

State of Minnesota
Emergency Medical Services Regulatory Board
Executive Committee Meeting Agenda

June 16, 2016 – 10:00 a.m.
EMSRB Offices – 4th Floor Conference Room

[Map & Parking](#)

1. Call to Order – 10:00 a.m.

2. Public Comment – 10:05 a.m.

The public comment portion of the Executive Committee meeting is where the public may address the Executive Committee on subjects which are not part of the meeting agenda. Persons wishing to speak must complete the participation form provided at the meeting room door prior to the start of the meeting. Please limit remarks to 3 minutes. The Executive Committee will listen attentively to comments but, in most instances, will not respond at the meeting. Typically, replies to issues or concerns expressed will be made via letter or phone call within a week.

3. Approve Agenda – 10:10 a.m.

4. Approve Minutes – 10:15 a.m.

- Approval Executive Committee Meeting Minutes from April 26, 2016

Attachments

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5. Board Chair Report – 10:20 a.m.

6. Executive Director Report – 10:40 a.m. – Tony Spector

- NEMSIS Reporting Issue
- Offline Licensing and Credentialing Process
- Agency Staffing Report
- U of M Research Project Cancelled by U of M

7. EMS Standards Crisis of Care Update on Work Group Progress – 11:00 a.m.

Aaron Burnett, M.D./Robert Norlen

CSC 1

8. Committee Reports – 11:15 a.m.

- Complaint Review Panel Report – Matt Simpson
- DPSAC Committee Report – Megan Hartigan/Robert Norlen
- Legislative Ad-Hoc Committee Report – Kevin Miller
- MDSAC Report – Aaron Burnett, M.D.
- Post Transition Education Standards Workgroup - Lisa Consie/Mary Zappetillo

9. New Business – 11:45 a.m.

10. Adjourn – 11:55 a.m.

Next Executive Committee Meeting: August 18, 2016 -- Minneapolis

If you plan to attend the meeting and need accommodations for a disability, please contact Melody Nagy at (651) 201-2802. In accordance with the Minnesota Open Meeting Law and the Internal Operating Procedures of the Emergency Medical Services Regulatory Board, this agenda is posted at: <http://www.emsrb.state.mn.us>

State of Minnesota
Emergency Medical Services Regulatory Board
Executive Committee Meeting Minutes
April 26, 2016

Attendance: J.B. Guiton, Board Chair; Aaron Burnett, M.D.; Megan Hartigan; Kevin Miller; Tony Spector; Executive Director; Melody Nagy, Office Coordinator; Robert Norlen, Field Services Supervisor; Chris Popp, Compliance Supervisor; Mary Zappetillo, EMS Specialist; Greg Schaefer, Assistant Attorney General; Tiffany Sedillos, Assistant Attorney General

Absent: Jeffrey Ho, M.D.; Matt Simpson

1. Call to Order – 10:00 a.m.

Mr. Guiton called the meeting to order at 10:12 a.m.

2. Public Comment – 10:05 a.m.

The public comment portion of the Executive Committee meeting is where the public may address the Executive Committee on subjects which are not part of the meeting agenda. Persons wishing to speak must complete the participation form provided at the meeting room door prior to the start of the meeting. Please limit remarks to 3 minutes. The Executive Committee will listen attentively to comments but, in most instances, will not respond at the meeting. Typically, replies to issues or concerns expressed will be made via letter or phone call within a week.

None.

3. Approve Agenda – 10:10 a.m.

Mr. Guiton asked for a motion to approve the agenda.

Motion: Dr. Burnett moved to approve the agenda. Mr. Miller seconded. Motion carried.

4. Approve Minutes – 10:15 a.m.

Approval Executive Committee Meeting Minutes from January 22, 2016.

Motion: Mr. Miller moved to approve the minutes from the January 22, 2016 Executive Committee. Ms. Hartigan seconded. Motion carried.

5. Board Chair Report – 10:20 a.m.

Request by Minnesota Medical Association to Speak to the Board regarding Provider Orders for Life-Sustaining Treatment (POLST) to Speak to the Board

Mr. Guiton said there is a newer-version of the POLST form. It has been updated by the Minnesota Medical Association and they would like to give a presentation to the Board. The EMSRB should adopt the new form and distribute it widely.

Expectations for Committee and Work Group Reports to the Full Board

Mr. Guiton said he expects documents pertaining to Board and Committee agenda items included with the agenda when it is circulated to board members and posted for public viewing, i.e., one week before Board and Committee meetings. He would like an executive summary and recommendations (when appropriate) for agenda items.

Mr. Spector said that he has received comments that the EMSRB is being open and transparent in our efforts to share meeting announcements.

Executive Director Annual Performance Review – Cindy Greenlaw-Benton

Mr. Guiton introduced Cindy Greenlaw-Benton and said the Board is looking for information on the process for the Executive Director's performance review. She is soliciting expectations from the Board as to the process.

Ms. Greenlaw-Benton referred to the management contract language that includes a mid-point and an annual review. The Board should review the position description and determine if the employee meets or exceeds these standards. There should be a meeting with the employee. This work often is done by a committee and may be shared with the full Board.

Mr. Guiton asked that the Executive Director Annual Performance Review be placed on the agenda for the July Board meeting. Mr. Guiton said he would like employee feedback and a 360 approach. He also inquired as to whether responses can be confidential.

Mr. Spector asked if the ad-hoc workgroup that selected the Executive Director should be the group tasked with evaluating the Executive Director. Dr. Burnett offered to chair this ad-hoc work group.

Motion: Ms. Hartigan moved to convene the search committee to complete annual reviews of the Executive Director and to report their findings to the Board. Dr. Burnett seconded. Motion carried.

Post Transition Education Standards Workgroup – Mary Zappetillo

Ms. Zappetillo said the work group met on April 25th for eight hours to develop recommendations to bring to the Board for teaching NCCR. There may be statutory changes needed in the future.

One of the things discussed and to be recommended to the Board for approval and adoption is that all National Continued Competency Requirements (NCCR) components of the National Continued Competency Program (NCCP) that are taught in Minnesota are to be administered by a Minnesota-approved education program for continuing education.

Mr. Miller asked how the EMSRB would implement this recommendation before a statute change. Ms. Zappetillo said the recommendation does not change what is currently done. The EMSRB will need to seek a statutory change to the hours requirement for a refresher. Mr. Schaefer said that the statutory language includes "Board approved".

Mr. Guiton said that the EMSRB should seek to remove the hours listed in the statute and replace with standard language for NCCP. There will be a time of transition. Ms. Zappetillo said that there will be a recommendation for the Legislative Ad-Hoc Work Group, and documents will be prepared for the Board meeting.

Ms. Zappetillo said that Advanced Cardiac Life Support (ACLS) and CPR are not required nationally but are required by our statute. We would like input from the Medical Direction Standing Advisory Committee (MDSAC) on this issue. Dr. Burnett suggested continuing ACLS or its equivalent as approved by the medical director.

Mr. Miller asked about the 30-hour national requirement versus the Minnesota 30-hour requirement. Ms. Zappetillo said this will be answered in the frequently asked questions document on our website.

6. Executive Director Report

EMS Standards Crisis of Care Meeting – Aaron Burnett, M.D./Robert Norlen

Dr. Burnett said this meeting is chaired by MDH. Information will be shared with the Board after the group has developed their plan.

Mr. Norlen said we appreciate this partnership with MDH. This group is meeting to set up standards during a public health threat. We need defined roles and responsibilities.

Legislative Update

Mr. Spector said the technical bill was passed by both committees and is waiting for the Governor's signature.

Mr. Spector said the EMSRB has yet to hear the status of its supplemental budget legislative funding request. He said that the funding is mission critical to for support, hosting, and maintenance of our new e-licensing system. The EMSRB cannot post and fill the Southwest EMS Specialist position until this funding is secured because of the need to have unencumbered funding for the e-licensing system.

Mr. Snoke said Mr. Spector has done a good job of presenting this request to the legislature for the EMSRB.

E-Licensing Transition Project Update

Mr. Spector said that one of the requirements from MN.IT is that the EMSRB must have an off-line system for new licenses and renewals. The EMSRB may be offline for a short time. Staff is working on development of this process.

Ambulance Standards Work Group

Mr. Spector said Mr. Norlen is doing a great job presenting this information. Mr. Coyne is the chair of this work group. The work group will be making a recommendation regarding adopting CAAS standards.

Mr. Miller asked about enforcement of the CAAS standards. He asked whether such enforcement would require new skills sets and work for inspections. He also asked if CAAS was the only development standards? Mr. Norlen said the work group will have further discussions about the standards and a discussion about exemptions and rule and statute language and good regulatory oversight of ambulances purchased in Minnesota.

Mr. Spector said the new e-licensing software sought by the EMSRB is intended to have a digital inspection process and checklist.

Mr. Norlen said we want inspections to be less-complicated for everyone. If an ambulance is built to the CAAS standards, inspections should be an easier process.

7. Committee Reports

Complaint Review Panel Report – Matt Simpson

Mr. Simpson was not able to attend the meeting today, but the Complaint Review Panel continues their work.

Data Policy Standing Advisory Committee Report – Megan Hartigan/Robert Norlen

Ms. Hartigan said the committee is meeting on May 3 and there will be an executive summary and documents to share with the Board.

Legislative Ad-Hoc Work Group Report

Mr. Miller said the Legislative Work Group has not met but will meet after session.

MDSAC Report – Aaron Burnett, M.D.

Dr. Burnett shared an announcement of the Medical Director's Course to be presented at the Arrowwood Conference. He asked for this information to be shared with all ambulance directors and medical directors.

Mr. Guiton suggested that the annual review of the Board's Internal Operating Procedures occur at the September Board meeting. He commented that the Legislative Ad-Hoc Work Group should be changed to a Standing Advisory Committee.

8. New Business

None.

9. Adjournment

Motion: Mr. Miller moved to adjourn the meeting. Ms. Hartigan seconded. Motion carried.

The meeting adjourned at 11:40 a.m.

Next meeting: June 16, 2016 at 10:00 a.m. at the EMSRB office

EMS Crisis Standards of Care - Planning and Implementation Guidance - DRAFT May 31, 2016

Minnesota Department of Health and Minnesota Emergency Medical Services Board

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**EMS Crisis Standards of Care
Planning and Implementation Guidance**

Minnesota Department of Health and Minnesota Emergency Medical Services Board
DRAFT May 31, 2016

Acknowledgements:

DRAFT

EMS Crisis Standards of Care Planning and Implementation Guidance

Minnesota Department of Health and Minnesota Emergency Medical Services Board
DRAFT May 31, 2016

PREFACE

The Emergency Medical Services (EMS) Crisis Standards of Care (CSC) Guidance document is a structured consideration and approach to shortfalls in the provision of EMS services by an individual or group of EMS providers and public safety answering points (PSAP) who are often the lead agencies for receiving requests for ambulance response. It is a decision support tool and assumes that incident management and an incident command are implemented and key personnel are familiar with the ethical frameworks and processes which underlie these decisions. Each EMS ambulance service licensee and medical director for each licensee will have to determine the most appropriate steps and actions to take when authorized by the MN Emergency Medical Services Board (MN EMSRB) in a State of Minnesota declared emergency.

Pre-event familiarization with the contents of this Guidance and development of regional and local crisis standards of care plans is recommended to aid with event preparedness, response and in anticipation of specific resource shortfalls. The Guidance address only basic common categories of pre-hospital EMS response, triage, treatment and transport. Regional Healthcare Preparedness Program Coalitions, Regional EMS Programs, Public Safety Answering Points/Dispatch, EMS dispatch centers, EMS personnel and EMS medical directors may determine additional coping mechanisms for their specific situation in addition to those outlined in this Guidance.

The content of this Guidance was developed by the Minnesota Department of Health (MDH), MN EMS Regulatory Board, MDH Science Advisory Team in conjunction with the EMS Crisis Standards of Care Work Group comprised of many subject matter experts in multiple areas of EMS preparedness and response and related emergency response and management disciplines whose input is greatly appreciated.

This Guidance does not represent policy of MDH or the MN EMSRB. EMS providers and their medical directors, PSAP/dispatch centers implementing these strategies in crisis situations should assure communication of this to their public safety, healthcare and public health partners to assure the invocation of appropriate legal and regulatory protections in accord with State and Federal laws. This Guidance may be updated or changed during an incident by the Science Advisory Team, MDH and MN EMSRB. Web links and resources listed are examples, and may not be the best sources of information available. Their listing does not imply endorsement by MDH or MN EMSRB. This guidance does not replace the judgement of the EMS operational management, medical directors or clinical staff and consideration of other relevant variables and options during an event.

