METROPOLITAN AREA HOSPITAL COMPACT

This Compact is made and entered into by and between the thirty undersigned hospitals located in the seven-county Minneapolis / St. Paul metropolitan area.

RECITALS

WHEREAS, this Compact is not a legally binding contract but rather this Compact signifies the belief and commitment of the undersigned hospitals that in the event of a disaster, the medical needs of the community will be best met if the undersigned hospitals cooperate with each other and coordinate their response efforts.

WHEREAS, the undersigned hospitals desire to set forth the basic tenants of a cooperative and coordinated response plan in the event of a disaster.

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

ARTICLE I

COMMUNICATION BETWEEN THE UNDERSIGNED HOSPITALS DURING A DISASTER

The undersigned hospitals will:

1.1 Communicate and coordinate efforts to respond to a disaster via their liaison officers, public information officers, and incident commanders primarily.

1.2 Receive alert information via web-based hospital status system regarding any disaster or special incident with radio notification by East and West Metro Medical Resource Control Centers (MRCC) as a back-up system.

1.3 Communicate with each other's Hospital Command Center (HCC) by; landline, fax, email, and will maintain 800 MHz radio capability to communicate as minimum redundant communications.

1.4 Utilize a Joint Information System (JIS) 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 hospital should designate a Public Information Officer (PIO) to coordinate with JIS. The RHRC will appoint a hospital PIO to the JIS as needed. The JIS may be coordinated through the Minnesota Department of Health (MDH), Minnesota Department of Public Safety – Division of Homeland Security and Emergency Management (HSEM), or the Minnesota Hospital Association (MHA). If no umbrella organization or PIO assigned by the Public Information Workgroup of the Compact Committee assumes responsibility, a PIO assigned by the RHRC Coordinator will assume this responsibility.

1.5 Provide name and age of disaster victims to the RHRC, jurisdictional assistance center and/or American Red Cross (ARC) assistance center for purposes of victim location by family members.

1.6 Provide to the RHRC, when permitted, appropriately detailed information about unidentified patients (John/Jane Doe) at their institution in order to facilitate identification.

ARTICLE II

ONGOING COMMUNICATION ABSENT A DISASTER

The undersigned hospitals will:

2.1 Meet at least twice yearly to discuss emergency response issues and coordination of response efforts.

2.2 Identify primary point-of-contact and back-up individuals for ongoing communication purposes. These individuals will be responsible for determining the distribution of information within their healthcare organizations.

2.3 Review on an annual basis existing plans and documents involving the metropolitan hospitals. This may include but is not limited to the metropolitan hospital compact response plans and memorandums of understanding.

ARTICLE III

FORCED EVACUATION OF AN UNDERSIGNED HOSPITAL

3.1 If a disaster affects an undersigned hospital(s) forcing partial or complete facility evacuation, the other undersigned hospitals agree to participate in the distribution of patients from the affected hospital, even if this requires activating emergency response plans at the receiving hospital.

3.2 In the event of an evacuation, East and West Metro Medical Resource Control Centers (MRCC), in conjunction, if necessary, with the Regional Hospital Resource Center (RHRC), will be the hospital point-of-contact to assist with organizing transportation (bus, Wheel Chair, BLS, ALS, critical care) for the evacuation and will distribute patients equitably to the unaffected undersigned hospitals

3.3 The undersigned hospitals in the Hennepin County EMS System will contact West Metro MRCC or the RHRC for assistance with location of available hospital beds and transportation of patients. The undersigned hospitals not in the Hennepin County EMS System, will contact East Metro MRCC or the RHRC (*See*, Exhibit C).

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. MRCC resource lists may be used by the affected undersigned hospital to help arrange transportation resources.

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 East and West Metro MRCC will determine bed availability and capability in the undersigned NDSM participating hospitals for the Federal Coordinating Center (FCC) at the Minneapolis VAMC using web-based status system.

4.2 If patients are to be received from outside the metropolitan area in response to the activation of the NDMS, these patients will be distributed according to the undersigned NDMS participating hospitals' bed capacity and capabilities per existing NDMS agreements. The RHRC will assist the FCC with assignment of incoming patients to appropriate hospitals.

4.3 If the National Disaster Medical System is activated in response to a disaster in the metropolitan area, East and West Metro MRCC and the RHRC will obtain information from the undersigned hospitals regarding the number of patients that require transportation and will coordinate resources with MDH, HSEM, and EMS agencies.

ARTICLE V

REPORTING BED CAPACITY AND CAPABILITY

5.1 The undersigned hospitals will use a designated web-based site to report the hospital's available staffed bed capacity, its capabilities and its Emergency Department's ability to receive patients. System capacity and reporting will be monitored by MRCC. The undersigned hospitals that provide emergency services to the public 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 (e.g.: telephone reporting).

5.2 Daily bed capacity and capabilities will include at a minimum: medical/surgical floor, monitored (step down), and ICU with additional bed categories and information collected as needed during an emergency incident.

