Montana COVID-19 Surge and Crisis Care Guide for Emergency Medical Services

The goal of this guide is to provide background on surge and crisis care issues related to the COVID-19 pandemic and present a structured approach to potential challenges in the provision of response by EMS services, first responders and public safety answering points (PSAP). While this guide recognizes the supporting role of regional and State assisting agencies, it is the responsibility of the EMS service leadership and medical director, in partnership with your local health facility and public health, to ensure operational plans are in place to protect your staff and provide quality care to your patients in challenging conditions. These guidelines provide a framework for decision making and should be flexible and adaptable for local circumstances.

Preface

In surge and crisis care, each EMS service and medical director will have to determine the most appropriate steps and actions for their agency based on their local situation and resources.

- Pre-planned actions are always preferred to ad hoc decisions.
- Pre-event familiarization with the contents of this guide and development of local and regional plans is recommended to aid with event preparedness, response and anticipation of specific resource shortfalls.
- This guide addresses common categories of pre-hospital EMS response, triage, treatment and transport.
- Local EMS services and their medical directors, health care facilities, public health, regional health care coalitions, and State support systems may determine additional issues and strategies for their specific situation in addition to those outlined in this guide.

"In a crisis standards of care event the focus changes from individual to population needs. The evolution from conventional to contingency to crisis modes isn't simply an operational shift, this is a legal shift as well involving changes in the applicable standards used to determine whether the duty of care was met for those who required assistance to the best degree possible given the circumstances."[198]

[198] IOM/NAM, *Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response*

Disclaimer: Much of this guide is based upon the work of the Minnesota Department of Health and Minnesota EMS Regulatory Board & various national framework documents. To expedite development of this guide for Montana EMS, incorporation of portions of these public works have been adopted.

Overview of Montana's EMS Services

In providing an EMS response to Montana's COVID-19 pandemic, Montana has the following EMS response services:

- 103 non-transporting units;
- 141 ground transporting ambulance services;
- 5 rotor-wing flight services; and
- 9 fixed-wing flight services.

Under typical circumstances, characteristics of the Montana EMS include:

- EMS responds to over 100,000 9-1-1 calls annually;
- Workforce consists of approximately 4,900 ECPs, over half are volunteers;
- 73% of services are in rural communities are staffed primarily by volunteers;
- 58% of services are basic life support;
- 35% provided limited levels of advanced life support (ALS);
- 2% (20 services) provided 24/7 ALS – located in urban communities.

It is not uncommon for EMS systems to operate near or at a surge for short to moderate periods of time (e.g. single vehicle crash with 3 patients). Under these circumstances:

- Local EMS services surge response would, in most cases, rely on mutual aid from other emergency responders or neighboring agencies;
- The threat of an extended COVID-19 pandemic may decrease the capacity for EMS to provide usual or mutual aid services;
- More robust planning is required when demand could result in poor outcomes for patients unless crisis strategies are implemented.

Assumptions

Montana's local jurisdictions vary widely in the threats they face, the vulnerability of their populations, and the response resources immediately available to respond to emergencies. They also employ a variety of strategies for coordination and oversight of day-to-day EMS services including local EMS providers that:

- cover single counties - some cover multi-county regions;
- operate as a governmental, tribal, hospital-based unit, non-profit organization, private entities and other forms of management;
- have varying levels of responsibilities for emergency management.

Montana's disaster medical system generally functions under a framework of Incident Command System (ICS) and National Incident Command System (NIMS) through which Disaster and Emergency Services (DES), Department of Public Health and Human Services (DPHHS), and other state agencies can support. Other key assumptions include:

- All incidents start at the local level. If or when local resources are overwhelmed, there is a request for assistance from neighboring jurisdictions, the State, or the federal government, in that order.
- Local government remains in charge of their jurisdictional authorities and response to disasters within its geographical area. Local, State and federal officials, agencies, and resources, from outside the jurisdiction who provide support and resources to the response will do so in an "Assisting Agency" role.
- State and federal governmental agencies may have a shared jurisdictional authority to respond to and mitigate a pandemic within the affected area. They may have a role to coordinate their activities with the local government agencies.

- Montana's response will include both public and private medical resources that need to operate in a coordinated manner for maximum effectiveness.
- Public safety EMS resources frequently have dual roles during disaster response and on a day-to-day basis. Communities may find EMS service curtailed as personnel are required to support other response and leadership responsibilities.

Planning and Implementation - General

Medical direction

Crisis strategies and tactics need to balance community versus individual needs. Risk to the individual patients must be balanced against the demand. Therefore, involvement of medical directors is critical to the success of the plans, strategies and tactics. Important consideration regarding the role of the medical director includes the following.

