



EMS Scope of Practice, Protocols, Reciprocity, and Medical Control and Direction for AMR/FEMA Federal EMS Deployments

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American Medical Response (AMR) is under contract with the Federal government to provide EMS in response to Federally-declared disasters and other Federal events as approved by FEMA. Each state defines and regulates the scope of practice for EMS personnel within its borders. It is anticipated that EMS responders from various states may be deployed to disasters pursuant to the AMR/FEMA Federal EMS Contract. The purpose of this guide is to establish clinical guidelines, a minimum scope of practice, and reciprocity procedures for all authorized EMS disaster providers, regardless of their state of origin. This guide is limited to those EMS responders who are officially deployed by AMR to respond to Federal disasters pursuant to the AMR/FEMA Contract. For EMS deployments pursuant to the AMR/FEMA Contract, the *National EMS Core Content*¹ will be used to the domain of out-of-hospital care. It specifies what knowledge and skills are necessary and will also determine how these tasks will be performed. The scope of practice for the AMR/FEMA Contract shall be the *National EMS Scope of Practice Model*² which specifies who (which level of practice) will perform specific skills and how much knowledge providers will have at each level. The *National Model EMS Clinical Guidelines*³ were approved by the National Association of State EMS Officials (NASEMSO) to provide a resource to prehospital clinical practice, maximize patient care, safety and outcomes. They are a set of clinical guidelines that can be used “as is” or adapted for use on a state or regional level to ensure a more standardized approach to the practice of patient care. In the absence of local, state, and regional EMS protocols the *DHS-Wide EMS Basic Life Support (BLS) & Advanced Life Support (ALS) Protocols*⁴ produced by the Department of Homeland Security’s (DHS) Office of Health Affairs (OHA) may be used. Under remote, austere, or hostile conditions, local, state, and regional prehospital protocols and medical direction may be inaccessible or impractical, in these situations the DHS OHA *Austere Emergency Medical Support (AEMS) Field Guide*⁵ may be used if authorized by the AMR Office of Emergency Management (OEM) medical director.

Role of the National EMS Scope of Practice Model

The *National EMS Scope of Practice Model* shall be used to identify the psychomotor skills and knowledge necessary for the minimum competence of each nationally identified level of EMS provider who responds to an event pursuant to the AMR/FEMA Federal EMS Contract. It divides the core content into levels of practice, defining the minimum corresponding skills and knowledge for each level.

The Role of State Government

State EMS offices have statutory authority, scope, and jurisdiction to regulate and coordinate the provision of EMS within its borders for conventional emergency care or when the need arises to provide contingency or crisis care. The state EMS office may be responsible for requesting and coordinating federal medical assets. The State determines the scope of practice of State-licensed EMS personnel within its jurisdiction.

The *National EMS Scope of Practice Model* is a consensus-based document that was developed to improve the consistency of EMS personnel licensure levels and nomenclature among States; it does not have any regulatory authority. It represents a transition from the historical connection between scope of practice and the EMS National Standard Curricula. It is a document, guided by data and expert opinion that reflects the skills representing the *minimum* competencies of the levels of EMS personnel. The *Scope of Practice Model* will serve EMS in the future, as it is revised and updated to include changes in medical science, new technology, and research findings.

While each State has the right to establish its own levels of EMS providers and their scopes of practice, staying as close to this *Model* as possible, *and especially not going below it for any level*, will facilitate reciprocity, standardize professional recognition, and decrease the necessity of each State developing its own education and certification materials.

Some states permit licensed EMS personnel to perform skills and roles beyond the minimum skill set as they gain knowledge, additional education, experience, and (possibly) additional certification. The adoption of skills and roles beyond those in the Model will diminish national consistency and may impede interstate mobility and legal recognition for EMS personnel. If the EMS regulatory authorities in disaster-affected states wish to have AMR/FEMA EMS Contract providers perform skills beyond their legal scope in their state of origin, the disaster state must provide the additional education and certification.