ARTICLE VI

ALTERNATE CARE SITE

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

6.2 If an alternate care site (ACS) is required, the RHRC will coordinate site selection with the hospitals, emergency management, and MDH and provide assistance with ACS administration, staffing, and site operations. Jurisdictional emergency management and public health agencies will support the operation of such sites.

6.3 The undersigned hospitals may be asked to contribute volunteer staff to an alternate care site on an urgent basis, subject to availability.

6.4 If available, each undersigned hospital will provide teams within 24 - 48 hours to staff the alternate care site. Each team will be expected to care for 50 patients requiring ongoing austere medical care. A suggested team is 1 MD, 1 PA/NP or other physician, 6 RN or LPN/EMT-P, and 4 health care assistants / EMT, and 10 other support personnel. These teams will function as a unit (for example, the 'green team') at the alternate care site.

- Each undersigned hospital >200 operating beds will plan to contribute 2 teams rotating 12 hour shifts for 40-80h.based on the event.
- Each undersigned hospital < 200 operating beds will plan to contribute 1 team rotating 12 hour shifts for 40-80h. based on the event.
- Ongoing staffing after 80h will involve at least some hospital staff, with outside agencies, medical reserve corps volunteers, MN-1 Disaster Medical Assistance Team, and other alternative staff also being utilized to provide for ongoing care. The RHRC will work with County and State (MN-Responds) resources as well as the hospitals to help coordinate ongoing medical staffing.

ARTICLE VII

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

7.1 In the event of a disaster when patient care staff is in surplus at one of the undersigned hospitals and lacking at another, the undersigned hospital with the surplus will share staff to help ensure that the available hospital beds in the metropolitan area are adequately staffed during a disaster (*See*, Exhibit B).

7.2 In the event that needed supplies are in surplus at one of the undersigned hospitals and lacking at another, the undersigned hospital with the surplus should share supplies to help ensure that patients in the metropolitan area receive necessary treatment during a disaster (*See*, Exhibit B).

7.3 The above staff and supply sharing should occur in cooperation between the incident commanders/ designated command center staff at the involved undersigned hospitals (*See*, Exhibit B).

ARTICLE VIII

MISCELLANEOUS PROVISIONS

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

8.2 Amendments to this Compact must be in writing and signed by the participating hospitals.

8.3 An undersigned hospital 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 hospitals and the officers of the metropolitan hospital compact.

_____ _____

Signed Dated

_____ _____

Printed name Title and hospital represented

_____

Received Dated

Participating Hospitals:

Abbott Northwestern
Bethesda Hospital*
Children's Hospitals and Clinics of MN Minneapolis
Children's Hospitals and Clinics of MN St Paul
Fairview Ridges
Fairview Southdale
Gillette Children's Hospital*
Hennepin Healthcare System/HCMC
Lakeview Hospital
Maple Grove Hospital
Mercy Hospital
North Memorial Healthcare
Northfield Hospital
Park Nicollet Health Services/Methodist
Phillips Eye Institute*
Prairie Care*
Mayo Clinic Health System New Prague
Regency Hospital*
Regina Hastings
Regions
Ridgeview Waconia
St. John's Hospital
St. Joseph's Hospital
St. Francis Regional Medical Center
Shriners Hospitals for Children/Twin Cities
University of Minnesota Medical Center – Riverside Campus
University of Minnesota Medical Center – University Campus
United Hospital
Unity Hospital
Woodwinds
Veteran's Affairs Medical Center *

*** denotes facilities which cannot participate in full compact due to institutional restrictions, but support the process and general provisions.**

EXHIBIT A

DEFINITION OF TERMS

Affected Hospital: The facility directly impacted by the event/disaster. Also recipient hospital for supplies and personnel. The hospital where disaster patients are being treated and have requested personnel or materials from another facility. Also referred to as the patient-transferring hospital when evacuating/transferring patients from the facility during a medical disaster.

Assisting Hospital: The donor hospital that provides personnel, pharmaceuticals, supplies, or equipment to a facility experiencing a disaster. Also referred to as the patient-receiving hospital when involving evacuated patients.

Alternate care site: A facility established to provide ongoing patient care in a non-hospital environment, primarily to serve as austere care overflow bed space during an 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 (e.g.: a casualty collection point at a air crash site), or between the hospital and outgoing transportation resources (e.g.: an airport hanger during a National Disaster Medical System evacuation from the Twin Cities area).

Disaster: a situation in which an incident's resource requirements exceed available resources.

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

Hospital Command Center (HCC): The hospital's coordination center for response to an incident.

Joint Information System (JIS): A process of information coordination 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. May or may not involve a physical location of operations.

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 in relation to hospital resources, coordinating EMS communications during a disaster, tracking patients during a disaster, and obtaining resources (medical director consultation / notification, Critical Incident Stress Management (CISM) contact point, transport resources) among other responsibilities.

