Approved: 22 June 2020

Post-COVID-19 Remobilization of the Membership Plan

Phase I: Resuming Regularly Scheduled Meetings

OKWG
Completed 10 JUN 2020

COVID-19 Remobilization of the Membership Plan – Phase I

This plan has been developed for Oklahoma Wing, using the template provided by the Civil Air Patrol National Headquarters to enter Phase I, Resuming Regularly Scheduled Meetings.

Additional staffing and resources have been coordinated with Southwest Region, to cover gaps in this wing's available resources.

NOTE: *Deviations from the template are authorized, but should be coordinated by contacting the COVID-19 Planning Team at COVID-19Plans@capnhq.gov.*

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Narrative Summary of Coordination and Events To-Date in Oklahoma Wing:

On 7 MAR 2020, the first patient, a male in his 50s from Tulsa, OK, was diagnosed with COVID-19 after returning from travel to Italy. By 13 MAR, there were four cases, including the first in Oklahoma City, a woman in her 60s who had returned from Florida. By 15 MAR 20, 7 cases had been diagnosed, and by 18 MAR, there were 29 diagnosed, active cases and the first fatality, in Tulsa. Through this period, access to testing was severely limited. On 22 MAR, there were 67 cases and a second death. By 23 MAR, 81 cases had been diagnosed, and people were urged to voluntarily stay home and practice social distancing. The 18-49 year age group comprised the largest number of cases at this time.
The third death occurred 24 MAR, and the diagnosed case load had increased to 106, a daily increase of 26, or, a 31% increase over the previous day. Oklahoma State Department of Health recommended home isolation, social distancing and frequent and effective hand washing as mitigating measures. The Governor issued executive orders requiring at risk persons to stay at home until 30 APR, and barring visitors at nursing homes and long-term care facilities. Gatherings were limited to 10 persons or less, and the counties with reported cases saw non-essential businesses closed. The infected rate continued to increase in an exponential fashion. Restaurants were allowed and encouraged to remain open for to-go and curb-side pickup.
On 25 MAR, a 55% day-to-day increase was observed (50 new cases), and the 65 and older group was the predominant group affected. Two more patients died, bringing the total to 5. Testing supplies and facilities remained restricted.

By 31 MAR, 525 people were positively diagnosed with COVID-19, and 23 had died. A significant percentage of tests were returning positive results (31%), a product of the limits on testing due to supply availability. OSDH reported orders for significant amounts of personal protective equipment (PPE) had been placed.

On 1 APR, cases grew to 719, or 21% over the previous day. Sufficient testing supplies were judged available to encourage all healthcare providers to test any patient with COVID-like symptoms. On 3 APR, the case count had reached 988, with 38 deaths. Drive-thru testing was available in 17 counties.

By 7 APR, cases had risen to 1462 and deaths to 67 (case-fatality ratio: 4.58%). by 10 APR, 865 *Recovered* cases, and 88 deaths. With 841 *active* cases, the State had begun to see recoveries. The case:fatality ratio was 5.16%, and the rate per 100,000 people was 45.5.

For the week of 17-23 APR, 660 cases were confirmed, and two, unconfirmed but probable cases were noted. By this time, the rate of change in cases/week had begun to decline. Total confirmed cases stood at 3017, and total probable cases were 41. Total deaths ascribed to COVID-19 were 179. Testing had risen to 47,984 total specimens received with a total of 31309 positive speciments. 69 of 77 counties in Oklahoma had at lease one confirmed case of COVID-19.

For the 23-29 APR timeframe, 579 cases were confirmed (8% decrease vs the previous week). Total cases stood at 3473. 44 deaths were attributed to COVID-19. As of 28 APR, 61,619 tests had been administered; 3717 were positive.

Based on the epidemiology report from the Oklahoma State Department of Health, 1-7 MAY, an additional 712 cases were confirmed (18.5% increase) and the total of confirmed cases was 4330. However, an 11.6% decrease in deaths for the period (38) was noted. Total deaths stood at 250. Of 89,857 total tests performed, 4779 were positive. 71 of 77 counties have had at least one confirmed case of COVID-19.

For the week of 8-14 MAY, the State Epidemiology report stated that an additional 632 cases were confirmed (week-to-week decrease of 11.2%) and the total number of confirmed cases stood at 4962. An additional 24 deaths were recorded, 37% less than the week prior, for a total of 284. 118,751 tests had been administered of which 5645 were positive. An additional county, for a total of 72 of 77, has had at lease one confirmed case of the disease. Antibody testing was introduced into the report, but not used to calculate case rates, as integrating the results of serology testing is not as straightforward as testing for the acute disease. Also, an outbreak in Texas County posed problems in accounting for total cases and deaths, as the persons under investigation comingled between Oklahoma and Kansas.

For 15-21 MAY an additional 718 cases (+13.6%) were seen for a total of 5680. 20 deaths were recorded for a total 304. of 152,998 tests performed, 6589 were positive. Hospitalizations for this period stood at 190, with a total of 917 individuals, to date, requiring hospitalization. 73 of 77 counties had recorded at least a single COVID-19 case.

For 28 MAY, the last Epidemiology Report published, an additional 590 cases have been confirmed (-17.8%) for a total of 6270. An additional 22 deaths (+10%) brings the death toll to 326. 7114 of 188,665 specimens have tested positive. 160 individuals remain in-hospital with a total ever admitted to 975. No additional counties were added to the list with cases.

Mitigating actions
The Governor instituted the following actions to mitigate spread of the virus. Additional actions by the State Health Department are noted above.
Safer At Home 24 MAR
Schools closed 17 MAR
Gathering restrictions 24 MAR to 24 MAY
Non-essential business closures 1 APR to 24 APR

Contact tracking and tracing were always a priority in Oklahoma for infectious diseases, but the rapid rate of infection for COVID-19 overwhelmed the existing system. At this time contact tracing personnel are still being recruited and trained; 1 JUL is a reasonable target for initiation of effective tracing.
Testing strategies in Oklahoma have been selectively adequate but highly subject to availability of test materials and processing capacity (hardware and personnel). Early in the course of the pandemic, testing was reserved solely for those who had traveled to a known hot-spot (overseas), had been in close contact with a traveler, or had been in close contact with a person who had tested positive, **AND** who exhibited COVID-19 or Influenza-Like-Illness (ILI) symptoms. As more tests became available in the state, testing criteria were modified to allow testing of symptomatic persons where a positive or negative test would materially affect the course of treatment. Eventually, as drive-through testing sites became available, criteria were eased to allow testing of any symptomatic person, but required a health care provider's referral. At this time, criteria have loosened to allow anyone regardless of symptoms, or lack thereof, to receive molecular testing for acute disease. Also, testing facilities and supplies within Oklahoma are essentially unrestricted. This testing strategy virtually guarantees the dilution of the testing results and providing a falsely low value of positive tests vs total testing, at odds with the intent of the variable.
Serology testing, essential on-demand, is also now available. Of note, serology, or antibody testing for COVID-19 is not as reliable as that for the various forms of influenza because of the potential for detection of similar but less virulent coronavirus strains (diminished specificity) and the need to amplify the total antibody response (limited sensitivity). Most of the serology testing is more than adequately specific at this time for COVID-19 and SARS-CoV-2, but sensitivity of the two primary tests is disappointingly low, ranging from 97-91%. Although these numbers appear to be adequate, in terms of laboratory evaluation for serological testing, they are lacking. Finally, conferred immunity following infection and recovery from COVID-19 is not assured and has not been demonstrated. Some studies have found few, or no antibidies (nominally, immune globulin G, or IgG) in recovered patients. These findings are being investigated in larger trials than those initially reported, but the results, until then, cannot be viewed as favorable. Conversely, at least one vaccine in clinical trials provided an early report that 20% (8 of 40 participants) demonstrated a neutralizing antibody response after a single, nominal dose of the vaccine at several weeks. Thus, the utility of serology testing, and the future of conferred immunity remain rather opaque at this time.

As the text of the White House gating guidelines allow for some interpretive leeway, Oklahoma took a rather expansive view of these criteria versus the approach mandated by Civil Air Patrol. The Oklahoma criteria are listed below. Each 14 day period allowed for advancement to a more lenient phase of open operations and return to normal business and leisure activities.

Proposed State or Regional Gating Criteria Satisfy Before Proceeding to Phased Comeback

SYMPTOMS	CASES	HOSPITALS
Downward trajectory of influenza-like illnesses (ILI) reported within a 14-day period **AND**	Downward trajectory of documented cases within a 14-day period **OR**	Treat all patients without crisis care **AND**
Downward trajectory of covid-like syndromic cases reported within a 14-day period	Downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests)	Robust testing program in place for at-risk healthcare workers, including emerging antibody testing

Daily case and testing statistics, as well as hospitalizations and deaths, are available but are not required for this report. The State of Oklahoma elected to use a linear trend line to demonstrate tendencies rather than a 14 day moving average. In addition, as long as the linear interpolation retains the correct orientation, and regardless of spikes, Oklahoma has chosen to continue to pursue opening operations. Thus, a full three phase return to normal operations (or close) was achieved in approximately 6 weeks, despite the occasional spike in cases or rates.
On the other hand, Oklahoma was lucky in that only a small percentage of positive cases required hospitalization. Because of this, and of adequate hospital facilities around the state, headroom for hospitals and ICUs remains strongly positive.

At this time, Oklahoma has been declared to be in Phase 3. Restrictions remain on at risk populations, and social distancing and use of cloth face coverings is recommended. Whether this will be sufficient to continue a downward trend, or whether early and aggressive reopening will lead to another spike, or wave of cases remains to be seen.

All cities and counties in Oklahoma have eased restrictions on businesses, gatherings and travel. Restrictions on other activities, including nursing home visitation (considered a significantly at-risk population) are slated to be eased within the next 10 days. Unlike some other states, Oklahoma has not seen a sharp increase in cases (in excess of those attributable to greater testing), hospital admissions, or deaths. Because deaths are not, however, reported in a timely manner (one recent daily summary included deaths from April), we do not consider the day-over-day death total an adequate indicator of status of the disease in the State.

The most recent COVID-19 State Epidemiological Weekly Summary is included as a separate addendum (PDF).

OKWG proposes opening no earlier than 22 JUN 2020 pending completion of all open items on the official Template/Checklist, and based on State-reported data should be able to achieve that date.

Approval from the CAP COVID-19 Planning Committee has ***NOT*** been received at this time.

OKWG proposes to reopen with limited in-person meetings (<10 members) and is recommending an outdoor venue to allow better dispersion of viral aerosols. Masks, social distancing, and hand hygiene are mandated in the plan. A return to limited flight operations and limited Emergency Services operations and training is planned for Phase I. OKWG intends to implement, as possible, all of the activities identified in the National guidance for Phase I remobilization.

Ongoing evaluation of cases and statistics for the State of Oklahoma and OKWG will be performed with a weekly tag-up of the Medical Officers in the Wing, with, at best, consensus evaluations forwarded to the Wing Commander.

Notification of Phase transitions will be by email, sent by the Wing Commander or his designee, and shall occur at least 5 days prior to a forward transition, but may provide short notice if a need to revert to an earlier phase is determined to be necessary. In both cases, an *Execute/Effective* date and time will be given for implementation of the transition.

