MCMCA Macomb County Medical Control Authority **EDUCATION BULLETIN 2022-001** **COVID-19 PROTOCOL UPDATES** **UPDATED MAY 09, 2022**	Issued (Date): May 09, 2022 Luke Bowen, MBA, EMT-P I/C MCA Operations Manager Luke.bowen@mcemsmca.org 586-792-1350

FOR DISTRIBUTION TO ALL LIFE SUPPORT AGENCIES, EMS PROVIDERS, AND MEDICAL CONTROL HOSPITALS

PURPOSE:
This bulletin is issued to notify Life Support Agencies and medical control hospitals that the Macomb County EMS Medical Control Authority is issuing an updated set of COVID-19 Emergency Protocols.

NOTE:

- All previously issued COVID-19 are RESECINDED. The protocols listed and attached herein are the only COVID-19 protocols in effect in Macomb County.
- Other COVID-19 protocols are still available for use should a spike occur that imapcts system performance, and they can and will be implemented immediately when needed.

CURRENT COVID-19 PROTOCOLS:

- 14.05: Infection Prevention During The Coronavirus Disease (Covid-19) Pandemic
- 14.07: Nasopharyngeal Specimen Collection for COVID-19
- 14.10: Destination and Transport During the Coronavirus (COVID-19) Pandemic
- 14.11: Immunization Support During COVID-19 Outbreak
- 14.12: COVID-19 Rapid Antigen Testing
- 14.13: Monoclonal Antibody Administration
- 14.14: Interfacility High Flow Nasal Oxygen (HFNO)

CURRENT CDC GUIDANCE FOR COVID-19 MITIGATION CAN BE FOUND AT:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Thank you,

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Infection Prevention During the Coronavirus Disease (COVID-19) Pandemic

Purpose: To outline infection prevention and personal protective actions when providing treatments during the COVID-19 pandemic. To outline the appropriate decontamination for people, equipment, and vehicles utilized in treatment and transport of patients.

I. Applicable patients – Due to community spread and the significant increase in asymptomatic and pre-symptomatic patients, **all patients,** and bystanders, should be considered positive for COVID-19.

II. Universal Source Control
   a. Patients will have a surgical mask applied prior to being placed in an ambulance unless they are receiving oxygen by mask.
   b. Anyone accompanying the patient in any part of the ambulance regardless of COVID-19 symptoms will minimally have a surgical mask applied prior to entering the ambulance.

III. All patient contacts include:
   a. Protective equipment according to bodily fluid exposure.
   b. Respiratory protection as outlined below.

IV. Guidance for respiratory protection utilization based on situation

Situation	Appropriate Respiratory Protection
Greater than 6 feet from any patient (not within an ambulance)	Surgical Face Mask
Within 6 feet of any patient	N 95
Patient compartment when patient present	N 95
Cab of ambulance when patient present	N 95

V. During Treatment
   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 will wear at least a surgical face mask.
   d. Aerosol Generating Procedures
      i. Perform aerosol-generating procedures only when clinically indicated.
      ii. Keep patient and aerosolization away from others without PPE (e.g., bystanders, EMS personnel not in PPE, etc.).

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

iii. Preferably, aerosolized procedures should be done NOT within the ambulance. When treating patient in the ambulance, activate patient compartment exhaust fan at maximum level.
iv. Use HEPA filtration for to expired air from the patient. (Ventilators, CPAP, biPAP, BVM)

VI. Patient Compartment –
a. When practical, utilize a vehicle with an isolated driver and patient compartment.
b. Only necessary personnel should be in the patient compartment with the patient.
c. All compartments should have ventilation maintained, with outside air vents open and set to non-recirculated mode.

VII. 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 will minimally have a surgical mask applied.
b. Personnel driving the transport vehicle should doff PPE (except for respirator) and perform hand hygiene before entering the driver's compartment. Respirator (N 95) 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 (if known) 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, regardless of COVID-19 patient status.
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.)
j. Minimize delays in moving symptomatic (or confirmed/suspected or patients with respiratory symptoms) directly to a room to limit exposure to others (e.g., hallway passerby).
k. Doff PPE after leaving patient room and perform hand hygiene before touching documentation tools.

VIII. Cleaning of Transport Vehicle and Equipment
a. All equipment that was involved in patient care and equipment that was inside of patient compartment of ambulance should be cleaned, regardless of COVID-19 patient status.
b. 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.

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

c. Vehicle disinfection should include door handles, steering wheel, and other surfaces contacted by personnel.
d. Perform hand hygiene after cleaning is complete and PPE doffed and disposed of.