- Optimally, the medical director should have a role during the crisis situation to provide subject matter expertise, while acting as a liaison among the hospital, public health and EMS service.
- Since the medical director is ultimately responsible for the care provided, any change to usual Standard Operating Procedures (SOPs) will require physician input and approval.
- Engagement level of medical directors varies widely across the state, so the COVID-19 response may introduce additional challenges. The EMS service and the medical director will need to agree on an appropriate level of participation early on.

Integration with Health Care Coalitions

It's critical that EMS services do *not* work on surge and crisis care plans in isolation but do so in concert with their regional framework and partners. Consistency of plans and knowing what others in the region (and adjacent regions) are planning is critical to success. Surge strategies and SOPs do not have to be identical, but if they are similar or complementary, it will optimize mutual aid response.

Health Care Coalitions (HCC) (http://mthcc.org/) have been formed to assist with regional coordination, planning and response. Each HCC also has at least one Regional Health Care Preparedness Coordinator to facilitate information sharing, situational awareness and resource coordination among members for pandemic surge. The HCCs have mechanisms in place to communicate among partners and support among disciplines.

Surge Capacity

Most EMS services are familiar with the concept of *surge capacity*, which is the ability to increase services to match demand. *Surge capability* is slightly different - it requires increased capabilities in equipment, staff and resources to meet the patient's needs. COVID-19 surge response may present new challenges for adequate PPE, staff availability, alternate transportation modes and alternate care sites. Considerations for surge capacity planning include the following.

- EMS must plan for COVID-19 surge capacity across multiple functions (e.g., dispatch, response, treatment, transport).
- Available resources must be utilized to their maximal capacity and additional resources obtained from known sources via pre-existing mechanisms (e.g., mutual aid agreement)
- Some actions can be accomplished with minimal risk (e.g. mutual aid to meet demand) and some carry significant risk (e.g., not responding to some 911 calls due to overwhelming demand).
- The goal is to maximize the potential benefits of surge capacity strategies to mitigate the crisis, while minimizing the risks associated with deviations from routine operations.
- Strategies that are most appropriate to the situation and offer the least risk to the patient and EMS personnel should be identified and selected, proceeding to riskier strategies as demand increases and options decrease.

Surge capacity is best visualized as three categories across a continuum (see Figure 1):

Conventional - usual strategies and resources (e.g., dispatch of additional ambulances, mutual aid, extending staff shifts for a few hours);

Contingency - uncommon strategies and resources that incur a small risk to patients such as staffing ambulances with less personnel or a delayed level of response;

Crisis - disaster strategies used when demand forces choices that pose a significant risk to patients but is the best that can be offered under the circumstances (e.g. recommending self-transport, shelter in the home, medical personnel accompanying patient in a private vehicle).

