Medical Unit COVID-19 Concept of Operations Plan, Emergency Medical Committee

Introduction

As a response agency, the wildland fire community needs to be ready and prepared to adjust operations to meet the complexities of fighting wildland fires in a COVID-19 pandemic environment. While this document provides the Medical Unit Leader (MEDL), Command and General Staff (C&G), and other wildland fire planners broad-based COVID-19 medical guidelines, preparations, and response should be managed to the unique characteristic each fire presents.

Due to the potential serious operational impacts COVID-19 could have on the 2020 fire season, the Fire Management Board (FMB) established the Medical and Public Health Advisory Team (MPHAT) to serve as the interagency body responsible for providing consistent review and recommendations for all wildland fire COVID-19 planning material. This document was reviewed by the MPHAT and guides the wildland fire medical posture and COVID-19.

It is important to note that one solution or guideline may not apply to all situations. It is impossible to establish one set of protocols/procedures that work for every single jurisdiction. However, clear national guidance is required to decrease the risk of serious impacts to fire operations due to COVID-19 infections.

⇒ Medical Unit Concept of Operations

The Medical Unit Concept of Operations (CONOPS) plan is a dynamic document that summarizes the roles and responsibilities of the MEDLs and the function and operational posture of a COVID-19 Medical Unit. Additionally, this plan addresses the interdependencies a MEDL and the Medical Unit have with the incident’s C&G, state and local public health departments, and other augmented units such as the National Guard (NG).

Plan Development and Maintenance

The NWCG Emergency Medical Committee (EMC) is responsible for the development and maintenance of this plan. Specialized plans such as this should be reviewed frequently, as the science, strategy, and tactics of firefighting in a pandemic are rapidly changing.

Purpose, Scope, and Planning Assumptions

Purpose

The purpose of this plan is to provide a baseline framework for incident personnel to plan for and react to suspected or confirmed COVID-19 infections, and to reduce the rate of spread within the fire community. This plan will also provide several checklists to aid in navigating the complexities of COVID-19. These lists can be updated as needed to meet the best practices and lessons learned of Incident Management Teams (IMT) and individual suppression modules. The MPHAT has incorporated key emergency medical and public health concepts into applicable procedures to help ensure continuity of interagency wildland fire capability during COVID-19.

Scope

This plan applies foundational guidelines that may be adopted independently by the NWCG members. and other planning officials involved with wildland fire response during COVID-19.

Assumptions

The Medical Unit COVID-19 CONOPS Plan is based on the following assumptions:

- To keep the workforce healthy throughout the fire season, all aspects of the wildland fire community have a role to play in identifying and preventing the spread of COVID-19.
- Despite interagency planning, when COVID-19 does present within the wildland fire community each agency may still have individual policies and procedures that must be addressed per agency standard.
- COVID-19 may be spread by people showing NO symptoms. Symptoms of COVID-19 may appear 2-14 days AFTER exposure to the virus, which means incident personnel could be infected and not know it for a prolonged period. Symptoms of COVID-19 infection can also be mild and confused with typical symptoms experienced by firefighters due to environmental exposure to smoke, and camp crud.
- Isolation separates sick people with a contagious disease from people who are not sick. Quarantine separates and restricts the movement of people who were potentially exposed to a contagious disease to see if they become sick. Throughout this plan, isolation is used on wildland fire incidents to separate individuals with symptoms presumed to be COVID-19 positive. Quarantining should not occur on wildland fire incidents unless necessary; rather asymptomatic individuals with potential exposure should follow the Centers for Disease Control and Preventions (CDC) Critical Infrastructure Worker’s Guidance.
- A risk assessment should be completed when COVID-19 mitigations have been put in place to ensure mitigations do not inadvertently increase or transfer risk elsewhere. For example, modifying incident command posts (ICP) and base camps, altering communal spaces such as catering and showers; and dispersing campsites and sleeping areas are all potential mitigations where the impact on incident contract requirements and fire operations must be considered.
- There is a critical national shortage of COVID-19 personal protective equipment (PPE). Supplies issued by the National Cache System and incident caches will be prioritized for medical personnel and suspected COVID-19 patients. The responding medical personnel should be prepared for three days of PPE self-sufficiency.
• Embracing the “Module as One” insulation theory as outlined in the MPHAT Interim Guidance for Prevention and Management of COVID-19 During Wildland Fire Operations should be utilized at all levels of fire response to decreasing the spread of COVID-19.
• State and local public health departments may have stricter COVID-19 guidance than listed in this document. It is incumbent on the MEDL and/or other appropriate local agency or incident leaders to understand and implement any additional pandemic controls put in place by the local jurisdiction.
• The COVID-19 situation is dynamic, requiring frequent updates to planning products and interim guidance memorandums. It is incumbent upon MEDLs, incident commanders (ICs), and IMTs to stay current.

