OUTBREAK PLAN/COVID-19 RESPONSE

PURPOSE:

To provide guidance to the facility on how to prepare for new or newly evolved infectious diseases whose incidence in humans has increased or threatened to increase in the near future and that has the potential to pose a significant public health threat and danger of infection to the residents, families and staff of the facility.

ASSUMPTIONS

This document contains general policy elements that are intentionally broad. It is customizable depending the specific care center demographics, location and current disease threats. It is not comprehensive and does not constitute medical or legal advice.

Every disease is different. The local stat, and federal health authorities will be the source of the latest information and most up to date guidance on prevention, case definition, surveillance, treatment and skilled nursing center response related to a specific disease threat.

This document contains recommendations that may not be applicable to all types of long-term care facilities. Modification should be made based upon the regulatory requirements and the structure and staffing for the specific care setting.

GOAL:

To protect our residents, families, and staff from harm resulting from exposure to an emergent infectious disease while they are in our center.

Lessons Learned

Through this pandemic, Atlas Healthcare Group has gained insight in several ways. As a long-term care organization, we could not foresee the challenges associated with a pandemic, however we have learned valuable information along the way, from our response to and our experience with COVID-19. The lessons we gained from this experience remains a continued focus within the facility and are as follows:

i. Working closely and following guidance of the healthcare experts such as CDC, NHSN, NJDOH and local Department of Health
ii. The need for constant review and revision of infection control policies and procedures
iii. Continued education in Infection Control policies and procedures
iv. The importance of the screening process for resident, staff, visitors, and volunteers
v. The importance of testing and continued testing to identify asymptomatic carriers

vi. The need to have continued communication with residents, families/guardians and staff regarding COVID-19
vii. Hypervigilance of and oversight of the environment to identify activity that may be a threat to the spread of COVID-19.

DEFINITIONS

Cohorting – means the practice of grouping patients who are or are not colonized or infected with the same organism to confine their care to one area and prevent contact with other residents.

Emerging Infectious Disease – Infectious diseases who incidence in humans has increased in the past two decades or threatens to increase in the near future have been defined as "emerging". These diseases, which respect no national boundaries, include:

i. New infections resulting from changes or evolution of existing organisms
ii. Known infections spreading to new geographic areas or populations
iii. Previously unrecognized infections appearing in areas undergoing ecologic transformation
iv. Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures.

Endemic level – means the usual level of given disease in a geographic area

Epidemic – refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area.

Isolating – means the process of separating sick, contagious persons from those who are sick

Long-term care facility – means a nursing home, assisted living residence, comprehensive personal care home, residential health care facility or dementia care home licensed pursuant to P.L. 1971, c.136 (C.26:2H-1 et seq.)

Outbreak – According to the Centers of Disease Control and Prevention, an outbreak is an occurrence of more cases of a disease than would be normally expected in a specific place or group of people over a given period.

Pandemic – A sudden infectious disease outbreak that becomes very widespread and affects a whole region, a continent, or the world due to a susceptible population. By definition, a true pandemic causes a high degree of mortality.

General Preparedness for Emergent Infectious Diseases (EID)

a. The care center's emergency operation program will include a response plan for a community-wide infectious disease outbreak such as pandemic influenza. This plan will:
  i. build on the workplace practices described in the infection prevention and control policies
  ii. include administrative controls (screening, isolation, visitors)

- **iii.** address environmental controls (isolation rooms, plastic barriers, sanitation stations, and special areas for contaminated waste)
- **iv.** address human resource issues such as employee leave
- **v.** be compatible with the care center's business continuity plan.

b. Clinical leadership will be vigilant and stay informed about EIDs around the world. They will keep administrative leadership briefed as needs on potential risks of new infections in their geographic location through the changes to existing organisms and/or immigration, tourism or other circumstances.

c. As part of the emergency operations plan, the care center will maintain a supply of personal protective equipment (PPE) including moisture-barrier gowns, face masks, assorted sizes of disposable N95 respirators and gloves. The amount that is stored will minimally be enough for several days of center wide-care but will be determined based on storage space and costs.

d. The care center will develop plans with their vendors for re-supply of food, medications, sanitizing agents and PPE in the event of a disruption to normal business including EID outbreak.

e. The care center will regularly train employees on EID response through drills and exercises as part of the center's emergency preparedness training.

f. The care center has contracted with infectious Disease: Michael Barnish, DO. FAC.