Levels of EMS Certification

Emergency Medical personnel have designations or titles based upon the amount of education and scope of care they provide to patients. The *National EMS Scope of Practice Model* and the National Registry of EMTs defines and describes four certification or licensure levels of EMS provider⁶. It establishes a framework that ultimately determines the range of skills and roles that an individual possessing a state EMS license is authorized to do in a given EMS system. The primary purpose of National EMS Certification is to protect the public by assuring EMS providers can safely and effectively practice at the entry level competencies. National EMS Certification is delivered by the National Registry of EMTs (NREMT) in all 50 states. Most states, the District of Columbia, the US Army, US Air Force, and the Department of Homeland Security require successful completion of the National EMS Certification process to obtain a license to deliver care as part of their initial licensure process. National EMS Certification also facilitates interstate movement of EMS personnel as 49 states recognize the NREMT certifications for reciprocity. No EMS provider can work with National EMS Certification alone; all must possess a state license or authorizing agency designation to work. Individual state EMS rules or regulations may further define EMS provider scope of practice. Below are the designations and a description for each.

- **Emergency Medical Responder (EMR)**
The primary focus of the Emergency Medical Responder is to initiate immediate lifesaving care to critical patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and to assist higher level personnel at the scene and during transport. Emergency Medical Responders function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Responders perform basic interventions with minimal equipment.
- **Emergency Medical Technician (EMT)**
The primary focus of the Emergency Medical Technician is to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This

individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Emergency Medical Technicians perform interventions with the basic equipment typically found on an ambulance. The Emergency Medical Technician is a link from the scene to the emergency health care system.

- **Advanced Emergency Medical Technician (AEMT)**

The primary focus of the Advanced Emergency Medical Technician is to provide basic and limited advanced emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Advanced Emergency Medical Technicians function as part of a comprehensive EMS response, under medical oversight. Advanced Emergency Medical Technicians perform interventions with the basic and advanced equipment typically found on an ambulance. The Advanced Emergency Medical Technician is a link from the scene to the emergency health care system.

- **Paramedic**

The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance. The Paramedic is a link from the scene into the health care system.

Reciprocity

All EMS providers responding pursuant to the AMR/FEMA Federal EMS Contract are licensed or certified in their state of origin. The *National EMS Core Content* and the *National EMS Scope of Practice Model* are used to establish minimum competency for state licensure and practice. All states should therefore grant reciprocity to EMS providers responding pursuant to the AMR/FEMA Federal EMS Contract. The following language may be used by State Medical Directors or other licensing or regulatory authority in the affected state(s):

AMR/FEMA EMS Reciprocity Authorization

All EMS providers responding to (*name of jurisdiction*) under the AMR/FEMA Federal EMS Contract, who are currently state-licensed or certified in their home state, shall be granted reciprocity to practice at their respective level of certification or licensure while officially deployed.

(Signature & Title of granting authority)

Date

Scope of Practice During Disasters, Public Health Emergencies, and Extraordinary Circumstances

It is virtually impossible to create a scope of practice that takes into account every unique situation, extraordinary circumstance, and possible practice situation during disasters. This is further complicated by the fact that EMS personnel are an essential component of disaster preparedness and response. In many cases, EMS personnel are the only medically trained individuals at the scene of a disaster when

other health care resources may be overwhelmed. This document cannot account for every situation, but rather is designed to establish a system that works for entry-level personnel under normal circumstances. It is assumed that the scope of practice of EMS personnel may be modified or changed in times of disaster or crisis with proper education, medical oversight, and quality assurance to reasonably protect patient safety.²

Crisis Standards of Care for Use in Disaster Situations

For disaster scenarios in which the health system may be stressed to its limits, it is important to describe the conditions under which standards of care would change due to shortage of critical resources. “Crisis Standards of Care” is defined as a substantial change in usual health care operations and the level of care it is possible to deliver, which is made necessary by a pervasive (e.g., pandemic influenza) or catastrophic (e.g., earthquake, hurricane) disaster. This change in the level of care delivered is justified by specific circumstances and is formally declared by a state government, in recognition that crisis operations will be in effect for a sustained period. In disaster situations, tribal or state governments should authorize appropriate agencies to institute crisis standards of care in affected areas, adjust scopes of practice for licensed or certified healthcare practitioners, and alter licensure and credentialing practices as needed in declared emergencies to create incentives to provide care needed for the health of individuals and the public. The formal declaration that crisis standards of care are in operation enables specific legal/regulatory powers and protections for healthcare providers in the necessary tasks of allocating and using scarce medical resources and implementing alternate care facility operations.⁷

The goal of the health and medical response to a mass casualty event is to save as many lives as possible. To achieve this goal, health and medical care will have to be delivered in a manner that differs from the standards of care that apply under normal circumstances. The U.S. Department of Health and Human Services, Agency for Health Care Research and Quality has prepared a document, *Altered Standards of Care in Mass Casualty Events*⁸, which addresses some of these issues. Some of the key elements of an EMS mass casualty response are summarized below.

