Update 8 - COVID-19 – From Office of the Medical Director 13MAR2020 1500

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

This is not a short communication. Please read it in its entirety for your safety and wellbeing and for the safety and wellbeing of the citizens we collectively are entrusted to treat.

Delineation of Chief Medical Officer Oversight Duties:

To allow our EMS system best preparedness and capabilities, the following duty delineations are effective immediately until further notice:

COVID-19 focused or related issues:
Jeffrey M. Goodloe, MD – Chief Medical Officer
jeffrey-goodloe@ouhsc.edu – non emergent
918-704-3164 – emergent

Non-COVID-19 issues:
Curtis Knoles, MD – Assistant Chief Medical Officer
curtis-knoles@ouhsc.edu – non-emergent
405-514-4877 – emergent

OMD Division Chiefs Howerton, McAnallen, and Cox remain available as resources per their usual duties and contact methods as well.

911 Medical Call Screening

Already recently implemented, unless what appears to be an obvious non-infectious disease related issue, callers are being asked by EMSA communications professionals if the patient has a fever and respiratory symptoms. If affirmative, in the dispatch notes subsequently sent, an advisement will contain "Respiratory PPE Advised."

Effective at 1700 hours today, EMSA communications professionals are activating Protocol 36 within the Medical Priority Dispatch System (MPDS). MPDS is the standard call screening, prioritization, and pre-arrival instructions to the caller that EMSA has utilized for 20+ years. Protocol 36 is for Pandemic/Epidemic/Outbreak issues. With the World Health Organization declaring COVID-19, as caused by the SARS-CoV02 virus, a worldwide pandemic this week, now is the time to activate this protocol. Callers with influenza like illness as their chief medical concern will typically be assigned into this dispatch protocol. Mobile Data Terminals in EMSA ambulances and dispatch information received by affiliated agencies that receive EMSA dispatch notes, will see "Pandemic Flu-Like Illness" in the comments. This will be an additional advisement for respiratory PPE to be worn by those contacting the patient. *It does NOT mean the patient has COVID-19; it means PPE is advised.*

It is vital for responding EMS professionals to remember that our Emergency Medical Dispatchers (EMDs) are equally committed to the safety and wellbeing of everyone in our community and in our EMS system. The best EMD in any EMS system is still at the limitation of what the caller can provide in response to validated question sequencing specified by MPDS.

Response Configurations

What does the term "response configuration" mean? It means who/what apparatus is sent on a 911 medical call. Also, effective today at 1700 hours, EMSA communications professionals, at my specifications, are using selective activation of fire departments in the following summarized options contained within MPDS Protocol 36:

Alpha Level Calls: NO FIRE DEPARTMENT RESPONSE INDICATED

Chest pain/discomfort, less than 35 years of age, single OR multiple flu symptoms
Flu symptoms only (cough, fever, chills, sore throat, vomiting/diarrhea, muscle aches, etc)

Of note, Fire Departments that have traditionally followed MCB/OMD recommended responses are already NOT responding on MPDS Protocol 26 Alpha 04 "Sick Person – Fever/Chills" calls.

Charlie Level Calls: NO FIRE DEPARTMENT RESPONSE INDICATED

Abnormal breathing with single OR multiple flu symptoms
Chest pain/discomfort, at or greater than 35 years of age, single OR multiple flu symptoms

Delta Level Calls: NO FIRE DEPARTMENT RESPONSE INDICATED

Ineffective breathing with flu symptoms

<u>Delta Level Calls: FIRE DEPARTMENT RESPONSE WILL BE ACTIVATED</u>

Difficulty speaking between breaths with flu symptoms
Not alert with flu symptoms
Changing color with flu symptoms

The careful and deliberate considerations, unanimous among the OMD team, strives to preserve ongoing availability of Fire Department EMTs and Paramedics for the most serious of medical conditions AND reduce clinically unnecessary patient contacts (potential exposures to COVID-19) to EMS personnel truly essential for the patient encounter at hand. The Delta level call described as "ineffective breathing" by MPDS is so vague as to what is meant by "ineffective" we are categorizing in as above for now. We will monitor all these MPDS-linked decisions and correlate with patient conditions, revising if indicating. We currently do the same in an ongoing manner for the over 1200+ MPDS call classifications. These new Protocol 36 determinants will simply join that process.

There will be instances when EMSA personnel arrive and due to either clinical assessment findings and/or logistical issues, Fire Department personnel will be requested. We're all in this together. The collective effort of helping one another and simultaneously protecting one another continues to apply in this new era of COVID-19.