Phase I: Resuming Regularly Scheduled Meetings

Item#	Task	OPR/Assigned Personnel	Date Tasked	Suspense	Date Completed	Notes
1.1.	Verify state government guidance currently allows or will allow gatherings on the date proposed for resuming meetings (Review of overall directives in impacted state)	G. Creager	13 MAY 20		13 MAY 20 Updated: 1 JUN 20	Oklahoma is in Phase 3 status with a Safer-at-Home requirement for older and at risk populations
1.2.	Hold meeting with between Plan Coordinator and Health Services Officer	G. Creager. R. Platner	13 MAY 20		13 MAY 20	Plan Coordinator/HSO: G. Creager Asst HSO: R. Platner
1.2.1.	Wing priorities for training events should be coordinated	D. McCollum, B. Herold	1 JUN 20	3 JUN 20	13 JUN 20	Operations Order for Phase I
1.2.1.1.	Check state and local health guidance regarding gatherings (Review of each jurisdiction impacted by this plan)	G. Creager, R. Platner	1 JUN 20	3 JUN 20	8 JUN 20 Updated 10 JUN 20	State guidance supercedes local guidance per Executive Order. Some municipalities have retained more restrictive requirements, but these are all at Phase III at this time
1.2.1.2.	Prepare information for subordinate units on temperature screening, health education, and sanitation	R. Platner	4 JUN 20	8 JUN 20	7JUN 20	One page training document suitable for posting in all Squadron, SAREX/OPEX and Mission spaces
1.2.2	Consult with Wing Legal Officer about resuming meetings	G. Creager	4 JUN 20	8 JUN 20		Email sent 4 JUN 20
1.2.3	Coordinate with Wing Director of Safety	G. Creager	4 JUN 20	8 JUN 20	10 JUN 20	Coordinate with J. Emory
1.2.3.1	Verify proper risk planning tools are available to units	J. Emory	4 JUN 20	8 JUN 20	7 JUN 20	
1.2.3.2	Prepare to communicate with subordinate units on Safety-related matters (see 1.7. below)	J. Emory	4 JUN 20	8 JUN 20	10 JUN 20	Coordinate with J. Emory
1.2.4	Coordinate with Wing Director of Cadet Programs	B. Welch	4 JUN 20	8 JUN 20	10 JUN 20	
1.2.4.1	Prepare recommendations for units regarding meeting activities and alternatives to maintain optimal distance while at meetings	B. Welch	4 JUN 20	8 JUN 20	14 JUN 20	
1.2.4.2	Prepare bullets for units to incorporate when sending messages to parents about the resumption of meetings	B. Welch	4 JUN 20	8 JUN 20	14 JUN 20	

Phase I: Resuming Regularly Scheduled Meetings (Continued)

Item#	Task	OPR/Assigned Personnel	Date Tasked	Suspense	Date Completed	Notes
1.3.	Have subordinate unit commanders verify that local governments do not have more restrictive social-distancing guidelines than those at the state level	G Creager	2 JUN	10 JUN		Most Grp 2 CC's have complied, as have several Grp 1 CC's; awaiting completion. Executive order issued by Governor supercedes local regulations.
1.4.	Send copy of planning documents to the CAP COVID-19 Planning Team at COVID-19Plans@capnhq.gov, and copy the Region CC to reinstate meetings.	D. Roberts/G. Creager	13 MAY 20	15 JUN 20	14 JUN 20	
1.4.1.	Briefly describe/ summarize previous coordination accomplished	G. Creager	10 JUN 20	15 JUN 20	14 JUN 20	Multiple advisory committee meetings with Wing Staff leadership; several emails to HSOs, Safety Officers and subordinate unit Commanders, as well as informational email to Wing membership
1.4.2.	Verify no jurisdictional restrictions are in place from State or Local Governments	G. Creager	10 JUN 20	15 JUN 20		Ongoing. Executive order issued by the Governor supercedes local public heal executive orders.
1.4.3.	Set date to resume meetings; this is also the start of Phase II.	G. Creager	10 JUN 20	20 JUN 20	14 JUN 20	TBD: Based on Phase I opening but not earlier tha 15 JUL 20
1.5.	Receive approval from the CAP COVID-19 Planning Team to reinstate meetings. Plan for one-week lead time.	D. Roberts/G. Creager	10 JUN 20	N/A		
1.6.	Publish the date that meetings may resume to subordinate units	D. Roberts/G. Creager	10 JUN 20	N/A		Pending initiation of Phase I and ongoing evaluation of case increase/decrease rates in state
1.7.	Task Wing Director of Safety to communicate the following to subordinate units	G. Creager	3 JUN 20	10 JUN 20	11 JUN 20	Guidance provided by LtCol Emory to all Wing and subordinate unit Safety Officers. Reenforcing email will be mailed to subordinate unit Commanders and HSOs
1.7.1.	Units will review CAPFs 160, 160S, and 160HL to be sure COVID-19 risks are considered and mitigated	J. Emory	3 JUN 20	15 JUN 20		
1.7.2.	Unit Safety Officers s will emphasize continued use of face coverings, gloves, hand sanitizer, and social distancing, hand washing and surface cleaning/disinfection	J. Emory	3 JUN 20	15 JUN 20		
1.8.	Task Wing Health Service Officer to	G. Creager	2 JUN 20	12 JUN 20	3 JUN 20	Information relayed to Commanders, HSOs, Unit

	communicate the following to subordinate units:	R. Platner				Safety Officers by email
Item#	**Task**	**OPR/Assigned Personnel**	**Date Tasked**	**Suspense**	**Date Completed**	**Notes**
1.8.1.	Units will ensure no members or guests with a temperature of 100.4 or greater are admitted (a temperature at or above 100.4°F is the CDC recognized point where there is a fever). Units will require members to take their temperature at home or may screen with no-touch thermometers prior to entry.	G. Creager R. Platner	2 JUN 20	12 JUN 20	3 JUN 20	Information relayed to Commanders, HSOs, Unit Safety Officers by email
1.8.1.1	No-touch thermometers will be provided to each unit	G. Creager/D. Roberts	3 JUN 20	20 JUN 20		Pending arrival of devices and distribution to Squadrons; delivery anticipated 17 JUN 20
1.8.2.	Educate members on their stratified level of risk (i.e., Low-risk vs. High-risk)	G. Creager R. Platner	2 JUN 20	12 JUN 20	3 JUN 20	Information relayed to Commanders, HSOs, Unit Safety Officers by email
1.8.3.	Units perform all appropriate public health measures (e.g., social distancing, surface cleaning/disinfection, face coverings, hand sanitizer, at-home temperature check or no-touch temperature check prior to entry and routine symptom checks)	G. Creager R. Platner	2 JUN 20	12 JUN 20	3 JUN 20	Information relayed to Commanders, HSOs, Unit Safety Officers by email
1.8.3.1.	Units shall be responsible for obtaining approved cleaning and sanitizing supplies and appropriate PPE to support appropriate sanitation, face covering and social distancing requirements Units with reduced financial resources may apply to Wing for funding assistance	G. Creager	10 JUN 20	12 JUN 20	11 JUN 20	Email to subordinate unit commanders, HSO and Safety Officers
1.8.4	Units will ensure no more than 10 members are together at gatherings. Squadrons with more than 10 members must submit a plan on how they will comply with restrictions	G. Creager R. Platner	2 JUN 20	12 JUN 20	3 JUN 20	Information relayed to Commanders, HSOs, Unit Safety Officers by email
1.9.	Task Wing Director of Cadet Programs to communicate the following to	B Welch	2 JUN 20	8 JUN 20	13 JUN 20	Email 2 JUN 20

	subordinate units:					
1.9.1.	Units identify ways to meaningfully engage and fully participate in meetings without formations, drill, or other close-distance activities	B Welch	2 JUN 20	8 JUN 20		Assistance available from G. Creager if required
1.9.2.	Units draft a local message to parents to inform them about what CAP is doing to keep Cadets safe while they participate	B Welch	2 JUN 20	8 JUN 20		
1.10.	Task Wing Director of Operations to communication the following to subordinate units.	B. Herold	2 JUN 20	10 JUN 20	11 JUN 20	Direction to subordinate units is attached as an addendum.
1.10.1	Identify flight operations permitted during Phase I	B. Herold	2 JUN 20	10 JUN 20	11 JUN 20	
1.10.2.	Identify requirements (Currency, etc) for senior members	B. Herold	2 JUN 20	10 JUN 20	11 JUN 20	
1.10.3.	Identify requirements for cadets that have earned their Private Pilot's License to return to flying	B. Herold	2 JUN 20	10 JUN 20	11 JUN 20	
1.10.4.	Identify requirements for cadets training to earn their Private Pilot's License	B. Herold	2 JUN 20	10 JUN 20	11 JUN 20	
1.10.5.	Identify cleaning standards for aircraft and vehicles before and after use	B. Herold	2 JUN 20	10 JUN 20	11 JUN 20	

HEADQUARTERSOKLAHOMA WING
CIVIL AIR PATROL
UNITED STATES AIR FORCE AUXILIARY
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FROM: Health Services Officer 14 June 2020
TO: Oklahoma Wing Personnel
SUBJECT: COVID-19 Remobilization of the Membership Plan –Phase 1

1. OKWG's remobilization plan will be implemented in a stepwise manner as a Wing; subordinate units are not authorized to remobilize or advance to a new phase ahead of approval by the Wing Commander. The current plan has been submitted to National and expedited review is expected. Until positive review is received, and some plan deficiencies are corrected, we will not remobilize; thus, if you have been asked for information and have not responded, please provide the information as rapidly as possible.

The current target date for OKWG Remobilization is 22 JUN 20.

1.1. Phase I remobilization will be restricted. in-person meetings are restricted to small (<10) groups, and no close activities such as formations or drill are authorized. Some flight operations are authorized. Maj Herold will update everyone on the authorized activities. Cloth face coverings and social distancing are required at this stage, and excellent hand hygiene, utilizing soap and water or hand sanitizer with at least a 60% alcohol content are mandated. Breaks to engage in hand hygiene should be planned for hourly execution and shall occur at least every 90 minutes.

1.1.1. Commanders will work with their staff to determine effective methods to resume in-person meetings. Because of better dispersion, and thus lower viral load/exposure, it is recommended that meetings be held outdoors when possible. Regardless of the venue for the actual meeting, no more than 10 members may be present physically in Phase I.

1.1.2. Masks may be, and should be removed for PT, especially for runs, but all personnel are reminded of the need to enforce social distancing. Mask use during strenuous activity should be avoided if possible (social distancing), and frequent breaks should be enforced if face coverings are used during significant exertion.

1.1.3. All personnel should bring their own water or other hydration supplies and should avoid using public, common sources of water (e.g., drinking fountain). At the discretion of the Safety Officer or Health Services Officer present, failure to bring personal hydration may be deemed a sufficient reason to refuse access to the activity.

1.1.4. With the onset of summer, Commanders, Safety Officers and Health Services Officers shall assure that adequate water and cool-down breaks, consistent with CAPR 60-1 2.6.

1.2. Temperature checks will be instituted for in-person meetings and training. Until units receive their no-touch thermometers, an at-home self-check of temperature is authorized. Any member or visitor who arrives and has an elevated temperature of 100.4F (38C) is to be advised to return home and seek medical care, and shall not be admitted to the meeting. In addition, all participants should be asked some variation of the following, and responses indicating potential exposure of illness shall result in the member being advised to return home:

- Are you feeling well at this time?
- Within the last week have you had a fever greater than 100.4F (38C)?
- Do you have a cough?
- Are you having trouble breathing?
- Have you traveled either within the US or abroad within the last 21 days, to an area where COVID-19 remains an active disease problem?
- have you had a recent change in your sense of smell or taste?

1.2.1. Within the plan is a reference to no-touch thermometers as well as a cleaning and sanitation requirement.

- The Wing is acquiring and will provide a no-touch thermometer to each Squadron for their use at no cost to the subordinate unit
- Each squadron is responsible for obtaining appropriate cleaning supplies. Provisions may be made at the Wing level if the cost of cleaning supplies is beyond the existing budget of the unit

2. The goal of the remobilization order and planning to to safely proceed to a more normal battle rhythm. This does not mean CAP remobilization is tightly linked to any given State's phased reopening schedule. Each Phase transition requires a plan be submitted to and approved at the National level prior to transition. In the event that CAP guidance is more restrictive than State guidance, CAP guidance shall prevail. Similarly, if we encounter a point where State guidance is more restrictive, the State guidance is used. Simply put, the more restrictive guidance shall be used.