Minnesota Department of Public Safety – Division of Homeland Security and Emergency Management: DPS division responsible for disaster response coordination and mitigation. DPS-

HSEM is the state agency which will coordinate state and federal resource response during a disaster.

Minnesota Department of Health: (MDH) works to protect, maintain and improve the health of all Minnesotans. This work covers a broad range of activities, from monitoring infectious diseases to investigating complaints in nursing homes and hospitals, from preventing chronic disease to reducing health disparities.

MNTrac: An internet-based hospital status system used by all Twin Cities metropolitan hospitals to report open/closed/divert status in real time and to facilitate communications and resource monitoring. Messaging functions via MNTrac can reach all hospitals with messages simultaneously. Additional functionality according to the compact language adds bed capacity reporting provisions which are to be updated daily so that real time data is available in case of a mass casualty incident / disaster. MNTrac is overseen by the Minnesota Department of Health.

Multi-Agency Coordination (MAC) – mechanism by which multiple agencies from multiple jurisdictions share information and develop policy guidelines to insure coordination of activities occurring across multiple jurisdictions or agencies. Mechanisms exist in the metro area to allow the RHRC, Metropolitan EMS Board, regional EMS Regulatory Board, regional HSEM representative, Metro Local Public Health Association, metro emergency management, and MDH to coordinate activities in the event that an incident occurs that affects multiple jurisdictions and thus cannot be managed well from a single jurisdictional EOC.

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.

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

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. HCMC will have this function in the metro area unless otherwise assigned during an incident.(Note: Regional Hospital Preparedness Coordinator (RHPC) is a position contracted by MDH under the Healthcare Preparedness Program (HPP) grant to assure regional grant planning activities are accomplished.)

EXHIBIT B

RESOURCE REQUESTS, SHARING, AND EVACATION OPERATIONS

1. Requirements for non-medical resources (e.g.: security staff, food, fuel, potable water) should be made to the Emergency Operations Center in the facility's jurisdiction if the needs cannot be met through usual vendors and sources or, where applicable, from within an affiliated healthcare system (summary of request process see algorithm - Appendix 1)

2. Initiation of transfer of personnel, material resources, or patients: Only the incident commander or designee at each hospital has the authority to initiate the transfer or receipt of healthcare personnel, medical resources, or patients after making a determination as to the resources required

3. The affected hospital (patient-transferring hospital) is responsible for notifying and informing the RHRC of its healthcare personnel or material needs.

4. Upon the request by the incident commander or designee of the affected hospital, the Regional Hospital Resource Center (RHRC) will contact other participating hospitals to determine the availability of additional healthcare personnel or material resources as required by the situation. The affected hospital will be informed as to which hospitals should be contacted directly for assistance that has been offered. The command center of the affected and assisting hospitals will coordinate directly to arrange the assistance (EXCEPT in cases of emergent hospital evacuation, when MRCC will assist equitably distributing patients to facilities with regard to capacity).

5. Authorization: The affected hospital will have supervisory direction over the assisting hospital's staff, borrowed equipment, supplies, pharmaceuticals and other materials once they are received.

6. Documentation: During a disaster, the affected hospital will accept and honor the assisting hospital's standard requisition forms. Documentation should detail the items involved in the transaction, condition of the material prior to the loan (if applicable), and the party responsible for the material.

7. Clinical personnel offered by assisting hospitals should be limited to staff that are **fully accredited (e.g.: licensed) and credentialed in the assisting institution**. No resident physicians, medical/nursing students, or in-training persons should be volunteered.

8. Assisting hospitals assume the legal and financial responsibility for transferred patients upon patient's arrival into the assisting hospital.

9. The affected hospital will reimburse assisting hospital for cost of personnel, equipment and supplies provided by the assisting hospital. The cost of such will be at the assisting hospitals' usual and customary rates of staff reimbursement or supply cost unless otherwise agreed to in writing by both parties.

A. Medical Operations/Loaning Personnel

1. Communication of request: The request for the transfer of personnel initially can be made verbally. The request, however, must be followed up with written documentation. This should ideally occur prior to the arrival of personnel at the affected hospital. The affected hospital will identify to the assisting hospital/RHRC the following:

   a. The type and number of requested healthcare personnel.
   b. An estimate of how quickly the request is needed.
   c. The location where they are to report.
   d. An estimate of how long the personnel will be needed.

2. Documentation: The arriving donated personnel will be required to present their assisting hospital identification badge at the site designated by the affected hospital's designated labor pool / check-in site. The affected/recipient hospital will be responsible for the following:

   a. Meeting the arriving donated personnel.
   b. Confirming the donated personnel's ID badge with the list of personnel provided by the assisting hospital.
   c. Providing additional identification, e.g., "visiting personnel" badge, to the arriving donated personnel as needed.
   d. Completing any credentialing required by facility bylaws (and compliant with relevant standards including Joint Commission)

   The affected/recipient hospital will accept the professional credentialing determination of the assisting/donor hospital (subject to verification of credentials when required) but only for those services for which the personnel are credentialed at the assisting hospital.

