UH COVID-19 LTC/PAC Playbook

COVID-19 Outbreak Pre-Planning and Management

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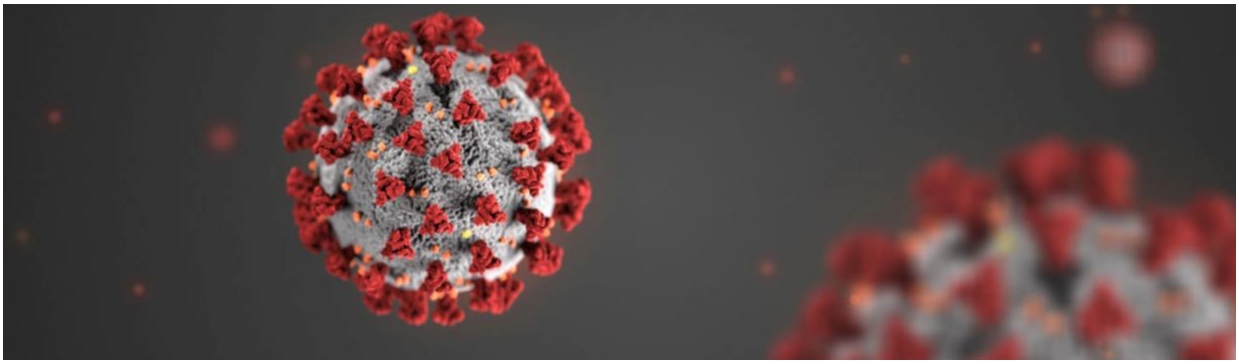
University Hospitals



COVID-19 Incident/Emergency Management Pre-Plan

(Long-Term Care / Post-Acute Care Facilities)

- Team Building
- Transmission Reduction
- Triage Preparedness
- Targeted Conversations
- Telehealth Capabilities
- Test & Treat in Place
- Transitions of Care

Seven (7) Pillars of COVID-19 Incident/Emergency Management Pre-Planning

Document Hyperlinked Sections Index:

COVID-19 Incident/Emergency Management Pre-Plan

Long-Term Care / Post-Acute Care Facilities

CDC Guidance to LTC Facilities

I. Pillar 1: Team Building

a. Form an interdisciplinary coalition of local/regional healthcare stakeholders including:

   i. Nursing Facility Leadership
      1. Administrator
      2. Director or Nursing
      3. Medical Director
      4. Consultant Pharmacist
      5. Consider Others: Attending Physicians, Advanced Practice Providers (APPs), Social Services, Admissions Director, Therapy Department Leadership, etc.

   ii. Hospital or Health System Leadership
      1. HICS (Hospital Incident Command Structure) Post-Acute Care Liaison
      2. Chief Medical and/or Nursing Officer
      3. Hospitalist Physician

   iii. Other Local/Regional Healthcare Entities:
      1. Local Public Health Department (City/County)
      2. Local EMA (Emergency Management Agency)
      3. EMS/Transportation Providers
      4. State/Local LTC Ombudsman
      5. Hospice & Home Health Care Providers

b. Identify & designate a hospital based HICS representative who can serve as a centralized point of contact for team communication, coordination of resources, and daily reporting

c. Develop communication strategies and tools to facilitate daily reporting, team/coalition communication, and management and transfer of residents:

   i. Health Department:
      1. Ensure you have an established contact with your local health department; when to call; how to report COVID-19 Person Under Investigation (PUI) or COVID-19 positive residents; and what support they might be able to provide in terms of staff education, facility-preparedness, PPE resources, COVID-19 testing, and interfacility surge guidance.

2. ODH Local Health Department resource guide: https://odh.ohio.gov/wps/portal/gov/odh/find-local-health-districts

ii. Local Health System(s) or Hospital(s)

1. Establish a point of contact with your local hospital, preferably one who is connected to the HICS and can serve as a centralized point of contact and communication for the team

2. Develop and utilize a daily situational reporting (SIT-REP) to communicate daily with the coalition's central point of contact and communication within the HICS (COVID-19 Daily Facility Situation Report). This tool is used to assess facility status and need, and to help local hospitals to prepare for surge within the community. The SIT-REP should include the following for your facility:
    a. Contact information
    b. Current census & bed availability
    c. COVID-19 resident population status report
        i. Total number of COVID-19 positive residents
        ii. Total number of COVID-19 PUI residents
        iii. Total number of COVID-19 tests pending
        iv. Number of active COVID-19 positive residents currently in the facility (removing those who are deceased or released from isolation)
    d. Code status reports
    e. Clinical decline/concern & hospitalization risk
    f. PPE supplies
    g. Staffing vacancies
        i. Total number of COVID-19 positive staff
        ii. Total number of COVID-19 PUI staff who are being self-quarantined and not working
        iii. Total number of COVID-19 tests pending

