

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. See MPHAT [Hazard Assessment and Prevention Toolkit for COVID-19](#).
- 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 come along 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 EMTTP).

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 Screening 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

[Appendix D, The COVID-19 IMT Response Action Process](#) is a baseline key to help supervisors, team members, and medical personnel choose appropriate actions for suspected COVID-19 patients. This matrix provides a course of action for the IMTs for individuals who are symptomatic and their close contacts. 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.

[Appendix H, Triaging and Caring for Symptomatic or Positive Workers on the Fireline](#) can be used by [MEDLs](#) to track and provide care for fire personnel. Information documented on this form is considered a medical record and needs to be protected.

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, The COVID-19 IMT Response Action Process](#) 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. Refer to [MPHAT guidance on Wildland Fire Agency's Roles in Public Health Case Investigation and Contact Tracing](#) on how IMTs and employers can work with health departments to perform this public health function.

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 intervention so there is a backup plan for handling a suspected case internally to the fire organization.

[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. Refer to [MPHAT guidance on Wildland Fire Agency's Roles in Public Health Case Investigation and Contact Tracing](#) on how IMTs and home units can engage with and contact health departments locally.

⇒ 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 [Guideline 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](#).



	N95 Respirator	Surgical N95 Respirator	Surgical Mask	Comfort Mask	Cloth Face Cover
INTENDED USE	Non-medical Workers	Healthcare Workers	Healthcare Workers & Patients	General Public	General Public
INTENDED PROTECTION	Wear	Wear	Wearer (Splash Only) & Others	Others	Others
TESTING & APPROVAL	NIOSH	NIOSH & FDA	FDA	None	None
FACE SEAL FIT	Tight-fitting	Tight-fitting	Loose-fitting	Loose-fitting	Loose-fitting
CERTIFICATION MARKINGS	Required	Required	None	None	None
FIT TEST REQUIRED	Yes	Yes	No	No	No
MEDICAL CLEARANCE	Required	Required	N/A	N/A	N/A
RESPIRATORY PROTECTION PROGRAM	OSHA-required	OSHA-required	Facility-determined	None	None
USER SEAL CHECK	Required	Required	None	None	None
FILTRATION	> 95%	> 95%	N/A	N/A	N/A
FLUID RESISTANT	No	Yes	Yes	No	No
STRAPS	2	2	1 or 2	1	0, 1, or 2
LEAKAGE	Minimal	Minimal	Extensive	Extensive	Extensive
USAGE LIMITS	Single-use*	Single-use*	Single-use	Single-use	Reusable

* 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 [MEDL](#)s 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.

- Unmet needs.

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

During Mobilization Process

1. Contact State EMS to:
 - Process limited recognition of EMS resources.
 - Develop a list of local EMS and ambulance provider contacts.
 - Ascertain statewide availability of BLS/ACLS ambulance resources.
2. Contact [Local, County, State Public Health](#) to:
 - Ascertain COVID-19 protocols, testing, contact tracing, and videoconference/telehealth capabilities.
 - Obtain 24/7 contact information.
 - Coordinate with [LOFR](#) for public health availability to advise C&G.
3. Contact all possible destination hospitals and clinics to:
 - Obtain 24/7 contact information.
 - Obtain COVID-19 protocols, patient receiving procedures, and testing availability.
 - 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

State	State Public Health Department	State COVID-19	State EMS	GACC
Alabama	334-206-5300	800-270-7268	334-206-5383 Website	SACC
Alaska	907-269-7800	800-478-2221	907-465-3027 Website	AICC
Arizona	602-542-1025	844-542-8201	602-364-3150 Website	GBCC/SWCC
Arkansas	501 661-2000	800-803-7847	501-661-2262 Website	SACC
California	916-558-1784	833-422-4255	916-322-4336 Website	ONCC/OSCC
Colorado	Missing	Missing	303-691-4932 Website	RMCC
Connecticut	860-509-8000	800-203-1224	860-509-8000 Website	EACC
Delaware	740-368-1700	866-408-1899	302-223-1350 Website	EACC
District of Columbia	Missing	Missing	202-671-4222 Website	Missing
Florida	850-245-4444	866-779-6121	850-245-4440 Website	SACC
Georgia	404-657-2700	844- 442-2681	770-996-3133 Website	SACC
Hawaii	808- 586-4400	877-275-6569	808-733-9210 Website	ONCC
Idaho	208-334-5500	888-330-3010	208-334-4000 Website	GBCC/NRCC
Illinois	217-782-4977	800-889-3931	217-785-2080 Website	EACC
Indiana	317-233-7811	877-826-0011	317-234-6804 Website	EACC
Iowa	515-281-7689	800-244-7431	800-728-3367	EACC