3. Supervision: The affected hospital's incident commander or designee identifies where and to whom the donated personnel are to report, and professional staff of the recipient hospital will supervise the donated personnel. An appropriate supervisor will brief the donated personnel of the situation and their assignments. If appropriate, the "emergency staffing" rules of the recipient hospital will govern assigned shifts. The donated personnel's shift, however, should not be longer than the customary length practiced at the assisting/donor hospital.

4. The Medical Director of the affected hospital will be responsible for providing a mechanism for granting emergency credentialing privileges' for physician, nurses and other licensed health care providers to provide services at the recipient hospital.

5. Demobilization procedures: The affected hospital will provide and coordinate any necessary demobilization procedures and post-event stress debriefing. The affected hospital is responsible for providing the donated personnel transportation necessary for their return to the assisting hospital.

B. Transfer of Pharmaceuticals, Supplies or Equipment

1. Communication of Request: The request for the transfer of pharmaceuticals, medical supplies, or equipment initially can be made verbally. The request, however, must be followed up with a written communication. This should ideally occur prior to the receipt of any material resources at the recipient hospital. The affected hospital will identify to the assisting hospital/RHRC the following:

   a. The quantity and exact type of requested items.
   b. An estimate of how quickly the request is needed.
   c. Time period for which the supplies will be needed.
   d. Location to which the supplies should be delivered.

   The assisting hospital will identify how long it will take to fulfill the request.

2. Documentation: The recipient hospital will honor the donor hospital's standard order requisition form as documentation of the request and receipt of the materials. The recipient hospital's security officer or designee will confirm the receipt of the material resources. The documentation will detail the following:

   a. The items involved.
   b. The condition of the equipment prior to the loan (if applicable).
   c. The responsible parties for the borrowed material.

   The donor hospital is responsible for tracking the borrowed inventory through their standard requisition forms. Upon the return of the equipment, etc, the original invoice will be co-signed by the senior administrator or designee of the recipient/affected hospital recording the condition of the borrowed equipment.

3. Transporting of pharmaceuticals, supplies, or equipment: The recipient hospital is responsible for coordinating the transportation of materials both to and from the donor hospital, though the donor hospital may offer transport. Upon request, the receiving hospital must return and pay the transportation fees for returning or replacing all borrowed material.

4. Supervision: The recipient hospital is responsible for appropriate use and maintenance of all borrowed pharmaceuticals, supplies, or equipment.

5. Financial and legal liability: The affected hospital, to the extent permitted by law, is responsible for all costs arising from the use, damage, or loss of borrowed pharmaceuticals, supplies, or equipment.

6. Demobilization procedures: The affected hospital is responsible for the rehabilitation and prompt return of the borrowed equipment to the assisting hospital.

C. Transfer/Evacuation of Patients

1. Communication of request: The request for the transfer of patients initially can be made verbally to the appropriate MRCC (emergent evacuation) or RHRC (urgent evacuation – allows time to set up RHRC). The request, however, must be followed up with a written communication as soon as possible. The affected hospital will identify for MRCC and appropriate local EMS agencies / RHRC

   a. The number of patients needed to be transferred.
   b. The general nature of their illness or condition.
   c. Any type of specialized services required

2. Patient facility assignment: In cooperation with the RHRC, the MRCC responsible for the affected facility will equitably distribute patients according to facility resources as determined by existing capacity information or gathered information during the event.

3. Documentation: The affected hospital is responsible for providing the assisting hospital with the patient's medical records, insurance information and other patient information necessary for the care of the transferred patient. The affected hospital is responsible for tracking the patient destinations of all patients leaving their facility and the assisting hospital is responsible for tracking all patients arriving to their facility.

4. Transporting of patients: The affected hospital is responsible for coordinating (with MRCC and the RHRC) and financing (if necessary) the transportation of patients to the assisting hospital. Once admitted, that patient becomes the assisting hospital's patient and under care of the assisting hospital's admitting medical staff until discharged, transferred or reassigned. The affected hospital is responsible for transferring of extraordinary drugs or other special patient needs (e.g., equipment, blood products) along with the patient if requested.

5. Reimbursement for care should be negotiated with each third party payer under the conditions for admissions without pre-certification requirements in the event of a disaster.

6. Notification: The affected hospital is responsible for notifying both the patient's family/ legal guardian and the patient's attending or personal physician of the situation. The assisting hospital may aid in these efforts.

EXHIBIT C

REGIONAL HOSPITAL RESOURCE CENTER (RHRC) FUNCTIONS

1. Contact for resource requests from an individual facility in the absence of a community emergency is the **administrator on-call** for the respective institution via their main operator. The RHRC is not activated in this situation.

2. The RHRC may be contacted by any member hospital affected by an emergency circumstance by calling 612-873-9911 or 612-873-3232 and request that RHRC on-call be paged or hailing the RHRC via 800 MHz radio on EMH-CALL. The RHRC function is activated when the on-call officer of the compact determines that a need exists for situational awareness communication, multiple hospital coordination activities, resource allocation, patient movement, and other complex responses to a community emergency.