- The goal of an organized and coordinated response to a mass casualty event should be to maximize the number of lives saved.
- Changes in the usual standards of health and medical care in the affected locality or region will be required to achieve the goal of saving the most lives in a mass casualty event. Rather than doing everything possible to save every life, it will be necessary to allocate scarce resources in a different manner to save as many lives as possible.
- The basis for allocating health and medical resources in a mass casualty event must be fair and clinically sound. The process for making these decisions should be transparent and judged by the public to be fair.
- Protocols for triage need to be flexible enough to change as the size of a mass casualty event grows and will depend on both the nature of the event and the speed with which it occurs.
- Only the authorized healthcare regulatory authority for the disaster has the authority to activate or sanction the use of altered standards of care under certain conditions.
- Legal issues related to liability, licensing, and intergovernmental or regional mutual aid agreements must be addressed.

In 2012 the National Academy of Sciences, Institute of Medicine (IOM), published the document, *Crisis Standards of Care – A Systems Framework for Catastrophic Disaster Response*⁹ which states that public health disasters justify temporarily adjusting practice standards and/or shifting the balance of ethical concerns to emphasize the needs of the community rather than the needs of individuals. Therefore,

professional care delivered in a catastrophic disaster may need to be modified to address the demands of the situation, including by focusing more intently on the needs of the entire affected community.

State EMS offices and prehospital care agencies should be actively engaged in the development and implementation of crisis standards of care (CSC) plans. Adjustments to scopes of practice, treatment modalities, and ambulance staffing and call response will all figure significantly into state, local, and EMS agency-specific disaster response plans. Other areas that can be leveraged to maximize scarce EMS resources include the authority to activate restricted treatment and transport protocols, which may entail modifying the emergency medical dispatch criteria implemented at public safety answering points (PSAPs).

The emergency health care system will be stressed to its limits during a mass casualty incident. Dispatch and regional call centers, local EMS agencies, and hospital will undertake contingency measures utilizing their emergency operations plans and medically approved protocols to implement surge medical capabilities. These measures may include

- EMS agencies requesting assistance from neighboring jurisdictions for personnel and equipment through mutual-aid agreements;
- PSAPs and call centers altering their dispatch protocols, sending fewer resources, and allowing EMS providers to respond to fewer requests for assistance;
- Transport destinations being adjusted to allow transport to clinics or other alternate sites of care in addition to hospitals;
- EMS personnel utilizing disaster triage system (sort, assess, life-saving interventions, treatment/transport; simple triage and rapid treatment [START]; and JumpSTART triage methods so they can assess patients within 60 seconds and categorize them for immediate or delayed care; and
- EMS personnel utilizing the National Incident Management System (NIMS) incident command system (ICS), which provides a consistent model for all organizations involved in the disaster response.

Fundamental changes in prehospital care may result during a disaster, including a change in the scope of practice of EMS personnel to allow them to administer vaccines or perform other tasks for which they receive just-in-time training. EMS personnel may be asked to function in extraordinary settings, such as shelters, alternate care sites, patient receiving centers, clinics, and tented free-standing medical units. They may be asked to alter the staffing levels for an ambulance, utilizing a driver and one medical attendant; use other modes of transportation, such as vans and buses; or not transport at all by treating and releasing patients. Extraordinary circumstances may require EMS personnel to assist in the evacuation of patients at a health care facility to alternate care sites. This, in turn, may require them to provide care to patients for longer than usual for EMS providers, who normally provide care for patients at the scene and during transport and transfer.

EMS in Austere Conditions

“Austere EMS” is defined as the delivery of EMS care under conditions of limited personnel and equipment resources and outside the existing framework of normal EMS. Special medical support protocols and procedures may be needed under austere conditions. EMS providers operating under remote, austere, or hostile conditions are expected to provide prehospital care in these environments with little or no support when operational security is a consideration. In some situations, communications are not assured and evacuation may be delayed significantly. Care providers in an austere situation may be forced to improvise and adapt their medical procedures based on existing circumstances to provide care

for and prepare the patient for evacuation to a safer environment. The document *Austere Emergency Medical Support (AEMS) Field Guide*, published by the U.S. Dept. of Homeland Security, Office of Health Affairs, is intended improve the EMS providers' capability to provide the best possible prehospital care until the patient can be transferred for definitive medical treatment. The Guide is a series of suggested best practices. Medical providers are strongly encouraged to follow these suggestions, and should consider doing so in whole or in part to the extent that his/her training or experience is sufficient.

