UB|MD EMS

To: All EMS Personnel

From: Joseph Bart, DO, FACEP, Medical Director

CC: UB|MD EMS Program Agency

Date: February 1, 2020 (v.1.2 Rev March 6, 2020)

Re: Coronavirus (COVID-19)

UB|MD EMERGENCY MEDICINE EMS DIVISION

MODIFIED RESPONSE GUIDELINE FOR COVID-2019

SCREENING:

- Public Safety Answering Points (PSAP) and other emergency call centers should implement modified caller queries and immediately communicate pertinent information to EMS practitioners before arrival on scene.
- The PSAP (911 center) is encouraged to add questions about to callers to determine if they could be a Patient of Interest (PUI)
    - This is based on current illness and travel history.
- If information about the caller or patient seems to be suspicious for COVID-19, the PSAP will notify dispatch centers to communicate that to the EMS crews so they may don appropriate PPE.

ASSESSMENT:

- If 911 call takers advise that the patient is suspected of having COVID-19, EMS clinicians should put on appropriate PPE before entering the scene. EMS clinicians should consider the signs, symptoms, and risk factors of COVID-19 (https://www.cdc.gov/coronavirus/2019-nCoV/clinical-criteria.html).
- If information about potential for COVID-19 has not been provided by the PSAP, EMS clinicians should exercise appropriate precautions when responding to any patient with signs or symptoms of a respiratory infection.
- As an initial scene assessment, EMS personnel may perform a verbal assessment without entering the premises if the patient is alert and responding to questions.
- If direct patient assessment is warranted, Initial assessment should begin from a distance of at least 6 feet from the patient, if possible.

    - Patient contact should be minimized to the extent possible until a facemask is on the patient. If COVID-19 is suspected, all PPE as described below should be used.
    - If COVID-19 is not suspected, EMS clinicians should follow standard procedures and use appropriate PPE for evaluating a patient with a potential respiratory infection.
    - Non-EMS responders (Law Enforcement, fire personnel) are encouraged , when possible, to not make unnecessary entry.
- A facemask should be worn **by the patient** for source control (**An N-95 is not to be given to the patient)**
- If a nasal cannula is in place, a facemask should be worn over the nasal cannula. Alternatively, an oxygen mask can be used if clinically indicated. If the patient requires intubation, see below for additional precautions for aerosol-generating procedures.
- During transport, limit the number of providers in the patient compartment to essential personnel to minimize possible exposures.

INFECTION CONTROL FOR EMS:

- EMS providers should institute Standard, Contact, Airborne Precautions, and eye protection including the use of an N95 respirator and goggles or face shield.
- EMS clinicians who will directly care for a patient with possible COVID-19 infection or who will be in the compartment with the patient should follow Standard, Contact, and Airborne Precautions, including the use of eye protection. Recommended PPE includes:
    - A single pair of disposable patient examination gloves.
        - Change gloves if they become torn or heavily contaminated,
    - Disposable isolation gown,
    - Respiratory protection (i.e., N-95 or higher-level respirator), and
    - Eye protection (i.e., goggles or disposable face shield that fully covers the front and sides of the face).

Improve epidemic or pandemic preparedness by practicing the fundamentals of infection control on everyday “routine” calls:

- Change gloves frequently and avoid contaminating your patient compartment, computer tablets, and other equipment within the ambulance patient care compartment
- Between calls, use disinfectant appropriately on equipment
- Use soap and water when access to running water is available
- Use your PPE! (And remember that the N95 goes on you and the surgical mask goes on the patient who is not in moderate/severe respiratory distress)

USE OF ALBUTEROL:

- Patients with wheezing from diagnoses asthma or COPD – use standard protocols
- Patients with suspected smoke inhalation and wheezing, use standard protocol
- **Patients with NEW Cold and Flu symptoms (see above)**
    - Consider the potential for patient expose as per the CDC criteria above
    - If suspected infectious patient under investigation (PUI) consider **NOT** using nebulized respiratory treatments such as albuterol.
        - **The aerosolization of the medication may allow for increased distance of exposure when the patient is exhaling a contagious virus.**
    - Contact on-line medical direction with questions on the use of albuterol via nebulizer.