   Regional Hospital Resource Center Activation will be classified:
   - **Partial Activation:** RHRC staff will assist with situational awareness communications or other informational needs. Coordination will usually be virtual.
   - **Full Activation**: RHRC Coordination Center will open a physical location to manage resource or transfer needs and support other hospital response efforts. This may be co-located with other entities as a Multi-Agency Coordination Center, or at a jurisdictional Emergency Operations Center, at MDH, or at HCMC and/or virtual.

3. The RHRC provides a central coordination point for the Compact hospitals during a community emergency. The RHRC serves as the clearinghouse for collecting and disseminating current information about the event, equipment, bed capacity and other hospital resources during a disaster. The information collected by the RHRC is to be used only for disaster preparedness and response.

4. The notified RHRC representative will notify the RHRC including the Compact officers of activation. The officers shall be responsible for hospital response coordination including developing strategies and tactics to address the situation when necessary. These decisions shall be guided by as much input as possible from member hospitals. The RHRC activation does not preclude individual facilities from coordinating with other institutions or agencies (particularly local public safety or emergency management for logistical support), but should be kept appraised of such coordination efforts to the degree that they affect medical response or resources available. The guidance provided by the Compact officers and the RHRC during an emergency to the hospitals is not binding.

5. The RHRC will establish Multi-Agency Coordination with public health, EMS, emergency management, and other stakeholder agencies at the regional level to represent the interests of the metropolitan hospitals as required by an incident to assist with maintenance of common operating picture and resource and policy coordination.

   The RHRC may request staffing assistance from member hospitals during a protracted event or in the event that the coordination function workload overwhelms capabilities.

Other Minnesota regional RHRC's could also be called upon to assist.

6. During an emergency that requires patient movement (inbound or outbound) the RHRC will act as the coordination point for patient movement activities as required by the demands of the incident. Such activities may include (but is not limited to) coordination of patient lists, transfers, coordination of patient transportation, coordination of patient movement with MDH and MRCC (outbound) or the VA and NDMS system (inbound).

7. The affected hospital (or hospitals) is responsible for notifying the RHRC of its medical personnel or material needs or its need to evacuate patients (evacuations require immediate notification of the local MRCC as well). Upon request by the affected hospital's incident commander or designee, the RHRC will contact the other participating hospitals to determine the availability of additional personnel or material resources, including the availability of beds, as required by the situation (MRCC will coordinate bed availability data and hospital destination/assignment during an emergency facility evacuation). The affected hospital will be informed as to which hospitals should be contacted directly for assistance that has been offered. The command center of the affected and assisting hospital will then coordinate directly for this assistance EXCEPT in the case of emergent/urgent hospital evacuation or other special circumstances, when the RHRC and MRCC will assist as coordinators.

8. In the event that the RHRC recognizes inadequate resources to meet requests, or anticipates such situation developing during a community emergency, an immediate conference (via telephone, or in person) of the Compact hospital ICs or designees shall occur, during which the best strategy for allocation of limited resources shall be made. The appointment of a Regional Medical Advisory Team and Triage Team may be required (see Appendix 2). If time does not permit such consultation the Compact Chair, Vice-chair, or Secretary (in order of succession) shall agree upon an allocation strategy that seems to provide the greatest good for the greatest number of persons. The RHRC will then allocate resources accordingly. At the earliest opportunity, a conference as described above shall occur to discuss the decision(s) and determine future actions.

