HAWAII STATE DEPARTMENT OF HEALTH

Long Term Care and COVID-19:
What to Expect If There is a Case in Your Facility

Before a Case Occurs

- Provide the Hawaii Department of Health (HDOH) Disease Outbreak Control Division (DOCD) Healthcare Associated Infections (HAI) Team with emergency contact information for your facility administration and infection control (able to respond within 1 hour). Please email the name, title, and 24/7 contact telephone number for the person(s) you designate to receive urgent case notifications from HDOH to Caitlin Cook, HAI Epidemiologist (Caitlin.Cook@doh.hawaii.gov).
- Know HDOH's telephone numbers for reporting a COVID-19 case:
  Oahu (Disease Reporting Line): (808) 586-4586
  Maui District Health Office: (808) 984-8213
  Kauai District Health Office: (808) 241-3563
  Hawaii District Health Office: (808) 933-0912
  After Hours (Physician's Exchange): (808) 600-3625 or call Toll Free 1-800-360-2575

- Have a COVID-19 Response Plan in place (CDC guidance can be found here). Response plans should address:
  - Infection control measures to prevent introduction and transmission of COVID-19 within your facility
  - Active symptom-based surveillance of both residents and staff
  - Exclusion policies for symptomatic staff
  - Isolation and cohorting strategies (cohorting should address both residents and staff)
  - Personal protective equipment supply and usage
  - Testing plan
- The HAI Team is available to provide technical guidance on facility Response and Testing Plans for COVID-19. Email Caitlin Cook at Caitlin.Cook@doh.hawaii.gov.

When a Case Occurs: Initial Steps

I. Notification to HDOH/HDOH notification to facility – Report by telephone to a live person (not voicemail) as soon as a provisional or confirmed diagnosis of COVID-19 is established in a resident or staff member at a long-term care facility (LTCF) or assisted living facility (ALF).

II. Gather Information

   - Note: A HDOH investigator will interview the case to obtain information listed below. Facilities can assist by reviewing records and providing detailed information they may have on schedules, census, and work duties.

- **COVID-19 case in an employee**
  - **Employee information:**
    - Where does case work? Do they stay on one unit, or do they "float"?
    - What is their role
    - Who else works with the employee, including shared spaces (office, workroom, breakroom, meals)
    - Did employee adhere to:
      - Universal source control (face coverings)
      - Physical distancing measures during work activities
    - Does employee work in other healthcare facilities or non-healthcare related jobs
    - Does employee carpool/socially interact with co-workers?
    - How are the nursing stations arranged, do staff sit near each other?
  - **Staffing schedules**
    - Determine which employees shared shifts, had "huddles" or group meetings, where employees may have had closer interactions in the 14 days prior to symptom onset.
  - **Close contacts**
    - Identify all individuals who had close contact[1] with the case within 2 days prior to symptom onset and after onset of symptoms.
    - **Does the case have any direct contact with residents**
      - Even for auxiliary or administrative staff, consider potential direct interactions with residents (e.g., administrator may cover a nursing shift). Types of activities and PPE worn may determine whether those interactions would constitute close contact.

- **COVID-19 case in a resident**
  - **Resident information:**
    - Where and with whom does the resident reside
      - Proactively print the daily patient room assignment map and save each day's for at least two weeks.
      - Room number, roommates.
      - Review census to determine whether resident was transferred between rooms within the last 14 days, with particular attention to the 2 days prior to symptom onset.
      - Does the resident share a bathroom with anyone, including "Jack-and-Jill" style bathroom?
      - Were they taken outside of the facility for any reason (i.e., dialysis)?

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[1] Close Contact definition (based on latest CDC guidance last updated May 29, 2020): Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. Until more is known about transmission risks, consider an exposure of 15 minutes or more as prolonged. However, **any duration** should be considered prolonged if the exposure occurred **during performance of an aerosol generating procedure**, such as: open suction of airways, sputum induction, cardiopulmonary resuscitation, endotracheal intubation and extubation, non-invasive ventilation (e.g., BiPap, CPAP), bronchoscopy, and manual ventilation. It is uncertain whether aerosols generated from some procedures (e.g. nebulizer administration, high flow O2 delivery) may be infectious.

- **Staffing schedules**
  - Compile list of all healthcare personnel who provided direct care to the patient within the last 14 days, with particular attention to the 2 days prior to symptom onset.

