CHULA VISTA FIRE DEPARTMENT

EMS Bulletin

EMS Bulletin #: **20-02**

Subject: **CoVID 19 Information**

Date: March 11, 2020

STA:	Int:	Date:	Int:	Date:
A:				
B:				
C:				
Other:				

To:

- ☐ All Department Members
- ☐ Fire Suppression Personnel
- ☐ Fire Prevention Personnel
- ☒ All Paramedics
- ☒ All EMTs
- ☐ All Communications Personnel
- ☒ All Chief Officers
- ☐ All Company Officers & Acting Company Officers
- ☐ All Engineers & Certified Driver/Operators
- ☐ CVPD
- ☐ Public Works
- ☐ Other

From: Chris Scott, Division Chief, EMS
Jennifer Farah, M.D., Medical Director

Disposition: Read/Post/Retain

Thank you for your continued efforts to keep our Chula Vista citizens safe and healthy. I'm sure you've been overwhelmed with many mixed messages from the media regarding COVID-19. My hope is to clarify the expectation put upon you, the EMS providers on the front lines, and hopefully in doing so, offer some general reassurance on the matter. During this time of year, with so many patients exhibiting upper respiratory infection symptoms, cough and fever, it can be challenging to identify who exactly is at risk for having COVID-19. And with that, who poses a risk to you for an exposure. Below are the criteria the CDC is using to determine who qualifies as a Patient Under Investigation (PUI) and therefore who warrants specialized testing for COVID-19. Please carefully review the contents of this memo.

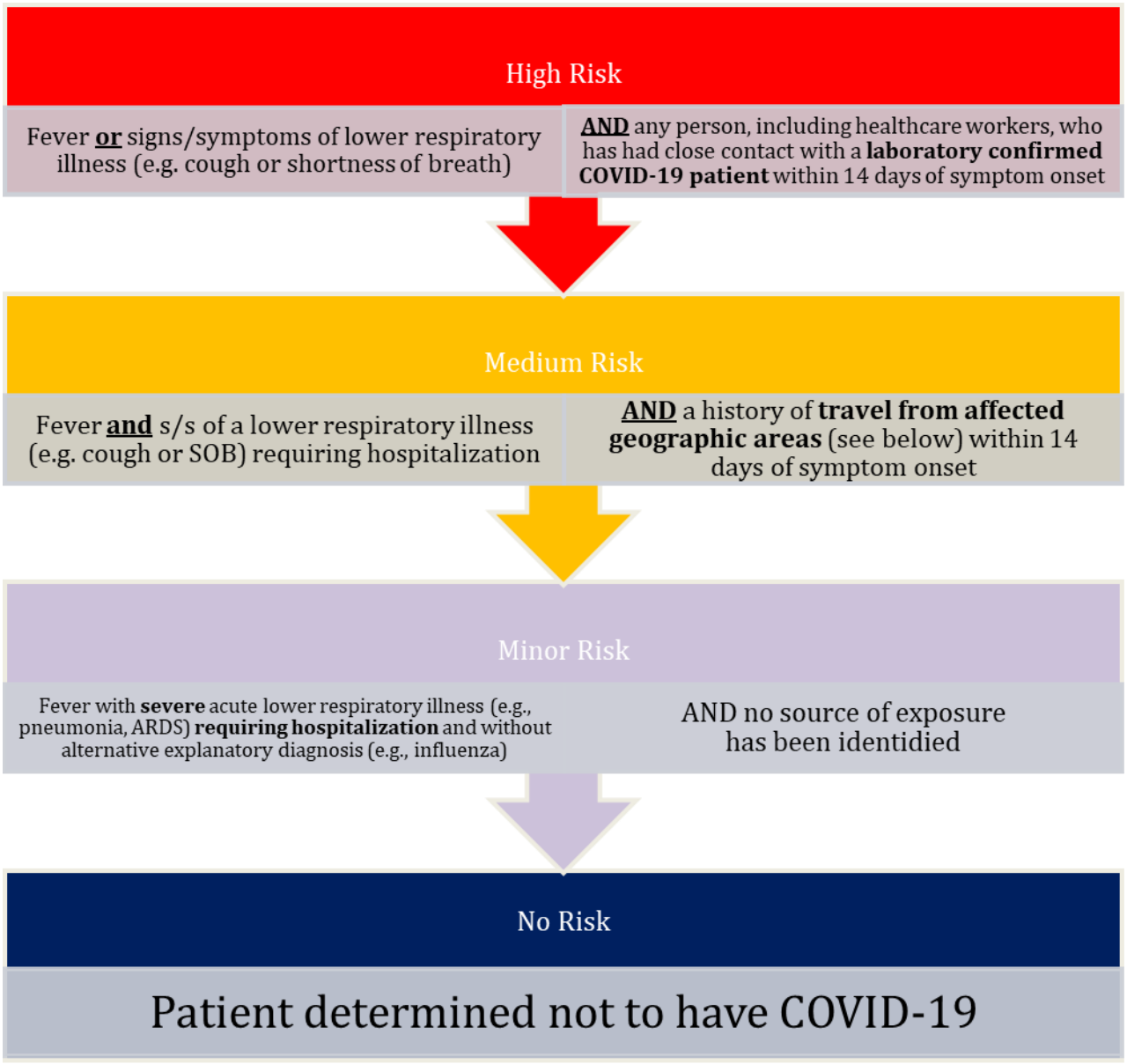
Many components of the following criteria are already embedded in our dispatch prompts; thus you should be given advanced notice of a potential case prior to your arrival. However, in the event you discover these risks factors in conjunction with reported symptoms after arrival, please don the appropriate PPE (gown, gloves, facemask and eye protection), place a facemask on the patient, and notify the receiving hospital. After transfer of care, please also contact your on-duty battalion chief for further instructions. Please do not hesitate to reach out to me with any questions or concerns. This is an ongoing matter, and the EMS Division will disseminate relevant updates as soon as they become available.

