STATE AND REGIONAL/LOCAL EMS TASKS IN STATE CRISIS STANDARDS OF CARE DEVELOPMENT

Template 6.1. Core Functions of EMS Systems in the Development of State Crisis Standards of Care (CSC) Plans

Function 1. Assess Jurisdictional Authority and Planning Resources

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State Task 1		
State EMS office participates with the state lead agencies responsible for CSC planning and implementation (state health department/emergency management agency [EMA]) in assessing the scope, jurisdiction, and authority of existing state and regional EMS infrastructure for CSC planning and implementation: • advisory committees, • regional trauma/EMS advisory councils/committees, and • health care coalitions.	The BEMSTS is AZ's State EMSO, working with the BPHEP in ADHS. BPHEP works with the AZDEM. AZ Healthcare Coalitions. EMS is represented on the Regional Healthcare Coalitions (HC). • How does BEMSTS communicate with the HC? Need a method of communication for EMS with these regions. • How much communication is there of EMS with AZDEM? • Need to reach out to EMS providers to communicate the AZDEM disaster/response plans.	High ☐ Medium ☐ Low ☐
State Task 2		
State EMS office, in collaboration with the state health department, EMA, and legal counsel, develops an inventory of applicable federal, state, and local legal and regulatory authorities and protections, including those related to EMS personnel and provider agency liability, licensing, credentialing, and mutual aid agreements. Includes • understanding how authorities and protections can be used to facilitate CSC strategies and identifying gaps to be addressed for revision of the plan, including EMS agency licensing, operations (e.g., staffing, advanced life support [ALS]/basic life support [BLS] licensure), and dispatch center operations; and • state and local medical directors examining regulatory implications with respect to changing dispatch protocols, ambulance staffing, scope of practice, treat-and-release policies, destination policies, and disaster triage decisions.	Emergency Management Assistance Compact (EMAC). AZADEM Mutual Aid. State Emergency Response & Recovery Plan. ESAR-VHP, A.R.S. § 26-314, § 36-2263, A.A.C. R8-2-701, et seq. Legal Issues in PHE. BPHEP CSC Project. AZ Tribal PHEP Strategic Plan 2010-13. BEMSTS Statute & Rule Book Apr 2013 • Do we want an expanded SOP for EMTs in AZ under a CSC situation? Local medical directors approve additional skills/treatment. • Who are out-of-state providers attached to when entering AZ for a federally-declared disaster? • EMS Council approved a CSC about 2 yrs. Ago for pandemic flu. Clinical practice workgroup developing criteria. • Dispatch protocols mentioned but not interoperability. Waiver of rule for transporting patients outside the provider's individual Certificate of Necessity (CON). • Dr. Walters: CSC committee met for prehospital care suggested BEMSTS prehospital care stick /w START, Jump START. • Aggregate of federal and state waivers developed by ADHS. Perhaps generating a document/packet of rules needing to be waived for EMS (e.g., intra-CON transport waiver, alternative transport, etc.). • Guidance on alternative transport modes (stretcher vans), alternative approved destinations, etc. – this needs to be statewide, not at the individual local medical director level. • The document could recommend EMS agencies follow local county/regional guidelines for alternative destination/transport approvals. • Yuma has inter-state and inter-country treatment /transport requirements.	High ☐ Medium ☐ Low ☐

	• Base hospital liability, base hospital CSC implementation process – involved medical directors in development. • Stafford Act liability protection levels for providers. ESAR-VHP makes the volunteer provider covered as an emergency worker and covered under county liability protections, and eventually under the specific facility liability protections. • AZDEM notifies counties/regions of declaration of disaster and when the disaster declaration ends. This affects the flow and access to federal disaster funds. Web-EOC is a statewide resource for local EOCs to monitor. • Perhaps a process that includes AZDEM (or other designated agency) sends out CSC are invoked and that regions/counties/locals be aware of "5 top standards or requirements are to be followed/implemented). • What is the trigger for this CSC? – Is it a statewide event, regional event, national event, global event? • We need to write the EMS CSC as a "worst-case-scenario," with realistic applications to allow for expansion of these EMS CSC. • An event affecting a region will be necessary to invoke CSCs.	
State and Regional/Local Task 3		
State EMS, regional infrastructure, and local EMS agencies identify and review existing state, regional, and local surge capacity, mass casualty, and CSC plans. Includes • identifying gaps in the state/regional/local plans; • reviewing after-action reports from previous functional exercises addressing surge capacity and CSC needs; • searching resources from other states and national organizations (see the "Notes and Resources" column); • identifying at-risk populations for inclusion in EMS CSC planning (refer to the EMS for Children program); and • identifying and reviewing resource documents that may assist state, regional, and local EMS agencies in assessing CSC needs and developing CSC plans.	2013-2014 PHEP CPG. BPHEP Response Plans. PHEP Deliverables BP2 FY 2013-2014. Healthcare Preparedness Deliverables BP2 FY 2013-2014. ArMA Physician's Disaster Guide. BPHEP CSC Project. SERRP. ADHS Dem. & Effective Risk Comm. Rsch. Rpt. Apr 05. Healthcare Overcapacity Guide. ADHS RERP Jan 2012. ICS - Basics for Child Care Fac. • Emerg. Mgmt Assistance Compact (EMAC), AZ reaches out to other states to request perceived needs. • Intra-state compact is also available. • At-risk populations (AZDEM-Access & Functional Needs Pop. Planning). • A registry exists of at-risk/special needs populations to enable local responding agencies to assist these populations. Need a process to inform representative agencies of special populations of the registry. • Can ADHS/AZDEM prepare a web-process to enable populations to pre-register in the registry. • Yuma County (Michelle Smith) developed a doctor office locus process to register special needs populations.	High ☐ Medium ☐ Low ☐

