Healthcare Partner/EMS Provider Coordination Conference Call

COVID-19

February 28, 2020
9:00 – 10:00am
Purpose of Partner Conference Call

- Assure and coordinate situational awareness between partners and PHD/EMSA
- Share best practices to prevent spread of COVID-19
- Discuss and confirm guidance to assure health care worker safety
- Identify resource shortages and determine solutions
- Promote coordinated and efficient response to protect the community
Conference Call Schedule

• Change of Schedule Needed
• Thursdays, 8:30 am proposed
Agenda

I. Situation Update
   • PHD Actions
   • CAHAN Alerts
   • Testing

II. Guidance Updates
   • Updates to travel alerts and Person Under Investigation (PUI) definition
   • Updates to EMS Guidance

III. Mitigation of Risk to Healthcare & EMS
   • Provider Checklist
   • Hospital Preparedness Checklist-CDC
   • CDPH Healthcare Preparedness Checklist

IV. Resources and Supply Chain
   • Santa Barbara County PPE Survey for hospitals, outpatient and ems providers
   • Report on current supply chain issues/shortages
   • Report any estimates of potential unmet needs for daily or suspect care

V. Issues and discussion with long term care facilities, home health agencies, ambulatory surgery centers etc.

VI. Questions? Additional Issues?
COVID-19 Situation Update

2/28/20

- 83,105 worldwide cases, 2,858 deaths (70 outside China)
- Sustained community transmission:
  - South Korea (2,200)
  - Italy (650/17, 7,000 tests)
  - Japan
  - Iran (245/26, vice president sickened, prominent cleric died)

Other countries have cases and limited community transmission
COVID-19 Situation Update

- CA: 33 cases (24 in repatriated persons), 230 persons tested
- CA: First case of community transmission in US
  - Solano County CA
- Case has no history of travel or to anyone of known risk
- Presented to first hospital (Feb 15)
- Hospitalized, transferred to UC Davis Hospital (Feb 19)
- Initially CDC did not test as did not meet the PUI definition
- CDC team in Solano trying to identify/quarantine all contacts
- Healthcare workers at multiple facilities are in quarantine and being tested, no positives yet reported
- 3 students at UC Davis isolated
### COVID-19: Confirmed Cases in the United States*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel-related</td>
<td>12</td>
</tr>
<tr>
<td>Person-to-person spread</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total confirmed cases</strong></td>
<td>14</td>
</tr>
<tr>
<td><strong>Total tested</strong></td>
<td>445</td>
</tr>
</tbody>
</table>

* This table represents cases detected and tested in the United States through U.S. public health surveillance systems since January 21, 2020. It does not include people who returned to the U.S. via State Department-chartered flights. Numbers closed out at 4 p.m. the day before reporting.

### COVID-19: Cases among Persons Repatriated to the United States†

<table>
<thead>
<tr>
<th>Location</th>
<th>Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wuhan, China</td>
<td>3</td>
</tr>
<tr>
<td><strong>Diamond Princess Cruise Ship</strong></td>
<td>42</td>
</tr>
</tbody>
</table>

*Numbers closed out at 4 p.m. the day before reporting.
*Cases have laboratory confirmation and may or may not have been symptomatic.
Public Health Objective

Slow the spread of disease through taking action to prevent exposure:

• Isolate sick until test negative-can take 4 weeks
• Identify, quarantine, test exposed persons for 14 days
• Implement social distancing if local community transmission:
  • Closing schools, cancelling community events, religious services
  • Limiting public transport, closing businesses, etc
• Encourage businesses to implement social distancing in the worksite, screen workers, take measures such as cleaning, liberal sick time, work from home, anticipate personnel shortages, etc.
• Provide public guidance on how to prevent disease spread
Public Health Department Actions

• Issuing updated provider guidance via health alerts and local CAHAN alerts
• Participating in CDPH and CDC guidance teleconferences
• Monitoring returned asymptomatic travelers (4-10 per week)
• Assessing shortages of PPE via survey to healthcare partners
• Receiving calls from providers re suspect cases
• Implemented EMS screening
• Receiving calls from the public, established recorded info line
• Website page with updated information and links to resources
COVID-19: Who is at risk?

