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Some health authorities and organizations are instructing that all elective procedures be postponed. AAAASF does not dictate adherence to recommendations regarding case selection during this health crisis, but expects facilities to adhere to any legal or regulatory orders. AAAASF continues to monitor the situation closely and expects that facilities that chose to operate will so do in a manner that is safe for patients, staff, and members of the community.

For those facilities that continue to provide care, it is incumbent upon AAAASF to ensure that appropriate precautions have been taken to protect patients, families, and staff. Although facilities accredited under AAAASF Outpatient Programs are not required to adhere to Medicare infection control and emergency preparedness standards, AAAASF standards in all programs do, however require healthcare facility protocols developed to prevent the spread of disease and infection along with documented safety manuals. The resources provided below contain COVID-19 specific prevention practices and communications for use by all facilities to aid in achieving compliance with requisite protective measures. The specific materials provided below are not required if the facility is able to create its own procedures or has access to materials from health authorities. They are provided for your assistance.

If the facility is not able to take appropriate precautions such as providing appropriate personal protective equipment (PPE) to staff and patients, the facility should consider discontinuing such services or closing entirely. We expect facilities to operate safely under all conditions. This includes compliance with all standards as well as CDC and WHO guidance regarding COVID-19.

AAAASF Official Guidance on Compliance:
All AAAASF healthcare facilities must be prepared for the possible arrival of patients with COVID-19. All facilities must ensure staff are properly trained, equipped, and capable of practices required to prevent the spread of respiratory diseases including COVID-19. The following guidance is provided to assist in that requirements and is subject to change as the situation evolves.

1. Starting in the Lobby, facility should have:
    a. Signage at the entrance instructing all who enter with symptoms of respiratory illness to:
        i. Immediately put on a mask and keep it on
        ii. cover their mouth/nose when coughing or sneezing
        iii. use and dispose of tissues
        iv. perform hand hygiene after contact with respiratory secretions.
    b. Hand sanitizer station equipped with masks and tissues and instructions for use, located close to the entrance and in all common areas.
    c. “No-touch” receptacles for disposal of tissues in waiting rooms and common areas.
    d. Ensure that patients and visitors limit their movement within facility thereby decreasing their surface points of contact.
        i. Plans for visitor access and movement that have been reviewed and updated within the last 12 months and incorporates “Social Distancing”
        ii. Maintain a record (with contact information) of all visitors.
        iii. If possible, have visitors wait in vehicles or alternate sites until patient ready for discharge

e. Use space wisely, prohibit visitors and assure appropriate distancing in the waiting room
    i. If possible, a separate well-ventilated space that allows separation by 6 or more feet, with easy access to respiratory hygiene and cough etiquette supplies, or
    ii. For patients that cannot be immediately placed in a room, a system that allows waiting in a personal vehicle or outside the facility (if medically appropriate) and be notified when it is their turn.

2. The Governing Body/Medical Director must:
    a. Have an infection control policy and procedures as well as an emergency preparedness plan that includes, among other hazards, pandemics, with specific reference to COVID-19.
    b. Communicate effectively within the facility and plan for appropriate external communication related to COVID-19.
    c. Hold daily staff meetings to educate on signs and symptoms of COVID-19, changes in practices (e.g. management of patients and visitors), and encourage staff to raise any concerns
        i. Ensuring all staff have a complete understanding of infection control and monitor for strict adherence.

    d. Establish a policy dealing with confirmed/suspected COVID-19 diagnosis in staff requiring
        i. Exposed staff to self-quarantine.
        ii. Disinfection of the entire facility.
    e. Have a written process for auditing adherence to recommended PPE use by Health Care Professionals (HCP).
    f. Have a written process for auditing adherence to recommended hand hygiene practices by HCP.

    g. Develop a policy to prioritize critical – non-elective cases, reschedule elective cases as appropriate.
        i. Patients over 50, or with underlying co-morbidities, such as diabetes, heart disease, or cancer who will be treated in the facility should be provided with additional protective measures

        ii. Patients should only continue to be seen if normal staffing can be maintained. Patients should not be put in jeopardy by skeleton crews
3. An Emergency Preparedness Plan (EPP) must be appropriate to the facility and include information on how the facility is integrated into the community's activities to help when possible, with personnel or equipment.
    a. Include "Pandemic Disease such as COVID-19" on the risk assessment and establish proper policies/protocols to deal with such.
    b. Documentation of staff training in infection control and Pandemic Emergencies, including COVID-19.
    c. If the facility maintains essential equipment such as ventilators that are in short supply for nearby hospitals you may consider offering your equipment, or if the facility is closed, you may consider offering your center as an isolation unit for COVID-19 patients or others the hospital may not be able to handle.
4. The Infection Prevention and Control Program (IPCP) requires:
    a. Facility leadership including the Medical Director, quality officers, Facility Administrators, Back-up Administrators, Director of Nursing, Infection Control Nurse and Management Staff review the CDC's COVID-19 guidance. https://www.cdc.gov/coronavirus/2019-nCoV/guidance-hcp.html
    b. All policies are consistent with the current CDC recommendation.
    c. Education and job-specific training for HCP regarding COVID-19 including:
        i. Signs and symptoms
        ii. How to safely collect and handle specimens collected as part of your routine practice
        iii. Employing correct infection control practices and PPE use
        iv. Triage procedures including patient placement
        v. HCP sick leave policies and policies to respond to HCP exposures

vi. How and to whom COVID-19 cases should be reported

d. Review of staff records for active communicable diseases, required PPD testing, and immunizations ensuring that all required documentation is present.
e. Supplies to:
    i. Ensure an adequate supply of tissue paper, hand sanitizer, and PPE such as masks, gloves, and protective eyewear for staff
    ii. Address shortages/back-orders of infection control supplies (e.g. PPE, hand sanitizer), including proposed alternatives.
        1. Any temporary practices must be based on authoritative guidance.
        2. If the facility is unable to provide adequate PPE, the facility should strongly consider shutting down.

5. Facility must adopt and maintain a written patient screening protocol.

    a. Facility's patient screening process must promptly identify and isolate patients with suspected COVID-19 pending a decision from the Medical Director whether to see the patient in the facility, advise the patient to contact their primary care physician or emergency room, and inform the correct facility staff, public health authorities, and AAAASF.
    b. All patients should be screened for elevated temperature utilizing a medical grade thermometer upon check-in to facility.

6. Environmental Services processes address:

    a. Proper cleaning and disinfection of environmental surfaces and equipment in the patient room.
        i. Public areas such as the waiting room, bathrooms, front desk, and doorknobs must be under constant cleaning with EPA-registered products that are effective against human coronaviruses.
        ii. Exam rooms must be cleaned using disinfectant after each patient.
    b. Non-dedicated equipment is cleaned and disinfected after use according to manufacturer's recommendations.

    c. All HCP with cleaning responsibilities understand the contact time for selected products.
    d. On all hard, non-porous surfaces, facility uses an EPA-registered hospital-grade disinfectant that:
        i. Has an EPA-approved "Emerging Viral Pathogen Claim for SARS-CoV-2"; or
        ii. If there are no available EPA-registered products that have an "Emerging Viral Pathogen Claim for SARS-CoV-2"; products with label claims against human coronaviruses.
    e. High touch items, such as brochures and magazines should be removed
7. Staffing protocols:
    a. Encourage staff to discuss any symptoms and allow sick leave if a staff member or member of the staff's family becomes a known or suspected COVID-19 case.
    b. Follows the local/state public health authority's policies and procedures for monitoring and managing HCP with potential for exposure to COVID-19, including ensuring that HCP have ready access, including via telephone, to medical consultation.
    c. Have a process to conduct symptom and temperature checks prior to the start of any shift
8. Facility has policies and procedures for patient examinations and procedures that require:
    a. once in the exam room, the patient receives a mask and paper gown; the provider must have a mask and gloves and PPE as needed, even for tasks as minor as physical examination.
    b. aerosol-generating procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) are to be performed in an AIIR using appropriate PPE.
    c. facility documents the staff in contact with each patient and limits the staff in contact with each patient.

    d. the dedication of non-critical patient-care equipment to individual patients with terminal cleaning between patients
9. Post-operative follow-up should be conducted virtually by telephone or video conference if possible.

A special note about supplies:

During these difficult times, consider relocating your stockpiles of hand sanitizers, alcohol wipes, facial tissue and extra rolls of toilet paper to a more secure location. Incidents of these items disappearing from the bedside and in public locations have been noted. As in many things, vigilance and awareness of our surroundings is crucial to quality patient care and the patient experience.

AAAASF strongly feels that by working together to maintain compliance and being extremely cognizant of infection control practices that we can all help to attribute to the flattening of the curve of COVID-19, thus ensuring patient safety and in turn a more rapid return to normalcy for all.

Stay safe.