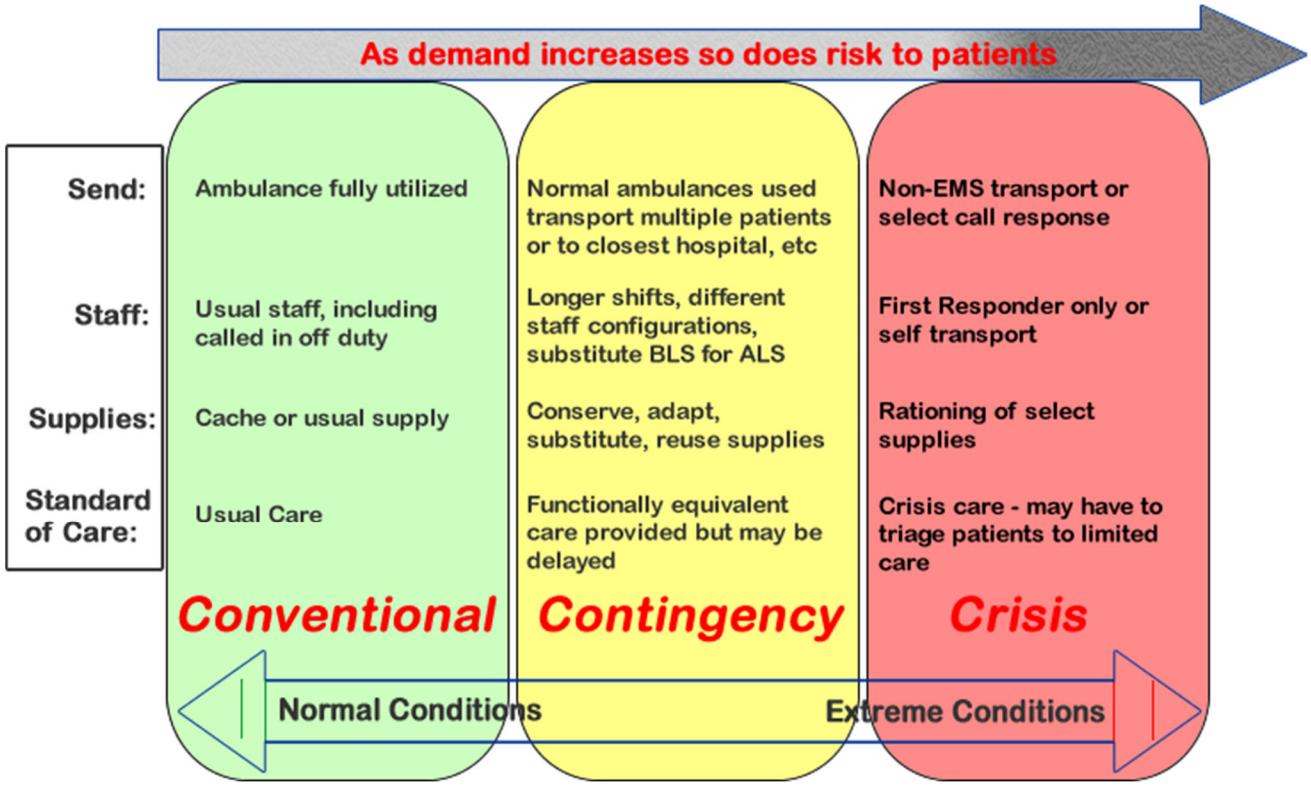


Figure 1: Continuum of surge capacity demand

Crisis Care

Crisis Care is required for a longer-term and more pervasive situation where adequate resources are not available to meet the needs and a systematic approach is required. At a minimum, EMS services and their staff, the medical director and local health care facility need to be engaged in decisions and triggers. This may include, but is not limited to, dispatch and triage decisions, alternate care sites, alternate care systems, and treatment recommendations.

Crisis Care is invoked when demand forces the agency to make decisions that may place the patient at a higher risk of a poor outcome but are the best that can be offered given the circumstances. Key points about Crisis Care include:

- Strategies not thought out ahead of time likely will not be considered or cannot be implemented.
- Strategies should be proportional to the resources available and this may result in moving back and forth along the surge capacity continuum (see Figure 1). As more resources arrive, you should shift to lower risk strategies (e.g., back to contingency and eventually conventional status).

Indicators and triggers

An "indicator" is a predictor of a possible event (e.g., increasingly positive testing of COVID patients in

a community) that requires analysis to decide if a "trigger point" has been reached, which will initiate action. Characteristics of these triggers are included below.

- Scripted triggers are automatic if/then decisions - Whenever possible, scripted triggers should be developed for staff so they have actions they can take immediately to prevent delay. If there is less specific information available, a manager or medical director should be involved to process the information and decide on necessary actions.
- Responder and dispatch personnel should have a low threshold for passing indicator information along to supervisors for situational awareness and potential action.

The EMS service should determine what strategies or options it may employ in a disaster and then decide on indicators that might be available and a trigger point for staff to take tactical action. These will vary by service. For example, in a very rural area, a longer response time for an ambulance may be normal, but in an urban area, this could prompt implementation of call triage and recommendations for private transport for stable patients.

For an extended event such as COVID-19, the agency should review and modify their procedures, as needed. Plans should be flexible and not "lock in" for the duration of an incident. Allow transition back to conventional care as more resources arrive or demand falls, or both (see Figure 1). For the example above, this would mean the recommendation for private transport should cease once ambulances are available.

Roles and responsibilities

RESPONSE ENTITY	ROLE	RESPONSIBILITIES
Public Safety Answering Point/9-1-1 Dispatch Center	Support agency	• Answers 911 calls • Provides emergency medical dispatch support • If equipped, may transfer to secondary center/ public safety answering point (PSAP) • Determines appropriate response based on situation • Provides communication point for incident responders
Non-Transporting Units / QRUs	First response	• Frequently the first personnel on scene to assess and report on the situation • Provides initial triage and care and help determine what additional resources may be needed • Support and assist arriving ambulance personnel on scene as needed
Ground and Air Transport Services	Emergency response and patient transport	• Interface with local and regional hospitals

		• Adjust response and transport guidelines to reflect the situation at hospitals • Coordinate patient destination hospitals to the degree possible to avoid overloading a single facility
Local / Regional Disaster and Emergency Services (DES)	Support agency	• Local assistance for all supply and resources requests
Local Public Health	Support agency	• Local assistance to EMS service and medical director for public health and other coordination of emergency response issues
Regional Health Care Coalitions	Support agency	• Regional resource for sharing of information and coordination of emergency response with other services. Local requests for assistance may be forward to the HCC.
State Disaster and Emergency Services	State support agency	• State resource for issues and requests that cannot be met at the local or regional level. • Statewide coordination of all response efforts
EMS & Trauma Systems / DPHHS	State support agency	• State EMS resource for information about EMS capabilities and needs • Works on mission specific activities delegated from the State DES level • EMS and Trauma Systems (EMSTS) COVID-19 web pages

