Department of ***Public Safety***
Office of the EMS Medical Director
Monroe County, New York

Timothy Kohlmeier
Interim Public Safety Director

Jeremy Cushman, MD, MS, EMT-P
EMS Medical Director

COVID-19 FAQ's for EMS/Fire/Law Enforcement

Dispatch and Response / Assessing and Transporting Patients

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Dispatch and Response

1) Will all COVID-19 patients be coded under the 36 card?
    a. No. Use of the 36 Card (Pandemic Influenza) helps to limit the number of personnel being dispatched to patients self-identifying with flu-like symptoms. Similarly, the 33 Card (Interfacility Transport) is used when the patient was assessed by a healthcare provider. The use of this card also helps to limit the number of personnel being potentially on scene. Importantly, if the patient is being transported to "test for coronavirus" or similar after being assessed by a healthcare provider, it will be coded on the 33 card.
    b. Understand that EMD coding is never perfect as it is highly dependent on the information the caller provides. Although we are making use of the 33 and 36 cards to minimize the number of responders and resources to these requests for service, it remains critical that ALL patients are screened from >6 feet as to fever or respiratory symptoms. As any call, regardless of coding, could potentially have patients with symptoms warranting proper PPE.

2) Are premise warnings still being used and what do I do if I respond to a location with a premise warning?
    a. Yes, premise warnings are still being used to identify individuals under home quarantine or isolation as requested or required by the County Health Department.
    b. The responder prior to entry should don gloves and respiratory PPE, then once six feet away from the individual, offer a surgical mask to them regardless of symptoms.

3) What calls are Fire Departments responding on?
    a. Fire departments are **no longer** responding on all 26 (Sick Person), 33 (Interfacility), and 36 (Pandemic Influenza) calls for service except those that are cardiac/respiratory arrest.
    b. Many fire departments are restricting their responses to large occupancy dwellings for all but critical patients. This is a department by department decision and has the support of Dr. Cushman – contact him directly with any questions.
    c. Additional call types will be restricted as community spread continues.

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4) I have a patient and need Fire Department resources but they have an illness, can I still call for them?
    a. Yes. Although we should minimize the number of personnel on scene, if patient care requires additional personnel, they should be requested. Follow-on responders must be advised prior to making patient contact to don appropriate PPE.

5) What calls should law enforcement be responding on?
    a. Law Enforcement should consider advising, and not responding, to all medical calls for service, unless there is information on the job that indicates a crime, injury, abuse/neglect, or a safety concern.
    b. This is at the jurisdiction's discretion and will not be done automatically by ECD.

6) What about law enforcement transporting individuals in a patrol vehicle?
    a. Any individual being transported in a patrol vehicle should have a surgical mask placed on them prior to placement in the vehicle.
    b. If the individual cannot or is noncompliant with wearing a mask, the officer/deputy should wear any available mask (surgical or N95).
    c. If the individual is being released, the mask can be removed when they exit the vehicle and be disposed of in a garbage bag.
    d. If the individual is being transported to Central Booking at the Monroe County Jail, the mask should be left in place until screened by Jail medical staff.

7) What is being done about call volume and "unnecessary" 911 calls for EMS?
    a. Plans are being put into place to shunt certain 911 calls to a nurse information line.
    b. At this time, there are no alternative destinations for EMS.

8) What about "riders" in the ambulance?
    a. Ambulances may not allow family members/others in the cab space of an ambulance.
    b. Only minors should have a family member/care provider in the patient compartment and should have a surgical mask in place regardless of symptoms.
    c. No other visitors/guests as all area ED's will not allow them entry.

9) What about Paramedic and EMT students or explorers riding as an "extra"?
    a. EMT and Paramedic programs have suspended their hospital and field clinical programs as of Sunday March 15.
    b. Departments should not allow any observers, explorers, or shadowers.

10) Are there any other resources that are changing as a result of this event?
    a. The Mobile Stroke Unit has been taken offline and no longer available due to staffing and community resource need.