⇒ Roles and Responsibilities of MEDL and Medical Unit Operations

COVID-19 Medical Action Plan

Appendix A contains a COVID-19 Medical Action Plan to help MEDLs and other team members plan and respond to COVID-19. One of the complicating factors of pandemic planning in a wildland fire emergency response is the potential for communal spread. This could significantly impact suppression operations and potentially halt them.

There are several key points in the Medical Action Plan:

• Designating and maintaining isolation areas—It is paramount to separate suspected COVID-19 patients from others immediately. Sick individuals should be transferred to a medical facility and/or arrangement should be made for them to return to their home station as appropriate. In the event these arrangements do not occur quickly, a quarantine area that restricts the movement of a patient and gives them an isolated place to sleep, eat, bathe, etc., while awaiting while waiting will be necessary. This requires cross-section IMT planning.
• Screening and Non-Medical Personnel—Not all screening needs to be completed by medical personnel, nor can it be to maintain the flow of personnel to their morning work locations. IMTs may have to rely on collateral duty staff from other IMT sections for screening. Additionally, utilizing Liaison Officers (LOFRs) to coordinate with state/local public health and C&G will alleviate pressure when just one MEDL is available.
• Implementation of Telemedicine—Although not widely used in wildland fire operations, telemedicine functionality can be an enormous asset to MEDLs.

Stakeholder Contact Information

Appendix B contains State Public Health, State COVID-19, and State Emergency Medical Services (EMS) contact information. It is important to note, Local Public Health Departments may have their control measures for COVID-19 that must be implemented on incidents. Once MEDLs receive their Resource Order, they must contact both state and local public health departments immediately to plan for added measures.

Mirrored Isolation Medical Unit (IMU) and Staffing

Due to the potential of infectious disease spread on large fires, a subordinate Medical Unit dedicated to the management of potential COVID-19 patients should be established to immediately isolate potential COVID-19 patients. The IMU would consist of a designated MEDL and two emergency medical technicians (EMTs) minimum who would not comingle or be available to trade shifts with the ICP Medical Unit supporting non-COVID needs. Other considerations for staffing of high-risk fires (fires in an active COVID-19 outbreak location, remote location with a lack of medical care facilities, etc.) could include the ordering of a resource that provides a physician assistant or registered nurse.

Wildland fire agencies understand the normal circumstances and resource levels that coincide with Preparedness Level. It is anticipated that COVID-19 will have an impact on the available resource levels including EMS support personnel (MEDL, EMTB, EMTF, and EMTP).

Alternate Location Determinations

Many aspects of traditional wildland fire response support and operations will be different while COVID-19 transmission is still a threat. To increase social distancing, modifications of the ICP and incident base should include the use of spike camps, hotels, and dispersed camping to support the “Module as One” concept. MEDLs should consider the need for suspected patients to be isolated on location if these areas are hours away from the IMU. Refer to Appendix A for further recommendations.

