

Protocol Changes for COVID 4/27/2020

All protocols were renumbered and placed into a separate section of protocols (14) for easy of access and clarity.

14.01 Privileging and Participation – No changes (previous 8.35)

14.02 Staffing – No changes (previous 8.36)

14.03 Dispatch Screening – New protocol

14.04 Conventional Response – (previous 8.32)

Remove fever, add sore throat, loss of taste/smell as screening criteria

Add priority 2 clarification

14.05 Personal protection – (previous 8.31)

Removal of fever and addition of sore throat, loss of taste/smell to signs and symptoms

Added precaution language from 8.30

Added language about sealing driver's compartment and ventilation.

Added opening rear doors of vehicle before driver's compartment

Added source control face masks on all involved.

14.06 Clinical Treatment – name change – (previous 10.20)

Added MDI dosing

Added indications of licensure level for interventions

Added epinephrine IM for respiratory distress

14.07 Nasopharyngeal Specimen collection – (previous 8.34)

Name change, some clarification in procedure

14.08 Resuscitation – (previous 10.21)

Changed wording for types of symptoms prior to arrest to include sore throat, loss of taste/smell

14.09 Telemedicine – No changes - (previous 8.33)

14.10 Destination – (previous 8.30)

Addition of section regarding bypass of hospitals without critical care or isolation capabilities.

Addition of source control language.

Precautions language moved



Michigan
***EMERGENCY* COVID-19 PANDEMIC**
PRIVILEGING AND PARTICIPATING FACILITIES RELEASE
DURING COVID-19 RESPONSE

Initial Date: 03/23/2020
Revised Date: 04/24/2020

Section: 14-01

Privileging and Participating Facilities Release During COVID-19 Response

Purpose: Establish a mechanism allowing EMS agencies/Medical Control Authorities (MCA) to give prehospital care across jurisdictional boundaries during the COVID-19 response.

1. During the COVID-19 response all MCA, EMS Agencies, and Emergency Departments assist and support each other. This provides an approved/authorized process allowing EMS agencies to function within an MCA during the COVID-19 response.
2. Requests for support may be made to the MCA or EMS agencies within the state through each MCA's local Healthcare Coalition. Response is dependent on the availability of equipment and personnel.
3. For the purpose of load balancing hospitals during the COVID-19 pandemic, personnel and agencies from different MCAs will be allowed to operate in any MCA for the duration of the response.
 - a. Personnel should function according to the protocols of their home MCA.
 - b. When need diminishes, previously approved privileging protocols will be immediately reinstated.
 - c. Agencies operating under this protocol during the COVID-19 response will return to their normal approved response areas when the need for cross-MCA function has lapsed.

MCA Name:
MCA Board Approval Date:
MCA Implementation Date:
Protocol Source/References:

Staffing During the COVID-19 Pandemic

Purpose: To provide direction for staffing alterations and vehicle usage during the COVID-19 Pandemic according to [Executive Order 2020-39](#).

- I. Ambulance Staffing
 - A. Advanced life support (ALS) vehicles operate with the minimum staffing of a paramedic and a medical first responder (MFR), or higher.
 - B. Limited ALS (LALS) vehicles operate with the minimum staffing of an advanced emergency medical technician specialist (AEMT-S) and an MFR, or higher.
 - C. Basic Life Support (BLS) vehicles operate with the minimum staffing of an emergency medical technician and an MFR, or higher.
- II. Vehicle Status
 - A. Life support agencies (LSA), when staffing is not available for vehicles as they are currently licensed may staff them at a lower level to respond to requests for service.
 - B. A vehicle that is licensed as an ALS vehicle may respond without a paramedic, if equipment that is outside the currently staffed personnel's scope of practice is secured in a way that it is not accessible.
 - C. A vehicle that is licensed as an LALS vehicle may respond without an AEMT-S, if equipment that is outside the currently staffed personnel's scope of practice is secured in a way that it is not accessible.
 - D. A vehicle that is licensed as a BLS vehicle may respond without an EMT, if equipment that is outside the currently staffed personnel's scope of practice is secured in a way that it is not accessible. A BLS ambulance must have an EMT in order to transport.
- III. Equipment and Medications
 - A. Equipment and medications that are accessible at any time, must be within the scope of practice of the personnel currently staffing the vehicle.
 - B. It is acceptable to utilize ALS equipment in their BLS functionality (e.g. monitors set to AED mode)
- IV. Scope of practice
 - A. Personnel continue to be limited to their licensed scope of practice.
 - B. This protocol does not preclude Healthcare providers who maintain current Michigan health professional licenses outside of EMS (e.g. RN, MD, PA) and that continuously work in emergency services, from practicing at their scope of practice in an ambulance with MCA approval. This scope is not covered by the level of license of an LSA vehicle.
- V. Reporting

If an agency finds that they need to alter their staff in accordance with this protocol and the executive order, they should report the status to the MCA in which the altered staffing occurred.