Introduction

The Minnesota Emergency Medical Services (EMS) system has a long-standing history of providing exemplary service to the people of Minnesota, both visitors and residents alike. It serves as a vital link to the healthcare system statewide, especially in rural areas of the state where access to medical care is less readily available.

Comprised of both volunteer and paid professional EMS organizations, Minnesota's EMS system runs the gamut from a volunteer ambulance service that may respond to a mere 20 calls a year to a busy urban service responding to more than 20 calls a day. While the volunteer EMS services are generally located in the more rural areas, the paid ambulance agencies are found in the higher population centers (e.g., Duluth, Rochester, St. Cloud, Marshall, Mankato, Moorhead, East Grand Forks) of greater Minnesota, as well as in the Twin Cities metropolitan area of Minneapolis – St. Paul.

Minnesota EMS providers are faced with a variety of actual and potential large-scale incidents that could quickly exhaust the resources of local EMS services. Risk analysis studies have determined that there is a significant risk for natural, man-made and terrorism related disasters throughout the state. There are international ports on Lake Superior in northern Minnesota that serve oceangoing vessels from around the world. Highways and railways crisscrossing the state are used for transport of hazardous materials. Pandemics such as H1N1 flu virus can have an impact on EMS services statewide. Minnesota borders Canada in some of the most rural portions of the state creating cross-border issues of concern. The potential for natural or man-made disasters present significant EMS resource issues and problems, for EMS providers in Minnesota. Minnesota also has two (2) nuclear power plants, both located outside of the Twin Cities metropolitan areas which could potentially impact EMS resources in the event of a radiological release at one of these plants.

To respond to disasters, local EMS services would, in most cases, rely solely on mutual aid response from neighboring EMS services to try to fill the resource and equipment gaps necessary to meet the pre-hospital care and transportation needs of patients. Development of well trained, equipped and ready to respond EMS system has enhanced capabilities and fill current gaps in EMS response and resource availability for all types of disasters that may occur in Minnesota.

To assist further in filling gaps for EMS response and resources Crisis Standards of Care (CSC) refers to medical care provided in situations in which demand is so great that we are not able to provide usual services and have reached a point where we need to do the 'greatest good for the greatest number'. Emergency Medical Services (EMS) systems often operate near this threshold, but could benefit from more robust and structured planning for situations where demand exceeds resources.

The Minnesota Department of Health (MDH) and the EMS Regulatory Board (EMSRB) convened a statewide EMS workgroup in the spring of 2016 to provide input on crisis care issues and solutions for EMS which drove the development of this document. This guidance would not have been possible without the diverse and practical input provided by the group; their efforts will benefit the citizens of the State. This workgroup and resulting guidance is

part of a larger process by MDH to document Crisis Standards of Care policies as well as engage the public in discussions about the ethics and principles of crisis care.

This document provides an overview of crisis care operational considerations for EMS. In depth discussion of the framework, ethics, and practical applications of crisis standards of care may be found in the 2012 National Academies of Sciences, Engineering and Medicine, Institute of Medicine (IOM) (now known as the Home and Medicine Division (HMD)) report including a specific section on EMS care:

(<http://www.nationalacademies.org/hmd/Reports/2012/Crisis-Standards-of-Care-A-Systems-Framework-for-Catastrophic-Disaster-Response.aspx>). An additional document that may be of assistance to EMS is a card set designed for shortage situations (staff, medications, etc.) developed by the MDH Science Advisory Team (SAT) which is available at:

<http://www.health.state.mn.us/oep/healthcare/crisis/standards.pdf>

Rural EMS can face great challenges due to difficulties in staffing, limited vehicles, and long response times that can be exacerbated in a disaster. In urban areas, increases in demand during major incidents or epidemics can rapidly exceed resources available. The goal of this document is to provide background on these issues and practical strategies across the continuum of EMS response that can be implemented at the local level. This guidance document is aimed at the EMS services themselves and though it does detail the supporting role of state agencies it is the responsibility of the EMS service to apply this guidance with the help of their management team and medical director to ensure operational plans are in place.

Crisis Care

Most EMS agencies are familiar with the concept of surge capacity – the ability to increase services to match demand. Surge capability is slightly different in it requires specialized equipment or training to meet the patient’s needs – an example might be a contaminated patient or one with a highly infectious disease. This guidance is focused on capacity, but services should remember that specialized patients (pediatric, highly infectious disease) can push services into crisis care as well. Adequate supplies, training, and regional policies are just as important for capability as well as overall capacity.

Surge capacity strategies that may be implemented are not all equal. Some can be accomplished with minimal risk (mutual aid) and some carry significant risk (not answering some 911 calls with an ambulance due to overwhelming demand). Maximizing the potential benefits of surge capacity strategies to mitigate the crisis while minimizing the risks associated with deviations from routine SOP’s is the goal. We need to choose the strategies that are most appropriate to the situation and offer the least risk to the patient and crew, proceeding to riskier strategies as demand increases and options decrease.

Surge capacity is therefore divided into three categories across a spectrum (Fig.1):

- Conventional – usual strategies and resources – e.g. dispatch of additional ambulances, extending staff shifts for a few hours
- Contingency – uncommon strategies and resources that incur a small risk to patients – e.g. staffing ambulances with less personnel or a lower level of response (delayed or single agency)
- Crisis – disaster strategies used when demand forces choices that pose a significant risk to patients but is the best that can be offered under the circumstances – e.g.

response coordination in each of eight regions of the state) and State and local government agencies.

The following is a capsule summary of the role of State and local entities in crisis situations and key responsibilities – it is not intended to be comprehensive:

Table 1: Key agency roles and responsibilities

Agency	Role	Key Responsibilities
MDH	State lead agency for health-related issues	<ul style="list-style-type: none"> • Facilitate healthcare resource requests to state / inter-state / Federal partners • Request State Disaster or Public Health Emergency Declarations and Governor’s emergency orders as required from HSEM to support response • Request CMS 1135 waivers as required during response to allow patient billing when usual conditions cannot be met • Convene Science Advisory Team (SAT) to discuss or develop incident specific medical / resource triage policy • Support healthcare coalition information exchange and policy development • Provides testing, treatment, and other information during infectious disease events to providers and population
EMSRB	State lead agency for EMS disaster issues	<ul style="list-style-type: none"> • Carry out duties and responsibilities assigned to the EMSRB in the Minnesota Emergency Operations Plan (MEOP) and the Governor’s Executive Order 15-13 Assigning Emergency Responsibilities to State Agencies. • Request Ambulance Strike Teams (AST) from regions as required • Request inter-state (EMAC) or Federal (Federal Ambulance Contract) resources as needed • Suspend selected regulatory statutes / rules to facilitate crisis care activities during declared disaster • Provide support to regional coalition / response through regional EMS program personnel • Support local EMS medical directors by providing guidance on patient care guideline development through the State EMS Medical Director and the Medical Director Standing Advisory Committee

Agency	Role	Key Responsibilities
Local Emergency Management	Local lead for incident support	<ul style="list-style-type: none"> • Request resources from local and State EOC as required • Facilitate local declarations of emergency • Facilitate suspension of ordinances / rules as required to support response • Provide incident information / common operating picture to local and State agencies
State Emergency Management (HSEM)	State lead for incident support	<ul style="list-style-type: none"> • Provide point of contact (State Duty Officer / State EOC) for resource requests • Request State declaration of emergency as required • Recommend Federal Disaster Declaration request to Governor as required • State level coordination of overall disaster response/recovery
Regional healthcare coalition	Regional coordination of health / medical response	<ul style="list-style-type: none"> • Information sharing and coordination of activities between public health, hospitals, EMS, and emergency management • May provide / develop regional policies for disaster response / crisis care
Local EMS agency	Local EMS response	<ul style="list-style-type: none"> • Incident command / branch command for EMS – request and manage assets as required • Develop policies for crisis care situations • Interface with local hospitals and regional healthcare coalition to share information / status • Respond to calls for medical assistance
Public Health	Lead or support agency	<ul style="list-style-type: none"> • Supporting agency to EMS (lead agency for pandemic/epidemic situations) • Can provide community communications (e.g. when to call 911) • Supports/coordinates alternate care sites as appropriate • Supports/coordinates hotlines as appropriate • Communicates health alerts and other information to partner agencies • Lead for community based interventions (vaccination, isolation, prophylaxis)
Public Safety Answering Point (PSAP) / 911 center	Support agency	<ul style="list-style-type: none"> • Answers 911 calls • Provides emergency medical dispatch support (if equipped) • Determines appropriate response based on situation / algorithms / SOPs

Agency	Role	Key Responsibilities
		<ul style="list-style-type: none"> • Provides communication point for incident responders • May assign radio talkgroups during an incident

EMS Legal and Regulatory Considerations

The authority for declarations of an emergency are vest in in federal, state and local laws. The principle laws enabling such declarations and authorities enabled by those actions include:

- 1): Federal Declarations:
 - (a) Stafford Act 942 U.S.C. §§5121 – 52060;
 - (b) Public Health Emergency declarations (§319 Public Health Service Act);
 - (c) Federal Public Readiness and Emergency Preparedness Act (PREP) Act Declarations
(42 U.S.C. §§247d-6d to 247d-6e.
- (2): Declarations by Minnesota Governor (§12.03, Subd. 3):
 - (a) National Security Emergency;
 - (b) Peacetime Emergency;
- (3): “Declarations” by MDH Commissioner:
 - (a) Minn. Stat. §151.37, Subd. 2(b); (prescribing legend drugs)
 - (b) Minn. Stat. §144.4197; (administer vaccinations or dispense legend drugs)
 - (c) Minn. Stat. §144.4198, Subd. 2; (closed point of dispensing legend drugs)
 - (d) Minn. Stat. §145A.06, Subd. 7. (use of medical reserve corps)
- (4): Declaration of Local Emergency (Minn. Stat. §12.29)

Federal Declarations:

If the jurisdictions are severely affected a disaster or public health emergency, HSEM may recommend the Governor request a Presidential Declaration of Disaster (PDD or Federal declaration). A Federal Coordinating Official then becomes Minnesota’s conduit to request Federal resources such as ambulances through Federal contracts. Additionally, the State may use mutual aid from surrounding states through the Emergency Management Assistance Compact (EMAC) which can often deliver aid more rapidly than Federal processes. Appendix 1 includes a summary of key federal actions which can be taken with and without a federal declaration.

The Stafford Act enables the President to declare an emergency or disaster if a state governor:

- Requests the declaration through the regional FEMA office;
- (Certifies federal assistance is needed because state and local resources are not sufficient; and
- Activates the state’s emergency operations plan.

However, the President can declare an emergency without request of state Governor if the primary responsibility rests with the United States because the emergency involves a subject area for which, under the laws of the United States, the United States exercises exclusive or preeminent authority” such as it has with federal facilities, tribal lands, nuclear materials, weapons of mass destruction, national defense.

The Secretary of Health and Human Services (HHS) may declare a public health emergency in the absence of any formal request from a state governor; or a Presidential declaration under the Stafford Act. The declaration of a public health emergency enables the Secretary the discretionary authority to authorize a range of actions during a crisis of care event important to EMS and healthcare facilities. Appendix 1 presents a summary of key actions the Secretary may implement in a public health emergency.

The PREP Act was enacted to alleviate liability concerns related to manufacturers, distributors, program planners, “Qualified persons”, the United States, and officials, agents, and employees of any of the above who are involved with the development, distribution and administration of medical countermeasures including EMS personnel. The Act authorizes the Secretary to issue a declaration providing immunity from tort liability. When authorized by the Secretary a PREP Act declaration is published in the Federal Register.

Minnesota State Declarations:

The Minnesota Emergency Management Act (MEMA); Minnesota Statutes chapter 12 (<https://www.revisor.mn.gov/statutes/?id=12>) provides that the Governor has general direction and control over Emergency Management. There are two types of Governor declared emergencies under MEMA:

- National Security Emergency; and
- Peacetime Emergency

The Governor may, by proclamation, declare a national security emergency in all or any part of the State if information from the President, FEMA, DOD, indicates an imminent disaster from enemy sabotage or other hostile action.

Governor may declare “peacetime emergency” if there occurs:

- An act of nature , terrorist incident, industrial or hazardous materials accident, or civil disturbance;
- Endangers life and property, and
- Local government resources are inadequate to handle the situation.

