Novel Coronavirus 2019 (COVID-19) Health Care Isolation Center Plan – FINAL UPDATED April 16, 2020

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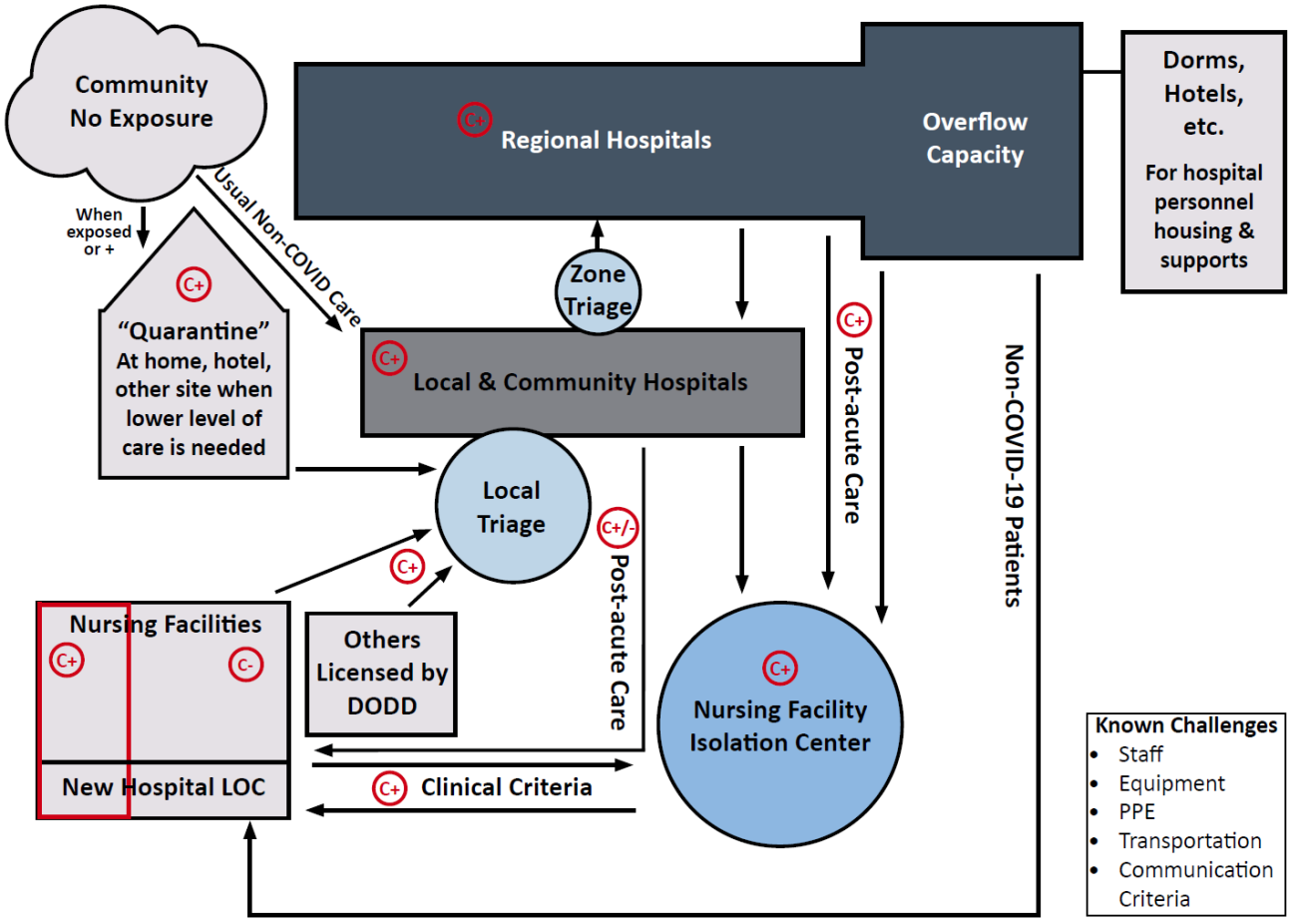
I. Introduction

The Health Care Isolation Center Plan was developed to provide guidance to local level congregate facilities within each Regional COVID-19 Planning Zone for the establishment of centers that specialize in the care of patients with active or convalescent COVID-19 infection or who have other health care needs and require quarantine for up to 14 days following exposure to COVID-19 . These centers are called Health Care Isolation Centers (HCICs) and operate under the guidance of the Ohio Department of Health.

The following diagram portrays the relationship of HCICs with multiple other care sites. While much of the focus has been on the limited resources that hospitals may endure during a pandemic, the role of caring for individuals at home as well as in nursing facilities and other congregate care sites remains critical to controlling common sources of infection. As such, HCICs may provide significant relief for post-acute hospital care as well as for long term care facilities unable to maintain sufficient clinical support for residents.



One of the most critical public health actions the health care system can take during a pandemic is to expeditiously identify individuals with COVID-19 infection and immediately isolate them to prevent further spread. A second step is to trace all contacts who may have been exposed and quarantine them for a 2week period of observation to monitor them for signs of illness before letting them return safely to the general public. The following diagram describes the segments of the population according to COVID-19 status

Patient/Resident COVID-19 Status

One of the most important things we can do during this public health crisis is to identify and physically separate individuals based on their exposure to and contraction of COVID-19. This action is necessary to prevent the spread of the infection to both patients/residents and health care personnel. With this in mind, patients/residents should be divided into the following three status categories: no exposure, exposed, and COVID-19 +.

No Exposure
No Symptoms

Many residents appear well and are able to receive care as they would under usual circumstances. Even with these individuals, staff should create a culture of safety and practice vigilant sanitation and cleaning (e.g. frequent handwashing, daily sanitation) and staff interacting with non-exposed patients/residents should wear facemasks.

Exposed
No Symptoms

A subset of patients/residents will be been notified by the local health district and/or will have known direct contact for an extended period of time with someone who has contracted COVID-19. These individuals require careful monitoring for a 14 day period, and additional PPE should be used when interacting with people in this status.

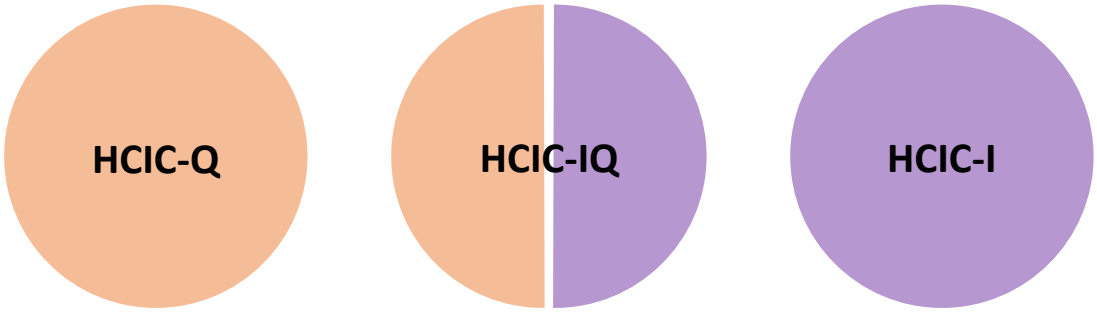
COVID-19 +
Confirmed or Suspected

At this point in the pandemic, all people who have respiratory symptoms and those who have tested positive for the illness should be carefully assessed and monitored for escalating symptoms. We realize that this categorization is not perfect, as the CDC recently acknowledged that people who have COVID-19 are infectious 2 days before symptoms appear. With an abundance of caution, we recommend additional required PPE when working with these individuals, as outlined in this document.

The HCIC plan anticipates that these centers will be established at the local level through collaboration with a coalition of local partners and with regulatory and operational guidance from the State of Ohio. If the resource needs of a locally managed HCIC are unable to be met by local sources, the State of Ohio will assist through the process outlined in Appendix 4.

II. Definitions

- **Health care Isolation centers (HCICs)** provide a "COVID-19 level of care" and/or a "quarantine level of care." HCICs will be categorized as follows:
    - An HCIC-Q will provide only a quarantine level of care (services for the individuals shown in orange above).
    - An HCIC-I will provide only a COVID-19 level of care (services for the individuals shown in purple above).
    - An HCIC-IQ will provide both a quarantine level of care and a COVID-19 level of care (individuals shown in orange and purple above) in separate units.



Additionally:

- For the COVID-19 level of care, HCIC-Is and HCIC-IQs will both serve individuals post-hospitalization who are not yet ready to return to their prior residence due to medical and/or isolation needs, as well as individuals who cannot receive needed care with isolation in their congregate setting, but whose level of need does not rise to the level of hospitalization, are also candidates for the HCIC-Is and HCIC-IQs

  - Quarantine level of care is provided in HCIC-Qs and HCIC-IQs for individuals exposed to COVID-19, who in addition to needing nursing facility care, require physical separation from both asymptomatic non-COVID residents as well as from those residents who have COVID-19. Often these residents are awaiting further evaluation and testing and require different infection control precautions.
  - No HCICs should be used for clinically stable individuals who can be treated safely where they live (including a NF).
  - All HCICs, regardless of category, must be located in a physically separate space.
  - There may be HCIC-Is and HCIC-IQs that can provide ventilator-level care, but many will not be able to provide this level of respiratory support.

