

Guidelines for EMS During COVID-19 Pandemic Transports to Non-Traditional Destinations

The purpose of this document is to provide guidance for EMS Systems when making modifications to System Plans to address the demand on health system resources and the expanded COVID-19 healthcare delivery system during the evolving COVID-19 pandemic situation. As the number of people infected with the COVID-19 virus in Illinois continues to increase, the Illinois EMS System must maintain the flexibility to adapt to the changes being made in the healthcare services delivery model. EMS System transport decisions must continue to be based on the principles of the right place, right time, and right care. However, the focus of EMS delivery systems must shift from individual patient needs to the overall needs of the population being served.

Illinois's COVID-19 healthcare service delivery model has been expanded to include the establishment of Alternate Care Site¹ (ACS) and COVID-19 Isolation Facilities² (CIF). EMS may receive 911 calls to transport patients from either type of facility to a higher level of care, but **will not** transport 911 patients directly to these types of facilities. See *Transport Options for EMS During COVID-19 Pandemic* diagram for a detailed description of the different types of facilities to which patients who call 911 may be transported or referred for self-transport. EMS Systems must remain cognizant of exposure risks to EMS providers and Personal Protective Equipment (PPE) supply limitations. EMS Systems must be prepared to revise existing System Plans to change the EMS standard of care and move toward adoption of crisis care standards, which include the transport of patients to non-traditional destinations, including Urgent Care Facilities, and non-transport of patients who do not have an urgent need for ongoing medical evaluation and intervention.

A study published in 2019 titled *Examination of EMS Decision Making in Determining Suitability of Patient Diversion to Urgent Care Centers*³ was conducted to determine EMS provider ability to use existing protocols to effectively identify which patients are appropriate for diversion from the Emergency Department (ED) to an alternate treatment setting. The study found a high degree of consistency in transport location determination among EMS providers and ED

¹Alternate Care Sites (ACS) are facilities that focus on providing medical care to COVID-19 patients who are experiencing acute symptoms related to the virus and/or recovering from an illness but are not yet ready to return home or to their congregate living arrangements. ACS have the capability to admit patients for overnight/extended care and can be used to decompress hospitals and manage patients infected with the COVID-19 virus who have a chief complaint of a medical nature.

²COVID-19 Isolation Facilities are facilities where people who have mild to moderate COVID-19 related illness or test positive for the COVID-19 virus but remain asymptomatic are housed in an effort to decrease potential exposures to household and community contacts. The level of care provided is focused on symptom relief.

³Carroll, G., Levy, K., Pescatore, R., Hong, R. (2019). *Examination of EMS Decision Making in Determining Suitability of Patient Diversion to Urgent Care Centers*. Healthcare, March: 7(1): 24

physicians. However, the authors cautioned that the level of care decision cannot be left entirely up to EMS providers operating under existing System protocols since the EMS providers in the study under triaged patients close to 12% of the time; which could result in a poorer outcome caused by delayed care. Strict protocols with clear medical direction and increased capacity for Online Medical Control consultation are needed in order to better assist EMS providers with making appropriate transport decisions when the options for transport expand beyond the traditional ED and include a “no transport” option.

EMS Systems should consider the following when developing System Plan Amendments to address the increasing demand on EMS and healthcare resources during the COVID-19 pandemic and the expanding COVID-19 healthcare system in Illinois:

- Erring on the side of caution in transport destination decision-making may not always be what is best for the patient. The utilization of non-traditional transport destination likely means that the demand for ED and traditional hospital services exceeds the available capacity. EMS providers must identify which patients may be appropriate candidates for non-traditional destinations. Although a non-traditional destination may have a limited level of care, EMS providers must evaluate whether the patient’s interests are better served by more timely treatment or waiting an extended time for a higher level of care. This should be done in collaboration with on-line medical control. Higher levels of care must be reserved for the most critical patients (e.g. stroke, myocardial infarction, severe respiratory compromise).
- Transport decision Standard Operating Procedures (SOP) should provide specific parameters for patient age, chief complaint, and chief complaint to assist EMS providers with determining the appropriate levels of care. EMS Systems should consider the scope of professional practice for providers staffing the non-traditional transport destinations and any equipment and service limitations.
- Identify the capabilities and capacities of each hospital within your Region to treat and admit patients with severe respiratory compromise. If patient care will not be compromised, Resource and other hospitals should be prioritized as transport destinations for patients with severe respiratory illness since these facilities have been identified to have an increased capacity for the on-going management of patients with this type of illness.
- Identify healthcare system resources within your EMS Region that are capable of providing a specified level of care to non-critical EMS patients (e.g. urgent care facilities; licensed, independent emergency centers). Establish agreements with these facilities regarding the receipt of EMS patients during the COVID-19 pandemic. Include use of these facilities in the System Plan Amendment submitted to IDPH.

- Re-assess the types of calls to which EMS is automatically dispatched and identify call types that may be appropriate to send alternate resources, such as first responder companies and/or law enforcement, to assess the situation and then request EMS resources as needed. Call types to consider include motor vehicle accidents, assaults, intoxications, persons down from unknown cause, falls without a priority one complaint, assist the citizen, and other calls that the dispatcher deems as non-emergent.
- Establish patient status criteria to determine which types of patients may be appropriate for self-transport, non-EMS transport, delayed EMS transport, batched transport, or no transport (even if patient will not sign a refusal). Determine protocol for making these decisions.
- Determine alternate standards of care to conserve PPE and supplies and to decrease EMS provider risk of exposure to COVID-19. Strategies to consider include:
 - Changing the initial patient assessment process (1 responder vs 2; limiting equipment initially brought from ambulance on all types of calls).
 - Screening all patients for COVID-19-like illness.
 - Decreasing the use of the stethoscopes. Instructing EMS providers to only auscultate a patient's lungs posteriorly.
 - Avoiding all aerosol generating procedures unless absolutely necessary to sustain the patient. Adopt strategies to minimize provider risks during aerosol generating procedures (e.g. keep the doors of the ambulance open, limit the number of providers involved).
 - Establishing PPE extended use and PPE re-use policies.
 - Reinforcing proper cleaning for re-usable supplies (e.g. safety glasses), patient care equipment (e.g. blood pressure cuffs, patient cot), and the ambulance compartment.
 - Limiting the circumstances for which a family member may accompany the patient in the ambulance (e.g. minor children).
 - Designating Urgent Care Facilities as the preferred transport destination, as appropriate for a patient's condition, for non-COVID-19 patients whose illness or injury falls within the scope of services provided by the Urgent Care Facility. In addition to decreasing community risk of exposure to COVID-19, this strategy will help to decrease the amount of PPE required by Urgent Care Facilities.
- Establish PPE and supply exchange policies for non-traditional transport destinations.
- Evaluate whether staffing requirements can be modified for some types of calls (e.g. an emergency medical responder drives the ambulance, while one paramedic treats multiple patients in the back) or BLS resources can be sent for initial assessment of certain types of non-COVID-19 ALS calls.

- Change protocols for use of Online Medical Control for “routine” emergency care to allow EMS providers to work within the full scope of the SOPs with required Online Medical Control consultation if the EMS provider does not feel transport is required.
- Evaluate whether the use of batched and/or delayed transport is appropriate for conserving EMS resources. Establish protocols for how patients will be maintained while awaiting transport to their final destination (e.g. driver monitor’s the first patient already in the back of the ambulance while paramedic goes to assess another patient at the second response location).
- Maintain awareness of the mechanisms established to monitor bed availability status at all health system facilities within your EMS System. Incorporate the use of these mechanisms into the procedures used for making transport destination decisions.