3. Follow any established protocols for facility/facility or provider/provider communication during patient transfers.
    a. For direct admission of COVID-19 positive or PUI to the hospital floor (bypassing Emergency Department) Physician-to-Physician coordination and handoff is required.
    b. For COVID-19 positive or PUI residents being sent to the Emergency Department (ED), at minimum a Nurse-to-Nurse coordination and handoff is required prior to moving the patient.

iii. When a resident or staff member tests positive for COVID-19 or is designated as a COVID-19 PUI notify the following to begin contact tracing and appropriate isolation precautions:
    1. Local health department

2. HICS-designated centralized team contact

3. Facility Medical Director & resident's attending physician

4. Resident (or their responsible party) if the resident is being designated as COVID-19 Positive or COVID-19 PUI

5. All residents and/or their responsible parties when a COVID-19 index case is present within the facility

6. Any sending or receiving facility/agency where the resident was residing or receiving care in the fourteen (14) days prior to their onset of symptoms (or positive test)

II. Pillar 2: Transmission Reduction

a. Establish a COVID-19 facility population screening and monitoring protocol for residents, staff, vendors, and visitors:

i. Establish persons with suspected illness as a COVID-19 PUI (Person Under Investigation) if falling into one or more of these categories:

1. Symptoms and Clinical Features of COVID-19:

a. **Fever** (≥ 100.4ₒF/38ₒC or ≥2ₒF above established baseline), or
b. **Cough**, or
c. **Dyspnea** (shortness of breath), or
d. Other viral-like symptoms: Chills, Muscle/Body Aches, Fatigue, Sore Throat, New Loss of Taste or Smell, nausea, vomiting, diarrhea, weakness or lethargy, runny nose, nasal congestion, etc.

2. Exposure to a person having known COVID-19 infection:

a. CDC gives Public Health Guidance for Community-Related Exposure, and defines exposure as an individual who has had:
i. Close contact (< 6 feet), and
ii. For ≥ 15 minutes, and
iii. Irrespective of PPE utilization

b. CDC also gives Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel (HCP) with Potential Exposure to COVID-19, and defines exposure as a HCP who has had:
i. Close contact (< 6 feet), and
ii. For ≥ 15 minutes (or any duration if the exposure occurred during performance of an aerosol generating procedure), and
iii. With a patient, visitor or HCP having confirmed COVID-19 infection, and
iv. Exposed HCP not wearing appropriate PPE

ii. COVID-19 Illness Severity Classifications:

1. **Mild Illness**: individuals who have any of the various signs and symptoms of COVID-19 but without shortness of breath or abnormal chest imaging

2. **Moderate Illness**: individuals with evidence of lower respiratory disease by clinical assessment or imaging and an oxygen saturation (SpO2) ≥ 94% on room air

3. **Severe Illness**:
    a. Respiratory rates > 30 breaths per minute, or
    b. SpO2 < 94% on room air (or decrease from baseline of > 3%), or
    c. Ratio of arterial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) < 300 mmHg, or
    d. Lung infiltrates > 50%

4. **Critical Illness**: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction

iii. Brief interactions are less likely to result in transmission; however, symptoms and the type of interaction (e.g. an infected person coughing directly into the face of the exposed individual) remain important.

iv. Screening/monitoring should be performed daily at a minimum, however it may be clinically appropriate to screen/monitor residents more frequently (this determination should be made on a case-by-case basis in conjunction with the facility medical director.

v. Restrict access to all symptomatically ill and/or non-essential persons

vi. Staff with clinical features of COVID-19 should be tested and return to work in conjunction with CDC Return to Work Guidance:

b. Other practical ways to reduce COVID-19 transmission risk include:

i. Reduce close contact exposure (minimum 6 feet of social and professional distancing when possible)

ii. Appropriate utilization of Personal Protective Equipment (PPE) – For additional information see CDC guidance: Using Personal Protective Equipment

iii. Dedicated staffing on individual floors or units within the facility

iv. Consolidate resident care activities such as nursing care, personal care, and medication administration.

1. Work with the consultant pharmacist and medical director to discontinue any non-essential or unnecessary medications

2. Work with the consultant pharmacist to reduce the number times that medication administration is taking place on patients with known or suspected COVID-19

v. Utilization of virtual care platforms (telehealth) for facility staff, ancillary staff, visitors, and providers when possible to reduce close contact exposure and in some cases to preserve PPE

vi. Ongoing training and monitoring of transmission-based precautions including: Isolation techniques; droplet and contact precautions; handwashing and coughing technique; social and professional distancing, and donning/doffing of PPE

vii. Environmental strategies such as enhanced ventilation systems; sterilization/sanitization of PPE, surfaces/floors, personal devices; equipment; dedicated staff entrance with area to store personal items

viii. Masking of all staff, especially when providing close contact resident care or in situations where social/professional distancing are difficult

ix. Appropriate and timely cohorting of residents

c. CMS has issued Nursing Home Reopening Guidance that outlines criteria that could be used to determine when nursing homes could relax restrictions on visitation and group activities and when such restrictions should be reimplemented.