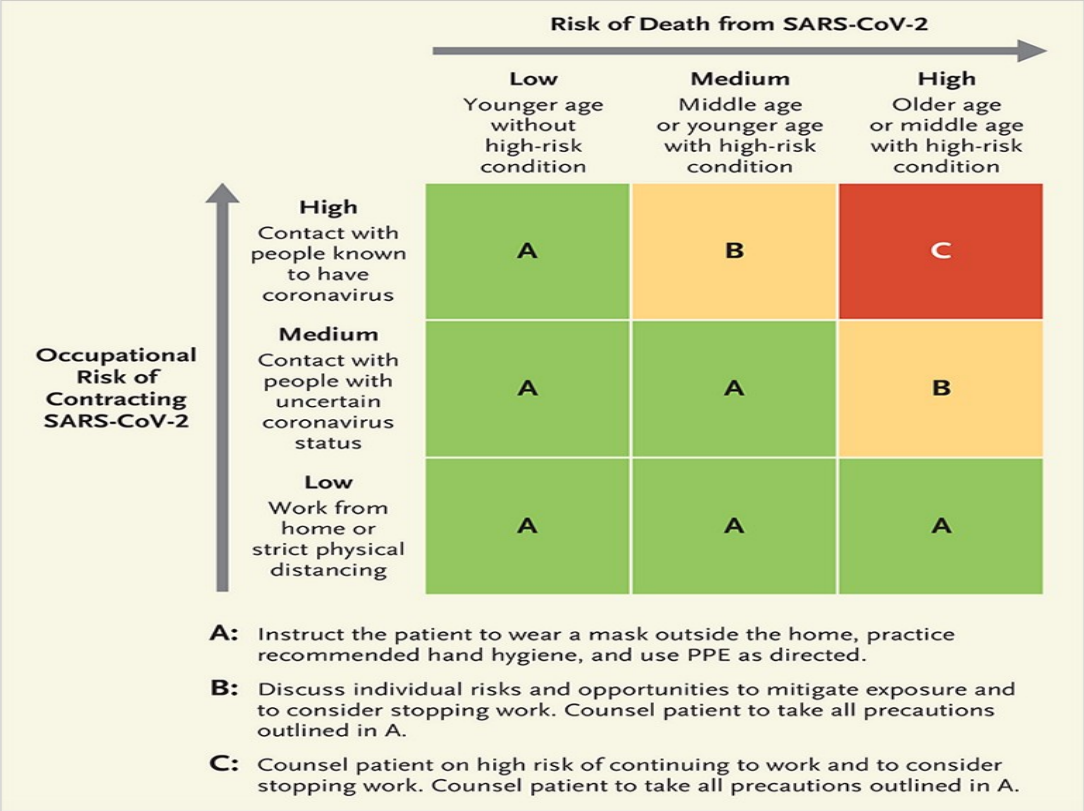
2.1. With National approval of a plan to proceed, Phase change shall occur at the sole discretion of the Wing Commander. He may elect to remain in a phase beyond the minimum time required (14 days with continuing downward trends). Transition is not mandated to be tied to a strict timeline. It is in the best interests of OKWG to balance the need to remobilize and start the process of normalizing training and education, with a constant awareness of safety. To that end, if conditions change in the state and warrant moving back to an earlier Phase, this will also be at the sole discretion of the Wing Commander.

2.1.1. An email from the Wing Commander or his designee will be sent prior to any Phase transitions. For transitions forward, the announcement will be made at least 5 calendar days prior to

the transition. In the event of reversion to an earlier Phase, as much notice as possible will be given, but an effective date/time will be provided and this date/time will mark the initiation of the retrograde transition.

2.2. The Wing Health Services Officer will be engaging the various Medical Officers (physicians) within the Wing to consult and serve as an evaluation board, so that the Wing Health Services Officer can appropriately advise the Wing Commander if, in their expert opinion, conditions are such that A) transition is safe and reasonable; B) remaining in the current phase is recommended; or, C) reverting to an earlier phase is recommended. This evaluation will occur on at least a weekly basis by telecon or email exchange.

3. CDC guidance for at risk persons can be found at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html and may be initially evaluated using this chart:



Note that this chart provides a quick-look evaluation and does not replace a careful reading of the CDC criteria.

3.1. During Phase I, persons considered at risk should not attend in-person meetings or events, and should be encouraged to telework. Members will self-evaluate their status, but all are reminded of the

Core Value of Integrity. If a Member self-certifies as low-risk and acquires the illness at a CAP activity of any sort, the potential for adverse psychological effect on Members at ALL levels of the overall organization are likely to be felt.

3.2. Any person who lives in a household with at-risk persons should consider themselves at risk while in Phase 0 (current state) and Phase I.

3.3. Persons who have traveled to areas within the United States, or overseas and have encountered heightened COVID incidence, or where Public Health guidance indicates an increased risk, should, upon return to Oklahoma, self-quarantine for 14 days, and discuss with their County Health Department or primary care provider about seeking molecular (swab-based) testing regardless of symptoms.

3.3.1. Persons who have traveled as indicated above should not attend meetings and should honestly self-assess their risk profile. Wing and Unit Health Services Officers are available to discuss individual questions. The Wing Health Services Officer is available to support these discussions as needed.

3.3.2. All personnel should, within the next 14 days, prepare and provide to your unit Commander, CAP Forms 160, 160S and 160 HL for evaluation. Commanders or their designee shall notify the Wing Health Services Officer of failure to comply and of any extenuating circumstances they are aware of.

4. Commanders shall develop, in concert with Deputy Commander, Cadets and Cadet Programs Officer to develop a communication to Cadets, and parents/guardians detailing the steps that will be taken to keep Cadets safe in this transition program. Included these steps please emphasize masks, social distancing, temperature checks and asking about health status as well as hydration requirements and attention to heat stress injury.

4.1. The Wing Health Services Officer is available to assist with developing these communications, if needed.

5. All personnel are asked to consider and recommend novel approaches to participation and training. Examples might include:

- Several meetings per week allowing accommodation of all members at least every other week in an in-person
  meeting
- Live-streaming the small-group in-person meetings with other members using teleconferencing technologies
- Meeting outdoors to enhance social distancing rather than within an enclosed room
- ad hoc unstructured meetings to allow free-form participation, anchored with a theme, e.g.,

Aerospace: Space Force, or Aircraft: principles of flight, where Cadets are the principal organizers and presenters, and their mentors can help with questions, but are not responsible for teaching

- Other ways to "Think Outside the Box" to engage Cadets and Seniors.

6. The Oklahoma Wing is not closed, nor is Civil Air Patrol. In the event of a major activation OKWG can receive waivers in short order to allow an emergency remobilization. This does not infer that the phased approach is inappropriate or unnecessary, but emphasizes our flexibility in response to significant events.

If you have any questions, I am available to work with you to answer them.

Capt Gerald Creager, CAP
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FROM: DCS-Operations 7 June 2020
TO: Oklahoma Wing Personnel
SUBJECT: Operations COVID-19 Remobilization of the Membership Plan –Phase 1

Item 1.10 Task Wing Director of Operations to communicate the following to subordinate units:

1. 1.10.1 Flight Evaluations permitted during Phase 1
    a. Annual Form 5 and Form 91 evaluations that fall in June and July 2020 cycle
    b. Annual Form 5U and Form 91U evaluations that fall in June and July 2020 cycle
    c. Initial Form 5U and Form 91U evaluations that were are on hold due to COVID-19

2. 1.10.2 Senior Member Currency Training
    a. Private and Transport Mission Pilots effectively start proficiency training that was suspended during the COVID-19 shutdown.
        i. Private pilot proficiency flights continued under OKMISC self-funded mission
        ii. Proficiency flights for TMP's can resume under 20-A-3339
            1. This will cease the need for the Engine Preservation program currently in place.

    b. Unit Members whose Emergency Service currency expires during June and July 2020 use 20-T-3179 Individual Unit ES Training
        i. Units will build an Ops Plan and upload to mission files.
        ii. No more than ten members attend ground training

    c. The following sUAS training for Recreation pilots, Technician, Mission Pilot and Observers training to continue throughout Phase 1.

3. 1.10.3 Identify requirements for cadets that have earned their Private Pilot's License to return to flying.
    a. No OKWG Cadets have earned their Private Pilot's License

4. 1.10.4 Identify Cadets training to earn their Private Pilot's License

    a. OKWG has one Cadet enrolled in the wings program and will be allowed to continue training under mission number 20-T-3176 with Instructor Pilot and Solo flights per current training plan for the mission number.
    b. Mission number expired 30 April 2020 and requires coordination with NHQ to extend end date.

5. 1.10.5 Identify cleaning standards for aircraft and vehicles before and after use.
    a. All units and OKWG members who use aircraft and vehicles will sanitize IAW Memo dated March 20, 2020 tilted COVID-19 AIRCRAFT AND VEHICLE CARE
        i. Document is located at gocivilairpatrol.com Civil Air Patrol COVIS-19 Information Center.

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OKLAHOMA COVID-19 WEEKLY REPORT

Weekly Epidemiology and Surveillance Report
May 29 – June 4, 2020

PURPOSE To provide up-to-date weekly epidemiological data on COVID-19 in Oklahoma.

SNAPSHOT

	May 29 – June 4	Change[1]	Total
Confirmed cases	637	8.0%	6,907
Recovered cases[2]	545	-37.7%	5,781
Deaths	18	-18.2%	344

1. Change from the week of May 22-May 28, 2020.
2. Currently not hospitalized or deceased and 14 days after onset/report.

The average age of cases was **48** years.

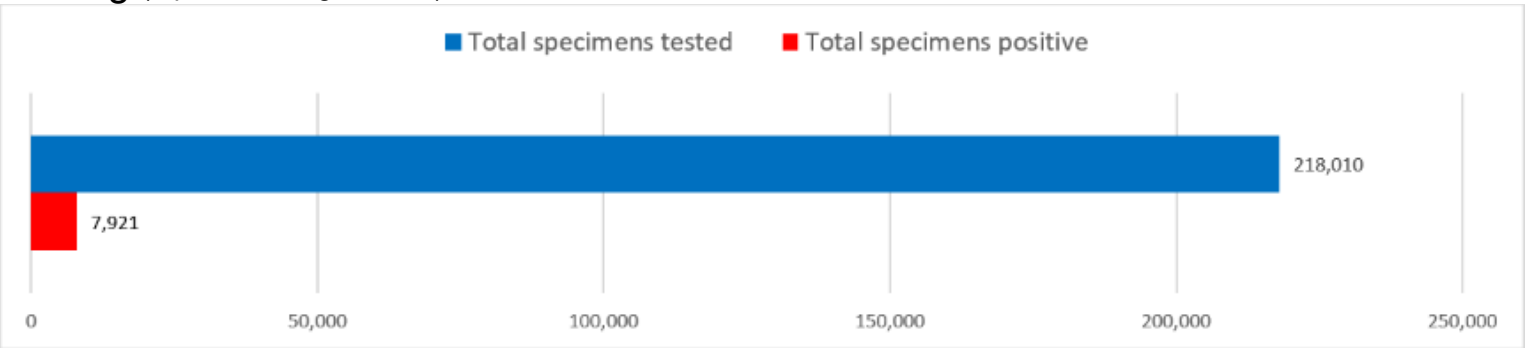
The youngest case was **less than a year old** and the oldest case was **102 years**.