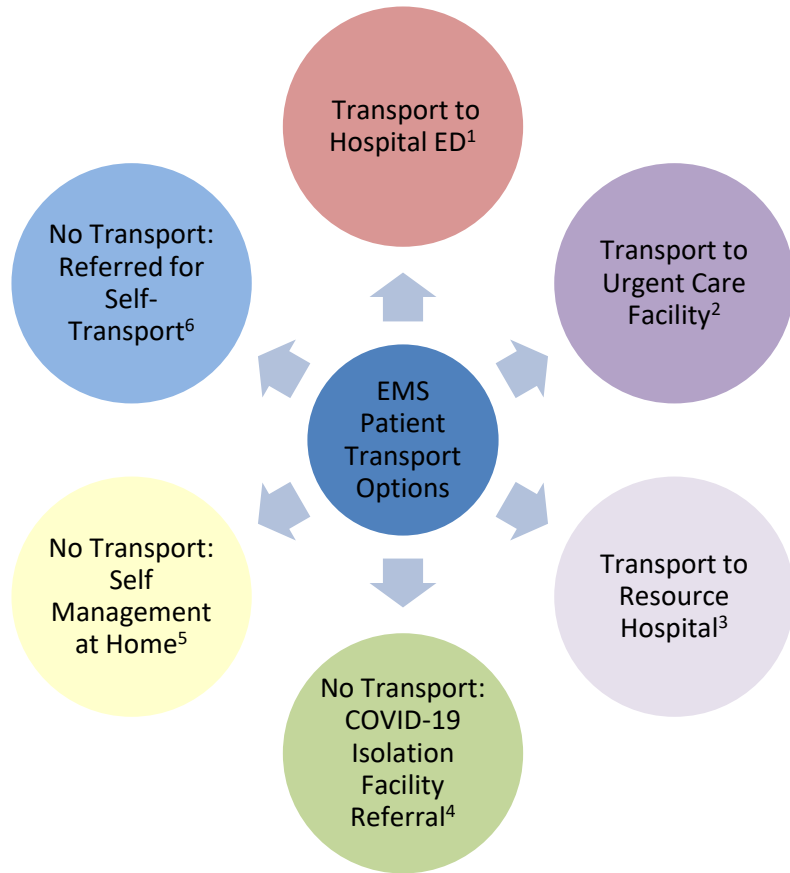
Call Center Considerations

- EMS Medical directors should work with Public Safety Answering Points/911 call centers to develop screening tools to identify low acuity patients that can self-transport to a non-traditional transport destination.
- Develop screening tools to identify lower acuity patients for whom treatment and transport can be delayed or who may not qualify for an EMS response.
- Evaluate options for assigning physician, nurse, and/or nurse practitioner resources to the call center to triage patient symptoms prior to dispatching EMS resources for certain types of calls.

TRANSPORT OPTIONS FOR EMS PATIENTS DURING COVID-19 PANDEMIC

EMS goals during the COVID-19 Pandemic:

- Sustain capabilities for providing EMS services to patients who call 911
- Prioritize transport resources for patients who require immediate medical treatment
- Transport patients directly to the appropriate level of medical care



¹Hospitals are prioritized for patients with critical injuries and illnesses that require advanced treatment interventions, surgery, intubation, or specialty care. Conditions that fall within this scope include: heart attack, stroke, advanced trauma injuries, aneurysm, open fracture, acute abdomen, GI bleed, obstetrical emergency, significant burn, inhalation injury, and pediatrics. All patients accepted regardless of COVID-19 status. Some hospitals have established COVID-19 screening areas external to the Emergency Department (ED) as the point of entry through which all patients must pass prior to entering the ED.

²Urgent Care Facilities can provide medical care for acute problems to non-COVID-19 adult and pediatric patients. Urgent Care Facilities typically do not have the capacity to admit patients for long-term care. Urgent Care Facilities may receive patients who are transported by EMS, referred from primary care or Emergency Departments that are at capacity, and self-referrals/walk-in. Medical conditions that fall within this scope include: asthma, lacerations, closed fractures, dehydration, changes in mental status (not suspected of being stroke related), nausea/vomiting/constipation, rashes, allergic reactions, diabetic reaction, acute congestive heart failure, acute vision changes, and fevers.