Specializations

In some cases, specialty certifications may be used to respond to local needs for flexibility or to recognize continuing education. Specialty certifications may evolve to accommodate subtle differences in skills, practice environment, knowledge, qualifications, services provided, needs, risk, level of supervisory responsibility, amount of autonomy and/or judgment/critical thinking/decision making.²

Scope of Practice for Special Populations

EMS professionals are expected to meet the urgent health care needs of all patients, regardless of age or co-morbidity, consistent with their defined scope of practice. Recognized special populations include, but may not be limited to, children, older patients, patients with disabilities, and patients with limited access to health care due to geographic, demographic, socioeconomic, or other reasons.²

Scope of Practice for EMS Personnel Functioning in Nontraditional Roles

During disasters, EMS professionals may be required to function in health care settings other than out-of-hospital care. Common settings include, but are not limited to, emergency departments, hospital units (including critical care), shelters, urgent care settings, free-standing medical units, etc. State regulations must be clear as to the extent to which the State's EMS scope of practice applies to EMS personnel functioning in these nontraditional roles and settings.

Providing EMS Mass Medical Care with Scarce Resources

In the event of a catastrophic disaster, the resulting mass casualties will likely overwhelm the local EMS resources and community health care systems. Indeed, if the event incapacitates health care workers, damages facilities, or destroys supplies, the capacity of the health care system to respond may be severely compromised. In the case of a mass casualty incident, in which emergency health care personnel, medical and transport equipment, and hospital beds are scarce, EMS personnel will be forced to modify their care from conventional to crisis care. This means moving from usual standards of care, in which the goal is to save everyone, to crisis standards of care, in which as many lives as possible are saved with the resources that are available. Resource shortages may include limited staff, supplies, and equipment; a lack of fuel or medicines; limited mutual aid; or disruption of coordination and communication functions. Strategic approaches to utilizing these scarce resources should be implemented, and should include maximizing the use of available personnel, community response teams and health care personnel registries, disaster triage criteria, and altered transport modes and patient destinations. If other communities are faced with similar demands (as would be the case of an influenza pandemic or a nuclear detonation, for example), the arrival of additional health care resources, including assistance from the Federal Government, likely would be significantly delayed¹⁰. EMS providers from across the U.S. may be called upon pursuant to the AMR/FEMA Federal EMS Contract to provide first-responder rescue, assessment, care, and transportation and access to the emergency medical health care delivery system. In these mass casualty incidents (MCI), it may be necessary to allocate scarce resources in a manner that is different from usual circumstances but appropriate to the situation. Emergency medical services in the United States are

provided through a complex system composed of highly variable organizational structures. The variability of EMS response systems is further exacerbated by important differences in EMS preparedness training, guidelines, and response capacity – posing significant coordination and communications challenges for EMS leaders and planners. The U.S. Dept. of Health and Human Resources, Agency for Healthcare Research and Quality, has published a guide, *Mass Medical Care with Scarce Resources*¹¹ to address these situations and present planners with approaches and strategies that would enable them to provide the most appropriate standards of care possible under the circumstances of an MCI. It will serve as a guide for EMS disaster responders pursuant to the AMR/FEMA Contract.

EMS in an MCI: Expected Shortages and Needs

In the case of an MCI, many health care resources at the local and regional levels will be overwhelmed or eliminated. Those EMS response agencies that are able to remain operational likely will encounter a demand for services that will outstrip the supply and available resources. EMS systems will confront:

- Personnel shortages.
- Breakdowns in supply chains.
- Lack of coordination and information sharing among diverse EMS providers, public safety, hospitals, trauma center, and public health.
- Breakdown of logistic support for operational sustainability, including such things as fuel shortages; inadequate availability of transport vehicles; and shortages in supplies, equipment, and pharmaceuticals.
- Overloading of hospital emergency departments and associated services such as intensive care capabilities; specialty services such as burn care or decontamination units; and specialized equipment such as ventilators, PPE, or negative pressure rooms.
- Breakdowns in local “burden sharing” strategies (mutual aid agreements) due to overwhelming demand and lack of surge capacity.
- The need to implement modified treatment protocols to meet the extraordinary conditions of the MCI that may be limited to reasonable life-sustaining activities where appropriate.

