COVID-19

EMS Emergency Operations Plan

Version 4.5
(updates in red)
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Background

CDC is responding to an outbreak of respiratory disease caused by a novel (new) coronavirus that was first detected in China and which has now been detected in more than 100 locations internationally, including in the United States. The virus has been named “SARS-CoV-2” and the disease it causes has been named “coronavirus disease 2019” (abbreviated “COVID-19”).

On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization (WHO) declared the outbreak a “public health emergency of international concern” (PHEIC). On January 31, Health and Human Services Secretary Alex M. Azar II declared a public health emergency (PHE) for the United States to aid the nation’s healthcare community in responding to COVID-19. On March 11, WHO publicly characterized COVID-19 as a pandemic. On March 13, the President of the United States declared the COVID-19 outbreak a national emergency.

Purpose

The purpose of the Gila River Health Care Emergency Medical Services (GREMS), Emergency Operations Plan is to focus on a tailored response to COVID 19 that requires coordination among executive officers, officers, crewmembers and staff. It shall serve to instruct all EMS employees in the efforts to operate within the framework of the Gila River Indian Community Multi-Agency Coordinating System and/or Incident Management Team and the policy and procedures of Gila River Health Care.

GREMS will be involved in the treatment and transport of the acutely ill or recovering patients with known or suspected exposure to infectious disease to emergency departments, residential care facilities, home or an alternate care site determined by state, county or local health departments.

Requests for service will continue and GREMS’ primary role & responsibility will be concentrated upon emergency response, resource management, surveillance, public education, call screening, and employee protection.

Concept of Operations

The number of COVID-19 cases will likely increase. To further minimize personnel impact and protect our patients we are implementing the following guidelines:

Daily Screenings

- Each employee will have tympanic temperature assessed and recorded immediately upon arrival for work.
- Each employee will complete COVID 19 Screening form upon arrival to shift.
- If temperature is above 100.4 Fahrenheit, the employee will be sent immediately home. Current GRHC directives will dictate leave classification and benefits.
- If an employee answers “yes” to any question they are to contact GRHC employee health for further guidance.
  - If GRHC employee health is unavailable contact the on EMS on call Operations Chief
- Return to work will be based on current GRHC directives.
Frequent Cleaning and Disinfection

In addition to routine station and equipment cleaning, all personnel shall frequently clean and disinfect high-touch surface areas in the station with disinfectant provided by the department via surface wiping as described by the chemical manufacturer (safety data sheet). Areas include but are not limited to:

- Tables
- Computers and accessories
- Hard-back chairs
- Doorknobs and handles
- Light switches
- Remote controls
- Desks
- Faucets, toilets and sinks
- Ambulance cab and patient compartment
- Vehicle cab and equipment area
- Equipment and equipment carriers

Wear gloves when cleaning and disinfecting surfaces. Clean hands immediately after gloves are removed. If surfaces are dirty, they could be cleaned using a detergent or soap and water before disinfection. Further information is available at:


*See the fogging and misting section for information on enhanced station disinfecting options.

Personal Hygiene

- Frequent hand washing with soap and water for at least 20 seconds. When this is not available use hand sanitizer.
- Uniforms should be kept at and laundered at work
- No civilian clothes to be laundered by department/community owned machines
- Uniforms shall be changed and laundered after contact with a patient suspected of COVID-19 or other infectious disease
- Shower before bed
- Weekly washing of bedding

Face Masks

- N95 with procedure/surgical mask or higher level respirator are to be worn at all times.
  - All EMS traffic
  - N95 re-use guidelines are currently in effect
- N95 or higher-level respirator
  - Inside EMS vehicle, when more than 1 occupant
  - Refueling vehicles
  - Inside and around GRHC campuses, including B100
  - N95 re-use guidelines are currently in effect
- May use/reuse procedure/surgical masks while in your EMS station as long as it is not:
  - Previously used on an EMS call
  - Torn or damaged
Soiled or contaminated

Exceptions:
- When one is alone in their assigned bunk
- Actively eating
  - Must maintain physical distancing
  - Once eating is finished, must don face mask
- No cloth or gaiter type masks will be allowed while working

Station Behavior

- Ensure bay and station doors remain closed (no propping of doors open)
- Grocery shop on days off for station/personal meals
- Maintain physical distancing practices, to include but not limited to:
  - Dining table
  - Day room
  - Other common areas
- Exercise in station gyms only, clean and disinfect equipment afterwards
- No public access of stations

Pre-Response

Gila River PSAP is actively screening calls utilizing the CDC recommendations to provide early warning of a possible risk to first responders. Ensure you are actively engaged in the CAD notes during response.