Please see helpful resources and links:

- CDC Guidance for reporting suspected cases: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fclinical-criteria.html

- CDC resources for healthcare facilities
- CDC Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making handout
- Patient Under Investigation (PUI) form
- Coronavirus Disease 2019 (COVID-19) Situation Summary available on the CDC website.
- CMS Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV) dated February 6th containing information that is useful for non-Medicare facilities as well.
- CMS Infection Prevention, Control and Immunizations Tool
- Required for Medicare ASCs: ASC Infection Control Worksheet with ASF Standards
- AORN has ongoing discussions and tool kit about COVID-19 available

Sample Screening Questions

1. Before arriving for an appointment, patients should be questioned about potential exposure/symptoms, including:
    a. Whether they have traveled to any HIGH ALERT areas/overseas in the last 14 days. If yes to any HIGH ALERT area, (listed below) **RESCHEDULE**.
    b. Whether they have had any contact with a known person with the virus. If yes, the patient is instructed to RESCHEDULE their surgery.
    c. Whether they or their responsible adult/ride have had a fever or signs/symptoms of respiratory illness (e.g.: cough, shortness of breath) If yes, the patient is instructed to **RESCHEDULE** their surgery.
        i. If any are present, the patient should be referred to their primary care physician for advice
2. Upon arrival to facility, ask all patients (and visitors) as they are signing in for their appointment:
    a. Ask if they have traveled within the US/Internationally within 14 days
    b. Ask if they have had contact with an ill traveler or acquaintance
    c. Ask if they or their responsible adult/ride have a fever or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)
        i. If the answer is yes:
            1. The receptionist will give the person a mask and gel and attempt to isolate them or ask the person to wait in their car (if isolation is not possible) for the medical director to make required care decisions.
            2. Call a manager for assistance, who will further assess the individual for fever >100.4, cough, difficulty breathing.
            3. I**mmediately contact Michon Mayfield, Director of Accreditation - AAAASF at 224-701-6034**.
            4. Call local Department of Health where the individual resides.
            5. Advise patient to inform their primary care physician and follow-up
            6. Advise individual of DOH instructions and where to go
            7. If the individual is too ill to transport themselves, call 911 and inform the dispatcher of the individual's potential exposure and respiratory symptoms.

Sample COVID-19 Screening Questionnaire

2019 Novel Coronavirus Screening 2020 Questionnaire

Patient/Visitor Name: _____ DOB:_____

Please circle YES or NO to the following questions:

1.) Have **you and/or anyone accompanying you today** traveled outside the U.S.A in the last 14 days?

YES NO

2.) Have **you and/or anyone accompanying you today** been in close contact with a person known to have 2019 Novel Coronavirus?

YES NO

3.) Do you **and/or anyone accompanying you today** currently have a fever or any respiratory symptoms such as a cough or shortness of breath?

YES NO

If answered yes to any of the above:

Name of person: _____ Phone #: _____

Dates of Travel & Location: _____

Signature of person completing this questionnaire: _____

Relationship to patient/minor (if applicable): _____ Date:_____

Nurse Assessment: _____

Temp: _____ Additional Vitals (if needed): _____

Additional Assessment needed? Yes / No

_____

Nurse: _____ Date/Time: _____

Additional Screening Processes

As the COVID-19 cases continue to grow, the following are additional steps that can help decrease chances of spread.[1]

- Screen everyone using the pre-arrival questions (above) **prior** to coming to the center. Remind them to cancel and reschedule if they have ANY cold/flu/coronavirus-like symptoms (cough, fever, runny nose, sore throat, sneezing, congestion, etc.) This is regardless of travel.
- Post signs outside of the waiting room for people to NOT enter the facility if they have symptoms.
- Reschedule anyone who is caring for someone who is ill with these types of symptoms or has been diagnosed with COVID-19.
- Screen everyone again upon arrival—with arrival questions (above) and consider **symptom check w/temperature**. Check staff and providers daily.
- Reschedule anyone who has traveled (foreign or domestic in the last 14 days). Domestic travelers have been in airports, and possibly in contact with people from highly affected areas.
- Limit the escorts who come with the patient to only one. Ask the escort to wait in the car or anywhere outside of the facility, to be called when the patient is ready for pick up.
- Consider (for providers) not scheduling anyone who is older or has an underlying medical condition that would put them at greater risk if they are exposed to the virus.
- Staff and providers practice as much social distancing as possible—including avoiding small spaces like meeting rooms or lunch rooms.
- Be diligent about hand hygiene and PPE use.
- Surfaces within the center need to be thoroughly cleaned with EPA approved products. High-touch surfaces must be wiped down between patients and frequently throughout the day.
- As able, limit vendors from entering the facility.
- Check the CDC website daily (https://www.cdc.gov/coronavirus/2019-nCoV/index.html) as well as [local or state health department] for instructions or directives.
- Please also see information from CDC and APIC.

[1] These steps may be especially important if your center is located in an area with rapidly growing numbers of cases. These are some suggestions from the CDC and other IC experts to elevate the safety of centers.

Sample Visitor Management Policy

COVID-19 Visitor Management Program

We continue to closely monitor the spread of COVID-19 in our community and want to reiterate **the safety of our patients, residents, their families and our caregivers remains our top priority**. Under CDC recommendation, we have instituted a Visitor Management Program for all responsible adults who have accompanied a patient for their procedure.

More than one person accompanying a patient is strongly discouraged.

Unless the patient is a minor, only one adult will be allowed into the waiting room per patient.

All who accompany a patient must sign the visitor log and provide name, contact phone number, email address, name of patient they are with.

In addition to following our routine stringent infection control protocols and procedures, we are in a heightened state of vigilance about disinfecting our facility. Special emphasis is placed on sanitizing high touch areas in common areas and restrooms.

No reading material will be allowed into our waiting area or stored for visitor use.

Accompanying adults will be asked for a cell/mobile contact number that will be used for notification when the patient is ready for discharge and/or other update information.

All family members will be required to keep a minimal “social” distance from staff and other visitors.

All family members will be requested to wait for in one of the following locations until contacted:

1. [e.g. 3rd floor lobby area]
2. [e.g. 2nd floor lobby area]
3. [e.g. 1st floor café]
4. [e.g. Courtyard]
5. Own vehicle/outside parking area

Only parents of minor children will be requested to wait in the facility waiting room and will allowed into the clinical area.

Your cooperation in this matter is appreciated as we continue to serve our patents and community by providing the highest quality health care in a safe responsible manner. We recognize this is an evolving situation and specifics are likely to change.

Sample Front Lobby Signage

CENTER LOGO/NAME

STOP

Coronavirus Alert

If you have:

Traveled within the last 14 days

Have <u>ANY</u> symptoms; such as a fever, congestion,

cough or shortness of breath (or any other cold/flu/COVID-19 symptoms)

Please call us at XXX-XXX-XXXX before entering.

Thank you.

AANA Anesthesia Care Infographic

ANESTHESIA CARE OF THE PATIENT WITH CORONAVIRUS DISEASE 2019 (COVID-19)

Excellence in care, safety, and continuous improvement of care are hallmarks of the anesthesia profession. Nurse anesthetists may be called upon to care for patients infected with COVID-19. The AANA is committed to supporting CRNAs and the healthcare team to safely deliver patient care while maintaining the health of the nurse anesthetist and the families and the community they serve.

The following considerations are specific to the perioperative setting and summarize recommendations of respected national and international organizations.

ENFORCE FREQUENT, METICULOUS HAND HYGIENE

Hand hygiene is the single most important measure in protection against cross infection. Hand washing is essential before and after donning or doffing PPE.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

Protection must be available for all providers. N95 masks should be worn for all known or suspected cases of COVID 19, as well as for any asymptomatic open airway cases. A powered air-purifying respirator (PAPR) may also be warranted.

WEAR DISPOSABLE OR CAPS AND BEARD COVERS

Disposable fluid-resistant long-sleeved gowns, goggles and disposable full-face shields are recommended for frontline providers.

PRIOR TO INTUBATION

Don appropriate gloves, facemask/PAPR, eye shield and gown. Plan to limit the distance traveled with contaminated equipment. Double glove and use the outer glove to sheath the laryngoscope blade after intubating.

THE MOST EXPERIENCED ANESTHESIA PROFESSIONAL SHOULD INTUBATE THE PATIENT

Limit the number of staff members during airway manipulation to reduce the risk of unnecessary exposure.

ALLOCATE ORs SPECIFICALLY FOR PATIENTS WITH CONFIRMED OR SUSPECTED COVID-19

In addition, these patients should not be brought to preoperative holding or recovery areas.

TAKE STEPS TO MINIMIZE AEROSOLIZATION OF THE VIRUS

Preoxygenate the patient for five minutes with 100% FiO2 and perform rapid sequence induction (RSI) to avoid manual ventilation of the patient's lungs. Use a video-laryngoscope to improve intubation success and avoid awake fiberoptic intubations, when possible. Atomized local anesthetic will aerosolize the virus.

PLACE A HIGH-EFFICIENCY HYDROPHOBIC FILTER

Place between the facemask and breathing circuit or between the facemask and reservoir bag to avoid contaminating the atmosphere.

FOLLOW STRICT ENVIRONMENTAL CLEANING AND DISINFECTION PROCEDURES

Dispose all used airway equipment in a double-zip-locked plastic bag for proper decontamination and disinfection.

As this is a dynamic and evolving situation, please refer to the Anesthesia Patient Safety Foundation, World Health Organization, and Centers for Disease Control and Prevention for current information.

