



EMS Pandemic Response Protocol FAQ

10 Apr 2020

Pandemic Response Phase 1

1. Phase 1, #2, “Management of Acute Respiratory Symptoms during COVID-19 Pandemic” (page 161)

a. EMT

- i. Under EMT, #1, the protocol indicates to maintain an SpO₂ >93%. In the current December 1, 2019 Maine EMS protocols, the goal is to maintain a SpO₂ >94%. Why the change?
 1. *The change is based on some of the early research work from China, where SpO₂ > 93% on room air was used as a cut-off to help determine patients who could be managed at home vs. those who needed hospitalization. This is based on currently best available evidence.*
- ii. Under EMT, #2, the protocol indicates that an EMT can assist a patient with their own albuterol or albuterol/ipratropium MDI. Is OLMC required to perform this or to repeat, if needed, in 20 minutes as indicated?
 1. *OLMC is **not** needed for this. It is considered a standing order based on the EMT’s assessment. The MDPB believes that OLMC will be busy due to the anticipated surge in ED volume and unduly burdening them with questions to which the answer will likely be “yes”, the use of OLMC is felt to be unnecessary.*

b. AEMT

- i. Under AEMT, #5, the protocol indicates that an AEMT can assist a patient with their own or use an MDI from EMS-supplied medication (if available), albuterol or albuterol/ipratropium MDI. Is OLMC required to perform this or to repeat, if needed, in 20 minutes as indicated?
 1. *OLMC is **not** needed for this. It is considered a standing order based on the AEMT’s assessment. The MDPB believes that OLMC will be busy due to the anticipated surge in ED volume and unduly burdening them with questions to which the answer will likely be “yes”, the use of OLMC is felt to be unnecessary.*
- ii. Under AEMT, #5, with regard to the use of albuterol and Duo-neb metered dose inhalers (MDI’s) the Phase 1 protocol states it is acceptable for AEMT’s to give either albuterol (already in the AEMT scope of practice) OR Duo-neb MDI. Does the use of Duo-neb in nebulized form apply as well to AEMT’s under the Phase 1 protocol?
 1. *No. AEMTs may only administer albuterol via nebulizer under this protocol at this time. Both albuterol and Duo-neb were placed as options for MDI treatment, in the Phase 1 protocol because the idea is to avoid nebulizer use as much as possible, and a Duo-neb MDI may be all that the patient has. Therefore, the option to use either MDI was included for AEMTs. However, Paramedics may give either medication if nebulizer use is necessary.*



c. Paramedic

- i. Item #10 Magnesium Sulfate administration - Some services are having difficulty acquiring the needed 50ml normal saline bags. How should magnesium sulfate be mixed for administration?
 1. **There are TWO options:**
 - a. *Using a 250ml NS bag, withdraw 200ml (leaving 50ml) and discard removed fluid, then add the 2gm magnesium. **OR***
 - b. *If there is a need for more fluids (i.e., shock, dehydration) the magnesium can be mixed and administered in a larger volume. Do not mix in volumes greater than 250ml to ensure entire dose is infused.*
 2. **Note about volume:** Most of the COVID-19 patients do not present in shock initially and the need for volume may be limited. Also, limiting the amount of fluid may help prevent ARDS later in disease progression. However, if your patient is showing signs of dehydration or shock, treat accordingly.

Pandemic Response Phase 2

1. **Is the “Go-Live” date/time a time after which implementation is mandatory, or is it an “earliest start time?” What if a hospital isn’t ready to implement the Phase 2 protocol yet?**
 - a. *This is a time of “earliest start.” If you, as an EMS service, or your receiving hospital are not ready to implement the protocol, EMS should coordinate any transport action with OLMC at the receiving facility.*
2. **Can local EMS programs and Medical Directors elect not to enact Phase 2 protocols?**
 - a. *No. Maine EMS authorizes protocols at the state level, therefore, once authorized, the protocol is authorized across the state as a whole. That being said, Maine EMS understands that different localities will have different paces by which they are able to implement the protocol (see above). Also, Maine EMS understands that different parts of the state may experience surge at different times, therefore the protocol may get “more use” in different parts of the state by OLMC, i.e., if a hospital is NOT experiencing surge, OLMC may still prefer to transport mild-to-moderate COVID-19 patients.*
3. **Under Phase 2 protocol, in the instance of a non-transport, or “care at home” situation, would this be considered a “patient care and transport refusal”? Should this be documented as a refusal?**
 - a. *This situation should be considered an alternative care option rather than a refusal. Accommodations are being made in MEFIRS to account for the unique circumstances of the patient’s disposition under pandemic conditions. The following should be documented in the patient care report if it is a non-transport:*
 - i. *Consultation with OLMC and their recommendation regarding transport vs non-transport*
 - ii. *Instructions left by the EMS Clinician for the patient*
 - iii. *That the patient understood the instructions*



4. In the event of a “care at home” or non-transport patient disposition, what sort of care instructions should be left by EMS?

