TOLEDO FIRE AND RESCUE DEPARTMENT PANDEMIC PLAN

CONTENTS

Introduction

Influenza pandemics are extreme infectious disease outbreaks. Although many infectious disease outbreaks (e.g. Severe Acute Respiratory Syndrome [SARS], Ebola, HIV, West Nile Virus, H1N1) can cause devastation, these infections are typically limited in their spread to either localized areas or regions, or to at-risk populations. Pandemic influenza, like COVID-19, is an explosive global event in which most, if not all, populations worldwide are at risk for infection and illness. In past pandemics, influenza viruses have spread worldwide within months and are expected to spread even more quickly today given modern travel patterns.

It is the sheer scope of influenza pandemics, with their potential to rapidly spread and overwhelm societies and cause illnesses and deaths among all age groups, which distinguishes pandemic influenza from other emerging infectious disease threats and makes pandemic influenza one of the most feared emerging infectious disease threats.

COVID-19 Current Situation

Coronavirus disease 2019 (COVID-19) is a virus strain, identified as the cause of an outbreak of respiratory illness first detected in Wuhan, Hubei Province, China. Coronaviruses are a large family of viruses, some causing illness in people and others circulating among animals, including camels, cats, and bats. Rarely, animal coronaviruses can evolve and infect people and then spread, such as was seen with Middle East respiratory syndrome (MERS) in 2014 and severe acute respiratory syndrome (SARS) in 2003 and is now being seen with COVID-19.

COVID-19 has only been identified in humans since December 2019. Health experts are still learning the characteristics of this virus. They are concerned because the disease has the potential to cause severe respiratory illness in some people and, because it is new and not predictable like the flu. There currently is no vaccine to prevent COVID-19 and no specific antiviral treatment.

COVID-19 likely came from an animal because the first cases were linked to a large seafood and animal market, suggesting a possible zoonotic origin to the outbreak. However, more information is needed to figure out the possible role that animals play in transmission of COVID-19.

COVID-19 is primarily spread through respiratory droplets, which means to become infected; people generally must be within 6 feet of someone who is contagious and come into contact with these droplets. Symptoms of COVID-19 generally appear within two to 14 days after exposure and include fever, cough, and difficulty breathing. Reported cases have ranged from mild illness (similar to a common cold) to severe pneumonia that requires hospitalization.

Currently, there are no vaccines available to prevent COVID-19 infection. The Centers for Disease Control and Prevention (CDC) recommends typical infectious disease precautions, just as those used to prevent cold or flu:

- Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer if soap and water are not available.

- Avoid touching your mouth, nose, or eyes.
- Cover coughs/sneezes with your arm or a tissue.
- Avoid exposure to others who are sick.
- Stay home if you are ill (except to visit a health care professional) and avoid close contact with others.
- Get adequate sleep and eat well-balanced meals to ensure a healthy immune system.
- Clean and disinfect frequently touched objects and surfaces.

The CDC does not recommend the routine use of facemasks by the general public to prevent respiratory illness and is not recommending their use at this time for the prevention of COVID-19.

I. ASSUMPTIONS

A pandemic is unlike any crises we have encountered. No one can predict when it might arrive, where it might strike, how long it will last, and how serious its impacts might be. Prudence requires we assume for a worst-case scenario. Accordingly, the Toledo Fire and Rescue's Pandemic Plan is based on the following assumptions.

- Communicable biological agents such as a pandemic influenza may cause a significant (up to 30%) reduction in all mortuary and first responder staffs due to illness, death, or the need to care for ill family members.
- A pandemic incident will require integration with local, regional, state and federal level responses and will be conducted in accordance with the Incident Command System and the National Incident Management System.
- The department may not be able to perform all services at full capacity throughout the pandemic.
- Confusion within the community and demand for information could overwhelm our existing communications systems.
- Some vendors may be unable to provide services or deliver supplies.
- Pandemic-related financial stress, possibility of civil unrest, and enhanced opportunities may increase the risk of security threats.
- Alternate unit staffing models may need to be adopted.
- Patients infected by COVID-19 may need to be cared for at home versus being transported to a hospital for care.

II. PLANNING PROCESS/ INTRODUCTION TO THE RESPONSE PLAN

A. Plan Goal:

The goal of the plan is to protect employees, the community, departmental facilities, property and operations during any pandemic and maintain normal operations, to the extent possible consistent with those goals. In the event that normal operations cannot be maintained, the goals will be to maximize the continuity of the department's essential services to the community. Finally, the plan will provide for a return to full operations and services as quickly as possible.

B. Plan Scope:

This plan is intended to anticipate the potential issues that will impact the department, its employees, the community, and the operations that may be affected by an influenza pandemic. The nature of a pandemic flu is that it will primarily impact the employees, the community and their security. Unlike most other potential disasters, such as floods or severe storms, the primary threat is not physical destruction of records, facilities or response units. This plan, therefore, will focus only on the threats reasonably related to pandemic flu. The department's procedures manual, the City of Toledo's Emergency Operations Plan and Lucas County Emergency Operations Plan should address other threats and response measures. The Toledo Fire and Rescue Bureau of Special Operations will work with departmental administration, the TFRD EMS Bureau and community partners in developing and implementing all appropriate procedures.

C. Plan Missions:

- Identify the hazards that will be produced by a pandemic
- Provide for the protection of personnel and advise on how they can mitigate the impact of a pandemic on themselves and their families.
- Plan for and reduce the impact of the outbreak
- Maintain essential operations during an outbreak

D. Triggers:

The following events should be considered trigger events for implementation of all or portions of this plan. Specific triggers for each escalating response stage, called the Transitional Medicine Framework (Traditional, Transitional Medical Phases 1-4, Catastrophic, and Recovery) for Fire/EMS identified in the Lucas County Medical Surge Plan can be viewed in section VI, Emergency Response Operations.

- Determination by the Centers for Disease Control and/or Ohio Department of Health that a flu outbreak is imminent or begun.
- Recommendation by The Lucas County Board of health and Lucas County Commissioner to implement a response protocol.
- Irrefutable evidence that an outbreak has occurred within our community and is not a generic seasonal flu outbreak.
- Excessive employee absenteeism, pandemic-induced or not, that results in the agency being in jeopardy of experiencing a pandemic related business crisis.

Note: during the traditional medical phase (normal day–to-day operations) principal activities are planning and education to include identification of resources, acquisition of resources, education of professionals, and development/refinement of response strategies.

E. Plan Activation:

The TFRD recognized the importance of coordinating and integrating with diverse local, regional, state and federal agencies and has committed staff from the Special Operations Bureau to develop, maintain and nurture these relationships. Thus, The Special Operations Bureau is directly linked with local and state health officials, local and state emergency management agency officials, and local and regional hospital networks. As in the current COVID-19 situation, or any future events, the Special Operations Bureau will work within these networks to closely monitor information related to infectious outbreaks. As evidence surfaces that an infectious contagion may affect departmental personnel and/or operations, bureau personnel will communicate daily within these networks, obtain the most accurate information and communicate back to the EMS Bureau, Toledo Fire Administration, Operations Deputy and surrounding fire agencies within Lucas County. If the threat escalates or becomes imminent, EMS staff may want to accompany Special Operations staff to briefings/deliberations led by the Toledo-Lucas County Health Commissioner. Results of these deliberations and briefings will be communicated back to the Toledo Fire Administration, Operations Deputy and surrounding fire agencies within Lucas County. The current situation and or projected impact of the event may drive activation of this plan. Activation of this plan, or portions of this plan will be the decision of the Fire Chief, advised by the Deputy Chief of Special Operations, Deputy Chief of EMS, Toledo Fire and Lucas County EMS Medical Directors, Special Operations staff and in conjunction with the Lucas County Medical Surge Plan. The above individuals will communicate daily or as needed for continued assessment of the crisis and determination of the appropriate response.

Note: The plan is scalable. An infectious disease event is dynamic and unpredictable. Although the actions outlined in this plan are based upon specific impact levels, the plan is meant to be flexible. Some actions may need to be taken earlier than planned, and some actions may not be taken at all. In addition, other actions not specifically outlined in this plan may need to be taken as the need arises. This plan is not intended to exclude other actions that may be necessary to maintain the Department's services to the City of Toledo.