Function 2. Development of Consistent and Comprehensive Plans Under the State Disaster Medical Advisory Committee (SDMAC) Structure		
TASK TARGET CAPACITIES	**CURRENT STATUS**	**PRIORITY**
State Task 1		
State EMS office establishes a state-level, multidisciplinary, and transparent EMS crisis care workgroup of the SDMAC to draft portions of the state CSC plan pertaining to the provision of EMS. The workgroup's representation may include	BPHEP CSC Project. AZ Healthcare Coalitions. AZDEM-Access & Functional Needs Pop. Planning. STAB, EMS Council, and MDC statutory committees should provide liaisons to the CSC Workgroup. • Prepare a list of EMS CSC Workgroup members for distribution. • Would like to have AZDEM representative on the EMS CSC Workgroup. • Inter-communication between CSC workgroups.	High ☐ Medium ☐ Low ☐
• state health department/Emergency Support Function (ESF)-8 lead for consistency with SDMAC efforts;		
• state EMS agency;		
• regional EMS/trauma advisory committee;		
• regional health care coalition representatives;		
• state/local EMA;		
• hospital specialty care (trauma, burn, poison control, pediatric);		
• EMS agencies (urban, rural, private, and public providers);		
• state EMS medical director and regional/agency directors;		
• call center and dispatch center personnel;		
• additional health care expertise (if applicable, regional medical coordination center or regional DMAC, local clinical care committee and triage team, private practitioners, community clinics, long-term care facilities, medical associations, hospital associations, professional health care associations, and mental health agencies and providers [including American Red Cross Disaster Mental Health]);		
• EMS legal counsel; and		
• EMS for Children.		
State and Regional/Local Task 2		
State EMS office, regional infrastructure, and local EMS agencies outline state and local EMS agency roles, responsibilities, and actions. Includes	AZHAN. AZ-ESAR-VHP. AZ-EIN. • These questions have been discussed in earlier function/Tasks above. • Activation being covered by the CSC Legal Workgroup. • BEMSTS CSC Guidelines. • EM Resource for situational awareness to (HAVBED) web-based resource to assist in real-time status of bed capacity/availability. • BEMSTS has functionalized several of these processes in conjunction /w BPHEP who then will filter these processes down to the regional & local level. • A single messaging system is necessary rather than several methods of information dissemination. • SDMAC will be available to assist in coordinating and making recommendations to other state and local stakeholders. • CSC and managing conflicts between EMS and county public health – is this a task or need that can be addressed in the state plan?	High ☐ Medium ☐ Low ☐
• identifying when to activate CSC plans (indicators and triggers, process);		
• establishing a CSC component activation and notification process;		
• identifying how stakeholders will collaborate with state and federal partners;		
• identifying communications and monitoring systems that support resource distribution and allocation;		
• identifying strategies and processes for situational awareness; and		
• ensuring that private-sector entities are included in planning efforts and identifying their roles.		

State and Regional/Local Task 3		
State EMS office, regional infrastructure, and local EMS agencies ensure connectivity and uniformity with regional advisory committees/councils and other regional resources. Includes • ensuring consistent disaster triage policies; • addressing modified pre-arrival instructions and deferral of service or modified resource assignment; and • integrating call centers, poison control centers, 211 centers and "ask a nurse" resources into CSC plans.	• Identify who the additional call centers, develop an MOU to deliver a consistent message. • Do the individual regional EMS councils have a disaster preparedness workgroup/sub-committee? The each have disaster protocols. • Regional Healthcare Coalitions have a disaster preparedness component. These coalitions need to coordinate with the EMS regional councils with regards to disaster preparedness. This will facilitate distribution of information to the individual EMS agencies/providers. The regional healthcare coalitions need more EMS representation to reduce disconnection between EMS and the coalitions. • The media is used to distribute information to the public, including what to expect regarding assistance, how to contact services, and preparing for shelter-in-place status.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 4		
State EMS office, regional infrastructure, and local EMS agencies identify clinical and administrative triggers for activation of the CSC plan. Includes • considering critical infrastructure disruption; • addressing the doubling of EMS and 911 call volume (or routinely pending calls with potentially life-threatening complaints); • considering the failure of contingency plans to accommodate call volumes; and • understanding the transitions from conventional to contingency to crisis standards of care and administrative and operational changes implemented at each level.	• Who is assigned this task? Andrew: BEMSTS/BPHEP work together. What Triggers are out there already? • Dave Riding: Tucson PSAP takes its lead from public health. Public health interfaces /w hospitals. Call volume and supplemental info is used to move toward disaster mode. • Local is the alerts the situation to the State.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 5		
State EMS office, regional infrastructure, and local EMS agencies consider aspects of palliative care in CSC plans. Includes considering the role of EMS in the provision and facilitation of palliative care, especially in prolonged incident, including necessary education and resources.	• EMS providers will serve to expand primary care under CSC mode. • Palliative Care should be a component to the alternative standards. Special populations need to be considered in this task, not so much the critical care patient populations. Is there a balance between the two populations for EMS CSC care delivery? • EMS to triage to appropriate palliative care and continue care of other needs-level populations. • Are EMS providers meant not to provide the palliative care vs. just triage patients to other resources to receive palliative care. • We need to define the role of EMS providers with respect to rendering/triaging palliative care. • Palliative care facilities to look for pool of certified professionals to provide palliative care (e.g., EMT, paramedic). Is there a legal aspect to using retired no longer certified EMS personnel providing palliative care at designated resources? Can the legal	High ☐ Medium ☐ Low ☐

