Update 6 - COVID-19 – From Office of the Medical Director 06MAR2020 1200

To All EMS Personnel in the EMS System for Metropolitan Oklahoma City & Tulsa

The Office of the Medical Director, and Dr. Goodloe specifically, continues to monitor updated information related to the illness known as COVID-19, caused by the SARS-CoV-2 coronavirus. *You can be assured the safety and wellbeing of the citizens we collectively are entrusted to treat AND for you has our highest attention.*

As communicated on 2 MAR in the 1000 hrs briefing to you, we have unfortunately seen an expected growth of cases within the United States. As of 1200 hrs today, I have not received any confirmation of cases of COVID-19 in Oklahoma, but I want to be very open with you in that I believe this virus exists within Oklahoma, specifically within our major metropolitan areas. In the words of highly esteemed infectious disease expect, Dr. Michael Osterholm from the University of Minnesota Center for Infectious Disease Research and Policy (CIDRAP), “Absence of evidence is not evidence of absence.”

This is to be expected as part of the course of a viral disease that is known to be more infectious (easier to spread from a single infected person to others) than influenza AND able to be spread by an asymptomatic individual, in other words, before that person develops fever to know they are sick with an infection. While notable efforts have been made to “contain” the global spread of this disease, the results have been the slowing of its progression, not stopping it.

I have attended multiple detailed briefings scheduled throughout this week with national and international resources. OMD and EMSA executive leadership attended a meeting with both Oklahoma City County Health Department and Tulsa Health Department called by me to explore strategies designed to minimize the impact of COVID-19 on our EMS system. Our partnerships with local public health officials and the ongoing collaborations that result is invaluable as we respond to this viral disease as a healthcare system.

As I participate in COVID-19 community partner briefings ahead, I want to personally share with you key parts of my intended message and then specific actions we need to be focusing on:

Our EMS system is a vital part of keeping our communities safe and well, in time of illness and injury. COVID-19 is understandably an increasing focus for people. We still have individuals with myocardial infarctions, strokes, sepsis, serious trauma from motor vehicle collisions, gunshot wounds, and fractures from falls amidst the myriad of emergencies we respond to, stabilize, and transport to hospitals every day. We must protect our system’s ability to meet those needs and absorb the additional demand for service that will accompany the *serious* cases of COVID-19.

We will need the healthcare system's help AND the public's help in NOT utilizing 911 and our EMS system for milder illness suspected due to COVID-19. Individuals with milder cases of a flu-like illness should remain at home in self-care, treating fevers and muscle aches with over the counter remedies of acetaminophen and/or ibuprofen. Treat cough with over the counter cough suppressants, realizing no such medication (and no prescription cough suppressant) fully eliminates cough.

Presenting to a hospital when a flu-like illness is mild will cause an overdemand on available resources and may ironically actually expose a patient to the SARS-CoV-2 virus that does not yet have the virus. Individuals are safer at home unless respiratory symptoms worsen and impair breathing.

PPE is important. In a briefing this week, Dr. Michael Sayre, Medical Director for Seattle Medic One (the Seattle Fire Department's ambulance program) correctly stated that if you are using the CDC-specified PPE, with correct donning and doffing, in caring for a COVID-19 patient, that does not constitute an exposure. An exposure would be treating a COVID-19 patient without this PPE. An analogy can be made to starting IVs as we do throughout every 24-hour period. Wearing gloves and handling the needle/sharps carefully avoids us having a bloodborne illness exposure.

While you have utilized and/or trained on droplet and airborne PPE, for your safety, I want to share the following resources today:

1. CDC guidelines on mask, eye protection, gown, gloves – both donning and doffing. This is sent as an attachment to accompany this communication and can also be found in PDF at https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf

2. Video training shared this morning by the Seattle Fire Department on donning and doffing PPE found at www.emsonline.net/Announcements/Infectious-Disease-Safety-Procedures.aspx

   Once accessing this site, the initial video that displays is the Doffing Procedure. Clicking it will start the short video and simultaneously bring up a safety video menu. Clicking that menu icon will then bring up links to the Donning Procedure and Handwashing short videos. Please view these videos for your safety. We thank our colleagues in the Seattle Fire Department for sharing these timely resources.