Approaches to the Allocation of Scarce Resources

In the face of a catastrophic MCI, there likely will be scarcities and mismatches regarding EMS personnel, transport capacity, and destination availabilities for patient treatment. As a result, creative strategies will need to be implemented for coordinating and maximizing the use of available staff members and resources. Approaches to the allocation of scarce resources to be considered should include, but not be limited to, the following:

- **Maximize the availability of EMS personnel** through modified or extended shifts, deployment of no more than two providers per vehicle, and use of one-person response vehicles for “patient evaluation” prior to dispatch of transport resources.
- **Maximize the use of available EMS personnel.** Some medical protocols may be suspended (e.g., base contact for certain interventions) to allow for greater efficiency and flexibility in patient management. EMS personnel may be used in nontraditional settings (e.g., alternative care sites, hospitals, pharmaceutical distribution centers) for field triage, treatment, or transport. Their scope of practice may be extended to provide vaccinations or medications or to deliver nontraditional medical care at the scene or in the home.
- **Community Emergency Response Teams (CERTS)**¹². The CERTs program educates people on disaster preparedness for hazards that may impact their area and trains them in basic disaster

response skills, such as fire safety, light search and rescue, team organization, and disaster medical operations. Using the training learned in the classroom and during exercises, CERT members can assist others in their neighborhood or workplace following an event when professional responders are not immediately available to help. CERT members also are encouraged to support emergency response agencies by taking a more active role in emergency preparedness projects in their community.

- **Maximize personnel protection for personnel.** Universal precautions should be used for every patient encounter, if at all possible. To minimize the number of responders exposed to pathogens or chemicals, specialized protections should be used to the extent possible and adjusted to the nature of the incident (e.g., distribution of antibiotics, vaccines, or antidotes to staff and family members). In the case of chemical incidents, decontamination needs must be evaluated and addressed prior to transportation to preserve transport capability. Similarly, security personnel should be assigned to protect EMS response operations, logistics centers, and stockpile depots.
- **Maximize patient triage and evaluation.** Specific mass casualty triage systems should be used whenever many patients require prehospital medical treatment and/or transport. This allows for an organized approach to treatment that includes a system for prioritizing the patients who require immediate medical care for survival. Triage is a continuous process; it is necessary to reevaluate patient priorities as their clinical status improves or deteriorates and more resources become available.

The Federal Interagency Committee of Emergency Medical Services (FICEMS) was created, in part to ensure coordination among the Federal agencies involved with state, local, tribal or regional EMS and 9-1-1 systems. FICEMS has statutory authority to identify the ways in which Federal agencies can streamline their processes for support of EMS. With input from the National EMS Advisory Council (NEMSAC), they recommend national implementation of the Model Uniform Core Criteria (MUCC) for mass casualty triage¹³. SALT Triage is compliant with the MUCC criteria and is recommended as the national standard for all mass casualty triage systems. **S.A.L.T.** is the acronym for **S**ort, **A**ssess, **L**ife-saving interventions, treatment and/or **T**ransport and is a method that EMS responders use to effectively and efficiently evaluate victims during a MCI.