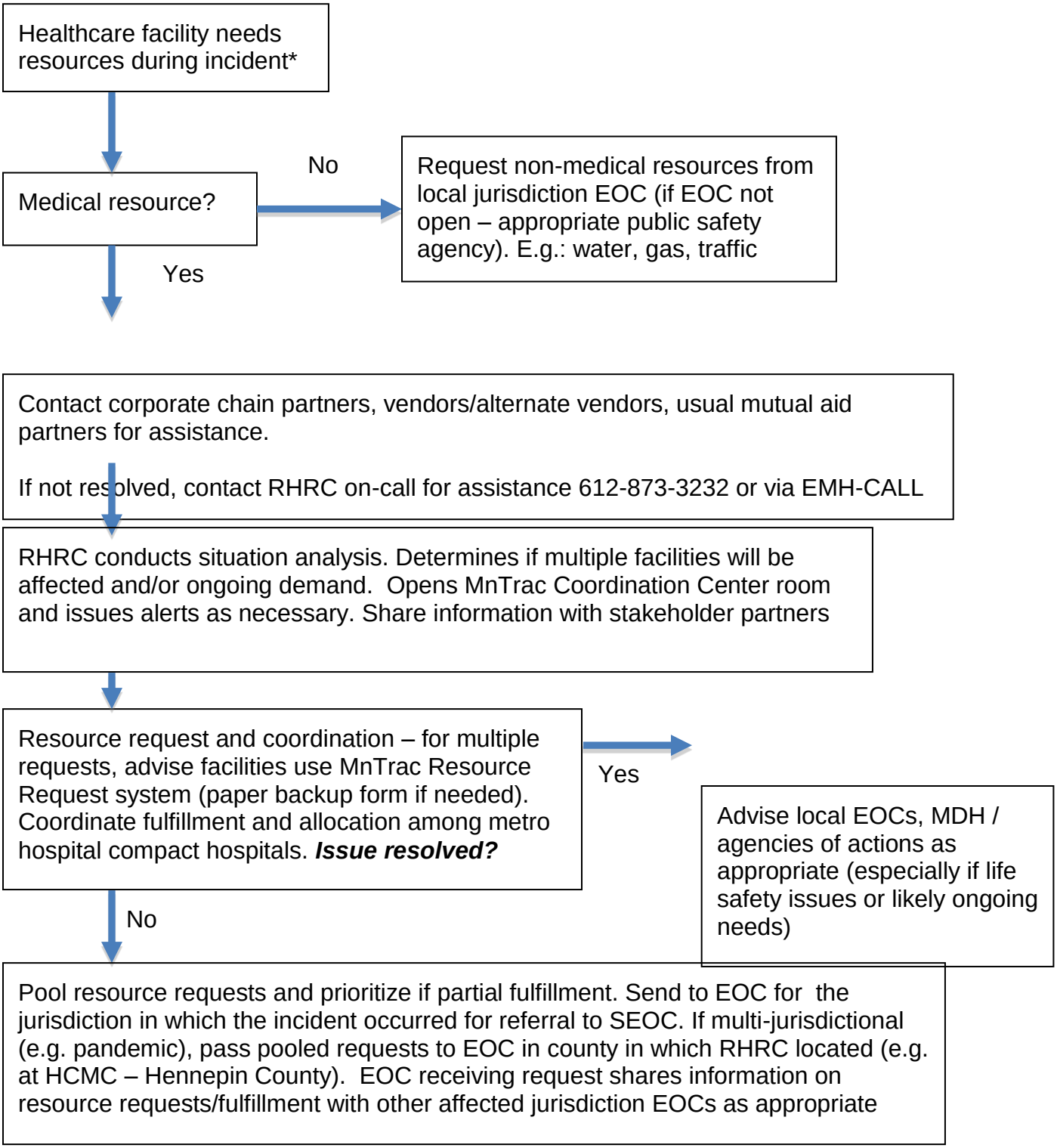
9. During a compact exercise or emergency, each hospital will report to the RHRC the current status of their ED and inpatient capacity, and any additional personnel or materials so requested based upon the demands of the incident including durable medical supplies, specialty staff, or support staff.

10. During an emergency, only the hospital incident commander (or designee) at each hospital has the authority to request or offer assistance through the compact.

11. Hospitals may seek resources and staff directly from other hospitals within the system during an emergency if they so choose, but will notify the RHRC of actions taken if those resources are likely to be in demand at multiple facilities.

Appendix 1

Metro Hospital Compact Emergency Resource Request Process



Appendix 2

* Resources required but no emergency incident – use usual corporate partners, alternate vendors, direct request to department at other facility (e.g. pharmacy, bioelectronics) per usual mutual aid processes

Metro Hospital Compact Scarce Resource Triage: Concept of Operations

I. Purpose: To describe the actions of the metropolitan hospital compact and other health and medical entities to a situation in which inadequate resources are available to provide usual medical care.

II. Scope: Seven county Minneapolis/St. Paul metropolitan region, specifically including the thirty hospitals of the Metropolitan Hospital Compact.

III. Foundation: When resources in an emergency situation do not allow provision of usual care, a shift from patient-centered to community-centered decision-making must occur, with allocation of limited resources to those most likely to benefit.

- Foundational ethical and system principles as outlined in the Institute of Medicine document 'Guidance for Establishing Crisis Standards of Care for Use in Disaster Situations: A Letter Report' are adopted as the basis for this concept of operations.
    - The decision process and tool for critical care decision-making as published by the MN Dept. of Health are used as the decisional foundation but must be adapted to the specifics of the incident (http://www.health.state.mn.us/oep/healthcare/standards.pdf).[1]
- Principles to be respected in the process
    - Fairness
    - Equitable processes including transparency, consistency, proportionality, and accountability
    - Community and provider engagement, education, and communication
    - Rule of law – including the environment of the decisions and the authority to make them
- Pre-existing conditions to resource triage:
    - Incident management system must be activated (if isolated situation must at least notify administrator on-call) at the healthcare facility, with Clinical Care Committee or other decision-making group convened per the facility plan
    - Surge capacity fully employed within healthcare facility
    - Maximal attempts at obtaining the resource from vendors, mutual aid, and implementation of conservation, substitution, adaptation, and re-use performed
    - Patient transfer or resource importation not possible or will occur too late to consider bridging therapies
    - Request for necessary resources made to local and regional health officials
    - Declared state of emergency (or in process, or not applicable if an isolated situation)

