



# IDHS OFFICE OF EMS COVID-19 OVERVIEW / STATUS REPORT



March 26, 2020  
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Kraig Kinney, State EMS Director

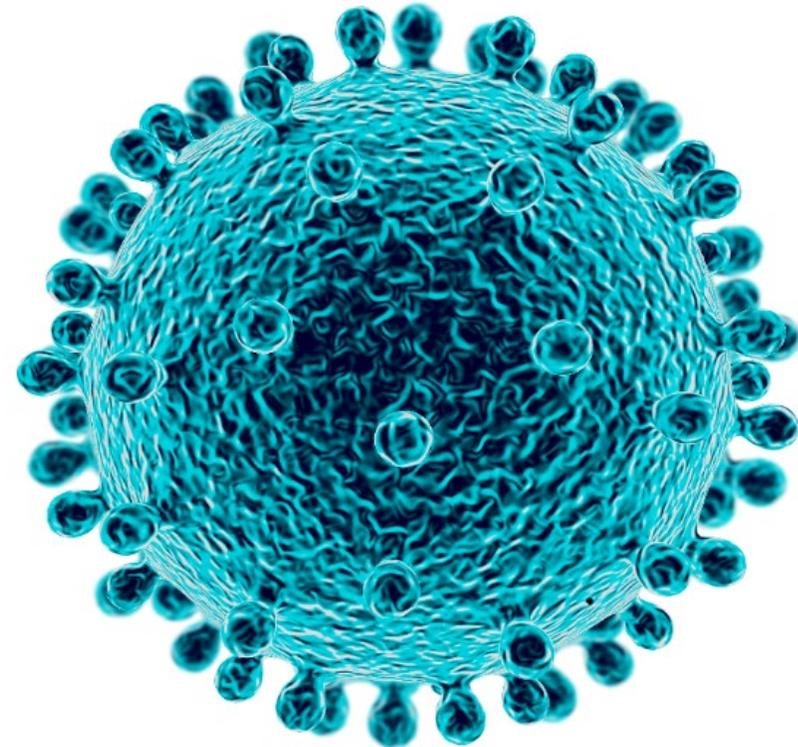


THIS PRESENTATION IS INTENDED TO CAPTURE THE CURRENT STATUS OF THE COVID-19 PUBLIC HEALTH EMERGENCY AND ADDRESS MANY OF THE AREAS THAT THE OFFICE OF EMS IS RECEIVING THE MOST QUESTIONS ABOUT. AS ALWAYS THE MOST CURRENT UPDATES WILL BE ON THE IDHS WEBSITE WITH A SPECIAL COVID-19 LINK.

# CORONAVIRUS



- Coronaviruses are a large family of viruses - some cause illness in people, and others only infect animals.
- Some coronaviruses infect animals then spread to people, and then spread person to person such as:
  - Middle East Respiratory Syndrome (MERS)
  - Severe Acute Respiratory Syndrome (SARS)
  - **Coronavirus Disease 2019 (COVID-19)**
- Common coronaviruses include some that cause mild upper-respiratory illnesses, like the common cold.



Coronaviruses have a crown-like appearance under the microscope

# WORLDWIDE NUMBERS



Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)