Largest study to date China CDC Weekly article
http://weekly.chinacdc.cn/en/article/id/e53946e2-c6c4-41e9-9a9b-fea8db1a8f51

- A total of 72,314 patient records—44,672 (61.8%) confirmed cases, 16,186 (22.4%) suspected cases, 10,567 (14.6%) clinically diagnosed cases (Hubei Province only), and 889 asymptomatic cases (1.2%)
- Among confirmed cases, most were aged 30–79 years (86.6%)
- Cases considered mild (80.9%)
- 1,023 deaths occurred among confirmed cases for an overall case fatality rate of 2.3%
- 1,716 health workers have become infected and 5 have died (0.3%).
COVID-19: Do we know who is at risk?


<table>
<thead>
<tr>
<th>Baseline characteristics</th>
<th>Confirmed cases, N (%)</th>
<th>Deaths, N (%)</th>
<th>Case fatality rate, %</th>
<th>Observed time, PD</th>
<th>Mortality, per 10 PD</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–9</td>
<td>416 (0.9)</td>
<td>–</td>
<td>–</td>
<td>4,383</td>
<td>–</td>
</tr>
<tr>
<td>10–19</td>
<td>549 (1.2)</td>
<td>1 (0.1)</td>
<td>0.2</td>
<td>6,625</td>
<td>0.002</td>
</tr>
<tr>
<td>20–29</td>
<td>3,619 (8.1)</td>
<td>7 (0.7)</td>
<td>0.2</td>
<td>53,953</td>
<td>0.001</td>
</tr>
<tr>
<td>30–39</td>
<td>7,600 (17.0)</td>
<td>18 (1.8)</td>
<td>0.2</td>
<td>114,550</td>
<td>0.002</td>
</tr>
<tr>
<td>40–49</td>
<td>8,571 (19.2)</td>
<td>38 (3.7)</td>
<td>0.4</td>
<td>128,448</td>
<td>0.003</td>
</tr>
<tr>
<td>50–59</td>
<td>10,008 (22.4)</td>
<td>130 (12.7)</td>
<td>1.3</td>
<td>151,059</td>
<td>0.009</td>
</tr>
<tr>
<td>60–69</td>
<td>8,583 (19.2)</td>
<td>309 (30.2)</td>
<td>3.6</td>
<td>128,088</td>
<td>0.024</td>
</tr>
<tr>
<td>70–79</td>
<td>3,918 (8.8)</td>
<td>312 (30.5)</td>
<td>8.0</td>
<td>55,832</td>
<td>0.056</td>
</tr>
<tr>
<td>≥80</td>
<td>1,408 (3.2)</td>
<td>208 (20.3)</td>
<td>14.8</td>
<td>18,671</td>
<td>0.111</td>
</tr>
<tr>
<td>Baseline characteristic</td>
<td>Confirmed cases, N (%)</td>
<td>Deaths, N (%)</td>
<td>Case fatality rate, %</td>
<td>Observed time, PD</td>
<td>Mortality, per 10 PD</td>
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<td>---------------------</td>
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<tr>
<td>Comorbid condition†</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>2,683 (12.8)</td>
<td>161 (39.7)</td>
<td>6.0</td>
<td>42,603</td>
<td>0.038</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1,102 (5.3)</td>
<td>80 (19.7)</td>
<td>7.3</td>
<td>17,940</td>
<td>0.045</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
<td>873 (4.2)</td>
<td>92 (22.7)</td>
<td>10.5</td>
<td>13,533</td>
<td>0.068</td>
</tr>
<tr>
<td>Chronic respiratory disease</td>
<td>511 (2.4)</td>
<td>32 (7.9)</td>
<td>6.3</td>
<td>8,083</td>
<td>0.040</td>
</tr>
<tr>
<td>Cancer (any)</td>
<td>107 (0.5)</td>
<td>6 (1.5)</td>
<td>5.6</td>
<td>1,690</td>
<td>0.036</td>
</tr>
<tr>
<td>None</td>
<td>15,536 (74.0)</td>
<td>133 (32.8)</td>
<td>0.9</td>
<td>242,948</td>
<td>0.005</td>
</tr>
<tr>
<td>Missing</td>
<td>23,690 (53.0)</td>
<td>617 (60.3)</td>
<td>2.6</td>
<td>331,843</td>
<td>0.019</td>
</tr>
</tbody>
</table>
CAHAN Alerts

- Come from CDPH and local PHD
- Assure key contacts at your facility/agency are enrolled
  - At least two individuals per facility/agency
- Contacts are responsible for reading and disseminating the information and guidance within their facility/agency
The California Department of Public Health, Center for Health Care Quality will conduct a conference call for California healthcare facilities on Tuesday, 2/18/2020 at 7:45 AM PST to provide updates on the Coronavirus.

