The American Holistic Nurses Association (AHNA) supports the Center for Disease Control (CDC) and the World Health Organization (WHO) in acknowledging the immediate global public health risk of the COVID-19.

This update is intended to provide our members with the most accurate and up to date information on the date of issuance.

COVID-19 Now a Pandemic

A pandemic is a global outbreak of disease. Pandemics happen when a new virus emerges to infect people and can spread between people sustainably. Because there is little to no pre-existing immunity against the new virus, it spreads worldwide.

SITUATION REPORT:

On March 11, the COVID-19 outbreak was determined a pandemic by the World Health Organization, and is the first pandemic known to be caused by a new coronavirus. In the past century, there have been four influenza viral pandemics.

“Pandemics of respiratory disease follow a certain progression outlined in a “Pandemic Intervals Framework.”” Pandemics begin with an investigation phase, followed by recognition, initiation, and acceleration phases. The peak of illnesses occurs at the end of the acceleration phase, which is followed by a deceleration phase, during which there is a decrease in illnesses. Different countries can be in different phases of the pandemic at any point in time and different parts of the same country can also be in different phases of a pandemic.” –Center for Disease Control


Nine new countries/territories/areas; African Region, European Region, and Region of Americas in have reported cases of COVID-19 in the past 24 hours. A WHO high-level technical mission concluded a visit to Iraq to support the Iraqi Ministry of Health in their COVID-19 prevention and containment measures.

WHO is working around the clock to establish 3 negative-pressure [contagious respiratory disease isolation] rooms in Baghdad, Erbil and Basra to accommodate patients who might require more sophisticated medical treatment.

WHO is providing guidance on early investigations; the data collected from the protocols are used to refine recommendations for surveillance and case definitions, to characterize the key epidemiological transmission features of COVID-19. This will help understand spread, severity, spectrum of disease, impact on the community and to inform operational models for implementation of countermeasures such as case isolation, contact tracing and isolation.

To decrease the stressed resources on healthcare facilities the goal at this point in the pandemic is ‘flattening the curve’. What does this entail? In epidemiology, the idea of slowing a virus' spread so that fewer people need to seek treatment at any given time is known as “flattening the curve.” Social distancing, community isolation, and cancelling events, these are measures intended to keep the number of infected members in society at a manageable level. Brandon Specktor, “In less than a month, the global number of confirmed COVID-19 cases doubled from about 75,000 cases on Feb. 20 to more than 153,000 on March 15.”

Efforts in many countries have failed thus far. Italy, with cases nearly doubling over a period of only 4 days, has filled to capacity sending critical patients to other facilities due to limited resources. Having more information, more planning, the rest of the world has an opportunity to flatten the curve more quickly.
A LESSON FROM HISTORY:

In 1918, when a strain of influenza known as the Spanish Flu, caused a global pandemic, we can look at two U.S. cities — Philadelphia and St. Louis — Drew Harris, a population health researcher at Thomas Jefferson University in Philadelphia told the story to National Public Radio (NPR);

In Philadelphia, city officials ignored warnings from infectious disease experts that the flu was already spreading in the community. The city instead moved forward with a massive parade that gathered hundreds of thousands of people together, Harris said.

"Within 48, 72 hours, thousands of people around the Philadelphia region started to die," Harris said. Ultimately, about 16,000 people from the city died in six months.

In St. Louis, meanwhile, city officials quickly implemented social isolation strategies. The government closed schools, limited travel and encouraged personal hygiene and social distancing. As a result, the city saw just 2,000 deaths — one-eighth of the casualties in Philadelphia.

WHO Director-General's remarks at the media briefing on COVID-19 on 3/13/2020 were that of support and gratitude toward the resilience of international medical community.

"Today I want to send a personal and sincere thank you to every health worker around the world – especially nurses and midwives, who we are celebrating this year through the International Year of the Nurse and the Midwife. You do a heroic job. We know that this crisis is putting a huge burden on you and your families. We know you are stretched to the limit. You have our admiration, our respect, and our commitment to doing everything we can to keep you safe and enable you to do your job."

He continued with the following points:

- **More than 132,000 cases of COVID-19 have now been reported to WHO, from 123 countries and territories.**
- Europe has now become the epicenter of the pandemic, with more reported cases and deaths than the rest of the world combined, apart from China.
- Supplies of personal protective equipment have been distributed to 56 countries, we’re shipping to a further 28 countries, and we’ve sent almost 1.5 million diagnostic tests to 120 countries.
- Continue to take a comprehensive approach: Japan is also demonstrating that a whole-of-government approach led by Prime Minister Abe himself, supported by in-depth investigation of clusters, is a critical step in reducing transmission.
- First, prepare and be ready. Every health worker should be able to recognize this disease, provide care and know what to do with their patients. Every health facility should be ready to cope with large numbers of patients, and ensure the safety of staff and patients.
- Second, detect, protect and treat. You can’t fight a virus if you don’t know where it is....break
the chains of transmission. Every case we find and treat limits the expansion of the disease.

