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.

We have to hold two disparate ideas in our heads: It is true that the personal risk of COVID to the average young and healthy person is quite small, but at the same time the risk to the healthcare system upon which we all depend is very high. -Eric Toner, MD

Clinical Management Updates:
1. Therapeutic Options: There are still no US Food and Drug Administration (FDA)-approved drugs specifically for the treatment of patients with COVID-
19. At present clinical management includes infection prevention, supplementary oxygen, ventilatory support. Investigational drugs in several hundred clinical trials are underway. NIAID is exploring broad-spectrum antiviral compounds for activity against COVID-19, and plans to evaluate Kaletra, also known as lopinavir and ritonavir, and interferon-beta for their activity against COVID-19. The CDC has information on several research studies, and exclusion criteria, for trials using remdesivir, chloroquine, hydroxychloroquine. From [https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/therapeutic-options.html). A World Health Organization lopinavir-ritonavir research study in China was unsuccessful.

2. Passive Antibody Therapy: an investigational treatment offering serum transfusion from recently recovered COVID-19 patients. During the SARS-Cov-1 Outbreak similar treatment yielded some viral neutralization against the pathogen:

From [https://www.jci.org/articles/view/138003](https://www.jci.org/articles/view/138003), "human convalescent serum is an option for prevention and treatment of COVID-19 disease that could be rapidly available when there are sufficient numbers of people who have recovered with sufficient viral neutralizing antibodies, can donate immunoglobulin-containing serum. The serum can be prophylactic for vulnerable, high-risk or immunocompromised persons, and health-care providers. Potentially it can reduce symptoms in affected patients, or effectively prevent disease in those exposed, shortly after the onset of symptoms. Historically, this is within several days and benefits lasted weeks to months...

In contrast, active vaccination requires the induction of an immune response that takes time to develop and varies depending on the vaccine recipient. Thus, passive antibody administration is the only means of providing immediate immunity to susceptible persona."

3. Theoretical studies: Antibody dependent cellular cytotoxicity. Possibility of using antibodies from convalesced patients, or animal hosts


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**Recommended Screening Criteria Update:**

**Anosmia**, the loss of sense of smell, and ageusia, an accompanying diminished sense of taste, have emerged as peculiar telltale signs of Covid-19, the disease caused by
the coronavirus, and possible markers of infection; https://www.nytimes.com/2020/03/22/health/coronavirus-symptoms-smell-taste.html Anosmia, has been seen in patients ultimately testing positive for the coronavirus with no other symptoms. A large number of the initial deaths of medical personnel in Wuhan were ENT physicians. Two ENT’s in Great Britain are in critical condition. Due to the gaining evidence, Prof. Claire Hopkins, president of the British Rhinological Society, recommended, “adults who lose their senses of smell should isolate themselves for seven days, even if they have no other symptoms…We really want to raise awareness that this is a sign of infection”. Triage nurses and staff should be advised to wear complete PPE when encountering patients with a chief complaint of anosmia or ageusia. Self-isolation, and testing of these patients should be seriously considered.

Supply & Advocacy Updates:

The Nurse Community Coalition led a call to legislative action in attempt to address concerns over PPE, supply shortages, and safety for front line healthcare workers. https://www.aacn.org/~/media/aacn-website/policy-and-advocacy/covidletter.pdf?la=en

“We urge you to support the immediate distribution of PPE to frontline health care personnel from the Strategic National Stockpile (SNS), and mandate that sustainable PPE levels should always be maintained at the SNS, including before, during, and following an outbreak, pandemic, or other emergency.”

• Reauthorize Title VIII Nursing Workforce Programs: Include Title VIII Nursing Workforce Reauthorization Act (H.R.728/S.1399) …legislation helps meet the nation’s demand for nursing services by addressing all aspects of nursing education, practice, recruitment, and retention & provides much needed stability for nursing schools, the workforce, and the community.

• Increase Funding for Title VIII and NINR… ensures we have resources in place to support the nursing pipeline and provide evidence based nursing care during the COVID-19 pandemic.

• Remove all Unnecessary Barriers to Practice…that prevent providers, especially APRNs, from practicing to the full extent of their education and clinical training. We request the inclusion of provisions that would remove Medicare and Medicaid conditions of participation and certification requirements that prevent APRNs from practicing to the top of their license under State law.