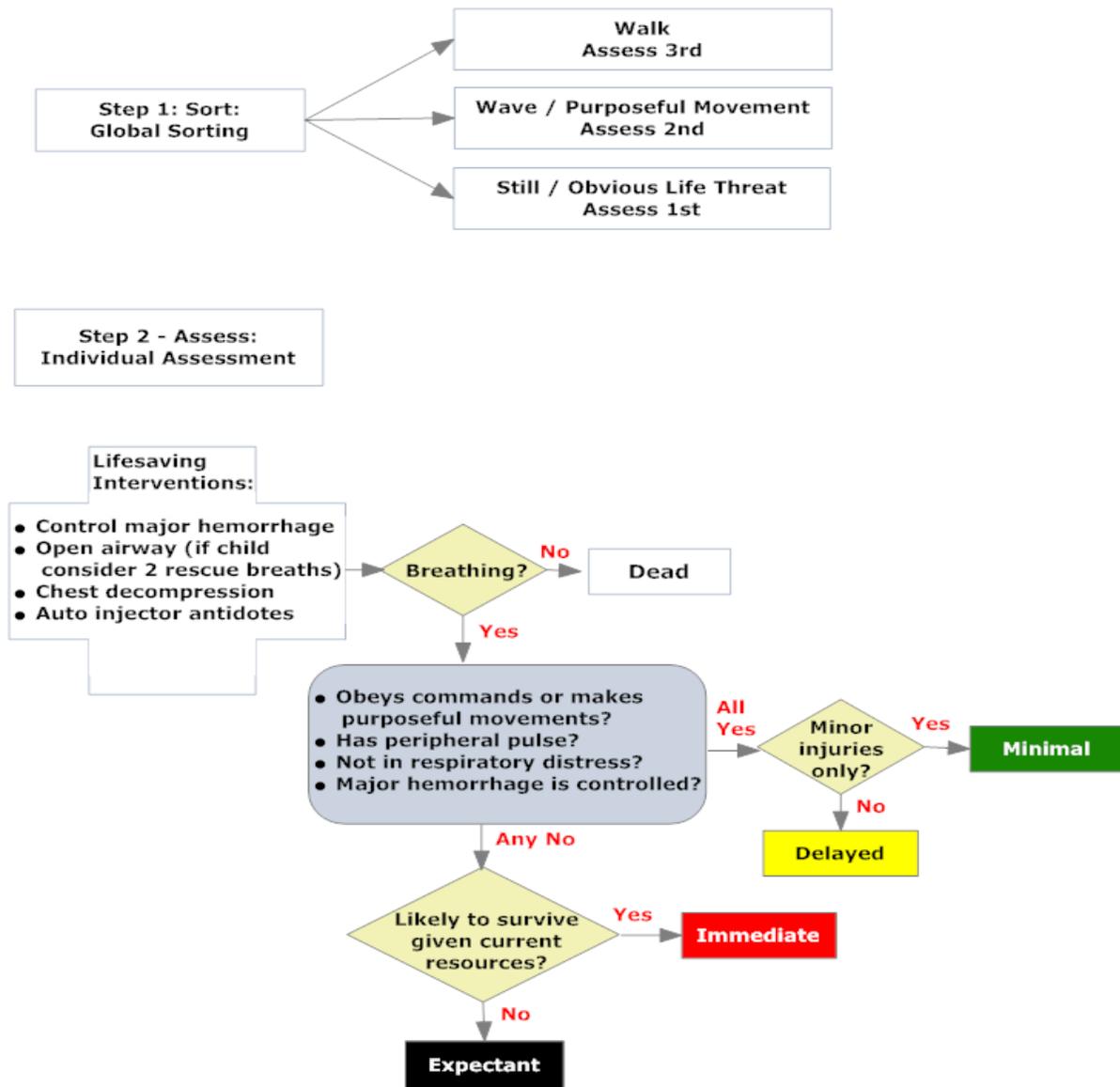
The SALT Triage system assigns patients into one of five categories based on the urgency of their medical condition and potential for survival.

1. Minimal
2. Delayed
3. Immediate
4. Expectant
5. Dead

Triage Levels and Color Coding

	Green: MINIMAL . Patients with minor injuries who will eventually require care
	Yellow: DELAYED . Patients whose lives are not in immediate danger and who will require urgent, not immediate, medical care
	Red: IMMEDIATE . Patients whose lives are in immediate danger and who require immediate care
	Black: EXPECTANT . Patients who are either dead or who have such extensive injuries that they cannot be saved with the limited resources available.

S.A.L.T. Mass Casualty Incident Triage System (Sort-Assess-Lifesaving Interventions/Treatment-Transport)



- **Maximize transport capability.** Public and private ambulance services should be coordinated and steps taken to ensure that they do not self-dispatch to MCIs. Paramedic-initiated alternative transport mechanisms also should be put into place (e.g., buses, taxis, privately owned vehicles). Mutual aid agreements should be in place and implemented to deploy and use available transportation assets, staff members, and staging locations. Transport assets should be loaded to their full capacity and patients taken to the closest appropriate hospital or care site. Air transport should be used to take patients to distant facilities (unless the incident presents contamination risks). Noncritical calls should be batched by geographic area. Bypass, diversion, or closure rules could be suspended to promote equitable distribution of patients and to try to avoid the overloading of any one hospital. Secondary transport needs should be anticipated so that patients can be transferred from overloaded hospitals or care sites to those that are less affected. Ambulances and paratransit vehicles should avoid transporting patients to far destinations greater than 200 miles or 6 hours, because it is anticipated they will be needed for multiple round trips. In addition, transporting patients in ground vehicles longer than 6 hours may adversely affect the patient's clinical status.
- **Maximize destination choices.** A centralized coordination of patient transport should be in place to minimize hospital overloading and maximize the use of other available resources, such as primary care providers, alternative care sites, medical evaluation centers, or triage centers.

