METROPOLITAN EMERGENCY SERVICES BOARD
EMERGENCY PREPAREDNESS SUBCOMMITTEE

LOCATION: MESB- 2099 UNIVERSITY AVE W, ST PAUL
September 5, 2023 9:00 a.m.

1. **Call to Order** – Subcommittee Chair, Tyler Lupkes

2. **Roll Call**

3. **Approval of Agenda** – Lupkes

4. **Approval of Minutes of Previous Meeting (Page 2)** – Lupkes

5. **Presentation**

   a. 55th Civil Support Team

6. **Action Items**

7. **Discussion Items**
   A. EMS System Plans for escalating incidents- Lupkes
   B. MESB Progress Reports – Hayes
      a. Grants
      b. Review of Ambulance Strike Team Class
      c. Website updates- www.emsmn.org
   C. Workgroup Updates- Lupkes
      a. Incident Response Plan **(Page 4)**
      b. Ambulance Strike Team **(Page 6)**
   D. MN EMS Triage Guidelines- Approved by STAC & EMSRB **(Page 52)**
   E. EMS Services & MRCC Updates
   F. Special events within the Region- Lupkes/ Hayes

8. **Other Business**

9. **Adjourn**

Reminder: Next meeting scheduled for November 7, 2023, 9:00 a.m.

Future Meeting Dates

November 7, 2023

Metropolitan Emergency Services Board
Emergency Preparedness Subcommittee
Draft Meeting Minutes
May 2, 2023

Committee Members:

Allina –Kyle Strege
Anoka County – **Absent**
Burnsville Fire **- Absent**
CentraCare **- Absent**
Cottage Grove EMS – John Prichard
Edina - Ryan Quinn
EMSRB Rep – Charles Soucheray
HealthPartners – Tyler Ostman
Hennepin County PH – **Absent**
Hennepin EMS -Tyler Lupkes
Lakes Region EMS - **Absent**
Lakeview EMS – John Muller
Minneapolis Fire **- Absent**
M Health Fairview – Mike Pelumbo
MRCC EAST - **Absent**
MRCC WEST **- Absent**
North Memorial Ambulance – Scott Oberlander
Northfield EMS – Joe Johnson
Ridgeview EMS - **Absent**
St. Paul Fire – **Absent**
University of Minnesota - Robert Ball
White Bear Lake - **Absent**
Healthcare Coalition – **Absent**

Others Attending:
Greg Hayes, MESB; Ron Bombeck, MESB

1. **Call to Order- 0906**

2. **Roll call- NO QUORUM**

3. **Approval of Agenda**

4. **Approval of Previous Meeting Minutes**

5. **Action Items – None**

6. **Discussion Items**

   A. West Metro EMS Plans- *Tyler L gave an overview of how the EMS plans work including notification, dispatching and deployment. Group discussed the naming of the "plan" vs "Box Alarm", etc.*

   B. MESB Progress Reports – Hayes
      a. Grants- *Update on the current grants and funding for the next Biennium.*
      b. Training- *Training updates on past training offerings and low attendance.*
      c. MIR Bus- *Greg H gave an update of the MIR Bus move to M Health. Working on Deployment plan.*
      d. Ambulance Strike Teams Leader for the Metro – *At Allina North Base.*

   C. Workgroups- T*yler L gave an update on Ambulance Strike Team and the Incident Response plan workgroups. No meetings held yet due to summer events.*
      i. AST Workgroup- Bob B, Brent Baker, Nick L, Ron B,

ii. *IRP Workgroup- Joe J, Quinn, Scott O, John M.*

D. Trauma Field Triage from STAC- *Greg H. gave an update of the revisions. The new document is under revision at the EMSRB. Give any feedback on changes to Greg or Dylan at the EMSRB.*

E. MN III IMT- Greg Gave an update on the EMS side of the field day and the partnership.

F. EMS Services & MRCC Updates & Special events within the Region- Lupkes/ Hayes

a. Northfield updates given on staffing issues and trucks. 2 MCI's and thanked the agencies an WMRCC

b. Allina Lakefront music fest July 13th & 14th. North Metro has a few special events with the PGA and Fireworks show.

c. EMSRB- New laws going into effect. Requirement to submit mutual aid agreements to be on file with the EMSRB. Also, a copy of any agreement if there is a 12 coverage. The Metro Region Compact counts as the required agreement. Additional reimbursements for training and body armor.

d. Bus- No issues

e. U of M- *Concert this weekend. 33,000 tickets sold.*

f. Northfield- Jessie James Days

g. M-Health Fairview- Vikings training camp as well as other large events ove the next month.

h. Health Partners- Update on call volumes

i. North- Nothing other than city festivals.

j. Edina- A few special events. New Special Operations chief is working with all the parties running the events to create better communications and planning.

k. Hennepin- Supporting the U of M, Vikings and Aquatennial.

7. Other Items- NONE

The meeting adjourned at 850 a.m.

C — 2nd IN or LATE ARRIVING AMBULANCES
(Report to EMS Command or designee)

Notification

1. Go to assigned radio tactical talkgroup.
2. Contact the Communication Center of the agency controlling the incident for instructions.
3. Approach scene using designated route to avoid hazards.
4. Upon arrival at assigned area, contact EMS Command, or Staging Supervisor if established.
5. All responders will identify themselves using the following format: Dept Name, Type of Resource, and Radio #.

At Staging

- Remember other vehicles, do not block entry/exit routes.
- Stay inside the vehicle until assigned a duty.

Loading Patients and Leaving the Scene

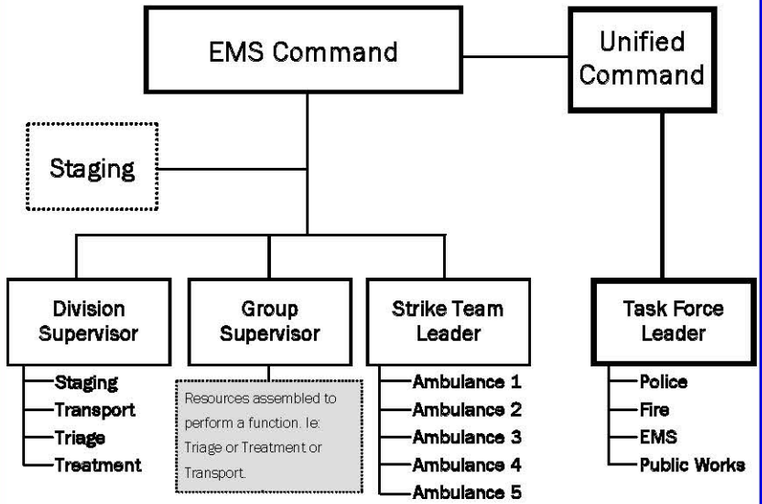
1. Quickly load patients and provide treatment while transporting to the appropriate hospital!
2. Provide EMS Command, or designee, the number of patients and triage category being transported.
3. Contact your Communication Center and advise them of your status.
4. Immediately contact MRCC/Medical Control by RADIO.
5. Communicate: Radio-ID, Destination, Age, Gender, First Name, Last Name, Chief Complaint, Triage Color, ETA. *(Crews may be prompted for additional information.)*
6. In order to facilitate patient tracking, prior to clearing destination/ receiving facility EMS crews are encouraged to contact MRCC or Medical Control with patient(s) name(s) and/or physical description of patinet(s) in not given previously.

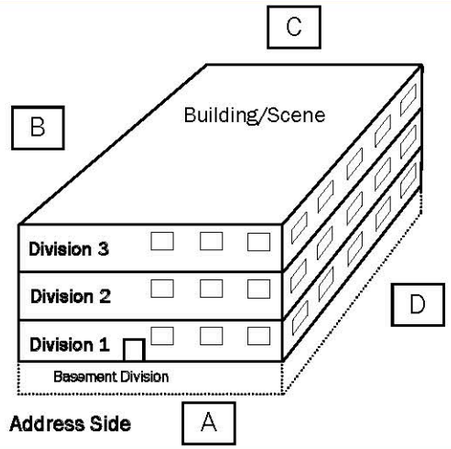
Metro Region
EMS System

Funded and Created by the:
Metropolitan Emergency Services Board,
Metro Region EMS System,
Emergency Preparedness Sub-Committee

Using Divisions/Groups

- In large or widely scattered scenes (ie: natural disasters) establish divisions/groups early to maintain operational control.
- Divisions are geographic areas with assigned resources.
- Groups are resources assembled to perform a specific function.
- Divisions operate independent from one another. Division Supervisors report to EMS Command.
- Requests for resources (vehicles, talkgroups, personnel, etc.) must be made through EMS Command.





EMERGENCY MEDICAL SERVICES INCIDENT RESPONSE PLAN

GUIDELINES

This plan is based on the principles and guidelines of the National Incident Management System (NIMS) and assumes responders have a working knowledge of the Incident Command System (ICS) and the positions it utilizes.

- The command structure presented in this plan may require expansion to meet the needs of larger or more complex incidents.
- Refer to agency specific guidelines for special incidents: HazMat, Police Tactical Operation, Fire Standby, Water Rescue, Structural Collapse, Rehab, etc.
- MRCC should be notified if the incident may impact hospital and/or EMS systems.

- **FIRST ARRIVING CREW:** *Refer to Panels A & B .*
- **2nd IN or LATE ARRIVING AMBULANCES:** Refer to Panel C.
- Do NOT respond unless requested!

Operational Considerations

- Contact MRCC/Medical Control of the potential for contaminated patients to self transport.
- Ensure crews are wearing proper protective equipment.
- Ensure crews are wearing identification vests.
- Multi-patient/MCI buses. (Contact MN Duty Officer 651.649.5451)
- MCI Trailer - Additional supplies - Mobile Comm. Unit.
- Access to and use of mutual-aid management staff.
- Need for command staff call-

Revised: June 2011

A EMS COMMAND
(Coordinate with Incident Command (IC)/form Unified Command)

- Upon arrival at the scene, the role of EMS Command will be assumed by an individual and announced on the radio. (Example: "[*name*] will be EMS Command, or Division Supervisor, etc.")
- Announce arrival of EMS to IC face to face or via radio.
- Any change in the person filling the role must also be announced.
- EMS Command is responsible for all unassigned positions within the Incident Response Plan (IRP) until delegated.
- Radio discipline on scene is maintained by allowing only EMS Command or designee to interface with the Communication Center.
- To manage complex incidents, EMS Command may appoint staff to serve in support roles.
- EMS Command must provide regular Situation Reports (SITREPs).
- Consider notifications for hospitals, command staff, etc.
- Give early consideration to resource needs.