Thank you,

Jennifer Farah, MD
Medical Director, Chula Vista Fire Department
jfarah@chulavistaca.gov (please use this email for any future correspondences)

COVID-19 Threat Assessment

(CDC 3/3/2020)



Affected Geographic Areas

(CDC 2/28/2020)

- China
- Iran
- Italy
- Japan
- South Korea

The following is a breakdown of the CDC's exposure risk categories and post-exposure recommendations. **Please note the difference in exposure risk with the addition of appropriate PPE (gown, gloves, facemask and eye protection) and application of a facemask on the source patient.** Further information can be found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

COVID-19 Exposure Risk Category

(CDC 3/5/2020)

Source Patient **Not** Masked

Risk Factors Prolonged close contact with a COVID-19 PT who was NOT wearing a facemask (Source Control)	Exposure Category	Recommended Monitoring for COVID-19 (until 14 days after last potential exposure)	Work Restrictions for asymptomatic First Responders (HCP)
Healthcare Professional (HCP) PPE: None	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection[b]	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing gown or gloves[a,b]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)[b]	Low	Self with delegated supervision	None

Source Patient Masked

Risk Factors **Prolonged close contact with a COVID-19 PT who was wearing a facemask (Source Control)**	Exposure Category	Recommended Monitoring for COVID-19 (until 14 days after last potential exposure)	Work Restrictions for asymptomatic First Responders (HCP)
HCP PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection	Low	Self with delegated supervision	None
HCP PPE: Not wearing gown or gloves[a]	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a face mask instead of a respirator)	Low	Self with delegated supervision	None

[a]The risk category for these rows would be **elevated by one level if HCP had extensive body contact** with the patients (e.g., rolling the patient).

[b]The risk category for these rows would be **elevated by one level if HCP performed or were present for a procedure likely to generate higher concentrations of respiratory secretions or aerosols** (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction). For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure.

For this guidance ***high-risk*** exposures refer to HCP who performed or were present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on patients with COVID-19 when the healthcare providers' eyes, nose, or mouth were not protected.

Medium-risk exposures generally include HCP who had prolonged close contact with patients with COVID-19 where HCP mucous membranes were exposed to material potentially infectious with the virus causing COVID-19. These scenarios involve interactions with symptomatic patients who were not wearing a facemask for source control. Because these exposures do not involve procedures that generate aerosols, they pose less than that described under *high-risk*.

Low-risk exposures generally refer to brief interactions with patients with COVID-19 or prolonged close contact with patients who were wearing a facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure.

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures HCP should still perform self-monitoring with delegated supervision.

HCP with no direct patient contact and no entry into active patient management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have *no identifiable risk*.)

Additional Scenarios:

- Refer to the footnotes above for scenarios that would elevate the risk level for exposed HCP. For example, HCP who were not wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure.
- Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision.
- HCP not using all recommended PPE who have only brief interactions with a patient regardless of whether patient was wearing a facemask are considered low-risk. Examples of brief interactions include:
    - brief conversation at a triage desk;
    - briefly entering a patient room but not having direct contact with the patient or the patient's secretions/excretions;
    - entering the patient room immediately after the patient was discharged.
- HCP who walk by a patient or who have no direct contact with the patient or their secretions/excretions and no entry into the patient room are considered to have no identifiable risk.