For febrile, respiratory patients, apply a simple surgical-style mask to the patient if clinically safe for them. Additional quantities of these masks are coming to emergency apparatus as soon as logistically possible. EMSA executive leadership has ordered quantities for the whole EMS system and these leaders will best be able to answer any questions regarding timing of availability of these masks.

The above measures are important. The mask you use on you should be an N95 mask (it is imperative to use at least N95 as a simple mask has been proven to be ineffective for healthcare professionals), eye protection should be goggles, wrap around eye wear, or a face shield. A gown - or Tyvek suit if gowns are not available – is designed to protect uniform clothing. Use the standard gloves we use on all patients.

Keep also in mind the benefit of keeping distance, preferably 6 feet or more when logistically and clinically able, from the patient's face. I understand 6 feet is often impractical in the confines of providing care in small residences, hallways, and within an ambulance. Keep as much distance as logistically possible is what I am reminding for your safety.

I will be specifically advising our healthcare community and the public that when they see EMS professionals in PPE that does NOT automatically equate to caring for a confirmed COVID-19 patient. It does equate to smart infection control actions by medical professionals.

As of today (Friday, 6 MARCH 2020, 1200 hrs Central Time), I am directing the following specific precautions to be applied once it is known the patient has a febrile respiratory illness. **For emphasis these directives are meant to only apply to patients with febrile respiratory illness:**

If personnel are still enroute to the patient, communications personnel should advise "Respiratory PPE advised" via appropriate data and/or voice methods. Don PPE to protect from droplet and airborne pathogens if you will be directly treating the patient before you make patient contact.

If personnel are already on scene with a patient, don PPE to protect from droplet and airborne pathogens and minimize the number of personnel actively treating the patient to the smallest number clinically necessary for that patient's needs.

Minimize use of nebulized albuterol and ipratropium to those patients with serious dyspnea with bronchospasm. If nebulized therapy is needed, position yourself away from the exhalation stream of the nebulizer and patient. During transport, sit behind the patient, not to the patient's side unless ongoing clinical care needs demand being beside the patient.

Avoid use of endotracheal intubation. In patients that require invasive/advanced airway placement, pace an iGel airway instead.

Again, these measures will be for a presently unknown interim duration and will apply to patients with febrile respiratory illness. Cardiac-suspected cardiac arrest patients, non-febrile respiratory distress patients, traumatic injury patients, and all others should continue to receive our usual and customary treatment protocol-specified care.

I've share this recently, but I want to say this again so you will understand the impacts ahead: Despite all of the above measures, I predict some of us, me included as I'm actively seeing patients in the Emergency Department setting too, will acquire COVID-19. Yes, we can REDUCE our risk by thinking and acting smartly, using good PPE, and doing frequent, thorough hand washing. Avoid touching your nose and mouth at work as much as humanly possible. I've already this week applied the concepts above to a patient sent to the Emergency Department via POV with concerns for COVID-19. Smart PPE choices, a calm demeanor, and confidence in clinical assessment got the patient and my ED team through the encounter comfortably and fortunately able to reassure the patient we did not suspect COVID-19 and that testing was not required by the Oklahoma State Department of Health. I believe I will be involved in a significant number of patient encounters with COVID-19 concerns in the weeks and months ahead.

The spectrum of COVID-19 illness severity is continuing to show approximately 80% mild, 15% requiring hospitalization, and 5% requiring ICU admission. There are fatalities, as we've clearly seen in the Seattle metropolitan area recently and those, as predicted to date, are in older individuals with pre-existing, chronic ailments. You and I will see the more serious cases because of the nature of EMS and Emergency Medicine.

As communicated previously, our EMS system's approach can change based upon new, scientifically validated approaches and we will assuredly advise in a timely manner if it does.

Expect more frequent updates on this subject from me. Our sincere goal is to keep our patients as safe and healthy as possible AND to keep you as safe and healthy as possible. Those are not mutually exclusive goals. We will continue to achieve both.

We are open to any specific questions if you have them.

Dr. Goodloe

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