- **Congregate settings** include nursing facilities, residential care facilities and other designated facilities where individuals reside and receive services.
- **COVID-19 Community Provider** is any HCIC that the Director of the Ohio Department of Medicaid designates as such in accordance with Section 14 of Am. Sub. H.B. 197 passed the 133rd General Assembly. Not all HCICs recommended by the Ohio Department of Health may be designated as a COVID-19 Community Provider. An HCIC-I, an HCIC-Q, and an HCIC-IQ may be designated as a COVID-19 Community Provider.
- **COVID-19 level of care** requires a level of care comparable to that required for admission to a nursing home, a COVID-19 diagnosis (tested or probable[1]) and a physician order.
- **COVID-19 care needs** can be classified in the following 5 levels:
  - Individuals at the **quarantine level** have been exposed to COVID-19 but have no symptoms and do not have a probable or positive COVID-19 diagnosis. They should be monitored closely for symptoms for up to 14 days after exposure, in keeping with public health guidance.
  - Individuals at **Level 1** have minor symptoms. The preference is that individuals at level 1 remain in their residences (including nursing facilities).
  - Individuals at **Level 2** require oxygen or other respiratory treatment. They should be monitored carefully for signs of deterioration.
  - Individuals at **Level 3** do not require hospitalization in all cases but may require care beyond a traditional NF's capacity. This may include ventilator and other medical care if the HCIC-I or HCIC-IQ can safely provide care to the individual.
  - Individuals at **Level 4** are individuals at meet Level 3 requirements who are deteriorating and require hospitalization. They require urgent assessment by medical personnel and may require intensive care.
- **Health care facility** is a licensed and/or certified facility that provides medical care.
- **Quarantine level of care** requires a level of care comparable to that required for admission to a nursing home, exposure to COVID-19 which requires quarantine, and a physician order.

[1] On April 5, 2020, the Council for State and Territorial Epidemiologists developed a definition of COVID-19 cases which referenced "probable" cases. Previous versions of this document referred to these individuals as having "presumptive" or "presumed" diagnoses.

III. HCIC Purpose

All HCICs can play an important role in Ohio's response to COVID 19 by relieving pressure on the hospital systems for post-acute care, as well as support existing health care personnel and resources by delaying or avoiding a hospitalization. There is a strong preference to manage the spread of COVID-19 by treating and/or quarantining individuals in place whenever possible, including in nursing and other congregate facilities, although in some circumstances HCICs may be needed.

HCIC-Is and isolation units within HCIC-IQs only serve individuals with active COVID-19 infection requiring health care services with a COVID-19 level of care equaling level 1 through 3 (*not a COVID-19 quarantine level of care)*. HCIC-Is and isolation units within HCIC-IQs will provide the medical care required for the full convalescence of the COVID-19 infection. There may be HCIC-Is and HCIC-IQs that can provide ventilator-level care.

HCIC-Qs and quarantine units within HCIC-IQs provide an environment where individuals with other health care needs can safely be quarantined following exposure to COVID-19 (*i.e. COVID-19 quarantine level of care*.)

All HCICs will be strategically located within the existing public health hospital zones (Appendix 4):

- Zone 1: Northeast, Northeast Central and Northwest
- Zone 2: Central, Southeast Central and Southeast
- Zone 3: Southwest and West Central

IV. Assumptions

This is an evolving pandemic which has required the State of Ohio to declare a state of emergency. The following are assumptions related to the COVID-19 pandemic and HCICs:

Each HCIC will be developed and approved to meet the need within each public health hospital zone.

- There may be shortages of personal protective equipment (PPE) and medical supplies for HCIC staff.
- There may be health care staff with asymptomatic COVID-19 infection working in the HCICs in isolation and quarantine units, as individuals may be infectious before they develop symptoms.
- Individuals in HCICs will have significant health care needs related to COVID-19 and non-COVID-19 conditions.
- All HCIC-Is and HCIC-IQs must be able to provide level 3 care; not all HCIC-Is and HCIC-IQs will provide ventilator care.
- HCIC-IQs must operate separate and distinct units for quarantine care (orange level) and isolation care (purple leve). This includes designated staff and appropriate levels of PPE for each unit, as outlined in Appendix 5.

V. Individuals Served in HCICs

In order to limit the spread of the virus, long term care facilities, including HCICs, must separate individuals with COVID-19 exposure from individuals with probable or positive COVID-19 diagnoses. Admission to HCIC-I and isolation units within HCIC-IQs must be limited to individuals who either have a positive COVID-19 test result or a probable COVID-19 diagnosis. Admission to HCIC-Qs and quarantine units within HCIC-IQs must be limited to individuals who require NF services and infection control needs related to COVID-19 exposure.

- All HCICs must be prepared to admit individuals from congregate settings and hospitals. The HCIC may serve as a step-down setting after a hospital stay if necessary, to maintain isolation or quarantine needs, or meet clinical needs.
- Individuals admitted to the HCIC-I or the isolation unit within an HCIC-IQ must have a COVID-19 level of care 1-3.
- Individuals admitted to the HCIC-Q or the quarantine unit within an HCIC-IQ must have a COVID-19 quarantine level of care.
- Individuals admitted to all HCICs must have a physician's order.
- An individual with a quarantine level of care will have a 14-day maximum length of stay in the HCIC-Q or quarantine unit within an HCIC-IQ. Within 14 days, the individual should either be discharged safely to home (including an appropriate congregate setting) or receive a probable or positive COVID-19 diagnosis and be immediately transitioned to an HCIC-I or the isolation unit within an HCIC-IQ.
- No individual should be transferred to an HCIC if they are clinically stable and can safely be served in their home, including a congregate setting. The determination that someone can be safely served at home or in a congregate setting will be made by the treating clinician, in accordance with guidelines issued by the Ohio Department of Health.
- The operator of each HCIC must coordinate hospital transfers and discharges from the HCIC using the processes created in the Regional Zone.
- All HCICs will assume responsibility for discharge planning including:
    - Ensuring discharge from the HCIC is clinically indicated and aligned with the individual's preferences of care setting. Individuals may be discharged to home settings or congregate settings, such as nursing facilities. If the individuals were receiving services in a NF when they became ill with COVID-19 or needed to be quarantined with COVID-19, in most cases they should return to the same NF. A decision that discharge is appropriate will be made in accordance with guidelines issued by the Ohio Department of Health, Appendix 6.
    - Discharge from all HCICs requires a physician's order and must adhere to guidelines issued by the Ohio Department of Health. A discharge checklist can be found in Appendix 10.
- Transfer of an individual from any HCIC to a hospital requires coordination with the Regional public health Zone triage official (see the graphic above). A transfer checklist can be found in Appendix 9.
- Individuals treated at any HCIC are not candidates for experimental or novel therapies, such as untested drugs or multi-patient ventilator use.

VI. All HCIC Providers

- Only providers with a demonstrated history of providing care at acceptable levels of quality and safety will be considered as potential operators of all types of HCICs. A nursing facility on the Special Focus Facility list will not be considered as a possible operator of an HCIC. The operator's compliance history will be considered.
- When approving requests for approval as an HCIC, any necessary surveys will be completed. ODH will consider requests from the following:
    - A new health care facility ready for survey
    - A health care facility with a pending application
    - A health care operator/owner who has closed or vacant health care facility

  - A health care facility with unused/closed floor or wing which can be dedicated to this HCIC only, must be able to be closed off from other parts of the building and have dedicated staff which is not shared between the 2 areas
  - A Residential Care Facility which was previously a NH which could be easily converted back with minimal interruptions to current residents
  - A health care facility who has recently decreased their capacity and can increase capacity with minimal movement of current residents. The HCIC must be able to be closed off from other parts of the building and have dedicated staff.
  - A health care operator/owner who could consolidate residents into one building freeing up space in another building
- All HCICs must have access to all medications prescribed for their patients, including oxygen, bronchodilators and associated supplies.
- Staff working in any HCIC can only work in that HCIC during the time the HCIC is opened. An HCIC-IQ must have separate staff dedicated to each unit (i.e. separate staff for the quarantine unit and separate staff for the isolation unit.)
- The staffing plan for an HCIC should not create staff shortages at other facilities or home and community based service providers operated by the HCIC operator.
- The HCIC should have adequate supplies of PPE in accordance with current procurement plans and protocols.
  - Primary responsibility for meeting PPE requirements rests with the HCIC.
  - Existing public health hospital zones are responsible for assisting the HCIC in meeting the needs of individuals, as appropriate.
  - PPE contingency and crisis planning and use should be done in accordance with the guidance in Appendix 5
  - Per the information in Appendix 5, use of PPE items may be subject to extended use and reuse per state guidance.
- If available, PPE for an HCIC-Q and a quarantine unit in an HCIC-IQ will include, but is not limited to:
  - Medical/surgical masks
  - N95 respirators for use with any patients with cough or any other reason for aerosolization
  - Eye protection/face shields
  - Extended and reuse gowns, including cloth isolation gowns
  - Disposable gloves
- If available, medical PPE for an HCIC-I and an isolation unit within an HCIC-IQ will include, but is not limited to:
  - N95 disposable respirators
  - Eye protection/face shields
  - Extended and reuse gowns, including cloth isolation gowns
  - Disposable gloves
- The HCIC must be able to share patient information with pharmacies, hospitals, nursing facilities, and outpatient clinicians.

VII. HCIC-I and HCIC-IQ Providers

- The care provided in an HCIC-I and the isolation unit within an HCIC-IQ is complex and requires clinical expertise in caring for individuals with respiratory illnesses. This may include ventilator care.
- Operators of HCIC-Is and HCIC-IQs have clinical capacity to provide care to individuals with probable or confirmed COVID-19 diagnoses at Levels 1, 2 and 3 and other comorbidities of the individual.
- An HCIC-I that is contained within a larger health care facility should have a separate entrance.
    - An HCIC-IQ should have a separate entrance for the isolation unit.
- An HCIC-I or an HCIC-IQ providing services with one or more individuals using ventilators must have a respiratory therapist in the HCIC 24/7. (If providing ventilator care, the facility must be able to meet physical plant, including back-up power sources, and staffing requirements necessary to provide services to individuals using ventilators.
- HCIC-Is and HCIC-IQs must have 24/7 access to a pulmonologist or clinician who can help manage individuals with COVID-19. This may be done through telemedicine.

