**MDH Crisis Standards of Care Workshop – Orientation, Overview, Discussions**

The following is designed as a half-day Crisis Standards of Care (CSC) workshop involving hospital, EMS and community partners to receive introductory presentations on CSC and engage in discussions around issues and gaps in crisis care planning within the health care and EMS sectors. These discussions presume a basic knowledge of the conventional, contingency, and crisis care spectrum as well as a familiarity with the hospital and EMS specific attachments of the Minnesota Crisis Standards of Care Framework.

The workshop structure is based on hospital tables (clinical and administrative personnel), EMS tables (operational, medical director and administrative), and a health care community members table (Health Care Coalition, Local and Tribal Public Health, Emergency Management, Public Safety Communications) for each round of discussions.

**OBJECTIVES:**

* Gain an understanding of the hospital and EMS provider responsibility in developing local and regional crisis care response plans that are in line with the Minnesota CSC Framework
* Gain an understanding of the crisis activation triggers and information sharing leading up to and during a crisis care incident.
* Gain an understanding of the crisis care prioritization processes (such as clinical triage) and considerations regarding limited resources (e.g. staff, stuff, space, etc.).
* Identify gaps within the hospital and EMS sections of the Minnesota CSC Framework which require additional clarification or modification.
* Identify hospital and EMS resource and support requirements needed for the development of local and regional crisis standards of care plans and suggested next steps.

**MDH CSC Table Discussions – Round 1 – Tornado**

**Overview**

During an early June evening the National Weather Service Storm Prediction Center reported a large complex of thunderstorms moving into the state of Minnesota. Tornado Watches were issued for large segments of the state, effective until 10:00 am the next day. At 5:45 pm, an EF-5 tornado struck your community and an adjacent town. It affected multiple jurisdictions including crossing multiple counties. Debris has shut down several main roads, disrupted cellular and landline phone service, and left most of the area without power. Deaths resulting from the tornado are unknown at this time, but are estimated to be in the 100s. Public safety agencies are conducting damage assessments and EMS agencies are mobilizing to address patient care needs. EMS cannot keep up with 911 requests. Residents of a few damaged nursing homes and residential treatment facilities are being relocated to temporary shelter; however, these sites are unsuitable for those requiring a higher level of medical support due to loss of electrical power. Outpatient clinics and private medical practices are understaffed or simply closed.

Local Emergency Operations Centers (EOC) and the MN State Emergency Operations Center (SEOC) are open as is the MDH Department Operations Center (DOC).

Your local hospital/LTC/clinic has been damaged and there is limited information about whether other localities can take patients. Victims are already arriving in the parking lot on foot and by private vehicle as well as by EMS transport. Several clinics and long-term care facilities have been damaged, with some needing evacuation. Only priority structure fires (e.g., fires in or near buildings suspected of containing occupants or hazardous materials) are receiving public safety assistance. Fire departments from counties experiencing less damage are sending whatever assistance they can. Dispatch centers are initiating mutual aid from unaffected counties within the state on request of local and county incident command (IC) through their respective EOCs. The 9-1-1 emergency lines are inoperable in some areas as telephone service has been interrupted and requests for service are far in excess of resources available. Several ARMER tower sites are inoperable. Many of the injured cannot reach local hospitals due to damaged roads and debris. EMS cannot meet the community needs as well as the requests to assist with hospital and LTC evacuations and transfers. Staging areas have been set up in multiple locations adjacent and within the region wide damage zone and are receiving victims.

**Questions:** You will have 30 minutes to discuss the following. Please cover at least the primary questions, addressing the secondary as you have time. If the questions are not directly applicable, please consider how you might influence efforts or what added value you can provide. Please be prepared to present at least three key issues and potential solutions in a brief (3 minute) report-out to the group.

 **Primary**

1. How will your EMS/ambulance dispatch decide which 911 calls to respond to and how are they prioritized? Will ambulance personnel have authority to make transport, alternate transport or non-transport decisions at the scene of a request?
2. How will patients be prioritized for evacuation (including hospitals, long term care, and other settings)?
3. What alternate transportation resources could you send to assist with evacuation in affected hospitals or health care organizations, such as skilled nursing facilities?
4. How would the health care partners obtain assistance (staff, stuff, evacuation assistance) from the coalition, emergency management, or parent health care system.
5. How are local health care organizations represented at the local EOC? (by public health, coalition, other?)
6. How would emergency management coordinate or prioritize resource requests when multiple requests for the same resource are made? What is the coalition role in this?
7. How can Emergency Management and Public Health assist health care organizations with risk communication (such as public messaging, i.e. “Don’t call 911 unless an emergency”) and resource support?
8. What is the role of the coalition, local public health, or emergency management in this event?

