

Protocol to Facilitate Local COVID-19 Collaboration Among Hospitals, Nursing and Other Congregate Care Facilities, and Local Health Districts

April 16, 2020

Phase I: Local Facility Efforts that Reinforce Hospital Preparedness

A. Existing Nursing Facility / Congregate Care Facility Surge Preparation to Reduce COVID-19 Risk

As outlined in the *Pre-Surge Planning Toolkit for Providers of Long-Term Services and Supports* (toolkit), facilities have already undertaken a number of activities to prepare for and currently manage COVID-19 residents:

1. **Education.** Facilities have ongoing training for all personnel to better understand the nature of this contagious infection and the facility plans developed to protect and treat both residents and personnel. Facility efforts may be enhanced once local coalition clinical personnel join the partnership. Education efforts require ongoing effort and feedback of facility performance.
2. **Engineering controls.** Facilities have created as much physical separation of those with and without known or suspected COVID-19 infection by identifying floors, wings or sections of the floor plans for cohorted patients and staff. (Refer to the toolkit for more information regarding the cohorting of patients.)
 - a. Facilities must be prepared for the expeditious cohorting of residents while awaiting clinical and testing evaluation, so partial “prepacking” of some elaborate settings may be considered to save time at critical moments.
 - i. Ideally, the facility will identify an area to support at least 6 COVID-positive residents should be identified in advance of the first positive COVID-19 case in order to minimize movement under duress.
 - ii. Separate entrances and egresses to the COVID-19 area may exist.
 - iii. The HVAC system may be a key variable in identifying the rooms most advantageous for COVID-19 residents, but airborne infection isolation rooms, although preferred, are not required.
 - iv. Facilities should also identify a dedicated space for residents who have been exposed who require greater supervision, monitoring, and PPE than those in the general population. It is important not to mix those exposed (“orange” in the toolkit) with those who actually have COVID-19 either tested or probable (“purple” in the toolkit).
 - v. Staff assignments should also be dedicated to the same resident spaces (e.g. If assigned to the COVID-19 positive (purple) unit, personnel should stay in that unit the entire shift).
 - b. Rooms designated as donning/doffing rooms have been identified as have other equipment required to treat residents in place. Ideally donning/doffing rooms are

separate to not cross contaminate PPE and personnel. Chairs and specific bins for clean and used PPE are required.

- c. Some sites have additional locations designated for specimen collection, which minimizes droplet exposure in the facility as well as exposure to couriers bringing collected specimens to the laboratories. Appropriate in-facility personnel may be trained for specimen collection or arrangements can be made with special teams linked to local hospitals, local health districts or the state ODH laboratories.
- d. The facility should execute a tabletop planning exercise to identify key gaps and issues that need to be addressed before they experience their first case of COVID-19.

3. Administrative controls.

- a. Facilities have limited the number of all personnel accessing the site, often cross-training staff.
- b. Visitors have been restricted and enhanced alternative communication strategies are in place.
- c. All facilities have limited movement policies in place to reduce the inadvertent spread of infection through droplets, contact or fomites.
- d. Extra cleaning protocols have been implemented in keeping with CDC guidance.
- e. Telemedicine has been emphasized as the preferred modality for initial clinical assessments that may include appropriateness for further evaluation and testing for both COVID-19 and non-COVID-19 conditions.
- f. All personnel must wear facemasks, with priority for medical facemasks given to direct care staff.
- g. All personnel must be afebrile and pass a symptom checklist before they are granted access to working.
- h. All personnel should stick to the level of infection control unit assigned for the entire shift. If this is not possible, after checking in and donning appropriate PPE, start with the “cleanest” areas with the unexposed, asymptomatic (“green”) residents and work up to greater levels of infection control (orange and then purple) without backtracking. This will require some preplanning and bundling of care such as getting the resident up for the day, changing linens and assisting with feeding all at once.
- i. Return to work policies have been established in accordance with state and national infection control guidance.
- j. All health care personnel without symptoms but with some form of exposure should only work in areas of equal or higher level of infection control requirements. For example, if staff had a small break in PPE which was reported given the culture of everyone watching out for everyone, during the next 2 weeks of monitoring and wearing masks, these workers would only be assigned to the exposed (orange) unit who are also getting monitored or to the COVID-19 positive unit.
- k. The facility should execute a tabletop planning exercise to identify key gaps and issues that need to be addressed before they experience their first case of COVID-19.

