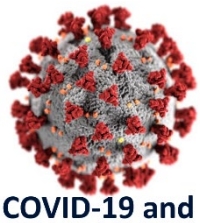
Rapid Lesson Sharing

Event Type: Positive COVID-19 Incident at a Remote Alaska Duty Station

Date: July 2020

Location: Alaska



COVID-19 and Fire Season 2020 Lessons

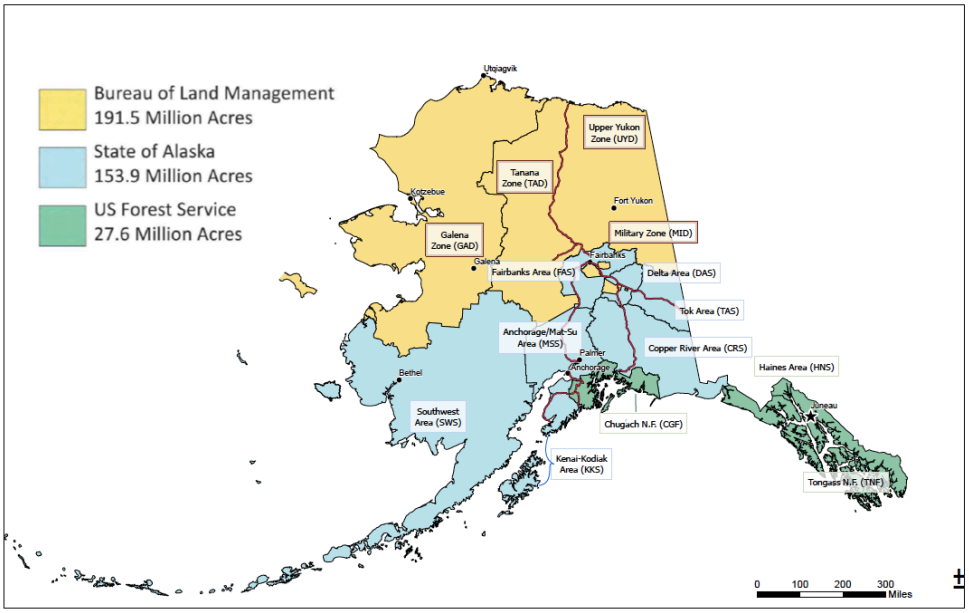
For the latest on COVID-19 visit CDC.gov/COVID19

Success Story:

How this Remote Alaska Duty Station was Pre-Prepared for a COVID-19 Positive Incident

This RLS was created in response to the first confirmed positive COVID-19 case in the Alaska fire community. This incident happened at one of Alaska's remote "off the road system" duty stations—meaning the only way in or out of the community and station is by airplane or boat.

This RLS is intended to provide a few brief overview of lessons learned, especially with regard to self-monitoring for COVID-19 symptoms and maintaining diligence when taking basic precautions as an entire firefighting community.



Alaska Fire Protection Services map that shows the areas that remote bases like the one in this COVID-19 incident are responsible for covering.

A Pre-Planned, Rehearsed, and Well-Documented Response Plan

On Thursday, July 16, at approximately 10 a.m., a contracted pilot at a remote base in Alaska discovered he had lost his sense of taste and smell at breakfast. He returned to his room and notified his manager of this acute loss. The manager reported this information to the Fireline Medic on staff at the base.

What happened next—and more particularly WHY it happened the way it did—led to this incident being shared for an RLS. During any other fire season, someone not tasting breakfast as they normally would have would not have raised an eyebrow. In this case, this subtle sign not only raised eyebrows but triggered a pre-planned, rehearsed, and well-documented response plan.

Exactly one month earlier, the Fire Management Officer of this remote fire protection zone based out of a small village, made some pivotal decisions that would affect the outcome of this incident. For this potential COVID-19 environment, he established a lookout, identified safety zones, identified trigger points, and communicated these to the personnel he supervised. A trained and equipped Fireline Medic was ordered and put in place at

this remote station to serve as the "Lookout". Living quarters that could serve as "Safety Zones" were also identified and reserved.

In addition, dedicated, specially equipped transport vehicles and procedures were identified ("Escape Routes"). Screening questions and tools were put in place and used regularly. Employees were informed of "Trigger Points" of illness to look for and had their temperatures taken when they came for their meals at the mess hall three times per day.

COVID-19 related Rapid Lesson Sharing documents provided by the Wildland Fire Lessons Learned Center were reviewed and used for guidance. Six-foot spacing and the "Module as One" guidelines became the rules of every day. Without these safeguards being in place, the following story would undoubtedly have ended differently.

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Screen Ill Employees Using a Screening Tool

The medical plan had been to screen any ill employees by telephone using a screening tool (see box below) with specific questions. Any employee who screened positive for COVID-19—meaning they answered "Yes" to a set of pre-identified questions—would be treated as COVID-positive until ruled out. A positive screening would mean the employee would be considered a patient, isolated, cared for and have food delivered by the Fireline Medic until transferred for testing or cleared of any possible communicable illness.