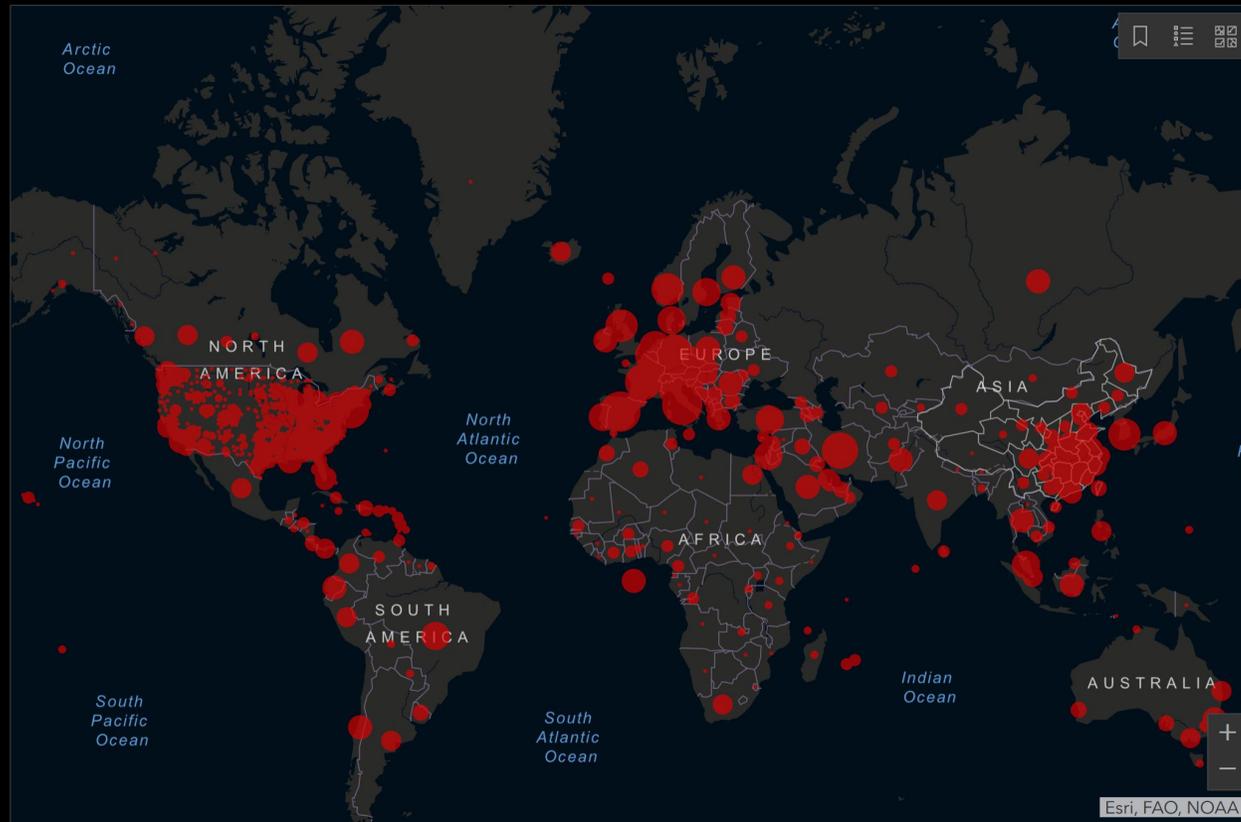
Total Confirmed  
**487,648**

Confirmed Cases by Country/Region /Sovereignty

- 81,782 China
- 74,386 Italy
- 69,197 US
- 56,188 Spain
- 39,502 Germany
- 29,406 Iran
- 25,604 France
- 11,125 Switzerland
- 9,642 United Kingdom
- 9,241 Korea, South
- 6,440 Netherlands
- 6,235 Belgium
- 6,001 Austria
- 3,404 Canada
- 3,191 Norway

Admin1 Admin2 Admin3

Last Updated at (M/D/YYYY)  
**3/26/2020, 7:29:49 AM**



Cumulative Confirmed Cases Active Cases

**175**  
countries/regions

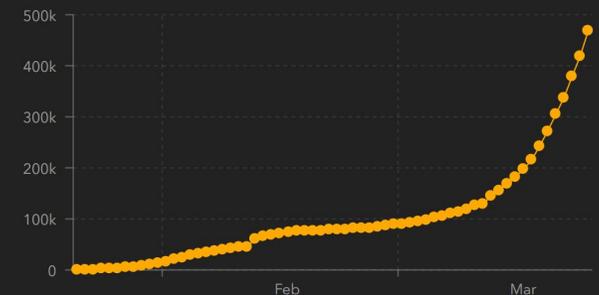
Lancet Inf Dis Article: [Here](#). Mobile Version: [Here](#). Visualization: JHU CSSE. Automation Support: [Esri Living Atlas team](#) and [JHU APL](#). Contact [US](#). [FAQ](#).  
Data sources: [WHO](#), [CDC](#), [ECDC](#), [NHC](#), [DXY](#), [1point3acres](#), [Worldometers.info](#), [BNO](#), state and national government health departments, and local media reports. Read more in this [blog](#).  
Downloadable database: [GitHub](#): [Here](#). Feature layer: [Here](#).

Total Deaths  
**22,030**

- 7,503 deaths Italy
- 4,089 deaths Spain
- 3,169 deaths Hubei China
- 2,234 deaths Iran
- 1,331 deaths France
- 465 deaths United Kingdom
- 356 deaths Netherlands
- 280 deaths New York City New York US

Total Recovered  
**117,749**

- 61,201 recovered Hubei China
- 10,457 recovered Iran
- 9,362 recovered Italy
- 7,015 recovered Spain
- 4,144 recovered Korea, South
- 3,900 recovered France
- 3,547 recovered Germany
- 1,336 recovered Guangdong China



Confirmed Daily Increase

# UNITED STATES DISEASE BURDEN



Coronavirus COVID-19 Global Cases by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)

Total Confirmed

**69,197**

Confirmed Cases by Country/Region /Sovereignty

81,782 China

74,386 Italy

**69,197 US**

56,188 Spain

39,502 Germany

29,406 Iran

25,604 France

11,125 Switzerland

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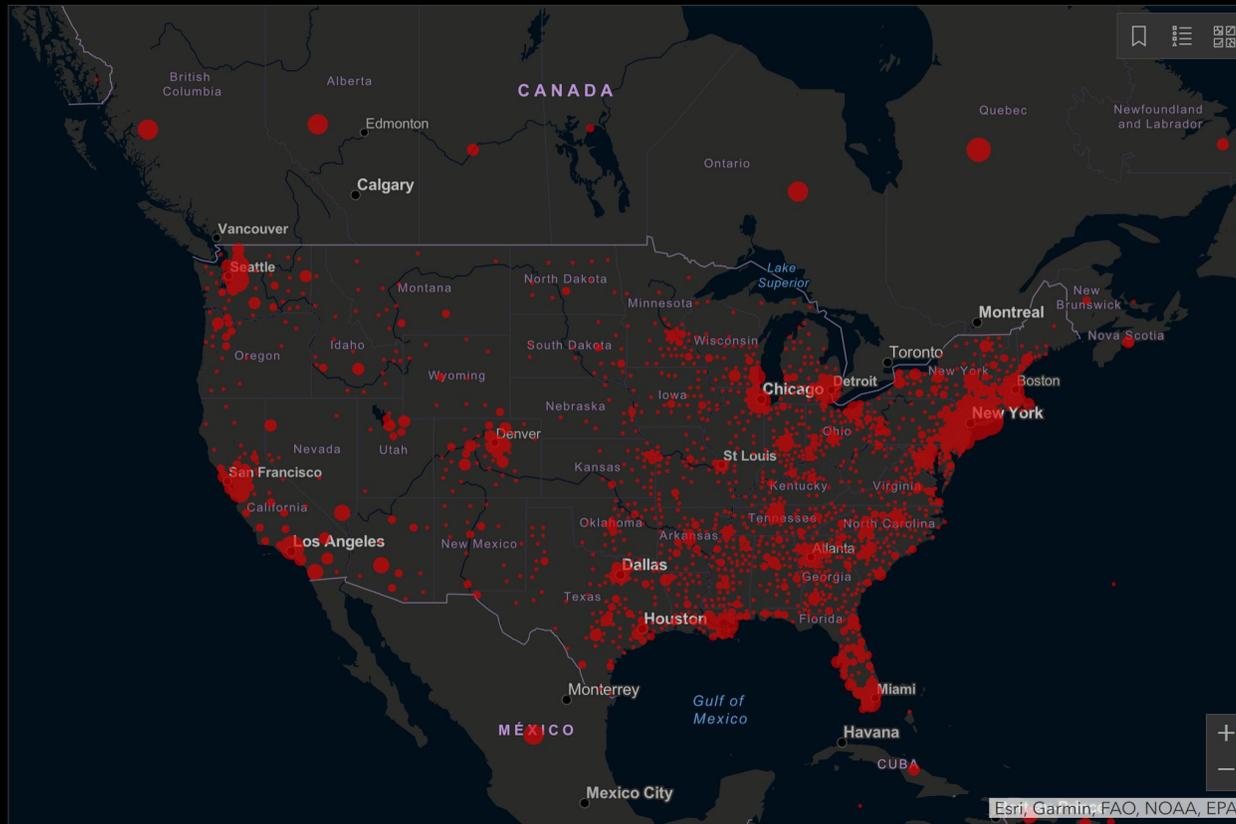
3,404 Canada