Response

To enhance Health Care Provider (HCP) safety:

- Minimum PPE for all patient encounters
  - Responder
    - N95 with procedure/surgical mask covering or higher level respirator
    - Gloves
    - Eye protection (Safety glasses, goggles, or disposable face shield that completely covers the front and sides of the face). Personal sunglasses/prescription glasses are not considered eye protection. (**disinfect using approved cleaner between patients**)
  - Patient
    - Procedure/surgical mask
- For suspected COVID-19 patient encounters (either via dispatch information or by initial assessment)
  - Provider
    - N95 or higher-level respirator
    - Gloves
    - Eye protection (Safety glasses, goggles, or disposable face shield that completely covers the front and sides of the face). Personal sunglasses/prescription glasses are not considered eye protection. (**disinfect using approved cleaner between patients**)
    - Gown (if available)
  - Patient
    - Procedure/surgical mask
- Limit the number of providers during initial screening/assessment
- When possible, conduct initial screening/assessment from greater than 6 feet away
- When possible, conduct patient assessment outside
If Dispatch/CAD indicates “Coronavirus illness (suspected)” or if a patient is symptomatic with fever, cough and/or difficulty breathing; providers with direct patient contact or entering the patient care area (within six-foot radius) shall don the prescribed Personal Protective Equipment (PPE): Currently the CDC and AZDHS are recommending providers utilize droplet precautions based on the coronavirus profile. The exception to this is when you are performing aerosolized procedures when an N95 or higher level respirator shall be donned by the provider.

What is the difference between contact precautions, airborne precautions and droplet precautions?

- **Contact Precautions**: For patients with known or suspected infections that represent an increased risk for contact transmission.
- **Airborne Precaution**: For patients known or suspected to be infected with pathogens transmitted by the airborne route (e.g., tuberculosis, measles, chickenpox, disseminated herpes zoster).
- **Droplet Precautions**: For patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing or sneezing.

**PPE Recommendations for the Care of Patients with Known or Suspected COVID-19**

- **Procedural/Surgical Masks** are an acceptable alternative to respirators when the supply chain is compromised. **N95 Respirators** should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to Healthcare Professionals.
- N95 respirators or respirators that offer a higher level of protection and shall be used instead of a procedural/surgical mask, when performing or present for an aerosol-generating procedure.
- **Eye protection** (i.e., goggles or disposable face shield that fully covers the front and sides of the face). Personal eyeglasses and contact lenses are NOT considered adequate eye protection.
- A single pair of disposable patient examination gloves. Change gloves if they become torn or heavily contaminated, and isolation gown.
  - If there are shortages of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of EMS clinicians (e.g., moving patient onto a stretcher).
- **Placement of procedural/surgical mask on the patient**
Treatment Guidelines for Care of Patients with Suspected/Confirmed COVID-19

- The following guidelines have been implemented from the state and with the approval of Gila River EMS’ Medical Director, Dr. Ryan Southworth.

### EMS Guideline for Care of Patients with Suspected COVID-19

**Clinical concern for COVID-19 infection & symptoms requiring EMS Treatment and Transport**

**Don Enhanced PPE**
- Place surgical mask on patient (may use NC under mask)

**Stabilizing Measures**
1. Perform all basic and advanced airway procedure in enhanced PPE
   - Administer oxygen (NC preferred) and titrate to SaO₂ of ≥ 86%, using ≤ 6LPM O₂.
   - Avoid high flow oxygen.
   - Place surgical mask over nasal cannula or oxygen mask.
2. Obtain IV/Io access as indicated.
3. Administer IVF only to treat shock (SBP <90).
4. Modify standard guidelines to minimize aerosolization of the virus.*
5. When available, insert viral filter between BVM/SGA/ETT and bag/ventilator.