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Assessing and Transporting Patients

1) How do I assess patients?
    a. PPE donning guidance is available at https://www.mlrems.org/GetFile.aspx?fileID=25923.
    b. An assessment protocol to identify those who are appropriate to remain home and all associated documents are now available at https://www.mlrems.org/GetFile.aspx?fileID=25937.

2) What do I do after ***EVERY*** patient encounter?
    a. After every patient encounter, or after transfer of patient care, doff and properly dispose of PPE.
    b. Use hand sanitizer prior to getting back into vehicles/apparatus.
    c. Wash hands when water/soap available.
    d. Wipe down all patient care surfaces with disinfectant after each use.
    e. A decontamination guide is available at https://www.mlrems.org/GetFile.aspx?fileID=25936.

3) What is source patient control?
    a. Source patient control refers to placing a surgical mask on a patient. Due to illness spread, all patients should have source control. This is a critical component of protecting responders and others.

4) What do I do for a pediatric patient?
    a. A pediatric patient, of any age, with cough, cold, flu, or other respiratory symptoms should have source control and if not possible, make sure responders have appropriate PPE. Although it's unlikely the pediatric patient will have COVID-19 as the source of their illness, the role of children in transmitting the virus is still unknown.

5) Where should I transport a potential COVID-19 patient?
    a. Any area hospital is capable of receiving a potential COVID-19 patient. The patient should go to the hospital based upon their preference or specific specialty center needs (e.g., trauma, cardiac, etc.), although Strong West should only receive patients with mild symptoms to help minimize the need for secondary transfer.

6) What do I do about aerosol-generating procedures such as nebulizer administration, CPAP, Intubation, or BVM use?
    a. Determine the clinical necessity of nebulizer administration given the patient's presentation. If possible, defer or consult with medical control before using nebulizers.
    b. An N-95 or higher-level respirator, instead of a facemask, should be worn in addition to the other recommended PPE if available.
    c. EMS providers that are performing ANY aerosol-generating procedure (e.g., bag valve mask (BVM) ventilation, oropharyngeal suctioning, endotracheal intubation, nebulizer treatment, continuous

601 Elmwood Avenue • Box 655 • Rochester, New York 14642
(585) 463-2900 • fax: (585) 473-3516

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positive airway pressure (CPAP), or bi-phasic positive airway pressure (BiPAP)) should wear ALL recommended PPE (N95 mask preferable if available, eye protection, gown, and gloves).

d. If possible, BVMs, and other ventilatory equipment, should be equipped with HEPA filtration to filter expired air.
e. EMS organizations using ventilators should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive-pressure ventilation.
f. At this time we are not moving to Albuterol MDI with spacers.
g. This guidance may change as there are changing recommendations given greater understanding of transmission.

7) What do I change about performing CPR?
   a. When performing CPR, the least number of personnel necessary to provide care should be used. All others should remain 6 feet away or more and provide assistance from a distance to the personnel performing CPR or other procedures.
   b. Individuals performing CPR should have at minimum mask (N95 or surgical, as available), eye protection, gloves, and gown (if available).
   c. Consider use of supraglottic airways as an alternative should there be a concern for aerosolization based on the patient's presentation.
   d. Consider field termination per protocol or with medical control guidance when clinically appropriate.

8) What about source control for a patient with a non-rebreather mask or trach collar?
   a. Appropriate provider PPE remains critical.
   b. Source control is difficult, but can be provided by surgical mask overlying the trach, trach collar, or non-rebreather mask.

9) Should the driver of an ambulance wear their mask while driving the ambulance?
   a. No. The passageway between the cab and patient compartment should be closed. If there is no ability to close/secure that passageway, then utilize plastic and duct tape to limit air movement from the patient care compartment to the cab area.
   b. However, the driver of the ambulance should wear a mask while providing any direct patient care or assisting with patient movement – along with gloves and eye protection.