	workgroup look into this and determine if a waiver can be instituted under disaster declarations? • Use of volunteers to provide palliative care at designated sites. • ESF-6 Mass Care addresses use of volunteers. •	

State and Regional/Local Task 6		
State EMS office, regional infrastructure, and local EMS agencies integrate mental health response into CSC plans. Includes	• Performed at the state level. Use of Regional Behavioral Health Agencies. BPHEP and BEMSTS will work on this to consolidate this task. • Psychological First Aid is a resource.	High ☐ Medium ☐ Low ☐
• engaging and integrating existing mental health care resources in CSC planning and implementation to develop a mass casualty/CSC mental health concept of operations (CONOPS);		
• training EMS personnel in mass casualty variant of psychological first aid that includes rapid mental health triage; and		
• providing a comprehensive EMS responder resilience system for mental health support for all EMS personnel that includes pre-event stress inoculation, personal resilience planning, and triage/self-monitoring of responder stress.		
State and Regional/Local Task 7		
State EMS office, regional infrastructure, and local EMS agencies ensure that CSC planning at all levels	• State protocol used for local resources to adopt to their respective plans. • State Plan should include clear lines of communications and expectations that trickle down to local providers. • Local providers can request assets through normal channels.	High ☐ Medium ☐ Low ☐
• establishes clear lines of authority and roles and responsibilities of stakeholders (e.g., state health department, local health departments, state EMA, local EMAs, EMS, health care, federal partners);		
• identifies processes for coordinating and facilitating resource requests and allocations (e.g., defines role of state EMA in managing requests and allocations within and across states and with federal assets);		
• promotes collaboration with federal partners (e.g., Department of Health and Human Services [HHS]/Office of the Assistant Secretary for Planning and Response [ASPR]) and consistency in scope of care for federally-deployed ESF-8 assets (i.e., across federal teams and with the state and local entities these federal teams support);		
• integrates incident command system principles; and		
• ensures inclusion of EMS-specific CSC into state and regional plans as extension of mass casualty or surge capacity planning.		

Function 3. Stakeholder and Public Engagement

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State and Regional/Local Task 1		
State EMS office may assist the state health department and the SDMAC in engagement with local EMS stakeholders on CSC planning. Regional and local EMS stakeholders	• EMS CSC workgroup and other workgroups is part of this task.	High ☐ Medium ☐ Low ☐
• understand their role in CSC planning and implementation;		
• understand the role of local health care stakeholders in CSC planning and implementation;		
• understand state CSC processes;		
• understand applicable federal, state, and local legal authorities; and		
• have the opportunity to review and provide comments on the draft state CSC plan.		
Regional/Local Task 2		
Regional infrastructure and local EMS stakeholders interface with local health care facilities and local health departments/public health agencies to ensure congruency of assumptions and plans.	• Sharing of the State plan locally. Without a state plan this does not occur. • Dissemination of State plan by BEMSTS through regional EMS councils and advisory Committees • Who maintains the list: regional councils maintain their own, the	High ☐ Medium ☐ Low ☐

	AZHAN, BEMSTS through advisory Committees • These groups to be included in the AZHAN and their respective role and activities.	

State Task 3		
To engage the public (including at-risk populations), state EMS office may participate with the state health department and SDMAC to • coordinate, conduct, and prepare findings on public engagement to help inform the public about the state CSC plan; • share public engagement findings with regional and local EMS stakeholders to assist them in the development of local and regional CSC policies and plans; and • make the draft state CSC plan, with the EMS component, available for public review and comment.	• This is being done by the Public Engagement Workgroup of the BPHEP. • BPHEP using the medical marijuana model of regionalized public engagement. BPHEP will share the model with BEMSTS.	High ☐ Medium ☐ Low ☐
State Task 4		
State EMS office reviews the EMS component of the state CSC plan with applicable public officials (and/or their senior staff) within the state and informs them of their roles in a CSC response.	• BEMSTS three statutory committees (MDC, EMS Council, STAB) and their standing committees.	High ☐ Medium ☐ Low ☐
State Task 5		
State EMS office ensures that legal authorities are described appropriately in the plan and that recommended actions in the plan are in accordance with applicable federal, state, and local laws and regulations.	• EMS Workgroup to coordinate response with Legal Workgroup.	High ☐ Medium ☐ Low ☐

