TIDEWATER EMERGENCY MEDICAL SERVICES COUNCIL, INC.

The Tidewater EMS Council and the Regional Operations Medical Directors would like to offer guidance to EMS agencies regarding screening of providers and management of personnel surrounding the COVID-19 pandemic. Each EMS agency is encouraged to adapt these recommendations according to department needs and current best practices, and should consider consultation with their Operational Medical Director. Screening of EMS Providers should occur for all personnel regardless of patient contact given that community spread of COVID-19 is present.

Screening EMS Providers

EMS agencies should develop a policy to begin screening EMS upon entry to the facility/station at the beginning of each shift. Given community spread of COVID-19, EMS providers may be exposed to COVID-19 in the community or at home and increase the risk of transmission to patients or other EMS personnel. Therefore, TEMS recommends EMS personnel self-monitor twice daily with the oversight of their EMS agency, especially prior to starting work. The goal of EMS provider screening is early identification of EMS personnel with symptoms of illness to prevent possible exposures of other EMS personnel and patients.

Lessons learned nationally suggest that EMS providers who were screened with a temperature check twice daily were able to identify a low-grade fever prior to onset of upper respiratory symptoms. The identification of the low-grade fever reduces exposure to additional staff and patients through preventative measures. EMS agencies should consider keeping a temperature log of providers.

Recommendations:

1. All EMS personnel should self-screen twice daily, once prior to coming to work, and the second ideally timed approximately 12 hours later for possible symptoms of COVID-19 (i.e. elevated temperature >100.0 and/or cough or shortness of breath).
2. If EMS personnel have symptoms, they should contact their place of work immediately and stay home from work.
3. The EMS agency should screen all personnel prior to the start of working their shifts. The EMS agency should develop and implement screening systems that cause the least amount of delays and disruption possible (i.e. staff self-report, single use disposable thermometers or thermal scanners, etc.). This screening may be done by station supervisors and does not require nurses.
4. EMS personnel who develop a fever should be sent home and NOT allowed to work.
5. EMS personnel with mild respiratory symptoms without fever may continue to work, if possible in positions without direct patient contact, at the discretion of supervisors. Personnel should wear masks around others and follow hand hygiene and infection control guidance. One example of this scenario would be a provider with known pre-existing seasonal allergies.
6. EMS personnel who are in the same room and have NOT donned appropriate PPE while performing a high hazard, aerosol-generating procedure (i.e. intubation [supraglottic or direct laryngoscopy], bag mask ventilation, CPR, or nebulized treatments) on a confirmed or suspected COVID-19 patient should quarantine at home for a minimum of 7 days and perform active screening as described by the CDC. The EMS provider may return to work after 7 days if they never develop symptoms (with 100% mask use for additional 7 days).

7. Testing for COVID-19 is not recommended for asymptomatic persons, even if exposed during a high hazard procedure. Home quarantine is recommended as per above (unless they develop symptoms when testing is an option if feasible).
8. EMS providers with other healthcare exposures may work and follow self-screening guidelines.
9. If EMS agencies anticipate/experience a significant decrease in available staff numbers, they are encouraged to notify TEMS.

Return to Work Protocol

Use one of the strategies identified below to determine when an EMS provider may return to work in healthcare settings.

1. Test-Based Strategy – The EMS provider was tested for COVID-19 and should be excluded from work until:
   - Resolution of fever without the use of fever-reducing medications and
   - Improvement in respiratory symptoms (i.e. cough, shortness of breath), and
   - Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥ 24 hours apart (total of two negative specimens).
2. Non-Test-Based Strategy – The EMS provider was not tested for COVID-19 and should be excluded from work until:
   - At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (i.e. cough, shortness of breath); and
   - At least 7 days have passed since symptoms first appeared

Return to Work Practices and Work Restrictions

After returning to work, the EMS provider should:

1. Wear a facemask at all times while in the healthcare facility/function until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.
2. Be restricted from contact with severely immunocompromised patients (i.e., transplant, hematology-oncology) until 14 days after illness onset.
3. Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (i.e. cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles).
4. Self-screen for symptoms and seek re-evaluation from a healthcare provider if respiratory symptoms recur or worsen.

Crisis Strategies to Mitigate Staffing Shortages

Healthcare systems, healthcare facilities, and the appropriate state, local, territorial, and/or tribal health authorities might determine that the recommended approaches cannot be followed due to the need to mitigate HCP staffing shortages. In such scenarios:

1. HCP should be evaluated by occupational health to determine appropriateness of earlier return to work than recommended above
2. If HCP return to work earlier than recommended above, they should still adhere to the Return to Work Practices and Work Restrictions recommendations above. For more information, see CDC's Interim U.S. Guidance for Risk Assessment and Public Health

3. Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19.

References:

*Centers for Disease Control and Prevention. (2020, March 07). Healthcare personnel with potential exposure to COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
*Centers for Disease Control and Prevention. (2020, March 10). Criteria for return to work for healthcare personnel with confirmed or suspected COVID-19 (interim guidance). https://www.cdc.gov/coronavirus/2019- ncov/healthcare-facilities/hcp-return-work.html
*Centers for Disease Control and Prevention. (2020, March 10). Interim guidance for EMS. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html
*Los Angeles County Department of Public Health. (25 March 2020). Guidance for monitoring EMS personnel. http://publichealth.lacounty.gov/acd/docs/EMSMonitoringCOV.pdf
*Penn Medicine: Infectious Disease Department