Functional Planning Considerations

Dispatch

As in normal operations, the goal of COVID-19 dispatch response is to provide the most appropriate services available. While many dispatch centers utilize Emergency Medical Dispatch (EMD) to assess the call and prioritize responses, public safety answering point-PSAPs in many rural areas often do not have these resources or training. Irrespective, coordination among dispatch, the EMS service and medical director is essential. Determining the best services to match a request can be difficult. A possible dispatcher algorithm for consideration is presented in Attachment #1.

Implementation of Centers for Disease Control and Prevention (CDC) recommendations for dispatch screening questions and the close coordination with response to suspected or reported COVID patients should assure that emergency responders arrive on scene prepared and safe. A standard page or radio code such as “PPE Advised” should be employed consistently and provided to all emergency responders.

Dispatch centers should examine their operations and determine:

- Are there options for adding supplemental staff and dispatchers to support additional communications call volumes when appropriate?
- Is there a technical capability to roll calls over to other dispatch centers if call volumes exceed pre-determined call wait times?
- Is there a capability to develop arrangements, policy and procedures to transfer calls to a clinical provider that could help prioritize the need for an ambulance in areas where EMD's are not normally available? This could be hospital-based personnel or call transfer to another dispatch center with EMD capability.

Part of the goal during a crisis is to decrease the call volume at the PSAP. This may be accomplished by keeping the public up to date with incident information to reduce non-emergency 911 calls. Work with emergency management, local public health and local media to communicate to the public the stress on the system and to only call 9-1-1 for life-threatening emergencies.

Staffing

During a pandemic, EMS service staff could be severely and disproportionately affected by self-quarantine and other factors. Agencies should examine the following possibilities when planning for surge situations:

- Maximal utilization of current staff - consider extending shifts and changing schedules;
- Explore mutual aid from nearby services - though current mutual aid focuses on ambulances, it may also be possible to share staff across services to maximize the use of the available vehicles;
- Change in crew configuration – e.g. one Paramedic/EMT rather than two Paramedics or one Emergency Medical Responder / one EMT rather than two EMT's;
- Use of direct response by staff in personal vehicles - this could involve emergency care providers (ECPs) not affiliated with the EMS service that can respond to provide assessment and basic care if an ambulance is not available.

While Community Integrated Health (CIH) providers are limited at this point, plans are being considered to provide for a CIH “Light” program with “just-in-time” training specific to COVID-19. Further information will be forthcoming.

50-6-322 MCA allows volunteer, rural EMS services to staff and ambulance with one EMT and one trained driver. EMSTS has waived traditional staffing requirements to allow all EMS services to provide staffing with one EMT and one trained driver. A prepopulated waiver form is available on the EMSTS website that the service needs to complete and return and it will be approved.

The State is activating the Montana Healthcare Mutual Aid System (MHMAS). This registry is being utilized to track information and credentialing for healthcare providers who are available to respond to staffing needs in hospitals, alternate care sites, ambulances, etc. Persons interested in deployment to communities can register at:

Montana Healthcare Mutual Aid System

Supplies & Resources

Current supply chain models rely on "just-in-time"' inventory processes with minimal stock. Few EMS services can maintain significant contingency stocks of disposable supplies. The COVID-19 pandemic has necessitated increased usage of personal protective equipment (PPE) and other supplies and a challenge with supply chains not yet able to meet demand. While some national stockpile resources have become available, EMS is likely to be challenged with adequate supplies throughout this event.

Resource requests (supplies, staff, equipment) for response and recovery originate at the local level and are progressively forwarded to the next level until filled. If a local jurisdiction is unable to provide the necessary requested assistance from within the jurisdiction, they would then request mutual aid from nearby areas. If resources are not available within their mutual aid “region”, the request will be forwarded to the State as appropriate.

The State Emergency Coordinating Center is asking that all local resource orders be submitted through local emergency operation center procedures and validated by the local DES coordinator or their designee. Medical supplies, such as PPE, should be submitted on the electronic reporting form below. An order form is needed for each facility/organization needing assistance.

COVID-19 Medical Resource Request Form

Strategies and tactics to maximize resources will be necessary. Consider the following:

- Substitute: Use an essentially equivalent device resource for one that would usually be

available.