VIII. HCIC Regulatory Oversight

- Individuals interested in operating an HCIC should contact the Ohio Department of Health as set forth in Appendix 10, the HCIC Center Requirements/Application/TA packet.
    - An HCIC must include a letter signed by the facility and the regional hospital zone documenting the need for the isolation and/or quarantine capacity with their application.
- HCICs will comply with the rules and guidelines issued by the Centers for Medicare and Medicaid Services (CMS) as any bed capacity increase will be in certified beds only pursuant to the 1135 waivers issued by CMS, and any additional conditions as stated below.
- All HCICs must be in physically discrete space. Such separate identifiable capacity requires a separate building or wing.
- All HCICs must comply with all rules and guidelines promulgated by CMS for participation in the Medicare/Medicaid program as well as additional conditions related to staffing, infection control and respiratory care.
- The State Long Term Care Ombudsman will have the same role and access to all HCICs as nursing homes.
- All protocols related to COVID-19 issued by the CDC, CMS and ODH for nursing facilities apply to all HCICs.
- ODH may approve a waiver of capacity limits on behalf of CMS to increase the number of people that may receive services in an HCIC. For example, circumstances that may lead to a waiver of capacity limit include the following
    - Relicensing rooms that were previously delicensed for the period of time the facility is operated as an HCIC.
    - Converting single rooms to double rooms for the period of time the facility is operated as an HCIC.

- Repurposing common space to create a multi-bed ward for the period of time the facility is operated as an HCIC.
- HCICs must have dedicated full time infection control personnel available 24/7.
- There will be enhanced state oversight of HCICs. Enhanced oversight will include check-in phone calls, weekly notification of admissions, discharges and transfers to and from the HCIC, and appropriate technical assistance.

IX. Medicaid Provider and Fiscal Considerations

- The Medicaid Director will designate HCICs who meet an identified need within a Regional Hospital Zone as a **COVID-19 Community Provider** as authorized by Section 14 of Am. Sub. H.B. 197 as passed by the 133rd General Assembly.
- HCICs that have been designated as COVID-19 Community Providers will be reimbursed using a tiered flat per diem rate system that matches reimbursement to the care needs related to the COVID-19 diagnosis or exposure. Per diem rates will be established using high need RUGS weights and Ohio NF cost experience. **Draft** rates under consideration are as follows:
  - Quarantine Level: $250 per day
  - Level 1: $300 per day
  - Level 2: $448 per day
  - Level 3: $820 per day
  - Level 3 on ventilator: $984 per day
- ODM will collaborate with the managed care plans to determine the most appropriate way to reimburse the HCICs for individuals who are enrolled in those plans.
- Patient liability applies to the HCIC payments.
- The Ohio nursing facility franchise fee applies to licensed beds. HCIC beds will fall into three different categories.
  - Beds that are **not** currently licensed as SNF beds will be **certified only** as nursing facility beds for the duration of the HCIC program. These beds will not be subject to the franchise fee.
  - Beds that are **currently licensed as SNF beds but not certified** will be certified as nursing facility beds for the duration of the HCIC program. These beds will remain subject to the franchise fee.
  - Beds that are **currently licensed and certified as SNF beds** and are repurposed as HCIC beds for the duration of the HCIC program will remain subject to the franchise fee.
  - Nursing facilities also have the ability to temporarily add beds to create surge capacity for non-COVID related needs in their communities. Franchise fee will be calculated for those beds in the same manner it is calculated for beds added for purposes of creating HCICs.
- ODM will identify any additional cost report accounts or schedules that are needed to appropriately capture the costs, revenues and utilization related to HCICs.
- If individuals receiving care in a HCIC are not already eligible for Medicaid, enrollment will be completed by attestation. Patient liability will be calculated based on the financial information provided by the individual through the attestation process. (Note that in the alternative, hospitals may choose to complete a presumptive eligibility determination prior to an individual's discharge.)
- The Ohio Department of Medicaid may terminate the provider agreement for any HCIC designated as a COVID-19 Community provider at any time with 30 days notice.

X. Technical Assistance

The Ohio Department of Health and the Ohio Department of Medicaid will provide designated technical assistance teams to support providers during the start-up, operation and closure of HCICs. The technical assistance team will include resources from both state agencies and the Regional Public Health Hospital Zone.

XI. Closing HCICs

An HCIC shall continue to exist until such time that CMS rescinds the 1135 waiver allowing for temporary expansion bed capacity for the care and treatment of residents with COVID-19. A certified bed increase granted to an HCIC shall be temporary. The beds shall not be sold or transferred between nursing facilities.

Appendix 1: Public Health Guidance for HCICs

This appendix provides public health guidance for HCIC staff. As we know, this is an evolving pandemic with new data and information produced frequently. COVID-19 occurs primarily through respiratory droplets, person-to-person contact (within about 6 feet), and from surfaces that have been contaminated with the virus. For this reason, all personnel at HCICs should wear extended and re-use masks. The guidance provided below describes additional precautions needed to ensure safety of all individuals.

Current science suggests that SARS-CoV-2 may remain viable for hours to days on a variety of surface types. Frequent cleaning and disinfection of surfaces is the best practice to prevent transmission of COVID-19 and other viral respiratory illness in a home, quarantine station and HCIC.

It is the intent of this appendix to provide the most current and accurate guidance available for the protection of patients receiving care in HCICs, the HCIC staff, volunteers, and service providers. This list of public health guidance is subject to change as the data and science evolves around this pandemic.

A. LAUNDERING LINEN AND CLOTHING

Guidance for general household laundering (Interim Recommendations for US Households with Suspected / Confirmed Coronavirus Disease 2019) https://www.cdc.gov/coronavirus/2019-ncov/prepare/cleaning-disinfection.html

1. Clothing, towels, linens and other items that go in the laundry

- Wear disposable gloves when handling dirty laundry from an ill person and then discard the gloves after each use. If using reusable gloves, those gloves should be dedicated for cleaning and disinfection of surfaces for COVID-19 and should not be used for other household purposes. Thoroughly wash hands immediately after gloves are removed.
- If no gloves are used when handling dirty laundry, be sure to wash hands immediately afterwards with soap and water for at least 20 seconds.
- If possible, do not shake dirty laundry. This will minimize the possibility of dispersing virus through the air.
- Launder items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and then dry the items completely. Dirty laundry from an ill person can be washed with other people's items.
- Clean and disinfect clothes hampers according to guidance above for surfaces. If possible, consider placing a bag liner that is either disposable (can be thrown away) or can also be laundered.

2. Soiled linens or clothing

- Immediately remove and wash clothes or bedding that have blood, stool, or body fluids on them.
- Wear disposable gloves while handling soiled items and keep soiled items away from your body. Clean your hands (with soap and water or an alcohol-based hand sanitizer) immediately after removing your gloves.
- Read and follow directions on labels of laundry or clothing items and detergent. In general, using a normal laundry detergent according to washing machine instructions and dry thoroughly using the warmest temperatures recommended on the clothing label.
- More on laundry, specifically for caregiver-type contact can be found in the Centers for Disease Control and Prevention (CDC) webpage titled "Preventing the Spread of Coronavirus Disease 2019

in Homes and Residential Communities" at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html

B. DISINFECTION/CLEANING COVID-19

It is recommended that HCICs follow the CDC guidance for cleaning and disinfecting for COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/prepare/cleaning- disinfection.html

The CDC defines cleaning and disinfecting for household settings and general public as:

- **Cleaning** refers to the removal of germs, dirt, and impurities from surfaces. Cleaning does not kill germs, but by removing them, it lowers their numbers and the risk of spreading infection.
- **Disinfecting** refers to using chemicals to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs on a surface *after* cleaning, it can further lower the risk of spreading infection.

C. DISPOSAL OF WASTE AND TRASH

If an individual is healthy with no signs and symptoms, special considerations for handling trash are not necessary. HCICs should provide a dedicated trash can in each living quarter with a liner.

Cleaning staff should use gloves when removing garbage bags, handling, and disposing of trash. Immediately wash hands after disposal of trash and gloves. When necessary, local jurisdictions will provide county-specific guidance regarding trash disposal.

D. FOOD SAFETY AND COVID-19

Ohio Department of Health (ODH) follows guidance in accordance with the CDC and Food and Drug Administration (FDA) for information regarding food safety and the COVID-19. Additional information can be found here: https://www.fda.gov/food/food-safety-during- emergencies/food-safety-and-coronavirus-disease-2019-covid-19

Coronaviruses are generally thought to be spread from person-to-person through respiratory droplets. Currently, there is no evidence to support transmission of COVID-19 through food.

At this time the FDA is not aware of reports where human illness has suggested COVID-19 was transmitted through food or food packaging. However, washing and sanitizing of all food contact surfaces and utensils is advisable. In addition, it is always important to follow good hygiene practices (i.e., wash hands and surfaces often, separate raw meat from other foods, cook to the right temperature, and refrigerate foods promptly) when handling or preparing food.

E. COVID-19 MEDICAL MONITORING & INFECTION CONTROL

Although most patients admitted to the HCIC come from hospitals as part of their post-acute care plan, some may be admitted from nursing facilities unable to manage the level of critical care required. Most clinically stable COVID patients will not be admitted from nursing facilities. Patients admitted to the HCIC-Is and isolation units within HCIC-IQs will have a clinical severity score of 1-3 as determined by tools such as the NEWS score (Appendix 7).

F. RELEASING PATIENTS FROM HCICs

COVID testing is not required for releasing patients from HCICs. Although the CDC has endorsed test-based and non-test based strategies for release from hospitals or HCICs, recent ODH guidance strongly prefers non test based strategies.

These non-test-based criteria to establish the release from transmission-based precautions (isolation). Criteria include:

- 7 days since onset of symptoms AND
- 3 days with no fever without use of fever-reducing medication AND
- 3 days of stable and improved respiratory status.

In congregate living situations (such as nursing facilities) and with individuals who are hospitalized or severely immunocompromised, criteria for release from isolation criteria include:

- 14 days since onset of symptoms AND
- 3 days with no fever without fever-reducing medication AND
- 3 days of stable and improved respiratory status.

Ultimately, clinician judgement is required to determine release from transmission-based precautions. Treating clinicians may determine that a test-based strategy is necessary in very specific clinical situations.

The HCICs are held to the same standard for discharge planning as hospitals. Discharge documentation should include date of onset of symptoms, isolation status, and need for continued transmission-based precautions, clearly establishing that the site of discharge placement has the ability to meet infection-control requirements. Airborne infection isolation rooms are not mandatory upon release.

