Sierra – Sacramento Valley EMS Agency Program Policy			
Crisis Standard Of Care Procedures			
	Effective: 12/01/2019	Next Review: 09/2022	**838**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: Victoria Pinette – Executive Director		SIGNATURE ON FILE

PURPOSE:

To provide a mechanism for altering the EMS system in response to an unprecedented demand for medical/health services beyond the capacity of current system providers and resources available through local, regional, state, and/or federal mutual aid.

AUTHORITY:

A. California Health and Safety Code, Article 1, § 101040.

B. California Health and Safety Code, Division 2.5, § 1797.172.

C. California Code of Regulations, Title 13, Division 2, Ch. 5, Art. 1, § 1100.3.

D. California Code of Regulations, Title 22, Division 9.

DEFINITIONS:

A. **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.

B. **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 S-SV EMS administrator/designee in some counties, and assumed by the public health officer/designee alone in other counties (838-D).

C. **OA EOC –** The OA (county) Emergency Operations Center.

D. **Crisis Standard of Care –** A level of medical care delivered to individuals under conditions of duress (disaster, pandemic, etc.), or when medical/health resources are insufficient for demand.

E. **Quick Response Vehicle (QRV) –** A non-transport vehicle staffed with at least one AEMT or Paramedic and equipped with appropriate medical equipment/supplies.

F. **Field Treatment Site (FTS) –** A site activated to manage casualties/medical evacuees when the local area capacity to rapidly treat/place these individuals at an established medical facility is overwhelmed. A FTS is used for the assembly, triage, medical stabilization and subsequent evacuation of casualties to an established medical facility if and when necessary/available. A FTS provides medical care for a period of up to 72 hours, or until patients are no longer arriving at the site. FTS activation, coordination, and support is managed from the Medical/Health Branch of the OA EOC, and supported by the public health department and S-SV EMS.

G. **Alternate Care Site (ACS) –** A location that is not currently providing healthcare services and will be converted to enable the provision of healthcare services to support inpatient and/or outpatient care required after a declared catastrophic emergency. These specific sites are not part of the expansion of an existing healthcare facility, but rather are designated under the authority of the local government. ACSs are established by the public health department with support from the OA EOC and S-SV EMS. Activation of an ACS usually requires a minimum of 72 hours. ACSs may also be activated to provide on-going treatment to injured patients when a FTS is demobilized and hospital capacity is still overwhelmed.

ASSUMPTIONS:

A. The Medical/Health Branch of the OA EOC or MHOAC has established collaboration with the S-SV EMS medical director and other affected agencies to coordinate EMS system response changes.

B. Mutual-aid resources are scarce or unavailable.

C. Appropriate waivers, proclamations, and/or declarations required to implement specific medical/health system changes have been identified and secured.

PROCEDURE:

A. MHOAC and S-SV EMS Collaboration:
   1. During a significant incident, prior to a locally declared emergency, the S-SV EMS medical director 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. During a locally declared emergency, the MHOAC or Medical/Health Branch Director of the OA EOC should collaborate with the S-SV EMS medical director, and other appropriate agencies, to modify the EMS delivery system in order to meet increased demand.

B. System Access:

1. The MHOAC and S-SV EMS should collaborate with the OA EOC to establish priorities for 911 medical-aid response based upon available system resources.

2. The MHOAC and S-SV EMS should collaborate to complete the Crisis Standard Of Care EMS System Orders (838-B) and inform all public safety answering points (PSAPs), ambulance dispatch centers, control facilities (CFs), hospitals, and EMS providers of these orders to maintain the stability of the EMS system.

3. The MHOAC and S-SV EMS should collaborate to ensure notification of all medical/health system providers that a public access telephone number (e.g. 211) and/or website for individuals seeking minor medical care, social services and/or other non-emergent needs has been established.

4. The OA EOC, in cooperation with the MHOAC and S-SV EMS, should consider establishing FTSs for rapid triage, treatment and referral.