**Transport to the closest appropriate receiving facility**

**Provide receiving facility notification:**
- “Possible COVID-19” and Primary Symptoms
- If any aerosolizing measures (SVN, CPAP, BVM, CPR) are in use
- If a patient is not transported, provide strict follow-up or call back instructions.

*Medications:
- No nebulizer use for patients with likely COVID-19, when nebulizer is absolutely necessary, administer in open air space and discontinue prior to entering any enclosed space, including hospital hallways.
- Consider using patient’s own MDI, 1-2 puffs every 5 minutes.
- Administer 0.3 mg of IM epinephrine, 1mg/mL, no more than once every 20 minutes, if needed for respiratory distress, use caution in patients over the age of 50 or with known cardiac disease.

*Noninvasive Positive Pressure Ventilation (NIPPV):
- Avoid CPAP/BIPAP unless absolutely necessary and discontinued prior to entry into a public space, including hospital hallways. If viral filter is available, place between the mask and oxygen delivery port.

*Advanced Airway Management:
- Early RSI is not recommended in the prehospital setting.
- Avoid endotracheal intubation and high flow O₂.
- Insertion of supraglottic airways (SGA) is preferred.
- Passive oxygenation during cardiac arrest may be achieved with a SGA device with viral filter if available.
- When ventilation is necessary, agencies should use available devices to limit exposure to aerosolized particles (examples: viral filters, etc.)

**Enhanced PPE:** prioritize use of masks blocking aerosolized particles (N95, P100, etc.) when any medication or procedure is being provided that generates aerosolized particles (nebulizers, PPV, airway suction, etc.) and when available wear gown, gloves and eye protection.

* updated on 7/9/20
When Transporting the Patient

- Drivers, if they provide direct patient care (e.g., moving patients onto stretchers), shall wear all recommended PPE. After completing patient care and before entering an isolated driver’s compartment, the driver shall remove and dispose of PPE and perform hand hygiene to avoid soiling the compartment.
  - If the transport vehicle does **not** have an isolated driver’s compartment, the driver shall remove the face shield or goggles, gown and gloves and perform hand hygiene. **An N95 with procedure/surgical mask covering or higher level respirator shall continue to be used during transport.**
- EMS clinicians shall notify the receiving healthcare facility that the patient has an exposure history and signs and symptoms suggestive of COVID-19 so that appropriate infection control precautions may be taken prior to patient arrival.
- Keep the patient separated from other people as much as possible.
- Family members and other contacts of patients with possible COVID-19 should **not** ride in the transport vehicle, if possible. If riding in the transport vehicle, they should wear a procedural/surgical mask.
- Isolate the ambulance driver from the patient compartment and keep pass-through doors and windows tightly shut.
- Use vehicles that have isolated driver and patient compartments that can provide separate ventilation to each area.
  - Close the door/window between these compartments before bringing the patient on board.
  - During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.
  - Use the rear exhaust fan to draw air away from the cab, toward the patient-care area, and out the back end of the vehicle.
- On arrival, after the patient is released to the facility, EMS clinicians shall remove and discard PPE based on guidelines and perform hand hygiene. Used PPE shall be discarded in accordance with current procedures.
  - **N95 re-use guidelines are currently in effect**

Precautions for Aerosol-Generating Procedures

- **An N95 with procedure/surgical mask covering** or higher-level respirator shall be worn in addition to the other PPE described above for EMS clinicians present for or performing aerosol-generating procedures.
- EMS clinicians should exercise caution if an aerosol-generating procedure (e.g., bag valve mask (BVM) ventilation, oropharyngeal suctioning, endotracheal intubation, nebulizer treatment, continuous positive airway pressure (CPAP), bi-phasic positive airway pressure (biPAP), or resuscitation involving emergency intubation or cardiopulmonary resuscitation (CPR) is necessary.