Function 4. Monitoring, Evaluation, and Modification of the CSC Plan

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State and Regional Task 1		
State EMS office and regional infrastructure partner with state and regional EMAs to integrate the state CSC plan into appropriate emergency operations plan (ESF-8 Public Health and Medical Annex) and the state surge capacity plan/annex or other state emergency response plan with EMS-specific information, as applicable.	• BPHEP to add this to the SERRP as part of ESF-8.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 2		
State EMS office and regional infrastructure notify EMS stakeholders of plan adoption and strategies to be utilized.	• EMS regional councils, BEMSTS advisory committees, county health officers. • BEMSTS to coordinate with BPHEP in getting all three advisory committees together.	High ☐ Medium ☐ Low ☐
State Task 3		
State EMS office notifies intrastate (regional advisory committee and local EMS committees) and interstate EMS partners, as appropriate, of the adoption of the state CSC plan and distributes the plan to them to promote consistency and transparency in CSC planning and response efforts. State EMS office informs applicable federal partners with EMS-relevant responsibilities (e.g., HHS regional emergency coordinators) of plan adoption and strategies	• BPHEP taking the lead on this task via plan implementation workshops.	High ☐ Medium ☐ Low ☐

or likely resource requests that would involve their personnel (e.g., national ambulance contract).		
State and Regional Task 4		
State and regional infrastructure make public versions of state and regional CSC plans available on the state EMS or other applicable website for public access. State EMS office and regional infrastructure conduct an awareness campaign throughout the state to inform stakeholders about the state CSC plan and processes.	• BPHEP taking the lead on this task via plan implementation workshops	High ☐ Medium ☐ Low ☐

State and Regional/Local Task 5		
State EMS office, regional infrastructure, and local EMS agencies ensure that state, regional, and local EMS components of the overall CSC plan are operational, up-to-date, and ready for activation. Includes	2012-17 Training & Exercise Plan Priorities (HCC). 2013 Capabilities Planning Guide Purpose (HCC). PHEP CPG 2013 Recomm. Priority Sorted Rpt.. • BPHEP taking the lead on this task via plan implementation workshops.	High ☐ Medium ☐ Low ☐
• conducting regular education with EMS stakeholders, and as appropriate, public officials and the public regarding the plan and its implementation;		
• tracking developments in EMS CSC planning and guidance (within and external to the state);		
• conducting tabletop and functional exercises involving the EMS component of the CSC plan at the state, regional, and local levels;		
• reviewing and updating the EMS component of the plan on a regular (annual or more frequent) basis, as needed;		
• soliciting input from EMS and other stakeholders and the public about the plan, including continuing to conduct public engagement activities; and		
• notifying EMS and other stakeholders and the public, as necessary, of any substantive changes to the plan.		

Template 6.2. Core Functions of EMS Systems and EMS Personnel in the Implementation of CSC Plans

Function 1. Assessment and Activation

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State Task 1		
State EMS office, in collaboration with the state public health agency and state emergency management agency (EMA), assumes the role of state EMS lead in collaboration with the state public health agency/Emergency Support Function (ESF)-8 lead and state EMA. (If the state EMS office is the ESF-8 lead, it follows guidance for state functions and delegates EMS-specific functions below.)	• The Bureau of EMS & Trauma System (Bureau) does collaborate with ADHS and EMA. • Bureau has a liaison at both the State EOC and the Health EOC.	High ☐ Medium ☐ Low ☐
State Task 2		
Dispatch/call centers, EMS providers, and state EMS office recognize incident and assess medical needs and the necessity of implementing the state CSC plan.	• There a so many dispatch centers, most likely the awareness/knowledge of Standards of Care (SOC) is limited. • There is no oversight from the dispatch call centers regarding capabilities. • There is no single 911 call center in AZ. Each municipality has its own PSAP. • If EMS establishes a protocol, not all PSAPs will implement the state CSC. They can adapt, but education will be necessary. • The CSC would be implemented from the bottom up (e.g.,	High ☐ Medium ☐ Low ☐

	agency level on up the system chain).	
State Task 3		
State EMS office consults with the state disaster medical advisory committee (SDMAC) regarding medical care and policy issues.	• Compliance depends upon whether collaboration is before or during a declaration. • In concert with Bureau statutory committees, collaboration would be performed. • There's a difference between incident-specific and planning-specific.	High ☐ Medium ☐ Low ☐

State Task 4		

State EMS office, in collaboration with the SDMAC, activates/authorizes implementation of the EMS component of the state CSC plan based on triggers identified in the plan.	• The Bureau-level will not be a trigger, but would go through the ADHS Director to collaborate in communicating implementation of EMS resources.
	• Triggers identified in the plan – do the following. If occurs, plan is implemented. Bureau/ADHS would share when triggers are met.
	• Triggers could include system out of meds.
	• The Pandemic Influenza Plan includes triggers and how to switch from standard dispatch/transport modes to alternate destination mode.
	• The IOM has a list of triggers and will be provided.
	• Triggers include:
	  • State Governor declaration;
	  • Resource for HC agencies unavailable;
	  • Multiple HC facilities similarly impacted;
	  • Limited access to medical countermeasures;
	  • Supply caches already distributed.
	•
		High ☐
		Medium ☐
		Low ☐