Please see conference call details below.

**Participation Access Information**
- Toll-free: 844-721-7239
- Access Code: 7993227
Guidance Updates


• February 27th – CDC Updated PUI
• February 24th – Interim Guidance for PH Personnel Evaluating Persons Under Investigation and Asymptomatic Close Contacts
• February 24th – Information for Travel (New Travel Alerts)
• February 23rd – FAQ’s
## PUI Updates - February 27, 2020

**Read Footnotes**


<table>
<thead>
<tr>
<th>Clinical Features</th>
<th>&amp;</th>
<th>Epidemiologic Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever(^1) or signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)</td>
<td>AND</td>
<td>Any person, including health care workers(^2), who has had close contact(^3) with a laboratory-confirmed(^4) COVID-19 patient within 14 days of symptom onset</td>
</tr>
<tr>
<td>Fever(^1) and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization</td>
<td>AND</td>
<td>A history of travel from affected geographic areas(^5) (see below) within 14 days of symptom onset</td>
</tr>
<tr>
<td>Fever(^1) with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization(^6) and without alternative explanatory diagnosis (e.g., influenza)(^2)</td>
<td>AND</td>
<td>No source of exposure has been identified</td>
</tr>
</tbody>
</table>
Affected Geographic Areas with Widespread or Sustained Community Transmission

Last updated February 26, 2020

- China
- Iran
- Italy
- Japan
- South Korea

See all COVID-19 Travel Health Notices.

The criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria.
If you spent time in South Korea during the past 14 days and feel sick with fever or cough, or have difficulty breathing:

- Seek medical advice. Call ahead before you go to a doctor’s office or emergency room. Tell them about your recent travel and your symptoms.
- Avoid contact with others.
- Do not travel while sick.
- Cover your mouth and nose with a tissue or your sleeve (not your hands) when coughing or sneezing.
- Clean your hands often by washing them with soap and water for at least 20 seconds or using an alcohol-based hand sanitizer that contains 60%-95% alcohol immediately after coughing, sneezing or blowing your nose. Soap and water should be used if hands are visibly dirty.
Clinician Information

Healthcare providers should obtain a detailed travel history for patients with fever or acute respiratory symptoms. For patients with these symptoms who were in South Korea and had onset of illness within 2 weeks of leaving, consider the novel coronavirus and notify infection control personnel and your local health department immediately.

Although routes of transmission have yet to be definitively determined, CDC recommends a cautious approach to interacting with patients under investigation. Ask such patients to wear a face mask as soon as they are identified. Conduct patient evaluation in a private room with the door closed, ideally an airborne infection isolation room, if available. Personnel entering the room should use standard precautions, contact precautions, and airborne precautions, and use eye protection (goggles or a face shield). For additional healthcare infection control recommendations, visit CDC’s Infection Control webpage.
Testing for COVID-19

• CDPH lab (VRDL) can now test with 48 hour turn around
• Additional county level labs will be testing in 1-2 weeks
• Details will be on CDPH website

1. Patient must meet the PUI definition
2. Call PHD, speak to health officer
3. CDC will be contacted and assigns a PUI#
4. VRDL will perform testing

*If patient does not meet criteria but highly suspect the health officer/clinician can still request a PUI# from CDC*
Sources of Disease Risk to Facility or Agency

- Staff
- Patients
- Visitors

Facility or Agency
Mitigation of Risk to Healthcare & EMS

- All EMS providers should be prepared to safely screen and transport suspect/confirmed patients
- All hospitals should be prepared to safely accept and test suspect/confirmed patients
- All outpatient providers should be prepared to safely screen and isolate suspect patients
- All providers should be able to monitor their staff for disease and track potential exposures
- Some outpatient providers (surgery centers/pain management/small offices) will only screen and exclude/refer; prevent entrance into facility
Mitigation of Risk to Healthcare & EMS

• Review Infection Control Guidance from CDC link: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html