Among the actions this triggers under Chapter 12 of Minnesota Statutes are:

- Potential for reimbursement for cities / agencies incurring expenses
- Powers for emergency management to commandeer available resources if required (though notably, they may not commandeer healthcare resources that are ‘in use’)
- Liability protections for state responders
- The ability of the Governor to issue emergency orders to meet the specific needs of the incident
- The ability of State agencies to suspend administrative rules in order to facilitate a response

If the jurisdictions are severely affected, HSEM may recommend the Governor request a Presidential Declaration of Disaster (PDD or Federal declaration). A Federal Coordinating Official then becomes Minnesota’s conduit to request Federal resources such as ambulances through Federal contracts. Additionally, the State may use mutual aid from surrounding states through the Emergency Management Assistance Compact which can often deliver aid more

rapidly than Federal processes. Disaster declarations may be applied retroactively (i.e. they can be back-dated) and may be statewide or specific to selected jurisdictions.

While many response provisions under MEMA require the Governor's "emergency" or "disaster" declaration as a prerequisite, not every emergency power requires such declaration. Appendix 1 presents a summary of key actions the Governor may implement under MEMA which require and do not require a Governor's Emergency Declaration.

State Agencies:

Agencies that issue rules, such as the Minnesota Department of Health and the EMS Regulatory Board (<https://www.revisor.mn.gov/statutes/?id=144E.16>) have their authorities and some enforcement actions in statute (law). Laws are more difficult to modify, even in times of emergency. Rules, on the other hand, are more easily suspended.

Minnesota Department of Health:

The Commissioner of MDH maintains authority to implement provisions of Minnesota's mass dispensing laws (Minn. Stat. §151.37, Subd. 2(b)) when the Commissioner finds such action necessary to protect the public health and safety and provides for broad authority and protections in the types, use and administration of those medical interventions. Commissioner may call for MN Responds MRC Volunteers if requested by local board of health, federal government, First Nation, or other state via EMAC and "in the public interest." When activated, volunteers are afforded the protections provided in Minn. Stat. §145A.06, Subd. 7(a), (f)(1).

Minnesota EMS Regulatory Board:

The MN EMSRB under Minn. Stat. §144E.266 may suspend certain state ambulance licensure statutes during a Governor declared emergency or disaster. Appendix 1 identifies MN EMSRB statutes that may be suspended during a legally declared disaster. Note that even during these periods, resources may be available that allow the usual requirements to be met, and at those times, the agency should continue to meet those statutes or rules.

Local Emergency Declaration:

Minn. Stat. §12.29 provides that a mayor of a municipality or county board chair may declare a "local emergency." The length the declaration is 3 days, unless a longer period approved by governing body. The local emergency declaration invokes necessary portions of their response and recovery aspects of the applicable local or interjurisdictional disaster plans and may authorize aid and assistance under those plans.

It is critical that EMS agencies know if there are local ordinances that may apply to them. These cannot be in conflict with State laws and rules, but could be more proscriptive (for example, some counties specify a response time standard and staffing standards for EMS). These ordinances may need to be relaxed in a crisis, and EMS should work with local Emergency Management to determine how this would happen.

Tribal - Tribal and territorial areas are independent legal entities and though they interface with surrounding jurisdictions they are self-governing and have the ability to make and enforce their own laws and rules. Tribes are also allowed to directly seek Federal assistance

though in most cases they will also interface with the State as resources are often available more rapidly through local and State channels than Federal.

Liability:

Liability is always a significant concern when care is being provided in unusual ways or circumstances. There are four major areas of protection to keep in mind:

1. If a responder is not going to receive any substantial reimbursement for the care, the Good Samaritan laws protect that responder from liability unless it is 'willful and wanton' misconduct.
2. Responders acting on behalf of the State (e.g. Medical Reserve Corps, MN Mobile Medical Team) have broad liability protections and damage caps from the State.
3. Responders that are working in alternate care sites have broad protections under Chapter 12 regardless of whether they are paid to be there.
4. Medical malpractice is situational. Just as on a daily basis a critical access hospital cannot be held liable for not having a trauma surgeon, in a disaster you are held to the standard of care that a 'reasonable provider' would have given in that situation with those resources. Therefore, if you are following plans or guidance developed by 'reasonable providers' prior to the incident it would be very hard to obtain a legal judgment.

Having pre-existing plans for crisis situations provides significant protections for agencies as well as the responders. If these plans are reasonable, are based on guidance/best practices documents, and approved by the agency (or optimally, by multiple agencies and the jurisdiction), it will be very difficult to find liability if the actions conformed to those expectations in these situations.

This also raises the issue of 'duty to plan'. This is not a new concept in risk analysis, but is somewhat new in disaster response and was the basis for a multi-million dollar civil judgment against Tenet Health for their failures to plan for hurricane impacts on their health system in New Orleans prior to Katrina. Employers must make efforts to protect their employees and customers from reasonably anticipated harms.

Additionally, many government agencies including the Occupational Health and Safety Administration (OSHA) can hold employers liable when risks should have been commonly recognized and were not sufficiently mitigated. Thus, because any EMS agency could experience a crisis situation, not having a plan to address the situation could result in liability for the agency.

Reimbursement - Finally, there may be insurance/payor issues that need to be addressed during crisis care. Generally, if a patient is not taken to a hospital, CMS (Centers for Medicare and Medicaid Services) and private insurance will not pay for ambulance transport. However, if the hospital is not operating (tornado) or the hospital is overwhelmed and the patient is more appropriate for a clinic or alternate care site, CMS may authorize an 1135 waiver that can allow reimbursement under specific disaster codes. A Federal declaration must be obtained prior to seeking an 1135 waiver and information justifying why the actions are in the patients' best interest must be supplied to the regional CMS office. MDH may make 1135 waiver requests on behalf of EMS or hospitals. For additional information please see:

<https://www.cms.gov/About-CMS/Agency-Information/H1N1/downloads/requestingawaiver101.pdf>

Non-ambulance transport generally cannot be billed to insurance, though the hours the personnel worked and supplies used *may* be reimbursable with proper documentation supplied to the State. Agencies should keep careful records and work with local Emergency Management on these administrative and financial issues.

EMS Surge Capacity

EMS must plan for surge capacity in multiple domains. The resources available must be utilized to their maximal capacity and additional resources obtained from known sources via pre-existing mechanisms (e.g. mutual aid agreement, request to local emergency manager, though the State Duty Officer, etc.). These include 'Send' (dispatch and response assets), 'Staff', and 'Supplies' and may include novel transport destinations as a resource. This is about assessing current or potential assets, and is *not* about the policy development that is the focus of the Planning and Implementation sections below.

Dispatch

Many EMS agencies are dispatched by public safety answering points (PSAP's). Sometimes, all or selected EMS calls are transferred to an Emergency Medical Dispatcher (EMD) who can perform caller interrogation to collect critical information, assign different priorities to calls based on the acuity, dispatch appropriate EMS/fire/rescue resources and then give prearrival instructions to the caller to provide basic medical care while awaiting EMS arrival. PSAPs in rural areas often do not have these resources.

EMS agencies should examine their dispatch process and determine:

- Potential for supplemental staff/dispatchers – sometimes the configuration of the dispatch center does not allow for additional personnel. Note that in rural areas, even if call volumes are tripled, this may not result in substantial call handling burdens, though the availability of the EMS crew may be dramatically affected.
- Rollover of calls to other dispatch centers or PSAP's
- Auto-answer to divert calls related to a particular event to a hotline rather than a dispatcher (water contamination, pandemic influenza, etc.)
- Transfer of calls to a clinical provider that can help prioritize the need for an ambulance if this service is not normally available (this could be hospital based personnel, transfer to another dispatch center with EMD capability, use of a medical director, etc.)
- Use of an algorithm to assist non-medically trained dispatchers in determining the need for an ambulance (see below under Planning and Implementation)

Ambulances/Transport

EMS agencies generally do not have significant additional ambulance capacity available, and should account for the following in their plans:

- Maximal use of existing ambulances
- Mutual aid from surrounding agencies (including knowledge of capacity, special capabilities, and response times) or from a parent health system
- Request via the State Duty Officer use of Ambulance Strike Teams (AST) (generally 5 ambulances, Basic Life Support (BLS) or Advanced Life Support (ALS) or combination, plus one supervisor per team). These teams if available, can provide support within

hours that can help the community augment 911 responses and/or provide inter-hospital transfers for victims from an overloaded community hospital to referral centers or potentially assist in other clinical areas.

- Request and use of mass casualty incident buses – two buses in the metro (Minneapolis Fire and Metropolitan Emergency Services Board, Metro Region EMS System), 1 in St. Cloud (VA), and 1 in Fargo. These resources can move many patients at a time to assist evacuating a hospital or long-term care facility. Plans should include guidance for when it is appropriate to request these assets.
- Mutual aid including ambulances from neighboring states may be obtained via request to the State EOC via the Emergency Management Assistance Compact. Significant aid would be limited to state-declared disasters.
- Federal ambulance contracts can provide hundreds of ambulances but requires a Federal declaration of disaster, in addition to a request, and time to get the ambulances to the location. Therefore at minimum 24 hours would be required to see significant contributions from these contractors.
- Scheduled BLS provider engagement – if the service area has scheduled BLS providers those resources may contribute substantially during a disaster. Their capabilities and contact information should be available and the point at which they become involved should be predefined.
- Wheelchair (WC) vans – local WC service providers may be a very helpful asset particularly with long-term care evacuations, though they may contribute to other predefined responses as well.
- Buses- school buses or public transit buses are climate controlled and capable of assisting with mass movements or batched transports.
- Private transport – use of private vehicles, with or without medical personnel may need to be used to augment ambulance services. In general, it is better to get a patient to the hospital faster rather than wait long periods of time for an ambulance. Prioritizing ambulatory and other selected patients to private transport can significantly reduce burden on EMS services. The threshold for recommending private transport should be specified at the dispatch level (see below Planning and Implementation).
- Plans should include guidance for when requests of these additional assets are appropriate.

Staff

Flexibility of staffing often correlates with run volumes (small volume volunteer services often have less flexibility than large urban services) though exceptions occur. During a pandemic or epidemic, EMS staff could be severely and disproportionately affected, dramatically reducing staffing options. EMS agencies should examine the following possibilities when planning for surge situations:

- Maximal utilization of current staff – consider extending shifts and changing schedules
- Mutual aid from nearby services – though current mutual aid focuses on ambulances, in some cases it may also be possible to share staff across services to maximize the use of the vehicles available. Also, services that are part of a health system may obtain staff from other areas if the event affects a single area/jurisdiction.
- Change in crew configuration – for example, 1 paramedic/ Emergency Medical Technician – Basic (EMT-B) rather than 2 ALS providers or 1 first responder/1 EMT-B rather than 2 EMT-B (note that some areas of the state are already allowed to do this)

- Use of direct response by staff in personal vehicles – this could involve community paramedics, or simply a first responder that can respond to provide assessment and basic care if an ambulance is not available
- Medical Reserve Corps (MRC) – depending on the community, MRC members may have qualifications that would enable them to contribute to EMS operations if this was a priority for their use. MRC can be activated by the county or State (MDH) on request during a disaster
- MN Mobile Medical Team (MMT) – the MMT has a broad array of providers and could be used to supplement EMS and emergency service personnel or used to staff an alternate care site to relieve the burden on EMS personnel
- Disaster Medical Assistance Team (DMAT) – DMAT teams are Federal versions of the MMT and may provide emergency and alternate care site medical services. DMAT teams are available during Federally declared disasters and are operational within 48 – 72 hours . DMAT teams do not staff ambulances directly but can provide support in many areas where EMS personnel might otherwise be requested to assist

Supplies

Currently supply chain models rely on ‘just-in-time’ inventory processes with minimal stock (par) levels. Few services are able to maintain significant disposable supplies in stock. Services should identify key supplies required in a disaster and attempt to assure that adequate supplies are available by increasing par levels and rotating those items through existing stock. These may include:

- Hemorrhage control – particularly tourniquets and dressings
- Backboards (helpful for transferring multiple patients, and for short carries over uneven terrain)
- Medications – particularly pain medication which will be in high demand, IV fluids
- Triage tags/tagging system
- Specialty supplies for pediatrics, burn (in particular, airway, pain management, IV access and fluids and burn sheets/dressings) and potentially chemical (auto-injectors)

Note the vast majority of disaster medical care focuses on basic life support skills, with the predominant ALS contribution of narcotic pain medications (and occasionally airway, chest decompression, etc.)

Services may cache supplies in a disaster trailer. Caches can be problematic for two reasons: 1) Supplies may become outdated or compromised without a system of checks 2) A personnel member has to retrieve the cache from its storage location, which may take time.

EMS agencies should understand their supply chain – where things come, what is available within the region, etc. so there are no surprises when replenishing stocks after a major incident. Drug shortages occur on a routine basis, and are a good reminder the supply chain is fragile, and adaptations and substitutions may need to occur (consistent with crisis care frameworks – see IOM 2012 for more information) when usual supplies are not available. These ‘routine’ shortages are useful opportunities to engage medical directors and supervisors in creating new standard operating procedures (SOP’s) that contribute to familiarity with the process and options during a crisis.