Local Threat

a. Once notified by the public health authorities at either federal, state and/or local level that the EID is likely to or already has spread to the care center's community, the care center will activated specific surveillance and screening as instructed by Centers for Disease Control and Prevention (CDC), state agency and/or local public health authorities.

b. The care center's Infection Preventionist (IP) will research the specific signs, symptoms, incubation period and route of infection, the risk of exposure, and the recommendations for skilled nursing care centers as provided by the CDC, Occupational Health and Safety Administration (OSHA), and other relevant local, state and federal health agencies.

c. Working with advice from the care center's medical director and/or clinical consultant, Director of Nursing, Administrator , facility laboratory (Aculabs, Genesis), local and state public health authorities, the IP will review and revise internal policies and procedures, ensure medications, environmental cleaning agents, and personal protective equipment (PPE) is available as indicated by the specific disease threat.

d. Staff will be educated on the exposure risk, symptoms, and prevention of the EID. Place special emphasis on reviewing the basic infection prevention and control, use of PPE, isolation and other infection prevention strategies.

e. If the EID is spreading through an airborne route, the care center will activate its plan to ensure that employees who may be required to care for a resident with the suspected or known case are not put at undue risk of exposure.

f. Provide residents and families with education about the disease and the care the center's response strategy at a level appropriate to their interest and need for information.

g. Brief contractors and other relevant stakeholders on the care center's policies and procedures related to minimizing exposure risks to residents.

h. Post signs regarding hand sanitation and respiratory etiquette and/or other prevention strategies relevant to the route of infection at the entry of care center along with instruction that anyone who is sick is asked to refrain from visiting the center.

i. To ensure that staff, and/or new residents are not at risk of spreading the EID into the care center, screening for exposure risk and signs and symptoms may be done prior to admission of a new resident and/or allowing new staff persons to report to work.

j. Self-screening – staff will be educated on the care center's plan to control exposure to the residents
    i. Reporting any suspected exposure to the EID while off duty to their supervisor and public health
    ii. Precautionary removal of employees who report and actual or suspected exposure to the EID.
    iii. Self-screening for symptoms prior to reporting to work
    iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws

k. Self-isolation- in the event there are confirmed cases of the EID in the local community, the care center may consider closing the care center to new admissions, and limiting visitors based on the advice of local public health authorities.

l. Environmental cleaning – the care center will follow current CDC guidelines for environmental cleaning specific to the EID in addition to routine cleaning for the duration of the threat.

m. Engineering controls – the care center will utilize appropriate physical plant alterations such as use of private rooms for high-risk residents, plastic barriers, sanitation stations, and special areas for contaminated wastes as recommended by local, state and federal public health authorities.

Suspected Case in the Care Center

a. Place a resident or on-duty staff who exhibits symptoms of the EID in an isolation room and notify the local public health.

b. Under the guidance of public health authorities, arrange a transfer of the suspected infectious person to the appropriate acute care center via emergency medical services as soon as possible.

c. If the suspected infectious person requires care while awaiting transfer, follow care center policies for isolation procedures, including all recommended PPE for staff at risk for exposure.

d. Keep the number of staff assigned to enter the room of the isolated person to a minimum. Ideally, only specially trained staff and prepared (i.e. vaccinated, medically cleared and fit tested for respiratory protection) will enter the isolation room. Provide all assigned staff additional training and supervision in the mode of transmission of this EID, and the use of the appropriate PPE.

e. If feasible, ask the isolated person to wear a facemask while staff is in the room. Provide care at the level necessary to address essential needs of the isolate individual unless it is advised otherwise by public health authorities.

f. Conduct control activities such as management of infectious wastes, terminal cleaning of the isolation room, contact tracing of exposure individuals, and monitoring for additional cases under the guidance of local health authorities, and in keeping with guidance from the CDC.

g. Implement the isolation protocol in the care center (isolation rooms, co-horting, cancelation of group activities and social dining) as described in the care center's infection prevention and control plan and/or recommended by local, state or federal public health authorities**.**

h. Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities, and in keeping with guidance from the CDC.

