problems increase in hospitals as patient families, searching family members, and bereaved family members share space and services (NN) • Increasing BH problems resulting from social distancing (e.g., depression, suicide, substance abuse, etc.) (SO) **Crisis triggers:** • Specialty psychiatric units not available and unable to safely board in ED or other locations • Alternative BH treatment sites/services are at capacity • BH patients can no longer be maintained in ED or general medical treatment areas • Most service provision/consultation occurs in ways other than face to face • BH problems compromise function/ services in hospitals as patient families, searching family members, and bereaved family members share space and services; key hospital resources are redirected to manage the situation (NN) • Pervasive BH problems resulting from social distancing (e.g., depression, suicide, substance abuse, etc.) (SO) **Tactics:** • Increase surveillance of BH needs and resources across systems • Update mutual aid strategies/plans • Activate plans and strategies for obtaining outside BH or other help	**Indicators:** • Specialty psychiatric units are no longer at capacity • Admission of and services to BH (e.g., psychiatric, detox) patients admitted increases (Note: This marker of recovery involves increasing admits because it is *relative to the ability to admit* vs. prior lack of beds.) • Decreasing numbers of BH patients being maintained in ED or general medical treatment areas • Health care facilities require less alternative space usage, freeing up beds for BH patients • Care and consultation again begin to occur face to face • Decreasing BH problems resulting from social distancing (e.g., depression, suicide, substance abuse, etc.)/less social distancing **Triggers:** • Specialty psychiatric units admissions and census return to baseline • Admission of and services to BH (e.g., psychiatric, detox) patients returns to baseline • BH patients being maintained in ED or general medical treatment areas returns to baseline **Tactics:** • Maintain/increase surveillance of BH needs and resources across systems • Deactivate incident-specific hotlines and alternate care spaces • Activate plans and strategies for release or return of outside BH or other help

Supplies

Indicators:
- Demand increases for psychiatric medications and medications used to treat substance abuse disorders
- Supply of psychiatric medications and medications used to treat substance abuse disorders decreases
- Patients have lost their prescriptions/medications in the earthquake or are unable to access them (NN)
- Remaining functioning pharmacies have limited computer capacity to confirm prescription status (NN)
- Reports of self-medication increase
- Increasing numbers of patients begin to experience/exhibit withdrawal symptoms

Triggers:
- Demand for psychiatric medications and medications used to treat substance abuse disorders increases by X%
- X% reduction in supply of psychiatric medications and medications used to treat substance abuse disorders
- X% increase in numbers of behaviorally agitated patient requests for detox services for withdrawal symptoms of any type (from a wide variety of licit and illicit drugs)

Tactics:
- Increase monitoring of supply and demand for BH-related medications
- Implement strategies to optimize efficiency of supply lines/processes
- Explore alternative supply lines and processes to ensure medication availability
- Circulate guidance on alternative medications, dangers of self-dosing, and resources for help/detox

Indicators:
- Demand or projected demand for psychiatric medications and medications used to treat substance abuse disorders exceeds supply
- Supply of psychiatric medications and medications used to treat substance abuse disorders decreases to the point of limited medication provision
- Self-medication becomes a significant factor in large numbers of law enforcement, emergency medical services (EMS), hospital encounters
- Health care organizations are referring increasing numbers of patients experiencing/exhibiting withdrawal symptoms

Crisis triggers:
- Key psychiatric and substance abuse treatment medications are no longer available
- Self-medication becomes a significant factor in large numbers of law enforcement and health care organization encounters and compromises systems function (e.g., adverse impact on worker productivity, high demand for medical intervention, increased costs, etc.)

Tactics:
- Increase monitoring of supply and demand for BH-related medications
- Implement strategies to optimize efficiency of supply lines/processes
- Implement alternative supply lines of supply lines/processes
- Implement alternative supply lines processes to ensure medication availability
- Implement BH patient evacuation to out-of-state hospitals (SO)
- Recommend triage strategies and dosing strategies to address critical shortages

Indicators:
- Demand for psychiatric medications and medications used to treat substance abuse disorders and is returning toward baseline
- Supply of psychiatric medications and medications used to treat substance abuse disorders increases
- Self-medication becomes a declining factor in law enforcement, HCO encounters
- HCOs see a declining number of patients experiencing/exhibiting withdrawal symptoms

Triggers:
- Demand for psychiatric medications and medications used to treat substance abuse disorders returns to baseline
- Supply of psychiatric medications and medications used to treat substance abuse disorders adequate to meet community needs
- HCOs see a return to baseline in the number of patients experiencing/ exhibiting withdrawal symptoms