III. Pillar 3: Triage Preparedness, Management & Recovery

a. Creating capacity for COVID-19 positive and COVID-19 PUI in the facility:

i. Home/Community (Long-Stay Residents): Transition residents to home or community, with/without Home Health Care services, when safe and where suitable caregiver support is available.

ii. Home/Community (Short-Stay Residents): Transition clinically stable short-stay residents to their home or community with Home Health Care services when safe and where suitable caregiver support is available:

1. Establish a plan of care upon admission to reduce targeted length of stay (LOS) in the SNF and to accelerate discharge to home/community in conjunction with Home Health Care services

2. Involve patient/responsible party with a Home Health Care representative in early care planning discussions (within 48-72 hours of SNF admission) to set a target date for accelerated discharge and to facilitate the timely completion of all necessary home and clinical needs assessments

3. Use of virtual care platforms can serve to extend nursing support/monitoring and provider (Physician & APP) services into the home/community settings

iii. Hospital and Alternate SNF Placement

1. The LTC/PAC facility must make every effort to accept the readmission of COVID-19 positive patients back to their facility from the hospital when they have been deemed clinically stable, unless the facility is unable to safely manage them and/or where there is:
    a. Insufficient staffing
    b. Insufficient personal protective equipment (PPE)
    c. Inability to appropriately cohort or isolate
    d. Halting of admissions/readmissions by a governing healthcare authority

2. Restrict movement of COVID-19 positive or COVID-19 PUI residents to alternate sites of care unless deemed medically and clinically necessary.

3. When possible, coordinate transfers in advance to enhance planning and reduce the risk of exposure to frontline healthcare workers

4. If you are unable to manage an asymptomatic or clinically stable, COVID-19 positive or COVID-19 PUI resident safely and effectively in your facility, consider transferring to a Health Care Isolation Center (HCIC) in your region; there are three (3) types of HCIC designations:

    a. **HCIC-I**: This is a facility having a designated isolation unit for COVID-19 positive residents

    b. **HCIC-Q**: This is a facility having a designated quarantine unit for COVID-19 PUI resident (suspected based on clinical features or exposure risk)

    c. **HCIC-IQ**: This is a facility having both a dedicated isolation and quarantine unit.

b. Develop a COVID-19 Isolation and Quarantine capability within your facility:

    i. Establish a dedicated space within your facility in preparation for any residents who are determined to be COVID-19 PUI or COVID-19 Positive; ideally two (2) separate units as follows:

        1. Quarantine Unit: For patients who are COVID-19 PUI (suspected based on clinical features or exposure risk)

        2. Isolation Unit: For patients who are COVID-19 positive

    ii. Identify an area of congregated rooms or an entire wing/hall/unit with following recommendations including:

        1. Recommend a minimum of 6-beds each

        2. Recommend private rooms

        3. Adequate and readily accessible (on the unit) supply of personal protective equipment (PPE), including:
            a. Gowns
            b. Gloves
            c. Clinical Masks & N95 Masks
            d. Eye Protection
            e. Hats
            f. Booties

        4. Dedicated COVID-19 staffing and equipment to reduce likelihood of transmission to the non-COVID-19 population (consider utilizing COVID+ staff who are now able to return to work per CDC guidelines)

5. Consider a system for remote patient vital sign monitoring (including Pulse Oximetry) to monitor residents for decompensation in real time and to limit close contact exposure and PPE utilization for staff

6. Proximity to a separate facility entrance

7. Dedicated areas for staff PPE donning/doffing

c. COVID-19 Risk Assessment, Triage & Testing and Return to Work for ***Healthcare Personnel*** (HCP)

i. Neither COVID-19 Positive or COVID-19 PUI

1. **Low Risk** for COVID-19 transmission: No clinical features/symptoms of COVID-19 and no known direct exposure to a person with known COVID-19 infection

2. COVID-19 testing is not Priority 1 or 2

3. Continue daily facility screening/monitoring for the development of clinical features of COVID-19 infection

4. Continue appropriate handwashing/sanitizing technique and applicable transmission-based precautions

5. Worker to self-monitor and self-report (prior to resident care) any development of COVID-19 clinical features, close contact/exposure with a known COVID-19 positive person, and/or travel risk for COVID-19

ii. COVID-19 PUI

1. **Moderate Risk** for COVID-19 infection/transmission: with confirmed close contact with known COVID-19 positive person but without clinical features of COVID-19

a. COVID-19 testing is Priority 2

b. Continue daily facility screening/monitoring

c. Continue appropriate handwashing/sanitizing technique and transmission-based precautions

d. Worker to monitor and report (prior to resident care) any development of COVID-19 clinical features, new close contact/exposure with a known COVID-19 positive person, and/or travel risk

e. Wear mask for a minimum of fourteen (14) days from time of close contact with a COVID-19 positive person