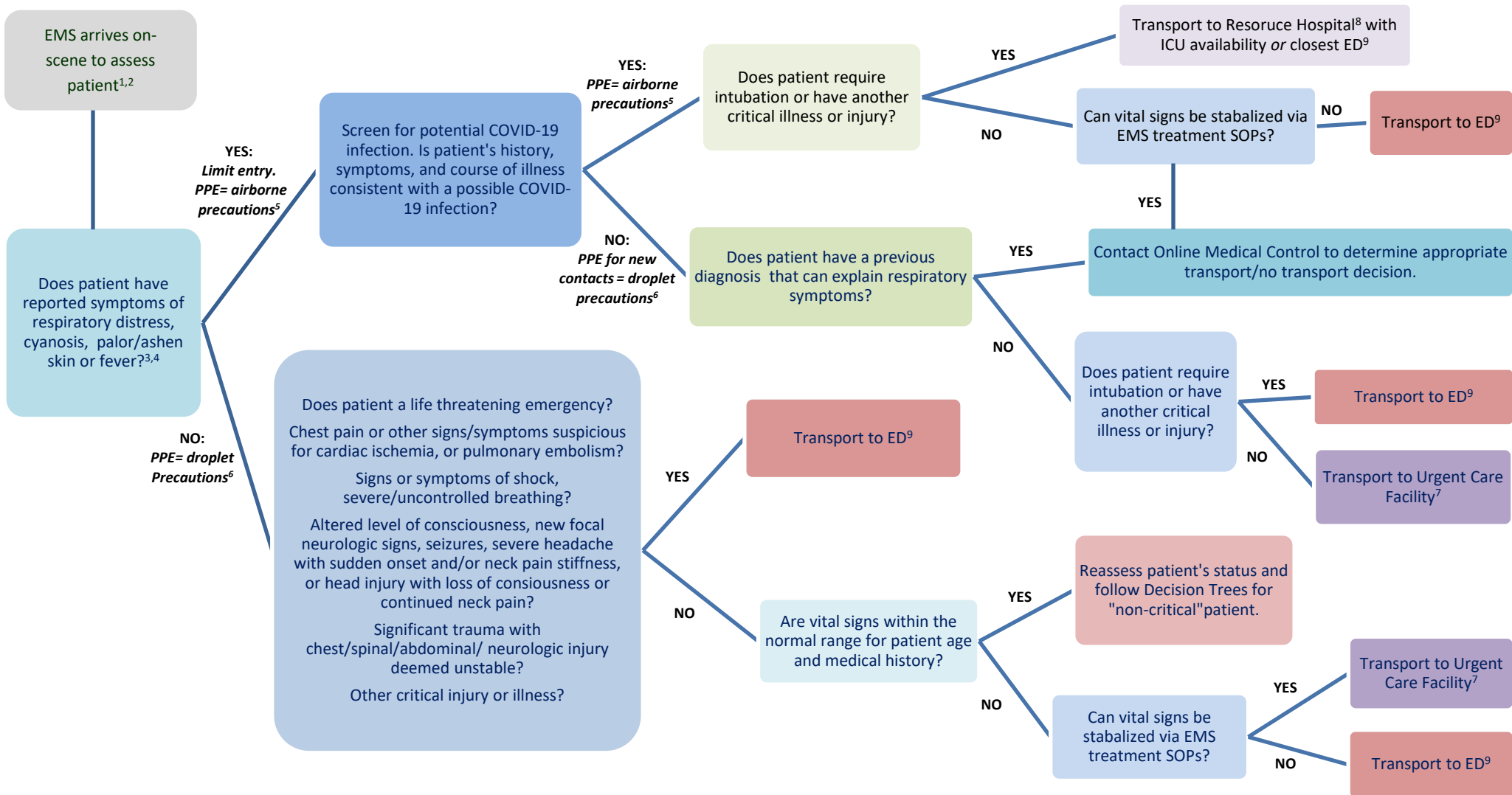
³All hospital Emergency Departments have the **capability** to stabilize patients with severe respiratory illness. Resource Hospitals have increased **capacity** for the on-going management of these patients.

