May 2022

Appendix 3.5.1 cmhpc medical surge coordination

## 

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## Purpose

The Central Minnesota Health care Preparedness Coalition’s (CMHPC) Medical Surge Plan outlines the support role that the Regional Health care Preparedness Coordinator (RHPC) plays during a medical surge event at a CMHPC member facility. This plan will integrate region-wide medical, health and community resources before, during and after an emergency which exceeds the ability of the health care system.

## Assumptions

* To manage medical surge, during incidents, only the most acutely injured or ill should be treated at hospitals. Clinics and other medical facilities (i.e., surgery centers) may be requested to assist if needed.
* The CMHPC HMAC may be activated to assist with surge capacity, patient transportation needs, staffing needs, resource sharing and requests, and communications. Regional staff will work in cooperation with the appropriate Hospital Command Centers and Local or State Emergency Operations Centers. See CMHPC Regional Coordination Plan.
* Facility level Crisis Standards of Care plans may need to be implemented with the Medical Surge Plan to address shortages of equipment, supplies, pharmaceuticals, beds, personnel, and sources of transportation.
* Central Region Hospitals have Emergency Operations Plans (EOPs) that address medical surge capacity and capabilities and activation and operation of Alternate Care Sites (ACS). The HMAC can support medical surge or ACS plans as needed.
* This plan does not cover isolation or quarantine which are not medical surge conditions; they are public health containment measures used to control the spread of communicable diseases which may occur in single, cluster or larger patient quantities.
* Risk communications and resource management procedures are described in the Communications Plan.

## Definitions\*\*\*

|  |  |
| --- | --- |
| Conventional capacity: | The spaces, staff, and supplies used are consistent with daily practices within the institution. These resources are used during a major mass casualty incident that triggers activation of the facility emergency operations plan. Health care institutions will maintain conventional standards as long as possible. |
| Contingency capacity: | The spaces, staff and supplies used are not consistent with daily practices, but provide care to a standard that is functionally equivalent to usual patient care practices. These contingency resources may be used temporarily during a major mass casualty incident or on a more sustained basis during a disaster (when the demands of the incident exceed community resources). The duration of contingency resource use will be dependent on the scope of the situation. |
| Crisis capacity: | Adaptive spaces, staffing, and supplies are not consistent with usual standards of care but provide sufficiency of care in the setting of a catastrophic disaster (i.e., provide the best possible care to patients given the circumstances and resources available). Crisis capacity activation constitutes a significant adjustment to standards of care. This category of care will be limited in duration as soon as additional resources become available contingency or conventional practices should resume. |

*\*\*\* Patient Care Resources for Scarce Resource Situations, MDH and Institute of Medicine 2012 – Crisis Standards of Care*

## Planning for Medical Surge

The intent of the CMHPC Medical Surge Plan is to add specific Medical Surge tenets to be used by the HMAC to coordinate the response to a medical surge event. The CMHPC Response Plan outlines the HMAC Activation, Information Gathering process, HMAC Operations, and additional details about the response.

### Immediate Bed Availability (IBA)

IBA is a means to provide appropriate levels of care to all patients during a disaster by availing 20% of staffed beds to higher acuity patient within four (4) hours of a disaster and identifying and providing the appropriate care for lower acuity patients. Each hospital in the CMHPC will adjust their facility Medical Surge Plans to accommodate the 20% increase by off-loading patient, early discharges, increasing staff, etc.

The CMHPC will be asked to demonstrate the capability of all the hospitals in the region to both deliver appropriate levels of care to all patients as well as to provide no less than 20% immediate availability of staffed beds within a few hours of notification of the event.

Real time data and capacity will be assessed as needed by MNTrac alerts and using a pre-designed Survey Monkey survey. See also Essential Elements of Information.

