Because Protocol 36 may change EMS responses to certain patients, it must be implemented with a complete understanding of its use and underlying dispatch objectives. Since Protocol 36 is not used during normal (non-outbreak) operations, it requires advanced planning and setup, with “just-in-time” training and orientation for EMDs, as well as for EMS administrators and responders.

This Special Procedures Briefing is designed to give you the information needed to implement at dispatch, correctly triage, and set up potentially decreasing response levels to possible flu patients during an officially declared flu outbreak.

Protocol 36 will help manage suspected flu patients in a manner that utilizes scarce EMS, hospital, and community health care resources effectively and efficiently during a declared pandemic. Correctly routing flu patients at the first point of contact with the EMS system (9-1-1, 9-9-9, 0-0-0, 1-1-2, etc.) will be critical in an emerging outbreak environment.
Limitations for Protocol 36 Use:
Protocol 36 is to be used under the following circumstances only:

- When the public health authority (or head of government) in your district, state, province, region, or county has officially declared a flu outbreak/emergency, or when a flu outbreak is considered to be imminent by heads of government/public health authorities.

- When the EMS authority, system Medical Director, and the emergency communications center Director have authorized its use.

- When a response plan for each of the Protocol 36 Determinant Codes (including the suffix codes designating each triage level) has been pre-approved by the EMS authority and the system Medical Director.

Note: Announced elevation of WHO (World Health Organization), CDC (Centers for Disease Control), Health Canada, UK NHS, or other national/international public health threat scales does not necessarily require reduced/limited response in your EMS system. These announced levels may have nothing to do with what is happening in your area.

Surveillance: (Level 0):
Agencies may choose to implement Protocol 36 strictly as a surveillance tool to collect detailed flu information from 9-1-1 callers before widespread EMS and hospital system resource depletion has occurred in their regions. This method of use therefore will not reduce or limit the standard EMS response during this initial stage. The purpose of surveillance is to identify patterns, trends, and geographical clusters of symptoms. Such surveillance may be requested or required by local public health authorities to try to determine if a flu outbreak is occurring in your region.
Before implementing this practice, local medical control authorities must consider both the benefits and potential drawbacks to handling cases using Protocol 36. In most systems, approximately one-third of all medical cases presented to 9-1-1 will be initially handled using Protocol 36 once it is implemented. This includes chest pain patients who may normally receive aspirin delivery instructions, and asthma patients who may normally receive instructions on using a prescribed inhaler.

Should your agency implement Protocol 36 for surveillance purposes, use only the first triage level (Level 0), and always set the response for each of the Protocol 36 determinant codes in Triage Level 0 to be equivalent to the standard response used for the corresponding determinant code from the (non-flu) chief compliant type for the patient’s condition. For example, a code of 36-C-1 (Abnormal breathing with single flu symptom or Asthma/COPD) will be assigned the same response as a 6-C-1 (Abnormal breathing), since 6-C-1 is the code for this patient when Protocol 36 is not in use.

Additionally, ProQA – the software version of the Medical Priority Dispatch System – contains a flu surveillance tool for early symptom identification: the Severe Respiratory Infection (Flu-Like) Symptoms screen. It is accessed by clicking on the “Severe Respiratory Infection (Flu-Like) Symptoms” (V) button on the ProQA Toolbar (circled in red above). This screen – designed and actively updated by a special CBRN (Chemical, Biological, Radiological, and Nuclear) FastTrack Committee within the International Academies of Emergency Dispatch (IAED) – was developed for ProQA-user agencies that choose not to implement Protocol 36, but still have a need to collect flu-like symptoms for real-time or retrospective data analysis, and for providing alerts to responding EMS crews.

Since specific symptoms may change as a particular outbreak spreads and more information is known about the disease, the IAED may rapidly update this screen based on information from various public health organizations such as the Centers for Disease Control (CDC), Health Canada, United Kingdom National Health Service (NHS), Australian Commonwealth Department of Health, and the World Health Organization (WHO). Updates will be posted on the ProQA ftp (file transfer protocol) website for rapid download availability to all ProQA users with a current compatible software version.

Expert data-mining software (such as FirstWatch™) can track special ProQA data in near real-time to detect potential outbreaks within specific geographic regions, so emerging patterns and subsequent alerts can be made to the proper public health and governmental authorities.
Implementing Protocol 36 for actual Response Triage in a Declared Pandemic:

Should a full-scale pandemic outbreak reach your region, it could rapidly overwhelm the capacity of your emergency medical response system. At the height of the pandemic, EMS resources will likely be severely depleted due to extreme call load, overload or quarantining of receiving facilities, and a high incidence of EMS workforce illness. Hospitals may become full. Flu patients may require special treatment – including a response that is different from a standard mobile EMS response provided under non-outbreak conditions. Some patients initially treated by paramedics or ambulance personnel may be left at home. Sicker patients may be transported to designated patient collection points that will serve as makeshift treatment facilities. Other patients may be given a limited amount of care over the phone, with no mobile response from EMS units, due to isolation and quarantine measures – or simply from complete ambulance system depletion.