⁴COVID-19 Isolation Facilities are facilities where people who have mild to moderate COVID-19 related illness or an asymptomatic COVID-19 infection are housed in an effort to decrease potential exposures to household and community contacts. The level of care provided is focused on symptom relief. These facilities may receive patients via walk-in or referral from a healthcare provider. All transports to this type of facility are self-transports. **EMS DOES NOT transport patients to this type of facility.**

⁵COVID-19 Telehealth/Telephone Triage Protocols are used to determine a “no transport” decision. Online Medical Control provides the patient with home treatment instructions.

⁶EMS determines that the patient requires non-urgent medical care. Patient instructed to self-transport to Alternate Care Site, Urgent Care Facility, primary care office/clinic, or COVID-19 Isolation Facility. If patient lacks transportation resources, referral made to human services providers and/or paratransit provider.

EMS GUIDELINES FOR PATIENT TRANSPORT DURING COVID-19 PANDEMIC: DECISION SUPPORT FOR CRITICAL PATIENTS



¹If at any time an EMS provider determines the patient's symptoms are incompatible with sustained life, immediate transport to a hospital ED is warranted.

²To the extent possible, the number of EMS personnel in contact with the patient should be limited in an effort to conserve PPE and decrease risk of exposure.

³Responders already wearing PPE should not downgrade if PPE recommendation changes.

⁴Standard precautions plus transmission based precautions (based on risk assessment) should be used for every patient.

⁵Airborne precautions = N-95 mask or higher level protection

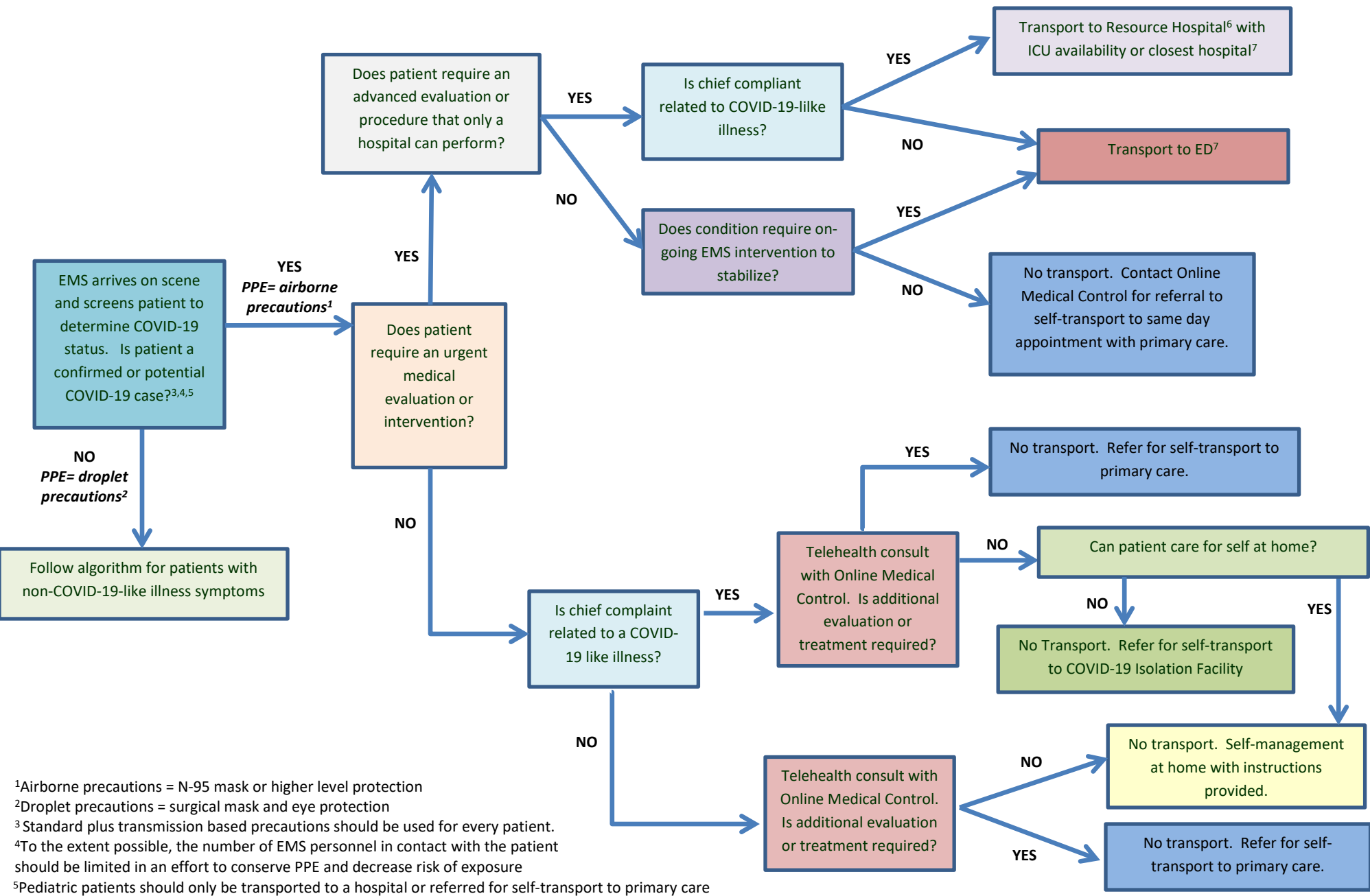
⁶Droplet precautions = surgical mask and eye protection