Tactics:
- Continue/improve monitoring of supply and demand for BH-related medications
- Evaluate efficacy of strategies to optimize efficiency of supply lines/processes
- Review and revise recommendations for medication use/triage

TABLE 6-1
Continued

BH Indicator Category	Contingency	Crisis	Return Toward Conventional
Other categories: **Fatality management**	**Indicators:** • Hospital and civic morgues approach capacity • Community distress over visible disinterment in local cemeteries (NN) • Death becomes an increasing topic in conversation, media, and public meetings • Recovered remains are partial, creating increased stress on workers, families (NN) • It becomes increasingly clear that body recovery will be a protracted process, increasing stress on workers and families (NN) • Citizens are increasingly agitated because of delays in issuance of death certificates and resulting inability to obtain survivor benefits and services **Triggers:** • Community experiences mass fatalities in a very short period of time • Death-related supplies are increasingly difficult to obtain (e.g., body bags, caskets, etc.) • Burials are delayed **Tactics:** • Review mass fatality plans • Seek advice from BH bereavement specialists, disaster mortuary operational response teams (DMORTs), faith community, other experienced sources • Review and provide risk/crisis communication training • Convene stakeholders on a regular basis to monitor and assess trends/issues	**Indicators:** • Death rate continues unabated or increases • The population is unable to gather for support and ceremonies because of contagion • Hospital and civic morgues are at or over capacity • Death dominates conversation, media, and public meetings • Delayed recovery, including decomposition of remains, increases stress for workers and families (NN) **Crisis triggers:** • Temporary interment and "unofficial" burials occurring or considered • Death-related supplies cannot be obtained (e.g., body bags, caskets, etc.) • Storage of remains becomes a problem and temporary solutions are employed **Tactics:** • Implement and adapt mass fatality plans • Open family assistance center (NN) • Seek advice from BH bereavement specialists, DMORTs, faith community, other experienced sources • Expand risk/crisis communication training • Continue to convene stakeholders on a regular basis to monitor and assess trends/issues • Implement mutual aid (including temporary morgues) • Coordinate with faith-based and cultural advocacy groups to address concerns and manage expectations about burial options, processes, risks	**Indicators:** • Death rate declines • The population is increasingly able to gather for support and ceremonies • Death becomes less dominant in conversation, media, and public meeting • Burials are resuming; issues of storage of remains become less acute • Death certificate processing times are becoming shorter • Media sensational and provocative stories about bodies decline and are replaced with stories of survival, resilience, and moving forward **Triggers:** • Hospital and civic morgues can accommodate demand • Death-related supplies are more available (e.g., body bags, caskets, etc.) **Tactics:** • Evaluate and modify mass fatality plans • Update roster of BH bereavement specialists, DMORTS, faith community, other experienced sources • Enlist those who can help the community memorialize the event and its aftermath as a way of individual and collective healing • Expand and institutionalize risk/crisis communication training • Continue to convene stakeholders on a regular basis to monitor and assess trends/issues • Demobilize family assistance centers and other resources as appropriate

Other categories:
Risk/crisis communications

Indicators:
- Key government officials refuse to make public statements
- "Experts" in media are increasing community fear/confusion/anger
- Racial and ethnic groups in the community are differentially affected or obtaining and understanding different information
- Rumors are growing
- There is inconsistency in health messages from various official sources
- Messaging is increasingly inconsistent with current standards of care and status of health system elements
- Issues of social justice, historical animosities, incapable leadership, etc., begin to increase in the media and at public events

Triggers:
- Event involves high degree of risk or concern (contagion, contamination, delayed effects)
- Public is demanding answers/reassurance/direction
- Media are providing inconsistent messaging

Tactics:
- Community leaders promoted as credible sources of information
- Review, update, and implement crisis communication plans
- Implement Joint Information System — develop, vet, and circulate press and information releases
- Proactively schedule briefings and make credible experts available
- Provide just-in-time crisis communication training for formal and informal leaders
- Seek specialized consultation and advice regarding risk/crisis communication
- Increase content monitoring and analysis of media (including social media) for tone, accuracy, usability, consistency
- Obtain information from non-traditional sources to determine how information is being provided/interpreted in vulnerable or specific cultural groups

Indicators:
- Public is increasingly insistent and angry at lack of direction and answers
- Media continue to providing inconsistent messaging even when provided credible information
- Some community leaders are discredited as sources of information; they are marginalized and/or removed
- Key government officials continue to refuse to make public statements
- "Experts" in media are increasing community fear/confusion/anger; some come to the community and create increased disruption
- Racial and ethnic groups in the community are differentially affected or obtaining and understanding different information; talk of demonstrations and civil protest increases
- Rumors are growing
- There continues to be inconsistency in health messages from various official sources
- Messaging is increasing inconsistent with current standards of care and status of health system elements
- Information is inaccurate and changing about locations for vaccinations, causing anger among the general population