Appendix 2

Infection Control

This survey tool must be used to investigate compliance at F880 and determine whether the facility is implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19 and other communicable diseases and infections. Entry and screening procedures as well as resident care guidance has varied over the progression of COVID-19 transmission in facilities. Facilities are expected to be in compliance with CMS requirements and surveyors will use guidance that is in effect at the time of the survey. Refer to QSO memos released at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.

This survey tool provides a focused review of the critical elements associated with the transmission of COVID-19, will help surveyors to prioritize survey activities while onsite, and identify those survey activities which can be accomplished offsite. These efficiencies will decrease the potential for transmission of COVID-19, as well as lessen disruptions to the facility and minimize exposure of the surveyor. Surveyors should be mindful to ensure their activities do not interfere with the active treatment or prevention of transmission of COVID-19.

If citing for noncompliance related to COVID-19, the surveyor(s) must include the following language at the beginning of the Deficient Practice Statement or other place determined appropriate on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to [properly prevent and/or contain – or other appropriate statement] **COVID-19**."

If surveyors see concerns related to compliance with other requirements, they should investigate them in accordance with the existing guidance in Appendix PP of the State Operations Manual and related survey instructions. Surveyors may also need to consider investigating concerns related to Emergency Preparedness in accordance with the guidance in Appendix Z of the State Operations Manual (e.g., for emergency staffing).

For the purpose of this survey tool, "staff" includes employees, consultants, contractors, volunteers, and others who provide care and services to residents on behalf of the facility. The Infection Prevention and Control Program (IPCP) must be facility-wide and include all departments and contracted services.

Surveyor(s) reviews for:

- The overall effectiveness of the Infection Prevention and Control Program (IPCP) including IPCP policies and procedures;
- Standard and Transmission-Based Precautions;
- Quality of resident care practices, including those with COVID-19 (laboratory-positive case), if applicable;
- The surveillance plan;
- Visitor entry and facility screening practices;
- Education, monitoring, and screening practices of staff; and
- Facility policies and procedures to address staffing issues during emergencies, such as transmission of COVID-19

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1. Standard and Transmission-Based Precautions (TBPs)

CMS is aware that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for

not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact their healthcare coalition for assistance (https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx), follow national and/or local guidelines for optimizing their current supply or identify the next best option to care for residents. Among other practices, optimizing their current supply may mean prioritizing use of gowns based on risk of exposure to infectious organisms, blood or body fluids, splashes or sprays, high contact procedures, or aerosol generating procedures (AGPs), as well as possibly extending use of PPE (follow national and/or local guidelines). Current CDC guidance for healthcare professionals is located at: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html and healthcare facilities is located at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html. Guidance on strategies for optimizing PPE supply is located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the State Agency should contact the CMS Regional Location.

General Standard Precautions

☐ Are staff performing the following appropriately:

- Respiratory hygiene/cough etiquette,
- Environmental cleaning and disinfection, and
- Reprocessing of reusable resident medical equipment (e.g., cleaning and disinfection of glucometers per device and disinfectant manufacturer's instructions for use)?

Hand Hygiene

☐ Are staff performing hand hygiene when indicated?

☐ If alcohol-based hand rub (ABHR) is available, is it readily accessible and preferentially used by staff for hand hygiene?

☐ If there are shortages of ABHR, are staff performing hand hygiene using soap and water instead?

☐ Are staff washing hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids)?

☐ Do staff perform hand hygiene (even if gloves are used) in the following situations:

- Before and after contact with the resident;
- After contact with blood, body fluids, or visibly contaminated surfaces;
- After contact with objects and surfaces in the resident's environment;
- After removing personal protective equipment (e.g., gloves, gown, facemask); and
- Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care)?

☐ When being assisted by staff, is resident hand hygiene performed after toileting and before meals?

☐ Interview appropriate staff to determine if hand hygiene supplies (e.g., ABHR, soap, paper towels) are readily available and who they contact for replacement supplies.

Personal Protective Equipment (PPE)

☐ Determine if staff appropriately use PPE including, but not limited to, the following:

- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
- Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin;
- Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care; and
- An isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions.

☐ Is PPE appropriately removed and discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national/local recommendations), followed by hand hygiene?

☐ If PPE use is extended/reused, is it done according to national and/or local guidelines? If it is reused, is it cleaned/decontaminated/maintained after and/or between uses?

☐ Interview appropriate staff to determine if PPE is available, accessible and used by staff.

- Are there sufficient PPE supplies available to follow infection prevention and control guidelines? In the event of PPE shortages, what procedures is the facility taking to address this issue?
- Do staff know how to obtain PPE supplies before providing care?
- Do they know who to contact for replacement supplies?

Transmission-Based Precautions (Note: PPE use is based on availability and latest CDC guidance. See note on Pages 1-2)

☐ Determine if appropriate Transmission-Based Precautions are implemented:

- For a resident on Contact Precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment;
- For a resident on Droplet Precautions: staff don a facemask within six feet of a resident;
- For a resident on Airborne Precautions: staff don an N95 or higher level respirator prior to room entry of a resident;
- For a resident with an undiagnosed respiratory infection: staff follow Standard, Contact, and Droplet Precautions (i.e., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis);
- For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available. A facemask is an acceptable alternative if a respirator is not available. Additionally, if there are COVID-19 cases in the facility or sustained community transmission, staff implement universal use of facemasks while in the facility (based on availability). When COVID-19 is identified in the facility, staff wear all recommended PPE (i.e., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability).

- Some procedures performed on residents with known or suspected COVID-19 could generate infectious aerosols (i.e., aerosol-generating procedures (AGPs)). In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously. If performed, the following should occur:
  - Staff in the room should wear an N95 or higher-level respirator, eye protection, gloves, and an isolation gown.
  - The number of staff present during the procedure should be limited to only those essential for resident care and procedure support.
  - AGPs should ideally take place in an airborne infection isolation room (AIIR). If an AIIR is not available and the procedure is medically necessary, then it should take place in a private room with the door closed.
  - Clean and disinfect the room surfaces promptly and with appropriate disinfectant. Use disinfectants on List N of the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-COV-2 or other national recommendations;

- Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare setting prior to use on another resident;
- Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare setting (effective against the organism identified if known) at least daily and when visibly soiled; and
- Is signage on the use of specific PPE (for staff) posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide)?

☐ Interview appropriate staff to determine if they are aware of processes/protocols for Transmission-Based Precautions and how staff is monitored for compliance.

☐ If concerns are identified, expand the sample to include more residents on Transmission-Based Precautions.

1. Did staff implement appropriate Standard (e.g., hand hygiene, appropriate use of PPE, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment) and Transmission-Based Precautions (if applicable)? ☐ Yes ☐ **No F880**

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2. Resident Care

☐ If there is sustained community transmission or case(s) of COVID-19 in the facility, is the facility restricting residents (to the extent possible) to their rooms except for medically necessary purposes? If there is a case in the facility, and residents have to leave their room, are they wearing a facemask, performing hand hygiene, limiting their movement in the facility, and performing social distancing (efforts are made to keep them at least 6 feet away from others). If PPE shortage is an issue, facemasks should be limited to residents diagnosed with or having signs/symptoms of respiratory illness or COVID-19.

☐ Has the facility cancelled group outings, group activities, and communal dining?

☐ Has the facility isolated residents with known or suspected COVID-19 in a private room (if available), or taken other actions based on national (e.g., CDC), state, or local public health authority recommendations?

☐ For the resident who develops severe symptoms of illness and requires transfer to a hospital for a higher level of care, did the facility alert emergency medical services and the receiving facility of the resident's diagnosis (suspected or confirmed COVID-19) and precautions to be taken by transferring and receiving staff as well as place a facemask on the resident during transfer (as supply allows)?

☐ For residents who need to leave the facility for care (e.g. dialysis, etc.), did the facility notify the transportation and receiving health care team of the resident's suspected or confirmed COVID-19 status?

☐ Does the facility have residents who must leave the facility regularly for medically necessary purposes (e.g., residents receiving hemodialysis and chemotherapy) wear a facemask (if available) whenever they leave their room, including for procedures outside of the facility?

2. Did staff provide appropriate resident care? ☐ Yes ☐ **No F880**

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3. IPCP Standards, Policies and Procedures

☐ Did the facility establish a facility-wide IPCP including standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19?

☐ Does the facility's policies or procedures include when to notify local/state public health officials if there are clusters of respiratory illness or cases of COVID-19 that are identified or suspected?

☐ Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.

3. Does the facility have a facility-wide IPCP including standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19? ☐ Yes ☐ **No F880**

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4. Infection Surveillance

☐ How many residents and staff in the facility have fever, respiratory signs/symptoms, or other signs/symptoms related to COVID-19?

☐ How many residents and staff have been diagnosed with COVID-19 and when was the first case confirmed?

☐ How many residents and staff have been tested for COVID-19? What is the protocol for determining when residents and staff should be tested?

☐ Has the facility established/implemented a surveillance plan, based on a facility assessment, for identifying (i.e., screening), tracking, monitoring and/or reporting of fever (at a minimum, vital signs are taken per shift), respiratory illness, and/or other signs/symptoms of COVID-19 and immediately isolate anyone who is symptomatic?

☐ Does the plan include early detection, management of a potentially infectious, symptomatic resident that may require laboratory testing and/or Transmission-Based Precautions/PPE (the plan may include tracking this information in an infectious disease log)?

☐ Does the facility have a process for communicating the diagnosis, treatment, and laboratory test results when transferring a resident to an acute care hospital or other healthcare provider; and obtaining pertinent notes such as discharge summary, lab results, current diagnoses, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals?

☐ Can appropriate staff (e.g., nursing and unit managers) identify/describe the communication protocol with local/state public health officials?