• Include Home Health Care Planning Improvement Act: Include the bipartisan Home Health Care Planning Improvement Act (H.R.2150/S.296). Currently, Medicare law prohibits APRNs from certifying Medicare patients for home health benefits and from signing home health plans of care. As the nation continues to battle COVID-19 and experts warn that there may be a shortage of hospital beds in the upcoming weeks, it is critical that Medicare beneficiaries have timely access to home health care services. By including this legislation, you would not only open hospital beds for patients with COVID-19 and other critical care patients, but also allow the beneficiary to remain in their home and decrease potential exposure to the virus or other complications from delays in care.

• Include Public Health Service Modernization Act: Include the bipartisan United States Public Health Service Modernization Act of 2019 (S. 2629/H.R. 4870) to create a Ready Reserve Corps to respond to public emergencies, such as natural disasters or pandemics like COVID-19.

• Fund Child Care for Health Care Workers…government-funded child-care services ensure that they are able to continue their work to combat this pandemic.
We urge Congress to include these shared priorities in the COVID-19 package and as you work to support the health care workforce, and nurses who are on the frontlines.

On March 18, a member of AACN board of directors, Theresa M. Davis, PhD, RN, NE-BC, CHTP, FAAN, represented the American Association of Critical-Care Nurses at the White House to brief President Trump, Vice President Pence and the Coronavirus Task Force on the state of COVID-19 care. ‘Nurses are always on the frontlines and have been right from the start, but our hospitals are not as prepared or supplied as they should be to face this global pandemic.’ Joined by leaders from other nursing organizations representing ENA, ANA, the Academy of Nurses and the American Association of Colleges of Nursing, Dr. Davis laid out the crucial role of critical care nurses amid this pandemic, praised the courage of nurses and other healthcare workers & stated, “We need the supplies and equipment necessary to protect our patients, ourselves, our communities … and to save patients’ lives.” Emphasizing the urgent need for masks, PPE, ventilators, medicine and other vital life-saving equipment.


Additionally, Defense Secretary Mark Esper agreed to supply 5 million N95 masks and other PPE stock from strategic reserves, with the first 1 million masks ready immediately. The Pentagon is also ready to distribute up to 2,000 ventilators.

In response to the growth of limited resources, after funding for telemedicine was approved the American Medical Association (AMA) published guidelines for implementation: AMA Quick Guide to Telemedicine in Practice https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice

Global Situation Summary: COVID-19 has surpassed 300,000 cases
German Chancellor Angela Merkel is undergoing voluntary quarantine after one of her physicians recently tested positive for SARS-CoV-2. Merkel has announced that Germany will implement further restrictions in order to curb the spread of COVID-19.

The number of reported COVID-19 cases in Pakistan has nearly tripled since last Thursday. As of today, the Pakistan Ministry of National Health Services reports 887 confirmed cases (103 new since yesterday), compared to 302 on March 19.

Hong Kong has reported a surge in cases over the past week or so. The Hong Kong Centre for Health Protection reported 149 cases on March 15, but that number more than doubled through yesterday, when Hong Kong reported 357 cases.

Singapore has also recorded a high number of cases in people with a recent history of travel. The Singapore Ministry of Health reported a total of 137 imported cases since March 21 and only 36 domestic cases.

Global Research:

Researchers in Westlake University, Hangzhou China revealed how the virus attaches to the angiotensin-converting enzyme 2 (ACE2) receptor on human respiratory cells, https://www.nature.com/articles/s41591-020-0820-9 Speculation exists that the unique features of the cells show it does not fit ‘computer generated models’ for genetic alteration. https://www.scripps.edu/news-and-events/press-room/2020/20200317-andersen-covid-19-coronavirus.html “By comparing the available genome sequence data for known coronavirus strains, we can firmly determine that SARS-CoV-2 originated through natural processes,” author Kristian Andersen, PhD, associate professor of immunology and microbiology at Scripps Research. In addition to Andersen, authors on the paper, "The proximal origin of SARS-CoV-2," include Robert F. Garry, of Tulane University; Edward Holmes, of the University of Sydney; Andrew Rambaut,
of University of Edinburgh; W. Ian Lipkin, of Columbia University. Virologists are yet to identify what coronavirus COVID-19 would have evolved from; the DNA matches pangolins and bats.