Regional/Local EMS and Dispatch Center Task 5		
Regional/local EMS and dispatch centers understand when to initiate jurisdictional CSC plans based on local and regional emergency response plan triggers and the state CSC plan State EMS office and local EMS providers, in collaboration with the state public health agency, regularly test the triggers in the CSC plan.	See Task 2 comments. Differences are task 2 refers to state/local, task 5 refers to regional.	High ☐ Medium ☐ Low ☐

Function 2. Alerts and Notifications

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State and Regional/Local Task 1		
State EMS office utilizes the statewide integrated communications system to provide and receive timely alerts during a CSC incident.	Bureau is well tapped into this. EMSystem, web-based system, Health Services Portal (SIREN), Public Health, AZ 211, Social Media, and HAN System, 800 Mhz Radios.	High ☐ Medium ☐ Low ☐
State Task 2		

State EMS office establishes redundant and interoperable communications systems in case a disaster affects routine communications systems.	• Whether creating a central list of communication resources listed in Function 2,Task 2 to determine order of use. • If a disaster affects routine resources, the satellite Internet is available (bypasses communication links when routine resources are tied-up). • Social media can serve as a primary resource for citizens to obtain information on disasters.	High ☐ Medium ☐ Low ☐

Regional/Local Task 3		
Regional infrastructure and local providers understand what actions to take when state EMS office or lead ESF-8 agency sends notifications about a crisis or potential crisis situation.	• This is a weakness. EMS should be included in county disaster and state disaster plans. • During the pandemic influenza exercise, the Bureau developed protocols posted onto the Bureau's webpage. • Depending upon the level of the emergency, the communication pathway would be different (e.g., regional, vs. Bureau, State EOC, etc.). State EOC would communicate through the EM managers. • If a statewide declaration, State EOC activates and the area affected by the disaster, the affected county would provide/disseminate and receive information. • The All-Hazards Response Plan doesn't cover all treatments (incorporate by reference in CSC the schema from the All-Hazards Plan). • Pan Flu ESF-8 is the lead.	High ☐ Medium ☐ Low ☐
Regional/Local Task 4		
Regional infrastructure and local providers understand when to request that the state ESF-8 lead agency activate/authorize CSC strategies.	See Function 2 tasks comments above.	High ☐ Medium ☐ Low ☐
Public Safety Answering Points (PSAPs) and Call Centers Task 5		
PSAPs and call centers understand when to send alert messages to stakeholders if the CSC plan is anticipated, activated, and terminated.	PSAPs will be willing partners. Education and direction of PSAPs will be necessary.	High ☐ Medium ☐ Low ☐

Function 3. Command

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State and Regional/Local Task 1		
State EMS office implements the incident command structure (ICS) within affected jurisdictions. Includes:	• This scenario is unlikely as the state will not go to a local level to operate.	High ☐

• ensuring that command staff are trained and have exercised the use of alternate care sites, transportation modes, and staffing configurations (and other crisis adaptations) according to local/ regional plans;	• ADHS does cover regional plans. • A table-top exercise of CSC with respect to ICS/NIMS will be appropriate. • In order to activate CSC, this requires a statewide declaration. • The CSC Plan will conform to NIMS and local staff are trained in ICS at local level. • The State has a well-established response training capability using the NIMS format.	Medium ☐ Low ☐
• ensuring that command staff are well versed in incident action planning and how to incorporate appropriate technical experts (such as the SDMAC) into the planning process for long-term incidents; and		
• ensuring that appropriate resources (job aids) are available to guide capacity expansion decisions as needed.		
State Task 2		
All stakeholders understand the ESF-8 role in CSC incident and how the chains of command of the state emergency operations center (EOC) and agency internal operations center coordinate the development, communication, and implementation of new CSC strategies in response to incident-specific demands.	The model is in place via ESF-8 but not with respect to CSC.	High ☐ Medium ☐ Low ☐

Function 4. Control

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State and Regional/Local Task 1		
State EMS office understands how to request additional resources and integrate requested assets within existing resources. Involves:	• The Bureau has a well-established knowledge and application of requesting additional resources and integrating requests. • Local fire departments/regional dispatch, etc. to AZMAC to EMAC to Federal assets.	High ☐ Medium ☐ Low ☐
• jurisdictions, regional structures, and local emergency management and public health systems;		
• regional hospital coalitions and regional EMS/trauma committees/councils;		
• federal partners (Department of Health and Human Services [HHS]/Office of the Assistant Secretary for Planning and Response [ASPR], Federal Emergency Management Agency [FEMA], National Disaster Medical System [NDMS], Department of Homeland Security [DHS]);		
• the Emergency Management Assistance Compact; and		
• multistate regional coalitions.		
Regional/Local Task 2		
State EMS office ensures that EMS providers utilize triage, treatment, transport, and transfer protocols approved by the medical director within the response area as required during a CSC incident.	Once the Alternate Triage Treatment & Transport Guidelines for Pandemic Influenza are modified for CSC, is will be covered.	High ☐ Medium ☐ Low ☐
Regional/Local Task 3		
Regional EMS infrastructure and local EMS agencies work in cooperation with local law enforcement and understand the EMS options for security and access controls during a disaster.	This is currently well in place.	High ☐ Medium ☐ Low ☐

