ASPR TRACIE Technical Assistance Request

Requestor:
Requestor Phone:
Requestor Email:
Request Receipt Date (by ASPR TRACIE): 6 June 2016
Response Date: 17 June 2016
Type of TA Request: Standard

Request:

ASPR TRACIE received two technical assistance (TA) requests for Crisis Standards of Care (CSC) guidance and examples with strong Emergency Medical Services (EMS) components. The first requestor is working on CSC guidelines for the ESF #8 community and asked for guidance to help extend their plan to ambulance services and/or pre-hospital care. The second requestor is updating their current state CSC plan and wanted examples of CSC plans with strong EMS components or EMS documents that address CSC. Below is the response ASPR TRACIE provided for both requests.

Response:

Section I provides recommendations from ASPR TRACIE SME Cadre members regarding EMS CSC. Section II includes links to plans, general guidance/ templates, and other resources specific to EMS and CSC. Section III includes links to various resources and guidance documents that may be helpful in the CSC plan development process. And Section IV, "Milestones for CSC Planning and Implementation," is an excerpt from the Institute of Medicine's CSC documents, which can be used to assess the progress of CSC planning and includes the agency(ies) responsible for each step.

I.   Crisis Standards of Care SME Comments:

EMS can face crisis situations at any time, particularly in rural areas when a mass casualty incident overwhelms available resources and dispatchers may not have medical training. In urban settings with good mutual aid agreements, crisis care situations are less frequent and may be more related to pandemics or incidents where infrastructure is damaged. However, even a moderate incident at a time when the system is extremely busy can severely tax resources. Surge capacity planning for EMS needs to incorporate crisis principles, knowing that personnel may need to take immediate actions to address a shortage of resources. In most cases, the shortage can be resolved within hours through resource requests/mutual aid and will not involve disaster declarations or ongoing formal changes to the standards of practice.

Dispatchers should have direction and understand their authority to change the resources assigned based on availability. EMS responders should be prepared to consider novel transportation options, including private vehicles when ambulance response will be too delayed to meet the patient's needs. Additionally, disaster changes to standard operation procedures and

"patient left at scene" protocols must be made in concert with the EMS medical director and manager.

Line and supervisory personnel should understand the triggers for implementing crisis care changes and, through the planning process, understand the regulatory requirements that may need to be waived or suspended to support the disaster response strategies in addition to understanding how local and state legal powers may be used in a disaster to support response. During a prolonged incident, the local healthcare coalition should integrally involve EMS to determine proactive strategies to reduce 911 call volumes, transports to hospitals, and implement other tactics based on incident action planning with other stakeholders.

This collection of materials provides a wealth of information for planners, but the ultimate success of the effort depends on agency, coalition, and state planning activities to assure integration of these strategies and relief mechanisms into response plans so that there is not a need to develop ad hoc strategies during a disaster.

II. EMS CSC Resources

A. Sample Plans

Michigan Department of Community Health. (2012). [Annex 1. Specific Guidance for Emergency Medical Services and Medical Control Authorities](#).

> This Annex to the State of Michigan's *[Ethical Guidelines for the Allocation of Scarce Resources and Services During Public Health Emergencies](#)* provides specific guidance for EMS and medical control authorities. This annex addresses considerations and potential strategies for implementation of the guidelines in the EMS setting. It includes information on ethical obligations and duty to provide care, ethical resource and service allocation decision process, EMS standards of care, treat and release protocols, alternate transport, PPE use, notification, and antivirals/ chemoprophylaxis.

Minnesota Department of Health and Minnesota Emergency Medical Services Regulatory Board. (2016). [DRAFT Surge Operations and Crisis Care Planning and Implementation Guidance for Emergency Medical Services](#). (ASPR TRACIE can provide a copy upon request- not for further distribution or reproduction without permission).

> This draft guidance was developed to help address the crisis care issues and solutions for EMS and should be used as a decision support tool. It addresses common categories of pre-hospital EMS response, triage, treatment, and transport. In addition to providing roles/responsibilities and legal and regulatory considerations, it discusses planning and implementation factors for both rural and urban settings.

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B. CSC Plans with EMS Elements

The following plans are not specific to EMS, but have an EMS component.

Arizona Department of Health Services. (2015). Arizona Crisis Standards of Care Plan.

> Page 28 includes concept of operations for prehospital and EMS.

Oregon. (2014). Oregon Crisis Care Guidance.

> Page 14 includes guidance for ambulatory care, 911 dispatch, and EMS.

C. Guidance/ Templates

Institute of Medicine of the National Academies. (2012). Crisis Standards of Care Volume 3: Emergency Medical Service.