5. The MHOAC and S-SV EMS should collaborate to authorize altered triage and response protocols for the 911 system, including consideration of the following:

   - Suspension of emergency medical dispatch (EMD) pre-arrival instructions.
   - Implementation of symptom-specific triage (i.e., specialized EMD specific to a pandemic outbreak).
   - Implementation of the Altered 911/EMD Triage Algorithm (838-A).

6. The OA EOC, in cooperation with the MHOAC and S-SV EMS, should consider establishing a transport center for medical transport requests from all system access points (public access numbers, PSAPs, EMS providers, FTSs, ACSs, hospitals, other healthcare facilities), including consideration of the following:

   - Augmenting medical transportation with alternative vehicles (buses, taxis, etc.).
   - Developing and implementing a medical transportation scheduling process.
   - Working with designated CFs to direct destinations of transport resources (including ACSs, clinics, etc.).

C. EMS Response:

1. The OA EOC, in cooperation with the MHOAC and S-SV EMS, should consider:

   - Establishing EMS muster stations to consolidate personnel, equipment, supplies, and emergency response/transport vehicles.
   - Expanding available EMS resources by converting all ambulances to BLS transport units (EMR/EMT staffing) and implementing QRVs with available AEMT or Paramedic personnel.

- QRVs may consist of supervisor vehicles, other company vehicles, shared resources from other emergency response agencies, rental vehicles, private vehicles, etc.
- QRVs will be equipped with appropriate communications equipment, LALS/ALS equipment and supplies, etc.

- Implementation of Crisis Standard Of Care Prehospital Treatment Orders (838-C) to establish alternative treatment and transport of patients in the prehospital setting.
- Developing additional disaster caches to augment EMS supplies (i.e., flu cache of electrolyte replacement fluids, ibuprofen, Pepcid, etc.).
- Developing, equipping and deploying a specialty response team to respond to specific types of patients.

2. The OA EOC should work collaboratively with the MHOAC and S-SV EMS to develop a family/patient brochure for distribution by EMS personnel to the public, which may include the following:

   - Explanation of the current healthcare situation and the crisis standard of care directions currently being implemented.
   - Preventive measures to avoid exposure to the applicable health threat(s).
   - Available community resources (public access telephone number, website, etc.).

D. Just-In-Time Training:

EMS provider agencies, in cooperation with the OA EOC, MHOAC and S-SV EMS, should develop just-in-time training for prehospital personnel to include:

1. Altered 911/EMD Triage Algorithm (838-A).

2. Crisis Standard Of Care EMS System Orders (838-B).

3. Crisis Standard Of Care Prehospital Treatment Orders (838-C).

4. Family/patient brochure.

5. Consideration of other appropriate just-in-time training (grief support, etc.).

EXAMPLES:

Example of Altered 911/EMD Triage

Access Point	Symptom Specific	Immediate	Delayed	Minor	Deceased
Public Access #	Refer to Symptom Specific ACS	Refer to 911	Refer to Scheduled Transport Center	TBD	TBD
PSAP/ Ambulance Dispatch	Dispatch Specialty Unit/Team	ALS Response	Refer to Scheduled Transport Center	Refer to Public Access #	Refer to Public Access #
Scheduled Transport Center	Dispatch Specialty Unit/Team	ALS Response	Schedule Transport	Refer to Public Access #	Refer to Public Access #
Prehospital EMS	Transport to Symptom Specific ACS	Treat & Transport	Treat & Release or Refer	Refer to Public Access #	Witnessed: Attempt resuscitation Unwitnessed: Refer to Public Access #

Example of Altered EMS System Response

- All ambulances staffed with BLS personnel (EMR/EMT).
- All AEMT and Paramedic personnel assigned to QRVs to respond to patients with immediate medical needs (AEMT/Paramedic personnel may be placed on supervisor vehicles, fire apparatus, or deployed in other non-traditional EMS response vehicles).
- After providing on-scene medical care/intervention, patients are handed off to a BLS transport unit, making the QRV available to respond to the next call in need of ALS intervention.
- Other options may include: Treat & release, referral to public access telephone number, referral to transport center for scheduled transport to hospital or other medical facility, etc.