## CMHPC Healthcare Facility Capacity Table

|  |  |  |
| --- | --- | --- |
| Agency Name | **Bed Type** | **Bed Total** |
| Buffalo Hospital | Adult Intensive Care Unit | 4 |
|  | Medical and Surgical - Adult | 23 |
|  | Non Critical Monitored - Adult | 12 |
|  | Obstetrics/Gynecology OBGYN | 16 |
| Cambridge Medical Center | Adult Intensive Care Unit | 6 |
|  | Medical and Surgical - Adult | 26 |
|  | Psychiatric - Adult | 14 |
| CentraCare Health - Long Prairie | Medical and Surgical - Adult | 12 |
|  | Obstetrics/Gynecology OBGYN | 2 |
| CentraCare Health - Melrose | Medical and Surgical - Adult | 12 |
|  | Obstetrics/Gynecology OBGYN | 2 |
| CentraCare Health - Monticello | Adult Intensive Care Unit | 3 |
|  | Medical and Surgical - Adult | 18 |
|  | Obstetrics/Gynecology OBGYN | 6 |
|  | Psychiatric - Adult | 10 |
| CentraCare Health - Paynesville | Medical and Surgical - Adult | 12 |
|  | Non Critical Monitored - Adult | 3 |
|  | Obstetrics/Gynecology OBGYN | 2 |
| CentraCare Health - Sauk Centre | Medical and Surgical - Adult | 20 |
|  | Medical and Surgical - Pediatric | 2 |
|  | Non Critical Monitored - Adult | 3 |
|  | Obstetrics/Gynecology OBGYN | 2 |
| CHI St. Gabriel's Health - Little Falls | Adult Intensive Care Unit | 6 |
|  | Medical and Surgical - Adult | 15 |
|  | Obstetrics/Gynecology OBGYN | 4 |
| Cuyuna Regional Medical Center - Crosby | Adult Intensive Care Unit | 6 |
|  | Medical and Surgical - Adult | 19 |
|  | Medical and Surgical - Pediatric | 2 |
|  | Obstetrics/Gynecology OBGYN | 6 |
| Essentia Health Sandstone | Medical and Surgical - Adult | 9 |
| Essentia Health-St. Joseph's Medical Center Brainerd | Adult Intensive Care Unit | 10 |
|  | Medical and Surgical - Adult | 59 |
|  | Medical and Surgical - Pediatric | 6 |
|  | Non Critical Monitored - Adult | 8 |
|  | Obstetrics/Gynecology OBGYN | 10 |
|  | Psychiatric - Adult | 20 |
| Lakewood Health Systems - Staples | Adult Intensive Care Unit | 3 |
|  | Medical and Surgical - Adult | 22 |
| M Health Fairview Lakes Medical Center - Wyoming | Adult Intensive Care Unit | 10 |
|  | Medical and Surgical - Adult | 30 |
|  | Obstetrics/Gynecology OBGYN | 15 |
| M Health Fairview Northland Medical Center - Princeton | Adult Intensive Care Unit | 4 |
|  | Medical and Surgical - Adult | 22 |
|  | Nursery | 15 |
|  | Obstetrics/Gynecology OBGYN | 15 |
| Mille Lacs Health System Hospital - Onamia | Medical and Surgical - Adult | 18 |
|  | Psychiatric - Adult | 7 |
| Riverwood Health Care Center - Aitkin | Adult Intensive Care Unit | 4 |
|  | Medical and Surgical - Adult | 19 |
|  | Medical and Surgical - Pediatric | 1 |
|  | Obstetrics/Gynecology OBGYN | 2 |
| St. Cloud Hospital | Adult Intensive Care Unit | 43 |
|  | Medical and Surgical - Adult | 203 |
|  | Medical and Surgical - Pediatric | 14 |
|  | NICU - Neonatal ICU | 28 |
|  | Non Critical Monitored - Adult | 92 |
|  | Non-Critical Monitored - Pediatric | 4 |
|  | Obstetrics/Gynecology OBGYN | 44 |
|  | Pediatric Intensive Care Unit | 4 |
|  | Psychiatric - Adult | 20 |
|  | Psychiatric - Pediatric | 9 |
|  | Rehabilitation beds - Inpatient | 20 |
| Tri County Hospital - Wadena | Adult Intensive Care Unit | 2 |
|  | Medical and Surgical - Adult | 20 |
|  | Obstetrics/Gynecology OBGYN | 3 |
| Welia Health- Mora | Adult Intensive Care Unit | 3 |
|  | Medical and Surgical - Adult | 16 |
|  | Obstetrics/Gynecology OBGYN | 4 |

The table above shows the standard bed availability for each hospital within the region. Real time data and capacity will be assessed as needed by MNTrac alerts and/or using a pre-designed Survey Monkey survey. The above capacity numbers were effective 15 May 2022 and taken from MNTrac.