- 4. Personal Protective Equipment.** All facilities have assessed their need for PPE and are now reporting this data daily into the survey that has transparency at the state Emergency Operations Center.
- a. All personnel must wear facemasks, with priority for higher grade medical facemasks given to direct care staff and all N-95s to be worn by personnel working directly with COVID-19 positive (tested or probable) residents.
 - b. All facilities are in the CDC's "contingency" phase of PPE management, which requires extended wear and limited re-use of PPE. Some facilities will resort to "crisis" levels of some PPE items.
 - i. Because clothes can be changed and hands and surfaces washed, **masks and eye protection are the most important PPE items to ensure adequate supply.**
 - c. In the event that the facility has residents who are severely hard of hearing or require visual cues to continue swallowing or other therapies, face shields should be requested as these are not the most common form of PPE.
 - d. Personnel have been educated to understand the need to:
 - i. Keep clothing simple to minimize chances of contamination as well as to facilitate ease of donning and doffing.
 - ii. Avoid makeup to allow for the re-sanitization of PPE.
 - iii. Address facial hair, piercings and other items that may cause air leaks if N95s are required must also be addressed to maximize the protection of both personnel and residents. Many sites have requested supplies of smaller size masks to match the existing workforce.

B. Additional Operational Considerations

- 1. Medications.** In recognition of the greater stress on limited staff confined to specifically dedicated spaces and the personnel absences due to COVID-19, facilities may consider other opportunities to minimize the amount of time required for clinical staff to accomplish routine tasks. This efficiency may minimize potential inadvertent transmission as well as free staff up for more time to assess and care for residents.
- a. Tighter management of medication lists to streamline efficient administration could be particularly helpful as many medications are given on an "as needed" basis but have not been utilized in the recent past.
 - b. Sliding scale insulin orders may be minimized in favor of establishing individual patterns and shifting to longer-acting preparations.
 - c. One of the most important changes to make is to convert all aerosolized medications, such as Albuterol, to metered dose inhaler (MDI) modes of administration as able.
 - d. In addition, discontinuing medications of minimal value such as generic vitamins as well as proton pump inhibitors (PPIs) or other non-essential medication that may prolong QTc may render COVID-19 treatment safer by eliminating side effects or drug interactions.
 - e. Pharmacists at NF pharmacy benefit managers may be able to assist facilities with these types of medication tasks. Medication changes may require or need to be supplemented by consultation with the residents' primary care providers; many of these visits could take place using telehealth methods.

2. **Attention to bathing routines and laundry.** Many residents without private rooms use floor showers and are bathed with assistance from facility personnel. These personnel may be exposed to aerosolized virus during bathing or when handling cross-contaminated laundry.
 - a. Face masks may become damp rendering them far less effective.
 - b. Consideration should be given to preferring baths or non-aerosolizing methods to address hygiene needs.
 - c. Two separate laundry bins should be available so that clean and dirty laundry are kept in separate spaces.
 - d. Laundry bins with wheels may prevent the need to carry heavy loads through the facility, thereby avoiding contamination of staff and other surfaces.
3. **Enhanced communication with residents and families, possibly supporting extended leaves home. Given all of the changes in facility policy and social isolation, emotional needs must be addressed.**
 - a. Despite enhanced efforts to communicate with families on a daily basis, families may prefer to take their loved ones home, especially since they may have greater flexibilities given the stay at home order.
 - b. Families may require additional in-home supports, such as aide or nursing services, in order to accomplish this goal; these services can be arranged with community partners.
 - c. If extended leaves take place, facilities may have greater opportunities residents who are well, those who are exposed, and those who may become COVID-19 positive. Having extra capacity for this physical separation before it is needed is a crucial step in facility preparedness.
4. **Advance Care Planning.** Many facilities have already undertaken a routine process to review the desired care wishes of their residents and have ensured that their residents' records are clearly marked with these wishes. Keeping these records are up-to-date ensures those who desire not to be resuscitated are not unnecessarily transported for emergency care, and instead receive the extra supports and symptom management they desire at the facility.
 - a. The pandemic provides additional opportunity to clarify the 'Do Not Resuscitate Comfort Care- Arrest' (DNRCC-Arrest) definition, as residents may receive treatment for COVID-19 other illnesses until a "full code" is required; if a full code is required, the medical team should not perform CPR or intubation with artificial ventilation. This level of detail is particularly important, as all codes and intubations, even with laryngoscopy, carry the highest aerosolization and exposure risk to involved personnel.
 - b. Clear communication and documentation of residents' wishes are important components of an overall plan to limit exposure to COVID-19 infection within a facility.