PLEASE CONTACT THE AANA WITH QUESTIONS OR CONCERNS

practice@aana.com

847-655-8870

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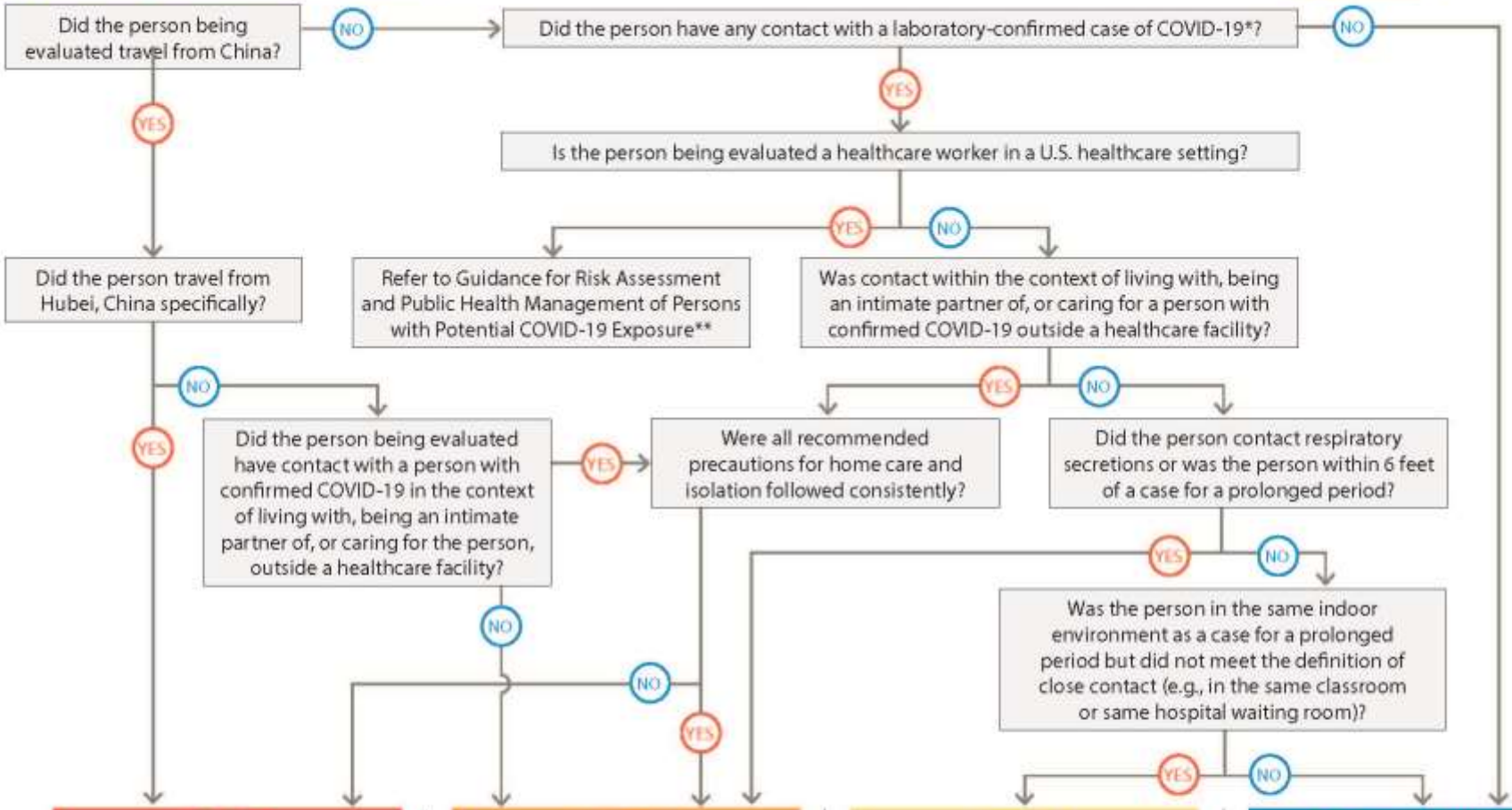
1. Anesthesia Patient Safety Foundation. Perioperative considerations for the 2019 Novel Coronavirus (COVID-19). https://www.apsf.org/news-updates/perioperative-considerations-for-the-2019-novel-coronavirus-covid-19/. Accessed February 27, 2020.

CDC COVID-19 Risk Assessment and Public Health Management Decision Making Tool

Coronavirus Disease 2019 (COVID-19) Risk Assessment and Public Health Management Decision Making *Each question refers to within the past 14 days*

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention



	High Risk	Medium Risk	Low Risk	No identifiable risk
Actions for people without symptoms consistent with COVID-19	Remain under quarantine authority; no public activities; daily active monitoring; controlled travel	Stay home; active monitoring or self-monitoring with public health supervision; recommend to not travel	Self observation	None
Actions for people with symptoms consistent with COVID-19	Immediate isolation; medical evaluation guided by PUI definition; pre-notify healthcare services; controlled travel	Immediate isolation; medical evaluation guided by PUI definition; pre-notify healthcare services; controlled travel	Stay home from work or school, avoid contact with others, don't travel. Seek health advice	None; routine medical care

These examples may not cover all potential exposures to laboratory confirmed case of COVID-19. If you are concerned about an exposure that does not align with these categories, please contact the CDC Emergency Operations Center at 1-800-232-4636

*Or a case diagnosed clinically with COVID-19 infection outside of the United States who did not have laboratory testing

**Healthcare provider (HCP) guidance outlines risk categories to determine work exclusion and monitoring procedures. After identifying risk category in the HCP guidance, use the categories outlined here to determine quarantine requirements.

02/14/20

CDC COVID-19 Fact Poster

Share Facts About COVID-19

Know the facts about coronavirus disease 2019 (COVID-19) and help stop the spread of rumors.

FACT 1

Diseases can make anyone sick regardless of their race or ethnicity.

People of Asian descent, including Chinese Americans, are not more likely to get COVID-19 than any other American. Help stop fear by letting people know that being of Asian descent does not increase the chance of getting or spreading COVID-19.

FACT 2

Some people are at increased risk of getting COVID-19.

People who have been in close contact with a person known to have COVID-19 or people who live in or have recently been in an area with ongoing spread are at an increased risk of exposure.

FACT 3

Someone who has completed quarantine or has been released from isolation does not pose a risk of infection to other people.

For up-to-date information, visit CDC's coronavirus disease 2019 web page.

FACT 4

You can help stop COVID-19 by knowing the signs and symptoms:

- Fever
- Cough
- Shortness of breath

Seek medical advice if you

- Develop symptoms

AND

- Have been in close contact with a person known to have COVID-19 or if you live in or have recently been in an area with ongoing spread of COVID-19.

FACT 5

There are simple things you can do to help keep yourself and others healthy.

- Wash your hands often with soap and water for at least 20 seconds, especially after blowing your nose, coughing, or sneezing; going to the bathroom; and before eating or preparing food.
- Avoid touching your eyes, nose, and mouth with unwashed hands.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.

For more information: **www.cdc.gov/COVID19**

CS 315446-A 03/13/2020

CDC Mitigation Strategy (10 pages)

Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission

Background

When a novel virus with pandemic potential emerges, nonpharmaceutical interventions, which will be called community mitigation strategies in this document, often are the most readily available interventions to help slow transmission of the virus in communities. Community mitigation is a set of actions that persons and communities can take to help slow the spread of respiratory virus infections. Community mitigation is especially important before a vaccine or drug becomes widely available.

The following is a framework for actions which local and state health departments can recommend in their community to both prepare for and mitigate community transmission of COVID-19 in the United States. Selection and implementation of these actions should be guided by the local characteristics of disease transmission, demographics, and public health and healthcare system capacity.

Goals

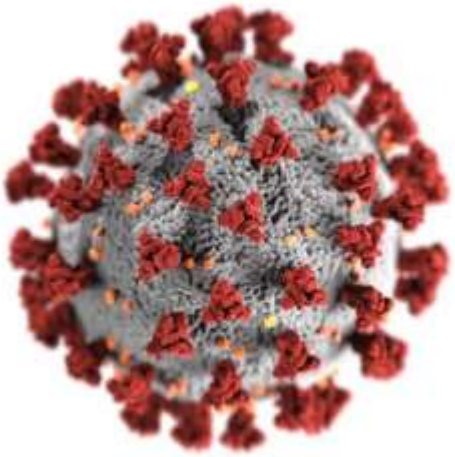
The goals for using mitigation strategies in communities with local COVID-19 transmission are to slow the transmission of disease and in particular to protect:

- Individuals at increased risk for severe illness, including older adults and persons of any age with underlying health conditions (See Appendix A)
- The healthcare and critical infrastructure workforces

These approaches are used to minimize morbidity and mortality and the social and economic impacts of COVID-19. Individuals, communities, businesses, and healthcare organizations are all part of a community mitigation strategy. These strategies should be implemented to prepare for and when there is evidence of community transmission. Signals of ongoing community transmission may include detection of confirmed cases of COVID-19 with no epidemiologic link to travelers or known cases, or more than three generations of transmission.