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

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

Destination and Transport for Patients During the Coronavirus (COVID-19) Pandemic

Purpose: To direct patient transport and destination for patients and to conserve resources during the COVID-19 pandemic.

I. Decision to transport a patient by ambulance or other means will be based on
   A. Patient condition
   B. Resource availability
   C. Medical Control

II. Ambulance Transport
   A. Patient (or patient's authorized decision maker) destination requests will be honored if ALL of the following are met:
      1. The facility has appropriate resources and capabilities to care for the patient
      2. Transport time does not remove the transporting unit from its geographic service area for longer than a closer facility with capability to treat the patient
   B. The receiving facility should be notified of the incoming patient as early as practical
   C. 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)

III. Emergency Departments may need to go on diversion (via EMResource) if it is determined they have insufficient capacity or internal disaster

IV. Specialty care patients will be transported to an appropriate facility, (stroke, STEMI, Trauma, etc.) per applicable protocol

V. Final destination determination, if in question, will be from online medical control physician. 

Immunization Support During COVID-19 Outbreak

Purpose: To outline mechanisms for EMS to support immunization administration (influenza, COVID-19, and other routine vaccinations) and tracking during the COVID-19 Outbreak.

This protocol may be utilized by all EMS agencies and personnel that have been trained to administer IM injections per MCA selection.

MCA Selection for Immunization Administration

☐ **Paramedic**

☐ **EMT-Specialist**

☐ **EMT with IM Training* with supervision** (Paramedic/RN/etc, supervision may be virtual)

***EMTs must be trained in immunization reactions and must be able to treat anaphylactic reactions. (Access to epinephrine)**

I. Documentation
   A. Vaccine administration will be documented in the Michigan Care Improvement Registry (MCIR).
   B. When possible, EMS should inquire immunization status of patients and document their immunization status in the EPCR. Patients behind on vaccinations may have specific components noted in the narrative section of the EPCR.

II. Clinics
   A. Personnel may be utilized to administer vaccines at mass vaccinations clinic where their services are requested (local health department, hospital, etc).
   B. Agencies may host vaccination clinics at their facilities provided there is access to MCIR for documentation.

III. In Home Vaccinations
   A. May be administered when ordered by a physician.
   B. Documentation in MCIR must be coordinated prior to administration and must be completed after administration.
   C. A home visit for a vaccination requires documentation by EMS personnel in an electronic platform.

IV. Information on vaccine administrations (clinic, in-home, etc.) will be provided to the MCA (if not noted in the MI EMSIS system) on request.

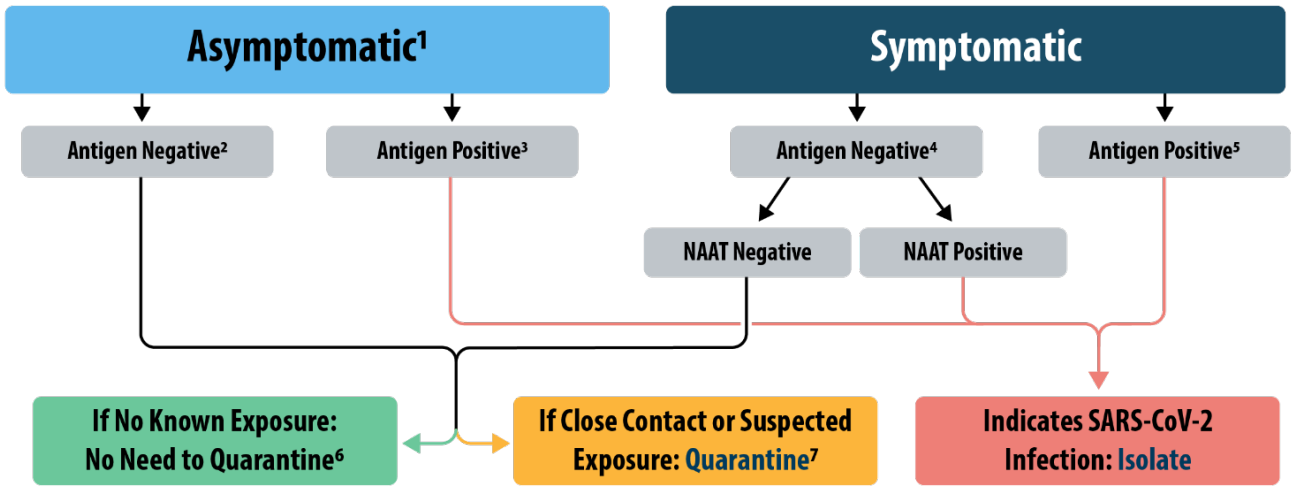
COVID-19 Rapid Antigen Testing

I. Mandatory Elements for Program:
- A. COVID-19 Testing Plan
- B. CLIA Waiver that includes antigen test
- C. Reporting process to:
  - i. Local Health Department
  - ii. Michigan Disease Surveillance Syndrome (MDSS) (through online form)