3,191 Norway

Admin1 Admin2 Admin3

Last Updated at (M/D/YYYY)

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Cumulative Confirmed Cases

Active Cases

**175**

countries/regions

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Downloadable databases: [GitHub](#): [Here](#). Feature layer: [Here](#).

Total Deaths

**1,046**

280 deaths  
New York City **New York US**

100 deaths  
King **Washington US**

44 deaths  
Unassigned **New Jersey US**

37 deaths  
Orleans **Louisiana US**

31 deaths  
Unassigned **Georgia US**

31 deaths  
Unassigned **New York US**

21 deaths  
Wayne **Michigan US**

20 deaths  
Suffolk **New York US**

Total Recovered

**619**

619 recovered  
Recovered **US**

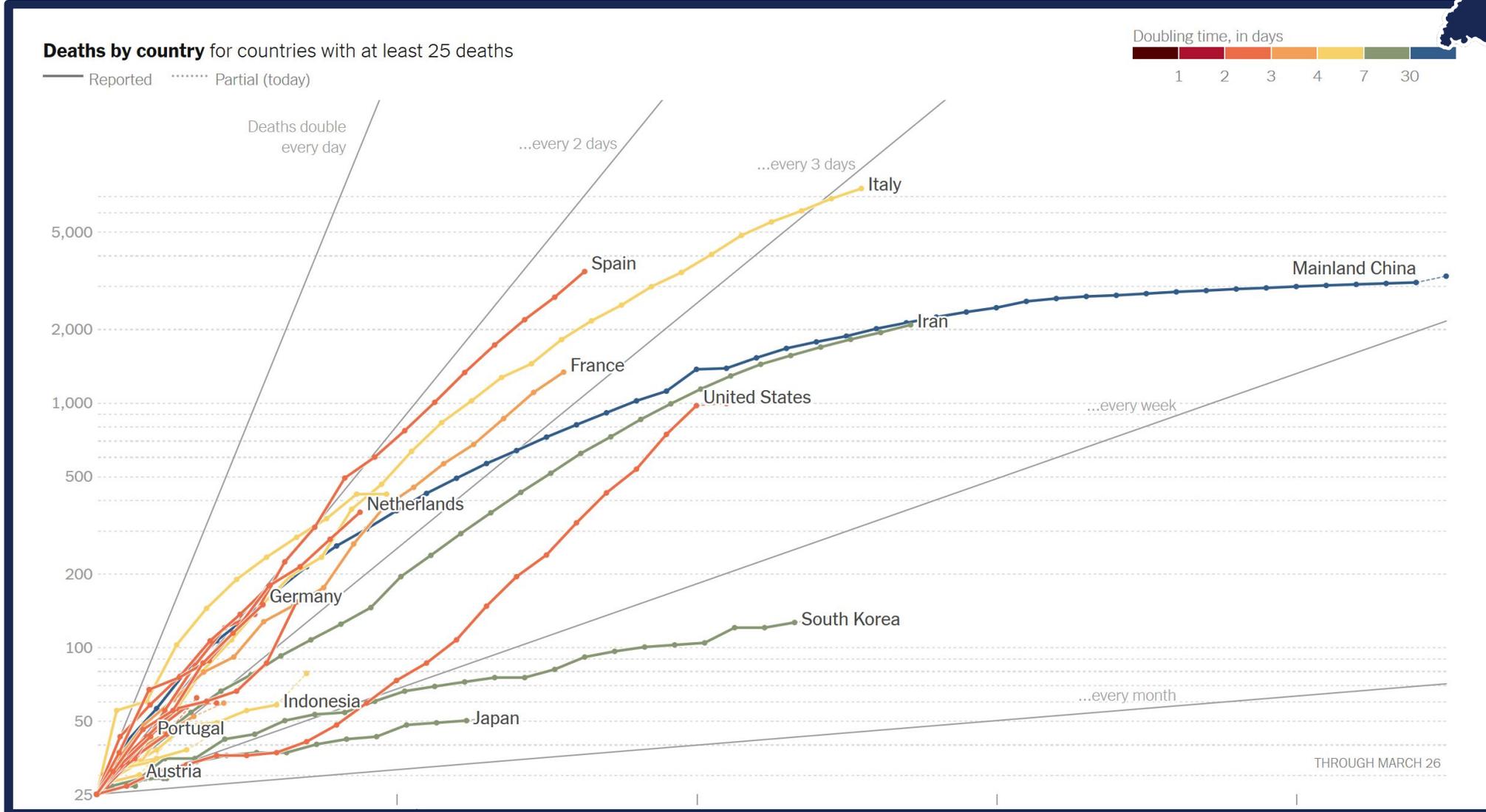


Confirmed

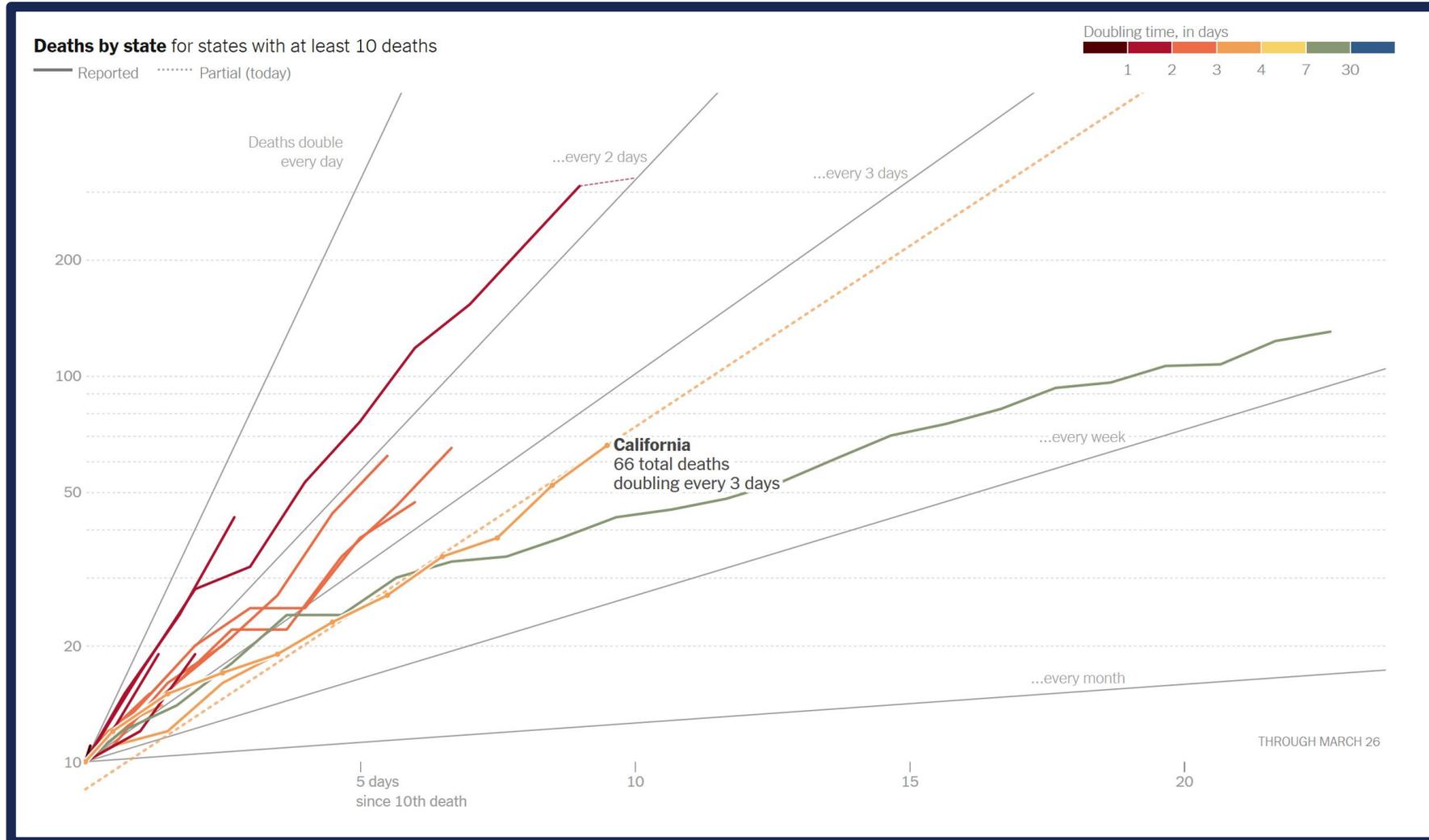
Daily Increase



# DEATHS BY COUNTRY



# US DEATHS



# CORONAVIRUS



- SARS-CoV-2 is an RNA virus
  - COVID-19 is the name of the illness it causes
  - It is part of the family of coronaviruses
  - This family contains four coronaviruses which are *widely* distributed and usually cause the common cold
- SARS-CoV-1 and MERS
  - These caused epidemics with high mortality which are somewhat similar to illness of COVID-19
  - SARS-CoV-2 is most closely related to SARS-CoV-1
- SARS-CoV-2 is mutating, which may complicate matters even further
  - Virulence and transmission will shift over times, in ways which we cannot predict
  - New evidence suggests that there are roughly two different groups of COVID-19
  - This explains why initial reports from Wuhan described a higher mortality than some more recent case series (Tang et al. 2020; Xu et al 2020).

# DROPLET TRANSMISSION OF SARS-COV-2



- COVID-19 transmission can occur via *large* droplet transmission (with a risk limited to ~6 feet from the patient)