Recommendations for Pairing of Fireline Medical Staff

Frequently on incidents, medical staff are assigned in pairs to the fireline. This happens for multiple reasons; EMTs who lack medical and/or fire experience are paired with a seasoned staff member; or they are paired due to extended travel distances, or incident complexity, etc. This staffing strategy normally means the sharing of a single vehicle. The first line of defense against person to person COVID-19 infections is to not pair in vehicles, but if there is no other way to ensure adequate coverage for fire operations, the following guidelines should be applied when pairing medical support staff in one vehicle:

• The personnel are staffed “Module as One” to include a designated vehicle.
• Do not rotate in/out individual personnel.
• If one of the pair is demobilizing, then the other is solo and “Module as One” — do not re-pair the staff member with someone new.

Recommendations During and After Vehicle Use:

• Thoroughly disinfect all surfaces inside the vehicle, and commonly touched surfaces outside the vehicle BEFORE and AFTER deployment following CDC guidelines.
• Use an approved disinfectant solution spray or wipes and allow for sufficient contact time for the disinfectant to work.
Instruct passengers to refrain from touching surfaces of the vehicle.
Assure adequate ventilation inside the vehicle by opening air vents and windows when possible. Turn on ventilation systems and avoid using recycled air.
Wash hands regularly with soap and water for at least 20 seconds or use an alcohol-based hand sanitizer containing at least 60% alcohol when handwashing facilities are not available. Key times to clean hands include:
- Before, during, and after preparing food.
- Before eating food.
- Before and after using the toilet.
- After nose blowing, coughing, or sneezing.
- Before and after work shifts.
- Before and after work breaks.
- After handling another passengers’ personal belongings.
- Before and after putting on, touching, or removing cloth face coverings.
- Before wearing and after removing gloves.
- Before and after pumping gas.

Surveillance of Incident Personnel for COVID-19 Infections and Transmission

Recommend Use of the MPHAT Wildland Fire COVID-19 Screen Tool

The Wildland Fire COVID-19 Screening Tool is a baseline questionnaire to be implemented within the “Module as One” construct at the beginning of the operational period. This tool may not meet the minimum level of screening for state and local public health departments, so it is critical MEDLs understand any layered requirements. One caveat for the efficiency of this system: giving the tool out to supervisors is easy, but ensuring the tool is used should be the focus. Any medical information gathered is subject to the American with Disabilities Act (ADA) confidentiality requirements There may be some individuals that do not believe COVID-19 is easily transmitted, this can directly impact operations or worse lead to the death of a responder.

Overcoming resistant biases to the enhanced measures emphasized this season will require constant visual and verbal education and situational vigilance. View the most current version of the Wildland Fire Interim Screening Protocol and Tool and other FMB Memorandums, or go to the Fire Management Board Home Portal.

Medical Treatment Support Matrix

The Medical Treatment Support Matrix (Appendix D) is a baseline key to help supervisors, team members, and medical personnel choose appropriate actions for suspected COVID-19 patients. This document has two pages. The first matrix is designed for situations where no dedicated MEDL or Medical Unit is available, such as initial attack. The second matrix is designed for larger fires, where an established IMU has been established. It is incumbent upon the MEDL and medical staff to become familiar with agency protocols for the assessment and treatment of patients with flu-like illnesses, specifically COVID-19.

Emerging Incident

Due to the chaotic environment of emerging incidents, the ICs, and Fire Management Officers (FMOs) may find it difficult to pull away from fire operations to concentrate on a suspected COVID-19 patient. Due to limited medical support, ICs and FMOs should ensure the incident medical plan includes procedures for care and transport of suspected patients. Another coordination resource is the local dispatch center, duty officer, and the Hospital Liaison.

The Appendix D Medical Treatment Support Matrix can be used to help ICs and FMOs understand the requirements of isolating and caring for a suspect COVID-19 patient. Not all responders will have adequate supply of COVID-19 PPE, the following is a recommended list for all responders treating a suspected COVID-19 patient:

Good

- Care Provider: Cloth face covering and gloves.
- Patient: Any face covering available.

Better

- Care Provider: Surgical mask and gloves.
- Patient: Cloth face mask.

