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Tactical EMS

Proactively expanding the EMT and paramedic scope of practice

Some agencies have responded to the COVID-19 pandemic by implementing concepts that have been discussed for years

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A year ago, most people would have thought that paramedics performing nasal swab collections, EMTS performing CNA duties in skilled nursing facilities, and paramedics dispensing prescribed medications to patients was out of the question.

The COVID-19 pandemic has been an opportunity for EMS to step up and provide support to the healthcare infrastructure and critically needed services to those that need it most. Some EMS systems across the nation have found novel ways to assist and help mitigate the pandemic public health crisis.

ALTERNATIVE EMS DELIVERY MODELS

The COVID-19 pandemic has been an opportunity for EMS to step up and provide support to the healthcare infrastructure and critically needed services to those that need it most. (AP Photo/Elaine Thompson)

Here in Alameda County, California, we knew early on in the COVID-19 pandemic that EMS would have to move well beyond our comfort zone and expand our knowledge base, our skill set and our normal delivery model.

During the month of April, the Alameda County average daily call volume was down by 10.9%. The community did their part, mostly, in abiding by the Shelter in Place order. Fewer people were out and about, therefore reducing the number of motor vehicle accidents and other traumatic injuries. The average daily transport rate for the month of April was down 26.9 %.

The Alameda County Emergency Medical Services Agency was incentivizing, although not reimbursing, the EMS system providers to *not* transport those patients who could be safely guided to non-emergency department options. Options included not transporting at all, as many of the callers were "worried well" who were concerned about a COVID-19 potential infection, even though they exhibited no symptoms, contacts or relevant travel history.

We also initiated and moved forward our budding Assess and Refer policy, in which non-emergent "patients" are directed towards medical services more specifically aligned with their needs, such as dental care, clinic appointments, behavioral healthcare, pharmacy refills, etc. We did everything possible to lessen the burden on the receiving hospitals so that they could conserve resources for a potential surge of COVID-19 patients.

These efforts were successful and our community has not yet experienced the surge to the level some predicted. However, the outbreaks in the local skilled nursing, long-term care and other congregate facilities was surging with COVID-19 positive patients, as seen in other parts of the country. The patients and these facilities needed help.

EMT AND PARAMEDIC SCOPE OF PRACTICE FILLS A GAP

In a proactive move, the California state Emergency Medical Services Authority (EMSA) allowed all EMTs and paramedics to perform their current scope of practice in hospitals, medical facilities,

alternate care sites, long-term care and shelter care sites. In addition, the Alameda County EMS Agency asked for, and received authorization for EMTs and paramedics to:

- Assist in the administrations of prescription oral medication
- Perform paramedic-facilitated phlebotomy
- Dispense meds from bubble packs and/or multidose containers
- Administer prescribed medications including: ocular, transdermal, inhaled, oral, intravenous, intramuscular and subcutaneous medications

With the 20%-30% reduction in EMS call volume in April and May, we were able to stave off potential EMS layoffs by filling a needed gap in the long-term care and skilled nursing facilities with EMS personnel.

The impact on these facilities was – and still is – profound, with over half the deaths from COVID-19 occurring in these types of congregate living, long-term care homes.

Some of the staff in these facilities were sick, and appropriately staying home. In addition, some staff were refusing to come to work out of fear of getting sick or bringing the virus home to their families. Some of the families of healthcare workers did not want their loved ones working in these high-risk environments.

Another widespread problem within the long-term care facilities was the general lack of knowledge about communicable disease isolation precautions, proper use of PPE, including donning and doffing. EMS folks tend to be pretty good at PPE and isolation skills, so they soon became the "experts" and advisors to the facilities on best practices in isolation, PPE, and general guidelines for separating staff and patients into appropriate zones to avoid cross contamination. To date, we have staffed over 488 shifts with EMS personnel to over nine different long-term care facilities in Alameda County.

In addition to supporting direct patient care medical needs, our own EMS agency at the Emergency Operations Center Medical Health Branch became the point for PPE and COVID-19 related material (testing supplies, medications, disinfectant wipes, hand-sanitizer, etc.) procurement, storage, warehousing and dissemination to the first responder and healthcare community. To date, we have processed over 1,956 resource requests and have distributed:

- Over 1.2 million N95 masks
- 1.4 million surgical masks
- 93,300 bottles of hand sanitizer
- 15,200 goggles
- 201,000 isolation gowns

- 2,100 infrared thermometers
- Thousands of boxes of gloves, head/foot covers, disinfectant wipes, Tyvek suits and more

For some EMS providers and EMS agencies, our normal working conditions, expectations and job descriptions have changed dramatically because of COVID-19. The EMS industry can either step up to the challenge, or hide in the comfortable bubble of running 911 calls. Some EMS systems have taken the opportunity to implement ideas and changes that have been bounced around in concept form for years (Assess and Refer, expanded scope, community paramedicine-oriented home healthcare, refusal of transport, etc.) This is the time for EMS to shine.

One should never let a catastrophe go by without trying something new.

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About the author

Jim Morrissey is a former Tactical Paramedic for the San Francisco FBI SWAT team and the founder of the Tactical Medical Association of California (TMAC). Jim is also the Terrorism Preparedness Coordinator for the Alameda County EMS Agency. Jim has a master's degree in Homeland Security from the Naval Postgraduate School in Monterey, CA. He can be reached at jim.morrissey@acgov.org.

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Posted by **AsianEMT012** today at 12:00 am

Need to EXPAND the EMT level scope of practice to the AEMT level scope of practice. Allow AEMT scope of practice to get into the Paramedic scope of practice, and the Paramedic scope of practice get more into the LPN, RN, or even certain elements of the PA level such as suturing, stapling, amputations, administering more drugs, and other advanced PA level medical procedures!

Need to make the EMT training longer and involve more technical medical training, not just basic first aid! Need to allow AEMT's to do more C.T. and IV type therapies, and allow Paramedics to do more PA, LPN, RN type medical procedures. Paramedics and EMT's are the backbone of medicine, yet, we're underpaid, undertrained, and understaffed because of the refusal to expand the scopes of practices!!

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Posted by **robertjbuck2006** Jul 13, 2020

We need to bring this to the forefront. If ANYONE has any questions about how vital EMT's and Medics have been, are, and will be in the future, they need only pop out a lawnchair in ANY ER, Urgent Care, Day Surgery facility. We are everywhere! What's annoying is that this has been going on since long before even I joined the Fire Service in 1989. I have always picked up PRN shifts in the hospitals (particularly because we worked 48's so what else am I gonna go, right?). But this "hear no, see no, speak no" is just BS. It always has been and I have no idea why, oh wait...WE'RE CHEAPER! Yeah, I forgot that on average we pull in HALF what an RN does even though we are always the go to for "hard sticks", your average ER doc comes to us at least twice a shift in a panic, and then some charge waltzs' into your patients room and asks condescendingley "what are you doing?" Hahaha. We have always been the go to. Why it's taken this long is the question, not should scope be expanded. If you're asking why, you're just lying to yourself. And that's one of the FEW things we can't fix.

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