Guideline Name:		Department:
Post-Overdose Response Team Operating Guidelines		Orange County Emergency Services

Effective Date:	Issued:	Approval(s):
July 1, 2024	June 28, 2024	Kim Woodward, EMS Division Chief

Scope
EMS System

Purpose
To outline all components of the Post Overdose Response Team regarding operation and function within the EMS system. In addition to this document, PORT staff must adhere to all applicable policies and SOGs within the Orange County EMS system including but not limited to Attendance Policy, Vehicle Checkout and Resupply unless program specific direction differs from those policies are indicated in this document.

Definitions
PORT: Post-Overdose Response Team
MOUD: Medication for Opioid-Use Disorder
PSS: Peer Support Specialist
CP: Community Paramedic
CHS: Community Health & Safety
'PORT Primary Program Functions' definition:

i. MOUD administration
ii. MOUD patient transport to treatment facility

Guidance

I. Daily Shift Responsibilities

Client contact and navigation is primarily the responsibility of the Peer Support Specialist (PSS). However, as there are shift days and hours in which the PSS is not in-service, and as daily responsibilities and duties will be dynamic, achieving these objectives should always be a team effort. Both staff designations (PORT Community Paramedic and Peer Support Specialist) have the capability of conducting any of the contact, navigation and follow-up actions related to clients. Only the CP or designated staff filling in for the CP may document any medication administration items or manage narcotics.

1) Program expectations prior to checking in-service:

a) Manually import all PCR referrals and Overdose Incidents since last upload into case management software
b) Determine and document priority level for each newly added referral
c) Determine any active clients who require action and ensure plans are in place for at least one contact attempt to all viable referrals within 72 hours of referral submission
   i) Action items include scheduled visits, post-MOUD follow-up, providing referrals to treatment locations, or any other related core program objectives.
d) All ALS non-transport inventory must be present prior to checking online
   i) This includes standard narcotic kits and CP MOUD narcotics kits
e) Check in-service via radio-silent route when possible
f) Participate in EMS shift briefing and convey any applicable PORT1 events or other pertinent information for the day

2) **Program expectations prior to shift conclusion**:

a) Ensure any items that will affect the following shift's operations have been adequately documented throughout the shift and are up to date (i.e. medication dosing visits, outgoing referral status, details directly related to client care, etc.)
b) Attempt to adjust time of checking offline to allow for anticipated documentation needs
c) Ensure all daily events have been documented in Apricot and ESO prior to shift conclusion
d) Return all narcotics to secure storage and complete associated narcotic transfer documentation
e) Contact Communications directly by phone or radio to request the PORT be marked offline
f) Restock the unit's medical inventory to par and leave vehicle keys, radios, computers and gas card within PORT office

II. Referral and Client Management

1) New Referrals

a) All incoming referrals should have a minimum of one contact attempt made within 24 hours, not to exceed 72 hours from referral creation.
b) Contact examples include a phone call, a text message or an unscheduled visit
c) New referrals should remain in the new referral status report until at least one of the following criteria are met:

i) Referral is determined to have no intervention or contact needed based on available information
ii) At least three referral contact attempts have been made with no successful contact, or without indication that the individual has interest in services
iii) Referral has resulted in '*MOUD treatment*' status or '*ongoing services required*' status

2) <u>Active MOUD Patients</u>

Daily responsibilities of active MOUD patients should include the following:

a) <u>Prioritizing daily PORT primary program functions over all other daily activities</u>
   i) Exception to system surge status as referenced in EMS System Surge Status section
b) Scheduling ongoing MOUD appointments for the following shift
c) Ensuring all appropriate documentation has been obtained for outgoing treatment referrals
d) Management and coordination of outgoing treatment referrals
e) Ensuring that confirmed outgoing referrals are scheduled and all logistical details and needs are documented

3) <u>Non-MOUD Patients Receiving Services</u>

PORT responsibilities for clients who are non-MOUD program service recipients should include the following until determined to no longer need services or until enrolled in MOUD services:

a) At least one weekly contact attempt to determine needs and schedule services accordingly
b) Efforts made to accommodate harm-reduction needs that are requested or offered to the client

4) <u>Post-MOUD Services Follow-up</u>

PORT responsibilities for clients who have concluded receiving program MOUD services directly from the PORT should include follow up at the following intervals

a) 1 week, 1 month, 3 months, 6 months, 1 year, 2 years
   i) This should include 1 successful contact attempt. If unable to successfully make contact, at least three attempts should be made in total.