Employer Consideration

a. Management will consider its requirements under OHSA, Center for Medicare and Medicaid (CMS), state licensure, Equal Employment Opportunity Commission (EEOC), American Disabilities Act (ADA) and other state of federal laws in determining the precautions it will take to protect is residents. Protecting the residents and other employees shall be of paramount concern. Management shall consider the following:

   i. The degree of frailty of the residents in the center
   ii. The likelihood of the infectious disease being transmitted to the residents and employees

iii. The method of spread of the disease (for example, through contact with bodily fluids, contaminated air, contaminated surfaces)
iv. The precautions which can be taken to prevent the spread of the infectious disease and
v. Other relevant factors

b. Once these factors are considered, management will weigh its options and determine the extent to which exposed employees, or those who are showing signs of the infectious disease, must be precluded from contact with residents or other employees.

c. Apply whatever action is taken uniformly to all staff in like circumstances.

d. Do not consider race, gender, marital status, country of origin, and other protected characteristics unless they are documented as relevant to the spread of the disease.

e. Make reasonable accommodations for employees such as permitting employees to work from home if their job description permits this.

f. Permit employees to use sick leave, vacation time and FMLA where appropriate while they are out of work.

g. Permit employees to return to work when cleared by licensed physician, however, additional precautions may be taken to protect the residents.

h. Employees who refuse at any time to take the precautions set out in this and other sections of this policy may be subject to discipline.

i. To notify residents, staff, families/guardians and attempt to keep them informed of their response to the outbreak.

Contingency Staffing Capacity Strategies

When staffing shortages are anticipated, the facility management will use contingency capacity strategies to ensure staffing needs are met.

In order to provide a safe working environment and sufficient coverage for resident care, Human Resources will collaborate with facility management to understand and anticipate the staffing needs of the facility.

Human Resources will communicate with the health department, emergency planning agencies and healthcare coalitions (state and local) to identify available options for additional staffing.

Contingency Staffing Strategies are adopted when staffing shortages are anticipated. Contingency strategies are based on current guidelines from the CDC and CMS and include:

1. Adjusting schedules, hiring additional staff and rotating positions including:
    a) Cancelling non-essential procedures
    b) Cross-training staff so that they can be assigned to essential resident care functions.
    c) Addressing social factors, such as childcare issues and transportation by offering flexible scheduling and accommodations of adjusted hours to the extent possible
    d) Identifying sources of additional licensed and non-licensed staff
    e) Asking staff to postpone elected time off.
2. Identifying outside facilities that have been designated as isolation or alternate care sites with appropriate levels of staff
3. Allowing asymptomatic staff who have been exposed to COVID-19 to continue to work when:
    a) They report normal temperature and lack of symptoms every day before reporting to work;
    b) They wear a facemask at work for 14 days after the exposure event: and
    c) They agree to stop any resident care activities, report to their supervisor, and leave the facility when symptoms develop.
4. Prioritizing exposed and symptomatic personnel for testing.
5. Notifying residents, family and other staff members of measures that will be taken to protect them from exposure if staff with suspected or confirmed COVID-19 are allowed to work.