Kansas	785-296-1500	877-427-7317	Website 785-296-7296	RMCC
Kentucky	502- 564-3970	800- 722-5725	Website 866-975-2367	SACC
Louisiana	225-342-9500	866-310-7977	Website 225-925-4022	SACC
Maine	207-287-3707	866-811-5695	Website 207-626-3860	EACC
Maryland	410-767-6500	877-275-8343	Website 410-706-5074	EACC
Massachusetts	617-624-6000	800-985-5990	Website 617-753-7300	EACC
Michigan	517-373-3740	888-535-6136	Website 517-241-3024	EACC
Minnesota	651-201-5000	651-201-3920	Website 651-201-2800	EACC
Mississippi	601-576-7400	877-978-6453	Website 601-576-7400	SACC
Missouri	573-751-6400	877-435-8411	Website 573-751-6356	EACC
Montana	406-444-0936	888-333-0461	Website 406-444-3895	NRCC
Nebraska	402-471-3121	800-448-3000	Website 402-471-2158	RMCC
Nevada	775-684-4000	800-860-0620	Website 775-687-7590	GBCC/ONCC
New Hampshire	603-271-4501	866-444-4211	Website 603-223-4200	EACC
New Jersey	609-292-7834	800-962-1253	Website 609-633-7777	EACC
New Mexico	505-827-2613	855-600-3453	Website 505-476-8200	SWCC
New York	518-402-0836	888-364-3065	Website 518-402-0996	EACC
North Carolina	919-855-4800	888-892-1162	Website 919-855-3935	SACC
North Dakota	701-328-2372	866-207-2880	Website 701-328-2388	NRCC/RMCC
Ohio	614-466-3543	833-427-5634	Website 614-466-9447	EACC
Oklahoma	405-271-5600	877-215-8336	Website 405-271-4027	SACC
Oregon	503-947-2340	866-698-6155	Website 971-673-0520	NWCC
Pennsylvania	717-787-8092	877-724-3258	Website 717-787-8740	EACC
Rhode Island	401-222-5960	401-222-8022	Website 401-222-2401	EACC
South Carolina	803- 898-3432	855-472-3432	Website 803-545-4204	SACC
South Dakota	605-773-3361	800-997-2880	Website 605-773-4031	NRCC/RMCC
Tennessee	615-741-2584	833-556-2476	Website 615-741-2584	SACC
Texas	512-776-7111	877-541-7905	Website 512-834-6700	SACC/SWCC
Utah	801- 538-6003	800-456-7707	Website 801-538-6435	GBCC
Vermont	802-863-7200	866-652-4636	Website 802-863-7310	EACC
Virginia	804-864-7000	877-275-8343	Website 804-888-9100	SACC
Washington	800-525-0127	800-525-0127	Website 360-236-2830	NWCC
West Virginia	304-558-0684	800-887-4304	304-558-3956	EACC

Wisconsin	608-266-1865	877-947-2211	Website 608-266-1568 EACC
Wyoming	307-777-7656	888-425-7138	Website 307-777-7955 GBCC/NRCC/RMCC

⇒ Appendix C: Wildland Fire COVID-19 Screening

[FMB COVID-19 Interim Screen Protocol for Wildland Fire Personnel](#)

⇒ Appendix D: COVID-19 IMT Response Action Process

[NMAC COVID-19 IMT Response Action Process](#)

⇒ 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

Before arrival at an assignment the [MEDL](#):

- Should contact Comp-Claims or the Finance Section Chief/designee to discuss the process for Comp-Claims filing and specifically COVID-19 patients.
- Should have the appropriate forms, CA-1, etc. be available in both electronic and paper formats.
- Should also contact the local, county, or state public health for COVID-19 protocols, testing procedures, and the availability of telehealth videoconferencing.
- Should contact any potential receiving hospital or clinic for their COVID-19 protocols and how patients should be received and the availability of telehealth videoconferencing.

On assignment:

- **Important:** Federal employees have 30 days to file a CA-1. It is recommended to complete the CA-1 as soon as possible should the patient's condition deteriorate.
- **Important:** The Department of Labor requires a positive COVID-19 test to continue with a CA-1 claim.
- The [MEDL](#) should have on hand envelopes such as the Injury Illness Case File Envelope for Protected Health Information storage.
- A patient care report (PCR) should be generated by the fire medical staff on all suspected COVID-19 patients and included in the envelope.
- If paper documentation must be used, consider placing the documents individually in 2-gallon clear sealable plastic bags. The bags may then be disinfected if the potential for contamination exists.
- For any suspected COVID-19 patient, the [MEDL](#) and/or Comp-Claims should also refer the patient and their supervisor to the DOL/OWCP COVID-19 guidance webpage. <https://www.dol.gov/owcp/dfec/InfoFECACoverageCoronavirus.htm>

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 [Employees' 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 are 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.

⇒ Appendix H: Triaging and Caring for Symptomatic or Positive Workers on the Fireline

[Appendix H: Triaging and Caring for Symptomatic or Positive Workers on the Fireline \(docx\)](#)

PRINT Medical Unit COVID-19 Concept of Operations Plan

[PDF of this page](#)