The average age of individuals who died was 75 **years**.

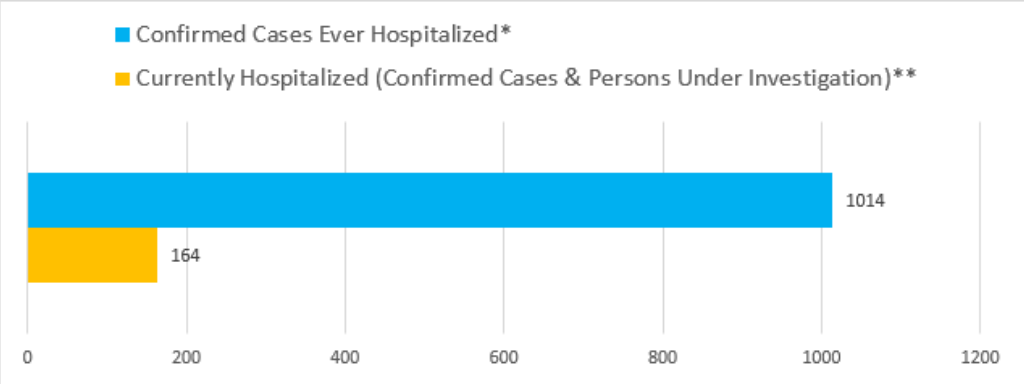
The youngest individual to die from COVID-19 was **22 years** and the oldest was **101 years**.

Persons aged 50 and over	Persons aged 50 and over	Females	Males
46%	**97%**	**53%**	**51%**
of cases	of deaths	of cases	of deaths

Testing (reported through June 4)



Hospitalizations



*Ever hospitalized includes discharged, deceased, currently hospitalized and recovered as of 6/4/2020.
**Source OSDH Beds Survey. Note, facility response rate of 86% on 5/28/2020.

KEY POINTS

- **637** confirmed cases in the past week
  8.0% increase from the week before (May 22-28).
- **18** deaths occurred in the past week
  18.2% decrease from the week before (May 22-28).
- **1,014 (14.7%)** confirmed cases have been hospitalized
- **218,010** specimens have been tested in total.
- **74** counties (out of 77) have had at least one confirmed case of COVID-19

GATING CRITERIA

- Progress on meeting the components of the reopening guidelines proposed by the White House, called the “gating criteria”. More information available at https://www.whitehouse.gov/openingamerica/

Proposed State or Regional Gating Criteria to Satisfy Before Proceeding to Phased Comeback

SYMPTOMS	CASES	HOSPITALS
Downward trajectory of influenza-like illnesses (ILI) reported within a 14-day period AND Downward trajectory of covid-like syndromic cases reported within a 14-day period	Downward trajectory of documented cases within a 14-day period OR Downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests)	Treat all patients without crisis care AND Robust testing program in place for at-risk healthcare workers, including emerging antibody testing

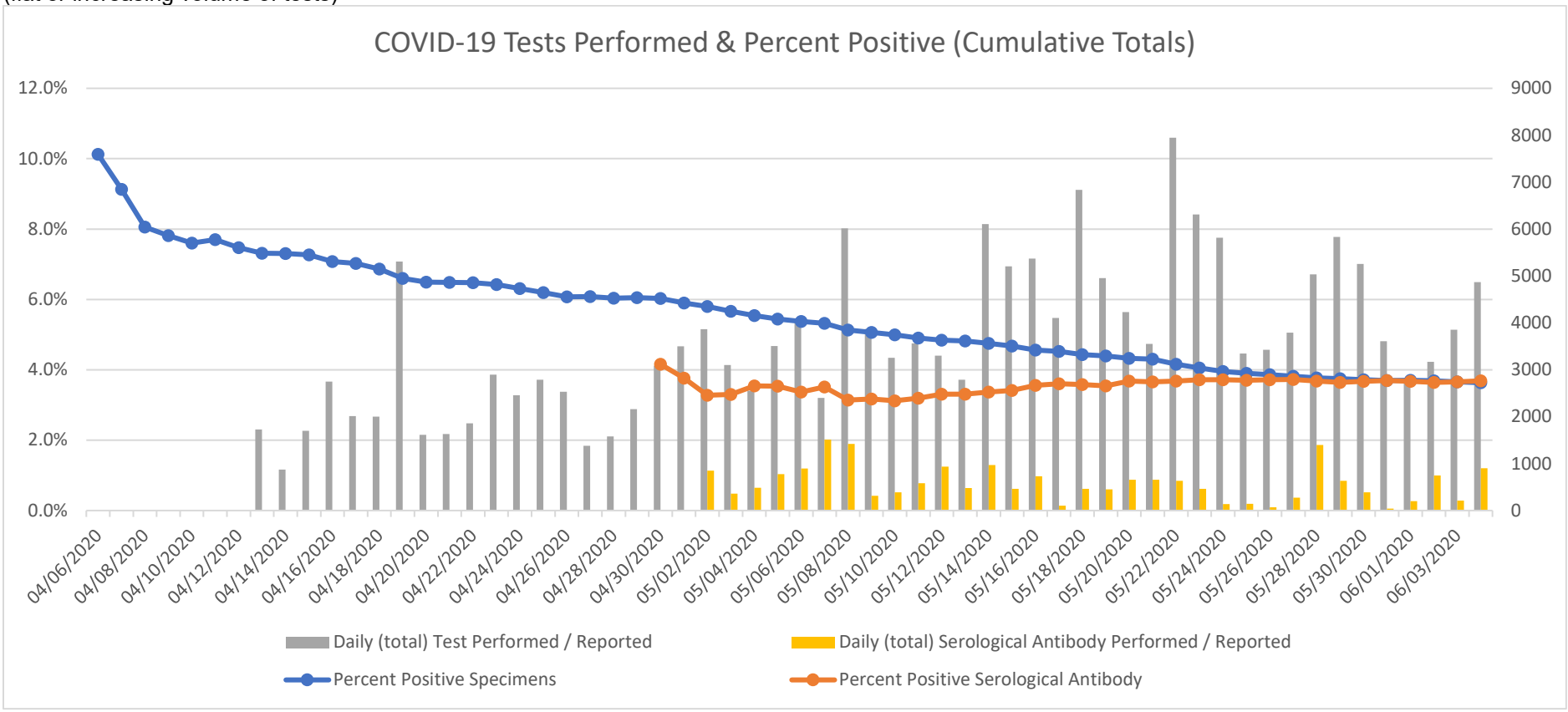
DISEASE TESTING

	May 29 – June 4	Total Number
Specimens tested[1], count	29,345	218,010
Specimens positive, count (%)	807 (2.8%)	7,921 (3.6%)
Antibody tested, count	3,124	23,402
Antibody positive, count (%)	117 (3.7%)	863 (3.7%)

1. Includes state and private laboratories.
Note: Specimen counts may not reflect unique individuals.

Downward trajectory of positive tests as a percent of total tests within a 14-day period

(flat or increasing volume of tests)



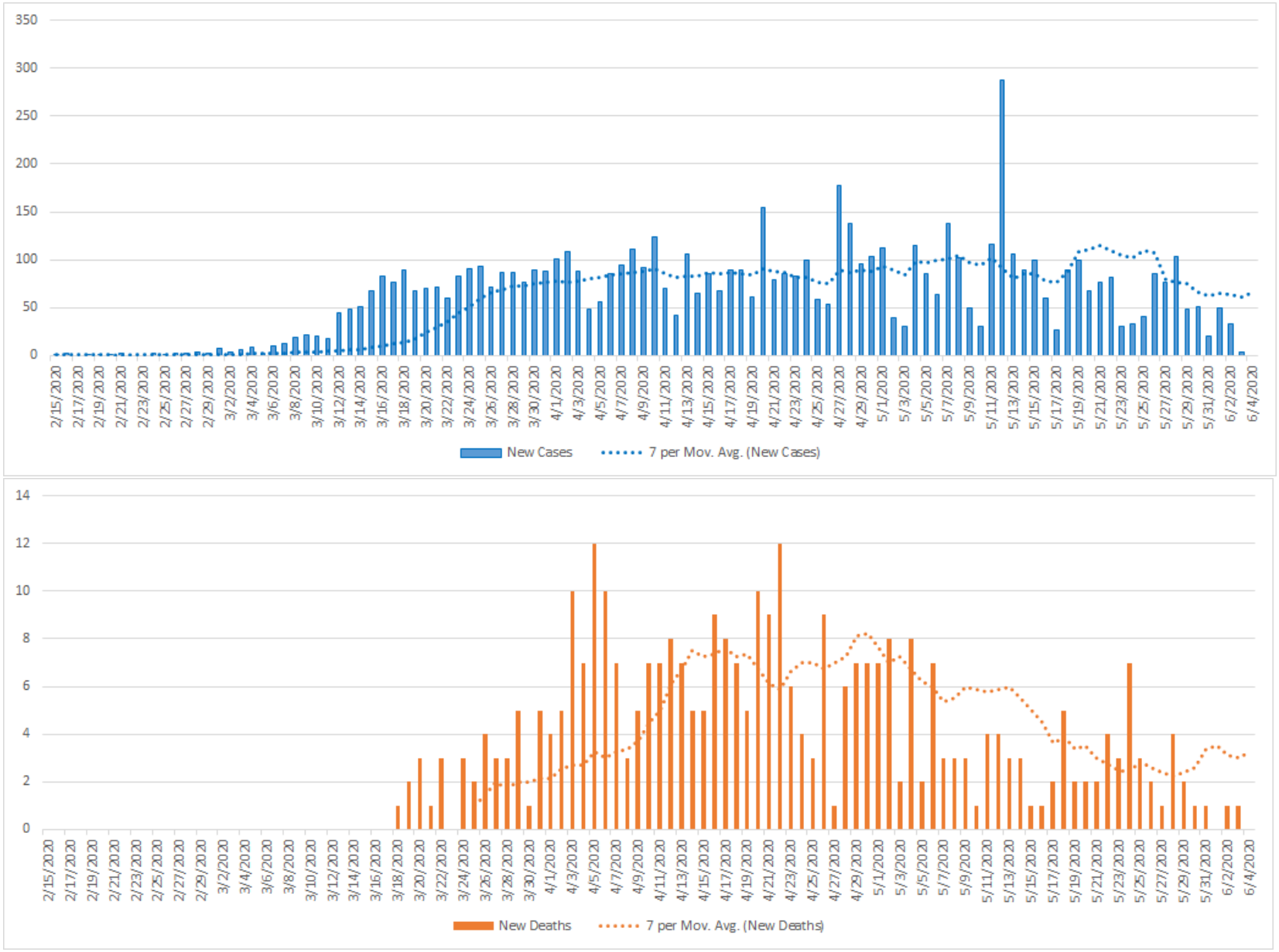
Oklahoma, May 29 – June 4, 2020

EPIDEMIOLOGICAL ESTIMATES

	Estimate	Notes / Interpretation
Cases		
Cumulative incidence	175.2 (per 100,000 persons)	From March 7 to June 4, there were about 175 (per 100,000) new cases of COVID-19 in Oklahoma.
Absolute change in cumulative incidence from previous week	1.2 (per 100,000 persons)	Compared to May 22 - May 28, there was 1 (per 100,000) more case of COVID-19 reported in Oklahoma during the past week (May 29 - June 4).
Disease Severity		
Case-fatality risk (crude)	5.0%	The estimate is not adjusted for the lag time from reporting to death (i.e., delay between the time someone dies and the time their death is reported). The fatality estimate could be lower due to cases that were undiagnosed or had milder symptoms.
Cumulative Hospitalization rate (overall)	25.7 (per 100,000 persons)	About 26 people per 100,000 have ever been hospitalized for COVID-19 during this outbreak.