In the future the Department may choose to designate a pandemic flu coordinator to lead the planning and response efforts to an outbreak.

F. Components of the Plan

- Continuity of Essential Functions
- Employee Health and Safety
- Crisis communications
- Emergency Response Operations

III. CONTINUITY OF ESSENTIAL FUNCTIONS

In the event that the Toledo Fire and Rescue Department is unable to operate at full capacity throughout a pandemic due to staff illness, state or local directives, public health related policies, or other pandemic-related problems, the department recognizes the following core functions to be sustained to maximize the agency's ability to provide emergency services to the community, recover from the event, and resume normal operations afterward:

- Operations
- EMS
- Communications/Dispatch
- Building and Vehicle Maintenance
- Finance/ Administration
- Special Operations (if in a supporting role)

Members from the TFRD Training and Fire Prevention Bureaus may need to return to frontline operations. Additionally, members from the above mentioned bureaus may need to return to support frontline operations while these critical bureaus maintain only core staff.

Most core-identified bureaus above may currently operate with replacement personnel without cross training. However, two critical areas where personnel should be cross-trained in the event primary personnel become sick are Finance and Dispatch. The Deputy Chief of each of these units is responsible for ensuring depth for these and other bureau positions.

A. Preparations

Prior to an event, the Department will:

- Identify and prioritize critical functions in each bureau
- Cross train employees so the Department has sufficient employee depth to accomplish critical functions
- Develop alternative work procedures, such as telecommuting, staggered shifts, restricted access to any fire department property, working from home, paperless processes which will reduce the potential exposure, limit travel and/or move to 12-hour shifts/disaster staffing
- Determine critical resources for all bureaus
- Determine which critical resources should be stockpiled
- Establish alternate supply chains for critical resources
- Prioritize the purchase, storage, and maintenance of stockpiled resources.
- Identify successors to bureau leadership.
- Determine triggers for discontinuing continuing education requirements.
- Establishing a security plan if needed.
- Determine triggers for establishing a departmental operations center
- Disseminate departmental plan for employee review.

An available resource to estimate expected staff level reductions is FluWorkLoss and can be found at https://www.cdc.gov/flu/pandemic-resources/tools/fluworkloss.htm

The CDC also has two other resources available to predict increased demands on the health care sector in an influenza pandemic:

FluSurge: https://www.cdc.gov/flu/ pandemic-resources/tools/flusurge.htm
FluAid: https://www.cdc.gov/flu/ pandemic-resources/tools/fluaid.htm

B. Operational Adjustments

During an event, the Department may:

- Re-assign employees to maintain critical functions
- Implement alternative work procedures
- Adjust emergency operations to best serve the community.

Each bureau head is responsible for business continuity planning in their area see Attachment A. (TFRD Continuity of Operations Plan). Bureau contingency plans integrate into this plan and future departmental continuity of operations planning. This is not a one-time task but rather an ongoing job responsibility for bureau leadership. All job functions are to be continually evaluated for their sustainability during a crisis event.

Business continuity planning includes recovery planning. Recovery efforts will depend upon the nature of the impact. Aspects of the business continuity plan can be applied to recovery efforts as well.

IV. EMPLOYEE HEALTH AND SAFETY

The Toledo Fire Department is committed to ensuring the health and safety of our employees. This is an ongoing process of identifying hazards, providing training, modifying policies and work practices, and providing necessary resources to support safety efforts. This process will continue throughout an infectious disease event.

The primary hazard of an infectious disease event is employee exposure to the infectious agent. By minimizing exposure, we will minimize infection. The Department will minimize exposure through:

- Training/work practices and procedures
- Disease monitoring
- Protective equipment.
- Ensuring employee mental health
- Pharmaceuticals

A. Training/ Work Practices and Procedures:

Infectious disease training of Lucas County EMT-Paramedics and Toledo Fire EMT-Basics is delivered by Lucas County EMS and the Toledo Fire Training Bureau, as recommended by ALS and BLS medical direction. Training contains information on "blood borne pathogens and other potentially infectious materials" and the Toledo Fire Department's and Lucas County EMS' "infection control (exposure) protocol."

Every EMS training session includes infectious disease updates as applicable and reinforces the proper use of Personal Protective Equipment (PPE) as appropriate. This training includes information on a variety of pathogens and is applicable to a widespread infectious disease event.

Outbreak-specific training and information will be provided when an infectious outbreak is identified. The TFRD Special Operations Bureau in conjunction with the EMS and Training Bureaus will coordinate the training. The training will include the characteristics of the infectious agent, prevention, treatment and any new medical orders issued as a result of the disease.

Each bureau head is responsible for evaluating the risk of infectious disease exposure in their area. In addition, bureau heads must plan how their bureaus may further modify work practices during an infectious disease event to reduce the risk of exposure. Modified work practices must be tested prior to an event. Specific tactical guidance to reduce risk of exposure at emergency scenes was released with the 2009 H1N1 Outbreak and the 2014 EBOLA Scare to line personnel and shared with Lucas County Fire Chiefs and Lucas County EMS. This information can be found in Attachment B: "Pandemic General Response Tactical Guidance" and applies to future pandemic events with minor modification. In addition to response procedures, the training encourages employees to practice good hygiene (e.g., frequent hand-washing/sanitizing) and regular workspace disinfecting.

B. Disease Monitoring:

Early recognition that an infectious disease is impacting the City of Toledo and Department will allow a more rapid response to the problem and help limit the exposure of employees.

The Department maintains a general awareness of infectious disease through the news media, automatic email updates from the Toledo-Lucas County Health Department and other email list servers, and by participation in regional public health planning by members of the NW Ohio Regional Disaster Preparedness Network.

Overall responsibility for infectious disease surveillance rests with the Toledo-Lucas County Health Department. The Department, other EMS Agencies, and Lucas County Hospitals each monitor specific areas and share information during day-to-day EMS operations.

The TFRD monitors the number of weekly sick calls of its personnel. On average, 20 uniformed and non-uniformed personnel per week call off sick due to personal illness. Multiple week spikes in this number may provide early clues to a developing problem. This information can be relayed

to the Toledo-Lucas County Health Department and be coupled with other disease monitoring data for further review and actions as needed.

C. Personal Protective Equipment:

The Toledo Fire Department is committed to maximizing protection against communicable disease for (its) members. The proper use of Personal Protective Equipment (PPE) minimizes exposure to infectious disease. TFRD and Lucas EMS work practices require: "Gloves and Eye Protection to be worn for all patient contacts." Gowns and masks are worn when body fluid splash protection is required or an infectious situation is known or suspected.

During an infectious disease outbreak, the Department will adjust PPE protocols with guidance from the TFRD and Lucas EMS Medical Directors and recommendations of public health officials. This may include using masks and gowns for all patient contacts. Depending on the situation, non-uniformed employees could also be required to use PPE.

Large quantities of PPE will be required during a pandemic event. All TFRD personnel were issued and fit-tested in N-95 masks, taught proper donning and doffing procedures, and trained in its proper use and limitations. The department maintains a limited supply of respirators for all Lucas County Fire Departments. Additional equipment includes APRs with particulate filters and PAPRS for patient transport units. All employees were exposed to this additional equipment when the N-95 masks were distributed. When appropriate this additional equipment may be used. Depending upon the situation, this equipment may need to be rationed (prioritized use) according to departmental function. For example, Life Squads first, TFRD Medic Units second, Engine Crews third, and so on.

While the TFRD provides PPE, training, work place practices and procedures, disease monitoring, and provides mental health support, a person's best defense against the flu is obtaining the vaccine. The TFRD provide s the opportunity for each employee to receive the seasonal flu shot, and it is very possible that the COT and L92 Health Plans cover this as well.

D. Employee Mental Health

This Pandemic Preparedness and Response Plan focuses on the physical health of employees, but a pandemic will affect their emotional health as well. Supervisors will be instructed to monitor employees for signs of stress. Additionally, the department will make counseling services available, as needed through the employee assistance program and departmental and volunteer CISD teams. These services will be offered to employees and their families.

V. CRISIS COMMUNICATIONS

The intent of the crisis communications section is to identify what information will be required during the incident, who may be the requestors of the information, where inquiries can be directed and adjustments in resources to address the required need for information. This section also describes the provider source of unsolicited information.