Best

- Care Provider: N-95 mask, gown, gloves, face shield, etc.
- Patient: Surgical mask.

*A face mask or covering should not be used on a patient if it interferes with their ability to breathe.

Additionally, any suspected COVID-19 patient should be physically isolated from the group.

Employee Contact Assessment
A key element of the social context to reducing the risk of COVID-19 workplace-related exposure is having the ability to conduct an Employee Contact Assessment (ECA). Different than formal Public Health Contact Tracing Protocols which involves testing and a formal interview, an ECA relies only on the documentation of the individual who may be COVID-19 positive.

The ECA should be completed by an employee and/or the supervisor when an employee becomes symptomatic. The ECA captures supportive details, including but not limited to, time entered, and exited multi-person vehicles, buildings, and other social settings, different areas visited throughout the day, and people the employee may have come in contact with. In general, it is a good idea for employees and supervisors to mentally track this information so when completion of an ECA becomes necessary the information is readily available. The ECA can be found in Appendix E.

Local Public Health

The roles and responsibilities of local public health departments vary across the nation, however with COVID-19 impacts, almost all agencies will have a public health response team and/or plan. These offices have the potential to contribute significantly to managing a suspected COVID-19 exposure or outbreak during wildland fire operations, it is important to note the availability of public resources may be scarce. It may be best to plan for minimal public health response team and/or plan. These offices have the potential to contribute significantly to managing a suspected COVID-19 exposure or outbreak.

Appendix B provides State Public Health Departments, State COVID-19, and State EMS Contacts, however MEDLs, Safety Officers, and Liaisons should find local health departments before the assignment.

⇒ Personal Protective Equipment (PPE)

PPE is specialized equipment designed to protect personnel such as health care providers who may be exposed or encounter hazards such as infectious agents. COVID-19 specific PPE includes gloves, face masks, protective eyewear, face shields, and protective clothing. Due to the exponential drain on health care facilities during this pandemic, the nation is experiencing a critical shortage of PPE.

When to Use COVID-19 PPE

On wildland fires, if COVID-19 PPE supplies are limited, it should be reserved for medical personnel only. All line and camp medical staff should have at minimum, supplies for three operational periods before arriving at their assignment. A mask should be placed on all suspected COVID-19 patients, this can include a cloth face covering or bandana if a medical mask is not available at that time.

EMS clinicians who will directly care for a patient with possible COVID-19 infection or who will be in the compartment with the patient should follow standard precautions and use the PPE as described below. Recommended PPE includes:

- N-95 or higher-level respirator or facemask (if a respirator is not available).
  - N-95 respirators or respirators that offer a higher level of protection should be used instead of a facemask when performing or present for an aerosol-generating procedure.
- Eye protection, i.e., goggles, or disposable face shield that fully covers the front and sides of the face. Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
- A single pair of disposable patient examination gloves. Change gloves if they become torn or heavily contaminated, and isolation gown.
  - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of EMS clinicians, e.g., moving patient onto a stretcher.
- When the supply chain is restored, fit-tested EMS clinicians should return to the use of respirators for patients with known or suspected COVID-19.
- Drivers, if they provide direct patient care (e.g., moving patients onto stretchers), should wear all recommended COVID-19 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, gloves, and perform hand hygiene. A respirator or facemask should continue to be used during transport.
- All personnel should avoid touching their face while working.
- On arrival, after the patient is released to the facility, EMS clinicians should remove and discard PPE and perform hand hygiene. Used COVID-19 PPE should be discarded in accordance with routine procedures.
- Other required aspects of Standard Precautions (e.g., injection safety, hand hygiene) are not emphasized in this document but can be found in the guideline titled Guiding for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings.