CASES AND DEATHS

New cases (by date of onset) and **new deaths** (by date of death) of COVID-19 in Oklahoma, February–June 2020

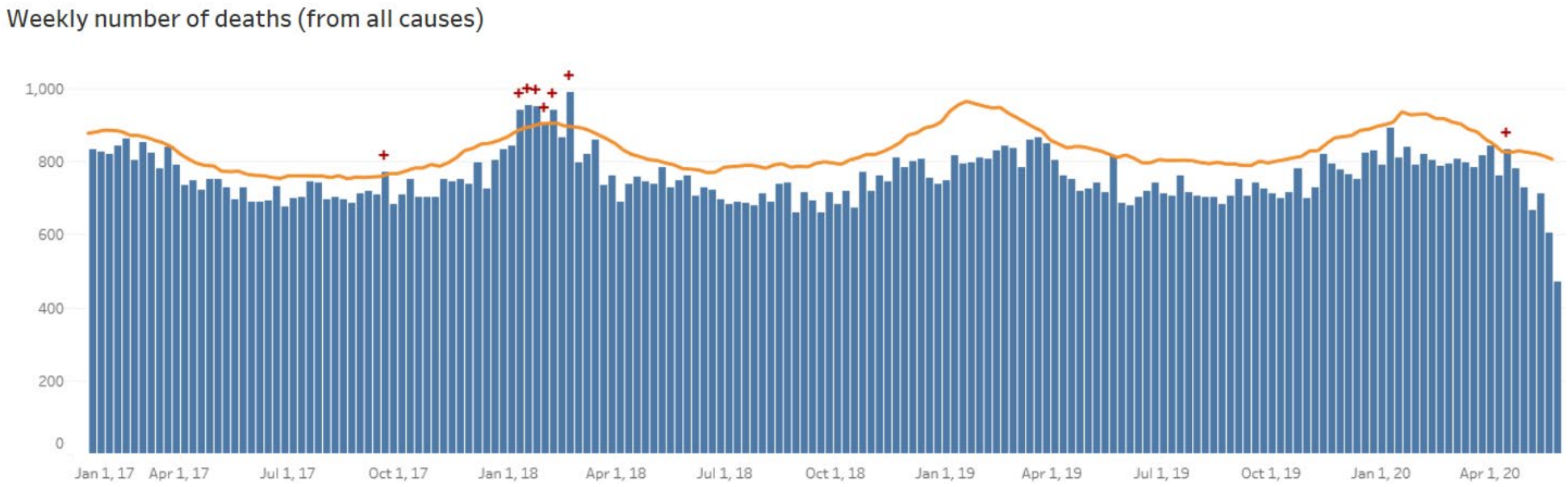


Data as of June 4, 2020.

Please note the different axes for new cases (top—from 0 to 350 for new cases) and new deaths (bottom—from 0 to 14 for new deaths). Additionally a 7 day lag has been applied to the trend line based on information collected to-date for 5/3 and 5/23 where within 7 days of onset date 90% of the cases had been reported.

Oklahoma Excess Death Analysis

+ indicates observed count above threshold
Predicted number of deaths from all causes
threshold for excess deaths



Source: CDC, National Center for Health Statistics, https://www.cdc.gov/nchs/nvss/vsrr/covid19/excess_deaths.htm#dashboard, June 4 2020 12pm.

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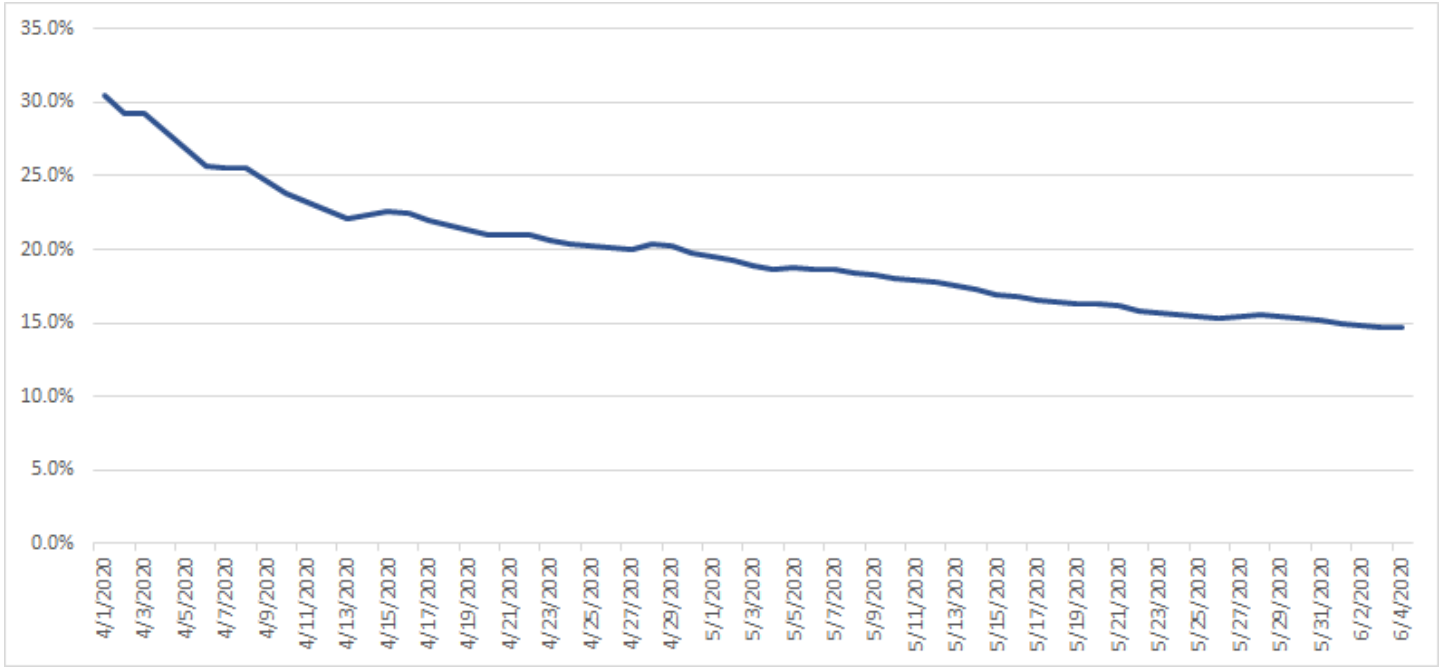
Cumulative Percent of Cases Ever Hospitalized (by date of report)



Source: OSDH Acute Disease Registry

TIME TO EVENT*

	N	Median	10th to 90th Percentile
Time from Symptom Onset to Test (Specimen Collection)[1,2]	3,851	4 days	0-14 days
Time from Symptom Onset to Hospitalization[1,3]	742	5 days	0-15 days
Length of Hospitalization Discharged Alive[4]	668	6 days	2-21 days
Length of Hospitalization Deceased[4]	221	8 days	2-23 days
Time from Symptom Onset to Death[1,5]	215	13 days	4-31 days

*Data as of June 4, 2020.

1. Limited to cases with a known date of symptom onset.
2. Limited to cases with a known date of a test (specimen collection) on or after the date of symptom onset.
3. Limited to cases with a known hospital admission date on or after the date of symptom onset.
4. Limited to cases with a known admission and discharge date from the hospital.
5. Limited to cases who are deceased.

DEMOGRAPHIC INFORMATION as of June 4, 2020

	Cases count (%)[1]		Deaths count (%)[1]		Cumulative Incidence Rate[2]	Cumulative Mortality Rate[2]
Oklahoma	6,907		344		175.2	8.7
Gender						
Male	3,241	(46.9)	177	(51.5)	165.9	9.1
Female	3,666	(53.1)	167	(48.5)	184.2	8.4
Age group						
Under 1- 4	98	(1.4)	0	(0.0)	37.6	
5-14	137	(2.0)	0	(0.0)	25.5	
15-24	764	(11.1)	1	(0.3)	142.1	0.2
25-34	1,119	(16.2)	2	(0.6)	206.0	0.4
35-44	1,100	(15.9)	4	(1.2)	224.3	0.8
45-54	961	(13.9)	13	(3.8)	208.8	2.8
55-64	1,047	(15.2)	47	(13.7)	212.2	9.5
65-74	759	(11.0)	91	(26.5)	211.6	25.4
75-84	515	(7.5)	88	(25.6)	274.4	46.9
85+	403	(5.8)	98	(28.5)	550.6	133.9
Unknown	4	(0.1)	0	(0.0)		
Race						
American Indian or Alaska Native	443	(6.4)	24	(7.0)	144.2	7.8
Asian or Pacific Islander	193	(2.8)	2	(0.6)	217.9	2.3
Black or African American	647	(9.4)	27	(7.8)	224.9	9.4
Multiracial/Other	288	(4.2)	8	(2.3)	69.6	1.9
White	4,510	(69.6)	265	(77.0)	158.5	9.3
Unknown	826	(12.0)	18	(5.2)		
Ethnicity						
Hispanic or Latino	1,404	(20.3)	11	(3.2)	327.2	2.6
Not Hispanic or Latino	4,568	(66.1)	284	(87.5)	130.0	8.6
Unknown	935	(13.5)	31	(9.3)		

1. Percentages may not add up to 100 due to rounding.
2. Rate per 100,000 population

HEALTHCARE & NON-HEALTHCARE

Status[1]	Non-Healthcare Worker count (%)*	Healthcare Worker count (%)*
Active	711 (12.1)	71 (7.0)
Deceased	339 (5.8)	5 (0.5)
Recovered	4,843 (82.2)	938 (92.5)
Total	**5,893**	**1,014**

* Percentages may not add up to 100 due to rounding.
1. Data as of June 4, 2020

CASES & DEATHS BY LONG-TERM CARE AND CORRECTIONAL FACILITIES

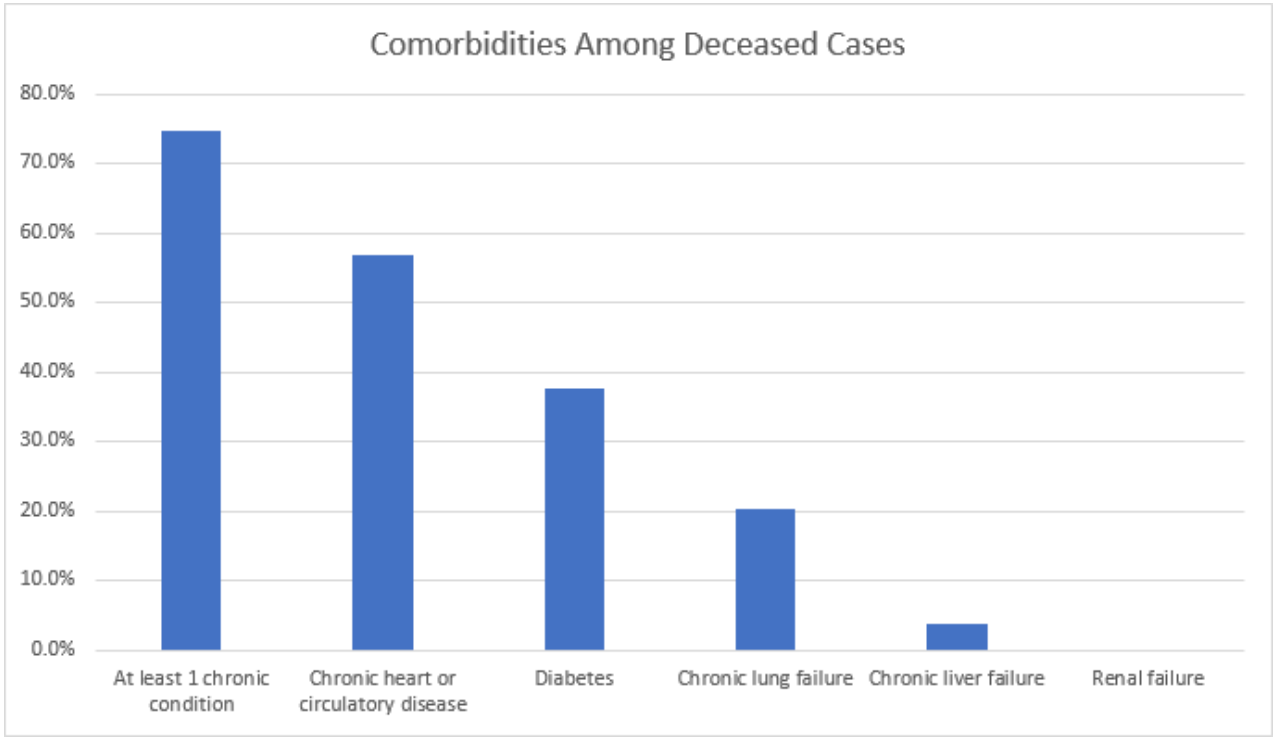
		Cases	Deaths
LTCF[1,2]			
	Residents	915	181
	Staff	552	3
Total		**1,458**	**184**
Correctional Facilities[2,3]			
	Inmates	325	2
	Staff	57	0
Total		**382**	**2**

1. Long term care facility or nursing home
2. Data as of June 4, 2020..
3. Correctional facilities include prisons, jails, and juvenile detention centers.

