

COVID-19 and Rural EMS

July 7, 2020

Wyoming COVID – 19

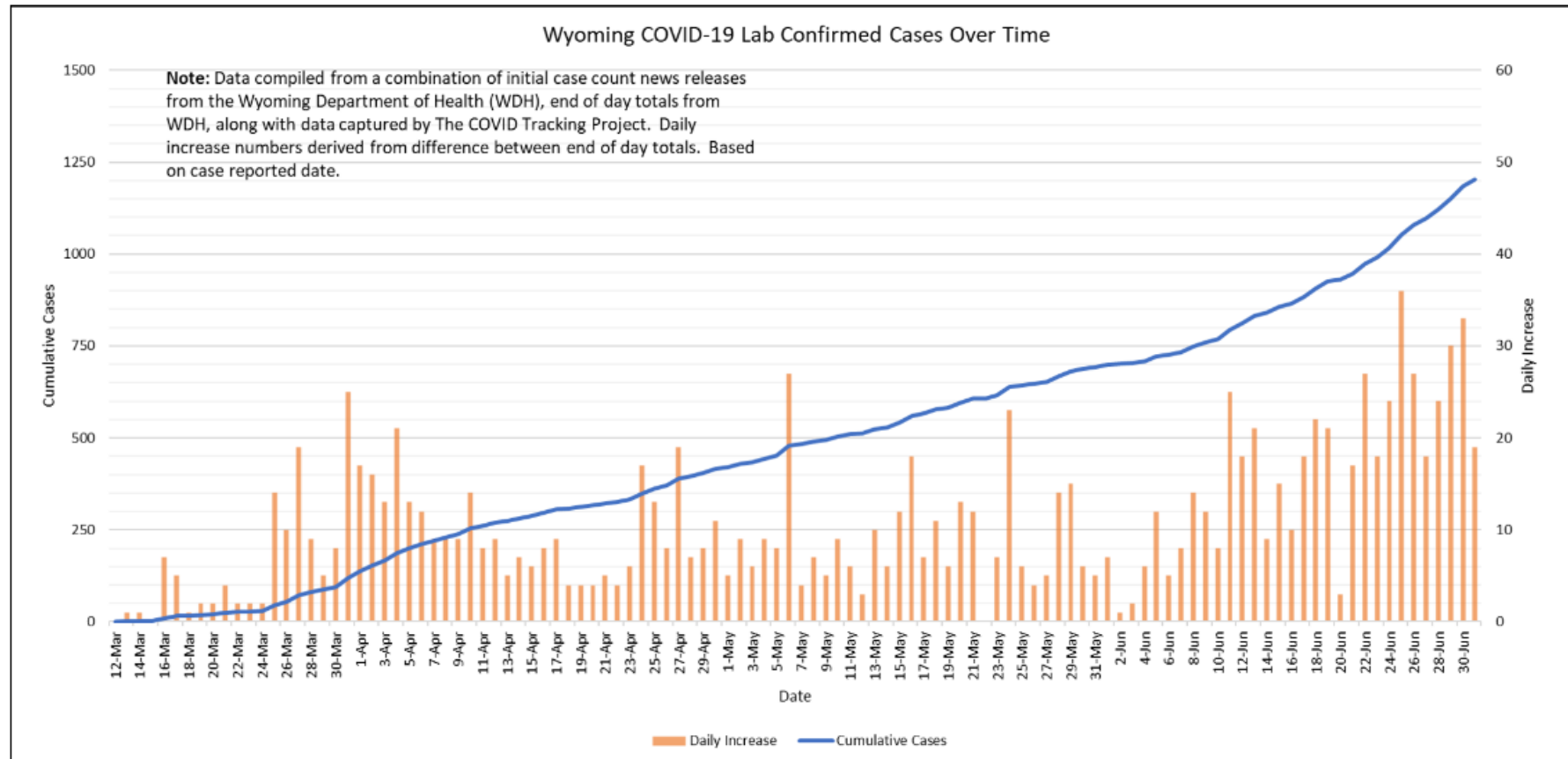
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Wyoming COVID-19 status:

- To date, Wyoming has not experienced an overly burdensome case load: 1,119 total cases, 20 deaths



Immediate Wyoming EMS issues:

- Limited testing capacity
- Office of EMS (OEMS) became heavily engaged in support of the Emergency Operations Center (EOC) (all other work ground to an immediate halt)
 - Hospital Preparedness Program (HPP), licensing, data, trauma program
- Local EMS was ill-prepared:
 - Thermometers
 - Personal protective equipment (PPE)
 - Powered air purifying respirator (PAPRS)
 - Confusion over medical direction/blurred lines of authority
 - Lack of control (unnecessary exposures); triggered a “get with the program” email from the OEMS

What we did:

- Distributed all guidance as it was available
 - Utilized existing listservs/licensing system
- Removed licensing hurdles
- Worked with the [REPLICA](#) Commission to make the Compact “active”
- Opened existing Medicaid rules for Community Paramedicine to all agencies
- Utilized EMResource to monitor PPE and patient status for both hospitals and EMS
- Developed statewide transport plan using the “Iamresponding” app

Andy's root cause analysis

1. Lack of leadership/organization prior to COVID results in poor readiness (ie., thermometers).
2. Minimal staffing leaves no room for exposed providers.
3. The required response (avoid transport) **directly** contradicts how we fund EMS. This long-standing issue that hasn't seen change for *decades* puts EMS in a compromised position.
4. Lack of integration (fault lies with local emergency medicine (EM) as well as EMS) means EMS is left out of planning and not counted as a resource.
5. Disengaged Medical Directors leaves EMS without guidance/coordination.

For the next pandemic...

1. Emphasize planning/preparedness (How much, what type of PPE is needed? Do we need to count band-aids?)
2. Regionalize Medical Direction.
3. We need bandwidth/telehealth connections.
4. EMS has to see themselves as part of the overall response.
5. Change at the CMS level

Florida

Steve McCoy, Emergency Medical Services Administrator

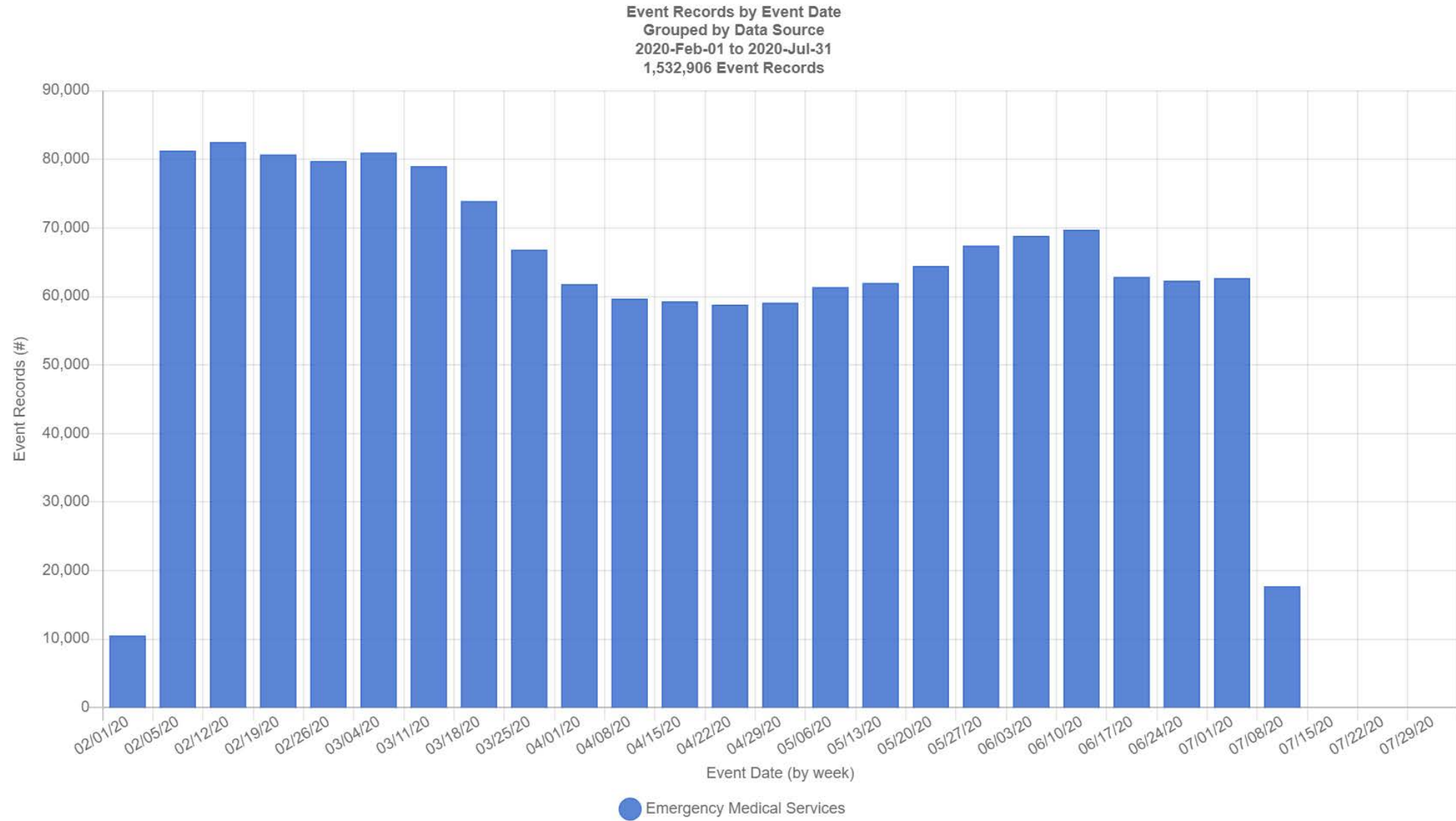
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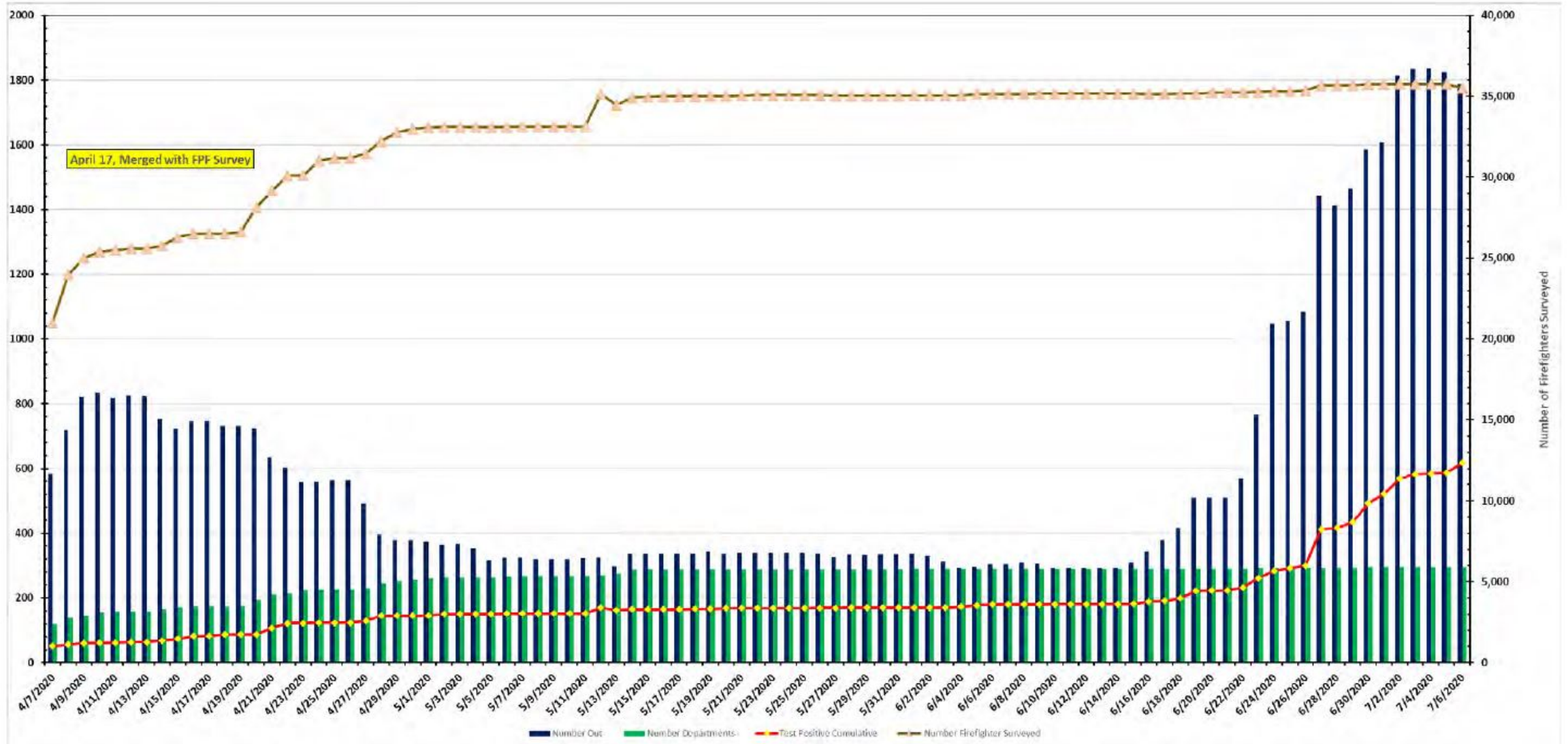
Changes in EMS

- PPE shortages (public vs for-profit distribution)
- Changes disaster preparedness & response
- Longer transports
- Facility access requiring screening
- Decrease in staffing
- Lower call volumes

