

# INDIANA DEPARTMENT OF HOMELAND SECURITY COVID-19 EMS MANUAL

DECEMBER 2020





## TABLE OF CONTENTS

A. Introduction	03
B. Rules and Waiver	04
C. Dispatch Guidance	06
a. Expanded Questioning	06
b. Alternate Dispatch Protocols	06
D. Operational Guidance	07
a. PPE Guidance	07
b. Exposure Guidance	07
c. Alternate Vehicles	07
d. Alternate Providers	08
E. Clinical Guidance	09
a. Assessment	09
b. Guidance for Non-Transport	10
i. Adult and Pediatric Stay-at-Home Recommendations and Handouts	
ii. Modified Cardiac Arrest Protocol Examples	
c. Aerosol Generating Procedures	18
d. Other medical care	20
F. Guidance for Hospitals and EMS for Ambulance Diversion Requests	23
G. Indiana Regional Healthcare Surge Response Plan	24
H. Organizational Leadership and Responsibilities of Health Care Facilities to the COVID-19 Outbreak of 2020	30
I. Surge Capacity and Outflow Tract Considerations	31
J. References	

# INTRODUCTION

Emergency medical services (EMS) play a vital role in responding to requests for assistance, triaging patients, and providing emergency medical treatment and transport for ill persons.

However, unlike patient care in the controlled environment of a healthcare facility, care and transports by EMS present unique challenges because of the nature of the setting, enclosed space during transport, frequent need for rapid medical decision-making, interventions with limited information, and a varying range of patient acuity and jurisdictional healthcare resources.

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.

## **Purpose:**

This manual was developed by the Indiana Department of Homeland Security (IDHS) to provide guidance and recommended protocols related to COVID-19 for EMS agencies around the state. The manual is intended to be used as a reference tool for the large amount of information released on COVID-19. The information is in accordance with the Center of Disease Control and Prevention (CDC) and Indiana State Department of Health (ISDH) and will be updated frequently as the situation changes. The current COVID-19 pandemic has led to alterations in recommended practices in order to best protect healthcare providers (HCP) and prevent the rapid spread of this unique infectious disease. As the situation progresses with regards to expanded dispatch protocols, personal protective equipment (PPE), aerosolizing treatments, transport recommendations, and other operational and clinical guidance for EMS, this manual will stand as an easy-to-access collection of IDHS recommended practices.

Special thanks to Gregory Faris, MD and Roxanna Lefort, MD and to all that contributed information to and helped with the creation of this manual.

# RULES AND WAIVERS

IDHS has three (3) waivers to date during the COVID-19 pandemic response. Below you will find a summary of the 3 waivers issued. Please read the individual Waivers for full details.

1. Guidance and Blanket Waiver for Coronavirus COVID-19 (3/11/20)  
<https://www.in.gov/dhs/files/Guidance-and-Blanket-Waiver-on-COVID-19-Coronavirus.pdf>
  - a. EMS organizations may work with their Medical Director and dispatch to develop 911 screening policies
  - b. EMS organizations along with Medical Direction may alter their existing protocols or create new protocols including alternate means of transport. Changes must be reported to the EMS Field Manager
  - c. EMS organizations may dedicate a state EMS response vehicle for response and/or transport of suspected COVID-19 patients
    - i. Equipment may be minimized (see document for details)
    - ii. Must notify the EMS District Manager
2. Guidance on EMS Preparedness for Coronavirus COVID-19 General Waiver #2 (3/17/20)  
<http://www.in.gov/dhs/files/COVID-19-General-Waiver-Order-2-03172020.pdf>
  - a. EMS organization should work with dispatch and Medical Direction to determine priority of calls
  - b. Medical Director may designate alternate destinations or downgrading of patients. Protocol changes must be reported to EMS District Manager
  - c. Medications with expirations may be used after the specified expiration date IF 1) the shortage is the result of a public health emergency and/or 2) the use has been recommended by CDC, FDA
  - d. Sanitation procedures are still in effect and should mirror CDC recommendations
  - e. For BLS transport ONLY, patients may be transported in non-ambulance if 1) there are not sufficient ambulances in the system due to a public health emergency and 2) the alternate transport guidelines have been approved by Medical Direction for non-critical patients.
  - f. Consumables and PPE are waived from compliance at minimum stocking level during shortages.
  - g. 24-hour ALS coverage is waived if there is are staffing shortages but must be reported to dispatch and IDSH District Manager
  - h. If staffing shortages occur, having an EMT or higher along with paramedic on ALS runs is waived. Preference is for the second provider to be EMR.

3. Guidance on EMS Preparedness for Coronavirus COVID-19 General Waiver #3 (3/24/20)

<https://www.in.gov/dhs/files/General-Waiver-Order-3-03242020.pdf>

- a. EMS providers heading to and from work are essential providers.
- b. If an EMS certified individual is on a truck then a nurse, physician or physician assistant may function as a paramedic for 1) interfacility transport 2) if there is a staffing shortage 3) the health care provider has been briefed on the vehicle and safety. This must be reported within 24 hours to the EMS District Manager.
- c. EMS organizations should use EM Resources to track all PPE
- d. EMS certificates set for expiration on 3/31/20 will be extended to 5/22/20.
- e. NREMT has issued provisional status certification.
- f. EMT didactic courses may continue.
- g. EMT clinical requirements may continue.
- h. Portfolio requirements are not waived.

4. EMT Course Clinical Education Requirements During COVID-19 General Waiver #4 (9/8/2020)

<https://www.in.gov/dhs/files/EMS-General-Waiver-4-09082020.pdf>

- a. Didactic education instruction guidelines such as in person or virtual are left to training institutions.
- b. Psychomotor examinations continue with applicable social distancing (including maximum persons) being practiced.
- c. Clinical education is modified in that the current minimum is eight (8) hours of ambulance clinical, hospital or other clinical experience are at the discretion of the local training institution, and required patient contacts remain at 10, however, 3 must be live patients while the remainder may be simulation experience patients.
- d. IF a training institution is unable to do ambulance clinicals due to COVID restrictions, there is a defined process to notify IDHS and supply a substitute experience such as virtual simulation.
- e. Provisions apply to all previously approved EMT classes and any new class approved and initiated before June 30, 2021.

# DISPATCH GUIDANCE

## 1. Expanded Questioning

Public Safety Answering Points (PSAPs) or Emergency Medical Dispatchers (EMDs) serve a critical role in the identification of callers that may have risk factors for COVID-19. As such, it is critical that PSAP/EMDs modify their queries to help identify potential COVID-19 patients prior to the arrival of first responders. The altered queries should never supersede the need to provide emergent lifesaving instructions to the caller. The goal of expanded questioning is to determine the presence of signs or symptoms consistent with COVID-19 as well as risk of exposure to another individual with COVID-19. Currently, there is enough community spread within many parts of Indiana that most individuals have the potential for exposure. Examples of Expanded Questioning include:

- a. Have you/patient had any of the following: FEVER, COUGH, MUSCLE ACHES, SHORTNESS OF BREATH OR DIFFICULTY BREATHING?
- b. Have you or anyone in the household been diagnosed with COVID-19?
- c. Have you/patient had close contact with any individual with known COVID-19 OR is suspected to have COVID-19?
- d. Have you/patient had contact with someone with flu-like illness (if so, when?)
- e. Do you or anyone else in your household have a pending COVID test waiting to receive test results?"

\*\*\*If the caller/patient screens positive for potential COVID-19 then the information must be relayed to all first responders including Fire, Police, and EMS through the CAD and/or during the dispatch process.\*\*\*

## 2. Alternate Dispatch Protocols

PSAP/EMDs represent the public link to medical care. As the spread of COVID-19 occurs, increased call volume to PSAPs is expected to occur. This increase in call volume will lead to increased EMS utilization. In the situation where the increased EMS volume leads to straining the EMS system, consideration should be given to tiered dispatch response. In some ways, this occurs in many dispatch centers currently; however, expansion of this tiered response to include referral to another resource or an alternate care response may be necessary. Pursuant to IDHS General Waiver #2, such expansion is allowable. The decision to move to a tiered dispatch including dispatch initiated alternate care response or referral must be made in conjunction with the dispatch center and medical direction. Currently, examples of such alternate response protocols are scarce.

# EMS OPERATIONAL GUIDANCE

## 1. **Personal Protective Equipment (PPE) Guidance** (IDHS PowerPoint)

<https://www.in.gov/dhs/files/IDHS-COVID19-PPE-Guidance-Revised-11092020.pdf>

- a. There is a significant shortage for all levels of PPE including facemasks of all types. This shortage has led to alterations in the recommendations for PPE for providers.
- b. N95 masks may be re-used up to 8 hours of use if they are not soiled or wet and continue to be easy to breathe through.
- c. CDC recommends use of N95 mask (or higher), gown, gloves and eye protection for patients with suspected COVID-19 unless supplies are short at which point surgical facemask is acceptable along with gown, gloves and eye protection.
- d. N95 mask, gown, gloves and eye protection should be worn if any aerosol generating procedure is performed.
  - i. Aerosol generating procedures = CPR, CPAP/BiPAP, intubation, BVM, nebulized medications, suctioning
- e. Every attempt should be made to place a surgical mask on the patient prior to contact.

## 2. **Exposure Guidance**

<https://www.in.gov/dhs/files/COVID19-Healthcare-Professional-Risk-Assessment-Revised-11062020.pdf>

- a. Low risk exposure = brief interaction with COVID-19 patient OR prolonged interaction with COVID-19 patient if the HCP is wearing a mask and the patient is wearing a mask.
- b. Medium risk exposure = prolonged close contact to COVID-19 patient where HCP had the potential to have infectious material in the mouth OR aerosol generating procedures where HCP was masked but not N-95.
- c. High risk exposure = prolonged close contact with COVID-19 patient without a face mask on OR aerosol generating procedure without face mask on.
- d. Thorough breakdown of recommendations for quarantine are located in the PowerPoint.

## 3. **Alternate Vehicles**

- a. The blanket waiver has allowed alternate vehicles for response and/or to patients concerned for COVID-19. The alternate vehicle is not required to have the standard equipment necessary for an ambulance. Respiratory and resuscitation equipment (A) thru (L) must be on the ambulance as well as PPE and equipment for diagnostic testing and assessment.

- b. BLS non-transport vehicles may be utilized to transport stable suspected patients. The vehicle must maintain respiratory and resuscitation equipment (A) thru (G) and equipment for assessment and diagnostic testing.

#### **4. Alternate providers**

- a. In light of the shortage of providers, staffing on ambulances may be altered based on IDHS waivers. For both paramedic response and AEMT response, there is no longer a minimum requirement of training for the second person responding in an ambulance. IDHS does recommend the second responder to be at least an EMR, however this is not a requirement.
- b. For inter-facility transports, care for an ALS patient may be provided if there is an EMS certified provider along with a physician, registered nurse or physician assistant.

# CLINICAL GUIDANCE

**Note that all clinical guidance must be written into protocol at the local level and approved by the EMS provider agency medical director.**