Function 5. Communications

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State Task 1		
State EMS office ensures real-time exchange of information among stakeholders to assess the magnitude of the incident and evaluate ongoing resource needs and requests.	This can be achieved through EMA to the EMS Office rather than the EMS Office being responsible.	High ☐

		Medium ☐ Low ☐
State and Regional/Local Task 2		
State EMS office ensures that policies and procedures are in place to provide and receive situational communications among staff, facilities, and agencies within the affected region, including by the following means: • e-mail, text messaging, paging, telephone, amateur radio, satellite phone, and other devices; • announcements, handouts, postings, and traditional media; and • web-based and social media.	• This role has been the responsibility of ADHS, covering via email, HAN to communicate with providers/facilities. • County disaster plans include HAM Radio resources.	High ☐ Medium ☐ Low ☐

State, Regional/Local, and Dispatch Center Task 3		
All stakeholders ensure that interoperable and redundant systems exist to communicate with • local EMS and dispatch centers, • EOCs (emergency management), • the regional medical multiagency coordination center (as applicable), • hospitals and alternate care facilities in the area, • federal partners, • law enforcement, • other appropriate state agencies (e.g., department of mental health), • local public health agencies, and • neighboring states.	This role continues to evolve.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 4		
State EMS office, regional and local EMS agencies, and medical directors understand the roles and functions of the SDMAC, state EMS medical director, state health officer/ commissioner, regional medical coordination center, regional call centers, and regional EMS or trauma advisory committees and how information is received or communicated to these bodies.	• This has not yet been developed. If statewide disaster is declared the Bureau could be tasked with this responsibility. • Educating the Bureau's Statutory Advisory Committees on the CSC Plan & new infrastructure will facilitate meeting this role. • Ontario Protocol with AZ modifications for ICU allocation would be implemented. • Regional Medical Coord. & SDMAC are new infrastructure components that need to be communicated to Advisory Bodies.	High ☐ Medium ☐ Low ☐

Function 6. Coordination

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State Task 1		
State EMS office understands interstate assets and Emergency Management Assistance Compact (EMAC) process, as well as NDMS capabilities, and, in cooperation with the state EMA and state health department, how to integrate outside assets with existing resources.	The Bureau is well-versed in this responsibility and has regular exercises.	High ☐ Medium ☐ Low ☐

State and Regional/Local Task 2		
State EMS office implements available electronic incident management and patient tracking systems to manage assets and track patient movement.	The BPHEP has this capability via EMTrack. This functionality is being piloted by various local agencies. To the extent this can be piloted for disasters, better data may facilitate this function under CSC mode.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 3		
State and local EMS agencies understand the authority, scope, and jurisdiction for all response organizations and how they interface within the ICS during a CSC incident.	The forthcoming CSC Plan will have the schematics in place. Education will be a necessity to fulfill this role.	High ☐ Medium ☐ Low ☐

Function 7. Public Information

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State and Regional/Local Task 1		
Through the ICS, state EMS office and local EMS agencies ensure appropriate risk communication and consistent messaging to the public via the media, as well as organization-/agency-specific means (website, calling programs, e-mail, social media) regarding use of 911 and EMS resources, when EMS should be called, limitations on response, etc.	This will be a component of the forthcoming CSC Plan. External communication partners are working on developing this component.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 2		
All stakeholders in the emergency health care system coordinate information with other response organizations through the joint information system (JIS) and joint information center (JIC).	Yes (this is the whole HEOC information).	High ☐ Medium ☐ Low ☐

Function 8. Operations

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
CONVENTIONAL CARE		
State and Regional/Local Task 1		
All EMS stakeholders understand their roles and authority in providing routine care through medically approved triage, treatment, and transport protocols and using normal modes of transportation, staffing, and equipment, including mutual-aid resources.	Yes.	High ☐ Medium ☐ Low ☐
CONTINGENCY CARE		
State and Regional/Local Task 1		
EMS providers expand mutual-aid agreements/operations and response plans to substitute, conserve, and adapt staffing, transportation, patient triage, and destinations while still	Yes (regularly exercised). Pandemic Influenza Plan.(**new ATTTG changes 2013) – PMD updated and went to MDC. AEMT scope,**	High ☐

providing medical care functionally equivalent to conventional care.	**new cert level categories etc (EMCT). Rev Date: 5/16/13 approved by MDC/PMD.**	Medium ☐ Low ☐
CRISIS CARE		
State and Regional/Local Task 1		
EMS providers expand mass casualty and surge capacity plans to include • reuse and reallocation of supplies, • alternate modes of transportation (buses), • sheltering in place and transport to alternate care sites, • modification of the ambulance staffing configuration (one medical person and a driver), • use of medically approved protocols for patient care based on established triggers in the CSC plan, • dispatch screening protocols, • use of regional call centers to assist with coordination of assets and patient destination, • treat-and-release protocols, • 211, 311, and other call centers (e.g., nurse call centers), and • declarations and emergency orders to facilitate the provision of sufficient care.	This is ensured via regular table-top exercises. Changes might include items in red. Some of the particulars will be dependent upon content of the Governor's declaration. **Change "protocol" terms to "Guidelines.**	High ☐ Medium ☐ Low ☐