- This is typical for respiratory viruses such as influenza
- Transmission via large droplet transmission can be prevented by using a standard surgical-style mask

# SURFACE TRANSMISSION



- Also called fomite-to-face (fomite=any inanimate object that, when contaminated with or exposed to infectious agents can transfer disease to a new host)
- This mode of transmission has a tendency to get overlooked, but it may be incredibly important
- This is how it works:
  - Someone with coronavirus coughs, emitting large droplets containing the virus
  - Droplets settle on surfaces in the room, creating a thin film of coronavirus
  - The virus may be shed in nasal secretions as well, which could be transmitted to the environment
  - Depending on the type of surface, virus may persist for roughly four days
    - Someone else touches the contaminated the surface hours or days later, transferring the virus to their hands
    - If the hands touch a mucous membrane (eyes, nose, or mouth), this may transmit the infection

# BLOCKING CONTACT TRANSMISSION



- Any effort to limit spread of the virus must block contact transmission
- The above chain of events can be disrupted in a variety of ways:
  - Regular cleaning of environmental surfaces (e.g. using 70% ethanol or 0.5% sodium hypochlorite solutions)
  - Hand hygiene (high concentration ethanol neutralizes the virus and is easy to perform, so this might be preferable if hands aren't visibly soiled)
  - Avoidance of touching your face (which we know is really really hard to do)
  - *Any* medical equipment could become contaminated with COVID-19 and potentially transfer virus to providers
  - A recent study found *widespread* deposition of COVID-19 in one patient's room, but fortunately this seems to be removable by cleaning with sodium dichloroisocyanurate