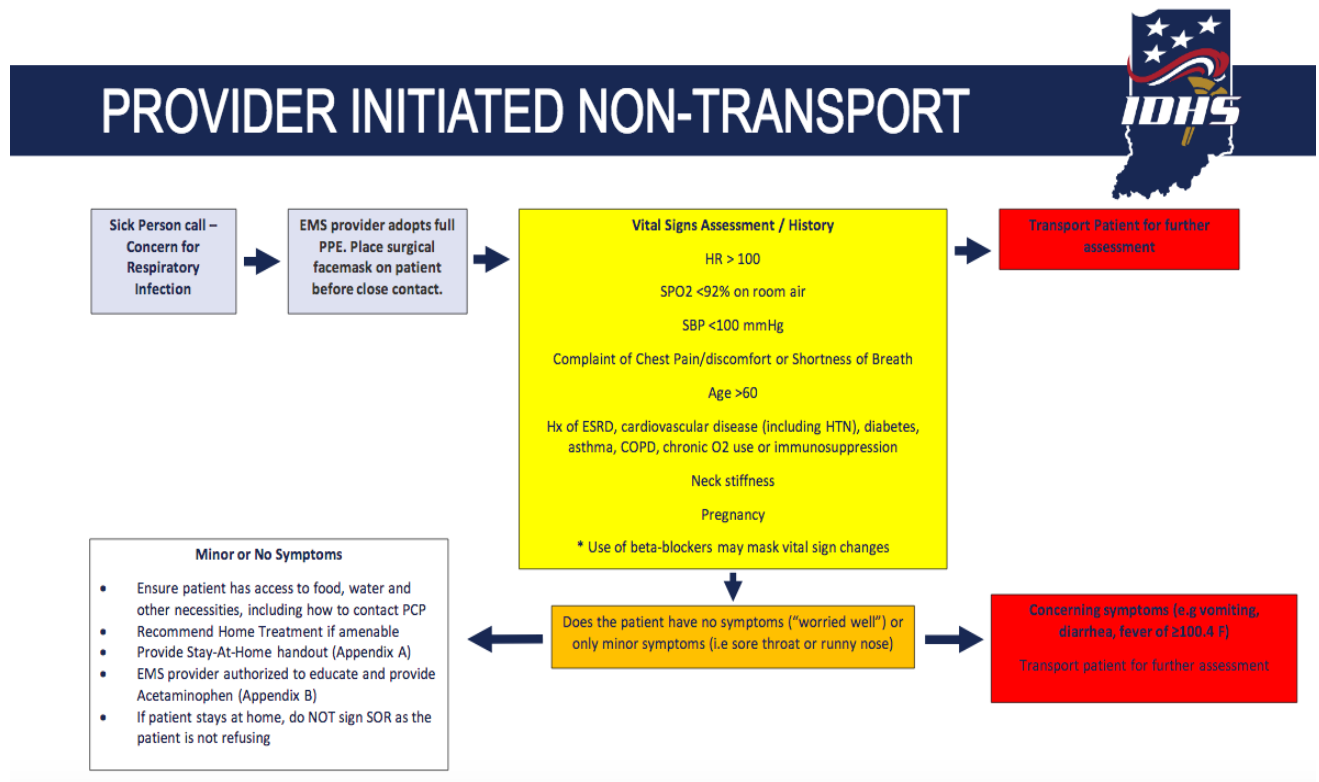
## **Assessment**

- a. If PSAP call takers advise that the patient is suspected of having COVID-19, EMS clinicians should put on appropriate [PPE](#) before entering the scene. EMS clinicians should consider the signs, symptoms, and risk factors of COVID-19 (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>).
- b. If information about potential for COVID-19 has not been provided by the PSAP, EMS clinicians should exercise appropriate precautions when responding to any patient with signs or symptoms of a respiratory infection and consider the possibility of infection in all contacts.
- c. Initial assessment should begin by scanning the room and keeping a distance of at least 6 feet from the patient, if possible. Patient contact should be minimized to the extent possible until a facemask is on the patient. If COVID-19 is suspected, all [PPE](#) as described below should be used. If COVID-19 is not suspected, EMS clinicians should follow standard procedures and use appropriate PPE for evaluating a patient with a potential respiratory infection.
- d. A facemask should be worn by the patient for source control. If a nasal cannula is in place, a facemask should be worn over the nasal cannula. Alternatively, an oxygen mask can be used if clinically indicated. If the patient requires intubation, see below for additional precautions for aerosol-generating procedures.
- e. Consider having the patient exit the room/location on their own if safe/feasible. If approved by the local Medical Director, alternative means of screening a patient such as telemedicine are acceptable.
- f. Assessments may be tailored to focus priority symptoms and minimize distance to the patient.
- g. Notify the receiving hospital as early as possible if COVID-19 is suspected.
- h. During transport, limit the number of providers in the patient compartment to essential personnel to minimize possible exposures.

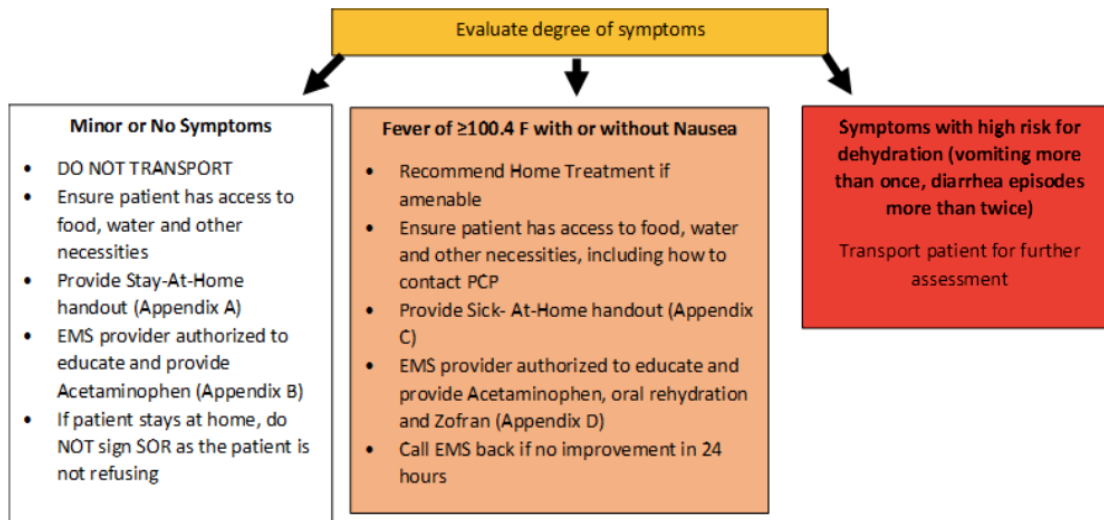
# GUIDANCE FOR NON-TRANSPORT

In the current pandemic situation in which healthcare systems are managing a surge of critically ill patients, a plan for EMS providers to have the ability to not transport “worried well” patients can help prevent overwhelming the emergency departments. The plan allows EMS providers to follow a protocol to safely not transport low risk patients with minor or no symptoms after ensuring patients have access to appropriate resources and can identify worsening symptoms.

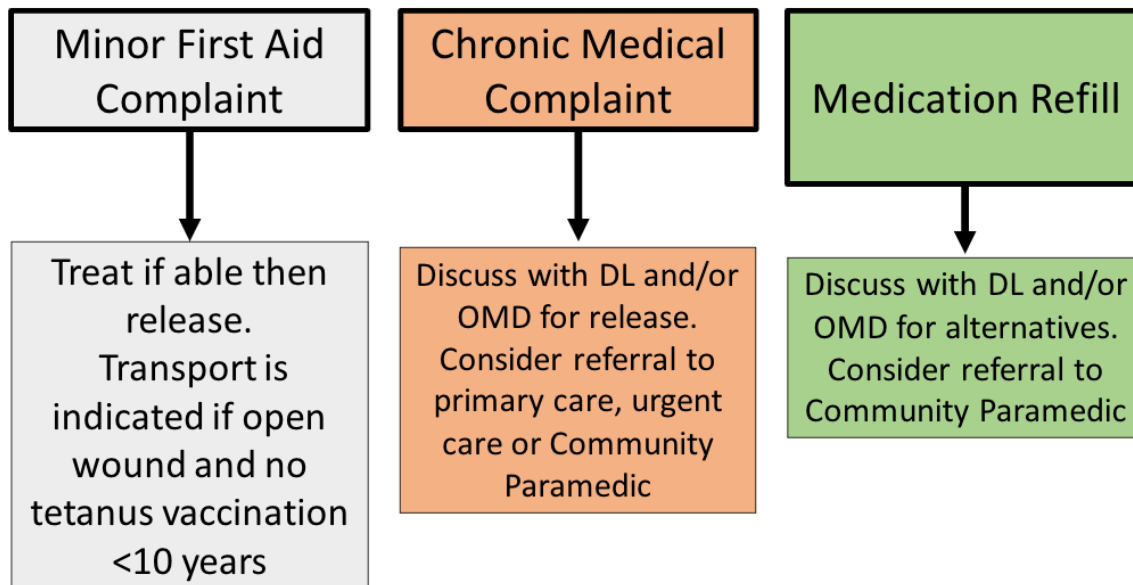
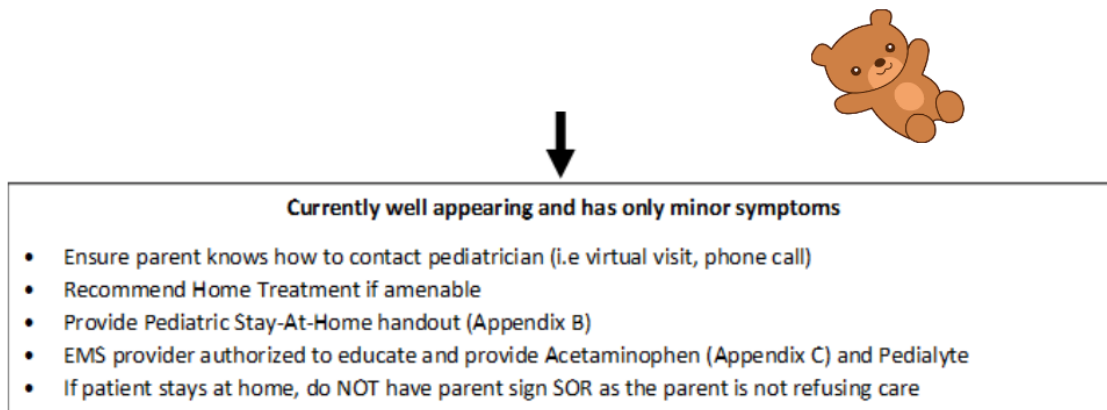
<https://www.in.gov/dhs/files/IDHS-COVID19-EMS-Initiated-Refusal-To-Transport-Protocol-03202020.pdf>



As further stress is placed on the EMS system, more stringent transportation guidelines will need to be placed. The above slide shows a protocol that recommends non-transport of asymptomatic/mildly symptomatic patients, this may need to be modified to REFUSAL of transport. Non-transport of conditions that are thought to be mild may also not be transported. Changes in the approach to cardiac arrest may also need to be modified. The below protocol may serve as an example.



Disagreements with No-Transport determinations will be adjudicated by a District Lieutenant or OMD



**Stay-At-Home Treatment (Minor or Mild Symptoms)**

Your child has received a medical assessment from EMS. During this current Public Health Emergency, you are advised to manage your child's symptoms at home instead of going to the Hospital. This will limit your exposure to others who can get your child sick. **Based on our assessment, your child does not need immediate care in the emergency department. You should seek care with your regular healthcare provider or doctor's office.**

IF YOUR CHILD WORSENS, YOU CAN CALL US BACK – DIAL 9-1-1

Please do the following:

- Use Tylenol (acetaminophen) for fever, sore throat, muscle aching and headache. See the medication handout for important information about these medications.
- Make sure your child stays hydrated. Pedialyte or popsicles can be helpful to maintain hydration.
- Follow up with your primary care doctor if your child is not better in 3 days – please call them for an appointment.
- Separate family members as much as possible. The person sick should stay in a specific room and away from other people in your home. Ideally, they should use a separate bathroom, if available. Limit visitors in the house.
- Avoid contact with pets. This includes petting, snuggling, being kissed or licked, and sharing food.
- Avoid sharing personal household items. Don't share dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people or pets in the home. After using these items, they should be washed thoroughly with soap and water.
- Extra cleaning for all "high-touch" surfaces. These include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables. Also, clean any surfaces that may have blood, stool, or body fluids on them. Use a household cleaning spray or wipes and follow the instructions on the label.

Call 9-1-1 if you notice:

- Difficulty breathing
- Signs of chest pain or abdominal pain
- Severe abdominal pain
- Confusion or you are unable to rouse your child
- A seizure
- Vomiting more than once or having several episodes of diarrhea
- Develop a fever greater than 100.4 F or higher, not relieved by use of anti-fever medicine after 6 hours

## Appendix C-Pediatric

### Stay-At-Home Medication

Acetaminophen (Tylenol)	Do Not Use Without First Talking to a Doctor If:
Take every 4-6 hours if there is fever or pain	<ul style="list-style-type: none"> <li>Your child is &lt;12 weeks old</li> <li>Your child has liver problems or is using other products containing acetaminophen</li> </ul>

### Acetaminophen Dosage Table for Fever and Pain\*

Child's Weight (pounds)	6-11	12-17	18-23	24-35	36-47	48-59	60-71	72-95	96+	
Syrup: 160 mg/5 mL	1.25	2.5	3.75	5	7.5	10	12.5	15	20	mL
Chewable 80 mg Tablets	--	--	1 ½	2	3	4	5	6	8	tabs
Chewable 160 mg Tablets	--	--	--	1	1 ½	2	2 ½	3	4	tabs
Adult 325 mg Tablets	--	--	--	--	--	1	1	1 ½	2	tabs
Adult 500 mg Tablets	--	--	--	--	--	--	--	1	1	tabs

# **STAY AT HOME- ADULT**

## Appendix A-Adult

### **Stay-At-Home Treatment (Minor or Mild Symptoms)**

You have received a medical assessment from EMS. It appears you do not require immediate care in the Emergency Department. You should seek care by calling your doctor's office and following the instructions below.