- Adapt: Use a resource that is not equivalent but provides the best possible care.
- Conserve: Use smaller quantities or change practices (e.g. limit number staff in contact with a patient).
- Reuse: Use single use items again, after appropriate disinfection or sterilization.
- Optimize Allocation: Allocate resources to patients whose need is greater or whose prognosis is more likely to result in a positive outcome with limited resources.

Transport Considerations

Ambulance services (urban and rural) generally do not have significant additional ambulance capacity available. Any alteration of transport consideration will be done collaboratively among EMS leadership, the medical director and others as appropriate. In the COVID-19 pandemic, ambulance resources may be severely limited and alternate transport options may need to be considered. Plans should consider maximal use of existing ambulances including:

- Mutual aid from surrounding agencies, including neighboring states. This should include agencies typically providing non-emergency transportation. Significant aid from surrounding states or through Emergency Management Assistance Compact (EMAC) will be unlikely during COVID-19.
- Many non-transporting units, fire departments and search and rescue have vehicles capable of patient transports. Work with these agencies to determine their capabilities in terms of staff and equipment.
- National Guard ambulances and potentially airlift capacity could contribute to patient movement. Use of these assets would only be activated through resource requests through local DES to the State.

Ambulance service providers need to weigh the risks and benefits of patient transport in a non-traditional vehicle (e.g., wheelchair vans, school or public transit buses) versus the risks and benefits of waiting for an ambulance to arrive. Some considerations that should be considered include:

- Time sensitivity - Does the patient have a time sensitive condition?
- Decreased time to treatment - Does the time to the hospital by a non-ambulance increase the chances of the patient having a successful outcome?
- Can the patient be appropriately stabilized on-scene while awaiting arrival of an ambulance?
- Patient restraints - Although not always possible, patients and any attendants being transported to a hospital in a non-ambulance should have appropriate patient restraints (child and adult).

Use of private vehicles, with or without medical personnel, may need to be used to augment ambulance services. In general, it may be better to get a patient to the hospital faster rather than wait long periods of time for an ambulance. Prioritizing ambulatory and other selected patients to private transport can significantly reduce burden on ambulance service agencies. Depending on the patient condition and availability of staff resources, make plans for the following options:

- Family members or others transporting stable patient in private vehicle without escort/attendant (e.g., low acuity patient with non-life-threatening conditions).
- Family members or others transporting patient in vehicle with EMS personnel following in another vehicle (e.g., stable but with potential for deterioration).
- Others transporting in private vehicle with EMS personnel in the vehicle with them monitoring or providing care (e.g., unstable - highest risk to patient and provider).
- Non-ambulance public safety vehicle (fire or police) transporting patient (e.g., professional driver and marked vehicle but limited ability to provide any medical care).

Destinations

While rural EMS services usually transport patients to a single hospital, urban services may have a choice of more hospitals. A conscious decision should be made early in response to distribute patients across facilities rather than overburden a single hospital.

In a pandemic surge, hospitals may set up a screening site for those with mild symptoms so they can focus on the sickest individuals. Additionally, alternate care sites for low acuity patients may be implemented such as a clinic, urgent care center, field hospital other community venue. It is appropriate for ambulance service personnel to transport to those locations provided they are open, appropriately staffed, and the patient does not have any severe symptoms. These are generally surge dependent options for the ambulance service leadership and medical director to consider, develop event-specific policy, and communicate to the crew.

CMS Ambulance Flexibilities to fight COVID-19 - CMS is temporarily expanding the list of allowable destinations for ambulance transports. During the COVID-19 event, ambulance transports may include any destination that is able to provide treatment to the patient. These destinations may include but are not limited to: any location that is an alternative site determined to be part of a hospital, critical access hospital (CAH) or skilled nursing facility (SNF), community mental health centers, federally qualified health centers, physician's offices, urgent care facilities, ambulatory surgery centers, any other location

furnishing dialysis services outside of the end-stage renal disease (ESRD) facility, and beneficiary's home.

Consideration may be made for transport out of the community to a nearby community that is not in a surge status. The disadvantage of spreading patient transports between other and more distant hospitals or facilities is that increasing distance results in additional time.

- Particularly in rural areas, inter-facility transfers can take essential local EMS resources out of the service area for hours at a time
- Utilizing EMS units from the receiving facility/community or more aggressive use of air ambulances for transfer may be of substantial benefit to preserve community response.
- EMS may be tasked with balancing patient load between facilities. i.e. EMS may transport a critical patient from a CAH to a higher level of care but may need to transport a lower acuity patient from receiving facility back to the CAH.

During this pandemic, the medical director and EMS service leadership may also approve broader discretion for patients being left at scene by the ambulance service crew (if the condition is not emergent and appropriate follow-up and/or alternate transportation can be arranged). This should **only** be invoked when additional calls are pending in the system and **only** for conditions and circumstances that the medical director approves via SOP or online medical control. Consider using the Board of Medical Examiners Influenza Pandemic Protocol (Attachment #2) for guidance.