1. Patient Tracking

Utilizing the MNTrac System, the regional coordinator will send an alert requesting all facilities update the current bed capacity. If the capacity does not meet the need of the medical surge response the Regional Coordinator will reach out to neighboring Regional Coordinators or the MNHCC.

Facilities are encouraged to track patient locations specific to the event and track any transfers or specific patient movement.

1. Emergency Medical Services (EMS)

The CMHPC includes the Central Regional EMS Coordinator to streamline planning efforts. EMS would also be included in the HMAC upon activation. EMS agencies within the Region are encouraged to plan and train with other coalition members. They are invited to participate in training and exercises.

## Types of Medical Surge

### RHPC Role in Pandemic and Infectious Disease Response

With PHPC, consider activation of the HMAC to:

* + Disseminate information from Minnesota Department of Health to the members.
  + Coordinate with Public Health Departments.
  + Establish periodic briefings to assess impact on Coalition, including:
    - Current capacities and needs.
    - Reporting and monitoring of influenza like illnesses.
    - Assess status of staffing and patient load at coalition hospitals.
    - Anticipate needs for upcoming period.
  + RHPC can assist with communications and information sharing under the direction of MDH and LPH.
  + Encourage healthcare facilities to activate their facility pandemic plan.
  + RHPC can assist with resource requests for coalition.
  + See Appendix 3.5.1.2. Pediatric Surge Plan

### RHPC Role in a Mass Casualty Incident (MCI), Pediatric Surge, or CBRNE/HAZMAT Event

* The RHPC can evaluate the response and activate the HMAC if needed. The HMAC can assist with:
  + Bed availability within the region and with neighboring regions
  + Resource requests and allocation
  + Situational awareness
* Refer facilities to their MCI/Medical Surge Plans as assist as requested.
* The RHPC (with or without HMAC Activation) can provide general support for Coalition members as requested.

1. RHPC Role in Burn Surge

* The RHPC and the HMAC may assist with a response to a Burn Mass Casualty Incident. See Appendix 3.5.1.1 CMHPC Burn Surge Plan.

1. RHPC Role in an Infectious Disease Surge

* The RHPC and the HMAC may assist with a response to an Infectious Disease outbreak. See Appendix 3.5.1.5 Regional Infectious Disease Plan

### Facility Evacuation or Facility Shelter-in-Place

Facilities within the CMHPC are asked to have their own plans in place for evacuation or shelter-in-place. The rhpc will support the facility as needed, to include the activation of the HMAC. Patient movement coordination

There are four levels of Patient Movement:

### Levels of Patient Movement

* Local Level
  + Utilization of Mutual Aid agreements and partnerships with local Emergency Medical Services to handle most of the patient movement.
* Regional Level
  + Utilization of the Healthcare Coalition Regional plans/processes to coordinate patient movement to include:
    - Activation of Regional Mutual Aid agreements
    - Cross border/cross regional cooperation
    - Utilization of the MNTrac program to identify locations with bed availability including sending out regional bed availability alerts.
    - Activation of the MNHCC SHCC
* State Level
  + When local and regional activities are overwhelmed or more resources are required, the State may consider:
    - The MDH Department Operations Center (DOC)
    - Activation of the State Emergency Operations Center
    - Activation of the Emergency Management Assistance Compact (EMAC) to enlist the assistance of neighboring states.
    - Request Federal assistance
* Federal Level
  + When all local, regional, and state assets are overwhelmed or the State identify that resources are exhausted, the State my reach out to the federal partners for assistance.