SCENE SIZE-UP

It is vital to communicate an accurate scene size-up so the appropriate resources can be started. It is better to start more resources and cancel them, than to have a delayed response.

The information should include:

- Type of Incident.
- Potential number of patients.
- Types of injuries.
- Severity of injuries.
- Give staging location.
- Best route in/out.
- Is the on-call Medical Director needed on scene?

Do hospitals need to be alerted to the incident or potential patients? If yes, contact MRCC.

This will initiate:

- MNTrac EMS System Advisory
- MRCC Patient Tracking.

EMS Command is responsible for the Safety and Accountability of EMS Personnel unless delegated.

B EMS OPERATIONS
(Responsible for Triage, Treatment, Transport, & Staging until delegated)

TRIAGE SUPERVISOR
(Coordinate with Operations and/or Transportation Supervisor)

1. Provide EMS Command with approximate number of patients.
2. Identify, corral, and monitor "walking wounded."
3. Update EMS Command with resource needs.
4. Expedite and coordinate patient movement to transport area.

TRIAGE

The category descriptions below serve only as guidelines and should not preclude medical personnel from categorizing a patient based on experience or other clinical findings.

GREEN: minor, may go to hospital triage area.

YELLOW: moderate, requires an ER bed.

RED: critical, requires ER stabilization room.

BLACK: dead. Do *NOT* move.

TREATMENT SUPERVISOR
(Coordinate with Triage and/or Transportation Supervisor)

- Organize medical care in treatment area.
- Update EMS Command with resource needs (supplies, personnel, etc.).
- Provide for medical needs of "walking wounded."
- Direct First Responders when caring for multiple patients.

STAGING SUPERVISOR
(Report to EMS Command or designee)

- Establish staging area and keep entry/exit routes open.
- Respond to requests for resources from EMS Command or designee.
- Assign the appropriate resource to meet request.
- Provide requested resources with location of assignment, talkgroup, and any special instructions.
- Keep EMS Command updated on resources in staging.

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TRANSPORTATION SUPERVISOR
(Report to EMS Command or Division Supervisor)

- Requests resources through EMS Command.
- Coordinate the rapid loading of transporting vehicles.
- Record the triage color and number of patients transported by each vehicle. Record names if possible.
- Keep entry/exit routes open.

Patient Tracking

EMS Unit				Receiving Hospital

Resource Accountability

In=At scene Out= Left scene

Resource	In	Out

Minnesota Ambulance Strike Team and Emergency Medical Task Forces Guidelines (MNAST/EMTF)

Minnesota Ambulance Strike Team and Emergency Medical Task Force Guidelines Table of Contents

ACKNOWLEDGMENTS

This document was developed and exercised by the Metro Region Emergency Preparedness Committee and workgroups representatives from:
Burnsville Fire EMS, Cottage Grove Fire EMS, St. Paul Fire EMS, Minneapolis Fire, MAC Airport Fire EMS, Mdewakanton Fire-EMS, Maplewood Fire-EMS, Hennepin EMS, Allina Health EMS HealthEast Ambulance Service, North Memorial Ambulance Services (Metro and Forest Lake), Lakeview EMS, Northfield EMS, Woodbury Public Safety EMS, Lakes Regions EMS, Ridgeview EMS, North Memorial Ambulance-Marshall, Willmar EMS

With additional assistance from the Metro Region Emergency Medical Services (EMS) Communications Committee representatives from:
East and West Metro Resource Communications Center with members listed above.

Leadership and Coordination by the Metropolitan Emergency Services Board (MESB), Metro Region EMS System Coordinator and MESB support staff.

Support from the Metro Region EMS System: Technical Operations Committee, Minnesota Ambulance Association, MN Emergency Medical Services Regulatory Board, Metro Region Medical Directors

In Collaboration with other MN EMS Regional Directors/Coordinators.

Use of the following state ambulance strike team programs for documents regarding policies and procedures as guidelines:
California, Florida, New York, Pennsylvania, and Texas

And

Texas Engineering Extension Service (TEEX)
Emergency Services Training Institute (ESTI)
for the Ambulance Strike Team/Emergency Medical Task Force Leader Training.

past events such as extensive regional flooding, wildland fires, National Special Security Events, wind storms, and unscheduled healthcare facility evacuations, clearly delineates the need for a coordinated, well-defined EMS response to major emergencies and catastrophic disasters. Furthermore, new and unique risks and hazards facing the state and nation have created significant challenges for EMS responders that require specialized training, organization and equipment for any well-coordinated, safe, and efficient response to major incidents. To provide the best possible organized response to a major disaster, it is prudent to move forward to develop and sustain a unified system that coordinates EMS resources from both government and non-government based ambulance services. Ambulance Strike Team (AST), a group or taskforce of similar EMS assets, is a proven concept for the effective management of resources operating under the National Incident Management System.

Originally, the AST concept was developed by the Metro Region EMS System for metro ambulance services that voluntarily participated in improving their preparedness status at the local, regional, state and national level. The Metro Region sought funding through the federal Department of Homeland Security (DHS), the Hospital Healthcare Preparedness Program (HHPP), Metropolitan Medical Response System (MMRS), Minnesota Homeland Security Grant Program (SHSP), and regional EMS Support Act and Relief Funds were utilized for the expansion of AST planning and participation to all the eight (8) EMS Regional Systems. It was through this collaborative effort that brought the current regional EMS components together to form, when requested, a statewide MNAST. A MNAST deployment may consist of ambulances from multiple regions. However, Regional based AST leaders can operate either independently (within their agency to muster an AST) or as part of the MNAST. Regionally based AST leader cadres have been created to coordinate the just-in-time training, development, and deployment of the MN Ambulance Strike Team (MNAST).

Participating EMS services provide needed EMS resources and incident management support, when requested, to areas impacted by a disaster when local EMS resources may be overwhelmed and negatively impacted. The MNAST resources are only requested by the local impacted EMS agency through the Minnesota Duty Officer (MDO), MN State Emergency Operations Center (SEOC) or Emergency Management Assistance Compact (EMAC).

Presently, funding for MNAST sustainment continues only through a few regional EMS systems. Regardless of funding, the MNAST project has repeatedly proven its viability by surging EMS capacity through regional collaboration and enhances the capabilities of individual ambulance services to respond to events/ incidents that exceed local, county, or regional resources.

Definitions, Organization, Roles and Responsibilities

Strike Teams and Task Forces:

A MN Ambulance Strike Team will include five (5) staffed ambulances with common communications and an AST Leader. The NIMS typing is nationally defined and variable based on EMS capabilities.

Emergency Medical Task Force (EMTF) is any combination of resources (within span of control) up to five (5) ASTs assembled for a medical mission, with common communications and a taskforce leader. Additional assets such as base of operations tents, communication trailer, mass casualty bus(es), may be required. An EMTF would be self–sufficient for multiple 12-hour operational periods, depending on need.

EMS Multi-Agency Coordinating Group (EMSMACG):

The membership of the EMSMACG is strictly voluntary. Every EMS Regional System has representation as follows:

- Each EMS Regional director/coordinator
- Up to two (2) EMS provider representatives (alternates recommended) who are MNAST leaders
- Metro EP Committee Chair or designee
- One (1) EMSRB representative

The EMS Regional Systems will assist in identifying licensed ambulance services in their area willing to participate in training, exercise and deployment in responses to an event/incident that overwhelms existing resources both interstate and intrastate.

The EMS Regional Systems will also continue to assist participating services, information sharing among other emergency preparedness organizations, review of plans, distribution of funds, and periodic reporting of project progress for the area it serves.

The members of the MN Ambulance Strike Team (**MNAST)** will report directly to the **MN EMS Multi-Agency Coordinating Group (EMSMACG)** assigned to the activation.

One of the goals of the **MNAST/EMTF** is to prevent the self dispatching of additional ambulances and resources, which have proven to be disruptive in past events and can increase risk to both requested and unrequested responders.

Ambulance Deployment Request Process

Requests for the MN Ambulance Strike Team (MNAST)/Emergency Medical Task Force (EMTF) must be made through the Minnesota Duty Officer (MDO), MN State Emergency Operations center (SEOC), the MN Emergency Management Assistance Compact (EMAC) Coordinator.

The **EMSMACG** will facilitate the ambulance deployment formation with the local EMS Regional Director/Coordinator(s). The local EMS Regional Director/Coordinator will coordinate resource typing based on the all hazard event/incident and activate the MNAST/EMTF response.

Participating ambulance providers/members in each region will meet the minimum requirements for training and equipment according to the guidelines set out in this document.

Ambulance Strike Team Requirements

AMBULANCE SERVICES:

- Must be a Minnesota licensed ambulance service.
- Ambulance service with two or more transport vehicles may participate
- Ambulance services must maintain coverage of their primary service area 24/7.
- Minimum crew response in accordance with EMS staffing regulations for the level of service provided.
- Must meet equipment and supply standards in accordance with EMSRB requirements.
- Regions will maintain a list of participating ambulance services.

INDIVIDUAL REQUIREMENTS:

- Must have current Minnesota certification as an Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT) or Paramedic; as required by the National Incident Management System (NIMS) definition of an EMS Strike Team. See attached.
- The EMS Regions will comply with the NIMS definition for a Type II EMS Strike Team.
- Must be a current member of a licensed ambulance service in the State of Minnesota.
- Must meet physical health and training standards as described in attached guideline.

PHYSICAL REQUIREMENTS

- Able to work 12-hour shifts under potentially austere (hot/cold long hours, etc.) conditions.
- Individual must have the ability to supply and control their own personal medications for at least ten days. Deployments are intended to last 72 hours; however longer periods may be experienced.
- EMS medical director signature attesting that personnel meet the following requirements:
- Capability and willingness to wear and work in Level B or Level C personal protection equipment depending upon training level (infection control measure; not for warm/hot zone or hazmat response).

IMMUNIZATION REQUIREMENTS*

It is recommended that **MNAST/EMTF** members have all the following vaccinations.

Baseline and Annual Needed:

☐ **Tuberculin Skin Test:** Documentation of testing and result. If you have had a positive *result in the past, please following up with a practitioner, and show documentation of* treatment plan.