A. Dispatch

A significant increase in service requests will require changes to how the Department manages the intake and disposition of calls into the 911 system. The first challenge is answering more 911 telephone calls than the Department is normally able to answer. The second challenge is providing service to all callers when Department resources are limited. The plan for the latter is addressed in Attachment K: Catastrophic and Transitional Medical Phase IV Actions Detail (Medical Direction Triage Command, Centralized EMS Transport, Modified Unit Staffing)

Increased Call Volume/911 Telephone Call Intake

A plan to address an increase in 911 call volume should be coordinated with Toledo Police, Lucas County EMS, and Lucas County Sheriff call takers as the Communication Bureau acts as the primary 911 call center and redirects calls to the appropriate agency depending on the nature of the call. Other supporting community agencies should also be involved in the planning process. As the incident escalates an increase in public information released by the Toledo-Lucas County Public Health Department should coincide with an increase in 911-call volume. Providing the community with accurate, timely incident information should help alleviate some of the pressure from the dispatch center.

Additionally, the Department's Communications Bureau can accommodate a finite increase in 911-call volume by increasing available staff as long as employees remain healthy and unexposed. Sharing of mutual dispatch resources may need to be considered if 911 and dispatch operations become hampered.

In severe circumstances, Department staff may be assigned directly to Communications to assist with logistics and supervision. In addition, dispatch assignments to BLS incidents may be bypassed in order to respond to ALS emergencies and fires.

B. Internal

Relevant incident information will be coordinated by and distributed internally as needed by the Special Operations and TFRD EMS Bureaus. These bureaus will seek guidance and/or approval from the Fire Chief, Assistant Chief, Deputy of EMS, Deputy of Operations, Deputy of Communications, TFRD and Lucas County EMS Medical Directors in conjunction with the Toledo-Lucas County Health Department and Lucas County EMS.

C. External

During a pandemic the demand for information by the community and surrounding agencies will be high. As appropriate the TFRD will utilize partner resources to ensure inquiries are routed to the right place for required information. Community inquiries can be referred to the United Way 211 Call Center, the Toledo-Lucas County Health Department, or other web-established sites designed to provide incident information. Media inquiries that cannot be addressed by the Fire Chief of his designee should be forwarded to the Lucas County Joint Information Center established by the Toledo-Lucas County Health Department (for this type of incident).

The TFRD will also maintain communications with surrounding agencies to include Lucas County Fire Chiefs, private EMS providers, the Toledo-Lucas County Health Department, Lucas County EMS, NW Ohio Regional Coordinators and the NW Ohio Disaster Preparedness Network. As appropriate, information will be shared and distributed.

D. Communications Hardware

In order for the department to conduct daily operations, communications capability is critical. Thus, the TFRD currently utilizes a countywide 800 MHz communications system that enables seamless communications within the department and across mutual aid agencies in the county. Additionally, these radios are programmed with Ohio's Multi-Agency Radio Communications System (MARCS) talkgroups and the National Public Safety Planning Advisory Committee (NPSPAC) talkgroups. Redundant back-ups within the system along with the Lucas County Tactical Interoperable Communications Plan and the NW Ohio Regional Communications Plan ensure that communications can be maintained for the department.

The county-wide 800 MHz system is comprised of 12 towers located within Lucas County. In the event that one or more towers become inoperable or if the main dispatch site is lost, communications can be maintained through redundancies and back-up systems. If Lucas County experiences a catastrophic radio failure with the 800 MHz system a back-up conventional analog system was built to provide basic communications capability. The department can communicate on conventional channels 7, 8, and 9 or on the MARCS System during a major failure. Beyond this capability the TFRD has access to multiple, redundant communications capability identified in the Lucas County Tactical Interoperable Communications Plan and the NW Ohio Regional Communications Plan. If for some reason the CAD system located at the Lucas County Emergency Services Building becomes inoperable, the Safety Building located behind TFRD Headquarters may be used as a back-up dispatch center as long as the primary server located in the basement of the Lucas County Emergency Services Building is intact.

VI. Emergency Response Operations

A. Lucas County Transitional Medical Framework

The previously established Lucas County MEMS Committee's Transitional Medical Framework provides the structure by which the TFRD will respond to a pandemic and how the department's response integrates with other agencies in the community. It defines Traditional Medicine, and Transitional Medicine for escalating phases of a pandemic: Phases 1,2,3,4, the Catastrophic Phase and the Recovery Phase and attaches specific actions during each phase for hospitals, public health, and EMS. Possible Triggers are identified to establish which phase of the plan to enact. The model will be used as a tool for planning/response and for other agencies, such as law enforcement, city government, and the Red Cross to place their actions at each phase alongside current agency actions to ensure congruence of response within the community.
Below are EMS specific actions.

Traditional Medical Phase:

Description: At this point, there is no evidence of an actual or imminent disaster threatening Lucas County. During the traditional phase, the community's efforts are directed toward a series of activities that will help the community prepare for **a** response to any disaster, infectious or otherwise.

EMS Will:

- Educate personnel on current pandemic flu issues as identified by local, state and federal public health officials. Include relevant preparedness efforts, pre-hospital inclusion/exclusion criteria and response strategies.
- Identify appropriate level (s) of protection for personal protection for first response agencies and equipment that will provide this protection.
- As departmental and grant funding allows, purchase/stockpile needed equipment.
- Engage with local hospital, public health and other partners in developing a countywide/region-wide response strategy. This includes patient evaluation, care, triage and transportation strategies at each phase of the Transitional Medical Framework.
- Develop an internal response strategy/plan that integrates with countywide and regional plans. This includes and internal antiviral distribution/ vaccination plan and should consider response at modified staffing levels. Train personnel on plan
- Fit-test personnel in N-95 masks as appropriate. (Moved from Level 1)
- Ensure annual flu vaccinations for all personnel. Make mandatory during an outbreak or pandemic as available. Acquire employee signature on refusal form if employee refuses vaccine.
- Participate in Ethics Committee discussions.
- Create a "sick screening checklist" for employees and plan a procedure for sending home sick employees
- Discuss Pre-hospital Inclusion-Exclusion Criteria.
- Participate in local and regional exercises; test plans; make appropriate revisions.

- Develop alternate DOA procedure for fire and EMS

Transitional Medical Phase, Level 1:

Possible Triggers:

1) Clusters of influenza-like illnesses (ILI) in multiple locations on one continent other than North America (WHO Pandemic Phase 5/ Federal Stage 2) suggestive of human-to-human transmission.
2) Clusters of an outbreak in multiple locations in North America suggestive of human-to-human transmission.
3) A particularly serious outbreak in Indiana, Michigan, Pennsylvania, and Kentucky but not in Ohio. Human-to-human transmission is possible. Morbidity/mortality is considerable.

Description: At this stage, there is no change in care delivery because there is no definitive outbreak within Lucas County confines. However, information exists suggesting that a serious outbreak could be developing and could eventually impact the county.

EMS Will:

- Re-educate personnel on infectious disease patient care protocol.
- Ensure personnel, units and stations have enough equipment to adhere to protocol, surgical and N-95 masks, and disinfecting solution.
- Obtain and distribute/update case definition to EMS personnel and dispatch. Dispatch can pre-scene "ill-persons" and notify EMS responder if patient fits the case definition. EMS can then begin interview at a distance and wear appropriate PPE.
- Inventory existing supply of PPE and put vendors on notice.
- Have fire and EMA providers in Lucas County report available resources to EMA/RMRS
- Maintain contact and receive updates from local public health and regional coordinators as appropriate. Distribute information to personnel, other Lucas County Fire Chiefs and EMS systems in the county.
- Patient care and transport remains as is.
- EMS reports daily transports of ILI to local health department.
- Provide personal and family preparedness guidelines to staff.
- Review locations of on-campus and off-campus ACCs and NEHCs.
- Assess mental health support resources, plan for potential needs.

Transitional Medical Phase, Level 2:

Possible Triggers:

1) Clusters of influenza-like illnesses (ILI) on more than one continent other than North America (WHO Phase 6/Federal Stage 3).
2) Increased numbers of suspect cases located in multiple locations within the U.S. highly suggestive of human-to-human transmission.
3) Few scattered numbers of suspected cases around the U.S., but with an unusually high mortality rate or significant morbidity. Human-to-human transmission is possible.