• Cal-OSHA: https://www.dir.ca.gov/dosh/Coronavirus-info.html

• Must provide training NOW on COVID and PPE

• Reports from providers
  • Challenges
  • Training Needs
  • Adherence to CDC/Cal-OSHA guidelines for respiratory, contact, and standard precautions
  • Aerosolizing procedures require a PAPR (or P100 for field EMS only)
Cal-OSHA Interim Guidance 2019-nCoV

- [Https://www.dir.ca.gov/dosh/Coronavirus-info.html](Https://www.dir.ca.gov/dosh/Coronavirus-info.html)

Training

All employers covered by the ATD Standard must provide comprehensive training to employees on their initial placement and at least annually. Employers must also provide a training update to employees regarding changes to their ATD exposure control plan that apply to 2019-nCoV. This update must specifically address:

- Signs and symptoms of 2019-nCoV.
- Modes of transmission of 2019-nCoV and source control procedures.
- Tasks and activities that may expose the employee to 2019-nCoV.
- Use and limitations of methods to prevent or reduce exposure to 2019-nCoV including appropriate engineering and work practice controls, decontamination and disinfection procedures, and personal and respiratory protective equipment.
- Selection of personal protective equipment, its uses and limitations, and the types, proper use, location, removal, handling, cleaning, decontamination and disposal.
- Proper use of respirators.
- Available vaccines, when they become available.
- What to do if an exposure incident occurs.
- The employer’s surge plan if applicable.
PPE Guidance and Training

Personal Protective Equipment
For 2019-Novel Coronavirus

DONNING

For respiratory protection use an N-95 respirator or above
For eye protection use goggles or a face shield

DOFFING

Use Caution with Aerosol-Generating Procedures:
- Conduct in an Airborne Infection Isolation Room (AIIR).
- Personnel should use PAPR* for respiratory protection.
- Limit the staff to only those necessary.

Discontinuation of isolation precautions and patient discharge
- This should be determined on a case-by-case basis in accordance with the Los Angeles County Department of Public Health.
- Contact at 213-240-7941 during business hours or 213-974-1234 after hours.

* For more information on usage of PAPR respiratory protection during Aerosol-Generating Procedures visit:
http://publichealth.lacounty.gov/acid/docs/CoVPPEPoster.pdf
Updates from EMS

• Insert dispatch center update sent on 2/27
• EMS Provider Alert to Dispatch re PUI
• Dispatch PSAP Alert with updated screening Protocols
Communication of information regarding patients at risk (pre or post transport/exposure)

- PHD is informed by CDPH of travelers at risk
- Hospital and EMS providers must be informed prior to transport
  - **Dispatch Screening**
    1. EMD PSAP: Questions regarding travel, dates, and country in the EIDS tool (optional)
    2. ALL PSAP: Travel screening algorithm provided for Breathing Problem or Sick Person
    3. Healthcare provider call identifying suspect patient for transfer, all units shall be advised “Patient meets travel advisory criteria, follow public health/EMS agency PPE guidelines
Update to screening questions sent out to dispatch on February 27, 2020 by the EMS Agency
Provider Checklist

- Developed by PHD and sent out via CAHAN to all healthcare partners on February 12, 2020
- Updated on 2/28/20 with new PUI information- will be sent out later today
CDC Hospital Preparedness Checklist

Coronavirus Disease 2019 (COVID-19) Hospital Preparedness Assessment Tool

All U.S. hospitals should be prepared for the possible arrival of patients with Coronavirus Disease 2019 (COVID-19). All hospitals should ensure their staff are trained, equipped and capable of practices needed to:

- Prevent the spread of respiratory diseases including COVID-19 within the facility
- Promptly identify and isolate patients with possible COVID-19 and inform the correct facility staff and public health authorities
- Care for a limited number of patients with confirmed or suspected COVID-19 as part of routine operations
- Potentially care for a larger number of patients in the context of an escalating outbreak
- Monitor and manage any healthcare personnel that might be exposed to COVID-19
- Communicate effectively within the facility and plan for appropriate external communication related to COVID-19

The following checklist does not describe mandatory requirements or standards; rather, it highlights important areas for hospitals to review in preparation for potential arrivals of COVID-19 patients.