☐ **Influenza Vaccine:** Documentation of current vaccine done in the fall.

Baseline Vaccines Needed:

☐ **Tetanus-Diphtheria (Td):** Documentation of Td in the last ten years. If you did not complete the basic three dose series please contact your practitioner, and show documentation of treatment plan.

☐ **MMR (Measles, Mumps, Rubella):** Documentation of at least one of the following:
a). Documentation of two doses of MMR **if born after 1956**.
b). Documentation of one dose of MMR **if born before 1956.**
OR
c). Positive blood titers for Measles/Mumps/Rubella.

☐ **Varicella (Chicken Pox):** Documentation of one of the following:
a). Two dose series.
b). Positive titer indicating immunity.
c). Reliable history of chickenpox and signing of form confirming history with service provider.

☐ **Polio:** Documentation of one single lifetime booster as an adult. If you did not complete the basic childhood series, please contact your practitioner, and show documentation of treatment plan.

☐ **Hepatitis B:** Documentation of one of the following:
a). Three doses of Hepatitis B vaccine. Direct caregivers will need a documented positive Hepatitis B antibody titer. The titer should be drawn 1 to 2 months after the third dose.
b). Documented positive Hepatitis B antibody titer.

☐ **Hepatitis A:** Documentation of 2 dose series.
You will be considered temporarily deployable after completion of the first dose but will be required to complete the second dose within 6 to 12 months.

OPTIONAL / SUGGESTED FOR THOSE AT HIGH RISK OR ADULTS OVER 65 YEARS OF AGE:
Pneumococcal polysaccharide vaccine (PPV) – Not required but recommended for those at high risk.

***Taken from MN-DMAT 1 Immunization Requirements.**

TRAINING (See Training Matrix Appendix G)

Training may be obtained through the Department of Health's Learning Management System (LMS), Emergency Management Institute-FEMA Independent Study Program and other appropriate training modalities approved by the EMS Regulatory Board.

Minimum training required for each person includes the following:

- Valid driver's license

Core NIMS Required Courses or equivalent NIMS course link: training.fema.gov

- IS 100 Introduction to the Incident Command Structure
- IS 200 Basic Incident Command Structure
- IS 700 National Incident Management System (NIMS)
- IS 800-B National Response Framework
- Hazmat Awareness Course
- Emergency Vehicle Driving Course

Core EMS Recommended Courses

- Emergency Vehicle Driving Course
- Weapons of Mass Destruction Awareness Course
- Emerging Infectious Diseases (**http://cpheo.sph.umn.edu/cpheo/online/home.html)**
- A Basic Medical Response to Terrorism Course **(CDP)**
- DEEP training and Psychological First Aid
- Basic Animal Rescue Training (**BART**)
- EMS Operations for Multi-Casualty Incidents (MCI) or HSEM approved course
- 1st Responder Mass Dispensing**(http://cpheo.sph.umn.edu/cpheo/online/home.html)**
- Alternate Care Site Operations**(http://cpheo.sph.umn.edu/cpheo/online/home.html)**
- IS 1900 National Disaster Medical System **(training.fema.gov)**
- Mass Casualty Incident Bus Awareness Course (**in development**)

Required for Ambulance Strike Team Leaders –All of the above plus:

- IS 300 **(training.fema.gov)**
- IS 400 **(training.fema.gov)**
- Mass Casualty Incident Bus Awareness Course (**in development**)
- MN State Ambulance Strike Team Leader Course (includes deployment and demobilization).
- The AST leader must have the capability and experience to manage, coordinate, and direct the actions of the ambulance crews at a wide variety of emergency situations. His includes maintaining all required records, and ensuring the logistical, physical, and emotional needs of all personnel are met during the entire activation of the team.

Each team leader is required to attend a minimum (50%) of the annual CME training sessions (8 hours a year) provided for MNAST.

RECOMMENDED EQUIPMENT AND SUPPLIES

Team Leader Supplies and Equipment

- Triage Tags (minimum 200)
- Communications equipment (800 MHz radios and Cell Phones (Push to talk)
- Supplemental Level C/ **CBRNE** Personal Protective Equipment (**PPE**):2 per day for a 3/day period
- Waterless hand sanitizer
- Antibacterial wipes for cleaning equipment and/ or rigs
- 500 sets of disposable linen
- 100 Redress kits (dry decon)
- **GPS** system (handheld) – compatible with the National Grid System, allocated to strike team leader at a minimum. Recommended for each crew.
- Minimum of N95 (vented preferred, 100 N95/truck) or Full Face **APR**
- Credit Card – purchasing power to provide for fuel/necessities
- Petty-cash – minimum $1000/ 72 hour deployment. Team Leader Only!
- State run forms for documentation.
- **MRE's** for team
- 100 ft rope
- Personal Floatation Device (**PFDs**): inflatable, suspender style.
- **ICS** Forms

Vehicle Supplies and Equipment

Ambulances must meet State Communication Requirements.

- Minimum requirements: regional/statewide tactical channel capability.
- Staging area has a radio technician to program radios.

Communication needs:

1. Communications to the home base – all ambulances/command vehicles should be equipped with radios and /or cell phones with the ability to communicate to their base from any destination in Minnesota.
2. Communications in-transit – Units within an ambulance deployment should be able to communicate with each other en route to the incident. Options may include cell phones, satellite phones, vehicle point to point radio capabilities.
3. Communications at the scene – A programmable hand-held radio, utilizing the primary frequency, may provide the ability to maintain communications outside of the vehicle and stay in contact with the **MNAST** Leader. The ARMER system is the backbone when available is the state's preferred mode of communication using the **EMS** channels assigned.
4. Have written Tactical Interoperability Communication Plans (TIC).
5. Suggested Equipment:
    - Vehicle or handheld GPS navigation system
    - 110V power inverter
    - Redundant communication capabilities

Fuel purchasing power to provide for fuel/necessities (fuel card/PO/etc.)

Personal Supplies and Equipment - Recommend Living Wills

- Cell Phone and charger (personal)
- Minimum Level C Personal Protection Equipment (include N95's)
- Cash minimum $100/per week per person
- Potable water one gallon per person deployed
- Identification vests with reflective stripes – Meets Federal **ANSI** requirements with State Ambulance Strike team logo
- **ANSI** certified Safety Helmet.
- 1 qt H2O Drinking container: camel back or nalgene bottle w/ insulation recommended.
- Mess Kit
- 1 MRE
- Snacks
- Books, cards, etc.
- Sunscreen/ Bug repellent
- Sun Glasses
- Spare eye glasses
- Eye & Ear protection (**OSHA** Approved)
- Work Gloves
- Personal medications: -recommend **ASA,** Ibuprofen, Benadryl, and Imodium.
- Copy of Prescription Medications
- Credentials, Drivers License, picture ID's
- Hat
- Flashlight, headlamp & spare batteries(rechargeable) and a charger
- Credit card, cash.
- Team Uniform, (2 pants -3 shirts) **Note: Place in Ziploc bags.**
- T-shirts, underwear (1 pair/each day of deployment) **Note: Place in Ziploc bags.**
- Work boots (**OSHA** approved recommended).
- Pillow
- Sleeping bag/ pad
- Off time clothing
- Outer jacket/ weather appropriate
- Large Zip lock bags
- Rain Gear
- Toilet Paper
- **Survival Kit** to include: compass, "pencil flares", water purification, glow sticks, strobe light, signal mirror, waterproof matches, wire, nylon cord, candles, energy gel, space blanket,
- Leatherman type tool.
- Personal hygiene items
- Washcloth & towel
- Shower sandals
- Mosquito netting
- Cold weather Clothing: gloves, boots, hat, long underwear, extra sweater

The following constitute Level C equipment:

Full-face mask, (**NIOSH** approved).
Metro Region HCID PPE Pack
Hooded chemical-resistant clothing (overalls; two-piece chemical-splash suit disposable chemical-resistant overalls)
Gloves, outer, chemical-resistant
Gloves, inner, chemical-resistant
Boots, outer, chemical-resistant steel toe and shank
Boot, covers, outer, chemical-resistant
Hard Hats (**OSHA** guidelines)
Face shield (1)
Duct or chemical resistant tape

REIMBURSEMENT

Reimbursement will be the responsibility of the ambulance providers**.** Reimbursement may be available through FEMA, state or local funds, based on the disaster declaration or incident.

NOTE: Documentation must be available for inspection and auditing of the above costs and expenditures.

COMMITMENT

- A two-year minimum commitment is required of each team leader / member.
- Upon separation of a team leader / member from the **MNAST,** all issued equipment must be returned.
- Recommend **8 hours a year** for continued medical education for team leaders / members, provided for the MN Ambulance Strike Team by the **MN EMSMACG**. (Refer to Training Page 7).

Concept of Operations

MN Ambulance Strike Team (MNAST) / Emergency Medical Taskforce (EMTF)

1). There will be two possible MNAST/EMTF configurations, ordered as such:

Type II - ALS:

5 - ALS ambulances (an approved vehicle and 2 personnel each with at least one paramedic).
1 -Team Leader with a command vehicle.

Type IV - BLS:

5 - BLS staffed ambulances (an approved vehicle and 2 personnel each with at least one Emergency Medical Technician).
1 -Team Leader with a vehicle.

Note: A supply trailer can also be utilized if deployed to an incident where supplies/sustainment of the team.

2). Requests for MN Ambulance Strike Team or Emergency Medical Task Force must come through the Minnesota Duty Officer, State Emergency Operations Center or the MN EMAC Coordinator.

All requests will go through the Minnesota Duty Officer:
Landline: 651-649-5451 or 1-800-422-0798. Satellite Phone: 1-254-543-6490
TDD: 1-800-627-3529 FAX: 651-296-2300

Requests should be by quantity, type, and kind. (i.e. “One, Type II, Ambulance Strike Team”, or if more resources are required, “One, Type II Ambulance Strike Team and One, Type IV, Ambulance Strike Team”).
Once a resource request has been made to the Minnesota Duty Officer (MDO), the MDO will notify West Medical Resource Control Center (WMRCC) of the request. The WMRCC will page out the request to the EMS MAC group who will be responsible for filling the request for MNAST resources and coordinating the response.

Ambulance providers in each EMS region participating in an MNAST/EMTF will meet the minimum requirements for training and equipment according to the MN Ambulance Strike Team Guidelines. Agencies not meeting these minimum requirements will not participate in the MNAST/EMTF deployments at any time, based on current resource levels, a Region or Operational Area continues to have the ability to provide individual ambulances for mutual aid response.