2. **High Risk** for COVID-19 infection/transmission: COVID-19 PUI with clinical features of COVID-19 and with/without close contact/exposure with known COVID+ person:

   a. COVID-19 testing is Priority 1

   b. **DO NOT RETURN TO WORK** until cleared by a symptom-based strategy

   c. Self-isolate and wear a mask

   d. Notify provider and escalate clinical care as needed

   e. Continue appropriate handwashing/sanitizing technique and applicable transmission-based precautions

   f. Return to work decision making should follow CDC Return to Work for Healthcare Personnel guidance

iii. COVID-19 Positive:

1. Facility to report positive test result to the local health department and the facility medical director

2. **DO NOT RETURN TO WORK** until cleared by a time or symptom-based strategy

3. Self-isolate and wear a mask

4. Continue appropriate handwashing/sanitizing technique and applicable transmission-based precautions

5. Notify provider and escalate clinical care as needed

6. Return to work decision making should follow CDC Return to Work for Healthcare Personnel guidance

7. CDC no longer recommends a test-based strategy for determining when to allow a HCP to return to work (except in rare situations)

d. Discontinuation of Isolation Precautions and Return to Work for HCP [See CDC: Return to Work for Healthcare Personnel (HCP) guidance and CDC: Discontinuation of Transmission-Based Precautions for Patients with COVID-19]

i. HCP (or patient) with mild to moderate illness who is ***NOT*** severely immunocompromised:

1. Symptom-Based Strategy (for HCP with confirmed COVID-19 infection and **with** symptoms)

a. At least 10 days have passed since symptoms first appeared, **AND**

b. At least 24 hours have passed since last fever without the use of fever-reducing medications, **AND**

c. Symptoms (e.g. cough, shortness of breath) have improved

2. Time-Based Strategy (for HCP with confirmed COVID-19 infection, with mild to moderate illness, and **without** symptoms)

a. If asymptomatic throughout the infection, HCP may return to work when at least 10 days have passed since their first positive viral diagnostic test.

ii. HCP (or patient) with severe to critical illness OR who is severely immunocompromised:

1. Symptom-Based Strategy (for HCP with confirmed COVID-19 infection and **with** symptoms)

a. At least 20 days have passed since symptoms first appeared, **AND**

b. At least 24 hours have passed since last fever without the use of fever-reducing medications, **AND**

c. Symptoms (e.g. cough, shortness of breath) have improved

2. Time-Based Strategy (for HCP with confirmed COVID-19 infection, with severe to critical illness or severely immunocompromised, and **without** symptoms)

    a. If asymptomatic throughout the infection, HCP may return to work when at least 20 days have passed since their first positive viral diagnostic test.

iii. The use of test-based strategies for removal of isolation and transmission-based precautions, and return to work for HCP

1. CDC Criteria:

    a. Resolution of fever without the use of fever-reducing medications, **AND**

    b. Improvement in respiratory symptoms (e.g. cough, shortness of breath), **AND**

    c. At least two (2) consecutive negative COVID-19 tests collected ≥ 24 hours apart

2. CDC Decision Memo on viral shedding and recommendations for using test-based strategies – summary statement:

    a. 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms

    b. No patient had replication-competent virus 20 days after onset of symptoms

    c. Due to risk of extensive and close contact with vulnerable individuals in healthcare settings a more conservative period of 20 days was applied to CDC HCP return to work guidance

    d. Because the majority of patients no longer appear to be infectious 10-15 days after the onset of symptoms, facilities operating under critical staffing shortages might choose to allow HCP to return to work after 10-15 days instead of 20.

e. COVID-19 Risk Assessment, Triage & Testing for ***Residents***

i. Not a COVID-19 Positive or PUI (Person Under Investigation)

1. **Low Risk** for COVID-19 transmission: No clinical features/symptoms of COVID-19 and no known direct exposure to a person with known COVID-19 infection

2. COVID-19 testing is not Priority 1 or 2

3. Continue daily facility screening/monitoring for the development of clinical features of COVID-19 infection

4. Continue appropriate handwashing/sanitizing technique and applicable transmission-based precautions

ii. COVID-PUI

1. **Moderate Risk** for COVID-19 infection/transmission: PUI with confirmed close contact with known COVID-19 person but without clinical features of COVID-19:

a. COVID-19 testing is Priority 2

b. Continue daily facility screening/monitoring

c. Continue appropriate handwashing/sanitizing technique and applicable transmission-based precautions

d. Wear mask for a minimum of fourteen (14) days from time of close contact with known COVID-19 positive person

e. Transition patient to dedicated COVID-19 PUI bed/unit if possible

f. Isolate and institute transmission-based precautions

2. **High Risk** for COVID-19 infection/transmission: COVID-19 PUI with clinical features of COVID-19 and with/without close contact/exposure with known COVID-19 positive person:

a. COVID-19 testing is Priority 1

b. Wear mask until all symptoms are completely resolved or a minimum of fourteen (14) days from illness onset, whichever is longer.

c. Transition patient to dedicated COVID-19 PUI bed/unit if possible

d. Isolate and institute transmission-based precautions per CDC guidance

e. Institute remote vital sign monitoring if possible

f. Notify provider and escalate clinical care as needed

iii. COVID-19 Positive: Any resident/patient testing positive

1. Facility to report positive test to:

   a. The local health department

   b. The facility Medical Director

   c. Any sending facility, agency or healthcare provider caring for the resident in the past fourteen (14) days.