COMORBIDITIES AMONG DECEASED CASES

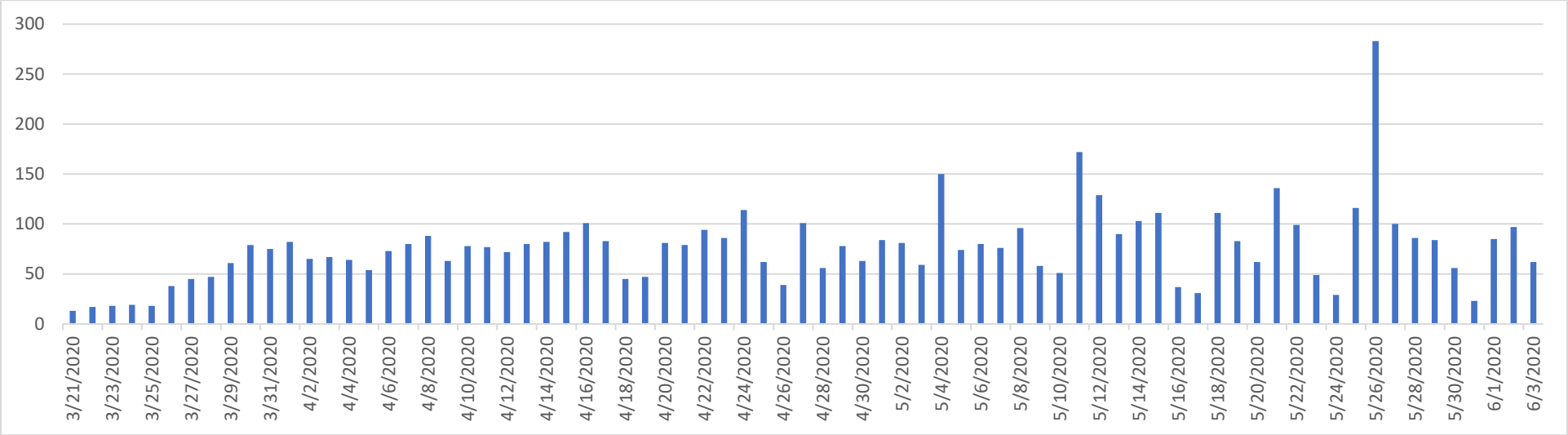
Comorbidities	Number (%)
At least 1 chronic condition*	257 (74.7)
Chronic heart or circulatory disease	196 (57.0)
Diabetes	130 (37.8)
Chronic lung failure	70 (20.4)
Chronic liver failure	13 (3.8)
Renal failure	0 (0)

*Chronic conditions include; chronic heart or circulatory disease, diabetes, chronic lung failure, chronic liver failure and renal failure



RECOVERED CASES

Distribution of **recovered cases of COVID-19**, March-June 2020, Oklahoma

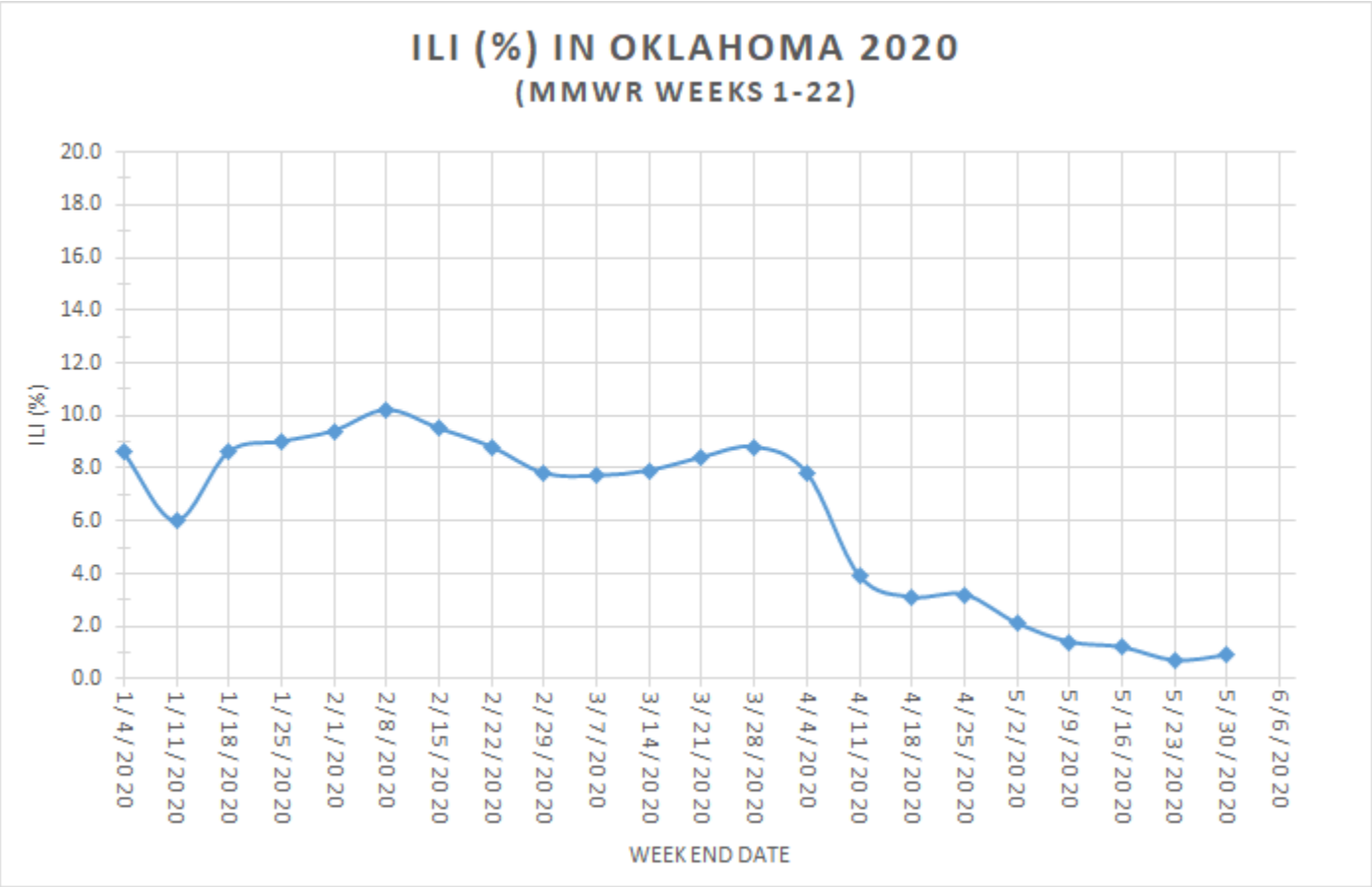


Note: A recovered case is an individual currently not hospitalized or deceased AND 14 days after the onset of symptoms

Symptoms Criteria

Downward trajectory of influenza-like illnesses (ILI) reported within a 14-day period

Weekly percentage of **Influenza-Like Illness (ILI)** (%), Morbidity and Mortality Weekly Report, Oklahoma, Jan–May 2020



Interpretation: Data on Influenza-Like Illness shows a slight increase in the daily number and weekly percentage of influenza-like illness cases in the past week.

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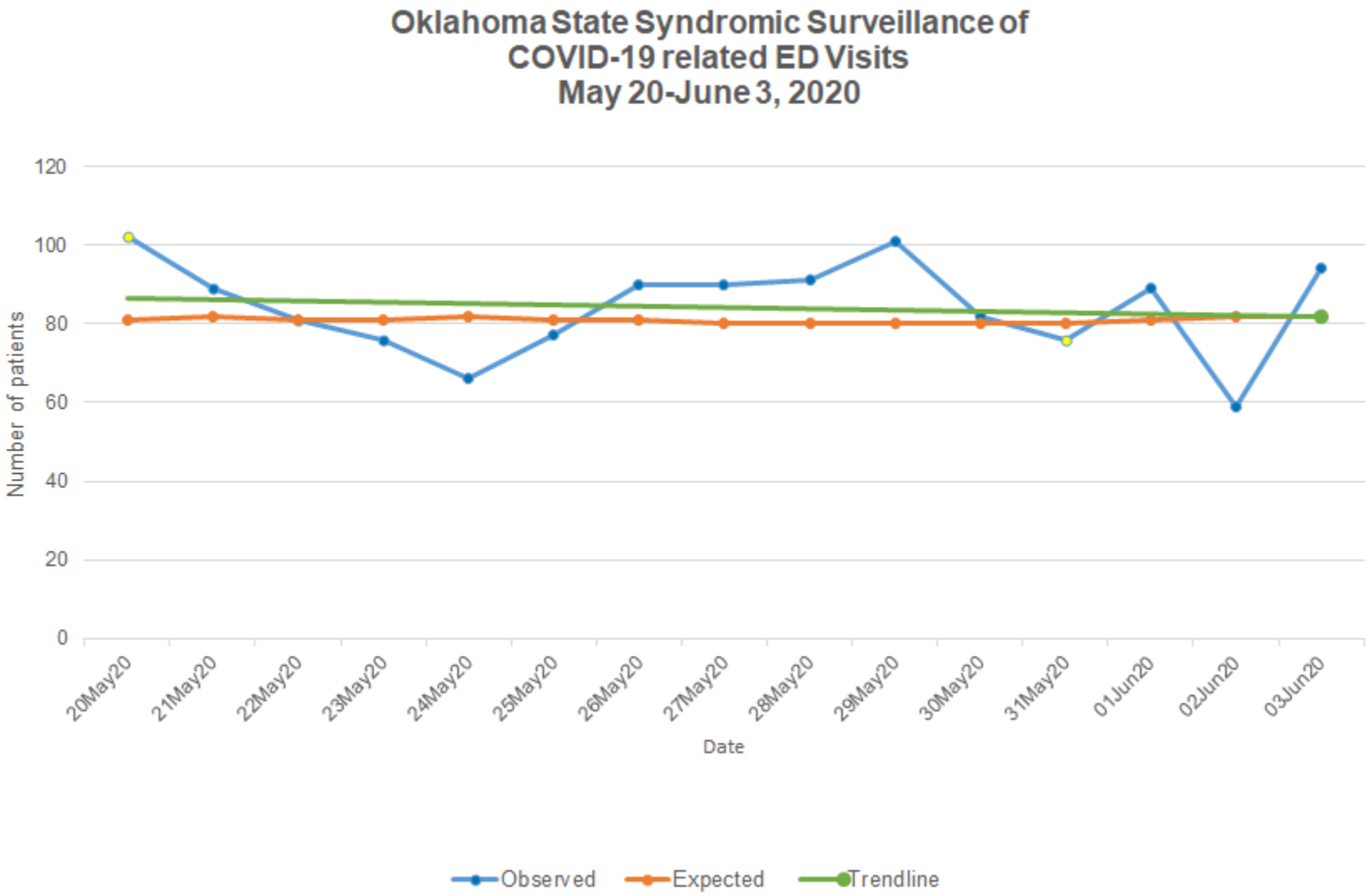
Slight downward trajectory of covid-like syndromic cases reported within the past 14-day period