- **General information to collect for cases in employees and residents**
  - **Onset date**
    - Work with HDOH to determine case's illness onset date. The case's infectious period is considered to be from 2 days prior to their first symptom onset until clearance from isolation[2, 3].
  - **Absentee logs**
    - Review employee absentee logs to determine if other staff have called out sick starting from 14 days prior to the case's illness onset, particularly those who may have had close contact or worked in the same area as the case.
  - **Hospital transfers**
    - Review records of all residents transferred to hospitals starting from 14 days prior to the case's illness onset. Note any with unexplained fever or new onset of respiratory symptoms. Records may need to be requested from the hospital to confirm diagnoses.

III. Infection Control Mitigation Measures

a. HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset

☐ Determine which residents received direct care from and which HCP had unprotected exposure to an HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset.

- Residents who were cared for by the HCP under investigation should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of HCP COVID-19 testing are known. If the HCP is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.
- Exposed HCP should be assessed for risk and need for work exclusion.

b. Resident with new-onset suspected or confirmed COVID-19

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[2] Clearance from isolation of healthcare personnel: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fhcp-return-work.html

[3] Clearance from isolation of Residents: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

☐ Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of SARS-CoV-2 testing.

- Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit).
- If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission.

☐ If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.

☐ Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit).

- Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.

☐ Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented.

☐ Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections.

- Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.

☐ Counsel all residents to restrict themselves to their room to the extent possible.

☐ HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents.

- If HCP PPE supply is limited, implement strategies to optimize PPE supply, which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated. Broader testing could be utilized to prioritize PPE supplies (see section on using testing).

☐ Notify HCP, residents, and families and reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning).

- Promptly (within 12 hours) notify HCP, residents, and families about identification of COVID-19 in the facility :
  - Provide educational sessions or handouts for HCP, residents, and families
  - Maintain ongoing, frequent communication with residents, families, and HCP with updates on the situation and facility actions
- Monitor hand hygiene and PPE use in affected areas

☐ Maintain all interventions while assessing for new clinical cases (symptomatic residents):

- Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions.
- If testing is available, asymptomatic residents and HCP who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing
- The incubation period for COVID-19 can be up to 14 days and the identification of a new case within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.

IV. Communication

- Notification of Residents and Staff
  - The facility must notify residents (and their families) and staff of any identified case(s) among residents or staff at the facility within 24 hours of becoming aware of the case, per CMS guidelines.
  - Per CMS guidance, the notification should include:
    - Information or update on each new case identified, or whenever 3 or more residents or staff with new onset of respiratory symptoms are identified within 72 hours of each other
    - A description of infection control mitigation measures enacted
    - No personally identifiable information
    - See https://www.cms.gov/files/document/qso-20-29-nh.pdf for full specifications of notification requirements.
  - Please share a copy of your notification letter with DOCD to ensure accuracy of case details and messaging.
  - It might be helpful to have an updated listserv of email addresses of patients' families or representatives to easily disseminate information.

        - Consider special notification to the medical directors, physicians and nurse practitioners who work at the facility
            - Facility administrator or designee should call the attending physician for the case and the medical director for the facility
            - Consider a town-hall style meeting with all providers
        - Ensure you report to the National Healthcare Safety Network (NHSN)

    - Notification of Other Facilities

        - HDOHD roles and responsibilities
            - DOCD will inform additional facilities if made aware of a case or close contact of a case who also works or was transferred to/from another facility within the relevant time period (e.g., infectious period, quarantine period). DOCD may also make inquiries at other facilities, which may require disclosure of the case's identity, if a case was present at another facility prior to their infectious period and the source of infection is unknown.
            - DOCD will disclose only as much information, to the minimum parties necessary, as is needed to complete a case or cluster investigation and to prevent spread of infection, based on the facts known about the case or cluster.
            - DOCD and the facilities are responsible for protecting the identity of individuals involved in a case investigation.

        - Facility roles and responsibilities
            - Facilities are mandated by law to report certain infections, diseases and conditions to DOCD (including COVID-19).
            - Facilities must notify receiving facility upon transfer of a patient with known or suspected COVID-19 infection.
            - Except for required patient and resident notifications, interfacility transfer notifications, and notifications deemed necessary for public health investigation and response, facilities may choose to disclose the existence of resident and staff COVID-19 cases (without identifying information) at their facility by mutual agreement. Factors to consider when determining what, when, and how information will be disclosed:
                - Workforce capacity
                - Compensation / rights of workers who might be excluded as a result of notifications
                - Patient, family, and staff anxiety, heading off rumors
            - It might be helpful for the facility to have a vendor list compiled ahead of time in order to promptly communicate to vendors

        - Healthcare Association of Hawaii's roles and responsibilities include serving as a potential mediator of case disclosures between and among facilities. HDOH encourages adaption of the best-practice of transparent communication between facilities.