<u>Notification to Resident, Families, and Resident Representatives</u>

1. The facility will use or more of the following methods to communicate information to residents, families, and family representatives on mitigating actions implemented by the facility to prevent or reduce the risk of transmission including, if normal operations of the facility will be altered. Methods used may include but not limited to the following:
    i. Phone calls/Texts
    ii. Email
    iii. Letters
    iv. Video communication
    v. Window visit
    vi. Creating or increase email listserv communication to update families
    vii. Virtual Visitation Coordinator – an assigned staff member to contact families for inbound calls and conduct regular outbound calls to keep families up to date
    viii. Offer a phone line with a voice recording updated at set times with the facility's general operation status
    ix. Host conference calls, webinars or virtual "office hours" at set times on minimum of a weekly basis, where families can call in, or log onto a conference line and the facility staff can share the status of activities or happenings in the facility and family members can ask questions or make suggestions.
    x. Update the facility website, at a minimum on a weekly basis, to share status of the facility and include information that helps the families know what is happening to their loved ones.

2. Notification will be made either email, phone line or test to residents, families and their representative by 5 p.m. the next calendar day following subsequent occurrence of either:
   i. Each time a single confirmed infection of COVID-19 is identified, **OR**
   ii. Whenever 3 or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

Cohorting

a. Include the potential for transmission of infectious agents in patient placement decisions.

b. Place patients who pose a risk for transmission to others (e.g., uncontained secretions, excretions or wound drainage) in a single patient room when available

c. Determine patient placement based on the following principles:
   i. Route of transmission of the known or suspected infectious agent.
   ii. Risk factors for transmission in the infected patient
   iii. Risk factors for adverse outcomes resulting from and HAI in other patients in the area or room being considered for patient placement
   iv. Availability of single-patient room

d. Consult infection control professionals before patient placement to determine the safety of alternative room that do not meet engineering requirements for negative pressure room, EID is airborne.

e. Place together (cohort) patients who are presumed to have the same infection (based on clinical presentation and diagnosis when known) in areas of the facility that are away from other patients, especially patients who are at increased risk for infection (e.g., immunocompromised patients).

f. Consider using temporary portable solutions (e.g., exhaust fan) to create a negative pressure environment in the converted area of the facility. Discharge air directly to the outside, away from people and air intakes, or direct all the air through HEPA filters before it is introduced to other air spaces.

g. Residents remain on appropriate precautions until the Attending Physician, the Medical Director or guidance from federal, state or local guidance orders them discontinued.

Cohorting is only one element of infection prevention and control measures used for outbreak control. When testing compacity is available and the facility spacing permits, patients/residents should be organized into the following cohorts:

a) **Cohort 1 – COVID-19 Positive:**

This cohort consists of both symptomatic and asymptomatic patients/residents who test positive for COVID-19, including any new or re-admissions who have tested positive. If feasible, care for COVID-19 positive patients/residents on a separate closed unit. Patients/residents who test positive for COVID-19 are know to shed the virus, regardless of symptoms; therefore, all positive patients/residents would be placed in the positive cohort.

b) **Cohort 2 – COVID-19 Negative; Exposed**
This cohort consists of symptomatic and asymptomatic patients/residents who test negative for COVID-19 with an identified exposure to someone who was positive. **All symptomatic COVID-19 negative patients/resident should be considered exposed but should also be evaluated for other causes of their symptoms.** Even though symptomatic COVID-19 negative patients/residents might not be a threat to transmit COVID-19, they still may have another illness, such as influenza. Asymptomatic patients/residents should be closely monitored for symptom development.

c) **Cohort 3 – COVID-19 Negative, Not Exposed**
This cohort consists of patient/residents who test negative for COVID-19 with no COVID-19 like symptoms and are thought to have no known exposure. In situations of widespread COVID-19, all negative persons in a facility would be considered exposed. Cohort 3 should only be created when the facility is relatively certain that patients/residents have been properly isolated from all COVID-19 positive and incubating patients/residents and staff. The facility may not be able to create this cohort.

d) **Cohort 4 – New Admissions or Re-admissions**
This cohort consists of all persons from the community or other healthcare facilities whose COVID-19 status is unknown. This cohort serves as an observation area where persons remain for 14 days to monitor for symptoms that may be compatible with COVID-19. Testing at the end of this period could be considered to increase certainty that the person is not infected.