# WHAT IS AIRBORNE TRANSMISSION?

- Strictly speaking, 'aerosols' refer to particles in suspension in a gas, such as small droplets in air (particles typically  $<10\ \mu\text{m}$ )
  - Airborne transmission of an infective agent occurs when these small particles are inhaled into lower respiratory tract (TB, Measles, Chicken Pox)
  - Appropriate PPE to protect needs to be N-95
- A recent study on SARS-CoV-2 demonstrated the ability of virus to persist in aerosols for hours, making aerosol transmission plausible
- Data from studies of SARS-CoV-1 and MERS-CoV indicates that airborne transmission likely happens to some degree with both of these viruses as well
  - Transmission seems to be heightened with aerosolizing procedures, such as airway suctioning, ETI, NIPPV, bronchoscopy, BVM
  - However probably not the main mode of transmission

# $R_0$ : TRANSMISSION OF SARS-COV-2



- $R_0$  is the average number of people that an infected person transmits the virus to.
  - If  $R_0$  is  $<1$ , the epidemic will burn out
  - If  $R_0 = 1$ , then epidemic will continue at a steady pace
  - If  $R_0 >1$ , the epidemic will increase exponentially
- Current estimates put  $R_0$  at  $\sim 2.5-2.9$ 
  - For comparison, seasonal flu has a reported median  $R_0$  of 1.28 (IQR 1.19–1.37), while measles has an  $R_0$  usually reported as 12–18
- $R_0$  is a reflection of both the virus and *also* human behavior
  - Interventions such as social distancing and improved hygiene will *decrease*  $R_0$
  - Control of spread of COVID-19 in China proves that  $R_0$  is a *modifiable* number that can be reduced by effective public health interventions.
- The  $R_0$  on board the Diamond Princess cruise ship was 15 – illustrating that cramped quarters with inadequate hygiene will *increase*  $R_0$

# WHEN CAN TRANSMISSION OCCUR?



- Asymptomatic transmission (in people with no or minimal symptoms) appears to be possible
- Symptomatic transmission appears to occur over roughly ~8 days following the initiation of illness
- Median incubation period is estimated to be 5.1 days (95% CI, 4.5 to 5.8 days), and 97.5% of those who develop symptoms will do so within 11.5 days (CI, 8.2 to 15.6 days) of infection
  - These estimates imply that, under conservative assumptions <1% of cases will develop symptoms after 14 days of active monitoring or quarantine
  - Patients may continue to have positive pharyngeal PCR for weeks after convalescence
    - However, virus culture methods are unable to recover viable virus after ~8 days of clinical illness

# SYMPTOMS OF COVID-19



- Commonly cause constitutional symptoms, upper respiratory symptoms, lower respiratory symptoms, and, less commonly, gastrointestinal symptoms
  - Most patients will present with constitutional symptoms and lower respiratory symptoms (e.g. fever and cough)
- Fever
  - The best available data suggests that only about half of patients are febrile at the time of admission
  - Absence of a fever does not exclude COVID-19
- Gastrointestinal presentations
  - Up to 10% of patients can present initially with gastrointestinal symptoms (e.g. diarrhea, nausea), which precede the development of fever and dyspnea
  - Some patients may present with gastrointestinal symptoms only and most diagnostic algorithms will fail to detect and isolate these patients
- “Silent hypoxemia” – some patients may develop hypoxemia and respiratory failure without dyspnea (especially elderly)
- Physical examination is generally nonspecific

# INFORMATION FOR EMS AND PSAP



- When preparing for and responding to patients with confirmed or possible coronavirus disease 2019 (COVID-19), **close coordination and effective communications** are important among 911 Public Safety Answering Points (PSAPs)—commonly known as 911 call centers, the EMS system, healthcare facilities, and the public health system.
- **Each PSAP and EMS system should seek the involvement of an EMS medical director** to provide appropriate medical oversight.
- When COVID-19 is suspected in a patient needing emergency transport, prehospital care providers and healthcare facilities should be **notified in advance** that they may be caring for, transporting, or receiving a patient who may have COVID-19 infection.

# RECOMMENDATIONS FOR PSAP



- **PSAPs or Emergency Medical Dispatch (EMD) centers (as appropriate) should question callers** and determine the possibility that this call concerns a person who may have signs or symptoms and risk factors for COVID-19.
- 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.
- Patients in the United States who meet the appropriate criteria should be evaluated and transported as a PUI. Information on COVID-19 will be updated as the public health response proceeds.
- **Information on a possible PUI should be communicated immediately to EMS clinicians before arrival on scene** in order to allow use of appropriate personal protective equipment (PPE). PSAPs should utilize medical dispatch procedures that are coordinated with their EMS medical director and with the local or state public health department.