4) Suspected cases are being reported in Ohio as well as elsewhere

Description: The possibility of a pandemic or epidemic directly impacting Lucas County is more real than theoretical. Therefore, at this level, the stakeholders and public should begin activating their plans. From the medical infrastructure point-of-view, the concept is to absorb as much of the basic medical care of the community so as to allow the hospitals to prepare for the possibility of a major infectious disease catastrophe reaching Lucas County.

EMS Will:

- Fully implement infectious disease patient care protocol if not implemented during phase 1
- Ensure station living spaces are sanitized frequently as needed.
- Monitor number of transported suspected cases. Follow-up with personnel if transport returns as confirmed case.
- Emphasize personnel/family preparedness measures to continue. Encourage good personal hygiene, social distancing practices. Obtain guidance form EMA and public health.
- Update personnel on current case definition and situation status as appropriate.
- Maintain contact and receive updates from local public health and regional coordinators as appropriate. Distribute information to personnel, other Lucas County Fire Chiefs and EMS systems in the county.
- Monitor PPE levels, re-stock, stockpile as able.
- Continue EMS reports on daily transports of ILI to local health department.
- Increase communications with State Board of EMS and other regional EMS systems.
- Plan mental health support, implement as needed.

Transitional Medical Phase, Level 3:

Potential Triggers:

1) Clusters of influenza-like illnesses (ILI) are being reported in North America and elsewhere (WHO Phase 6/Federal Stage 4).
2) Increased numbers of suspect cases located in multiple locations within the U.S. highly suggestive of human-to-human transmission and beginning to encroach upon Ohio.
3) Multiple scattered suspected/definitive cases around the U.S., but with an unusually high mortality rate or significant morbidity. Human-to-human transmission is probable.
4) Suspected cases are being reported in Northwest Ohio as well as elsewhere. Human-to-human transmission is likely.

Description: It is now obvious that a pandemic or a severe epidemic is occurring. It has not yet reached Lucas County, but the events that are in existence indicate that its arrival is imminent.

EMS Will:

- Complete all actions from Transitional Medical Phase 3.
- Plan with hospitals in declaring diversion status, (EMS or BLS diversion). Identify in EM System/ Image Trends. Establish criteria for transport.
- Review both internal and county response strategy/plan.

- Dispatch will work to triage the increase in 911-call volume, influenza-like illness (ILI) surveillance initiated. This coincides with an increase in public education from public health.
- Local "short list" of stakeholder management communicates daily. (Moved from Phase 2)
- Review pre-hospital inclusion/exclusion parameters
- Officers screen oncoming personnel for influenza-like illness (ILI) symptoms and send employee home if they meet the case definition. "roll-call sick screening" Maintain log of actions.
- Implement procedure for sending home sick employees.
- Refer all media inquiries to the media center/JIC
- Implement mass fatality plan.
- Pre-deploy "good" body bags.
- Contact DMORT.
- Implement mental health support.
- Implement modified DOA procedure

Transitional Medical Phase, Level 4:

Potential Triggers:

1) Major increase of influenza-like illnesses (ILI) cases in and around the community (WHO Phase 6/Federal 5).

2) Infectious disease outbreak or epidemic has reached Lucas County. Numbers are few.

Description: Active and passive surveillance have revealed the pandemic or epidemic has arrived in Lucas County.

EMS Will:

- Continue with all actions in Phases 2 and 3.
- Activation of Medical Direction Triage Command (consider one medical director for all Lucas EMS- existing EMS Medical Directors operate out of dispatch with support staff 24/7 on a rotational basis.)
- Initiate centralized EMS transport
- Consider movement to alternate staffing schedule (12 hour shifts)
- Consider modified unit staffing (1 paramedic/ 1 BLS provider on ALS unit if staffing is limited)
- Consider BLS units as back up to ALS units and/or adding additional vehicles. Coordinate with Lucas County Fire Chiefs to identify alternate ALS resources
- Modify ALS/BLS in consultation with the Toledo Fire and Rescue Department and LCEMS Medical Directors
    - Yellow transported by BLS, ALS if available to ACC or other non-hospital care provider (ACC +).
    - Reds transported by ALS.
    - Consider eliminating BLS transport
    - Consider using other alternate transport methods through EOC, busses for example

- Monitor EMS sick calls for self and family, implement disaster sick-call policy (standard rules for doctor slips may not apply).
- Alternate charting methods. Image Trends patient tracking may be implemented. Utilize "drop cards"
- Have Lucas County fire and EMS report available response units at pre-determined intervals.

Catastrophic Phase:

Potential Triggers:

1) Lucas County medical services are totally overwhelmed. (WHO Phase 6/Federal Stage 5)

Description: The outbreak has reached such a level that Lucas County is witnessing a deterioration at all healthcare site due to patient volume, lack of personnel, and/or inadequate resources. Numbers of fatalities are increasing. Hospitals are inundated with critical care patients. There is a disruption of infrastructural services at all levels due to lack of personnel and re-supply. At this point, there will be a prioritization of care delivery and a re-allocation of scarce resources to those patients who meet specific inclusion criteria consistent with "Providing the Greatest Good for the Greatest Number." Those who do not meet those criteria or who fail to respond to intensive care will be excluded or removed from those resources. However, they will still receive palliative care and respect as a human being. Should the situation change in terms of personnel or resources, the extant criteria will be modified or cancelled to a more appropriate level of care.

EMS Will:

- Encourage good personal hygiene, social distancing practices.
- Provide personnel situation status update as appropriate.
- Maintain contact with local public health and regional coordinators as appropriate
- Ration PPE/ Patient care supplies given Inclusion-Exclusion Criteria. Modify infectious disease patient care protocol given available supplies. Acquire supplies as able.
- Continue Medical Direction Triage Command
- Continue disaster staffing
- Consider further modified unit staffing or limiting number of available units depending on available staff.
- Patient transfer from out-of-county to county hospitals only by Lucas County Health Commissioner approval.
- Continue providing mental health support as available

Recovery Phase:

Potential Triggers:

1) Lucas County is witnessing a drop in influenza-like illnesses (ILI) among its citizens
2) Ohio (through ODH) is witnessing a drop in influenza-like illnesses (ILI) among its citizens
3) The United States is witnessing a drop of influenza-like illnesses (ILI) among its citizens
4) CDC has declared the pandemic is on the wane.

Description: The Recovery Phase occurs when the Public Health Commissioner believes that all the indicators point to an end of the pandemic/epidemic. It is important that the measures in place to mitigate the spread of disease are not removed too quickly. However, there should be a gradual liberalization from these measures with an intense epidemiological evaluation of the County's health status in order to witness any adverse rise in infectious cases.

EMS Will:

- Continue good personal hygiene, social distancing practices.
- Maintain contact with local public health and regional coordinators as appropriate
- Create after-action report for incident
- Update plans based on lessons learned, make adjustments to operating procedures as needed.
- Return to normal staffing schedule and unit staffing as available personnel allow.
- Restock needed supplies. Return to standard operating procedures as staffing, supplies, and health care system recovery allows.
- Implement pandemic flu training/exercises and personal preparedness measures for staff.
- Continue with local hospital, public health and other partners in developing / improving a countywide/region-wide response strategy
- Ensure availability of CISD
- Recognition ceremonies for fallen members, heroes.

B. TFRD Vaccination Plan

Vaccination along with education, good hygiene habits and personal protection is the best way to prevent disease. The TFRD supports this through offering seasonal flu vaccines to its personnel, providing infectious disease training and providing the proper personal protection. The following is an outline of how the TFRD will administer seasonal flu or other incident specific vaccines as appropriate.

Currently the only personnel employed by the TFRD able to administer vaccinations are nurses or doctors (EMS Medical Direction) according to their standard of practice. Thus there is a limited supply of personnel available to inoculate employees. The TFRD EMS Bureau will keep a current list of licensed nurses willing to assist with inoculations and maintain the capability to properly store the vaccine until delivery to personnel.

Note: During the 2009 H1N1 Outbreak Ohio's Governor declared a health emergency allowing certified EMT-Paramedics and Intermediates to give the H1N1 Vaccine only (not seasonal), as

long as they were trained prior with the Center for Disease Control's/Ohio Department of Health's training module and were under appropriate medical direction. For this particular incident the available inoculation pool was larger as all Lucas County paramedics were given the training. The intent was to allow trained employees to assist in inoculating first responder agencies and the general population as needed.

The TFRD Medical Director is responsible for securing enough supply of the vaccine to offer to each TFRD employee. TFRD will work with the medical director to identify and secure funding sources for the vaccine.

Upon arrival of the vaccine the TFRD EMS Bureau will allow all platoons two different opportunities on two different shifts to receive the vaccine (two different blocks of time over two shifts for a total of 4 blocks of time, an example is from 0900-1100 hours and from 1300-1500 hours on two different A, B and C-shifts). Depending on demand and available personnel to inoculate, this can be delivered at the EMS Bureau or at each battalion station (Stations 13, 18 and 4's) for the 6 tours of duty. The EMS Bureau must also allow for personnel off on these tours to receive the vaccine if desired by appointment and communicate vaccine availability to staff personnel as well. The EMS Bureau is also responsible for all required paperwork involved in vaccine administration. The TFRD Bureau of Special Operations will provide support as needed.

Attachment A: TFRD Bureau of Special Operations Continuity of Operations Plan

Attachment B: Pandemic General Response Tactical Guidance

The following provides tactical response guidance for personnel to use when responding to persons in a biological – pandemic crisis. Although used during the H1N1 Pandemic in 2009, the guidance can be modified and updated for the next pandemic or other contagious biological incident.

According to the Centers for Disease Control: "most respirators (e.g. N95) are designed to seal tightly to the wearer's face and filter out very small particles that can be breathed in by the user. For both facemasks and respirators, however, limited data is available on their effectiveness in preventing transmission of H1N1 (or seasonal influenza) in various settings. However, the use of a facemask or respirator is likely to be of most benefit if used as early as possible when exposed to an ill person and when the facemask or respirator is used consistently." Thus the CDC recommends that health care workers caring for persons with known, probable or suspected of influenza-like illness wear respirators, N-95 mask or other type respirator. The TFRD has a supply of N-95 respirators, particulate filters that adapt to departmental issued air purifying respirators (APRs) and positive air purifying respirators (PAPRS). The level of recommended respirator for any incident will be dependent upon virulence and transmissibility of the virus and/or available resources. Additionally, Basic Care recommendations are as follows:

1. Personnel should assess all patients for symptoms of acute febrile respiratory illness (fever plus one or more of the following: nasal congestion/ rhinorrhea, sore throat, cough, or possibly body aches, headaches, chills or fatigue (**use current case definition if available) AND** if the patient has had direct contact with a confirmed or probable case in the last 7 days from 6 feet away.
    a. If negative for the assessment above personnel should proceed with normal EMS care.
    b. If positive for the assessment above, personnel should follow the next steps. .
    c. The person may not know if they were in direct contact with a confirmed case but may still have the above symptoms. Personnel should keep suspicions high and protect themselves when in doubt. Personnel then should:
2. Place a non-rebreather or surgical mask on the patient as signs and symptoms indicate.
3. Don N-95 mask themselves along with accompanying crew.
4. Avoid droplet producing procedures whenever possible including nebulizers, bag-valve-mask, suctioning or intubation.
5. Alert receiving hospital personnel of the possibility of an infectious patient
6. Use normal disinfection techniques.

Masks should be considered for re-use when it is not wet or has not been directly contaminated. Mask re-use is the decision of TFRD personnel.

Personnel should be reminded that a clean new mask can be donned with bare hands. However when removing the mask personnel should use gloved hands to discard the mask or place in a paper bag, then back into their fanny pack if they decide to reuse the mask. Gloves should be discarded afterward. If the mask is being reused, it should be donned and doffed with gloved

hands. Then hand washing should follow after mask removal. Personnel should avoid touching a contaminated mask with bare hands then touching their face.

After mask use and reporting, personnel should follow normal disinfecting techniques for the decontamination of the medic units:

- Air out the unit
- Wear goggles and gloves while using Neutral Disinfectant Cleaner (NDC) disinfectant to wipe down all frequently touched surfaces in patient care compartments and allow to air dry.
- Mop floors as needed
- Wash hands, using alcohol based hand-wash products are acceptable.

Other disease specific information, situational updates and general information on ways to keep personnel safe should be shared and reinforced to include:

- Washing hands frequently with soap and water or using alcohol-based hand cleaner when soap and water are not available.
- Covering mouths and noses with a tissue when coughing or sneezing
- Avoid touching eyes, nose and mouth
- People who are sick with an influenza-like illness (ILI) (fever plus at least cough or sore throat and possibly other symptoms like runny nose, body aches, headaches, chills, fatigue) should stay home and keep away from others as much as possible, including avoiding travel, for at least 24 hours after fever is gone except to get medical care or for other necessities.
- Avoiding close contact (i.e. being within about 6 feet) with persons with influenza-like illness (ILI)

PAGE INTENTIONALLY LEFT BLANK

Attachment C: Lucas County Medical Directors Guidance on EMS Care and Transportation Considerations on COVID-19

Sequences of Care in COVID 19 for EMS in Lucas County and NWO Ohio

- When COVID-19 enters and spreads in our community, take extra measures to put distance between yourself and other people to further reduce your risk of being exposed to this new virus.
    - Stay home as much as possible.
        - Consider ways of getting food brought to your house through family, social, or commercial networks
    - If you are in Self-Isolation (known exposure without symptoms) or Self-Quarantine (confirmed COVID by testing with minor or no symptoms'), stay in contact with Toledo/Lucas County Health Department and contact them before seeking any type of medical attention for all non-emergency symptoms (see below).
    -
- Individuals need a plan should they get sick, especially if they have chronic medical conditions such as lung disease, heart disease, kidney failure, diabetes, cancer
    - Stay in touch with others by phone or email. You may need to ask for help from friends, family, neighbors, community health workers, etc. if you become sick.
    - Determine who can provide you with care if your caregiver gets sick, and what facility or location can meet your needs for further assessment.
    -

For **NON-EMERGENCY** medical assessment needs, if you are not under monitoring with the Health Department, contact your private provider directly. If you are advised to go to a treatment location, wear your face mask to protect others from viral spread. Depending on the severity of your cold or flu symptoms it may be best to remain and home and treat them symptomatically. It's important to understand that testing for COVID19 is restricted to only those patients that meet criteria based on symptoms, risk factors and history of risk/exposure, and that this is a changing set of criteria established by the CDC. Most patients seeking such testing will not qualify for actual testing under current parameters. There is no medicine available currently for treatment of COVID19 and symptomatic treatment for viral symptoms would be the likely instructions.

TRANSPORTATION CONSIDERATIONS for EMS Providers

The following guidelines are the premise of thinking for dealing with COVID19 transportation issues and other emerging infectious disease issues for the future. EMS crews are to have an open and honest discussion after a full and complete assessment, Online Medical Control is involved, AND if the Docs answering the EMS phone/radio understand the value in NOT transporting these folks, we will have a successful program. This document will be distributed to the EMS and EC staffs to target this education to those users.

For patients under monitoring with the TLCHD, transportation for non-emergency symptoms and signs is by private vehicle. Evaluation at an Emergency Department is preferable as they have isolation room capability.

For ambulance transportation needs, the considerations for Mode of Transportation are not changed due to COVID19, they are the same as previous. The Medical Directors below are in favor of not transporting otherwise well patients with minor symptoms in fire department apparatus if they meet criteria and have had a medical screening exam and have contacted medical control.

- **BLS** With concerns for COVID19 and viral respiratory presentations in general, minor cases should not be transported by EMS. There generally is no need for an EC visit for minor flu symptoms or due to concern for COVID19 without emergency symptoms. These patients should remain at home. There is no medical reason to transport viral infection patients in BLS apparatus, private vehicle is appropriate. If patients need attention for other non-viral medical issues private vehicle is appropriate, in the same circumstances as it would be normally. For patient with more severe symptoms, see ALS below. BLS is used for non-life or limb threats in patients that are not able to walk on their own. Patients that can ambulate are transported in private vehicle, and if viral suspicion exists these patients should wear a mask.
- **ALS** Is used for patients with Life or Limb threatening signs or symptoms, such as difficulty breathing, chest pain, stroke symptoms, abdominal pain, active labor and changes in level of alertness. Trauma with changes to vital signs, fractures to major bones, penetrating injuries, head injuries in elderly or on blood thinners.
- **Private Ambulances** are used for both BLS and when patients may need to move from one hospital to another.
- **Mobile ICU** are used to move critically ill patients from one hospital to another hospital ICU. For COVID19 these would be patients on respiratory support (machine) or other life support measures.

Indications for EMS ALS Transport of Probable COVID19 Patients

- **Emergency Signs & Symptoms** that would forgo calling Health Department first:
  - Difficulty breathing or shortness of breath
  - Persistent pain or pressure in the chest
  - New confusion or inability to awaken
  - Bluish lips or face

PAGE INTENTIONALLY LEFT BLANK

Attachment D: Pandemic Incident COVID-19 Coronavirus (SOP)

Toledo Fire and Rescue Department Operations Manual

Date Issued:	**March 12, 2020**
Revised Date:	
Pages:	**1**

Approved by: _____
Fire Chief

Purpose:
The purpose of this procedure is to provide personnel with instructions when responding to patients potentially infected with or exposed to COVID-19 (coronavirus).

Overview:
The U.S. Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) consider the 2019 Novel Coronavirus (COVID-19) to be a very serious public health threat. However, based on current information, the CDC has stated that the **immediate health risk from COVID-19 to the general American public is considered low at this time.** Nevertheless, the CDC is taking proactive preparedness steps and issued interim guidance for healthcare providers on infection control and prevention for COVID-19.

Symptoms and Exposure:
Patients with the following signs/symptoms should prompt the EMS Clinician to suspect COVID-19

1. Fever ***AND***:
    - Symptoms of acute respiratory illness
    - Cough
    - Difficulty breathing
    - Hypoxia
2. ***AND*** close contact with COVID-19 or travel to an endemic area (see below)
    International Areas with Sustained (Ongoing) Transmission
    Last updated February 28, 2020
    - **China (Level 3 Travel Health Notice)**
    - **Iran (Level 3 Travel Health Notice)**
    - **Italy (Level 3 Travel Health Notice)**
    - **Japan (Level 2 Travel Health Notice)**
    - **South Korea (Level 3 Travel Health Notice)**

NOTE: Close contact with individual with known or suspected COVID-19 is defined as:

- a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

- b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

- If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, facemask, eye protection), criteria for Person Under Investigation (PUI) consideration are met.

Procedure:

Dispatch Information

- Initial Screening by 911 Call-Takers and EMS Dispatch:
  Three (3) questions will be asked by Lucas County call-takers to all individuals calling 911, which will determine three (3) levels of response based upon the answers to these questions.
  Question 1: Do you have a fever, or other symptoms?
  Question 2: Have you traveled to and from one of the 5, Level 2 and Level 3 countries listed on page 1. **OR** A country or domestic location where sustained transmissions of COVID-19 are occurring?
  Question 3: Have you been in direct contact with a known COVID-19 infected patient?
  If the patient answered any of these questions affirmatively, then Dispatch shall communicate to the enroute apparatus this information, preferably via MDT. Notification shall also be made to the hospitals and the Toledo Lucas County Health Department (TLCHD) early on regarding affirmative answers to Questions 2 and/or 3.

- If Dispatch advises that the patient is suspected of having COVID-19, EMS crews should put on appropriate PPE before entering the scene. EMS crews should consider the signs, symptoms, and risk factors of COVID-19.

- **Recommended Personal Protective Equipment:**
  - PPE shall consist of, and be donned in the following order:
    - ✓ Fluid resistant gown
    - ✓ Facemask or Respiratory Protection: NIOSH – certified, fit-tested N-95 Facemask or higher level of protection
    - ✓ Eye Protection: Goggles or full face shield
    - ✓ Two (2) sets of gloves

On-Scene

Prior to Patient Contact

- Arriving on scene, crews will ask the patient the same preliminary questions as asked by Lucas County 911 call-takers to rule-out definitively any suspicions of the COVID-19 virus.
- As making entry into the residence, limit the amount of contact with household structure or belongings.
- Isolate the patient as best as possible from others in the location. Use caution when approaching the patient.

On-Scene

Patient Care

- Initial contact with the patient shall be made by only two (2) members of the arriving apparatus. (As much as possible, these two (2) individuals should be paramedics, as there may be ALS symptoms associated with the patient.) These 2 personnel should assess the situation and determine if they can handle the situation or if more members are needed.
- If patient has need of advanced life support treatment, then all efforts will take place by as many personnel as necessary to treat the patient, regardless of the concerns of COVID-19 symptoms.
- Initial assessment should begin from a distance of at least 6 feet from the patient, if possible. In as much as possible, attempt to have only one crew member within the 6 foot hot zone assessing the patient. Patient contact should be minimized to the extent possible until a facemask is on the patient.
- 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.
- If conditions allow, have the patient come outside for evaluation.
- Making as little contact with the patient, treat the patient's medical issues, including ascertaining a history from the patient asking direct questions that would detail the COVID-19 risk. Request other resources as needed, i.e. Manpower, ALS response, Law Enforcement…..
- During treatment, limit the number of medical interventions as possible without endangering the patient.
- If information about potential for COVID-19 has not been provided by Dispatch, EMS crews should exercise appropriate precautions when responding to any patient with signs or symptoms of a respiratory infection. Also, crews shall ask the patient the same preliminary questions as asked by Lucas County 911 call-takers to rule-out definitively any suspicions of the COVID-19 virus. If COVID-19 is suspected, all PPE as described below should be used. If COVID-19 is not suspected, EMS crews should follow standard procedures and use appropriate PPE for evaluating a patient with a potential respiratory infection.

Transportation

- Transportation decisions will be based on Attachment L - the "Lucas County Medical Directors Guidance on EMS Care and Transportation Considerations"
- Limiting the amount of contact with the patient, move them as safely as possible to the medic unit. If it's possible, have the patient ambulate themselves into the medic unit.
- After putting the patient into the medic unit or Life Squad, EMS crews should remove and discard PPE and perform hand hygiene. Used PPE should be discarded in accordance with routine procedures. Put on a fresh set of gloves.
- Drivers, if they provide direct patient care (e.g., moving patients onto stretchers), should wear all recommended PPE. After completing patient care and before entering an isolated driver's compartment, the driver should remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.
    - If the transport vehicle does **not** have an isolated driver's compartment, the driver should remove the face shield or goggles, gown and gloves and perform hand hygiene. A respirator should continue to be used during transport.
- EMS crews should notify the receiving healthcare facility that the patient has an exposure history and signs and symptoms suggestive of COVID-19 so that appropriate infection control precautions may be taken prior to patient arrival.
- During transport, limit the number of providers in the patient compartment to essential personnel to minimize possible exposures.
- While transporting patients with flu-like symptoms it will be next to impossible to maintain the recommended 6 foot safe distance; in this case, if possible, attempt to stay behind the patient. Keep air circulating by opening windows to all fresh air to circulate in the passenger compartment.
- Keep the patient separated from other people as much as possible.
- Family members and other contacts of patients with possible COVID-19 should **not** ride in the transport vehicle, if possible. If riding in the transport vehicle, they should wear a facemask.
- Isolate the ambulance driver from the patient compartment and keep pass-through doors and windows tightly shut.
- When possible, use vehicles that have isolated driver and patient compartments that can provide separate ventilation to each area.
    - Close the door/window between these compartments before bringing the patient on board.
    - During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.
    - If the vehicle has a rear exhaust fan, use it to draw air away from the cab, toward the patient-care area, and out the back end of the vehicle.
    - Some vehicles are equipped with a supplemental recirculating ventilation unit that passes air through HEPA filters before returning it to the vehicle.
- If a vehicle without an isolated driver compartment and ventilation must be used, open the outside air vents in the driver area and turn on the rear exhaust ventilation fans to the highest setting. This will create a negative pressure gradient in the patient area.

- Follow routine procedures for a transfer of the patient to the receiving healthcare facility (e.g., wheel the patient directly into an Airborne Infection Isolation Room)

Documentation of Patient Care:

- Documentation of patient care should be done after EMS clinicians have completed transport, removed their PPE, and performed hand hygiene.
    - Any written documentation should match the verbal communication given to the emergency department providers at the time patient care was transferred.
- EMS documentation should include a listing of EMS clinicians and public safety providers involved in the response and level of contact with the patient (for example, no contact with patient, provided direct patient care). This documentation may need to be shared with local public health authorities.
- Within ESO Electronic Health Record (EHR) the Influenza Screening and Patient Travel Forms have been enabled please complete accordingly. Secondary Impressions related specifically to COVED-19 are now available:
    - COVID-19 - Confirmed by testing
    - COVID-19 - Exposed to confirmed patient
    - COVID-19 – Suspected – no known Exposure

Personnel Safety & Decon

- Change gloves often: after patient contact and before you begin your report on ESO or before beginning decon procedures.
- Wear appropriate PPE when deconning yourself and equipment. (Gloves and goggles)
- Wash hands before and after patient contact.
- All personnel should avoid touching their face while deconning and working.
- Clean and disinfect the vehicle in accordance with standard operating procedures. All surfaces that may have come in contact with the patient or materials contaminated during patient care (e.g., stretcher, rails, control panels, floors, walls, work surfaces) should be thoroughly cleaned and disinfected using an EPA-registered hospital grade disinfectant in accordance with the product label.
- Clean and disinfect reusable patient-care equipment before use on another patient, according to manufacturer's instructions.
- After delivery of the patient, leave the rear doors of the transport vehicle open to allow for sufficient air changes to remove potentially infectious particles.
    - The time to complete transfer of the patient to the receiving facility and complete all documentation should provide sufficient air changes.

- When cleaning the vehicle, EMS clinicians should wear a disposable gown and gloves. A face shield or facemask and goggles should also be worn if splashes or sprays during cleaning are anticipated.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly, to include the provision of adequate ventilation when chemicals are in use. Doors should remain open when cleaning the vehicle.
- Use disinfectant wipes to clean your tablet and keyboard after each contact.

- DO NOT SPRAY DISINFECTANT DIRECTLY ON THE MDT / TABLET.
- If no wipes are available, spray NDC on a towel and wipe electronics.
- Do not put equipment back into rig before sanitizing with spray and wipes.
- Med Units and Life Squads shall be disinfected after each transport, before leaving ED. Don gloves and goggles prior to deconning the unit.

    - While at Hospital: Use supplied disinfectant wipes to decon electronics or surfaces hard to spray, including surfaces in the driver compartment
    - Spray all potentially infected surfaces of the medic unit passenger compartment and equipment with Neutral Disinfectant Cleaner (NDC) disinfectant.
    - Allow 10 minutes to dry; disinfection works by drying, not wetting.
    - After 10 minutes, wipe the sprayed surfaces of the medic unit or equipment with a clean rag. Those surfaces are now clean and disinfected
    - Soiled rags, towels, and clothing can be laundered and dried using the station extractor and clothes dryer.

- Doff and dispose of gloves when complete and wash your hands with soap and water for 20 seconds.

EXPOSURE

- **IF –** TFRD Crews transport a patient with suspected COVID-19 based on symptomatology and travel (endemic countries or significant local exposure) **AND** did not wear **FULL PPE** during patient contact:
    - Full PPE Defined as:
        - Gloves
        - Face Mask (surgical)
            - **N-95 Required for CPAP, Airway procedures, Aerosol administration**
        - Gown
        - Wrap-around Eye Protection
- **THEN** - Either the crew or ED staff should contact TLCHD at **419-213-4264 or 419-213-4218**.
    - This is the number for the on call TLCHD epidemiologists.
    - The PH Official will call back and ask questions regarding:
        - Patient Symptoms
        - Patient Travel
        - EMS Provider level of contact
        - EMS Provider PPE
    - The PH Official will then offer guidance regarding personal decon and any isolation/quarantine indicated
        - NOTE - Crews are likely not exposing others themselves if asymptomatic (i.e. if they are coughed on, they are not immediately contagious)
        - Vehicle should be decontaminated per current protocol

- If crews did not wear full PPE, especially gown, they should shower and change clothes

**This plan will hopefully eliminate confusion as to which agency/guidelines to follow for post-exposure actions. Crews should be encouraged to ask screening questions, wear full PPE with any suspicious patient, and limit crew members in contact with the patient during transport, including limiting those in the back of the transport vehicle.

PAGE INTENTIONALLY LEFT BLANK

Attachment E: Catastrophic and Transitional Medical Phase IV Actions Detail (Medical Direction Triage Command, Centralized EMS Transport)

Medical Screening and Triage for Pandemic Flu Guidelines:

Clinical Criteria for COVID-19

- Fever > 38 C: (100.4 F), and the presence of at least one of the following:
- Cough
- Difficulty breathing
- Dyspnea

Evaluate the patient for the signs of COVID-19 clinical symptoms. The combination of any of the above are the clinical criteria for pandemic influenza. Assess the following:

- Vital signs
    - Pulse
    - Blood Pressure
    - Respiratory Rate
    - Lungs Sounds
    - SpO2
    - Skin Turgor
- High Risk Criteria
    - Pregnancy
    - Children 6 months of age or under
    - Persons 60 – 80 years old with conditions such as asthma, COPD, CAD, CHF or other chronic disorders.
    - Diabetes, Renal Failure, HIV + or immunosuppressant

GREEN PATIENT:

- Meets clinical criteria **or** has high risk criteria and
    - Stable vital signs (use age appropriate values for pediatric patients)
    - Pulse < 100
    - Respirations < 24
    - Systolic BP > 100
    - SpO2 > 95%
    - Normal skin turgor
    - No dyspnea, lungs clear, no cough productive for colored phlegm
- **Treatment and Transport Recommendations**
    - Consider no transport
    - Recommend OTC medications,
    - Provide home care and infection control guidelines and give follow up information.
    - If available and < 48 hours from symptoms onset suggest antivirals (available from Public Health)

YELLOW PATIENT:

- Meets the clinical criteria and is in a high risk group **or**
- Meets the clinical criteria and has one of the following:
    - Abnormal vital signs (use age appropriate values for pediatric patients)
    - Pulse 100 - 120
    - Respirations 24 - 30
    - SpO2 92 – 95%
    - Systolic BP 90 - 100
    - Abnormal skin turgor (tenting)
    - Productive cough or colored phlegm
    - Rales, ronchi or wheezing
- **Treatment and Transport Recommendations**
    - Treat the symptoms, i.e. dehydration, SOB by following established protocols.
      Consider no aerosol treatment for wheezing to reduce contamination
    - Transport to regular hospital bed or alternate care site

RED PATIENT:

- Meets the clinical criteria **and** any of the following
    - Significant dyspnea
    - Altered mental status
    - Significantly altered vital signs (use age appropriate values for pediatric patients)
    - Pulse > 120
    - Respirations > 30
    - SpO2 < 92%
    - Systolic BP < 90
    - Clinical impression of dehydration
- **Treatment and Transport Recommendations**
    - Treat the symptoms by following established protocols;
      consider no aerosol treatments to reduce contamination, and if high risk,
    - Transport to critical care capable facility

      OR
    - Treat the symptoms by following the established protocols
      consider no aerosol treatments to reduce contamination and, if **NOT** high risk,
      Transport to a critical care capable facility if:
        - ✓ SpO2 < 90% with O2 < 6 lpm
        - ✓ Respirations > 30 after initial treatment
        - ✓ Systolic BP < 90 after 500cc NSS
        - ✓ Fever > 40 C (104 F)
        - ✓ Persistent tachycardia > 120/m
        - ✓ Altered mental status
    - Otherwise transport to a hospital with regular beds or alternate care site

PAGE INTENTIONALLY LEFT BLANK

Attachment F: TFRD Sick Screening Checklist

TOLEDO FIRE AND RESCUE DEPT.
COVID-19 CORONAVIRUS
SCREENING TOOL

Member _____ Date_____ Time_____
Last, First

Indicate ☒ if the following symptoms are present:

Fever over 100° F [37.8° C] or greater ☐

Cough ☐

Runny Nose ☐

Sore Throat ☐

Chest Pain ☐

Mygalgias or Body Aches ☐

Difficulty Breathing or Wheezing ☐

Nausea and/or Vomiting in last 12 hours ☐

Diarrhea in last 12 hours ☐

_____ _____
Signature of member taking report I.D. #

_____ _____
Shift Station

PAGE INTENTIONALLY LEFT BLANK

Attachment G: PSAP 911 Caller Screening

Recommendations for 9-1-1 Public Safety Answering Points (PSAP)

It is important for the PSAPs to question callers to ascertain if there is anyone at the incident location who is possibly afflicted by the COVID-19 virus or other type of flu virus, to communicate the possible risk to EMS personnel prior to arrival, and to assign the appropriate EMS resources. PSAPs should review existing medical dispatch procedures and coordinate any modifications with their EMS medical director and in coordination with their local department of public health.

Interim recommendations:

- PSAP call takers should screen all callers for any symptoms of acute febrile respiratory illness. Callers should be asked if they, or someone at the incident location, has had nasal congestion, cough, fever or other flu-like symptoms in accordance with the current case definition.
- PSAP call takers should ask if the caller or anyone else at the incident location has been in close contact with a COVID-19 infected patient in the previous two weeks.
    - If the PSAP call taker suspects a caller is noting symptoms of acute febrile respiratory febrile illness, they should make sure any first responders and EMS personnel are aware of the potential for “acute febrile respiratory illness” before the responders arrive on scene.

PAGE INTENTIONALLY LEFT BLANK

Attachment H: Disaster DOA Protocol

Modified Death Procedure- EMS Incident

Draft Oct 19 2009

Date Issued:	Date Reviewed:	Next Review Date:

1. The modified death procedure is an addendum to the departmental established Death Procedure. The purpose of the Modified Death Procedure is to address times when there is a non-acute mass casualty incident that results in numerous fatalities, such as during a pandemic flu event where a lethal strain of flu virus is circulating in the population, or other lethal contagious biological incident.

2. According to the current Death Procedure, if the cause of death is unknown or there are signs of violence or any other unusual circumstances, TFRD personnel must remain on scene until police or the coroner arrive on scene. This procedure is established to identify when TFRD personnel do not need to remain on scene and await arrival of police or coroner during a mass casualty incident.

BACKGROUND:

3. According to the Ohio Revised Code the Coroner does not have jurisdiction over remains of pandemic flu victims unless deceased is unknown or body not claimed.

   i. ORC 313.12 Notification of coroner in case of death by violence, casualty, suicide, or suspicious or unusual manner.

   ii. OAC 73-123 Coroner does have jurisdiction of the body if the deceased is unknown or if the body is not claimed.

4. Thus the Board of Health can make orders for disposition of bodies to protect the public and prevent disease.

   i. ORC 3707-19 Disposal of body of person who died of communicable disease.

5. According to the NW Ohio Non-Acute Mass Fatalities Incident Plan the county coroner, emergency management agency director and the local public health commissioner via Unified Command may establish a Central Mortuary Processing Center to act as a

collecting and processing facility for all human remains that do not fall under jurisdiction of the county coroner as described above.

i. The Central Mortuary Processing Center Leader may chose to utilize non-traditional means of transportation, such as buses, trucks, and vans and non-traditional drivers and handlers for transportation of fatality victims.

ii. It is also possible that when "official" resources are not available, or are not able to quickly respond to requests for transport of the deceased, family members may transport the deceased to a known local collection point/morgue.

PROCEDURE:

6. The Deputy Chief of Operations **must** indicate that the Modified Death Procedure is in effect in accordance with the Fire Chief and Unified Command for the incident.

7. Upon arrival to the scene confirm the person is deceased.

   i. **The victim shows signs of decomposition.**
   ii. **The victim shows signs of rigor mortis** (Note: All 4 extremities should be physically assessed for stiffness related to rigor mortis).
   iii. **Victim displays extreme dependent lividity** (Physically roll patient to evaluate dependent body areas for signs of blood pooling).

8. Ascertain from family member or caller deceased's condition prior to death. Family member or caller must identify that the deceased had a confirmed case of the lethal agent or had displayed signs and symptoms consistent with the agent's modality prior to death.

9. If the caller is a family member inform them that they have the option to transport the body themselves to the Central Mortuary Processing Center (CMPC) or have the responding unit remove of the remains.

10. If the family member chooses to remove the body themselves, obtain their signature on your report with explanation and phone number, assign a triage tag to the body, offer to help place the deceased member in a body bag or give the family member a body bag and call in the triage number to the CMPC via dispatch.

11. If the caller is not a family member or the family member chooses to have the responding unit remove the remains, follow the procedure below.

12. Request that dispatch contact the 24-hour Central Mortuary Processing Center Transport Response Line. The CMPC Transport Response Team will then meet the requesting crew at the location and retrieve the body and other needed information.

13. Obtain standard DOA information on run report and names of The CMPC Transport Response Team members.

14. If the CMPC Transport Response Team(s) are overwhelmed or unavailable the Fire Chief may chose to establish TFRD-DOA Unit(s). These Unit(s) would be responsible for supplementing the CMPC Transport Response Team by responding to DOA calls, placing the remains in a body bag, tagging the deceased with the provided triage tag, ensuring the data is entered into the Image Trends Patient Tracking Software by self or through a call to the CMPC, and transporting the body to the CPMC. TFRD-DOA Unit personnel will be trained and be provided the appropriate PPE. The Lucas County Sheriff's Office may also establish DOA Transport Units to assist. The TFRD Communications Bureau has technologies available to ensure information privacy.

15. If the cause of death is unknown or there are signs of violence or any other unusual circumstances, the Standard Death Procedure for EMS Incident-Not Hospice applies: <u>ONLY THE CORONER CAN MODIFY THIS POLICY DURING A MASS CASUALTY INCIDENT.</u>

    i. Do not move or disturb the body or any other objects on the premises. Prevent anyone else from doing so.

    ii. Fire personnel at the scene will call for a police crew through Dispatch by radio (code 18) or by telephone.

    iii. If the police are not on the scene within 15-20 minutes, the Officer in charge or Dispatch will call the Police Detective Bureau. They will page an investigator from the coroner's office. If the coroner's investigator cannot be contacted, call the coroner.

    iv. The first to arrive (police, coroner, etc.) will take over the investigation. At that person's arrival, Fire personnel will furnish them with all the information at their disposal and assist as needed. At this point, the Fire Department's responsibility is ended.

    v. Identify the police unit on the scene on the EMIRS.

16. The CMPC will attempt to notify family members of the deceased. If the deceased remains unclaimed the body will become a coroners case handled outside departmental operations.

PAGE INTENTIONALLY LEFT BLANK

Attachment I: TFRD Pandemic Staffing Plan

TOLEDO FIRE AND RESCUE DEPARTMENT PANDEMIC STAFFING PLAN

In the event the City of Toledo experiences an increase in runs as a result of a pandemic, the Toledo Fire and Rescue Department will institute the following plan in regards to staffing

1. Provided the personnel are available we will put Medic 4, Medic 19 and Medic 6 in service and increase staffing to 117.
2. In the event the TFRD personnel are not available and we aren't able to maintain the 111 minimum staffing the following steps will be taken
    a. With 100 firefighters available the following rigs will be taken out of service
        i. Engine 12 (4 people)
        ii. Engine 19 (4)
        iii. R15 (3)
    b. With 90 firefighters available
        i. E12 (4), E19(4) R15(3),
        ii. E14 (4)
        iii. E13 company (6)
    c. With 80 firefighters available
        i. E12 (4), E19(4) R15(3), E21(5), E13 company (6)
        ii. Move E14 into Station 21
        iii. Cross Staffing of the following apparatus
            1. E4/TL4 (3)
            2. E17/TL17 (3)
            3. E5/TL5 (3)

            Or
            1. E4/TL4 (3)
            2. E25 (6)

All non-essential TFRD staff personnel will be moved to the line to assist with staffing. The Fire Chief or his designee will determine who is essential and non- essential.

DISTRIBUTION OF PLAN

All personnel are required to familiarize themselves with this plan and to comply with its guidance.