> This volume outlines the roles and responsibilities of state EMS in CSC planning and implementation in the overall context of a CSC response system, as well as operational considerations entailed in carrying out those roles and responsibilities. Template 6.1 focuses on core functions for EMS systems in CSC planning and Template 6.2 includes core functions of EMS systems and personnel in implementation of CSC plans.

Minnesota Department of Health. (2013). Patient Care: Strategies for Scarce Resource Situations.

> This card set can help facilitate an orderly approach to resource shortfalls at a healthcare facility. It is a decision support tool to be used by key personnel, including incident management, who are familiar with ethical frameworks and processes that underlie these decisions.

D. Other Related Resources

Cunningham, C. (n.d.). Crisis Standards of Care-The Ohio EMS Experience. Ohio Department of :Public Safety. (Accessed 6/17/2016.)

> This PowerPoint presentation discusses the EMS adaptation matrix for conventional, contingency, and crisis conditions for dispatch, response, patient assessment, and transportation.

Metropolitan Washington Council of Governments. (n.d.). Critical Care Standards-An Assessment for the Northern Virginia EMS Agencies-White Paper. (Accessed 6/17/2016.)

> This white paper provides an overview of the status of CSC in the Fire/EMS community in Northern Virginia. Interviews were conducted with each Fire/EMS jurisdiction. During

the interview, an infectious disease outbreak was used as the basis for questions and answers. The results show the differences among the localities regarding CSC planning and policies.

National Association of State EMS Officials. (2015). Emergency Medical Services Domestic Preparedness Improvement Strategy.

Goal five of the Improvement Strategy is specific to creating model guidelines for EMS crisis standards of care. The document provides an overview of the objectives and implementation activities to achieve the goal.

Rehn, M., Kruger, AJ. (2014). Quality Improvement in pre-hospital critical care: increased value through research and publication. Scandinavian Journal of Trauma, Resuscitation, and Emergency Medicine. 22:34. (Abstract only).

The authors examine the use of the value equation to depict the relationship between resources expenditure and quality. Increased value of pre-hospital critical care involves moving a system from quality assurance to quality improvement (QI). A QI system for pre-hospital critical care includes leadership involvement, multi-disciplinary buy-in, data collection infrastructure, and long-term commitment.

III. General Guidance/Resources

A. Foundational Institute of Medicine Documents

The Crisis Standards of Care publication (2012) by the Institute of Medicine (IOM) of the National Academies serves as a key CSC foundational document. It includes seven volumes that provide discipline-specific recommendations and assessment tools for CSC planning:

1. Introduction and CSC Framework
2. State and Local Government
3. Emergency Medical Services
4. Hospitals
5. Alternate Care Systems
6. Public Engagement
7. Appendixes

These additional resources provide detail about the indicators and triggers, and community planning and issues with CSC:

- Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response
- Crisis Standards of Care: Summary of a Workshop Series
- Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report

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- [2013 Crisis Standards of Care Indicators and Triggers Report](#)

B. ASPR TRACIE Resources

ASPR TRACIE developed two related Topic Collections: [Crisis Standards of Care](#) and [Pre-Hospital (e.g., Emergency Medical Services, rescue, first responder, mass gathering)](#). These provide links to plans, tools, templates, and other resources vetted by subject matter experts.

ASPR TRACIE has also provided numerous responses to requests for TA from states, locals, and regions regarding CSC issues. Sample TA requests can be found in the [Assistance Center](#) and the full redacted versions of the CSC-specific TA responses can be found in the [Information Exchange](#).

The first issue of ASPR TRACIE's newsletter, [*The Exchange*](#), was released in February 2016 and focuses on CSC planning and activation. The issue includes articles from authors with experience in local, state, and federal CSC planning.

C. ASPR Community of Interest

ASPR's "[Communities of Interest: For Crisis Standards of Care and](#) [Allocation of Scarce Resources](#)" serves as a clearinghouse of resources and information and allows local, state, and regional practitioners to share various CSC plans, tools, and templates.