# EXPANDED QUESTIONING



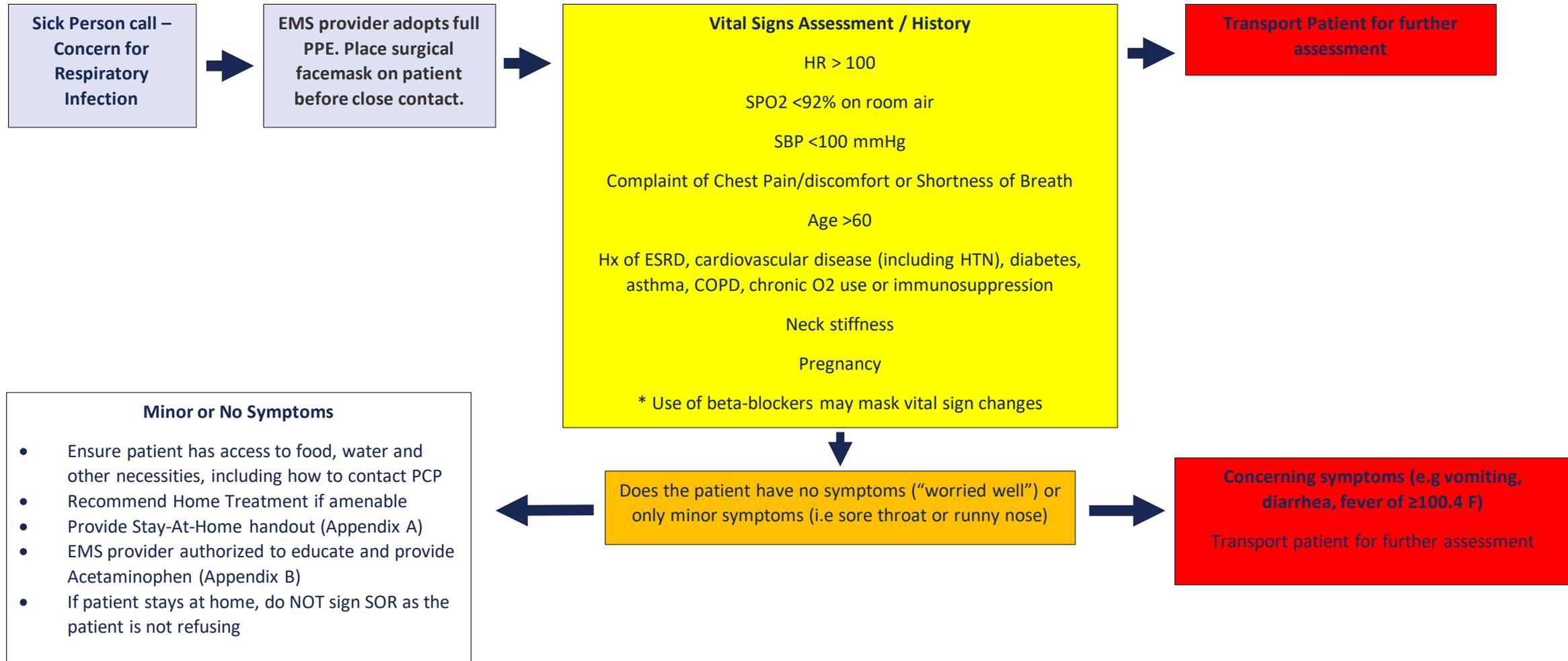
- **Expanded Infectious Disease Questions include the following:**
  - Have you/patient had any of the following: FEVER, COUGH, and SHORTNESS OF BREATH OR DIFFICULTY BREATHING?
- **Individual specific questions include:**
  - Measured body temperature
  - Fever (hot to touch)
  - Chills
  - Difficulty breathing or shortness of breath
  - Persistent cough
  - Any other new respiratory problems (sneezing, coughing, wheezing, etc.)

# EMS GUIDANCE FOR COVID-19 CORONAVIRUS



- Modified scene safety and assessment
  - Do a room scan before entering and remain 6 feet away from the patient or any family members.
    - Is anyone coughing or respiratory distress?
    - Does anyone acknowledge having a fever?
    - Any previous contact with a known patient?
    - Is the location a high-risk facility (assisted living, ECF, jail)?
  - Limit number of responders that access the patient to only those that are necessary for patient care or movement.
  - Consider having the patient exit the room/location on their own if safe/feasible.
  - Any patient that receives aerosol-generating procedures should be treated with PPE precautions.

# PROVIDER INITIATED NON-TRANSPORT



# RECOMMENDED PERSONAL PPE



- EMS clinicians who will directly care for a patient with possible COVID-19 infection or who will be in the compartment with the patient should follow Standard, Precautions and use the PPE as described below. Recommended PPE includes:
  - **N-95 or higher-level respirator or facemask** (if a respirator is not available),
  - **Eye protection** (i.e., goggles or disposable face shield that fully covers the front and sides of the face). Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
  - **A single pair of disposable patient examination gloves.** Change gloves if they become torn or heavily contaminated, and
  - **Isolation gown.**



# RECOMMENDED PERSONAL PPE



- Drivers, if they provide direct patient care (e.g., moving patients onto stretchers), should wear all recommended PPE. After completing patient care and before entering an isolated driver's compartment, the driver should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.
- If the transport vehicle does **not** have an isolated driver's compartment, the driver should remove the face shield or goggles, gown and gloves and perform hand hygiene.  
**A respirator or facemask should continue to be used during transport.**

# RECOMMENDED PERSONAL PPE



- **All personnel should avoid touching their face while working.**
- On arrival, after the patient is released to the facility, EMS clinicians should remove and discard PPE and perform hand hygiene. Used PPE should be discarded in accordance with routine procedures.
- Other required aspects of Standard Precautions (e.g., injection safety, hand hygiene) are not emphasized in this document but can be found in the guideline titled [Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings](#).



# AEROSOL GENERATING PROCEDURES

- If possible, **consult with medical control before performing aerosol-generating procedures** for specific guidance.
- **An N-95** or higher-level respirator, instead of a facemask, should be worn in addition to the other PPE described above, for EMS clinicians present for or performing aerosol-generating procedures.,
- **EMS clinicians should exercise caution if an aerosol-generating procedure** (e.g., bag valve mask (BVM) ventilation, oropharyngeal suctioning, endotracheal intubation, nebulizer treatment, continuous positive airway pressure (CPAP), bi-phasic positive airway pressure (biPAP), or resuscitation involving emergency intubation or cardiopulmonary resuscitation (CPR)) is necessary.
- **If possible, the rear doors of the transport vehicle should be opened and the HVAC system should be activated during aerosol-generating procedures.** This should be done away from pedestrian traffic.

# AEROSOL GENERATING PROCEDURES



- **Aerosol Generating Procedures**
- Bag valve mask ventilation
- Oropharyngeal suctioning
- Endotracheal intubation
- Nebulizer treatment
- Continuous positive airway pressure (CPAP)
- Cardiopulmonary resuscitation

# EMS GUIDANCE FOR COVID-19 CORONAVIRUS



- There is a shortage of all masks including N95 masks. Providers should consider alternatives and plan accordingly. For instance, for scene initial assessment, SCBA is an option if responders are fire-based.
- EMS providers need to focus on safety, but it is also not realistic to use new masks for every response due to the limited supply. Simple face masks are an acceptable alternative. Use N95 for the most serious cases or when aerosol generating procedures must be performed.
- **PRIORITIZE** the use of N95 respirators.