Federal stockpiles contain significant quantities of medications, specialized incident supplies, and prophylactic antibiotics in the Strategic National Stockpile (SNS). These can be accessed during a Federal declared disaster through the State Duty Officer if sufficient supplies are unavailable locally. Regional healthcare coalition and State options should be exhausted prior to inquiring about SNS assets.

Destinations

Destinations are included under 'resources' as it is critical that EMS have the ability to safely off-load patients to make the ambulance available again. In general, hospitals are the default destination. During disasters, the closest hospitals to the scene usually receive a significant numbers of walk-in casualties, therefore a conscious decision should be made to distribute casualties across several hospitals rather than overly burden a single hospital. EMS should understand the trauma and other capabilities of the facilities in the area and also be able to get capacity information for local hospitals rapidly via radio, phone, or MnTrac. This information should be utilized to distribute patients/casualties among receiving hospitals.

In prolonged events such as a pandemic, or those in which the local hospital is damaged and not operational, alternate destinations may have to be used. Clinics, urgent care centers, or alternate care sites (e.g. a 'field hospital' or site where an MMT or DMAT is operational) or even an influenza screening center may be appropriate sites depending on the situation. However, these are generally event-dependent options for the medical directors and supervisors to consider, develop event-specific policy, and communicate appropriate destinations to the crews. Local ordinance and 1135 waivers may be needed to facilitate these changes.

Planning and Implementation - General

Indicators and Triggers

An 'indicator' is a predictor of a possible surge event (e.g. a tornado warning, report of several cases of unusual respiratory illness) that requires gathering of additional information or analysis to decide if a 'trigger' point has been reached to take action.

There are two types of triggers, scripted triggers are built into SOP's and are automatic 'if/then'. Whenever possible, scripted triggers should be developed for front line personnel so they have actions they can take immediately to prevent delay. Non-scripted triggers require additional analysis and consideration involving supervisory staff. These are often part of an incident action planning cycle. The less specific the information available, the more difficult it is to apply a scripted trigger and the more likely an experienced supervisor or subject matter expert (SME) will be involved to process the information and decide on necessary actions. Responder and dispatch personnel should have a low threshold for passing indicator information along to supervisors for situational awareness and potential decision-making.

Rather than focus on indicators and triggers in isolation, the agency should determine what strategies or options it may employ in a disaster and then decide on indicators that might be available and a 'trigger point' for staff to take tactical action. Though this may sound complex, it is all about establishing thresholds for action. A tornado warning, while an indicator, does not trigger disaster related actions. A report to a dispatcher of a tornado touchdown in a

populated area *should* generate specific actions by dispatch staff just as a report of a fire in a building would (first alarm assignment).

Constructing SOPs and algorithms for line personnel should specify when to take certain actions. This is critical to the success of crisis response plans. Delays in decision making occurs with unfamiliar situations and unclear authority when they could have been automatic.

Note triggers are important at every level of response from local to State to Federal and the thresholds may vary (e.g. the threshold for a local disaster declaration is different than for a Federal declaration). Detailed information on indicators and triggers (including templates for EMS) is available in the 2015 IOM report -

<http://www.nationalacademies.org/hmd/Reports/2013/Crisis-Standards-of-Care-A-Toolkit-for-Indicators-and-Triggers.aspx>

Agency Policy

EMS agencies should first look at their resources (send, staff, supplies) and determine which policy options best apply to their service across the surge capacity spectrum from conventional to crisis care. This should be a joint effort involving supervisory, medical direction, and responder/dispatcher staff and potentially members of the regional healthcare coalition and regional EMS program. Indicator and trigger thresholds should be determined. These will vary by service, for example in a very rural area response time of 30 minutes to an ambulance request may be normal, and in an urban area would lead to implementation of call triage and recommendations for private transport.

Once the indicators and triggers have been determined, agency policy should be developed to give personnel clear expectations of what they will do and when they will do it, as well as the notifications that should occur to supervisors and surrounding agencies when these triggers are activated. Delegating authority to the responders and dispatchers should be done when possible, and the adoption of clear policies helps facilitate decisions as well as provides accountability across the agency.

Education, training, and exercising should be conducted to assure successful implementation of the policies. During an event that lasts longer than a day, the agency should review and modify their procedures as needed if it is clear there are issues with the original plan. Plans should be flexible to not 'lock in' disaster response protocols for the duration of an incident but allow transition back toward conventional care as more resources arrive or demand falls, or both (e.g. do not keep recommending private transport once ambulances are available).

Medical Direction

Crisis strategies and tactics balance community and individual needs. This presents risk to the patients who must be balanced against the demand. Therefore, involvement of medical directors is critical to the success of the plans, strategies and tactics. Local EMS medical directors should know the area and resources and be engaged with other agencies in the area in these planning discussions. Optimally, the medical director should have a role during the crisis situation providing subject matter expertise at minimum, and act as a liaison between the hospital and EMS. However, the engagement level of EMS medical directors varies widely across the state, and the EMS agency and medical director will need to agree on an

appropriate level of engagement. If needed, EMS medical directors at a regional level may be able to serve as a resource or provide guidance.

Medical directors must also approve of triage strategies used by their service (including baseline strategies such as Simple Triage And Rapid Treatment (START) or Sort, Assess, Lifesaving Intervention, Treatment/Transport (SALT) as well as any incident-specific guidance that allows EMS to leave patients at the scene or transport to alternate destinations. Since the medical director is ultimately responsible for the care provided, any change to usual SOPs will require physician input and approval.

EMS medical direction in Minnesota occurs at the local level; however the Medical Direction Standing Advisory Committee (MDSAC) of the EMSRB through the State EMS Medical Director may support local medical directors by providing resource documents including sample patient care guidelines. In situations with unique clinical circumstances such as pandemics the MDSAC is a resource that can offer guidance on clinical circumstances from physicians with EMS expertise.

Integration with Regional Operations

Minnesota is divided into eight healthcare preparedness program (HPP) regions, each of which has a healthcare coalition consisting of leadership from hospitals, EMS, public health, and emergency management. The EMS lead in each region is the EMSRB Regional Program Manager. Each region also has a Regional Healthcare Preparedness Coordinator (RHPC) who works primarily with the hospitals and EMS, and a corresponding Public Health Preparedness Coordinator (PHPC) who works with local and tribal public health agencies. The RHPCs and PHPCs have direct communication with the State Health Department.

It is critical that EMS agencies do *not* work on these plans in isolation, but do so in concert with their regional framework. Consistency of plans and knowing what others in the region are planning is critical to success. Surge strategies and SOPs do not have to be identical, but if they are similar it will help greatly in education, training, and mutual aid response. The HPP coalition helps coordinate not only planning, but also response. During a response, the HPP coalition assures information sharing between partners and support for and between disciplines in the area. The regional HPP coalition can also engage with neighboring coalitions and the State (MDH/EMSRB) to coordinate information and policies. The HPP coalition members interface with emergency management to assure that resource requests are processed and a common operating picture is maintained. The HPP coalition may also convene workgroups during planning or a response to help develop regional tactics (e.g. to discuss hotline/virtual support/common EMS practices in the area during a response).

The key is to only implement crisis strategies when planned assistance from regional partners is inadequate (either too little or too late) to prevent inappropriate decisions to implement crisis standards of care from being made. Coordination with the regional partners *must* be achieved as soon as possible when a crisis situation develops so the services can return to conventional operations as soon as possible. The sooner a crisis situation is recognized (indicators), pre-planned resources and coordinating mechanisms are activated (triggers), the shorter the crisis period will be.

Planning and Implementation – Rural

This section offers strategies and tactics with a focus on rural constraints. However, the diversity of services in rural areas or their proximity to urban areas may require adaptation. This guidance is generally directed toward a volunteer service dispatched by a PSAP with no emergency medical dispatch (EMD) capability. Advanced life support (ALS) services with EMD may wish to refer to the “Urban” strategies section below. Note that an EMS Crisis Standards of Care Matrix summary of issues is presented in Appendix 2.

Multi-agency coordination/policy development/IAP/IMS

Rural agencies should know their regional EMS program contacts and plans for regional Multi-Agency Coordination (MAC) during an event to help coordinate healthcare response efforts across the geographic region during a disaster. Due to the distances involved, engagement often is virtual, involving conference calls and electronic coordination platforms such as MnTrac. In conjunction with the regional HPP Coalition, the MAC can assist local agencies with resource issues (in conjunction with local emergency management), policy development, and joint incident action plans.

The use of the incident management system (IMS) during an event is extremely important and cannot be overstated. Use of the National Incident Management System (NIMS) is required by EMS, but incident action plans (IAP's) - (management by objectives) are seldom used due to the short nature of most events. In longer term events, use of the planning 'P' and the IAP cycle greatly facilitates development of common goals and identifies, obtains, and documents use of resources. **The State has a Type III incident management team that can assist in a local incident if required, but all agencies can utilize the framework, and the MAC can serve as a regional support for this process.** (for more information see <https://www.fema.gov/media-library/assets/documents/25028> and page 6 for the 'Planning P').

Dispatch/911/PSAP's

Part of the goal during a crisis is to decrease the call volume at the PSAP. This may be done by a variety of measures:

- Work with public health and local media to communicate to the public the stress on the system and to only call 911 for life-threatening emergencies.
- Keeping the public up to date with incident information can reduce non-emergency 911 calls. Thus, ongoing information provision to the community through the Public Information Officer (PIO) or Joint Information System (JIS) can be helpful.
- Activate an 'auto-answer' that may be as simple as 'Due to extreme demands on our 911 system please stay on the line only if you have a life-threatening emergency' or may involve options to route a caller to a hotline if they have questions about influenza symptoms, toxin exposure, or family reunification depending on the event. Auto-answer systems should be available to PSAPs if possible and optimally should be activated whenever the dispatcher cannot answer the phone right away. Some dispatch centers have roll-over to other PSAPs when they cannot answer by a certain number of rings, in this case a trigger for use of the auto-answer should be determined and the dispatcher empowered to activate the system.

During a crisis, once a call is received by the 911 center with a request for emergency medical services the goal is to provide the best services available. Given the long response and transport times in rural areas, and the lack of medically trained dispatchers in many communities, determining the best services for a request can be difficult. A possible

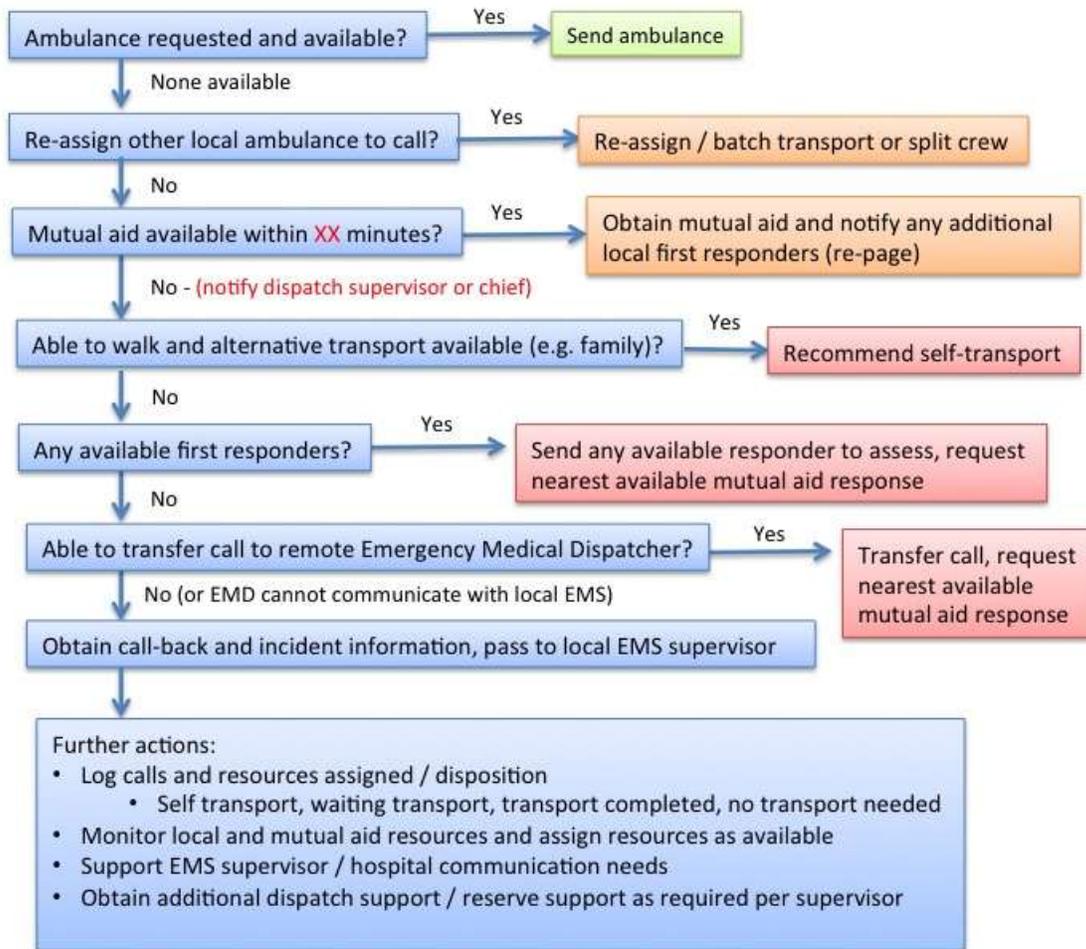
algorithm is presented in Fig. 2. Dispatchers should be empowered to use an algorithm such as this whenever the situation occurs, with a trigger to notify supervisory personnel whenever mutual aid is not available in a timely manner (the number of minutes should be specified by local decision based on usually available resources). The use of private transport may seem unusual to providers, but may represent the best medical care when care would otherwise be delayed. The community may have first responders that are not currently on the ambulance(s) and can respond to subsequent calls for assistance directly to the scene and to help the patient determine the best option for transport. In these situations, maintaining the minimum staff on the ambulance may be best to conserve clinical personnel and allow remaining staff to be available.