D. Healthcare System Preparedness Capabilities and Implementation Guidance & Public Health Preparedness Capabilities

The following guidance can help jurisdictions develop new and improve existing CSC plans:

- Capability 10, Function 4 of the [HHS Healthcare Preparedness Capabilities](#) (January 2012) is specific to developing CSC guidance. The Healthcare Preparedness Capabilities refers to CSC as "state led processes to guide healthcare organizations during crisis standards of care when resources are scarce and when requested." The criteria for developing CSC guidance include:
  - P1. State crisis standards of care guidance
  - P2. Indicators for crisis standards of care
  - P3. Legal protections for healthcare practitioners and institutions
  - P4. Provide guidance for crisis standards of care implementation processes
  - P5. Provide guidance for the management of scarce resources
  - S1. Crisis standards of care training

- Capability 10, Function 1, Resource P5 of the [CDC Public Health Preparedness Capabilities](#) (March 2011) notes the following indicators for standards of care levels:

  P5: (Priority) Written plans should include processes (e.g., MOUs or other written agreements) to work in conjunction with emergency management, healthcare organizations, coalitions, and other partners to develop written strategies that clearly define the processes and indicators as to when the jurisdiction's healthcare organizations and health care coalitions transition into and out of conventional, contingency, and crisis standards of care.204 Jurisdiction should utilize the risk assessment to build jurisdiction-specific strategies and triggers.

- [HPP BP3 Implementation Guidance](#) – Per this guidance, Hospital Preparedness Program (HPP) awardees are required to post their approved CSC plan on the ASPR COI site (see page 19) by the end of BP5 (July 2017). The guidance also includes CSC-specific indicators (Medical Surge Indicator 1 and Continuity of Healthcare Operations Indicator 3) and assessment factors (Healthcare Coalition Development Assessment Factors, #16).

IV. Milestones for CSC Planning and Implementation

The following is an excerpt of the [Crisis Standards of Care document](#) (Institute of Medicine, 2012) (specifically, [Crisis Standards of Care, Volume 1: Introduction and CSC Framework](#), pages 1-41) that provides milestones for CSC planning and implementation.

Listed below are critical milestones that can be used to assess the progress of CSC planning, along with the proposed lead agency responsible for facilitating discussion, plan development, and implementation for each milestone (six of them list EMS as a lead/support agency). Many of these elements can be conducted in a single project year.

NOTE: Those elements that are designated for subsequent project years are shaded in gray and noted with an asterisk.

- Establish a state disaster medical advisory committee (SDMAC) or equivalent with representation that includes all emergency response partners (EMS, public health, emergency management, health care systems, community-based practitioners, public safety, others) **(governor's office, state health department).**

- Ensure the development of a legal framework for CSC implementation in the state in collaboration with the state emergency management agency and EMS offices and the SDMAC **(governor's office, state legislature, state attorney general's office, state health department, state emergency management agency).**

- Promote understanding of the disaster response framework among elected officials and senior (cabinet-level) state government leadership **(state health department, state emergency management agency).**

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- Develop a state health and medical approach to CSC planning that can be adopted at the regional/ local level by existing health care coalitions, emergency response systems (including the regional disaster medical advisory committee [RDMAC]), and health care providers **(RDMAC, state health department).**

- Engage health care providers and professional associations by increasing their awareness and understanding of the importance and development of a CSC framework **(state and local health departments and EMS agencies, health care coalitions and member organizations).**

- Encourage participation of the out-of-hospital medical community in planning for disaster response, including the development of plans to maximize the effective use of all available materiel and personnel resources **(state and local health departments, health care coalitions, professional health care organizations).**

- Ensure that local and state plans include clear provisions that permit an adaptation of EMS systems under disaster response conditions, including changes in protocols, destinations, practices, and personnel **(state and local health departments, state EMS agencies).**

- Develop and conduct public community engagement sessions on the issue of CSC **(state and local health departments).***

- Support surge capacity and capability planning for health care facilities and the health care system, including the development of plans for allocating scarce resources and promotion of community resilience and mental health in surge response efforts **(state and local health departments, health care coalitions).**

- Plan for an alternate care system capability to manage a surge in demand for health and medical services **(state and local health departments, health care coalitions).***

- Support scarce resource planning by the RDMAC for health care facilities and the health care system so these plans can coalesce at the (regional) hospital coalition level **(state and local health departments, health care coalitions).**

- Incorporate risk communication strategies into CSC plans **(governor's office, state and local health departments, EMS and emergency management agencies, health care coalitions and member organizations).**

- Exercise CSC plans at the local/regional level with state participation (including having the state exercise regional, intrastate, and interstate coordination if feasible) **(governor's office, state and local health departments, emergency management and EMS agencies, health care coalitions and member organizations).***

- Exercise CSC plans at the interstate level **(governor's office, HHS regional emergency coordinators, state health department, state EMS and emergency management agencies).***

- Use information identified during provider engagement, public/community engagement, and exercise events as elements of a process improvement cycle in order to further refine the development of disaster response plans **(governor's office, state and local health departments and EMS agencies, health care coalitions and member organizations).***

- Develop a process for continuous assessment of disaster response capabilities based on existing information and knowledge management platforms, and create a mechanism for ensuring that these CSC planning milestones are being achieved **(governor's office, state health department and emergency management agency).***

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