Elements to be assessed

1. Infection prevention and control policies and training for healthcare personnel (HCP):

   - Facility leadership including the Chief Medical Officer, quality officers, hospital epidemiologist, and heads of services (e.g., infection control, emergency department, environmental services, pediatrics, critical care) has reviewed the Centers for Disease Control and Prevention's (CDC) COVID-19 guidance.
   - Facility provides education and job-specific training to HCP regarding COVID-19 including:
     - Signs and symptoms of infection
     - How to safely collect a specimen
     - Correct infection control practices and personal protective equipment (PPE) use
     - Triage procedures including patient placement
     - HCP sick leave policies and recommended actions for unprotected exposures (e.g., not using recommended PPE, an unrecognized infectious patient contact)
     - How and to whom COVID-19 cases should be reported

CDPH Healthcare Facility Preparedness Checklist

• CDC Healthcare Facility Checklist

• CDPH All Facilities Checklist- included in AFL-20-10
Update Your Screening Posters

• Call ahead
• Call from outside building
• Other measures to prevent entrance to your building
• Determine how you will reduce chance of exposures
Minimize Chance for HCP Exposure

- Ensure that patients with symptoms of suspected 2019-nCoV or other respiratory infection (e.g., fever, cough) are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

- Ensure rapid triage and isolation of patients with symptoms of suspected 2019-nCoV or other respiratory infection (e.g., fever, cough):
  - Identify patients at risk for having 2019-nCoV infection before or immediately upon arrival to the healthcare facility.
  - Implement triage procedures to detect persons under investigation (PUI) for 2019-nCoV during or before patient triage or registration (e.g., at the time of patient check-in) and ensure that all patients are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of 2019-nCoV or contact with possible 2019-nCoV patients.

<table>
<thead>
<tr>
<th>Epidemiologic risk factors</th>
<th>Exposure category</th>
<th>Recommended Monitoring for 2019-nCoV (until 14 days after last potential exposure)</th>
<th>Work Restrictions for Asymptomatic HCP</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. HCP (with unprotected eyes, nose, or mouth) who have prolonged close contact with a patient who was not wearing a facemask. Note: A respirator confers a higher level of protection than a facemask. However, they are grouped together in this scenario because (even if a respirator or facemask was worn) the eyes remain uncovered while having prolonged close contact with a patient who was not wearing a facemask.</td>
<td>Medium</td>
<td>Active</td>
<td>Exclude from work for 14 days after last exposure</td>
</tr>
<tr>
<td>D. HCP (with unprotected eye, nose, and mouth) who have prolonged close contact with a patient who was wearing a facemask.</td>
<td>Medium</td>
<td>Active</td>
<td>Exclude from work for 14 days after last exposure</td>
</tr>
<tr>
<td>E. HCP (not wearing gloves) who have direct contact with the secretions/excretions of a patient and the HCP failed to perform immediate hand hygiene Note: If the HCP performed hand hygiene immediately after contact, this would be considered low risk.</td>
<td>Medium</td>
<td>Active</td>
<td>Exclude from work for 14 days after last exposure</td>
</tr>
<tr>
<td>F. HCP wearing a facemask or respirator only who have prolonged close contact with a patient who was wearing a facemask Note: A respirator confers a higher level of protection than a facemask. However, they are grouped together in this scenario and classified as low-risk because the patient was wearing a facemask for source control.</td>
<td>Low</td>
<td>Self with delegated supervision</td>
<td>None</td>
</tr>
</tbody>
</table>

Healthcare Personnel with Potential Exposure Guidance (CDC)-2/8/20

3. Manage Visitor Access and Movement Within the Facility

- Establish procedures for monitoring, managing and training visitors.
- Restrict visitors from entering the room of known or suspected 2019-nCoV patients (i.e., PUI). Alternative mechanisms for patient and visitor interactions, such as video-call applications on cell phones or tablets should be explored. Facilities can consider exceptions based on end-of-life situations or when a visitor is essential for the patient’s emotional well-being and care.
- Visitors to patients with known or suspected 2019-nCoV (i.e., PUI) should be scheduled and controlled to allow for:
  - Screening visitors for symptoms of acute respiratory illness before entering the healthcare facility.
  - Facilities should evaluate risk to the health of the visitor (e.g., visitor might have underlying illness putting them at higher risk for 2019-nCoV) and ability to comply with precautions.
  - Facilities should provide instruction, before visitors enter patients’ rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the patient’s room.
  - Facilities should maintain a record (e.g., log book) of all visitors who enter patient rooms.
  - Visitors should not be present during aerosol-generating procedures.
  - Visitors should be instructed to limit their movement within the facility.
  - Exposed visitors (e.g., contact with 2019-nCoV patient prior to admission) should be advised to report any signs and symptoms of acute illness to their health care provider for a period of at least 14 days after the last known exposure to the sick patient.
- All visitors should follow respiratory hygiene and cough etiquette precautions while in the common areas of the facility.