PPE Doffing Procedures

- The patient side of PPE is considered contaminated, do not touch with hands
- If hands become contaminated, immediately wash hands with soap and water or use hand sanitizer.
- Gloves – Using a gloved hand, grasp the palm area of the other gloved hand and peel off hand. Slide fingers under the wrist area of the remaining gloved hand and peel off. Dispose of gloves.
- Protective Gown – When donning protective gown, use only inside surfaces to pull the gown away. Fold the inside out as you remove keeping all exterior surfaces concealed. Discard the gown properly.
• Eye protection – grasp safety glasses from the ear pieces/arm and remove. If heavily soiled dispose of glasses. If no apparent contamination, clean safety glasses appropriately with medical equipment disinfectant or soap and water. **Decontaminated or washed safety glasses are to be re-used if possible.**
• Respiratory protection – Grasp the elastic bands from the rear and remove the N95 respirator without touching the face. Dispose of the N95.
  o **N95 re-use guidelines are currently in effect**

**Post-Response**

Cleaning EMS Transport Vehicles after Transporting a Persons Under Investigation (PUI) or Patient with Confirmed COVID-19.

• The following are general guidelines for cleaning or maintaining EMS transport vehicles and equipment after transporting a PUI:
  o After transporting the patient, leave the rear doors of the transport vehicle open to allow for sufficient air changes to remove potentially infectious particles.
  o The time to complete transfer of the patient to the receiving facility and complete all documentation should provide sufficient air changes.
  o When cleaning the vehicle, EMS clinicians shall wear an N95 with procedure/surgical mask covering, disposable gown, gloves and safety glasses or face shield.
  o Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly, to include the provision of adequate ventilation when chemicals are in use. Doors should remain open when cleaning the vehicle.
  o Clean and disinfect the vehicle in accordance with standard safety procedures.
  o All surfaces that may have come in contact with the patient or materials contaminated during patient care (e.g., stretcher, rails, control panels, floors, walls, work surfaces) shall be thoroughly cleaned and disinfected using an EPA-registered hospital grade disinfectant in accordance with the product label.
**Fogger and Mister Disinfecting**
This equipment and disinfectant *does not* supersede surface wiping with approved disinfectants and procedures but they may be used *as an option* to enhance station, equipment and vehicle disinfecting.

- Fogging using the “Blue” foggers with VitalOxide
  - Monday Interior Station Duties
  - Saturday Interior Vehicle Duties
  - As needed with supervisor oversight
  - Respirator, eye protection, gloves, long sleeves, long pants and shoes required for use
  - Requires *only* a light mist over surface areas

- Electrostatic (ionized form of fine misting) using the Steramist System (proprietary blend *only*)
  - Saturday Interior Vehicle Duties
  - As needed for vehicles/equipment with supervisor oversight
  - Full-face respirator, eye protection, gloves, long sleeves, long pants and shoes required for use
  - Requires *only* a light mist over surface areas
  - Only to be used by formally trained personnel (read protocol before each use)

- Electrostatic (ionized form of fine misting) using the EvaClean System (proprietary blend *only*)
  - Monday Interior Station Duties
  - Saturday Interior Vehicle Duties
  - As needed with supervisor oversight
  - Respirator, eye protection, gloves, long sleeves, long pants and shoes required for use
  - Requires *only* a light mist over surface areas

Note: Read all manufactures safety data (directions, precautions, procedures and first aid) prior to any use.

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**Commonality of Description**

**N95 Respirators** (pictures are for example only)

![N95 Respirators](image1)

**Half Face Piece Respirator with P100 cartridge** (picture is for example only)

![Half Face Piece Respirator](image2)

**Procedural/Surgical Mask** (picture is for example only)

![Procedural/Surgical Mask](image3)
Operational Exceptions

When N95 respirators are in low supply the Centers for Disease Control & Prevention provides guidelines for reuse practices.