### Patient movement assumptions

* During mass casualty incidents, local jurisdictions will follow existing comprehensive emergency management plans, and healthcare facilities’ existing surge and evacuation plans.
* Patient Coordination refers to conducting situational assessment and coordinating the placement of patients in an appropriate facility, based on their level of acuity and needs.
* As with any response, the patient movement process should start at the local level. If local-level facilities are unable to find a facility to accept patients, then they can reach out to the region for guidance.
* All healthcare facilities will do what is best to maximize their care and determine their triggers based on capability. (e.g.)
  + Unexpected or overwhelming number of patients present to emergency rooms and clinics
  + Significant increase in patients due to health threat
  + Shortage of equipment, supplies, pharmaceuticals, beds
  + Shortage of personnel
  + Disruption of transportation affecting ability to move patients
* There are potentially significant differences in the policies and procedures among partner agencies. These differences will require flexibility during an escalated incident where inter‐agency collaboration is necessary.

### Healthcare Delivery

Six key components of surge planning for healthcare delivery systems include:

1. Bed Capacity
2. Staffing
3. Communications
4. Continuation of Essential Healthcare Services/Crisis Standards of Care
5. Alternate Care
6. Transportation

#### **Bed Capacity**

It will be important to track the types and numbers of beds available to provide coordination of available assets to ensure a streamlined process for patient transfers. Hospital bed reporting (for the type and availability) may be event specific and may include the following categories:

* Adult
* Pediatric
* Medical/Surgical
* Orthopedic
* Telemetry
* Cardiac
* Critical Care
* Surgical/Trauma
* Maternity/(OB/GYN)
* Burn
* Swing

*Tasks and Responsibilities*

*Healthcare Facilities and Systems*:

* Activate individual healthcare organization’s internal surge plans.
* Update bed availability through MNTrac and with preestablished reporting structure.
* Communicate directly with receiving hospitals to triage patients to appropriate available beds (critical care, burn pediatric, behavioral health, etc.)
* Increase bed availability within the healthcare facility based on facility surge planning prior to requesting additional capabilities.
* *Implement additional plans, such as rapid discharge, early discharge with appropriate follow up, transfer of appropriate patients to corresponding hospitals and long term care facilities, and forward movement of patients to transfer in- patients to other hospitals in an effort to make additional beds available nearer the incident.* 
  + Consider transferring patients back to their community healthcare facilities for recovery.
  + Develop discussion points to use when communicating with patients – it is essential that the patients and their families are comfortable with the decision for relocation.
* Work with Emergency Medical Services to ensure availability of resources to accommodate the transfer process.
* Ensure that accurate reporting of bed availability is in the MNTrac system.
* Utilize the MNTrac Availability Status report to identify available beds.
* Facilities that are not surging may need to keep patients and use resources such as telehealth and support from the larger systems to maintain and provide care

*Regional Healthcare Coalition:*

* Determine and track regional bed availability by type.
* Coordinate the communication of regional bed availability among hospitals and other applicable healthcare organizations.
* Assist with information gathering and sharing among hospitals and healthcare organizations.
* Utilize the MNTrac system to obtain updated bed availability by issuing a regional bed alert.

#### **Staffing**

During a medical surge event, additional staff will be needed to handle the influx of patients to hospitals and healthcare organizations for an acute period or over an extended period. Staffing refers to all staff including clinical and nonclinical personnel.

*Tasks and Responsibilities*

*Healthcare Facilities and Systems*

* Activate the hospital’s surge staffing plan. This may involve staff recall and changes in shift scheduling (e.g. 8 hours shift become 12-hour shifts). This may also result in the reassignment of staff from non‐patient care, administrative or elective care areas into primary care roles.
* Physicians, physician assistants, nurse practitioners, nurses, pharmacists, respiratory therapists, paramedics, EMTs, communications specialists, support personnel, administrative roles, and others who may fill clinical roles will need to be considered on an ongoing basis in order to ensure adequate staffing.
* Request additional medical professional staffing.

*Regional Healthcare Coalition:*

* Assist with communicating and dissemination of the status of staffing needs and requests of hospitals and other healthcare organizations to appropriate supporting agencies such as other healthcare providers or public health agencies.

If additional assistance is needed with staffing, beyond what local healthcare and regional coordination can provide, staffing assistance may be available through coordination with the Statewide Coordination Center.