**CONSERVE  
TO  
PRESERVE!!  
  
USE WISELY!!**

# EMS GUIDANCE FOR COVID-19 CORONAVIRUS



- CDC guidance is that an N95 mask remains effective for at least 8 hours. There are many factors to consider, such as removal and re-application, discarding if the respirator is physically contaminated (blood or secretions on the respirator, use for aerosol generating procedures), etc.
- Clean your hands with soap and water before and after application or adjustment of any face mask.
- **NOTE THAT A PROVIDER MAY USE A CLEANABLE FACE SHIELD OVER AN N95 RESPIRATOR TO PROTECT ITS LONGEVITY.**

**CONSERVE  
TO  
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# EMS GUIDANCE FOR COVID-19 CORONAVIRUS



- If approved by local Medical Director, alternative means of screening a patient such as telemedicine are acceptable (such as utilizing a “facetime” type option).
- EMS should only take essential equipment inside when treating a possible or suspected Covid-19 patient.
- Assessments may be tailored to focus on priority symptoms and minimize distance to patient. For instance, listening to breath sounds.

# EXPOSURE GUIDANCE



- **Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19.** However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures HCP should still perform self-monitoring with delegated supervision.
- **HCP with no direct patient contact and no entry into active patient management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19** (i.e., they have *no identifiable risk*.)
- <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
- ISDH Testing Hotline 1-877-826-0011

# EXPOSURE GUIDANCE



- EMS agencies should develop sick-leave policies for EMS personnel that are nonpunitive, flexible, and consistent with public health guidance. Ensure all EMS personnel, including staff who are not directly employed by the healthcare facility but provide essential daily services, are aware of the sick-leave policies.
- EMS personnel who have been exposed to a patient with suspected or confirmed COVID-19 should notify their chain of command to ensure appropriate follow-up.
- **EMS providers who are exposed to potential COVID patients with recommended PPE in place do not quarantine. They will continue to work unless they develop symptoms (fever/cough/SOB) at which time they will abstain from duty and seek medical evaluation.**

# TESTING GUIDANCE FOR PUBLIC SAFETY



- EMS provider agencies are reporting increasing numbers of personnel out on quarantine.
- Asymptomatic EMS providers do not need testing.
- When possible, patient source testing should be performed.
- Indications for testing a SYMPTOMATIC EMS provider includes
  - If that individual exposed themselves to high risk persons, or
  - That person potentially exposed a large number of other public safety personnel.
- Follow your agencies SOP or occupational health provider for reporting exposures.
- All testing requires a physician's order. Check with your local hospital.

# EMS OPERATIONS

# ESSENTIAL FUNCTION



- The Governor of the State of Indiana has issued Executive Order #20-08 Directive for Hoosiers to Stay at Home. In this Executive Order, only Essential Businesses and Operations should continue. In the definition In Paragraph 14, “essential businesses and operations” includes “healthcare and public health operations” as well as “essential government functions.” EMS qualifies in both categories. EMS is performing healthcare and EMS is a essential function of the political subdivisions of the State by statute.

# ESSENTIAL FUNCTION



- EMS would qualify as essential services and it is vital that EMS has the staff, ambulances, and equipment/supplies needed to operate. The following personnel would be included:
  - All certified EMS personnel (EMR, EMT, AEMT, Paramedic) that are responding or on duty to respond to medical calls.
  - All administrative personnel that are involved in coordination of EMS resources for an organization
  - All personnel that are directly involved with the maintenance and repair of ambulances or equipment to keep them operational (fleet mechanics).
  - Dispatch personnel essential for both emergency and interfacility transport
  - Supply-related that keeps ambulances operational (including ordering).

# EMS OPERATIONS CHANGES



- Waivers Issued:
- General Waiver #1
  - EMS may designate a Covid-19 response ambulance and may remove equipment except airway management.
  - ALS patients must still be transported with full ALS capability.

# EMS OPERATIONS CHANGES



- Waivers Issued:
- General Waiver #2
  - 836 IAC 1-1-8(c)(2) and 836 IAC 2-2-3(4) expiration dates on medicines and equipment may be disregarded as needed.
  - 836 1-2-1(c) requirement for transport only by certified ambulance relaxed for non-critical patients.
  - Emergency care equipment for BLS ambulance (836 IAC 1-3-5), BLS non-transport vehicles (836 IAC 1-11-4), AEMT ambulance (Emergency Rule, LSA Document #12-393(E), SECTION 6), Paramedic ambulance (836 IAC 2-2-3), and ALS non-transport vehicles (836 IAC 2-14-5) is waived from minimal compliance stocking including for PPE.
  - 836 IAC 2-2-1(g) which requires 24-hour ALS coverage is waived IF there is not sufficient staffing due to the Public Health Emergency impacting staffing.
  - 836 IAC 2-2-1 (h) and (836 IAC 2-7.2-1(g)) which removes the requirement that an EMT must accompany an Advanced EMT or paramedic on runs. EMR or driver may accompany.

# EMS OPERATIONS CHANGES



- Waivers Issued:
- General Waiver #3
  - 836 IAC 2-2-1 is waived to allow a nurse, physician, or physician's assistant to substitute for a paramedic on an ALS or "paramedic response" when:
    - The transport is interfacility.
    - There is a staff shortage as a result of the Public Health Emergency.
    - The substituting person has been given an overview of ambulance operations and the equipment available.

# ACCESS TO EXPOSURE INFORMATION



- There have been a few hospitals that have been refusing to share exposure notifications with EMS staff.
- This information is mandated by the Ryan White Act and on March 24, 2020, the the Office for Civil Rights (OCR) at the U.S Department of Health and Human Services (HHS) issued guidance indicating that PHI may be disclosed by entities such as hospitals when “first responders may be at risk for an infection” and “when disclosure is necessary to prevent or lessen a serious and imminent threat.”
- Our nation needs our first responders like never before and we must do all we can to assure their safety while they assure the safety of others," said Roger Severino, OCR Director. "This guidance helps ensure first responders will have greater access to real time infection information to help keep them and the public safe," added Severino.