Please do the following:

- Plan to stay at home and rest for the next 2-3 days
- Avoid cigarette smoke
- Avoid close contact (<6 feet distance) with people who are sick
- Use Tylenol (acetaminophen) for fever, sore throat, muscle aching and headache. See the medication handout for important information about these medications.
- Drink plenty of fluids, such as water, orange/apple/grape juice, lemonade or sports drinks – up to eight to twelve eight-ounce glasses a day. You can also use an Oral Rehydration Solution.
- Follow up with your primary care doctor if you are not better within a week

**Prevent the spread of germs by covering your cough/sneezes and clean your hands often. Wash your hands with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food. Avoid touching your eyes, nose, and mouth with unwashed hands.**

Call 9-1-1 if you:

- Start coughing blood or have very heavy mucous
- Have chest pain/discomfort or difficulty breathing
- Have a severe headache or neck stiffness
- Have a seizure
- Start vomiting
- Have diarrhea longer than a day, or your stools are red or black in color
- Have severe abdominal pain
- Develop a fever greater than 100.4 F or higher, not relieved by use of anti-fever medicine after 6 hours
- Feel faint or think you are going to pass out

Appendix B-Adult

**Stay-At-Home Medication**

<b>Name of Medicine</b>	<b>How to Take</b>	<b>Do Not Use Without First Talking to a Doctor If:</b>
Acetaminophen (Tylenol)	<p>325mg tablets</p> <ul style="list-style-type: none"><li>• Adults: take 2 tablets every 4 to 6 hours while symptoms last</li><li>• Do not take more than 10 tablets in 24 hours, unless directed by a doctor</li><li>• Do not use for more than 10 days unless directed by a doctor</li></ul>	<ul style="list-style-type: none"><li>• You have chronic liver or are using other products containing acetaminophen</li></ul>

# ***SICK AT HOME- ADULT***

## Appendix C-Adult

### **Sick-At-Home Treatment (Respiratory Illness + Fever, with or without nausea)**

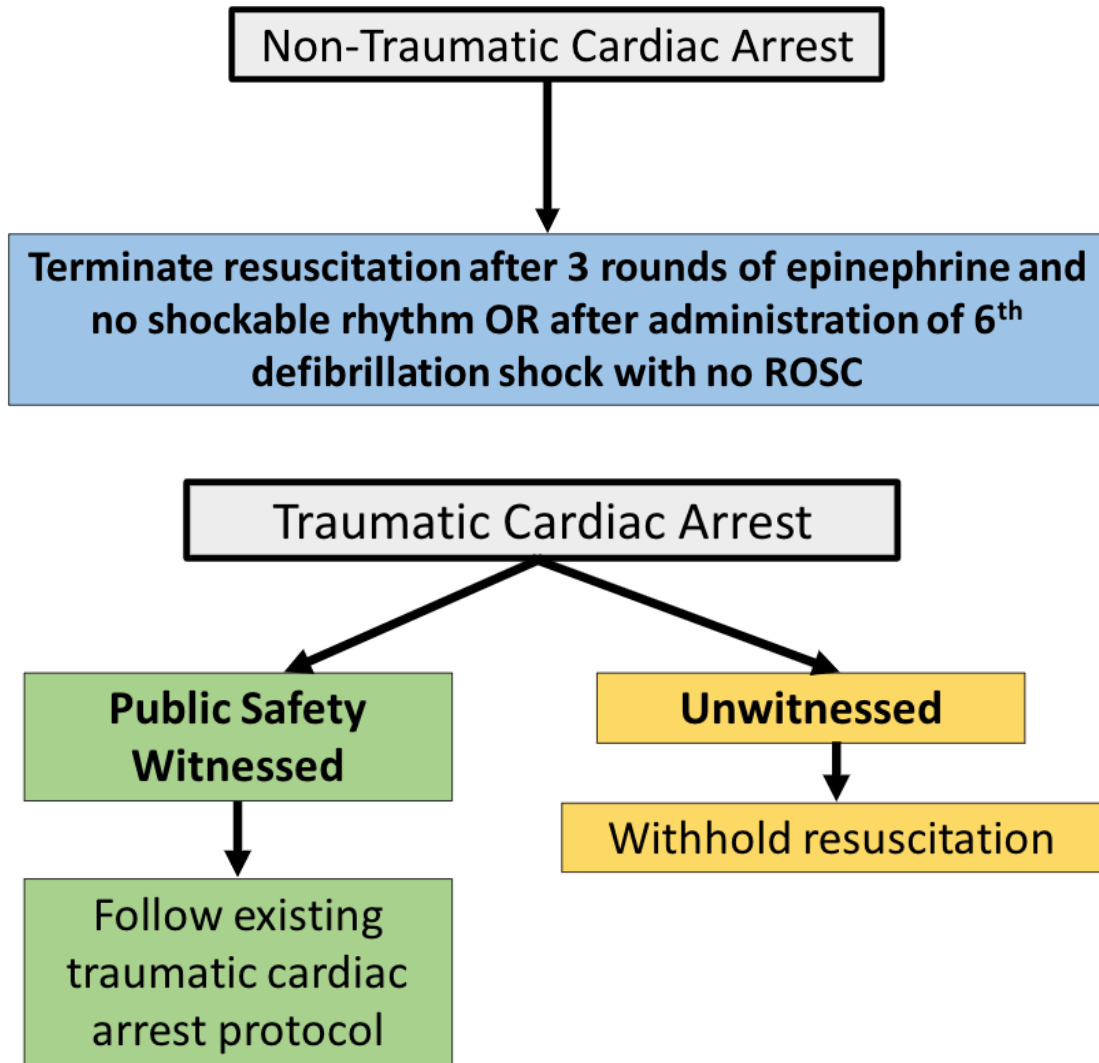
You have received a medical assessment from EMS. It appears you do not require immediate care in the Emergency Department. You should seek care by calling your doctor's office and following the instructions below. You should restrict activities outside your home, except for getting medical care. Do not go to work, school, or public areas. Avoid using public transportation, ride-sharing, or taxis. **Only leave your home after you have discussed your medical situation with your doctor.**

Please do the following:

- **Call EMS (9-1-1) back if you are not better in 24 hours for re-assessment or if you feel that you are worsening**
- Rest at home for the next 2-3 days- As much as possible, you should stay in a specific room and away from other people in your home. Also, you should use a separate bathroom, if available.
- Prevent the spread of germs by wearing a facemask, cover your cough/sneezes and clean your hands often. Avoid close contact with other people (<6 feet distance)
- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food. If soap and water are not readily available, use an alcohol-based hand sanitizer. Soap and water are the best option if hands are visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.
- Avoid cigarette smoke
- Use Tylenol (acetaminophen) for fever, sore throat, muscle aching and headache. See the medication handout for important information about this medicine.
- Drink plenty of fluids, such as water, orange/apple/grape juice, lemonade or sports drinks – up to eight to twelve eight-ounce glasses a day

Call 9-1-1 if you:

- Start coughing blood or have very heavy mucous
- Have chest pain/discomfort or difficulty breathing
- Have a severe headache or neck stiffness
- Have a seizure
- Start vomiting
- Have diarrhea longer than a day, or your stools are red or black in color
- Have severe abdominal pain
- Develop a fever greater than 100.4 F or higher, not relieved by use of anti-fever medicine after 6 hours
- Feel faint or think you are going to pass out



## Aerosol Generating Procedures

- a) If possible, consult with medical control before performing aerosol-generating procedures for specific guidance.
- b) 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.
- c) 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 (see below for alternate protocol details).
- d) BVMs, and other ventilatory equipment, should be equipped with HEPA filtration to filter expired air, if available.
- e) EMS organizations should consult their ventilator equipment manufacturer to confirm appropriate filtration capability and the effect of filtration on positive-pressure ventilation.
- f) If possible, the rear doors of the transport vehicle should be open and the HVAC system should be activated during aerosol-generating procedures. This should be done away from pedestrian traffic.
- g) Alternate protocols to consider for aerosol generating procedures:

### Nebulized Medications

1. Use should be avoided if possible – do not administer if the patient is (1) not hypoxic, (2) has no increased work of breathing and (3) has only minimal wheezing
2. If a patient has their own Metered Dose Inhaler, its use is preferred over a nebulizer (4 puffs of MDI are roughly equivalent to 2.5mg neb albuterol)
3. If a nebulizer must be used:
  - i. First dose of nebulized medicine should be given on-scene (avoid delivery in back of ambulance of ambulance if possible)
  - ii. Do not use T-Piece nebulizer, use only mask with flow rate 6lpm or less
  - iii. Use surgical face mask over nebulizer mask

### Oxygen administration equipment

1. Nasal cannula is preferred over a non-rebreather mask.
2. Place surgical facemask over any use of oxygen delivery devices (cannula, NRB or nebulizer mask).

### BVM Ventilation

1. Use HEPA filter in-line with mask or attached to BVM exhaust if available. Do not use both filters at the same time.
2. Maintain tight face seal.
3. Avoid gastric insufflation and overly forceful ventilation.

### Advanced Airway Management

1. The preferred first-line advanced airway management is the use of an i-Gel with filter system attached during insertion.
2. Endotracheal intubation is to be avoided whenever possible.

### Suctioning

1. Unnecessary suctioning should be avoided.
2. The use of a droplet shield should be utilized if available.

### CPAP

1. The use of CPAP should be avoided when possible.
2. The use of CPAP devices with filters is preferred over non-filtered CPAP devices if CPAP must be used.
3. Avoid use of nebulizer treatments with CPAP when possible. If necessary, be sure to use the port closest to the patient as the filter will prevent albuterol from getting to the patient.

### Cardiac Arrest

1. PPE as noted above should be worn for the management of cardiac arrest, including the provision of CPR

### Transport

1. Avoid aerosol generating procedures performed inside the ambulance.
2. If intervention in the ambulance must be performed, minimize individuals in the patient compartment during any aerosol generating procedure.
3. Turn on fan to maximum compartment air flow.

### At Hospital

1. Communicate with receiving hospital to ensure they are ready for patient arrival.
2. Discontinue any nebulizers and CPAP prior to entering hospital.
3. Transition to nasal cannula with surgical facemask over patient while moving from ambulance to patient room.

### Pediatric considerations

1. Use bag-valve-mask filter that does not increase dead space (i.e. an exhaust filter does not increase dead space).
2. In the event of short-duration ventilation support (e.g. seizure), bag-valve-mask ventilation is preferred over supraglottic airway placement or intubation.
3. In the case of Pediatric Cardiac Arrest, supraglottic airway with a filter is the preferred method of airway management.

## **Other Medical Care**

## **Management of Acute Respiratory Symptoms during COVID-19 Pandemic**

Due to the outbreak of COVID-19, all patients presenting acute respiratory symptoms especially respiratory failure, pneumonia and fever should be considered infected with COVID-19 until proven otherwise.

This includes patients with known asthma and COPD. To prevent spread of COVID - 19 the following guidelines will may be followed:

**Nebulized medications** should be **avoided** in all patients at this time due to **risk to others**. A Cochrane review found that metered-dose inhalers **with spacers are at least as effective, and likely more effective, than nebulized medications**.

First line for ASTHMA ONLY and COPD ONLY  
{note **NOT FOR ARDS GENERAL MANAGEMENT**}:

### **Inhaled Beta Agonist:**

Albuterol MDI (90 mcg/puff) with spacer:

**Adult:**

8 puffs every 20min up to 4 hours then every 1-4 hr

**Pediatric:**

8 puffs every 20 min for 3 doses, then as needed every 1-4 hrs

**Anticholinergic Agent:**

Ipratropium MDI (18mcg/puff) with spacer:

Adult:

8 puffs every 20min, as needed for 3 hours

**Pediatric: (severe asthmatic cases only)**

4-8 puffs every 20 min as needed, up to 3 hours

**Or Combination Inhaled MDI:**

Albuterol with Ipratropium (90 mcg albuterol with 18 mcg ipratropium per puff)

Adult:

8 puffs every 20min, as needed for 3 hours

**Pediatric: (severe asthmatic cases only)**

4-8 puffs every 20 min as needed, up to 3 hours

**Other Medications for bronchoconstriction therapy:****Magnesium sulfate:**

Adult:

2 grams IV over 20 min

Pediatric:

50 mg/kg up to 2 grams IV over 20 min

**Epinephrine (1 mg/mL)**

Adult:

0.3-0.5 mg IM every 20 min for 3 doses

Pediatric:

0.01 mg/kg IM up to 0.3-0.5 mg every 20 min for 3 doses

**Terbutaline (1mg/mL):**

Adult:

0.25 mg subcutaneously every 20 min for 3 doses

Pediatric:

0.01 mg/kg subcutaneously every 20 min for 3 doses, then every 2-6 hours as needed

10mcg/kg intravenously over 10 minutes, followed by an infusion of 0.4mcg/kg/min

**Steroids:**

Neither the CDC nor the WHO has recommended steroid administration for viral pneumonia.

In general, steroid therapy does not appear to add any clinical outcome benefits in the treatment of COVID-19 infection. As well, steroid therapy may slow down clearance of the virus. The decision to use steroids in a patient during the COVID-19 outbreak should be based on patient individual presentation and best clinical judgement, if there is another indication for steroids such as COPD exacerbation. Generally, steroids should be avoided unless they are indicated for another reason such as exacerbation of asthma or COPD

**Oxygen Therapy:**

- Give supplemental oxygen therapy immediately to patients with severe acute respiratory infection and respiratory distress, hypoxemia or shock and target saturations > 88% if intubated.
- High-flow nasal oxygen (HFNO) and Non-invasive ventilation (NIV) should only be used in selected patients. Guidance on these techniques is changing rapidly.
- In patients suspected of CoV19 infection, due to uncertainty around the potential for aerosolization, HFO and NIV should be used with airborne precautions until COVID-19 infection has been ruled out.
- Patients treated with either HFNO or NIV should be closely monitored for clinical deterioration.
- There is strong evidence that the use of NIV in the treatment of COVID-19 pneumonia is associated with a worse outcome. On this basis, WHO recommends, where possible, to avoid using NIV and adopt instead standards that provide for early intubation.