Disaster Operations: Response and Recovery

MN Ambulance Strike Team / Emergency Medical Task Force

ORDERING / REQUESTING PROCESS

In advance and in preparation for an EMS response, the EMS regional directors/coordinators will work with ambulance providers to identify resources: personnel, ambulances and command vehicles, stocked with equipment as designated. Each region will maintain current EMS resource capabilities for the region, so that resources can be identified immediately as needed.

Each EMS regional system will designate a point of contact (POC) for the current incident from their EMSMACG members. Each region needs to maintain/designate a POC of 24/7 during a MNAST/EMTF response. This POC information will be available to the MDO, EMSMAC, or SEOC when an MNAST/EMTF is requested.

Field Level

At the time the Incident Commander requests additional ambulance resources the incident commander will:

- Prepare to receive and deploy the requested resources.
- Prepare to logistically support those resources.

Level Jurisdiction

- The Local jurisdiction will reasonably deplete its own resources, including any resource received from neighboring jurisdictions through “move-up,” “back-up,” or “cover” agreements.
- Once it is determined that outside assistance is needed, will contact the MDO to request additional ambulance resources. They should be prepared to give standard resource request information (**type of taskforce (TF) needed, staging point, mission, expected duration**).

Region

- Each EMS regional system will maintain an Emergency Resource Directory (ERD) listing ALS and BLS transport resources and qualified MN Ambulance Strike Team/Emergency Medical Task Force leaders.
- A Regional POC will receive a request for assistance.
- The Regional POC in the region requesting assistance will work with the EMS Branch Director to ensure logistical and operational support for the MNAST/EMTF.

- ***The assisting region(s) POC communicates the request to West MRCC (612-347-3145) to activate the MNASTE/EMTF participating EMS services within the region.***
- Ambulances and personnel from appropriate services are assembled and dispatched as quickly as possible. Potentially to have a MNAST/MTF notification/deployment to staging area 2 hours from time of request.
- The assisting POC will recommend rendezvous points for mobilization of the MNAST/EMTF. The rendezvous could occur enroute or at the staging areas within the requesting region. Each EMS Region should identify potential staging areas in advance.
- The regional POC will communicate approximate time of arrival to the MDO at the earliest opportunity and notify the MDO when the MNAST/EMTF is enroute.
- The regional POC will coordinate communications (e.g., MNAST/EMTF talk group).

State

- **The MDO or SEOC will serve as the state POC for all MNAST/EMTF requests.**
- The MDO will notify WMRCC to contact the EMSMACG coordination of activities.
- The MN EMS MACC may open to identify available resources and coordinate inter-regional responses as needed.
- The MN EMS MACC will work with other agencies at the SEOC to provide additional resources.
- The EMS MACC will follow up on appropriate documentation from provider services used in the MNAST/EMTF, to submit for reimbursement if available.

RESOURCE MANAGEMENT

Enroute

- The EMSMACG will initiate notification of MNAST/EMTF through The EMSMACG will appoint/notify Team Leader and Staging area via (ARMER) 800 MHz radio MNAST/MTF TAC Channel or other via other interoperable communication systems. If the EMS MACC has not been activated the Metro Region POC will act in their absence. When time allows, an AST Leader will be deployed in advance for assessment purposes prior to AST deployment.

- All units will contact the MNAST/EMTF leader vehicle by radio, or phone, while en-route to the assembly point. The decision to travel together will depend on the location of individual ambulances at the time of dispatch.

- At the rendezvous or assembly point, the MNAST/EMTF leader vehicle will be responsible for the following:
  1. Introducing team members.

2. Identify strengths, weaknesses, and capabilities of the AST and make assignments accordingly.
3. Brief the team members on current incident conditions, safety issues.
4. Determine response route, considering time of day, traffic, food, and fueling stops.
5. Make and communicate travel plans (who leads, who “brings up the rear”, etc.). Identify a radio talk group for communications while enroute.
6. Conduct a checklist assessment of the MNAST/EMTF readiness and equipment availability. Distribute equipment and uniform items.
7. Notify the jurisdictional dispatch center of status and ETA to incident.
8. Ensure appropriate resources are present.

- If a resource is unable to continue to respond for any reason (mechanical failure of the ambulance, illness of team members, etc.) the MNAST/EMTF leader shall contact the EMSMACC to advise and request replacement.

- Each ambulance crew shall maintain responsibility for their personal equipment, the ambulance, and the medical equipment/supplies. Any problems should be reported to the MNAST/EMTF leader.

At The Incident

- The MNAST/EMTF shall report to and check in at the incident.
- The MNAST/EMTF leader will be responsible for the following:
    1. Act as the MNAST/EMTF liaison to the local EMS and other response jurisdictions or incident management team.
    2. Maintaining a unit activity log for the entire incident.
    3. Providing information to staging about MNAST/EMTF and its assets.
    4. Receiving Incident Briefings and copies of the Incident Action Plan (IAP).
    5. Briefing MNAST members on the Incident and their assignments.
    6. Reporting for Line Assignment(s) or to a Staging Area as directed.
    7. Obtaining orientation to hospital locations (local information).
    8. Determining preferred travel routes and briefing team members.
    9. At least daily PAR checks with the coordinating group.

Communications

Communications equipment, protocols, etc. vary within the state. It is the EMS agency's responsibility to ensure that the minimum communications equipment described below is available to ambulances, ambulance/medical personnel and MNAST/EMTF leaders. The MNAST/EMTF leaders are responsible to contact the local public safety answering point (PSAP) or incident appointed COML for radio frequency assignments. The EMSMACG will attempt to have this information prior to arrival at local check-in or staging area.

Communications needs for MNAST/EMTF:

1. **Communications to the home base.**
    - All resources will be equipped with radios and cell phones (satellite phones available to ASTL) with the ability to communicate to their home base from any destination in Minnesota.
    - Metro Base-Minnesota Emergency Medical Services Coordinating Center (EMSMACC); State Emergency Operations Center; Emergency Management Assistance Compact (EMAC) Coordinator
    - Communications in-transit - Redundant capabilities are recommended.
    - Units within an MNAST/EMTF must be able to communicate on ARMER with each other enroute to the incident.
    - **Interoperability** includes use of statewide or regional EMS talk groups/frequencies, cell phones, common radio talk groups/frequencies (e.g.: designated tactical channels), etc.

2. **Communications at the scene.**
    - Be prepared for as many options as possible.
    - The MNAST/EMTF leader vehicle shall have the ability to communicate with the appropriate Incident Operations staff at the incident.
    - Ambulances will coordinate medical information communications to the receiving
    - Facilities, according to the local plans per the EMS Branch Director or designee.

PROTOCOLS – ENROUTE AND AT THE INCIDENT

During a response into another Minnesota jurisdiction, and when requested as part of an MNAST/EMTF, an EMS worker may utilize the scope of practice for which s/he is trained and accredited according to the policies and procedures established by his/her home agency and Medical Director.
EMS personnel will not overextend their medical scope of practice, regardless of direction or instructions they may receive from any authority while participating on a MNAST/EMTF, unless approved by their individual Medical Director.

AT INCIDENT SUPPORT

The MNAST/EMTF reporting to the scene of a disaster or other incident should not expect support services to be in place in the first 24-72 hours of the incident. For this reason, all MNAST/EMTF are expected to be self-sufficient for up to 72 hours. The location and magnitude of the disaster will determine the level of support services available. The MNAST/EMTF leader may have to utilize commercial services for food, fuel and supplies until these services are established by incident logistics. Obtaining replacement medical supplies during the first days of a disaster may also be difficult. EMS Branch Director/Command, the jurisdictional EOC, the requesting regional EMS POC, and the hospitals are all good sources of information and guidance.
The facilities, services, and material at an incident are typically provided by the Logistics Section, MNAST/EMTF leader will contact their EMS Branch Director, or designee for instructions on accessing these services. The Logistics Section consists of the following units:

- Communications Unit
- Medical Unit
- Food Unit
- Supply Unit
- Facilities Unit
- Ground Support Unit

The MNAST/EMTF Leader is expected to attend all operational shift briefings and keep all personnel on the team informed on conditions. If the individual units of the MNAST/EMTF are assigned to single resource functions, i.e., patient transportation, triage, or treatment, the MNAST/EMTF leader will contact all team/task force personnel during each operational period. If possible, all units in a MNAST/EMTF will stay together when off-shift unless otherwise directed by the MNAST/EMTF leader. At minimum, all team members will remain in constant communications.

MNAST/EMTF CODE OF CONDUCT

- While deployed, act as if you are constantly on camera. You likely are!
- Events of this nature attract the media and attorneys. Your actions reflect your organization, and the State of Minnesota.
- Respect private property. Do not enter a private residence or business without the owner's permission, except in life-safety emergencies. Looters will be prosecuted.
- A community impacted by a large-scale emergency/disaster will be in distress, independent of personal impact. Crews should exercise extreme patience and understanding treat the public, and all other emergency responders with respect. Follow the Incident Command Structure.
- No alcohol or drugs during deployment.
- Remember your mission is to help the sick or injured. This is not a vacation!
- Take only essential personal items. All personal items need to fit in the side compartment of your ambulance. Lawn chairs, televisions, or large radios are not permitted.
- Do not bring pets. Rescued animals need to be brought to an animal rescue group. Ambulance Strike Team personnel **are not** to keep rescued animals.
- Ambulance personnel are responsible for wearing all appropriate safety and personal protection equipment. Ambulance services will not be responsible for lost or damaged property.
- You are responsible for the ambulances, and all equipment issued to you.
- Firearms are not permitted.

If there are any questions regarding any of the above, follow up with the deployed Ambulance Strike Team/Emergency Medical Task Force Leader.

DEMOBILIZATION

The Planning Section is responsible for the preparation of the Demobilization Plan to ensure that an orderly, safe, and cost-effective movement of personnel and equipment is accomplished from the incident. The Logistics Section is responsible for the implementation of the plan.

Demobilization and release will take place in accordance with the Incident Demobilization Plan and the MNAST/EMTF Demobilization Plan. At no time shall a crew or individual team member leave without receiving departure instructions from their MNAST/EMTF leader vehicle.

The MNAST/EMTF Leader will coordinate between Incident Command and EMSMACC to develop the team demobilization plan. Determine release from the scene and review checklist for team demobilization (e.g. radios, personnel and equipment).