MEDICAL CARE BRANCH		
State Task 1		
State EMS office understands when to shift from contingency to crisis care on assessment of a response in progress or recommendation of the SDMAC and knows how to identify specific needs of response organizations and the resources at risk.	Yes, once the **threshold identified**. **Threshold triggers differ by agency/region.**	High ☐ Medium ☐ Low ☐
State Task 2		
State EMS office understands the process for requesting resources and coordinating these resources with federal partners and regional and local response organizations.	Yes.	High ☐ Medium ☐ Low ☐
State Task 3		
State EMA activates the EOC (if not already done) and the crisis care annex that details the role of the SDMAC and waivers of regulatory standards. Includes • activation guidelines and triggers, • roles and responsibilities, • documentation of decisions (medical records and incident documentation), and • triage protocols and possible decision tools.	Yes (**ADEM & ADHS**). The Annex has all of the items in red. **Proposed Arizona CSC Triggers** **1) A State declaration of emergency AND** **2) any one of the following;** ***resources for healthcare facilities and agencies are unavailable or un-deliverable,** ***Multiple healthcare facilities/agencies are similarly impacted, patient transport not possible in greater than the short term,** ***Limited access to medical countermeasures and/or** ***Supply caches already distributed; no short term resupply.**	High ☐ Medium ☐ Low ☐
MENTAL HEALTH		
State Task 1		
State EMS office participates in a rapid mental health triage/incident management system	Yes. **Regional Behavioral Health Authority. Mental/Psych. FA**	High ☐

linking local, regional, and state disaster systems of care, including health care facilities and mental health resources, in ICS operations.	**available as resource.**	Medium ☐ Low ☐
State Task 2		
State EMS office provides for access to a continuum of evidence-based mental health interventions for adults and children.	**No. ADHS working to coordinate/communicate this .**	High ☒ Medium ☐ Low ☐
Regional/Local Task 3		
Regional infrastructure and local public and private EMS agencies provide training in basic "neighbor-to-neighbor, family-to-family" psychological first aid for the general public and health care workers that includes triage.	**This requires further research and level of discussion to assess.**	High ☐ Medium ☐ Low ☐
Region/Local Task 4		
Regional infrastructure and local public and private EMS agencies provide CSC-specific behavioral coping components in risk communications.	**This requires further research and level of discussion to assess. RFIs should include this Task. ADHS/Division of Behavioral Health can coordinate this.**	High ☐ Medium ☐ Low ☐

State and Regional/Local Task 5		
All stakeholders complete a CSC gap analysis with plan to enhance local disaster mental health and spiritual care capacities and capabilities.	**No. This requires further research and level of discussion to assess.**	High ☐ Medium ☒ Low ☐
Regional/Local Task 6		
Regional infrastructure and local public and private EMS agencies develop a health care worker resilience system with integrated triage and referral components.	No. This is a second-tier initiative.	High ☐ Medium ☐ Low ☐
PALLIATIVE CARE		
State Task 1		
State EMS office, with medical direction, defines the role of EMS personnel in providing symptomatic management for patients needing palliative care and provides the necessary training and resources.	Will be addressed in the CSC (Triage Treatment and Transport CSC).	High ☐ Medium ☐ Low ☐
State Task 2		
With palliative care experts, state EMS office provides just-in-time training that may be appropriate for EMS personnel, especially in a sustained CSC incident.	**No. This needs to be researched further to be addressed. Contracts are for mental health first aid and psychological first aid.**	High ☐ Medium ☐ Low ☐
Regional/Local Task 3		
State and local medical directors address palliative care, if appropriate, in the emergency operations plan, including triage tools and any agency-specific protocols or policies (which	Once CSC field protocols are developed.	High ☐

are approved by medical directors at the state or agency level).		Medium ☐ Low ☐

Function 9. Logistics Staffing Resources

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
State and Regional/Local Task 1		
State EMS office, regional infrastructure, and local EMS providers understand available staffing resources within jurisdictions and utilize established processes for requesting and allocating the workforce (Medical Reserve Corps [MRC], Emergency System for Advance Registration of Volunteer Health Professionals [ESAR-VHP], state strike teams, NDMS teams, military/National Guard personnel, including ambulances).	Yes.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 2		
State EMS office, regional infrastructure, and local EMS agencies utilize a resource monitoring system to track staffing resources and understand when to activate mutual-aid agreements or alternative staffing patterns.	This is done at the local provider level.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 3		
All stakeholders ensure that call-back criteria and policies are in place, including maintenance of current and accurate employee contact information.	**This is done at the local provider level.**	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 4		
State EMS office, regional infrastructure, and local EMS providers have the capability to assess the number of staff available for large-scale incidents.	**This is done at the local provider level.**	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 5		
State EMS office, regional infrastructure, and local EMS providers ensure that staff receive personal preparedness training to assist with family needs and are prepared for on-site accommodation of staff and family members, as appropriate.	**This is done at the local provider level.**	High ☐ Medium ☐ Low ☐
TRANSPORTATION AND EQUIPMENT RESOURCES		
State and Regional/Local Task 1		
State EMS office, regional infrastructure, and local EMS agencies conduct an assessment of the types and location of EMS transportation and equipment resources available within the state and know how to request resources from other jurisdictions (through EMAC, the federal ambulance contract, medication caches, equipment trailers).	**State ESF-8 responsibilities to integrate federal ambulance contract, etc. AZ Mutual Aid Compact involved.**	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 2		
State EMS office, regional infrastructure, and local EMS agencies, with medical direction, identify strategies for appropriate substitution, conservation, adaptation, reuse, and reallocation of scarce equipment and supplies.	Yes (just-in-time decisions made by the SDMAC with EMS input.).	High ☐ Medium ☐ Low ☐
State/Regional/Local Task 3		