**Management of Acute Respiratory Symptoms during COVID-19 Pandemic****References:**

1. Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected: Interim guidance V 1.2. [https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-\(ncov\)-infection-is-suspected](https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected)
2. Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19) <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html#minimize>
3. Italy (2020-03-13) Guidelines for the treatment of people with COVID-19 disease Edition 2.0, 13 March 2020 <https://covid.idwiki.org/books/protocols/page/italy-%282020-03-13%29>



### **Guidance for Hospitals and EMS for Ambulance Diversion Requests**

Michael A. Kaufmann, MD, FACEP, FAEMS  
State EMS Medical Director  
Indiana Department of Homeland Security

Hospital resources, including emergency services, may occasionally be overwhelmed and may not be able to provide optimal patient care. Factors contributing to this problem include a shortage of qualified health care providers, lack of hospital-based resources, and ongoing hospital and emergency volume in response to COVID19 community transmission.

While many hospitals have attempted to respond to ED overcrowding by diverting incoming ambulances to other hospitals, diversion creates its own problems, delays patient care, and further reduces our EMS systems ability to respond to calls for emergency assistance in a timely fashion.

A patient's choice of hospital or other facility should be complied with unless contraindicated by state, regional or system/service protocol or the assessment by a certified EMS provider shows that complying with the patient's request would be injurious or cause further harm to the patient. Patient transfer can be arranged following emergency care and stabilization.

### **HOSPITAL DIVERSION REQUESTS**

A hospital may notify the EMS system of a temporary inability to provide care in the emergency department (ED) and request ambulances divert patients to an alternate hospital facility.

**A request to divert to another facility may be honored by EMS providers when patient condition and EMS system status allow.**

A diversion request does not mean the hospital ED is closed, but usually means the current emergency patient load exceeds the Emergency Department's ability to treat additional patients promptly.

If the patient's condition is unstable and the hospital requesting diversion is the closest appropriate hospital, ambulance service personnel should notify the hospital of the patient's condition and to expect the patient's arrival.

This procedure should also be followed when a patient demands transport to a facility on diversion.

A hospital declaring diversionary status for EMS patients is simply a request for EMS to consider an alternate hospital destination. The hospital may not refuse care for a patient presented to their facility and is subject to EMTALA rules and regulations.



## Indiana Regional Healthcare Surge Response Plan (IRHSRP) to the COVID-19 Outbreak of 2020

### Executive Summary

Healthcare systems in Indiana must prepare for major emergencies or disasters involving human casualties. Such events will severely challenge the ability of healthcare systems to adequately care for large numbers of patients (surge capacity) and/or victims with unusual or highly specialized medical needs (surge capability). Hospitals and healthcare systems should apply the guidance listed here to coordinate effectively with one another, and to integrate with other response organizations that have established response plans in place to organize and prepare for the medical surge that accompanies these disasters.

The Indiana Regional Healthcare Surge Response Plan emphasizes responsibility and collaboration in addition to state authority to facilitate participation and support of the medical response. The entire system priority is designed to preserve the healthcare systems ability to receive, triage, stabilize, disposition, and provide ongoing care (including intensive care) for prolonged periods of time. In this way, the IRHSRP describes a framework of coordination and integration across six tiers of response.

- A five-step approach to identify critical from non-critical patients and ensure the 911 EMS system maintains the ability to transport these patients to definitive care.
- Utilize real-time digital solutions in EMResource to optimize patient destination and monitor hospital resources while providing the greatest benefit to patients regardless of their locations.
- Regionalize different healthcare system entities into one functional unit to maximize resource and patient allocation in a geographic area.
- Create surge facilities that have the capacity and capability to accept ongoing patient admissions while allowing other facilities in a unified system the opportunity for decompression.
- Expand inpatient, ICU, and stepdown care in way that maximizes throughput of patients and provide acuity level resources to all that need them.
- Ensure continuous availability of EMS resources so that patient discharges and transfers can continue in an uninterrupted manner when needed.

## The Plan:

Medical surge is the ability to provide adequate medical evaluation and care during events that exceed the limits of the normal medical infrastructure of an affected community. It encompasses the ability of the healthcare system to survive a hazard impact and maintain or rapidly recover operations that were compromised.

The Regional Surge Response Plan provides guidance to predefined regions within the state as a framework that helps healthcare systems handle large numbers of patient. This is contingent upon the systems working together collaboratively in a way that shares resources and works toward a common goal of keeping the system operational for patient care while managing the influx of patients from the given threat. This document outlines and guides that response. This living document can be adapted locally to meet the existing infrastructure and needs of a given geographic area and the state will assist and support to implement these guidelines.

The goal of the Healthcare Regional Surge Response Plan is to keep the health care system operational. This includes our prehospital system of care provided by EMS provider agencies. The entire system is built upon the healthcare systems ability to receive, triage, stabilize, disposition, provide ongoing care (including intensive care) for prolonged periods of time. This creates a vital role for keeping emergency departments open and operational, while at the same time ensuring that hospitals can discharge patients from their facility in a timely manner so that new patients can be admitted. Equally important is the EMS systems' ability to respond, care for, and transport emergency patients. This plan combines both of those priorities into an effort to maintain patient flow both into and out of the regional system.

**Prehospital Planning:** In an effort to keep EMS operational, while at the same time allocating resources to those patients needing care, and attempting to direct non-emergency or less critical patients away from the emergency departments, EMS provider and local communication/dispatch agencies should adopt the following guidance.

- Step 1 – Give dispatch the authority to screen patients and NOT send an ambulance for non-critical lower acuity patients. These are often referred to as alpha or omega calls but can be expanded to include other non-critical conditions. This can be accomplished through medical director defined criteria or expanded/modified caller queries. Additionally, consideration for extra workforce such as retired physicians, nurses, or other healthcare providers could be embedded in dispatch agencies to assist in real time decision-making.
- Step 2 – Give EMS providers the authority to screen patients and initiate refusals for noncritical patients. This is unique in most circumstances and is referred to as EMS provider-initiated refusals of care. This should be initiated once call volume and need for ambulances has overwhelmed the capacity of existing assets available in a community or region.

- Step 3 – Expand the workforce by easing rules/regulations allowing for non-traditional crew configurations and staffing patterns. This should be done locally. [IDHS has published](#) more than 14 blanket rule waivers in response to the Coronavirus response.
- Step 4 – Create a network of EMS providers via EMResource to assist with real-time communications and availability should mass patient movements be necessary. Via EMResource we will know only contact info, but dispatch, ambulance status, PPE Status, Ventilator Capacity (more than 300 vents statewide on ambulances) and workforce.
- Step 5 – Alternate transport vehicles – Many patients that are ambulatory or non-critical could be moved in alternate vehicles including automobiles, SUVs, passenger vans, or other suitable, but non-state certified vehicles operated as part of an EMS provider agency.

Regional hospital facility planning: This will require the available facility resources in the given area to function as one healthcare system with multiple locations. While each healthcare system can function independently on their internal response to patient surge, patient movement to and from those facilities will need to be coordinated from an outside source. This will require detailed communication, coordination, and cooperation amongst healthcare system leadership. Treating the region as a solitary system will allow for optimal resource utilization, real time patient navigation and asset allocation, to keep patients moving into and out of appropriate facilities. Additionally, unilateral determination of diversion status will not be an option.

It is anticipated that all hospitals will be operating at or above capacity during the peak of patient surge. As such a “relief-valve” will need to be created to give hospitals the ability to decompress. This is ideally created through the designation or creation of a surge hospital. The surge hospital can be one of several types of facilities. It might be a local or regional hospital, a temporary facility, or other medical center with bed capacity that is made available through discharges of existing patients, or lateral transfers to more distant facilities that are less impacted by the surge. Example: Sydney and Lois Eskenazi Hospital will be the designated Surge facility for the central Indiana region. As other hospitals in the area reach and exceed their maximal capacity to care for critically ill patients, the surge hospital can become the intended receiving hospital for these patients. This reallocation of patients and resources would happen in real time as additional space and need occur. This will require on demand patient movement between facilities, based on their surge capacity, and coordinated through the Regional Operations Center.

This activity will be coordinated through each Regional Operation Center (ROC) under the guidance of the Indiana Regional Healthcare Surge Response Plan to the COVID-19 Outbreak of 2020.

For this response, this capability consists of the ability to perform the following functions:

- Function 1: Coordinate a regional hospital systems surge plans
- Function 2: Support activation of medical surge including real time information monitoring utilizing capacity/capability of multiple assets from EMResource and other real time tracking tools
- Function 3: Support jurisdictional medical surge operations for both 911 and interfacility movement of patients with just-in-time guidance for destination and transportation options
- Function 4: Coordinate with local hospitals for surge overflow

In conjunction with jurisdictional partners, coordinate with the jurisdiction's healthcare response through the collection and analysis of health data (e.g., from emergency medical services, fire service, law enforcement, public health, medical, public works, utilization of incident command system, mutual aid agreements, and activation of Emergency Management Assistance Compact agreements) to define the needs of the incident and the available EMS, healthcare staffing and resources. This will be done by real time monitoring of available sources which may include EMResource, EMTrac/IndyTrac, ImageTrend, or other operations monitoring software.

At the time of an incident, the ROC will provide health-related data to healthcare organizations or healthcare coalitions that will assist the healthcare organizations or healthcare coalitions in activating their pre-existing plans to maximize scarce resources and prepare for any necessary shifts into and out of conventional, contingency, and crisis standards of care. Support activation of medical surge including real time information monitoring utilizing capacity/capability of multiple assets from EMResource and other real-time tracking tools.

The 911 system will continue to function as built, but as hospitals start hitting capacity, the ROC will need a mechanism to direct patients to open facilities in real time. This will be a moving target and will require real-time monitoring and real-time destination information to go to EMS provider agencies in route to hospitals. This task will utilize a transport officer to monitor all traffic and provide real time guidance in the EOC/ROC. This is highly dependent upon hospitals and healthcare systems sharing data and regularly updating their facility capabilities with accurate and reliable information. Without this, the system will not be able to function in a coordinated fashion.

IndyTrac will be our source for real time hospital availability for the central Indiana region. This is a city- wide view, but likely NOT something that can be replicated in other parts of the state. We will need to adapt EMResource for this in other areas utilizing the EMTrac function. EMResource can provide this functionality, but only when appropriately updated.

In the 24-48 hours after the surge plan is activated, an initial allotment of patients will need to be mobilized and moved away from the surge hospital. While it is understood that the surge hospital will also likely be receiving patients independently, they also will receive priority for patient offloading.

This should be accomplished through formal diversion status or directing non-COVID 911 patients away from the surge facility. Hospital discharges and lateral transfers will need to be done by private EMS provider agencies in the region in an attempt to keep 911 providers functional for emergency response calls. Most hospitals already have preferred provider call lists to reach private ambulance services. This process will continue, as to not disrupt daily operations or create an additional layer to access transporting EMS provider agencies. The goal is to keep patients moving OUT of hospitals using the private EMS provider agencies. This allows 911 EMS provider agencies to keep bringing patients into the facilities. Once those hospital call lists are exhausted and no private local EMS providers are available, whether it's for a discharge or a transfer, the EMS Resource Center can be contacted for additional assistance (317-233-5439.) This function will be answered/served by a combination of ESF4 and ESF9 desks within the State EOC. The EMS Resource Center will attempt to find any other available private or municipal EMS provider agencies in any specific region of the state. When all possible providers are exhausted, the call will be transferred to the ING (the Indiana national guard) to facilitate urgent patient movement. This process will be implemented in an attempt to reduce delays and bottlenecks at the hospitals by moving patients out as quickly as possible. The EMS Resource Center will also be available to coordinate other requests for EMS assistance anywhere in the state, whether it be locating an available EMS provider agency, or asking them to assist in non-emergency functions as available such as test sample collection from patients to routine scheduled transports for high risk patients (such as dialysis transports of COVID positive patients, etc.). While not intended for dispatching, the State EOC EMS Resource Center will be a “one-stop shop” for EMS assistance.

The ROC operations director will also monitor hospital bed availability, ICU availability, and resources at the hospitals through EMResource. In this capacity the ROC will function as “central intelligence” to help initiate central coordination to the surge facility. The ROC and EOC should be located in the same facility to enhance communication and situational awareness. This will be variable depending on local structure and resources.

PPE will be managed through ISDH, with input from the ROC as EMResource is updated in real time and additional needs for PPE develop throughout the region.

# ORGANIZATIONAL LEADERSHIP AND RESPONSIBILITIES OF HEALTH CARE FACILITIES

Hospitals may be individual facilities, part of a corporate chain, or part of a federal system (such as Department of Veterans Affairs [VA] medical centers or military hospitals). It is recognized that it may be very difficult to create policy across institutions located in disparate geographic areas or across different healthcare systems that is consistent with any given medical surge plan. As such, healthcare system facilities, should be expected to provide care and resources commensurate with what is being provided in the community in which they are located. Thus, if the hospital system has resources in excess of those available in the community, it should allow patients into the system or commit resources to the community to allow equilibration of resource availability. This will require an unprecedented amount of collaboration and cooperation amongst hospital CEOs, CMOs and other leadership individuals. Likewise, information sharing and resource planning such as ICU bed availability, ventilator availability and other oftentimes proprietary information will need to be freely shared with the Regional Operation Center. It is incumbent on the healthcare system leadership to convey this to ground-level operations. Additionally, each regional system should operate to its maximum capacity before transferring patients outside of the regional system partnership in order not to overburden other regions.