III. Dispatch and Response

A. The PORT must always report '*Crew A*' or '*Crew B*' to differentiate whether PSS is present on unit. This information should be conveyed upon any radio communication in which the unit is checking en-route to an incident.

   i. When utilizing radio silent means of communication, this information must be documented in the notes section.

B. Any Orange County Emergency Services employee that is not credentialed as an EMS provider may operate the PORT response vehicle for general transportation purposes but is restricted from operating the vehicle with emergency lights or sirens in any situation.

C. With exception of being the closest unit to an ECHO level call or adhering to EMD dispatch guidelines when assigned as an ALS independent response vehicle during surge status; the response vehicle is not permitted to travel with emergency lights or sirens engaged under any condition.

D. With the exception of being the closest unit to an ECHO level incident, the PORT may decline or elect to not initiate response to any of items a. and b. listed below in 'Active EMS Incidents' provided any of the following justifications:

   i. Response would impact a previously scheduled PORT primary program function
   ii. Response could result in considerable overtime accrual of a staff member
   iii. Excessive response distance to incident in relation to primary responding unit

   These justifications are meant to serve as appropriate suggestions and the decision to decline an incident in which the unit has been dispatched to should be determined on a case-by-case basis with patient care, and program-level responsibilities of the highest consideration.

1) <u>ACTIVE EMS INCIDENTS</u>

The Following are the four scenarios in which the PORT will or may respond to an active EMS incident when in-service. <u>Direct contact with, and approval from Northside or Southside EMS Battalion Chief is required prior to response to any incident not described below, with first attempt to be made to the EMS Battalion Chief associated with the location of the incident within the county.</u>

a) <u>The PORT will be automatically dispatched as a secondary unit to all of the following EMDs:</u>

i) **Overdose** – *All variants*
ii) **Mental Disorder/Behavioral** – *Only incidents that triggered an EMS response*
iii) **Public Assist** – *Only incidents which trigger/warrant an EMS response*

b) The PORT will be notified via CAD text for the following incident types. Response will be determined by the team based upon proximity and additional dispatch information determination:

   i) Unconscious/Fainting
   ii) Unknown Medical Problem
   iii) Falls (*Alpha/Bravo*)
   iv) All ECHO level incidents
      (1) *The PORT is expected to only respond to ECHO level incidents in which they are available and can reasonably determine to be the closest unit.*
      (2) *The PORT should remain on scene in these situations until at least the time that the minimum EMS units required per the associated determinant have arrived.*

c) Manual attachment to an active EMS dispatch of a PORT client or Program Client

   i) Examples include a perceived high-risk patient in which program staff has been unable to contact, a currently enrolled MOUD client, etc.

d) Manual attachment to any EMS incident in which secondary information or dispatch details indicate potential for call type to be related to program purpose.

   i) The PORT may self-initiate attachment to any EMS incident with reasonable impression that the incident is program related.

2) SCHEDULED FOLLOW UP VISITS

a) The PORT shall self-initiate a response to any pre-scheduled patient visits within Orange County. *Refer to 'self-initiated dispatch' section for further process guidance.*
   i.) Examples of these incidents include post-overdose follow up, daily buprenorphine administration, in-person assessment, etc.

3) UNSCHEDULED VISITS

a) The PORT may initiate an unscheduled visit at any location within Orange County that is believed to benefit a referred or imported potential client. This may include, but is not limited to, a referral received with no contact information provided, a referral where the team has been unable to make contact after repeat attempts, or a current program enrollee who is suddenly unable to be contacted.

b) Each of the following items must be in place or occur for an unscheduled visit to be initiated:

   i) Location is within geographic constraints of Orange County
   ii) Location address has been manually searched in Freedom and Apricot to rule out any documented safety-related premise alerts (Freedom) or client alerts (Apricot)
   iii) The PORT self-initiates incident over radio upon arrival on scene in place of silent dispatch

IV. EMS System Utilization and Requests

A. With the exception of 'EMS System Surge Status', all of the following pathways shall occur as a conversation between the EMS Battalion Chief and the PORT Community Paramedic
B. With the exception of 'EMS System Surge Status' should any of the following requests be determined to have a high likelihood of impact on PORT primary functions or result in additional overtime pay of PORT staff, the PORT community paramedic reserves the ability to decline the request
C. With the exception of 'EMS System Surge Status', any of the following service requests should take place through direct phone contact with the PORT when possible, not as a request passing through communications.

1) <u>GENERAL REQUEST FOR SERVICE</u>

a) EMS Battalion Chiefs may request medical or program services of the PORT for any active EMS incident in which there is reason to believe that their presence would be advantageous to the incident or patient. The PORT cannot be utilized to replace a dispatched ambulance under any circumstances.