☐ Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

4. Did the facility provide appropriate infection surveillance? ☐ Yes ☐ **No F880**

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5. Visitor Entry

☐ Review for compliance of:

- Screening processes and criteria (i.e., screening questions and assessment of illness);
- Restriction criteria; and
- Signage posted at facility entrances for screening and restrictions as well as a communication plan to alert visitors of new procedures/restrictions.

☐ For those permitted entry, are they instructed to frequently perform hand hygiene; limit their interactions with others in the facility and surfaces touched; restrict their visit to the resident's room or other location designated by the facility; and offered PPE (e.g., facemask) as supply allows? What is the facility's process for communicating this information?

☐ For those permitted entry, are they advised to monitor for signs and symptoms of COVID-19 and appropriate actions to take if signs and/or symptoms occur?

5. Did the facility perform appropriate screening, restriction, and education of visitors? ☐ Yes ☐ **No F880**

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6. Education, Monitoring, and Screening of Staff

☐ Is there evidence the facility has provided education to staff on COVID-19 (e.g., symptoms, how it is transmitted, screening criteria, work exclusions)?

☐ How does the facility convey updates on COVID-19 to all staff?

☐ Is the facility screening all staff at the beginning of their shift for fever and signs/symptoms of illness? Is the facility actively taking their temperature and documenting absence of illness (or signs/symptoms of COVID-19 as more information becomes available)?

☐ If staff develop symptoms at work (as stated above), does the facility:

- Place them in a facemask and have them return home;
- Inform the facility's infection preventionist and include information on individuals, equipment, and locations the person came in contact with; and

- Follow current guidance about returning to work (e.g., local health department, CDC: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html).

6. Did the facility provide appropriate education, monitoring, and screening of staff? ☐ Yes ☐ **No F880**

7. Emergency Preparedness - Staffing in Emergencies

☐ Policy development: Does the facility have a policy and procedure for ensuring staffing to meet the needs of the residents when needed during an emergency, such as a COVID-19 outbreak?

☐ Policy implementation: In an emergency, did the facility implement its planned strategy for ensuring staffing to meet the needs of the residents? (N/A if a emergency staff was not needed)

7. Did the facility develop and implement policies and procedures for staffing strategies during an emergency?

☐ **Yes** ☐ **No E0024**

Section 3087 of the 21st Century Cures Act, signed into law in December 2016, added subsection (f) to section 319 of the Public Health Service Act. This new subsection gives the HHS Secretary the authority to waive Paperwork Reduction Act (PRA) (44 USC 3501 et seq.) requirements with respect to voluntary collection of information during a public health emergency (PHE), as declared by the Secretary, or when a disease or disorder is significantly likely to become a public health emergency (SLPHE). Under this new authority, the HHS Secretary may waive PRA requirements for the voluntary collection of information if the Secretary determines that: (1) a PHE exists according to section 319(a) of the PHS Act or determines that a disease or disorder, including a novel and emerging public health threat, is a SLPHE under section 319(f) of the PHS Act; and (2) the PHE/SLPHE, including the specific preparation for and response to it, necessitates a waiver of the PRA requirements. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been designated as the office that will coordinate the process for the Secretary to approve or reject each request.
The information collection requirements contained in this information collection request have been submitted and approved under a PRA Waiver granted by the Secretary of Health and Human Services. The waiver can be viewed at https://aspe.hhs.gov/public-health-emergency-declaration-pra-waivers.

Appendix 3

Coronavirus Disease 2019

Ohio Department of Health

How to Request Resources Through Your County EMA

RESOURCE REQUESTS BEGIN AT THE COUNTY LEVEL

The emergency management system in Ohio is a tiered effort. When a local government or health care facility needs additional resources or supplies to deal with an emergency, a request for resources should be placed with the respective county Emergency Management Agency (EMA), who will attempt to find resources at the local or regional level.

When an emergency exceeds the capacity of the local government, the county EMA will make a request to the state through the Ohio Emergency Management Agency (Ohio EMA). If an emergency exceeds the capacity of the state, aid is requested by Ohio EMA through the Federal Emergency Management Agency (FEMA).

When making a request to the county EMA, specificity about the situation at hand is of paramount importance – details matter.

When reaching out to your county EMA, be prepared with the following information:

- Details about the incident/situation
- The gap between existing resources and what is needed to handle the incident/situation
- Details about how you have tried to fill that gap locally (asked for volunteers; reached out to the local business community, attempts to purchase goods, etc.)

FIND YOUR COUNTY EMA HERE: https://webeoctraining.dps.ohio.gov/ohiocountyEMADirectorList/countyemalist_web.aspx

To learn more about the emergency management system in Ohio, check out the Ohio Elected Officials Guide To Emergency Management: at www.ema.ohio.gov under the heading, “Are You Ready Ohio?”

For additional information, visit coronavirus.ohio.gov.

For answers to your COVID-19 questions, call 1-833-4-ASK-ODH (1-833-427-5634).

If you or a loved one are experiencing anxiety related to the coronavirus pandemic, help is available. Call the Disaster Distress Helpline at 1-800-985-5990 (1-800-846-8517 TTY); connect with a trained counselor through the Ohio Crisis Text Line by texting the keyword “4HOPE” to 741 741; or call the Ohio Department of Mental Health and Addiction Services help line at 1-877-275-6364 to find resources in your community.

CORONAVIRUS DISEASE 2019 Ohio | Department of Health

Protect yourself and others from COVID-19 by taking these precautions.

PREVENTION

For additional information call **1-833-4-ASK-ODH** or visit **coronavirus.ohio.gov.**

STAY HOME

PRACTICE SOCIAL DISTANCING

GET ADEQUATE SLEEP AND EAT WELL-BALANCED MEALS

WASH HANDS OFTEN WITH WATER AND SOAP (20 SECONDS OR LONGER)

DRY HANDS WITH A CLEAN TOWEL ORAIR DRY YOUR HANDS

COVER YOUR MOUTH WITH A TISSUE OR SLEEVE WHEN COUGHING OR SNEEZING

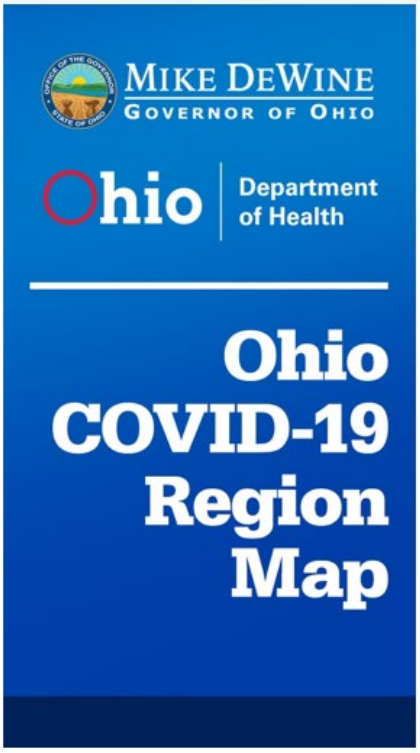
AVOID TOUCHING YOUR EYES, NOSE, OR MOUTH WITH UNWASHED HANDS OR AFTER TOUCHING SURFACES

CLEAN AND DISINFECT "HIGH-TOUCH" SURFACES OFTEN

CALL BEFORE VISITING YOUR DOCTOR

PRACTICE GOOD HYGIENE HABITS

Appendix 4: Regional Hospital Zones (map)



Bob Wyllie, CMO Cleveland Clinic **National Guard: NW: Col. Gregg Biddle & NE: Col. James McCandless**		
Zone 1 Regions 1, 2 & 5	Jan Ruma, VP HCNO (2) CEO Cleve Clinic (2) Univ Hosp (3) Summa (1) Regional Mercy	(1) ProMedica (5) Aultman (2) MetroHealth (5) Akron Childrens
Andy Thomas, CMO, OSU **National Guard: Central: Col. Charlie Buchanan**		
Zone 2 Regions 4, 7 & 8	(7) Holzer Health (7) Adena Health (4) Trinity, Mt. Carmel (4) OhioHealth	(4) Nationwide Childrens (4) OhioHealth
Rick Lofgren (UC Health, CEO) **National Guard Southwest: Col. Bryan Moore & Southeast: Col. Gerry Clark**		
Zone 3 Regions 3 & 6	(3) Premier Health (6) TriHealth (3) Dayton Children's (3) Cincinnati Children's (3) GDAHA	(3) Kettering (6) Christ Hospital (6) Bon Secours Mercy

Clinical Resource Team: Bridget Harrison, Gov. DeWine's Office, Maureen Corcoran, Director Medicaid *4-1-20 Updated*

Appendix 5: PPE Guidance

Personal Protective Equipment (PPE)

This toolkit includes guidance, strategies, and options to optimize supplies of PPE while minimizing the spread of COVID-19 and protecting health care personnel and other staff. Optimizing the use of PPE is critical during this phase of "pre-surge planning" as we prepare for an increase in the number of people who are COVID-19 positive (+).

PPE TYPE	CONVENTIONAL CAPACITY	CONTINGENCY CAPACITY	CRISIS CAPACITY
MASK 	Under normal circumstances, provide patient care using infection prevention and control without any change in daily practices. PPE should be used according to product labeling and local, state, and federal requirements.	During periods of expected PPE shortages, take action to change daily standard practices (cancel elective and non-urgent procedures) to reduce the use of PPE. Shift PPE supplies from disposable to re-usable, implement extended wear, and ensure appropriate cleaning and disinfection.	During periods of known PPE shortages, use additional conservation measures, including PPE use that does not correspond with U.S. standards of care. In addition to the contingency strategies (extended use and re-use), also use PPE beyond the manufacturer-designated shelf life, prioritize the use of PPE for selected activities, and use alternative items that have not been evaluated as effective.
EYE PROTECTION 			
GOWN 			
GLOVES 			

Long Term Services & Supports (LTSS) Personal Protective Equipment (PPE) Contingency Planning

- LTSS agencies facilities understand their PPE inventory, supply chain, and utilization; and they are working locally to address PPE needs.
- Agencies and facilities may operate at multiple levels of capacity by type of PPE (i.e. at contingency capacity for masks, crisis capacity for eye protection).
- Agencies and facilities must continue to implement control measures to reduce the number of people interacting with patients/residents, maximize telehealth services, reduce face-to-face contact by staff, cohort patients/residents, and dedicate personnel for care.