What are transport and receipt of patient protocols for hospitals?

Alert hospital prior to arrival of suspect patient:
- Field to hospital via EMS transport
- Via referral from facility
- Questions regarding communication from clinic to hospital for transfer?

Before Arrival
- When scheduling appointments, instruct patients and persons who accompany them to call ahead or inform HCP upon arrival if they have symptoms of any respiratory infection (e.g., cough, runny nose, fever) and to take appropriate preventive actions (e.g., wear a facemask upon entry to contain cough, follow triage procedures).
- If a patient is arriving via transport by emergency medical services (EMS), the driver should contact the receiving emergency department (ED) or healthcare facility and follow previously agreed upon local or regional transport protocols. This will allow the healthcare facility to prepare for receipt of the patient.
What do small facilities such as dialysis, ambulatory surgery centers do?

Protect your facility
1. Provide phone screening to determine if:
   1. Person has traveled to an affected country within 14 days
   2. Person has illness/symptoms fever/cough/difficulty breathing
   3. Person has had contact with person returning from affected area
   4. Person has had contact with person under investigation for COVID-19
2. Do not allow suspect patient into the facility, ask to wait in car or outside until PHD is called or ambulance, if needed
3. Protect your staff
   1. Provide N95 fit testing and PPE if your facility will have potential patients
Dialysis

• How do dialysis providers provide services to persons with infectious diseases?
Resources and Supply Chain

Report on current supply chain issues/shortages

• McKesson reports that orders are filled based on previous ordering history (October-December average was used)
• Facilities that never order certain products have orders cancelled
• N-95’s, gowns, goggles, patient masks limited availability
• Some alternatives are available (suits instead of gowns)
• CDPH has requested 300,000 masks, delivery in April
  • 3M 8511 is the only model that will be available
• Caches of masks are expired, may be authorized to use
3M 8511 N95 Respirator
Disaster Supply Caches

- PHD has gown/glove sets approximately 3,000
- PHD has a small cache of N-95’s that is supporting Disease Control
- Direct Relief:
  - N-95 masks sent to China
  - Some availability of 1 type of N-95 medical mask
  - Policy on distribution to healthcare facilities has not been established
  - Will not be distributing masks to general public
PHD PPE Survey

• Hospitals, Clinics, EMS Providers
• Link sent 2/26/20
• Complete initial survey by March 4th
• Regular survey schedule
• Results: Monitor shortages and make requests to CDPH
• Make strategic decisions
• Must report to CDPH
Develop MAC Group for scarce medical resources (PPE and other)

Representatives from:
• Infection Disease Physicians
• Coalition clinical advisor
• PHD, EMSA, OEM, Health Officer
• Long Term Care
Surge Planning
Surge Questions

Are our healthcare providers ready to:
• Separate COVID patients from non-COVID
• Maintain staffing and PPE?
• Are there enough ICU beds and ventilators for severely ill?
• Are there models of expected surge of hospitalized patients?
• Will local or bedside testing be available to allow for cohorting of hospitalized patients in rooms or floors?
• Can we anticipate the types of care that will be needed?
• Will responding to COVID-19 result in delays in care for other patients? For dialysis, cancer treatment, elective surgeries, etc?
Surge Considerations: What care do hospitalized patients need?

JAMA article:

• All patients admitted to the hospital have pneumonia with infiltrates on chest x-ray and ground glass opacities on chest computed tomography.\(^8\,^9\)

• 1/3 of patients subsequently developed acute respiratory distress syndrome and required care in the intensive care unit.

• Particularly true for patients with comorbid conditions such as diabetes or hypertension.\(^8\)

• [https://jamanetwork.com/journals/jama/fullarticle/2760782](https://jamanetwork.com/journals/jama/fullarticle/2760782)
Issues for specific facility/agency types

Discussion of Issues related to:

• Skilled Nursing Facilities and Long Term Care
  • Protecting residents
  • PPE and staff
  • Screening staff and contractors
  • Visitors
Wrap Up!

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