Phase II. Forming a COVID-19 Clinical Coalition Facility-Hospital-Local Health District Clinical Coalition

A. The purpose of the coalition is to plan and build local coordinated COVID-19 clinical support to ensure better care for the entire community - those with and without COVID-19 infections.

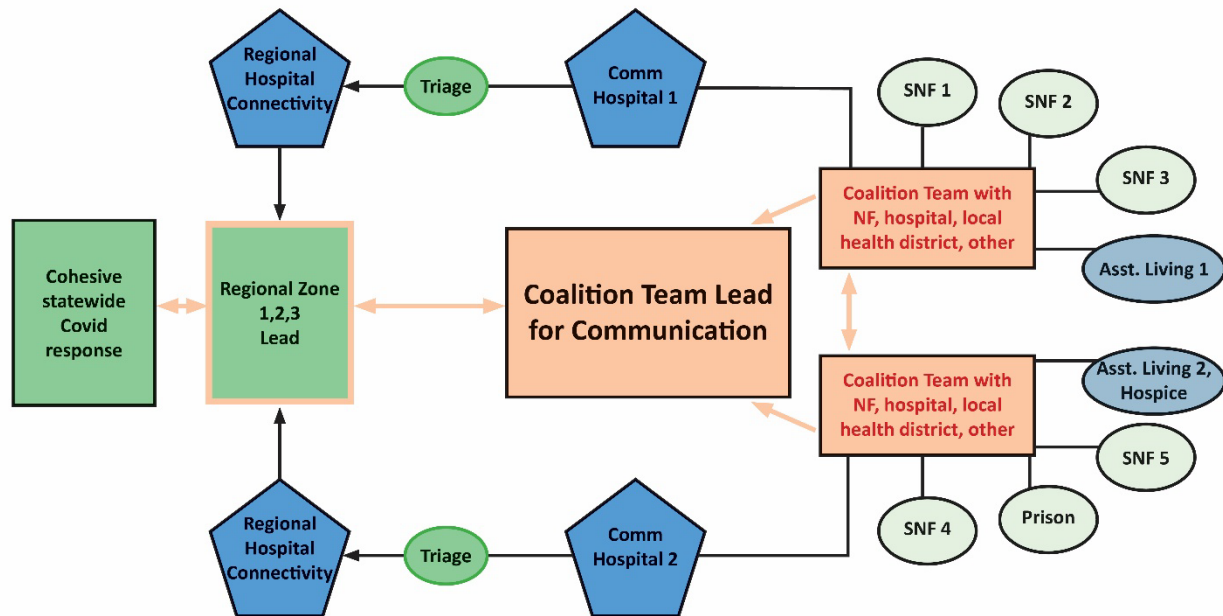
- a. As resources shift to address the pandemic, residents and community members with serious health issues may fear exposure to infection and forego needed care, creating system stressors at a later point in time.
- b. Those with infection may not get needed resources, such as testing and treatment, in a timely manner – delayed care can accelerate the need for higher level resources.
- c. Some individuals in who may be infected with COVID-19 have particularly challenging health and environmental needs – for example, those living in memory care units. The coalition should explore and plan for addressing these types of unique needs within the community using available resources.

The local coalition will create a broader community view that extends beyond individual systems to share planning and problem-solving for maximal collective impact. Opportunities include:

- a. Streamlining real-time information sharing and communication.
- b. Ensuring timely consultation with local infectious disease and public health experts to manage needs unique to the community. Some parts of the health system may typically lack access to these types of expertise, so it should be shared across the community.
- c. Maximizing resources with allocation based on broader identified areas of need- often focused on PPE and testing; standardized approaches to testing and treatment to improve efficiency and reduce unnecessary variation that may not garner the best clinical results
- d. Connecting systems of data collection to ensure transparency within the region and zone; this is critical to ensure the effectiveness and challenges of local response to the pandemic.