Indeed, it is likely that the vast majority of victims of a mass casualty event may end up being most appropriately managed in the home setting, either because their illness or injury is not severe enough to warrant institutionalized care or because the successful outcome of such inpatient treatment in the setting of scarce and limited resources would be considered futile and potentially wasteful.

Many view the community hospital as a “safe haven,” a place to go for food, shelter, protection, and medical attention. However, particularly in the event of a transmissible infectious disease in which hospitalized patients represent the sickest patients in the community, the concept of “safe haven” may not be applicable. In fact, it may be more dangerous to be in the hospital setting than to remain at home. It is important for community planners to highlight the concept of the home as a “safe haven” in their risk communication strategies and develop measures to support this concept. Emergency planners, therefore, must incorporate the likelihood of home care delivery in all aspects of their planning efforts. This planning must focus on the possibility that some rudimentary degree of medical care will need to be delivered in the home setting, often with limited outside professional assistance.

Mass Evacuation Transportation

The National Response Framework (NRF) assumes that up to 100,000 patients and evacuees may require transport, regulating, and tracking during a catastrophic incident. It is important to estimate the transportation resources needed to evacuate patients and evacuees from healthcare facilities and other locations. The Agency for Healthcare Research and Quality has created a *Mass Evacuation Transportation Model*¹⁴ that estimates the time required to evacuate patients from healthcare facilities and transport them to receiving facilities. The model considers the transportation requirements of different types of patients (for example ambulatory patients or patients requiring constant medical attention during the evacuation); the availability of ambulances, wheelchair vans, and buses; the location of evacuating and receiving facilities; and the surge capacity of receiving facilities.

Unsolicited Medical Personnel Volunteering at Disaster Scenes

AMR prohibits self-deployment in response to the AMR/FEMA Federal EMS Contract. Only those personnel who are officially authorized and credentialed by AMR may respond pursuant to a FEMA deployment. Furthermore, AMR concurs with the position statement of ACEP and NAEMSP regarding unsolicited medical personnel.

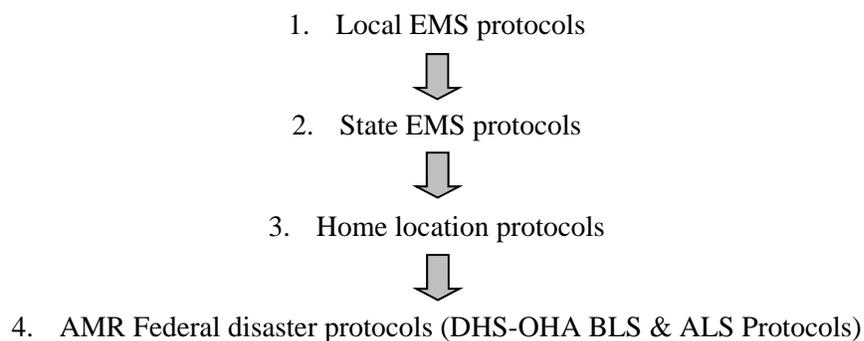
“The American College of Emergency Physicians (ACEP) and the National Association of EMS Physicians (NAEMSP) believe an organized approach is needed for the utilization of unsolicited medical personnel who volunteer to respond to disaster scenes or mass casualty incidents. To ensure the efficient, effective, and safe mobilization of such volunteer medical resources, medical command must come under the authority of the medical director for the emergency medical services (EMS) system and the jurisdiction's established incident command system (ICS). This practice will ensure the integration of all medical functions in the area and accountability under the jurisdiction's established (ICS) without hampering authorized and established functioning rescue efforts.