Legal and regulatory considerations

Crisis care actions that will occur during this pandemic should be undertaken with consideration for the impact of legal and regulatory standards. Guidance and support from local, tribal and Federal governments and State agencies will be provided as it evolves. The ability of the Governor and the President to issue emergency declarations and promulgate enforceable orders and rules to address the contingencies created by the pandemic are provided by law. This is a very dynamic facet of this pandemic.

EMS leadership and medical directors need to review The Governor's declarations and directives for application to EMS operations, professional licensing, etc.

Governor's Coronavirus Task Force – Joint Information Center

Waiver of EMS Service Licensing Requirements

50-6-325 MCA. Waiver of licensing requirements

(1) The department may waive any licensing requirements under this part upon submission and approval of a written application for waiver by a person subject to licensing under this part.
(2) The department may waive a licensing requirement if the person provides sufficient justification to allow a finding by the department that:
  (a) the waiver is necessary to avoid significant financial or other hardship; and
  (b) granting the waiver would not jeopardize patient care or the public health and safety.
(3) A waiver must be issued on a temporary basis, not exceeding 6 months, and may be renewed by the department upon submission and approval of an additional application for waiver of licensing requirements.
(4) A waiver granted by the department may be revoked for good cause after notice and an opportunity for a hearing before the department have been provided to the person affected by the department's action.

To date, the department has waived various requirements for personnel on EMS services (i.e. two licensed persons on all calls). The waiver provides for relieve for EMS services that are not included under 50-6-322 MCA which allow volunteer, rural EMS services to staff an ambulance with at least one EMT and one trained driver. Services who completed and return the waiver will be allowed the same.

Department of Labor / Health Care Provider Licensing

The Department of Labor is accommodating adjustments to licensing allowed under their statutes. The department has implemented an Interstate Licensing Registration process allowing out-of-state health care providers to be able to quickly become authorized to practice in Montana.

Liability

Response by healthcare providers may raise legal and liability concerns among health care and public health professionals. While traditional liabilities and protections continue to be in place, extreme service demands coupled with constrained supplies and diminished personnel, will challenge EMS provision of usual services and care expected by the community. EMS leadership and medical directors need to work closely with legal (private liability carrier, county attorney, etc.) to understand their role and risks in crisis care.

The federal Coronavirus Aid, Relief, and Economic Security Act strengthens the provision of liability for certain volunteer healthcare professionals:

Section 3215: Limitation on Liability for Volunteer Health Care Professionals During COVID-19 Emergency Response

- Limits liability for health care volunteers under Federal and State law for “any harm caused by an act or omission of the professional in the provision of health care services during a public health emergency” for the duration of the COVID-19 emergency.

- This applies if:
  (1) the professional is providing health care services in response to such public health emergency, as a volunteer; and
  (2) the act or omission occurs
    (A) in the course of providing health care services;
    (B) in the health care professional's capacity as a volunteer;
    (C) in the course of providing health care services that
      (i) are within the scope of the license, registration, or certification of the volunteer, as defined by the State of licensure, registration, or certification; and
      (ii) do not exceed the scope of license, registration, or certification of a substantially similar health professional in the State in which such act or omission occurs; and
    (D) in a good faith belief that the individual being treated is in need of health care services.

This section ensures liability protections for health-care volunteers during the COVID-19 public health emergency by preempting **"the laws of a State or any political subdivision of a State to the extent that such laws are inconsistent with this section, unless such laws provide greater protection from liability."**

Recovery

Planning for recovery should begin while the event is ongoing. Recovery is the restoration of services to their pre-existing or optimized conventional state. The basic philosophy of recovery is to "build back better" after an incident.

However, because of the dynamic nature of the COVID-19 pandemic, a return to conventional care may be temporary, and does *not* mean the recovery phase has truly begun. EMS services should assure they are prepared to be flexible across the surge continuum and be certain the situation has concluded prior to ending the response. For example, EMS services may be able to operate in conventional status during the night in a pandemic, but during daytime hours may remain in crisis mode due to call volumes.