II. Utilization of Antigen Tests
- A. Appropriate utilization
  - i. Not to be used in the course of an emergency call
  - ii. May be utilized in symptomatic individuals who are employees of an agency or a partner organization
  - iii. May be used as part of a public health surveillance operation (e.g., special event)
- B. Performance of Test
  - i. Don appropriate PPE
  - ii. Collect specimen per manufacturer's instructions and with supplied manufacturer materials
  - iii. Test must be performed per manufacturer's instructions
  - iv. For antigen test cards, be careful to keep cards correctly associated with the correct person (if multiple tests running at the same time)

III. Result Reporting
- A. All results must be reported to MDSS (positive and negative)
- B. Positive results must be reported to the local health department

IV. Result follow-up – Antigen Test Algorithm for Community Settings.



https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-tests-guidelines.html

Monoclonal Antibody Administration

I. Authorization for Administration

A. Intravenous administration, per MCA selection

MCA Selection for IV Infusion
▣ Paramedic
▣ EMT-Specialist

B. Subcutaneous administration, per MCA selection

MCA Selection for Subcutaneous Administration
▣ Paramedic
▣ EMT-Specialist
▣ EMT- Basic

C. EMS personnel who have been trained and authorized to administer mAb by the subcutaneous (SC) route may be permitted to administer mAb by SC route.
   i. Training must include supervised practice in both drawing up and administering the medication using aseptic technique.
   ii. This must include direct supervision/observation in delivering at least 6 subcutaneous injections of medication to actual patients. Supervision can be provided by clinicians with experience providing mAb therapies (RN, EMT-P).
   iii. Personnel must be authorized by medical control prior to administering medication.

II. Verify that the patient meets current criteria[1]. Current criteria are available on the medication-specific Fact Sheet for Health Care Providers and allows for clinical judgement. Trained and authorized EMS personnel may administer monoclonal antibodies with a patient specific order from a physician or other authorized prescriber or is operating under a physician standing order.

III. Monoclonal Antibody Administration

A. Assure that the standardized order form (or other comparable approved order form) is complete and signed (electronic okay) by the ordering prescriber and that the form matches the medication being administered. A verbal order, signed by a licensed healthcare professional or EMS personnel, is acceptable.

[1] Criteria may change. This protocol is applicable to the criteria in the most current FDA published Fact Sheets for Health Care Providers for the specific mAb medication used.

B. Provide a copy of the Fact Sheet for Patients, Parents, and Caregivers appropriate to the medication to be used and that the patient or the patient's authorized representative has signed a copy of Fact Sheet and agrees to have the medication administered.
   i. The signed Fact Sheet should become part of the EMS patient care record and a copy provided to the ordering prescriber.
   ii. If the patient is unable to sign, the ordering prescriber or the facility is responsible for assuring the authorized representative has received the Fact Sheet and agrees to treatment.
   iii. Fact Sheet for Patients, Parents and Caregivers are located here.

C. Refer to the appropriate Fact Sheet for Healthcare Provider for detailed information on the specific medication being administered. This document should be accessible at all times and should be reviewed prior to the authorized EMS personnel administering this medication for dosing and administration specifics. All authorized mAb medications may administered by the intravenous route for treatment of mild to moderate COVID-19. The use of mAb for post exposure prophylaxis and use by the subcutaneous (SC) route have been authorized for certain mAb medications. Additionally, MDHHS has issued guidance on the use of the SC route of administration. Authorized EMS personnel should assure that the administration of mAb products are done in accordance with the applicable FDA Fact Sheet for Health Care Providers and applicable guidance by MDHHS.

D. Perform administration as directed in the appropriate Fact Sheet for Healthcare Provider.

E. If applicable, discontinue the infusion and flush IV with 10 mL of NSS, keeping the IV in place during monitoring period.

F. Treat any significant mAb administration related symptoms (e.g., nausea, fever, etc.) in accordance with appropriate approved protocols and/or prescribers orders consistent with the EMS personnel's scope of practice.

