NOR-CAL EMS	1305	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 Medical Surge, 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.
4. **Operational Area (OA)** An intermediate level of the State of California emergency organization, consisting of a county and all political subdivisions within the geographical boundaries of the county.
5. **Medical/Health Operational Area Coordinator (MHOAC)** The public health officer/designee who is responsible for obtaining and coordinating services and allocation of resources within the OA in the event of a disaster or major incident where mutual aid is requested. The MHOAC role is shared between the public health officer/designee and Nor-Cal EMS administrator/designee in some counties and assumed by the public health officer/designee alone in other counties (838-D).
6. **OA EOC** The OA (county) Emergency Operations Center.
7. **Quick Response Vehicle (QRV)** A non-transport vehicle staffed with at least one AEMT or Paramedic and equipped with appropriate medical equipment/supplies.
8. **Field Treatment Site (FTS)** A site used for the assembly, triage (sorting), medical and austere medical treatment, relatively long-term holding (up to 72 hours), and subsequent evacuation of casualties when access to medical facilities is limited or resources overwhelmed. FTS activation, coordination, and support is managed from the Medical/Health Branch of the OA EOC and supported by the public health department and Nor-Cal EMS.
9. **Alternate Care Sites (ACS)** may be created to enable healthcare providers to provide medical care for and designed to accommodate a surge in those seeking care for acute conditions injured or sick patients or continue care for chronic conditions in non-traditional environments (e.g., schools and stadiums) or they may include facilities like mobile field hospitals during a public health emergency (e.g. when an FTS is demobilized and resources remain scarce). ACS are established by public health department with support from the OA EOC/Nor-Cal EMS. Activation of an ACS usually takes a minimum of 72 hours.

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. The intent of changes to standards of care shall be made with the goal of protecting against inequities. These changes may increase scope of practice when necessary.

Basic tenet: The EMS Medical Director, County and Nor-Cal Medical Health Operational Area Coordinators (MHOACs), Region III Regional Disaster Medical Health Coordinator/Specialist (RDMHC/S) 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 acting MHOAC.

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. Normal EMS systems will not be functioning and operating under normal standards.
3. The Medical/Health Branch of the Operational Area EOC is opened and collaboration with the Nor-Cal EMS medical director and other affected agencies has begun to coordinate EMS system response changes.
4. There has been, or anticipated, a proclamation of a declared disaster/emergency /waivers to implement specific medical/health system changes.

Procedure:

County MHOAC, OA EOC and Nor-Cal EMS collaboration:

1. During a significant incident, prior to a locally declared emergency, the Nor-Cal EMS medical director/MHOAC should collaborate with the affected county public health officer, Office of Emergency Services (OES), and other appropriate agencies to modify the EMS delivery system in order to meet increased demand.

2. Nor-Cal EMS shall establish its Department Operations Center (DOC) to coordinate with OA's and send a liaison as appropriate to the appropriate EOC.

3. During a locally declared emergency, the affected Operational Area (OA) MHOAC or Medical/Health Branch Director of the OA EOC should collaborate with the Nor-Cal EMS medical director, and other appropriate agencies, to modify the EMS delivery system in order to meet increased demand

EMS system response:

1. MHOAC, OA EOC and Nor-Cal EMS should consider establishing:
    a. Establishing EMS Muster stations to consolidate personnel, equipment/supplies and response vehicles
    b. Converting ambulances to BLS (EMR/EMT staffing) and implementing QRV with ALS personnel.
        i. QRV may consist of any vehicle (Supervisor, Public, Rental, Private).
    c. Establishing Field Treatment Sites/Alternate Care Sites
2. Utilizing Emergency System/Treatment Guidelines (1305A / 1305B) to establish alternative transport/ treatment and destination for patients.
3. Caches of equipment to augment EMS supplies (Electrolyte fluids, Ibuprofen, Flu Cache etc.)
4. Equipping/deploying special response teams to respond to specific patient types.
5. Development of Public Information bulletin which may include:
    a. Explanation of the current healthcare situation and the crisis standard of care direction currently being implemented.
6. Development of Just in Time Training for prehospital personnel, and allied agencies as appropriate:
    a. Altered dispatch protocols
    b. Emergency System Guidelines
    c. Any disease/incident specific training (Organophosphate, grief support, etc.)
    d. Any specific skill for increased of scope (i.e. Vaccinations)