2) <u>HIGH-RISK REFUSALS</u>

a) EMS Battalion Chiefs may request the PORT in place of themselves for high-risk refusal scene response.

3) EMS SYSTEM SURGE STATUS

a) In the event that the EMS system consists of no available ALS units during any period in which the PORT is online, EMS Battalion Chiefs may utilize the PORT resource as an ALS non-transport unit until additional ALS units are available.
b) When requested in this situation, the PORT will transition to this role regardless of any scheduled primary program functions that this may impact and will become a system asset for the duration that no ALS unit is available.
c) If the PORT unit is reassigned in this manner, the PORT members are responsible for utilizing all available options to ensure that any scheduled dosing appointment occurring during that duration is addressed. This should include:

i. Initiating urgent contact to any scheduled patient that may be impacted
ii. Assessment of the urgency of the patient's needs to determine if further efforts are indicated
iii. Direct contact to EMS5 if there is no other option available to successfully supply the patient with their scheduled dose and a determination is made that the duration of time in which they will be without a dose will cause potential for harm

4) ADDITIONAL RIDER REQUEST

1) A PORT staff member (CP or PSS) may accompany an EMS unit within the ambulance in transport to the hospital as requested, provided all the following criteria are in place:
   a) PORT is present on the scene of the incident at time of transport departure
   b) Accompanying the EMS unit is not anticipated to impact any previously scheduled PORT primary program functions.
2) PORT is in 'Crew B' staffing at time of request
3) When this occurs, the second PORT member shall follow the transport unit to the destination in the PORT vehicle.

5) ASSISTANCE WITH OTHER CHS PROGRAMS

1) CP units may request assistance from PORT1 for daily services such as scheduled lift assist or transfer requests. These requests should be accepted as able and only if accepting the request will not be anticipated to interfere with any core PORT services.

V. Self-Initiated Dispatch Standards

1) As it pertains to PORT program services, self-initiated dispatch shall only be utilized for scheduled visits within Orange County. This process is to be utilized in these situations to limit system radio traffic.

2) When utilizing this method, the PORT shall adhere to the following practices:

   a) Create the incident with advanced notice prior to the scheduled event to decrease the likelihood of being dispatched to another incident.
   b) Utilization of Freedom as follows:
      i) Create an event through the 'Self Init' button
      ii) Manually enter the address details of the event location
      iii) Select 'Community Paramedic Visit' in nature code section
      iv) Document applicable 'crew' status and any other pertinent information directly in the 'notes' section
      v) Check the 'Enroute' box prior to sending the notification as applicable
      vi) Upon arrival at the scheduled visit, mark on-scene via Freedom
      vii) Keep portable radio on-person and isolated to 'OPS 1' channel for duration of event
      viii) Utilize Freedom to clear from the event

VI. Documentation

1) PORT 1 will utilize ESO PCR software and/or Apricot case management software for all client and patient interactions. This section is meant to define when the PORT CPs are to utilize ESO for documentation. ***See the Apricot PORT manual for details on Apricot documentation.***

2) An ESO incident shall be created anytime buprenorphine is induced or administered. If the PORT initiates buprenorphine on the scene of an active EMS incident in which the patient disposition of that incident is not transport, an additional incident number should be generated for PORT services.
   a) Utilize the 'MIH Visit' option for the run type section
   b) Utilize 'PORT Team' for the shift section
   c) Utilize 'non-transport-medical treatment (ALS Equipped)' for unit capability
   d) Utilize 'ALS-Community Paramedicine' for level of care
   e) Utilize 'EMS Special Service' for EMD Complaint

VII. Narcotics and Secured Storage

1) PORT CPs will utilize badge access to retrieve narcotics at the beginning of each shift and to return narcotics to secured storage at the conclusion of each shift. In addition to the procedures outlined in this section, the CP must also adhere to the EMS Controlled Substances SOG.
2) Under no circumstances should PORT staff utilize their access to retrieve medical equipment for any other EMS units apart from EMS5 or EMS Battalion Chiefs unless

approved by direct supervisor or EMS-1 or EMS-2. Access to this area is limited to those with badge access.

3) When the PORT is online and narcotics are not on the CP's person, all narcotics kits must be locked in the glove compartment of the response vehicle.
4) PORT CPs must be in possession of at least one par 'CP MOUD' kit while in service. Possession and release of these kits must be documented in Operative IQ and shall be utilized according to the following inventory levels:
   a) Full Inventory Kit:
      i) (*10*) 8 mg buprenorphine + naloxone strips
      ii) (*5*) 4 mg buprenorphine + naloxone strips
   b) Minimum Par Kit (*minimum requirement for a PORT unit to remain in service):*
      i) ≥(5) 8 mg buprenorphine+naloxone strips
      ii) ≥(2) 4mg buprenorphine+naloxone strips
5) If a consultation with medical control dictates administration of a dose that is smaller than that available in current available inventory, medical direction will advise procedures for modifying a dose.