Since wildland fire medical personnel have varied experience with isolation protocols, the MEDL should ensure all staff have the appropriate knowledge base on how to don, remove, and dispose of PPE. As a reference and refresher, it is recommended the MEDL have staff read Guidance for the Selection and Use of Personal Protective Equipment (PPE) in Healthcare Settings.
Understanding the Differences – Respirators, Masks, & Cloth Face Covers (Revised 4/20/2020)

<table>
<thead>
<tr>
<th>INTENDED USE</th>
<th>N95 Respirator</th>
<th>Surgical N95 Respirator</th>
<th>Surgical Mask</th>
<th>Comfort Mask</th>
<th>Cloth Face Cover</th>
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<td>Wearer (Splash Only) &amp; Others</td>
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<td>Others</td>
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<tr>
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<td>Facility-determined</td>
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<td>&gt; 95%</td>
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<td>N/A</td>
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<tr>
<td>FLUID RESISTANT</td>
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<td>Yes</td>
<td>No</td>
<td>No</td>
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<td>2</td>
<td>1 or 2</td>
<td>1</td>
<td>0, 1, or 2</td>
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<tr>
<td>LEAKAGE</td>
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<td>Minimal</td>
<td>Extensive</td>
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<td>USAGE LIMITS</td>
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<td>Single-use*</td>
<td>Single-use</td>
<td>Single-use</td>
<td>Reusable</td>
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</table>

* Extended wear and re-use may be authorized when approved by the bureau safety program following CDC guidelines. Decontamination and re-use is not authorized.

Ordering PPE for Wildland Fire Medical Personnel

There are several ways to obtain PPE.

1. Order Infectious Disease Barrier Kits for the incident
   a. The NFES 1660 – Individual infectious disease barrier kit.
   b. The NFES 1675 – Multi-person infectious disease barrier kit protection for up to ten people.
2. Use your incident buying team or other local procurement support.
3. Bring a 3-day supply for yourself from home unit.

Guidance for Non-Medical Incident Staff

Regardless of the situation (ICP, incident base, spike camps, etc.) the CDC currently recommends wearing cloth face coverings in the community. This is to include wearing cloth face coverings while at work when social distancing cannot be maintained; and/or when operating outside the “Module as One.” ICs and MEDL can increase the precautions to align with state and local public health guidance.

It is recommended all personnel resourced to an incident bring several washable face coverings.

⇒ Relationships Between MEDL and C&G

It will be expected that MEDLs will compile a daily briefing for the C&G. Elements of this can include, but not limited to:

- Updates of all suspected and confirmed incident COVID-19 cases.
- Emerging trends in infectious rates in surrounding areas, to include neighboring fires.
- Number of patients awaiting return to the home unit and any delays in demobilization.
- Potential impacts to operations resourced to the fire.
- Potential impacts to IMT.
- Changes in remote or spike camp aid stations.
COVID-19 reaches far beyond the MEDL and impacts almost all elements of a traditional fire camp setting. To be successful in planning, it will require the MEDL to coordinate much deeper in the IMT than in past years. At a minimum:

- Liaison Officers (LOFR) will be an enormous asset in pandemic planning. It is inherent in their position to connect the needs of the IMU with the community and the Public Health Department.
- Safety Officers (SOFR) will be instrumental in coordinating screen and isolation and quarantine procedures.
- There will be substantial coordination required with the Logistics Section for all aspects of setting up the IMU, to include separate sanitation, feeding, showering for suspected patients. Additionally, incident bases and spike camps will need similar support if it is not feasible to transfer patients back to the IMU during one operational period.

⇒ Appendix A: COVID-19 Medical Action Plan

Pre-Mobilization when Resource Order is obtained

1. Begin personal daily log.
   a. Use the Wildland Fire COVID-19 Screening Tool.
   b. Adapt aspects of the Employee Contact Assessment (locations visited throughout the day, list of individuals in contact with, etc.) to being the “Module as One” process.

2. Check the following sites for most current information on COVID-19 symptoms, care of patients, and other relevant guidance for EMS.
   a. CDC Guidance for First Responders
   b. CDC Guidance for Healthcare Professionals
   c. COVID-19 Current Symptoms
   d. EMS.GOV

3. Evaluate the severity of COVID-19 in the location of the fire.
   a. Look for communities/locations near the fire with elevated COVID-19 cases.
   b. Relay any serious concerns to C&G.