Teams should obtain necessary supplies to assure that the ambulances leave in a “state of readiness” whenever possible. If unable to replace lost, used or damaged equipment, the MNAST/EMTF leader shall notify their incident Agency Representative prior to leaving. The MNAST/EMTF lead vehicle will return all radios and equipment on loan from the incident.

Timekeeping and supply records (NIMS Forms) will be recorded and shall be submitted to the appropriate personnel at the incident prior to departure. Copies shall be maintained by the MNAST/EMTF leader.

All MNAST/EMTF personnel will receive a debriefing from the MNAST/EMTF leader prior to departure from the incident.

Vehicles will be inspected for safety prior to departure from the incident. Any issue will be communicated to both the MNAST/EMTF leader and jurisdictional emergency management.

The MNAST/EMTF leader will review travel procedures with the MNAST/EMTF.

The EMS Branch Director will notify the IC and EMSMACC of ambulance release time, travel route, and estimated time of arrival back at home base.

The MNAST/EMTF is still a team upon return and may be reactivated at any time.

NIMS Forms:

Can be acquired online at: www.nimsonline.com

ICS 201: Incident Briefing

ICS 202: Incident Objective

ICS 204: Division Assignment List

ICS 205: Incident Radio Communication Plan

ICS 213: General Message Form

ICS 214: Unit Log Form

ICS 215A: Incident Action Plan Safety Analysis

ICS 218: Support Vehicle Inventory

ICS 221: Demobilization Checkout

ICS 259-3: Resource Order Form

ICS 228: Incident Cost Work Sheet

ICS 229: Incident Cost Summary

Compensation/Claims Unit Leader Position Checklist

Future ConOps documents in development:

Mass Casualty Incident (MCI) Bus Orientation

Checklists:

- **MNAST/EMTF Leader**
- **MNAST Member – personal equipment, MNAST ambulance equipment**
- **MNAST Communications**

Revision and Distribution

This document will be reviewed bi-annually by the EMSMACG

Changes in this plan will be made available on the MESB-EMS website and be distributed through the MESB-EMS list serve.

Table recording distribution of “change pages”

Record of Revisions

REVISION GROUP	DATE	COMMENT
Metro Region AST Guide-Lines Task Force.	**August 21, 2017**	

Appendices

A. **Duties and Responsibilities of MN Ambulance Strike Team Leaders.**

B. **MN Ambulance Strike Team Resource Typing**

- **Typed Resource Definitions: Emergency Medical Services Resources**

  FEMA 508-3, May, 2005 www.fema.gov/emergency/nims/

- **National EMS Responder Credentialing: EMS Job Titles**

  FEMA 509-3, July,2007

  www.fema.gov/emergency/nims/rm/job_titles.shtm

C. **Metro Region Form 210 – Unit Log for State Ambulance Strike Team Leaders.**

All other NIMS forms www.nimsonline.com/

D. **Mass Casualty Incident Bus Policies and Procedures (in development).**

E. **Training Matrix**

F. **MNAST Equipment and Supply List**

G. **Healthcare All Hazards Plan: Annex L – Prehospital Care**

Reference to:
Emergency Support Functions: ESF 8 & 9
See at www.fema.gov/emergency/nrf/mainindex.htm

Appendix A

Duties and Responsibilities of Strike Team and Task Force Leaders

The MN Ambulance Strike Team (MNAST) / Emergency Medical Task Force (EMTF) Leader is responsible for:

1) Assuring the safety and condition of the personnel and equipment.
2) Coordinating the movement of the personnel and equipment traveling to and returning from an incident.
3) Supervising the operational deployment of the team at the incident, as directed by the EMS Branch Director, Division/Group Supervisor, Operations Section Chief, or Incident Commander. Doing daily briefings with the team and MN EMS MACC maintaining familiarity with personnel and equipment operations, including assembly, response, and direct actions of the assigned units, keeping the team accounted for always.
4) Contacting appropriate Incident personnel and EMSMACC with problems encountered on the incident, including mechanical, operational, or logistical issues.
5) Ensuring personnel have adequate communications capability (see communications section).
6) Maintaining positive public relations during the incident.
7) Prior to deployment, determining mission duration, special circumstances, reporting location and contact information.
8) Ensuring completion and submission of ICS documents for timekeeping, reimbursement, and demobilization.

In summary, the MNAST/EMTF leader must have the capability and experience to manage, coordinate, and direct the actions of the ambulance crews at a wide variety of emergency situations. This includes maintaining all required records, and ensuring the logistical, physical, and emotional needs of all personnel are met during the entire activation of the team.

Appendix B-

Sample of Metro Region EMS System Ambulance Strike Team (AST) Resource Indentification.

MN	STRIKE TEAM		CREW		MEDICAL TASK FORCE TYPING	
MN	Team # 1	1	Crew # 1	1	ALS	A
	Team # 2	2	Crew # 2	2	BLS	B
	Team # 3	3	Crew # 3	3	Bus	M
			Crew # 4	4	Gator	G
			Crew # 5	5		
			Team Leader	0		

Example:

MN 24A would refer to MNAST #2, #4 crew, Advanced Life Support. MN20 would refer to the Team Leader (TL) of MNAST #2.

Medical Taskforce Typing would only need to be used if we change from an **AST** to a **MTF**.

Appendix C – Sample: Unit Log for MN Ambulance Strike Team Leaders

TL Unit Log	Incident Name:	Date Prepared:	Time Prepared:
MNAST Leader: Name	Telephone:	Operational Period:	
AST Resource Typing #	EMS Agency	Personnel Roster Names:	Cell Phone Numbers:
Activity Log			
Time:	Major Event:		
Prepared by: (Name and Position)			

Appendix D

Metro Mass Casualty Incident Buses (MCI)

1. **Minneapolis Fire Bus – Max. Cap. 12 Horizontal/10 Sitting**
2. **MAC Airport Fire Bus – Max. Cap. 18 Horizontal/20 Sitting**

Policies and Procedures are in the development.

Appendix E – Sample of:

METROPOLITAN EMS REGIONAL COMPACT

This Compact is made and entered into by and between the thirty undersigned Emergency Services (EMS) agencies located in the seven-county metropolitan area.

RECITALS

WHEREAS, this Compact is not a legally binding contract but rather this Compact signifies the belief and commitment of the undersigned EMS services that in the event of a disaster or special event/incident, the medical needs of the community will be best met if the undersigned EMS agencies cooperate with each other and coordinate their multi-jurisdictional, multi-agency mutual aid response efforts.

WHEREAS, the undersigned EMS agencies desire to set forth the basic tenets of a cooperative and coordinated response plan in the event of a disaster or special event/incident with the goal to provide a consistent level of care using resource sharing throughout the Metro Region rather than allowing for the provision of divergent standards of care during such events.

WHEREAS, the undersigned EMS agencies desire to cooperate and collaborate in the event of a disaster or special event/incident, in which an EMS agency(s) within the Metropolitan Region becomes incapable of managing a large volume of incident related calls and/or incapable of managing calls within their PSA with the usual bordering/partnering mutual aid agencies, by deploying assets or other support services as requested through usual mutual aid requesting protocols or by the Metro Regional EMS Multi-Agency Coordination Center (EMS-MACC), a metro Medical Resource Control Center (MRCC), and/or a Metro Regional EMS Incident Management Team in order to support the affected requesting agency(s).

NOW THEREFORE, in consideration of the above recitals, the undersigned EMS Agencies agree as follows:

ARTICLE I

COMMUNICATION BETWEEN THE UNDERSIGNED EMS AGENCIES DURING A DISASTER OR SPECIAL EVENT/INCIDENT

The undersigned EMS agency will:

1.1 Communicate and coordinate efforts to respond to a disaster or special event/incident in accordance with the Incident Response Plan (IRP) via their National Incident Management System (NIMS) compliant Incident Command Structure (ICS), primarily incident branch commanders and agency management, to the coordinating MRCC and the Metro Regional EMS-MACC and/or Metro EMS Incident Management Teams when activated or deployed.

1.2 Receive alert information via web-based EMS status system regarding any disaster or special event/incident with as well as a concurrent radio notification by East and West Metro MRCCs as a redundant back-up system.

1.3 Communicate with the Metro Regional EMS-MACC, when activated, and each other's Emergency Operations Centers (EOC) by phone, fax, email, and will maintain radio capability to communicate with MRCC as a minimum back-up.

1.4 Utilize a Joint Public Information Center (JPIC) during a disaster to allow their public relations personnel to communicate with each other and release consistent community and media educational / advisory messages. Each undersigned agency should designate a Public Information Officer (PIO) who will be their EMS liaison with the JPIC. Depending on the event, this may be coordinated through the Metro Regional Hospital Resource Center (RHRC), Minnesota Department of Health, Minnesota Division of Emergency Management, or the Minnesota Hospitals and Healthcare Partnership. If no umbrella organization assumes responsibility, Hennepin County Medical Center (Hennepin Healthcare Services, Inc.), North Memorial Medical Center and/or Region's Hospital communication departments will assume and coordinate this responsibility.

1.5 Provide according to the procedure outlined in the Metro region Incident Response Plan (IRP) through the coordinating MRCC, name and age of disaster victims which would then be disseminated to the regional EMS-MACC when activated, the RHRC or American Red Cross for disaster welfare inquiries for purposes of victim location by family members unless special circumstances preclude such information sharing. Provide to the coordinating MRCC, when permitted, appropriately detailed information about unidentified patients (John/Jane Doe) and their dispositions in order to facilitate identification.

ARTICLE II

ONGOING COMMUNICATION ABSENT A DISASTER

The undersigned EMS Agencies will:

2.1 Meet at least twice yearly under the auspices of the Metropolitan Regional EMS Emergency Preparedness Committee of the Metropolitan Emergency Services Board (MESB), to discuss continued emergency response issues and coordination of response efforts. Meeting minutes, agendas, and progress reports will be shared with appropriate organizations such as the MESB, the RHRC, the Metropolitan Medical Response System (MMRS), regional emergency managers and county EMS councils or committees.

2.2 Identify primary point-of-contact and back-up individuals for ongoing staffing of Metro Regional EMS Incident Management Teams, the Metro Regional EMS-MACC and communication purposes. These individuals will be responsible for determining the distribution of information within their EMS organizations and agencies.