Key components and functions of a local coalition are described below.

Coalition Problem Solving Diagram



B. Key members of a local coalition must be identified with one individual taking the lead. Because of the nature of the pandemic, the local coalition for COVID-19 must have particularly strong **clinical** leadership to be able to provide infection control and treatment guidance across many care sites in the community. Clinical leadership ensures the team will be persistently focused on the health needs of community members and should include:

1. **Representation from nursing facilities and other congregate care sites.** These individuals are extremely important given the risk of clusters of outbreaks that can easily overwhelm both the residents and staff in congregate care settings, as well as the local hospital. These centers are also crucial for post-acute care placement for those with or without COVID-19 infection. Attention should be given to include individuals from care settings that may not have significant infectious disease and/or medical expertise, including many assisted living facilities.
2. **Clinical leadership from the hospital.** Hospital leadership is important to support the “Treat in Place” public health guidance and to seamlessly connect facilities to testing, transportation, treatment and other locally established care protocols. The potential for rapidly fluctuating hospital and intensive care resources must also be communicated and managed across the entire system. This clinical leadership is focused on these patient care issues, working in close concert with, but not replacing important public health functions.
3. **Local public health.** Deep involvement of the local health commissioner or a delegate is critical, as local health districts hold responsibility for all of the contact tracing and state

reporting of COVID-19. Local health districts can also serve as the “go-to” link to many other community needs, including housing, food, and other social determinants of health.

- 4. The local EMS or Emergency Management.** A representative from this sector is **Representative** key to ensure connectivity to mass fatality considerations. as well as communication with the state Emergency Operations Center.

Local coalitions should be comprised of not more than six individuals who serve on a “steering committee” and are connected to many other supporting entities that participate in the local coalition work. Careful attention to limiting the size of the steering committee is important because of the known complexities of large group dynamics. While communities may have many larger advocacy and political groups, the steering committee must be focused on limiting the health impact related to COVID-19.

Coalition members may include (but not be limited to) to the following individuals:

- Actively practicing hospitalists, family physicians, internists, intensivists, infectious disease or epidemiology experts, advanced practice providers affiliated with the local hospital or Nursing Facilities;
- Nursing or other congregate care facility Medical Director, Director of Nursing or Infection Control, or administrator;
- Hospital Medical Director or department chairs (particularly the Emergency Department or Intensive Care Director), Director of Nursing or infection control, clinical pharmacist or head of case management or community Home Care entity, hospital administrator;
- Local health commissioner, public health nurse or epidemiologist;
- Home Health, Hospice and Palliative Care Provider lead;
- Local EMS or Fire chief or Emergency Management representative; or
- Strong community leaders from Mental health, Not-for-profit entities such as United Way, or other existing respected public or private entities.

- C. A streamlined communication process** must be developed to facilitate daily, real-time information to inform testing, treatment and management strategies. One good example of this currently happens at University Hospitals in Cleveland, where a shared daily situation report is produced and daily discussion includes many health sectors collaboratively identifying and communicating about common issues that need to be flagged for adjacent communities’ local coalitions, as well for the state clinical leadership team.

The communication process must include the follow key steps to maintain a patient-centered focus:

- 1. Designate a single point of contact** from the Nursing or other facility, the hospital, the local health district and the local EMA at a minimum, with a chosen leader for the team who has the responsibility to report to the regional Zone leader.

2. **Establish basic organizational structure** including a cadence of routine meetings and data management with a routine structured agenda items such as canvassing all congregate care sites for maximal preparedness, identifying special environments that require a “strike team” to surge expertise and resources for COVID-19 source control, identifying dynamic shortages of personnel, PPE and testing as part of a strategy to seamlessly manage hospitalizations and post-acute care, and creating clear and consistent community messaging.
- D. Ensure that a centralized phone number is established** for all community entities, not just the hospital. Some successful entities have utilized local incident command centers for this function.
- E. A standardized triage algorithm for core functions such as the need for care** in the Emergency Department or other setting is essential in controlling access to the health system in a way that minimizes exposure. The algorithm includes both COVID-19 and non-COVID-19 patients in order to expedite critical care and track continued use of other medically necessary services even during the pandemic. It is important to not create pent-up demand for those with significant chronic conditions who may then present at higher levels of acuity at a time that those intensive care resources are most stressed.
- F. COVID-19 testing using an algorithm** that honors the state public health standards.