2. Wear mask until all symptoms are completely resolved or a minimum of fourteen (14) days from illness onset, whichever is longer;

3. Transition patient to dedicated COVID-19 PUI bed/unit if possible;

4. Isolate and institute transmission-based precautions per CDC guidance

5. Institute remote vital sign monitoring if possible;

6. Notify provider and escalate clinical care as needed;

7. Removal of isolation and transmission-based precautions and/or movement of a COVID-19 positive resident out of a dedicated COVID-19 unit to another location should be done in coordination with and under the guidance of the local health department.

8. Symptomatic patients with COVID-19 should remain in Transmission-Based Precautions until they have fulfilled CDC guidance for a symptom or time-based strategy to remove isolation precautions (see Section III.d.)

f. COVID-19 Triage Management & Recovery Strategies

i. **Facility Triage/Cohort Zone Strategy**:

1. **Gray Zone**: These zones are "**neutral"** and include spaces such as nurses' station and ante-chambers

2. **Green Zone**: This zone is a "**cold**" zone for COVID negative residents who are asymptomatic and without known direct COVID exposure; this is the general population of the facility and the clinical goal is to protect and defend this group of residents.

3. **Orange Zone**: This zone is a "**warm**" zone; primarily comprised of COVID-19 PUI patients (symptomatic and/or known exposure); a dedicated unit where patients can be isolated in place and remain until COVID-19 diagnosis is confirmed or excluded.

    a. If testing unavailable: patients must clear a symptom or time-based strategy for removal from transmission-based precautions; then move to the "**Yellow**" Zone

    b. If testing available:

        i. Patients who test positive for COVID-19 move to the "**Red**" Zone

        ii. Patients who test negative and are asymptomatic move to the "**Yellow**" Zone

        iii. Patients who test negative and are symptomatic remain in the "**Orange**" Zone until they meet a symptom-based strategy for discontinuation of transmission-based precautions; then move to the "**Yellow**" Zone

4. **Red Zone**: This zone is a "**hot**" zone; it is intended to be utilized as an isolation unit for COVID-19 positive patients and for those testing negative for COVID-19 but displaying active clinical features/symptoms of COVID-19

    a. Removal of a patient from the red zone requires Symptom/Time-Based strategy for discontinuation of transmission-based precautions; then move to "**Yellow**" Zone

5. **Yellow Zone**: This zone is a "**cool**" zone; utilized for quarantining of new admissions and/or cooling down of COVID-19 positive patients who have been cleared to transition from the "**Orange**" or "**Red**" Zones; the Yellow Zone allows for the safe entrance of new facility admissions ("Re-Opening Strategy") and safe movement of COVID-19 positive or PUI patients back into the "**Green**" Zone (General Population).

IV. Pillar 4: Targeted Conversations

a. Advance Care Planning (ACP) & End-of-Life Conversations

i. Work with facility clinical leadership and health care providers to proactively engage in advance care planning conversations with all residents (and/or their responsible parties) to address:

1. Clinical conditions, prognosis, & goals of care

2. Advance directives (i.e. Living Will and/or Durable Power of Attorney for Health Care)
    a. Ensure access to all Advance Directives and make them available to any receiving healthcare facility, agency or provider for all care transfers;

3. Code Status (i.e. Full Code, DNR-Comfort Care Arrest, DNR-Comfort Care)
    a. Utilize the approved/recognized Ohio DNR Comfort Care Order Form and include with all care transfers
    b. Re-educate staff and providers on DNR interpretation and messaging during pandemic crisis to simplify understanding and encourage use of DNR-CCA:

        i. Full Code = Full Medical Care prior to arrest and at the time of arrest

        ii. DNR-CCA = Full Medical Care prior to arrest and comfort care at the time of arrest

        iii. DNR-CC = Comfort Care prior to arrest and at the time of arrest

ii. Prioritize advance care planning conversations for residents having an “Unknown” or “Full Code” status & re-message these residents or their responsible parties as to the importance of considering a transition from Full Code to DNR-CCA for COVID-19 positive residents during a time pandemic crisis:

1. To reduce unnecessary hospital transfers of patients who have arrested and/or may be deceased;

2. To reduce close contact of COVID-infected patients with healthcare workers whenever possible;

3. To reduce the unnecessary utilization of PPE resources

iii. Consider the utilization of ACP conversation resources such as:

1. The Conversation Project (COVID-19): © 2020 Institute for Healthcare Improvement & Ariadne Labs, or

2. The Serious Illness Conversation: © 2015 Ariadne Labs

iv. Engage local hospice providers to assess their ability to care for COVID-19 patients, and to develop processes to streamline communication and engagement with residents (or their family/responsible party) when appropriate

V. Pillar 5: Telehealth Capabilities

a. Virtual/Telehealth Strategy

i. As a facility team, select a virtual/telehealth platform which will be simplest to implement

ii. Options during the COVID-19 pandemic crisis include common technologies that are not generally acceptable in healthcare settings such as: Zoom®, Skype®, FaceTime®, etc.

1. Test your system in advance and develop protocols for use that will help to coordinate staff and providers (especially when the provider's access to patients is limited by COVID-19 restrictions or infection)

2. Practical application of virtual technology:
    a. Provider (Physician/APP) visits (for both offsite and onsite encounters) to reduce close clinical contact and preserve PPE supplies;
    b. Nursing and Interdisciplinary Team rounding
        i. Maximize planned (and unplanned) resident care to accomplish interdisciplinary assessment and provider engagement
        ii. Coincide daily provider COVID rounds with routine resident care delivered by nursing staff, nursing aides or other facility staff who needs to provide direct resident care.
    c. Family, friends, and/or responsible party
    d. Outside healthcare specialists/providers
    e. Clergy

iii. Consider implementing a remote vital sign monitoring platform

iv. For additional information and resources see CDC guidance: Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic

VI. Pillar 6: Test & Treat in Place

a. Strive to manage clinically stable COVID-19 residents in the facility

b. **Testing**: Practical aspects to COVID-19 testing in LTC/PAC facilities

i. Testing should be done in accordance with the local/county health department and follow ODH testing prioritization guidance.

ii. Clinically stable residents should not be transferred to a local hospital for testing unless deemed necessary by the team/coalition;

iii. Testing strategies:

1. **Individual**: reserved for residents and/or healthcare workers who have symptoms consistent with COVID-19 infection or exposure to an infected person

2. **Group**: Testing of entire units or facility populations, including direct-care staff, may be warranted in certain situations as some people will actively shed virus in an asymptomatic or pre-symptomatic state

iv. Utilization of a hospital “hotline” and “testing team” model to improve coordination/allocation of resources and to circumvent the need to utilize external laboratories with protracted result turnaround times;

v. Test ordering, collection, and results should be tracked closely and reported through a centralized point of contact within the HICS team to ensure timely communication, intervention, coordination of resources, and hospital surge planning.

vi. If there are limited testing capabilities, prioritize testing for residents/staff by risk status;

vii. There are typically three (3) potential sources for testing in the SNF and the Medical Director should explore which is best suited to the facility population and situation, taking into account availability and turnaround time:
1. Local Health Department (in conjunction with ODH)
2. SNF in-house laboratory services
3. Local hospital or medical center

c. **Treatment**: See CDC: Therapeutic Options for COVID-19 Management

   i. There are no drugs or therapeutics presently approved by the FDA to prevent or treat COVID-19.

   ii. Current clinical management includes infection prevention and control measures and supportive care, including supplemental oxygen and mechanical ventilatory support when indicated.

   iii. The National Institutes of Health have published Interim Guidelines for the Medical Management of COVID-19

VII. Pillar 7: Transitions of Care

a. Transfer to the hospital

i. Pre-transfer communication with receiving facility; call the transfer center to coordinate transfer communications;

1. Physician-to-Physician for direct hospital admission to regular nursing floor, step-down unit, or ICU (bypass ED)

2. Nurse-to-Nurse report must be given prior to patient's departure from the SNF to allow for proper preparedness

ii. Proper notification to transporting agency as to COVID-19 positive or PUI status and Code Status (including Ohio DNR Form if applicable)

iii. Diversion to ED or ICU (for floor/step-down destinations) on a planned direct hospital admission

1. Vital Sign Concerns:
    a. Heart Rate < 50 or > 120 beats per minute with symptomatic changes in condition
    b. Systolic Blood Pressure < 90 or > 200 with symptomatic changes in condition
    c. Pulse Oximetry SpO2 < 88% on supplemental O2 and in significant respiratory distress or change in mental status
    d. Respiratory Rate < 8 or > 24 breaths per minute and in significant respiratory distress
2. Severe chest pain
3. Obvious respiratory distress or imminent respiratory failure
4. Syncope, altered mental status, or shock
5. Other medical emergency requiring immediate intervention

iv. Call ED prior to arrival with patient report so that they can prepare for the COVID-19 positive or PUI patient

v. **NOTE**: Potential for limited transport during a public health disaster:

1. During a time of public health disaster, no resident of a long-term care or skilled nursing facility may be removed from the facility and transferred to a hospital unless a physician determines it is medically necessary.