COVID-19 Related Emergency Department Visits, Oklahoma State Syndromic Surveillance, May 20-June 3, 2020

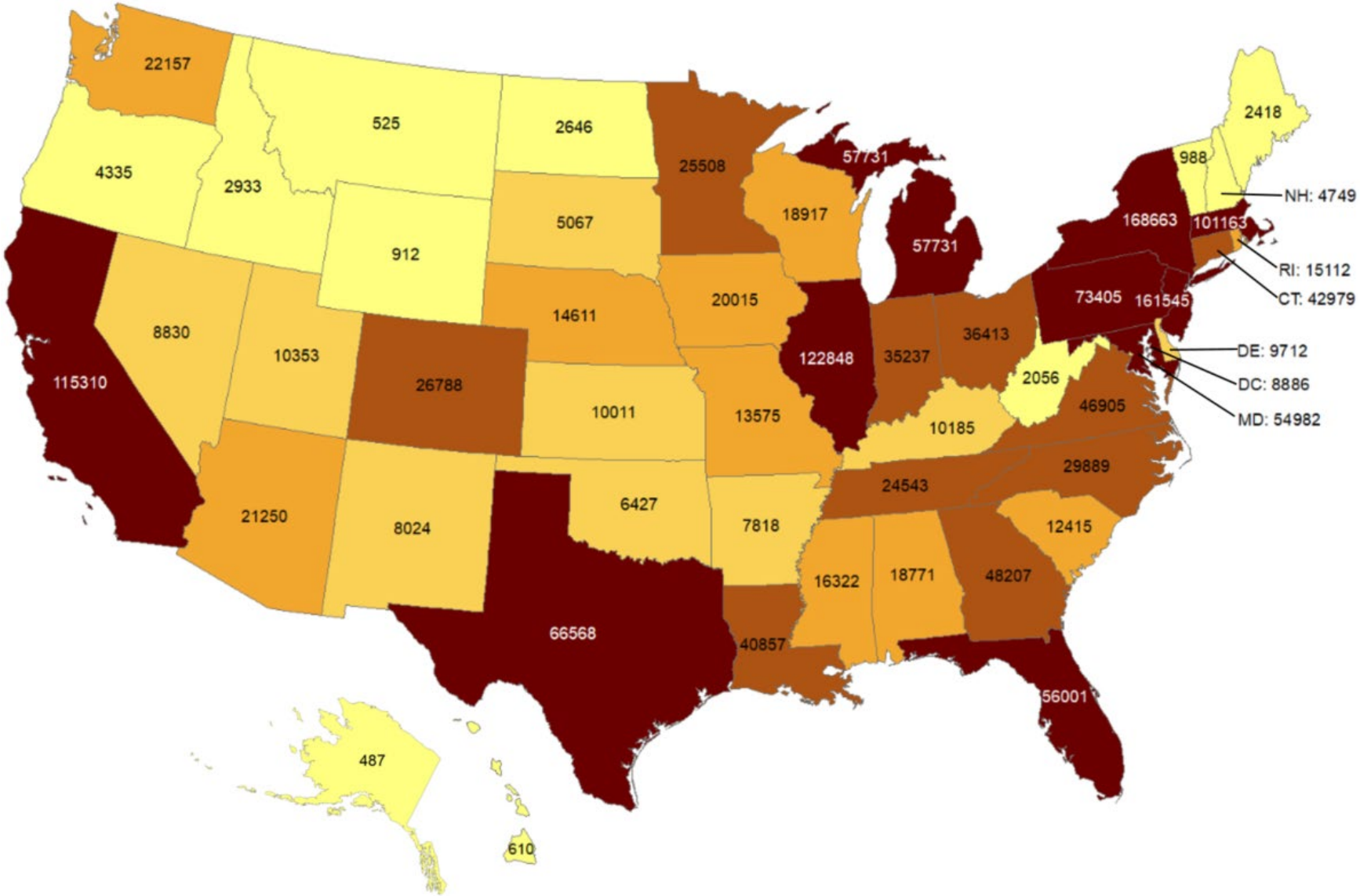


Interpretation: Data from syndromic surveillance shows a slight decrease in the number of COVID-19 related emergency department visits in the past 2 weeks.

OKLAHOMA IN COMPARISON

Total number of reported COVID-19 cases

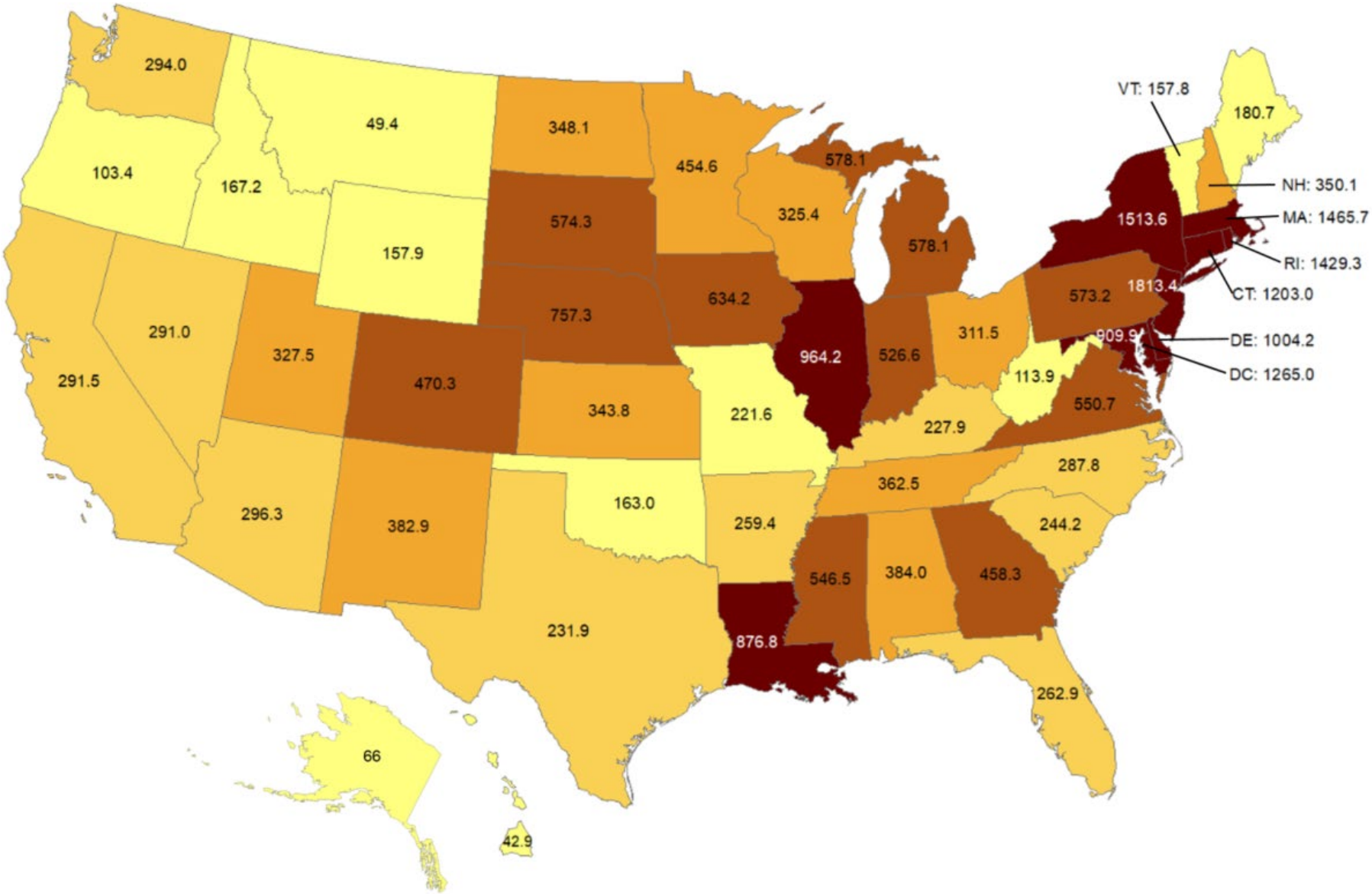
Oklahoma ranks **39** (out of all States and DC) in the total number of reported COVID-19 cases in the US.



Data from CDC. Available at https://www.cdc.gov/covid-data-tracker/index.html
Data as of June 3, 2020

Cumulative incidence of reported COVID-19 cases

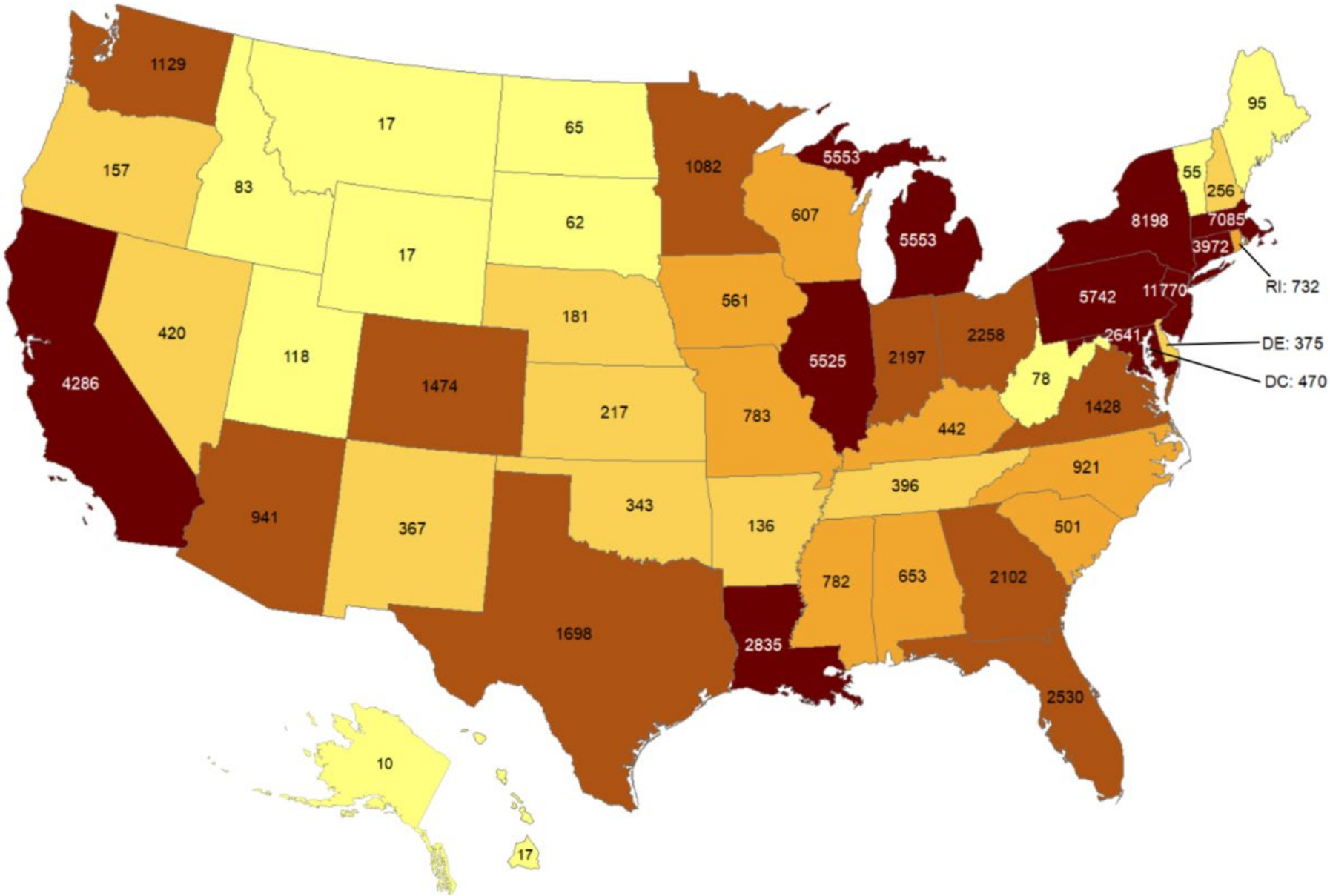
Oklahoma ranks **45** (out of all States and DC) in the cumulative incidence (per 100,000 persons) of reported COVID-19 cases in the US.