#### **Communications**

Communication challenges often coincide with coordination activities, within and among organizations. In efficient emergency operations, most communications have occurred before the incident. Goals and tasks are often determined by tradition and are formalized in statutes, contracts, charters, mutual aid agreements, and standard operating procedures. These are especially important if critical infrastructure has been compromised because a medical surge has occurred.

*Tasks and Responsibilities*

*Healthcare Facilities and Systems*

* Notify regional coalition of potential medical surge situation.
* Maintain and monitor situational information.
* Maintain ongoing communications with local/county EM.
* Maintain ongoing communications with the local public health.

*Regional Healthcare Coalition:*

* Support health facilities and systems to maintain and monitor real‐time information through designated communications systems.
* Maintain ongoing communication with healthcare facilities and systems.
* Provide any updates to relevant health and medical information to the health and medical community (single hospital or healthcare facility/systems, EMS, etc.).

If the response includes more than one coalition or region, working with the MDH and the SHCC to assist with communications may become necessary.

#### **Continuation of Essential Healthcare Services/Crisis Standards of Care**

As defined by the Minnesota Department of Health – Science Advisory Team, Crisis standards of care (CSC) is when health care systems are so overwhelmed by a pervasive or catastrophic public health event it is impossible for them to provide the normal, or standard, level of care to patients. In situations like this, a formal declaration by state government would occur to recognize health care systems are in crisis operations that may last for some time. MDH supports CSC planning as it is impossible to predict the timing and severity of a future outbreak and waiting for the disaster to strike would be too late. In recognition of this potential, a Science Advisory Team, composed of physicians, public health, ethicists, facility operations, and others subject matter experts were asked to anticipate what resource shortages might occur, and potential changes health care systems may need to implement in response. A current situation where crisis standards of care were enacted was for the 2020 COVID-19 response, where health care worker Personal Protective Equipment (PPE) became scarce.

As resource demands begin to exceed supply, health care systems begin to move from conventional, to contingency measures, and finally to crisis standards as seen in the table on the next page.

### Allocation of resources along the care capacity continuum

As incident demand/resource imbalance increase the risk of morbidity/mortality to patient increases.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Conventional** | **Contingency** | **Crisis** |
| Space | Usual patient care space fully utilized | Patient care areas re-purposed example: post anesthesia monitored units used for ICU care | Facility damaged/unsafe or non-patient care areas (classrooms etc.) used for patient care |
| Staff | Usual staff called in and utilized | Staff extension (brief deferrals on non-emergent service, supervision of broader groups of patients, change in responsibilities, documentation, etc.) | Trained staff unavailable or unable to adequately care for volume of patients even with extension techniques |
| Supplies | Cached and usual supplies used | Conservation, adaptation, and substitution of supplies with occasional re-use of select supplies | Critical supplies lacking, possible reallocation of life-sustaining resources |
| Standards of care | Usual care | Functionally equivalent care | Crisis standards of care |
| **Normal Operating Conditions** |  |  | **Extreme operating conditions** |

The MDH Crisis Standards of Care Plan: <https://www.health.state.mn.us/communities/ep/surge/crisis/index.html>

Patient Care Strategies for Scarce Resource Situations:

<https://www.health.state.mn.us/communities/ep/surge/crisis/standards.pdf>

#### **Alternate Care Sites**

An Alternate Care Site (ACS) is a facility that is temporarily converted for healthcare use during a public health emergency to reduce the burden on hospitals and established medical facilities. Conceptually, these sites are a last stand strategy and will only be utilized after all other load balancing options have been exhausted. These would only be viable once the state has entered Crisis Standards of Care.

There are 2 types of ACS sites:

* Hospital based alternate care site (HACS) – the hospital has identified, equipped, and staffed additional areas within their facility/footprint for patient care.
* Community based alternate care site (CACS) – Located near a hospital but not within the hospital which can include hotels, dorms etc.
  1. Work with Local Emergency Management and the health care coalition to establish the CACS.
  2. May include working with State partners in activating the State identified Alternate Care Sites.