- A paper released (not yet peer reviewed) by scientists in China reported that A/ O Blood types were more susceptible to COVID-19. During a fast-evolving pandemic, accessing research ahead of peer-review does not indicate a recommendation for guidance of practice; https://www.medrxiv.org/content/10.1101/2020.03.11.20031096v1 The study, Relationship between ABO Blood Group and the COVID-19 Susceptibility, completed by Chinese researchers, focused on 2,173 Covid-19 patients, from three hospitals, in Wuhan and Shenzhen. The teams looked at the distribution of blood types in the normal population in each area, and then compared it to their sample of patients with Covid-19. "Meta-analyses on the pooled data showed that blood group A had a significantly higher risk for acquiring COVID-19 compared with non-A blood groups, whereas blood group O had a significantly lower risk for the infectious disease compared with non-O blood groups." This occurred in both regions.

**World Health Organization**

*Why Testing should be a Priority: Diagnostic testing for COVID-19 is critical to tracking the virus, understanding epidemiology, informing case management, and to suppressing transmission.*


- **WHO outlined critical priority actions** for preparedness, readiness, and response actions for COVID-19 and has defined four transmission scenarios: 1. Countries with no cases (No Cases); 2. Countries with 1 or more cases, imported or locally detected (Sporadic Cases); 3. Countries experiencing clusters of cases related in time, geographic location, or common exposure (Clusters of cases); 4. Countries experiencing larger outbreaks or sustained and pervasive local transmission (Community transmission)

- **When testing facilities are limited**, available facilities tend to be located in or near a capital city, making timely access to testing difficult for people living in rural areas, consider mobile laboratories, or, automated integrated NAAT systems operated in remote regions and by staff with minimal training.

- For areas within a country with no circulation, the objectives remain to test all suspected cases in order to detect first cases in new areas as rapidly as possible, & take immediate measures to prevent further spread, however, in
the setting of limited resources in areas with community transmission, prioritization for testing should be given to:

- people at risk of developing severe disease, vulnerable populations who will require hospitalization / advanced care.

- symptomatic health workers *regardless of whether they are a contact of a confirmed case* – to reduce the risk of nosocomial transmission

- the first symptomatic individuals in a closed setting (e.g. schools, long-term living facilities, prisons, hospitals) to quickly identify outbreaks and ensure containment measures; other symptomatic individuals may be considered probable cases & isolated without additional testing

- Countries should track the quantity, & results of testing & report to WHO: Indicators could include the number of SARI/ILI cases reported (compared with previous years in same month/week), the number of patients tested for COVID-19, the number of patients who test positive for COVID-19, the number of tested suspected cases per 100,000 population, and the number of ICU admissions for COVID-19.

### Table 2. Example situations and management alternatives if testing capacity is overwhelmed

<table>
<thead>
<tr>
<th>Situation</th>
<th>Alternatives if system is overwhelmed and testing is not possible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected case, mild, with no risk factors</td>
<td>Register as a suspected case, home isolate according to WHO guidelines, and do not test</td>
</tr>
<tr>
<td>Suspected case requiring admission in health care facility regardless of severity</td>
<td>Strongly recommended to test. If testing is not possible, implement isolation measures warding against nosocomial transmission (i.e., no cohort isolation possible). Test and treat other possible causes according to local guidelines.</td>
</tr>
<tr>
<td>Symptomatic health care worker identified as a contact</td>
<td>Strongly recommended to test.</td>
</tr>
<tr>
<td>Symptomatic health care worker with no known COVID-19 contact</td>
<td>In areas with COVID-19 community transmission, test</td>
</tr>
<tr>
<td>Increased number of suspected cases in a specific demographic group (potential cluster)</td>
<td>Test subset of the suspects</td>
</tr>
<tr>
<td>Closed settings, including schools, hospitals, long-term living facilities</td>
<td>Test initial cases. Consider other symptomatic individuals as probable cases</td>
</tr>
<tr>
<td>Recovering patient test negative twice</td>
<td>If clinically recovered, discharge after additional 14 days in self-isolation</td>
</tr>
<tr>
<td>Contact tracing in areas of community transmission</td>
<td>Quarantine contacts for 14 days, in lieu of testing. If symptomatic, assume COVID-19 and extend quarantine</td>
</tr>
<tr>
<td>Patients hospitalized for severe disease in setting with no testing capacity</td>
<td>Consider as suspected case and take precautions as if COVID-19 positive, treat for treatable local diseases</td>
</tr>
</tbody>
</table>