⁷Urgent Care Facilities can typically treat asthma, lacerations, closed fractures, dehydration, changes in mental status (not suspected of being stroke related), nausea/vomiting/constipation, rashes, allergic reactions, diabetic reaction, acute congestive heart failure, acute vision changes, and fevers.

⁸All hospital EDs have the **capability** to stabilize patients with severe respiratory illness. Resource Hospitals have increased **capacity** for the on-going management of patients with severe respiratory illness.

⁹Some hospitals have established COVID-19 screening areas external to the ED as the point of entry through which all patients must pass prior to entering the ED.

EMS GUIDELINES FOR PATIENT TRANSPORT DURING COVID-19 PANDEMIC: DECISION SUPPORT FOR NON-CRITICAL PATIENTS WHO HAVE COVID-19-LIKE ILLNESS SYMPTOMS



¹Airborne precautions = N-95 mask or higher level protection

²Droplet precautions = surgical mask and eye protection

³Standard plus transmission based precautions should be used for every patient.

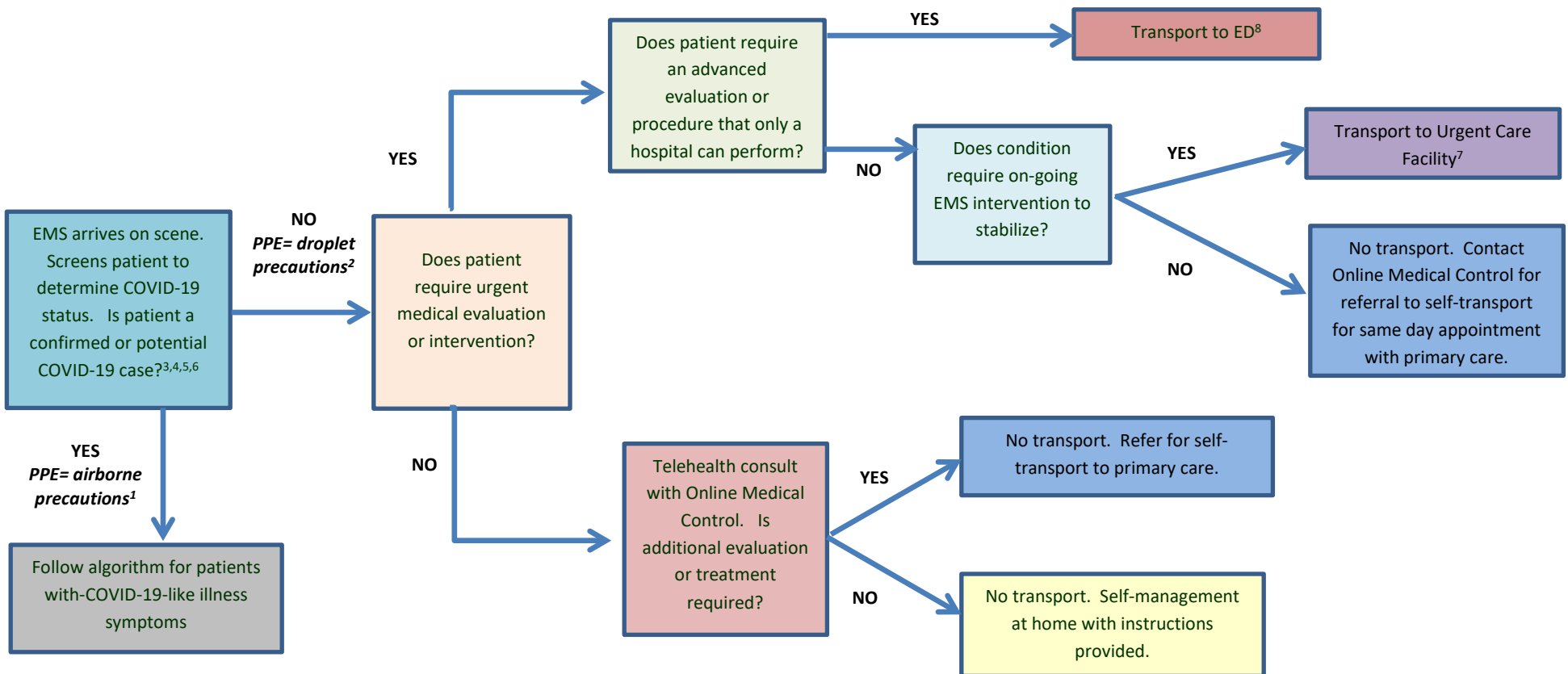
⁴To the extent possible, the number of EMS personnel in contact with the patient should be limited in an effort to conserve PPE and decrease risk of exposure

⁵Pediatric patients should only be transported to a hospital or referred for self-transport to primary care

⁶All hospital Emergency Departments have the **capability** to stabilize patients with severe respiratory illness. Resource Hospitals have increased **capacity** for the on-going management of patients with severe respiratory illness.