Michigan
***EMERGENCY* COVID-19 PANDEMIC**
DISPATCH SCREENING GUIDELINES FOR
COVID-19 OUTBREAK

Initial Date: 03/11/2020
Revised Date: 04/27/2020

Section 14-03

Dispatch Screening Guidelines for COVID-19 Outbreak



Purpose: To outline screening criteria for PSAPs and EMD centers.

- I. Caller Inquiries/COVID-19 Screening:
 - A. PSAPs who perform EMD services and EMS agency EMD centers should perform modified caller inquiries/focused screening.
 - B. Through the normal EMD caller interrogation process, patients should be considered as **screening for COVID-19** who report symptoms of:
 1. Fever or chills,
 2. cough,
 3. sore throat,
 4. shortness of breath,
 5. muscle pain,
 6. headache,
 7. loss of sense of taste/smell, OR
 8. that report a diagnosis or have suspected COVID-19
 - C. All callers should be inquired as to these symptoms or considerations for **ALL** members of the household, regardless of the nature of the initial call or who the patient in question is at the time. This may occur after standard EMD caller interrogation
 - D. Any indication for the above symptoms or considerations for any member of the residence will be relayed to responding personnel to don appropriate COVID-19 PPE.
- II. For PSAPs not currently performing EMD services (or transferring callers to secondary EMD Centers), when information is volunteered by the caller indicating the patient may have the above symptoms advise responders to don PPE. This should be done in accordance with local PSAP policies and should not delay EMS dispatch.

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***EMERGENCY* COVID-19 PANDEMIC**
DISPATCH SCREENING GUIDELINES FOR
COVID-19 OUTBREAK

Initial Date: 03/11/2020
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Section 14-03

 <p>MDHHS Michigan Department of Health & Human Services</p>	<h2 style="margin: 0;">COVID-19 Guide Card</h2> <h3 style="margin: 0;">PSAP/EMD Scripted Questions and Responder Alerts</h3>	 <p>BIETP Bureau of EMS, Trauma & Preparedness</p>
All Callers		
Any Caller Reports that Patient Has Fever, Chills, Cough, Shortness of Breath, Sore Throat, or Loss of Sense of Taste/Smell, Muscle Pain, Headache		
No	Call Prioritization as Usual and Inquire about other members of the residence with these symptoms	
Yes	Alert Responders: <i>"Patient screens for COVID-19 risk and reports infectious symptoms, don appropriate PPE*."</i>	
Any Caller Reports that Any Member of the Residence Has Fever, Chills, Cough, Shortness of Breath, Sore Throat, or Loss of Sense of Taste/Smell, Muscle Pain, Headache		
No	Call Prioritization as Usual	
Yes	Alert Responders: <i>"Person in residence screens for COVID-19 risk and reports infectious symptoms, don appropriate PPE*."</i> Advise Caller: <i>"Individuals with these symptoms should remain as far away from EMS personnel as possible."</i>	
Other Caller Concerns or Suspicion for COVID-19		
For any patient expressing concerns or suspicion for COVID-19 but not under public health monitoring and negative for COVID-19 screening questions, Alert Responders that <i>"The patient expresses concern for COVID-19 but is not reportedly under public health monitoring and COVID-19 screening questions are negative, don PPE as appropriate."</i>		
NOTE: The query process should never supersede the provision of pre-arrival instructions to the caller when immediate lifesaving interventions (e.g., CPR or the Heimlich maneuver) are indicated.		
* Appropriate PPE includes standard, contact, airborne precautions, and eye protection.		
Revised: 4/27/2020		

Conventional Response to Potential COVID-19 Outbreak

Purpose: To reduce risk of exposure of EMS personnel during the conventional response phase of a COVID-19 outbreak.