Volunteer medical personnel (e.g., physicians, nurses, emergency medical technicians, etc.) should not respond to a disaster scene unless officially requested by the jurisdiction's established ICS. All personnel must understand the authority and resources of local EMS and health care systems, the importance of staffing their facilities as their primary responsibility, and the dangerous conditions associated with on-site operations.”¹⁵

Disaster Clinical Protocols

EMS responders who are deployed pursuant to the AMR/FEMA Federal EMS Contract shall follow the local clinical protocols in effect for the disaster area. If local EMS protocols are otherwise unavailable, disaster responders should follow state EMS protocols for the disaster-affected state, if they exist. If state protocols are unavailable, disaster responders should follow the protocols from their home location, i.e., the protocols they use back home in daily practice in non-disaster times. As a last resort, if the above options are unavailable, AMR will provide protocols to be used by its disaster responders. The guideline for these protocols shall be the *DHS-Wide BLS & ALS Protocols*. For a practicing provider to be proficient with these protocols, he/she must be certified and licensed at the appropriate level, and demonstrate and document all the skills and knowledge the protocols require. A provider's scope of practice may expand (e.g., administration of intravenous therapy by BLS providers) only with additional training and confirmation of competency by a medical director. In any case, at no time should any EMS provider perform procedures that are beyond their scope of formal training and certification, regardless of the protocols in place. The following flowchart summarizes this hierarchy.

DISASTER CLINICAL PROTOCOLS HIERARCHY

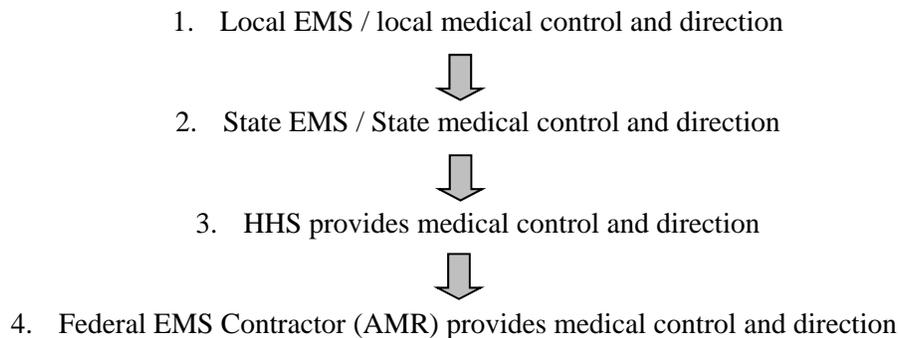


Medical Control and Direction During Disasters

Because the medical control of emergency medical services is within the domain of emergency medicine, it remains the responsibility of emergency physicians to provide both direct patient care and medical control of out-of-hospital emergency medical services during disasters.¹⁶

EMS responders who are deployed pursuant to the AMR/FEMA Federal EMS Contract shall follow medical control and direction of the local EMS jurisdiction if available. If local medical control is unavailable, EMS disaster responders shall follow medical control and direction from the authorized medical director of the disaster-affected state. If that is unavailable, the national ESF8 primary agency, U.S. Dept. of Health and Human Services or their delegate(s) shall provide medical control and direction. If that is unavailable, and as a last resort, the official AMR medical liaison assigned to the disaster shall provide medical control and direction. The following flowchart summarizes this hierarchy.

Medical Control and Direction During Disasters



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- ² National EMS Scope of Practice Model. National Highway Traffic Safety Administration. DOT HS 810 657. February 2007.
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- ³ National Model EMS Clinical Guidelines. National Association of State EMS Officials (NASEMSO). Volume 11-14.
<https://www.nasemso.org/Projects/ModelEMSClinicalGuidelines/documents/National-Model-EMS-Clinical-Guidelines-23Oct2014.pdf>
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<http://www.amr.net/Files/PDFs/DRT-References-and-Resources/DHS-FEMA-ALS-BLS-Protocols.aspx>
- ⁵ Austere Emergency Medical Support (AEMS) Field Guide. U.S. Dept. of Homeland Security, Office of Health Affairs. Created 12/2/2011, modified 4/24/2014.
<http://www.amr.net/Files/PDFs/DRT-References-and-Resources/DHS-Austere-EMS-Field-Guide.aspx>
- ⁶ National Registry of Emergency Medical Technicians®.
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- ⁷ Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report. Institute of Medicine of the National Academies. ISBN: 0-309-14431-0. 2009.
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