4. Communicate with Logistics Section Chief (LSC).
   a. Establish a mob-order of multi-patient infection disease isolation kits (NFES 1675) to meet the needs of medical staff and suspected patients for 3-5 days.
   b. Discuss previous isolation location established by the prior team, if no location is set-up before arrival, discuss isolation location availability (Yurts, trailers, physical locations such as office space, hotels, schools, etc.).

5. Obtain supplies and equipment.
   a. There is a critical national shortage of PPE and select medical equipment.
   b. Bring PPE for three days, and a “no-contact” thermometer if possible.
   c. Bring food and water for three days to be able to adapt to modified ICP situations.

During Mobilization Process

1. Contact State EMS to:
   a. Process limited recognition of EMS resources.
   b. Develop a list of local EMS and ambulance provider contacts.
   c. Ascertain statewide availability of BLS/ACLS ambulance resources.

2. Contact Local, County, State Public Health to:
   a. Ascertain COVID-19 protocols, testing, contact tracing, and videoconference/telehealth capabilities.
   b. Obtain 24/7 contact information.
   c. Coordinate with LOFR for public health availability to advise C&G.

3. Contact all possible destination hospitals and clinics to:
   a. Obtain 24/7 contact information.
   b. Obtain COVID-19 protocols, patient receiving procedures, and testing availability.
   c. Inquire as to videoconference/telehealth capabilities.

Arrival at Incident

1. Screen all team members utilizing the Wildland Fire COVID-19 Screening Tool, utilize the Medical Treatment Support Matrix for suspected patients and encourage the team to adapt aspects of the Employee Contact Assessment (locations visited throughout the day, list of individuals in contact with, etc.).

2. Immediately designate COVID-19 medical staff. Consider mirrored operations, to include one MEDL and supporting staff for COVID-19, and one MEDL, and supporting staff for standard incident response, per SOP. Communicate both rosters to C&G and Communications.

3. Discuss with C&G how to support “Module as One” with assigned medical staffing.

4. Develop suspected line personnel COVID-19 Incident Within an Incident Plan.

5. Ensure there is no assignment swapping between fire medical staff and isolation staff, and no swapping of line personal if they are assigned in pairs.

COVID-19 Operations for Type 1 and Complex Type 2 Fires:
Designated Isolation Medical Unit (IMU)

- Placement of IMU should be located away from others, to include:
  - Check-in desk or other location outside the IMU.
  - Consider a visual barrier to the front door such as flagging and signs to stop unauthorized people from entering.
- The IMU should be equipped with a computer and functioning internet for the ability to contact providers and public health via secure telemedicine platforms. If no internet available, a secondary site with the internet should be authorized.
- Consider the ability to expand if needed. Is there a secondary location that may be better, such as moving off-site to a physical building (empty school, office with a designated entrance not shared with anyone else, or hotel/motel, etc.)?
- Secure secondary “holdover” isolation area for suspected patients who are unable to immediately return to the home station. This removes suspected positive patients out of the initial assessment and treatment area, thus decreasing the potential rate of transmission.
- Ensure there is adequate parking for staging an ambulance if required.
- No personal gear will be stored in IMU.
- No food or water consumption by medical staff in IMU.
- Store bottled water for patients in clearly marked COVID-19 cooler.
- No overnight sleeping of staff in IMU. Move patients to holdover isolation.

Suspected COVID-19 Patients:

Any patient experiencing flu-like symptoms should be considered COVID-19 positive until proven otherwise.