Implementation is based on:

- Emphasizing individual responsibility for implementing recommended personal-level actions
- Empowering businesses, schools, and community organizations to implement recommended actions, particularly in ways that protect persons at increased risk of severe illness
- Focusing on settings that provide critical infrastructure or services to individuals at increased risk of severe illness
- Minimizing disruptions to daily life to the extent possible



Guiding principles

- Each community is unique, and appropriate mitigation strategies will vary based on the level of community transmission, characteristics of the community and their populations, and the local capacity to implement strategies (Table 1).
- Consider all aspects of a community that might be impacted, including populations most vulnerable to severe illness and those that may be more impacted socially or economically, and select appropriate actions.
- Mitigation strategies can be scaled up or down depending on the evolving local situation.
- When developing mitigation plans, communities should identify ways to ensure the safety and social well-being of groups that may be especially impacted by mitigation strategies, including individuals at increased risk for severe illness.
- Activation of community emergency plans is critical for the implementation of mitigation strategies. These plans may provide additional authorities and coordination needed for interventions to be implemented (Table 2).
- Activities in Table 2 may be implemented at any time regardless of the level of community transmission based on guidance on from local and state health officials.
- The level of activities implemented may vary across the settings described in Table 2 (e.g., they may be at a minimal/moderate level for one setting and at a substantial level for another setting in order to meet community response needs).
- Depending on the level of community spread, local and state public health departments may need to implement mitigation strategies for public health functions to identify cases and conduct contact tracing (Table 3). When applied, community mitigation efforts may help facilitate public health activities like contact tracing

For more information: **www.cdc.gov/COVID19**

CS 313926-A 03/16/2020

Table 1. Local Factors to Consider for Determining Mitigation Strategies

Factor	Characteristics
Epidemiology	• Level of community transmission (see Table 3) • Number and type of outbreaks (e.g., nursing homes, schools, etc.) • Impact of the outbreaks on delivery of healthcare or other critical infrastructure or services • Epidemiology in surrounding jurisdictions
Community Characteristics	• Size of community and population density • Level of community engagement/support • Size and characteristics of vulnerable populations • Access to healthcare • Transportation (e.g., public, walking) • Planned large events • Relationship of community to other communities (e.g., transportation hub, tourist destination, etc.)
Healthcare capacity	• Healthcare workforce • Number of healthcare facilities (including ancillary healthcare facilities) • Testing capacity • Intensive care capacity • Availability of personal protective equipment (PPE)
Public health capacity	• Public health workforce and availability of resources to implement strategies • Available support from other state/local government agencies and partner organizations

Table 2. Community mitigation strategies by setting and by level of community transmission or impact of COVID-19

Factor	Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting		
	None (preparedness phase)	Minimal to moderate	Substantial
Individuals and Families at Home "What you can do to prepare, if you or a family member gets ill, or if your community experiences spread of COVID-19"	• Know where to find local information on COVID-19 and local trends of COVID-19 cases. • Know the signs and symptoms of COVID-19 and what to do if symptomatic: » Stay home when you are sick » Call your health care provider's office in advance of a visit » Limit movement in the community » Limit visitors • Know what additional measures those at high-risk and who are vulnerable should take. • Implement personal protective measures (e.g., stay home when sick, handwashing, respiratory etiquette, clean frequently touched surfaces daily). • Create a household plan of action in case of illness in the household or disruption of daily activities due to COVID-19 in the community. » Consider 2-week supply of prescription and over the counter medications, food and other essentials. Know how to get food delivered if possible. » Establish ways to communicate with others (e.g., family, friends, co-workers). » Establish plans to telework, what to do about childcare needs, how to adapt to cancellation of events. • Know about emergency operations plans for schools/workplaces of household members.	• Continue to monitor local information about COVID-19 in your community. • Continue to practice personal protective measures. • Continue to put household plan into action. • Individuals at increased risk of severe illness should consider staying at home and avoiding gatherings or other situations of potential exposures, including travel.	• Continue to monitor local information. • Continue to practice personal protective measures. • Continue to put household plan into place. • All individuals should limit community movement and adapt to disruptions in routine activities (e.g., school and/or work closures) according to guidance from local officials.

Factor	Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting		
	None (preparedness phase)	Minimal to moderate	Substantial
Schools/childcare "What childcare facilities, K-12 schools, and colleges and universities can do to prepare for COVID-19, if the school or facility has cases of COVID-19, or if the community is experiencing spread of COVID-19)"	• Know where to find local information on COVID-19 and local trends of COVID-19 cases. • Know the signs and symptoms of COVID-19 and what to do if students or staff become symptomatic at school/childcare site. • Review and update emergency operations plan (including implementation of social distancing measures, distance learning if feasible) or develop plan if one is not available. • Evaluate whether there are students or staff who are at increased risk of severe illness and develop plans for them to continue to work or receive educational services if there is moderate levels of COVID-19 transmission or impact. » Parents of children at increased risk for severe illness should discuss with their health care provider whether those students should stay home in case of school or community spread. » Staff at increased risk for severe illness should have a plan to stay home if there are school-based cases or community spread. • Encourage staff and students to stay home when sick and notify school administrators of illness (schools should provide non-punitive sick leave options to allow staff to stay home when ill). • Encourage personal protective measures among staff/students (e.g., stay home when sick, handwashing, respiratory etiquette). • Clean and disinfect frequently touched surfaces daily. • Ensure hand hygiene supplies are readily available in buildings.	• Implement social distancing measures: » Reduce the frequency of large gatherings (e.g., assemblies), and limit the number of attendees per gathering. » Alter schedules to reduce mixing (e.g., stagger recess, entry/dismissal times) » Limit inter-school interactions » Consider distance or e-learning in some settings • Consider regular health checks (e.g., temperature and respiratory symptom screening) of students, staff, and visitors (if feasible). • Short-term dismissals for school and extracurricular activities as needed (e.g., if cases in staff/students) for cleaning and contact tracing. • Students at increased risk of severe illness should consider implementing individual plans for distance learning, e-learning.	• Broader and/or longer-term school dismissals, either as a preventive measure or because of staff and/or student absenteeism. • Cancellation of school-associated congregations, particularly those with participation of high-risk individuals. • Implement distance learning if feasible.

Factor	Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting		
	None (preparedness phase)	Minimal to moderate	Substantial
Assisted living facilities, senior living facilities and adult day programs "What facilities can do to prepare for COVID-19, if the facility has cases of COVID-19, or if the community is experiencing spread of COVID-19)"	• Know where to find local information on COVID-19. • Know the signs and symptoms of COVID-19 and what to do if clients/residents or staff become symptomatic. • Review and update emergency operations plan (including implementation of social distancing measures) or develop a plan if one is not available. • Encourage personal protective measures among staff, residents and clients who live elsewhere (e.g., stay home or in residences when sick, handwashing, respiratory etiquette). • Clean frequently touched surfaces daily. • Ensure hand hygiene supplies are readily available in all buildings.	• Implement social distancing measures: » Reduce large gatherings (e.g., group social events) » Alter schedules to reduce mixing (e.g., stagger meal, activity, arrival/departure times) » Limit programs with external staff » Consider having residents stay in facility and limit exposure to the general community » Limit visitors, implement screening • Temperature and respiratory symptom screening of attendees, staff, and visitors. • Short-term closures as needed (e.g., if cases in staff, residents or clients who live elsewhere) for cleaning and contact tracing.	• Longer-term closure or quarantine of facility. • Restrict or limit visitor access (e.g., maximum of 1 per day).

Factor	Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting		
	None (preparedness phase)	Minimal to moderate	Substantial
Workplace "What workplaces can do to prepare for COVID-19, if the workplace has cases of COVID-19, or if the community is experiencing spread of COVID-19)"	• Know where to find local information on COVID-19 and local trends of COVID-19 cases. • Know the signs and symptoms of COVID-19 and what to do if staff become symptomatic at the worksite. • Review, update, or develop workplace plans to include: » Liberal leave and telework policies » Consider 7-day leave policies for people with COVID-19 symptoms » Consider alternate team approaches for work schedules. • Encourage employees to stay home and notify workplace administrators when sick (workplaces should provide non-punitive sick leave options to allow staff to stay home when ill). • Encourage personal protective measures among staff (e.g., stay home when sick, handwashing, respiratory etiquette). • Clean and disinfect frequently touched surfaces daily. • Ensure hand hygiene supplies are readily available in building.	• Encourage staff to telework (when feasible), particularly individuals at increased risk of severe illness. • Implement social distancing measures: » Increasing physical space between workers at the worksite » Staggering work schedules » Decreasing social contacts in the workplace (e.g., limit in-person meetings, meeting for lunch in a break room, etc.) • Limit large work-related gatherings (e.g., staff meetings, after-work functions). • Limit non-essential work travel. • Consider regular health checks (e.g., temperature and respiratory symptom screening) of staff and visitors entering buildings (if feasible).	• Implement extended telework arrangements (when feasible). • Ensure flexible leave policies for staff who need to stay home due to school/childcare dismissals. • Cancel non-essential work travel. • Cancel work-sponsored conferences, tradeshows, etc.

Factor	Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting		
	None (preparedness phase)	Minimal to moderate	Substantial
Community and faith-based organizations "What organizations can do to prepare for COVID-19, if the organizations has cases of COVID-19, or if the community is experiencing spread of COVID-19)"	• Know where to find local information on COVID-19 and local trends of COVID-19 cases. • Know the signs and symptoms of COVID-19 and what to do if organization members/staff become symptomatic. • Identify safe ways to serve those that are at high risk or vulnerable (outreach, assistance, etc.). • Review, update, or develop emergency plans for the organization, especially consideration for individuals at increased risk of severe illness. • Encourage staff and members to stay home and notify organization administrators of illness when sick. • Encourage personal protective measures among organization/members and staff (e.g., stay home when sick, handwashing, respiratory etiquette). • Clean frequently touched surfaces at organization gathering points daily. • Ensure hand hygiene supplies are readily available in building.	• Implement social distancing measures: » Reduce activities (e.g., group congregation, religious services), especially for organizations with individuals at increased risk of severe illness. » Consider offering video/audio of events. • Determine ways to continue providing support services to individuals at increased risk of severe disease (services, meals, checking in) while limiting group settings and exposures. • Cancel large gatherings (e.g., >250 people, though threshold is at the discretion of the community) or move to smaller groupings. • For organizations that serve high-risk populations, cancel gatherings of more than 10 people.	• Cancel community and faith-based gatherings of any size.