When possible, it may be very helpful to screen calls using a medical provider. This approach has been developed and utilized following prior major disasters in some communities. This could involve a partnership with the EMS system medical director, the area hospital, or a dispatch center with EMD capability. During a pandemic event even tripled call volumes in a rural area may not cause severe stress on available ambulance resources. This may be an infrequently required asset and capability in epidemic events but one that should be considered in the right circumstances. Most likely a single no-notice incident will overwhelm calls to rural community PSAP's and EMS supervisory personnel (potentially including a medical director) will have to assist in prioritizing the response to calls that are pending. Dispatch should always have contact information for an available EMS operations supervisor/manager as well as the Regional EMS Program Manager.

Figure 2:

EMS Dispatch - Triage Tree

v. April 28, 2016

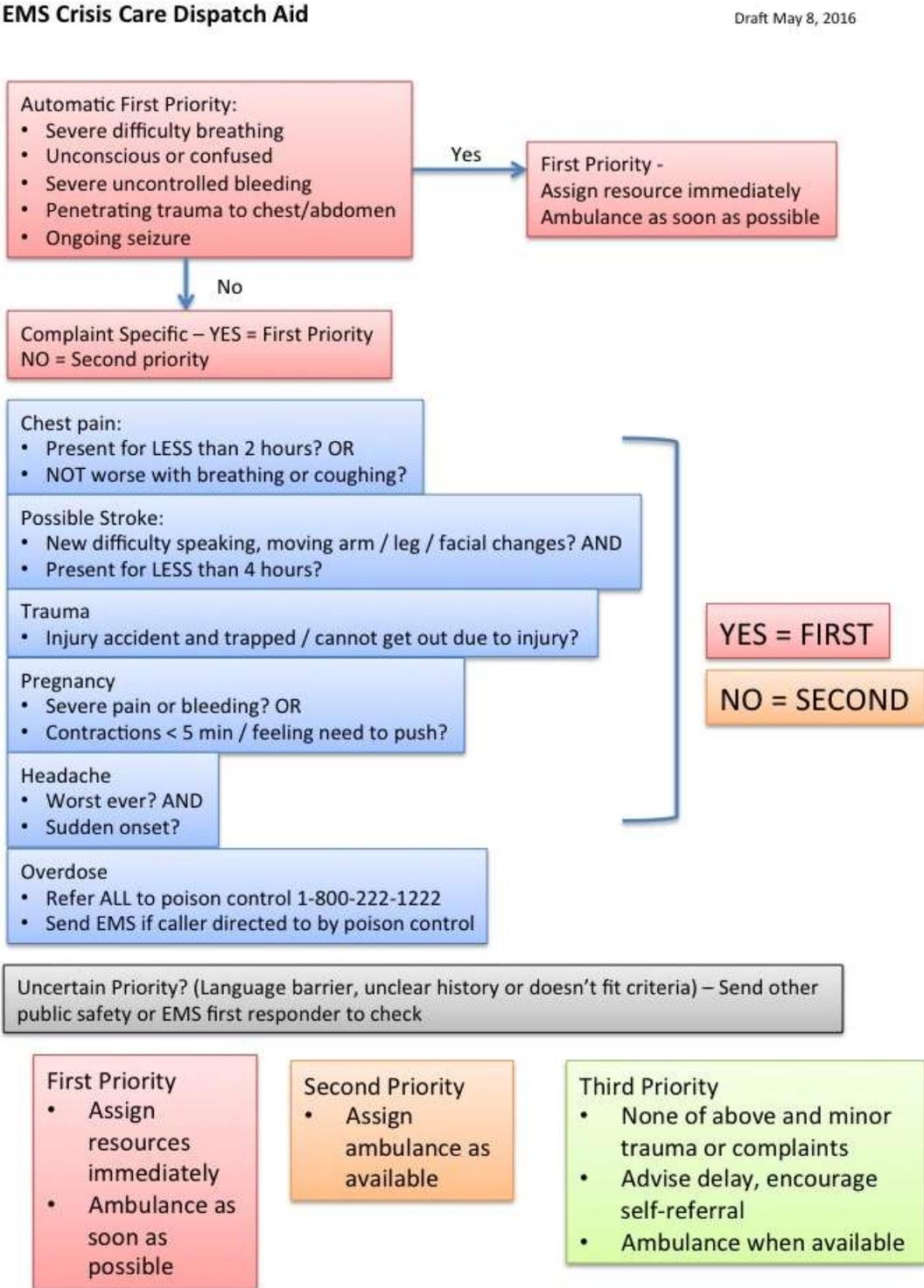


Notes:

- Assumes non-EMD PSAP - for EMD PSAP triage calls based on priority dispatch levels and in conjunction with medical direction
- Supervisors for EMS and public safety should be notified when any 'red box' / 4th level is used
- Dispatcher should have authority, process, and contact numbers for activating this algorithm
- Dispatcher should have contact information for regional ground and rotor-wing resources
- Identify support mechanism for call triage decisions (EMS supervisor / lead medic, hospital personnel and document responsibilities / contact information prior to event)
- Identify role of EMS supervisor / medical director in this process
- First responders without an ambulance should coordinate appropriate care with receiving hospital / EMS supervisor
- Consider *not* sending EMS initially on calls for potential injury accidents until confirmed significant injuries.
- Consider other call type triage based on local system and dispatcher training

Additionally, if the PSAP does not use an emergency medical dispatch system the service may wish to authorize the use of an algorithm by non-medically trained personnel to prioritize ambulance dispatches during a disaster as shown below in Fig. 3.

Figure 3: Disaster dispatch algorithm to prioritize pending EMS calls



Treatment

During no-notice disasters, care should focus on BLS measures with rapid transport to the hospital. Ambulance personnel should understand what changes to SOPs may be invoked during a disaster (for example, some ambulance services do not require calling in for on-line physician verbal orders during a disaster and allow the ambulance personnel to work within the full scope of their SOP for a complaint without medical control contact). During no-notice or prolonged disasters such as a pandemic the medical director and supervisory staff may approve broader discretion for patients being left at scene by EMS (if the condition is not emergent and appropriate follow-up and/or transportation can be arranged). This should ONLY be invoked when additional 911 calls are pending in the system and ONLY for conditions and circumstances that the medical director approves via SOP (see Appendix 2 – Hennepin County ALS Pandemic Protocols – Triage/Treatment). A responder may find themselves on scene with a patient that is to be transported by private vehicle – if the responder feels they need to provide ongoing care during transport, they may have to determine how they can safely accompany the patient. For patients that are stable, the responder could follow the patient’s vehicle or just assist with loading the patient safely and assure the family will take the patient to the hospital if other calls are pending.

Transport

Batch transports (more than one patient/ambulance) should be encouraged. Batch transport can also be used during pandemic or other events where calls are pending and the current patient is stable. As noted above, use of non-traditional transport including any available wheelchair vans and private vehicles may be the best option. Minivans with a flat cargo area offer lower loading height as well as a protected environment compared to pickup trucks. Pickups may offer an advantage in non-crisis conditions for getting patients to roadways from remote areas that require a high-clearance 4WD vehicle.

Inter-facility/Inter-hospital transfers can take precious local resources out of the service area for hours at a time. The use of Ambulance Strike Teams, EMS units from the receiving facility / community, or more aggressive use of rotor-wing transfer may be of substantial benefit in order to preserve community response assets. In some situations, the hospital may need to board patients they wish to have transferred while EMS continues to respond to high volumes of 911 calls. The hospital should understand this ‘dual priority’ ahead of time and EMS supervisory staff and medical directors may need to be involved in this negotiation.

Transports to Hospital in Non-Ambulance:

In a crisis EMS resources may be severely limited and alternate transport options may need to be considered. One option would be transport of patients via a motor vehicle that is not an ambulance with EMS providers administering care in the vehicle during transport. Appendix 3 provides specific considerations and guidance to be taken into account when the option or need occurs to use a non-ambulance for transport with EMS providers administering patient care.

Destination

EMS units universally transport to hospitals as they cannot receive reimbursement for non-hospital transports. Further, they usually transport to a single hospital in the response area, with occasional exceptions.

During a disaster, the closest hospital can quickly become overwhelmed with self-presenting as well as EMS transported patients. In these cases it may be appropriate to change protocols. These changes should be considered ahead of an event. It will usually require a supervisor/manager to approve transport to non-hospital facilities, but a crew may have to make a decision about the most appropriate destination hospital and should be empowered to do so.

The disadvantage with taking patients to a hospital that is further away is simple – distance = time. The time the crew takes to transport the patient to a further facility is time they could be spending responding. This can be reduced with lights-siren transport to the hospital though this increases provider and patient risk as well as risk to other drivers. However, when an incident is in an area where the transport time is not significantly longer, and/or when that facility may be larger or offer a higher trauma level of care it is appropriate to try to balance transports between facilities rather than risk overloading one. Patient tracking becomes important in this situation.

In some events where there are many patients that have mild symptoms (pandemic or a hazardous materials release – for example chlorine) the hospital may be over-loaded caring for very sick individuals and may set up a screening site for those with mild symptoms. This could be a clinic or other community venue. It is appropriate for EMS to transport to those locations provided they are open, appropriately staffed, and the patient does not have any severe symptoms.

EMS may be asked to provide on-site transport support for these facilities, as well as to shelters, and to support fire personnel at fire suppression scenes during a disaster. Unless there is an active need for transport, these support/stand-by roles must be declined if the service is in a crisis situation and having difficulty answering all their requests.

Planning and implementation - Urban

Multi-agency Coordination/Policy Development/IAP/IMS

Urban agencies benefit from close mutual aid relationships and more resources compared to rural environments, but can easily enter crisis mode by a very large or prolonged event (e.g. pandemic with 3x increase in call volumes). EMS agencies should know their regional EMS program contacts and dispatch numbers as well as plans for regional Multi-Agency Coordination (MAC) during an event that will help coordinate efforts across the geographic region during a disaster. The MAC should include the regional planners, EMS agencies, and interface with coalition partners such as hospitals, public health, and emergency management. In conjunction with the regional healthcare preparedness coalition, the MAC can assist local agencies with resource issues, policy development, and joint incident action plans.

The use of the incident management system (IMS) during an event is extremely important and cannot be overstated. Use of the National Incident Management System (NIMS) is required by EMS, but incident action plans (IAP's) - (management by objectives) are seldom used due to the short nature of most events. In longer term events, use of the planning 'P' and the IAP cycle greatly facilitates development of common goals and identifies, obtains, and documents use of resources. **The State has a Type III incident management team that can assist in a local incident if required, but all agencies can utilize the framework, and the MAC can serve as a regional support for this process.** (for more information see <https://www.fema.gov/media-library/assets/documents/25028> and page 6 for the 'Planning P').

The critical role of the MAC in a disaster is to maintain consistency across the region – one area should not be in conventional status while others are in crisis. Therefore, information sharing about system demand and the ability to facilitate mutual aid to load balance are key functions the MAC must be prepared to provide. This situation will be dynamic and requires frequent monitoring.

