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RE: Joint Recommendations for Development and Implementation of Crisis Standards of Care in Tennessee EMS Systems

To all Tennessee EMS Leadership and EMS Medical Directors,

The following are recommendations from members of the Tennessee Chapter of the National Association of EMS Physicians (NAEMSP). They are meant as recommendations of best practices in the clinical care of patients with possible COVID-related illness and in the operational approach of EMS systems to the COVID pandemic.

This document will be kept as up to date as possible, however, as the COVID-19 crisis evolves, more experience and expert guidance will be available and should be considered when developing individual policies and procedures.

Thank you for all your time and effort in making our communities safer and healthier.

[Click HERE for online access to the maintained document.](#)

Sincerely,

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Joint Recommendations for EMS Best Practices: *Crisis Standards of Care in Tennessee*



Adapted from [COVID-19: Considerations, Strategies, and Resources for Emergency Medical Services Crisis Standards of Care](#) published by the Federal Healthcare Resilience Task Force - EMS/Prehospital Team on April 25, 2020, and other similar agency and state-specific documents.

Overview

In response to the COVID-19 pandemic, emergency medical services (EMS) agencies may need to adjust operations and standards of care in order to preserve and effectively allocate limited EMS and healthcare system resources in the face of overwhelming demand due to the pandemic response. This document provides an overview of general considerations, potential strategies, and existing resources that EMS agencies may use to inform changes to their operations and standards of care.

General Considerations

Continuum of Care, Indicators, and Triggers

- Changes to standards of care should take place along a continuum of levels of care:
 - *Conventional*: normal level of healthcare resources
 - *Contingency*: demand for healthcare resources begins to exceed supply
 - *Crisis*: resources are exceeded by demand or depleted; functionally equivalent care is no longer possible to address all requirements
- Advanced planning for alterations in response procedures and in the allocation of resources will be required at the contingency level of care, with the primary goal of avoiding a transition into the crisis level of care.
- EMS agencies should clearly identify indicators that will signal a shift in the level of care that is able to be provided and that will trigger changes to standards of care. Triggers should be established in conjunction with local and state EMS and public health agencies.
- The level of care that can be delivered will be dynamic and shift rapidly. Standards of care should be adjusted up or down to match the circumstances (resource availability vs. demand) at any given time, consistent with pre-identified indicators and triggers.

Legal

- National and state emergency declarations that have been issued to carry out activities around the COVID-19 response may provide EMS agencies additional flexibility and liability protections, including the waiver and/or suspension of certain state laws and regulations governing EMS.
- EMS agencies should nonetheless ensure that any changes to their operations and standards of care comply with the EMS laws and regulations in the State of Tennessee and their respective jurisdictions.
- EMS agencies should coordinate operational adjustments with relevant state, regional, and local EMS authorities—including EMS Medical Direction.

- Civil rights norms and laws are not suspended in the disaster context. Federal civil rights laws and regulations apply, and have not been suspended or waived.
 - Changes to standards of care, including denials of care, must be made after nondiscriminatory consideration of each situation, free from stereotypes and biases based on disability or age— including generalizations and judgments about the quality of life, or relative value to society.
 - If particular groups receive favorable treatment, this priority should stem from relevant factors (e.g., greatest likelihood of survival) and/or promote important community goals (e.g. achieving the best outcomes for the largest number).
- There is never a justification for careless decision making or willful misconduct, especially in the setting of a disaster response, when patients are at their most vulnerable.

Ethical

- Standards of care at all levels of care should adhere to core ethical principles, including fairness, duty to care, duty to steward resources, transparency in decision-making, consistency, proportionality, and accountability.
- When resource scarcity reaches crisis levels, clinicians are ethically justified to use available resources to sustain life and well-being to the greatest extent possible for the greatest number possible.
- EMS medical directors should synthesize relevant ethical considerations into clear guidance for EMS agencies and clinicians on resource allocation and clinical decision-making in the context of crisis standards of care.

Communications

- Changes to standards of care should be communicated to the public in a proactive, honest, transparent, and accountable manner.
- EMS clinicians should also be provided clear guidance by their medical director on:
 - Relevant changes to EMS laws, regulations, policies, and procedures; including changes in legal protections for providers.
 - How to apply changes to standards of care in an informed and consistent manner, in order to ensure that decisions are reasonable under the circumstances