Factor	Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting		
	None (preparedness phase)	Minimal to moderate	Substantial
Healthcare settings and healthcare provider (includes outpatient, nursing homes/long-term care facilities, inpatient, telehealth) "What healthcare settings including nursing homes/ long-term care facilities, can do to prepare for COVID-19, if the facilities has cases of COVID-19, or if the community is experiencing spread of COVID-19)"	• Provide healthcare personnel ([HCP], including staff at nursing homes and long-term care facilities) and systems with tools and guidance needed to support their decisions to care for patients at home (or in nursing homes/long-term care facilities). • Develop systems for phone triage and telemedicine to reduce unnecessary healthcare visits. • Assess facility infection control programs; assess personal protective equipment (PPE) supplies and optimize PPE use. • Assess plans for monitoring of HCP and plans for increasing numbers of HCP if needed. • Assess visitor policies. • Assess HCP sick leave policies (healthcare facilities should provide non-punitive sick leave options to allow HCP to stay home when ill). • Encourage HCP to stay home and notify healthcare facility administrators when sick. • In conjunction with local health department, identify exposed HCP, and implement recommended monitoring and work restrictions. • Implement triage prior to entering facilities to rapidly identify and isolate patients with respiratory illness (e.g., phone triage before patient arrival, triage upon arrival).	• Implement changes to visitor policies to further limit exposures to HCP, residents, and patients. Changes could include temperature/ symptom checks for visitors, limiting visitor movement in the facility, etc. • Implement triage before entering facilities (e.g., parking lot triage, front door), phone triage, and telemedicine to limit unnecessary healthcare visits. • Actively monitor absenteeism and respiratory illness among HCP and patients. • Actively monitor PPE supplies. • Establish processes to evaluate and test large numbers of patients and HCP with respiratory symptoms (e.g., designated clinic, surge tent). • Consider allowing asymptomatic exposed HCP to work while wearing a facemask. • Begin to cross train HCP for working in other units in anticipation of staffing shortages.	• Restrict or limit visitors (e.g., maximum of 1 per day) to reduce facility-based transmission. • Identify areas of operations that may be subject to alternative standards of care and implement necessary changes (e.g., allowing mildly symptomatic HCP to work while wearing a facemask). • Cancel elective and non-urgent procedures • Establish cohort units or facilities for large numbers of patients. • Consider requiring all HCP to wear a facemask when in the facility depending on supply.

Table 3. Potential mitigation strategies for public health functions

Public health control activities by level of COVID-19 community transmission		
None/minimal	Moderate	Substantial
Evidence of isolated cases or limited community transmission, case investigations underway, no evidence of exposure in large communal setting, e.g., healthcare facility, school, mass gathering.	Widespread and/or sustained transmission with high likelihood or confirmed exposure within communal settings with potential for rapid increase in suspected cases.	Large scale community transmission, healthcare staffing significantly impacted, multiple cases within communal settings like healthcare facilities, schools, mass gatherings etc.
• Continue contact tracing, monitor and observe contacts as advised in guidance to maximize containment around cases. • Isolation of confirmed COVID-19 cases until no longer considered infectious according to guidance. • For asymptomatic close contacts exposed to a confirmed COVID-19 case, consideration of movement restrictions based on risk level, social distancing. • Monitoring close contacts should be done by jurisdictions to the extent feasible based on local priorities and resources. • Encourage HCP to develop phone triage and telemedicine practices. • Test individuals with signs and symptoms compatible with COVID-19. • Determine methods to streamline contact tracing through simplified data collection and surge if needed (resources including staffing through colleges and other first responders, technology etc.).	• May reduce contact tracing if resources dictate, prioritizing to those in high-risk settings (e.g., healthcare professionals or high-risk settings based on vulnerable populations or critical infrastructure). • Encourage HCP to more strictly implement phone triage and telemedicine practices. • Continue COVID-19 testing of symptomatic persons; however, if testing capacity limited, prioritize testing of high-risk individuals.	• May reduce contact tracing if resources dictate, prioritizing to those in high-risk settings (e.g., healthcare professionals or high-risk settings based on vulnerable populations or critical infrastructure). • Encourage HCP to more strictly implement phone triage and telemedicine practices. • Continue COVID-19 testing of symptomatic persons; however, if testing capacity limited, prioritize testing of high-risk individuals.

Appendix A: Underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age.

- **Blood disorders** (e.g., sickle cell disease or on blood thinners)
- **Chronic kidney disease** as defined by your doctor. Patient has been told to avoid or reduce the dose of mdications because kidney disease, or is under treatment for kidney disease, including receiving dialysis
- **Chronic liver disease** as defined by your doctor. (e.g., cirrhosis, chronic hepatitis) Patient has been told to avoid or reduce the dose of medications because liver disease or is under treatment for liver disease.
- **Compromised immune system (immunosuppression)** (e.g., seeing a doctor for cancer and treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications, HIV or AIDS)
- **Current or recent pregnancy** in the last two weeks
- **Endocrine disorders** (e.g., diabetes mellitus)
- **Metabolic disorders** (such as inherited metabolic disorders and mitochondrial disorders)
- **Heart disease** (such as congenital heart disease, congestive heart failure and coronary artery disease)
- **Lung disease** including asthma or chronic obstructive pulmonary disease (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function or that require home oxygen
- **Neurological and neurologic and neurodevelopment conditions** [including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury].

CDC Get Your Clinic Ready for COVID-19

Get Your Clinic Ready for Coronavirus Disease 2019 (COVID-19)

A new respiratory disease—coronavirus disease 2019 (COVID-19)—may impact your community.

Get ready! Steps you take to prepare your clinic for flu can also help protect your patients and healthcare workers from COVID-19:

Before Patients Arrive

- **Prepare the clinic.**
  - Know which of your patients are at higher risk of adverse outcomes from COVID-19.
  - Consider and plan for providing more telemedicine appointments.
  - Know how to contact your health department.
  - Stay connected with your health department to know about COVID-19 in your community. Step up precautions when the virus is spreading in your community.
  - Assess and restock supplies now and on a regular schedule.

- **Communicate with patients.**
  - Ask patients about symptoms during reminder calls.
  - Consider rescheduling non-urgent appointments.
  - Post signs at entrances and in waiting areas about prevention actions.

- **Prepare the waiting area and patient rooms.**
  - Provide supplies—tissues, alcohol-based hand rub, soap at sinks, and trash cans.
  - Place chairs 3–6 feet apart, when possible. Use barriers (like screens), if possible.
  - If your office has toys, reading materials, or other communal objects, remove them or clean them regularly.

When Patients Arrive

- **Place staff at the entrance to ask patients about their symptoms.**
  - Provide symptomatic patients with tissues or facemasks to cover mouth and nose.
  - Limit non-patient visitors.

- **Separate sick patients with symptoms.**
  - Allow patients to wait outside or in the car if they are medically able.
  - Create separate spaces in waiting areas for sick and well patients.
  - Place sick patients in a private room as quickly as possible.

After Patients are Assessed

- **After patients leave, clean frequently touched surfaces** using EPA-registered disinfectants—counters, beds, seating.
- **Provide at-home care instructions** to patients with respiratory symptoms. Consider telehealth options for follow up.
- **Notify your health department** of patients with COVID-19 symptoms.

Train and prepare your staff now

- Ensure that clinical staff know the right ways to put on, use, and take off PPE safely.
- Recognize the symptoms of COVID-19— fever, cough, shortness of breath.
- Implement procedures to quickly triage and separate sick patients.
- Emphasize hand hygiene and cough etiquette for everyone.
- Ask staff to stay home if they are sick.
- Send staff home if they develop symptoms while at work.

CS 315699-A 10/7/2020

For more information: **www.cdc.gov/COVID19**

CDC COVID-19 Symptoms Poster

SYMPTOMS OF CORONAVIRUS DISEASE 2019

Patients with COVID-19 have experienced mild to severe respiratory illness.

Symptoms* can include

FEVER

COUGH

*Symptoms may appear 2-14 days after exposure.

SHORTNESS OF BREATH

Seek medical advice if you develop symptoms, and have been in close contact with a person known to have COVID-19 or if you live in or have recently been in an area with ongoing spread of COVID-19.

For more information: **www.cdc.gov/COVID19-symptoms**

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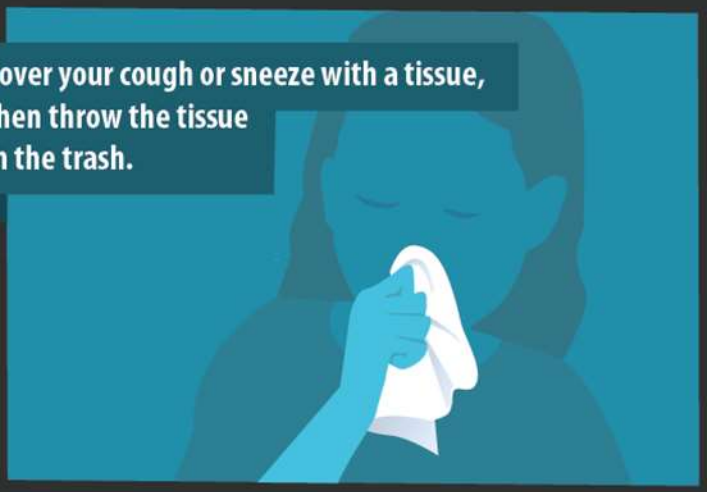
CDC Stop the Spread of Germs Poster

STOP THE SPREAD OF GERMS

Help prevent the spread of respiratory diseases like COVID-19.