2. If it is determined, subsequent to the resident being removed from the facility, that there is no medical necessity for the resident to be treated at, or admitted to, a hospital, or if there

is no longer a medical necessity present, the resident shall be immediately returned to and placed back in the facility

vi. **Avoid**:

1. Sending clinically stable COVID-19 PUI residents to the hospital for COVID-19 testing; this testing can be completed in the LTC/SNF setting in conjunction with your local health department, facility laboratory services provider, and/or through agents of the local hospital.

2. Activating EMS via 911 for non-emergent facility transfers

vii. **Always**:

1. Coordinate transfers of patients to hospitals using direct admission protocols and/or through a dedicated transfer center process

2. Send with the resident their Ohio DNR Form & advance directives (as applicable)

3. Send with the resident their medications, especially multi-dose inhalers (MDIs) and other respiratory medications

b. Return to SNF Practices for COVID+ Residents

i. Patients who resided in a skilled-long term care facility prior to transfer to the hospital that receive a COVID-19 positive test should be discharged back to the facility of residence once they are medically stable. Patients that tested positive for COVID-19 prior to admission should be transferred back to their facility of residence per CDC guidance as follows:

1. If Transmission-Based Precautions are still required upon discharge, the facility must adhere to infection prevention and control recommendations for the care of COVID- 19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19, such as a unit or wing designated to house COVID-19 residents

2. If Transmission-Based Precautions are to be discontinued, but the patient has persistent symptoms from COVID-19 (e.g. persistent cough), resident should be placed in a single room, be restricted to their room, and wear a facemask during care activities until all symptoms are completely resolved or until CDC symptom/time-based guidance achieved.

3. If Transmission-Based Precautions have been discontinued and the patient's symptoms have resolved**,** patient should be admitted without further restrictions.

ii. Patients not living in a skilled long-term care facility prior to hospitalization who receive a COVID-19 positive test and require discharge to a skilled long-term care facility should be admitted to a nursing facility with a functioning isolation unit, or to a designated Health Care Isolation Center (HCIC). The facility should follow CDC guidelines based on whether Transmission-Based Precautions are still required.

VIII. Resource Appendix

a. UH Seven (7) Pillars of COVID-19 Incident/Emergency Management Pre-Planning
(Zoom Cloud-Based Training / Handout)

b. UH COVID-19 Direct Admission Process Tool
(PDF® Version / Word® Version)

University Hospitals
Center for Patient Flow Management

Required Information for Direct Admits from SNFs & Other Congregate Living Settings

PATIENT DEMOGRAPHICS			
Patient Name			
Patient DOB			
COVID-19 Status (P=Positive; N=Negative; PUI=Person Under Investigation; NT=Not Tested, PP=Past Positive)			
Current COVID-like symptoms			
MOST RECENT SET OF VITAL SIGNS			
Temperature	Heart Rate		
Respiratory Rate	Weight		
Blood Pressure	Pulse		
Oxygen Needs			
TRANSPORT NEEDS	**Yes**	**No**	
Cardiac Monitor			
IV			
Oxygen Therapy			
Notes			
RECEIVING HOSPITAL REQUEST			
Name of Desired Hospital			
City of Desired Hospital			
Desired Level of Care			
FACILITY CONTACT INFORMATION			
Facility Name			
Facility Address			
Facility Contact Name			
Facility Contact Phone Number			
Patient Location (floor/unit)			
PRIMARY CARE PHYSICIAN			
Facility Physician		Facility Phone Number	
PCP Name		PCP Phone Number	
PROCESS			
Care Provider/Facility calls with above information to UH CPFM 216-844-1111 CPFM starts case, finds the proper admitting provider and hospital CPFM calls sending provider back for Provider to Provider conference CPFM completes bed selection and transport needs based on provider conference and patient needs CPFM will call back care facility with bed and transport information			

c. UH COVID-19 Daily Facility Situation Report (Excel® Version)

COVID-19 Daily Facility Situation Report

Today's Date (00/00/00)			
Facility Information			
Facility Name			
Street Address			
City			
Zip Code			
County			
Current Patient Census	SNF	LTC	AL/IL
Number of Patients In-House	0	0	0
Number of C-19 Positive	0	0	0
Number of C-19 Persons Under Investigation (PUI)	0	0	0
Number of C-19 Test Pending	0	0	0
Employee Status	RN/LPN	Nursing Assistant	Ancillary Services
Number of C-19 Positive	0	0	0
Number of C-19 PUI	0	0	0
Number of C-19 Test Pending	0	0	0
Code Status of Patients	Full Code	DNR CC Arrest	DNR CC
Number of Unstable or Declining Positive/PUI In-House	0	0	0
PPE Supplies	# of Days Left In Stock		
N95 Masks	0		
Face Shields	0		
Gloves	0		
Gowns	0		
Shoe/Boot Covers	0		
Staffing Vacancy	RN/LPN	Nursing Assistant	EVS/Nutrition
Based on Pre COVID-19 Staffing Levels	0%	0%	0%

d. ODH COVID-19 Testing in Ohio (Prioritization Table)