Florida EMS Call Volume

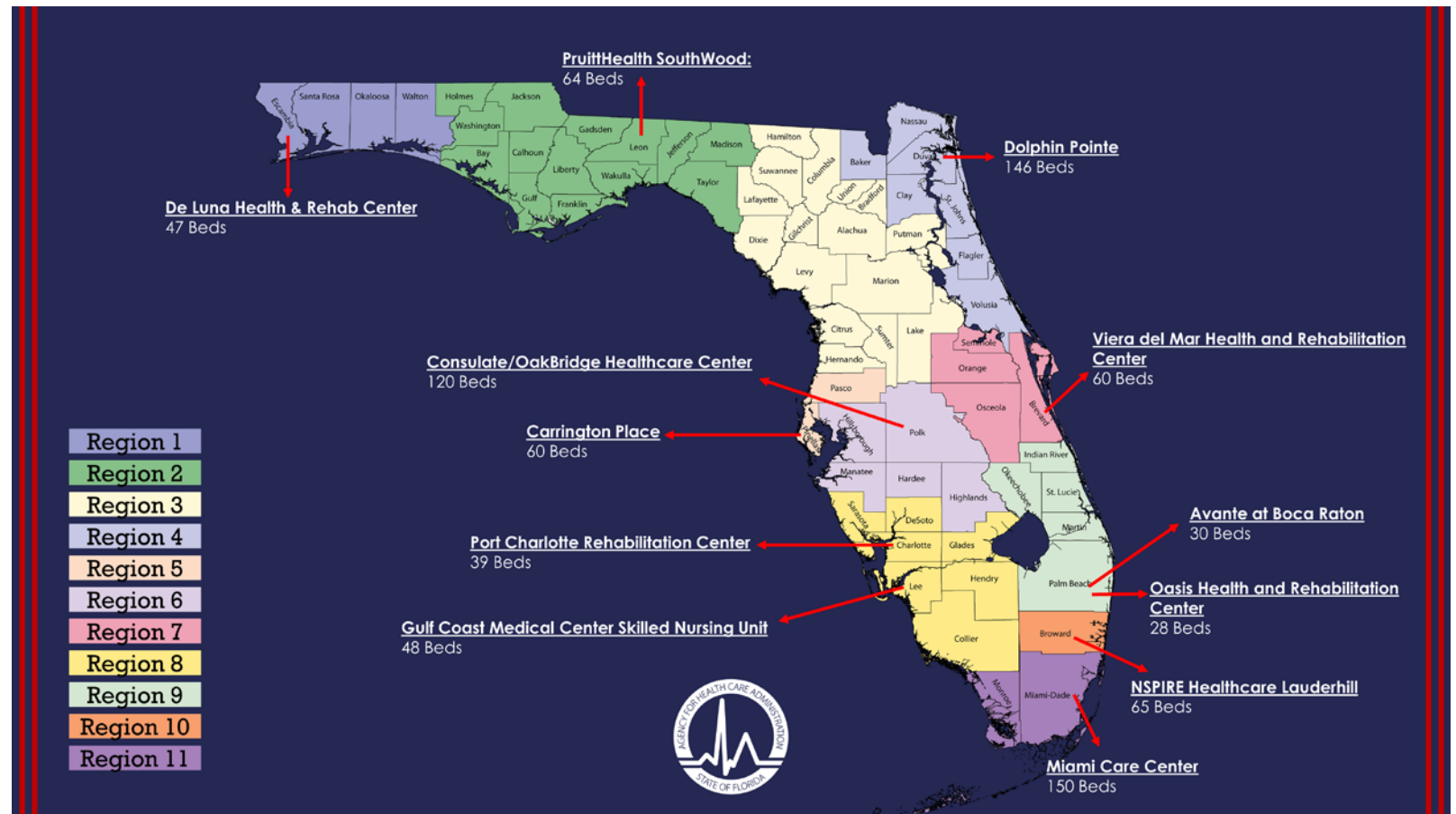


Florida Professional Firefighter Survey



Repurposed Resources

- Long-term care facility assessments
- Mobile testing teams
- Staffing drive-throughs
- State-sponsored interfacility transfers



Contact Information

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Lakes Region



National EMS Perspective on COVID-19

- Current fragility of national EMS system exposed
- Shined on a light on resources available or not available based on ownership type
- Marked disconnection between what modern EMS is and the services it provided (Treatment in Place (TIP), who provides EMS, Federal Emergency Management Agency (FEMA), transportation)
- Workforce (current workers, future workers, value proposition)
- National EMS system composition (80/20 rule)
- The devastating effects current reimbursement model (transportation, cost of readiness, fee for service)

Current Work

- Same 4 items:
 - PPE at the “Gold Standard” level (5th and then 3rd priority, FEMA regions EMS is green)
 - Financial resources (Paycheck Protection Program (PPP), Centers for Medicare and Medicaid Services (CMS) loan, direct appropriation, \$100 billion in CARES Act for health care)
 - FEMA Reimbursement for all ownership types (generally only government, 25% state match)
 - Priority access to testing and future vaccine (2nd priority, now first for symptomatic)
- National partnership
- Flex consideration
 - Information sharing
 - Education
 - Connection
 - Invest in leaders and leadership