- I. Requests for EMS should be screened for risks for COVID-19 according to **Dispatch Screening Guidelines for COVID-19 Outbreak**.
- II. Priority one and two responses* who screen for potential COVID-19:
 - a. Normal agency response
 - b. First unit on scene:
 - i. Initial responder(s) enter at minimum level of personnel (if non-transporting and transporting units arrive at the same time, transporting personnel enter scene wearing appropriate PPE, while non-transporting personnel provide support as needed).
 - ii. After initial assessment, personnel who have made patient contact request additional (specific) resources, as indicated.
- III. Priority three** patients who screen for possible COVID-19:
 - a. Initial response by transporting agency ONLY, unless transporting agency delayed by more than 30 minutes.
 - b. Transporting personnel make contact wearing appropriate PPE.
 - c. After initial assessment, if more resources are needed, personnel request specific necessary resources (e.g., lift assist).
- IV. Responses to health facilities (those with licensed health care staff present) with a patient who screens positive for possible COVID-19:
 - a. Initial response by transporting agency only unless information indicating clear need for additional personnel (e.g., patient being ventilated).
 - b. Minimal personnel enter the scene and assess the patient.
 - c. After initial assessment, if more resources are needed, personnel request specific necessary resources.

*Priority one includes patients with potential life-threatening emergencies including, but not limited to, shortness of breath, chest pain, and/or altered mental status. Priority two includes patients with serious illness or injury without immediate life-threatening conditions listed as priority one patients.

**Priority three includes patients with cough and/or sore throat but without other Priority one symptoms.

Personal Protection During Treatment of Patients at Risk for Coronavirus Disease (COVID-19) and Decontamination of Equipment after Use

Purpose: To outline infection prevention and personal protection when providing treatments for patients who are at risk for COVID-19. To outline the appropriate decontamination for people, equipment, and vehicles utilized in treatment and transport of patients at risk for COVID-19.

- I. Applicable patients –
 - a. Patients who have been identified prior to arrival as at risk for COVID-19 by a 911 Public Safety Answering Point (PSAP) and/or Emergency Medical Dispatch Center (EMDC), local health department, other healthcare provider (urgent care, long term care) or CDC quarantine station.
 - b. Patients encountered by EMS personnel who have signs and symptoms of respiratory illness (cough, shortness of breath, sore throat, loss of taste/smell) or fever (including subjective by history), chills, repeated shaking with chills (rigors), muscle pains, or headache.
- II. Personal Protection –
 - a. Standard, contact, and airborne precautions must be observed if within six feet of patient.
 - i. Standard precautions - The principle that all blood, body fluids, secretions, excretions except sweat, nonintact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions include a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered.
 - ii. Contact precautions - intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the patient or the patient's environment. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Strict hand hygiene must be performed after each patient encounter and after doffing gloves.
 - iii. Airborne precautions – intended to prevent transmission of infectious agents that remain infectious over long distances when suspended in the air. EMS personnel caring for patients on Airborne Precautions wear an N95 or higher-level respirator or mask that is donned prior to room entry. Personnel who are not providing aerosolized treatments and not in close proximity (in the closed compartment of the ambulance) with a patient with active respiratory symptoms may use a surgical mask in lieu of an N95 respirator.
 - b. Contact with these patients should include the use of eye protection/face shield.
 - c. All patient contacts should include universal source control:

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- i. A surgical mask should be applied to all patients, especially prior to being placed in an ambulance, unless they are receiving oxygen by mask.
- ii. A cloth or sewn face covering or surgical mask should be applied to anyone accompanying patient in ambulance regardless of COVID-19 symptoms.

III. Guidance for PPE utilization based on situation

Proximity to Patient	Facemask or Respirator Determination	
	Patient wearing mask for entire encounter	Patient not wearing mask or removed during treatment
Greater than 6 feet from symptomatic patient (excluding patient compartment of ambulance)	Unnecessary personnel should not enter patient care area, no respirator required. All personnel should always have at least a sewn facemask in place.	Unnecessary personnel should not enter patient care area, no respirator required. All personnel should always have at least a sewn facemask in place.
Between 3 and 6 feet of symptomatic patient	If personnel must be in this area, surgical facemask required	If personnel must be in this area, surgical facemask required
Within 3 feet, including direct patient care	Surgical Facemask	Respirator required
Present within 6 feet (or in the same room) when patient receives aerosol generating procedure.	Respirator required	Respirator required
Patient with respiratory symptoms or distress (cough, shortness of breath) or confirmed COVID-19 positive in patient compartment of ambulance)	Respirator required	Respirator required
Patient without respiratory symptoms or distress, not known to be COVID-19 positive, AND COVID-19 not suspected.	Surgical Facemask	Surgical Facemask

IV. During Treatment

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Protocol Source/References: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html>,
<https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html>,
<https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html>

Personal Protection During Treatment of Patients at Risk for
Coronavirus Disease (COVID-19) and Decontamination of Equipment after Use

Initial Date: 02/12/2020

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- a. The number of responders within six feet of the patient should be limited to the fewest number to provide essential patient care.
 - b. A (surgical type) facemask should be placed on the patient for source control. Do not place N-95 or similar masks on patients as these increase the work of breathing.
 - c. Any family or bystanders should not be within six feet of responders, and if they are should wear a cloth facemask.
 - d. Aerosol Generating Procedures
 - i. In addition to PPE, there should be increased caution in aerosol-generating procedures (BVM, suctioning, emergency airways, nebulizers, etc)
 - ii. Perform aerosol-generating procedures only when clinically indicated.
 - iii. Keep patient and aerosolization away from others without PPE (e.g., bystanders, EMS personnel not in PPE, etc).
 - iv. Preferably, aerosolized procedures should be done OUTSIDE of the ambulance. When treating patient in the ambulance, activate patient compartment exhaust fan at maximum level.
 - v. When possible, consider using HEPA filtration to expired air from the patient. (Ventilators, CPAP, biPAP, BVM)
- V. Patient Compartment –
- a. When practical, utilize a vehicle with an isolated driver and patient compartment.
 - b. Seal any openings between the driver and patient compartment.
 - c. Only necessary personnel should be in the patient compartment with the patient.
 - d. All compartments should have ventilation maintained, with outside air vents open and set to non-recirculated mode.
- VI. Patient Transfer
- a. Friends and family of the patient should not ride in the transport vehicle with the patient. If they must accompany the patient, they should have a cloth facemask applied.
 - b. Personnel driving the transport vehicle should doff PPE (with the exception of respirator) and perform hand hygiene before entering the driver's compartment. Respirator (N95) or surgical facemask should be maintained throughout.
 - c. Ventilation in the driver's compartment should be set to bring in outside air and on maximum speed.
 - d. Notification of infectious risk should be made to receiving facility as soon as feasible.
 - e. Upon arrival at receiving facility, open patient compartment doors BEFORE opening driver's compartment doors.
 - f. Maintain mask on patient and filtered exhaust while transporting patient to room.
 - g. Patients should never be transported into a hospital with a nebulizer treatment in progress.
 - h. If patient care requires CPAP, contact receiving hospital to coordinate hand-off in a manner that minimizes hospital environmental risk.
 - i. Avoid transporting the patient within 6 feet of others (e.g., unprotected hospital staff, patients, bystanders, etc.)

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Protocol Source/References: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html>,
<https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html>,
<https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html>

- j. Transfer patient care via verbal report.
 - k. Doff PPE after leaving patient room and perform hand hygiene before touching documentation tools.
- VII. Cleaning of Transport Vehicle and Equipment
- a. Personnel should wear disposable gown and gloves for decontamination of the vehicle. A face shield or facemask and goggles should be worn if there is a potential for splashing or sprays.
 - b. Maintain doors open during cleaning.
 - c. Disinfect after cleaning using EPA-registered, hospital-grade disinfectant to all surfaces that were touched, or all surfaces if aerosol-generating procedures were performed. Products with statements for emerging viral pathogens should be used.
 - d. All equipment that was involved in patient care and equipment that was inside of patient compartment of ambulance should be cleaned.
 - e. Ambulances should be thoroughly cleaned (including door/compartment handles and ambulance cab) at the beginning and end of each shift in which patient transport occurred, regardless of COVID-19 patient status.




Clinical Treatment for Patient with Suspected or Confirmed COVID-19

- I. Applicable patients:
Patients prescreened or encountered by EMS personnel who may or may not have been pre-identified by 911/EMD as a potential COVID-19 patient:
 - A. Have signs and symptoms of respiratory illness (cough, shortness of breath)
 - B. Have signs and symptoms of respiratory illness (cough, shortness of breath) AND known exposure to patient with suspected COVID-19
 - C. Have other signs or symptoms associated with COVID-19 (fever, chills, shaking with chills, sore throat, loss of sense of taste/smell, muscle pain, headache, profound fatigue).
- II. Personal Protective Equipment:
 - A. Standard, contact, and airborne precautions
 - B. Surgical masks for personnel may be substituted for N95 masks when no aerosolized procedures are taking place and when not in an enclosed area (e.g. ambulance patient compartment) with actively coughing patient.
 - C. Surgical masks or non-rebreather masks with supplemental oxygen for patients in respiratory distress should be applied to the patient whenever possible to perform source control. All patients regardless of COVID-19 suspicion should have surgical mask applied for source control.
- III. Treatment:
 - A. Follow **General Prehospital Care Protocol and other applicable protocols modified as below**
 - B. Patients should receive oxygen to maintain SPO2 \geq 94%
 - i. Nasal cannula should be applied under a surgical mask.
 - ii. Non-rebreather masks, for patients with hypoxia or respiratory distress should be used in lieu of surgical masks.
 - iii. Combined nasal cannula at 6 LPM and non-rebreather mask at 12-15 LPM may be considered in patients remaining hypoxic after non-rebreather alone.
 - C. Assess breath sounds
 - i. For patients with clear breath sounds, continue supportive oxygenation.
 - ii. For patients with wheezing
 -  1. Preferred mechanism for pharmacological intervention is albuterol by metered dose inhaler (MDI) with spacer (including assisting patient with personal inhaler of albuterol), if available.
 - a. Administer 4 puffs over 30-60 seconds (equivalent to 2.5 mg of albuterol)
 - b. Dose may be repeated as needed every 5 minutes.
 2. If patient has wheezing with moderate to severe dyspnea and there is not access to MDI and the patient has a known history of asthma/COPD
 - a. Administer bronchodilator via nebulizer in open area with maximum air ventilation, with N95 or greater respirator applied to personnel, and single rescuer monitoring patient from maximal distance possible. Contact medical control for direction, as needed.

Michigan
***EMERGENCY* COVID-19 PANDEMIC**
CLINICAL TREATMENT FOR PATIENT WITH
SUSPECTED OR CONFIRMED COVID-19

Initial Date: 03/23/2020
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- b. **DO NOT** administer nebulized medication in closed ambulance.
 -  c. For patients with known history of asthma/COPD and in moderate to severe dyspnea WITH wheezing, may administer:
epinephrine (1 mg per mL) 0.3 mL IM. (Skill may be BLS or MFR, depending on MCA selection.)
 - iii. For patients with severe respiratory distress AND a history of CHF or COPD and positioning, oxygenation, and other treatments (e.g. nitroglycerin 0.4 mg SL q 3 minutes for CHF) are not effective:
 -  1. Apply CPAP per protocol.
 - 2. Use HEPA filter for exhalation port, if available.
 - 3. CPAP being utilized in the patient compartment should be limited to necessity and only when all providers in the patient compartment have N95 respirators in place.
 - 4. Contact receiving hospital as early as possible to advise them of patient requiring CPAP to allow for appropriate transition of care upon arrival.
 - D. Hypotensive patients – those with SBP <90mmHg with signs and symptoms of shock
 -  i. Administer normal saline 250 mL bolus.
 - ii. Reassess BP and signs and symptoms of shock prior to administering more fluid
 - iii. Normal saline boluses of 250 mL may be repeated to a maximum of one liter as signs/symptoms persist before contacting medical control.
 - E. Airway management
 - i. **DO NOT** Intubate or perform (mouth to mask/mouth) rescue breathing on patients with suspected COVID-19.
 - ii. Utilize supraglottic airways with ETCO2 if an advanced airway needs to be placed.
 - iii. Place filter inline for ventilations or utilize a BVM with filtration capability, if available.
 - IV. Time sensitive patients:
 - A. Patients in need of immediate intervention will be treated with a minimum of gloves, eye protection, and mask
 - V. Transport:
 - A. Interventions should be performed **PRIOR** to loading into or closing patient compartment of the ambulance.
 - B. Only one provider will remain with patient for transport, if possible.
 - C. Follow COVID-19 Destination and Transport Protocol
 - VI. **Cardiac arrest- Follow CARDIAC ARREST IN A PATIENT WITH SUSPECTED COVID-19**

Nasopharyngeal Specimen Collection for COVID-19

- I. Applicable patients: Patients who have received a referral or order from a clinician (primary care, local health department, medical control physician) for specimen collection.
- II. Collection Procedure for Nasal Pharyngeal Sampling:
 - A. Don appropriate PPE
 - i. N95 Mask
 - ii. Gown
 - iii. Gloves
 - iv. Eye protection
 - B. Place patient in seated position
 - C. Tilt patient's head back slightly to visualize nasal passages
 - D. Ask patient to remove face mask and close eyes
 - E. **Gently insert swab along nasal septum, just above the floor of the nasal passage, to the nasopharynx**
 - i. Stop when resistance is met
 - ii. Do not force swab further
 - iii. If you detect resistance to the passage of the swab, back off and try reinserting it at a different angle, closer to the floor of the nasal canal.
 - iv. The swab should reach a depth equal to the distance from the nostrils to the outer opening of the ear.
 - F. Rotate swab several times (keep in passage 10 seconds)
 - G. Gently remove swab while rotating
 - H. Place swab into collection tube according to directions
 - i. Place swab into tube before breaking stick
 - ii. Tighten cap securely
 - I. Have patient reapply face mask
- III. Packaging procedure:
 - A. Label tube
 - i. Patient name
 - ii. Patient DOB
 - iii. Source
 - B. Place tube in plastic bag with absorbent material
 - C. Place sample in 95kPa bag
 - D. Place bagged sample on ice pack
 - E. Follow instructions according to referral source or ordering physician for shipping or delivery.
- IV. Key Information:
 - A. Uncomfortable procedure, be gentle with patient
 - B. Questions or issues with packaging should be handled by referral source, according to directions on collection materials provided

Additional Information and Video: <https://www.nejm.org/doi/full/10.1056/NEJMvcm2010260>

Cardiac Arrest in a Patient with Suspected or Confirmed COVID-19

- I. Applicable patients are patients in cardiac arrest with known previous symptoms or known diagnosis of COVID-19 (coronavirus disease). Concerning pre-arrest symptoms include:
 - A. respiratory illness (cough, shortness of breath, sore throat)
 - B. fever (all patients with fever prior to arrest should be suspected as having COVID-19)
 - C. loss of sense of taste/smell
 - D. muscle pain (myalgias)
 - E. headaches
 - F. chills with or without repeated shaking (rigors)
- II. Personal Protective Equipment:
 - A. Standard, contact, and airborne precautions
 - B. CPR and assisting ventilations are aerosolized procedures. N95 masks or equivalent are required. Do not perform CPR without respiratory precautions in place.
- III. Treatment:
 - A. For patients with NO pre-arrest symptoms as noted above and not known to be COVID-19 positive, follow **General Cardiac Arrest Protocol**.
 - B. For arrests of patients with known pre-arrest symptoms noted above or known COVID-19 infection treat according to **General Cardiac Arrest Protocol** EXCEPT:
 - i. Airway interventions will be limited to BLS procedures, including supraglottic airway. **DO NOT INTUBATE**.
 - ii. When CPR is being performed, only necessary personnel should be next to the patient. Personnel should remain at least 6 feet from patient when not performing interventions, as able.
 - iii.  If no return of spontaneous circulation (ROSC) within 10 minutes of resuscitation, contact medical control for possible termination orders.
 - iv. Patients in continuous cardiac arrest **WILL NOT BE TRANSPORTED**, regardless of mechanical CPR device. Resuscitation will either be terminated on scene or ROSC sustained (continued palpable pulse and systolic BP ≥ 60 mmHg for >5 minutes) **BEFORE** moving the patient to the patient compartment of a vehicle.
 - C. For witnessed arrests inside the patient care compartment of known or suspected COVID-19 patients:
 - i. Pull vehicle to the side of the road and perform resuscitation in full PPE, with doors **OPEN**.
 - ii. If patient has mechanical CPR device in place and has lost ROSC, the device may be resumed with continued transport to the hospital, as long as all personnel in the patient compartment have sufficient respiratory PPE in place.

Michigan
***EMERGENCY* COVID-19 PANDEMIC**
TELEMEDICINE AND STATIONARY TREATMENT OF
LOW ACUITY PATIENTS DURING COVID-19 OUTBREAK

Initial Date: 03/16/2020

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Section 14-09

Telehealth and Stationary Treatment of Low Acuity Patients During Covid-19 Outbreak

Purpose: To reduce unnecessary EMS transport to hospital emergency departments during the COVID-19 outbreak while assuring delivery of appropriate healthcare services.

I. Description:

This Emergency System Protocol describes the process to be followed by Paramedics when, following an appropriate clinical assessment including a telemedicine medical control consultation with an authorized physician, it is determined that the patient is not experiencing a medical emergency and will not likely benefit from transport by EMS to the hospital emergency department.

II. Definitions:

- A. **Emergency Patient:** means an individual with a physical or mental condition that manifests itself by acute symptoms of sufficient severity, including, but not limited to, pain such that a prudent layperson, possessing average knowledge of health and medicine, could reasonably expect to result in 1 or all of the following:
 - 1. Placing the health of the individual or, in the case of a pregnant woman, the health of the patient or the unborn child, or both, in serious jeopardy.
 - 2. Serious impairment of bodily function.
 - 3. Serious dysfunction of a body organ or part.
- B. **Non-Emergency Patient:** For the purposes of this protocol, a non-emergency patient means an individual who has been **jointly** assessed by both EMS and an authorized medical control telemedicine physician and has been determined to not meet the definition of an emergency patient as defined above.
- C. **EMS Telemedicine Application:** means a telecommunication application that is HIPPA-compliant and provides for remote medical control between the treating paramedic and the supervising authorized medical control physician and has been approved by the local medical control authority.
- D. **Medical Control Telemedicine Physician:** means a physician authorized by the local medical control authority Medical Director and serving as a representative of the local medical control authority.
- E. **Alternate Destination:** means a healthcare facility other than a hospital emergency department approved by the local medical control authority Medical Director to which a non-emergency patient may be transported. This may include physician offices, clinics, urgent care centers, and other approved alternate care centers.
- F. **Alternate Transport:** means a vehicle, other than a licensed ambulance, used to safely transport a non-emergency patient to a hospital emergency department or approved alternate destination. This may include wheelchair van, private vehicle, ride share vehicle, licensed non-transporting EMS vehicle, non-licensed public safety vehicle, or other type of vehicle type approved by the local medical control authority Medical Director.
- G. **Alternate Treatment Plan:** This means a treatment plan for the non-emergency patient that involves home care, transport to an alternate destination, or transport using and alternate vehicle.

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TELEMEDICINE AND STATIONARY TREATMENT OF
LOW ACUITY PATIENTS DURING COVID-19 OUTBREAK

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III. Qualifying Patients:

This protocol is intended for patients who, following patient assessment and medical control telemedicine consultation, are determined to not be an emergency patient as defined above and are in not in need of EMS transport to a hospital emergency department. Examples include, but are not limited to:

- A. Mild respiratory infection findings including sore throat, cough, muscle pain
- B. Mild respiratory illness with bronchospasm without signs of infection
- C. Vomiting and diarrhea without signs of significant dehydration or circulatory shock
- D. Mild exacerbations of chronic medical conditions
- E. Mild soft tissue injuries such as superficial abrasions, lacerations, and minor burns
- F. Minor orthopedic injuries such as sprains, strains, and contusions
- G. Minor medical complaints such as urinary tract infection or minor skin infection without fevers or other comorbid factors
- H. Other clinical conditions appearing to be of low acuity associated with stable vital signs.

IV. Excluded Patients:

This protocol does not apply to patients who, following paramedic assessment are felt to reasonably have a clinical condition consistent with an emergency patient as defined above. Examples include, but are not limited to:

- A. Significantly abnormal vital signs (excluding fever and mild tachycardia) that fail to resolve with initial treatment
- B. Hypoxia, defined as a room air SPO₂ less than 92% that does not promptly improve with EMS treatment
- C. Chest pain suggestive of an acute cardiopulmonary condition, regardless of EKG finding
- D. Labored breathing following EMS treatment
- E. Acutely altered level of consciousness
- F. Significant acute pain of known or unknown etiology
- G. Other conditions that may otherwise be consistent with an emergency patient

V. Process:

- A. Paramedic dons appropriate PPE and limits EMS personnel contact, as appropriate
- B. Paramedic completes assessment in accordance with appropriate protocols, including complete vital signs (BP, HR, RR), temperature, and SPO₂.
- C. Paramedic initiates treatment per appropriate protocols
- D. If patient clinically appears to be an emergency patient continue with treatment and transport per appropriate protocols
- E. If patient clinically appears to be a non-emergency patient, contact Medical Control Telemedicine Physician for consultation using MCA-approved EMS telemedicine application.
- F. Paramedic provides appropriate clinical presentation to Medical Control Telemedicine Physician and provides for telemedicine video consultation between the physician and patient.
- G. If physician determines the patient continues to represent an emergency patient, the paramedic continues treatment and transports to hospital emergency department per appropriate protocol.