### United States Updates:

To further reduce the risk of transmission of COVID-19 and enhance the safety of staff, the National Institutes of Health is shifting all non-mission-critical laboratory operations to a maintenance phase. Beginning on Monday, March 23, only mission-critical functions within NIH research laboratories will be supported. https://www.nih.gov/news-events/news-releases/nih-shifts-non-mission-critical-laboratory-operations-minimal-maintenance-phase
The US CDC reported 33,404 total (confirmed and presumptive) COVID-19 cases and 400 deaths nationwide on March 23, more than double the number of cases reported on Friday and just shy of twice the reported deaths. Of these cases, 97.0% do not have an identified exposure—travel-related or close contact of a known case—and are still under investigation.

Congress passed a supplemental appropriation of $10 million on March 6 for worker-based training to prevent and reduce exposure of hospital employees, emergency first responders, and other workers who are at risk of exposure to coronavirus through their work duties. The National Institutes of Health plans to launch a website with educational resources for coronavirus workers dealing with the spread of COVID-19.


https://www.courierpress.com/story/news/2020/03/18/coronavirus-deaconess-ask-public-provide-medical-face-masks/2865273001/ Evansville ID. Deaconess Health System, including Henderson’s Methodist Health, has asked the public to sew face masks for staff fighting coronavirus. The video & pattern is available www.deaconess.com/masks. Each mask will be sterilized after receipt by the medical facilities. The effort is being matched in multiple cities nationwide.

Johns Hopkins Center for Health Security is analyzing and providing updates on the emerging coronavirus. Updates from 3/24/2020:

- The White House announced the federal government’s intention to provide 100% cost sharing—via FEMA—for National Guard units activated by states in response to the COVID-19 pandemic. The National Guard units will still support state governments (i.e., will not be federalized), but this measure is intended to make it more financially feasible for states to activate them to support local response activities.

- Eric Toner MD, Get Ready for a 1918-like Scenario, validates “community mitigation strategies—such as isolating the sick, home quarantining the
exposed, canceling mass gatherings, and social distancing—have worked to tamp down the height of the epidemic wave and therefore have kept the healthcare systems functional in other parts of China, Hong Kong, Singapore, South Korea, and Japan, but to be effective, these measures need to be vigorously implemented several weeks before hospitals become overwhelmed… Unless patients are transferred, we enter the uncharted territory of having to ration life-saving care in order to save the most lives—something we have never done before in an organized way. The story is similar for ventilators. We have to keep in mind that these calculations are based on an average US city, but the prevalence of ICU beds varies by a factor of 2 across the United States…some areas will do better than this, but others might be even more severely affected", (2020) Clinicians’ Biosecurity News.

Hospitals should be all-out preparing now for their worst-case scenario.

For the general public: we need to keep our hospitals functioning so that if we get sick with COVID-19 or have a heart attack or stroke, we can get appropriate care. To do this we all play an essential role. The reason schools may close and gatherings may be canceled is to slow down the epidemic and spread it out over time, this is the flattening of the curve. Despite the temporary hardships this entails, we must adhere to public health guidance.

Harvard Global Health Institute-

“If the novel coronavirus continues to spread widely in the U.S., hospitals in certain parts of the country will be particularly stressed and have far too few beds to treat the influx of patients, according to data released March 17. Based on this data, ProPublica created maps to show the pressure hospitals across the U.S. would face under several different scenarios. Most communities in the U.S. lack the number of beds needed to take care of a surge of COVID-19 patients, & the scenarios developed by ProPublica show why public health experts are focused on slowing the spread of the virus over a longer period of time.”

The Following Scenarios are from their report:

- **Scenario 1: 20 percent of adults are infected over 18 months**
  This is the best-case scenario. Some parts of the country would be able to handle the surge in hospitalizations without freeing up already occupied beds or adding more beds. However, even with cases of COVID-19 spread out over 18 months, hospital beds would be roughly 95 percent full if nothing is done to expand capacity, according to ProPublica. Based on infection rates that occurred in past pandemics, the 20 percent estimate is conservative.

- **Scenario 2: 20 percent of adults are infected over 12 months**
  If COVID-19 infected only 20 percent of the adult population over a year, many cities across the U.S. would not have enough beds to treat the influx of patients without adding new beds or displacing other patients, according to ProPublica's analysis.