Avoid close contact with people who are sick.

Cover your cough or sneeze with a tissue, then throw the tissue in the trash.



Avoid touching your eyes, nose, and mouth.

Clean and disinfect frequently touched objects and surfaces.

Stay home when you are sick, except to get medical care.

Wash your hands often with soap and water for at least 20 seconds.

cdc.gov/COVID19

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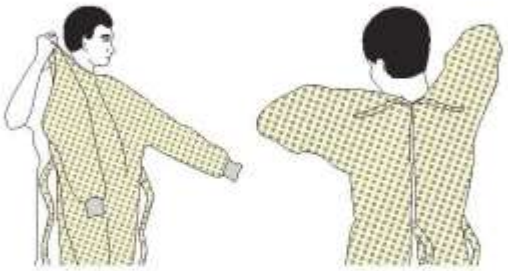
CDC PPE Instructions

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

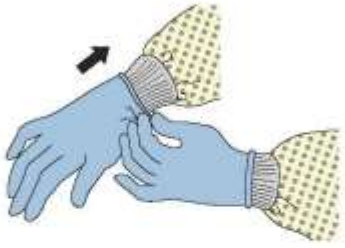
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

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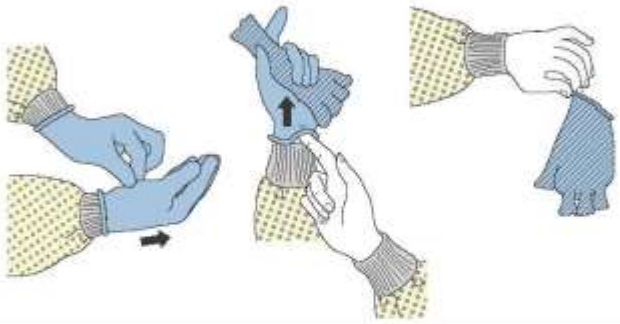
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

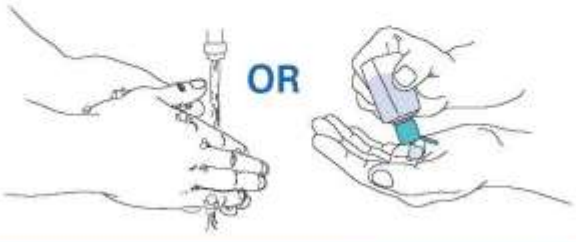
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container

5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

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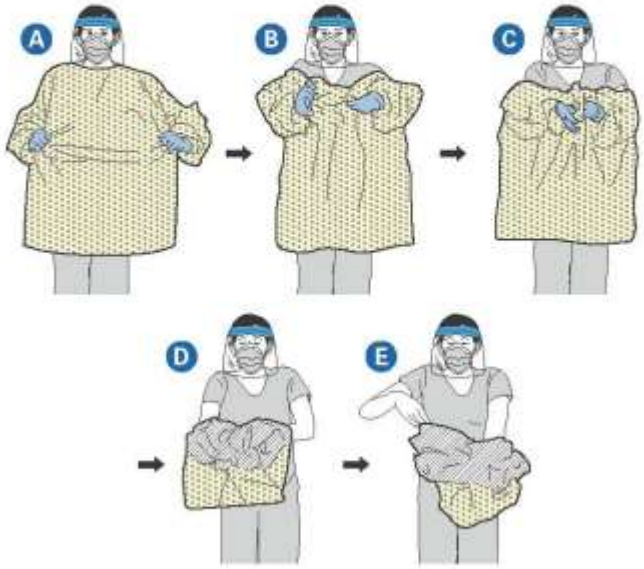
HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container

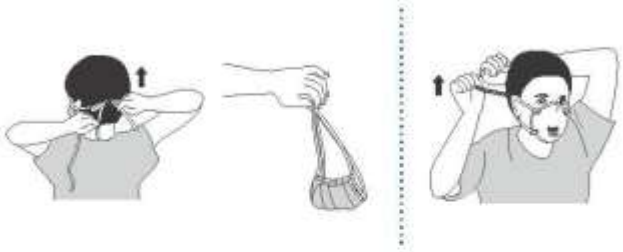


2. GOGGLES OR FACE SHIELD

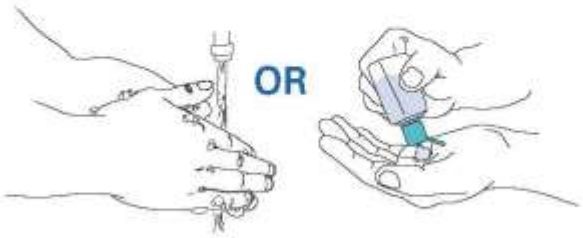
- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CS250672-E

ASPR COVID-19 Healthcare Planning Checklist (11 pages)

COVID-19 Healthcare Planning Checklist

Hover over form fields for instructions.

Planning for a potential emerging infectious disease pandemic, like COVID-19, is critical to protecting the health and welfare of our nation. To assist state, local, tribal, and territorial partners in their planning efforts, the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response has developed the following checklist. It identifies specific activities your jurisdiction can do now to prepare for, respond to, and be resilient in the face of COVID-19. Many of the activities in this checklist are specific for COVID-19, however many, pertain to any public health emergency.

This checklist is adapted from a variety of HHS Pandemic Influenza Pandemic Planning resources. It is not intended to set forth mandatory requirements by the Federal government. Each jurisdiction should determine for itself whether it is adequately prepared for disease outbreaks in accordance with its own laws and authorities. We strongly encourage continued review of HHS' Centers for Disease Control (CDC) COVID-19 guidance which is available on their website for the most current information.

1. **Safety / Infection Control Activities**

Completed	In Progress	Not Started	Activities
○	○	○	1.1 Develop a pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.2 Develop an agency/facility pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.3 Provide staff education about COVID-19 infection control and update polices as required.
○	○	○	1.4 Support N95 respirator fit-testing for all agency/facility employees and just-in-time education on recommended infection control precautions including fit checking, applying simple mask to patients with cough, and hand hygiene.
○	○	○	1.5 Monitor availability of N95 respirators/powered air purifying respirators (PAPRs) and other supplies including alcohol-based hand disinfectants, gloves, etc., and watch and alert coalition members to supply shortages. Make recommendations on possible alternatives.
○	○	○	1.6 Prepare guidelines for conservative and re-use of N95 respirators/PAPRs if severe shortages are imminent (ideally regionally and in conjunction with local public health, occupational safety, and infection prevention providers and agencies - for example, consider use by only the highest-risk staff, re-use in selected situations, continued use while working on cohorted units, etc.).
○	○	○	1.7 Plan contingencies if appropriate levels of respiratory protection are unavailable.
○	○	○	1.8 Develop guidance for staff monitoring for signs of illness (including self-reporting, self-quarantine, and start/end of shift evaluation) and create a mechanism for reporting both illness and absenteeism.
○	○	○	1.9 Develop a return to work post illness policy for health care workers. This should be as consistent as possible across the coalition.
○	○	○	1.10 Encourage HCFs to plan for staff access to medical care for themselves and their families; determine whether illness will be handled as workers' compensation or personal insurance depending on situation/criteria and share best practices.
○	○	○	1.11 Determine contingency plan for at-risk staff (e.g., pregnant, other defined risk groups) including job expectations and potential alternate roles and locations.
○	○	○	1.12 Evaluate the need for family support to enable staff to work (e.g., childcare, pet care). Provide information for family care plans.

2. EMS Activities

Completed	In Progress	Not Started	Activities
○	○	○	2.1 Determine coordination mechanisms, scope, and likely authorities between coalition EMS agencies including information sharing, resource monitoring/assistance, and policy coordination. Work with local intelligence fusion centers to assist with information sharing and coordination.
○	○	○	2.2 Determine actions that the state EMS agency is likely to take including: • Suspension or modification of operational requirements for EMS agencies • Specific emergency orders or actions that may limit liability and/or expand scope of operations
○	○	○	2.3 Determine local ordinances or laws that may affect EMS disaster operations and the authorities or ability to suspend or modify if needed to support non-traditional operations.
○	○	○	2.4 Evaluate available indicators that may be needed for planning or by other partners and how to track them, e.g., EEI such as number of transports, number of potential COVID-19 cases, staff illness/absenteeism.
○	○	○	2.5 Evaluate indicators that have effects on EMS and coordinate access through the health care coalition (e.g., status of emergency departments, alternate care sites, epidemiologic information/ forecasting, weather (e.g., snowstorms), availability of staff, availability of supplies).
○	○	○	2.6 Determine vulnerable supplies and coordinate with vendors and the health care coalition to develop contingency plans/allocation plans.
○	○	○	2.7 Develop public messages that emphasize using 911 only for life-threatening emergencies and coordinate with the joint information system.
○	○	○	2.8 Develop information sharing process both for internal staff and between EMS agencies.
○	○	○	2.9 Develop just-in-time education for EMS personnel relative to infection prevention and control, self-care, transmission and family protection, and normal stress responses.
○	○	○	2.10 Pre-identify strategies and resources to ensure behavioral health support for staff to mitigate adverse stress and grief and loss reactions.
○	○	○	2.11 Determine virtual coordination mechanisms that will enable remote engagement of senior staff to prevent exposures and maximize ability to engage in both daily and incident operations.
○	○	○	2.12 Determine how agency/regional EMS incident action plans will be managed.
○	○	○	2.13 Prepare to initiate auto-answer/recorded answering of 911 calls including diversion of information or non-emergency calls to another call center (e.g., public health hotline). Consider activating a community hotline if such a call center does not exist.
○	○	○	2.14 Evaluate protocols for conducting call screening to recognize COVID-19 -like symptoms (e.g., cough and fever) and advise the responding EMS personnel of a potentially infectious patient.