ARTICLE III

ADAPTIVE OPERATIONS AND FORCED EVACUATION OF A METRO-RHRC AFFILIATED HOSPITAL

3.1 If a disaster or response to a special event/incident affects an undersigned agency(s) forcing partial or complete adaptive operations, the other undersigned EMS agencies agree to participate in the distribution of requests for service within the affected EMS agency's Primary Service Area (PSA), even if this requires activating emergency response plans at the assisting agency(s).

3.2 In the event of an emergent hospital/medical center evacuation, East and/or West Metro Medical Resource Control Centers (MRCC), in conjunction the Metro Regional EMS-MACC, will coordinate all patient transportation (bus, WC, BLS, ALS, critical care) with the Regional Hospital Resource Center (RHRC), the hospitals' point-of-contact, and assist affected hospital(s)/medical center(s), as requested, with the internal organization of transportation plans for the evacuation of patients and will distribute run volumes equitably.

3.4 In the event of an **anticipated** evacuation, transportation arrangements will be made in accordance with the affected hospital's usual and customary practice.

ARTICLE IV

RESPONSE WHEN THE NATIONAL DISASTER MEDICAL SYSTEM IS ACTIVATED

4.1 If the National Disaster Medical System (NDMS) is activated in response to a disaster outside the metropolitan area, the RHRC will determine bed availability and with the Minneapolis Veterans Administration Medical Center communicate EMS needs to the agency providing service to the Minneapolis-St. Paul Airport. East and/or West Metro MRCC, upon request, will determine the surge capability of the undersigned agencies. Regional EMS Incident Management Teams and/or the Metro Regional EMS-MACC will be deployed and activated to assist with patient reception/evacuation planning and coordination of EMS activities with the RHRC upon request.

4.2 If the National Disaster Medical System is activated in response to a disaster in the metropolitan area, East and West Metro MRCC and the EMS-MACC, will obtain information from the RHRC and/or regional healthcare facilities regarding the number of patients that require transportation, and will coordinate the EMS response and resource allocation with support from the RHRC, Minnesota Department of Health and the Department of Public Safety – Division of Homeland Security and Emergency Management.
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ARTICLE V

REPORTING SURGE CAPACITY AND CAPABILITY

5.1 The undersigned EMS agencies will use a designated web-based site to report the agency's surge capacity, its capabilities and its ability to transport patients. System capacity and reporting will be monitored by MRCC. The undersigned agencies will update this information on the web site at least once daily so that MRCC has current information to immediately determine system resources in the event of a disaster. In the event that the electronic system is non-functional, manual methods may be used to collect this data (eg: telephone reporting).

5.2 Surge capacity and capabilities will include at a minimum: licensed ALS and BLS vehicles, available staff and support personnel. A taskforce will examine optimum data and time reporting with input from each of the undersigned agencies.

ARTICLE VI

AUXILIARY HOSPITAL AND CASUALTY COLLECTION LOCATION

6.1 An alternate care site (ACS) auxiliary hospital and/or casualty collection location may be required in the event a disaster overwhelms the metropolitan area hospitals' capacity and capabilities.

6.2 If an ACS, auxiliary hospital and/or casualty collection location is required, HCMC will coordinate administration, staffing, and site operations in Hennepin County for the west metropolitan area. Regions Hospital will coordinate administration, staffing, and site operations in Ramsey County for the east metropolitan area.

6.3 The undersigned agency may be asked to contribute volunteer and/or EMS staff to an ACS, auxiliary hospital or casualty collection location on an urgent basis, subject to availability.

6.4 The Regional EMS Incident Management Teams and/or the Metro Regional EMS-MACC will provide assistance the RHRC and the administrative coordinating entity to determine the extent of EMS involvement and will construct short and long-term action plans.

ARTICLE VII

STAFF, MEDICAL SUPPLIES, AND PHARMACEUTICAL SUPPLIES IN THE EVENT OF A DISASTER

7.1 In the event of a disaster or special event/incident when patient care staff is in surplus at one of the undersigned agencies and lacking at another, the undersigned agency with the surplus will share staff to help ensure that the available EMS agencies in the metropolitan area are adequately staffed during a disaster or special event/incident.

7.2 In the event that needed supplies are in surplus at one of the undersigned agencies and lacking at another, the undersigned agency with the surplus will share supplies to help ensure that patients in the metropolitan area receive necessary treatment during a disaster or special event/incident.

7.3 The above staff and supply sharing will occur in cooperation between the management staff, incident commanders and designated EOC staff at the involved undersigned agencies.

ARTICLE VIII

MISCELLANEOUS PROVISIONS

8.1 This Compact together with the attached Exhibits, constitutes the entire compact between the undersigned EMS agencies.

8.2 Amendments to this Compact must be in writing and signed by the participating agencies. Exhibits, such as the Incident Response Plan and response procedures, which are reviewed and revised periodically by some or all of the participating agencies, may be replaced with updated versions without formally amending this Compact. Such updated Exhibits shall be provided to all participating agencies and shall become effective as to each agency upon receipt.

8.3 An undersigned EMS agency may at anytime terminate its participation in the Compact by providing sixty-day (60) written notice to the lead administrator at each of the undersigned agency.

8.4 This Compact is not intended to create a joint venture between any of the undersigned EMS agencies. Each EMS agency is responsible for supervising its own employees and volunteers, and shall not be liable for the acts or omissions of any other EMS agency based on the terms of this Compact. Neither Party to this Compact nor any officer of any Party within the Compact shall be liable to any other Party within the Compact or to any other person for failure of any undersigned agency to furnish assistance to any other Party within the Compact.

8.5 The undersigned agencies shall indemnify and hold harmless the other parties of this Compact, their officers, employees, members, shareholders, directors, attorneys, agents, assigns, and other related parties, persons, entities against all third party claims, losses, damage, liability, suits, judgments, costs and expenses arising from negligence or intentional misconduct of personnel assigned by any undersigned agencies based upon terms of this Compact.

Signed	Dated
Printed name	Title and EMS agency represented
Received	Dated

Participating EMS Agencies:
ALF Ambulance
Allina Health EMS
Belle Plaine Community Ambulance Service
Burnsville Fire Department
CART Ambulance, Inc.
Chaska Fire Department Ambulance (Ridgeview)
Columbia Heights Fire, Rescue and Emergency
Cottage Grove EMS
Edina Fire Department
Hastings Fire Department EMS
HCMC EMS
HealthEast Medical Transportation
Lakeview EMS
Life Link III
Lower St. Croix Valley Fire Department
MAC Airport Fire
Mahtomedi Fire Department Ambulance Service
Maplewood EMS
Marine on St. Croix Ambulance
Mdewakanton Fire Department
Minneapolis Fire Department
New Prague Ambulance
North Aircare
North Memorial Ambulance
North Memorial Ambulance-Forest Lake
Northfield Hospital EMS
Oakdale Fire Ambulance
Ridgeview Ambulance Service
St. Paul Fire Department
University of Minnesota Ambulance
White Bear Lake Fire Department
Woodbury Ambulance

EXHIBIT A

DEFINITION OF TERMS

Affected EMS Agency: The EMS agency directly impacted by the event/disaster and the EMS agency's PSA where disaster occurred may be the recipient agency for supplies and personnel from another agency.

Assisting EMS Agency: The contributing EMS agency that provides personnel, pharmaceuticals, supplies, and/or equipment to an agency experiencing a disaster or special event/incident requesting assistance.

Alternate Care Site (ACS): A facility established to provide ongoing patient care in a non-hospital environment, primarily to serve as austere care overflow bedspace during a epidemic or other prolonged emergency situation with mass casualties.

Casualty Collection Location: An area established to collect or triage casualties either between the scene of an incident and the hospital (eg: a casualty collection point at a air crash site), or between the hospital and outgoing transportation resources (eg: an airport hanger during a National Disaster Medical System evacuation from the Twin Cities area).

Disaster or special event/incident: A situation in which an incident's resource requirements exceed available resources to the point which an EMS agency is incapable of managing a large volume of incident related calls and/or incapable of managing calls within their PSA with the usual bordering/partnering mutual aid agencies.

Emergency Operations Centers (EOC): The coordination center for emergency response to an event or incident. The State, County, City, and affected EMS agency may each have their own EOC for their portion of the event, but liaison efforts between such centers are of critical importance.

Joint Public Information Center (JPIC): A source of information that is designated by more than one agency or group to speak on behalf of all during an emergency to assure consistent messages and flow of information.

National Incident Management System (NIMS): The Incident Command System that identifies the command structure and operational branches during an emergency. All public safety agencies in the State of Minnesota use a NIMS compatible system.

Metro Regional EMS Incident Management Team: A team comprised of specialized, NIMS trained and incident command experienced EMS management and supervisory personnel from agencies within the Metro Region who when requested and deployed will either assist the EMS Branch Commander on scene of a disaster or special event/incident, assist EMS Branch Command at various EOC's, and/or provide staff for the EMS-MACC.

Metropolitan Medical Response System (MMRS): The organization of public safety and health agencies that has provided the planning, oversight, and integration of weapons of mass destruction planning into emergency planning for the cities of Minneapolis and St. Paul under a grant from the U.S. Department of Health and Human Services.

East and West Metro Medical Resource Control Centers (MRCC): Communications hubs located at Regions Hospital and Hennepin County Medical Center respectively that are responsible for coordinating patient destination during a disaster or special event/incident in relation to hospital resources, coordinating EMS communications and tracking patients during such an event as well as obtaining resources (medical director consultation / notification, CISD contact point, transport resources) among other responsibilities.

Minnesota Homeland Security Emergency Management (MHSEM): Department of Public Safety division responsible for disaster response coordination and mitigation. DPS-DEM is the state agency which will coordinate state and federal resource response during a disaster.

National Disaster Medical System (NDMS): A contingency system of voluntarily committed hospital beds throughout the United States that may be activated when a disaster overwhelms regional healthcare resources and requires evacuation of patients to another region of the nation for care. Plans are in place for the reception of patients into, and evacuation out of the Twin Cities region should this type of event occur.

MNT*rac:* Minnesota systems for Tracking Resources, Advisory/Alerts, and Communication is a database driven, password protected web application. The application has been designed specifically to track bed capacity, pharmaceuticals and resources (i.e. ventilators, personal protective and decontamination equipment) from all hospitals within the state to support surge capacity needs. Hospital bed diversion status, emergency event planning, emergency communication, and alert notifications are supported in real time.