**Secondary**

1. Is there a plan for and a pre-designated community alternate care site? How would this be used and staffed? Who is responsible for this?
2. What role does the coalition/EM/community have in notifying the public that the hospital has evacuated, who and how will it be done?

**MDH CSC Table Discussions – Round 2 – Pandemic**

**Overview**

H8N4 is a new human influenza virus that appears to have originated from birds in Asia and has adapted to humans. It appears to cause significant morbidity and mortality and has rapidly spread from Asia to the Western Hemisphere including the United States. This pandemic strain of flu appears to be affecting all age groups but there are some indications that the elderly (>65 years of age) are not as severely affected. However, children are more affected compared with usual seasonal outbreaks.

The first case of H8N4 identified in Minnesota is a school age child who had recently traveled to Washington, D.C. The child is hospitalized in a Metro area hospital, rapidly declines requiring mechanical ventilation and dies within 24h. There is a great deal of public concern and media attention given the age and severity of this first case. Local and state elected officials have voiced significant concerns to the Governor’s office demanding action. According to the CDC, an estimated 25-50% of the population exposed to this flu strain will develop clinical symptoms compared with a seasonal flu strain where only 5-15% of population becomes ill. Those who develop H8N4 disease and recover will typically have two-three weeks between being ill and recovering depending on the severity of their illness and their general pre-infection health.

* It is unclear if oseltamivir (Tamiflu) is effective, but appears to be and is being used for persons 1 year of age and older. Spot shortages of oseltamivir (Tamiflu) are increasingly reported.
* Unclear how patients under one year of ages should be treated.
* There appears to be no cross protection from the current influenza vaccines.
* Discussion of production of an H8N4 vaccine have started but a vaccine is at least 4 to 5 months away.
* Due to the novel nature of this virus and high mortality, airborne isolation precautions are recommended.
* All areas in Minnesota are now reporting cases. Many deaths are occurring and the public and public officials are alarmed.
* Hospitals are experiencing difficulty with the number of patients because of declining staff availability, backordered resources, an influx of ambulatory patients seeking evaluation, a lack of ventilators, and a lack of both ICU and airborne isolation rooms.
* Within most of the state schools have been closed, and many public gatherings such as sports, concerts and theater events have been cancelled.
* The state of Minnesota has surge capacity for about 11,500 hospital beds (currently 8,723 available medical surgical staffed beds-1,234 additional beds available with surge) of which 1,476 are ICU (154 additional ICU beds available with surge).
* Minnesota currently has 1700 ventilators statewide.
* Hotlines have been established statewide so that nurses and pharmacists can provide information and prescribe antiviral medications if necessary.

**Questions:** You will have 30 minutes to discuss the following. Please cover at least the primary questions, addressing the secondary as you have time. Please be prepared to present three key issues and potential solutions in a brief (3 minute) report-out to the group.

 **Primary**

1. Does Emergency management have a role in this response? What is their role in managing resources? What information does Emergency Management they want to have for situation awareness?
2. What plans are in place to coordinate crisis care on a regional level (that is, determine consistent policies and process across the area and not just within a facility)?
3. Does your health care facility have a plan for clinical triage and management of resources (such as ventilators, medications, N95 masks, etc.) in place? What is your coalition’s role with managing these resources?
4. What clinical personnel should be working with the incident commander/planning section in the healthcare facility to assure that the plans reflect clinical needs? Is there a current expectation to integrate them?
5. Does your health care facility have a plan for clinical triage and management of resources (such as ventilators, medications, N95 masks, etc.) in place? What is your coalition’s role with managing these resources?
6. Are there pre-developed plans for EMS to change response protocols or destinations during a pandemic? How would these be approved/implemented? Who makes those decisions?
7. What is the ‘overflow’ plan for ambulance dispatch (may include a diversion of emergency calls)?
8. Is there a regional plan for managing transfers of patients when beds are scarce? (I.e. patient from smaller hospital is intubated and needs an ICU bed – do you have to call around to all hospitals or is there a central process?)
9. Does your long term care facility have a plan to reduce the impact of or respond to a pandemic event to reduce risk to residents or patients and what would that be?
10. If it has not yet been discussed, what are some adaptive strategies that EMS/health care/LTC/ clinics could use to cope with the strains of a pandemic?
11. Is there a plan for augmented outpatient acute care services at the hospital level? At the community level?

**Secondary**

1. How can the health care system/coalition assist in supporting Alternate Care Sites and other non-hospital care (e.g. clinic care)?
2. What are some consistent policies that might need to be developed across the region for health care systems during the pandemic?
3. If you do not usually provide critical care, is there guidance on whether such care will be attempted if referral is not possible?)
4. How do you assure that the right clinical and other input is obtained in the planning process and that the strategies are supported by administration?