COVID-19 SCREENING TOOL

1. Have you	
Yes / No	Traveled from or through locations identified by the CDC as increasing epidemiologic risk for COVID-19 within the last 14 days? https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html
Yes / No	Had close contact with anyone diagnosed with COVID-19 within the last 14 days?
2. Do you currently have a	
Yes / No	Fever (>100.4°F) or chills
Yes / No	Cough or shortness of breath
Yes / No	Any two of the following: body aches, fatigue, headache, runny nose, nausea, vomiting, diarrhea, bilateral conjunctivitis, rash, any abnormal changes/loss of taste or smell.
3. Perform a temperature check _____°F Method: oral / forehead /temporal / ear	

INSTRUCTIONS

Use this Screening Tool at the entrance to ICP or camps. Incident medics will screen all personnel who come to the Medical Unit.

Negative Screening: If answers to all the questions are NO, and there are no obvious signs of respiratory infection, e.g., frequent coughing, and temperature is < 100.4°F**,** continue check-in process or other duties.

Positive Screening: If answers to any of the questions are YES, *or* if the person has a temperature >100.4°F *or* if the person has obvious signs of a respiratory illness, ask them to wait in a separate area (6 feet from others or outside), and contact incident management.

The Fireline Medic had pre-screened the patient by his telephone call that reported an acute loss of taste and smell. At approximately 10:16 a.m., the Fireline Medic donned the full set of personal protective equipment (PPE) that was supplied for this very purpose and followed the specific procedures in place. Limiting contact and maintaining distance, even in full PPE, a medical assessment was completed. The result, based on the Fireline Medic's professional training, experience and opinion concluded with a "high likelihood of a COVID-positive patient."

The type of small bush plane that is typically used for moving people and supplies to and from remote bases in Alaska. (This photo was not taken at the base in which this COVID-19 incident occurred).

This set of unique symptoms and travel history, combined with the Fireline Medic's previous experience treating COVID-19, trigged the highest level of concern.

Loss of Taste and Smell

The patient had arrived at this remote station on Monday July 13, by way of several commercial flights originating in the Lower 48 with the final one on a small Alaskan "bush plane." (See photo above.) He had been monitoring his health and temperature each day after his arrival at this remote station. In addition, he had been trying to maintain distance from others when eating at the mess hall and limiting his close contact with anyone else. He had not had and did not have a temperature. He showed no flu-like signs or COVID symptoms or breathing problems. Therefore, he was asymptomatic aside from one acute set of symptoms—the loss of taste and smell.

He stated that: "*breakfast just didn't taste like it should. It was bland. I could not smell things I could smell before."* This set of unique symptoms and travel history, combined with the Fireline Medic's previous experience treating COVID-19, trigged the highest level of concern.

Early contact with the clinic and its well-trained doctor, prior to any medical incident occurring, proved to be an invaluable step that the Fireline Medic had taken upon first arriving at the base.

Relationship with Village Doctor

Part of every medical plan (ICS 206) is to identify the location and capabilities of local medical resources. Because this remote station was in a small Alaskan village, the medical resources were limited and had the primary mission of protecting the local population. Early contact with the clinic and its well-trained doctor prior to any medical incident occurring proved to be an invaluable step that the Fireline Medic had taken upon first arriving at the base.

The local village does have an Abbott ID NOW Rapid COVID-19 testing machine. The Fireline Medic had experience drawing samples for this machine and had worked with the village doctor to establish a relationship in the development of the medical plan for the base.

Fireline Medic's Multi-Step Precautionary Process
When the pilot reported his potential COVID-19 symptoms at 10:32 a.m. that day, in accordance with the unit's written plan, the Fireline Medic contacted the local village doctor. To limit contact and movement of the possible COVID-19 positive patient—particularly to avoid taking the patient into the village and unnecessarily exposing other healthcare providers—the Fireline Medic carefully removed his full PPE, bagged the now contaminated gear, sanitized himself and anything he had contacted, then proceeded to the local clinic.

In the clinic's lobby, without the need to contact or approach anyone, a paper bag with the patient's name and the sample swab with container was retrieved, along with a note with instructions for returning the sample. The Fireline Medic returned to the patient (who was isolated in his room), donned a new full set of PPE, and obtained the nasal sample for testing.

The sample was collected, labeled, and placed in a suitable biohazardous transport container. The Fireline Medic once again meticulously removed and disposed of the used PPE. Once sanitized, he returned to the clinic with the sample for testing. The sample was left, with no contact or proximity to staff, in the pre-arranged drop point at 1200 hours.

Registration Paperwork Delay
One of the potential challenges that was identified during pre-planning exercises ended up causing a minor delay. This was the process of registration paperwork that was required by the local clinic before the sample could be processed. The paperwork essentially boiled down to answering how and by whom the testing that this small local clinic was about to conduct would be paid? It took several hours and a couple phone calls, in addition to transporting the patient out of his room to obtain an internet signal to allow for the emailing of his registration paperwork.