COVID-19 Testing in Ohio
Help prevent the spread of COVID-19

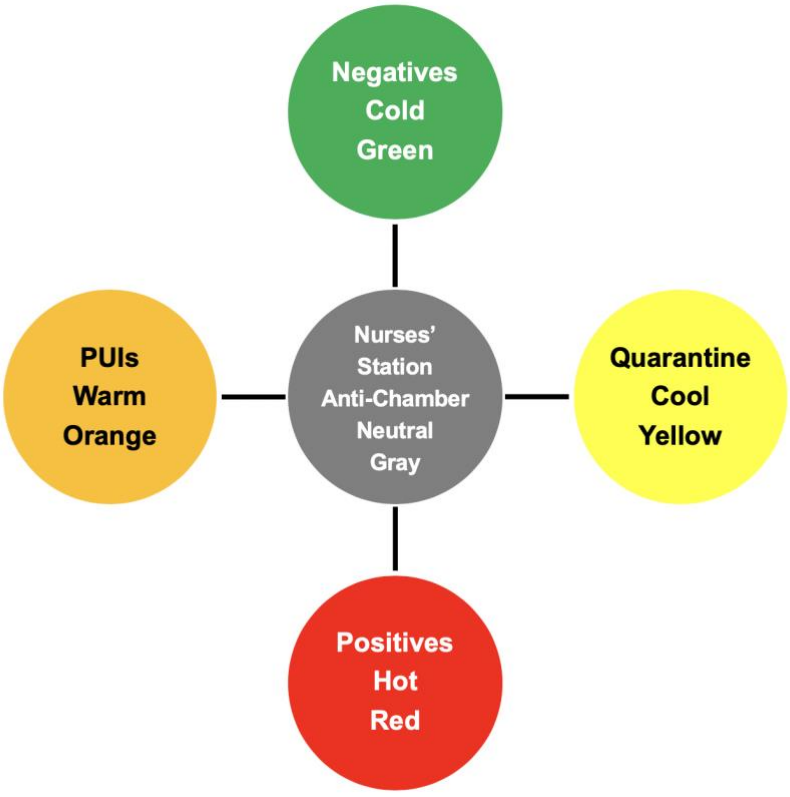
Priority 1	**Ohioans with symptoms who are:** • Hospitalized. • Healthcare workers. This includes behavioral health providers, home health workers, nursing facility and assisted living employees, emergency medical technicians (EMTs), housekeepers and others who work in healthcare and congregate living settings.*
Priority 2	**Ohioans with symptoms who are:** • Residents of long-term care/congregate living settings. • First responders/public health workers/critical infrastructure workers. • 65 and older. • Living with underlying conditions. ◦ Consideration should be given for testing racial and ethnic minorities with underlying illness, as they are at increased risk for COVID-19 and more severe illness. **Ohioans without symptoms who are:** • Residents or staff directly exposed during an outbreak in long-term care/congregate living settings. **Other Ohioans who are:** • Designated by public health officials to evaluate/manage community outbreaks (such as in workplaces, other large gatherings).
Priority 3	**Ohioans with and without symptoms who are:** • Receiving essential surgeries/procedures, including those that were reassessed after a delay. • Receiving other medically necessary procedures not requiring an overnight stay/inpatient hospital admission, as defined by their providers' process for COVID-19 testing.
Priority 4	**Individuals in the community to decrease community spread, including individuals with symptoms who do not meet any of the above categories.**
Priority 5	**Asymptomatic individuals not mentioned above.**

*Congregate living settings are those where more than six people live and where there is a propensity for rapid person-to-person spread of infectious disease. (Some examples are assisted living/nursing centers; Ohio Veterans Homes; residential facilities for mental health/substance use treatment; psychiatric hospitals/group homes; centers/facilities/group homes for people with intellectual disabilities; homeless and domestic violence shelters; youth detention centers; prisons; and jails.)

Ohio Department of Health

e. COVID-19 Cohort Zone Strategy for Nursing Facilities

Green	Orange	Red	Yellow
• COVID-19 Negative • "Cold" Unit • General Population • Strategy: Protect and Defend; Mask, Screen and Test as Indicated	• COVID-19 PUI • "Warm" Unit • Isolate • Strategy: Test for COVID-19 and Cohort Accordingly	• COVID-19 Positive • "Hot" Unit • Isolate • Strategy: Time, Symptom and/or Test-Based Strategy for Transition	• Quarantine • "Cool" Unit • Cool Down Area for Patients Moving from Orange/Red • Strategy: Safer Re-Opening and Transition to General Population



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