Dispatch/911/PSAP's

Part of the goal during a crisis is to decrease the call volume at the PSAP. This may be done by a variety of measures:

- Work with public health and local media to communicate to the public the stress on the system and to only call 911 for life-threatening emergencies.
- Keeping the public up to date with incident information can reduce non-emergency 911 calls. Thus, ongoing information provision to the community through the Public Information Officer (PIO) or Joint Information System (JIS) can be helpful.
- Activate an 'auto-answer' that may be as simple as 'Due to extreme demands on our 911 system please stay on the line only if you have a life-threatening emergency' or may involve options to route a caller to a hotline that may have questions about influenza symptoms, toxin exposure, or family reunification depending on the event. Auto-answer systems should be available to PSAPs if possible and optimally should be activated whenever the dispatcher cannot answer the phone right away. Some dispatch centers have roll-over to other PSAPs when they cannot answer by a certain number of rings, in this case a trigger for use of the auto-answer should be determined and the dispatcher empowered to activate the system.

During a crisis, once a call is received by 911 with a request for medical services the goal is to provide the best service available.

Medical priority dispatch is very helpful in prioritizing pending calls. A log should be kept of calls that are pending or were referred to self-transport. The following adaptations should be considered during a crisis:

- No response or first responder with AED only to cardiac arrest calls (recommend use of AED if available on-site)
- First responder (fire / police) only on following until clear that EMS transport required:
 - Motor vehicle crashes
 - Assaults
 - Intoxication
 - Slumper/'one-down' calls

- Fall (without other priority 1 complaints)
- Continue priority dispatch (i.e. maintain response to priority 1 (echo, delta, charlie, bravo) calls for as long as possible) recommending private transport when available based on current wait times for ambulance (e.g. recommend to priority 3 (omega and alpha) first, to CP and other priority one last)

Type	Capability	Response Time
Omega	Referral or Alternate Care	None
Alpha	Basic Life Support	Cold (single unit)
Bravo	Basic Life Support	Hot (multiple units)
Charlie	Advanced Life Support	Cold (single unit)
Delta	Advanced Life Support	Hot (multiple units)
Echo	Advanced Life Support and special units	Hot (multiple units)

Dispatch centers should have authority to use crisis dispatch algorithms and must immediately notify supervisory staff. Unless the situation is clearly limited to hours, the supervisor should notify the regional points of contact for the EMS MAC.

Treatment

During no-notice disasters, care should focus on BLS measures with rapid transport to the hospital. Providers should understand what changes to SOPs may be invoked during a disaster (for example, some services do not require calling in for on-line orders during a disaster and allow the providers to work within the full SOP for a complaint without medical control contact). During no-notice or prolonged disasters such as a pandemic the medical director and supervisory staff may approve broader discretion for patients being left at scene by EMS (if the condition is not emergent and appropriate follow-up and/or transportation can be arranged). This should ONLY be invoked when additional 911 calls are pending in the system and ONLY for conditions and circumstances that the medical director approves via SOP (see Appendix 4 – Hennepin County ALS Pandemic Protocols – Triage/Treatment).

During a prolonged event, printed information may be available for EMS to distribute to persons seeking care for pandemic or other conditions.

Transport

Urban EMS crews may be given the discretion to leave patients at the scene as stated above. Also, crews may 'batch transport' or transport more than one victim from a single scene or may respond to calls sequentially when their first patient is stable and another call is pending in the same general area.

Mass casualty buses (two in the metro area) or less traditional transport (scheduled BLS, self-transport by family, public transport, wheelchair van) may all be utilized as appropriate. The EMS agency should know how and when to use these resources if they will help relieve stress on the emergency response system.

Interfacility transfers may be required to redistribute casualties to more appropriate levels of care. The use of AST's if available and use of scheduled BLS or wheelchair transports may help

to reduce the burden of these transports. In some situations, the hospital may need to hold on to patients they wish to have transferred while EMS continues to respond to high volumes of 911 calls. The hospital should understand this 'dual priority' ahead of time and EMS supervisory staff and medical directors may need to be involved in this negotiation.

Use of on-line medical control or contact with a duty supervisor may be helpful to resolve specific medical or logistical questions and a mechanism for crews and dispatch to contact these individuals should be available at all times.

Transports to Hospital in Non-Ambulance:

In a crisis EMS resources may be severely limited and alternate transport options may need to be considered. One option would be transport of patients via a motor vehicle that is not an ambulance with EMS providers administering care in the vehicle during transport. Appendix 3 provides specific considerations to be taken into account when the option or need to use a non-ambulance for transport and EMS providers administering patient care occurs.

Destination

EMS should seek to avoid overloading a single hospital with victims from a no-notice event. In the metro area, the Medical Resource Control Centers (MRCC) maintain lists on MnTrac of the 'first wave' assignments for hospitals based on their trauma level. MRCC can assist ambulances with hospital assignments based on the triage category of their patient and the known bed availability being reported by individual hospitals via the MnTRAC system. In general, critical trauma should go to a Level 1 trauma center and burns to a designated Burn Center unless these centers are over capacity. Otherwise, the closest appropriate hospital should be chosen. Critical medical patients may need to be diverted away from Level 1 trauma centers to allow those facilities to focus their resources (ie ICU beds) on trauma patients. Though patient preference is usually honored when choosing a destination hospital (particularly in the metro area) this is not possible during crisis care (as well as weather and other situations). The closest appropriate hospital should be chosen to allow the crew to get back into service as quickly as possible.

In cases such as a pandemic, it is possible that screening / alternate care sites, or designated clinics/urgent cares may be an appropriate destination for EMS units. These locations and protocols would be developed regionally with input from operations and medical direction and would be implemented in special circumstances.

Recovery

Planning for recovery should begin while the event is ongoing. Recovery is the restoration of services to their pre-existing state (or optimized conventional state – whether this is above or below the prior state).

However, because of the dynamic nature of crisis conditions (particularly during long events such as pandemics) a return to conventional care does *not* mean the recovery phase as truly begun, as recovery is a stable state. EMS agencies should assure that they are prepared to be flexible across the surge spectrum and be certain that the situation has concluded prior to ending the response.

During recovery, there are multiple priorities including debris removal, strategic re-building of damaged infrastructure, etc. Some priorities for EMS specifically include:

- Final documentation of supply and time costs for potential reimbursement
- Return of borrowed equipment
- Restoration of equipment to usual state
- Replacement of supplies
- Provision of mental health support to affected staff (psychological first aid or more specific strategies depending on the situation)
- Support for provider families affected by the incident
- After-action reviews of the event and development of a corrective action plan for future similar events

EMS may need to provide ongoing support to other agencies as they continue body recovery and other operations. EMS should also confirm with local Emergency Management that there are no other functions required of them and participate in community recovery planning and after-action analysis.

Conclusion

EMS agencies in Minnesota are diverse, but all are at risk of situations in which demand can exceed the available resources and require adaptive strategies. All of us have a duty to plan for such situations and empower our EMS providers through training and standard operating procedures to make good choices that truly do the 'greatest good for the greatest number' of patients while assuring available additional resources are requested in a timely manner. Though these situations are rare, ad hoc decisions in novel conditions are often sub-optimal; the unique risks of these situations to our patients requires deliberate planning.

This guidance should provide a valuable framework on which agencies can modify their operational plans to incorporate crisis standards of care conditions.

The key planning steps for each EMS agency following review of the document are:

1. Convene a planning group with supervisory staff and medical director
2. Identify resources and limitations ('send', 'staff', and 'supplies')
3. Determine **limitations and options**, then **resource and policy** needs, then **indicators / triggers** in the following areas:
 - a. Dispatch
 - b. Response
 - c. Treatment
 - d. Transport
4. Develop formal written policy
5. Discuss policy with surrounding agencies, regional HPP Coalition, Regional EMS Program and receiving hospitals
6. Educate and exercise new policies and procedures

Appendices

5. Ambulance Requirements Suspended during Declared Disasters – identifies authority and specific ambulance statutes the EMSRB may suspend during a legally declared disaster.

6. EMS Crisis Standards of Care Matrix – provides a summary of tactics for each phase of response across conventional, contingency, and crisis
7. Transports to Hospital in Non-Ambulance – provides considerations to account for if non-ambulance resources are used to transport a patient to a hospital.
8. Hennepin County ALS Pandemic Protocols – Triage/Treatment – these protocols may be used after approval of the medical directors during a pandemic to determine patients that can be left at the scene.

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APPENDIX 1:

State Ambulance Requirements Suspended during Declared Disasters

During this time of extensive disaster preparedness planning, the EMSRB recognized the need to allow for suspension of certain ambulance requirements during legally declared disasters. The following legislation was enacted during the 2005 session and became **effective August 1, 2005**.

Minnesota Statutes, section 144E.266, provides:

EMERGENCY SUSPENSION OF AMBULANCE SERVICE REQUIREMENT.

(a) The requirements of sections [144E.10](#); 144E.101, subdivisions 1, 2, 3, 6, 7, 8, 9, 10, 11, and 13 ; [144E.103](#); [144E.12](#); [144E.121](#); [144E.123](#); [144E.127](#); and [144E.15](#), are suspended:

(1) throughout the state during a national security emergency declared under section [12.31](#);

(2) in the geographic areas of the state affected during a peacetime emergency declared under section [12.31](#); and

(3) in the geographic areas of the state affected during a local emergency declared under section [12.29](#).

(b) For purposes of this section, the geographic areas of the state affected shall include geographic areas where one or more ambulance services are providing requested mutual aid to the site of the emergency.

Suspension of specific ambulance requirements in legally declared disasters.

The disasters must be declared by the Governor (5-day limit) or local disasters declared by the mayor or county board chair (3-day limit), in accordance with Minnesota Statutes, section 12.31 and 12.29. The following requirements would be suspended in the area affected by the disaster or for those responding to requested mutual aid in the affected area:

Explanation of Specific Requirements Suspended:

- 1) [144E.10](#): license required to operate an ambulance service;
- 2) [144E.101 subd. 1](#): requires certified personnel and staffing appropriate to the level of service on ambulance; also requires ambulance service to have medical director;
- 3) [144E.101, subd. 2](#): requires at least one ambulance attendant in patient compartment and EMT-P in patient compartment if ALS care provided.
- 4) [144E.101, subd.3](#): requires ambulance service to offer continual service (24 hours a day, every day of the year);
- 5) [144E.101, subd. 6](#): basic life support staffing and care requirements;
- 6) [144E.101, subd. 7](#): advanced life support staffing and care requirements;
- 7) [144E.101, subd. 8](#): part-time advanced life support staffing and care requirements;
- 8) [144E.101, subd. 9](#): specific requirements for specialized life support ambulances;
- 9) [144E.101, subd. 10](#): requires driver of ambulance to have driver's license and emergency driving course;
- 10) [144E.101, subd. 11](#): requires on-call schedule, documentation of personnel qualifications, and statement signed by medical director accepting responsibilities;
- 11) [144E.101, subd. 13](#): limits ambulance to assigned PSA, except when called for mutual aid or requested by transferring physician;
- 12) [144E.103](#): equipment and safety restraints requirements; requires drugs approved by medical director for ALS;
- 13) [144E.12](#): licensure of air ambulances;
- 14) [144E.121](#): requirements for air ambulance;

- 15) 144E.123: requires pre-hospital care data be collected and submitted to Board on every response; requires copy of patient care report to be left at hospital;
- 16) 144E.127: allows substitution of physician, RN, or PA for one of required ambulance attendants on inter-hospital transfer;
- 17) 144E.15: requires board approval for relocating base of operations within PSA.

MEMA Powers Requiring a Governor's Declaration:

1. Order evacuations, shelters, and otherwise control the movement of persons and vehicles, and cancel public meetings and events. MEMA, §12.21, Subd. 3(7) (iv)-(vi)
2. Alter or adjust state employee working hours and conditions. MEMA, §12.21, Subd. 3(10)
3. Authorize the Commissioner of Education to close schools.
4. -MEMA, §12.21, Subd, 3(11)
5. Require any person to perform emergency management services, under threat of criminal prosecution. MEMA, §12.34, Subds. 1(1) & 3
6. Commandeer vehicles, tools, appliances, medical supplies*, other personal property, or facilities subject to compensation. MEMA, §12.34, Subd. 1(2)
(* NOTE: MEMA defines "medical supplies" as excluding medication, equipment, instruments, or materials deemed essential for a provider's practice or facility; or medication, equipment, etc., owned or used by individuals for treatment or care. MEMA, §12.03, Subd. 6a.
7. Take possession of fatalities; provide safe disposition including mass burial. MEMA, §12.381, Subd. 1
8. Authorize volunteer health professionals licensed in another state or Canadian Province to practice in Minnesota. MEMA, §12.42
9. Issue Executive Order authorizing temporary medical care facilities. MEMA, §12.61
10. Activate requests for assistance pursuant to the Interstate Emergency Management Assistance Compact (EMAC). EMAC, Minn. Stat. §192.89, Subd. 4

MEMA Powers Not Requiring a Governor's Declaration:

1. During an emergency or disaster, Governor may enter contracts, incur obligations, and exercise powers in light of the exigencies without compliance with time-consuming procedures and formalities prescribed by laws pertaining to contracts, employment, purchasing supplies and equipment, budgeting, etc. MEMA, Minn. Stat. §12.36
2. MEMA, Minn. Stat. §13.37, also grants to local political subdivisions the same authority to enter contracts, incur obligations, and exercise powers in light of the exigencies without compliance with time-consuming procedures and formalities prescribed by laws pertaining to contracts, employment, purchasing supplies and equipment, budgeting, etc.
3. Governor may direct personnel, equipment and supplies of police, fire-fighting, health, or other forces of one political subdivision to assist another in an imminent emergency. MEMA, Minn. Stat. §12.33
4. Volunteer protections under §12.22, Subd. 2(a): Individuals who volunteer with state /political subdivision, who register, and act under direction and control are considered

employees of the state /political subdivision for workers' compensation and tort claim defense and indemnification

5. Mutual aid agreement (§12.27);
6. Local assistance (§12.331);
7. Activating emergency response personnel (§12.35)

Federal Assistance During a Declared Disaster:

Federal Assistance to “support” state and local efforts under the Stafford Act includes:

1. Federal personnel, equipment, facilities, managerial, technical and advisory services in response and recovery efforts;
2. Coordination of disaster relief assistance (including volunteers) provided by federal, state, local agencies and private organizations; and
3. Provide technical and advisory assistance to state and local governments for essential community services, health and safety measures, information services, recovery activities.

Through the Federal Emergency Management Agency specific disaster relief may include: individual assistance, public assistance and hazard mitigation assistance.

The Secretary of Health and Human Services can declare “Public Health Emergency” under the Public Health Service Act. The Secretary may determine, after consultation with such public health officials as may be necessary, that:

1. A disease or disorder presents a public health emergency (including significant outbreaks of infectious diseases or bioterrorist attacks, otherwise exists);
2. Provides notice to Congress within 48 hours;
3. Terminates when the Secretary determines that the emergency no longer exists or after 90 days, whichever occurs first; and
4. May be renewed by the Secretary for additional 90 day periods.
5. If the Secretary of Health and Human Services (HHS) issues a declaration of a public health emergency it enables the Secretary the discretionary authority to authorize a range of actions which includes:
6. may authorize the use of an investigational medical product;
7. may waive or modify certain Medicare, Medicaid and CHIP requirements, such as:
 - a. Conditions of participation;
 - b. Pre-approval requirements for healthcare services;
 - c. Requirement that healthcare providers be licensed in the state in which they provide services;
8. Waive sanctions under EMTALA for redirecting a patient to another location – if the transfer is pursuant to a state emergency plan or if the transfer is necessitated by the circumstances of the declared emergency;
9. Waive sanctions and penalties arising from noncompliance with HIPAA privacy regulations related to:
 - a. obtaining patient’s agreement to speak with family or friends;
 - b. distributing a notice of privacy practices; or

- c. the patient's right to request privacy restrictions or confidential communications
10. Waive other participation or program requirements, or certification requirements (e.g., caps on critical access hospital beds);
11. Waive Stark self-referral sanctions;
12. Access Public Health Emergency Fund (when funds are available);
13. Make grants, provide awards for expenses, and enter into contracts and conduct and support investigations;
14. Extend deadlines, waive sanctions for submission of data or reports; and
15. Waive certain restrictions on requirements for medical countermeasure distribution
16. Exempt select agent requirements (PHS Act §351A);
17. Adjust Medicare payment for Part B drugs (SSA §1847A);
18. Waive Ryan White HIV~Aids requirements (PHS Act Title XXVI);
19. Exceptions to telemedicine practices (21 USC § 801); and
20. Allow State and local government access to federal General Services Supply schedules when using federal funds.

Following the declaration of a Public Health Emergency, the exercise of any of these authorities is discretionary; these authorities do not automatically result when a PHE is declared, and the existence of a PHE does not create a right of entitlement for those who may benefit from any action the Secretary is authorized to undertake.

Federal actions not requiring a public health emergency determination:

1. Deploy approved, licensed, or cleared countermeasures from the Strategic National Stockpile (SNS);
2. Deploy National Disaster Medical System teams, U.S. Commissioned Corps;
3. Provide temporary assistance to States and localities to meet health emergencies;
4. Conduct research, surveillance, investigations; and
5. Quarantine and isolation

APPENDIX 2:

EMS Crisis Standards of Care Matrix

	Conventional	Contingency	Crisis
Public messaging	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Public messages - Limit calls to 911 	<ul style="list-style-type: none"> Public messages - Limit calls to 911 – risk to others if not true emergency
PSAP/EMS Dispatch	<ul style="list-style-type: none"> Priority dispatch Standard dispatch procedures or protocols 	<ul style="list-style-type: none"> Mutual aid as required and normally requested Priority dispatch but pend calls of non-emergent nature (A) (1) Consider adjusted response assignments (e.g. no EMS until injuries confirmed at MVC) (A,C) (2) 	<ul style="list-style-type: none"> Auto-answer with diversion of non-emergency calls to health care provider healthline / 311 / other source (A) Medical screening for necessity – decline or refer callers to other transportation options (taxi, bus, special transportation, etc.) (A, possible C,S for liability issues?) or to prescribing line (S) (3) Priority dispatch of emergency calls only (A,C) Adjusted response assignments as per Contingency (A,C)
Response	<ul style="list-style-type: none"> Usual resources and response standards 	<ul style="list-style-type: none"> Mutual aid Consider additional use of BLS or alternate transport (A) Consider alternate staffing and shift patterns 	<ul style="list-style-type: none"> Additional mutual aid, strike teams or MCI bus? (A,C, possible S) Non-medical vehicle drivers (A,C, possible S) Alternate response – BLS, wheel chair/special transportation, school or public transit buses, other (A,C,S) Additional trained staff unavailable or unable to respond to volume of requests even with extension techniques (A,C,S)
Treatment – Standard of Care	<ul style="list-style-type: none"> Assess and treat per usual Standard Operating Procedures (SOP) and standard of care 	<ul style="list-style-type: none"> Assess and treat per SOP, radio control for unusual situations; functionally equivalent care (ALS, BLS) Conservation, adaption and substitution of supplies with occasional re-use of selected supplies 	<ul style="list-style-type: none"> Broaden discretion of EMS to leave patient at scene according to crisis plan or radio contact with MD/RN (A,C, possible S) and/or refer to alternate transport options (4) Critical supplies lacking, possible re-allocation of personnel and life sustaining resources (A,C,S) Broaden on-scene treatment options (A,C, possible S) Crisis Standard of Care (A, C, S)
Transport	<ul style="list-style-type: none"> Transport to destination hospital of choice 	<ul style="list-style-type: none"> Transport to closest appropriate hospital (A,C) 	<ul style="list-style-type: none"> ‘Batch’ transports of multiple patients, private or public vehicle, buses, special transportation (A,C) (5) Transport to closest appropriate facility (A,C)

			<ul style="list-style-type: none"> • Transport to alternate care facility, i.e. clinic, specialty clinics, field medical station, alternate care site, other non-traditional patient disposition facilities (A,C, S)
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Notes:

A = Agency policy / SOP adjustment needed – operational policy development, service and medical director approval

C = County or City/ community ordinance may require exemption / waiver

S = State regulatory or other action needed (EMSRB, etc.)

1. Requires Emergency Medical Dispatch (EMD) – for 911 public safety answering points (PSAP) without medically trained dispatchers will require algorithm and/or referral to EMS EMD-providing service. Algorithms would need to be approved by local gov't entity and potential liability relief from locality.
2. Will require pre-scripting of changes to response assignments on paper or in computer aided dispatch (CAD) for dispatch to use – requires trigger for use approved by agency and medical director.
3. Medical screening may be carried out by dispatcher, or by medical provider (RN or MD) – staffing and scripting should be pre-planned and approved by agency
4. Left at scene discretion should be developed by agency policy (e.g. Hennepin County EMS System Pandemic Influenza Plan) and clear approval by agency, medical directors, and triggers for use should be described
5. Trigger and approval by agency supervisor / medical director should be described in policy

APPENDIX 3

Transports to Hospital in Non-Ambulance:

In a crisis, EMS resources may be severely limited and alternate transport options may need to be considered. One option would be transport of patients via a motor vehicle that is not an ambulance including the following options:

1. Family members or others transporting stable patient in private vehicle without escort/attendant (e.g. arm laceration with bleeding controlled by dressing)
2. Family members or others transporting patient in vehicle with EMS personnel following in another vehicle (stable but with potential for deterioration)
3. Family members or others transporting in private vehicle with EMS personnel in the vehicle with them monitoring or providing care (unstable – highest risk to patient and provider)
4. Non-ambulance public safety vehicle (fire or police) transporting patient (professional driver and marked vehicle but limited ability to provide any medical care in usual squad vs. private vehicle such as mini-van)

EMS providers need to objectively weigh the risks and benefits of patient transport in a non-traditional vehicle versus the risks and benefits of waiting for a formal ambulance to arrive. This may involve consultation with a physician or supervisor to assist with the assessment of the risks/benefits of the two options. Some considerations that should be taken into account when considering transport to a hospital by a non-ambulance with EMS personnel providing care during transport are:

- **Time sensitivity** - Does the patient have a time sensitive condition that can only be stabilized at a hospital and that is likely to continue to deteriorate until hospital arrival? This could include conditions such as ST elevation myocardial infarction (STEMI), acute stroke, sepsis, shock or multisystem trauma.
- **Decreased time to treatment** - Does the time to the hospital by a non-ambulance decrease the time to hospital arrival and increase the chances of the patient having a successful outcome?
- **Stabilization needed**- Can the patient be appropriately stabilized on-scene while awaiting arrival of an ambulance? Patients requiring spinal immobilization will need to be supine and may not be adequately restrained in a supine position in vehicles other than an ambulance.
- **Existing medical conditions** - Are there medical conditions present which will make transport by a non-ambulance more difficult? Many patients transported by a non-ambulance will need to be able to tolerate a seated position.
- **Spinal immobilization - Other transport available** - If a patient is to be transported supine in a vehicle other than an ambulance are there other marked emergency vehicles that can provide an escort for the transport? Are there other variables that can be adjusted to increase the safety of a supine transport in a non-ambulance like speed, route of travel, placing a helmet on the patient?
- **Patient restraints** - Although not always possible, patients and any attendants being transported to a hospital in a non-ambulance should have appropriate patient restraints while the vehicle is in motion; this will necessitate the patient is

able to sit upright for appropriate safety belt use while the vehicle is in motion. Vehicle collisions are one of the most common causes of death for patients and first responders even in well-marked emergency vehicles with lights and sirens

- **Driver distractions** - The provision of patient care by EMS personnel will be a distraction to the driver of the vehicle and the driver should be specifically cautioned about this
- **Car seats** - Children in car seats may be transported in a non-ambulance safely if the car seat is appropriately installed in the vehicle

Transporting a patient in a non-ambulance can be a stressful decision that could require the involved parties to operate outside their standard motor vehicle operating procedures regarding restraints. The private vehicle will likely not be equipped with lights/sirens so all speed limits and traffic laws must be obeyed for safety. The most experienced driver available should drive the vehicle. Public safety vehicle drivers (e.g. police) may not be used to driving with medical care enroute and should minimize speed in favor of safe transport.

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APPENDIX 4:

PANDEMIC INFLUENZA APPENDIX Approved 4-9-09 by Hennepin County EMS

Council

Policy context

These standing orders will be used to provide the best pre-hospital care to the greatest number of people during an extreme situation. They will only be put into place when resources are defined by the system as “Level Red,” which means EMS services are pending or not answering calls for which there is a significant risk of death for the patient. They do not supersede other protocols. You will be notified when this status is in effect.

Our ethical commitments are:

- A. **Limitation of Individual Autonomy:** The fair and just rationing of scarce resources requires public health decisions based on objective factors, rather than on the choice of individual leaders, providers, or patients. All individuals should receive the highest level of care given the resources available at the time.
- B. **Transparency:** Governments and institutions have an ethical obligation to plan allocation through a process that is transparent, open, and publicly debated. Governmental honesty about the need to ration medical care justifies institutional and professional actions of withholding and withdrawing support from individual patients. These restrictive policies must be understood and supported by medical providers and the public, ideally with reassurances that institutions and providers will be acting in good faith and legally protected in their efforts.
- C. **Justice/Fairness:** The proposed triage process relies on the principle of maximization of benefit to the population served. The triage process treats patients equally based on objective, physiologic criteria, and when these criteria do not clearly favor a particular patient, “first come, first serve” rules will apply...
- D. **Assurance:** In order to ensure “procedural justice,” EMS triage processes will be regularly evaluated to assure that the process has been followed fairly and consistently.
- E. **Documentation:** MNTrac records will include policy notations including the times the “Level Red” was in effect.

When an ambulance arrives on scene during “Level Red” status, instead of automatically offering transport to an emergency department, as under normal practice, you will assess the patient’s objective condition and triage him/her into the following categories:

	<input type="radio"/> provide homecare information
	<input type="radio"/> refer to a clinic or other medical destination
	<input type="radio"/> refer to use of alternate transportation to a hospital, clinic or other medical destination
	<input type="radio"/> transport by (and at the discretion of) law enforcement



- transport by ambulance to a hospital or other medical destination

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Standing Orders

A. If the patient’s complaint or symptoms are not listed in this Appendix, Paramedic’s discretion is advised as long as the decision is not in conflict with SOP.

B. When resources during a Pandemic are “Level Red,” **automatically offer to transport**  patients with the following presentations:

	1. Paramedic discretion – suspicion of critical illness/injury
	2. Altered vital signs (or age-specific abnormal vital signs), including any one of these: <ul style="list-style-type: none"> ○ SBP < 90 ○ SpO2 < 92% ○ RR > 30 (or respiratory distress) ○ HR > 120, or delayed capillary refill
	3. Breathing: <ul style="list-style-type: none"> ○ Respiratory distress ○ Cyanosis, or pallor/ashen skin
	4. Circulation/Shock: <ul style="list-style-type: none"> ○ Signs or symptoms of shock ○ Severe/uncontrollable bleeding ○ Large amounts of blood (or suspected blood) in emesis or stool
	5. Neurologic: <ul style="list-style-type: none"> ○ Unconscious or altered level of consciousness ○ New focal neurologic signs (CVA, etc.) ○ Status, multiple or new-onset seizure ○ Severe headaches – especially sudden onset or accompanied with neck pain/stiffness ○ Head injuries with more than brief loss of consciousness or continued neck pain, dizziness, vision disturbances, ongoing amnesia or headache, and/or nausea and vomiting
	6. Trauma: <ul style="list-style-type: none"> ○ Significant trauma with chest/spinal/abdominal/neurologic injury deemed unstable or potentially unstable ○ Suspected fractures or dislocations that cannot be safely transported by private vehicle

C. When resources during a Pandemic are “Level Red,” **consider patients with the following presentations for:**

- **transportation by ambulance**  - Note that many ‘transport by ambulance’ patients will not require emergency transport to the hospital – in which case, the crew may answer additional calls until the ambulance is full, or a critical patient is picked up, depending on system call volumes.
- **transportation by alternate means:**
private vehicle  **or police**  **to clinic**  **or hospital**. Except in very limited cases, the patient should NOT self-transport to the hospital/clinic, but could be driven by someone else.
- **homecare**  Give patient the Homecare form for their complaint and advise to contact PMD if symptoms persist or worsen. The form will have information pertaining to their complaint and list ways of caring for themselves, as well as what to look for that would prompt self-transport to a clinic or hospital, or transport via ambulance to the hospital. Advise the patient that this does not restrict them from seeking care at a clinic or hospital on their own, should they desire.

1. ABDOMINAL PAIN:

	<ul style="list-style-type: none"> ○ Pulsating mass ○ Marked tenderness/guarding ○ Pain radiating into back and/or groin/inner thighs ○ Recurrent severe vomiting not associated with diarrhea
 	<ul style="list-style-type: none"> ○ Recurrent severe vomiting associated with diarrhea – to emergency if associated with signs/symptoms of dehydration, to urgent care or clinic if no dizziness nor vital sign changes and normal exam
	<ul style="list-style-type: none"> ○ Intermittent vomiting and diarrhea without blood or evidence of dehydration

2. ANAPHYLAXIS/STINGS:

	<ul style="list-style-type: none"> ○ Patients who have had epinephrine administered for symptoms ○ Patients experiencing airway, hypotension or respiratory symptoms, after an allergy exposure
  	<ul style="list-style-type: none"> ○ Patients with itching after exposure – if rapid onset of symptoms, may require EMS transport; if delayed > 1hour, safe for private transport. All patients with history of anaphylaxis should be seen in emergency room if possible. Others may be seen in clinic or urgent care. EMS may administer diphenhydramine prior to clearing scene, up to 1mg/kg.

3. BACK PAIN:

	<ul style="list-style-type: none"> ○ Acute trauma with midline bony spinal tenderness ○ New onset of extremity weakness, sensory deficits, other neurological changes, incontinence of urine or bowel, urinary retention, or bloody urine ○ Concern for abdominal aortic aneurysm ○ Pain radiating into abdomen, or groin/inner thighs
 	<ul style="list-style-type: none"> ○ Inability to ambulate/care for self
	<ul style="list-style-type: none"> ○ Concern for kidney stone, bloody urine

4. BEHAVIORAL:

	<ul style="list-style-type: none"> ○ Uncontrolled agitation requiring sedation by EMS
 OR  OR 	<ul style="list-style-type: none"> ○ Suicidal ideation – must be left with a responsible party
 OR 	<ul style="list-style-type: none"> ○ Other emotionally disturbed patients may be transported at law enforcement's discretion or by other means

5. BLEEDING (LACERATIONS, ABRASIONS OR AVULSIONS):

	<ul style="list-style-type: none"> ○ Patient is on coumadin or other blood thinner with significant ongoing bleeding or large hematoma
 	<ul style="list-style-type: none"> ○ Significant lacerations after bandaging – heavily contaminated, bite-related, likely to involve foreign body, deep structure injury, sensory/motor deficit – to emergency room ○ Lacerations requiring simple repair – consider self-transport to physician’s office or urgent care center (however, some offices do not do procedures; patient will need to call ahead)
	<ul style="list-style-type: none"> ○ Abrasions or avulsions not requiring suturing or repair, no significant contamination. ○ Minor lacerations that do not require sutures

6. BURNS:

	<ul style="list-style-type: none"> ○ All chemical or electrical burns ○ Suspected inhalant burn ○ Significant third degree burns ○ Second degree burns to $\geq 5\%$ of body area ○ Second degree burns to face, mouth ○ Severe pain
	<ul style="list-style-type: none"> ○ Second degree burns to hands or feet, or to other location 1%-5% body surface area (size of patient’s palmar surface)
	<ul style="list-style-type: none"> ○ Second degree burns $< 1\%$ body surface area, non-critical location ○ First degree burns

7. CARDIAC ARREST:

	<ul style="list-style-type: none"> ○ Witnessed down time ≤ 10 minutes – follow usual resuscitation protocols
	<ul style="list-style-type: none"> ○ All others – report death to dispatch and return to service; do not wait for law enforcement or medical examiner arrival

8. CHEST PAIN:

	<ul style="list-style-type: none"> ○ Chest pain or other signs or symptoms suspicious for cardiac ischemia, pulmonary embolus, or other life threat
   	<ul style="list-style-type: none"> ○ Chest pain ongoing for >12 hours and a normal ECG ○ Pleuritic chest pain without hypoxia ○ Chest pain reproducible on physical exam to palpation is generally NOT concerning; unless ECG changes or known cardiac disease, unlikely to require treatment for acute coronary syndrome

9. DIABETIC:

 OR 	<ul style="list-style-type: none"> ○ Any patient on oral diabetes medications with low blood glucose – if transported by private vehicle must NOT drive self ○ Critical high glucose or signs of Diabetic Ketoacidosis/dehydration
	<ul style="list-style-type: none"> ○ Patients with typical hypoglycemia and explanation for low sugar (did not eat, etc.) can be left without medical control contact as long as family/friend is present and patient is eating

10. ENVIRONMENTAL:

	<ul style="list-style-type: none"> ○ Heat-related illness with any alteration in mental status (confusion, decreased LOC) ○ Frozen extremity ○ Hypothermia with AMS
 OR 	<ul style="list-style-type: none"> ○ Frostbite to face, hands, feet, other location suspected deeper injury, blisters, or frozen to touch
	<ul style="list-style-type: none"> ○ Heat-related illness without alteration in mental status – initiate external cooling at home under supervision of friends/family ○ Minor frostbite with tissues now soft, pink, no blisters, and NOT involving digits

11. ETOH/SUBSTANCE ABUSE:

	<ul style="list-style-type: none"> ○ Very decreased LOC or other confounding issues (head injury, suspicion of aspiration)
	<ul style="list-style-type: none"> ○ Otherwise may be transported at law enforcement's discretion
	<ul style="list-style-type: none"> ○ Patient may be left with a responsible individual who can assist the patient ○ Able to ambulate safely without assistance

12. EYE PAIN:

	<ul style="list-style-type: none"> ○ Impaled objects or possible penetrating injury to eye, or globe rupture ○ Chemical exposures (alkaline) – after decontamination and initial rinsing
 OR  	<ul style="list-style-type: none"> ○ Eye pain and/or acute changes to vision should receive transport for urgent evaluation to emergency department or other qualified clinic (e.g. eye clinic) ○ Chemical exposures (non-alkaline) – consult poison control for instructions; transport if symptoms / dangerous exposure
	<ul style="list-style-type: none"> ○ Chemical exposures (non-alkaline) – consult poison control for instructions; if no symptoms and limited toxicity likely, give instruction sheet

13. FEVER:

	<ul style="list-style-type: none"> ○ Fever plus altered mental status including confusion ○ Fever plus severe symptoms by paramedic assessment ○ Fever plus seizures, lethargy, stiff neck, rash, or blistering
 OR  	<ul style="list-style-type: none"> ○ ≤ 3 months with fever estimated at 100.5 degrees – to emergency room or clinic urgently ○ > 3 months with fever that does not reduce with anti-pyretics, or fever lasting more than 5 days – emergency room, urgent care, or clinic

14. HEADACHE:

	<ul style="list-style-type: none"> ○ With vision deficit, lethargy, or page 1 qualifiers (fever, etc.)
	<ul style="list-style-type: none"> ○ New headaches for patient require assessment ○ Usual headaches for patient may require treatment

15. MUSCULOSKELETAL INJURIES (ISOLATED):

	<ul style="list-style-type: none"> ○ Loss of distal pulses ○ Unable to effectively splint the affected part ○ Neurological changes or deficits ○ Open fractures ○ Displaced fractures or pain requiring injectable narcotics
	<ul style="list-style-type: none"> ○ Suspected fractures that are stable and do not require injected analgesia may be splinted appropriately and transported by private vehicle
 OR 	<ul style="list-style-type: none"> ○ Neck pain and back pain after MVC, that is delayed in onset and not associated with midline tenderness or neurologic symptoms

16. NOSEBLEED:

	<ul style="list-style-type: none"> ○ Signs of hypovolemia or dizziness upon standing ○ Patient is on blood thinners (Coumadin, lovenox, clopidogrel, etc.) ○ Continued high blood pressure (SBP >200) in setting of nosebleed ○ Continued severe bleeding despite EMS efforts to control
	<ul style="list-style-type: none"> ○ All other

17. OB/PREGNANCY:

	<ul style="list-style-type: none"> ○ Imminent delivery ○ Pain in abdomen or back ○ Profuse vaginal bleeding ○ Third trimester (>24 weeks) bleeding ○ Pre/eclampsia – syncope, seizure, altered mental status, SBP ≥ 140
	<ul style="list-style-type: none"> ○ All other

18. SWALLOWING PROBLEM:

	<ul style="list-style-type: none"> ○ Patient unable to manage own secretions due to pain or obstruction
	<ul style="list-style-type: none"> ○ All other

	<ul style="list-style-type: none"> ○ History of coronary disease or heart failure ○ Age =>55 ○ Pregnant ○ Chest pain, headache, or shortness of breath (or other symptoms concerning to paramedics)
	<ul style="list-style-type: none"> ○ Likely dehydration, with dizziness preceding the syncope ○ Other underlying medical conditions

20. TOXICOLOGIC:

	<ul style="list-style-type: none"> ○ Overdose or other toxic exposure – contact Poison Control and/or on- line medical control ○ If intentional, see Behavioral Health in this Appendix
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21. VULNERABLE PERSON IN POTENTIAL DANGER:

	<ul style="list-style-type: none"> ○ EMS should assure that person will not be left in dangerous environment ○ If safe disposition and transport can be arranged and the injuries do not otherwise require medical evaluation, other transport may be appropriate
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