On the scale of things, this delay may have been small, but without the access and the willingness of this doctor and clinic to process the sample, the test results may have taken a week or more. The rest of this story would be quite different.

Patient Tests Positive for COVID-19 – Contact Tracing Protocol Initiated
At 1451—less than five hours from the noted COVID-19 symptom onset—the clinic doctor notified the Fireline Medic that the patient had in fact tested positive for COVID-19. As pre-planned and already initiated, the contact tracing protocol was used. The patient's actions during the previous days had limited the close contacts on base to three persons in his module. One of his contacts, his relief, had returned to his home unit and was immediately notified. Two other persons in the patient's module had been asked early in the day to quarantine prior to the test result. A third potential indirect contact was placed on quarantine out of an abundance of caution.

Following predetermined notification procedures, the local public health agency was also notified of the patient's previous commercial flight into the village. As a result, three local residents were placed on notice to quarantine and self-monitor for 14 days. The risk to these local residents was kept to a minimum as a direct result of the commercial carrier's requirement to wear face masks during their flight. In general, there was little to no additional risk to the local community as the staff at the fire base have not interacted with the community this summer—as they have in the past under "normal" conditions.

A second item that was identified as a potential problem in the pre-planning stage became apparent: The number of isolation rooms and services that would have been required to manage multiple potential patients would have quickly overwhelmed the base. This problem was addressed by way of the pre-planning (mentioned earlier) that had gone into the "Escape Routes".

The rapid identification of the primary patient and all the potential contacts prior to any adverse medical conditions—such as difficulty breathing or flu-like symptoms—provided for routine, yet isolated, transportation options to be utilized. As a result, by 1930 on the day of the incident, the patient and all potential exposures at the base were flown to the closest city capable of providing the appropriate level of monitoring treatment and

isolation. Due to the precautions taken, the situation did not result in other positive COVID-19 cases at the remote base or in the surrounding community.

What are the Lessons?

What do you now know that you wish you'd known before the lessons were learned?

- Consider the potential for multiple patients and exposures from contact tracing in your planning for COVID-19 safety zones and escape routes.
- Identify and incorporate a registration and paperwork plan for COVID-19 testing in advance with your local public health agency.

What is something you would share with others who could be in a similar situation?

- Prepare and review your plan considering WHEN it will happen, not IF it will happen.
- Post a trained, skilled and equipped COVID-19 "Lookout" (a medic with some firsthand experience).
- With proper training and personal protective equipment and procedures, a single COVID-19 patient can be identified, tested, treated and transported without infecting others.
- Face masks, hand washing, and proper distancing works to greatly reduce the risk of spreading COVID-19. WEAR YOUR MASK—DON'T BE A COWARD.

Super Important Lesson About Heeding Your Symptoms: This Positive COVID-19 Patient's Loss of Taste and Smell Symptom Only Lasted Four Hours!

This patient's only symptom was the telltale loss of taste and smell, which the medical community has come to recognize as one of the more strange symptoms of COVID-19.

That, of course, tipped the individual off—as well as the Fireline Medic—that there should be a high index of suspicion for COVID-19.

With that said, this symptom was only experienced by the patient for approximately FOUR HOURS! He first experienced it at breakfast, but by the time he ate lunch his taste was back.

So think about that. If he had questioned it at all or hadn't been as brave as he was to speak up to his supervisor, then this COVID-19 positive individual would have just gone back to his business as usual and potentially exposed additional staff.

Successes

- A solid plan was in place and communicated to all parties.
- Employees were screened and informed on what trigger points to look for and how to act if they encountered them.
- A qualified medic was on hand and coordinated with local public health care agencies PRIOR to any medical incident.
- Having the access to COVID-19 testing and sampling sites and training with procedures and local resources.
- All other COVID-19 tests for the close contacts and any others who chose to be tested in response to this case came back negative.

Challenges

- Identifying and streamlining the paperwork and financial responsibility issues before actually needing to address them during the medical event.
- Having the resources (lodging facilities, transportation, food arrangements) to deal with multiple presumed COVID-19 positive patients that come from contact tracing.

- Ultimately, if you can immediately isolate an individual who screens positive for COVID-19 and then transport them to a testing facility, you are already on your way to a successful outcome. However, in Alaska the transportation component can be extra challenging based on the remote nature of several initial attack bases and needing to travel by air for testing and/or appropriate isolation and treatment facilities. A private vendor has been contracted to provide air transportation for either individuals who have already tested positive for COVID-19 or those who have screened positive but have not been able to be tested yet. This is to reduce potential risk and exposure to agency air crews. This contract has not been put to the test too much because of the current quiet fire season in Alaska. Thus, there remains some uncertainly around the details of this service.

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