PATIENT/RESIDENT STATUS	PPE TYPE	CONVENTIONAL CAPACITY *NO LONGER APPLICABLE*	CONTINGENCY CAPACITY	CRISIS CAPACITY
No Exposure *No Symptoms* 	**MASK**	• Surgical facemask	• Surgical/medical facemask: extended use/re-use all shift*	• Surgical/medical facemask preferred - extended use/re-use all shift* • When no approved mask is available: face shield w/ mask or non-NIOSH approved mask (non-medical/hand made)
	EYE PROTECTION	• Routine precautions	• Routine precautions	• Routine precautions
	GOWN	• Routine precautions	• Routine precautions	• Routine precautions
	GLOVES	• Routine precautions	• Routine precautions	• Routine precautions
Exposed *No Symptoms* 	**MASK**	• N95	• Surgical/medical facemask: extended use/re-use all shift* • N95 only with aerosol-generating procedures	• Surgical/medical facemask - extended use/re-use all shift* • When no approved facemask is available: face shield w/ mask or non-NIOSH approved mask (non-medical/hand made)
	EYE PROTECTION	• Goggles/face shield	• Extended use/re-use goggles or face shield	• Extended use/re-use safety glasses
	GOWN	• Isolation	• Use expired or cloth isolation gowns • Change in between residents	• Extended use/re-use of disposable or cloth gowns* • Dedicated to residentor room with like residents (no additional infection ex: C.diff) • Consider medical coveralls; when no gowns available: consider reusable/washable patient gowns, lab coats
	GLOVES	• Disposable	• Medical grade, non-sterile • Change between residents	• Non-medical, industrial
COVID-19 + *Confirmed or Suspected* 	**MASK**	• N95	• N95 extended use within isolation status; limited re-use*	• Surgical/medical facemask - extended use/re-use all shift* • N95 only with aerosolization
	EYE PROTECTION	• Goggles/face shield	• Extended use/re-use goggles or face shield	• Extended / re-use safety glasses
	GOWN	• Isolation	• Use expired or cloth isolation gowns • Change in between residents	• Extended use/re-use of disposable or cloth gowns* • Dedicated to resident or room with like residents (no additional infection ex: C.diff) • Consider medical coveralls; when no gowns available: consider reusable/washable patient gowns, lab coats
	GLOVES	• Disposable	• Medical grade, non-sterile • Change between residents	• Non-medical, industrial

Unless contaminated (wet, soiled, damaged)

Appendix 6

Coronavirus Disease 2019

Ohio Department of Health

Guidance for Discontinuing Transmission-Based Precautions in COVID-19 Patients

The Centers for Disease Control and Prevention (CDC) has endorsed both test-based and non-test-based strategies for release from transmission-based precautions for individuals treated for COVID-19, including both those who have tested positive and those suspected of having COVID-19 who have not been tested.

While in certain situations a test-based approach is ideal, due to the limited availability of testing and need to preserve testing capacity to identify newly infected patients who are at highest risk, hospitals, other healthcare facilities, and clinicians should almost always use the non-test-based strategies for discontinuation of transmission-based precautions.

After consultation with Ohio infectious disease physicians and the CDC, the Ohio Department of Health (ODH) recommends the following:

- Utilize the CDC non-test-based criteria to establish the release from transmission-based precautions (isolation). These criteria include:
  - 7 days since onset of symptoms AND
  - 3 days with no fever without use of fever-reducing medication AND
  - 3 days of stable and improved respiratory status.

- In congregate living situations (such as nursing facilities) and with individuals who are hospitalized or severely immunocompromised, criteria for release from isolation criteria include:
  - 14 days since onset of symptoms AND
  - 3 days with no fever without fever-reducing medication AND
  - 3 days of stable and improved respiratory status.

- Ultimately, clinician judgment is required to determine release from transmission-based precautions. Treating clinicians may determine that a test-based strategy is necessary in very specific clinical situations.

- For patients being released from hospitals, discharge planning and discharge documentation should include date of onset of symptoms, isolation status, and need for continued transmission-based precautions, clearly establishing that the receiving facility has the ability to meet infection-control requirements.

For patients transferred to nursing facilities and congregate care settings:

- For those facilities that do not have the ability to meet full isolation requirements, the following CDC and Centers for Medicare and Medicaid Services (CMS) guidance should be used:

    - Residents with known or suspected COVID-19 do not need to be placed in an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
    - Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. Confirmed positive and presumed positive residents may share rooms. Those exposed but not symptomatic shall be quarantined in a separate room/area.

- Facilities should consider a targeted approach, where designated wings/units, floors, or entire facilities are created for COVID-19 or suspected patients. Facilities should consider designating Health Care Personnel (HCP) who are assigned ONLY to those units to care for known or suspected COVID-19 patients to limit HCP exposure and conserve Personal Protective Equipment (PPE). These units are ideal for residents returning from hospital care who still need to complete the isolation period before being released into the general population of nursing facility residents.

- Nursing homes should admit any individuals that they would normally admit to their facility, including individuals without symptoms of COVID-19 previously in the community, in hospitals, or in other facilities where a case of COVID-19 may have been present. *No further testing is required for these asymptomatic and potentially exposed individuals.* These residents should be quarantined and monitored for 14 days and standard infection control practices including diligent handwashing and staff wearing surgical masks or other face covering utilized. If possible, a dedicated unit/wing for these residents could be established.

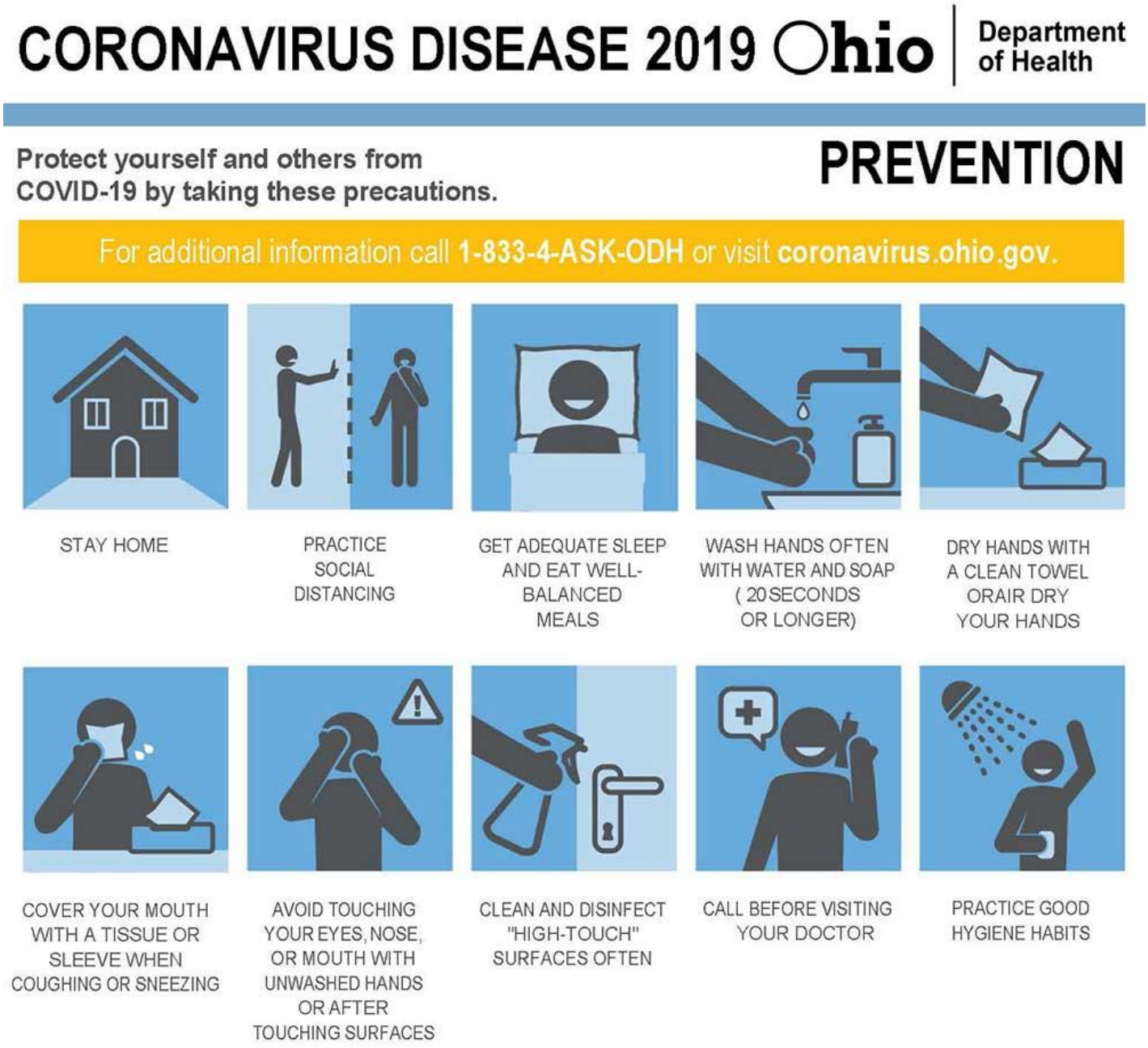
- Facilities should notify the health department about residents and staff with known or suspected COVID-019 and follow the Interim Infection Prevention and Control Recommendations for Patients with COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings, including information regarding recommended PPE.[1]

[1] Relative to PPE, *see also* "Strategies to Optimize the Supply of PPE and Equipment," https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html.

For additional information, visit coronavirus.ohio.gov.

For answers to your COVID-19 questions, call 1-833-4-ASK-ODH (1-833-427-5634).