Given the limited availability of testing, prioritization should follow:

1. Acute hospital inpatients;
 2. Health Care Personnel (HCP) from hospital, Nursing Facility and other care sites;
- (The first two categories could be compressed into one priority group to simplify the list.)
3. Residents of nursing facilities and other congregate sites; first responders;
 4. Others from the community (either directed by the ED or community clinicians) whose jobs do not expose large numbers of other individuals, and who may be able to self-isolate.

Communities may have a number of viable testing options:

1. Local hospitals
2. Local health departments
3. The state’s ODH lab
4. Mobile collection teams that connect to other testing sites to minimize the time from collection to receiving the test result (turn-around-time).
5. Use of mobile point-of-care machines that boast a more immediate turn-around-time may also be an option, pending the availability and distribution of reagents and machines. For regulatory reasons, mobile machines must be linked to a licensed lab.

The expediency of the result is critically important to most effectively trace contacts who have been exposed and need to be quarantined (also referred to as persons under investigation (PUIs)).

Many coalitions have prioritized the streamlining of testing processes as one of the most important functions.

- G. The data from the centralized number with the standardized triaging for testing and care must be collected, ideally for COVID-19 positive and negative patients.** This creates the platform for connectivity to the Regional Zone planning needed to garner additional resources as well to contribute to the most effective statewide plan.
- H. Broadening the coalition to connect, collaborate and synergize with other local COVID-19 coalitions within an extended geographic boundary** will facilitate streamlined care for individuals with and without COVID-19; this is essential to better protecting and preserving valuable personnel and PPE resources.
 - 1. Local coalitions should collaborate to establish shared protocols for using hospitals and other resources.** For example, coalitions could coordinate protocols for direct nursing facility to inpatient admission; these could be arranged to avoid delays, unnecessary ED usage, and use of unnecessary transportation resources. Similarly, local coalitions could work together to plan for when a hospital becomes overwhelmed with COVID-19 cases; in these situations, the plan could call for an adjacent local hospital to contribute personnel or PPE, or to divert non-COVID-19 cases such as obstetrical or orthopedic cases to a single site.
 - 2. Shared understanding between coalitions must extend to more efficiently use the limited health care workforce** to provide tele-care to individuals in their homes and communities. This could include use of telehealth for in-home monitoring, aide, nursing and medical services.
 - 3. Coordination across local coalitions could leverage an incident command center;** one good example of this occurs at University Hospitals in Cleveland. Rolling this consortium of local coalitions up into the regional Zones allows for a broader view of the evolving pandemic and enables a more robust, effective and real-time response.
- I. Streamlined treatment protocols that align with hospital best practice.** There is wide variation in care for COVID-19 patients, but assistance with assessment, appropriate personnel and PPE may be required to maximize treatment in place for NF residents with lower acuity. While this saves hospital resources for those with the most severe illness, nursing and other congregate care facilities may require tighter hospital partnerships to be successful with this strategy.