Regional Hospital Resource Center (RHRC): A designated regional hospital that performs clearinghouse functions for information during a disaster and may act to match available and requested resources from different facilities during a disaster situation. Resource needs may also be communicated from the RHRC to local/county emergency management and public health agencies. If a disaster occurs in East Metro, Regions Hospital will have primary responsibility for coordination, if the occurrence is in West Metro HCMC will have this function primarily.

Appendix F

Sample of Metro Region EMS Staging Plans

Staging is the strategic positioning of EMS vehicles, personnel and resources to identified locations that provide security, and facilities for staff until assigned, in response to an all hazards incident.

Command
Assign an EMS Staging Supervisor to each location with radio communication capability to coordinate resources with incident command.

Logistics
Position pre-staged EMS supplies (8 MESB Red Bags) at each location. Coordinate with Incident Command navigation support; food, hygiene resources for EMS personnel. Utilize services from Red Cross, Salvation Army, etc.

Planning
Based on requests, additional vehicles and resources could be diverted to or from the staging areas based on need.

The following areas could be used for **EMS STAGING in the Metro Region**, based on the location of the incident, will determine the appropriate location.

North EMS Staging Areas:

Primary-North Memorial Ambulance, 4501 68th Ave. North, Brooklyn Ctr.

Contact person: Kevin Novotny, 612-840-2918

Dispatch 24/7: 763-520-5789

South EMS Staging Areas:

Primary: Allina Savage Base Station, 8035 124th Street, Savage, 55372

Contact person: Jeff Lanenberg, 651-775-6723

Dispatch 24/7: 651-222-0555

South EMS Staging Areas continued:

Secondary: Mdewakanton Fire, 2330 Sioux Trail, Prior Lake, 55372

Contact person: Greg Hayes,

Dispatch 24/7: 952-233-1077

Central EMS Staging Area:

Primary-MESB, 2099 University Ave W., St. Paul, 55104

Contact person: Ron Robinson, 612-860-1257

Secondary-

Minneapolis Fire Training, #25-37th Avenue NE, Minneapolis, 55421

Contact person: Amber Lage, 612-240-6525

Dispatch 24/7 – 612-348-7251

East EMS Staging Areas:

Primary-Woodbury Public Safety, 2100 Radio Drive, Woodbury, 55125

Contact person: J.B. Guiton, 651-714-3698

Dispatch 24/7: Washington County Sgt. On Duty, 612-439-9381

Secondaries-

St. Paul Fire Training, 1683 Energy Park Drive, St. Paul,

Contact person: Matt Simpson, EMS Chief, 651-788-0534

Deputy Chief: 651-228-6214 or Ramsey Cty. Dispatch: 651-266-7702

Lakeview Ambulance, 927 West Churchill Street, Stillwater, 55082

Contact person: Jon Muller: 651-248-7458

Dispatch 24/7: 651-222-0555

Appendix G Training Matrix

	MEMBER	LEADER
MESB AST Leader Course		R
Mass Casualty Incident Bus	O	R
Basic Animal Rescue Course	O	R
Alternate Care Site Ops. (MERET)	O	R
Mass Dispensing Course (MERET)	O	R
DEEP and PSA	O	R
EMS Ops. For MCI Course	O	R
A Basic Medical Response to Terrorism	O	R
Emergency Vehicle Driving Course	R	R
Emerging Infectious Disease	O	R
Hazmat Awareness Course	R	R
Weapons of Mass Destruction Course	O	R
IS 1900	O	C
IS 400		R
IS 300		R
IS 800 B	C	C
IS 200	C	C
IS 100	C	C
IS 700	C	C
Immediate Strike Tea Crew		

C = Core NIMS Training, required
O = Optional, but recommended
R = Required

Appendix H

Personal Supplies and Equipment - Recommend Living Wills

- Cell Phone and charger (personal)
- Minimum Level C Personal Protection Equipment (include N95's)
- Cash minimum $100/per week per person
- Potable water one gallon per person deployed
- Identification vests with reflective stripes – Meets Federal ANSI requirements with EMS Strike team logo
- ANSI certified Safety Helmet.
- 1 qt H2O Drinking container: camel back or nalgene bottle w/ insulation recommended.
- Mess Kit
- 1 MRE
- Snacks
- Books, cards, etc.
- Sunscreen/ Bug repellent
- Sun Glasses
- Spare eye glasses
- Eye & Ear protection (OSHA Approved)
- Work Gloves
- Personal medications: -recommend ASA, Ibuprofen, Benadryl, and Imodium.
- Copy of Prescription Medications
- Credentials, DL, picture ID's
- Hat
- Flashlight, headlamp & spare batteries(rechargeable) and a charger
- Credit card, cash.
- Team Uniform, (2 pants -3 shirts) Note: Place in Ziploc bags.
- T-shirts, underwear (1 pair/each day of deployment) Note: Place in Ziploc bags.
- Work boots (OSHA approved recommended).
- Pillow
- Sleeping bag/ pad
- Off time clothing
- Outer jacket/ weather appropriate
- Large Zip lock bags
- Rain Gear
- Toilet Paper
- Survival Kit to include: compass, "pencil flares", water purification, glow sticks, strobe light, signal mirror, waterproof matches, wire, nylon cord, candles, energy gel, space blanket,
- Leatherman type tool.
- Personal hygiene items
- Washcloth & towel
- Shower sandals
- Mosquito netting
- Cold weather Clothing: gloves, boots, hat, long underwear, extra sweater

The following constitute Level C equipment:
Full-face mask, (NIOSH approved).
Hooded chemical-resistant clothing (overalls; two-piece chemical-splash suit disposable chemical-resistant overalls)
Gloves, outer, chemical-resistant
Gloves, inner, chemical-resistant
Boots, outer, chemical-resistant steel toe and shank
Boot, covers, outer, chemical-resistant
Hard Hats (OSHA guidelines)
Face shield (1)
Duct or chemical resistant tape

MNAST/MTF MCI Proposed Equipment Bags @ Staging Areas

Red Bag Supplies	Numbers
Dry Decon Kits	10
Yellow Triage Tape	1 roll
Vests	1 triage, 1 transport
Hudson Map Book	
Incident Response Plan Trifold	1
CBRNE pamphlet	1
Psychological First Aid Card	1

AST/MTF Vehicle Equipment Bags

Green Bag Supplies	Numbers
Helmet (Blue AST member)	1
Flashlight (helmet with clamp)	1 each
Extra Flashlight batteries	12 each bag - AA
AST member Vest	1
Dry Decon Kits	2
Bad Bug Kits	2
N95 Mask	2
Surgical Mask	2
White Coveralls	2
CBRNE Escape Hood	2
Work Gloves	1 pair
Modec Decon Formulation (MDF)	1 bottle
Chemical Neutralizer as necessary	1 bottle
Inflatable PFD	1
Incident Response Plan Trifold	1
CBRNE pamphlet	1
Psychological First Aid Card	1
Instruction Booklets: cell phone, helmets, PFD, GPS, EscapeHood	

MNAST/MTF Proposed Vehicle Equipment Bags

Team Member Clipboard

	General Message Form
	ICS 214
	ICS 205
	AST Guidelines
	AST ConOPs.
	Copy of Maps

Communications Equipment

Cell phone	1 per member
800 MHz radios/belt clip	1 per member
GPS unit	1 per vehicle

MISCELLANEOUS Vehicle Equipment

Coccoons	2 per vehicle
Bottled water	6 per vehicle

Uniforms

Blue AST shirt	1 per member
I.D. tag and lanyard	1 per member

Team Leader Bags

	Numbers
Clip board/extra pens	1 clipboard, 10 pens
Team Leader Binder	1
Green Bag with components	1 bag
Helmet - White Team Leader	1
Orange Reflective grease pen	2
Hudson Map Book	1
AA batteries	100 - AA
Hicks Solution	2 gallons
Spray bottles for Hicks Solution	2 bottles

Team Leader Communications

Above communications set	set
Satellite Phone	1

Pharmaceuticals for AST

Mark I Kits/Cyanide Anecdote Kit

1. **Purpose:** The purpose of this document is to provide the framework for the local and regional responses of EMS agencies, the MMRS and HHP assets and projects within the seven county Minnesota Metropolitan regions. The Emergency Management – Emergency Medical Services Annex provides information on the combined Metro Region EMS capabilities and allows for the local Emergency Manager and EMS Agency to discuss the local response capabilities.

2. **Incident notification:** Minnesota Duty Officer (MDO) – Homeland Security Emergency Management (HSEM) notify by PSAPS, MRCC, HAN, MNTrac Command Center.

3. **Incident Command and Control:** The National Incident Management System (NIMS) and the Minnesota Incident Management System (MIMS), which is NIMS compliant, are the basic structures used to coordinate the EMS response in the seven county Minnesota Metropolitan EMS Regions.

4. **Operations/Responsibilities:** The following are identified in the operations and responsibility plans:

    a. **EMS First Responder Emergency Care –** First Responders are defined differently in Primary Service Areas (PSA). The service provided by the First Responder agencies enhances the overall EMS system and ultimately the level of care the patient receives.
    b. **EMS Infection Control –** The Metro Region EMS has an EMS Exposure/Special Pathogen Situation Response Guide. This guide reviews the personal protective equipment (PPE) procedures (respiratory protection starts with surgical masks, proceed to N95's and then to PAPR as written) with fire personnel using SCBA as applicable. Hand washing, decontaminating equipment and rigs, and reporting any contamination contacts of concern are in place.
    c. **EMS Treatment and Transportation –** The EMS provided in each PSA is unique, based on the First Responders. It is the primary responsibility of each EMS

    d. Provider and their mutual aid partners to provide medical care within their respective PSA. Treatment includes basic and advanced life support procedures consistent with medical standards of care as defined in each EMS agencies protocols and by the authority of their respective Medical Director.

    e. **EMS Transportation Mutual Aid –** Each EMS agency is required by *Minnesota Statute Chapter 144E.101* to "have a written agreement with at least one neighboring licensed ambulance service for coverage during times when the licensee's ambulances are not available for service in its PSA. The Metro Region is in the process of obtaining a region-wide mutual aid compact/agreement with all of the EMS providers that would also be a part of an eight-region statewide mutual aid agreement.
    f. **EMS Communications / Metropolitan Medical Resource Control Center –** The Metro Region EMS providers communicate with essential Public Safety partners within their PSA. They also have the means to communicate with agencies on the regional and statewide level. Currently, in the Metro Region, EMS Providers plan to utilize, and migrate to the state resource - Allied Radio Matrix for Emergency Response (ARMER/800 MHz) system. ARMER provides an integrated system for digital radio and data transmissions. A basic tenet of its inception is to provide for all the interoperability needs required for a unified response to all emergencies. The interoperability components allow for system redundancy, inter-op capabilities between various frequencies such as VHF and UHF, as well as inter-op with the new 700 MHz frequencies. The EMS Region is committed to pursue interoperability in the field through its dedicated EMS tactical talk groups (TG), EMS Coordination TG, acquisition of an in-field cross-band repeater system, and its collaborative relationships with other ARMER stakeholders such as local and regional public safety providers. Resources of radios are available upon request.