Overall use of 911 for Medical Care

We are following available data from other systems, notably Seattle, to gauge what overall call volumes for our EMS system could become. It is too early to predict with accuracy. In the short term, Seattle Fire Department has NOT experienced a notable increase in calls for medical issues. I truly appreciate our colleagues at Oklahoma State

Department of Health, Oklahoma City County Health Department, and Tulsa Health Department for widely sharing a message of not going to the Emergency Department for mild illness suspected due to COVID-19 and instead contacting primary care providers and/or medical advice helplines. Our message will continue to be, save ambulances for serious emergencies.

This certainly does NOT mean we do not care about the health of persons in our communities. As we discussed in Update 6, "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."

Personal Protective Equipment

I am greatly encouraged and proud of how serious and professional the approach to PPE review and training is occurring throughout our EMS system. Continue those actions and seek answers to questions you have through your chain of command. We are committed, to the limits of PPE physically available in the weeks ahead, to using the best practices to keep you safe. I have directed OMD and EMSA/AMR leaders to "walk the process" from 911 dispatch through delivery of a patient at hospital and decontaminating an ambulance, preparing it for safe duty for the next patient with goals of finding and fixing any steps that would pose inadvertent risk to you AND finding ways to minimize how much PPE is consumed in that process so that we have PPE available in future calls, too. The goals are not mutually exclusive, they are complimentary.

Refer to Update 6 if needed for the information on links to the CDC and Seattle Fire Department resources on PPE education. EMSA/AMR has prepared a training video for our system's use and I will be asking that it be widely shared with all personnel.

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.

Personnel Temperature and Symptoms Monitoring

Your direct employer has final authority on assessments you may be instructed to perform at start of shift, during shift, and end of shift. I believe it is best practice to measure your temperature (fever is defined as a temperature at or exceeding 100.4F orally) and assess if you have any prominent flu-like symptoms at both start and end of shift and to be cognizant if you develop any fever or symptoms during your shift. If fever is present, or prominent flu symptoms are present, immediately notify your supervisor/chain of command per agency-specific instructions. Start of shift assessment conveys to the public we are taking their safety seriously as well and are responsible to avoid placing sick EMS professionals caring for them. End of shift assessment conveys to you and your families we are responsible to avoid sending you home sick without resources and/or further assessment. We want your families to be as safe as possible during these times as well. As I've always said, I will not ask of you what I am unwilling to do myself. I am performing the same self-assessment as described before and after any shifts I work in the Emergency Department.

Clinical Care Alterations:

As of today (Friday, 13 MARCH 2020, 1700 hours 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:**

HEPA filters are in the process of being ordered for placement in mechanical ventilator circuits to reduce potential for COVID-19 intake into the mechanical ventilators. Those are to be applied as soon as physically available in our EMS system and as educated at that time.

Avoid use of non-invasive positive pressure ventilation (NIPPV = CPAP or Bi-Level PAP) unless absolutely clinically necessary for that patient's needs. This therapy greatly increases ambient droplets and airborne particles from the patient. If NIPPV is required, position yourself away from the exhalation stream of the patient. During transport, sit behind the patient, not to the patient's side unless ongoing clinical care needs demand being beside the patient.

Again, these measures, like those announced in Update 6, 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.

Future Measures:

I am actively working with key stakeholders to minimize your risks at community housing and nursing home facilities. We are factoring the risks/benefits of asking our facility partners to bring patients whenever physically possible to or even outside entry/exit points of the facilities. Please understand this is NOT operational today and we are moving as quickly as we can in this matter, given the multitude of such facilities in our metropolitan areas.

I am also working to design a decision-making process whereby we can utilize clinically reasonable decisions to avoid transports to hospital. As with the immediately above measure, this is NOT operational today and we are moving as quickly as we can, working closely with other EMS systems looking to incorporate the same, always with patient safety at the forefront.

Today's perspective from the Chief Medical Officer:

I've shared 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 believe we all will be involved in a significant number of patient encounters with COVID-19 concerns in the weeks and months ahead.

Testing quantities are presently inadequate by any measure. This is not the fault of Oklahoma healthcare leadership. We are all wishing we had much, much greater availability of timely testing for COVID-19. Do not be lulled into thinking this is not a serious challenge for metropolitan Oklahoma City and Tulsa. As has been said, "absence of evidence is not evidence of absence."

We are headed into challenges that we frankly have not personally experienced in our local EMS system. The closest comparative I can make today is to the 1918 influenza pandemic and the oldest, wisest member of our EMS system (whomever that is in your opinion) wasn't on duty then. We will find answers and we will find them working together. You have my commitment to not rest long or well until we succeed in seeing COVID-19 fade from our primary concern.

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 and now closer to our state 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 additional 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. I am honored to be working alongside you in this time.

Dr. Goodloe

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