[1] Note that these guidelines do NOT recommend that general age or societal factors enter into decisions about resource triage. (Age-based triage may be an element that the community desires to incorporate, but there are no specific guidelines at present)

- Decision tools
    - Decision support tools are available for ventilators and similar critical care interventions at: http://www.health.state.mn.us/oep/healthcare/standards.pdf
    - The underlying disease state and its survival and epidemiology must be also accounted for in the decision process
    - The tools are not a substitute for clinical judgment and other medical prognostic factors may be considered
- Allocation and re-allocation:
    - Re-allocation of critical care resources only occurs when a triage team determines that the patient using the resource has a substantially worse prognosis (may have other factors affecting decision as well such as duration of use and limited benefits) – this substantial difference that justifies re-allocation will be explained in the medical record as well as recorded for internal review of decisions made.
    - Allocation decisions rely on the same criteria, but in this case smaller differences in prognosis between the patients may justify an allocation decision.
    - First-come, first served principles are the default if allocating between two patients with apparently equal prognosis and demand factors (that is, patient already on ventilator or waiting longer would keep/get the ventilator)
    - Lottery - if need for resource by time cannot be established
    - Random table and other tools may be used for broad demand for limited resources – this situation will be addressed by the Regional Medical Advisory Team as required

IV. Concept of Operations

1. Triage: This concept of operations refers only to proactive triage, when the incident scope and the resources are defined, and incident management in place. Reactive triage, occurring early in an event (usually in the emergency department) and in the absence of understanding the scope/impact of the event are *not* considered in this plan and rely on the clinical skills of the providers to allocate resources as needed to provide the greatest good for the greatest number of patients.
2. Triggers: A situation when demand exceeds supply for specific resources (personnel or material) and healthcare facilities face competing demand for resources. This may involve (but is not limited to) re-use or re-allocation or restriction of critical life-sustaining therapies (ventilators, ECMO).
3. Notification: Any facility unable to meet specific critical resource needs for patient care or in a situation when demand for critical resources exceeds supply (and having met the conditions above under foundation) may notify the Regional Hospital Resource Center (RHRC) directly via designated phone if the RHRC is open, via EMH-CALL talkgroup or at 612-873-3232 if RHRC is not open (request RHRC on-call be paged). RHRC on-call will assess situation including scope, acuity (decision timeframe) and duration of event:

4. Situations
    a. Non-sustained, limited situation – RHRC not activated – RHRC on-call will notify compact medical advisor (Dr. John Hick or Dr. Dan O'Laughlin). Medical advisor will discuss situation with caregivers on conference call and provide *facilitation* if action is immediately warranted including assuring that no substitute or adaptable resources are available to be obtained from regional/state/national level that would provide appropriate resolution nor is patient transfer possible/appropriate. Note that in this situation there are no emergency health powers in effect and RHRC personnel do not serve as a decision-maker. Strong consideration should be given for discussion of the case with MDH regarding event and any legal/policy implications.
    b. Sustained or pervasive situation requiring or likely requiring multiple triage decisions – RHRC opened (virtual or physical) to manage resources, information exchange and requests, communicate with MN Dept. of Health to assure appropriate resource requests and declarations of public health emergency. Assure hospitals/systems are appointing clinical care / triage teams as necessary. Stand up Regional Medical Advisory Team (RMAT) subject matter RMAT experts are taken from a list maintained by the RHRC including:
        i. Two adult critical care physicians
        ii. One pediatric critical care physician
        iii. Hospital administrator
        iv. Legal counsel (Hennepin County liaison to HCMC)
        v. One emergency physician
        vi. One medical advisor for the hospital compact
        vii. Subject matter experts per resource(s) involved
        viii. Ethics committee chair
        ix. Metro hospital compact chair or designee

        The RMAT will monitor capacity, severity of illness, resource availability, and scope/type of triage decisions being made across the metropolitan region. Virtual communication (Via a web-based status system coordination center) and conference calls will be the primary mechanism of coordination and decision-making as most of these members will have responsibilities at their home institutions as well as their regional responsibilities.

        A triage team at the regional level may be used to make decisions about patient transfers into metro and between metro hospitals based on resource availability, as well as to assist smaller hospitals with occasional triage decision-making. The two critical care providers from the RMAT may serve as the triage team or, if the incident requires long-term and frequent decisions, the regional triage team function will rotate between Allina, Fairview, and HealthEast systems every third day. These personnel will conference with the RMAT on their briefings on their 'on-call' days. All decisions made by the RMAT and any affiliated triage teams will be

documented and reviewed within 72h by the group for consistency. Documentation RMAT triage team decisions in the patient's medical record is the responsibility of the patient's healthcare facility.

Facilities making their own triage decisions should document according to usual incident management practices. Decisions affecting an individual patient should be documented in the medical record as to the situation and clinical factors weighing into the decision, as well as outlining the continued care that is to be provided.