If you or a loved one are experiencing anxiety related to the coronavirus pandemic, help is available. Call the Disaster Distress Helpline at 1-800-985-5990 (1-800-846-8517 TTY); connect with a trained counselor through the Ohio Crisis Text Line by texting the keyword “4HOPE” to 741 741; or call the Ohio Department of Mental Health and Addiction Services help line at 1-877-275-6364 to find resources in your community.



Appendix 7: NEWS 2 Scoring Matrix

NEW score	Frequency of monitoring	Clinical response
0	Minimum 12 hourly	• Continue routine NEWS monitoring
Total 1–4	Minimum 4–6 hourly	• Inform registered nurse, who must assess the patient • Registered nurse decides whether increased frequency of monitoring and/or escalation of care is required
3 in single parameter	Minimum 1 hourly	• Registered nurse to inform medical team caring for the patient, who will review and decide whether escalation of care is necessary
Total 5 or more Urgent response threshold	Minimum 1 hourly	• Registered nurse to immediately inform the medical team caring for the patient • Registered nurse to request urgent assessment by a clinician or team with core competencies in the care of acutely ill patients • Provide clinical care in an environment with monitoring facilities
Total 7 or more Emergency response threshold	Continuous monitoring of vital signs	• Registered nurse to immediately inform the medical team caring for the patient – this should be at least at specialist registrar level • Emergency assessment by a team with critical care competencies, including practitioner(s) with advanced airway management skills • Consider transfer of care to a level 2 or 3 clinical care facility, ie higher-dependency unit or ICU • Clinical care in an environment with monitoring facilities

Ohio Department of Aging | Ohio Department of Health | Ohio Department of Developmental Disabilities | Ohio Department of Medicaid

APPENDIX 8 - TOOL 6-A: Patient/Resident Transfer to Health Care
Isolation Center Checklist

Clinical Criteria for Transferring Patients/Residents to Health Care Isolation Centers (HCIC) During Pandemic

This checklist is intended to assist with communications when transferring COVID-19 residents to a health care isolation center (HCIC). It serves as an easy reference guide, ensuring details of care have been accurately relayed. It does not replace or supersede existing clinical or facility protocols. Please check all that apply.

KEY CRITERIA FOR TRANSFER OF COVID-19 RESIDENT	
☐	COVID-19+ status ☐ Confirmed (tested positive) ☐ Probable ☐ Exposed, if yes: Date of last exposure _____
☐	Advanced directive exists, designates desire for level of care at HCIC
☐	For confirmed and probable COVID-19 transfer to COVID-19 isolation unit at HCIC-I or HCIC-IQ, indicate patient/resident COVID-19 level of care. *See NEWS2 Assessment & Scoring Matrix.* ☐ Level 1 ☐ Level 2 ☐ Level 3
VITALS	
☐	Temp (F) < 95° or > 100°
☐	SBP (mmHg) < 90 or > 180
☐	HR (per/min) < 50 or > 110
☐	RR (per/min) < 14 or > 22
☐	Pulse ox %_____ on _____%FIO2, or ___L/nc
☐	Unable to maintain O2 sat > 90% on 40% FiO2
☐	Vital Signs Change of >25% of baseline
ADDITIONAL CONSIDERATIONS FOR HOSPITAL LEVEL OF CARE	
☐	Dyspnea cannot be managed despite medications and oxygen
☐	Evidence of organ dysfunction (angina, kidney failure)
☐	Other
OTHER CLINICAL INFORMATION	
☐	Patient Medical ID/wristband
☐	Diagnoses
☐	Medications

☐	Allergies
COMMUNICATIONS	
☐	NF or other congregate care facility communicates with family
☐	Before transport, NF or other congregate care provider communicates with HCIC partner to verify appropriate care available. The HCIC confirms they have all of the following on-site to appropriately care for the individual being transferred ☐ Medications ☐ Personnel ☐ Personal Protective Equipment (PPE)
☐	Note any special circumstances that must be communicated to the HCIC that may impact the facility's decision for admittance. For example: individual is an inmate of a prison, individual is also in recovery from a substance use disorder, etc.: _____ _____
☐	Communicate with emergency medical services regarding COVID-19 status
☐	Ensure patient is wearing medical facemask for transport

Ohio Department of Aging | Ohio Department of Health | Ohio Department of Developmental Disabilities | Ohio Department of Medicaid

Appendix 9 - TOOL 7-A: Health Care Isolation Center Discharge Criteria Checklist to Facility/Home

The health care isolation center (HCIC) discharge of an individual with COVID-19 to home or long-term services facility should be made in consultation with the individual's clinical care team, and local or state public health departments, as appropriate.

This checklist is intended to assist with communications when discharging COVID-19 residents from a HCIC. It serves as an easy reference guide, ensuring details of care have been accurately relayed. It does not replace or supersede existing clinical or facility protocols. Please check all that apply.

VERIFY RESIDENT CONTACT INFORMATION	
☐	Obtain and verify residence and patient's ability to return to residence
☐	Verify contact number for patient as well primary support person
VERIFY STABILIZATION OF CLINICAL CONDITION	
☐	Vital signs stable
☐	Temp 96-100
☐	SBP 90-160
☐	HR 60-100
☐	RR 14-22
☐	Pulse Ox >92% on RA for oxygen naïve patients; otherwise O2, 4L/nc
☐	Mental status stable or at baseline >24 hours
☐	Confirm with medical provider and bedside RN that patient is able to manage ADLs independently or with degree of available support at home/facility
☐	Verify lab values stable and any lab follow up: Test_____ Date_____
STATUS OF COVID-19 TESTING	
☐	Date of onset of symptoms_____
☐	Date of initial positive test (if done)_____
☐	If discharging to a non-congregate care setting (home or other), if no repeat COVID-19 testing, date patient met all of the following criteria_____ ☐ 7 days since symptom onset ☐ 3 days of no fever without antipyretics ☐ 3 days of stable respiratory status
☐	If discharging to a nursing facility or other congregate care setting date patient met all of the following criteria_____ ☐ 14 days since symptom onset ☐ 3 days of no fever without antipyretics ☐ 3 days of stable and improved respiratory status
FOR NON-COVID-19 PATIENTS - INFECTION CONTROL	
☐	Has the patient been in contact with anyone positive for COVID-19?
☐	If yes, date(s) of exposure_____
☐	Communicate with patient and care partners: COVID status, isolation and PPE requirements

☐	Confirm Patient has resources/supports to adhere to infection control requirements https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html
CONFIRM NEEDED EQUIPMENT	
☐	Oxygen
☐	DME
☐	Additional nursing services
MEDICATIONS	
☐	Review medication list
☐	Ensure a 30-day supply of each medication
CLINICIAN FOLLOW-UP	
☐	Verify date and time of specialist follow up
☐	Verify date and time of primary care follow up
DISCHARGE LOGISTICS	
☐	Patient transportation arranged
☐	Patient dietary needs addressed (special food, supplements, etc.)
☐	Patient communications device available and accessible, as applicable

Ohio Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor

Amy Acton, M.D., MPH, Director

April 16, 2020

Dear Long Term Care Providers.

As part of Ohio's response to the State of Emergency created by the COVID-19 pandemic, the Ohio Department of Health (ODH), in conjunction with the Ohio Department of Medicaid (ODM), is considering ways in which nursing homes can be leveraged to help meet the surge capacity needed to care for individuals infected with or presumed to be infected with the COVID-19 virus.

ODH and ODM have identified a way to utilize existing nursing homes through consultation and mutual agreement with the Public Health Planning Zone in which the facility is located, by allowing a home to surge their homes in several ways. During this State of Emergency, homes will be permitted to exceed their licensed capacity through the use of certified Health Care Isolation Center (HCIC) beds for quarantine (HCIC-Q), isolation (HCIC-I), or both (HCIC-IQ). Shortly after the end of the State of Emergency, homes will return to their normal licensed capacity and the Isolation Centers will cease operations.

1. Use of entire building as an Isolation Center: An Isolation Center can be as part of the existing nursing home, by temporarily relocating residents so the entire nursing home becomes an isolation center, or by utilizing another building to handle the surge coming into the nursing home.
   - This the the true stand alone model. This is identified when a sponsoring nursing home either uses the entire existing building as an Isolation Center or surges beds into a stand alone building and sets up an HCIC in order to treat COVID-19 patients. This type includes fiscal considerations in section IX of the HCIC Plan. An Isolation Center of this type may be a HCIC-Q, HCIC-I, or HCIC-IQ.
2. Use of a dedicated area as an Isolation Center: Creating an Isolation Center within an existing nursing home, by temporarily identifying an area of the building, that:
   a. Is a separate separately identifiable part of the building (e.g., a wing or floor)
   b. Has a separate entrance, if appropriate
   c. Has segregated, isolation center-only staff
   - This type is similar to the above model, however, it takes place within the nursing home or campus. The facility surges capacity within it's own home or campus and sets up an HCIC to treat COVID-19 patients. This type includes fiscal considerations in section IX of the HCIC Plan. . An Isolation Center of this type may contain an HCIC-Q, HCIC-I, or HCIC-IQ.
3. Internal Facility Cohorting to create HCIC: This is not a HCIC, but is done to accommodate creation of a HCIC. It is limited to a facility's ability to surge their capacity or space. Surging capacity of non-Covid positive or presumptive positive residents within the nursing home plan to facilitate other nursing homes becoming Isolation Centers or for the facility's needs during

the COVID-19 Pandemic. This type of surge does not implicate ODM's increased rates, but ODH must be aware of the increased capacity.

4. Internal Faciity Co-horting unrelated to an HCIC: This is not an HCIC but allows a facility to add certified capacity to create internal areas to isolate COVID-19 positive or presumptive positive residents or for facility needs during the COVID-19 pandemic. This type of surge does not implicate ODM's increased rates, but ODH must be aware of the increased capacity.

Any capacity increase is certified and not licensed and is temporary.

Please familiarize yourselves with the Health Care Center Isolation Plan released by ODH and ODM on April 16, 2020, for a better understanding of the requirements for each type before sending your requests.