Protocol 36 will identify potentially infected patients and assign a Determinant Code that accounts for both the patient condition and the locally designated triage level during an escalating crisis.

Typically there are three factors that influence system depletion during this type of crisis; the letters VCR can help you remember them:

- **V** = Volume  The increased volume of patients entering the system because of actual flu, suspected flu symptoms, or flu “scare.”

- **C** = Capacity  The reduced capacity of the receiving facilities due to ED overflow, increased admission, and/or their reduction in professional staff due to their own infection or quarantining.

- **R** = Response  The need to reduce (or even eliminate) mobile response due to increased (9-9-9, 9-1-1, 0-0-0, 1-1-2) call volume reduced numbers of response personnel, and/or their reduction in professional staff due to their own infection or quarantining.

**Selection of Protocol 36 by EMDs:**

**Rule 1 means:** During an outbreak, Protocol 36 will sort out suspected flu patients from those who have other non-flu related conditions such as emphysema, asthma, congestive heart failure, heart attack, stroke, etc. Therefore, once Protocol 36 is authorized for use by medical control, the EMD must always select Protocol 36 when any of the complaints listed in Rule 1 are present. Cases not exhibiting any flu symptoms will be shunted to the correct Chief Complaint through the MPDS interrogation process and assigned a Determinant Code consistent with the patient’s condition (e.g., 6-C-1, 10-D-1, etc.).

**Rule 2 means:** A patient with the flu will almost always have at least one of the flu symptoms defined on this protocol. During a declared outbreak, one flu symptom present is an indicator the patient is a true flu case. With two flu symptoms present, the EMD may reasonably conclude that the patient has the flu; hence there is no need to continue the remainder of the specific flu questions.

**Rules**

1. Once surveillance or triage is locally approved, use Protocol 36 for the medical Chief Complaints of breathing problems, chest pain, headache, and sickness. Do not go to Protocols 6, 10, 18, or 26 unless Protocol 36 directs you there.
2. Once two flu symptoms in Key Questions 4–12 have been identified, skip the rest of the questions to Key Question 13 and then choose the appropriate Determinant Code. If positive flu symptoms were mentioned in Case Entry, these Key Questions do not have to be asked again. More than one flu symptom creates a higher likelihood that the Chief Complaint is actually the flu.
3. If initial information identifies the Chief Complaint as Breathing Problems (6), Chest Pain (10), Headache (18), or Sick Person (26), and other flu symptoms are not identified, return to the original Chief Complaint and complete the call.
4. If the patient had a fever but took aspirin, acetaminophen (Tyleonol), or ibuprofen (Motrin), and the fever is now gone, answer the fever Key Question as “yes”.
5. If the complaint is Chest Pain (> 35) and sweats, vomiting, or a history of heart attack or angina are later identified, go to Protocol 10 and complete the call. While sweats and vomiting are symptoms of flu, they may also be present in heart attacks.
6. Patients of age 65 or older are unlikely to have H1N1 and should be handled according to their most prominent Chief Complaint.
**Rule 3 means**: Some patients whose Chief Complaint itself is a potential flu symptom (from the description of the complaint—e.g. Breathing Problems) will not have the flu. Instead they may have other serious underlying conditions such as asthma, heart attacks, heart problems, emphysema, stroke, etc. When no additional flu symptoms are identified in the Key Questions, the EMD must shunt to the correct Chief Complaint Protocol using the original complaint description given (i.e., Chest Pain, Breathing Problems, Headache, Sick Person) so these conditions can be properly prioritized and treated (ProQA does this automatically).

**Rule 4 means**: Sometimes patients will take analgesic drugs such as aspirin, acetaminophen paracetamol (Tylenol™), ibuprofen, etc., to relieve flu symptoms. If the patient reports that s/he had a recent fever that was since relieved by such a medication, it is still important to record the existence of the fever (before the drug was taken). Always answer the fever question “yes” when the caller reports a recent fever relieved by medication. Note: it is not necessary to ask the caller about fever medications, since the caller will typically offer this information spontaneously when the fever question is asked and medications were used to treat the fever.

**Rule 5 means**: Chest pain patients age 35 and over are at a significantly greater risk of having a heart attack. Protocol 10 (Chest Pain) should be used for all chest pain patients in this age group that have another heart-attack equivalent symptom (sweats, vomiting, history of heart attack or angina).

**Rule 6 means**: Do not use Protocol 36 for patients ages 65 and older. The latest data on the H1N1 influenza outbreak indicates they are unlikely to be infected with the H1N1 virus. Persons in this age group have likely developed a level of natural immunity to H1N1 earlier in their lifetimes.

Protocol 36 can only work effectively with precise and complete information. 100% compliance to the Case Entry and Key Question protocols are imperative in arriving at the correct Determinant Code and response. Cutting corners to save time actually makes the process less effective, saves little time, and may place certain patients at increased risk.