- [https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html](https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html)
CDC & NIOSH RECOMMENDED RE-USE GUIDELINES FOR N95 MASKS

TAKE THE FOLLOWING STEPS TO REDUCE CONTACT TRANSMISSION:

- **Discard N95 Respirators Following Use During Aerosol Generating Procedures.** (Intubation, Extubation, CPR, BIPAP/CPAP, Airway suctioning, high-flow oxygen, aerosolizing or nebulizing medications)
- **Discard N95 Respirators Contaminated with Blood, Respiratory or Nasal Secretions, or Other Bodily Fluids from Patients.**
- **Discard N95 Respirators Following Close Contact with Any Patient Co-Infected With an Infectious Disease Requiring Contact Precautions.**
- **Use a Cleanable Face Shield (Preferred) or a Surgical Mask Over an N95 Respirator and/or Other Steps (e.g., Masking Patients, Use of Engineering Controls), When Feasible to Reduce Surface Contamination of the Respirator.**
- **Hang Used Respirators in a Designated Storage Area or Keep Them in a Clean, Breathable Container Such as a Paper Bag Between Uses.** To minimize potential cross-contamination, store respirators so that they do not touch each other and the person using the respirator is clearly identified. Storage containers should be disposed of or cleaned regularly.
- **Clean Hands with Soap and Water or an Alcohol-Based Hand Sanitizer Before and After Touching or Adjusting the Respirator (If Necessary for comfort or to maintain fit).**
- **Avoid Touching the Inside of the Respirator.** If inadvertent contact is made with the inside of the respirator, perform hand hygiene as described above.
- **Use a Pair of Clean (Non-Sterile) Gloves When Donning a Used N95 Respirator and Performing a User Seal Check.** Discard gloves after the N95 respirator is donned and any adjustments are made to ensure the respirator is sitting comfortably on your face with a good seal.

There is no way of determining the maximum possible number of safe reuses for an N95 respirator as a generic number to be applied in all cases. Safe N95 reuse is affected by a number of variables that impact respirator function and contamination over time. However, manufacturers of N95 respirators may have specific guidance regarding reuse of their product. The recommendations below are designed to provide practical advice so that N95 respirators are discarded before they become a significant risk for contact transmission or their functionality is reduced.

Reference:
https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html
**Surveillance (Asymptomatic) Testing of EMS Staff**

As part of Gila River Health Care’s expanded testing plan, EMS will be conducting Surveillance (Asymptomatic) Testing of all staff on a Bi-weekly basis. The following guidance from AZDHS will be utilized in conjunction with current GRHC directives when notified of COVID-19 positive test results. GRHC directives may be exceed guidance listed below.

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**Arizona COVID-19 Guidance ‘Release from Isolation’ Flow Chart**

At the time of testing/evaluation, was the patient experiencing symptoms consistent with COVID-19?

- **YES**
  - **Was the patient tested for COVID-19 by PCR or antigen?**
    - **YES**
      - **What was the test result?**
        - **POSITIVE**
          - **ISOLATE until ALL the following are met:**
            - It has been at least 10 days* since symptoms appeared
            - No fever for 24 hours**
            - Other symptoms have improved**
            - Without the use of medicines that reduce fever.
        - **NEGATIVE**
          - **ISOLATE until ALL the following are met:**
            - It has been at least 10 days* since symptoms appeared
            - No fever for 24 hours**
            - Other symptoms have improved**
            - Without the use of medicines that reduce fever.
      - **NO**
    - **NO**
  - **NO**

- **NO**

**Was the patient tested for COVID-19 by PCR, antigen or serology?**

- **YES**
  - **Was the test serology?**
    - **YES**
      - **ISOLATE for 10 days* from when the specimen was collected***
        - **IF symptoms develop, follow guidance for symptomatic patients.**
    - **NO**
    - **NO isolation needed**
  - **NO**
    - **No isolation needed**

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*A person who had severe/critical illness or is severely immuno-compromised should:

- If symptomatic, stay home away from others or under isolation precautions until:
  - At least 20 days have passed since symptoms first appeared; AND
  - At least 24 hours have passed since last fever without the use of medicine that reduces fever; AND
  - Other symptoms have improved.

- If asymptomatic, stay home away from others or under isolation precautions until:
  - At least 20 days have passed since specimen collection of the first positive COVID-19 PCR/antigen testing while asymptomatic. If symptoms develop, follow guidance for symptomatic and tested positive for COVID-19.

Outside of these criteria above, extension of isolation is not routinely recommended if an individual is retested within 3 months of onset of symptoms or date of first positive test while asymptomatic.

**Updated: July 27, 2020**
Release from Isolation Guidance (AZDHS)

Recommendations for discontinuation of transmission-based precautions and home isolation, based upon person’s symptoms and clinical testing are below.