Indicators of EMS System Status for Designated Levels of Care

	Conventional	Contingency	Crisis
Surveillance Data	<p>Stabilization or decrease in patient encounters by EMS</p> <p>Stabilization or decrease in emergency department and/or hospital census</p>	<p>Increased patient encounters by EMS</p> <p>Increased emergency department and/or hospital census</p>	<p>Patient care demands exceed the available EMS resources, including mutual aid</p> <p>Patient care demands exceed the available hospital resources</p> <p>Surveillance data are impacted due to overwhelmed health care and/or data entry systems</p> <p>Incidence of illness and injury continues to escalate despite mitigation measures</p>
Community and Communications Infrastructure	<p>Stabilization or decrease in calls to emergency medical dispatch</p> <p>Communication systems, networks, and physical infrastructure returning to baseline functional state</p>	<p>Increased calls or ambulatory presentation of patients to EMS agencies seeking medical advice or treatment</p> <p>Compromised public safety communications systems</p>	<p>Emergency medical dispatch overwhelmed by call volumes and unable to answer all calls</p> <p>Operational or structural collapse of the communication centers</p>
Staff	<p>Approaching normal baseline levels of staffing</p> <p>Return to normal shift level and staffing</p>	<p>Members of the EMD and EMS workforce unable to report for duty due to illness, injury, or physical entrapment in residences</p>	<p>Overwhelming number of patients with insufficient staff to meet the demand for triage, treatment, and transport</p> <p>Significant portion of the EMD/EMS workforce is sustaining illness or physical fatigue due to extended work shifts and incident stress and are unavailable to respond</p>
Supplies	<p>Demand for PPE and medical supplies is reduced</p> <p>Manufacturers of needed PPE and medical supplies report improving product availability</p>	<p>Increased use of PPE and medical supplies</p> <p>Manufacturers report decreased stock available</p>	<p>Inadequate or depleted supply of PPE and/or medical supplies</p> <p>Manufacturers report insufficient or depleted stock, and/or factory closures and/or halted production due to loss of workforce</p>

Triggers for Enactment/Repeal of Designated Levels of Care

	Conventional	Contingency	Crisis
Surveillance Data	Stabilization or decrease in the number and/or acuity of dispatch requests	Significantly elevated number of dispatch requests Significantly increased encounters with similar signs and symptoms or high patient acuity	Multiple hospitals closed to EMS Mutual aid partners not able to answer calls involving potential life threats
Community and Communications Infrastructure	Number of requests for EMS are returning to baseline levels	>20% increase in emergency medical dispatch Patient tracking mechanisms and systems are overwhelmed	Inability of high-acuity patients to access the emergency response system
Staff	The number of EMD and EMS personnel reporting for duty is stabilizing Recovery of EMS personnel from illness	EMS crews are at or approaching minimal staffing Loss of 10% or more of the workforce	Unable to maintain staffing for EMS units Mutual aid staffing resources have been exhausted
Supplies	Requests for additional PPE and medical supplies are stabilizing. Manufacturers of disaster supplies and recovery equipment report a return to production	Available PPE is less than what is needed for the EMS workforce Use of medical supplies, medications, vaccines, and antidotes begins to exceed their replacement	PPE is severely limited or no longer available Vaccinations, medications, or antidotes are depleted to the point that equivalent treatment cannot be provided

Alterations of EMS Response for Designated Levels of Care

Call-Taking & Dispatch

	Conventional	Contingency	Crisis
Approach	Consider initial auto-answer during times of high call volume for the purpose of filtering high-acuity calls	Prioritize calls according to potential threat to life	Decline response to calls without evident potential threat to life ("No-Send" on non-emergency calls)
Expected Response	Routine response	Non-emergency calls held until resources are available	Extended response to all calls
Legal Alterations			

Resource Allocation

	Conventional	Contingency	Crisis
Ambulance Staffing (Transport EMS)		Consider altered EMS staffing based on available resources (e.g. utilize BLS staffing if unable to staff needed ALS units)	Non-EMS staffing (e.g. one medical provider, one driver)
Mutual Aid/Additional Resources	Utilize routine mutual aid agreements as needed	Utilize routine mutual aid partners (if available)	Request EMS units from emergency management (e.g. federal resources)
Resource allocation (Alternative personnel or response options)	Consider modifying resource assignments if needed based on availability of resources	Change transport EMS assignments to the closest available unit rather than ALS or BLS. Modify joint responses, depending on availability of transport EMS and first response resources (e.g. single-agency EMS responses if fire agencies are overtaxed, fire/rescue dispatched to MVC unless EMS are clearly required, etc.)	Utilize alternative EMS response (personnel and/or equipment) Consider single resource response (e.g. "fly cars") and utilizing first response personnel to screen patients with symptoms of potential life-threatening illness if transport EMS unit not available
PPE	Reuse PPE as able per current guidelines	Limit non-reusable PPE to high risk patients only	PPE used as available with daily symptom monitoring
Legal Alterations			

Clinical Care/Disposition

	Conventional	Contingency	Crisis
Non-Transport	Allow patients with very minor illness or injuries to use private transportation at their discretion	Recommend Non-Transport Options (patient choice): Encourage patients with minor injury/illness to use their own transportation to appropriate facilities.	No transport of non-emergent patients: Assess patients and decline to transport those without significant injury/illness (according to guidance from EMS medical director)
Hospital	Transport to the closest appropriate/requested Emergency Department	Hospital Diversion at EMS discretion (except for specialty care)	Closest facility (except for specialty care) including appropriate alternative care sites
Other Considerations		Consider scheduled transport (i.e. answer subsequent call(s) before transporting stable patients to the hospital) Consider EMS Transport to alternative destination if available (PCP/UCC/Other)	Consider batched transport (utilizing van, bus or similar multi-patient transport option) Consider alternative transport methods (CAC, taxi, etc.)
Clinical Care	Per routine Clinical Guidelines	Limit resource utilization as able	Only perform life-saving interventions Attempt no resuscitation of cardiac arrests (except ventricular fibrillation [VF] witnessed by EMS)
Legal Alterations			