2. EMS Activities (cont'd)

Completed	In Progress	Not Started	Dispatch Activities
○	○	○	2.15 Adjust response configurations to allow flexibility including: • Prioritization of calls for service (for services that do not currently use priority dispatch systems) including basic algorithms for non-medically trained dispatchers or referring calls to recorded information, nurse triage hotlines, public health information lines, or other technology-based systems • Recommending self-transport or referral to primary care if appropriate (may need to triage calls to medical provider to evaluate if this capability is available) • Assignment of less than usual resources (e.g., assign law enforcement only on injury accidents unless and until clear information that non-ambulatory/critical injuries a represent) • Assignment of non-traditional resources (e.g., using 'jump' cars, community paramedicine, and other responses) • Diversion to an alternate care site • Increasing interpretive service assistance
Completed	**In Progress**	**Not Started**	**Response Activities**
○	○	○	2.16 Develop triggers for implementing closest hospital transport - ideally done regionally.
○	○	○	2.17 Develop triggers for implementing 'batch' transports (e.g., answering another call immediately if your current patient is stable) - ideally regionally.
○	○	○	2.18 Determine indicators and triggers for changing staff shifts and crew configuration - ideally this should be implemented consistently in the region.
○	○	○	2.19 Provide criteria for patient assessment and emphasis on cough/respiratory and hand hygiene as well as strict adherence to appropriate infection control precautions per Centers for Disease Control and Prevention (CDC) guidance.
○	○	○	2.20 Develop criteria for on-scene denial of transport by EMS personnel for COVID-19 -like illness and other patients - with or without on-line medical control - ideally regional rather than agency-based criteria and process.
○	○	○	2.21 Develop/provide patient information sheets on homecare for COVID-19 -like illness including usual clinical symptoms and course, infection prevention, treatment, and when to seek additional medical care.
○	○	○	2.22 Develop/provide patient information sheets for other conditions that may be left without transport if the service volume suggests a relevant need (e.g., minor injuries).
○	○	○	2.23 Determine alternate transport resources and triggers to utilize them, e.g., private ambulance, wheelchair, contract/courier, for hire vehicles, military assets, buses.
○	○	○	2.24 Evaluate available staff vs. available transport units to determine ability to meet other non-transport missions (e.g., community paramedicine, EMS personnel staffing alternate care locations or providing hospital support).
○	○	○	2.25 Determine necessary changes to record-keeping including use of templates.

3. Hospitals and Health Care Activities

Completed	In Progress	Not Started	Coordination Regulatory Activities
○	○	○	3.1 Determine coordination mechanisms, scope, and likely authorities between coalition hospitals and health care systems including information sharing, resource monitoring/assistance, and policy coordination. This should include the role of the coalition to engage with vendors of PPE, pharmaceuticals, and other medical supplies that may be in shortage. Conduct a coordination conference call with healthcare facilities to ensure awareness and consistency.
○	○	○	3.2 Determine mechanism to engage outpatient settings (homecare, ambulatory care) in information sharing and policy/response coordination.
○	○	○	3.3 Determine mechanisms to engage skilled nursing facilities in information sharing and policy/ response coordination.
○	○	○	3.4 Determine actions that the state of emergency management or public health agency is likely to take that affect health care including: • Suspension or modification of requirements for hospitals or clinics • Specific emergency orders or actions that may limit liability or expand scope of operations (for facilities and providers, including volunteers) • Requests for 1135 waivers from the Centers for Medicare & Medicaid Services (CMS) • Crisis standards of care activation • Issuance of clinical guidelines for care and resource allocation • 'Taking powers' of the state relative to medical materials and staff (i.e., does the state have ability to commandeer resources under their emergency powers and does this include medical materials?) • Promulgation or enforcement of legal obligations of medical staff to provide care
○	○	○	3.5 Evaluate available indicators that may be needed for planning or by other partners and how to track them, e.g., number ED visits available beds, available ventilators, number of potential COVID-19 cases, staff illness/absenteeism.
○	○	○	3.6 Evaluate indicators that have effects on hospitals and coordinate access through the health care coalitions (e.g., status of EMS agencies, alternate care sites, epidemiologic information/ forecasting, availability of supplies).
○	○	○	3.7 Determine a process for expedited credentialing of supplemental staff and for the orientation/ mentoring of supplemental or shared staff.
○	○	○	3.8 Determine threshold for use and priority list for supplemental staff (e.g., first shared health care system staff, then similarity credentialed and licensed staff, then Medical Reserve Corps, etc.)
○	○	○	3.9 Determine indicators and potential triggers for implementation of alternate care systems in conjunction with public health.
○	○	○	3.10 Develop public messages that emphasize using emergency departments only for life-threatening emergencies and coordinate with the joint information system. Be prepared to manage the expectations of the public relative to scarce resources (what is the shortage, what is being done, who are the priority groups, etc.).
○	○	○	3.11 Determine common visitor policies for coalition hospitals.
○	○	○	3.12 Develop just-in-time education for health care personnel relative to COVID-19 transmission, clinical course, at-risk populations, complications, treatment prevention and control, self-care, transmission and family protection, and normal stress responses.

Completed	In Progress	Not Started	Coordination Regulatory Activities
○	○	○	3.13 Pre-identify strategies and resources to ensure behavioral health support for staff to mitigate adverse stress and grief and loss reactions.
○	○	○	3.14 Determine how facility/regional hospital incident action plans will be managed.
○	○	○	3.15 Determine how awareness of retail pharmacy stocks will be maintained and shared with ambulatory/emergency care workers.
○	○	○	3.16 Determine behavioral health support plan that includes use of individual HCF staff as well as local, regional, state and federal assistance for meeting patients and staff needs (including those in a leadership role.)
○	○	○	3.17 Determine direction for tracking response cost and lost revenue implications associated with response.
Completed	**In Progress**	**Not Started**	**Health Care Facility Activities**
○	○	○	3.18 Determine incident management activation/configuration based on impact (phased approach) as well as incident action plan cycle and development process.
○	○	○	3.19 Identify SMEs to inform operational decisions and potential resource allocation decisions.
○	○	○	3.20 Determine methods for patient/family information provision including alternate languages/ interpretive services.
○	○	○	3.21 Determine staff communication mechanisms and redundant information management process.
○	○	○	3.22 Determine indicators and potential triggers for changing services provided (e.g., limit elective services).
○	○	○	3.23 Determine strategies to maintain services for at-risk patients during outbreak period (e.g., pregnant, dialysis) but unrelated to COVID-19.
○	○	○	3.24 Determine likely resource shortages and identify relevant vendor, cache, and coalition options for managing shortages.
○	○	○	3.25 Develop service restriction plans in case of staff shortages or increased demand (e.g., respiratory care, nutritional support, pharmacy, laboratory, radiology, elective surgeries/ procedures).
○	○	○	3.26 Develop/update crisis standard of care language in emergency operations plan including the potential for triage decision-making (who, process, communication, considerations) and staff management (how will staff expertise be maximally utilized vs. add additional training for some staff.
○	○	○	3.27 Evaluate the plan for providing just-in-time staff education via electronic and other non-classroom means including information about the COVID-19, transmission, infection prevention measures, usual clinical symptoms and course, risk factors, and complications.
○	○	○	3.28 Establish connection with homecare and long-term care partners to facilitate rapid discharge process from the hospital.

Completed	In Progress	Not Started	
○	○	○	3.29 Develop indicators and possible triggers for implementing alternate systems of care (including phone and web-based assessments as well as in-person care) including establishing health care system-based alternate care sites (e.g., on-site or managed completely by health care entity at owned and re-purposed site).
○	○	○	3.30 Develop indicators and possible triggers for establishing community alternate care sites in conjunction with public health and emergency management including what support may be required from the health care system.
○	○	○	3.31 Develop demand staffing plans for all categories of staff. Modify staff responsibilities and shifts as required (supervisory staff work clinically, suspend most education and other administrative burdens, determine where less-trained staff can safely provide support and the extent of family member support).
○	○	○	3.32 Engage union/labor leaders in relevant discussions of staff responsibilities and hours during pandemics.
○	○	○	3.33 Anticipate supply shortages and coordinate with vendors, the health care coalition, and emergency management to coordinate resource supply, distribution, and scarce resource strategies.
○	○	○	3.34 Develop a plan for implementing a supplemental facility security/controlled access plan (which may be phased) particularly during the peak pandemic weeks to assure controlled campus ingress and egress and monitoring.
○	○	○	3.35 Provide patients and staff with information about stress responses, resilience, and available professional mental health resources. Develop staff monitoring for those exposed to high levels of cumulative stress or specific severe stressors (death of co-worker, etc.).
○	○	○	3.36 Consider ways to maintain staff resilience and morale when congregate gatherings and close physical contact are discouraged. This may need to include memorial services for staff members.
○	○	○	3.37 Determine if the fatality management plan is sufficient for an increased volume of decedents at the facility.
○	○	○	3.38 Develop procedure for notifying the state agency for healthcare administration if licensed bed availability/capacity changes as a result of COVID-19.
Completed	**In Progress**	**Not Started**	**Emergency Department Activities**
○	○	○	3.39 Determine screening process and location (e.g., curb side screening prior to entry, supplemental screening at intake, etc.).
○	○	○	3.40 Determine how suspect cases will be isolated from other waiting patients and during ED care.
○	○	○	3.41 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.42 Develop referral plans for patients that do not need emergency care.