Michigan
***EMERGENCY* COVID-19 PANDEMIC**
TELEMEDICINE AND STATIONARY TREATMENT OF
LOW ACUITY PATIENTS DURING COVID-19 OUTBREAK

Initial Date: 03/16/2020

Revised Date: 04/24/2020

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- H. If physician determines the patient's condition is consistent with a non-emergency patient, the patient is advised of the clinical justification for the determination.
- I. An alternate treatment plan will be collaboratively developed with the patient, paramedic, and physician as described below.
- J. When alternate transportation is indicated, the paramedic may clear the scene prior to arrival of the alternate transport vehicle.
- K. Initiate alternate treatment plan and document the encounter electronically utilizing an MCA approved documentation vendor.

VI. Alternate Treatment Plan Options:

- A. At home treatment and follow-up with outpatient medical provider. Treatment may include:
 - a. Common over-the-counter supportive self/family care and/or
 - b. Medical Control Telemedicine Physician provided prescription (optional), as appropriate
- B. Transport to an alternate destination using alternate transport (or licensed ambulance)
- C. Transport to the emergency department using alternate transport

VII. Non-911 Requests for Evaluation:

- A. Local public health and/or healthcare communities, outside of 911 EMS activation process
- B. EMS will attempt to honor non-emergent requests for evaluation originating from public health and healthcare sources, contingent upon the availability of EMS resources.
Paramedics should remind patients, public health, and healthcare personnel to contact 911 if the patient's condition worsens.

VIII. If physician determines an emergency does not exist and the patient insists on Transport by Licensed Ambulance to Hospital Emergency Department:

- A. Advise Physician.
- B. Physician consults with patient and family.
- C. Ambulance transport denied by physician
 - a. Collaborate with Physician and Family for alternate treatment plan
 - b. If patient continues to insist on EMS transport, contact MCA Medical Director or on call designee.

IX. Mandatory Review:

The use of this protocol requires notification within 24 hours and review by the local medical control authority Medical Director (or designee).

Michigan
***EMERGENCY* COVID-19 PANDEMIC**
DESTINATION AND TRANSPORT OF
PATIENTS AT RISK FOR CORONAVIRUS DISEASE (COVID-19)


Initial Date: 02/05/2020

Revised Date: 04/24/2020

Section 14-10

Destination and Transport for Patients at Risk for Coronavirus Disease (COVID-19)

Purpose: To direct patient transport and destination for patients with confirmed or suspected Coronavirus Disease (COVID-19).

- I. Applicable Patients –
 - A. Symptomatic patients with confirmed COVID-19 (positive test)
 - B. Patients who meet the current clinical criteria for suspected COVID-19
- II. Patients Transported by Emergency Medical Services
 - A. Transported by EMS, utilizing standard, contact, and airborne precautions, to the closest facility with inpatient critical care capabilities, if such a facility is within 60 minutes and patient is not in severe respiratory distress or continuing to deteriorate after initiation of supplemental oxygen.
 - B. Medical control may have a specific facility designated for patients with known or suspected COVID-19.
 - C. Patient may request a specific facility if:
 - i. The facility has appropriate facilities and capabilities and
 - D. Transport time is within 60 minutes. Treat patient according to **Clinical Treatment of a Patient with Suspected COVID-19** protocol.
 - E. The receiving facility should be notified of the incoming patient as early as practical.
 - F. Destination facilities may be facilities other than emergency departments or surgical centers per direction of medical control depending on current system capacity and clinical status of patient (e.g., low acuity).
 - G. Hospitals may need to go on diversion (via emResource) if it is determined they have insufficient capacity or capability to admit COVID-19 patients.
 - H. Patients presenting with potential COVID-19 are at risk for deterioration and may benefit from early, aggressive critical care services.
 - i. Patients should bypass closer hospitals without critical care services and transport directly to hospitals with critical care services (as designated by local medical control) when the transport time to such hospitals is less than 60 minutes.
 - ii. Patients remaining hypoxic after high-flow oxygen, those with significant respiratory distress despite oxygen, and those appearing in need of intubation should go to the closest hospital with emergency services.
 - I. Final destination determination, if in question, will be from online medical control. 

MCA Name:

MCA Board Approval Date:

MCA Implementation Date:

Protocol Source/References: <https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html>,

<https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html>