V. Communications:

1. Public information
    a. The RHRC will work with other agencies including state and local public health to provide public messaging via the Joint Information Center (JIC) regarding therapies being offered and managing expectations of the public (e.g.: not all patients are able to receive x treatment at this time and allocation of these treatments represents a 'trial' of therapy not an assignment).
    b. Healthcare facilities must provide information to clinic and emergency department patients outlining the situation, explaining waits, options, and any resource shortfalls, as well as the steps the facility is taking to address the needs
2. Provider information – healthcare facilities must provide daily updates to staff as to the situation and actions being taken at the facility. This should be part of the incident action planning process and facilitated by the public information officer.

VI. System monitoring and equilibration

1. Conference call each day between the hospital / health system clinical care committee leads and members of the RHRC and RMAT will provide opportunities for briefings, problem-solving, and discussion.
2. Daily data pertaining to resource triage from institutions must be reported to the RHRC using MnTrac or a designated on-line spreadsheet (for example, in ventilator triage situation - minimum SOFA score for intubated patients in their ICU and average SOFA score for affected patients in their ICU, number of vents in use, number of vents that could be accommodated if available).
3. Resource allocation of incoming assets – as resources become available from Federal and other sources the RHRC will provide information to MDH to facilitate allocation according to need. This may involve, depending on the situation allocation according to:
    a. Percentage of ICU beds in area
    b. Need based on shortfall
    c. Need based on clinical scoring systems (e.g.: highest priority for allocation to those facilities with the highest average ICU SOFA scores)

VII. Review and Appeals process – to assure fidelity to the ethical foundation and clinical decision-making surrounding triage decisions, the following quality assurance measures will be implemented:

1. Internal institutional review of decisions and documentation of resource allocation decisions, with adjustment of the process and tools as required
2. Clinical appeal – a provider who feels that the triage team data did not reflect a recent improvement may appeal a decision to re-allocate the resource to the team and provide updated data. This must occur immediately following a re-allocation decision.
3. Process appeal – if it is felt that there has been a wanton or egregious deviation from foundational ethics or usual decision-making process, provider or family may ask for an independent review. This will entail:
    a. A request to the facility staff to review the case from the family or caregiver stating the grounds to believe that:
        i. An *intentional* decision was made to deny or re-allocate care inconsistent with the usual process and tools outlined above
        ii. That this decision was made to provide an *unfair* advantage to another patient
    b. Facility will notify the RHRC. RHRC will notify a three person screening panel (appointed for incident or 'on-call' depending on incident scope) – clinical provider, ethicist, 'layperson' – e.g. clergy – from institution not involved with case will review the decision and its documentation. If initial review is satisfactory, no further action is taken. Summary is provided to the RHRC and the petitioner.
    c. If the screening reveals a significant concern, (e.g.: obvious favoritism to an employee in the allocation process not justified on clinical grounds), the case will be brought to an additional 6 person panel (same make-up as the screening panel from 2 other outside institutions not from the same health system). Further review including interviews may be required to reach a decision. This panel's interpretation will be provided in writing to the institution, RHRC, and petitioner.

VIII. Key Resources:

1. AMA (American Medical Association). 1995. Ethical considerations in the allocation of organs and other scarce medical resources among patients. Council on Ethical and Judicial Affairs, American Medical Association. *Arch Intern Med* 155(1):29–40.
2. Minnesota Department of Health. 2008. *Minnesota healthcare system preparedness program standards of care for scarce resources*. http//www.health.state.mn.us/oep/healthcare/standards.pdf
3. Institute of Medicine. *Guidance for establishing crisis standards of care for use in disaster situations: a letter report*. Washington, DC: Institute of Medicine, National Academies of Science; 2009. http://www.iom.edu/Reports/2009/DisasterCareStandards.aspx

4. Rubinson L. Hick JL. Hanfling DG. Devereaux AV. Dichter JR. Christian MD. Talmor D. Medina J. Curtis JR. Geiling JA. Task Force for Mass Critical Care. Definitive care for the critically ill during a disaster: a framework for optimizing critical care surge capacity: from a Task Force for Mass Critical Care summit meeting, January 26-27, 2007, Chicago, IL. Chest. 133(5 Suppl):18S-31S, 2008 May.
5. Devereaux AV. Dichter JR. Christian MD. Dubler NN. Sandrock CE. Hick JL. Powell T. Geiling JA. Amundson DE. Baudendistel TE. Braner DA. Klein MA. Berkowitz KA. Curtis JR. Rubinson L. Task Force for Mass Critical Care. Definitive care for the critically ill during a disaster: a framework for allocation of scarce resources in mass critical care: from a Task Force for Mass Critical Care summit meeting, January 26-27, 2007, Chicago, IL. Chest. 133(5 Suppl):51S-66S, 2008 May.

Summary of Regional Process for Resource Triage Situation

For more detailed information see: Metro Hospital Compact Scarce Resource Triage Concept of Operations