- Third, reduce transmission. Do not just let this fire burn. Isolate the sick and quarantine their contacts...measures that increase social distancing such as cancelling sporting events may help to reduce transmission and should be based on local context and risk assessment, and should be time-limited.
- Fourth, innovate and learn; we must all find new ways to prevent infections, save lives, and minimize impact. All countries have lessons to share...
- We thank all those countries who have supported WHO’s [COVID-19 Strategic Preparedness and Response Plan](https://www.who.int/about/partnership?interactive=true), including Japan, which this week contributed 155 million U.S. dollars.
- Funds raised will be used to coordinate the response, to buy masks, gloves, gowns and goggles for health workers, to buy diagnostic tests, to improve surveillance, and to invest in research and development.
- We thank Google, Facebook and the individuals who have already contributed. Every dollar donated is a dollar towards saving lives.

**INFECTION CONTROL**

New guidelines are an extension of common sense. The virus that causes COVID-19 is stable for several hours to days in aerosols and on surfaces, according to a new study from National Institutes of Health, CDC, UCLA and Princeton University scientists in *The New England Journal of Medicine*. SARS-CoV-2 is detectable in aerosols up to three hours, four hours on copper, 24 hours on cardboard and two to three days on plastic and stainless steel. Cleaning surfaces frequently using CDC recommended products is a must to prevent further surface contamination to person spread. Experts remind public the importance of hand-washing after touching surfaces and to avoid touching their face.


**World Health Organization Open Course on Infection Control**

[https://openwho.org/courses/COVID-19-IPC-EN?tracking_user=2yiOvleMC7LcTtU10A1PKZ&tracking_type=news&tracking_id=6C8X2DPNwSRoljO2X1BX3g](https://openwho.org/courses/COVID-19-IPC-EN?tracking_user=2yiOvleMC7LcTtU10A1PKZ&tracking_type=news&tracking_id=6C8X2DPNwSRoljO2X1BX3g)

**CDC issued updated infection control guidance for healthcare settings**, including guidance on the use of personal protective equipment (PPE) during a shortage (3/10/20)

UNITED STATES OF AMERICA

As of March 17, 2020, at noon, Johns Hopkins reported 5,145 cases within 53 jurisdictions of the United States, 91 cases ended in death. https://www.aha.org/news/headline/2020-03-12-coronavirus-update-house-legislation-disaster-declaration-letter The recent declaration of a State of Emergency was made after several states began closing schools and initiated social distancing protocols. The United States is currently in the initiation phases, but exposure is accelerating in states where community spread occurs. More states are reporting cases of COVID-19 as the virus moves across the country. Close contacts, within the same household, are increasing in occurrence. Three states have identified constant community spread.
ACUTE CARE CONCERNS

Today, Italy announced 3,233 more confirmed cases, boosting its overall total to 27,980, and 349 new confirmed deaths, 2,158 total. Physicians have credited two factors in alleviating the influx on the region's health systems: an immediate increase in COVID-19 lab testing and creation of a large facility just for infected patients.

"Importantly, the forecasts show that increasing ICU capacity is simply not enough," they said. "More resources should be invested to contain the epidemic." Their experience, they wrote, suggests that healthcare systems not organized in collaborative emergency networks should create one and that strict enforcement of community quarantines is needed. "In practice, the health care system cannot sustain an uncontrolled outbreak, and stronger containment measures are now the only realistic option to avoid the total collapse of the ICU system," they said.

March 11, 2020
Jama published, Summary of Caring for Critically Ill Patients With COVID-19, https://jamanetwork.com/journals/jama/fullarticle/2762996, explaining the process of initial differentiation of COVID versus other respiratory illnesses including influenza, and providing up-to-date COVID-19 specific considerations.

“…completed using upper (nasopharyngeal) or lower (induced sputum, endotracheal aspirates, bronchoalveolar lavage) respiratory tract samples for reverse transcriptase–polymerase chain reaction and bacterial cultures. There are suggestive but nonspecific radiographic changes, such as ground-glass opacities on computed tomography. Patients who have required critical care have tended to be older (median age ≈60 years), and 40% have had comorbid conditions, commonly diabetes and cardiac disease. Median duration between onset of symptoms and ICU admission has been 9 to 10 days, a gradual deterioration. The most documented reason for requiring intensive care has been respiratory support, of which two-thirds of patients have met criteria for acute respiratory distress syndrome (ARDS)”, Srinivas Murthy, MD, CM, MHSc; Charles D. Gomersall, MBBS; Robert A. Fowler, MD, CM, MSc

Modifications are described here:
In response to the updates, the World Health Organization (WHO) has released several new open courseware resources for healthcare professionals across interdisciplinary settings. These are available in multiple languages.