- Media
  - DOCD criteria to issue a press release include:
    - If the epidemiologic investigation reveals a threat to general public, or
    - If a press release is the best means to detect additional cases or prevent spread of disease.
  - If these conditions are not met, DOCD typically defers to impacted facility regarding release of investigation details and facility name to the public.
  - Given heightened public concern regarding COVID-19 and the likelihood that resident notifications will result in public knowledge, proactive media statements are strongly recommended, to provide timely and accurate information and assessment of risk.
  - DOCD will work with facilities to provide feedback on notification letters and media statements prepared by facilities.
  - When possible, DOCD will share HDOH-prepared media statements with facilities ahead of their release.
  - TIMING OF NOTIFICATIONS AND PRESS STATEMENTS BY HDOH: HDOH's top priority is always to prevent spread of infection. While communication is part of this process, there may be critical information to be gathered or actions to be taken before communication messages can be disseminated. It is important to allow enough time for collection of accurate information so that appropriate messages can be shared. Additionally, it is preferable for residents and families to hear about a case from the facility first and not from news media.

V. Testing

- Facilities should have testing plans in place that address:
  - **Triggers for testing**
    - Active Surveillance for COVID-19-like Illness should include testing of staff, residents, or visitors who report any symptoms compatible with COVID-19 (fever, cough, chills, body aches, sore throat, headache, runny nose, loss of sense of taste or smell, diarrhea or vomiting). For residents, any change in mental or functional status is also a reasonable trigger for testing.
    - In response to a case identified within the facility (resident, staff, or visitor), HDOH recommends testing all residents and staff who had direct contact with the case or resided/worked on the same unit as the case in the 14 days prior to the case's symptom onset. Staff who may share breakroom space with an employee case should also be tested. However, only close contacts of a case require quarantine or exclusion from work.
    - In the absence of a known case within the facility, periodic point prevalence surveys (testing all or part of a facility's staff and/or residents (regardless of symptoms) may be considered. Refer to this guidance from CDC.
  - **Specimen collection logistics**
    - Staff trained on specimen collection, handling, and labeling (Consider use of paraffin seal to prevent leakage)

        - Refrigerator space for specimen storage if samples cannot be transported immediately
        - Adequate staffing to complete necessary paperwork if many residents will be tested
        - Designated person who will order the testing and determine how results will be communicated?
        - A line list or table, containing key information of all individuals tested, to facilitate notification of results to facility administration and HDOH, and interpretation of results to guide next steps
            - Note unit/room, resident vs. staff, role (if staff), date of specimen collection, result date, and result value (positive/negative).
            - Assess each person tested for symptoms and document the presence/absence of symptoms on the line list, as well as specific symptoms if present
    - **What laboratory will perform the testing?**
        - Can a rapid turnaround time (results provided on the same day or next day) be guaranteed? (avoid out-of-state send-outs)
        - Weekend availability
    - **Does the testing plan differ for residents and staff?**
        - If testing plans differ, explain the distinction.
    - **Who to test?**
        - HDOH investigation may dictate targeted testing of certain groups, depending on the epidemiology of the case(s)
        - Will the facility plan to offer testing to residents and staff beyond those groups recommended by HDOH?
    - **What actions will take place if positive test results are identified?**
        - Cohorting plans; is there an existing COVID-19 unit or how will COVID-19 unit be stood up?
        - Staff floating restrictions
        - Remind staff not to carpool with other employees
        - Isolation precautions; will additional PPE be required?
        - In-service training and education to address suspected modes of transmission
- Testing at HDOH State Laboratories Division is available for the purposes of case and cluster investigations
    - SLD testing prioritized for groups of staff or residents who were close contacts of a case, or who were not close contacts but work/reside within same unit or area as a case
    - Based on findings of case/cluster investigation or initial testing, additional groups may be prioritized for testing at SLD
    - 24-hour turnaround for results from time of specimen receipt at SLD
    - HDOH is working to establish direct courier services to SLD for priority specimens; in the meantime, pickup by investigation staff can usually be arranged
- Swab Teams

- If no on-site nursing staff are trained in or available for NP swab specimen collection, Hawaii National Guard Swab Team can be activated for specimen collection for HDOH investigation purposes. HAI Team will discuss this option with facilities when an investigation is initiated.

HDOH acknowledges and thanks Hale Nani Rehabilitation and Nursing Center for their valuable input on this document.