Hospital Arrivals

1) Are there any changes to hospital destination? **(NEW 3/25)**
   a. For specialty services, not at this time. Specialty care destinations (Trauma, STEMI, Stroke, Burn, Pediatric) are unchanged.
   b. Due to the high incidence of myocarditis in COVID-19 positive patients, this may present as STEMI. EMS should not change their current practices, but recognize that myocarditis may be more frequent, and due to this, area hospitals are moving towards triaging STEMI patients in the ED

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before moving to the cardiac catheterization lab. Thus providers will notice a decrease in "direct to lab" STEMI patients. At this time, still route those patients to the appropriate STEMI center.

c. Due to visitor restrictions, it is more important than ever for EMS to identify a contact name and phone number for a witness or bystander of a stroke patient and relate that to ED/Stroke Team staff. This information is CRITICAL to be able to provide patients with tPA treatment and not having this information leads to treatment delays. Providers are strongly encouraged to use the stroke stickers, available in triage areas and at https://www.mlrems.org/GetFile.aspx?fileID=8452
d. UR Medicine is looking to increase utilization of Highland Hospital for non-COVID19 surgical and orthopedic cases:
    i. All major trauma or trauma as a result of a concerning mechanism should continue to come to SMH.
    ii. Isolated orthopedic trauma (minor mechanism such as fall from standing, etc) even open fractures due to minor mechanism (not polytrauma), can/should be transported to HH.
    iii. Abdominal pain, cholecystitis, appendicitis, acute (nontraumatic) abdomen presentations can/should be transported to HH.

2) What do I do with a patient I suspect has COVID-19 on hospital arrival?
    a. As above, implement source patient control and don appropriate PPE.
    b. Patients being transported to area Emergency Departments with fever, cough, or symptoms concerning for infectious illness should have a surgical mask placed prior to reaching EMS Triage (Source Control).
    c. Patients with a mask in place can proceed directly to EMS triage unless otherwise directed by hospital-specific procedures (below). Pre-notify hospital according to existing (Non-COVID-19) procedures.
    d. Patients that cannot wear a mask due to facial features or clinical conditions (respiratory distress, etc) must have prehospital notification prior to arrival and in most cases will be directed to the decontamination area through the exterior entrance to minimize exposure to others in triage. Do not enter EMS triage with a potentially infectious patient unless masked or otherwise directed by the receiving facility.

3) Are there new triage processes at area hospitals?
    a. Many area hospitals are establishing tents outside of the ED to triage, and in some cases evaluate and discharge patients. As ED's learn what processes will work, and which will not, we are working to have common processes in place across all EDs. Until that time, please be patient and understanding as we navigate and learn what works best when using these facilities.
    b. Highland Hospital Triage Updates **(NEW 3/25)**
        i. Alternative Triage Tent established, operates 10a-10p seven days a week
        ii. EMS is **not** to drop patients off at the alternative triage tent unless specifically directed by provider/charge nurse.
        iii. Two entry points for EMS for placement of ED patients:
            1. Regular EMS Doors for non-respiratory/non-COVID concern complaints.

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2. Decon Door for Respiratory/COVID concern complaints.

iv. Decision for which entrance is made by the provider/charge nurse at the hospital based on patient's symptoms during the day and tent hours.

v. Overnight there will be a doorbell outside the EMS doors that you are asked to press to alert the triage nurse of your arrival and will be told which door to enter the ED by the charge nurse.

vi. Any issues in regards to triage or other processes at Highland Hospital, contact Dr. Schueckler directly at 716-949-5211.

c. Unity Hospital Triage Updates **(NEW 3/25)**

i. Continue to prenotify for patients in which source control is not possible (nebs, intubated, CPAP, etc) or the Health Department has referred them to the ED for evaluation.

Additional Information

These FAQs, all associated documents, and links to CDC resources can also be found at:
https://www.mlrems.org/provider/covid-response/