VIII. MOUD Administration

In addition to all items present in the MOUD administration protocol, the following treatment requirements must be taken into consideration when providing induction, initiating gap coverage and administering ongoing MOUD:

1) Upon induction or initial dose of gap treatment, PORT1 must clearly communicate to the patient that PORT MOUD is a temporary service and that accepting this treatment implies commitment to engaging with and accepting ongoing treatment.

2) A maximum of seven consecutive days of MOUD treatment can be administered to each patient including the initial dose date.
   a) This is valid for induction or gap coverage treatment pathways
   b) If ongoing treatment services have not been established by the conclusion of that seven-day period, contact the Medical Director for further instruction
3) The following must occur during each MOUD administration:
   a) Confirmation of ongoing treatment dose for the patient is confirmed using all associated forms in case management software
   b) Standard baseline vital signs captured before and after each medication administration
   c) Administration event is documented in ESO in addition to case management software

4) With the exception of gap treatment clients in which another agency has agreed to provide ongoing treatment referrals in lieu of PORT, a concerted and urgent effort must be made to connect the client with ongoing treatment providers within the 7-day window of treatment.

IX. MOUD Protocol – Additional Items

1) **Patients Under 18 Years of Age**
   These situations will be reviewed on a case-by-case basis. Direct contact with the Medical Director is required for this determination to be made.

2) **MOUD Treatment Requests Outside of Active Withdrawal**
   a) For any patient that is not in active withdrawal to be initiated on MOUD treatment, previously prescribed dose must be confirmed from the previous organization responsible for treatment and/or pharmacy.
   b) If a confirmed gap dose cannot be achieved with the current available medication inventory, utilize the next highest dose capable of being administered.
      i) i.*e. if the patient has a confirmed prescription of 10 mg and the PORT only has access to 8 mg and 4 mg films, 12 mg should be administered to the patient at their normal interval.*
   c) If the confirmed previous patient prescription consisted of dosing twice per day, contact the Medical Director for further guidance on whether to attempt to continue at this interval, or combine the two daily doses into one daily dose.

3) **Suboxone Induction - Second Daily Interval Request**
   In the event that a patient who was initiated on MOUD requests additional treatment within the same day of induction, the PORT must contact the Medical Director for guidance.

X. Transport

1) The PORT may transport a client to any treatment location within Orange County as needed and available, never as a replacement in an EMS disposition pathway on an EMS incident.
2) Out-of-county transport will be reviewed on a case-by-case basis. Should a need for out-of-county transport arise, approval from EMS5 must be obtained.
3) *Any PORT staff member may decline transport if safety is of concern. Should any active member refuse, transport by either party shall not be initiated.*

XI. Station Utilization

The PORT has designated space reserved at the Philip Nick Waters Building and at New Hope Fire Station 2. For geographic response proximity to all areas of the county, the expectation is for the unit to utilize one of these two locations during the majority of daily operations as able.

XII. Staffing Coverage

1) If a designated PORT CP is unable to be present for a shift for any reason, the unit will adjust to a limited capacity operation with daily operations shifting to only satisfy primary program functions and continuation of these program functions.
2) The CHS Bureau Chief and appropriate staff will maintain an up to date on-call calendar for this purpose and will be the primary staff to fill this role as needed with the EMS Division Chief and EMS Deputy Chief reserved for secondary utilization.
3) PORT Community Paramedic Staff may also fill this on-call role, or the entirety of the vacant shift by direct approval from the CHS Bureau Chief or EMS Division Chief.

XIII. Continuing Education

PORT CPs may attend continuing education during dates in which they are not assigned to a PORT shift.

XIV. Ambulance Utilization for PORT EMS Staff

The PORT Community Paramedics may work additional EMS shifts if all of the following criteria are met:

- PORT CPs may only place a bid within 48 hours of the shift start time
- The assignment would not impact that staff members PORT schedule (directly or as an accumulation of maximum consecutive hours worked)
- The assignment would not result in the total number of hours worked during the week exceeding 72 hours.

If a PORT CP works a standard EMS shift, they are required to document the hours in which these shifts are worked and provide that detailed information to EMS5 at the conclusion of the pay period in order for those hours to be appropriately designated in KRONOS.