**Modified Responses During a Pandemic (Officially Enacted Triage):**

As previously mentioned, EMS responses during a pandemic may be significantly reduced compared to those under standard operating conditions. Each agency must develop a pre-approved response for each of the triage levels and Determinant Codes contained on Protocol 36. Remember that Level 0 is strictly for surveillance, so at Level 0, the response is always set to the same standard response assigned under (normal) non-flu situations to a particular priority level (A,B,C,D,E) or individual code.
Triage using Protocol 36 unfortunately means that certain patients that have a lowered priority code for response and care in system-overwhelm situations will be ones without the flu who are having heart attacks. Critical breathing conditions, etc., who will now have worse outcomes or die. Triage provides added gravity to the Star Trek statement, “The good of the many, outweighs the good of the few, or even the one!”

**Suffix Codes:**
The suffix codes reflect the locally designated triage level as set by your system administrators. There are four suffixes used for determinant coding: S, A, B, and C.

These suffixes correspond with the announced triage level (0, 1, 2, and 3) for the current stage of outbreak in your system or region. The assigned triage level will depend on several factors as defined earlier in this document.

**Reminder:** Suffix S (Surveillance) *does not* change the response.

The EMS authority, in consultation with the system Medical Director or Medical Advisory Group and Public Health Authority in your region, will determine (and may modify) the triage level at any time.

**Flu Surveillance & Triage Level Suffixes**
Locally enacted Flu Level designations may affect your agency’s response assignment. With the exception of Level 0, the other levels allow for locally designated, potentially different levels of patient triage and reduced response:

- **S** = Level 0 (surveillance only) – no change in response
- **A** = Level 1 (low triage) – consider referral of ALPHA cases only
- **B** = Level 2 (moderate triage) – consider reduced response for CHARLIE cases
- **C** = Level 3 (high triage) – consider referral of some CHARLIE cases and reduced response for DELTA cases
The EMD center must be in regular communication with these authorities so that any changes in the triage level are recorded and activated quickly and properly within the Medical Priority Dispatch System.

ProQA will automatically assign the correct triage level suffix to the case once the currently enacted triage level is recorded in Key Questions. The Key Question will be displayed as a (blue) operator question in ProQA (see below).

The current **tripe level suffix** is always attached to each Determinant Code, so that a **unique and different response can be assigned** for each triage level within that code. For example, a code of 36-A-1B may receive a different (reduced) response than a 36-A-1A. A coding of 36-C-1C could receive a different (and even more reduced) response than a code of 36-C-1B, to reflect the current, increasing degree of system depletion – and, therefore, a diminishing level of actual response.

Shown here is a sample response setup that displays the MPDS determinants in the ProQA software, matched with possible example responses for each of the triage levels (S, A, B, C).

**NOTE:** These are only examples. All actual responses must be locally defined.

**Responder Notification of Flu Symptoms and Infection Control:**

In order to facilitate the responder’s correct use of infection control measures, the first responders and EMS crew dispatched to the scene (when a locally determined EMS response is required) should be given the Chief Complaint and Determinant Descriptor and Code during the call notification and unit-dispatch process. It will be at the direction of the local medical control authority (physician Medical Director or Medical Control Board) to provide specific policies, procedures, and protocols for crew notification, protection, and infection control during an outbreak. The EMD may (at the direction of local medical and 9-1-1 authorities) provide a detailed responder script (see example below) for the responding crews. This responder script will typically include the patient's age, gender, status of consciousness, status of breathing, and Chief Complaint – including the determinant descriptor text, and the existence of any dispatch determined flu symptoms.
INITIAL (EARLY) NON-TRIAGE USE

In some cases, agencies have chosen to implement Protocol 36 to collect detailed flu information from 9-1-1 callers before widespread EMS and hospital system resource depletion has occurred in their regions, and therefore do not intend to reduce or limit the standard EMS response at this time. Before implementing this practice, local medical control authorities must consider both the benefits and potential drawbacks to handling cases using Protocol 36. In most systems, approximately one third of all medical cases presented to dispatch will be initially handled using Protocol 36 once it is implemented. This includes chest pain patients who may normally receive aspirin delivery instructions, and asthma patients who may normally receive instructions for using a prescribed inhaler.

Should your agency implement Protocol 36 under the above circumstance, use only the first triage level (Level 0 – Surveillance Only), and always set the response for each of the Protocol 36 Determinant Codes in Triage Level 0 to be the same as the standard response used in the corresponding Determinant Code for the (non-flu) Chief Compliant type for the patient’s condition. For example, a code of 36-C-1 (Abnormal breathing with single flu symptom or Asthma/COPD) will be assigned the same response as a 6-C-1 (Abnormal breathing), since 6-C-1 is the standard coding for this patient when Protocol 36 is not in use.

Please check the Academy website frequently for new versions and use updates: www.emergencydispatch.org

Protocol Improvement

The Academy welcomes written feedback on the improvement of the protocol. Use the Proposal for Change (PFC) process to make recommendations. It can be found at: www.emergencydispatch.org/res_downloads.php

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