Ohio Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor
Amy Acton, M.D., MPH, Director

HEALTH CARE ISOLATION CENTER (HCIC) REQUIREMENTS

PROCESS FOR FACILITIES

As part of Ohio's effort to address needed surge capcity in the continuing efforts for COVID-19, HCIC's centers have been established in accordance with the Novel Coronavirus-19 (COVID-19) Healthcare Isolation Center Plan. The Ohio Deparment of Health (ODH) and the Ohio Department of Medicaid (ODM) are working with the Centers for Medicare and Medicaid Services (CMS) concerning these centers. Any adjustments or additional information that may be needed will be immediately communicated to facilities and providers.

At this time, ODH and ODM require the following information for temporary HCIC locations: for HCIC-I, HCIC-Q, or both:

- Identifying Information:
  - Facility making request by name, address, city, zip code, county, and telephone number
  - Facility CCN
  - Facility License Number (if applicable)
  - Corporate Affiliate name (if applicable)
  - Name, address, city, zip code, county of the Isolation Center (if different than the current nursing home location
  - Identify if facility was previously certified and/or had licensed space and the last year in which the facility held certification and/or licensure
  - Name and contact information of the Administrator
- The number of certified beds proposed for service at the isolation location
- An attestation from the individual indicating that the isolation center:
  - Can meet the certification requirements
  - Has the requisite financial ability to operate
  - Has the ability to properly staff the isolation center
  - Meets the requirements outlined in Novel Coronavirus-19 (COVID-19) Healthcare Isolation Centers Plan, including that it is part of public health zone planning and what zone
  - Acknowledgment that the certified beds are temporary and will cease to exist when the facility no longer operates as a healthcare isolation center
- If the isolation center is going to be located within a current NH facility that houses non-COVID-19 residents, the Isolation Center will:
  - Be a separately identifiable part of the building (e.g., a wing or floor)
  - Have a separate entrance, if appropriate
  - Have segregated, isolation center-only staff
- A floor plan of the Isolation Facility or Unit
- A letter signed by the facility and the regional hospital zone documenting the need for the isolation and/or quarantine capacity with their application.

- A letter of readiness to ODH indicating that the facility is prepared for a survey of the facilty or unit, if applicable

Please send to the standard ODH nursing home email at liccert@odh.ohio.gov and james.hodge@odh.ohio.gov.

Once the notification (or application) is received, ODH will work with ODM to process the request and complete a survey, if applicable. Only HCICsthat are working within the public health hospital zone in coordination with the regional plan will be considered.

Ohio | Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor
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FACILITY CAPACITY INCREASE REQUIREMENTS AND PROCESS

For Internal Facility Cohorting Increases for Create or Unrelated to an HCIC

As part of Ohio's effort to address needed surge capcity in the continuing response for COVID-19, facilities in Ohio will be permitted to increase their certified capacity in order to create flexibility and measures to respond. This option is for capacity increase and is not a Health Care Isolation Center. The Ohio Department of Health (ODH) is working with the Centers for Medicare and Medicaid Services concerning these centers. Any adjustments or additional information that may be needed will be immediately communicated to facilities and providers.

A facility is required to complete an application if its request and plan meets either of the following conditions:

- The plan includes the facility increasing certified beds higher than its licensed capacity.
- The plan includes using non-certified space, which may include going beyond the four walls of the facility (ex: RCF space).

All other types of expansions that would be licensed and certified beds would be a normal capacity increase and regular procedure through ODH would be followed. This allows ODH to properly account for the temporary beds created in the state and allowing for proper identification for facilities that may require an onsite survey as part of their plan.

ODH requires the following information for expanding certified capacity beyond the facilities licensed capacity:

- Identifying Information:
  - Facility making request by name, address, city, zip code, county, and telephone number.
  - Facility CCN
  - Facility License Number (if applicable)
  - Corporate Affiliate name (if applicable)
  - Name and contact information of the Administrator
- The number of certified beds proposed for additional service
- Acknowledgment that the certified beds are temporary and will cease to exist when the current emergency situation ends
- A Floor Plan identifying changes and additions to capacity
- A letter of readiness to ODH indicating that the facility is prepared for a survey of the unit, if applicable.

Please send to the standard ODH nursing home email at liccert@odh.ohio.gov and james.hodge@odh.ohio.gov .

Once the notification (or application) is received, ODH will process the request and complete a survey, if applicable.

INSTRUCTIONS
For Completion of the Ohio Department of Health
HEALTH CARE ISOLATION CENTER/SURGE FACILITY REQUEST FORM

This form is for facilities that desire to: (1) utilize an entire new or existing facility as a Health Care Isolation Center; (2) utilize part of an existing facility as a Health Care Isolation Center; (3) expand its capacity or surge into un-certified space or a new building to support an HCIC; and (4) expand its capacity or surge into un-certified space or a new building to meet the needs of the facility and its residents. For purposes of this form, the latter two will be requested under Facility Surge.

Instructions

1. Complete every section of the Health Care Isolation Center/Surge Facility Request Form by typing. Incomplete or illegible forms will be returned.

2. Falsification or misrepresentation is prohibited by state law.

3. If there is insufficient space to complete an answer, continue the answer on an additional separate sheet. If multiple answers are listed on an additional separate sheet(s), please number your responses according to the question being answered.

4. Indicate if attaching supporting documentation.

5. The following ***must*** be included in order to be recommended for approval:

    a. A floor plan of the facility detailing where Health Care Isolation Center/Surge Facility, as applicable, including beds, will be located;

    b. A letter signed by the facility and the regional hospital zone documenting the need for the isolation and/or quarantine capacity (*HCIC only*); and

    c. A letter of readiness to ODH indicating that the facility is prepared for a survey of the facility or unit, if applicable.

6. Return this, along with any supporting documentation and your request to liccert@odh.ohio.gov and james.hodge@odh.ohio.gov.

Ohio Department of Health
Bureau of Regulatory Operations

Nursing Home/Residential Care Facility
Health Care Isolation Center/Surge Facility Request Form

Facility Name:			License Number (if applicable):
Street Address:			Facility CCN
City:	Zip:		County:
Telephone (including Area Code):	E-mail of Administrator:		Public Health Emergency Zone:
Name of Administrator:			LNHA Number (if applicable):

If Different Than Above

Isolation Center Name:		Include Licensed/Certified Space within Last 12 Months? ☐ YES ☐ NO
Street Address:		Telephone (including Area Code):
City:	Zip:	County:

Type of Surge Facility (select only one):		**Type of HCIC (Choose One)**
1 Use Entire Building as Isolation Center (select sub-type)	☐	☐ HCIC-Q
Existing Nursing Home	☐	☐ HCIC- I
New Surge Building	☐	☐ HCIC-IQ
2 Use Area Within Existing Nursing Home	☐	☐ HCIC-Q ☐ HCIC- I ☐ HCIC-IQ
3 Facility Surge Over Capacity or Into Non-Certified Space	☐	(Not Applicable)

Licensed Capacity:	Certified Capacity:	Current Certified Bed Utilization:	
		HCIC-Q	HCIC-I
Additional Certified Beds Requested:			
HCIC-Q:	HCIC-I:	Non-COVID Surge Over Capacity or Into Non-Certified Space:	

Attestation of Administrator

1. If requesting to be a Health Care Isolation Center, I meet the requirements:
    a. For federal certification as a nursing facility; and
    b. Outlined in the Novel Coronavirus-19 (COVID-19) Health Care Isolation Centers Plan, including that it is part of public health zone planning and what zone.
2. I have the requisite financial ability to operate the Health Care Isolation Center or Surge Facility.
3. I have the ability to properly staff the Health Care Isolation Center or Surge Facility, as applicable.
4. I acknowledge that any certified beds are temporary and will cease to exist when the facility no longer operates as a Health Care Isolation Center or Surge Facility, as applicable.

I DECLARE UNDER PENALTIES OF FALSIFICATION AS SET FORTH IN CHAPTERS 2921. OF THE OHIO REVISED CODE THAT THE ANSWERS PROVIDED ON THIS FORM ARE TRUE, CORRECT, AND COMPLETE.

Administrator's Signature:	Date:	Administrator's Name:

Health Care Isolation Center (HCIC) Technical Assistance Teams

The Ohio Department of Health (ODH) and the Ohio Department of Medicaid (ODM) will form technical assistance teams for each Regional Healthcare Zone to support the application process, start-up, operation and closure of HCICs.

Each zone will have a dedicated team, all teams will be led by leadership from ODH and ODM to include an epidemiologist from ODH, an Ombudsman from the State Ombudsman Office, a representative from the Department of Mental Health and Addiction Services and the Department of Developmental Disabilities.

ZONE 1	ZONE 2	ZONE 3
James Hodge-Team Lead	Rebecca Sandholdt-Team Lead	Julie Evers-Team Lead
ODH REP	ODH REP	ODH REP
ODH REP	ODH REP	ODH REP
ODM REP	ODH REP	ODM REP

Team Lead Point of Contact Information:

James Hodge
Email: James.Hodge@odh.ohio.gov

Rebecca Sandholdt
Email: Rebecca.sandholdt@odh.ohio.gov

Julie Evers
Email: Julie.Evers@medicaid.ohio.gov

Requests for Technical Assistance should come to the team leads. Identify in the request the topics to be discussed and a proposed time. The Team Lead will coordinate a call with the zone technical assistance team and other representatives within the respective agencies.

Topics for technical assistance include but are not limited to the following areas:

1. Application Process:
    a. Requirements to be a HCIC
    b. Submission process
    c. Documents required with application
    d. Approval process
    e. Notification process
2. Payment Process:
3. Survey Guidance:
    a. Focused Infection Control Survey
4. Infection Control Guidance:
    a. PPE guidance
    b. Testing

5. Admission and Discharge Guidance:
    a. Requirements for Admission
    b. Discontinuation of Isolation Precautions
    c. Checklists
6. General Operations Guidance:
7. Required Daily Check-in:
    a. What to report
    b. When to report
    c. How to report
8. Closure of HCIC:
    a. Notification process
    b. Disposition of equipment and supplies supplied by other entities