Data from CDC. Available at https://www.cdc.gov/covid-data-tracker/index.html
Data as of June 3, 2020

Total number of reported COVID-19 deaths

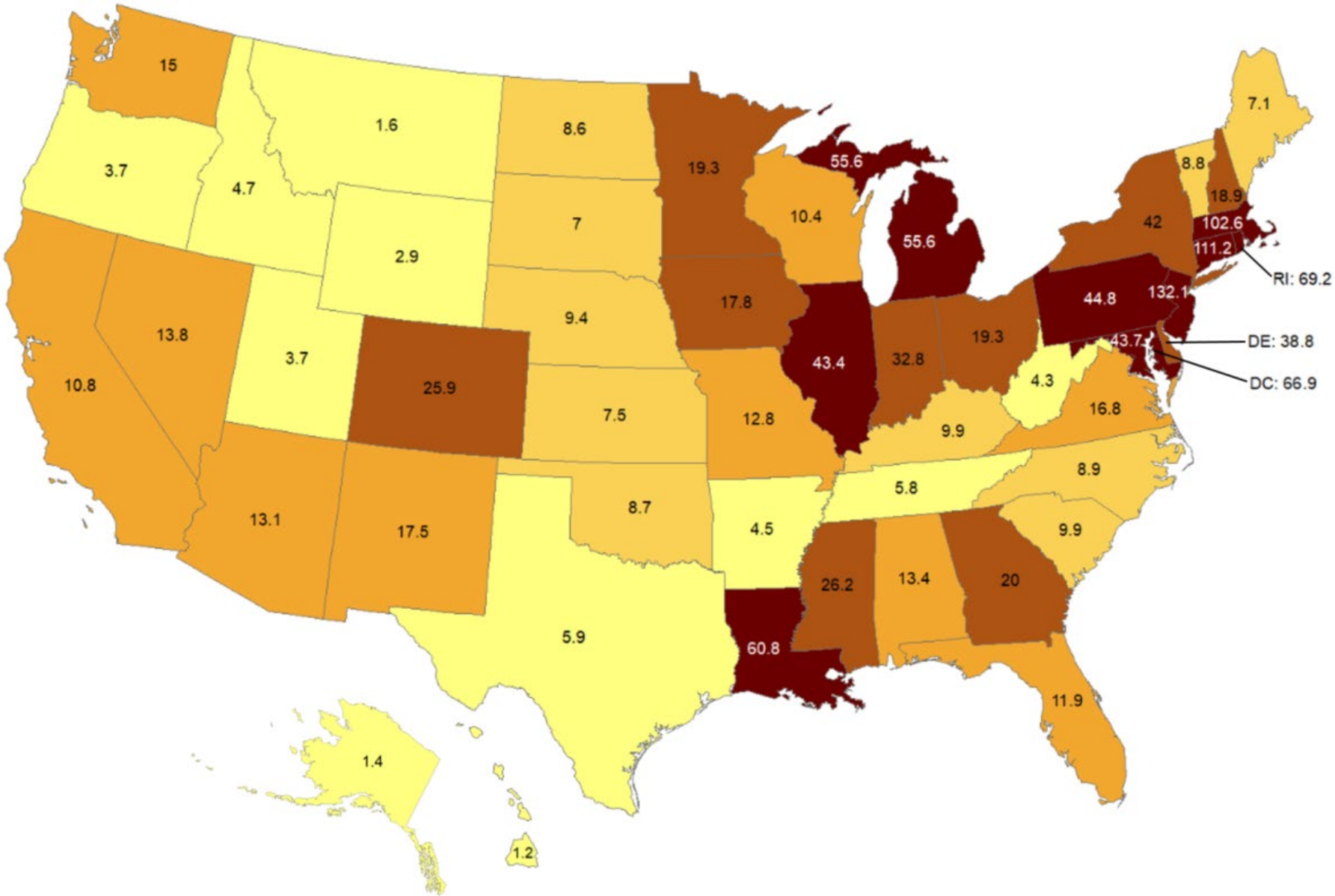
Oklahoma ranks **35** (out of all States and DC) in the total number of reported COVID-19 deaths in the US.



Data from CDC. Available at https://www.cdc.gov/covid-data-tracker/index.html
Data as of June 3, 2020

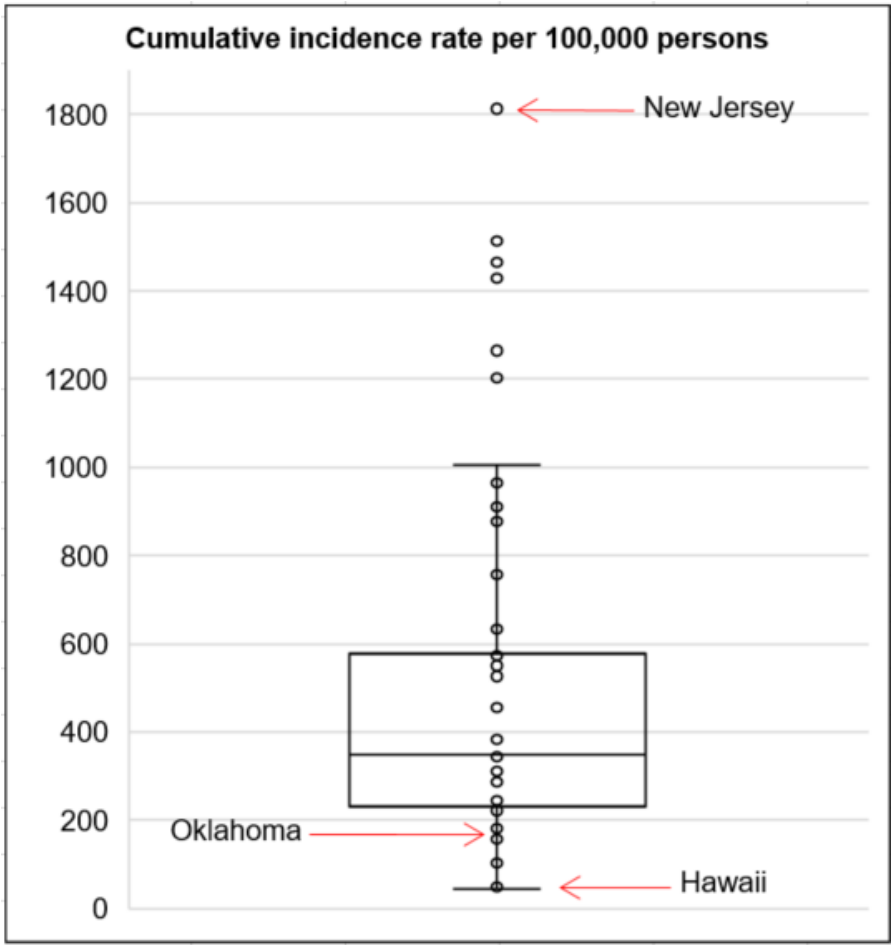
Cumulative death rate of reported COVID-19 cases

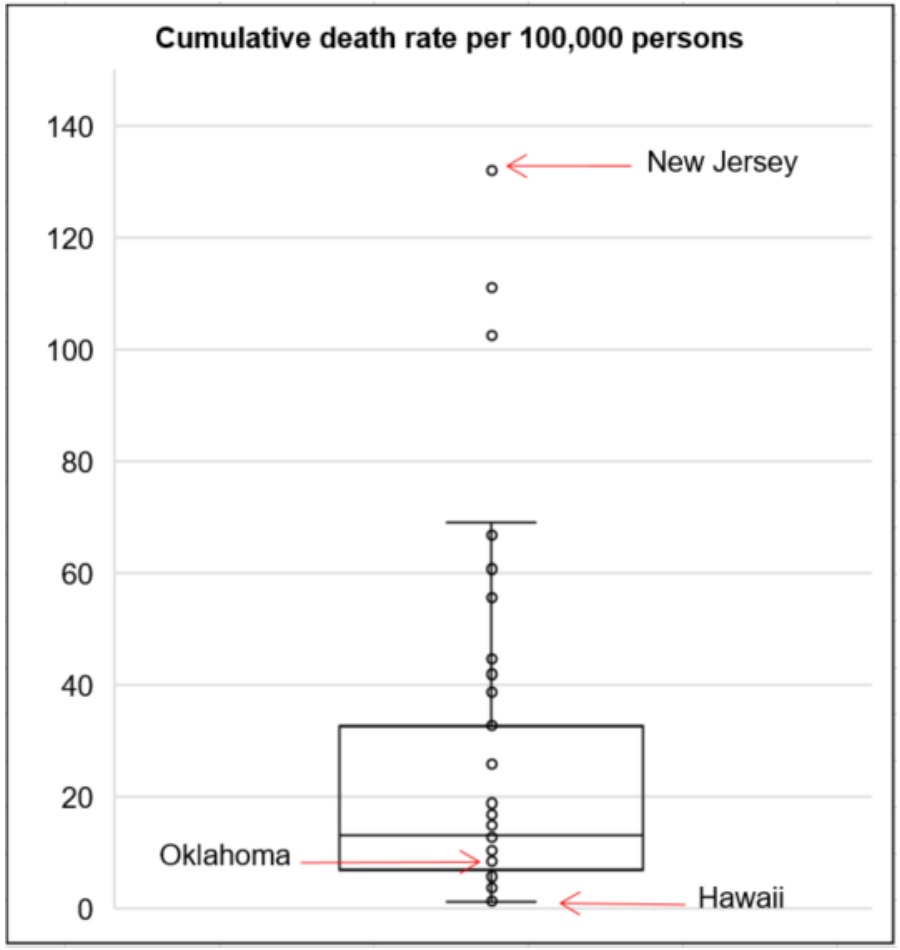
Oklahoma ranks **36** (out of all States and DC) in the cumulative death percent of reported COVID-19 cases in the US.



Data from CDC. Available at https://www.cdc.gov/covid-data-tracker/index.html
Data as of June 3, 2020

Cumulative incidence and cumulative death rate of reported COVID-19 cases





Interpretation: Oklahoma has cumulative incidence and cumulative death rate **below the median** of the US.

ACKNOWLEDGEMENT

The weekly report is made by possible through the efforts of county and city public health and healthcare professionals.

NOTES

Every effort is made to ensure accuracy and the data is up-to-date for the time period reported.
For daily updates on COVID-19, please visit https://coronavirus.health.ok.gov/