State EMS office, regional EMS infrastructure, and local EMS agencies utilize a resource tracking or deployment system to monitor the availability of ambulances and understand when to engage other modes of patient transportation.	Yes.	High ☐ Medium ☐ Low ☐
SPACE		
State and Regional/Local Task 1		
State EMS office, regional infrastructure, and local EMS providers understand when to initiate plans to transport patients to alternate care sites and the processes for requesting and allocating such space.	**ATTTG**	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 2		
State EMS office, regional infrastructure, and local EMS providers are able to recognize when to activate alternate call centers (such as 211 or nurse triage centers) to provide information to the public.	Yes.	High ☐ Medium ☐ Low ☐
Regional/Local Task 3		
Regional infrastructure and local EMS providers understand when to initiate treat-and-release protocols and processes approved by state and agency medical directors.	**ATTTG**	High ☐ Medium ☐ Low ☐

Regional/Local Task 4		
Regional infrastructure and local EMS providers identify regional staging areas for use when major mutual aid will be required but specific assignments are not yet available, and understand support requirements for those sites.	**ADHS to work with county emergency management on where the resources are located (e.g., staging areas).**	High ☐ Medium ☐ Low ☐
PSAPs and Call Centers Task 5		
PSAPs, regional call centers, and dispatch centers understand when to utilize CSC dispatch protocols and alter resource assignments.	No, anticipated June 2014.	High ☐ Medium ☐ Low ☐
SPECIAL POPULATIONS		
State and Regional/Local Task 1		
State EMS office, regional infrastructure, local EMS providers, and medical directors identify patient groups requiring special consideration with respect to transportation, treatment, equipment, and supplies.	**Yes.**	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 2		
Local EMS personnel are trained and exercised in managing special populations, including pediatric, burn, elderly, and non–English-speaking patients, and purchase and stockpile tools, equipment, and supplies to address special-population needs.	Yes (in coordination with the **ADHS**).	High ☐ Medium ☐

		Low ☐

Function 10. Planning

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY
DISASTER MEDICAL ADVISORY COMMITTEE		
State Task 1		
State EMS office understands how to interface with incident command, in particular the planning section and planning cycle, as well as how to interface with the SDMAC, its role in activating the CSC plan, and other strategies.	Yes **except SDMAC (SDMAC in development)**	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 2		
Technical specialists and medical directors understand their interface with command and planning sections.	Yes (routinely exercised).	High ☐ Medium ☐ Low ☐
PERSONNEL MANAGEMENT		
State and Regional/Local Task 1		
In collaboration with existing regional structures, state and local EMS agencies establish policies and procedures to integrate external staffing resources (MRC, ESAR-VHP, state strike teams, disaster medical assistance team [DMAT]) during a disaster based on mutual-aid agreements, EMAC, the NDMS plan, emergency operations plan, and appropriate annexes.	Yes (in place).	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 2		
In collaboration with existing regional structures, state and local EMS agencies develop an educational program and materials to orient external staffing resources on local, regional, and state triage and treatment policies and applicable elements of the state CSC plan.	**No. Just-in-time training is in place, but State CSC Plan is not yet developed.**	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 3		
State and local EMS providers develop policies for personnel management, such as altered staffing configurations, shift lengths, and staff roles, and address any collective bargaining issues that may arise prior to an incident.	Local provider level.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 4		
Need for nonmedical assistance for families, volunteers, and external staffing resources is addressed within the emergency operations plan.	**Yes**	High ☐ Medium ☐ Low ☐

Function 11. Jurisdiction, Scope, Authority, and Legal/Regulatory Issues

TASK TARGET CAPACITIES	CURRENT STATUS	PRIORITY

State and Regional/Local Task 1		
State EMS office and EMS providers examine the scope and delegation of authority to incident commanders during a disaster and make any necessary changes to ensure that CSC decisions are supported (i.e., that the incident commander is acting with the authority of the agency/jurisdiction). During a crisis, policy makers may require additional communications and coordination with the incident commander.	Yes.	High ☐ Medium ☐ Low ☐
State and Regional/Local Task 2		
State EMS officials understand the impact of the CSC plan on the provision of patient care within the appropriate jurisdiction, understand state and local laws and regulations that would impact the response organizations' ability to implement CSC, and identify possible solutions.	**No, CSC Plan not yet developed**	High ☐ Medium ☐ Low ☐