# SURGE CAPACITY AND OUTFLOW TRACT CONSIDERATIONS

Each hospital will need concrete goals for expansion during a disaster, including outpatient, inpatient, and specialty unit capacity. However, the extent to which a hospital can surge will vary. Recommendations are not standardized, but the focus should be on expanding all acute care resources for the most critically ill while shifting step down or less critical patients to facilities with fewer resources. The role of the institution in the community and its size contribute to this calculus. For example, it may be easier for a smaller hospital such as a neighborhood hospital or critical access hospital to surge to 200 percent for non-critical care beds, than attempting to create ICU capacity (in a less resource rich facility) by a much smaller factor. Less critical patients should be moved as rapidly as possible to less acute care type facilities once stability is achieved. The goal is to achieve an equilibration between stable discharges and critical admissions as to maintain patient movement. Only when the balance tips and all capacity for expansion has been exhausted should surge facility overflow occur. This tremendous effort will require near constant communication with facility and regional operations center. Additional surge facilities may be necessary depending on the ability for mitigation procedures to adequately spread the surge over a longer time period. The broader the surge, Healthcare systems, localities and regions will need to designate non-traditional care sites for both acutely sick and convalescing patients alike through the entirety of this surge response.

# REFERENCES

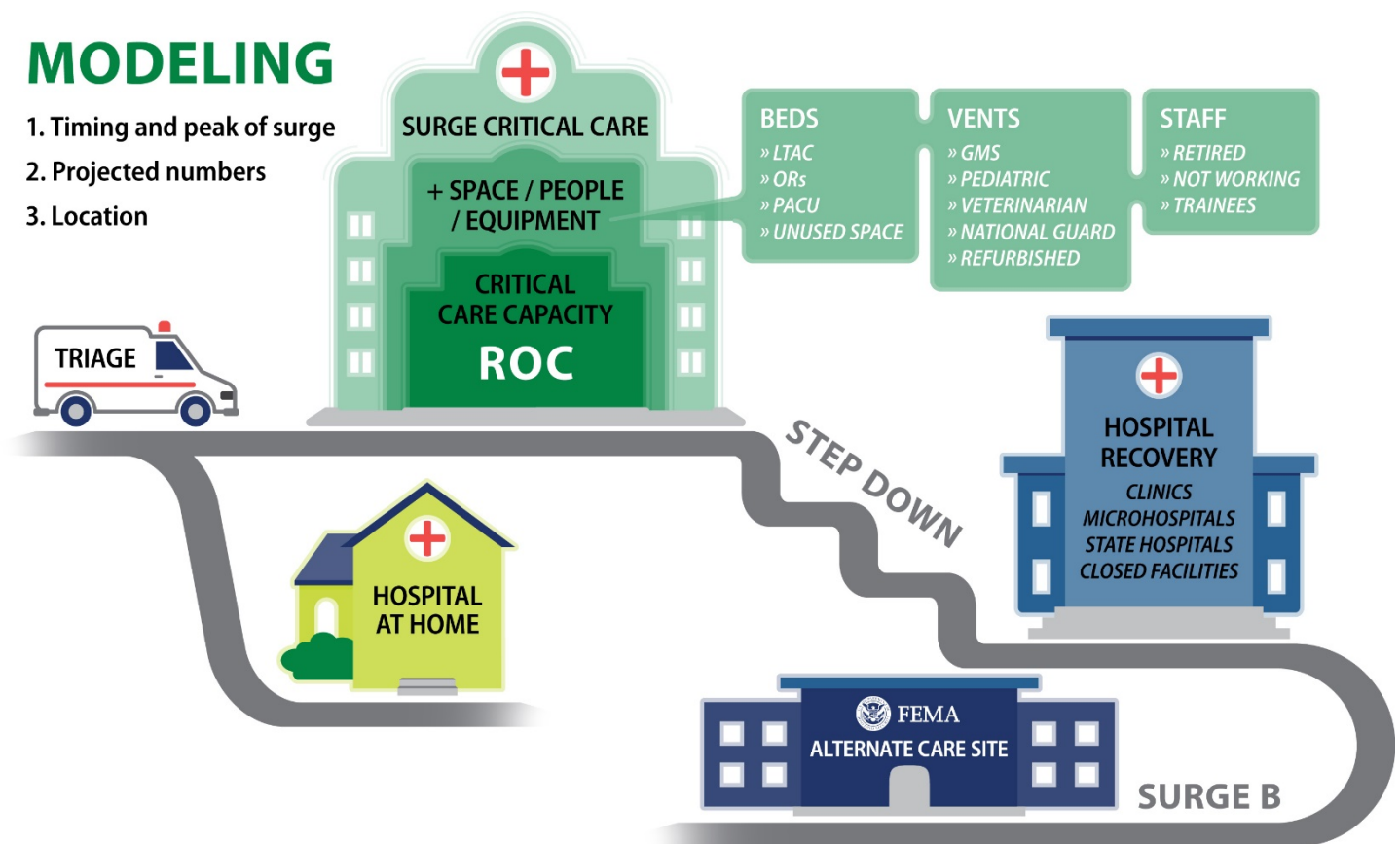
Medical Surge Capacity and Capability: A Management System for Integrating Medical and Health Resources During Large-Scale Emergencies, Second Edition, U.S. Department of Health and Human Services

Centers for Disease Control and Prevention (CDC). (2018). Public health emergency preparedness and response capabilities. Atlanta, GA: U.S. Department of Health and Human Services.

Hospital Surge Capacity and Immediate Bed Availability, U.S. Department of Health & Human Services, ASPR TRACIE <https://asprtracie.hhs.gov/technical-resources/58/hospital-surge-capacity-and-immediate-bed-availability/0>

## MODELING

1. Timing and peak of surge
2. Projected numbers
3. Location



# IHCP *bulletin*



INDIANA HEALTH COVERAGE PROGRAMS    BT2020XX    APRIL 2, 2020

## ***IHCP COVID-19 Response: IHCP revises policy for in-state ground transportation***

Effective April 3, 2020, and through the duration of the public health emergency for coronavirus disease 2019 (COVID-19) outbreak, the Indiana Health Coverage Programs (IHCP) is removing prior authorization (PA) requirements, including the 20 one-way trip limitation and 50-mile restriction, for all in-state ground transportation. All in-state ground transports must be medically necessary, and the transportation provider must maintain the supporting documentation.



All air and out-of-state transports will continue to require PA.

In the event that transportation providers transport members to nonenrolled alternative treatment locations, such as a field hospital or other facility designated to treat COVID-19, these providers should include destination modifier "H" for hospital to any base rate and mileage procedure codes billed.

Fee-for-service (FFS) claim reimbursement for nonemergency medical transportation (NEMT) will be performed by the NEMT broker, Southeastrans (SET). Other claim reimbursement scenarios such as hospital-to-hospital transfers, 9-1-1 responses, and claims for dually eligible members will be performed by the State's fiscal agent, DXC Technology. Managed care claim reimbursement will be performed by the respective managed care entity (MCE) or their broker.

For more information, refer to the [Transportation Services](#) provider reference module.

### **QUESTIONS?**

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

### **TO PRINT**

A [printer-friendly version](#) of this publication, in black and white and without photos, is available for your convenience.

### **COPIES OF THIS PUBLICATION**

If you need additional copies of this publication, please download them from the [Bulletins](#) page of the IHCP provider website at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

### **SIGN UP FOR IHCP EMAIL NOTIFICATIONS**

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope or sign up from the [IHCP provider website](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).





To Be Eligible: Must be a formerly certified or licensed (retired)  
EMR/EMT/AEMT/Paramedic with an expired cert/license after 03/31/2015

**OPTION 1:** Can assist with patient care with another certified or licensed provider supervising. Examples include assisting in an ED or ambulance by bagging a patient or taking vital signs.

- No certification or temporary certification
- Acting as a Good Samaritan—just no prohibited from performing certain actions that normally are limited to EMS.
- Would require a licensed or certified provider (and their organization) to approve and supervise Could be EMS, RT, nurse, NP, physician's assistant, physician, etc.

**Option 2:** Can obtain a Temporary Certification to be the primary caregiver for patients using an EMS certification or license.

- Must have a provider organization and Medical Director approve and affiliate including a supervising hospital as well if the certification/licensure is ALS
- To obtain a temporary certification:
  - Fill out a Reciprocity Application at <https://www.in.gov/dhs/3527.htm>
  - Provide evidence of affiliation via letter or emails with confirmation
- Email [emscertifications@dhs.in.gov](mailto:emscertifications@dhs.in.gov)

Reminder that anyone that is interested in volunteering outside the scope of this Order may still do so through the ISDH volunteer pool at

[https://redcap.isdh.in.gov/surveys/?s=9TDEN3ETC9&fbclid=IwAR3RVjLy-yX-4vPmcNay3pjJjYOAaSGZMg6VvCBMg\\_GwdnBqg1swuWR8PTk](https://redcap.isdh.in.gov/surveys/?s=9TDEN3ETC9&fbclid=IwAR3RVjLy-yX-4vPmcNay3pjJjYOAaSGZMg6VvCBMg_GwdnBqg1swuWR8PTk)

#INthistogether



March 27, 2020

To whom it may concern,

The question has been raised regarding the risk of intranasal administration of naloxone for presumed overdose victims. There is currently little evidence-based literature to administer or withhold this potentially lifesaving drug in the setting of unknown COVID19 infection. There is some data available to suggest that opioid and other drug addicted individuals may be at higher risk of having COVID19. In a more broad sense, there is little to no literature related to aerosol generation from any intranasal medication administration.

The risk here most likely lies not in the intranasal medication administration (oftentimes given to a patient not even breathing), but probably more in the potential for aerosol generation after revival due to cough and or sneezing. In an ideal, resource rich environment, it may be advisable to place a simple mask on a victim's face, covering the mouth, then give intranasal naloxone and cover both the nose and mouth after. But this requires even closer contact with a potential source of infection. Intranasal administration is not likely to be aerosol generating as the aerosol is created by the device with the drug going inward and not the patient sneezing or coughing outward until after the administration is complete. Lastly, the CDC has confirmed that intranasal naloxone is not considered to be an aerosol generating procedure (AGP) if performed correctly.

**Current recommendations are as follows:**

- Continue to administer intranasal naloxone to victims presumed to be suffering acute opioid overdose.
- After administration, back away a distance of at least six feet unless appropriate level PPE is available.
- Avoid known aerosol generating procedures such as bag valve mask ventilation until EMS arrives.

Sincerely,

Michael A. Kaufmann, MD, FACEP, FAEMS

Indiana EMS Medical Director



Thursday, April 16, 2020

To: Indiana EMS Officials

From: Kraig Kinney, J.D., State EMS Director and Counsel of EMS  
Kelly MacKinnon, J.D., Counsel Indiana State Department of Health

Re: EMS First Responders and Covid-19 Disclosures by Hospitals

\*\* Updated guidance as of April 15, 2020

**Issue:**

Is an Indiana hospital or other “covered entity” under HIPAA required to provide notification to emergency medical services (EMS) personnel when a patient transported by EMS has a positive or negative test for COVID-19?

**Discussion:**

The Ryan White Act of 2009 (summarized at <https://www.cdc.gov/niosh/topics/ryanwhite/>) addresses notification of emergency responders in Part G and requires that medical facilities of exposure to potentially life-threatening illness so that responders can make informed decisions about how to follow-up.

The Act requires a facility like a hospital or other covered entity to respond to two situations:

- 1) When a responder submits an inquiry based upon a potential exposure; or
- 2) When the medical facility determines the patient with an emergency has a listed airborne or aerosolized infectious disease.

The facility should have a Designated Officer that would initiate notification of name of the infectious disease and the date of the transport. The requirement is notification as soon as practicable, but no later than 48 hours after a request or a determination.

The National Institute for Occupational Safety and Health (NIOSH), as required, has determined the list of potentially life-threatening disease that includes severe acute respiratory syndrome (SARS-CoV).

<https://www.cdc.gov/niosh/updates/upd-11-02-11.html> The current Public Health Emergency addresses the commonly known COVID-19 which is also known as SARS-CoV 2 so it falls within the Ryan White Act for notification procedures for EMS responders.

Indiana has one key statute that addresses the notification for infectious disease for EMS responders:

**IC 16-41-10-4 Disclosure of exposure to infectious disease; treatment and counseling**

Sec. 4. (a) A medical director or physician notified under section 3 of this chapter shall, not more than forty-eight (48) hours after receiving the notification under section 3 of this chapter, contact the emergency medical services provider or law enforcement officer described in section 2 of this chapter to do the following:

- (1) Explain, without disclosing information about the patient, the dangerous communicable disease to which the emergency medical services provider or law enforcement officer was exposed.
- (2) Provide for any medically necessary treatment and counseling to the emergency medical services provider or law enforcement officer.

(b) Expenses of testing or treatment and counseling are the responsibility of the emergency medical services provider or the provider's or law enforcement officer's employer.

However, the limitations of this statute during a Public Health Emergency is that it requires each healthcare provider to submit an individual request and comes from the responder and not from the healthcare facility. This would unduly task the healthcare facilities with tracking down requests for many, if not all, transports, rather than the information coming from the facility itself for positive COVID-19 cases.

Furthermore, the Office of Civil Rights, which is tasked with HIPAA compliance directly addresses the confidentiality issue in its Guidance issued March 24, 2020. The guidance indicates that “disclosure to first responders to prevent a serious and imminent threat to the health and safety of a person or the public” is permitted under HIPAA. Given the community nature and spread of the COVID-19 virus, it is vital that our EMS responders are notified of encounters where they were potentially exposed so that those providers can seek guidance on issues such as quarantine and further protect the public at large by not allowing EMS providers to continue blindly treating patients when they may be contagious.

**Summary**

Due to the nature of the COVID-19 as a SARS-CoV 2, a respiratory and airborne droplet illness, ISDH and IDHS consider this to be covered by the Ryan White Act and direct hospitals and other covered entities to follow the Ryan White Act in terms of notifying EMS responders of a positive COVID-19 patient within a reasonable amount of time (preferably within a few hours) in order to curtail the further spread of this virus. This notification should be as simple as a COVID-19 positive patient as the disease and then the date of the transport. It is also vital that healthcare facilities notify crews that will be handling COVID-19 patients before the crew arrives if possible so that appropriate PPE can be worn.

#### **Addendum 4/15/2020**

Additional clarifications on this Guidance:

- EMS responders should only need to request notification of COVID-19 status when they were the direct patient caregivers AND there was a potential exposure—meaning that the patient appeared to be a COVID-19 patient based upon presentation and history as well the EMS responder did not have appropriate PPE for the types of care provided as determined by current CDC guidelines.
- Although the initial guidance references COVID-19 positive patients, the guidance was intended for a notification of some kind whether the patient was COVID-19 positive or negative. Either notification would permit EMS responders to quarantine or take other actions as necessary.
- Although the initial guidance references as simple a notification as possible, it should be sufficient enough for an EMS responder or their organization to determine which crew members were exposed. A simple date may not be sufficient. Other identifiers such as Incident / Response number or time of transport would also be a simple means of identifying the response without having to divulge the patient's other protected health information (PHI). Furthermore, a response number or time, would be identifiable for the crew involved but would not be traceable to the patient outside the EMS records, that are protected by HIPAA.

**This directive has been approved by Dr. Lindsay Weaver, Chief Medical Officer, Indiana State Department of Health, and Dr. Michael Kaufmann, State EMS Medical Director, in conjunction with their counsel.**



## ***IHCP COVID-19 Response: Ambulance providers to be reimbursed for response and treatment, no transport***

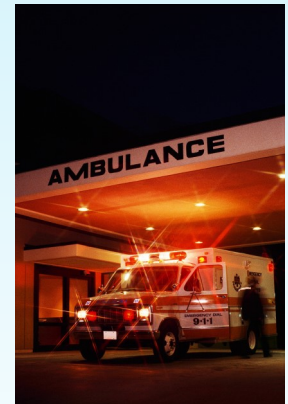
Effective for dates of service (DOS) on or after March 1, 2020, through the duration of the public health emergency for coronavirus disease 2019 (COVID-19), the Indiana Health Coverage Programs (IHCP) will reimburse Emergency Medical Services (EMS) providers for appropriate and medically necessary care billed under Healthcare Common Procedure Coding System (HCPCS) code A0998 – *Ambulance response and treatment, no transport*.

Policy changes in this bulletin apply to both fee-for-service (FFS) Traditional Medicaid and managed care benefit programs.

The A0998 HCPCS code is billed when care is provided in response to an emergency call to a member's home or on a scene, when an ambulance is dispatched, and treatment is provided to the patient without the patient being transported to another site. Submission of claim for reimbursement under code A0998 requires that the response originate through a 9-1-1 call. Until now, the IHCP reimbursed EMS providers for treatment rendered only when the patient was transported to the hospital emergency department.

Providers should submit A0998 only when **all** the following requirements are met:

- The member consents to evaluation and treatment.
- After the evaluation, the paramedic or emergency medical technician (EMT) and the patient agree there is not a medical emergency.
- The member does not desire transport to an emergency department for evaluation.
- The member is stable for referral to the patient's physician or other community resource.
- The member has the ability (mental capacity, transportation resources) to obtain assistance and medically indicated follow-up.



These changes apply retroactively to claims with DOS on or after March 1, 2020. Claims resubmitted beyond the original filing limit must include a copy of this bulletin as an attachment and be resubmitted within 180 days of this bulletin's publication.

### **Reimbursement requirements**

For DOS on or after March 1, 2020, ambulance providers (provider specialty 260) can bill A0998 when the criteria above are met. For FFS members, claims may be submitted to DXC Technology. Managed care claims shall be submitted to the appropriate managed care provider's medical payer address. A0998 can only be billed if the member is not transported. Claims are subject to postpayment review.

The rate for A0998 is \$76.71 and is effective from March 1, 2020, through the duration of the public health emergency.

### **Billing requirements**

Providers will continue to submit claims on the professional claim (CMS-1500 claim form, Provider Healthcare Portal professional claim, or 837P electronic transaction) as required before the public health emergency.



## ***IHCP COVID-19 Response: IHCP allows EMS providers to receive minimum BLS reimbursement***

Effective for dates of service (DOS) on or after March 1, 2020, through the duration of the public health emergency for coronavirus disease 2019 (COVID-19), Emergency Medical Services (EMS) providers will be reimbursed at a minimum basic life support (BLS) rate when transporting members that are COVID-19 positive or symptomatic.

*Note: The Centers for Disease Control and Prevention (CDC) guidelines define **symptomatic** as a patient presenting with any signs or symptoms associated with COVID-19, such as fever and so on, but a definitive diagnosis has not been established.*



Policy changes in this bulletin apply to both fee-for-service (FFS) Traditional Medicaid and managed care benefit programs. These changes apply to transportation provider specialty 260 – *Ambulance*.

EMS claim reimbursement under this policy for nonemergency medical transportation (NEMT) will be performed by the NEMT broker, Southeastrans (SET) or the respective managed care entity's (MCE's) transportation broker. Other claim reimbursement scenarios for EMS under this policy, such as hospital-to-hospital transfers, 9-1-1 responses, and claims for dually eligible members, will be performed by the State's fiscal agent, DXC Technology, or the member's MCE.

These changes apply retroactively to claims with DOS on or after March 1, 2020. Claims resubmitted beyond the original filing limit must include a copy of this bulletin as an attachment and must be resubmitted within 180 days of this bulletin's publication.

### **Reimbursement requirements**

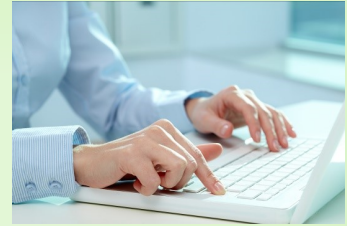
EMS providers should continue to bill the appropriate transportation code. When billing procedure code A0130 – *Nonemergency transportation, wheelchair van* or procedure code T2003 – *Nonemergency transportation; encounter/trip*, providers must include the CR modifier to have the BLS nonemergency transportation rate applied. Providers must also include one of the diagnosis codes listed in Table 1 on the claim, along with the CR modifier, to receive the enhanced rate. See Table 1 to identify the most appropriate diagnosis.

*Table 1 – Diagnosis codes to use for BLS nonemergency transportation rate*

ICD-10 CM	Code description	A0130 and T2003 pay at BLS rate
Z20.828	Contact with and (suspected) exposure to other viral communicable diseases	Bill for all suspected, probable, possible, or symptomatic members that have not yet received a positive test
B97.29	Other coronavirus as the cause of disease classified elsewhere	Use as principal (primary) diagnosis for confirmed/positive cases with DOS on March 1, 2020, through March 31, 2020
U07.1	2019-nCoV acute respiratory	Use as principal (primary) diagnosis for confirmed/positive cases with DOS on or after April 1, 2020

**Billing requirements**

Providers will continue to submit claims on the professional claim (*CMS-1500* claim form, Provider Healthcare Portal professional claim, or 837P electronic transaction) as required along with any necessary supplemental information before the public health emergency.

**QUESTIONS?**

If you have questions about this publication, please contact Customer Assistance at 1-800-457-4584.

**TO PRINT**

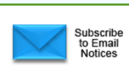
A [printer-friendly version](#) of this publication, in black and white and without photos, is available for your convenience.

**COPIES OF THIS PUBLICATION**

If you need additional copies of this publication, please download them from the [Bulletins](#) page of the IHCP provider website at [in.gov/medicaid/providers](https://in.gov/medicaid/providers).

**SIGN UP FOR IHCP EMAIL NOTIFICATIONS**

To receive email notices of IHCP publications, subscribe by clicking the blue subscription envelope or sign up from the [IHCP provider website](#) at [in.gov/medicaid/providers](https://in.gov/medicaid/providers).





# Battelle CCDS Critical Care Decontamination System™

## Enrollment, Process, Information

Thank you for your interest in the [Battelle CCDS Critical Care Decontamination System](#).<sup>TM1</sup>

The Battelle CCDS<sup>TM</sup> is grounded on a study Battelle completed for the FDA in 2016 in the event of a pandemic.

Battelle received an [FDA Emergency Use Authorization](#) (EUA) for the Battelle CCDS<sup>TM</sup> and we are now standing up decontamination sites across the United States.

This guide is designed to help you understand the process from CCDS enrollment to receiving your decontaminated N95.

Questions? Please visit our website: [www.battelle.org/N95](http://www.battelle.org/N95) or reach out to your Battelle point-of-contact (POC).

# About Battelle CCDS™

# Battelle CCDS™ - The Mission to Help

- **2016 FDA study:** Proves Vapor Phase Hydrogen Peroxide (VPHP) process to decontaminate N95 respirators is effective in the event of a pandemic
  - [FDA Report on Decontamination and Reuse of N95 Respirators](#)
- **January 2020:** Battelle scientists begin research on the novel coronavirus (SARS-CoV-2)
- **March 6-22:** Battelle builds the first CCDS system, tests validity, proves capacity effectiveness on thousands of N95 per cycle
  - [Critical Care Decontamination System Tech Summary](#)



Testing Run Cycles

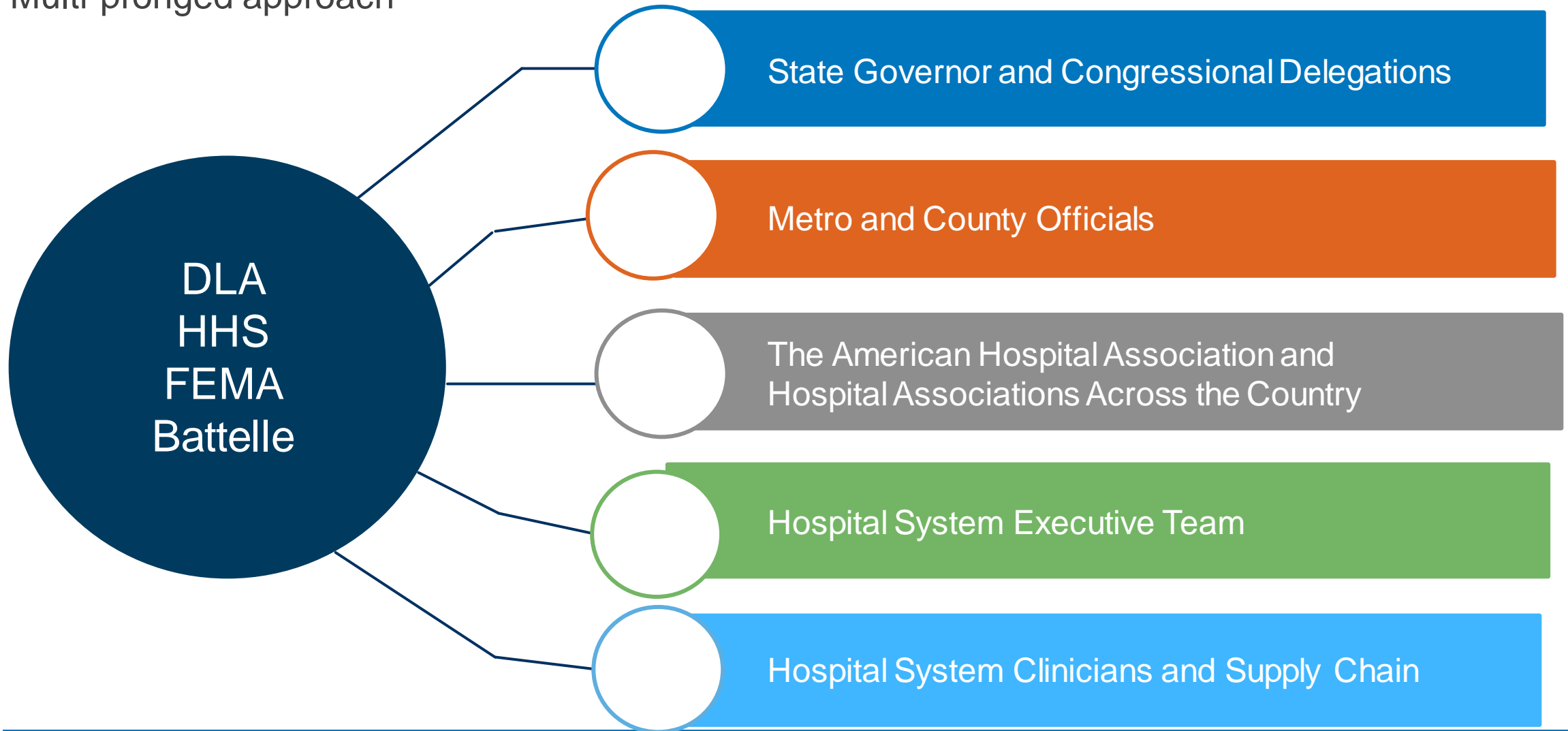
# Zero Cost and Scaling Up Across the U.S.

- **March 29:** Awarded [FDA EUA](#) to decontaminate N95 respirators up to 20 times for each mask and deployment across the U.S.
- **April 9:** Federal Government contract awarded
  - Zero cost to healthcare providers
  - Rapid scale and deployment of 60 CCDS systems to regions across the U.S.



# CCDS: Communication

Multi-pronged approach



# Enrollment and CCDS Process

# Battelle CCDS™ Process

## HEALTH CARE PROVIDER SIGN-UP PROCESS

Battelle CCDS Critical Care Decontamination System™



# CCDS: Fast Facts

- The Battelle Critical Care Decontamination System™ is a self-contained, mobile decontamination system that uses vapor phase hydrogen peroxide (VPHP) to decontaminate N95 respirator masks
- The Battelle CCDS™ decontamination cycle successfully generates a micro-condensation through the dwell phase and provide > 6-log reduction as indicated by collocated chemical indicator.
- Battelle CCDS™ renders SARS-CoV-2 non-infectious on N95 respirators and enables up to 20 reuses without degrading filter performance to help address the current U.S. PPE shortage
- Battelle CCDS™ is effective against both viral and bacterial agents. Battelle tested VPHP decontamination efficacy against SARS-CoV-2 in our Bio Safety Level 3 (BSL 3) laboratories.
- Battelle is the largest, private, non-profit research and development organization in the world.

# CCDS: PPE Collection

Detailed information on the N95 collection process and how to prep your N95s are included in instructions when you enroll.

- Your organization should create a collection station at the point of generation (i.e. hospital floor/unit)
- Each station should have a large plastic bag placed in a rigid container provided by the healthcare facility to collect compatible N95 respirators
- Bags are for compatible N95 respirators only. Do not throw other personal protective equipment (such as gloves), paper towels, or waste in the collection bag

**Important bagging tip:** Bag N95s in large plastic bags. Double bag. Wipe the outside with disinfectant. Place in a shipping box labeled with a bio-hazard label.

Visit our FAQ page for more information: [www.battelle.org/N95](http://www.battelle.org/N95) or contact your Battelle point-of-contact (POC) directly.

# CCDS: PPE Labeling

## 3-Digit Site Code

- Your 3-digit site code is hospital site specific and assigned by your Battelle POC
- Each N95 respirator and the outside of each shipping box must be labeled with the 3-digit site code
- Healthcare Systems adds 2-digits with additional identifying information (i.e. floor, department)
- Each healthcare system receives their own decontaminated N95 back.

**Important tip:** All N95s must be labeled correctly and be free of **blood, mucus, makeup** etc.



# CCDS: FAQs

**Q: Does each system get its own N-95 respirators back?**

**A:** Yes. Each N95 respirator and external shipping box is labeled with a 3-digit site specific hospital code that is assigned by Battelle

**Q: Will labeling respirators with permanent marker damage their performance?**

**A:** No. Battelle has tested N95 respirators from multiple manufacturers by labeling with permanent marker as described in the FDA EUA, then decontaminating via multiple cycles of CCDS. No performance issues have been observed.

**Q: Will labeling respirators with permanent marker impact decontamination effectiveness?**

**A:** No. Battelle tested CCDS decontamination performance with N95 respirators labeled with permanent marker, which has a known chemistry. No issues were observed.



Questions?  
Visit our FAQ page for more information:  
[www.battelle.org/N95](http://www.battelle.org/N95)



# ***BATTELLE***

**It can be done**

[www.battelle.org/N95](http://www.battelle.org/N95) | [www.battelle.org/decon](http://www.battelle.org/decon)

## **PERSONAL PROTECTIVE EQUIPMENT (PPE) DECONTAMINATION SERVICES AGREEMENT**

WHEREAS, on March 12, 2020, the World Health Organization declared COVID-19 a pandemic. On March 13, 2020, the President of the United States declared a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak;

WHEREAS, the Food and Drug Administration on March 29<sup>th</sup>, 2020 issued an Emergency Use Agreement ("EUA") authorizing Battelle Memorial Institute to operate the Battelle Critical Care Decontamination System (CCDS)<sup>™</sup> for use in decontaminating compatible N95 or N95-equivalent respirators ("compatible N95 respirators") for reuse by healthcare personnel (HCP)<sup>1</sup> to prevent exposure to pathogenic biological airborne particulates when there are insufficient supplies of Filtering Facepiece Respirators (FFR) during the COVID-19 pandemic;

WHEREAS, on April 10<sup>th</sup>, 2020 the Defense Logistics Agency, under authority of 10 U.S.C. 2304(c)(2), FAR Part 6.302-2, issued a contract to Battelle Memorial Institute to operate the CCDS<sup>™</sup>, in accordance with conditions of the EUA, to decontaminate compatible N95 respirators at site locations throughout the United States as directed by the U.S. Government (the "DLA Contract"). Under this program, qualifying customers can submit qualifying PPE to be decontaminated at a Battelle approved facility without cost to the customer;

WHEREAS, Client and Battelle acknowledge and understand that the provision of these services is intended to be within the scope of the Public Readiness and Emergency Preparedness Act ("PREP Act") and the PREP Act COVID-19 declaration by the U.S. Department of Health and Human Services, effective as of February 4, 2020;

WHEREAS, the EUA directs and requires Battelle to enter into agreements with customers requesting decontamination of compatible N95 respirators prior to providing such services to the facility; and

THEREFORE, now comes Battelle and [REDACTED] (and at Client's option, its affiliates and/or subsidiaries) ("Client"), referred to herein individually as a "Party" and collectively as the "Parties", to set forth the terms and conditions under which a customer can elect to participate in this program.

### **1. DURATION OF AGREEMENT**

This Agreement shall begin upon execution and last indefinitely until any one of the following occurrences:

- a) The Client notifies Battelle in writing that it no longer wishes to participate in the program;
- b) The DLA Contract under which this program operates expires or is terminated by the US Government;
- c) The US Government directs Battelle to no longer operate at the site location used by Client and an alternate location is not available;
- d) The EUA is revoked by the FDA pursuant to Section 564(b)(2) of the Federal Food, Drug, and Cosmetic Act;
- e) The participating healthcare facility violates the terms and conditions of this agreement, or any applicable US law or regulation governing this program, or whose status changes so that it no longer qualifies as an eligible healthcare facility; or
- f) Funding of the program is exhausted and is not available to continue processing N95 respirators.

---

<sup>1</sup> Healthcare personnel ("HCP") refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. These HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, dentists and dental hygienists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

- g) Battelle may terminate this agreement at its convenience for any reason.
- h) Battelle is unable to continue to process PPE for decontamination due to a force majeure event as described in Section 10 below.

Battelle will notify Client upon occurrence of any of the preceding events as soon as practical. In no event will Battelle be responsible to process PPE submitted by Client after occurrence of any of the preceding events regardless of Client's expectations or reliance on the program. Battelle will not be liable for any costs of substitute decontamination services sought by Client subsequent to the end of this program.

## **2. SERVICES PROVIDED**

Battelle will provide decontamination services to Client for hospital Personal Protective Equipment (PPE), limited to the PPE approved by the FDA as set forth in EUA for decontamination processing. Battelle will receive and store contaminated PPE prior to decontamination. Battelle will decontaminate and repackage PPE. Battelle will deliver a chain of custody form (or equivalent) indicating conditions of the decontamination implementation process in addition to chemical indicators which will be used to qualify each decontamination cycle will be provided for each decontamination cycle performed for all PPE upon retrieval. Battelle will comply with the terms and conditions of the EUA. If Client wishes to have Battelle assist in the transportation of PPE to and from Client, Client can request such assistance. In response, and at Battelle's sole discretion, Battelle may provide a subcontractor to coordinate transportation of PPE to and from the Battelle approved decontamination facility to Client location. These services will be provided to the Client at no cost.

## **3. CLIENT'S RESPONSIBILITIES**

- a. Client will be responsible for preparing PPE for transportation in the manner described in the instructions provided to Client
- b. Client shall make available to HCP who are or may be using the decontaminated respirators the authorized Fact Sheet for Healthcare Personnel that is required to be provided by Battelle.
- c. Client shall monitor HCP who use such respirators for the signs and symptoms of potential infection with SARS-CoV-2 or other respiratory infection and promptly report such information to Battelle, so that Battelle can provide a weekly report to FDA. Reports of adverse health indications should be reported up to and including 14 days after the last contact with suspected SARS-CoV-2 virus.
- d. Client shall inspect the decontaminated respirators upon receipt from Battelle. Any discoloration or other signs of degradation with a decontaminated respirator should promptly be reported to Battelle, and the healthcare facility should dispose of such respirator.
- e. The maximum number of times a N95 respirator can undergo the decontamination cycle is twenty (20) and the Client shall not submit N95 respirators that have reached this limit for decontamination.
- f. Client shall provide Battelle with a complete list of all subsidiaries and/or affiliates who utilize Services provided for in this Agreement. Client is responsible for obtaining a three-digit site code for each Client location that will be utilizing the Services provided for in this Agreement.
- g. Client shall make the literature listed in Section 4 below available to all subsidiaries and/or affiliates who utilize the Services provided for in this Agreement.

- h. Client shall certify that the personnel benefiting from the use of the Services herein are Healthcare Personnel as provided for in the EUA.

#### **4. RECEIPT OF LITERATURE**

Client acknowledges that it has received the following literature from Battelle related to this program.

- Instructions for Healthcare Personnel: Preparation of Compatible N95 Respirators for Decontamination by the Battelle Memorial Institute Using the Battelle Decontamination System ("Instructions for Healthcare Personnel");
- Instructions for Healthcare Facilities: Preparation and Collection of Compatible N95 Respirators for Decontamination by the Battelle Memorial Institute Using the Battelle Decontamination System ("Instructions for Healthcare Facilities"); and
- Labeling and instructions for use developed by Battelle that include the Fact Sheet, Instructions for Healthcare Personnel, and Instructions for Healthcare Facilities.

#### **5. WARRANTY AND LIMITATION OF LIABILITY**

**ALL SERVICES ARE PROVIDED TO CLIENT AS-IS. BATTELLE MAKES NO OTHER WARRANTY OR GUARANTEE, EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, WARRANTIES OF FITNESS FOR A PARTICULAR PURPOSE, MERCHANTABILITY, OR FOR ANY PARTICULAR RESULT.**

Notwithstanding any other provision of this Agreement to the contrary, in no event shall either Party be liable to the other for any indirect, incidental, special, punitive, or consequential damages, arising from or in connection with this Agreement and regardless of the cause of action or theory of law asserted.

In no event shall Battelle's maximum cumulative liability, regardless of the cause of action or theories of law asserted, exceed the total amount paid by Client to Battelle under this Agreement.

6. If Client is prohibited by law from indemnifying Battelle against third-party claims, then Section 6.A. will apply. If Section 6.A. does not apply, then Section 6.B. shall apply.

##### **A. LIABILITIES**

Each Party agrees to be responsible for any liability, claim, loss, damage or expenses, including without limitation, reasonable attorney fees, arising from its negligent acts or omissions in connection with its performance of this Agreement, or its failure to comply with the terms of this Agreement, as determined by a court of competent jurisdiction.

##### **B. INDEMNIFICATION**

Client agrees to indemnify, defend, and hold Battelle, its affiliates, and their respective directors, officers, employees, consultants, and agents harmless from any and all liabilities, demands, damages, costs and expenses (including reasonable attorneys' fees and court costs) arising from any third-party suits or claims to the extent based upon or resulting from Client's use of Battelle's services provided pursuant to this Agreement. Notwithstanding the foregoing, Battelle shall not be entitled to indemnification protection for claims related to its willful misconduct or gross negligence.

## **7. COMPLIANCE WITH LAWS**

The Parties agree to comply with all laws and regulations applicable to the performance of their respective obligations under this Agreement, including those related to export control, and neither Party shall export nor re-export any tangible goods, service or information related to this Agreement without first obtaining any required export licenses or other governmental approvals, if required by law. Each Party is responsible for its own compliance with this provision.

## **8. NON-ENDORSEMENT AND USE OF NAME**

Client agrees that it will not use or imply Battelle's name or marks, or use Battelle's reports, for advertising, promotional purposes, raising of capital, recommending investments, or in any way that implies endorsement by Battelle without Battelle's prior written approval.

## 9. FORCE MAJEURE

Neither Client nor Battelle shall be liable for any expenses, losses or damages (except payment of monetary obligations) resulting from delay or failure to perform caused by acts beyond the control of the Party delayed or unable to perform including, without limitation, acts or failure to act of government, war, acts of terror, civil unrest, extreme weather conditions, and pandemics (a "Force Majeure Event"). In the event of any delay or failure to perform occasioned by the foregoing, the time for performance will be extended by a period of time equal to the time lost by reason of such delay or failure to perform and any other affected provision(s) of the Agreement including, without limitation, price, shall be equitably adjusted provided that the Party delayed or unable to perform provided the other Party with written notice of the occurrence and impact of the Force Majeure Event.

## 10. MISCELLANEOUS

Each Party is, at all times, acting as an independent contractor under this Agreement and not as an agent, employee, joint venturer or partner of the other.

This Agreement may not be assigned in whole or in part without the prior written consent of both Parties, which shall not be unreasonably withheld or delayed. This Agreement shall be binding upon, inure to the benefit of, and be enforceable by and against the successors and permitted assigns of each Party.

Battelle makes no commitments with regards the time necessary to complete the decontamination process once PPE is received from the Client. Processing time will be dependent on the amount of PPE received from numerous health care providers.

The failure by one Party to require performance of any provision or to exercise any right, remedy or option available under this Agreement shall not affect that Party's right to require performance or to exercise such right, remedy or option at any time thereafter, nor shall a waiver of any breach or default of this Agreement constitute a waiver of any subsequent breach or default or a waiver of the provision itself.

If any part of this Agreement shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other part of this Agreement.

This Agreement may be modified or amended only by mutual agreement in writing. Battelle may require additional conditions of participation at any time in order for client to continue participation. No course of dealing, usage of trade, waiver, or non-enforcement shall be construed to modify or otherwise alter the terms and conditions of this Agreement.

This Agreement represents the entire agreement of the Parties and supersedes any prior discussions or understandings, whether written or oral, relating to the subject matter hereof and neither Party makes any representations other than as expressly set forth in this Agreement. In the event of any conflict or inconsistency between these terms and conditions and those of any Task Order, these terms and conditions shall control.

This Agreement shall be construed in accordance with the laws and enforced within the jurisdiction of the State of Ohio, without regard to its conflicts of law principles.

Clauses 5, 6, 7, 8, 9, and 10 shall survive termination or expiration of this Agreement.

**IN WITNESS WHEREOF**, the terms and conditions of this agreement are accepted by Client.

*[signature page to follow]*

**CLIENT**

BY: \_\_\_\_\_

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_

**Battelle Memorial Institute**

BY: \_\_\_\_\_

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_



## Instructions for Healthcare Facilities: Preparation and Collection of Compatible N95 Respirators for Decontamination by the Battelle Memorial Institute Using the Battelle Decontamination System

The U.S. Food and Drug Administration has authorized an Emergency Use Authorization (EUA) for the emergency use of the Battelle CCDS Critical Care Decontamination System™ (hereafter referred to as the “Battelle Decontamination System”) operated by the Battelle Memorial Institute (“Battelle”), for use in decontaminating compatible N95 or N95-equivalent respirators (“compatible N95 respirators”), for reuse by healthcare personnel. Healthcare personnel should follow these instructions, as well as procedures at their healthcare facility, to prepare compatible N95 respirators for decontamination by Battelle using the Battelle Decontamination System.

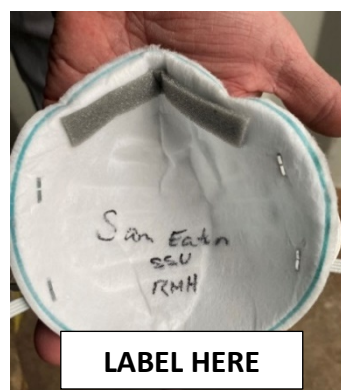
- **Due to incompatibility, the Battelle Decontamination System is not authorized for use with respirators containing cellulose-based materials**
- **All compatible N95 respirators provided to Battelle must be free of any visual soiling or contamination (e.g., blood, bodily fluids, makeup)**
- **If N95 respirators are soiled or damaged, they will be disposed of and not returned after decontamination**

### On-Site Collection/Marking

1. Your organization should create a collection station at the point of generation (i.e. hospital floor/unit)
2. Each station should have a bag provided by the healthcare facility to collect compatible N95 respirators.  
**NOTE: Bags are for compatible N95 respirators only. Do not throw other personal protective equipment (such as gloves), paper towels, or waste in the collection bag.**
3. With a permanent marker, the healthcare personnel should label their own individual compatible N95 respirators with a three-digit site code and a 2-digit location identifier (as shown below). The unique site code corresponds to the healthcare facility delivery address and will be assigned by Battelle. Your organization may designate the location identifier to correspond to a specific location/floor/unit within your site.
4. Healthcare personnel should follow the instructions provided by Battelle in Instructions for Healthcare Personnel: Preparation of Compatible N95 Respirators for Decontamination by the Battelle Memorial Institute Using the Battelle Decontamination.

—                      —                      —                      —                      —

Site Code	Site Location ID
(Assigned by Battelle Point Of Contact)	(Assigned by Healthcare Facility)



### **Preparation for Shipment:**

1. Bags containing the contaminated compatible N95 respirators to be decontaminated by Battelle ("primary collection bag") should be closed.
2. Place the primary collection bag into another bag ("secondary collection bag") (provided by the healthcare facility), which is then closed.
3. Decontaminate the secondary collection bag with alcohol or other suitable decontaminant.
4. Place the decontaminated bags into a rigid, closed box (supplied by the healthcare facility) clearly labeled with a biohazard symbol, and tape the box securely shut.
5. Label the outside of the box with the 3-digit site code and 2-digit location identifier.

### **Shipment under the healthcare facility's agreement with Battelle:**

1. Gather all boxes; complete one chain of custody form (provided by Battelle) per shipment, noting the number of boxes.
2. Coordinate with your organization's courier service to arrange transfer to designated Battelle location.

### **Reuse Information:**

Following decontamination, you will be provided **decontaminated compatible N95 respirators** that have been processed through a decontamination system for reuse by healthcare personnel in a healthcare setting during the COVID-19 pandemic. Before reuse, the healthcare facility should review the chain of custody form, which indicates successful decontamination, accompanying the returned respirators. The healthcare facility should also inspect each returned, decontaminated compatible N95 respirator for:

1. Numeric indication of the decontamination cycle number. **NOTE: Compatible N95 respirators will be disposed of after 20 decontamination cycles.**
2. Visible damage or soiling. **NOTE: Compatible N95 Respirators should be discarded and not reused if visually damaged or soiled.**

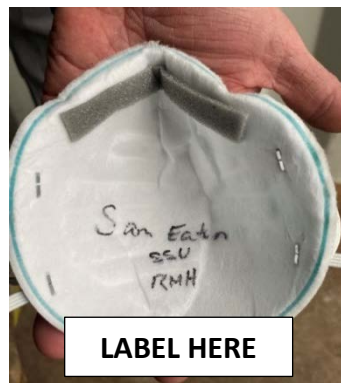
**Any problems should be immediately reported to Battelle.**

**Battelle Contact: 1-800-201-2011 or [solutions@battelle.org](mailto:solutions@battelle.org)**



**Compatible N95 respirators that are visually soiled or damaged should not be collected for decontamination and will be disposed of and not returned after decontamination.**







Monday, June 01, 2020

To: Indiana 911 Centers  
Indiana EMS Officials

From: Kraig Kinney, J.D., State EMS Director and Counsel of EMS  
[kkinney@dhs.in.gov](mailto:kkinney@dhs.in.gov)

Re: Health Departments Sharing PHI with 911 Call Centers -- REVISED

**Issue:**

Is a local health department or facility permitted to share any protected health information (PHI) for a COVID-19 positive patient with a 911 Call Center for 911 response notification?

**Discussion:**

In conjunction with ISDH, we released guidance on April 16, 2020, that a local health department would be permitted to released certain information such as addresses of COVID-19 positive patients to a 911 call center in order to alert potential emergency responders should a call come into the 911 center.

The Office of Civil Rights (OCR), which is tasked with HIPAA compliance directly addresses the confidentiality issue in its Guidance issued March 24, 2020. The guidance indicates that “disclosure to first responders to prevent a serious and imminent threat to the health and safety of a person or the public” is permitted under HIPAA. The OCR guidance included the following example:

*Example: A covered entity, such as a hospital, may provide a list of the names and addresses of all individuals it knows to have tested positive, or received treatment, for COVID-19 to an EMS dispatch for use on a per-call basis. The EMS dispatch (even if it is a covered entity) would be allowed to use information on the list to inform EMS personnel who are responding to any particular emergency call so that they can take extra precautions or use personal protective equipment (PPE).*

*Discussion: Under this example, a covered entity should not post the contents of such a list publicly, such as on a website or through distribution to the media. A covered entity under this example also should not distribute compiled lists of individuals to EMS personnel, and instead should disclose only an individual’s information on a per-call basis. Sharing the lists or disclosing the contents publicly would*

*not ordinarily constitute the minimum necessary to accomplish the purpose of the disclosure (i.e., protecting the health and safety of the first responders from infectious disease for each particular call).*

### **Summary**

Upon further review and additional discussion with ISDH legal and in accordance with IC 16-41-8-1, the release of communicable disease information collected for public health surveillance purposes is limited. This statute is stricter than HIPAA requirements for permitted releases of information and does not authorize the release of information in the 911 dispatch system to use in case of an emergency call to the residence of someone who has been reported as COVID positive. In general, IC 16-41-8-1 does not allow the release of information without the consent of the individual except for: non-identifiable statistical information; information to the extent necessary to enforce public health laws; or to protect the life or health of a named individual. The only arguable permitted release is to protect a named individual, a possible first responder. However, protection of a hypothetical responder does not meet the standard of a named individual requirement because, for most of the COVID positive individuals, they will not encounter first responders and the release will not protect anyone.

**In order to avoid potential conflict with the statute, a local health department or even HIPAA covered entities are not permitted share COVID-19 positive patient health information with 911 call centers.**

This also aligns with the ISDH position that all patient encounters should be treated as possible COVID-19 positive cases. The 911 system may have outdated information (either in terms of not the current list of known COVID patients or in terms of people moving to different residences).



Friday, September 11, 2020

To: EMS Providers  
From: Kraig Kinney, Director & Counsel of EMS  
Dr. Michael Kaufmann, State EMS Medical Director  
Re: COVID Testing requirements to enter ECFs

We have had many EMS provider organizations contacting us about a new CMS requirement that extended care facilities (ECFs) are asking EMS organizations to update them with weekly COVID negative tests for all crews in order to enter the ECF.

IDHS has been working with the Indiana State Department of Health (ISDH) regarding the issue. ISDH staff have also been in communication with CMS.

Under CMS memo QSO-20-38, only “facility staff” must be tested routinely (i.e., on the schedule based on county positivity). “Facility staff” is defined as “employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents **on behalf of the facility**, and students in the facility’s nurse aide training programs or from affiliated academic institutions.” (emphasis added)

The key phrase of the definition is “on behalf of the facility.” This is believed to be when the ECF has its own transport service for its patients and its operators paid directly by the facility would then be required to have the weekly COVID testing (depending upon the county positivity rate).

For 911 response, the EMS crews are not providing transport services “on behalf of the facility” but are rather providing emergency medical services for the patient directly. An emergency medical response crew should always have access without the need for the routine testing.

For prescheduled transport, EMS crews do not provide services “on behalf of the facility,” the services are provided for the patient benefit. There could be some contractual relationships between the EMS organization and the ECF but again this is for the benefit of the patient and not for the facility itself. The EMS staff do not report to nor are paid nor even contracted directly by the facility and are therefore EMS organization staff throughout and not facility staff.

For this reason, EMS crews do not fall within the memo’s definition of “facility staff,” which in turn means they are not subject to the testing regimen set forth in QSO-20-38.

In summary, both IDHS and ISDH advocate that a facility cannot bar an EMS worker from providing services to/for a resident because the worker has not been tested according to the facility’s schedule under QSO-20-38. The EMS crews do not have to be tested first. If a facility does wrongly exclude an EMS crew on this basis – and particularly if it leads to a resident-adverse situation – please notify IDHS so we can follow-up with ISDH to work with the ECF on future issues.



December 30, 2020

## OVERVIEW OF EMTS ADMINISTERING VACCINATIONS

### EXECUTIVE ORDER 20-51, ISSUED DECEMBER 22, 2020

[https://www.in.gov/gov/files/Executive\\_Order\\_20-51\\_New\\_Directives-Renewal\\_of\\_Other\\_Directives.pdf](https://www.in.gov/gov/files/Executive_Order_20-51_New_Directives-Renewal_of_Other_Directives.pdf)

The Executive Order suspends the “Basic Life Support” definition in IC 16-18-2-33.5(b) which prohibits the performance of invasive medical care techniques other than epinephrine injections for the “limited purpose of allowing EMTs, if authorized by the Indiana EMS Commission under its authority in Ind. Code§ 16-18-2-33.S(a)(I I), to administer the COVID-19 vaccination when their Emergency Medical Services (EMS) provider agency is operating and offering a COVID-19 vaccination administration site at a location specified by the local public health agency or by the Indiana State Department of Health.”

EMS Commission action at special session on Wednesday, December 30, 2020, unanimously approved the following motion:

**The Indiana EMS Commission authorizes emergency medical technicians (EMTs) to administer COVID-19 vaccines for the duration of the declared public health emergency, subject to the terms of Executive Order 20-51.**