A. For residents who required a specialized unit (i.e.; ventilator, cardiac…) those residents will be cohorted on the specialized specific unit and cohorted based on the resident's needs.

B. The facility should make every attempt to dedicate staff to each cohort.

C. If the facility is unable to cohort residents effectively or maintain adequate staff the facility may decide to limit admission.

<u>Test Based Prevention Strategy (PPS) Point Prevalence Survey</u>

Testing of Residents

1. If testing capacity allows, **facility-wide PPS of all residents** should be considered in facilities with suspected or confirmed cases of COVID-19. Early experience from nursing homes with COVID-19 cases suggests that when residents with COVID-19 are identified, there are often asymptomatic residents with SARS-CoV-2 present as well.
2. PPS of all residents in the facility can identify infected residents who can be cohorted on a pre-specified unit or transferred to a COVID-specific facility. If undertaking facility- wide PPS, facility leadership should be prepared for the potential to identify multiple asymptomatic residents with SARS-CoV-2 infection and make plans to cohort them.
3. If testing capacity is not sufficient for facility-wide PPS, performing PPS on **units with symptomatic residents** should be prioritized.
4. All residents will have molecular testing completed by or before May 26, 2020
5. All residents who test negative will be retested within 3-7 days after baseline testing.
6. If testing capacity is sufficient, and the COVID -19 status is unknown, new admissions and readmissions will be tested residents to determine status and will be considered a Person Under Investigation until test results received.

Resident Refusal of Testing

7. If a resident/patient refuses to undergo COVID-19 testing, then the facility shall:
   - Use person centered approaches to when explaining the importance of COVID-19 testing
   - Treat the individual as a Person Under Investigation
   - Placed on Transmission-Based Precautions until the criteria for discontinuing precautions have been met.
   - If and outbreak is triggered and a resident continues to refuse to be tested the facility should increase monitoring and maintain appropriated distance from other residents
   - Make a notation in the resident's chart
   - Notify any authorized family member or legal representative of this decision
   - Continue to check temperature on the resident at least twice per day.
2. The onset of temperature or other symptoms consistent with COVID-19 require immediate cohorting in the appropriate group.
3. At any time, the resident may rescind their decision not to be treated.

Retesting Residents

After the initial testing has been performed for residents and the results have been used to implement resident cohorting, the facility may consider retesting under the following circumstances:

- Retest any resident who was negative and develops symptoms consistent with COVID- 19.
- Retest all residents who was negative at some frequency (3-7 days) after the initial PPS, then weekly

to detect those with newly developed infection

- Consider continuing retesting until PPS do no identify new cases
- If testing capacity is not sufficient for retesting all residents, retest those who frequently leave the facility for dialysis or other services and those with known exposure to infected residents (such as roommates or HCP).
- Residents who had their initial positive viral test in the **past 3 months** and who are now asymptomatic do not need to be retested as part of facility-wide testing unless they develop symptoms or have been exposed to a COVID-19 positive individual..
- Residents who had a positive viral test at any time and become symptomatic after recovering from the initial illness should be evaluated and may need to be retested if an alternate illness etiology cannot be identified.

Testing of HCP

1. If testing capacity allows, PPS of **all HCP** should be considered with suspected or confirmed cases of COVID-19. Early experience suggests that, despite HCP symptom screening, when COVID-19 cases are identified in a nursing home, there are often HCP with asymptomatic SARS-CoV-2 infection present as well.
2. Baseline molecular testing of all direct care workers and non-direct care workers within the long-term care facility (i.e., administrative, housekeeping, dietary staff) shall be completed by or before May 26,2020.
3. Employees with initial negative results will be retested in 3-7 days.
4. Negative employees shall continue to work and follow current facility infection control practices.
5. New hires will be screened and tested upon hire.
6. New hires with negative results will have a repeat test within 3-7 days of baseline test.
7. Unless new hires are symptomatic, will be allowed to work, following the facility current facility infection control practices.
8. Testing Consent will be obtained from each employee and placed in their medical file.
9. All staff must continue weekly testing until directed by DOH to do otherwise.
10. Further retesting in accordance with the CDC guidance, amended and supplemented. CDC recommends **HCP with COVID-19 be excluded from work**.
11. If a staff member test positive for COVID-19 (Symptomatic or Asymptomatic), the facility may permit the employee to return to work subject to the CDC/NJDOH as follows:

HCP with laboratory-confirmed COVID-19 who have not had any symptoms (Either strategy is acceptable depending on local circumstances):

1. ***Time-based strategy***. Exclude from work until:
   - 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming

they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

2. ***Test-based strategy***. Exclude from work until:

   - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutives respiratory specimens collected ≥24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture

- The facility should continue to **assess the risk of exposed healthcare personnel to COVID-19** using the NJDOH Healthcare Personnel (HCP) Exposure to COVID-19 Case Risk Algorithm, which would include a 10-day furlough from work, while actively monitoring for symptoms.
- In facilities where staff attendance is strained by excessive callouts and furloughs, the facility, may **consider allowing asymptomatic HCP who have had a HIGH or MEDIUM risk exposure to a COVID-19 patient to continue to work provided the following**:
  1. HCP should **report temperature and absence of symptoms each day** prior to starting work (at least every 12 hours while at work) for the 10-day period after their exposure.
     - If HCP develop even **mild** symptoms consistent with COVID-19, they must **cease patient care activities**, **don a facemask (if not already wearing)**, and **notify their supervisor or occupational health services** prior to leaving work.
  2. *HCP wears a facemask while at work for the same 10-day period.*
- **Asymptomatic HCP who tested positive for COVID-19** should continue home isolation for 10 days after their first positive COVID-19 test AND have had no subsequent symptoms. Out of an abundance of caution they should follow masking guidance below.
- **Symptomatic HCP who have tested positive for COVID-19** may return to work 10 days after symptoms first developed AND 72 hours (3 days) after fever has resolved without the use of fever-reducing medications with a significant improvement in symptoms (whichever period is longer). HCP who have tested positive for COVID-19 shall be:
  1. Masked at work until symptoms have completely resolved or until 14 days after illness onset/positive test (whichever is longer) AND
  2. Restrict from caring for severely immunocompromised patients (e.g.: transplant, hematology-oncology) until 14 days after illness onset/positive test (whichever is longer).

Restesting HCP

- Ongoing weekly testing of all staff until guidance from NJDOH changes based on epidemiology and data about the circulation of virus in the community.
- Staff who testes positive for COVID-19 3 or more months ago must be tested weekly.

Refusal of Testing – HCP

- HCP who have signs or symptoms and refuse to be tested are prohibited from entering the building until return to work criteria has been met.
- If outbreak testing has been triggered and a staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed.
- The facility should follow its occupational health and local jurisdiction policies with respect to any asymptomatic staff who refuses testing.

IMPORTANT NUMBERS

New Jersey Department of Health		
Burlington County Department of Health	Raphael Meadow Center 15 Pioneer Blvd Westhampton, NJ 08060	(P) 609-265-5548 (F) 609-265-3152
Camden County Department of Health	512 Lakeland Rd. Blackwood, NJ 08012	(P) 856-379-6037
Gloucester County Department of Health	204 E. Holly Avenue Sewell, NJ 08080	(P) 856-218-4100
NJ After-Hours Department of Health Staff		(P) 609-392-2020
NJ After Hours Infectious Disease Questions		(P) 609-826-5964

References:
https://emergency.cdc.gov/coca/index.asp
https://emergency.cdc.gov/recentincidents/
https://www.cdc.gov/coronavirus/2019-ncov/hcp/caring-for-patients.html
https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html
https://www.cms.gov/files/document/qso-20-30-nh.pdf-0

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