- If a person is **symptomatic** and **awaiting** COVID-19 test results:
  - Stay home away from others or under isolation precautions until results are available. If results are delayed, follow guidance for symptomatic and tested positive for COVID-19. Once results are available, follow the recommendations below based on results.

- If a person is **symptomatic** and **tested positive** for COVID-19 by PCR, antigen testing, stay home away from others or under isolation precautions until:
  - At least 10 days* have passed since symptoms first appeared; AND
  - At least 24 hours have passed since last fever without the use of medicine that reduces fevers; AND
  - Other symptoms have improved.

- If a person is **symptomatic** and **tested negative** for COVID-19 by PCR or antigen testing, stay home away from others or under isolation precautions until:
  - At least 24 hours have passed since last fever without the use of medicine that reduces fevers; AND
  - Other symptoms have improved.

- If a person is **symptomatic** and has **not been tested** for COVID-19 by PCR or antigen testing, stay home away from others or under isolation precautions until:
  - At least 10 days* have passed since symptoms first appeared; AND
  - At least 24 hours have passed since last fever without the use of medicine that reduces fevers; AND
  - Other symptoms have improved.

- If a person is **asymptomatic** and **tested positive** for COVID-19 by PCR or antigen testing, stay home away from others or under isolation precautions until:
  - At least 10 days* have passed since specimen collection of the first positive COVID-19 PCR/antigen testing while asymptomatic. If symptoms develop, follow guidance for symptomatic and tested positive for COVID-19.

- If a person is **asymptomatic** and **tested positive** for COVID-19 by serology:
  - No isolation is required since there is a low likelihood of active infection. Take everyday precautions to prevent the spread of COVID-19.

- If a person is **asymptomatic** and **tested negative** for COVID-19 by PCR, antigen testing, or serology:
  - No isolation is required. Take everyday precautions to prevent the spread of COVID-19.

- If a person has other non-compatible symptoms and has not been tested for COVID-19, stay home away from others or under isolation precautions until:
  - At least 24 hours have passed since last fever without the use of medicine that reduces fevers; AND
  - Other symptoms have improved.

*A person who had severe/critical illness or is severely immunocompromised should:

- If symptomatic, stay home away from others or under isolation precautions until:
  - At least 20 days have passed since symptoms first appeared; AND
  - At least 24 hours have passed since last fever without the use of medicine that reduces fevers; AND
  - Other symptoms have improved.

- If asymptomatic, stay home away from others or under isolation precautions until:
  - At least 20 days have passed since specimen collection of the first positive COVID-19 PCR/antigen testing while asymptomatic. If symptoms develop, follow guidance for symptomatic and tested positive for COVID-19.
• Outside of these criteria above, extension of isolation is not routinely recommended if an individual is retested within 3 months of onset of symptoms or date of first positive test while asymptomatic.

**A person who had known close contact with a confirmed COVID-19 case should quarantine for 14 days from their last exposure to the case regardless of negative tests results or illness where no testing was performed. However, if they test positive for COVID-19 by PCR or antigen testing, they should follow the relevant isolation guidance. Healthcare workers and critical infrastructure workers should follow guidance that includes special consideration for these groups. If you are a healthcare worker or critical infrastructure worker, please follow-up with your employer or HR for specific guidelines. In addition, for people previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, quarantine is not recommended in the event of close contact with an infected person.

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Guidance for Asymptomatic HCP Who Were Exposed to Individuals with Confirmed COVID-19 (CDC)

Higher-risk exposures generally involve exposure of HCP eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure.

This guidance applies to HCP with potential exposure in a healthcare setting to patients, visitors, or other HCP with confirmed COVID-19. Exposures can also occur from a suspected case of COVID-19 or from a person under investigation (PUI) when testing has not yet occurred or if results are pending. Work restrictions described in this guidance might be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. Therefore, a record of HCP exposed to PUIs should be maintained. If test results will be delayed more than 72 hours or the patient is positive for COVID-19, then the work restrictions described in this document should be applied.