Crisis triggers:
- Issues of social justice, historical animosities, incapable leadership, etc., dominate the media and public events
- Civil unrest occurs

Tactics:
- Aggressive implementation of crisis communication plans—additional resources for rumor control, specific population targeted messages, social media responses
- Provide just-in-time crisis communication training for formal and informal leaders
- Seek specialized consultation and advice regarding risk/crisis communication
- Increase content monitoring and analysis of media for tone, accuracy, usability, consistency

Indicators:
- Public is increasingly satisfied with information they are receiving; less public anger and frustration
- Emerging community leaders are solidified in their roles as credible sources of information
- Discredited leaders are seen and heard from less
- Key government officials increase public visibility and apply risk/communications training in their public statements
- The media are moving on to other stories and outside "experts" are seen less frequently; the community is increasingly perceived as able to handle challenges
- Different racial and ethnic groups in the community are increasingly getting the same credible information; talk of demonstrations and civil protest decreases
- Rumors are identified early and accurate information is effectively communicated

Triggers:
- Media are providing more consistent messaging and increasingly use credible information
- Consistency in health messages from various official sources increases
- Messaging more accurately reflects current standards of care and status of health system

Tactics:
- Evaluate and revise crisis communication plans
- Institutionalize crisis communication training for formal and informal leaders
- Update roster of specialized consultants/advisers in risk/crisis communication

TABLE 6-1
Continued

BH Indicator Category	Contingency	Crisis	Return Toward Conventional
Other categories: Risk/crisis communications (continued)		• Deploy crisis counseling teams to health resource lines to address social unrest • Convene stakeholders regarding issues of, and strategies for, crisis communication • Focus on positive accomplishment or developments in communications • Meet with major media to emphasize gravity of situation and attempt to address conflicts in messaging	• Continue and enhance content monitoring and analysis of media for tone, accuracy, usability, consistency • Continue to convene stakeholders regarding issues of, and strategies for, crisis communication • Focus on positive accomplishments/developments • Continue to aggressively address rumors and monitor new developments

Decision-Support Tool: Blank Table to Be Completed

Prompted by discussion of the key questions above, participants should fill out this blank table (or multiple tables for different scenarios) with key system indicators and triggers that will drive actions in their own organizations, agencies, and jurisdictions.

Reminders:

- *Indicators* are measures or predictors of changes in demand and/or resource availability; *triggers* are decision points.
- The key questions were designed to facilitate discussion—customized for behavioral health—about the following four steps to consider when developing indicators and triggers for a specific organization/agency/jurisdiction: (1) Identify key response strategies and actions, (2) Identify and examine potential indicators, (3) Determine trigger points, (4) Determine tactics.
- Discussions about triggers should include (a) triggers for which a "bright line" can be described, and (b) *how* expert decisions to implement tactics would be made using one or more indicators for which no bright line exists. Discussions should consider the benefits of *anticipating* the implementation of tactics, and of *leaning forward* to implement certain tactics in advance of a bright line or when no such line exists.
- The example table may be consulted to promote discussion and to provide a sense of the level of detail and concreteness that is needed to develop useful indicators and triggers for a specific organization/agency/jurisdiction.
- This table is intended to frame discussions and create awareness of information, policy sources, and issues at the agency level to share with other stakeholders. Areas of uncertainty should be noted and clarified with partners.
- Refer back to the toolkit introduction (Chapter 3) for key definitions and concepts.

Scope and Event Type: _____

Indicator Category	Contingency	Crisis	Return Toward Conventional
Surveillance data	Indicators: Triggers: Tactics:	Indicators: Crisis triggers: Tactics:	Indicators: Triggers: Tactics:
Communications and community infrastructure	Indicators: Triggers: Tactics:	Indicators: Crisis triggers: Tactics:	Indicators: Triggers: Tactics:
Staff	Indicators: Triggers: Tactics:	Indicators: Crisis triggers: Tactics:	Indicators: Triggers: Tactics:
Space/infrastructure	Indicators: Triggers: Tactics:	Indicators: Crisis triggers: Tactics:	Indicators: Triggers: Tactics:
Supplies	Indicators: Triggers: Tactics:	Indicators: Crisis triggers: Tactics:	Indicators: Triggers: Tactics:
Other categories	Indicators: Triggers: Tactics:	Indicators: Crisis triggers: Tactics:	Indicators: Triggers: Tactics:

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