- **Scenario 3: 20 percent of adults are infected over 6 months**
  Even with only 20 percent of the adult population infected, the shorter timeline of six months would put significant pressure on hospitals across the U.S. The model developed by the Harvard Global Health Institute looks at hospital capacity across 306 US hospital markets, or
Scenario 4: 40 percent of adults are infected over 12 months
The Harvard team described a moderate scenario as 40 percent of the adult population contracting COVID-19 over a year. As with the first three scenarios, “flattening the curve,” or slowing the spread would be critical if 40 percent of the adult population were infected. You can see capacity estimates for each hospital region under different scenarios at ProPublica. Below is a breakdown of the five regions with the largest adult populations under the moderate scenario.

In each of the following cities, the influx of patients WILL experience a lack of critical care beds, personnel, and ventilators:

Los Angeles: The influx of patients would require 21,600 beds over a 12-month period, which is 3.3 times the available beds.

Houston: The influx of patients would require 14,300 beds over a 12-month period, which is 2.8 times the available beds.

Atlanta: The influx of patients would require 13,700 beds over a 12-month period, which is 4.1 times the available beds.

Manhattan: The influx of patients would require 11,500 beds over a 12-month period, which is 3.8 times the available beds.

Boston: The influx of patients would require 11,200 beds over a 12-month period, which is 4.4 times the available beds.

These numbers are factual, non-negotiable. The only change to the status quo is to practice known prevention strategies. The need for social distancing ever increasing, UK, India, Saudi Arabia, among others, are calling for becoming more restrictive while elected officials in the USA are calling for relaxation to deter economic impact. Evidence of health outcomes demonstrate this would be ill advised:

- Statistically, vulnerable populations, such as those over 60 years old, when exposed to the virus account for 80% of the COVID-19 deaths, 31% of 4,226 documented COVID-19 cases, 45% of hospitalizations and 53% of intensive care unit admissions.

This past week, every sector of the healthcare industry send a joint letter to Congressional leaders requesting immediate action to address supply challenges of this pandemic. Those signing, represented hospitals, physicians, nurses, clinical laboratories, health insurers, biopharmaceutical manufacturers, specialty and post-acute facilities, pharmacy benefit managers, and distributors. The issues asserted: 1- an Immediate mass production effort and distribution of supplies, ventilators, and PPE. 2- Modification of existing facilities, construction of temporary staging and screening sites, and expansion of telehealth and clinician licensure restrictions 3- Addressing access to care, and provision of medications preventing a disrupted supply chain. In response, by Friday March 20th, the US Army Corps of Engineers announced plans to convert existing structures into hospitals increasing clinical bed space to support COVID-19 response. Multiple State Nursing Boards have answered: practicing post graduation allowing flexibility of requirements for senior nursing students (GN’s), and implementing increased scope of practice for APRN’s. Universal action by all
nursing boards across the United States of America, would further alleviate the shortages yet to come.

**Resources**

Aerosol and surface stability of HCoV-19 (SARS-CoV-2) compared to SARS-CoV-1. Van Doremalen N, Bushmaker T, Morris DH, Holbrook MG, Gamble A, Williamson BN, Tamin A, Harcourt JL, Thornburg NJ, Gerber SI, Lloyd-Smith JO, de Wit E, Munster VJ. *N Engl J Med.* 2020 Mar 17. doi: 10.1056/NEJMc2004973. [Epub ahead of print]. PMID: 32182409. The results suggest that people may acquire SARS-CoV-2 through the air and after touching contaminated objects. However, although the viruses were able to infect cells in the laboratory, how much virus is likely to cause infections in people remains to be studied.


Laundering: *Wear disposable gloves. Wash hands with soap and water* as soon as you remove the gloves. *Do not shake* dirty laundry. Launder items according to the manufacturer’s instructions. Use the *warmest appropriate water setting* and dry items completely. Dirty laundry from an ill person *can be washed with other people’s items.* Clean and *disinfect clothes hampers.*

**CDC GUIDANCE:**

- Interim Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings
- Interim Guidance for Collection and Submission of Postmortem Specimens from Deceased Persons Under Investigation (PUI) for COVID-19, February 2020
- COVID-19 and Underlying Medical Conditions
- Healthcare Infection Control Guidance
- Ending Isolation for Immunocompromised Persons
- Clinical Care Guidance
- Home Care Guidance
- Guidance for EMS
- Healthcare Personnel with Potential Exposure Guidance
- Inpatient Obstetric Healthcare Guidance