The Metro Region has two (2) Medical Resource Control Center (MRCC); West MRCC is operated by HCMC – EMS Dispatch, and East MRCC is operated by Regions – EMS. Both MRCC's have a variety of core functions that enhance communications and coordination for EMS providers in Minnesota

g. **Patient Tracking –** The Metro Region EMS agencies utilize the triage system tags and tapes, and MRCC assists EMS agencies with MNTrac information regarding bed and service availability in hospitals. MCI static patient numbers of criticality for triage to hospital dispositions assist transports, and with the development of new MNTrac software patient tracking for notification will soon be available.

h. **EMS Triage and Scene Treatment –** The Metro Region EMS agencies have a Region wide Incident Response Plan (IRP). The IRP utilizes NIMS command and control principles and establishes a plan for all EMS providers to adhere to. The plan outlines, roles for EMS Incident Command, MRCCs, Transportation, Communications, and overall EMS scene control utilizing a similar START triage.

(Obtain the IRP Plan by contacting Ron Robinson, Metro Region EMS Coord. @ 651-643-8378)

i. **Equipment and Supplies –** Each EMS agency within the Metro Region maintains a minimum inventory requirement as outlined by *Minnesota Statutes Chapter 144E.103 Equipment*. The Minnesota Emergency Medical Services Regulatory Board (EMSRB) inspects and renews agency licensure every two years. EMS supply and equipment list databases have been organized and are available on request.

j. **EMS Public Information –** All EMS agencies in the Metro Region will coordinate with and support the Public Information Officer (PIO) as designated by the Incident Commander (IC).

k. **EMS Hazardous Materials Incident Response –** All EMS agencies in the Metro Region will follow agency protocols from the Department of Transportation Emergency Response Guide (DOT) and work with IC and/or requesting agencies that would provide information on the specific event (e.g. Poison Control).

l. **Decontamination –** All EMS agencies in the Metro Region will follow agency protocols and work with IC and/or requesting agencies that would provide information on the specific event. The EMS CBRNE document is a statewide resource to be used along with the DOT Response Guide for EMS patient care issues.

m. EMS System Coordination – The Metro Region has policies and operations in place for local EMS system coordination, along with mutual aid agreements. A committee titled: EMS Emergency Preparedness Committee will be the coordinating group in the event that an incident/event becomes larger than the local EMS agency and mutual aid can handle. This group would be requested by the local agencies to assist. This group could be activated whenever a regional or statewide EMS event would warrant**.**

n. **EMS Transportation Mass Casualty Protocols –** The Metro Region EMS Incident Response Plan (IRP) standardizes the roles for EMS Transportation, utilizing MRCC for overall transport needs.

o. **EMS Critical Incident Stress Management –** The Metro Region EMS Program is the major funding source for the Metro Critical Incident Stress Management (CISM) Team. The team provides:

- On scene support for protracted incidents to assess individuals for signs of stress and actions recommended, provide advise and counsel command staff and give support to victims or survivors.
- Demobilization debriefing sessions with responders after their shifts within a protracted incident. Assess and mange stress issues.
- Defusing occur shortly after the incident to allay stress reactions ongoing.
- Debriefing (CISM) occurs 24-72 hours after the incident.

Contact a CISM Coordinator at 612-347-5710 if services are needed.

p. **Medical Care, Shelter/Congregate Care Facilities –** Ongoing work yet in development.

q. Pharmaceutical SNS and Chempack Planning & Chempack Activation Plans – EMS agencies participate with multiple partners and are included in local plans.

r. **Strike Teams –**The Metro Region EMS program is the fiscal agent of a HSEM-EMSRB grant for EMS Strike Team Development. The region has been tasked to develop a deployable, self-reliant strike force of five (5) ambulances and at least one (1) team leader for up to 72 hours.

s. EMS Surge Capacity – The Metro Region EMS program has compiled the deployment information for all of the EMS agencies 24 hours a day, 7 days a week. This document provides a snapshot of the personnel and vehicles that are staffed. THIS DOES NOT MEAN THAT THESE RESOURCES ARE AVAILABLE! Many considerations need to be taken into account. It does provide a starting place for EMS Surge Capacity considerations**.**

t. **NDMS –** The Metro Region EMS has a plan for through put of patients with a National Disaster Medical System response.

u. **Metro Region EMS Staging Areas –** Four staging areas are currently assigned for regional staging sites for EMS resources entering or leaving the Metro Region. The purpose of these sites is to have responding agencies stage at these sites to receive necessary briefings, supplies, routes, assignments, etc. to assist in the overall coordination of the event that is taking place. The regional staging sites are:

- **North Memorial Ambulance Service – Brooklyn Center**
  (Staging for services coming from North and West)
- **Allina Health EMS – Savage Base**
  (Staging for services from the South)
- **Woodbury Public Safety – Woodbury**
  (Staging for services from the East)
- **St. Croix Valley EMS – Hudson, WI**
  (Alternate staging for services from the East, primarily Western WI. This staging area will depend on Homeland Security Emergency Management Agreements and state statutes).

u. Education and Exercise - there is an extensive education and exercise program plan. The plan is available upon request.

v. Collapse / Technical Rescue Resources – Both Minneapolis and St. Paul Fire services provide collapse and technical rescue resources (MN Taskforce 1) and will partner with EMS to meet the needs.

5. **Metro Region EMS Contact List:** The Metro Region **EMS** Coordinator maintains an **EMS** Contact list for the seven county Metro Regions that is updated annually. This contact list includes 24/7 contacts for each **EMS** agency in the Metro Region and an **EMS** Coordination Center (**MREMSCC)** contact list**. MREMSCC** is activated during a major incident to coordinate a regional response.

6. **Metro Region Resource List**: Additionally, the Metro Region **EMS** Coordinator maintains an **EMS** resource list for the nine county Metro Region that is updated annually. The resource list includes ambulance base locations, EMS disaster trailers, and other specialty equipment.

7. **Health and Medical Multi Agency Coordination Center (Healthcare MACC):** If a Health and Medical MACC is activated in the Metro Region, the Metro Region EMS Coordinator and/or a member of the Metro Region EMS Emergency Preparedness Committee will represent EMS in the regional MACC.

8. **EMS Emergency Preparedness Committee:** The members of the workgroup represent many of the EMS agencies of the Metro Region comprised of command level personnel. Their objectives in planning are outlined by regional EMS, HSPP, and Homeland Security grants. The group has been designated by the EMS Directors along with the EMS Coordinator to work through regional issues and events that would require a regional focus. Plans are being formulated for the workgroup to be the coordinating body if an incident/event becomes larger, such as a statewide event.

MINNESOTA EMERGENCY MEDICAL SERVICES REGULATORY BOARD

MINNESOTA STATEWIDE TRAUMA SYSTEM

Minnesota EMS Trauma Field Triage Guideline

August 2023

	Field Triage Indicator	Evidence[1]	Transport Directive[2]
Airway	Compromised and unsecure airway	▪ Airway obstruction ▪ Unable to intubate or place supraglottic airway	Transport to the closest designated trauma hospital within 30 minutes.
Breathing	Respiratory distress	▪ RR < 10 or > 29 ▪ Need for respiratory support ▪ Room-air pulse oximetry <90%	▪ Transport to a designated level 1 or 2 trauma hospital that is within 30 minutes transport time. ▪ If no level 1 or 2 within 30 minutes transport time, transport to closest designated trauma hospital within 30 minutes transport time, or to a more appropriate higher-designated trauma hospital if predetermined by local medical directions. ▪ If no designated trauma hospital is within 30 minutes transport time, transport to the closest hospital.
Circulation	Signs of shock	▪ HR > SBP ▪ Hypotension	
Disability	Unable to follow commands[3]	▪ GCS motor score < 6 ▪ AVPU < A	
Injury Pattern	Known or suspected high-risk injury	▪ Proximal penetrating injuries ▪ Skull deformity ▪ Chest wall instability ▪ Suspected pelvic fracture ▪ Extremity crushed, degloved, mangled, or pulseless ▪ Proximal amputation ▪ Uncontrolled hemorrhage ▪ Hemorrhage requiring tourniquet	

Mechanism of Injury	High-risk mechanism	▪ High-risk motor vehicle crash
		▪ Partial or complete ejection
		▪ Significant intrusion
		  ▪ > 12 inches occupant side
		  ▪ > 18 inches anywhere
		▪ Need for extrication
		▪ Death in same compartment
		▪ Unrestrained child < 10 y.o.
		▪ Vehicle telemetry data consistent with severe injury
		▪ Rider separated from vehicle with significant impact (motorcycle, ATV, horse, etc.)
		▪ Pedestrian or bicycle rider thrown, run over, or significant impact
		▪ Fall > 10 feet (any age)
			Consider transport to a designated trauma hospital.

EMS Judgement	Trauma with risk factors	▪ Low-level falls, < 6 or > 65 y.o. with significant head impact ▪ Anticoagulant use ▪ Suspected child abuse ▪ High-resource health care needs ▪ Pregnancy > 20 weeks ▪ Burns with concomitant trauma	

Children ≤ 14 y.o. should be preferentially triaged to a pediatric trauma hospital when possible.

[1] Items listed in the *Evidence* column suggest that the Field Triage Indicator may be met but are not required criteria for the purposes of Minnesota Statutes 144E.101, Subdivision 14.

[2] EMS agencies wishing to deviate from these trauma field triage guidelines due to the availability of local or regional resources can apply to the EMSRB in accordance with Minnesota Statutes 144E.101, Subdivision 14 if the deviation is in patients' best interest.

[3] Altered from baseline and resulting from a traumatic event