# EMS OPERATIONS CHANGES



- Data continues to be important during this Public Health Emergency.
- Image Trend has a Covid-19 worksheet that allows organizations to guide and track their staff in doing a Covid-19 assessment. Using this tool also allows IDHS to collect those data fields to help with tracking. The worksheet is on the State system for Elite but would need to be added if an organization owns its own version.
- **UNCHANGED:** Continue noting PPE usage and then the Primary Impression should still be the chief complaint of the patient (shortness of breath, fever, etc.)

# EMS OPERATIONS CHANGES



- **NEW:** For the Secondary impression the response for when a Possible Covid-19 case would present, the provider could mark
  - Contact with and (suspected) exposure to other viral communicable diseases (Z20.828)
  - Other coronavirus as the cause of diseases classified elsewhere (B97.29)
  - Encounter for observation for suspected exposure to other Biological agents ruled out. (Z20.818)
- **Note that logging responses for these codes not allows IDHS to track trends but is the same determinants that is going to be used nationally by NEMSIS for national EMS tracking.**

# EMS CERTIFICATIONS



- By Governor's Executive Order 20-09, all State certifications and licenses that expire during the Public Health Emergency are extended until May 22, 2020. All EMS certifications and licenses that were not already renewed have been reset in ACADIS with a May 22, 2020, expiration. Note that this does not change the certification cycle so those individuals that were extended would still have to renew by March 31, 2022, on their next cycle.

# EMS CERTIFICATIONS



- If EMS providers are still seeking to re-certify, there is a waiver to allow either an email or electronic verification in lieu of physical signatures for continuing education.

# EMS CERTIFICATIONS



- The NREMT is issuing provisional certifications if
  - Candidate has completed a course of instruction.
  - Candidate has passed a cognitive examination.
  - The psychomotor examination has not been completed.
- Indiana will recognize a NREMT provisional certification by issuing a Temporary Certification for 120 days.
- Application for a Temporary Certification from a NREMT provisional certification are done with an Application for Reciprocity submitted with the evidence of provisional certification.

# EMS EDUCATION



- EMS courses continuing are at the discretion of the Training Institution.
  - Portfolio requirement is not waived. Students must still be verified on essential skills. Small group instruction, use of simulation training, and other innovative adaptation may be utilized or that portion of the class may need to be postponed.
- EMT practicals have been cancelled through April 7, 2020, for the duration of the Stay At Home Order.
- EMT cognitive testing has resumed in Indiana at some Pearson Vue testing centers since EMS testing would be essential for workforce staffing. Candidates can see which test sites by logging into their NREMT account.

# REQUESTING PPE / EMRESOURCE



EMResource | Michael Kaufmann (MKaufmann2) | Indiana | [Log Out](#)

[Search](#) | [Help](#) | [Contact](#) | JUVARE

Setup | View | Event | Preferences | Form | Report | Regional Info | IM

Dashboard refresh help

- Update 8: COVID-19 - Contacts
- Update 9: COVID-19 - PPE
- Update 9: COVID-19 - Bed Capacities
- Update 5: COVID-19 - Bed Availability
- Update 4: COVID-19 Long-Term Care
- Update 1: COVID-19 Public Health
- Update 6: COVID-19 EMS
- COVID-19 IDOC

## EMS - COVID-19

EMS - COVID-19 Manage Dashboards

Red - PPE < 96 hours, no shipments



Yellow - PPE > 96 hours, no shipments



Green - PPE > 96 hours, some or normal shipments



### Ambulance Service Availability

Status	Resources
Available	235
Delay	3
Limited Availability	36
Unavailable	70

# REQUESTING PPE / EMRESOURCE



	EMS Provider	Is your service a transport service?	EMS Staffing	EMS Ventilators, number of	Ambulance Availability	PPE Status	24 hour Emergency Contact Number	Pri Co Na
	A & A Twp VFD	Yes	Yellow	0	Delay	N/A	317-223-7056	De
	Able Ambulance	--	Green	0	Limited Availability	Yellow	765-664-9011	De
	Aboite Twp VFD	Yes	Green	0	Available	Yellow	260-241-5696	Co
	Adams County EMS	Yes	Green	4	Available	Green	260-223-6679	Ke
	Adams Markleville Fire Protection	--	--	--	--	--	--	--
	Adams Twp Rescue	No	Green	0	Unavailable	Green	765-569-3705	Jar
	Adams Twp VFD	--	--	--	--	--	--	--
	Advance VFD	--	--	--	--	--	--	--

# REQUESTING PPE / EMRESOURCE



- All EMS provider agencies need to update their status in EMResource DAILY (at a minimum)
  - This is for visibility at a statewide ISDH level
  - Do not assume this is the same as reporting
- All requests for PPE should be reported to your local emergency management agency (EMA)
- It is also recommended to notify your local health department
- The EMA is collecting PPE needs from all public safety and will submit a formal request via WebEOC

# **EMS RESOURCE HOTLINE**

# EMS RESOURCE HOTLINE



- As the volumes increase, the hospital healthcare system will struggle with the surge.
- Dr. Kaufmann has been working with the Marion County metropolitan Regional Operating Center (ROC) on a surge capacity plan.
- The concept is that we must strive for balance in receiving new patients with moving less acute patients as soon as possible.
- This movement could be from an ICU bed to a regular admission or may even be discharges.

# EMS RESOURCE HOTLINE



- To facilitate the plan, the SEOC will be adding an EMS Resource Hotline.
- Hospitals will call this hotline when their local resources are not available and can request assistance in moving patients.
- The hotline operator would then try to pair an EMS resource with that need so that it is met in a timely manner.
- This would be a coordination position meant to pair resources and permit the timely movement of patients as operations increase.
- Although these would be interfacility transports, it is VITAL to the system that the patients are moved efficiently. Any assistance from EMS providers would be appreciated.



# THESE GUIDELINES ARE BEING OFFERED FOR ADDITIONAL INFORMATION

Please continue to monitor ISDH and CDC for additional and changing guidance:

- ISDH: <https://www.in.gov/isdh/28470.htm>
- CDC: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html>