1. A patient who presents symptoms outside of ICP should be evaluated by line medical or remote aid station staff. A mask should be placed on the patient’s face.
2. COVID-19 patients should be considered “Green patients” unless there is respiratory distress or other medical condition(s).
3. The radio report to alert the MEDL and COMMS should state “I have a green medical, influenza-like illness.” “Transport to (the IMU or nearest medical care facility) by--------, ETA--------.”
4. If the patient’s condition does not require an ambulance, the patient should be transported in the same vehicle they arrived in if practical. Additionally, the patient’s supervisor should accompany the patient to the ICP. All people riding in the vehicle should wear a mask.
5. If telehealth is available at the IMU, that is the preferred method of a physician consultation.
6. Initiate ECA, ensure reporting to local public health, and C&G.

⇒ Appendix B: State Public Health Departments, State COVID-19, and State EMS Contacts

State Public Health Departments, State COVID-19, and State EMS Contact List

<table>
<thead>
<tr>
<th>State</th>
<th>State Public Health Department</th>
<th>State COVID-19</th>
<th>State EMS</th>
<th>GACC</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>334-206-5300</td>
<td>800-270-7268</td>
<td>334-206-5383 Website</td>
<td>SACC</td>
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<tr>
<td>Alaska</td>
<td>907-269-7800</td>
<td>800-478-2221</td>
<td>907-465-3027 Website</td>
<td>AICC</td>
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<td>Arizona</td>
<td>602-542-1025</td>
<td>844-542-8201</td>
<td>602-364-3150 Website</td>
<td>GBCC/SWCC</td>
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<tr>
<td>Arkansas</td>
<td>501 661-2000</td>
<td>800-803-7847</td>
<td>501-661-2262 Website</td>
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<td>California</td>
<td>916-558-1784</td>
<td>833-422-4255</td>
<td>916-322-4336 Website</td>
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<td>Delaware</td>
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<td>850-245-4444</td>
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<td>Georgia</td>
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<td>Hawaii</td>
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Appendix C: Wildland Fire COVID-19 Screening

FMB COVID-19 Interim Screen Protocol for Wildland Fire Personnel

Appendix D: Medical Treatment Support Matrix
Situation: MEDL support available and COVID-19 designated Medical Unit is established in modified ICP and/or Spike Camp

An individual is identified with a possible COVID-19 infection based on the Screening Tool or they self-report symptoms consistent with COVID-19

Cough more than expected? Shortness of breath or difficulty breathing? Fever? Chills? Muscle pain outside your normal for firefighting? Sore throat? New loss of taste or smell?

* Take temperature with no-touch thermometer, if available *

All patient care assessments and treatments are given per agency protocol and guidelines

⇒ Appendix E: Employee Contact Assessment (ECA)

Employee Contact Assessment Form

⇒ Appendix F: COVID-19 Worker’s Compensation CA-1 and CA-2

COVID-19 procedures for IMTs and wildland fire are being established. The potential for COVID-19 infections may necessitate changes in the Finance Section’s approach to wildland fire, which could include the remote working of Finance Sections. Comp-Claims personnel may be encouraged to conduct phone interviews when possible and discouraged from personal interviews and meeting patients at the destination hospital. This will increase the need for guidance on Comp-Claims procedures for Medical Unit Leaders, fire medical personnel, and supervisors. Specific guidance is necessary for suspected COVID-19 patients and the special circumstances they present. The Department of Labor and Office of Workers’ Compensation Programs (OWCP) has issued guidance for COVID-19 related claims by Federal employees. State, local government, and contractors should follow their Comp-Claims procedures however, their treatment will follow the same public health and hospital guidance.

Recommendations
Specific guidance from DOL/OWCP which should be noted:

1. “Therefore, when an employee claims Federal Employees’ Compensation Act (FECA) benefits due to COVID-19, Federal workers who are required to have in-person and close proximity interactions with the public frequently—such as members of law enforcement, first responders, and front-line medical and public health personnel—will be considered to be in high-risk employment, thereby triggering the application of Chapter 2-0805-6 of the FECA Procedure Manual. In such cases, there is an implicit recognition that a higher likelihood exists of infection due to high-risk employment.”