- a. *EMS Clinicians should review and leave the following care instructions:*
 - i. *Home Care Instructions PDF*
 - ii. *Return to Care Instructions PDF*
 - iii. *Infection Control Instructions PDF*
- b. *Establishing a follow up plan with the patient is essential to ensure patient safety and must be completed prior to leaving the patient. This plan should account for a minimum of a phone contact within a 12-36 (average 24) hour period of time. The plan can take advantage of any of the following strategies*
 - i. *EMS contacts the patient’s Primary Care Provider to establish in-person or phone follow-up.*
 - ii. *EMS Service follows up with the patient by phone (if available).**
 - iii. *EMS should also encourage the patient, their families and/or their caregivers to be advocates as well, and to reach out to the Primary Care Provider for follow-up as well.*
 - iv. *Public Health authorities in the community can provide phone follow-up (if available, many communities have local public health liaisons or public health nurses who may be interested in providing such follow-up. The MDPB suggests reaching out to these individuals, if they exist in your community to inquire if this is a service, they may be willing to offer.*
 - v. *On-Line Medical Control, or the OLMC provider’s hospital may have resources that can follow up with these patients.*
 - vi. *For patients with established home health providers, these services may also be willing and interested in offering follow-up for the patient and should be considered an option for patients with these services in place.*
 - vii. *Finally, for patients in hospice, please consider engaging the patient’s hospice providers early. Supporting the patient with their COVID-19 infection as well as the underlying condition that prompted their need for hospice is essential and early engagement with the patient’s hospice providers is essential.*

** Resources in the form of a clinical bulletin will be published shortly that provides a guide for phone-based evaluation and provides EMS clinicians with a structured interview as well as actionable steps. This Clinical Bulletin is intended to support EMS agencies who opt to become the follow-up strategy for their community.*

5. What is the guidance regarding how to decide which hospital to call when the patient doesn’t have a “medical home?”

- a. *The patient should be transported to the closest appropriate facility, as you otherwise normally would.*

6. What if the patient and OLMC do not agree regarding being transported to the hospital vs being cared for at home?

- a. *If the patient insists on being transported to the hospital, you should transport the patient. The home care option is a three-party decision between the EMS Clinician, OLMC, and the patient. Each of the parties must agree to no transport vs. home care.*



7. **What is the proper course of action when a patient continues to request transport, even after they screen appropriate for home care?**
 - a. *See question #6 above*

8. **If the patient refuses transport and EMS feels the patient meets requirements for transport, is EMS expected to go through the screening process for refusals of suspected COVID-19 patients?**
 - a. *If the patient refuses transport and has the capacity to make their own medical decisions, this information should be documented as a refusal of transport with all of the pertinent information, per protocol (Grey 14-15). Please consider contact with OLMC with the goal of having OLMC speak directly with the patient to encourage transport in these circumstances. If the patient continues to defer transport, this should be documented thoroughly in a refusal, which should be signed by the patient.*

9. **Refusals are always a delicate matter, and clinical judgement plays a big part. Is the Phase 2 protocol just another “tool in our tool box” to help educate the patient, or does it give us (or OLMC) a level of authority to refuse transports that we feel are not justified?**
 - a. *This is a “tool in the toolbox” to use during a pandemic, when the hospital may be overwhelmed. It allows for some relief to the hospital by keeping mild-to-moderate patients home **if able to do so safely**. The scoring system, social situation and other screening criteria are all needed to make a decision regarding the “safety of remaining home” vs. “needing immediate emergency department care/intervention.” OLMC can offer guidance, as they know the status of their department at that time and can help triage the patient. EMS Clinicians are reminded that at this time, transport should be performed to patients who insist on being transported.*

10. **In consideration of Phase 2, should EMS Clinicians change their approach to patient care (i.e., our service does 12-Lead ECGs and obtains IV access on almost all respiratory patients)?**
 - a. *An appropriate patient assessment and evaluation is critical. Assessments (such as 12-Leads) and interventions (such as establishing an IV) indicate a need for ALS care, and should not be “routinely done.” If the EMS provider feels there is a need for ALS skills, it must be based upon current protocol guidelines, assessed patient care needs, and is indicative of the need for transport to the hospital for evaluation. These skills should not be utilized prior to a complete assessment, unless the patient’s condition is severe enough that a delay in performing them would be detrimental to the patient’s care. Thus, the patient would not be a candidate for home care and should then be transported.*