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<th>Personal Protective Equipment Used</th>
<th>Work Restrictions</th>
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<tr>
<td>HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19</td>
<td>• HCP not wearing a respirator or facemask^2</td>
<td>• Exclude from work for 14 days after last exposure^5</td>
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<td>• HCP not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask</td>
<td>• Advise HCP to monitor themselves for fever or symptoms consistent with COVID-19^4</td>
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<td>• HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure^1</td>
<td>• Any HCP who develop fever or symptoms consistent with COVID-19^5 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.</td>
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<tr>
<td>HCP other than those with exposure risk described above</td>
<td>• N/A</td>
<td>• No work restrictions</td>
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<td>• Follow all recommended infection prevention and control practices, including wearing a facemask for source control while at work, monitoring themselves for fever or symptoms consistent with COVID-19^4 and not reporting to work when ill, and undergoing active screening for fever or symptoms consistent with COVID-19^4 at the beginning of their shift.</td>
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<td>• Any HCP who develop fever or symptoms consistent with COVID-19^5 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.</td>
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</table>

HCP with travel or community exposures should inform their occupational health program for guidance on need for work restrictions.

HCP=healthcare personnel
1. Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. Until more is known about transmission risks, it is reasonable to consider an exposure of 15 minutes or more as prolonged.

2. Data are limited for the definition of close contact. For this guidance it is defined as: a) being within 6 feet of a person with confirmed COVID-19 or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19.

3. Determining the time period when the patient, visitor, or HCP with confirmed COVID-19 could have been infectious:
   1. For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions.
   2. For individuals with confirmed COVID-19 who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with COVID-19 may have been exposed could help inform the period when they were infectious.
      1. In general, individuals with COVID-19 should be considered potentially infectious beginning 2 days after their exposure until they meet criteria for discontinuing Transmission-Based Precautions.
      2. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing.

4. While respirators confer a higher level of protection than facemasks and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into this risk assessment. Cloth face coverings are not considered PPE because their capability to protect HCP is unknown.

5. If staffing shortages occur, it might not be possible to exclude exposed HCP from work. For additional information and considerations refer to Strategies to Mitigating HCP Staffing Shortages.

6. Fever is either measured temperature \( \geq 100.0^\circ F \) or subjective fever. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of patients in such situations. Occupational health programs should have a low threshold for evaluating symptoms and testing HCP.

**Personal Protective Equipment (PPE) Stop Loss**

**Supply Chain** - due to the possibility of concurrent worldwide supply chain interruptions on all personal protective equipment (PPE), EMS Administration continues to closely monitor and track our current supply and supply chains. All employees can assist in protecting these vital resources by reducing waste and adhering to the following procedure:

**Procedure:**

1. PPE supplies will be centralized to EMS Base 100 and EMS Base 200 in secure storage and assigned to the Logistics Chief for daily tracking and reporting
   a. Inventory will be taken and tracked daily
   b. Estimated burn rates will be identified and tracked
   c. PPE supply requests will be the same process through the daily unit/shop check-off process
   d. PPE will cease to be a 1 for 1 public safety department restock item
e. An evaluation on ambulance and gear bag “carry” numbers will be evaluated and adjusted based on the current environment and usage. This will be continually evaluated and adjusted in the unit/shop check-off software
f. Supply chain equipment constantly changes and therefore specific equipment types may continue to change

2. Back-up shops (vehicles) will not contain PPE supplies
   a. When transferring shops it will be required to transfer PPE items such as; N95 respirators, procedure masks, gowns, googles/glasses, face shields, PPE kits and gloves

**Continuity of Operations Plan**

**Planning** - The development and documentation of a COOP plan that when implemented, will provide for the continued performance of Gila River EMS (GREMS) essential functions under all circumstances. In order to reduce the pandemic threat, the plan should be to minimize the health, social, and economic impact of a pandemic on the Gila River Indian Community.

**Essential Functions** - Essential functions enable organizations to provide vital services, exercise civil authority, maintain the safety and well-being of the general populace, and sustain the economic base in an emergency. During a pandemic, or any other emergency, these essential functions must be continued in order to facilitate emergency management and overall community recovery.