Definitions

Self-monitoring means HCP should monitor themselves for fever by taking their temperature twice a day and remain alert for respiratory symptoms (e.g., cough, shortness of breath, sore throat). Anyone on self-monitoring should be provided a plan for whom to contact if they develop fever or respiratory symptoms during the self-monitoring period to determine whether medical evaluation is needed.

Active monitoring means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed people to assess for the presence of fever or respiratory symptoms (e.g., cough, shortness of breath, sore throat). For HCP with high- or medium-risk exposures, CDC recommends this communication occurs at least once each day. The

mode of communication can be determined by the state or local public health authority and may include telephone calls or any electronic or internet-based means of communication.

For HCP, active monitoring can be delegated by the health department to the HCP's healthcare facility occupational health or infection control program, if both the health department and the facility are in agreement. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

Self-monitoring with delegated supervision in a healthcare setting means HCP perform self-monitoring with oversight by their healthcare facility's occupational health or infection control program in coordination with the health department of jurisdiction, if both the health department and the facility are in agreement. On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, a facility may consider having HCP report temperature and absence of symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

Occupational health or infection control personnel should establish points of contact between the organization, the self-monitoring personnel, and the local or state health departments of authority in the location where self-monitoring personnel will be during the self-monitoring period. This communication should result in agreement on a plan for medical evaluation of personnel who develop fever or respiratory symptoms (e.g., cough, shortness of breath, sore throat)* during the self-monitoring period. The plan should include instructions for notifying occupational health and the local public health authority, and transportation arrangements to a designated hospital, if medically necessary, with advance notice if fever or respiratory symptoms occur. The supervising organization should remain in contact with HCP through the self-monitoring period to manage self-monitoring activities and provide timely and appropriate follow-up if symptoms occur in a HCP. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

Close contact for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters), of a person with COVID-19 for a prolonged period of time (such as caring for or visiting the patient; or sitting within 6 feet of the patient in a healthcare waiting area or room); or b) having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).

Data are limited for definitions of close contact. Factors for consideration include the duration of exposure (e.g., longer exposure time likely increases exposure risk), clinical symptoms of the patient (e.g., coughing likely increases exposure risk) and whether the patient was wearing a facemask (which can efficiently block respiratory secretions from contaminating others and the environment), PPE used by personnel, and whether aerosol-generating procedures were performed.

Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. However, until more is known about transmission risks, it is reasonable to consider an exposure greater than a few minutes as a prolonged exposure. Brief interactions are less likely to

result in transmission; however, clinical symptoms of the patient and type of interaction (e.g., did the patient cough directly into the face of the HCP) remain important. Recommendations will be updated as more information becomes available.

Risk stratification can be made in consultation with public health authorities. Examples of brief interactions include: briefly entering the patient room without having direct contact with the patient or their secretions/excretions, brief conversation at a triage desk with a patient who was not wearing a facemask.

Healthcare Personnel: For the purposes of this document HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.

Recommendations for Monitoring Based on COVID-19 Exposure Risk

HCP in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work

High- and Medium-risk Exposure Category
HCP in the high- or medium-risk category should undergo active monitoring, including restriction from work in any healthcare setting until 14 days after their last exposure. If they develop any fever (measured temperature >100.0°F or subjective fever) OR respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat) they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority and healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation.

Low-risk Exposure Category
HCP in the low-risk category should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. Asymptomatic HCP in this category are not restricted from work. They should check their temperature twice daily and remain alert for respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat)* . They should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or respiratory symptoms they may report to work. If they develop fever (measured temperature > 100.0°F or subjective fever) OR respiratory symptoms they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority or healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation.

On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, facilities could consider having HCP report temperature and symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

HCP who Adhere to All Recommended Infection Prevention and Control Practices
Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.

No Identifiable Risk Exposure Category
HCP in the no identifiable risk category do not require monitoring or restriction from work.

Community or travel-associated exposures
HCP with potential exposures to COVID-19 in community settings, should have their exposure risk assessed according to CDC guidance. HCP should inform their facility's occupational health program that they have had a community or travel-associated exposure. HCP who have a community or travel-associated exposure should undergo monitoring as defined by that guidance. Those who fall into the *high*- or *medium- risk* category described there should be excluded from work in a healthcare setting until 14 days after their exposure. HCP who develop signs or symptoms compatible with COVID-19 should contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work.

Personnel are encouraged to read the following supplemental information:

Exposure Control Plan and Surge Plan (Appendix M) found in Target Solutions File Center and attached to this bulletin release.

CDC website: https://www.cdc.gov/coronavirus/2019-ncov/index.html

SD County EMS/Epidemiology website:
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/dc/2019-nCoV.html