2. “Accordingly, DOL has created new procedures to specifically address COVID-19 claims. Employees filing a claim for workers’ compensation coverage as a result of COVID-19 should file Form CA-1, Notice of Traumatic Injury through your employer using the Employee Compensation Operations & Management Portal. The new procedures will also call the adjudicator’s attention to the type of employment held by the employee, rather than burdening the employee with identifying the exact day or time they contracted the novel coronavirus.”

3. The key evidence needed for a COVID-19 FECA CLAIM as required by the law are the following:
   a. “Exposure” – Federal employees who are required to interact with the public or front-line medical and public health personnel in high-risk employment, thus triggering the application of Chapter 2-0805-6 of the FECA Procedure Manual. In such cases, there is an implicit recognition of a higher likelihood of infection; OWCP will confirm the nature of your employment based on your position title and after confirming with your employer that your position is indeed considered high-risk.
   b. “Medical” – You will need to provide medical evidence establishing a diagnosis of COVID-19. You will also need to provide medical evidence establishing that the diagnosed COVID-19 was aggravated, accelerated, precipitated, or directly caused by your work-related activities. Please submit the results of any COVID-19 testing, if available.
      i. “Establishing causal relationships generally requires a qualified physician’s opinion, based on a reasonable degree of medical certainty, that the diagnosed condition is causally related to your employment conditions. This opinion must be based on a complete factual and medical background.”
      ii. “For your health and safety as well as the health of those around you, consider an appointment with your physician by videoconference or teleconference. A medical report generated as the result of such an appointment is compensable as long as it is signed by a physician.”

⇒ Appendix G: Recommendations for Difficult Situation

Every wildland fire is different, yet no fire season to date has experienced a national pandemic within 100 years. It is impossible to plan for all aspects of how COVID-19 will change wildland firefighting. However, listed below are two recommendations for large fire situations.

First, under an Area Command situation, the use of contracted urgent care or higher-level licensure. This has the potential to:

1. Alleviate an undue burden on the local EMS and medical system.
2. Assuage fears of bringing COVID-19 into an otherwise virus-free community.
3. Offer COVID-19 rapid testing, resulting in identifying possible pending outbreaks and/or getting firefighters back to work sooner.
4. Eliminate most ER visits, exponentially saving the paying agency.
5. Establish and/or help coordinate isolation or quarantine locations to support multiple fires, reducing the medical burden on IMTs, removing the potentially sick from camp.

Second, COVID-19 has varying levels of human adherence to CDC guidelines. Some feel the pandemic is hyperbole, others believe it is catastrophic. In the event the C&G feel the IMT is losing the battle on enforcing CDC guidelines, or there is a spike in suspected cases putting operations at risk, a visual and physical measure may help.

The following recommendation is a real-world solution from the meat and food packaging industry on the West Coast. The organization has three locations with approximately 800 employees. Several weeks ago, supervisory management was hearing complaints that employees were nervous about coming to work since they did not know if the person next to them had a fever and potentially infected with COVID-19.

In concert with the Medical Unit and Occupation Health Team, the senior management designed a program that addressed the “go or no-go” fever screening template.
1. Employees were screened outside the building by a non-medical technician at the beginning of each operational shift with a no-contact thermometer.
   a. A fever of 100.4˚F and above, the individual was asked to step into a separate location far from the waiting employee line. This location was staffed with medical professionals. NO-GO.
   b. A fever of less than 100.4˚F but higher than 99.9˚F, employees were asked to wait in a separate area in the shade. This was to address individuals who walked or biked to work. After a waiting period, the temperature was repeated. If still in the holding temperature zone, employees were given a screening by medical a professional.
   c. If the employee’s temperature was less than 99.9˚F they were given a colored wrist band to correlate with the day of the week and allowed to enter the building. All employees inside the facility would have the appropriate colored wrist band on to be on duty for that day.

Within a few days, tension at the facility had greatly diminished since the inception of the wristband visual identifier. Although unorthodox for wildland fire culture to adopt such a program, IC and Area Command (AC) may need creative measures to safeguard incident personnel.