Functions that are essential to EMS operations include:

- Maintenance of a 911 call center and other ways for the public to access EMS
- A system to determine the caller’s problem(s)
- A system to triage calls and designate appropriate medical response
- Maintenance of emergency vehicles and equipment
- Trained and available personnel to respond to calls
- Supporting legislation and regulations to enable EMS to function effectively
- Financial support to maintain a high-quality EMS system
- Medical direction and oversight
- Communications systems
- Public education.

**Delegation of Authority** - Clearly pre-established delegations of authority are vital to ensuring that all GREMS personnel know who has the authority to make key decisions in a COOP situation. Because extreme absenteeism may reach a peak at the height of a pandemic wave, delegations of authority are critical. GREMS utilizes the incident command structure (ICS) and the National Incident Management System (NIMS). This authority should be maintained during the pandemic period.

**Succession Planning** - An order of succession is essential to an organization’s COOP plan to ensure personnel know who has authority and responsibility if the leadership is incapacitated or unavailable in a COOP situation. Leadership training should be provided for mid- and upper-level EMS supervisory staff to ensure that in case of major illness, injuries or deaths, there will be individuals who can take on the role of EMS leadership.
Alternate Physical Facilities- Because a pandemic presents essentially simultaneous risk everywhere, the use of alternative operating facilities must be considered in a non-traditional way. COOP planning for pandemic influenza will involve alternatives to staff relocation/co-location such as social distancing in the workplace through telecommuting, or other means. Alternate operating facilities impact several aspects of EMS operations, including but not limited to:

- 9-1-1 call center
- Administrative offices
- Crew quarters - Ambulance bays/garages/repair facilities
- Emergency departments and alternate destinations

Effective Communications- The success of a viable COOP capability is dependent upon the identification, availability, and redundancy of critical communication systems to support connectivity of internal organizations, external partners, critical customers and the public. Systems that facilitate communication in the absence of person-to-person contact can be used to minimize workplace risk for essential employees and can potentially be used to restrict workplace entry of people with influenza symptoms. EMS relies on communications systems at multiple points in the emergency response process. EMS communication systems include:

- Accepting communications in to a 9-1-1 center
- Dispatching communications from a 9-1-1 center
- Routing communications to and between emergency operations centers
- Receiving communications from field personnel to medical control
- Coordination of communications within the field
- Communication with special needs populations
- Communication with destinations, such as hospitals, nursing homes
- Emergency communication with the public (e.g., warning systems)

Communication discipline is one of the keys to effective incident management, and ideally, these systems would be centralized through established ICS channels. There should also be a plan for backup or redundant communication strategies in case there are failures in primary communication methods. Similarly, other backup procedures for actions that can be taken when systems fail should be planned, tested in advance, and integrated into the planning process.
Emergency Ambulance Staffing Contingencies

The contingency plan is to monitor and prevent, respond to, and recover from a staffing shortage of any cause within the Gila River Indian Community.

### DAILY FOCUS ON PATIENT FLOW

**TRIGGER BLUE**  
(MILD - 25% REDUCTION)

- Normal Operations
- Business as Usual

**TRIGGER ORANGE**  
(MODERATE - 40% REDUCTION)

- Mild
- Normal Operation
- Business as Usual

**TRIGGER RED**  
(SEVERE - 60% REDUCTION)

- Moderate
- Urgent Operations
- Triage Inpatients/Operations

### ACTIVATION OF EMERGENCY OPERATIONS PLAN (DISASTER PLAN)

- Severe
- Emergent Operations Only
- Consolidate Services
- Consolidate Space

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<th>Absenteeism</th>
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**Department Actions:**

- No action, normal operating procedures
- No notification necessary

**Department Action:**

- Call staff that are off & determine who can work

**Hospital Command Center:**

- HCC is activated.
- Consider activating Branch ICs located on alternate campuses
- Hospital/clinic workforce shortage plan initiated
References

1. GRIC Task Force SitRep/IAP: www.gric-eoc.org
3. GRHC Information: www.GRHC.org/coronavirus
4. CDC: www.CDC.gov
5. AZ DHS: www.AZDHS.gov
8. VitalOxide: https://vitaloxide.com/
11. EMS.230.10 Unit and Equipment Decontamination
12. Steramist Ambulance Disinfection Protocol
13. Steramist Usage Form

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