IV. Monitoring and Administration Related Problems

A. Full vital signs should be obtained prior to beginning the administration.

B. For patients with vital signs within normal limits, vital signs should be monitored at least every 30 minutes during the administration and post-administration observation period.

C. For patients that have or develop any abnormal vital signs or experience any side effects, vital signs must be recorded at least every 15 minutes.

D. If a patient has minor symptoms during the administration
   i. Slow the rate of infusion (if applicable)
   ii. If symptoms do not improve, treat per appropriate protocols and consider discontinuing the administration.
   iii. If symptoms worsen, stop administration and contact prescribing health care provider or medical control.

E. If a patient has significant symptoms that appear to be administration-related, immediately discontinue the administration and contact the prescribing health care provider or medical control.

F. All patients must be monitored, as above, for at least 60 minutes after completing or discontinuing the administration. This monitoring and observation period may be

conducted by a Medical First Responder if immediate assistance is available from an EMT-Basic with appropriate BLS equipment immediately available.

G. At the conclusion of the 60-minute observation period, and:
   i. If there have been no changes in the patient's vitals, or the patient has improved since initial assessment, no contact with medical control is necessary. The patient may be released, with instructions to seek medical assistance or contact 911 if symptoms worsen.
   ii. If there are changes in the patient's status, but they have resolved/improved, consider making contact with the ordering clinician and advising of administration related symptoms and status. The patient may be released, with instructions to seek medical assistance or contact 911 if symptoms worsen.
   iii. If the patient experiences concerning or worsening symptoms (including COVID-19 related), provide continued care per appropriate protocols and transport to the hospital. Medical control must be contacted if the patient is refusing transport to the emergency department.

V. Documentation and Reporting

A. Any medication errors or serious adverse events must be reported to the prescribing health care provider and to the Medical Control Authority.

B. Electronic Patient Care Reports must be completed for each patient receiving administration of monoclonal antibody therapy administered by the authorized EMS personnel.
   i. Document vital signs, general assessment, and how the patient tolerates administration, including potential administration-related side effects or change in COVID-19 symptoms.
   ii. Document the lot number and expiration of the medication on order form and in narrative section of EMS patient care report.
   iii. In the narrative section document "MAB infused by EMS" or "MAB administered by EMS."

C. Additional Documentation
   i. Complete and submit the electronic Patient Profile Form
   ii. Assure that the ordering clinician receives a copy of the completed order form, EMS patient care record, and signed Fact Sheet for Patients, Parents, and Caregivers

Interfacility High Flow Nasal Oxygen (HFNO)

I. Indications
   A. Order from sending facility/physician
   B. Hypoxic respiratory failure, from COVID-19 or other respiratory process

II. Contraindications
   A. Inability to provide continuous, heated humidification using an approved delivery device
   B. Inability to provide therapy through appropriately sized nasal prongs
   C. Insufficient supply of oxygen to complete the transport

III. Procedure
   A. Ensure that an adequate supply of oxygen is available for the transport.
      i. Calculate the amount of oxygen needed prior to departure.
      ii. Ensure that you have at least two times the amount of oxygen anticipated.
   B. Perform appropriate patient assessment, including obtaining vital signs, pulse oximeter reading, cardiac rhythm, and current device settings
   C. Set FiO2 to maintain SpO2 at or above 94% (or to patient's baseline oxygen saturation, if known). Utilize facility settings as starting point, if available.
   D. Set flow rate in liters per minute (L/min) to decrease work of breathing.
      i. Utilize facility settings as starting point, if available.
      ii. Flow calculation: 2 L/kg/min up to the first 12 kg, plus 0.5 L/kg/min for each kg thereafter, up to a maximum flow rate of 60 L/min.
   E. Reassess vitals, work of breathing, mental status, and breath sounds. Reassessment should be continuous, but documentation of vitals must occur at least every five minutes throughout patient contact.
   F. Consider the need for escalation of respiratory support if patient remains in respiratory failure on more than 2 L/kg/min of flow or maximum settings for the delivery device.
   G. If patient deterioration occurs, terminate HFNO and begin positive pressure respiratory support via CPAP, BIPAP, BVM, or intubation, if necessary.

IV. Notes
   A. Pediatric patients must be accompanied by a nurse, nurse practitioner, respiratory therapist, or physician, who is credentialed and competent in dealing with the equipment.
   B. For suspected or confirmed COVID-19 patients, personnel must don respirators, eye protection, gowns, and gloves for transport.