During recovery, there are multiple priorities. Some priorities for EMS services specifically include:

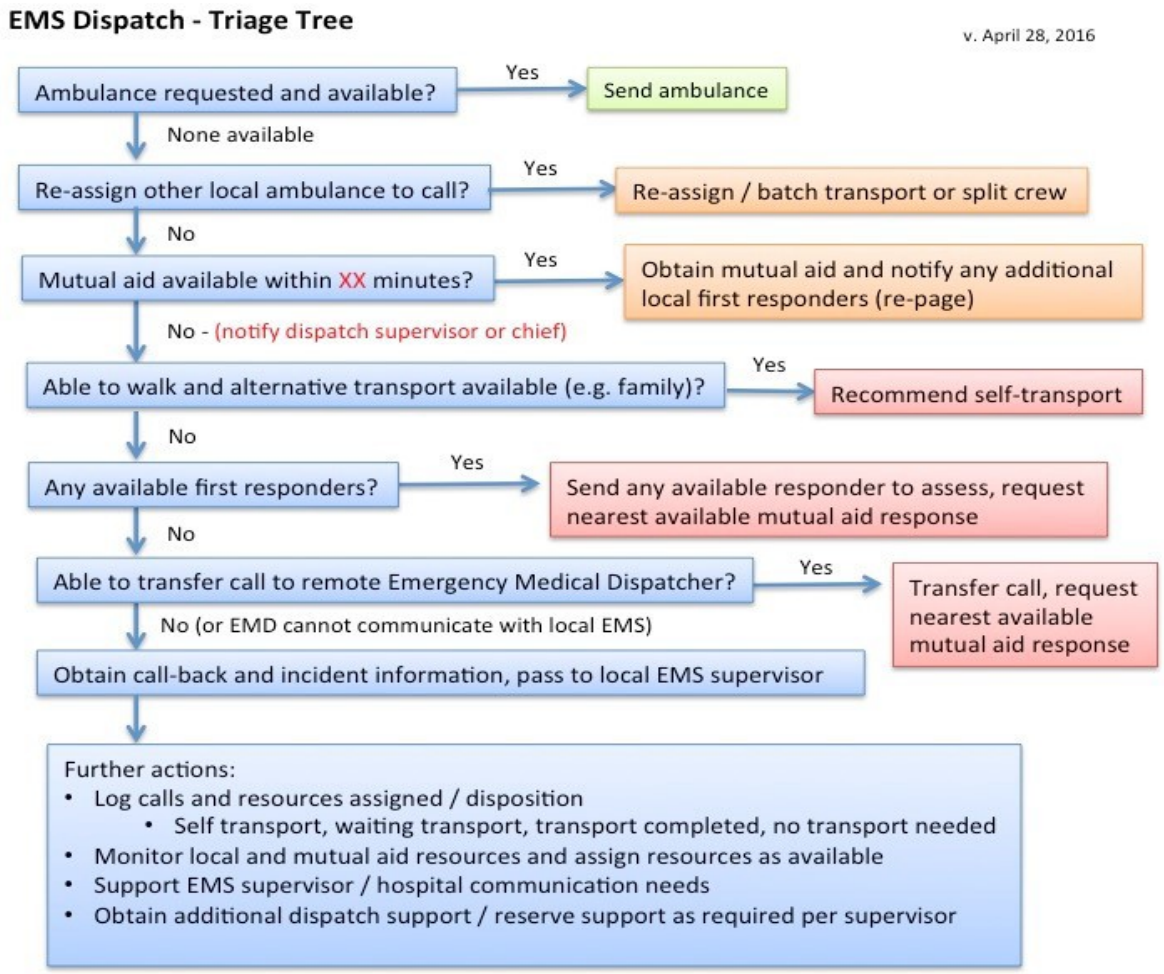
- Complete, detailed documentation of supply and time costs for potential reimbursement;
- Return of borrowed equipment;
- Restoration of equipment to usual state;
- Replacement of supplies;

- **Provision of mental health support to affected staff** (psychological first aid or more specific strategies depending on the situation);
- Support for provider families affected by the incident;
- After-action reviews of the event and development of a corrective action plan for future similar events.

EMS services may need to provide ongoing support to other agencies as they continue their operations. EMS services should also confirm with local Emergency Management there are no other functions required of them and participate in community recovery planning and after-action analysis.

Attachment #1

Example EMS dispatch-triage tree



Notes:

- Assumes non-EMD PSAP - for EMD PSAP triage calls based on priority dispatch levels and in conjunction with medical direction
- Supervisors for EMS and public safety should be notified when any 'red box' / 4th level is used
- Dispatcher should have authority, process, and contact numbers for activating this algorithm
- Dispatcher should have contact information for regional ground and rotor-wing resources
- Identify support mechanism for call triage decisions (EMS supervisor / lead medic, hospital personnel and document responsibilities / contact information prior to event)
- Identify role of EMS supervisor / medical director in this process
- First responders without an ambulance should coordinate appropriate care with receiving hospital / EMS supervisor
- Consider *not* sending EMS initially on calls for potential injury accidents until confirmed significant injuries.
- Consider other call type triage based on local system and dispatcher training

Reference: Minnesota Crisis Standards of Care Framework

Attachment #2

Montana BOME ECP Practice Guidelines

BOME Influenza Pandemic Protocol

General Comment:

*In the event that there is a public health or safety emergency in which health care resources are overwhelmed by demand, the EMT response will have to adapt to the severity of the situation and the available resources. This Influenza Pandemic protocol is to be used as a guide in the development of a local plan (based on the severity of the situation and the available resources) remembering that the local situation will change frequently, perhaps daily or hourly. This protocol is assuming that an Influenza Pandemic has overwhelmed the medical community and normal EMT operating procedures are not feasible or practical. The Montana Board of Medical Examiners recognizes that an organized **"treat and release protocol"** would not only be advantageous but necessary to maintain control and order to providing medical assistance in the community.*

ALL RESPONDERS: Physical Assessment:

When conducting your initial assessment, a patient, maintain a safe distance (6 feet) and utilize personal protection until you determine if influenza like symptoms exist. If no symptoms exist, then proceed with your patient assessment as normal. If influenza symptoms are present; utilize the triage tool identified below to assess and determine the severity of the illness and assist in transport decisions. The local medical director must determine, in consultation with the local public health department and health care facilities, what scores would facilitate transport or treat and release; this could change depending on the evolving characteristics of the viral infection and may change daily or even hourly depending on available medical resources.

Demographics:	Score
Age <6 months:	2
6 mo – 5 yrs	1
5 yrs- 65 yrs	0
65 yrs- 75 yrs	1
>75 yrs	5
Caregiver at home	-1

O2 saturation:	Score
> or = to 90%	0
86% - 89%	3
76% - 85%	4
= to or < 75%	5

Respiratory rate:	Score
8 - 24 resp / min	0
24 - 60	2
< 8 or > 60	3

Heart rate:	Score
< 6 mo & > 150 HR	2
Children > 6 mo & > 120 HR	2
Adults: > 110 HR	2

Blood pressure:	Score
<6 mo & cap refill > 2 seconds	2
90 - 100mmHg	2
< 90mmHg	4

Temperature:	Score
>103 F (39.4 C)	1

Mental Status:	Score
Confused	2
Unresponsive/ Obtunded	3

Able to tolerate PO?	Score
Yes	-1
No	1

Co morbidities:	Score
DM, asthma/COPD, CHF	1 each
Obesity	1
Pregnancy	2

Evaluator discretion:	Score
Evaluator may assign subjective	-1, 0, or +1

Patients who score:

>14 Patient should remain home with comfort measures provided
8 - 14 Should be transported to the emergency department for treatment
4 - 8 Should be directed for additional screening/assessment but does not require ambulance transport
< 4 Should not be transported and should remain home with provided instructions

Back to TOC

Attachment #2
EMS Mutual Aid Considerations

Local Activation of EMS Mutual Aid for a Surge

Local EMS leadership, the medical director, hospital leadership and DES should coordinate through frequent communication regarding availability of ambulances and crews including the level of care available. This communication should include anticipated interfacility transfer needs.

If local EMS has reached capacity and can no longer meet the 911 and interfacility transport needs of their community, a resource order needs to be placed with the local DES. The hospital, in consultation with their local EMS leadership and medical director, will determine the number of ambulances and personnel needed to meet the demand.

Local DES will communicate with surrounding communities regarding their availability to fill the resource need. If the need cannot be met by surrounding communities, local DES will elevate the request to the SECC.

Local Considerations:

- Incident check in location (direction should be given to incoming units regarding where to check into incident);
- Staging area for incoming ambulances;
- Communication, including radio channel for event;
- Documentation requirements (EMS will continue to use ImageTrend or other electronic patient care record (ePCR) for documentation of patient care);
- Shift structure (what hours will EMS crews be expected to work, 8 hrs, 12 hrs, 24 hrs?);
- Housing of ambulance personnel for down time;
- Refueling procedures (is local area providing or incoming resource providing?);
- Plan for restocking of ambulances (disposable equipment, PPE, oxygen, etc.).

EMS Considerations for Surge Response to an Event

EMS leadership and medical direction should assess daily their agency's ability to respond to a surge request. This information should be entered daily in EMResource – Juvare during the COVID-19 response period.

- ECPs available for deployment should have a personal bag ready. They should have enough supplies to sustain them for a minimum of two days to include: food, water, medications, clothing, etc.
- Ambulances should be overstocked with disposable supplies to sustain multiple responses without restock.
- A plan for restocking should be developed prior to response.
- Record keeping is vitally important for cost reimbursement. All expenses related to the response should be tracked. An expense form should be developed for use during deployment.
- A fuel card should be available for the duration of the incident.
- Ambulances should be equipped with computers or tablets for documentation of patient care.
- EMS should use the same documentation format during the surge event as they use in their day-to-day operations.