*Tasks and Responsibilities*

*Healthcare Facilities and Systems*

* Identify the need to activate an alternate care site. If unable to open a HACS then:
  + In collaboration with the SHCC/SEOC, county/local EM and local/county public health departments, make the decision to activate alternate care facilities, based on the current surge situation.
  + In collaboration with SHCC and local/county public health departments, determine the scope of care to be delivered within the alternate care facility.
* Assist county EM to determine staffing needs within the alternate care facilities that have been or may be activated.

*Regional Healthcare Coalition:*

* Support information sharing and activation tracking for alternate care facilities between, hospitals, EMS, local/county public health departments and local/county EM.
* Fulfill the regional operational roles identified by the current Minnesota ACS ConOps

*Emergency Medical Services:*

* Maintain communications with Healthcare facilities and the Regional EMS coordinator regarding any modifications in triage and transfer protocols.
* Coordinate with local dispatch any changes in patient transport destinations in accordance with regional and state guidance.

#### **Transportation**

Additional transportation capabilities will be required to support multiple aspects of medical surge. Transportation of the patients to, from, and between treatment facilities will be required. This may include utilizing alternate means of transportation with companies in which MOUs or MOAs have been established. Vehicles for use by the Patient Transportation System may be drawn from EMS task force, local transportation authorities, military transportation units, taxi companies, bus companies, and other sources. These transportation resources may include:

* Those equipped to carry a single recumbent patient (such as an ambulance)
* Those that can carry 30 non‐recumbent patients (such as a bus)
* Non‐recumbent wheelchair‐accessible vehicles (such as wheelchair‐accessible vans)

The best vehicles for patient transportation should be those vehicles that have the characteristics and capabilities most closely associated with the patient’s needs (e.g., Advanced Life Support (ALS)/Basic Life Support (BLS) ambulances).

**Tasks and Responsibilities**

*Healthcare Facilities and Systems*

* Identify the primary EMS agency that responds too and transfers from your facility
  + Assess the amount of resources available within the primary EMS agency
* Identify a secondary/alternate EMS agency that would be contacted if/when the primary agency is unable to fulfill the transfer/patient movement request
* Reach out to the Healthcare Coalition for information sharing and coordination assistance

*Regional Healthcare Coalition:*

* Working with the Regional EMS representative:
  + Coordinate the communication of available transportation resources among county EM, hospitals, and other applicable healthcare organizations.
  + Assist with transportation and transportation route availability among hospitals and healthcare organizations, county EM and SHCC.

*Emergency Medical Services:*

* Support the movement of patients between hospitals, other healthcare facilities and alternate care sites, as needed.
* Request additional capabilities through internal protocols, as needed.
* EMSRB/EMS MACC activation would only occur in the following situations
  + All local resources were exhausted
  + High-volume patient movement required a higher level of coordination.
* Mutual aid agreements are in place with some services.

### **CMHPC Patient Movement activities**

The CMHPC works with surrounding regions to discuss and identify alternative transfer patterns necessary to ensure that the appropriate patient care is available. Collaboration between both Central and West Central regions and St. Cloud Hospital allows for the back-and-forth movement of patients from around the regions to St. Cloud Hospital and reverse. Level loading occurs with the partners by transferring patients that require lower level of care to the critical access hospitals allowing for increased capacity at the higher acuity facilities. The regional process includes:

* An assessment or awareness of the capabilities of the hospitals/healthcare facilities in the region/state:
  + Identifying which facilities can care for higher acuity (level of care) patients
  + Identifying the resources available at facilities to ensure that the patients can receive the appropriate level of care. (See the attached MN Lower Acuity Hospital ICU Capacity/Capability Guide and the MN High Acuity Hospital Specialty Guide)
* Continuous awareness of the healthcare facilities current patient census and the type of care needed for the patients within the facility
  + Identifying if there are patients that can be moved out of ICU to medical surgical unit within the facility or if they can be transferred to another hospital to receive the appropriate level of care.
  + Identifying if a patient can be discharged to a skilled nursing facility, assisted living, or home with services.
* As with routine patient transfers – the decisions must be mutual amongst the facilities involved with the end-goal being that the patients are placed in facilities that can provide the appropriate level of care and still fall within the Centers for Medicaid and Medicare (CMS) standards of care.