⁷ Some hospitals have established COVID-19 screening areas external to the ED as the point of entry through which all patients must pass prior to entering the ED.

EMS GUIDELINES FOR PATIENT TRANSPORT DURING COVID-19 PANDEMIC: DECISION SUPPORT FOR NON-CRITICAL PATIENTS WHO DO NOT HAVE COVID-19-LIKE ILLNESS SYMPTOMS



¹Airborne precautions = N-95 mask or higher level protection

²Droplet precautions = surgical mask and eye protection

³Standard precautions plus transmission based precautions (based on risk assessment) should be used for every patient.

⁴Responders already wearing PPE should not downgrade if PPE recommendation changes.

⁵If at any time an EMS provider determines the patient's symptoms are incompatible with sustained life, immediate transport to a hospital ED is warranted.

⁶To the extent possible, the number of EMS personnel in contact with the patient should be limited in an effort to conserve PPE and decrease risk of exposure to patients with asymptomatic COVID-19 infection

⁷Urgent Care Facilities can typically treat conditions such as asthma, lacerations, closed fractures, dehydration, changes in mental status (not suspected of being stroke related), nausea/vomiting/constipation, rashes, allergic reactions, diabetic reaction, acute congestive heart failure, acute vision changes, and fevers.

⁸Some hospitals have established COVID-19 screening areas external to the ED as the point of entry through which all patients must pass prior to entering the ED.