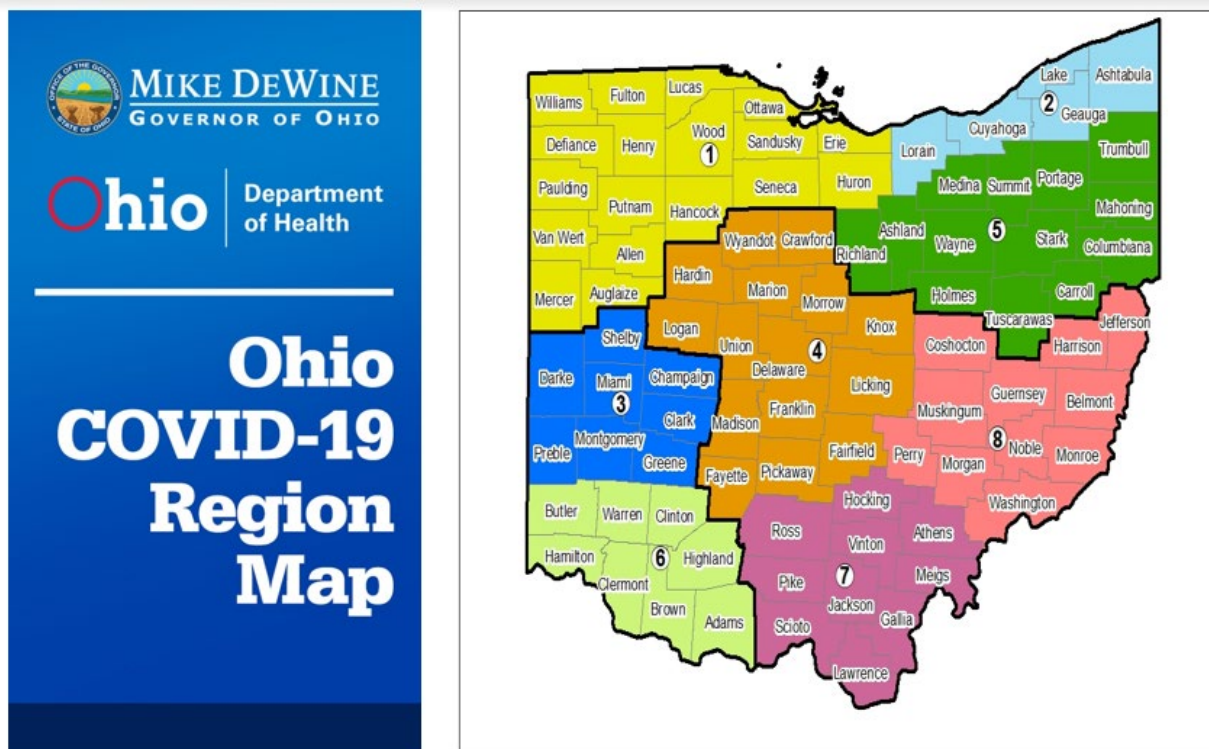
Challenges related to receiving residents from congregate care sites range from treating those who are not sick enough to be admitted to a hospital to caring for a surging number of individuals who have advanced in severity and create sudden intensive care unit strain. These challenges can be mitigated by establishing consistency in care through standards and guidelines of accepted

interventions that align with hospital practice (e.g. monitoring intensity and frequency, respiratory medications, IV fluids, other medications with thresholds for use.)

The local coalition should establish post-acute care guidelines that establish common understanding of accepted discontinuation of transmission-based precautions; these guidelines should be based on the state public health authority's guidance. The coalition may establish preferred sites for post-acute care for both COVID-19 positive and COVID-19 negative patients, which may or may not take advantage of health care isolation centers. Communication for needed changes in sites of care should occur through the established COVID-19 coalition which can also provide local guidance as it relates to the return to work for health care personnel.

Phase III. Connectivity to Regional Zone Plans

The eight public health regions designated by the Ohio Department of Health have been further coalesced into 3 Zones for maximal collective impact of a statewide COVID-19 response. Each Zone has a Leader who has support and responsibility for the entire Zone.



- Zone 1 is comprised of Regions 1, 2 and 5 along Ohio's Northern border (Leader: Dr. Wyllie from Cleveland Clinic)
- Zone 2 is comprised of Regions 4, 7 and 8 extending from central Ohio to the southeastern border (Leader: Dr. Thomas from the Ohio State University)
- Zone 3 is comprised of Regions 5 and 6 that include the greater Dayton and Cincinnati areas (Leader: Dr. Lofgren from UC Health)

Each local coalition is responsible for coordinating with and reporting to local partners, including the hospitals and congregate facilities. The local coalition must be responsible for addressing community-wide resource needs such as testing, personnel, transportation and PPE. This data should be fed to the state emergency operations center that is responsible for “keeping the finger on the pulse” of Ohio’s complete COVID-19 response.

At the state and local levels, there are multiple teams responsible for a variety of issues including:

- The overall strategy of Ohio’s response
- Clinical guidance as Ohio’s specific circumstances change
- Procurement and distribution of resources
- The development of a data infrastructure that allows for the most accurate predictive modeling to guide most effective response in the country.

Ohio’s network of local COVID-19 coalitions are a crucial component of implementing statewide detailed and robust plans.