Transport Considerations:

- Standard transportation to appropriate hospital receiving facility
    - There is no DOH referral center. At this point all receiving facilities are equal.
- Isolate the ambulance driver from the patient compartment and keep pass-through doors and windows tightly shut.
    - It is recommended to have the patient compartment exhaust vent on high and to isolate the driver compartment from the patient compartment. It is also recommended to have the driver compartment ventilation fan set to high without recirculation.
    - If driver/pilot compartment is not isolated from the patient compartment, the vehicle operator should don a NIOSH-approved, fit-tested respirator.
- **NO RIDERS** - Family members and other contacts of COVID-19 PUI patients should not ride in the transport vehicle.
- During transport, limit the number of providers in the patient compartment to essential personnel to minimize possible exposures.
- **EMS personnel must notify the receiving hospital before arrival if they are transporting a patient with suspected COVID-19, to their facility.**
- When providing hospital notification, please indicate if any family or support persons are accompanying the patient, as they too may need to be isolated. EMS agencies should have a plan for family members wishing to accompany the patient that prevents crew exposures.

- Hospitals may request EMS personnel deliver such patient(s) through a separate secure entrance.
- A hospital may not refuse patients with suspected coronavirus infection unless a municipal response plan designed to do so has been activated.

WHAT MAKES THIS VIRUS DIFFERENT?

- Limited information is available to characterize the spectrum of clinical illness associated with 2019-nCoV. No vaccine or specific treatment for 2019-nCoV infection is available; care is supportive.
- Coronavirus is not a new virus; however, as a novel virus, that means that we have never seen this strand of Coronavirus before. The implication of that is that we have no natural or man-made (vaccine) immunity to offer against it.
- The virus, when infected, creates common cold symptoms. While this is not a particularly dangerous set of symptoms, the complications are higher for our special populations
    - The very young/infants (limited immunity)
    - The very old (immunity decreases and co-morbidities)
    - Immunosuppressed (chemotherapy, cancer, HIV, etc.)
- Every person exposed could become infected and therefore infect others.
- The symptoms are unlikely to dangerously affect most people but could carry a higher rate of complications for the above patient populations.

Clinical Features	&	Epidemiologic Risk
Fever **or** signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	**AND**	Any person, including health care workers, who has had close contact[2] with a laboratory-confirmed[3,4] 2019-nCoV patient within 14 days of symptom onset
Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	**AND**	A history of travel from **Hubei Province**, China within 14 days of symptom onset
Fever[1] **and** signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization[4]	**AND**	A history of travel from mainland **China** within 14 days of symptom onset

STANDARD PPE:

PPE available shall be utilized to provide protection from a patient suspected to have COVID-19. EMS practitioners should use PPE appropriately, and for all interactions involving contact with the patient or the patient's environment. Standard PPE is acceptable. Medically, this is not a hazardous material response.

EMS practitioners should don PPE prior to patient contact and properly discard PPE immediately after patient contact to contain pathogens.

The following PPE is recommended for use by EMS when treating a patient with suspected 2019-nCoV infection:

- Standard Universal Precautions;
- DROPLET Contact Precautions,
- Eye protection (goggles or face shield);
- Disposable NIOSH-approved, fit-tested N95 respirator mask

Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.

TRANSMISSION:

Human coronaviruses are most commonly spread from an infected symptomatic or mildly symptomatic person to others through:

- The air by coughing and sneezing directly near you (~6 feet)
- Close personal contact
- Touching objects or surfaces with the virus on it, then touching your mouth, nose or eyes before washing your unwashed hands

POST EXPOSURE:

- If using appropriate PPE – you are NOT considered an exposure.
- There is no post-exposure prophylaxis or medication
- There is no current vaccine
- There is no testing for asymptomatic patients or post-exposure testing
- There is no specific recommendation for contamination of turnout gear. If there is significant soiling, use normal laundry procedures.

Additional information and resources:

CDC Novel Coronavirus home page:

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

CDC Coronavirus for health care professional:

https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

NYS EMS – 2019 Novel Coronavirus

https://www.health.ny.gov/professionals/ems/pdf/20-02.pdf