#### **Patient Exchange**

* In a surge setting, if a facility needs to transfer a patient to a facility that can provide a higher level of care, they may need to take a lower acuity patient (requiring less services) in exchange. Example: Level 3 trauma center transfers a patient to a Level 1 trauma center and the Level 1 trauma center transfers a medical surgical patient to the Level 3 for continued care.
  + This includes involvement of EMS doing reverse (two-way) transfers (drop off and pick up). It is important that the EMS agencies are involved in the decision-making process to ensure that the resources are available for this type of activity.
* The patient exchange will allow for the receiving hospital to decompress to accept a new higher acuity patient.

#### **Hospital Decompression Planning**

1. A group of hospitals or systems working together to identify variances to typical transfer patterns that will allow for a healthcare facility to remain free of the infectious disease (i.e. Covid-19).
   1. One or more hospitals agree to treat these highly infectious and high acuity patients; however, the other hospitals need to agree to take on more lower acuity patients.
   2. Patients that present to the low acuity hospital with infectious symptoms are immediately transferred to the higher acuity facility.
   3. Patients at the high acuity facilities that require less care are pre-emptively transferred for continued care to the lower acuity facilities – to allow for increased capacity at the higher acuity care centers.
      1. Options for continued care can include increased telemetry/consultation between the transferring facilities.

The CentraCare System has identified a process/decision tree to help facilitate some of the patient movement processes.

#### **The Central MN Hospital and Skilled Nursing Facility Surge Framework**



## Resources for Medical Surge

1. As a result of COVID-19 the SHCC developed the Critical Care Coordination Center (C4). This was funded and operated during the COVID-19 response. This resource may not be available outside of the COVID-19 operational period however it may be able to be reactivated for future longer-term events.

Statewide Healthcare Coordination Center Critical Care Coordination Center(C4):  
**Call Center (651-201-5615)**

**Functions of C4:**

* Monitor ICU bed availability and acuity
* Facilitate medical ICU transfer placement
* Provide support for level-loading of multiple critical care patients
* Provide critical care advice / support when required awaiting resources
* Handoff to EMSRB on-call for assistance with transportation if usual resources exhausted

**Functions C4 does *not* manage (contact RHPC):**

* Specialty transfers (trauma, pediatric, burn, etc.)
* Non-emergent transfers of patients
  + - Hospital to long term care transfers
    - Level-loading of medical/surgical patients
    - Regional coordination of healthcare resources (ventilators, staff, other resources)

1. Mobile Medical Team (MN-MMT)

A Minnesota Mobile Medical Team (MN-MMT) is a group of volunteer medical and support professionals who have received training and practice in providing acute medical care in a mobile field environment. When a community experiences a tornado, flood, or other incident that temporarily overwhelms its ability to provide health care services, the MMT can deploy either with the equipment needed to establish a range of clinical services (Type I) or without equipment to support staffing needs in existing care facilities (Type II). There are currently two MMTs organized under one model that could respond to incidents in Minnesota.

If a CMHPC member wants to request the MN-MMT, they should call their local emergency management (EM). Local EM will refer that request to the Minnesota Department of Homeland Security and Emergency Management (HSEM) or State Duty Officer who will pass the request to the Minnesota Department of Health (MDH). MDH will pass the request to the MN-MMT Leadership to finalize the request and plan for activation.

A full description of the Minnesota Mobile Medical Teams is provided on the Central/West Central website

1. Regional Caches and Supplies

The Region does have a cache of supplies and equipment that coalition members can request.

See Appendix 3.5.5 Resource Allocation Plan and Appendix 3.5.5.2 Regional Cache for details.

1. Crisis Standards of Care

Certain situations, such as medical surge, cause shortages of supplies at the local level as well as regional and state levels. This shortage may even extend nationally/globally. Minnesota Department of Health has created the Crisis Standards of Care plan that addresses how major shortages would be handled.

Refer also to Appendix 3.5.1.4 Crisis Standards of Care

## 