Completed	In Progress	Not Started	
○	○	○	3.59 Develop care plans that reduce the number of staff caring for suspect/confirmed cases and protocolize care.
○	○	○	3.60 Adjust daily nursing expectations/duties as required to meet demand.
○	○	○	3.61 Develop environmental services room decontamination and waste stream plans.
○	○	○	3.62 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.
○	○	○	3.63 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.64 Develop palliative care plans for implementation when needed.
Completed	**In Progress**	**Not Started**	**Outpatient Services/Community Health Centers/Free Standing Health Facilities Activities**
○	○	○	3.65 Develop staffing plan to allow for expanded service hours when needed. Determine if outpatient locations and services should remain open if the threat is too great to staff and patients.
○	○	○	3.66 Determine screening process and location (e.g., curbside screening prior to entry, supplemental screening at intake, separate well/ill clinics, etc.).
○	○	○	3.67 Develop telemedicine service plan for use for patients with special needs or general population.
○	○	○	3.68 Develop a plan to expedite medication refills, obstetrician visits, and other office visits prior to the arrival of COVID-19 cases in the community. The practice should have days to weeks to pre-emptively manage its workload in anticipation of limited elective services during the outbreak period.
○	○	○	3.69 Develop a process for screening and triage of phone and email requests for care to limit office visits to those that require an in-person provider evaluation.
○	○	○	3.70 Develop a process to limit/cancel non-essential visits which can 'flex' with the demands of the COVID-19 outbreak.
○	○	○	3.71 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies. Develop patient movement and transportation route plans.
○	○	○	3.72 Evaluate maximal use of space. Convert specialty clinics to acute care, extend hours, etc.
○	○	○	3.73 Consider which clinics may be converted into in-patient units (e.g., surgicenters).
○	○	○	3.74 Develop referral/deferral plans for patients that do not need acute care (e.g., perform virtual/ telephone medication management, automate prescription refills).
○	○	○	3.75 Assure administrative engagement in decision-making/use of incident management to assure continuity and consistency between providers and agencies/facilities.

Completed	In Progress	Not Started	
○	○	○	3.76 Develop infection prevention plan for the clinic specific to COVID-19 and conduct education and develop signage and other necessary materials.
○	○	○	3.77 Create templated charts for COVID-19 patients including discharge instructions and prescriptions.
○	○	○	3.78 Create 'fast-track' or other methods for rapid evaluation and prescribing for minor illness.
○	○	○	3.79 Determine how suspect cases will be isolated from other patients in the clinic space.
○	○	○	3.80 Consider specific clinics designated for suspect cases, or specific hours for acute illness clinics.
○	○	○	3.81 Develop care plans that reduce the number of staff caring for suspect/confirmed cases and protocolize care.
○	○	○	3.82 Determine at-risk and functional needs populations that may be impacted and assure access to care.
○	○	○	3.83 Plan to provide just-in-time staff education via electronic and other non-classroom means including information about COVID-19 transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.
○	○	○	3.84 Determine potential indicators/triggers for alternate care systems (including telephone prescribing/encounters and early evaluation and treatment locations as needed).
○	○	○	3.85 Provide or develop patient resources on COVID-19 including transmission, prevention, usual clinical course, risks for more severe disease, and when to seek medical care. These materials should also encourage patients to have at least a 30 day supply of usual medications on hand.
○	○	○	3.86 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.87 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.

Completed	In Progress	Not Started	**Homecare Activities**
○	○	○	3.88 Determine incident management process and authorities; assure administrative engagement and support.
○	○	○	3.89 Establish prioritization process for homecare intake or ongoing services including denial and referral to other services. Adjust home visit schedules and responsibilities as required.
○	○	○	3.90 Establish liaison process with hospitals to share information on current and projected capacity and needs.
○	○	○	3.91 Establish liaison process with health care coalition to provide updates on capacity and assist with resource and staffing issues including the process for requesting additional resources from coalition partners or emergency management.

Completed	In Progress	Not Started	
○	○	○	3.92 Determine contingency staffing plan.
○	○	○	3.93 Address staff transportation-related issues that may be anticipated such as reduced access to fuel.
○	○	○	3.94 Develop/provide education to homecare professionals about COVID-19 transmission, and complications (in addition to infection control/staff safety information as outlined above).
○	○	○	3.95 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.96 Develop/provide just-in-time training to staff taking on non-traditional roles as required to maintain critical services. Coordinate with health care coalition to determine potential options.
○	○	○	3.97 Obtain or develop printed materials (including at appropriate reading level and in relevant languages) for clients including information about COVID-19 (including infection prevention measures and clinical disease), service modifications due to COVID-19, and resources. These materials should encourage patients to have at least a 30 day supply of usual medications on hand.
○	○	○	3.98 Determine how volunteer/other staff could contribute to homecare activities.
○	○	○	3.99 Establish telephone/virtual support for clients to provide information and 'check in' status.
○	○	○	3.100 Monitor clients for mental health related issues and provide information on normal stress responses.
○	○	○	3.101 Provide just-in-time staff education via electronic and other non-classroom means including information about COVID-19, transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.
○	○	○	3.102 Assure that at-risk individuals serviced (e.g., on home oxygen, dialysis patients, etc.) have ongoing access to appropriate services and are listed in an agency database for easy reference.
○	○	○	3.103 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
Completed	**In Progress**	**Not Started**	**Long-term Care/Skilled Nursing Activities**
○	○	○	3.104 Determine incident management process and authorities; assure administrative engagement and support.
○	○	○	3.105 Liaison with the health care coalition/hospitals to assure maximal available residential beds.
○	○	○	3.106 Determine potential supply shortages and work with vendors and the health care coalition if resource availability is limited.
○	○	○	3.107 Develop a process to address shortages of supplies at the facility level including administration, nursing, medical direction, and subject matter expert input - ideally this can be a regional construct rather than at each facility.

Completed	In Progress	Not Started	
○	○	○	3.108 Develop a plan for more advanced care at the facility if hospital capacity is unavailable. This should involve nursing, medical direction, administrative representatives, and include consideration of telemedicine.
○	○	○	3.109 Determine any potential regulatory relief (CMS 1135 or other waivers, state regulations relief, staffing requirements, etc.) that may be needed to effectively respond to COVID-19 as well as issues regarding staff licensure/certification.
○	○	○	3.110 Determine with medical director and nursing director changes in thresholds for emergency department referral. These may vary across the period according to demand.
○	○	○	3.111 Evaluate potential staffing and responsibility changes and how less-trained staff and families could contribute to operations.
○	○	○	3.112 Evaluate potential staffing and responsibility changes and how less-trained staff and families could contribute to operations.
○	○	○	3.113 Develop a process for rapid credentialing and training of non-facility supplemental health care staff.
○	○	○	3.114 Develop infection detection process at the facility to promptly detect and isolate residents and staff with suspected COVID-19 and monitor their close contacts.
○	○	○	3.115 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.116 Develop visitor policies designed to minimize potential exposures (ideally consistent across the coalition) and communicate via physical (signs at entrances and on units) and electronic means. Determine if visitation should be restricted or stopped if threat is too high for patients and staff.
○	○	○	3.117 Communicate any change in services or policies to staff, residents, families, and the health care coalition.
○	○	○	3.118 Designate a point of contact for the health care coalition.
○	○	○	3.119 Designate a point of contact for family/resident information or questions.
○	○	○	3.120 Develop infection control/isolation plan for ill suspect or confirmed cases.
○	○	○	3.121 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.122 Assure fatality management plans are appropriate to address potentially increased numbers of deaths during a COVID-19 outbreak.
○	○	○	3.123 Plan for providing just-in-time staff education via electronic and other non-classroom means including information about COVID-19 , transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.

Completed	In Progress	Not Started	Alternate Care Site/System Activities
○	○	○	3.124 Assure integration with public health and other health systems regarding consistent scripts for web and telephone based nurse triage lines/9-1-1 public safety answering points/ poison control centers/locally generated "apps" and integration with additional telephone/virtual prescribing - particularly for at-risk populations.
○	○	○	3.125 Determine support needed from the health care system for `flu clinics' for early screening and treatment as planned by public health.
○	○	○	3.126 Understand/assist with plan for alternate care site(s) for hospital overflow - roles, responsibilities, authorities, staffing, material resources, criteria, level of clinical care (understanding that this may not be feasible if staff absenteeism is high at the hospitals).
○	○	○	3.127 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.
○	○	○	3.128 Assure enough staff, supplies, prophylaxis, and logistical support are on hand before opening the site.
○	○	○	3.129 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
			Comments: