NOR-CAL EMS	13-0106	Crisis Standards of Care
Nor-Cal EMS Policy & Procedure Manual		Disaster Medical
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Authority

Health and Safety Code Division 2.5, Sections 1797.150-152.

Purpose

The purpose of this policy is to help ensure continuation of Emergency Medical Services (EMS) during a Multi Casualty Incident (MCI) and/or a disaster. This policy applies to all levels of prehospital responders.

Definitions

1. Normal Operations are defined as the day-to-day EMS system functioning including limited mutual aid.
2. Disaster Operations represent a surge in the volume of patients, requiring additional resources from neighboring operational areas (mutual aid), regional resources, state assets, and/or federal resources.
3. Crisis Standards of Care can be defined as delivering care to individuals under conditions of duress. The physical conditions of the environment where care is being delivered may be suboptimal. Crisis Standards of Care is modified care delivery based upon the expected or encountered patients that overwhelm supplies and medical personnel currently available.

Expectations

The delivery of care in a disaster such as a pandemic or catastrophic earthquake is the ability to provide a certain “basic level” of care for every individual. This is in contrast to normal operations where there is a maximal effort and resources utilized for every individual. This is clearly a departure for EMS and more aligned with a Public Health model. The duration of the acute event and the subsequent stages of recovery can be variable.

Basic tenet: The EMS Medical Director, Medical Health Operational Area Coordinators (MHOACs) and Public Health Officers work collaboratively when there is a declared (or anticipated) disaster.

Activation / Deactivation of Crisis Standards of Care

Crisis Standards of Care are only enacted in a collaborative manner between the EMS Medical Director, MHOACs, and Public Health Officers. Communication of the decision to use Crisis Standards of Care will come through the Medical/Health Branch of the Emergency Operation Center (EOC) during the incident. For EMS, there needs to be confirmation from the Nor-Cal EMS Medical Director and/or his/her designee.

These guidelines are designed to be implemented in a tiered, stepwise manner. The Crisis Standards of Care that EMS would be functioning under is a continuum guidelines rather than a rigid set of orders.

Assumptions That Have Occurred

1. Normal mutual-aid resources are scarce or unavailable.
2. Each county has opened pre-identified sites for Alternate Care Sites (ACS) and/or Field Treatment Sites (FTS), including staffing.
3. Normal EMS systems will not be functioning and operating under normal standards.
4. The Medical/Health Branch of the Operational Area EOC is opened.
5. There has been, or anticipated, a proclamation of a declared disaster.

Broad Levels of System Modification

Level I

1. EMS providers will begin to operate as if there is radio failure.
2. All procedures and protocols shall be followed as written and there will be no need to ask for orders from the base hospital.
3. The only two exceptions will be when the provider specifically requires a Base Hospital Physician Order and/or the EMS provider needs assistance.

Level II

1. For Public Safety Answering Points (PSAPs) there will be a suspension of all Prehospital Arrival Instructions (PAIs).
2. This level will be further delineated for those PSAPs using standardized Emergency Medical Dispatch (EMD) standardized programs/processes.
3. The responses for example to Alpha and Omega calls would be modified.
4. Instead of both a Fire Responder and 911 Ambulance response to emergency requests, there might be only a Fire Response until the evaluation of the patient.
5. In addition, field responses can be altered from a code 3 to a code 2 for various chief complaints.

Level III

1. EMS providers will be allowed to “assess and refer” patients after evaluation for “non-emergent conditions.”
2. These categories and diagnoses will be carefully delineated.
3. The categories of responses that may be “assessed and referred” are non-life threatening, non-limb threatening illnesses and/or injuries
4. This will require coordination between PSAPs that use EMD standardized protocols and those PSAPs that do not. This will be occurring in those systems that do not utilize standardized EMD protocols.

Specific Levels of Response Defined

Level I or Moderate Saturation Level

1. System awareness is heightened.
2. Local providers are able to respond to all requests without change in the level of patient care provided.
3. Indicators of this level may include the following:

    A. Emergency Departments are experiencing a surge of patients and there are prolonged wait-times.
    B. There are prolonged Ambulance Patient Off-Load Times (APOT) for the EMS system.
    C. EMS call volume has sustained a prolonged surge.
    D. Local, regional and/or state agencies have issued alerts of the potential or actual threats (MCI reaching disaster proportion, Pandemic Event).

Level II or Substantial Saturation Level

1. The local and/or regional healthcare system is being substantially impacted. Emergency Departments are at capacity and there are extended patient wait times and APOT times.

    A. Coordination with Urgent Care Centers, other healthcare entities, and physicians’ offices are occurring.
    B. Consideration of opening ACS and FTS have begun.

2. Indicators of this level may include the following:

    A. Emergency Departments are unable to surge any further.
    B. Emergency Departments are still able to off-load to other healthcare facilities.
    C. Local, regional, state, and/or federal declaration/proclamation(s) have been issued or are anticipated shortly.
    D. EMS resources are delayed in both being dispatched and the subsequent response.

Level III or Critical Saturation Level

1. Critical saturation levels and/or declared disaster(s) have occurred.
2. Local Emergency Departments, physician’s offices, Urgent Care Centers, and other facilities that provide healthcare are beyond capacity.
3. Patients are not able to be moved to non-affected areas.
4. Indicators may be the following:

    A. Medical facilities can no longer meet the needs of the patients.
    B. Large number of patients are converging on local medical facilities.
    C. Mutual-aid is no longer available. There are requests for out of region, state and federal resources.
    D. EMS for 911 and Inter-Facility Transfer (IFT) response are critically impacted. IFT may be prioritized based upon resources available locally for transport and referrals centers availability.

Procedure Level I

Dispatch

1. PSAPs will notify RDMHS
2. PSAPs will notify all affected agencies within the Operational Area (OA) and regionally.

Emergency Medical Services:

1. Notification from the Local EMS Agencies (LEMSA) will occur regarding the functioning of the EMS system.
2. EMS providers will attempt to schedule additional staffing and adding EMS units to the system.

Control Facilities and Receiving Hospitals:

1. Activation of the Medical/Health Mutual Aid will occur.
2. Regional Disaster Medical Health Specialist (RDHMS) activation will have occurred.
3. Will notify the PSAPs of the situation.
4. Will notify other healthcare facilities to include Urgent Care Centers, physicians' offices, and SNFs of the current situation.
5. Consider scheduling additional staff and adjusting shifts.
6. Consideration of activation of the hospital's EOC.
7. Consideration of submitting a request to Licensing and Certification for flexible bed capacity and staffing.

Local Government

1. Notification of the Office of Emergency Services (OES), the LEMSA, Activation of the MHOAC, Public Health and Fire agencies.
2. Consideration of opening the OA EOC.
3. The planning section of the EOC will begin functioning.
4. Situation reports will be given via EMResource and other modalities to MHOAC, LEMSA, RDMHS, and if needed the State Operations Center (SOC) or Duty Officer.

Procedure Level II

Dispatch

1. PSAPs will continue to keep all agencies updated.
2. There will be suspension of all Prehospital Arrival Instructions (PAIs) using standardized EMD programs/processes.
3. Instead of both a Fire First Responder and EMS responses for a 911 call, there will be only a Fire Response until the patient is evaluated (for selected calls).
4. Responses will be altered depending on the chief complaint from code 3 to code 2 responses.

Emergency Medical Services

5. EMS providers will begin to operate as is there is radio failure.
6. All procedures and protocols shall be followed as written and there will be no need to ask for orders from the base hospital.
7. The only two exceptions will be when the provider specifically requires a Base Hospital Physician Order and/or the EMS provider needs assistance.

Control Facilities and Receiving Facilities

In addition to the Level I responses, the Hospital's EOC will be activated and staffed.

Local Government

In addition to the Level I responses, all operations become minimally staffed 24 hours per day.

Procedure Level III

Dispatch

1. Notify all agencies of achievement of Level III status.
2. Emergency Medical Services

3. Be given the ability to evaluate, treat, and release for non-life threatening or limb threatening illnesses and/or injuries (Assess and Refer).
4. Cancel or reschedule ambulance IFTs.
5. Implement austere levels of care after EMS Medical Director and Health Officers have conferred.
6. Lower acuity patients will be sent via EMS/Alternative Transportation to ACS and FTS preferentially.

Control Facilities and Receiving Facilities

Consider utilizing other medical staff/personnel at hospitals such as Emergency Medical Technicians, Paramedics, and Medical Assistants.

Local Government

1. Confirm on-going responses with Incident Commanders and Governmental Officials.
2. Continue the on-going coordination between local government and local responses using National Incident Management System (NIMS) structures.