The **Critical Care Severe Acute Respiratory Infection course** (SARI), includes hands-on practical management to be used by health care professionals involved in critical care during outbreaks of influenza virus (seasonal) human infection due avian influenza virus (H5N1, H7N9), MERS-CoV, COVID-19 or other emerging respiratory viral epidemics.

A **Simulation training package** is included with resources for staff in acute settings: [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/simulation-exercise](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/training/simulation-exercise)

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**SURGE PREPARATION**

Statistically, Italy has required more ICU beds and intervention then what was experienced in China. A recent AHA estimate for COVID-19 projected that 4.8 million patients would be hospitalized, 1.9 million of these would be admitted to the ICU, and 960,000 would require ventilatory support.
**Staffing to care for critically ill patients:** Having an adequate supply of beds and equipment is not enough. Based on AHA 2015 data, there are 28,808 privileged and 19,996 full-time equivalent intensivists in the United States; however, 48% of acute care hospitals have no intensivist board-certified physician who provides special care for critically ill patients. Based on our analysis, the intensivist deficit will be significant. Additionally, there are an estimated 34,000 critical care advanced practice providers (APPs) available to provide care for critically ill patients. In addition to intensivists, all other ICU staff, advanced practice providers, nurses, pharmacists, respiratory therapists, will also be in short supply. Without these key members of the ICU team, critical care cannot be adequately delivered. Moreover, an indeterminate number of experienced ICU staff may become ill, further straining the system as need and capacity surge.

The current estimate for maximum ventilated patients is approximately 135,000, within the supply of equipment. Immediate need is to focus on training staff, for long term mechanical ventilated and critical care patients.

**Augmenting critical care staffing:** To deal with this issue, the Society of Critical Care Medicine (SCCM), encourages hospitals to adopt a tiered staffing strategy in pandemic situations such as COVID-19. Hospitals with telemedicine capacity may also use the technology to connect with expert resources at other locations. Using this model, non-ICU trained inexperienced physicians, certified registered nurse anesthetists, operating room nurses, general ward nurses, non-ICU advanced practice providers and others (noted in red) greatly augment the trained and experienced ICU staff (noted in green). While the ratios shown in the figure depict generally accepted models of critical care staff augmentation, each hospital will need to adjust both to the demands for critical care using the available supply of personnel. SCCM offers free online training resources to help these non-typical ICU staff as they prepare to care for critically ill patients during the crisis. While the level of care may not be the same as in the typical ICU in non-crisis times, having the care directed by trained and experienced members of the ICU team is an effective way to maximize care for large numbers of critically ill patients. [https://sccm.org/Blog/March-2020/United-States-Resource-Availability-for-COVID-19?_zs=jxpjd1&_zl=w9pb6](https://sccm.org/Blog/March-2020/United-States-Resource-Availability-for-COVID-19?_zs=jxpjd1&_zl=w9pb6)

Current advisement recommends acute settings with limited ventilators may attempt high-flow nasal oxygen or noninvasive ventilation. However, the high gas flow of these 2 techniques is less contained than in the closed circuitry typical of invasive ventilators, which poses the risk of dispersion of aerosolized virus in the health care environment. Risk to benefit should be weighed before initiating these interventions. [https://sccm.org/getattachment/Blog/March-2020/United-States-Resource-Availability-for-COVID-19/United-States-Resource-Availability-for-COVID-19.png?_zs=jxpjd1&_zl=w9pb6](https://sccm.org/getattachment/Blog/March-2020/United-States-Resource-Availability-for-COVID-19/United-States-Resource-Availability-for-COVID-19.png?_zs=jxpjd1&_zl=w9pb6)
Septic shock and specific organ dysfunction such as acute kidney injury appear to occur in a significant proportion of patients with COVID-19–related critical illness and are associated with increasing mortality, with management recommendations following available evidence-based guidelines.

The CDC continues to advise elderly and immunocompromised individuals to remain out of public spaces, and avoid non-essential travel.

RESOURCES:

Healthcare Personnel with Potential Exposure to COVID-19

To view all technical guidance documents regarding COVID-19, please go to https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

Implementing Home Care

Guidance and Resources on Healthcare Supply of Personal Protective Equipment


Disposition of Hospitalized Patients with COVID-2019

Inpatient Obstetric Healthcare Guidance


Mental Health Considerations During COVID-19 Outbreak

COVID-19 Emergency Legal Preparedness Primer: A Primer


Get the Facts: Ready-to-Use Materials from APHA (American Public Health Association)'s Get Ready Campaign