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What Law Enforcement Personnel Need to Know about Coronavirus Disease 2019 (COVID-19)¹

<https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-law-enforcement.html>

Contact: PPEConcerns@cdc.gov



Date: March 4, 2020

(U) Background:

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The outbreak first started in China, but cases have been identified in a growing number of other areas, including the United States.

(U) Patients with COVID-19 have had mild to severe respiratory illness.

- Data suggests that symptoms may appear in as few as 2 days or as long as 14 days after exposure to the virus that causes COVID-19.
- Symptoms can include fever, cough, difficulty breathing, and shortness of breath.
- The virus causing COVID-19 is called SARS-CoV-2. It is thought to spread mainly from person-to-person via respiratory droplets among close contacts. Respiratory droplets are produced when an infected person coughs or sneezes and can land in the mouths or noses, or possibly be inhaled into the lungs, of people who are nearby. Close contact may include:
 - Being within approximately 6 feet of an individual with COVID-19 for a prolonged period of time.
 - Having direct contact with body fluids (such as blood, phlegm, and respiratory droplets) from an individual with COVID-19.

(U) To Protect Yourself from Exposure:

- If possible, maintain a distance of at least 6 feet.
- Practice proper hand hygiene. Wash your hands with soap and water for at least 20 seconds. If soap and water are not readily available and illicit drugs are NOT suspected to be present, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Do not touch your face with unwashed hands.
- Have a trained Emergency Medical Service/ Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
- Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Learn your employer's plan for exposure control and participate in all-hands training on the use of PPE for respiratory protection, if available.

¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-law-enforcement.html>

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(U) Recommended Personal Protective Equipment (PPE):

Law enforcement who must make contact with individuals confirmed or suspected to have COVID-19 should follow [CDC's Interim Guidance for EMS](#). Different styles of PPE may be necessary to perform operational duties. These alternative styles (i.e. coveralls) must provide protection that is at least as great as that provided by the minimum amount of PPE recommended.

The minimum PPE recommended is:

- A single pair of disposable examination gloves,
- Disposable isolation gown or single-use/disposable coveralls*,
- Any NIOSH-approved particulate respirator (i.e., N-95 or higher-level respirator), and
- Eye protection (i.e., goggles or disposable face shield that fully covers the front and sides of the face)

*If unable to wear a disposable gown or coveralls because it limits access to duty belt and gear, ensure duty belt and gear are disinfected after contact with individual.

(U) If Close Contact Occurred During Apprehension:

- Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
- Follow standard operating procedures for the containment and disposal of used PPE.
- Follow standard operating procedures for containing and laundering clothes. Avoid shaking the clothes.

Assessment:

(U) For law enforcement personnel performing daily routine activities, the immediate health risk is considered low. Law enforcement leadership and personnel should follow [CDC's Interim General Business Guidance](#).

Content source:

All content in this document is from the Centers for Disease Control and Prevention website <https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-law-enforcement.html>

As of March 4, 2020. Please check the website for update.

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West Virginia National Guard
Public Affairs Office
1703 Coonskin Drive
Charleston, WV 25311



PRESS RELEASE

FOR IMMEDIATE RELEASE
Release No. 20-020
March 10, 2020

WV National Guard
Public Affairs Office
(304) 561-6762

WVNG statement on COVID-19 monitoring at Camp Dawson

CHARLESTON, W.Va. – The West Virginia National Guard issues the following statement with regard to inquiries into Coronavirus Disease 2019 (COVID-19) monitoring at Camp Dawson:

At this time, there are no known cases of COVID-19 in West Virginia. An individual assigned to the West Virginia National Guard, who was undergoing training at Camp Dawson, was informed by their civilian employer on March 8, 2020, that they may have had direct contact with an individual who was diagnosed with COVID-19. The suspected contact took place Feb. 29, 2020, at the service member's employment location outside of the State of West Virginia.

Since the time of notification on March 8, 2020, the service member began self-quarantine actions and departed Camp Dawson on March 9, 2020, to their home of residence in Virginia. The service member has not displayed any symptoms and has remained under self-quarantine. Based on medical guidance, the incubation period for COVID-19 is 14 days. The service member's incubation period for exposure will end on March 14, 2020.

There is limited risk to the public and anyone who works on or has visited Camp Dawson. Out of an abundance of caution, we are taking all precautionary measures to protect the health of our force and maintain operational readiness. We will continue to evaluate current day-to-day operations to ensure the safety of all personnel working and training at Camp Dawson. We encourage individuals to follow the guidance issued by the Centers for Disease Control and Prevention and the West Virginia Department of Health and Human Resources (WVDHHR).

The WVDHHR has established a 24-hour hotline to address public and medical provider questions and concerns regarding COVID-19 at 1-800-887-4304. For the most up-to-date information, please visit coronavirus.wv.gov or <http://www.cdc.gov/COVID19>.

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For more information, contact the West Virginia National Guard Public Affairs Office at: (304) 561-6762 or email: hollir.nelson.mil@mail.mil.

West Virginia National Guard Facebook – www.facebook.com/WV.NationalGuard

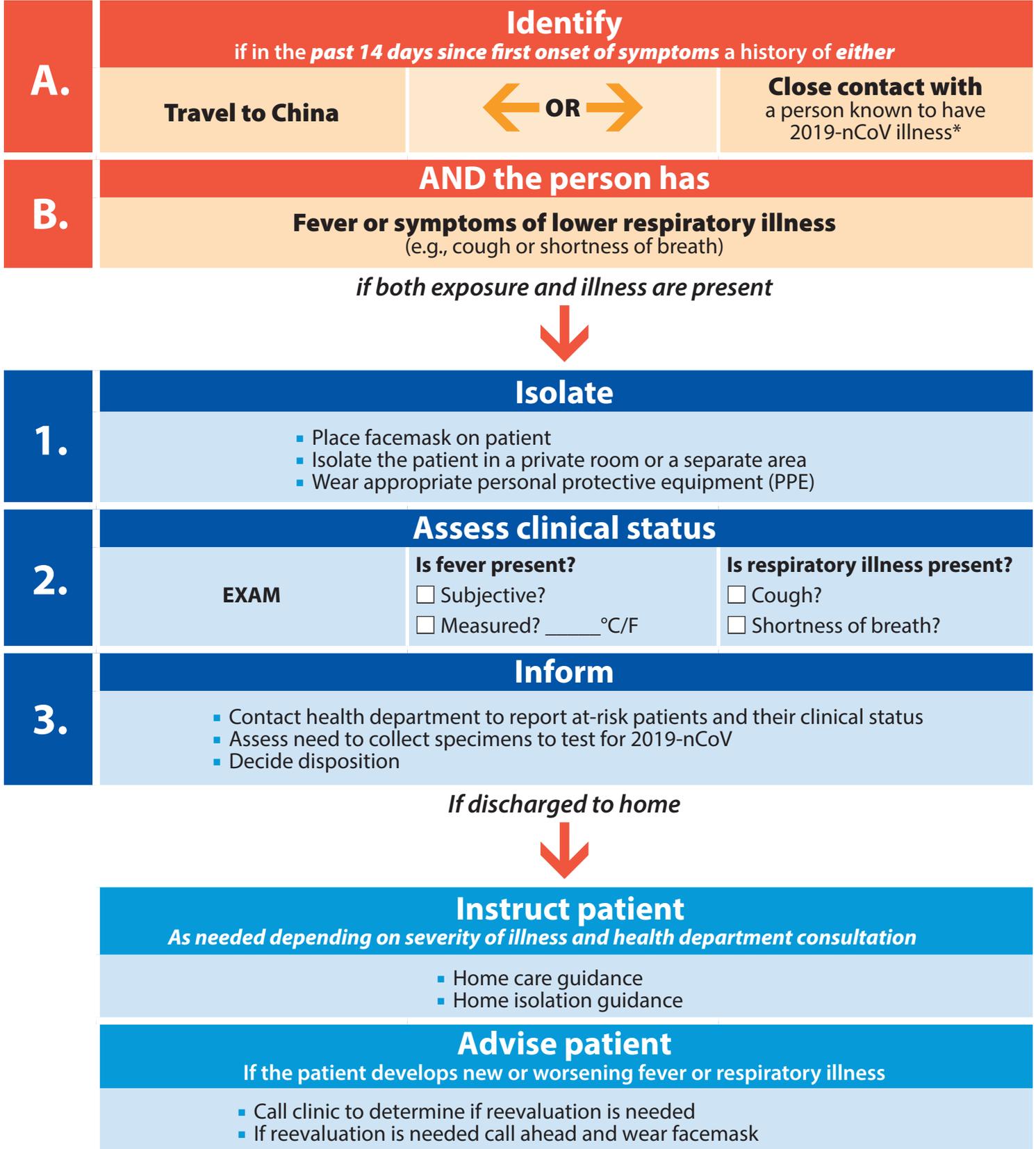
West Virginia National Guard Instagram – www.instagram.com/wv_nationalguard

West Virginia National Guard Twitter – www.twitter.com/wvnationalguard

West Virginia National Guard DVIDS – www.dvidshub.net/units/wv-ang

Flowchart to Identify and Assess 2019 Novel Coronavirus

For the evaluation of patients who may be ill with or who may have been exposed to 2019 Novel Coronavirus (2019-nCoV)



* Documentation of laboratory-confirmation of 2019-nCoV may not be possible for travelers or persons caring for patients in other countries. For more clarification on the definition for close contact see CDC's Interim Guidance for Healthcare Professionals: www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Bill J. Crouch
Cabinet Secretary

March 17, 2020

Robert Kadlec, MD
Assistant Secretary for Preparedness and Response,
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Dr. Kadlec:

First and foremost, thank you for all that you, the ASPR staff, and Trump Administration are doing to support a truly unprecedented global situation. The foresight, leadership, and planning that has been undertaken over the past decade through ASPR, PHEMCE, BARDA, SNS and the multitude of HHS agencies you coordinate in responses is remarkable. I especially appreciate your reach out today to West Virginia to explore both needs and opportunities we offer.

In association with the immediate needs listed on the attached page, I would like to propose a joint opportunity to domestically pilot and evaluate implementation of widespread community-based testing early in outbreak/pandemic response here. West Virginia provides a phenomenal opportunity to do so. We are a small state, have the highest risk population in the country¹, and are early in our COVID outbreak.

With medical leadership from WVU and others, we have been looking at lessons learned through various responses, especially efforts in South Korea and elsewhere that put a priority on both early social distancing (aiming for 75-90% of the population) and an emphasis on early, widespread community based testing to guide focused case follow up and management. We are well underway under Governor Justice's leadership in rapidly advancing the social distancing component, not waiting for identification of cases, although we now have our first. With the addition of rapid community based testing early, we can meet two critical objectives 1) reducing disease and death in arguably one of the nation's highest risk populations served by a rural health care system, and 2) piloting early application of these two interventions combined domestically. We would do so in combination with you, our university leadership involved in response, and state partners.

¹ Kaiser Family Foundation, **How Many Adults Are at Risk of Serious Illness If Infected with Coronavirus?** <https://www.kff.org/global-health-policy/issue-brief/how-many-adults-are-at-risk-of-serious-illness-if-infected-with-coronavirus/>. Excerpt: "The share of adults ages 18 and older who have a higher risk of developing a more serious illness varies across the country, ranging from 31 percent (Washington, D.C.) to 51 percent (West Virginia). In Washington State, California and New York, some of the states hardest hit by COVID-19 thus far, the share of adults at high risk is 40 percent, 37 percent and 40 percent respectively."

I sincerely appreciate your commitment to West Virginia and look forward to exploring this opportunity together with you. Disasters always offer applied science learning opportunities and I believe this is one we as a nation could benefit from both for this response and others in the future. I would be happy to connect your staff, our State Health Officer, Catherine Slemper, MD, MPH, and our University partners together with you to do so.

Sincerely,

A handwritten signature in blue ink that reads "Bill Crouch". The signature is fluid and cursive, with the first name "Bill" and the last name "Crouch" clearly legible.

Bill Crouch
Secretary

**Immediate Supply Needs: COVID19 Response
West Virginia**

Personal Protective Equipment in support of health care facilities, first responders, and local health departments (NOTE: This request was submitted earlier today to SNS)

300,000	N95 mask
300,000	Surgical masks
50,000	Goggles/face shields
200,000	Gowns
2000 boxes	Medium gloves
2000 boxes	Large gloves
2000 boxes	XL gloves

State Laboratory Testing Supplies

5,000 viral transport media
5,000 nasal swabs
3,000 extraction kits
3 CDC SARS-CoV2 testing kits

Community Based POD Site Testing:

Implementation of WV as a pilot for the nation -- examining the impact of early application of widespread community-based POD model testing in a high risk rural population.

Discuss implementation of rapid testing PODs/ Alternative models for rapid community-based testing. Needed supports would include core supplies as well as access to the self-screening website, data management and support system, partnership with commercial labs to support testing, etc.



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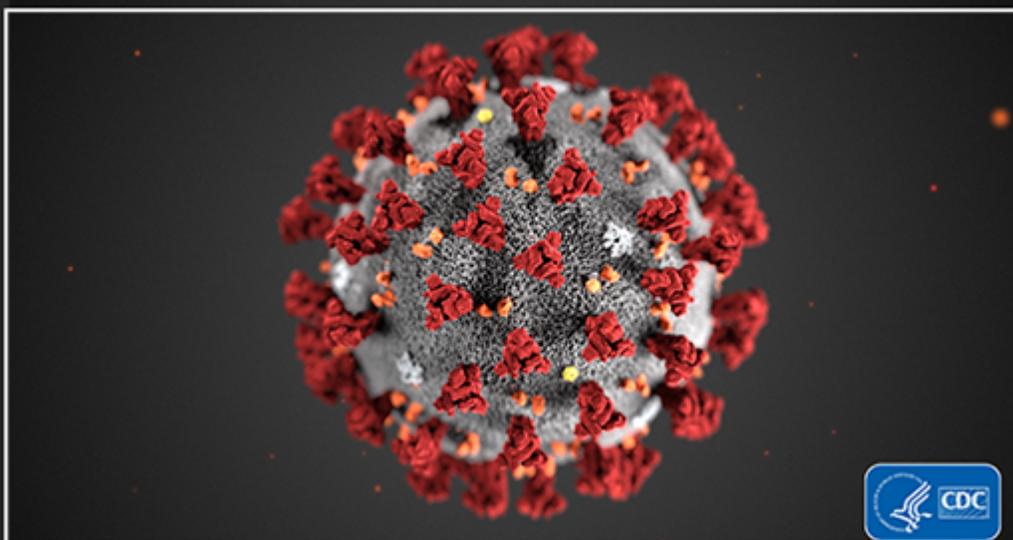
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March 2, 2020

[MEMBER RESOURCES](#)

IN THE SPOTLIGHT



[COVID-19 Update](#)

As the number of cases related to the coronavirus (COVID-19) rises in the United States, the Food and Drug Administration has recently [reported](#) the first shortage of a drug due to the outbreak. The shortage is related to an issue with the manufacturing of an active pharmaceutical ingredient used in the drug, which was not disclosed. Six deaths in the U.S. have been attributed to COVID-19, with confirmed cases in at least 10 states and the first reports of community spread occurring in Washington and Oregon, according to health officials and the [Centers for Disease Control and Prevention](#).

ASHP members now have free access to the Pharmacy Competency Assessment Center emergency

preparedness and infection prevention modules, available in the [COVID-19 resource center](#). We also encourage members to download our [sample list](#) of potential pharmacy public health roles at the local or state levels.

Last week, the National Institutes of Health announced that a new clinical trial of the investigational antiviral remdesivir has begun at the University of Nebraska Medical Center. Due to the impact on global health, a number of scholarly [publishers](#) are providing free access to articles related to coronavirus so that research findings and data on coronavirus can be shared openly to inform the public health response.



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ASHP's Commission on Goals, an interdisciplinary group of thought leaders that reviews healthcare trends and provides guidance on strategic areas of focus that have a bearing on



DIRECTOR'S STAY AT HOME ORDER

Re: Director's Order that All Persons Stay at Home Unless Engaged in Essential Work or Activity

I, Amy Acton, MD, MPH, Director of the Ohio Department of Health (ODH), pursuant to the authority granted to me in R.C. 3701.13 to "make special orders...for preventing the spread of contagious or infectious diseases" **Order** the following to prevent the spread of COVID-19 into the State of Ohio:

- 1. Stay at home or place of residence.** With exceptions as outlined below, all individuals currently living within the State of Ohio are ordered to stay at home or at their place of residence except as allowed in this Order. To the extent individuals are using shared or outdoor spaces when outside their residence, they must at all times and as much as reasonably possible, maintain social distancing of at least six feet from any other person, with the exception of family or household members, consistent with the Social Distancing Requirements set forth in this Order. All persons may leave their homes or place of residence only for Essential Activities, Essential Governmental Functions, or to participate in Essential Businesses and Operations, all as defined below.

Individuals experiencing homelessness are exempt from this Order, but are strongly urged to obtain shelter, and governmental and other entities are strongly urged to make such shelter available as soon as possible and to the maximum extent practicable (and to use in their operation COVID-19 risk mitigation practices recommended by the U.S. Centers for Disease Control and Prevention (CDC) and the Ohio Department of Health (ODH)). This order does not apply to incarcerated individuals, they are to follow the guidance of the facility in which they are confined. Individuals whose residences are unsafe or become unsafe, such as victims of domestic violence, are permitted and urged to leave their home and stay at a safe alternative location. For purposes of this Order, homes or residences include hotels, motels, shared rental units, shelters, and similar facilities.

- 2. Non-essential business and operations must cease.** All businesses and operations in the State, except Essential Businesses and Operations as defined below, are required to cease all activities within the State except Minimum Basic Operations, as defined below. For clarity, businesses, including home-based businesses, may also continue operations consisting exclusively of employees or contractors performing activities at their own residences (i.e., working from home).

All Essential Businesses and Operations are encouraged to remain open. Essential Businesses and Operations shall comply with Social Distancing Requirements as defined in this Order, including by maintaining six-foot social distancing for both employees and members of the public at all times, including, but not limited to, when any customers are standing in line.

- 3. Prohibited activities.** All public and private gatherings of any number of people occurring outside a single household or living unit are prohibited, except for the limited purposes permitted by this Order. Any gathering of more than ten people is prohibited unless exempted by this Order. This is

in accordance with President Trump's coronavirus guidelines issued March 16, 2020. Nothing in this Order prohibits the gathering of members of a household or residence.

All places of public amusement, whether indoors or outdoors, including, but not limited to, locations with amusement rides, carnivals, amusement parks, water parks, aquariums, zoos, museums, arcades, fairs, children's play centers, playgrounds, funplexes, theme parks, bowling alleys, movie and other theaters, concert and music halls, and country clubs or social clubs shall be closed.

4. **Prohibited and permitted travel.** Only Essential Travel and Essential Activities as defined herein, are permitted. People riding on public transit must comply with Social Distancing Requirements to the greatest extent feasible. This Order allows travel into or out of the State to maintain Essential Businesses and Operations and Minimum Basic Operations.
5. **Leaving the home for Essential Activities is permitted.** For purposes of this Order, individuals may leave their residence only to perform any of the following Essential Activities:
 - a. **For health and safety.** To engage in activities or perform tasks essential to their health and safety, or to the health and safety of their family or household members or persons who are unable or should not leave their home (including, but not limited to, pets), such as, by way of example only and without limitation, seeking emergency services, obtaining medical supplies or medication, or visiting a health care professional.
 - b. **For necessary supplies and services.** To obtain necessary services or supplies for themselves and their family or household members or persons who are unable or should not leave their home, or to deliver those services or supplies to others, such as, by way of example only and without limitation, groceries and food, household consumer products, supplies they need to work from home, automobile supplies (including dealers, parts, supplies, repair and maintenance), and products necessary to maintain the safety, sanitation, and essential operation of residences.
 - c. **For outdoor activity.** To engage in outdoor activity, provided the individuals comply with Social Distancing Requirements, as defined below, such as, by way of example and without limitation, walking, hiking, running, or biking. Individuals may go to public parks and open outdoor recreation areas. However, public access playgrounds may increase spread of COVID-19, and therefore shall be closed.
 - d. **For certain types of work** To perform work providing essential products and services at Essential Businesses or Operations (which, as defined below, includes Healthcare and Public Health Operations, Human Services Operations, Essential Governmental Functions, and Essential Infrastructure) or to otherwise carry out activities specifically permitted in this Order, including Minimum Basic Operations.
 - e. **To take care of others.** To care for a family member, friend, or pet in another household, and to transport family members, friends, or pets as allowed by this Order. This includes attending weddings and funerals.
6. **Elderly people and those who are vulnerable as a result of illness should take additional precautions.** People at high risk of severe illness from COVID-19, including elderly people and those who are sick, are urged to stay in their residence to the extent possible except as necessary

to seek medical care. Nothing in this Order prevents the Department Health or local health departments from issuing and enforcing isolation and quarantine orders.

- 7. Healthcare and Public Health Operations.** For purposes of this Order, individuals may leave their residence to work for or obtain services through Healthcare and Public Health Operations.

Healthcare and Public Health Operations includes, but is not limited to: hospitals; clinics; dental offices; pharmacies; public health entities, including those that compile, model, analyze and communicate public health information; pharmaceutical, pharmacy, medical device and equipment, and biotechnology companies (including operations, research and development, manufacture, and supply chain); organizations collecting blood, platelets, plasma, and other necessary materials; licensed medical marijuana dispensaries and licensed medical marijuana cultivation centers; obstetricians and gynecologists; eye care centers, including those that sell glasses and contact lenses; home healthcare services providers; mental health and substance use providers; other healthcare facilities and suppliers and providers of any related and/or ancillary healthcare services; and entities that transport and dispose of medical materials and remains.

Specifically included in Healthcare and Public Health Operations are manufacturers, technicians, logistics, and warehouse operators and distributors of medical equipment, personal protective equipment (PPE), medical gases, pharmaceuticals, blood and blood products, vaccines, testing materials, laboratory supplies, cleaning, sanitizing, disinfecting or sterilization supplies, and tissue and paper towel products.

Healthcare and Public Health Operations also includes veterinary care and all healthcare services provided to animals.

Healthcare and Public Health Operations shall be construed broadly to avoid any impacts to the delivery of healthcare, broadly defined. Healthcare and Public Health Operations does not include fitness and exercise gyms, spas, salons, barber shops, tattoo parlors, and similar facilities.

- 8. Human Services Operations.** For purposes of this Order, individuals may leave their residence to work for or obtain services at any Human Services Operations, including any provider funded by the Ohio Department of Aging, Department of Developmental Disabilities, Department of Health, Department of Job and Family Services, Department of Medicaid, Department of Mental Health and Addiction Services, Opportunities for Ohioans with Disabilities, Department of Veterans Services, and Department of Youth Services that is providing services to the public and including state-operated, institutional, or community-based settings providing human services to the public.

Human Services Operations includes, but is not limited to: long-term care facilities; day care centers, day care homes, group day care homes; residential settings and shelters for adults, seniors, children, and/or people with developmental disabilities, intellectual disabilities, substance use disorders, and/or mental illness; transitional facilities; home-based settings to provide services to individuals with physical, intellectual, and/or developmental disabilities, seniors, adults, and children; field offices that provide and help to determine eligibility for basic needs including food, cash assistance, medical coverage, child care, vocational services, rehabilitation services; developmental centers; adoption agencies; businesses that provide food, shelter, and social

services, and other necessities of life for economically disadvantaged individuals, individuals with physical, intellectual, and/or developmental disabilities, or otherwise needy individuals.

Human Services Operations shall be construed broadly to avoid any impacts to the delivery of human services, broadly defined.

- 9. Essential Infrastructure.** For purposes of this, individuals may leave their residence to provide any services or perform any work necessary to offer, provision, operate, maintain and repair Essential Infrastructure.

Essential Infrastructure includes, but is not limited to: food production, distribution, fulfillment centers, storage facilities, marinas, and sale; construction (including, but not limited to, construction required in response to this public health emergency, hospital construction, construction of long-term care facilities, public works construction, school construction, essential business construction, and housing construction); building management and maintenance; airport operations; operation and maintenance of utilities, including water, sewer, and gas; electrical (including power generation, distribution, and production of raw materials); distribution centers; oil and biofuel refining; roads, highways, railroads, and public transportation; ports; cybersecurity operations; flood control; solid waste and recycling collection and removal; and internet, video, and telecommunications systems (including the provision of essential global, national, and local infrastructure for computing services, business infrastructure, communications, and web-based services).

Essential Infrastructure shall be construed broadly to avoid any impacts to essential infrastructure, broadly defined.

- 10. Essential Governmental Functions.** For purposes of this Order, all first responders, emergency management personnel, emergency dispatchers, legislators, judges, court personnel, jurors and grand jurors, law enforcement and corrections personnel, hazardous materials responders, child protection and child welfare personnel, housing and shelter personnel, military, and other governmental employees working for or to support Essential Businesses and Operations are categorically exempt from this Order.

Essential Government Functions means all services provided by the State or any municipality, township, county, political subdivision, board, commission or agency of government and needed to ensure the continuing operation of the government agencies or to provide for or support the health, safety and welfare of the public, and including contractors performing Essential Government Functions. Each government body shall determine its Essential Governmental Functions and identify employees and/or contractors necessary to the performance of those functions.

This Order does not apply to the United States government. Nothing in this Order shall prohibit any individual from performing or accessing Essential Governmental Functions.

- 11. Businesses covered by this Order.** For the purposes of this Order, covered businesses include any for-profit, non-profit, or educational entities, regardless of the nature of the service, the function it performs, or its corporate or entity structure.

12. Essential Businesses and Operations. For the purposes of this Order, Essential Businesses and Operations means Healthcare and Public Health Operations, Human Services Operations, Essential Governmental Functions, and Essential Infrastructure, and the following:

- a. **CISA List.** On March 19, 2020, the U.S. Department of Homeland Security, Cybersecurity & Infrastructure Security Agency (CISA), issued a *Memorandum on Identification of Essential Critical Infrastructure Workers During COVID-19 Response*. The definition of Essential Businesses and Operations in this Order includes all the workers identified in that Memorandum.
- b. **Stores that sell groceries and medicine.** Grocery stores, pharmacies, certified farmers' markets, farm and produce stands, supermarkets, convenience stores, and other establishments engaged in the retail sale of groceries, canned food, dry goods, frozen foods, fresh fruits and vegetables, pet supplies, fresh meats, fish, and poultry, prepared food, alcoholic and non-alcoholic beverages, any other household consumer products (such as cleaning and personal care products), and specifically includes their supply chain and administrative support operations. This includes stores that sell groceries, medicine, including medication not requiring a medical prescription, and also that sell other non-grocery products, and products necessary to maintaining the safety, sanitation, and essential operation of residences and Essential Businesses and Operations;
- c. **Food, beverage, and licensed marijuana production and agriculture.** Food and beverage manufacturing, production, processing, and cultivation, including farming, livestock, fishing, baking, and other production agriculture, including cultivation, marketing, production, and distribution of animals and goods for consumption; licensed medical marijuana use, medical marijuana dispensaries and licensed medical marijuana cultivation centers; and businesses that provide food, shelter, and other necessities of life for animals, including animal shelters, rescues, shelters, kennels, and adoption facilities;
- d. **Organizations that provide charitable and social services.** Businesses and religious and secular nonprofit organizations, including food banks, when providing food, shelter, and social services, and other necessities of life for economically disadvantaged or otherwise needy individuals, individuals who need assistance as a result of this emergency, and people with disabilities;
- e. **Religious entities.** Religious facilities, entities and groups and religious gatherings, including weddings and funerals.
- f. **Media.** Newspapers, television, radio, and other media services;
- g. **First amendment protected speech.**
- h. **Gas stations and businesses needed for transportation.** Gas stations and auto supply, auto-repair, farm equipment, construction equipment, boat repair, and related facilities and bicycle shops and related facilities;
- i. **Financial and insurance institutions.** Bank, currency exchanges, consumer lenders, including but not limited, to pawnbrokers, consumer installment lenders and sales finance lenders, credit unions, appraisers, title companies, financial markets, trading and futures

exchanges, payday lenders, affiliates of financial institutions, entities that issue bonds, related financial institutions, and institutions selling financial products. Also insurance companies, underwriters, agents, brokers, and related insurance claims and agency services;

- j. Hardware and supply stores.** Hardware stores and businesses that sell electrical, plumbing, and heating material;
- k. Critical trades.** Building and Construction Tradesmen and Tradeswomen, and other trades including but not limited to plumbers, electricians, exterminators, cleaning and janitorial staff for commercial and governmental properties, security staff, operating engineers, HVAC, painting, moving and relocation services, and other service providers who provide services that are necessary to maintaining the safety, sanitation, and essential operation of residences, Essential Activities, and Essential Businesses and Operations;
- l. Mail, post, shipping, logistics, delivery, and pick-up services.** Post offices and other businesses that provide shipping and delivery services, and businesses that ship or deliver groceries, food, alcoholic and non-alcoholic beverages, goods, vehicles or services to end users or through commercial channels;
- m. Educational institutions.** Educational institutions-including public and private pre-K-12 schools, colleges, and universities-for purposes of facilitating distance learning, performing critical research, or performing essential functions, provided that social distancing of six-feet per person is maintained to the greatest extent possible. This Order is consistent with and does not amend or supersede prior Orders regarding the closure of schools;
- n. Laundry services.** Laundromats, dry cleaners, industrial laundry services, and laundry service providers;
- o. Restaurants for consumption off-premises.** Restaurants and other facilities that prepare and serve food, but only for consumption off-premises, through such means as in-house delivery, third-party delivery, drive-through, curbside pick-up, and carry-out. Schools and other entities that typically provide food services to students or members of the public may continue to do so under this Order on the condition that the food is provided to students or members of the public on a pick-up and takeaway basis only. Schools and other entities that provide food services under this exemption shall not permit the food to be eaten at the site where it is provided, or at any other gathering site due to the virus's propensity to physically impact surfaces and personal property. This Order is consistent with and does not amend or supersede prior Orders regarding the closure of restaurants;
- p. Supplies to work from home.** Businesses that sell, manufacture, or supply products needed for people to work from home;
- q. Supplies for Essential Businesses and Operations.** Businesses that sell, manufacture, or supply other Essential Businesses and Operations with the support or materials necessary to operate, including computers, audio and video electronics, household appliances; IT and telecommunication equipment; hardware, paint, flat glass; electrical, plumbing and heating material; sanitary equipment; personal hygiene products; food, food additives, ingredients and components; medical and orthopedic equipment; optics and photography equipment; diagnostics, food and beverages, chemicals, soaps and detergent; and firearm and ammunition suppliers and retailers for purposes of safety and security;

- r. **Transportation.** Airlines, taxis, transportation network providers (such as Uber and Lyft), vehicle rental services, paratransit, marinas, docks, boat storage, and other private, public, and commercial transportation and logistics providers necessary for Essential Activities and other purposes expressly authorized in this Order;
 - s. **Home-based care and services.** Home-based care for adults, seniors, children, and/or people with developmental disabilities, intellectual disabilities, substance use disorders, and/or mental illness, including caregivers such as nannies who may travel to the child's home to provide care, and other in-home services including meal delivery;
 - t. **Residential facilities and shelters.** Residential facilities and shelters for adults, seniors, children, pets, and/or people with developmental disabilities, intellectual disabilities, substance use disorders, and/or mental illness;
 - u. **Professional services.** Professional services, such as legal services, accounting services, insurance services, real estate services (including appraisal and title services);
 - v. **Manufacture, distribution, and supply chain for critical products and industries.** Manufacturing companies, distributors, and supply chain companies producing and supplying essential products and services in and for industries such as pharmaceutical, technology, biotechnology, healthcare, chemicals and sanitization, waste pickup and disposal, agriculture, food and beverage, transportation, energy, steel and steel products, petroleum and fuel, mining, construction, national defense, communications, as well as products used by other Essential Businesses and Operations.
 - w. **Critical labor union functions.** Labor Union essential activities including the administration of health and welfare funds and personnel checking on the well-being and safety of members providing services in Essential Businesses and Operations - provided that these checks should be done by telephone or remotely where possible.
 - x. **Hotels and motels.** Hotels and motels, to the extent used for lodging and delivery or carry-out food services.
 - y. **Funeral services.** Funeral, mortuary, cremation, burial, cemetery, and related services.
13. **Minimum Basic Operations.** For the purposes of this Order, Minimum Basic Operations include the following, provided that employees comply with Social Distancing Requirements, to the extent possible, while carrying out such operations:
- a. The minimum necessary activities to maintain the value of the business's inventory, preserve the condition of the business's physical plant and equipment, ensure security, process payroll and employee benefits, or for related functions.
 - b. The minimum necessary activities to facilitate employees of the business being able to continue to work remotely from their residences.
14. **Essential Travel.** For the purposes of this Order, Essential Travel includes travel for any of the following purposes. Individuals engaged in any Essential Travel must comply with all Social Distancing Requirements as defined in this Section.
- a. Any travel related to the provision of or access to Essential Activities, Essential Governmental Functions, Essential Businesses and Operations, or Minimum Basic Operations.

- b. Travel to care for elderly, minors, dependents, persons with disabilities, or other vulnerable persons.
- c. Travel to or from educational institutions for purposes of receiving materials for distance learning, for receiving meals, and any other related services.
- d. Travel to return to a place of residence from outside the jurisdiction.
- e. Travel required by law enforcement or court order, including to transport children pursuant to a custody agreement.
- f. Travel required for non-residents to return to their place of residence outside the State. Individuals are strongly encouraged to verify that their transportation out of the State remains available and functional prior to commencing such travel.

15. Social Distancing Requirements. For purposes of this Order, Social Distancing Requirements includes maintaining at least six-foot social distancing from other individuals, washing hands with soap and water for at least twenty seconds as frequently as possible or using hand sanitizer, covering coughs or sneezes (into the sleeve or elbow, not hands), regularly cleaning high-touch surfaces, and not shaking hands.

- a. **Required measures.** Essential Businesses and Operations and businesses engaged in Minimum Basic Operations must take proactive measures to ensure compliance with Social Distancing Requirements, including where possible:
 - i. **Designate six-foot distances.** Designating with signage, tape, or by other means six-foot spacing for employees and customers in line to maintain appropriate distance;
 - ii. **Hand sanitizer and sanitizing products.** Having hand sanitizer and sanitizing products readily available for employees and customers;
 - iii. **Separate operating hours for vulnerable populations.** Implementing separate operating hours for elderly and vulnerable customers; and
 - iv. **Online and remote access.** Posting online whether a facility is open and how best to reach the facility and continue services by phone or remotely.

16. Intent of this Order. The intent of this Order is to ensure that the maximum number of people self-isolate in their places of residence to the maximum extent feasible, while enabling essential services to continue, to slow the spread of COVID-19 to the greatest extent possible. When people need to leave their places of residence, whether to perform Essential Activities, or to otherwise facilitate authorized activities necessary for continuity of social and commercial life, they should at all times and as much as reasonably possible comply with Social Distancing Requirements. All provisions of this Order should be interpreted to effectuate this intent.

17. Enforcement. This Order may be enforced by State and local law enforcement to the extent set forth in Ohio law. To the extent any public official enforcing this Order has questions regarding what services are prohibited under this Order, the Director of Health hereby delegates to local health departments the authority to answer questions in writing and consistent with this Order.

18. COVID-19 Information and Checklist for Businesses/Employers. Business and employers are to take the following actions:

- a. Allow as many employees as possible to work from home by implementing policies in areas such as teleworking and video conferencing.
- b. Actively encourage sick employees to stay home until they are free of fever (without the use of medication) for at least 72 hours (three full days) AND symptoms have improved for at least 72 hours AND at least seven days have passed since symptoms first began. Do not require a healthcare provider's note to validate the illness or return to work of employees sick with acute respiratory illness; healthcare provider offices and medical facilities may be extremely busy and not able to provide such documentation in a timely way.
- c. Ensure that your sick leave policies are up to date, flexible, and non-punitive to allow sick employees to stay home to care for themselves, children, or other family members. Consider encouraging employees to do a self-assessment each day to check if they have any COVID-19 symptoms (fever, cough, or shortness of breath).
- d. Separate employees who appear to have acute respiratory illness symptoms from other employees and send them home immediately. Restrict their access to the business until they have recovered.
- e. Reinforce key messages — stay home when sick, use cough and sneeze etiquette, and practice hand hygiene — to all employees, and place posters in areas where they are most likely to be seen. Provide protection supplies such as soap and water, hand sanitizer, tissues, and no-touch disposal receptacles for use by employees.
- f. Frequently perform enhanced environmental cleaning of commonly touched surfaces, such as workstations, countertops, railings, door handles, and doorknobs. Use the cleaning agents that are usually used in these areas and follow the directions on the label. Provide disposable wipes so that commonly used surfaces can be wiped down by employees before each use.
- g. Be prepared to change business practices if needed to maintain critical operations (e.g., identify alternative suppliers, prioritize customers, or temporarily suspend some of your operations).

19. No limitation on authority. Nothing in this Order shall, in any way, alter or modify any existing legal authority allowing the State or any local health department from ordering (1) any quarantine or isolation that may require an individual to remain inside a particular residential property or medical facility for a limited period of time, including the duration of this public health emergency, or (2) any closure of a specific location for a limited period of time, including the duration of this public health emergency.

20. Savings clause. If any provision of this Order or its application to any person or circumstance is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision or application of this Order, which can be given effect without the invalid provision or application. To achieve this purpose, the provisions of this Order are declared to be severable.

21. Previous Orders superseded. This Order supersedes, only to the extent that it conflicts, and amends any previous Order which conflicts with the provisions of this Order.

22. Duration. This Order shall be effective at 11:59 p.m. on March 23, 2020 and remain in full force and effect until 11:59 p.m. on April 6, 2020, unless the Director of the Ohio Department of Health rescinds or modifies this Order at a sooner time and date.

COVID-19 is a respiratory disease that can result in serious illness or death, is caused by the SARS-CoV-2 virus, which is a new strain of coronavirus that had not been previously identified in humans and can easily spread from person to person. The virus is spread between individuals who are in close contact with each other (within about six feet) through respiratory droplets produced when an infected person coughs or sneezes. It may be possible that individuals can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose or eyes.

On January 23, 2020, the Ohio Department of Health issued a Director's Journal Entry making COVID-19 a Class A reportable disease in Ohio.

On January 28, 2020, the Ohio Department of Health hosted the first statewide call with local health departments and healthcare providers regarding COVID-19.

On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization declared the outbreak of COVID-19 a public health emergency of international concern.

On January 31, 2020, Health and Human Services Secretary, Alex M. Azar II, declared a public health emergency for the United States to aid the nation's healthcare community in responding to COVID-19.

On February 1, 2020, the Ohio Department of Health issued a statewide Health Alert Network to provide local health departments and healthcare providers with updated guidance for COVID-19 and revised Person Under Investigation (PUI) criteria.

On February 3, 2020, the Ohio Department of Health trained over 140 personnel to staff a call center for COVID-19, in the event it was needed.

On February 5, 2020, the Ohio Department of Health began updating and notifying the media of the number of PUIs in Ohio every Tuesday and Thursday.

On February 6, 2020, the Ohio Department of Health updated all agency assistant directors and chiefs of staff on COVID-19 preparedness and status during the Governor's cabinet meeting.

On February 7, 2020, the Ohio Department of Health and the Ohio Emergency Management Agency met to conduct advance planning for COVID-19.

On February 13, 2020, the Ohio Department of Health conducted a Pandemic Tabletop Exercise with State agencies to review responsive actions should there be a pandemic in Ohio.

On February 14, 2020, the Ohio Department of Health held a conference call with health professionals across the state. The purpose of the call was to inform and engage the healthcare community in Ohio. Presentations were provided by the Department of Health, Hamilton County Public Health, and the Ohio State University.

On February 27, 2020, the Ohio Department of Health and the Ohio Emergency Management Agency briefed the directors of State agencies during the Governor's cabinet meeting regarding preparedness and the potential activation of the Emergency Operations Center.

On February 28, 2020, the "Governor DeWine, Health Director Update COVID-19 Prevention and Preparedness Plan" was sent to a broad range of associations representing healthcare, dental, long-term care, K-12 schools, colleges and universities, business, public transit, faith-based organizations, non-profit organizations, and local governments.

On March 2, 2020, the Ohio Department of Health activated a Joint Information Center to coordinate COVID-19 communications.

On March 5, 2020, the Ohio Department of Health hosted the Governor's Summit on COVID-19 Preparedness, a meeting with the Governor, cabinet agency directors, local health department commissioners, and their staff.

On March 6, 2020, the Ohio Department of Health opened a call center to answer questions from the public regarding COVID-19.

On March 9, 2020, testing by the Department of Health confirmed that three (3) patients were positive for COVID-19 in the State of Ohio. This confirms the presence of a potentially dangerous condition which may affect the health, safety and welfare of citizens of Ohio.

On March 9, 2020, the Ohio Emergency Management Agency activated the Emergency Operations Center.

On March 9, 2020, the Governor Declared a State of Emergency in Executive Order 2020-01D.

On March 11, 2020, the head of the World Health Organization declared COVID-19 a pandemic.

On March 11, 2020, testing by the Ohio Department of Health confirmed that one (1) more patient was positive for COVID-19 in the State of Ohio.

On March 11, 2020, the Ohio Departments of Health and Veterans Services issued a Joint Directors' Order to limit access to Ohio nursing homes and similar facilities.

On March 15, 2020, the Ohio Department of Health issued a Director's Order to limit access to Ohio's jails and detention facilities.

On March 15, 2020, the Ohio Department of Health issued a Director's Order to limit the sale of food and beverages, liquor, beer and wine to carry-out and delivery only.

On March 15, 2020, the CDC issued Interim Guidance for mass gatherings or large community events, stating that such events that consist of 50 or more people should be cancelled or postponed.

On March 16, 2020 the Ohio Department of Health issued a Director's Order closing polling locations for the March 17, 2020 primary election.

On March 17, 2020 the Ohio Department of Health issued a Director's Order for the management of non-essential surgeries and procedures throughout Ohio.

On March 17, 2020 the Ohio Department of Health issued an Amended Director's Order to limit and/or prohibit mass gatherings and the closure of venues in the State of Ohio.

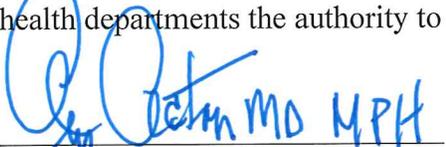
On March 19, 2020, the Ohio Department of Health issued a Director's Order closing hair salons, nail salons, barber shops, tattoo parlors, body piercing locations, and massage therapy locations.

Multiple areas of the United States are experiencing "community spread" of the virus that causes COVID-19. Community spread, defined as the transmission of an illness for which the source is unknown, means that isolation of known areas of infection is no longer enough to control spread.

The CDC reports that people are most contagious when they are most symptomatic (the sickest) however some spread might be possible before people show symptoms although that is not the main way the virus spreads.

Mass gatherings (10 or more persons) increase the risk of community transmission of the virus COVID-19.

Accordingly, to avoid an imminent threat with a high probability of widespread exposure to COVID-19 with a significant risk of substantial harm to a large number of people in the general population, including the elderly and people with weakened immune systems and chronic medical conditions, I hereby **ORDER** effective at 11:59 p.m. on March 23, 2020, all persons are to stay at home or their place of residence unless they are engaged in Essential Activities, Essential Governmental Functions, or to operate Essential Businesses and Operations as set forth in this Order. This Order shall remain in full force and effect until 11:59 p.m. on April 6, 2020, unless the Director of the Ohio Department of Health rescinds or modifies this Order at a sooner time and date. To the extent any public official enforcing this Order has questions regarding what services are prohibited under this Order, the Director of Health hereby delegates to local health departments the authority to answer questions in writing and consistent with this Order.



Amy Acton, MD, MPH
Director of Health

March 22, 2020



March 19, 2020

**MEMORANDUM ON IDENTIFICATION OF ESSENTIAL CRITICAL
INFRASTRUCTURE WORKERS DURING COVID-19 RESPONSE**

FROM: Christopher C. Krebs
Director
Cybersecurity and Infrastructure Security Agency (CISA)



As the Nation comes together to slow the spread of COVID-19, on March 16th, the President issued updated Coronavirus Guidance for America. This guidance states that:

“If you work in a critical infrastructure industry, as defined by the Department of Homeland Security, such as healthcare services and pharmaceutical and food supply, you have a special responsibility to maintain your normal work schedule.”

The Cybersecurity and Infrastructure Security Agency (CISA) executes the Secretary of Homeland Security’s responsibilities as assigned under the Homeland Security Act of 2002 to provide strategic guidance, promote a national unity of effort, and coordinate the overall federal effort to ensure the security and resilience of the Nation's critical infrastructure. CISA uses trusted partnerships with both the public and private sectors to deliver infrastructure resilience assistance and guidance to a broad range of partners.

In accordance with this mandate, and in collaboration with other federal agencies and the private sector, CISA developed an initial list of “Essential Critical Infrastructure Workers” to help State and local officials as they work to protect their communities, while ensuring continuity of functions critical to public health and safety, as well as economic and national security. The list can also inform critical infrastructure community decision-making to determine the sectors, sub-sectors, segments, or critical functions that should continue normal operations, appropriately modified to account for Centers for Disease Control (CDC) workforce and customer protection guidance.

The attached list identifies workers who conduct a range of operations and services that are essential to continued critical infrastructure viability, including staffing operations centers, maintaining and repairing critical infrastructure, operating call centers, working construction, and performing management functions, among others. The industries they support represent, but are not necessarily limited to, medical and healthcare, telecommunications, information technology systems, defense, food and agriculture, transportation and logistics, energy, water and wastewater, law enforcement, and public works.

We recognize that State, local, tribal, and territorial governments are ultimately in charge of implementing and executing response activities in communities under their jurisdiction, while the Federal Government is in a supporting role. As State and local communities consider COVID-19-related restrictions, CISA is offering this list to assist prioritizing activities related to continuity of operations and incident response, including the appropriate movement of critical infrastructure workers within and between jurisdictions.

Accordingly, this list is advisory in nature. It is not, nor should it be considered to be, a federal directive or standard in and of itself.

In addition, these identified sectors and workers are not intended to be the authoritative or exhaustive list of critical infrastructure sectors and functions that should continue during the COVID-19 response. Instead, State and local officials should use their own judgment in using their authorities and issuing implementation directives and guidance. Similarly, critical infrastructure industry partners will use their own judgment, informed by this list, to ensure continued operations of critical infrastructure services and functions. All decisions should appropriately balance public safety while ensuring the continued delivery of critical infrastructure services and functions.

CISA will continue to work with you and our partners in the critical infrastructure community to update this list as the Nation's response to COVID-19 evolves. We also encourage you to submit how you might use this list so that we can develop a repository of use cases for broad sharing across the country.

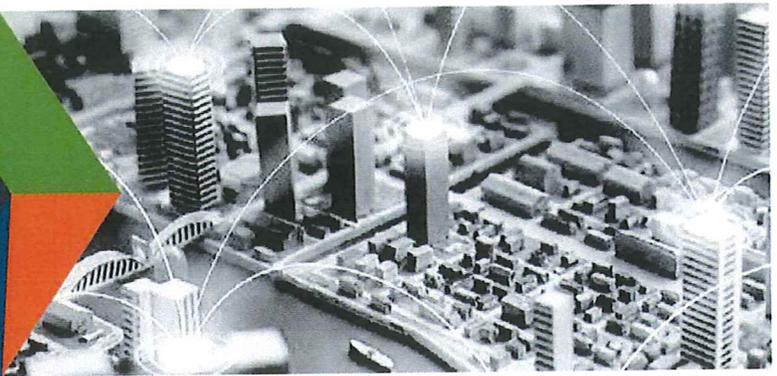
Should you have questions about this list, please contact CISA at CISA.CAT@cisa.dhs.gov.

Attachment: "Guidance on the Essential Critical Infrastructure Workforce: Ensuring Community and National Resilience in COVID-19 Response"



CISA
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DEFEND TODAY, SECURE TOMORROW



Guidance on the Essential Critical Infrastructure Workforce: Ensuring Community and National Resilience in COVID-19 Response

Version 1.0 (March 19, 2020)

THE IMPORTANCE OF ESSENTIAL CRITICAL INFRASTRUCTURE WORKERS

Functioning critical infrastructure is imperative during the response to the COVID-19 emergency for both public health and safety as well as community well-being. Certain critical infrastructure industries have a special responsibility in these times to continue operations.

This guidance and accompanying list are intended to support State, Local, and industry partners in identifying the critical infrastructure sectors and the essential workers needed to maintain the services and functions Americans depend on daily and that need to be able to operate resiliently during the COVID-19 pandemic response.

This document gives guidance to State, local, tribal, and territorial jurisdictions and the private sector on defining essential critical infrastructure workers. Promoting the ability of such workers to continue to work during periods of community restriction, access management, social distancing, or closure orders/directives is crucial to community resilience and continuity of essential functions.

CONSIDERATIONS FOR GOVERNMENT AND BUSINESS

This list was developed in consultation with federal agency partners, industry experts, and State and local officials, and is based on several key principles:

1. Response efforts to the COVID-19 pandemic are locally executed, State managed, and federally supported
2. Everyone should follow guidance from the CDC, as well as State and local government officials, regarding strategies to limit disease spread.
3. Workers should be encouraged to work remotely when possible and focus on core business activities. In-person, non-mandatory activities should be delayed until the resumption of normal operations.
4. When continuous remote work is not possible, businesses should enlist strategies to reduce the likelihood of spreading the disease. This includes, but is not necessarily limited to, separating staff by off-setting shift hours or days and/or social distancing. These steps can preserve the workforce and allow operations to continue.

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Essential Critical Infrastructure Workforce

5. All organizations should implement their business continuity and pandemic plans, or put plans in place if they do not exist. Delaying implementation is not advised and puts at risk the viability of the business and the health and safety of the employees.
6. In the modern economy, reliance on technology and just-in-time supply chains means that certain workers must be able to access certain sites, facilities, and assets to ensure continuity of functions.
7. Government employees, such as emergency managers, and the business community need to establish and maintain lines of communication.
8. When government and businesses engage in discussions about critical infrastructure workers, they need to consider the implications of business operations beyond the jurisdiction where the asset or facility is located. Businesses can have sizeable economic and societal impacts as well as supply chain dependencies that are geographically distributed.
9. Whenever possible, jurisdictions should align access and movement control policies related to critical infrastructure workers to lower the burden of workers crossing jurisdictional boundaries.

IDENTIFYING ESSENTIAL CRITICAL INFRASTRUCTURE WORKERS

The following list of sectors and identified essential critical infrastructure workers are an initial recommended set and are intended to be overly inclusive reflecting the diversity of industries across the United States. CISA will continually solicit and accept feedback on the list (both sectors/sub sectors and identified essential workers) and will evolve the list in response to stakeholder feedback. We will also use our various stakeholder engagement mechanisms to work with partners on how they are using this list and share those lessons learned and best practices broadly. We ask that you share your feedback, both positive and negative on this list so we can provide the most useful guidance to our critical infrastructure partners. **Feedback can be sent to CISA.CAT@CISA.DHS.GOV.**



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HEALTHCARE / PUBLIC HEALTH

- Workers providing COVID-19 testing; Workers that perform critical clinical research needed for COVID-19 response
- Caregivers (e.g., physicians, dentists, psychologists, mid-level practitioners, nurses and assistants, infection control and quality assurance personnel, pharmacists, physical and occupational therapists and assistants, social workers, speech pathologists and diagnostic and therapeutic technicians and technologists)
- Hospital and laboratory personnel (including accounting, administrative, admitting and discharge, engineering, epidemiological, source plasma and blood donation, food service, housekeeping, medical records, information technology and operational technology, nutritionists, sanitarians, respiratory therapists, etc.)
- Workers in other medical facilities (including Ambulatory Health and Surgical, Blood Banks, Clinics, Community Mental Health, Comprehensive Outpatient rehabilitation, End Stage Renal Disease, Health Departments, Home Health care, Hospices, Hospitals, Long Term Care, Organ Pharmacies, Procurement Organizations, Psychiatric Residential, Rural Health Clinics and Federally Qualified Health Centers)
- Manufacturers, technicians, logistics and warehouse operators, and distributors of medical equipment, personal protective equipment (PPE), medical gases, pharmaceuticals, blood and blood products, vaccines, testing materials, laboratory supplies, cleaning, sanitizing, disinfecting or sterilization supplies, and tissue and paper towel products
- Public health / community health workers, including those who compile, model, analyze and communicate public health information
- Blood and plasma donors and the employees of the organizations that operate and manage related activities
- Workers that manage health plans, billing, and health information, who cannot practically work remotely
- Workers who conduct community-based public health functions, conducting epidemiologic surveillance, compiling, analyzing and communicating public health information, who cannot practically work remotely
- Workers performing cybersecurity functions at healthcare and public health facilities, who cannot practically work remotely
- Workers conducting research critical to COVID-19 response
- Workers performing security, incident management, and emergency operations functions at or on behalf of healthcare entities including healthcare coalitions, who cannot practically work remotely
- Workers who support food, shelter, and social services, and other necessities of life for economically disadvantaged or otherwise needy individuals, such as those residing in shelters
- Pharmacy employees necessary for filling prescriptions
- Workers performing mortuary services, including funeral homes, crematoriums, and cemetery workers
- Workers who coordinate with other organizations to ensure the proper recovery, handling, identification, transportation, tracking, storage, and disposal of human remains and personal effects; certify cause of death; and facilitate access to mental/behavioral health services to the family members, responders, and survivors of an incident

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LAW ENFORCEMENT, PUBLIC SAFETY, FIRST RESPONDERS

- Personnel in emergency management, law enforcement, Emergency Management Systems, fire, and corrections, including front line and management
- Emergency Medical Technicians
- 911 call center employees
- Fusion Center employees
- Hazardous material responders from government and the private sector.
- Workers – including contracted vendors – who maintain digital systems infrastructure supporting law enforcement and emergency service operations.

FOOD AND AGRICULTURE

- Workers supporting groceries, pharmacies and other retail that sells food and beverage products
- Restaurant carry-out and quick serve food operations - Carry-out and delivery food employees
- Food manufacturer employees and their supplier employees—to include those employed in food processing (packers, meat processing, cheese plants, milk plants, produce, etc.) facilities; livestock, poultry, seafood slaughter facilities; pet and animal feed processing facilities; human food facilities producing by-products for animal food; beverage production facilities; and the production of food packaging
- Farm workers to include those employed in animal food, feed, and ingredient production, packaging, and distribution; manufacturing, packaging, and distribution of veterinary drugs; truck delivery and transport; farm and fishery labor needed to produce our food supply domestically
- Farm workers and support service workers to include those who field crops; commodity inspection; fuel ethanol facilities; storage facilities; and other agricultural inputs
- Employees and firms supporting food, feed, and beverage distribution, including warehouse workers, vendor-managed inventory controllers and blockchain managers
- Workers supporting the sanitation of all food manufacturing processes and operations from wholesale to retail
- Company cafeterias - in-plant cafeterias used to feed employees
- Workers in food testing labs in private industries and in institutions of higher education
- Workers essential for assistance programs and government payments
- Employees of companies engaged in the production of chemicals, medicines, vaccines, and other substances used by the food and agriculture industry, including pesticides, herbicides, fertilizers, minerals, enrichments, and other agricultural production aids
- Animal agriculture workers to include those employed in veterinary health; manufacturing and distribution of animal medical materials, animal vaccines, animal drugs, feed ingredients, feed, and bedding, etc.; transportation of live animals, animal medical materials; transportation of deceased animals for disposal; raising of animals for food; animal production operations; slaughter and packing plants and associated regulatory and government workforce
- Workers who support the manufacture and distribution of forest products, including, but not limited to timber, paper, and other wood products
- Employees engaged in the manufacture and maintenance of equipment and other infrastructure necessary to agricultural production and distribution

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ENERGY

Electricity industry:

- Workers who maintain, ensure, or restore the generation, transmission, and distribution of electric power, including call centers, utility workers, reliability engineers and fleet maintenance technicians
- Workers needed for safe and secure operations at nuclear generation
- Workers at generation, transmission, and electric blackstart facilities
- Workers at Reliability Coordinator (RC), Balancing Authorities (BA), and primary and backup Control Centers (CC), including but not limited to independent system operators, regional transmission organizations, and balancing authorities
- Mutual assistance personnel
- IT and OT technology staff – for EMS (Energy Management Systems) and Supervisory Control and Data Acquisition (SCADA) systems, and utility data centers; Cybersecurity engineers; cybersecurity risk management
- Vegetation management crews and traffic workers who support
- Environmental remediation/monitoring technicians
- Instrumentation, protection, and control technicians

Petroleum workers:

- Petroleum product storage, pipeline, marine transport, terminals, rail transport, road transport
- Crude oil storage facilities, pipeline, and marine transport
- Petroleum refinery facilities
- Petroleum security operations center employees and workers who support emergency response services
- Petroleum operations control rooms/centers
- Petroleum drilling, extraction, production, processing, refining, terminal operations, transporting, and retail for use as end-use fuels or feedstocks for chemical manufacturing
- Onshore and offshore operations for maintenance and emergency response
- Retail fuel centers such as gas stations and truck stops, and the distribution systems that support them

Natural and propane gas workers:

- Natural gas transmission and distribution pipelines, including compressor stations
- Underground storage of natural gas
- Natural gas processing plants, and those that deal with natural gas liquids
- Liquefied Natural Gas (LNG) facilities
- Natural gas security operations center, natural gas operations dispatch and control rooms/centers natural gas emergency response and customer emergencies, including natural gas leak calls
- Drilling, production, processing, refining, and transporting natural gas for use as end-use fuels, feedstocks for chemical manufacturing, or use in electricity generation
- Propane gas dispatch and control rooms and emergency response and customer emergencies, including propane leak calls
- Propane gas service maintenance and restoration, including call centers

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Essential Critical Infrastructure Workforce

- Processing, refining, and transporting natural liquids, including propane gas, for use as end-use fuels or feedstocks for chemical manufacturing
- Propane gas storage, transmission, and distribution centers

WATER AND WASTEWATER

Employees needed to operate and maintain drinking water and wastewater/drainage infrastructure, including:

- Operational staff at water authorities
- Operational staff at community water systems
- Operational staff at wastewater treatment facilities
- Workers repairing water and wastewater conveyances and performing required sampling or monitoring
- Operational staff for water distribution and testing
- Operational staff at wastewater collection facilities
- Operational staff and technical support for SCADA Control systems
- Chemical disinfectant suppliers for wastewater and personnel protection
- Workers that maintain digital systems infrastructure supporting water and wastewater operations

TRANSPORTATION AND LOGISTICS

- Employees supporting or enabling transportation functions, including dispatchers, maintenance and repair technicians, warehouse workers, truck stop and rest area workers, and workers that maintain and inspect infrastructure (including those that require cross-border travel)
- Employees of firms providing services that enable logistics operations, including cooling, storing, packaging, and distributing products for wholesale or retail sale or use.
- Mass transit workers
- Workers responsible for operating dispatching passenger, commuter and freight trains and maintaining rail infrastructure and equipment
- Maritime transportation workers - port workers, mariners, equipment operators
- Truck drivers who haul hazardous and waste materials to support critical infrastructure, capabilities, functions, and services
- Automotive repair and maintenance facilities
- Manufacturers and distributors (to include service centers and related operations) of packaging materials, pallets, crates, containers, and other supplies needed to support manufacturing, packaging staging and distribution operations
- Postal and shipping workers, to include private companies
- Employees who repair and maintain vehicles, aircraft, rail equipment, marine vessels, and the equipment and infrastructure that enables operations that encompass movement of cargo and passengers
- Air transportation employees, including air traffic controllers, ramp personnel, aviation security, and aviation management
- Workers who support the maintenance and operation of cargo by air transportation, including flight crews, maintenance, airport operations, and other on- and off- airport facilities workers

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PUBLIC WORKS

- Workers who support the operation, inspection, and maintenance of essential dams, locks and levees
- Workers who support the operation, inspection, and maintenance of essential public works facilities and operations, including bridges, water and sewer main breaks, fleet maintenance personnel, construction of critical or strategic infrastructure, traffic signal maintenance, emergency location services for buried utilities, maintenance of digital systems infrastructure supporting public works operations, and other emergent issues
- Workers such as plumbers, electricians, exterminators, and other service providers who provide services that are necessary to maintaining the safety, sanitation, and essential operation of residences
- Support, such as road and line clearing, to ensure the availability of needed facilities, transportation, energy and communications
- Support to ensure the effective removal, storage, and disposal of residential and commercial solid waste and hazardous waste

COMMUNICATIONS AND INFORMATION TECHNOLOGY

Communications:

- Maintenance of communications infrastructure- including privately owned and maintained communication systems- supported by technicians, operators, call-centers, wireline and wireless providers, cable service providers, satellite operations, undersea cable landing stations, Internet Exchange Points, and manufacturers and distributors of communications equipment
- Workers who support radio, television, and media service, including, but not limited to front line news reporters, studio, and technicians for newsgathering and reporting
- Workers at Independent System Operators and Regional Transmission Organizations, and Network Operations staff, engineers and/or technicians to manage the network or operate facilities
- Engineers, technicians and associated personnel responsible for infrastructure construction and restoration, including contractors for construction and engineering of fiber optic cables
- Installation, maintenance and repair technicians that establish, support or repair service as needed
- Central office personnel to maintain and operate central office, data centers, and other network office facilities
- Customer service and support staff, including managed and professional services as well as remote providers of support to transitioning employees to set up and maintain home offices, who interface with customers to manage or support service environments and security issues, including payroll, billing, fraud, and troubleshooting
- Dispatchers involved with service repair and restoration

Information Technology:

- Workers who support command centers, including, but not limited to Network Operations Command Center, Broadcast Operations Control Center and Security Operations Command Center
- Data center operators, including system administrators, HVAC & electrical engineers, security personnel, IT managers, data transfer solutions engineers, software and hardware engineers, and database administrators
- Client service centers, field engineers, and other technicians supporting critical infrastructure, as well as

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Essential Critical Infrastructure Workforce

manufacturers and supply chain vendors that provide hardware and software, and information technology equipment (to include microelectronics and semiconductors) for critical infrastructure

- Workers responding to cyber incidents involving critical infrastructure, including medical facilities, SLTT governments and federal facilities, energy and utilities, and banks and financial institutions, and other critical infrastructure categories and personnel
- Workers supporting the provision of essential global, national and local infrastructure for computing services (incl. cloud computing services), business infrastructure, web-based services, and critical manufacturing
- Workers supporting communications systems and information technology used by law enforcement, public safety, medical, energy and other critical industries
- Support required for continuity of services, including janitorial/cleaning personnel

OTHER COMMUNITY-BASED GOVERNMENT OPERATIONS AND ESSENTIAL FUNCTIONS

- Workers to ensure continuity of building functions
- Security staff to maintain building access control and physical security measures
- Elections personnel
- Federal, State, and Local, Tribal, and Territorial employees who support Mission Essential Functions and communications networks
- Trade Officials (FTA negotiators; international data flow administrators)
- Weather forecasters
- Workers that maintain digital systems infrastructure supporting other critical government operations
- Workers at operations centers necessary to maintain other essential functions
- Workers who support necessary credentialing, vetting and licensing operations for transportation workers
- Customs workers who are critical to facilitating trade in support of the national emergency response supply chain
- Educators supporting public and private K-12 schools, colleges, and universities for purposes of facilitating distance learning or performing other essential functions, if operating under rules for social distancing
- Hotel Workers where hotels are used for COVID-19 mitigation and containment measures

CRITICAL MANUFACTURING

- Workers necessary for the manufacturing of materials and products needed for medical supply chains, transportation, energy, communications, food and agriculture, chemical manufacturing, nuclear facilities, the operation of dams, water and wastewater treatment, emergency services, and the defense industrial base.

HAZARDOUS MATERIALS

- Workers at nuclear facilities, workers managing medical waste, workers managing waste from pharmaceuticals and medical material production, and workers at laboratories processing test kits
- Workers who support hazardous materials response and cleanup
- Workers who maintain digital systems infrastructure supporting hazardous materials management operations

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Essential Critical Infrastructure Workforce

FINANCIAL SERVICES

- Workers who are needed to process and maintain systems for processing financial transactions and services (e.g., payment, clearing, and settlement; wholesale funding; insurance services; and capital markets activities)
- Workers who are needed to provide consumer access to banking and lending services, including ATMs, and to move currency and payments (e.g., armored cash carriers)
- Workers who support financial operations, such as those staffing data and security operations centers

CHEMICAL

- Workers supporting the chemical and industrial gas supply chains, including workers at chemical manufacturing plants, workers in laboratories, workers at distribution facilities, workers who transport basic raw chemical materials to the producers of industrial and consumer goods, including hand sanitizers, food and food additives, pharmaceuticals, textiles, and paper products.
- Workers supporting the safe transportation of chemicals, including those supporting tank truck cleaning facilities and workers who manufacture packaging items
- Workers supporting the production of protective cleaning and medical solutions, personal protective equipment, and packaging that prevents the contamination of food, water, medicine, among others essential products
- Workers supporting the operation and maintenance of facilities (particularly those with high risk chemicals and/or sites that cannot be shut down) whose work cannot be done remotely and requires the presence of highly trained personnel to ensure safe operations, including plant contract workers who provide inspections
- Workers who support the production and transportation of chlorine and alkali manufacturing, single-use plastics, and packaging that prevents the contamination or supports the continued manufacture of food, water, medicine, and other essential products, including glass container manufacturing

DEFENSE INDUSTRIAL BASE

- Workers who support the essential services required to meet national security commitments to the federal government and U.S. Military. These individuals, include but are not limited to, aerospace; mechanical and software engineers, manufacturing/production workers; IT support; security staff; security personnel; intelligence support, aircraft and weapon system mechanics and maintainers
- Personnel working for companies, and their subcontractors, who perform under contract to the Department of Defense providing materials and services to the Department of Defense, and government-owned/contractor-operated and government-owned/government-operated facilities

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A detailed guide to the coronavirus drugs and vaccines in development

By [Damian Garde](#)² [@damiangarde](#)³

March 2, 2020



Adobe

In the months since the novel coronavirus rose from a regional crisis to a global threat, drug makers large and small have scrambled to advance their best ideas for thwarting a pandemic.

Some are repurposing old antivirals. Some are mobilizing tried-and-true technologies, and others are pressing forward with futuristic approaches to human medicine.

Here's a guide to some of the most talked-about efforts to treat or prevent coronavirus infection, with details on the science, history, and timeline for each endeavor.

Gilead Sciences

Approach: Treatment

Stage: Phase 3

Gilead's remdesivir, an intravenous treatment, has already been used to treat one infected patient in the U.S. and will soon be deployed in a pair of large, late-stage studies in Asia. Later this month, Gilead [will recruit about 1,000 patients](#)⁴ diagnosed with the coronavirus to determine whether multiple doses of remdesivir can reverse the infection. The primary goals are reducing fever and helping patients get out of the hospital within two weeks. The drug, which previously failed in a study on Ebola virus, is also being studied in smaller trials in China and the U.S.

Moderna Therapeutics

Approach: Vaccine

Stage: Phase 1

Moderna set a drug industry record with mRNA-1273, a vaccine candidate identified just 42 days after the novel coronavirus was sequenced. The company is working with the National Institutes of Health on a healthy-volunteer study expected to begin next month. If mRNA-1273 proves itself to be safe, the two organizations will enroll hundreds more patients to determine whether the vaccine protects against infection. Moderna's product is a synthetic strand of messenger RNA, or mRNA, designed to convince bodily cells to produce antibodies against the virus. The company, founded in 2010, is yet to win Food and Drug Administration approval for any of its mRNA medicines.

CureVac

Approach: Vaccine

Stage: Preclinical

Like Moderna, CureVac uses man-made mRNA to spur the production of proteins. And, like Moderna, it [got a grant](#)⁷ from the nonprofit Coalition for Epidemic Preparedness Innovations to apply its technology to coronavirus. CureVac has said it expects to have a candidate ready for human testing within a few months. The company is also working with CEPI on a mobile mRNA manufacturing technology, one that would theoretically allow health care workers to rapidly produce vaccines to respond at the site of an outbreak.

GlaxoSmithKline

Approach: Vaccine

Stage: Preclinical

GlaxoSmithKline, one of the world's largest vaccine manufacturers, is lending its technology to a Chinese biotech firm at work on a coronavirus vaccine. Under an agreement signed last month, GSK is providing its proprietary adjuvants — compounds that enhance the effectiveness of vaccines — to Clover Biopharmaceuticals, a privately held company based in Chengdu. Clover's approach involves injecting proteins that spur an immune response, thereby priming the body to resist infection. The company has not said when it expects to advance into human testing.

Inovio Pharmaceuticals

Approach: Vaccine

Stage: Preclinical

Inovio has spent the last four decades working to turn DNA into medicine, and the company believes its technology could quickly generate a vaccine for the novel coronavirus. Working with CEPI grant money, Inovio has come up with

a DNA vaccine it believes can generate protective antibodies and keep patients from infection. The company has [partnered with a Chinese manufacturer](#)⁸, Beijing Advaccine Biotechnology, and is working through preclinical development with a candidate called INO-4800. The company expects to progress into clinical trials later this year.

Support STAT: ⁹STAT is offering coverage of the coronavirus for free. Please consider a subscription to support our journalism. Start your free trial today.¹⁰

Johnson & Johnson

Approach: Vaccine and treatment

Stage: Preclinical

Johnson & Johnson, which has in the past responded to outbreaks of the Ebola and Zika viruses, is taking a multipronged approach to the coronavirus. The company is in the early days of developing a vaccine that would introduce patients to a deactivated version of the virus, triggering an immune response without causing infection. At the same time, J&J is working with the federal Biomedical Advanced Research and Development Authority on potential treatments for patients who are already infected, a process that includes investigating whether any of its older medicines might work against the coronavirus.

Regeneron Pharmaceuticals

Approach: Treatment

Stage: Preclinical

Regeneron has grown into a \$50 billion business based on its ability to craft human antibodies out of genetically engineered mice. Now it's tapping that technology in hopes of treating coronavirus. The company is immunizing its antibody-generating mice with a harmless analog of the novel coronavirus,

generating potential treatments for the infection. The most potent antibody results will go into animal testing, and if everything goes according to plan, Regeneron will be ready for human testing by late summer. The last time Regeneron embarked on this process, during the Ebola outbreak of 2015, it came up with an antibody cocktail that roughly doubled survival rates for treated patients.

[Related:](#) ¹¹

[**Allakos is running clinical trials in reverse, critics say, raising questions about its digestive disease drug**](#) ¹¹

Sanofi

Approach: Vaccine

Stage: Preclinical

Sanofi, which has successfully developed vaccines for yellow fever and diphtheria, is working with BARDA on an answer to the coronavirus. Sanofi's approach involves taking some of the coronavirus's DNA and mixing it with genetic material from a harmless virus, creating a chimera that can prime the immune system without making patients sick. Sanofi [expects to have a vaccine candidate](#) ¹² to test in the lab within six months and could be ready to test a vaccine in people within a year to 18 months. Approval would likely be at least three years away, the company said. Sanofi previously put its technology to work against SARS, a close relative of the novel virus.

Vir Biotechnology

Approach: Treatment

Stage: Preclinical

Vir Biotechnology, a company focused on infectious disease, has isolated antibodies from people who survived SARS, a viral relative of the novel coronavirus, and is working to determine whether they might treat the

infection. Teaming up with Chinese pharma contractor WuXi Biologics, the San Francisco-based Vir is in the early stages of development and hasn't specified when it expects to have products ready for human testing. Vir's CEO, Biogen veteran George Scangos, is also coordinating the trade group BIO's [response to the coronavirus outbreak](#)¹³.

About the Author



[Damian Garde](#)²

National Biotech Reporter

Damian covers biotech and writes [The Readout newsletter](#)¹⁴.

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11. <https://www.statnews.com/2020/02/26/allakos-is-running-clinical-trials-in-reverse-critics-say-raising-questions-about-its-digestive-disease-drug/>
12. <https://www.statnews.com/2020/02/18/sanofi-announces-it-will-work-with-hhs-to-develop-coronavirus-vaccine/>
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National Governors Association Center for Best Practices

REQUEST FOR APPLICATIONS

Improving Well-being and Success of Children and Families – Addressing Adverse Childhood Experiences Learning Collaborative

Purpose: To provide ten months of intensive technical assistance to up to five states interested in developing sustainable strategies to prevent and mitigate childhood traumas associated with Adverse Childhood Experiences (ACEs)

Optional Bidders' Calls:

March 11, 2020; 1:00 p.m. ET

Dial-in: 877-853-5257

Code: 202-624-5322#

March 17, 2020; 2:00 p.m. ET

Dial-in: 877-853-5257

Code: 202-624-5322#

Applications Due: Friday, April 3, 2020 at 5:00 p.m. ET – Please contact [Sweta Haldar](#) if you require an extension. We will allow extensions due to the focus of states on responding to covid-19.

Selection Announcement: Mid-to-late-April 2020

Project Period: May 2020 through March 2021
Virtual Kick-off convening in May 2020
Proposed in-person convening in fall 2020

NGA Contacts:

Sweta Haldar, Policy Analyst
shaldar@nga.org or 202-624-7729

Kandis Driscoll, Senior Policy Analyst
kdriscoll@nga.org or 202-595-2683

Sandra Wilkniss, Program Director
swilkniss@nga.org or 202-624-5322

PURPOSE

The Learning Collaborative, *Improving Well-being and Success of Children and Families – Addressing Adverse Childhood Experiences*, is a ten-month technical assistance opportunity for governors' advisors and other senior state officials to build sustainable, state-level approaches to prevent and mitigate the effects of adverse childhood experiences (ACEs). In this learning collaborative, state teams will learn from model states and other national, state and local experts through an in-person convening and ongoing technical assistance support. Participating teams will develop and implement a state-specific strategic action plan (based on lessons learned at the convening and tailored to the unique needs of their own states) that drives cross-sector policy, programmatic, financing and evaluation approaches to prevent and mitigate the effect of ACEs.

Through the collaborative, state participants will gain first-hand understanding of innovative, evidence-based policies, programs, and practices through a visit with the model states, facilitated by NGA Center staff and supplemented by experts who can address the unique needs of participating states. In addition, state action plan implementation will be informed by a comprehensive toolkit and NGA-facilitated technical assistance which includes peer-to-peer exchange among states and direct input from leading experts on best practices to move state policy.

In response to concerns about travel related to coronavirus, this project will begin in May with a short, virtual, opening meeting to introduce states to the project. In addition, NGA will conduct virtual strategic action planning sessions with each state to identify state goals, next steps, and technical assistance needs. Later this year, pending status of the pandemic, NGA will host a 1.5 day meeting to bring participating states together to learn from one another and state and national experts.

This project will feature lessons learned from model states leading state-wide work in preventing and mitigating ACEs. Tennessee's 3-branch, 2 science approach to addressing ACEs - [***Building Strong Brains: Tennessee initiative***](#) is a leading example of a statewide intervention to achieve a sustained culture change through philosophy, policies, programs and practices aimed squarely at preventing ACEs and changing the course of childhood trauma. For several years, the state has pursued an approach lead by all three branches of government and driven by mobilizing knowledge using two sciences: the science of brain development and communication science. Lessons learned from Tennessee will be supplemented with national and local expertise on other approaches. The [***ACEs Aware***](#) approach in California, led by the state's Surgeon General, Nadine Burke Harris. Launched in December 2019, California is pursuing a bold goal to cut ACEs in half in a generation through paying Medicaid providers to routinely screen for ACEs and training them how to screen and respond with trauma-informed care.

The NGA Center will arrange for up to five states (with teams of up to five individuals) to attend the in-person meeting, later this year. All agreed-upon expenses associated with the five team

members traveling to and participating in the in-person meeting will be covered by the NGA Center.

BACKGROUND

It is well-documented that ACEs - such as physical and emotional abuse or neglect, or domestic violence - have a significant and sustained impact on a person's life expectancy and overall health and well-being.¹ A milestone 1995 study conducted by the Centers for Disease Control and Prevention and Kaiser Permanente found that there was a "powerful, persistent correlation between the more ACEs experienced and the greater the chance of poor outcomes later in life, including dramatically increased risk of heart disease, diabetes, obesity, depression, substance abuse, smoking, poor academic achievement, time out of work, and early death."² Furthermore, ACEs were noted to be quite common in all populations, with almost two-thirds of study participants reporting at least one ACE and more than one in five reporting three or more ACEs.³

Since this original study, interest in preventing and addressing the consequences of ACEs has burgeoned across health, behavioral health, education and human service sectors. That interest is increasingly shaping policy discussions among state and local leaders – who are eager to build capacity to support effective prevention and intervention. Several converging factors have led to an opportune moment to harness that interest and move state policy, program and funding approaches toward real solutions including (among others):

- robust scientific evidence of the negative consequences of ACEs on overall health and wellbeing of individuals, families and systems that support them;
- addressing whole family health and wellbeing through two- or multi-generation approaches to family economic mobility and success;
- state strategies to coordinate implementation of the Family First Prevention Services Act (comprehensive child welfare reform) and align with other key federal-state programs such as Medicaid, WIOA, and other social supports;
- increased cross-sector interest in social emotional learning, trauma-informed schools/student wellbeing and safety; and
- preventing and addressing families torn apart and children displaced by the opioid crisis.

States participating in the NGA Learning Collaborative will have the opportunity to develop and begin to implement strategic action plans for working across education, economic, health and human services sectors to develop sustainable strategies to prevent and mitigate the effects of ACEs. The specific opportunity is described below.

¹ <https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/>

² <https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/>

³ <https://www.cdc.gov/violenceprevention/childabuseandneglect/cestudy/about.html>

LEARNING COLLABORATIVE DESCRIPTION

The NGA Center will provide technical assistance for ten months to up to five selected states working across health, education and human services sectors to build strategies to prevent and mitigate the effects of ACEs. Participating states will learn from the states of Tennessee, California and others that have developed innovative, impactful and sustainable cross-sector strategies for addressing ACEs and will develop and implement a cross-sector strategic action plan to address ACEs. The learning collaborative requires active participation from senior leaders in selected states at the convening and in the development and execution of the action plan. Participating states will:

1. **Attend virtual kick-off meeting(s).** NGA Center will host a virtual kick-off meeting in May 2020 to introduce state teams to the project and strategic action planning sessions with each state team to solidify state goals, next steps, and technical assistance needs.
2. **Attend in-person meeting.** Later this year, NGA will convene state teams from participating states for approximately one and a half days for an in-person meeting (originally proposed for **May 2020** but postponed due to coronavirus). The NGA Center will pay for travel and accommodations for up to five individuals from each participating state.
3. **Develop a high-level plan of action to adapt and implement lessons learned.** Within two months of the convening, participating states will develop and share with the NGA Center a high-level plan of action based on lessons learned from the kick-off meeting and tailored to the unique needs of each. The plan should include intended outputs and an implementation timeline.
4. **One optional in-state workshop.*** NGA staff and other national experts will meet with state teams individually, as needed during the technical assistance period. In-state workshops will allow the state team to discuss elements of their plan, have facilitated strategic planning time, and bring additional experts to the state to strengthen the team's work. Alternatively, the workshops could be used to support stakeholder engagement efforts or implementation needs.
*Travel decisions will be made on a case by case basis for at least the next couple months. In the meantime, NGA will be prepared to support state teams virtually as much as possible.
5. **Communicate technical assistance needs and participate in monthly calls.** NGA staff will provide customized technical assistance throughout the learning lab. That assistance includes (at least) monthly telephone consultations to assess progress, discuss challenges and identify technical assistance needs, peer-to-peer exchange opportunities via multi-state calls and/or webinars, facilitated meetings with other states or experts, and written technical assistance that provides information about other states' policies

and practices. Selected states also will receive technical assistance support from national, state and local experts facilitated by the NGA team.

TIMELINE

March 11, 2020; 1:00 p.m. EST	Optional Bidder’s Call
March 17, 2020; 2:00 p.m. EST	Optional Bidder’s Call
April 3, 2020; 5:00 p.m. EST	Applications Due (However, please let us know if you need an extension)
Mid-to-late April 2020	State Selection Announcement
May 2020	Virtual Kick-Off Meeting and Action Planning Objectives: <ul style="list-style-type: none"> • Introduce teams to the project • Highlight lessons learned from model states and other experts • Engage in state action planning with expert facilitated technical assistance and identify next steps
May 2020 – March 2021	State Site Visits/ Virtual Intensive Technical Assistance (optional) Objectives: <ul style="list-style-type: none"> • Address state-specific issues • Convene stakeholders to advance planning or implementation
Proposed for Fall 2020	In-person Convening Objectives: <ul style="list-style-type: none"> • Highlight lessons learned from model states and other experts • Address state-specific questions and technical assistance needs
Ongoing through March 2021	Monthly calls with NGA Center staff

REQUIRED APPLICATION CONTENT

All states in good standing with the National Governors Association may apply to participate in the learning lab.

To apply, states should submit:

- **Letter from the Governor.** The letter must include the governor’s interest in and desired outcome related to the technical assistance opportunity. The letter should indicate who the governor is designating as the team leader. The team leader will serve as the main point of contact between the NGA Center and the state.
- **Brief Narrative.** The narrative should not exceed **five (5)** pages (excluding the letter), and should include the following elements:
 - **Description of current challenges.** Applicants should provide a brief description of current challenges in addressing ACEs. (20 points)
 - **Description of current work across departments and agencies, as well as branches of government (if applicable) to prevent and mitigate the effects of ACEs.** Applicants should provide a brief description of how state departments and agencies are currently working together to prevent and mitigate the effects of ACEs, including specific goals and benchmarks of progress. This description should identify existing policy initiatives well as state priorities and a complete list of any technical assistance support the state is receiving from the NGA Center or other organizations related to ACEs. (25 points)
 - **Description of preliminary goals and expected outcomes.** Applicants should provide an overview of the state’s goals, expected outcomes, and how success will be measured for this learning opportunity. Applicants should also describe how they envision using this technical assistance opportunity to meet state goals, overcome challenges, and include an evaluation of readiness to adopt new strategies or approaches that may be realized through the learning collaborative. (35 points)
 - **Learning lab team.** Provide a brief statement describing the anticipated cross-agency core team that will participate in the learning lab, including the reason for each member and agency’s participation. If key individuals instrumental to implementing the state’s action plan are not included in the team, describe how these individuals will be included in this work. (20 points)

Provide the names, titles, and contact information of the team members and team leader. Team members must include representatives from the governor’s office and the health, education, and human services sectors with decision making authority, and may include:

- Governor’s health, education, human services, or workforce policy advisor;
- State health secretary (or designee);

- Medicaid director (or designee);
- Human services secretary or commissioner;
- Human services (or department of early childhood) leader focused on child care administration;
- State education agency leader focused on early childhood or K-12 education;
- State leader responsible for Head Start or Maternal, Infant, and Early Childhood Home Visiting Program; or
- Other leaders involved in health, human services, early childhood, and workforce programs and policy efforts.

SUBMISSION INFORMATION

The scheduled deadline for applications is **5:00 p.m. EST on April 3, 2020**. However, please contact us if you require an extension. Applications must be submitted by the governor's office. Please combine all application materials into a single PDF document and email to Sweta Haldar or shaldar@nga.org. Following submission, applicants will receive a confirmation email from the NGA Center verifying receipt of your application.

All questions should be directed to Sweta Haldar at 202-624-7729 or shaldar@nga.org.

This request for application (RFA) is not binding on the NGA Center, nor does it constitute a contractual offer. Without limiting the foregoing, the NGA Center reserves the right, in its sole discretion, to reject any or all applications; to modify, supplement, or cancel the RFA; to waive any deviation from the RFA; to negotiate regarding any proposal; and to negotiate final terms and conditions that may differ from those stated in the RFA. Under no circumstances shall NGA be liable for any costs incurred by any person in connection with the preparation and submission of a response to this RFA.

This project is made possible through generous support from the Robert Wood Johnson Foundation.

Marty Wright

From: AHCA/NCAL <ahcancal@ahca.org>
Sent: Monday, March 9, 2020 5:38 PM
To: Marty Wright
Subject: {MAILING LIST}} - spam>COVID-19 – Update #4

To view this email as a web page, go [here](#).



Steps to Prevent COVID-19 from Entering Your Facility

Our top priority at this point is to prevent COVID-19 from getting into long term care facilities. AHCA/NCAL has developed new guidance documents for [nursing facilities](#) and for [assisted living communities](#) to take reasonable efforts to prevent the entry of the virus.

The SNF guidance includes a recommendation to restrict all non-essential visits. This includes restricting family visits, school groups, bands, and other outside group activities. As we learn more about how serious this virus is for the elderly-particularly the experience in facilities caring for the elderly and how it can spread once it's in a facility-we believe this new guidance is prudent to help achieve our collective goal to prevent the entry of the virus and to put our residents first.

The AL guidance recognizes that assisted living communities vary in size, scope of care, and residents and families' ability to enter and exit the building freely. Therefore, the AL guidance includes some possible suggestions for the limitation of visitors, including asking residents to encourage their loved ones not to visit, establishing specific visiting hours, limiting the number of entrances, and enacting a sign-in policy for all visitors at a central entry point.

Local or State Public Officials may make additional restrictions depending on data about the local spread of COVID-19, which you should follow. Also, CMS and CDC may issue additional guidance in the future. We will keep you informed of any changes that impact SNF and AL guidance.

Please see the guidance documents for additional details for:

- [Nursing facilities](#)
- [Assisted living communities](#)

Our recommendations go beyond the CMS guidance issued on March 4th in [QSO 20-14-Nursing Homes](#) but are consistent with the guidance and regulations that we should restrict persons entering the building who pose a health risk to the residents.

To reflect this new guidance, we have also created a [screening checklist for SNF visitors](#) and updated our communication materials, including template letters to [employees](#) and [residents & family members](#), as well as [talking points for facilities without any confirmed cases](#) currently.

Please email COVID19@ahca.org with any questions.

For additional information and resources on the virus, visit our dedicated website on this issue: www.ahcancal.org/coronavirus.



This email was sent to: **mwright@wvhca.org**

This email was sent by: American Health Care Association
1201 L St. NW Washington, DC 20005 United States

We respect your right to privacy - [view our policy](#)

[Update Profile](#)



March 19, 2020

Dear Employer,

On 3/19/2020, the Occupational Safety and Health Administration (OSHA) received notification concerning employees having potential exposure to flu-like viruses. The specific nature of the concern is as follows:

1. Employees are not required to follow the CDC guidelines for prevention of exposure to the coronavirus that causes COVID-19 flu including, but not limited to, maintaining appropriate distances between employees.
2. Wash stations have ran out of soap and employees have had to wait until the cleaning crew comes on shift to have the soap dispensers refilled.

The following interim guidance may help prevent workplace exposures to acute respiratory illnesses, including seasonal flu and other flu-like viruses, in non-healthcare settings. The recommended strategies for employers to use at this time cover the following topics, and can be found at Centers for Disease Control and Prevention's (CDC) website which is updated regularly: <https://www.cdc.gov/flu/about/index.html>

The CDC is also recommending employers take the following steps to prevent the spread of Influenza and other Influenza-like viruses:

- **Actively encourage sick employees to stay home**
- **Accommodate sick employees through separation or telework (if possible)**
- **Emphasize respiratory etiquette and hand hygiene by all employees**
- **Perform routine environmental cleaning**
- **Check government websites (CDC, State Department) for any travel advisories (where applicable)**
- **Develop a workplace plan for public health emergencies**

OSHA's website <https://www.osha.gov> is a full service resource center, offering a wide range of safety and health related services in response to the needs of the working public, both employers and employees. These services include training and education, consultation, voluntary compliance programs and assistance in correcting hazards.

Currently, there is an outbreak of COVID-19, also known as Coronavirus. The CDC maintains a website that provides information to employers concerned with COVID-19 infections in the workplace. The information can be found at the following website and is updated regularly:
<https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html>

The CDC's general public website contains relevant information on what you should know, situation updates and information for communities, healthcare professionals, health departments, travel and laboratories: <https://www.cdc.gov/coronavirus/2019-ncov/index.html> In addition we recommend that you frequently check OSHA's web page at <https://www.osha.gov/coronavirus> for updates.

OSHA does not intend to conduct an inspection at this time. You are encouraged to investigate the alleged concerns and make any necessary corrections or modifications to minimize employee exposures to symptomatic employees in your workplace.

The concerned party involved has been advised of OSHA's response and has been provided with a copy of this letter. Section 11(c) of the Occupational Safety and Health Act provides protection for employees against discrimination because of their involvement in protected safety and health related activity.

If you have questions regarding this issue, you may contact me at the address in the letterhead. Your personal support and interest in the safety and health of your employees is appreciated.

Sincerely,



Prentice Cline
Area Director

Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response



[Strategies for Optimizing the Supply of N95 Respirators](#) offers a series of strategies or options on how healthcare facilities can optimize supplies of disposable N95 filtering facepiece respirators when there is limited supply availability. This checklist is intended to help healthcare facilities prioritize the implementation of the strategies following the prioritization used in the concept of surge capacity. The following strategies are categorized in a continuum of care and further organized according to the hierarchy of controls, as defined below.

Conventional Capacity Strategies consist of providing patient care without any change in daily practices

Engineering Controls reduce exposures for healthcare personnel (HCP) by placing a barrier between the hazard and the HCP.

- Isolate patients in an airborne infection isolation room (AIIR)
- Use physical barriers such as glass or plastic windows at reception areas, curtains between patients, etc.
- Properly maintain ventilation systems to provide air movement from a clean to contaminated flow direction

Administrative Controls refer to employer-dictated work practices and policies that reduce or prevent hazardous exposures.

- Limit the number of patients going to hospitals or outpatient settings by screening patients for acute respiratory illness prior to non-urgent care or elective visits
- Exclude all HCP not directly involved in patient care (e.g., dietary, housekeeping employees)
- Reduce face-to-face HCP encounters with patients (e.g., bundling activities, use of video monitoring)
- Exclude visitors to patients with known or suspected COVID-19
- Implement source control: Identify and assess patients who may be ill with or who may have been exposed to a patient with known COVID-19 and recommend they use facemasks until they can be placed in an AIIR or private room.
- Cohort patients: Group together patients who are infected with the same organism to confine their care to one area
- Cohort HCP: Assign designated teams of HCP to provide care for all patients with suspected or confirmed COVID-19
- Use telemedicine to screen and manage patients using technologies and referral networks to reduce the influx of patients to healthcare facilities

continue on next page

cont.

- Train HCP on indications for use of N95 respirators
- Train HCP on use of N95 respirators (i.e., proper use, fit, donning and doffing, etc.)
- Implement just-in-time fit testing: Plan for larger scale evaluation, training, and fit testing of employees when necessary during a pandemic
- Limit respirators during training: Determine which HCP do and do not need to be in a respiratory protection program and, when possible, allow limited re-use of respirators by individual HCP for training and then fit testing
- Implement qualitative fit testing to assess adequacy of a respirator fit to minimize destruction of N95 respirator used in fit testing and allow for limited re-use by HCP

Personal Protective Equipment and Respiratory Protection should be used as part of a suite of strategies to protect personnel, complementing the use of engineering and administrative controls as needed.

- Use surgical N95 respirators only for HCP who need protection from both airborne and fluid hazards (e.g., splashes, sprays). If needed but unavailable, use faceshield over standard N95 respirator.
- Use alternatives to N95 respirators where feasible (e.g., [other disposable filtering facepiece respirators](#), elastomeric respirators with appropriate filters or cartridges, powered air purifying respirators)

Contingency Capacity Strategies may change practices but may not have a significant impact on patient care or HCP safety

Administrative Controls

- Decrease length of hospital stay for medically stable patients with COVID-19 who cannot be discharged to home for social reasons by identifying alternative non-hospital housing

Personal Protective Equipment and Respiratory Protection

- Use N95 respirators beyond the manufacturer-designated shelf life for training and fit testing
- Extend the use of N95 respirators by wearing the same N95 for repeated close contact encounters with several different patients, without removing the respirator (i.e., [recommended guidance](#) on implementation of extended use)
- Implement [re-use](#) of N95 respirators by one HCP for multiple encounters with different tuberculosis patients, but remove it after each encounter

Crisis/Alternate Strategies are not commensurate with current U.S. standards of care but may need to be considered during periods of expected or known N95 respirator shortages.

When N95 Supplies are Running Low

Personal Protective Equipment and Respiratory Protection

- Use respirators as identified by CDC as performing adequately for healthcare delivery [beyond the manufacturer-designated shelf life](#)
- Use respirators approved under standards used in other countries that are similar to NIOSH-approved N95 respirators but that may not necessarily be NIOSH-approved
- Implement limited [re-use](#) of N95 respirators for patients with COVID-19, measles, and varicella
- Use additional respirators identified by CDC as NOT performing adequately for healthcare delivery beyond the manufacturer-designated shelf life
- [Prioritize the use of N95 respirators and facemasks by activity type](#) with and without masking symptomatic patients

When No Respirators Are Left

Administrative Controls

- Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients (i.e., those of older age, those with chronic medical conditions, or those who may be pregnant)
- Designate convalescent HCP for provision of care to known or suspected COVID-19 patients those who have clinically recovered from COVID-19 and may have some protective immunity to preferentially provide care

Engineering Controls

- Use an expedient patient isolation room for risk-reduction
- Use a ventilated headboard to decrease risk of HCP exposure to a patient-generated aerosol
- Personal Protective Equipment and Respiratory Protection
- Use masks not evaluated or approved by NIOSH or homemade masks as a last resort

From: [REDACTED]
Sent: Tuesday, March 17, 2020 12:37 PM
To: Crouch, Bill J <Bill.J.Crouch@wv.gov>; Samples, Jeremiah <Jeremiah.Samples@wv.gov>
Subject: [External] Child care with schools closed

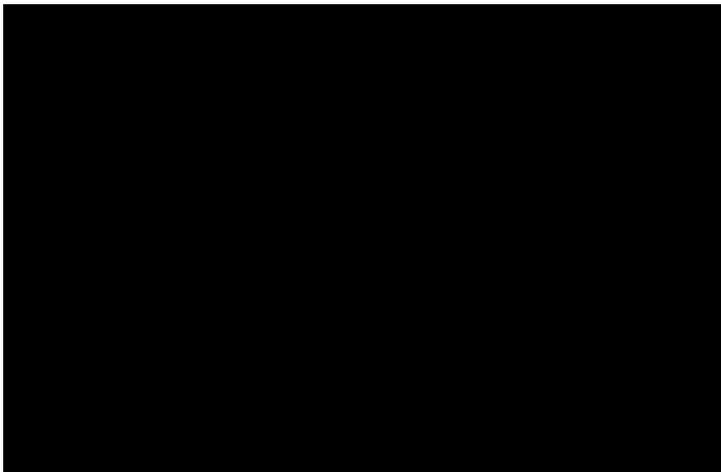
CAUTION: External email. Do not click links or open attachments unless you verify sender.

Bill and Jeremiah –

I have received requests from several of my health care clients about child care for employees of health care workers. They are having trouble maintaining staffing due to workers not being able to report for work due to lack of child care for their children, particularly for school aged children with the schools closed. I am told that some states are considering opening at least some schools to provide child care for health care workers.

I know everyone recognizes child care is a problem with the schools closed, but am not sure it has been considered specifically in relation to health care. Can you tell me if there is any discussion about this issue – lack of health care workers due to lack of child care for them?

Thank you. I know the coronavirus is an overriding matter and appreciate your taking the time to consider my question.





Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-14-NH

DATE: March 9, 2020

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes (**REVISED**)

Memorandum Summary

- ***CMS is committed*** to taking critical steps to ensure America's health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.
- **Guidance for Infection Control and Prevention of COVID-19** - CMS is providing additional guidance to nursing homes to help them improve their infection control and prevention practices to prevent the transmission of COVID-19, *including revised guidance for visitation.*
- **Coordination with the Centers for Disease Control (CDC) and local public health departments** - We encourage all nursing homes to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>).
- *Following the Food and Drug Administration's (FDA) emergency use authorization (EUA) expanding the use of certain industrial respirators to health care personnel, CMS is clarifying that such use is appropriate in Medicare/Medicaid certified providers and suppliers.*

Background

CMS is responsible for ensuring the health and safety of nursing home residents by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19, we are providing additional guidance to nursing homes to help control and prevent the spread of the virus.

Guidance

Facility staff should regularly monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of

potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day. Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and CMS to train and prepare staff to improve infection control and prevention practices. Lastly, facilities should maintain a person-centered approach to care. This includes communicating effectively with residents, resident representatives and/or their family, and understanding their individual needs and goals of care.

Facilities experiencing an increased number of respiratory illnesses (regardless of suspected etiology) among patients/residents or healthcare personnel should immediately contact their local or state health department for further guidance.

In addition to the overarching regulations and guidance, we're providing the following information (Frequently Asked Questions) about some specific areas related to COVID-19:

Guidance for Limiting the Transmission of COVID-19 for Nursing Homes

How should facilities monitor or *restrict* visitors?

If visitors meet the criteria below, facilities may restrict their entry to the facility. Regulations and guidance related to restricting a resident's right to visitors can be found at 42 CFR §483.10(f)(4), and at F-tag 563 of [Appendix PP of the State Operations Manual](#). Specifically, a facility may need to restrict or limit visitation rights for reasonable clinical and safety reasons. This includes, "restrictions placed to prevent community-associated infection or communicable disease transmission to the resident. A resident's risk factors for infection (e.g., chronic medical conditions) or current health state (e.g., end-of-life care) should be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious."

Facilities should *actively* screen *and restrict* visitation *by those who meet the following criteria*:

1. Signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat.
2. *In the last 14 days*, has had contact with someone *with a confirmed diagnosis of COVID-19*, or under investigation for COVID-19, *or are ill with respiratory illness*.
3. International travel within the last 14 days to *countries with sustained community transmission*. For updated information on *affected* countries visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>
4. *Residing in a community where community-based spread of COVID-19 is occurring*.

For those individuals that do not meet the above criteria, facilities can allow entry but may require visitors to use Personal Protective Equipment (PPE) such as facemasks (see expanded guidance below).

Limiting visitors and individuals: Expanded recommendations:

CMS is providing the following expanded guidance to prevent the spread of COVID-19 (in addition to the information above about restricting visitors).

- **Restricting** means the individual should not be allowed in the facility at all, until they no longer meet the criteria above.
- **Limiting** means the individual should not be allowed to come into the facility, except for certain situations, such as end-of-life situations or when a visitor is essential for the resident's emotional well-being and care.
- **Discouraging** means that the facility allows normal visitation practices (except for those individuals meeting the restricted criteria), however the facility advises individuals to defer visitation until further notice (through signage, calls, etc.).

1. Limiting or Discouraging visitation:

- a) **Limiting:** For facilities that are in counties, or counties adjacent to other counties where a COVID-19 case has occurred, we recommend **limiting** visitation (except in certain situations as indicated above). For example, a daughter who visits her mother every Monday, would cease these visits, and limit her visits to only those situations when her mom has a significant issue. Also, during the visit, the daughter would limit her contact with her mother and only meet with her in her room or a place the facility has specifically dedicated for visits.
 - b) **Discouraging:** For all other facilities (nationwide) not in those counties referenced above, we recommend **discouraging** visitation (except in certain situations). See below for methods to discourage visitation. Also see CDC guidance to “stay at home” <https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html#stay-home>.
2. Facilities should increase visible signage at entrances/exits, offer temperature checks, increase availability to hand sanitizer, offer PPE for individuals entering the facility (if supply allows). Also, provide instruction, before visitors enter the facility and residents' rooms, on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the resident's room. Individuals with fevers, other symptoms of COVID-19, or unable to demonstrate proper use of infection control techniques should be restricted from entry. Signage should also include language to discourage visits, such as recommending visitors defer their visit for another time or for a certain situation as mentioned above.
 3. In addition to the screening visitors for the criteria for restricting access (above), facilities should ask visitors if they took any recent trips (within the last 14 days) on cruise ships or participated in other settings where crowds are confined to a common location. If so, facilities should suggest deferring their visit to a later date. If the visitor's entry is necessary, they should use PPE while onsite. If the facility does not have PPE, the facility should restrict the individual's visit, and ask them to come back at a later date (e.g., after a 14 days with no symptoms of COVID-19).
 4. In cases when visitation is allowable, facilities should instruct visitors to limit their movement within the facility to the resident's room (e.g., reduce walking the halls, avoid going to dining room, etc.)
 5. Facilities should review and revise how they interact with volunteers, vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), other practitioners (e.g., hospice workers, specialists, physical therapy, etc.), and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility.

Have them dropped off at a dedicated location (e.g., loading dock). Facilities can allow entry of these visitors as long as they are following the appropriate CDC guidelines for Transmission-Based Precautions. For example, hospice workers can enter a facility when using PPE properly.

6. *In lieu of visits (either through limiting or discouraging), facilities can consider:*
 - a) *Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).*
 - b) *Creating/increasing listserv communication to update families, such as advising to not visit.*
 - c) *Assigning staff as primary contact to families for inbound calls, and conduct regular outbound calls to keep families up to date.*
 - d) *Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits.*
7. *When visitation is necessary or allowable, facilities should make efforts to allow for safe visitation for residents and loved ones. For example:*
 - a) *Suggest limiting physical contact with residents and others while in the facility. For example, practice social distances with no hand-shaking or hugging, and remaining six feet apart.*
 - b) *If possible (e.g., pending design of building), creating dedicated visiting areas (e.g., "clean rooms") near the entrance to the facility where residents can meet with visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting.*
 - c) *Residents still have the right to access the Ombudsman program. If in-person access is allowable, use the guidance mentioned above. If in-person access is not available due to infection control concerns, facilities need to facilitate resident communication (by phone or other format) with the Ombudsman program or any other entity listed in 42 CFR § 483.10(f)(4)(i).*
8. *Visitor reporting:*
 - a) *Advise exposed visitors (e.g., contact with COVID-19 resident prior to admission) to monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure and if ill to self-isolate at home and contact their healthcare provider.*
 - b) *Advise visitors to report to the facility any signs and symptoms of COVID-19 or acute illness within 14 days after visiting the facility.*

How should facilities monitor or restrict health care facility staff?

The same screening performed for visitors should be performed for facility staff.

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:
 - Immediately stop work, put on a facemask, and self-isolate at home;
 - Inform the facility's infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
 - Contact and follow the local health department recommendations for next steps (e.g., testing).

- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>).

Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>).

When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital?

Nursing homes with residents suspected of having COVID-19 infection should contact their local health department. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19.

Please check the following link regularly for critical updates, such as updates to guidance for using PPE: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident's diagnosis, and precautions to be taken including placing a facemask on the resident during transfer. If the resident does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially [appropriate](#). Pending transfer or discharge, place a facemask on the resident and isolate him/her in a room with the door closed.

When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?

A nursing home can accept a resident diagnosed with COVID-19 and still under Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions. If a nursing home cannot, it must wait until these precautions are discontinued. CDC has released [Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19](#).

Information on the duration of infectivity is limited, and the interim guidance has been developed with available information from similar coronaviruses. CDC states that decisions to discontinue Transmission-based Precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors (see current CDC guidance for further details).

Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present.

Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no

symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room).

Other considerations for facilities:

- Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>
- Increase the availability and accessibility of alcohol-based hand rubs (ABHRs), *reinforce strong hand-hygiene practices*, tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, resident check-ins, etc.
 - Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse’s stations, phones, internal radios, etc.).

Will nursing homes be cited for not having the appropriate supplies?

CMS is aware of that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks and ABHR) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for optimizing their current supply, or identify the next best option to care for residents. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the state agency should contact the CMS Branch Office.

What other resources are available for facilities to help improve infection control and prevention?

CMS urges providers to take advantage of several resources that are available:

CDC Resources:

- Infection preventionist training: <https://www.cdc.gov/longtermcare/index.html>
- CDC Resources for Health Care Facilities: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>
- CDC Updates: <https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html>
- CDC FAQ for COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/infection-prevention-control-faq.html>
- *Information on affected US locations:* <https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html>

FDA Resources:

- *Emergency Use Authorizations:* <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations>

CMS Resources:

- Long term care facility – Infection control self-assessment worksheet: https://qsep.cms.gov/data/252/A_NursingHome_InfectionControl_Worksheet11-8-19508.pdf
- Infection control toolkit for bedside licensed nurses and nurse aides (“Head to Toe Infection Prevention (H2T) Toolkit”): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment>
- Infection Control and Prevention regulations and guidance: 42 CFR 483.80, Appendix PP of the State Operations Manual. See F-tag 880: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>

Contact: Email DNH_TriageTeam@cms.hhs.gov

NOTE: The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC) to change. Please monitor the relevant sources regularly for updates.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

cc: Survey and Operations Group Management

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH



Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Larnont
Governor
Susan Bysiewicz
Lt. Governor

HEALTHCARE QUALITY AND SAFETY BRANCH

BLAST FAX 2020-07

TO: All Nursing Homes
FROM: Deputy Commissioner Heather Aaron, MPH, LNHA 
CC: Barbara Cass, RN., Branch Chief, Healthcare Quality and Safety Branch
DATE: March 9, 2020
SUBJECT: Visitor Restrictions

The State of Connecticut, Department of Public Health is committed to taking critical steps to ensure nursing home residents are protected from communicable diseases, including Coronavirus Disease (COVID-19).

To prevent the spread of Coronavirus Disease (COVID-19) in healthcare facilities, specifically Chronic and Convalescent Nursing Homes and Rest Homes with Nursing Supervision, effective **immediately**, the State of Connecticut Department of Public Health, is directing that all Chronic and Convalescent Nursing Homes and Rest Homes with Nursing Supervision impose restrictions on all visitors **except** when a current health state (e.g. end-of-life care) is in question. For example, the facility may allow a visitor(s) to a resident who is on hospice or end-of-life care as long as the appropriate personal protective equipment (PPE) is used in accordance with Centers for Disease Control and Prevention (CDC) guidance documents **and** when the resident meets the criteria based on exposure to COVID-19. Please refer to CDC guidance documents at www.cdc.gov/coronavirus/2019



Phone: (860) 509-7400 • Fax: (860) 509-7543
Telecommunications Relay Service 7-1-1
410 Capitol Avenue, P.O. Box 340308
Hartford, Connecticut 06134-0308
www.ct.gov/dph

Affirmative Action/Equal Opportunity Employer



Considerations for School Closure



Recommendations on school closure based on available science, reports from other countries and consultation with school health experts.

1. There is a role for school closure in response to school-based cases of COVID-19 for decontamination and contact tracing (few days of closure), in response to significant absenteeism of staff and students (short to medium length, i.e. 2-4 weeks of closure), or as part of a larger community mitigation strategy for jurisdictions with substantial community spread* (medium to long length, i.e. 4-8 weeks or more of closure).
2. Available modeling data indicate that early, short to medium closures do not impact the epi curve of COVID-19 or available health care measures (e.g., hospitalizations). There may be some impact of much longer closures (8 weeks, 20 weeks) further into community spread, but that modelling also shows that other mitigation efforts (e.g., handwashing, home isolation) have more impact on both spread of disease and health care measures. In other countries, those places who closed school (e.g., Hong Kong) have not had more success in reducing spread than those that did not (e.g., Singapore).
3. In places where school closures are necessary, the anticipated academic and economic impacts and unintended impacts on disease outcomes must be planned for and mitigated. Provision of academic support (e.g., tele-ed), alternatives for school-based meals as well as other services (e.g., behavioral and mental health services) for economically and physically vulnerable children, support for families for whom telework and paid sick leave is not available, ensuring that high risk individuals continue to be protected must all be addressed. Special consideration must be given for health care workers so that school closures do not impact their ability to work.

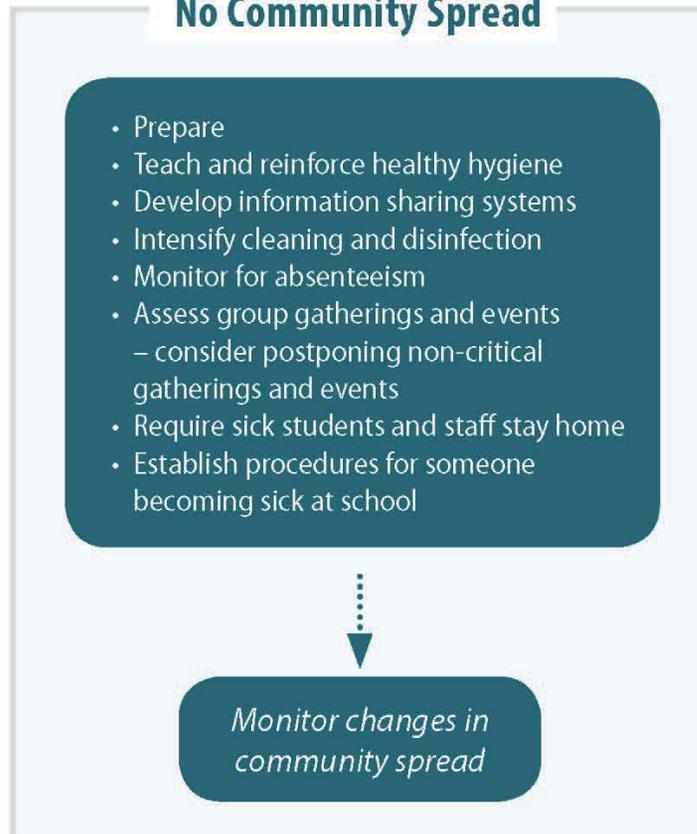
*Substantial community spread is defined as large scale community transmission, health care staffing significantly impacted, multiple cases within communal settings.

School Decision Tree

All Schools Regardless of Community Spread



No Community Spread



Minimal to Moderate OR Substantial Community Spread



Factors for Consideration for School Closure

Closing schools early in the spread of disease for a short time (e.g., 2 weeks) will be unlikely to stem the spread of disease or prevent impact on the health care system, while causing significant disruption for families, schools, and those who may be responding to COVID-19 outbreaks in health care settings. It may also increase impact on older adults who care for grandchildren. Waiting to enact school closures until at the correct time in the epidemic (e.g., later in the spread of disease) combined with other social distancing interventions allows for optimal impact despite disruption.

	Factors in favor of school closure	Factors against school closure	Further considerations
In response to school-based case (Less than 1 week closure)	<ul style="list-style-type: none"> • Impact on disease <ul style="list-style-type: none"> ○ Allows for decontamination ○ Allows time for epidemical evaluation and contact tracing; further action can be scaled based on epi investigation. 	<ul style="list-style-type: none"> • Impact on disease <ul style="list-style-type: none"> ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students. 	<ul style="list-style-type: none"> • May occur frequently during a wide-spread outbreak
Short-term closure (2 weeks)	<ul style="list-style-type: none"> • Impact on disease <ul style="list-style-type: none"> ○ Allows time for further understanding of the local COVID-19 situation (e.g., community spread) ○ Increases social distancing amongst immediate school community. ○ Gives time for potentially exposed individuals to develop symptoms while not in school • Impact on families <ul style="list-style-type: none"> ○ Children may be less impacted by social isolation from their peers for shorter time frames • Impact on school <ul style="list-style-type: none"> ○ Schools are better prepared for short-term closures because they've been more likely to have experienced those (e.g., for weather) ○ Given current timing, some schools may be able to take advantage of spring break closures 	<ul style="list-style-type: none"> • Impact on disease <ul style="list-style-type: none"> ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that early short-term closures are not impactful in terms of overall transmission. ○ Social mixing may still occur outside of school with less ability to monitor, especially among older students. ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • Impact on families <ul style="list-style-type: none"> ○ Key services are interrupted for students (e.g., meals, other social, 	<ul style="list-style-type: none"> • Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Concerns about household mixing of sick and well family members needs to be addressed • Consider non-closure social distancing first (e.g., staggering recess, cancelling assemblies and inter-school events.) • Economic impact if school staff are not paid during school closure must be considered.

	<ul style="list-style-type: none"> ○ Provides protection for older staff and students and staff with underlying medical conditions 	<p>physical health, and mental health services, after school programs)</p> <ul style="list-style-type: none"> ○ Economic impact for families because of the costs of childcare and lost wages. There may be a loss of productivity even for parents who are able to telework. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. ● Impact on schools <ul style="list-style-type: none"> ○ Potential academic impact because of the disruption to the continuity of learning ● Impact on health care <ul style="list-style-type: none"> ○ Available health care workforce is decreased as HCW stay home with children. 	
<p>Medium-term (4 weeks closure)</p>	<ul style="list-style-type: none"> ● Impact on disease <ul style="list-style-type: none"> ○ Provides more protection for older staff and students and staff with underlying medical conditions ● Impact on schools <ul style="list-style-type: none"> ○ Planned closures of longer periods may be easier for families to plan for than rolling closures with unexpected timing and duration, including possibly last-minute notice 	<ul style="list-style-type: none"> ● Impact on disease <ul style="list-style-type: none"> ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls) ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. ● Impact on families <ul style="list-style-type: none"> ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services, after school programs) are put at greater risk 	<ul style="list-style-type: none"> ● Disproportionate impact of children being out of school whose parents/family members are hourly and low-wage workers ● If a school closes for this length of time, schools must consider ways to continue key services ● Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. ● Consider coupling with other social actions to mitigate risk of increased social mixing in other community areas

		<ul style="list-style-type: none"> ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs) ○ High school seniors likely to lose ability to participate in their prom, graduation etc. ○ Some families may not have capacity for students to participate in distance learning (e.g., no computers, internet access issues) even if provided by school. ● Impact on schools <ul style="list-style-type: none"> ○ Significant impact on academic outcomes may occur. Losing one month of learning may prevent students from meeting grade level knowledge and skill expectations and may jeopardize schools' ability to meet standardized testing requirements ○ School staff may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) ● Impact on health care <ul style="list-style-type: none"> ○ Available health care workforce is decreased as HCW stay home with children. 	<ul style="list-style-type: none"> ● Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure. ● Economic impact if school staff are not paid during school closure must be considered.
<p>Long-term (8 weeks, 20 weeks closure)</p>	<ul style="list-style-type: none"> ● Impact on disease <ul style="list-style-type: none"> ○ Modeling data for other respiratory infections where children have higher disease impacts, suggests that longer closures are may have greater impact in terms of overall 	<ul style="list-style-type: none"> ● Impact on disease <ul style="list-style-type: none"> ○ Longer closures may result in more students congregating outside of school (e.g., other students' homes, shopping malls) 	<ul style="list-style-type: none"> ● Disproportionate impact of children being out of school for hourly and low-wage workers (compared to salaried workers who may have more flexible leave and telework opportunities)

	<p>transmission. Provides substantial protection for older staff and students and staff with underlying medical conditions</p> <ul style="list-style-type: none"> • Impact on schools <ul style="list-style-type: none"> ○ Schools without distance learning may see closures of this length as reason to implement distance learning approaches they may not have previously had or used 	<ul style="list-style-type: none"> ○ Will increase risk to older adults or those with co-morbidities, as almost 40% of US grandparents provide childcare for grandchildren. School closures will likely increase this percentage. • Impact on families <ul style="list-style-type: none"> ○ Students who rely on key services (e.g., meals, other social, physical health, and mental health services, after school programs) are put at substantial risk ○ Economic impact grows with length of closure; furthermore, this may exacerbate disparities among families at different SES levels (e.g., parents with lower wage jobs may lose jobs) ○ Student engagement with schools and peers diminishes, which could increase anxiety and other mental health and emotional problems. ○ High school seniors likely to lose ability to participate in their prom, graduation etc. • Impact on schools <ul style="list-style-type: none"> ○ Significant impact on academic outcomes will likely occur; losing 2 months of learning is likely to prevent many students from meeting grade level knowledge and skill expectations and will jeopardize schools' ability to meet standardized testing requirements ○ Loss of educational progress, even having to add an extra semester or 	<ul style="list-style-type: none"> • If a school closes for this length of time, schools must consider ways to continue key services • Research from school staff tells us that schools find closures more acceptable when other events, gatherings, and facilities in the community are also closed or cancelled. • Because closures are likely to increase anxiety among students, families, and community members, excellent messaging is needed along with the school closure. • Given current timing, 20-week closures may not impact schools much more substantially than 8 week closures. Many schools end for the year in late May; some continue until mid-June. • A 20-week scenario could still have substantial impact on parents who need to find summer care for students. If schools are dismissed, one would expect summer camps might be cancelled as well • Economic impact if school staff are not paid during school closure must be considered.
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		<p>year to graduate or move up a grade</p> <ul style="list-style-type: none"> ○ Staff within the schools may be differentially impacted (e.g., hourly workers may be less able to sustain longer closures) ○ Maintaining communication with school staff, families, and students becomes substantially more difficult as the school closure lengthens. ● Impact on health care <ul style="list-style-type: none"> ○ Available health care workforce is decreased as HCW stay home with children. 	
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Points for further consideration, regardless of degree of spread or length of potential closure

- Clear rationale, decision-making and communication with all stakeholders is extremely important. Families need to know who is making decisions, what those decisions are and when school-based mitigation efforts are planned to start and end.
- While we have data that can contribute to decisions about when to dismiss schools, there is almost no available data on the right time to re-start schools. We would advise to plan for a length of time and then evaluate based on continued community spread.
- The relationship between state and local education agencies and state and local public health must be strong and communication must be clear and thorough.
- Critical academic infrastructure and service provision must be considered during school closure.

From: Boggs, Mara (Manchin) <Mara_Boggs@manchin.senate.gov>
Sent: Thursday, March 19, 2020 9:47 PM
To: Slemp, Cathy C <Cathy.C.Slemp@wv.gov>; Crouch, Bill J <Bill.J.Crouch@wv.gov>; james.a.hoyer.mil@mail.mil
Cc: Cantrell, Phillip R CSM USARMY NG WVARNG (USA) <phillip.r.cantrell.mil@mail.mil>; Hewett, Christine (Manchin) <Christine_Hewett@manchin.senate.gov>; Berkley, Terri (Manchin) <Terri_Berkley@manchin.senate.gov>; Marsh, Clay <cbmarsh@hsc.wvu.edu>; Phalen, Missy (Manchin) <Missy_Phalen@manchin.senate.gov>
Subject: [External] Constituents who Contacted Senator Manchin and who have been Denied a COVID Test

CAUTION: External email. Do not click links or open attachments unless you verify sender.

Dr. Crouch, Dr. Slemp and General Hoyer,

Attached is the list of 98 West Virginians who have contacted Senator Manchin and have symptoms of COVID, but have not been able to get a test. Senator Manchin has directed his staff to contact each person who contacts him until they are tested, or their medical condition is resolved. The cells shaded in green are constituents that we have worked with who have received tests.

Most concerning is the [REDACTED] who had a temperature of 106, but whose physician said they wouldn't test him for COVID because they didn't have the tests to spare.

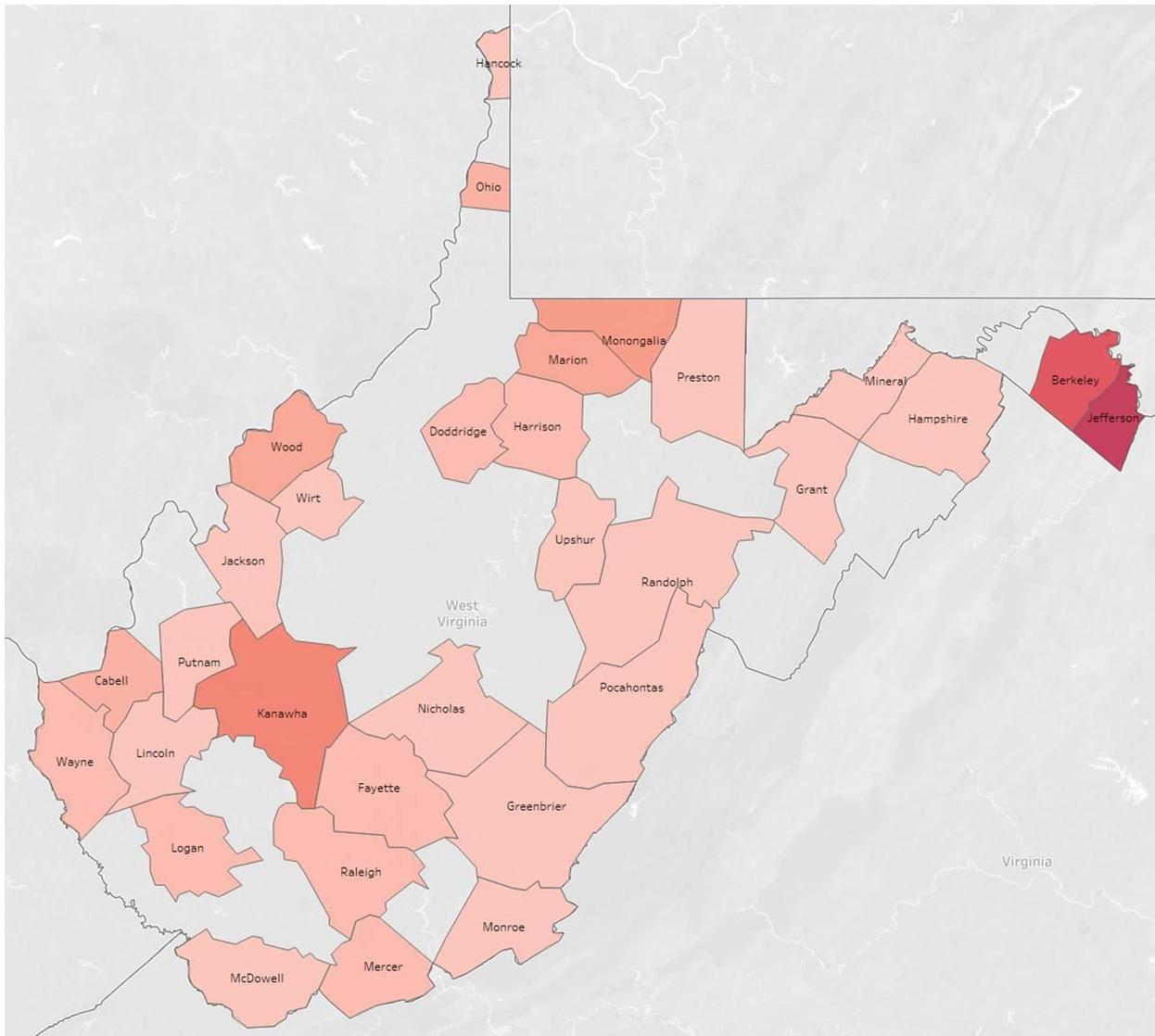
Good afternoon,

I don't know if I am just an anxious parent or have a valid concern. My son had a fever of 106.1 and was coughing so badly that he choked and lips started to turn blue. We called 911 and a squad came out and took us to [REDACTED] We got incredible care however I feel we didn't get complete care. My sons heart rate was elevated, the paramedic noted wheezing in his right lung. He was negative for flu and strep. They did a chest X-ray and that seemed clear they said. The doc said she called the infectious disease doctor and my son didn't meet criteria to test for covid but to treat him as such. They made it seem that there weren't going to test him because tests are scarce. I, however would feel more confident if he was tested. I would want to know if my healthcare workers are safe. My son rode in an ambulance that I am sure is in service as I type. Overly anxious mom or valid mom in the current state of affairs? You be the judge. [REDACTED]

Thank you for your time and attention,

[REDACTED]

A graphic depiction of the cases that Senator Manchin has received is below.



Mara Boggs
State Director
U.S. Senator Joe Manchin III
304-342-5855 (o)
202-679-5585 (c)



NCCHC has compiled the following information and resources:

[Treatment guide for medical providers](#)

Source: CDC

[Guidance for long-term care centers, which provides useful information for prisons and jails](#)

Source: CDC

Excellent information with three major tenets:

Prevent the introduction of respiratory germs INTO your facility

Prevent the spread of respiratory germs WITHIN your facility

Prevent the spread of respiratory germs BETWEEN facilities

Information comparing influenza with COVID-19

[Coronavirus Disease 2019 vs. the Flu](#)

Source: HopkinsMedicine.org

[How Does Coronavirus Compare with the Flu?](#)

Source: *New York Times*

Epidemiology

[Pathogenicity and transmissibility of 2019-nCoV-A quick overview and comparison with other emerging viruses](#)

Source: *Microbes and Infection*

Includes a chart with showing a comparison to SARS, MERS, H1N1 and more. This article concludes that 2019-nCoV seems to have relatively low pathogenicity and moderate transmissibility. However, more information on the biological and epidemiological features of the virus is urgently needed to further refine the risk assessment and response, which will ultimately benefit the 2019-nCoV control and prevention.



Jim Martin, MPSA, CCHP

Vice President, Program Development

National Commission on Correctional Health Care

773-880-1460, ext. 273 • jamesmartin@ncchc.org



Hernando County Sheriff's Office

P.O. BOX 10070 – BROOKSVILLE, FL 34603-0070 FAX 352 796-0493 PHONE 352 754-6830

CORONAVIRUS SCREENING

Inmate Name _____ CIN# _____

TRAVEL HISTORY

1. In the past 30 days, have you traveled outside of the United States? Yes No

When _____ Where _____

2. Does the inmate report a history of traveling to or from Europe or Asia Yes No

CONTACT HISTORY

3. In the past 30 days, have you had close contact with anyone known to have Traveled to Europe or Asia? Yes No

4. Have you or anyone you've been in contact with had laboratory confirmed Coronavirus? (The incubation period is 2-14 days.) Yes No

5. Do you have fever, cough, shortness of breath, or other symptoms of lower respiratory illness? Yes No

Detention Staff Signature Payroll # Date

If inmate answers "YES" to questions 2, 3 or 4 above, immediately place a mask on him/ her and escort to a reverse isolation cell in the medical unit. The nurse is to be notified and will complete the symptoms check list AFTER the inmate has been placed in reverse isolation.

TEMP: _____ RESPIRATIONS: _____
BP: _____ SHORTNESS OF BREATH: Y N
O2Sat: _____ COUGH: Y N IF YES, PRODUCTIVE: Y N

Medical Staff Signature Payroll # Date

From: Marsh, Clay <cbmarsh@hsc.wvu.edu>
Sent: Wednesday, March 18, 2020 8:51 PM
To: Crouch, Bill J <Bill.J.Crouch@wv.gov>; Slemp, Cathy C <Cathy.C.Slemp@wv.gov>
Subject: [External] Fwd: C/S email test Coronavirus testing

CAUTION: External email. Do not click links or open attachments unless you verify sender.

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From: Boggs, Mara (Manchin) <Mara_Boggs@manchin.senate.gov>
Sent: Wednesday, March 18, 2020 8:15:56 PM
To: Marsh, Clay <cbmarsh@hsc.wvu.edu>
Subject: FW: C/S email test Coronavirus testing

Sending to you because they are WVU employees and thought you'd want to know.

My caseworkers are still working these cases tonight. I think we are at about 100.

I'll include this on my spreadsheet tomorrow, which will also include a heat map too

-----Original Message-----

From: Phalen, Missy (Manchin) <Missy_Phalen@manchin.senate.gov>
Sent: Wednesday, March 18, 2020 7:28 PM
To: Berkley, Terri (Manchin) <Terri_Berkley@manchin.senate.gov>; Hewett, Christine (Manchin) <Christine_Hewett@manchin.senate.gov>
Cc: Boggs, Mara (Manchin) <Mara_Boggs@manchin.senate.gov>
Subject: C/S email test Coronavirus testing

-----Original Message-----

From: [REDACTED]
Sent: Wednesday, March 18, 2020 7:12 PM
To: sense, common (Manchin) <common_sense@manchin.senate.gov>
Subject: Coronavirus testing

Senator Manchin,

I am from [REDACTED] and work at [REDACTED]. There are five of us from the office that developed symptoms yesterday.

I have symptoms that could be coronavirus but also could be vague enough to be something else. I have had a high fever and a dry cough that developed rapidly. I have shortness of breath but only with increased activity (I am [REDACTED]). Some of my coworkers traveled out of state and internationally recently but not to 5 identified countries or the identified US hot spots. I also do not qualify for testing because I have not had contact with someone that has tested positive (only one in WV at this point).

I understand why people that are sicker, have more specific symptoms, or are at higher risk should be tested first when there are limited tests available. However, I wanted to let you know that there are many sick West Virginians that have not and will probably not be tested. I know you have concerns about this issue.

Thank you for all you do for our state and it's people.

[REDACTED]
[REDACTED]

[REDACTED]

From: Marsh, Clay <cbmarsh@hsc.wvu.edu>
Sent: Wednesday, March 18, 2020 8:50 PM
To: Crouch, Bill J <Bill.J.Crouch@wv.gov>; Slemper, Cathy C <Cathy.C.Slemper@wv.gov>
Subject: [External] Fwd: CoronaVirus

CAUTION: External email. Do not click links or open attachments unless you verify sender.

Hi Bill and Cathy

How do we approach this information that is being shared from Joe M office?

Should we refer to local testing using our partners (labcorp, quest)?

Thanks
Clay
Get [Outlook for iOS](#)

From: Boggs, Mara (Manchin) <Mara_Boggs@manchin.senate.gov>
Sent: Wednesday, March 18, 2020 8:23 PM
To: Marsh, Clay
Subject: FW: CoronaVirus

Here's one at your hospital in Keyser

From: Berkley, Terri (Manchin) <Terri_Berkley@manchin.senate.gov>
Sent: Wednesday, March 18, 2020 8:16 PM
To: Phalen, Missy (Manchin) <Missy_Phalen@manchin.senate.gov>
Cc: Boggs, Mara (Manchin) <Mara_Boggs@manchin.senate.gov>; Hewett, Christine (Manchin) <Christine_Hewett@manchin.senate.gov>
Subject: RE: CoronaVirus

Emailed and added to the list, Terri

From: Phalen, Missy (Manchin) <Missy_Phalen@manchin.senate.gov>
Sent: Wednesday, March 18, 2020 6:52 PM
To: Berkley, Terri (Manchin) <Terri_Berkley@manchin.senate.gov>; Hewett, Christine (Manchin) <Christine_Hewett@manchin.senate.gov>
Cc: Boggs, Mara (Manchin) <Mara_Boggs@manchin.senate.gov>
Subject: FW: CoronaVirus

From: [REDACTED]
Sent: Wednesday, March 18, 2020 6:40 PM
To: sense, common (Manchin) <common_sense@manchin.senate.gov>
Subject: CoronaVirus

To Whom It May Concern:

I was told to send an email if I or someone in my family had covid19 symptoms and wasn't tested. Well my husband started getting sick with what we thought was a normal cold on Wednesday March 11. He took off of work that following Thursday and Friday. He had a temperature of 100.4 on both days, experiencing a stuffy nose, and a horrible cough. The fever broke I believe Saturday or Sunday. Monday we were both home (he took off work again) and he was having trouble breathing, still having a stuffy nose, and a horrible cough. I woke up Monday morning as well not feeling great thinking that he just shared his "cold" with me. Since this would have been my husband's 3rd day of missing work I had him call his primary doctor to be seen and get a doctor's note. His doctor was out sick, so I called our Urgent Care. I wanted him to do this as well because we had seen all over the news telling us that with these symptoms we needed to call first. When I did I told her what my husband, and I, were experiencing. She put me on hold several times, then she came back on and told me that my husband and I needed to go over to [REDACTED] and get tested for the CoronaVirus. She told me that we needed to leave as soon as possible, and when we got there to call the hospital and let them know we were there because she was going to call over and let them know we were on our way. That they would come out and get us and do whatever they needed to do to test us. She made sure that we were going to leave right away, and I reassured her that we were going to drop my [REDACTED] at my in laws then go straight there.

When we got to [REDACTED] we did exactly what we were told to do, I called first and told them we were sitting outside the hospital. About 10 minutes later an older gentleman came out to my car and asked us our symptoms we told him exactly how we were feeling.... then he asked if we had been outside the country to which we answered "No".. He then asked if we had been in contact with someone who had tested positive for the virus, "Well, not that we are aware of. I calmly told him that I am a [REDACTED] and many of the families in my class take trips all the time so I do not know who they have come into contact with." We were denied testing but he led us inside to be seen, after paying \$100 just for one of us but that is another story. My husband received a breathing treatment, chest x-ray, steroid shot, a prescription for steroids, and an antibiotic. Well if he does by chance have the coronavirus then he should definitely not be taking steroids!! He cough does not sound any better! Just because he hasn't been out of the country doesn't mean he hasn't picked it up somewhere else. I need to know if there is anything you can do to help me sir! I am very concerned!!

I am sorry, I had to use my [REDACTED] email. My personal email would not accept the address for some reason.

[REDACTED]
[REDACTED]
[REDACTED]

February 22, 2020

Situation Update

Tidal Basin Healthcare Services

COVID - 19 | Novel Coronavirus

Developed by:

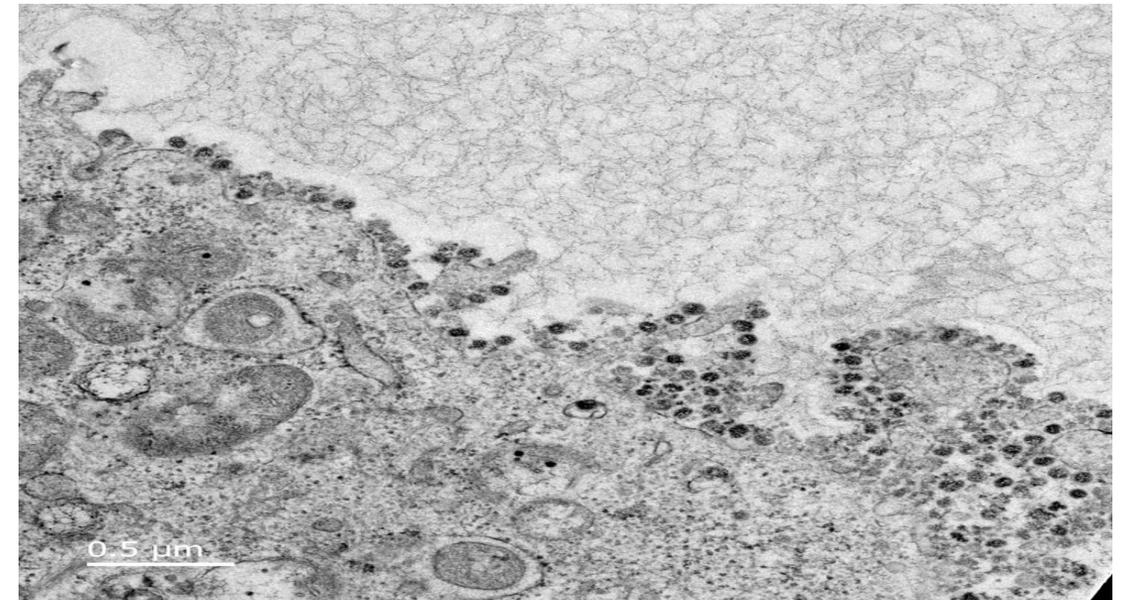
Kristopher J. Prickett, MS, PMP

Walker Schlundt, BSN, RN

Olivia Russell

Katie Geisert, DVM

Jessica Wiggs, LAPC, NCC

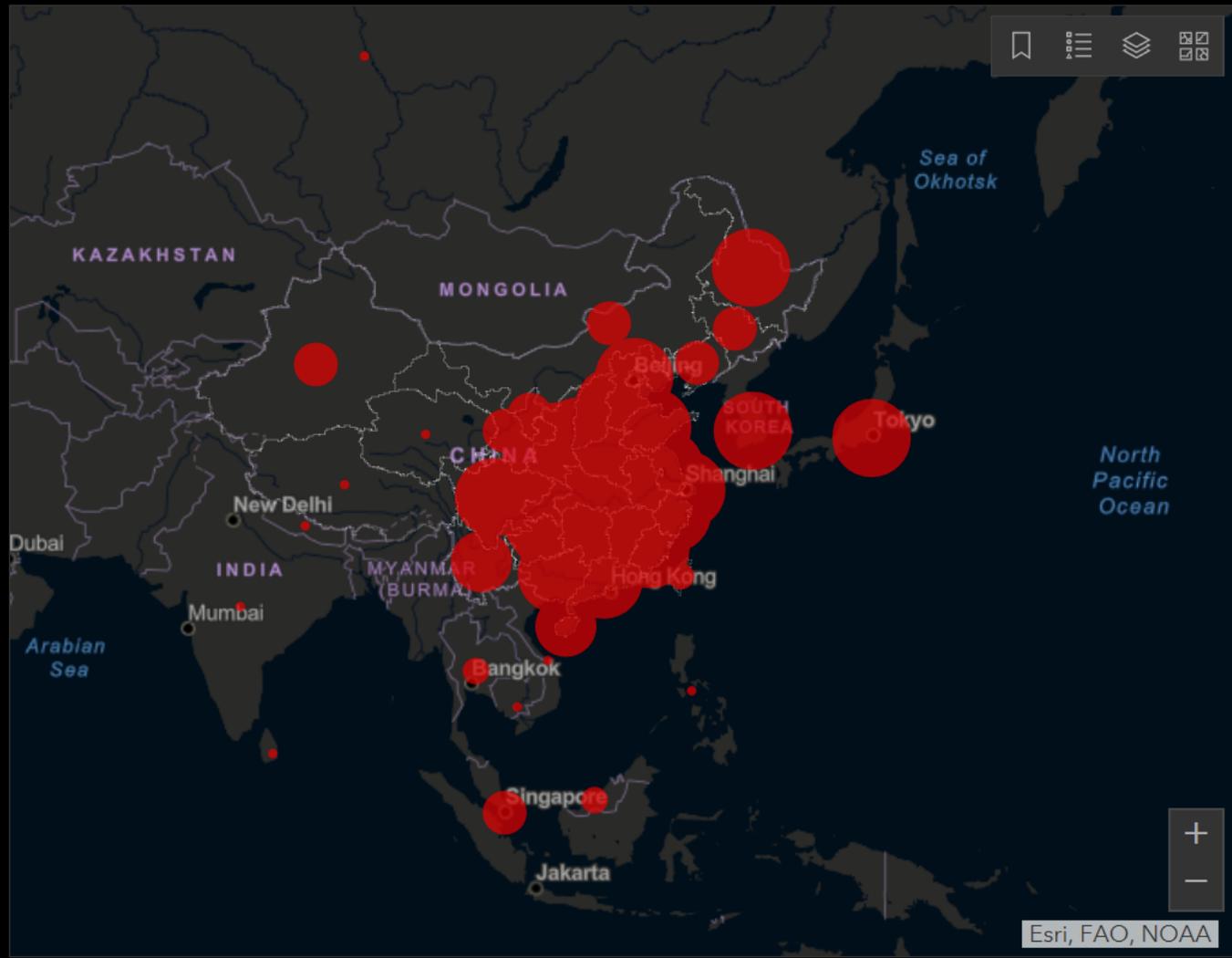




Total Confirmed
77,926

Confirmed Cases by
Country/Region

No Data



Esri, FAO, NOAA

Total Deaths

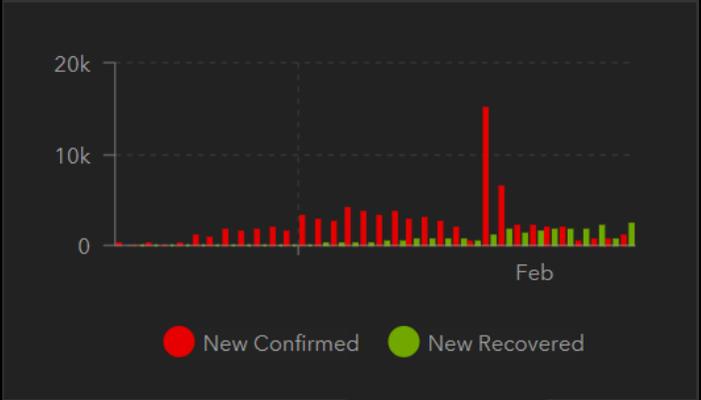
2,362

2,250 deaths	Hubei Mainland China
19 deaths	Henan Mainland China
12 deaths	Heilongjiang Mainland China
6 deaths	Anhui Mainland China
6 deaths	Chongqing Mainland China

Total Recovered

21,259

13,690 recovered	Hubei Mainland China
830 recovered	Henan Mainland China
728 recovered	Guangdong Mainland China
719 recovered	Zhejiang Mainland China
692 recovered	Hunan Mainland China



Actual Logarithmic Daily Increase

Country/Region

Last Updated at (M/D/YYYY)
2/22/2020, 9:53:02 AM

Lancet Article: [Here](#). Mobile Version: [Here](#). Visualization: [JHU CSSE](#). Automation Support: [Esri Living Data source](#): [WHO](#), [CDC](#), [ECDC](#), [NHC](#) and [DXY](#). Read more in this [blog](#). [Contact US](#).
Downloadable database: GitHub: [Here](#). Feature layer: [Here](#).
Point level: City level - US, Canada and Australia; Province level - China; Country level - other countries

Coronavirus Background



Coronaviruses are enveloped RNA viruses that are distributed broadly among humans, other mammals, and birds and that cause respiratory, enteric, hepatic, and neurologic diseases



Seven coronavirus species are known to cause human disease including COVID - 19. Four of the coronavirus are prevalent worldwide and typically cause common cold symptoms



The three other strains — Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV), Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and 2019 Novel Coronavirus (COVID - 19) — are zoonotic in origin and are linked to sometimes fatal illness



Coronaviruses are extremely small = < 100 NM in size

Clinical Presentation

Common



- Flu-like symptoms (low intermittent fever, dry unproductive coughing, headache and fatigue)
- Upper or/and lower respiratory tract infection symptoms
- Diarrhea (caused by virus colonization of the epithelial lining within the gastrointestinal tract)
- Dyspnea
- Rhinorrhea

Severe



- Pneumonia, confirmed by imaging with the presence of bilateral infiltrates
- Pneumonitis
- Hemoptysis
- Leucopenia
- Lymphopenia
- Acute cardiac event
- Kidney failure
- Acute Respiratory Distress Syndrome (ARDS)
- Secondary bacterial infection

Rate of Transmission



The incubation period for COVID – 19 is considered to be 2 to 14 days with a mean time of 5.2 days



It is unknown if shedding of a replication competent virus can occur during the incubation period



Cases of human to human asymptomatic viral transmission during the incubation period have been documented in Europe



The R_0 value of the virus is estimated to be between 2.2 and 4.5. Meaning, each infected patient could potentially infect 2 to 4 other people



The mean duration from illness onset to first medical visit is estimated at 5.8 days. The mean duration from symptom onset to hospital admission is estimated to be 12.5 days

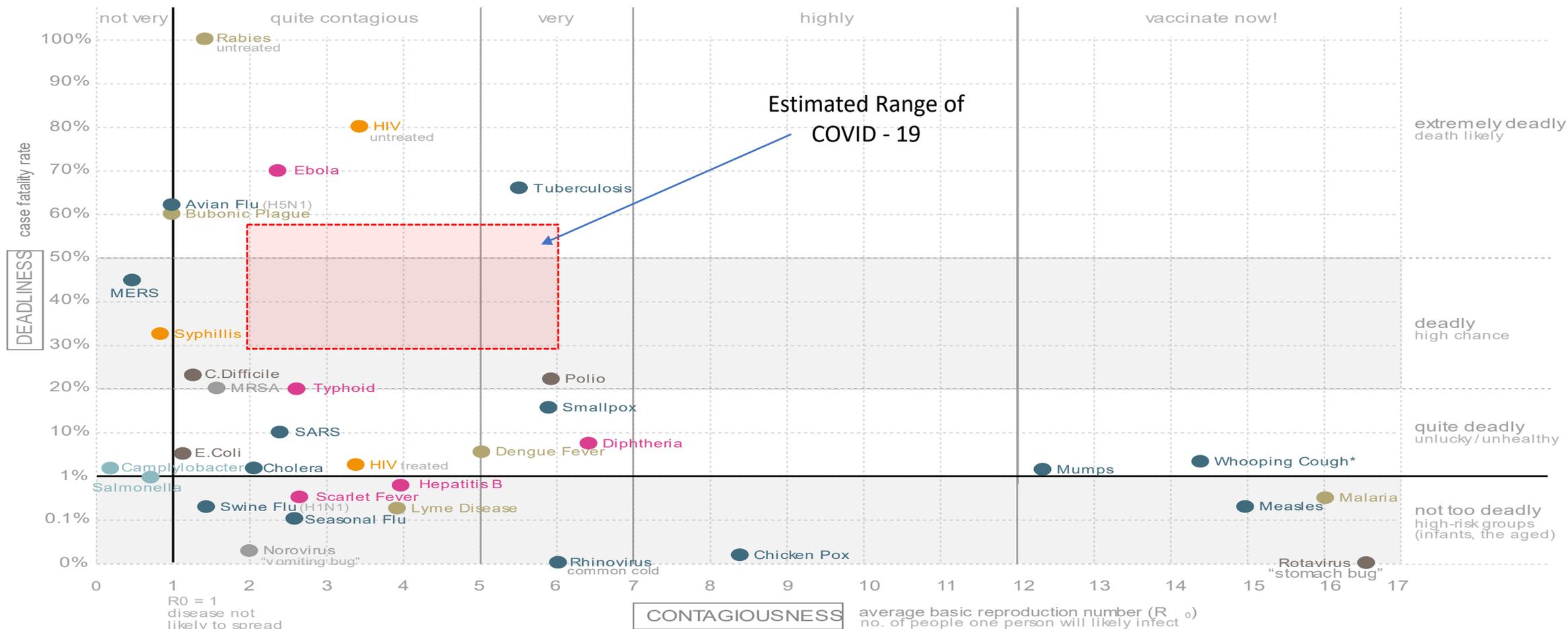


Epidemiological modeling suggests a doubling of the number of infected persons every 5.5 to 6.6 days

R₀ Virulence Reference

The Microbe-scope

PRIMARY TRANSMISSION METHOD: airborne, bites, body fluids, fecal-oral, food, sexual contact, surfaces



Method of Transmission



Spread through close contact with infected persons (6 feet)



Human-to-Human transmission is thought to spread mainly through aerosolized respiratory droplets produced when an infected person coughs or sneezes, similar to how seasonal influenza is spread



It should be noted that the severity of the infection is not indicative of transmission efficiency as patients with subclinical or extremely mild clinical presentations have been noted as being viral spreaders

Method of Transmission



Fecal - Oral transmission, though rare, is believed to be a human to human route of transmission for COVID - 19



It has been confirmed that transmission and subsequent infection can occur by touching a surface or object that is contaminated with COVID – 19 fomites and then touching your mouth, nose or eyes



Current peer reviewed estimates indicate that COVID - 19, similar to other coronaviruses, can survive on surfaces for up to nine days outside of the body at room temperature

Method of Transmission



COVID – 19 has been documented to spread through contact with mucosal membranes (saliva, sexual intercourse, contact with open wounds, etc.)



A case of vertical transmission from a mother to a newborn baby was documented in China. It is unknown if the newborn contracted the virus in the womb or immediately after birth

Specific Suspect Criteria



Clinical Features	&	Epidemiologic Risk
Fever or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including health care workers, who has had close contact with a laboratory-confirmed COVID - 19 patient within 14 days of symptom onset
Fever and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)	AND	A history of travel from Hubei Province , China within 14 days of symptom onset
Fever and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization ⁴	AND	A history of travel from mainland China within 14 days of symptom onset

Non-Specific Suspect Criteria

Non-Specific Suspect Criteria



<p>Patient develops an unusual or unexpected clinical course, especially sudden deterioration despite appropriate treatment, without regard to place of residence or history of travel, even if another etiology has been identified that fully explains the clinical presentation (WHO)</p>	<p>N/A</p>	<p>Recent travel (14 days) from the Hubei Province, China</p> <p>Suspected disease occurs in a healthcare worker who has been working with infected patients</p>
<p>Close contact with a person suspected or known to have infection due to COVID - 19 .The CDC defines close contact as being within 6 feet (2 meters) or within a room or care area for a prolonged period without personal protective equipment OR having direct contact with secretions of a person with COVID - 19 infection</p>	<p>N/A</p>	<p>Exposure to a healthcare facility in a country where hospital-associated COVID – 19 infections have been reported</p>

Treatment



No specific antiviral agent is available for treatment and no vaccine exists for COVID - 19



Severely ill patients should be treated empirically for other possible causes while diagnostic test results for COVID – 19 are pending



Patients with comorbidities, increasing age, or who are otherwise medically fragile have been documented as being more susceptible to COVID – 19 and are at an increased risk of complications



Infection control measures are an integral part of management and should be instituted as soon as COVID - 19 infection is suspected through negative pressure isolation, PPE and appropriate environmental/engineering controls

Treatment



Compassionate use of antiviral medications have shown some positive impact, but the effectiveness of in vivo (live person) use of antiviral drugs in patients infected with COVID – 19 is limited and no FDA approval exists for these indications at this time



Remdesivir and Chloroquine have been shown to effectively inhibit viral production of COVID – 19 in vitro (laboratory testing)



Compassionate use of Remdesivir and Chloroquine in patients infected with COVID – 19 have show limited patient improvement



Compassionate use of Lopinavir and Ritonavir, medications originally developed for the treatment of HIV/AIDS, have shown limited patient improvement

Precautions if you believe you have been infected with COVID - 19



Stay home except to get medical care



Social Distancing – Separate yourself from other people in your home



Wear a face mask when in the room with other people and when you visit a healthcare provider. Face masks protect others from your respiratory droplets



Before seeking medical care call ahead and let the provider know you need to be evaluated for COVID - 19 infection

General Precautions



Avoid sharing household items



Monitor for symptoms



Wash your hands regularly
Use alcohol-based hand sanitizers



Sanitize all high touch surfaces, such as counter tops,
tabletops, doorknobs, bathroom fixtures, toilets, phones,
keyboards, bedside tables etc.



It is recommended that all healthcare providers be fit tested
for N-95 masks as soon as possible

Mental Health Tips



Post event debriefings are critical to the overall mental health of care givers, providers and first responders



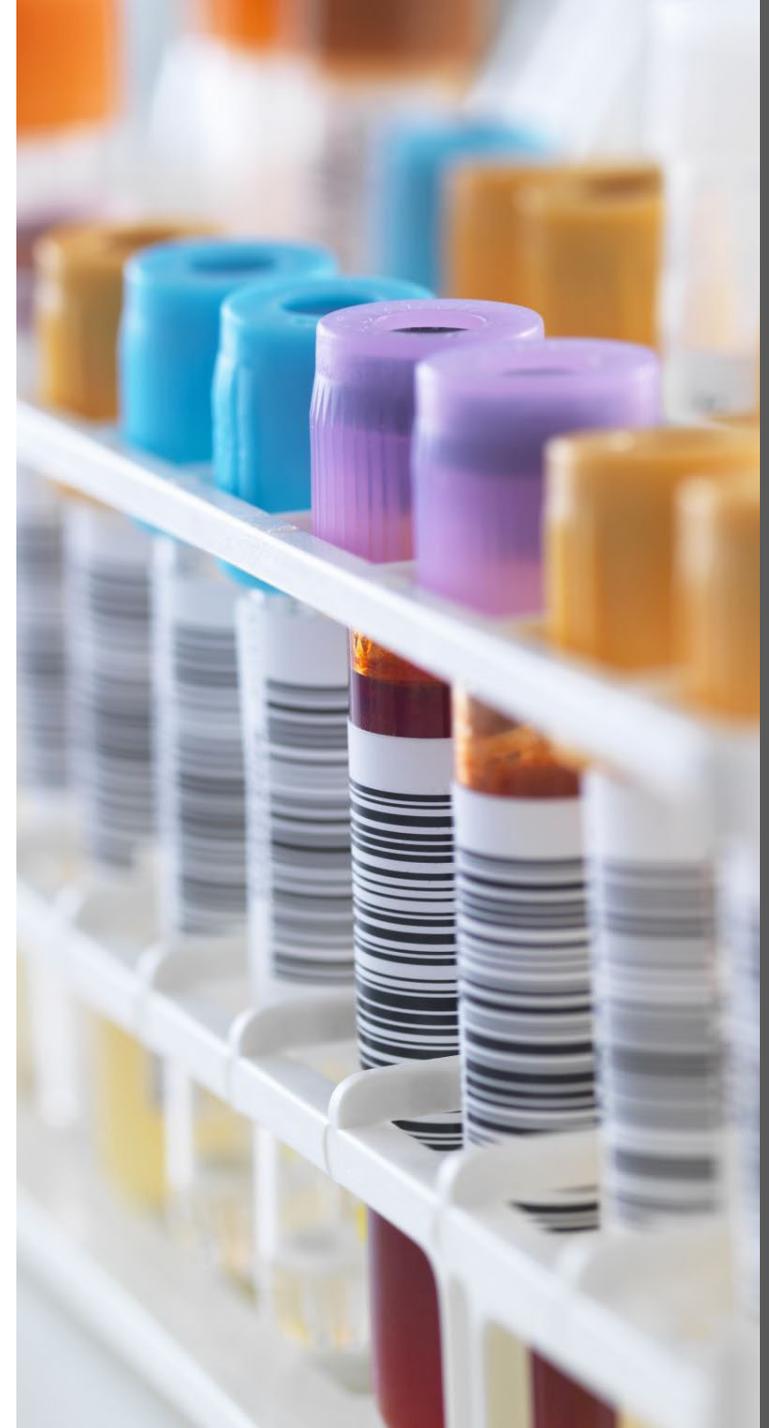
Heighten levels of stress and anxiety due to COVID – 19 can lead to an increased susceptibility to illness



It is important to take 5 minutes per day to care for your self so that you may care for others

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COVID-19 – Update #2

News reports today indicate that there have been several employees and staff with symptoms of COVID-19 identified in a skilled nursing facility in Washington state. This update #2 outlines some additional steps you should be taking since update #1 sent on Friday, February 28, 2020 to protect your residents, their families, as well as your staff and their families.

Since COVID-19 is spread from person-to-person through droplets in the air, very similar to how influenza spreads, centers should use the strategies known to reduce the spread of respiratory viruses which includes:

- Monitor your staff and visitors for following hand washing or use of alcohol hand gels
- Review your contact isolation procedures and make sure staff follow them consistently
- Review plans for cohorting residents in the same room or wing who become sick to prevent the spread to other residents and staff, should the outbreak continue to grow
- Remind staff, contractors, volunteers to stay home if they are sick (see detailed guidance [here](#))
- Starting now, post notices for visitors who are sick to stop visiting and work with families on alternate ways to visit their family members, like Skype, phone calls and email. Check with the local health department if they are recommending more restrictive criteria for visitations as COVID-19 spreads.
- Stay in close contact with your local and state health department.
 - Make sure your infection preventionist signs up for health department announcements as well as CDC announcements
- Monitor the CDC COVID-19 [website](#) for the latest information on Coronavirus prevention strategies, testing guidance and recommendations for health care workers.

Centers need to review testing guidelines for [testing](#) of persons under investigation suspected of COVID-19.

- Make sure your staff are aware and keep up with CDC and your local health department guidelines (which are changing) as to when to contact them for testing suspected cases.

You should provide information to your staff and their families on what they can do to protect themselves. Per CDC this includes:

- Following [preventive actions](#) known to prevent the spread of viruses including:
 - washing your hands, using alcohol-based hand sanitizers,
 - covering your cough, and
 - staying home when you are sick (which includes any of the following: fever, cough, runny nose, sore throat)
 - The CDC does NOT currently recommend the general public to use facemasks.

We have communicated to CDC and CMS that long term care providers are having trouble accessing types of personal protective equipment such as masks, gowns, etc. due to the worldwide shortage related to decreases in exports from select countries, including China, India, and Taiwan, and increases in demand.

COVID-19 – Update #2

The CDC has offered strategies for health care providers on how to optimize supplies of N95 respirators in the face of decreasing supply, which can be found [here](#). These strategies include

- Minimizing the number of health care professionals who need to use respiratory protection
- Use alternatives to N95 respirators, such as facemasks where feasible, and prioritize the use of N95 respirators for those with the highest risk of acquiring infection or experiencing complications from infection

You can learn more about the CDC's strategies for optimizing the supply of personal protective equipment [here](#).

If a health care provider, including long term care providers, is experiencing challenges meeting personal protective equipment needs, please contact your state and local health departments.

AHCA/NCAL will continue to provide updates and relay messages and concerns to CDC and CMS. Thank you to all members for keeping our residents and communities safe.

This message contains confidential information and is intended only for AHCA/NCAL membership. Dissemination, distribution or copying the contents of this email beyond this group is strictly prohibited.



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To: Mountain Health Employees

From: Susan Beth Robinson, Chief Human Resources Officer, Mountain Health Network

Re: COVID-19 Update

Date: March 19, 2020

Human Resources

New Emergency Telecommuting Policy

Effective Monday, March 23, 2020, Cabell Huntington Hospital and St. Mary's Medical Center will begin a phased-in approach to moving non-patient care related staff from work to home during the Covid-19 pandemic ("Emergency Telecommuting"). Emergency Telecommuting is being instituted to support social distancing measures and to keep as many non-patient care related staff out of the hospitals as possible. Emergency Telecommuting will remain in effect until further notice.

If you are in a non-patient care related role, your manager will be getting in touch with you about:

- whether or not Emergency Telecommuting is an option for your job (on a full-time or part-time basis) depending upon (1) your individual work responsibilities and the business needs of your department and (2) Internet connectivity and hardware availability;
- the date your telecommuting will begin (currently targeted for some time between March 23 and March 27);
- the process involved which will be coordinated by Information Services
- the Emergency Telecommuting Agreement and policy will be provided to you by your manager for signature. Please note that you will not be eligible for Emergency Telecommuting until your manager obtains your signed agreement.

Please note telecommuting is not available if you currently have no available work to do because of low work volume/census. You will be requested in these instances to take vacation or benefit time off without pay.

If you have any questions about your eligibility for Emergency Telecommuting, please contact your manager.



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Medical Services

Bill J. Crouch
Cabinet Secretary

Cynthia E. Beane
Commissioner

M E M O R A N D U M

TO: ALL BMS STAFF

FROM: Cynthia Beane, MSW, LCSW 
Commissioner

DATE: March 16, 2020

SUBJECT: COVID19

As the country is embracing the fluid situation with eh COVID-19 Pandemic, BMS is sensitive to our employees' and providers' health. So many of us are on the front lines of this epidemic, it is important to protect the health and well-being of our entire community - including each of you.

To ensure the safety of our community, BMS is moving quickly to promote and enable social distancing. So far, we have curtailed large events and are reducing the number of in-person meetings. All travel is cancelled. Please be sure to cancel any hotel stays or conference registrations you may have for the next eight (8) weeks.

Beginning tomorrow, and until we communicate otherwise, all BMS employees who want to telework from home should consult their supervisors for approved duties and expectations. Of course, any employee who is sick or has sick family members should stay home. These precautions are intended to keep sick or potentially sick people from spreading the virus, so that it will remain safer for those who must continue to report to the office.

For employees whose work cannot be done remotely, we encourage implementation of social distancing and following CDC recommended guidance which can be found at: <https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/mass-gatherings-ready-for-covid-19.html>



National Commission on
Correctional Health Care

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COVID-19 (Coronavirus): What You Need to Know in Corrections

From *February 28, 2020* in Health Care, Public Health

By Brent R. Gibson, MD, MPH, FACPM, CCHP-P
Chief Health Officer, NCCHC

We know you are worried about how COVID-19 might affect you and your work in correctional health care.

As of February 23, 14 COVID-19 cases had been diagnosed in the United States. An additional 39 cases were reported among repatriated U.S. citizens returning from Hubei province, China (three), and the Diamond Princess cruise ship. No deaths have been reported in the United States. In comparison, at least 14,000 people have died and 250,000 have been hospitalized during the 2019-2020 flu season, according to the CDC.

Available treatments for COVID-19 are supportive care (rest, fluids, etc.) and, while some people do become very ill and require hospitalization, most do not. Some infected people may have minor illness or no symptoms at all. There is no currently approved antiviral treatment or vaccine, although intensive research is ongoing.

Remember, simple preventive measures like proper hand washing are key to reducing the risk of outbreak.

Challenges you may face if the virus becomes widespread include:

- Loss of essential services
- Loss of infrastructure
- Shortage of workers
- Sudden increase in the number of patients
- Need to relocate care to an alternate facility

Essential decisions about allocation of resources should be made at a system level. It may relieve stress to remind the team to follow your facility's chain of command.

Here are some critical factors correctional leaders need to keep in mind to prepare for a possible outbreak:

Communications

All staff should have approximately the same answers. “Singing the same tune” will reassure staff, inmates and their families that the facility has prepared appropriately and is communicating well.

Appoint one point of contact for press inquiries and be ready if a news crew shows up at your facility.

Have a list of telephone contacts available to all staff: phone numbers for the chain of command, on-call physicians and nursing staff, local and state public health departments and off-site emergency/medical providers.

Make sure that all employees know what is expected of them in the event of an outbreak.

Your state and local health departments may not include you in their planning or communications. Make sure you are in touch. Also look for resources from:

The Centers for Disease Control and Prevention (CDC)

The World Health Organization (WHO)

Local authorities such as hospitals, medical centers and health care systems

Personal Protective Equipment

If PPE is used, train all personnel on its proper use. Employees must be properly fitted and trained for items such as masks.

Key protective items include gloves, masks and respirators (please understand uses and limitations of these), eye protectors, gowns, uniforms and shoe covers

Create or review your disease outbreak protocol/SOP. Follow your facility’s critical incident procedure to get started.

Identify staff responsible for planning and directing health care delivery

Calculate estimates of sick inmates based on your population – determine impact and disaster staging based on these figures.

Identify high- and low-priority health care functions as well as a facility-specific plan for health care delivery

Determine a plan for handling contact with individuals from outside the facility whose disease status is unknown.

Your plans should include:

Supplementing health care staff, if needed

Creating medical isolation areas or units

Ensuring supply of pharmacy and medical supplies in case normal supply sources are limited

Transporting patients for more advanced care.

Consider a clinical protocol addressing clinical guidelines for treatment of airborne pathogens or other highly contagious diseases

Review your plan for cleaning and disinfecting equipment and areas.
Inventory the types of cleaning agents and make sure staff has up-to-date training on proper cleaning methods.

Free Downloads

NCCHC is making its [**Standard on Infectious Disease Prevention and Control available for free download**](#) to help you formulate policies and procedures for reducing the risk of infectious disease transmission, including COVID-19.

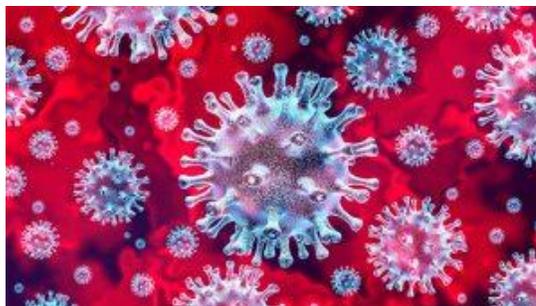
We also recommend this information on [**Coronavirus COVID-19 and the Correctional Facility**](#) from Dr. Anne Spaulding, Emory Center for the Health of Incarcerated Persons

Resources

[**https://www.cdc.gov/coronavirus/index.html**](https://www.cdc.gov/coronavirus/index.html).

[**https://www.who.int/health-topics/coronavirus**](https://www.who.int/health-topics/coronavirus)

[**https://medlineplus.gov/coronavirusinfections.html**](https://medlineplus.gov/coronavirusinfections.html)





To: Mountain Health Employees

From: Hoyt Burdick, MD, chief clinical officer, Mountain Health Network
Regina Campbell, chief nursing officer, Mountain Health Network
Larry Dial, MD, chief medical officer, Marshall Health

Re: COVID-19 Update

Mountain Health staff members are meeting regularly to discuss Coronavirus disease 2019 (COVID-19). The purpose of these meetings is to increase our preparedness in response to COVID-19, to dispute facts vs. fiction, and to distribute accurate, quality information to our staff and community.

Present at the meetings and offering reports are CHH, SMMC, Marshall Health and HIMG representatives from: infection prevention, purchasing, laboratory services, nursing, emergency departments, physician practices, human resources, environmental services, food service, and communications.

Highlights from the March 19 meeting:

Triaging/Screening

The triaging and screening at each entrance is working successfully, as one visitor at CHH was identified to be tested yesterday. Dr. Dial offered kudos to everyone who helped make an amazing amount of work get accomplished in a very short time.

Dr. Dial stressed the importance of telling staff that if they are sick, they should report themselves sick and stay home.

Testing

Marshall Health has established two drive-thru stations:

- CHH in front of the parking garage. Hours are Monday-Friday 8 a.m.-5 p.m.
- SMMC Center for Education. Hours are Monday-Friday 10 a.m.-4 p.m.

Both testing locations will remain open until further notice. The testing is only available to patients with an order from a physician, and they must present the order, insurance information, and a valid photo ID. Media were advised they could visit before the drive-thru testing began. After the availability, the site will be closed to the media to preserve HIPAA.

Supplies

Following the pattern in Europe, which was three weeks after the first positive case was reported, we can expect the surge. Paul Lageman (SMMC) and Maria Summers (CHH) reported they have

conducted a complete evaluation and checklist of resources for our current state and a projected future, ensuring that the models at both hospitals mirror each other. Evaluating bed and ICU availability is also part of the surge plan.

We are on par with ventilators currently, but we are working to obtain more as part of the supply plan. Rita is also working to secure other supplies from as many sources as possible. Rita asked that everyone work to educate staff regarding the use of masks. Resource information on the use of Personal Protective Equipment (PPE) will be placed on the Intranet sites for both hospitals.

Food Service

Seating in the cafeterias at both hospitals has been closed to the public and is available for hospital staff only. Staff are asked to please not move the chairs and abide by the 6-foot apart rule, by order of the Health Department.

Human Resources

A memo is forthcoming regarding a telecommuting plan for non-patient care related staff, which will start to be rolled out next week. HR is also working with managers on how to plan for low census.

Due to the suspension of elective surgeries, by order of Ohio Gov. Mike DeWine, Three Gables Surgery Center closed as of yesterday until further notice.

Communications

Linda Murray (CHH) reported that she and Jack Vital (SMMC) have started a Joint Incident Command (JIC) group on LiveProcess for departments to document their activities in order to keep everyone updated. Anyone needing more information or training should contact Linda or Jack.

Marketing emphasized that information in the internal daily memos or other internal information should not be shared on social media, as the official information for the public should come from Marketing. Employees are free to share official public releases, which can be found on both the CHH and SMMC Facebook pages and at mountainhealthnetwork.org.

Additional updates will be provided after each meeting. Links to the latest information regarding COVID-19 are available at www.mountainhealthnetwork.org/coronavirus.

Thank you for your efforts as we work together to protect the health and safety of our employees, patients and visitors.

Reducing spread by creating a public trust entity to support COVID-19 contact tracing while also protecting privacy

Issue

The location of Coronavirus and how people are becoming infected is not known or visible and, as such, mitigation efforts are requiring large parts of the US and the world to have “shelter in place” orders.

Solution

The solution is to deliver individual notifications to keep people informed regarding their whereabouts in relation to other individuals who have tested positive. The notification parameters would be based upon a set of algorithms developed by public health experts. While the use of the app will be voluntary, we will engage our private and public institutions to encourage all residents of the United States to download and use the app.

This capability will prevent the need to quarantine entire cities or regions but only the individuals and/or specific geographic area that may have been exposed. Also, it will prioritize testing to those individuals that may have been exposed.

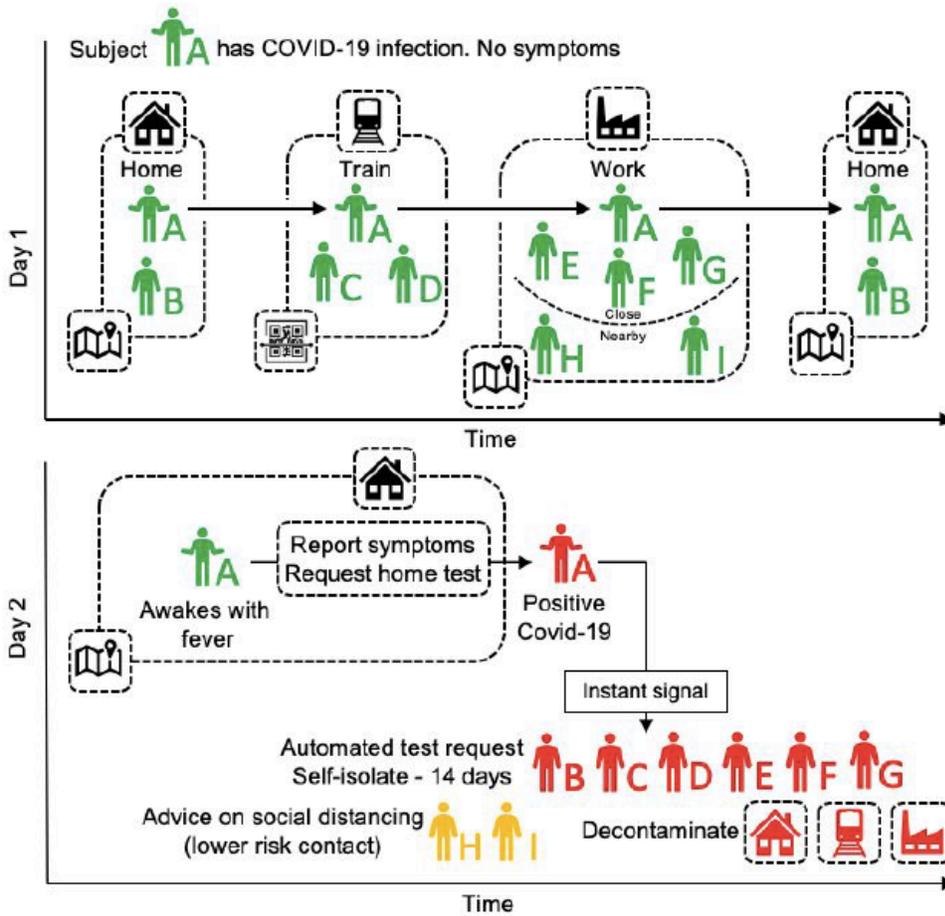
Approach

The technology exists to quickly create this solution, but the obstacle is addressing privacy concerns and developing confidence and public trust. In order to ensure we gain the confidence of the American public, we propose that a public trust is created that would be governed by a set of trusted private companies. This set of trusted private companies in coordination with other major corporations will work with all levels of government to create a public private partnership to oversee this solution for the public's benefit.

Summary Bullets

1. Public Trust created and administered by a set of trusted corporations
2. Supported by all major corporations
3. Voluntary program but highly encouraged
4. Consent provided at the time of download
5. App can be deleted at any time
6. Guided by the Public Health and Epidemiologist community as to data retention, algorithms that process notifications, and any other necessary requirements.
7. Provides a means to release large population sets currently Quarantined
8. Ability to target individuals and small regions with quarantine requests
9. Support directed testing of those that have had a potential exposure event thereby reducing the need to test large population sets
10. Accessible only by Public Health officials in support of Covid-19 management and containment

Notification Process overview



Bonsall, B., Fraser, C., & Parker, M. Policy forum – COVID-19 containment by herd protection. https://github.com/BDI-pathogens/covid-19_instant_tracing/blob/master/Policy%20forum%20-%20COVID-19%20containment%20by%20herd%20protection.pdf



FOR IMMEDIATE RELEASE (03-20-2020)



Cabell-Huntington Health Department Has Received Notification of a Positive Test for COVID-19

Contact:

Elizabeth A. Adkins, MS
Director of Health & Wellness/PIO
Cabell-Huntington Health Department
Office (304) 523-6483 ext. 258
Fax (304) 523-6482
elizabeth.a.adkins@wv.gov
cabellhealth.org

HUNTINGTON, West Virginia. The Cabell-Huntington Health Department has received notification of a positive test for COVID-19. While the patient was diagnosed in Cabell County, the patient is NOT a resident of Cabell County and will be receiving treatment at a tertiary care facility.

To be respectful and protect the patient's privacy no other information will be released.

###

From: Lopez, John V <John.V.Lopez@wv.gov>
Sent: Wednesday, March 18, 2020 7:33 AM
To: Crouch, Bill J <Bill.J.Crouch@wv.gov>
Cc: Samples, Jeremiah <Jeremiah.Samples@wv.gov>
Subject: Fw: [REDACTED] COVID-19

Thanks Sir ! I hated to bother you with this I know you have a lot going on.
I just want to make sure you are OK with my response(s). I think we need to have consistent message concerning these types of inquiries. If needed, I would be glad to get with Allison and put something together for you and Dr. Slemp to review/revise.

From: Crouch, Bill J <Bill.J.Crouch@wv.gov>
Sent: Wednesday, March 18, 2020 5:34 AM
To: Lopez, John V <John.V.Lopez@wv.gov>
Cc: Samples, Jeremiah <Jeremiah.Samples@wv.gov>
Subject: Re: [REDACTED]

John...I'm getting a bunch of these myself. There is no easy answer if they have gone to their local health department and/or their physician. We may need to create a response you can use fit these requests. I have a feeling we will get more. I will work on that with Cathy.

Bill

On Mar 17, 2020, at 6:22 PM, Lopez, John V <John.V.Lopez@wv.gov> wrote:

Secretary Crouch,

These are the types of emails I'm getting blown up with from the Governor's Office.
Everybody wants to be tested for the virus, but it's not the DHHRs responsibility to make that call.

Note: I don't think I should refer everyone one of these to Dr Slemp, she has a lot going on.

Please let me know if you think this response is acceptable for inquiries of this nature.

Thanks,

John V. Lopez, Director
WV Department of Health and Human Resources
Office of Constituent Services
350 Capitol Street, Room 601
Charleston, WV 25301
Phone: 304-356-2000
Email: John.V.Lopez@WV.Gov

From: Lopez, John V

Sent: Tuesday, March 17, 2020 6:18 PM

To: [REDACTED] >

Cc: Hughes, Thelma <Thelma.J.Hughes@wv.gov>; Mynes, Jennifer G <Jennifer.G.Mynes@wv.gov>; Pinnell, Kenneth L <Kenneth.L.Pinnell@wv.gov>

Subject: FW: [REDACTED], COVID-19

[REDACTED]

Thank you for contacting Governor Jim Justice's office. Your inquiry has been forwarded to our agency for review and response. The Department of Health and Human Resources (DHHR) is pleased to assist you.

I have reviewed your email below and I recognize your concerns. Please know the doctor(s) will need to make the final decision if someone is a candidate to be tested for the virus. These individuals are medical professionals and have the proper training to assess the situation.

We recognize this is a stressful time for everyone. Please know the DHHR is working closely with other state and federal agencies to make sure we are prepared for any outbreak of this virus. As you are aware, there is currently no vaccine to prevent the coronavirus (COVID-19). The best way to prevent illness is to avoid being exposed to this virus. However, as a reminder, the CDC always recommends taking every day preventative actions to help stop the spread of respiratory diseases, including:

- Avoid close contact with people who are sick.
- Avoid touching your eyes, nose, and mouth.
- Stay home when you are sick.
- Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
- Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe.
- Follow the CDC's recommendations for using a facemask.
 - The CDC does not recommend that people who are well wear a facemask to protect themselves from respiratory diseases, including COVID-19.
 - Facemasks should be used by people who show symptoms of COVID-19 to help prevent the spread of the disease to others. The use of facemasks is also crucial for [health workers](#) and [people who are taking care of someone in close settings](#) (at home or in a health care facility).
- Wash your hands often with soap and water for at least 20 seconds, especially after going to the bathroom; before eating; and after blowing your nose, coughing, or sneezing.
 - If soap and water are not readily available, use an alcohol-based hand sanitizer with at least 60% alcohol. Always wash hands with soap and water if hands are visibly dirty.
 - Keep a good social distance – stay away from crowds (more than 10 people)

The website www.coronavirus.wv.gov has been established to monitor this evolving virus. For additional information, please visit: <https://www.cdc.gov/coronavirus/index.html>.

In partnership with the WV Poison Center, WVDHHR now has information toll free number lined up for Coronavirus (COVID19) questions: **The number is 1-800-887-4304.**

Here is a link to a press release that was sent out concerning the virus:

[https://dhhr.wv.gov/News/2020/Pages/Information-Hotline-Established-to-Address-Coronavirus-Disease-2019-\(COVID-19\)-Concerns.aspx](https://dhhr.wv.gov/News/2020/Pages/Information-Hotline-Established-to-Address-Coronavirus-Disease-2019-(COVID-19)-Concerns.aspx)

Here is a link to the most recent press release from DHHR. This will provide more information about testing, etc. <https://dhhr.wv.gov/News/2020/Pages/COVID-19-Testing-Criteria-Explained-for-West-Virginia.aspx>

I hope you find this information helpful.
Thanks,

John V. Lopez, Director
WV Department of Health and Human Resources
Office of Constituent Services
350 Capitol Street, Room 601
Charleston, WV 25301
Phone: 304-356-2000
Email: John.V.Lopez@WV.Gov

From: Hughes, Thelma <Thelma.J.Hughes@wv.gov>
Sent: Tuesday, March 17, 2020 6:03 PM
To: Lopez, John V <John.V.Lopez@wv.gov>; Mynes, Jennifer G <Jennifer.G.Mynes@wv.gov>; Pinnell, Kenneth L <Kenneth.L.Pinnell@wv.gov>
Subject: [REDACTED]

Greetings,

The following e-mail message is being forwarded to the WV Department of Health and Human Resources for review and direct reply.

Thank you for addressing the concerns of Ms. DiSantis.

Thelma



Thelma Hughes
Senior Caseworker
Office of Governor Jim Justice
State Capitol
1900 Kanawha Boulevard, East
Charleston, WV 25305
304-558-2000
304-558-2722 (fax)



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From: Tanner, Kaylyn R <Kaylyn.R.Tanner@wv.gov>
Sent: Tuesday, March 17, 2020 2:39 PM
To: Hughes, Thelma <Thelma.J.Hughes@wv.gov>
Subject: FW: [External] Submit A Comment Alert From Governors Email - [REDACTED]

From: Office of the Governor <support@wvinteractive.com>
Sent: Tuesday, March 17, 2020 12:26 PM
To: Tanner, Kaylyn R <Kaylyn.R.Tanner@wv.gov>
Subject: [External] Submit A Comment Alert From Governors Email - [REDACTED]

CAUTION: External email. Do not click links or open attachments unless you verify sender.
[Office of the Governor](#)

[REDACTED] has been added

[Modify my alert settings](#) [REDACTED] [View SubmitAComment](#) | [Mobile View](#)

Title:	[REDACTED]
Organization:	[REDACTED]
Address1:	[REDACTED]
Address2:	
City:	[REDACTED]
State:	OH
Zip:	[REDACTED]
Phone:	[REDACTED]
Email:	[REDACTED]
Subject:	My WV daughter and her family NEED HELP
Message:	My daughter and one of her 4 kiddos, he is [REDACTED] have EVERY symptom of Corona19. Add to that, [REDACTED] and 3 of the kiddos are immunocompromised. They went to the [REDACTED], their private Dr, and [REDACTED] hospital yesterday to be tested. NO ONE WOULD TEST THEM because they haven't been out of the country. They all told her to quarentene their entire family and treat the symptoms. She is not able to return to work, which is where she most likely caught this. They have zero income, some food stamps, and no means to pay their home or utilities. It seems WV has no confirmed cases because they are not testing anyone! PLEASE, help them!!!! They cannot survive and I am disabled and live on disability, which doesn't leave me any extra. HELP THEM, PLEASE! I called the Health Dept head, [REDACTED], and he has yet to return my call. This is so wrong. She can't even get the unemployment because she has no means to get a note to show them to get help. Please, help them!
DateSubmitted:	3/17/2020
Completed:	No

Last Modified 3/17/2020 12:25 PM by (unknown)

Coronavirus Update: February 20, 2020

Dear Valued Customer,

As you know, we have experienced a surge in global demand for personal protective equipment (PPE). This surge is fueled by many forces; in particular, by the outbreak of COVID-19 (coronavirus) and a strong and persistent flu and illness season. Like many manufacturers and distributors, McKesson sources many of its PPE products from China. Over the past few weeks, our partners in China have been unable to produce and direct output towards our resupply orders. Furthermore, they tell us that they are uncertain as to when they might be able to return to both normal production and shipping levels. We believe that this dynamic is affecting many firms in our industry, although each firm may be affected relatively more or less depending on their customer mix and how much supply they receive from China-based partners.

Given the surge in demand and our relative inability to receive resupply, we foresee a time in the near future (within a few weeks) when we will begin to stock out of select PPE items. This outlook could change for the better if the situation in China changes very soon. We do have some sources of product within the U.S. and in other foreign countries. We are doing all we can to procure product from those sources, as well as working to identify new sources. Unfortunately, most other firms, including those representing Chinese demand, are doing the same. Our chances of finding fully adequate resupply from entirely new sources are not good. That is the situation we find ourselves in today.

With this in mind, we made some difficult decisions in order to take care of as many providers and patients as possible, to take care of those most in need and to do so for as long as possible. We have stopped selling PPE items in short supply to resellers and consumer websites. We have stopped taking orders for PPE items from new customers. And, importantly, we have limited unit sales to existing customers. These are imperfect actions to be sure. There are many cases to be made why we should supply more or less product to some providers and not others. It is also difficult to operationalize varying allocation methodologies. We encourage you to discuss this situation with your management and care teams and plan wisely for the coming weeks and months. Please know that we will continue to do everything we can to stabilize our supply chain and inventories as quickly as possible. We will continue to bring the full talent, reach and scale of McKesson to help mitigate and resolve this complex situation.

We recognize that this situation and our response to it are equally serious. We understand that your providers and patients are facing difficult challenges and decisions of their own. We will continue to strive to communicate often and openly with you. Thank you for your partnership. Thank you for your trust and patience. And thank you for taking care of our communities, during the best of times and the hardest of times.

Sincerely,

Stanton McComb

President, McKesson Medical-Surgical

McKesson Medical-Surgical
9954 Mayland Drive
Suite 4000
Richmond, VA 23233

mms.mckesson.com



MOUNTAIN HEALTH NETWORK
Cabell Huntington Hospital | St. Mary's Medical Center

2019-nCoV

coronavirus

Daily Briefing

March 20, 2020

Hoyt Burdick, MD
Larry Dial, MD
Regina Campbell, RN

AGENDA

- Status of Pandemic
- Mountain Health Updates
- Operational overview
 - Surge plan and Incident Command
 - Patients/Beds/Ventilators
 - Testing and Laboratory
 - Supplies
 - Human Resources
 - Communications/Information
- Current Needs



MOUNTAIN HEALTH NETWORK
Cabell Huntington Hospital | St. Mary's Medical Center

2019-nCoV

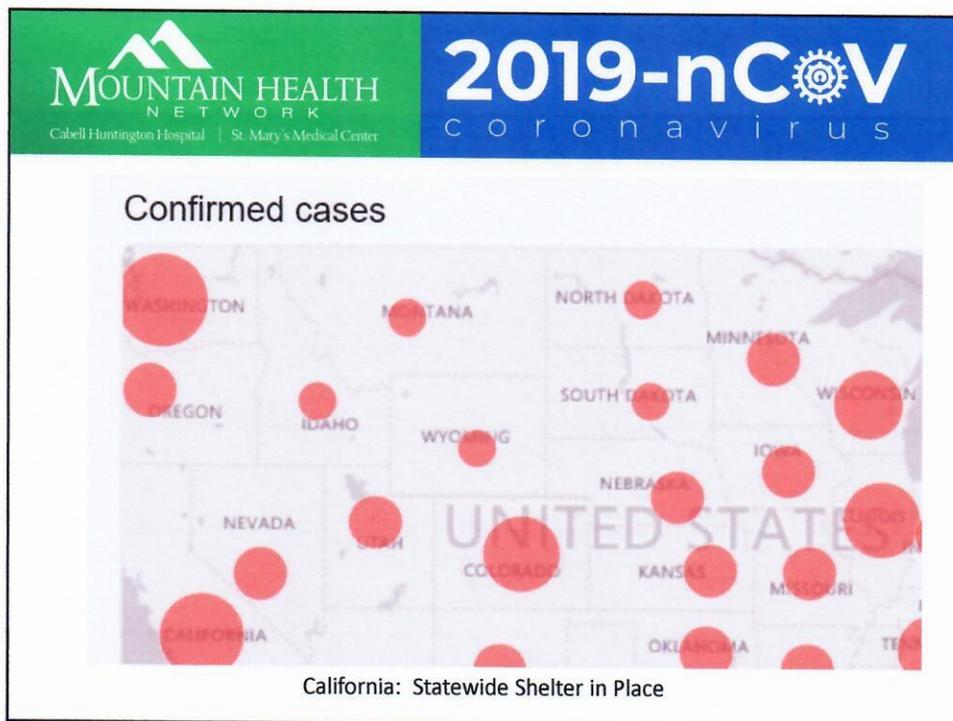
coronavirus

Coronavirus (COVID-19) pandemic

OVERVIEW

West Virginia cases	
Confirmed	Deaths
5	0

United States cases	
Confirmed	Deaths
14,387	217



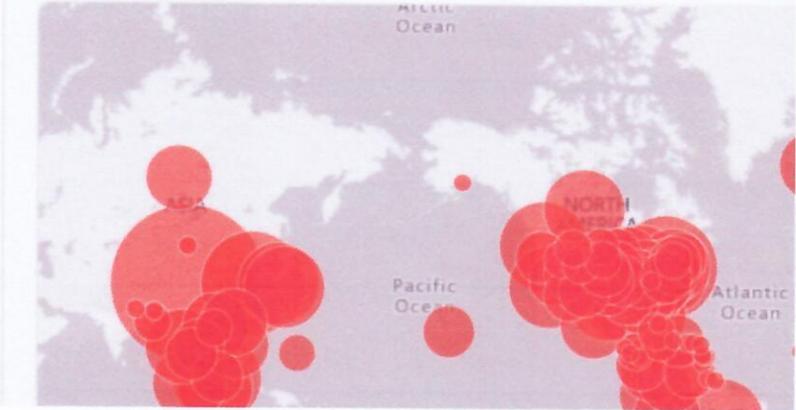


MOUNTAIN HEALTH NETWORK
Cabell Huntington Hospital | St. Mary's Medical Center

2019-nCoV

c o r o n a v i r u s

Confirmed cases



U.S. State Department: World Travel Advisory

Italian deaths > Chinese



MOUNTAIN HEALTH NETWORK
Cabell Huntington Hospital | St. Mary's Medical Center

2019-nCoV

c o r o n a v i r u s

Patient census, ICU Beds, Ventilators, Isolation

Metric / Resource	CHH	SMMC	MHN
Total Adult Inpatient & Obs. Daily Census	269		
Available ICU beds	17	9	26
Mech. Vents Available	24 (+11)	36	60
Covid-19 Evaluation Patients in Isolation	10	6	16



MOUNTAIN HEALTH NETWORK
Cabell Huntington Hospital | St. Mary's Medical Center

2019-nCoV

coronavirus

Surge Plan and Incident Command Update

- [Liveprocess.com](https://liveprocess.com)
- Stage of implementation
- Areas of concern



Date Posted	Post
03/19/2020 09:52 AM	Mar
03/19/2020 09:01 AM	Horr
03/19/2020 08:36 AM	Phar
03/19/2020 08:17 AM	Occ



MOUNTAIN HEALTH NETWORK
Cabell Huntington Hospital | St. Mary's Medical Center

2019-nCoV

coronavirus

Improving access to appropriate Covid-19 Testing

Screening Questions, Criteria, Ordering and Referral Process
Hours of operation





2019-nCoV
coronavirus

Mountain Health Network Updates

- Public Access Points and Screening Stations
- Drive-up testing (with orders or referral)
- Laboratory testing: reagents and media
- Supplies and PPE
- Human Resources
- Communications



2019-nCoV
coronavirus

Wins or Current Needs:





Message from Leadership:

Links to the latest information regarding COVID-19 are available at www.mountainhealthnetwork.org/coronavirus.

Webex (Microsoft Teams) meeting for Saturday morning 3/21/20.
Telephone call-in and/or computer WebEx.

Thanks to each one of you for your efforts as we work together to protect the health and safety of our employees, patients and visitors.



United States Department of Agriculture

Office of the Secretary
Washington, D.C. 20250

MAR 20 2020

Good afternoon,

Let me begin by thanking each of you for the monumental efforts that you are making to help our citizens protect and sustain themselves in the face of the COVID-19 pandemic. This health crisis has required each of us to take extraordinary action to ensure that all Americans, and especially children, get the food they need. Our partnership is the foundation for all of our success, and Secretary Perdue and I appreciate your dedication and energy in meeting this challenge. We are proud to serve our country with you.

Wednesday night, the President signed the Family First Coronavirus Response Act, which provides an array of new resources, programs, and flexibilities to enhance our “all options on the table” approach to feeding kids and helping families. We understand you are all eager to take advantage of these tools to help the people of your state.

Even before the law was enacted, the Food and Nutrition Service (FNS) began developing guidance and templates to facilitate rapid approval and implementation of the law. Beginning yesterday, today, and in those ahead, we expect to release these through our usual means, including posting on www.fns.usda.gov/coronavirus and through our “Partnerweb” site. The agency is also conducting webinars and information sessions with state program staff – the first with SNAP staff later today. You will hear from your usual FNS regional office program contacts on additional sessions as they are scheduled.

We understand the urgency of your need for information and answers. Rest assured that getting this information to you as rapidly as possible is our highest priority. Please stay in touch with your regional office contacts, and raise your questions or issues as they emerge, so we can work to address them as promptly as we can.

Thanks for your patience and diligence as we work together to “Do Right, and Feed Everyone.”

A handwritten signature in blue ink, appearing to read "Brandon Lipps".

Brandon Lipps
Deputy Under Secretary
Food, Nutrition, and Consumer Services



Families First Coronavirus Response Act/H.R. 6201

Signed into law March 18, 2020, the *Families First Coronavirus Response Act* requires public agencies, (federal/state governments, political subdivisions, schools) of any size and private employers with fewer than 500 employees to provide job-protected leave for qualifying needs related to a public health emergency under the *Family and Medical Leave Act* and paid sick leave under the *Emergency Paid Sick Leave Act* to eligible employees affected by the COVID-19 pandemic. Provisions of the Act, *Emergency Family and Medical Leave Act* and *Emergency Paid Sick Leave Act*, go into effect April 2, 2020, through December 31, 2020.

Emergency Family and Medical Leave Expansion Act

Effective Date: April 2, 2020, through December 31, 2020

Covered Employer: Public agencies (federal/state governments, political subdivisions, schools) of any size and private employers with fewer than 500 employees.

Eligible Employee: Any full-time or part-time employee that has been on the employer's payroll for **30 calendar days**. The Act permits employers to exclude health care providers and emergency responders from this emergency FMLA entitlement.

Emergency FMLA Entitlement:

Eligible employees are entitled to take up to twelve (12) weeks of Emergency FMLA leave for "a qualifying need related to a public health emergency."

Eligibility is limited to circumstances where an employee is unable to work (or telework) to care for a minor child if the child's school or place of child care has been closed or is unavailable due to a public health emergency.

- Eligible employees shall be granted unpaid leave or may take available accrued sick or annual leave during the first ten (10) days of leave.
- The remaining ten (10) weeks are paid at not less than 2/3 of the employee's regular rate of pay for the number of hours the employee would otherwise be scheduled to work. The maximum payment is \$200 a day and a \$10,000 total.
- For employees with variable hours each week, paid leave would be equal to the average number of hours worked per day over the previous six months.
- An eligible employee is entitled to twelve (12) weeks of Emergency FMLA leave.
- Emergency FMLA leave is job-protected, and the employer would restore an employee to the same or equivalent position upon their return to work.



Emergency Paid Sick Leave Act

Effective Date: April 2, 2020, through December 31, 2020

Covered Employer: Public agencies (federal/state governments, political subdivisions, schools) of any size and private employers with fewer than 500 employees.

Eligible Employee: Any full-time or part-time employee is immediately eligible for paid sick leave. Unlike the emergency FMLA requirements, there is no 30-calendar day employment requirement. The Act permits employers to exclude health care providers and emergency responders from this emergency entitlement.

Emergency Paid Sick Leave Entitlement:

Full-time employees who are unable to work or telework are eligible for up to eighty (80) hours of paid sick leave at their regular rate of pay because:

- The employee is subject to federal, state or local quarantine or isolation order related to COVID- 19
- The employee has been advised by a health care provider to self-quarantine because of COVID-19
- The employee is experiencing symptoms of COVID-19 and is seeking a medical diagnosis

Full-time employees who are unable to work or telework are eligible for up to eighty (80) hours of paid sick leave at two-thirds (2/3) of the employee's regular rate or minimum wage, whichever is greater when caring for an immediate family member because:

- The employee is caring for an individual subject or advised to quarantine or isolation
- The employee is caring for a son or daughter whose school or place of care is closed, or child care provider is unavailable, due to COVID-19 precautions
- The employee is experiencing substantially similar conditions as specified by the Secretary of Department of Health and Human Services.

Part-time employees: Part-time employees are eligible to take the number of hours they would normally work during a two-week period.

**The law limits paid leave to \$511 per day (\$5,110 in total) where leave is taken for an employee's own illness or quarantine; and \$200 per day (\$2,000 in total) where leave is taken for reasons to care for others or school closures.



Employers should also note that they cannot:

- Require an employee to use other paid leave before using the paid sick time provided in the new legislation.
- Require an employee to find a replacement to cover his or her scheduled work hours.
- Retaliate against any employee who takes leave in accordance with the Act.
- Retaliate against an employee who files a complaint or participates in a proceeding related to the Act—including a proceeding that seeks to enforce the Act.



*Sherri A. Reed,
Administrator*

*West Virginia Department of Veterans Assistance
West Virginia Veterans Nursing Facility
One Freedoms Way
Clarksburg, WV 26301
(304) 626-1600*

March 10, 2020

To Our Residents and Family Members:

We know some of you may be concerned about the spread of COVID-19 (the new coronavirus) being reported in the media and how it may impact us here at the West Virginia Veterans Nursing Facility. Ensuring residents are cared for in a safe and healthy environment is our greatest concern. At this time, we don't have any cases in our nursing facility. The Centers for Disease Control and Prevention (CDC) have recommended a variety of steps that we are implementing to help reduce the potential for the virus to enter our building. However, we need your help in battling COVID-19. Below are some examples of how you can help protect the residents, as well as prevent the spread throughout the community.

At this time, we request that you do not visit the facility if you have any symptoms of respiratory illness. Those symptoms include cough, fever, sore throat, runny nose, and/or shortness of breath. We understand that connecting with family members is incredibly important, and there are a variety of other ways you might consider connecting with them. These may include telephone, email, text, or through Skype or Facebook.

Our facility is following the recommendations of the CDC on prevention steps, including following strict handwashing procedures, and in many circumstances, wearing gowns and gloves when interacting with residents who are sick. We also are staying up-to-date with the CDC recommendations as they are updated. In addition, our nursing facility is in close contact with the local and state health department and are following their guidance. We are posting signs on our entryway doors to notify visitors of the symptoms of COVID-19 and request that you not enter the building if you are experiencing these symptoms.

We will notify you if any residents or staff are diagnosed with COVID-19. Should you have any questions, please feel free to contact us at the above address/phone number.

For additional information, please visit the CDC's coronavirus disease information page.

Sincerely,

A handwritten signature in blue ink that reads "Sherri A. Reed".

Sherri A. Reed, Administrator



Food and Nutrition Service
March 19, 2020

Mid-Atlantic Region
Dear Colleagues,

300 Corporate Blvd
Robbinsville, NJ
08691-1598

Last night the President signed HR 6201: Families First Coronavirus Response Act. I recognize States will be eager to take advantage of the range of flexibilities in the bill and contribute to our approach to feeding kids and helping families.

The U.S. Department of Agriculture intends to use all available program flexibilities and contingencies to serve our program participants across our 15 nutrition assistance programs while addressing COVID-19. Toward that end, the Food and Nutrition Service (FNS) has already begun to issue waivers to ease program operations.

I want to share that FNS will be rolling out templates to help reduce the burden and increase the speed at which waivers and polices can be approved for implementation. These templates and other guidance materials will be provided through our existing structures in the respective programs area. FNS is also conducting webinars and information sessions with state program staff providing information on the processes to be used.

I appreciate all that you are doing during this critical time; I want to personally assure you that I, and my staff of the USDA FNS Mid-Atlantic Regional Office, stand ready to do everything we can to support your efforts.

If you have any questions or concerns, please feel free to contact me at any time; my cell is 908.489.6380.

Sincerely,

A handwritten signature in cursive script that reads "Patricia N. Dombroski".

Patricia N. Dombroski
Administrator
Mid-Atlantic Region



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Office of the General Counsel

Bill J. Crouch
Cabinet Secretary

April L. Robertson
General Counsel

July 29, 2020

Derek Kravitz, Senior Associate
Quinlan
1901 North Fort Myer Drive, Suite 1021
Arlington, Virginia 22209
derek@quinlan.io

Dear Mr. Kravitz:

On March 30, 2020, the Department of Health and Human Resources received via email your request, pursuant to the Freedom of Information Act ("FOIA"), W. Va. Code §29B-1-1, *et seq.*, requesting a copy of the following documents be provided: email correspondence, and underlying documentation contained within, between Jan. 1, 2020, and March 31, 2020, that was sent to, from, or copied to Bill J. Crouch, containing any of the following non-case sensitive key-strings:

- "2019-nCoV"
- "coronavirus"
- "COVID-19"
- "COVID"

Attached are the public records in our custody that are within the scope of your request and not otherwise exempt from disclosure under FOIA. Please note that a portion of documents were withheld pursuant to W. Va. Code §29B-1-4(a)(2) and W. Va. Code §29B-1-4(a)(8). The responsibilities of this office with respect to your request are now at an end. You are advised that FOIA affords you the opportunity to seek injunctive or declaratory relief in the Circuit Court of Kanawha County.

Sincerely,

Debra Garnes for

Daron A. Light
Assistant General Counsel

DAL/dgg



Fraud Advisory

FOR IMMEDIATE RELEASE
March 19, 2020

<https://oig.ssa.gov>

Inspector General Warns Public About New Social Security Benefit Suspension Scam

The Inspector General of Social Security, Gail S. Ennis, is warning the public about fraudulent letters threatening suspension of Social Security benefits due to COVID-19 or coronavirus-related office closures. The Social Security Administration (SSA) will not suspend or discontinue benefits because their offices are closed.

The Social Security Office of the Inspector General has received reports that Social Security beneficiaries have received letters through the U.S. Mail stating their payments will be suspended or discontinued unless they call a phone number referenced in the letter. Scammers may then mislead beneficiaries into providing personal information or payment via retail gift cards, wire transfers, internet currency, or by mailing cash, to maintain regular benefit payments during this period of COVID-19 office closures.

As of Tuesday, March 17, 2020, local SSA offices are closed to the public due to COVID-19 concerns; however, Social Security employees continue to work. Social Security will not suspend or decrease Social Security benefit payments or Supplemental Security Income payments due to the current COVID-19 pandemic. Any communication you receive that says SSA will do so is a scam, whether you receive it by letter, text, email, or phone call.

Social Security will never:

- threaten you with benefit suspension, arrest, or other legal action unless you pay a fine or fee;
- promise a benefit increase or other assistance in exchange for payment;
- require payment by retail gift card, cash, wire transfer, internet currency, or prepaid debit card;
- demand secrecy from you in handling a Social Security-related problem; or
- send official letters or reports containing personally identifiable information via email.

If you receive a letter, text, call or email that you believe to be suspicious, about an alleged problem with your Social Security number, account, or payments, hang up or do not respond. We encourage you to report Social Security scams using our dedicated online form, at <https://oig.ssa.gov>. Please share this information with your friends and family, to help spread awareness about Social Security scams.

For more information, please visit <https://oig.ssa.gov/scam>. Members of the press may make inquiries to Social Security OIG at oig.dcom@ssa.gov.



March 17, 2020

The Honorable Jim Justice
Office of the Governor
State of West Virginia
State Capitol Complex, Building 1
Charleston, WV 25305

Dear Governor Justice,

The West Virginia EMS Coalition represents ambulance agencies, paramedics and EMTs throughout the Mountain State. We greatly appreciate the leadership your administration has provided as we face this unprecedented crisis involving COVID-19. As the situation continues to develop, new challenges are being identified daily that could not have previously been foreseen.

The membership of West Virginia EMS Coalition has recognized several opportunities where additional guidance and direction from the state could jointly benefit EMS agencies, dispatch centers, health care entities and the general public. Below is a summary of some the issues that we have identified

- Standardized screening processes at county 911 centers and improved communication with EMS.
- Clarification on the access points for care for those experiencing non-emergent symptoms of COVID-19.
- EMS Agencies and their personnel must maintain a high priority for essential COVID-19 medical supplies; N95 Masks and other Personal Protective Equipment. The state should also consider providing guidance, that includes local flexibility, to ensure availability PPE during all stages of the crisis,
- Suspension of local dispatch policies the increase the opportunity for non-transporting first responders to be exposed to the virus.

Each of these bullets is expanded upon in greater detail in the attached pages. As you consider these matters, the EMS community would welcome to chance to actively participate in discussions aimed at solving these and other challenges that will be identified in the coming days and weeks.

Please do not hesitate to contact me if our organization or membership can serve as a resource to your response team.

Sincerely,

A handwritten signature in black ink, appearing to read 'Chris Hall', is positioned above a vertical line that separates it from the typed name below.

Chris Hall, Executive Director
West Virginia EMS Coalition

304-544-9733 (mobile)

CC: Mike Hall, Chief of Staff, Office of the Governor
Brian Abraham, General Counsel, Office of the Governor
Bill Crouch, Secretary, Department of Health and Human Resources
Dr. Cathy Slep, Commissioner of the Bureau of Public Health
Dr. Michael Mills, State Medical Director, Office of EMS
Jeff Sandy, Secretary, Department of Military Affairs and Public Safety
General James Hoyer, West Virginia National Guard
Kenneth Tyree, West Virginia State Fire Marshal

Unified Screening Procedures and Protocols at 911 Centers

The Centers for Disease Control and Prevention has issued interim guidance for Emergency Medical Services Systems and 911 Public Safety Answering Points (PSAPs) for COVID-19 in the United States. This guidance states:

“PSAPs or Emergency Medical Dispatch (EMD) centers (as appropriate) should question callers and determine the possibility that a call concerns a person who may have signs or symptoms and risk factors for COVID-19. The query process should never supersede the provision of pre-arrival instructions to the caller when immediate lifesaving interventions (e.g., CPR or the Heimlich maneuver) are indicated. Patients in the United States who meet the appropriate criteria should be evaluated and transported as a person under investigation (PUI). Information on COVID-19 will be updated as the public health response proceeds.

Information on a possible PUI should be communicated immediately to EMS clinicians before arrival on scene in order to allow use of appropriate personal protective equipment (PPE). PSAPs should utilize medical dispatch procedures that are coordinated with their EMS medical director and with the local or state public health department.”

At this time, West Virginia’s 911 centers have not implemented uniform standards for patient screening and appropriate pre-arrival communication with emergency medical service providers. While some centers are appropriately screening 911 calls, many are not.

This is creating a number of potential problems:

- EMS personnel are not properly prepared to exercise appropriate precautionary measures when responding to a patient. While ideally EMS personnel would utilize personal protective equipment (PPE) on every call, it is not currently practical given the shortage of supplies.
- Absent appropriate pre-dispatch/arrival screenings, already limited EMS resources will be overly strained in response to the public’s concerns about COVID-19. Inappropriate utilization of ambulances and 911 by the public has been a long-standing problem in West Virginia. As public panic increases, appropriate screening measures will be increasingly important. A fever or flu like symptoms does not always necessitate ambulance transportation absent additional complicating factors.

- Ambulance agencies and personnel are caring for other patients besides COVID-19. Many of these patients are in high-risk categories. Failure to properly screen 911 callers and communicate appropriately with EMS personnel puts both EMS responders at risk but also increases the risk of exposure of these other high-risk patients.
- Every reasonable precaution must be taken to prevent exposure for EMS personnel and other first responders. Many of our rural counties have a small number of ambulance units and lack adequate staffing. A 14-day quarantine of EMS personnel and those they have contact with could wipeout the availability of emergency medical services in those areas for an extended period of time at height of the COVID-19 crisis. Appropriate screening and dispatch must be implemented for the safety of all West Virginians.

Clarification on the process for individuals to access testing and care when symptoms occur

The public and health care providers need clearer guidance from the state on how to proceed if individuals are experiencing symptoms.

EMS providers are receiving reports of patients being frustrated by a circular referral pattern when experiencing symptoms of COVID-19. Doctors' offices are instructing patients to call local health departments. Local health departments are telling patients to call their physicians.

Individuals are experiencing frustration as they receive this circular guidance. And it is leading to attempts to secure non-emergent health services through inappropriate channels such as calls to 911. As the volume of cases rises, this will create strain on the EMS system and draw resources away from true medical emergencies.

Shortages of Personal Protective Equipment (PPE) and well-intentioned prevention policies are creating increased risks when the outbreak hits West Virginia

West Virginia needs increased coordination among public health officials, emergency medical services agencies and other health facilities in developing guidance for the availability and appropriate use of masks and other PPEs.

While we are in the early stages of this public health crisis, there is already a shortage of PPE. Prior to the crisis' arrival in the United States, ambulance agencies faced backorders of masks starting in early November.

Out of an abundance of caution, some health care facilities with high-risk patients, such as nursing homes and dialysis centers, are requiring all EMS personnel entering their facilities to wear masks. While these types of policies appear wise on the surface, they are forcing EMS providers to utilize their already scarce supply of PPE without any evidence of exposure.

We are concerned the supply of PPE is being exhausted during the early stages and EMS and other health care workers will be unable to protect themselves when the virus reaches its peak. EMS Agencies and their personnel must maintain a high priority for essential COVID-19 medical supplies; N95 Masks and other Personal Protective Equipment. It is vital for EMS to carry out its mission during this unprecedented situation.

Some 911 Centers continue to dispatch non-transporting Fire Department First Responders on all calls

In some parts of the state, non-transporting fire department first responders are dispatched on all calls. While under normal circumstances this policy may be advantageous to the community, there is likely a public health and safety benefit to suspending this policy. Dispatching non-transporting first responders to every call creates unnecessary exposure risk for firefighters that could impede their ability to be available for other emergency responses such as fires.

We are aware that some counties have already taken already steps to temporarily suspend the dispatch of fire department first responders on all calls. However, this policy has not been adopted statewide.



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Andy Beshear
Governor

275 East Main Street, 5E-A
Frankfort, KY 40621
(502) 564-2888
Fax: (502) 564-6546
<https://chfs.ky.gov/agencies/os/oig>

Eric C. Friedlander
Acting Secretary

Adam Mather
Inspector General

**Novel Coronavirus (COVID-19) Guidance for
Long-Term Care Facilities (LTCF) Regarding Visitation
March 10th 2020, 9:00AM**

- On March 4, 2020, the Centers for Medicare and Medicaid Services issued guidance recommending that nursing facilities screen visitors and staff for symptoms of respiratory infection, international travel to restricted countries, and contact with anyone who has or is suspected to have COVID-19. Link to the CMS guidance: <https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/qso-20-14-nh.pdf>
- In addition to the recent recommendations from CMS, the Cabinet for Health and Family Services, Department for Public Health pursuant to authority granted in KRS 214.020 and Executive Order 2020-215 hereby issues this supplemental guidance by recommending that long-term care facilities limit visitation only to those loved ones that are **receiving end-of-life care**:

For visitors, this applies to:

- Visitors must have their temperatures taken at the facility's front desk before entry to the facility can be granted.
- Visitors with no fever, below 100 degrees Fahrenheit, are to be escorted by facility staff both to the patient's room and from the patient's room when the visitor is ready to leave.
- At no time is the visitor to be out of the room unescorted.
- Visitors with a temperature reading of 100.1 degrees Fahrenheit and above should not be granted entry to the facility and should be advised to seek medical attention if the visitor:
 - Shows additional signs or symptoms of respiratory infection such as cough and sore throat;
 - Has recently traveled internationally to restricted countries; or
 - Has had contact with someone with or under investigation for COVID-19.

If a visitor is denied entry to visit a loved one, the Cabinet further recommends that facilities should have phones available for patients to speak with visitors.

This guidance has been provided in consultation and agreement with the Department for Public Health. For questions regarding infection control, transmission-based precautions, and use of personal protective equipment, please call the Healthcare-Associated Infection/Antibiotic Resistance Prevention Program:

- Andrea Flinchum (502) 564-3261 ext. 4248
- Michael Curran (502) 564-3261 ext. 4249
- Chad Eldridge (502) 564-3261 ext. 4251

For the most up-to-date information, visit the following sites: CDC General COVID-19 site www.cdc.gov/covid19 Detailed information specific to long term care <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html> | KDPH - www.KYCOVID19.ky.gov



Supreme Court of Appeals State of West Virginia

News

Administrative Office
1900 Kanawha Blvd., East
Bldg. 1, Room, E-316
Charleston, West Virginia 25305
(304) 340-2305 Jennifer Bundy
(304) 340-2306 April Harless
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West Virginia Supreme Court Declares Judicial Emergency to Reduce In-Person Proceedings

For immediate release Sunday, March 22, 2020

CHARLESTON, W.Va. – In order to further limit potential exposure of the COVID-19 virus to litigants, jurors, attorneys, witnesses and the general public, the West Virginia Supreme Court of Appeals has issued an Administrative Order declaring a Judicial Emergency from March 23, 2020, through April 10, 2020, in all fifty-five (55) counties throughout West Virginia.

“Medical experts have consistently advised that in-person contact should be eliminated in all instances where such limitation is possible. We believe it is our responsibility to limit such in-person contact to the fullest extent possible while ensuring that our courts address emergency matters necessary to protect the health or safety of our individual citizens and our communities,” Chief Justice Tim Armstead said.

The Administrative Order was developed with input and recommendations of the justices of the Supreme Court of Appeals as well as circuit judges, family court judges and magistrates from throughout the state.

Under the March 22, 2020, order declaring a Judicial Emergency, the following changes become effective on March 23, 2020, and remain effective through April 10, 2020:

- Emergency proceedings required to protect the immediate health or safety of a party or the community will still be held, preferably by video conferencing or telephone where appropriate, and will not be delayed or extended. These emergency matters are those relating to:
 - Domestic violence;
 - Child abuse and neglect upon initial removal of a child or where there is an imminent threat to the health or safety of a child;
 - Infant guardianship;
 - Physical custody cases involving an imminent threat to the health or safety of a child;
 - Juvenile detention or placement in state custody;
 - Criminal initial appearances;
 - Bond hearings;

- Search warrants;
 - Criminal preliminary hearings;
 - Mental hygiene; and
 - Matters initiated by public health officials to enforce orders related to the COVID-19 crisis.
-
- All proceedings directed to take place and all acts required to be done during the emergency period of March 23, 2020, through April 10, 2020, are stayed and will be rescheduled to a date subsequent to April 10, 2020, by the presiding judicial officer.
 - Deadlines set forth in court rules, statutes, ordinances, administrative rules or otherwise that are set to expire during the period of March 23, 2020, through April 10, 2020, are extended to April 11, 2020. Deadlines relating to the emergency matters set forth above will remain in effect.
 - Only those deadlines, statutes of limitations, and statutes of repose **that are set to expire** during the period from March 23, 2020, through April 10, 2020, will be extended to April 11, 2020.
 - To the extent use of technology such as video conferencing and telephonic proceedings does not impermissibly infringe upon the Constitutional rights of a party or litigant, such resources should be used in the emergency matters to eliminate the need for in-person hearings or proceedings.

The Supreme Court is continually monitoring developments related to the COVID-19 outbreak and will assess the need to modify or extend the Judicial Emergency Order as circumstances warrant.

##

ADMINISTRATIVE ORDER

SUPREME COURT OF APPEALS OF WEST VIRGINIA

RE: JUDICIAL EMERGENCY DECLARED

WHEREAS, Article 8, Section 3 of the Constitution of West Virginia grants the Supreme Court of Appeals of West Virginia constitutional supervisory power over the circuit courts, family courts, and magistrate courts in West Virginia;

WHEREAS, Article 3, Section 17 of the Constitution of West Virginia requires that the courts of this state shall be open, and every person, for any injury done to him, in his person, property or reputation, shall have remedy by due course of law; and justice shall be administered without sale, denial or delay;

WHEREAS, the current COVID-19 crisis creates an unprecedented public health emergency that requires immediate action to encourage effective social distancing and reduce the need for people to leave their homes to protect the health and safety of the citizens of West Virginia; and

WHEREAS, the Supreme Court of Appeals of West Virginia desires to balance public health with the constitutional mandate that our courts continue to function for our citizens,

WHEREAS, W. Va. Code § 2-2-2 authorizes the Chief Justice of the Supreme Court of Appeals of West Virginia to declare an emergency in situations where conditions prevent the general transactions of court business;

THEREFORE, it is ORDERED that in order to protect the health and well-being of court employees, litigants, witnesses, jurors, attorneys, and the general public, a judicial emergency is declared for the day(s) of March 23, 2020, through April 10, 2020, in all fifty-five (55) counties in West Virginia. Pursuant to W. Va. Code §2-2-2(a), all proceedings and court deadlines, except the emergency proceedings described herein, directed to take place or any act required to be done on any day falling within this period of judicial emergency, are stayed. All jury trials are stayed during this period of judicial emergency. Deadlines set forth in court rules, statutes, ordinances, administrative rules, scheduling orders, or otherwise that are set to expire between March 23, 2020, and April 10, 2020, are hereby extended to April 11, 2020. Statutes of limitations and statutes of repose that would otherwise expire during the period between March 23, 2020, and April 10, 2020, are hereby extended to April 11, 2020. Deadlines, statutes of limitations, and statutes of repose that are not set to expire between March 23, 2020, and April 10, 2020, are not extended or tolled by this Order. Proceedings previously scheduled between March 23, 2020, and April 10, 2020, are continued until a later date determined by the presiding judicial officer. The Court may extend this order in the event the public health crisis continues.

It is further ORDERED that very limited emergency proceedings that are required to protect the immediate health or safety of a party or the community, specifically, domestic violence; child abuse and neglect only upon the initial removal or where there is an imminent threat to the health or safety of a child; infant guardianship; physical custody cases involving an imminent threat to the health or safety of a child; juvenile detention or placement in state custody; criminal initial appearances, bond hearings, search warrants, and criminal preliminary hearings; mental

hygiene; and matters initiated by public health officials to enforce orders related to the COVID-19 crisis are not limited by this Order, and applicable deadlines and time limits remain in effect. Magistrates may conduct those proceedings expressly required by Rule 1(b) of the Administrative Rules for the Magistrate Courts of West Virginia. Consistent with the Court's prior March 16, 2020, Administrative Order, these proceedings should utilize available technology to limit person-to-person contact whenever possible. To the extent they do not impermissibly infringe upon the constitutional rights of a party or litigant, any West Virginia state or local rules, including but not limited to criminal rules, civil rules, or administrative rules, that limit or preclude a judicial officer or court clerk's ability to utilize remote, telephonic or video technology to limit in-person contact, are suspended.

It is further ORDERED that it is the responsibility of each Chief Circuit Judge and each Chief Family Court Judge to notify the employees of all offices under their supervision of the content of this Order. Each judicial officer shall ensure that these functions are carried out remotely to the greatest extent possible to reduce the number of employees in a courthouse at any given time. The Chief Circuit Judge and the Chief Family Court Judge in every circuit shall prepare a schedule appointing at least one circuit judge and one family court judge to be on-call and available during regular business hours and shall develop a plan to ensure the public's continued access to the judicial system. The Chief Circuit Judge shall provide a copy of this schedule and communication plan to the Administrative Director of the Supreme Court of Appeals of West Virginia. The Circuit Clerk Office and Magistrate Clerk Office shall remain staffed with sufficient personnel to carry out the authorized functions, but in all counties, at least one person must answer telephone calls during regular business hours.

It is further ORDERED that this ORDER supersedes any local administrative order issued by a judicial official.

The Clerk of Court is hereby directed to distribute copies of this Administrative Order by appropriate means to all circuit judges, family court judges, and magistrates.

ENTERED: March 22, 2020



Tim Armstead, Chief Justice



Edythe Nash Gaiser, Clerk of Court

March 5, 2020

Dear Patient, Resident and Family Members,

Since the outbreak began in China, our senior management team, clinical leadership and Chief Medical Officer have been meeting regularly to address current concerns about an outbreak of the Coronavirus (COVID-19) in the United States, and the possibility of this impacting our Center. Our regional and center leaders are currently receiving regular updates on the latest admission screening guidelines and infection control protocols. Everything we are doing is in collaboration with the Centers for Disease Control and Prevention (CDC) and the Departments of Public Health.

While we are not in a current outbreak area, we are currently enhancing patient and visitor screening and precautions, based on recommendations from the Society for Post-Acute and Long-Term Care Medicine. If you meet ANY of the following criteria, you may NOT visit until your symptoms have resolved or you are cleared to do so.

- Fever
- Cough
- Shortness of Breath
- A known exposure to someone with COVID-19, or
- Traveled in the last 14 days to countries with widespread transmission and subject to a CDC Level 3 Travel Health Notice:

(<https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>)

We will be asking all visitors to sign a form to attest that they are not currently experiencing any symptoms. In the interest of protecting your loved one and other residents, patients and staff, if you meet any of the criteria above, we cannot permit entry until your symptoms have resolved.

If anything changes in our community, we will promptly advise of any modifications to our policies.

Finally, we would like to re-confirm emergency contact information for all of our patients and residents. Please call us at (304-949-2000) at your convenience so we can update our records.

Thank you for your support and cooperation.

Regards

Trista Hamrick

Trista Hamrick - CED
Center Executive Director

MEMORANDUM

March 18, 2020

To: Governors' Offices
From: Bill McBride, Executive Director
Re: Gubernatorial Actions to Support Medical Surge Capacity

The coronavirus and COVID-19 are spreading across the United States and experts predict significant disruption to the U.S. health care system. With hospitals typically operating at or near 100 percent capacity – particularly during flu season – the availability of facilities, equipment, personnel, and supplies can be limited. Federal- and state-level declarations of emergency provide governors a broad range of authorities to assist the health care system in meeting the surge in demand. The following are a selection of actions that may be within a governor's authority in various instances and settings.

Facilities: On their own recognition, some hospitals and health care facilities may create additional surge capacity for the increased patient load. They may do this in several ways, including: the early discharge of hospitalized patients who are close to being completely well; the diversion of patients away from overwhelmed facilities; the postponement of elective and non-emergency medical procedures; and the utilization of alternate care facilities. Governors can support these efforts in several ways. Reviews of literature, law, and best practice provide the following options:

- **Promote the availability and utilization of in-home care and telehealth options.** For example, states can consider covering the full continuum of COVID-19 testing and care, including phone consultation, and ensure that Medicaid reimburses for telehealth services statewide, and not just in rural or underserved areas. Call centers may be able to perform front-line triage responsibilities and keep the “worried well” out of inundated facilities.
- **Consider revising regulations** that may limit the functionality and availability of health care facilities, including free-standing emergency care facilities, school-based health centers, retail health clinics, and assisted living residences. This may include: expediting application and code compliance reviews, as well as site surveys; increasing the number of licensed or staffed beds allowed in health care organizations; increasing provider-to-patient ratios and other standards of care parameters¹.
- **Encourage cooperation between hospitals and other health care facilities**, even if they are business competitors. Governors can also promote data-sharing agreements, MOUs, and other collaborative activities to maximize the availability of treatment. They may also consider modifying statutes that govern access to and disclosure of protected medical information.
- **Encourage hospitals to postpone elective procedures** that require short supply resources like ventilators, ICU beds, and other high intensity beds.

Personnel: Research, as well as previous experience, reveals that the health care workforce will be significantly impacted during a pandemic. Exposure to infectious patients, lack of personal

¹ United States Department of Health and Human Services. (n.d.). The Role of the State in MSCC. Retrieved from <https://www.phe.gov/Preparedness/planning/mscc/handbook/chapter5/Pages/therole.aspx>

protective equipment, and the stress of long hours and intense activity make health care workers vulnerable to disease. Even if they are properly protected with vaccines or antiviral medications (neither of which are currently available for COVID-19), their family members may fall ill and require care at home. Efforts should focus on keeping health care workers healthy and on the job, as well as recruiting additional staff to meet surging need. Governors options include:

- **Confirm [liability protection for health care workers](#).** Liability protections ensure that health care workers, volunteers, and public servants are willing and able to participate in response activities.
- **Adjust professional licensure, permit, or fee requirements** for: state medical, nursing, or other health care providers; out-of-state medical, nursing, or other health care providers; pharmacists; and medical examiners.
- **Consider modifications to regulations or laws** regarding scope of practice, supervision requirements, and other similar measures to allow the maximum number of providers to provide the maximum amount of care, within reason. As an alternative to changing state laws, states can apply for a waiver or modification of Section 1135(b) of the Social Security Act, which can be authorized by the Secretary of Health and Human Services now that both a national emergency and public health emergency have been declared².
- **Encourage civilian participation in [volunteer programs](#).** Retired doctors, nurses, allied care professionals, and non-medical volunteers may have the ability to perform key functions across the health care system.

Non-Pharmaceutical Equipment and Supplies: As has already been realized, global demand for both durable and disposable medical equipment, including personal protective equipment (PPE), has increased. The commercial and governmental demands for such products have put immense stress on the supply chain. Although there has been intense public interest in masks and sanitizers, health care facilities, as well as government entities, are finding themselves competing for goggles, gloves, oxygen concentrators, tubing, ventilators, and other respiratory support equipment. Hoarding may further deplete stockpiles. Governors support for the production and distribution of key supplies can include:

- **Encourage [group purchasing orders \(GPOs\)](#)** and other bulk acquisition mechanisms to optimize supply availability and pricing.
- **Engage non-profit entities to facilitate donations** from private sector partners.
- **Ensure delivery of supplies by assisting retailers with “[the last mile](#).”** Delivery drivers may not be qualified as “essential personnel” and unable to pass through checkpoints or perimeters at controlled facilities or quarantined areas. Promote collaboration with transportation and policing agencies.
- **Discourage waste, theft, hoarding, and price-gouging.** Clearly communicating with the public about appropriate purchase and use of high-demand supplies may decrease these behaviors.
- **Examine the feasibility of redirecting personal protection/infection control supplies** (e.g., masks, gowns, alcohol and hand gels) from general over-the-counter outlets (e.g., chain drug or big box stores) to clinical care during times of shortage.

² Centers for Medicare and Medicaid Services. (March 15 2019). *Additional Emergency and Disaster-Related Policies and Procedures That May Be Implemented Only With a § 1135 Waiver* (p. 6). Retrieved from <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf>

Vaccines, Antivirals, and Other Medicines: Lastly, while there is no vaccine or antiviral available for COVID-19 yet, these products are actively being researched and developed for broad public use. Prior to the release of an effective vaccine or antiviral, the WHO recommends that governments identify groups for priority immunization³. In 2005, the National Vaccine Advisory Committee and the Advisory Committee on Immunization Practices developed recommendations for vaccine prioritization during influenza pandemic. They recommended that health care workers with direct patient contact receive the first vaccinations, followed by those with the highest risk of complications from infection or specific vulnerabilities. These groups are identified through epidemiologic findings, and for the case of coronavirus, would likely include the elderly as well as those with pre-existing conditions. Pregnant women and the immunocompromised are next on the priority list, followed by key government leaders, critical infrastructure operators, and public health emergency responders⁴. Governors' options to assist the distribution and uptake of effective vaccine include:

- **Consider policies that improve vaccine accessibility**, including those that eliminate cost-sharing and administrative barriers, such as prior authorization. When vaccines are free or low-cost, they are more likely to be utilized.
- **Review mass prophylaxis plans with experts** and review what can be done to expedite dispensing. Governors can work with private sector partners and major employers to develop on-site [points of dispensing](#), similar to at-work flu vaccination programs.
- **Clearly communicate with the public about vaccine safety**. Governors should anticipate and combat vaccine misinformation, and guard against black-marketeering, false advertising, and knock-off products.

Overall, governors have many means to support the enhancement of medical surge capability. Emergency declarations often grant state executives additional powers and governors should examine what additional prerogatives they may be allowed. Efforts to support medical surge capability should be done in concert with other crisis management activities, including information sharing, public information and warning, mass fatality management, and medical countermeasure dispensing.

A detailed description of medical surge capability, as well as associated tasks, planning, and resource requirements, is available [here](#).

For questions or concerns related to the contents of this memo, please contact NGA staff:

- *Melinda Becker* (mbecker@nga.org; 202.624.5336)
- *Lauren Stienstra* (lstenstra@nga.org; 202.624.7872)

³ Lister, S. A. (2005). *Pandemic Influenza: Domestic Preparedness Efforts* (p. 23). Retrieved from <https://fas.org/sgp/crs/homsec/RL33145.pdf>

⁴ Lister, S. A. (2005). *Pandemic Influenza: Domestic Preparedness Efforts* (p. 24). Retrieved from <https://fas.org/sgp/crs/homsec/RL33145.pdf>



FAQ

Spartan® Novel Coronavirus (2019-nCoV)

Does the CDC publish a list of disinfectants that are effective against Novel Coronavirus?

The EPA has not established any efficacy protocols for surface disinfectants because 2019 Novel Coronavirus (2019-nCoV) is so new. That said, it is a Coronavirus based syndrome which is an enveloped virus and is considered to be easy to inactivate on non-porous surfaces. The scientific community believes, based on its knowledge of the structure of Coronaviruses, that when an EPA protocol is established the results will show that if your surface disinfectant is effective for other Coronavirus's, such as the Human Coronavirus, it will be effective against the 2019 Novel Coronavirus (2019- nCoV).

The following Spartan disinfectants have the Human Coronavirus claim and can be used to clean and disinfect surfaces:

- Super HDQ Neutral® (1204)
- HDQ Neutral® (1202)
- hdqC 2® (4702)
- Super HDQL 10® (4704)
- GS Neutral Disinfectant Cleaner® (3502)
- GS High Dilution Disinfectant® 256 (3508, 3516)
- TB-Cide Quat® (1017, 1021)
- BNC-15® (1056, 4856)
- Profect® Healthcare Disinfecting Wipes (1091)
- Hard Surface Disinfecting Wipes (1085, 1086, 1087)
- Halt® (1018, 4806)
- PSQ II (1035)

Does the CDC recommend electrostatic sprayers?

Electrostatic sprayers are one of many options that can be used to apply disinfectants to hard surfaces. Most disinfectants require pre-cleaning in order to decontaminate the surface prior to disinfection. Specific to 2019-nCoV cleaning, the CDC is recommending a multi-step cleaning process with pre-cleaning preceding disinfection and observing recommended dwell times and post dwell cleaning instructions.

Are there specific instructions for cleaning airports?

The same procedures for any public facility would apply to airports. The CDC recommendations for airline personnel can be found here: https://www.faa.gov/other_visit/aviation_industry/airline_operators/airline_safety/safos/all_safos/media/2020/SAFO20001.pdf

What is dwell time?

Dwell time is the required period of time that a surface must remain wet in order for a disinfectant to perform completely. Check the product label for dwell time requirements as this is specific to each product.

What is the difference between disinfection and decontamination?

According to the EPA, disinfection is 100% kill of named organisms on the disinfectant product label. Per OSHA's Bloodborne Pathogen Standard, decontamination means the use of physical or chemical means to remove, inactivate, or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

What is the mode of transmission for Novel Coronavirus?

The most common transmission of all Coronaviruses is airborne (sneezing and coughing). The second most common transmission is through close contact with an infected person (shaking hands, etc.). Coronavirus may possibly be transmitted by contacting a contaminated surface and then rubbing your eyes, ears, nose, or mouth.

What is the recommended duration for hand washing and sanitizing?

The CDC recommends that you lather your hands for at least 20 seconds before rinsing. With waterless sanitizers, it is recommended that hands remain wet with sanitizer product for at least 30 seconds.

How do you protect yourself when cleaning for Novel Coronavirus?

The CDC recommends adherence to Standard, Contact, and Airborne Precautions, Including the Use of Eye Protection. The specifics may be found here: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html>

Does UV disinfection work for Novel Coronavirus?

Currently this is an unresolved issue with EPA.

Is Novel Coronavirus the same as SARS?

According to the CDC: No. Coronaviruses are a large family of viruses, some causing illness in people and others that circulate among animals, including camels, cats and bats. The recently emerged 2019-nCoV is not the same as the coronavirus that causes Middle East Respiratory Syndrome (MERS) or the coronavirus that causes Severe Acute Respiratory Syndrome (SARS). However, genetic analyses suggest this virus emerged from a virus related to SARS. There are ongoing investigations to learn more. This is a rapidly evolving situation and information will be updated as it becomes available.

Is microfiber effective for Novel Coronavirus clean up?

Microfiber is effective for pre-cleaning steps, as well as disinfectant application. Over time, with repeated laundering microfiber will lose its charge and become less effective for cleaning.

Do you recommend spray or wiping disinfectants?

Wiping is a more appropriate way of cleaning for disinfection. Spraying can actually cause surface contamination to aerosolize. The bloodborne pathogen standard may apply and provides suggestions.

According to the Guidelines of Environmental infection control for cleaning up bloodborne pathogens. "A suggested technique when flooding the spill with germicide is to lay absorbent material down on the spill and apply sufficient germicide to thoroughly wet both the spill and the absorbent material."

What is a one-step disinfectant?

A one-step disinfectant has been verified by the EPA to be effective against named organisms in the presence of 5% blood serum solution. These products generally do not require pre-cleaning in order to disinfect a hard surface as long as dwell time is observed. However, related to Novel Coronavirus, the CDC is recommending a multi-step cleaning process including pre-cleaning prior to disinfection.

Does the FDA monograph allow manufacturers to provide efficacy guidance for hand washes and sanitizers?

No, hand washes and sanitizers are over the counter drugs regulated by the FDA. The FDA monograph specifies the type of active and level used. Regarding efficacy, hand cleaners do not follow the same guidelines that hard surface disinfectants and sanitizers are subjected to. In vitro efficacy testing may be done on antimicrobial hand cleaner formulas but may not be used to promote prevention of any specific disease or organism.



Spartan Chemical Company, Inc.
1110 Spartan Drive, Maumee, OH 43537
www.spartanchemical.com

SERVICE/TECHNICAL SUPPORT
1-800-537-8990

Novel Coronavirus (COVID-19) Guidance for Schools and Child Care Facilities

The Washington State Department of Health (DOH) has developed this guidance to assist schools and child care facilities with their response to 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, at this time we believe that those over 60, immune-compromised or those with chronic medical conditions may be at higher risk for severe illness from COVID-19. Schools and child care facilities have experience managing respiratory infections and outbreaks among residents and staff and should apply the same outbreak management principles to COVID-19. Additional resources on how schools and child care facilities can prepare for and manage COVID-19 can be found here:

<https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-for-schools.html>

Prepare:

- **Stay informed about the local COVID-19 situation.** Know where to turn for reliable, up-to-date information in your local community. Monitor the [CDC COVID-19 website](#) and your [state and local health department websites](#) for the latest information.
- **Develop, or review, your facility's emergency operations plan.** Ensure your facility has a plan that includes strategies to reduce the spread of disease and establishes mechanisms for ongoing communication with staff, students, volunteers, families, and the community. This should be done in collaboration with local health departments and other relevant partners.
- **Monitor and plan for absenteeism.** A COVID-19 outbreak in your community could lead to staff and student absenteeism. Prepare alternative staffing plans to ensure as many of your facility's staff are available as possible. See the Department of Health's [Resources for Workplaces and Employers](#) for more specific information.
- **Establish relationships with key healthcare and public health partners in your community.** Make sure you know about healthcare and public health emergency planning and response activities in your community, and establish open lines of communication with leadership in your [local health jurisdiction](#).
- **Build relations with key community organizations, partners, and trusted leaders within your community.** In the event of a closure, you may need to rely on community partnerships to help mitigate impacts to families.
- **Create an emergency contact list.** Develop and continuously update emergency contact lists for key partners and ensure the lists are accessible in key locations in your facility. For example, know how to reach your local or state health department in an emergency.
- **Develop a communications plan.** A key component to preparedness is developing a communications plan that outlines how you plan to reach different audiences including ensuring all communications are culturally and linguistically appropriate as well as accessible for individuals with disabilities.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.

Communicate:

- **Communicate about COVID-19 with your staff.** Share information about what is currently known about COVID-19 and your facility's preparedness plans. Communicate your expectations for modeling respiratory etiquette, staying home when sick, and supporting employees who need to take care of a sick
- **Communicate about COVID-19 with students and families.** Provide updates about changes to your policies or operations. Use all communication channels that you have available and including direct communications (face-to-face, letters), electronic communications (your district or facility's website or social media pages), as well as parent meetings to share updates. Make sure to plan ahead for linguistic needs, including providing interpreters and translating materials.
- **Intentionally and persistently combat stigma.** Misinformation about coronavirus and COVID-19 can create fear and hostility that hurts people and makes it harder to keep everyone healthy. We're stronger as a community when we stand together against discrimination. Take advantage of these [resources](#) to prevent, interrupt, and respond to stigma.

Prevent:

- **Encourage sick individuals to stay home.** Instruct all staff, students, families, and volunteers to self-screen at home. If students or staff become sick at school, keep sick individuals separate from well students and staff until they can leave. Ensure that your sick leave policies are flexible and consistent with public health guidance and that staff are aware of these policies.
 - If individuals have fever, cough or shortness of breath and have not been around anyone who has been diagnosed with COVID19, they should stay home away from others until 72 hours after the fever is gone and symptoms get better.
 - If an individual believes they have had close contact to someone with COVID-19 but are not currently sick, they should monitor their health for fever, cough, and shortness of breath during the 14 days after the last day they were in close contact with the sick person with COVID-19. They should not go to work or school, and should avoid public places for 14 days.
- **Post signs.** As part of routine measures for the respiratory season, existing [signs](#) should be visible that reminds staff, visitors, and students to perform hand hygiene, sneeze/cough into their elbow, put used tissues in a waste receptacle and to wash hands immediately after using tissues. Recommend everyone to avoid close greetings like hugs or handshakes.
- **Perform routine environmental cleaning.** Follow the school's routine cleaning and disinfection program. Emphasize cleaning and [disinfecting](#) frequently touched objects and surfaces. The Department of Health Website has additional information on [Classroom Cleaning Tips for Teachers](#).

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.

- **Emphasize normally recommended actions to prevent the spread of disease.** You can help students and staff reduce their risk for getting and spreading viral respiratory infections by encouraging them to take simple steps which will also prevent COVID-19. These include:
 - Frequent hand washing with soap and water for at least 20 seconds, especially after going to the bathroom, before eating, and after they blow their nose. Help young children do the same. If hands are visibly dirty, use soap and water to clean hands.
 - If soap and water are not readily available, using an alcohol-based hand sanitizer with at least 60% alcohol.
 - Advising persons to avoid touching their eyes, nose, and mouth with unwashed hands.
 - Covering coughs or sneezes with a tissue, then throwing the tissue in the trash and cleaning hands with soap and water or hand sanitizer (if soap and water are not readily available).
 - Providing adequate supplies for good hygiene, including clean and functional handwashing stations, soap, paper towels, and alcohol-based hand sanitizer.

Mitigate:

- **If there is an identified case of COVID-19 in your community, work in close collaboration and coordination with your leadership, local health officials, and other health care and public health partners in your community to make decisions regarding measures to reduce the spread of COVID-19.**
- **Implement social distancing measures.** If there are cases of COVID-19 in the community, consider using social distancing rather than closing facilities until there is evidence that a case is linked to the school or child care facility in some way. Examples of social distancing include staggering recess times or canceling assemblies, inter-school competitions, and sporting events.
- **Communicate about potential exposure to COVID-19.** It is critical to maintain confidentiality of the individual while working to address potential fear and anxiety of students and staff.
- **Determine if, when, and for how long it may be appropriate to dismiss school and child care programs.** In general, schools and child care facilities should only close if a student, staff member, or administrator has been diagnosed with a confirmed case of COVID-19.
 - Consider closing schools and child care facilities for 2 to 5 days and cooperate with local health officials in their investigation during this time. Seek guidance from local health officials about the need to lengthen facility closures or resuming normal operations.
 - It is not recommended to preemptively close schools or child care facilities for cleaning if there are no confirmed cases of COVID-19 associated with the facility.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.

- **Assess the impacts of any decisions you make on the families you serve.** There are equity implications for any decision you may make, and the families you work with will be able to provide you the best feedback on and guidance on how to move forward in a child- and family-centered way. Here are some considerations:
 - A. When communicating updates and decisions: Families within Washington state are culturally and linguistically diverse. Make sure you are proactively providing language assistance.
 - B. When considering alternative learning opportunities, including distance learning: Providing options for distance or remote learning may be a useful mitigation strategy, but efforts should be made to ensure that all students will have access to the materials, equipment and technology necessary to participate. Another important equity consideration is the impact requiring remote learning will have on families that don't have available caregivers or other adults to supervise children at home. A plan for remote learning may disproportionately impact and have unintended negative consequences for single parent households, low wage and hourly workers, and other lower income families.

Additional COVID-19 Resources

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Schools \(K-12\) and Child Care Programs Guidance](#), Centers for Disease Control and Prevention
- [Classroom Cleaning - Tips for Teachers](#), Washington State Department of Health
- [Handwashing to Prevent Illness at School](#), Washington State Department of Health
- [Infectious Disease Control Guide for School Staff \(PDF\)](#), Washington State Office of Superintendent of Public Instruction
- [Workplace and Employers](#), Washington State Department of Health
- [Stigma Reduction](#), Washington State Department of Health
- [How Can I Be Prepared for a COVID-19 Outbreak?](#)

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Novel Coronavirus (COVID-19) Guidance for Institutions of Higher Education

The Washington State Department of Health has developed this guidance to assist institutions of higher education with their response to the 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, at this time we believe that those over 60, immune-compromised or those with chronic medical conditions may be at higher risk for severe illness from COVID-19. Institutions of higher education have experience managing respiratory infections and outbreaks among students and staff and should apply the same outbreak management principles to COVID-19. Additional resources on how institutions of higher education can prepare for and manage COVID-19 can be found here:

<https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-ihe-response.html>

Prepare:

- **Stay informed about the local COVID-19 situation.** Know where to turn for reliable, up-to-date information in your local community. Monitor the [CDC COVID-19 website](#) and your [state and local health department websites](#) for the latest information.
- **Develop, or review, your campus' emergency operations plan.** Ensure your institution has a plan that includes strategies to reduce the spread of disease and establishes mechanisms for ongoing communication with staff, students, volunteers, and the community. This should be done in collaboration with local health departments and other relevant partners.
 - Consider including additional guidance related to congregate settings for students who depend on student housing and food services. Develop contingency plan for students who utilize dining hall services, including the potential for distribution of pre-packed goods.
- **Develop, or review, your institution's plan for individuals studying or working abroad.** Continue to monitor the [CDC's Travel Health Notices](#) and create a plan for supporting students and staff in affected areas. Consider plans for [restricting travel](#) to and from affected areas, recalling students and staff from affected areas, ensuring continuity of communications, and providing support for individuals returning to campus.
 - **Provide recommendations and up-to-date information for students who may consider traveling during school breaks.**
- **Monitor and plan for absenteeism.** A COVID-19 outbreak in your community could lead to staff and student absenteeism. Prepare alternative staffing plans to ensure as many of your facility's staff are available as possible. See the Department of Health's Guidance for [Workplaces and Employers](#) for more specific resources and information. Proactively provide alternatives for students who may need to miss classes due to quarantine or isolation activities to ensure their adherence to public health guidance and protocol

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does not impact their academic performance or opportunities. This may include options for distance learning, alternative exam dates, or other make-up options for missed coursework.

- **Establish relationships with key healthcare and public health partners in your community.** Make sure you know about healthcare and public health emergency planning and response activities in your community, and establish open lines of communication with leadership in your [local health jurisdiction](#).
- **Build relationships with key community organizations and partners who may be impacted by your campus' closure.**
- **Create an emergency contact list.** Develop and continuously update emergency contact lists for key partners and ensure the lists are accessible in key locations in your institution. For example, know how to reach your local or state health department in an emergency.
- **Develop a communications plan.** A key component to preparedness is developing a communications plan that outlines how you plan to reach different audiences including ensuring all communications are culturally and linguistically appropriate as well as accessible for individuals with disabilities.
- **Assess impacts to other services and on campus.** If your institution also operates a childcare facility, workforce center, health center, restaurant, religious services, and/or other social services, you will need to consider the impacts of an outbreak or closure on any individuals who are employed in these settings, or are customers, clients, patients, or utilizers of these services. See www.doh.wa.gov/coronavirus for more specific guidance.

Communicate:

- **Communicate about COVID-19 with your staff.** Share information about what is currently known about COVID-19 and your facility's preparedness plans. Communicate your expectations for modeling respiratory etiquette, staying home when sick, and supporting employees who need to take care of a sick person.
 - Consider the impact of disease on staff and students that may be at higher risk for adverse health complications. Inform employees that some people may be at higher risk for severe illness, such as those over 60, immune-compromised or those with chronic medical conditions. Plan to accommodate their work.
- **Communicate about COVID-19 with students and families.** Provide updates about changes to your policies or operations. Use all communication channels that you have available including your email, university/college news, website, letters, and social media to share updates. Make sure to plan ahead for linguistic needs of the student population.
- **Communication with the larger community and other impacted individuals.** Once you have assessed the impacts to other services within your institution (e.g. onsite childcare), make sure you develop a specific communication outreach plan to ensure the individuals most impacted by your decision or closure receive the information they

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need. Proactively identify and meet any needs for language assistance through the translation of materials or interpretation services.

- **Maintain up to date information on your institution's website regarding procedures for access health facilities on campus.** If a staff member or student believes they should seek medical evaluation for COVID-19, it is important to place them in a private room away from others and ask them to wear a face mask. If the student is seen in a student health services facility, ensure that they call the clinic prior to making the appointment. Make sure that the clinic is aware to immediately notify your LHJ if they think the student has COVID-19. Your LHJ will provide you with guidance.
- **Intentionally and persistently combat stigma.** Misinformation about coronavirus and COVID-19 can create fear and hostility that hurts people and makes it harder to keep everyone healthy. We're stronger as a community when we stand together against discrimination. Take advantage of these [resources](#) to prevent, interrupt, and respond to stigma.

Prevent:

- **Encourage sick students and staff to stay home and away from others.** Separate staff and students who become ill from others on campus. Send them home immediately. Ensure that your sick leave policies are flexible and consistent with public health guidance and that staff are aware of these policies.
 - If individuals have fever, cough or shortness of breath and have not been around anyone who has been diagnosed with COVID19, they should stay home away from others until 72 hours after the fever is gone and symptoms get better.
 - If an individual believes they have had close contact to someone with COVID-19 but are not currently sick, they should monitor their health for fever, cough, and shortness of breath during the 14 days after the last day they were in close contact with the sick person with COVID-19. They should not go to work or school, and should avoid public places for 14 days.
- **Perform routine environmental cleaning.** Follow the institution's routine cleaning and disinfection program. Emphasize cleaning and disinfecting of all frequently touched surfaces, such as workstations, computer labs, shared equipment, classroom furniture, countertops, handrails, and doorknobs. Clean and maintain sports and recreational equipment and facilities on a regular basis.
- **Post signs.** As part of routine measures for the respiratory season, existing [signs](#) should be visible that reminds staff, visitors, and students to perform hand hygiene, sneeze/cough into their elbow, put used tissues in a waste receptacle and to wash hands immediately after using tissues. Recommend everyone to avoid close greetings like hugs or handshakes. Ensure that all classrooms and common areas around campus are well stocked with appropriate hygiene materials, including appropriate hand sanitizer at all entrances.

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- **Emphasize normally recommended actions to prevent the spread of disease.** You can help students and staff reduce their risk for getting and spreading viral respiratory infections by encouraging them to take simple steps which will also prevent COVID-19. These include:
 - Frequent hand washing with soap and water for at least 20 seconds, especially after going to the bathroom, before eating, and after they blow their nose. If hands are visibly dirty, use soap and water to clean hands.
 - If soap and water are not readily available, using an alcohol-based hand sanitizer with at least 60% alcohol.
 - Advising persons to avoid touching their eyes, nose, and mouth with unwashed hands.
 - Covering coughs or sneezes with a tissue, then throwing the tissue in the trash and cleaning hands with soap and water or hand sanitizer (if soap and water are not readily available).
 - Providing adequate supplies for good hygiene, including clean and functional handwashing stations, soap, paper towels, and alcohol-based hand sanitizer.

Mitigate:

- **If there is an identified case of COVID-19 in your school, work in close collaboration and coordination with your leadership, local health officials, and other health care and public health partners in your community to make decisions regarding measures to reduce the spread of COVID-19.**
- **Implement social distancing measures.** If there are cases of COVID-19 in the community, consider using social distancing rather than closing facilities until there is evidence that a case is associated with your institution in some way. Examples of social distancing include staggering class times or canceling large conferences and sporting events.
- **Communicate about potential exposure to COVID-19.** It is critical to maintain confidentiality of the individual while working to address potential fear and anxiety of students and staff.
- **Determine if, when, and for how long it may be appropriate to dismiss classes.** In general, facilities should only close or cancel classes if a student, staff member, or administrator has been diagnosed with a confirmed case of COVID-19.
 - Consider closing cancelling classes or closing facilities for 2 to 5 days and cooperate with local health officials in their investigation during this time. Seek guidance from local health officials about the need to lengthen facility closures or resuming normal operations.
 - It is not recommended to preemptively close facilities for cleaning if there are no confirmed cases of COVID-19 associated with the facility.
- **Assess alternative learning opportunities, such as web-based instruction, to assure continuity of instruction.** It is important to use an equity lens when making these plans.

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It may make more sense to cancel classes all together rather than deploying an alternative model that can be accessed by some, but not all, of your students.

Additional COVID-19 Resources

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Resources for Higher Education Institutions](#)
- [Workplace and Employers](#)
- [Persons Who are at Higher Risk for Serious Illness](#)
- [Communities and Community Organizations](#)
- [Stigma Reduction](#)
- [How Can I Be Prepared for a COVID-19 Outbreak?](#)

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Checklist for County Governments – COVID-19 Response for Long-Term Care and Residential Facilities

Planning for pandemic events is critical for county governments. This checklist identifies prevention and mitigation strategies for county governments to consider when working with long-term care and residential facilities.

1. Know what long-term care and residential facilities are in your county

- Be familiar with the landscape of long-term care and residential facilities in your county. Example types of facilities include:
 - Assisted Living Facilities
 - Adult Family Home
 - Enhanced Service Facility
 - Supportive Living
 - Group Homes
 - Regulated (DOH) Residential Centers
 - Nursing facilities
 - Intermediate Care Facilities
 - Psychiatric Hospitals
 - Detention Centers
 - Shelters (serving unhoused individuals)
- Engage with facility managers and leaders to understand their emergency operations plans. Encourage facility managers and leaders to consider the following in their emergency operations plan:
 - Strategies to reduce the spread of disease and mechanisms for ongoing communication with staff, volunteers, and residents.
 - An understanding of the demographic profile of the community where their facility is located (including cultural and linguistic considerations, access needs, etc.). Ensure that the needs of these populations are addressed in the operation plan.
 - The make-up of the residents in the facilities, including how many residents are served, their ages, and other demographic factors.
 - How residents interact with the community when outside of the facility. This could be routine outings to events, schools, or grocery stores.
- Assign a county employee to maintain contact and situational awareness with long-term care and residential care facilities.

2. Develop a communications plan

- Ensure long-term care and residential facilities are registered or tied into your local emergency alert and notification systems.
- Provide public health information on your county website. Reference links to guidance documents available from local, state, and federal public health agencies. Ensure that you provide information in all languages needed for your community.
- Collaborate as need with facilities on talking points for local constituents. Intentionally and persistently combat stigma as a part of your communications. For more resources about addressing stigma, visit [DOH's Stigma Reduction Webpage](#)

3. What to do if a facility has a COVID-19 outbreak

- If the county is notified of a case of COVID-19 in a facility, disseminate information to county employees and coordinate with the local public health jurisdiction and the public information officer at the county emergency operations center (EOC), if applicable.
- Determine what services the county provides to the impacted long-term care or residential facility. Identify essential services and any impacts to those services.
- Work with local public health officials to evaluate potential exposure of county staff and healthcare workers. Notify local public health and relevant partners. Consider whether quarantine is necessary for exposed individuals.
- Consider whether a facility has the proper capacity to isolate or quarantine individuals. If not, determine an appropriate alternative, including transportation logistics
- Comply with any additional facility protocols and requirements for infection control when visiting or working in facilities.
- Ensure that county first responders and emergency personnel are made aware of necessary precautions before responding to a potentially impacted facility.
- Coordinate with local health coalitions/jurisdictions for resource requests from facilities. Use the appropriate channel via the county's EOC.
- Keep track of county employees who physically visit the facility. Instruct employees to keep track of who they may come in contact with. If you find out an employee potentially has come in contact with COVID-19, inform your local health jurisdiction and follow public health recommendations.
- County employees should not self-deploy to an impacted facility without closely coordinating with County EOC.

4. Additional preparedness measures for all county agencies

- Review, update, or develop plans for:
 - Continuity of Operations – essential and non-essential functions.
 - Infection control protocols (should be updated for COVID-19).
 - Infectious disease outbreak plans.
 - Emergency response plans.

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- Crisis communication plan.
- Formalize mutual aid agreements with community groups/resources, neighboring jurisdictions, and other relevant entities.
- Establish relationships with key healthcare and public health partners, key community organizations, and trusted leaders within your community.
- Know where to turn for reliable, up-to-date information in your local community and pass it along to your employees. Monitor the CDC COVID-19 [website](#) and your state and local health department [websites](#) for the latest information.
- Instruct staff to strictly adhere to Infection control practices. For those who use personal protective equipment (PPE) ensure they are trained and PPE is for appropriate usage.
- Identify essential county services that may be accomplished remotely.

Additional COVID-19 Resources

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Local Health Jurisdictions](#)
- [Workplace and Employers](#)
- [Persons Who are at Higher Risk for Serious Illness](#)
- [Communities and Community Organizations](#)
- [Stigma Reduction](#)
- [How Can I Be Prepared for a COVID-19 Outbreak?](#)

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Novel Coronavirus (COVID-19) Guidance for Long-Term Care Facilities

The Washington State Department of Health developed guidance to assist long term and residential care facilities in response to the 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, at this time we believe that those over 60, immune-compromised or those with chronic medical conditions may be at higher risk for severe illness from COVID-19. Long-term care facilities have experience managing respiratory infections and outbreaks among residents and staff and should apply the same outbreak management principles to COVID-19.

Additional resources on how long-term care facilities can prepare for and manage COVID-19 can be found at [CDC's Resources for Healthcare Facilities](#) webpage.

Stay up-to-date:

Monitor public health updates from:

- [Local Public Health Department](#)
- [Washington State Department of Health](#)
- [Centers for Disease Control and Prevention Situation Summary](#)

Make a plan:

Review and update your infection control plan preparedness plan. If you do not have a plan, a planning checklist can be found here <https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf>.

For COVID-19, we recommend your plan include the following:

- A policy for when direct care staff should use personal protective equipment for residents with symptoms of respiratory infection.
- A plan for implementing respiratory hygiene throughout the facility. (See “Communicate with staff, residents, and visitors.”)
- A plan for grouping symptomatic residents using one or more of the following strategies:
 - Confining symptomatic residents and exposed roommates to their rooms.
 - Placing symptomatic residents together in one area of the facility.
 - Closing units where symptomatic and asymptomatic residents reside.
 - Assigning staff on either affected or non-affected units to prevent transmission between units.
 - Closing communal dining halls.
 - Canceling events where many people come together.

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- Cleaning and disinfecting frequently touched surfaces with [EPA-registered disinfectant](#) with a label indicating effectiveness against human coronavirus or emerging viral pathogens.
- Criteria and protocols for enforcing visitor limitations and how you will communicate those limitations.
 - Screen visitors for respiratory illness symptoms.
 - Consider screening visitors for recent travel to areas with COVID-19 transmission.
 - Ask visitors and family members not to visit the facility if they are experiencing respiratory symptoms. Suggest other options such as visiting by phone if possible.
- A proactive sick leave policy to address the needs of staff including:
 - Advising staff, caregivers, or volunteers who have respiratory symptoms that they should not report to work and to immediately report their symptoms to an identified manager.
 - Provide staff members with information about symptoms so they can self-assess before reporting for duty. (See “Communicate with staff, residents, and visitors.”)
- A plan for what to do if staff develop symptoms while at work.
- When staff can return to work after having a diagnosis of COVID-19. (As of February 29, public health requires confirmed cases to have two negative tests before isolation can be discontinued. This guidance may change as the situation evolves.)
- Plans to accommodate staff who need to care for ill family members.
- Identifying staff who may be at higher risk for severe COVID-19 disease and assigning them to unaffected units, if possible.
- Contingency staffing and patient placement plans:
 - Identify minimum staffing needs and prioritize critical and non-essential services based on residents’ health status, functional limitations, disabilities, and essential facility operations.
 - Contact your local health department for guidance on altered standards of care in case residents need acute care and hospital beds are not available.
 - Strategize about how your facility can help increase hospital bed capacity in the community.
- Criteria and protocols for closing units or the entire facility to new admissions when COVID-19 has been identified in the facility.

Identify and contact partners to coordinate:

Identify public health and professional resources in the table below.

	Contact Name	Phone	Email
Local Health			

Department of Health

State Long-Term
Professional Trade
Association

Identify contacts for local, regional, or state emergency preparedness groups, especially bioterrorism/communicable disease coordinators in the table below.

Name	Phone	Email
Local		
Regional		
State		

Contact local hospitals to learn who to coordinate with if one of your residents needs to be hospitalized or is being discharged from the hospital. ([List of hospitals in Washington state.](#))

- **Residents referred to the hospital:** If a resident is referred to a hospital, you will need to coordinate transport with the hospital, local health department, and medical transport service/emergency medical service to ensure that the resident can be safely transported and received by the hospital.
- **Residents discharged from the hospital:** When your resident is ready to be discharged, coordinate with the hospital regarding transportation and continued care needs, including any precautions to take in your facility. As the outbreak spreads, having open beds in hospitals is vitally important.

Hospital Contacts

Name	Phone	Email

Communicate with staff, residents, and visitors:

- Educate staff, residents, and family members of residents about COVID-19. Make sure they know the potential risks for residents and basic prevention measures, such as:
 - Wash hands often with soap and water or use alcohol-based hand sanitizer. (For staff tips, see [Clean Hands Count for Healthcare Providers.](#))
 - Cough and sneeze into the elbow or into a tissue. Throw away the tissue immediately after use and wash hands. (For staff tips, see [Respiratory Hygiene/Cough Etiquette in Healthcare Settings.](#))
 - Frequently clean and disinfect surfaces.

- Ask staff to use Personal Protective Equipment (PPE). PPE recommended when caring for COVID-19 patients, includes a gown, gloves, mask (or respirator), and eye protection. (See [Sequence for putting on Personal Protective Equipment \(PPE\)](#) for more information.)
- Staff and visitors should remain home if they are sick with cough, sneezing and/or fever. Inform staff about sick leave policies and/or the ability to work from home, if possible.
- Post signs at the entry, the reception area, and throughout the facility to help visitors, staff, and volunteers self-identify relevant symptoms and travel history. (See the [Novel Coronavirus Factsheet](#), available in 11 languages. Check for travel history information on CDC's [Coronavirus 2019 Information for Travel](#) page.)
- Let visitors know about any new policies or procedures in your preparedness plan and how they will impact their visits.
- Communicate with family members of residents to share information about the measures you are taking to protect your residents from COVID-19.
- Communicate with staff about any new policies and procedures in your preparedness plan that will impact how they do their work and what to do when they are sick.

Watch for respiratory infection and COVID-19 symptoms in residents and staff:

- Observe your residents and staff to detect respiratory infections.
 - Use and modify the resources below to monitor and track of influenza-like-illness among residents and staff:
 - [Respiratory Tract Infection Worksheet](#)
 - [Infection and Antibiotics Use Tracking Tool](#) and [Instructions](#)
 - Assess incoming residents with respiratory [symptoms](#) including coughing, fever or shortness of breath for:
 - Travel to an area with COVID-19 transmission in 14 days prior to illness onset
 - Any diagnostic testing for COVID-19
 - Recent admission to facilities with known active COVID-19 cases
- Sputum and oral swab specimens for COVID-19 should not be collected in the facility unless you have a procedure that has been cleared by your local health department.

In the case a resident has symptoms of COVID-19 or a known exposure:

Immediately contact your local health department. Your local health department will help assess the situation and provide guidance for further actions.

Novel Coronavirus (COVID-19) Guidance for Long-Term Care Facilities – Assisted Living Facilities

The Washington State Department of Health has developed this guidance to assist long-term and residential care facilities, such as Adult Family Homes, in response to the 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, at this time we believe that elderly patients and those with chronic medical conditions may be at higher risk for severe illness from COVID-19. Long-term care facilities have experience managing respiratory infections and outbreaks among residents and staff and should apply the same outbreak management principles to COVID-19.

Additional resources on how long-term care facilities can prepare for and manage COVID-19 can be found at [CDC's Resources for Healthcare Facilities](#) webpage.

Stay up-to-date:

Assign one person to monitor public health updates from:

- [Local Public Health Department](#)
- [Washington State Department of Health](#)
- [Centers for Disease Control and Prevention Situation Summary](#)

Make a plan:

Review and update your infection control plan preparedness plan. If you do not have a plan, a planning checklist can be found here <https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf>.

For COVID-19, we recommend your plan include the following:

- A policy for when direct care staff should use personal protective equipment for residents with symptoms of respiratory infection.
- A plan for implementing respiratory hygiene throughout the facility. (See “Communicate with staff, residents, and visitors.”)
- A plan for grouping symptomatic residents using one or more of the following strategies:
 - Confining symptomatic residents and exposed roommates to their rooms.
 - Placing symptomatic residents together in one area of the facility.
 - Closing units where symptomatic and asymptomatic residents reside.
 - Assigning staff on either affected or non-affected units to prevent transmission between units.
 - Closing communal dining halls, instead consider delivering meals to symptomatic residents.
 - Canceling events where many people come together.

- Cleaning and disinfecting frequently touched surfaces with [EPA-registered disinfectant](#) with a label indicating effectiveness against human coronavirus or emerging viral pathogens.
- Criteria and protocols for enforcing visitor limitations and how you will communicate those limitations.
 - Screen visitors for respiratory illness symptoms.
 - Consider screening visitors for recent travel to an area with COVID-19 transmission.
 - Ask visitors and family members not to visit the facility if they are experiencing respiratory symptoms. Suggest other options such as visiting by phone if possible.
- A proactive sick leave policy to address the needs of staff including:
 - Advising staff, caregivers, or volunteers who have respiratory symptoms that they should not report to work and to immediately report their symptoms to an identified manager.
 - Provide staff members with information about symptoms so they can self-assess before reporting for duty. (See “Communicate with staff, residents, and visitors.”)
 - A plan for what to do if staff develop symptoms while at work.
 - When staff can return to work after having a diagnosis of COVID-19. (As of February 29, public health requires confirmed cases to have two negative tests before isolation can be discontinued. This guidance may change as the situation evolves.)
 - Plans to accommodate staff who need to care for ill family members.
 - Identifying staff who may be at higher risk for severe COVID-19 disease and assigning them to unaffected units, if possible.
- Contingency staffing and patient placement plans:
 - Identify minimum staffing needs and prioritize critical and non-essential services based on residents’ health status, functional limitations, disabilities, and essential facility operations.
 - Contact your healthcare coalition for guidance on altered standards of care in case residents need acute care and hospital beds are not available.
 - Strategize about how your facility can help increase hospital bed capacity in the community.
- Criteria and protocols for closing units or the entire facility to new admissions when COVID-19 has been identified in the facility.

Identify and contact partners to coordinate:

Identify public health and professional resources in the table below.

	Contact Name	Phone	Email
Local Health			
Department of Health			

State Long-Term
Professional Trade
Association

Identify contacts for local, regional, or state emergency preparedness groups, especially bioterrorism/communicable disease coordinators in the table below.

Name	Phone	Email
Local		
Regional		
State		

Contact local hospitals to learn who to coordinate with if one of your residents needs to be hospitalized or is being discharged from the hospital. ([List of hospitals in Washington state.](#))

- **Residents referred to the hospital:** If a resident is referred to a hospital, you will need to coordinate transport with the hospital, local health department, and medical transport service/emergency medical service to ensure that the resident can be safely transported and received by the hospital.
- **Residents discharged from the hospital:** When your resident is ready to be discharged, coordinate with the hospital regarding transportation and continued care needs, including any precautions to take in your facility. As the outbreak spreads, having open beds in hospitals is vitally important.

Hospital Contacts

Name	Phone	Email

Communicate with staff, residents, and visitors:

- Educate staff, residents, and family members of residents about COVID-19. Make sure they know the potential risks for residents and basic prevention measures, such as:
 - Wash hands often with soap and water or use alcohol-based hand sanitizer. (For staff tips, see [Clean Hands Count for Healthcare Providers.](#))
 - Cough and sneeze into the elbow or into a tissue. Throw away the tissue immediately after use and wash hands. (For staff tips, see [Respiratory Hygiene/Cough Etiquette in Healthcare Settings.](#))
 - Frequently clean and disinfect surfaces.

- Ask staff to use Personal Protective Equipment (PPE). PPE recommended when caring for COVID-19 patients, includes a gown, gloves, mask (or respirator), and eye protection. (See [Sequence for putting on Personal Protective Equipment \(PPE\)](#) for more information.)
- Staff and visitors should remain home if they are sick with cough, sneezing and/or fever. Inform staff about sick leave policies and/or the ability to work from home, if possible.
- Post signs at the entry, the reception area, and throughout the facility to help visitors, staff, and volunteers self-identify relevant symptoms and travel history. (See the [Novel Coronavirus Factsheet](#), available in 11 languages. Check for travel history information on CDC's [Coronavirus 2019 Information for Travel](#) page.)
- Let visitors know about any new policies or procedures in your preparedness plan and how they will impact their visits.
- Communicate with family members of residents to share information about the measures you are taking to protect your residents from COVID-19.
- Communicate with staff about any new policies and procedures in your preparedness plan that will impact how they do their work and what to do when they are sick.

Watch for respiratory infection and COVID-19 symptoms in residents and staff:

- Observe your residents and staff to detect respiratory infections.
 - Use and modify the resources below to monitor and track of influenza-like-illness (ILI) among residents and staff:
 - [Respiratory Tract Infection Worksheet](#)
 - [Infection and Antibiotics Use Tracking Tool](#) and [Instructions](#)
 - Assess incoming residents with respiratory [symptoms](#) including coughing, fever or shortness of breath for:
 - Travel to an area with COVID-19 transmission in 14 days prior to illness onset
 - Any diagnostic testing for COVID-19
- Sputum and oral swab specimens for COVID-19 should not be collected in the facility unless you have a procedure that has been cleared by your local health department.

In the case a resident has symptoms of COVID-19 or a known exposure:

Immediately contact your local health department. Your local health department will help assess the situation and provide guidance for further actions.

Additional COVID-19 Resources:

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Long Term Care Facilities](#)
- [Workplace and Employers](#)
- [Persons Who are at Higher Risk for Serious Illness](#)

- [Communities and Community Organizations](#)
- [Stigma Reduction](#)
- [How Can I Be Prepared for a COVID-19 Outbreak?](#)

Novel Coronavirus (COVID-19) Guidance for Long-Term Care Facilities – Enhanced Living Facilities

The Washington State Department of Health has developed this guidance to assist long term and residential care facilities in response to the 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, at this time we believe that those over 60, immune-compromised or those with chronic medical conditions may be at higher risk for severe illness from COVID-19. Enhanced Services Facilities (ESF) have experience managing respiratory infections and outbreaks among residents and staff and should apply the same outbreak management principles to COVID-19.

Additional resources on how long-term care facilities can prepare for and manage COVID-19 can be found at [CDC's Resources for Healthcare Facilities](#) webpage.

Stay up-to-date:

Assign one person to monitor public health updates from:

- [Local Public Health Department](#)
- [Washington State Department of Health](#)
- [Centers for Disease Control and Prevention Situation Summary](#)

Make a plan:

Review and update your infection control plan preparedness plan. If you do not have a plan, a planning template can be found here <https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf>

For COVID-19, we recommend your plan include the following:

- A policy for when direct care staff should use personal protective equipment for residents with symptoms of respiratory infection.
- A plan for implementing respiratory hygiene throughout the facility. (See “Communicate with staff, residents, and visitors.”)
- A plan for grouping symptomatic residents using one or more of the following strategies:
 - Confining symptomatic residents and exposed roommates to their rooms.
 - Placing symptomatic residents together in one area of the facility.
 - Assigning staff on either affected or non-affected residents to prevent transmission between residents.
 - Closing communal dining halls, instead consider delivering meals to symptomatic residents.
 - Canceling events where many people come together.

- Cleaning and disinfecting frequently touched surfaces with [EPA-registered disinfectant](#) with a label indicating effectiveness against human coronavirus or emerging viral pathogens.
- Criteria and protocols for enforcing visitor limitations and how you will communicate those limitations:
 - Screen visitors for respiratory illness symptoms.
 - Consider screening visitors for recent travel to an area with COVID-19 transmission.
 - Ask visitors and family members not to visit the facility if they are experiencing respiratory symptoms.
- A proactive sick leave policy to address the needs of staff including:
 - Advising staff, caregivers, or volunteers who have respiratory symptoms that they should not report to work and to immediately report their symptoms to an identified manager.
 - Provide staff members with information about symptoms so they can self-assess before reporting for duty. (See “Communicate with staff, residents, and visitors.”)
 - A plan for what to do if staff develop symptoms while at work.
 - When staff can return to work after having a diagnosis of COVID-19. (As of February 29, public health requires confirmed cases to have two negative tests before isolation can be discontinued. This guidance may change as the situation evolves.)
 - Plans to accommodate staff who need to care for ill family members.
 - Identifying staff who may be at higher risk for severe COVID-19 disease and assigning them to unaffected residents, if possible.
- Contingency staffing and resident placement plans:
 - Identify minimum staffing needs and prioritize critical and non-essential services based on residents’ health status, functional limitations, disabilities, and essential facility operations.
 - Contact your healthcare coalition for guidance on altered standards of care in case residents need acute care and hospital beds are not available.
 - Strategize about how your facility can help increase hospital bed capacity in the community.
- Criteria and protocols for closing units or the entire facility to new admissions when COVID-19 has been identified in the facility.

Identify and contact partners to coordinate:

Identify public health and professional resources in the table below.

	Contact Name	Phone	Email
Local Health			

Department of Health
 State Long-Term
 Professional Trade
 Association

Identify contacts for local, regional, or state emergency preparedness groups, especially bioterrorism/communicable disease coordinators in the table below.

	Name	Phone	Email
Local			
Regional			
State			

Contact local hospitals to learn who to coordinate with if one of your residents needs to be hospitalized. ([List of hospitals in Washington state.](#))

- **Residents referred to the hospital:** If a resident is referred to a hospital, you will need to coordinate transport with the hospital, local health department, and medical transport service/emergency medical service to ensure that the resident can be safely transported and received by the hospital.

Hospital Contacts

Name	Phone	Email

Communicate with staff, residents, and visitors:

- Educate staff, residents, and family members of residents about COVID-19. Make sure they know the potential risks for residents and basic prevention measures, such as:
 - Wash hands often with soap and water or use alcohol-based hand sanitizer. (For staff tips, see [Clean Hands Count for Healthcare Providers.](#))
 - Cough and sneeze into the elbow or into a tissue. Throw away the tissue immediately after use and wash hands. (For staff tips, see [Respiratory Hygiene/Cough Etiquette in Healthcare Settings.](#))
 - Frequently clean and disinfect surfaces.
 - Ask staff to use Personal Protective Equipment (PPE). PPE recommended when caring for COVID-19 patients, includes a gown, gloves, mask (or respirator), and eye protection. (See [Sequence for putting on Personal Protective Equipment \(PPE\)](#) for more information.)

- Staff and visitors should remain home if they are sick with cough, sneezing and/or fever. Inform staff about sick leave policies and/or the ability to work from home, if possible.
- Post signs at the entry, the reception area, and throughout the facility to help visitors, staff, and volunteers self-identify relevant symptoms and travel history. (See the [Novel Coronavirus Factsheet](#), available in 11 languages. Check for travel history information on CDC’s [Coronavirus 2019 Information for Travel](#) page.)
- Let visitors know about any new policies or procedures in your preparedness plan and how they will impact their visits.
- Communicate with family members of residents to share information about the measures you are taking to protect your residents from COVID-19.
- Communicate with staff about any new policies and procedures in your preparedness plan that will impact how they do their work and what to do when they are sick.

Watch for respiratory infection and COVID-19 symptoms in residents and staff:

- Observe your residents and staff to detect respiratory infections.
 - Use and modify the resources below to monitor and track of influenza-like-illness (ILI) among residents and staff:
 - [Respiratory Tract Infection Worksheet](#)
 - [Infection and Antibiotics Use Tracking Tool](#) and [Instructions](#)
 - Assess incoming residents with respiratory [symptoms](#) including coughing, fever or shortness of breath for:
 - Travel to an area with COVID-19 transmission in 14 days prior to illness onset
 - Any diagnostic testing for COVID-19
- Sputum and oral swab specimens for COVID-19 should not be collected in the facility unless you have a procedure that has been cleared by your local health department.

In the case a resident has symptoms of COVID-19 or a known exposure:

Immediately contact your local health department. Your local health department will help assess the situation and provide guidance for further actions.

Additional COVID-19 Resources:

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Long Term Care Facilities](#)
- [Workplace and Employers](#)
- [Persons Who are at Higher Risk for Serious Illness](#)
- [Communities and Community Organizations](#)
- [Stigma Reduction](#)

- [How Can I Be Prepared for a COVID-19 Outbreak?](#)

Novel Coronavirus (COVID-19) Guidance for Correctional Facilities

The Washington State Department of Health developed guidance to assist correctional facilities in response to the 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, at this time we believe that those over 60, immune-compromised or those with chronic medical conditions may be at higher risk for severe illness from COVID-19. Correctional facilities have experience managing respiratory infections and outbreaks among residents and staff and should apply the same outbreak management principles to COVID-19.

Stay up-to-date:

Monitor public health updates from:

- [Local Public Health Department](#)
- [Washington State Department of Health](#)
- [Centers for Disease Control and Prevention Situation Summary](#)

This fact sheet provides basic information only. It is not intended to take the place of medical advice, diagnosis, or treatment.

- Staff, vendors, and volunteers with symptoms of an acute respiratory infection should not come to work and should report their symptoms through their chains of command or designated reporting locations.
- Correctional facilities should take measures to prevent visitors who test positive for COVID-19 from visiting the facility.
- All patient testing for COVID-19 should be arranged in consultation with local public health.
- Correctional facility staff should follow routine precautions as well as contact and droplet precautions when providing health care services to any person under investigation for COVID-19. Facilities that can safely conduct a clinical examination and collect specimens should also follow airborne precautions.

Introduction to the environment

- Respiratory infection outbreaks occur in correctional facilities throughout the year, but are more common during the winter months. COVID-19 may be introduced to a correctional facility through visitors, vendors, volunteers, or staff.
- The population in correctional facilities is likely to include individuals who have chronic health conditions which weaken their immune systems. Some incarcerated individuals

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may have chronic lung or neurological diseases which impair their ability to clear secretions from their lungs and airways.

- Correctional facility populations are also at risk because respiratory pathogens may be more easily transmitted in an institutional environment.
- Proper hand washing, social distancing, and covering your cough are protocols that should be implemented by all.
- Informational handouts and posters should be prominently displayed throughout the correctional facility and addressed through supervisory/operational staff briefings.
 - [DOH Coronavirus Factsheet](#)
 - [Slow the Spread of Germs Poster CDC \(pdf\)](#)
 - [Spanish Version CDC \(pdf\)](#)
 - [CDC Handwashing Posters](#)

Screening and Triage

- Correctional facilities should conduct passive screening of visitors, staff, and volunteers, and active screening of the incarcerated population (*see below for descriptions of active and passive screening*).
- The facility should also ensure that an employee health policy is in place to send employees home if symptoms begin to develop at work.

Passive screening of staff, volunteers, and visitors:

- Signs should be posted on entry to the buildings and at reception areas for anyone entering the facility (e.g., visitors, staff, volunteers) to self-identify if they have relevant symptoms and travel history/exposure, including:
 - Fever
 - Acute respiratory illness*(cough and/or shortness of breath)
 - Travel history to an impacted area OR have had contact with a person who has the above travel history and is ill.

*If experiencing respiratory symptoms, visitors must not visit the facility until symptoms completely resolve.

- As part of routine measures for the respiratory season, existing signs should be visible that remind staff, visitors, and incarcerated individuals to practice good health habits that include handwashing, sneeze/cough into their elbow, put used tissues in a waste receptacle, and to wash hands immediately after using tissues.
- Correctional facilities must instruct all staff and volunteers to self-screen at home. Staff, vendors, and volunteers with symptoms of an acute respiratory infection must not come

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to work and will report their symptoms to their respective facility. All staff should be aware of early signs and symptoms of acute respiratory infection.

- Facilities should provide further guidance (e.g., over the phone or at the reception desk) to volunteers and visitors who are experiencing symptoms of COVID-19 and have a recent travel history (within 14 days) to an impacted area.

Active screening of staff and the incarcerated population:

- Once activated, Staff Infection Control Screening Stations (SICS) will be established at facility entry points.
- Staff and contractors will be directed to single control points (ie: public access) when SICS have been implemented.
- SICS should be staffed with 1 medical staff member and 1 non-medical staff member to act as Finance/Admin Section Time Unit Leader (TUL).
- A table/counter will be set up for staff to fill out a COVID-19 specific screening questionnaire, provided by Headquarters/Health Services Division, while waiting in the evaluation line.
- Screening interview and taking of temperature takes approximately 1 minute.
- If an employee is determined unable to report to work, the TUL will document which employee is unable to work and who authorized the absence.
 - If a custody employee is determined unable to report to work, the TUL will immediately report the absence to the Shift Commander.
 - If a non-custody/contract employee is unable to work, the supervisor will be notified as soon as possible.
 - Staff displaying symptoms of COVID-19 will be sent home at the discretion of the Superintendent/designee or Incident Commander.
- Staff cleared to work will report to a muster location for an operational briefing (if needed).
- Each facility should identify options for telecommuting.
- Emergency staffing plans may be activated if staffing levels are significantly affected.
 - Each facility Superintendent/designee will determine essential posts to be staffed and essential functions to be accomplished.
 - Emergency staffing should be implemented in accordance with local emergency management plans.

In the event of active or suspected cases of COVID-19 are present at the facility, the following are examples of actions that should occur:

- Facilities should use predesignated isolation/quarantine areas for affected incarcerated individuals to be housed.

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- Cellmates of sick individuals will be isolated until it is determined that those individuals are free of COVID-19 symptoms.
- Restricted/limited movement of incarcerated individuals should be implemented to reduce the possibility of additional exposures.
- Visitation will be closed while on COVID-19 infection control protocols to prevent further potential exposures. Notification to the public should be made.
- All programming will be suspended (such as education, self-help, industries, and work programs).
- Meals will be served in the dining halls, when possible, to the unaffected population. Movement to and from the dining facilities will be operated to provide social distancing from those who are sick and those who are not.
- Meals for infected incarcerated individuals will be served in their assigned cells/medical facilities.
- Personal Protective Equipment (PPE) will be utilized by both staff and incarcerated individuals.

Social Distancing

- While facilities are on limited/restricted movement, internal program restrictions will be enforced.
- Incarcerated individuals pending transfer to another facility will be moved to the designated isolation unit for 72 hours prior to transfer. Transfer will be cancelled should the individual become symptomatic.
- Incarcerated Individuals being received by the facility will be maintained in the designated isolation unit for 72 hours prior to release into the general population.
- Incarcerated individuals scheduled for release will be placed into the isolation unit for 72 hours prior to release.
- Gatherings of staff and incarcerated individuals will be limited to prevent possible exposure.
- Volunteer managed programs will be cancelled while COVID-19 infection control protocols are in effect.
- Facility tours should be suspended.

Additional COVID-19 Resources

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Local Health Jurisdictions](#)

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.

- [Workplace and Employers](#)
- [Persons Who are at Higher Risk for Serious Illness](#)
- [Communities and Community Organizations](#)
- [Stigma Reduction](#)
- [How Can I Be Prepared for a COVID-19 Outbreak?](#)

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Novel Coronavirus (COVID-19) Guidance for Correctional Facilities

The Washington State Department of Health developed guidance to assist correctional facilities in response to the 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, at this time we believe that those over 60, immune-compromised or those with chronic medical conditions may be at higher risk for severe illness from COVID-19. Correctional facilities have experience managing respiratory infections and outbreaks among residents and staff and should apply the same outbreak management principles to COVID-19.

Stay up-to-date:

Monitor public health updates from:

- [Local Public Health Department](#)
- [Washington State Department of Health](#)
- [Centers for Disease Control and Prevention Situation Summary](#)

This fact sheet provides basic information only. It is not intended to take the place of medical advice, diagnosis, or treatment.

- Staff, vendors, and volunteers with symptoms of an acute respiratory infection should not come to work and should report their symptoms through their chains of command or designated reporting locations.
- Correctional facilities should take measures to prevent visitors who test positive for COVID-19 from visiting the facility.
- All patient testing for COVID-19 should be arranged in consultation with local public health.
- Correctional facility staff should follow routine precautions as well as contact and droplet precautions when providing health care services to any person under investigation for COVID-19. Facilities that can safely conduct a clinical examination and collect specimens should also follow airborne precautions.

Introduction to the environment

- Respiratory infection outbreaks occur in correctional facilities throughout the year, but are more common during the winter months. COVID-19 may be introduced to a correctional facility through visitors, vendors, volunteers, or staff.
- The population in correctional facilities is likely to include individuals who have chronic health conditions which weaken their immune systems. Some incarcerated individuals

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may have chronic lung or neurological diseases which impair their ability to clear secretions from their lungs and airways.

- Correctional facility populations are also at risk because respiratory pathogens may be more easily transmitted in an institutional environment.
- Proper hand washing, social distancing, and covering your cough are protocols that should be implemented by all.
- Informational handouts and posters should be prominently displayed throughout the correctional facility and addressed through supervisory/operational staff briefings.
 - [DOH Coronavirus Factsheet](#)
 - [Slow the Spread of Germs Poster CDC \(pdf\)](#)
 - [Spanish Version CDC \(pdf\)](#)
 - [CDC Handwashing Posters](#)

Screening and Triage

- Correctional facilities should conduct passive screening of visitors, staff, and volunteers, and active screening of the incarcerated population (*see below for descriptions of active and passive screening*).
- The facility should also ensure that an employee health policy is in place to send employees home if symptoms begin to develop at work.

Passive screening of staff, volunteers, and visitors:

- Signs should be posted on entry to the buildings and at reception areas for anyone entering the facility (e.g., visitors, staff, volunteers) to self-identify if they have relevant symptoms and travel history/exposure, including:
 - Fever
 - Acute respiratory illness*(cough and/or shortness of breath)
 - Travel history to an impacted area OR have had contact with a person who has the above travel history and is ill.

*If experiencing respiratory symptoms, visitors must not visit the facility until symptoms completely resolve.

- As part of routine measures for the respiratory season, existing signs should be visible that remind staff, visitors, and incarcerated individuals to practice good health habits that include handwashing, sneeze/cough into their elbow, put used tissues in a waste receptacle, and to wash hands immediately after using tissues.
- Correctional facilities must instruct all staff and volunteers to self-screen at home. Staff, vendors, and volunteers with symptoms of an acute respiratory infection must not come

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to work and will report their symptoms to their respective facility. All staff should be aware of early signs and symptoms of acute respiratory infection.

- Facilities should provide further guidance (e.g., over the phone or at the reception desk) to volunteers and visitors who are experiencing symptoms of COVID-19 and have a recent travel history (within 14 days) to an impacted area.

Active screening of staff and the incarcerated population:

- Once activated, Staff Infection Control Screening Stations (SICS) will be established at facility entry points.
- Staff and contractors will be directed to single control points (ie: public access) when SICS have been implemented.
- SICS should be staffed with 1 medical staff member and 1 non-medical staff member to act as Finance/Admin Section Time Unit Leader (TUL).
- A table/counter will be set up for staff to fill out a COVID-19 specific screening questionnaire, provided by Headquarters/Health Services Division, while waiting in the evaluation line.
- Screening interview and taking of temperature takes approximately 1 minute.
- If an employee is determined unable to report to work, the TUL will document which employee is unable to work and who authorized the absence.
 - If a custody employee is determined unable to report to work, the TUL will immediately report the absence to the Shift Commander.
 - If a non-custody/contract employee is unable to work, the supervisor will be notified as soon as possible.
 - Staff displaying symptoms of COVID-19 will be sent home at the discretion of the Superintendent/designee or Incident Commander.
- Staff cleared to work will report to a muster location for an operational briefing (if needed).
- Each facility should identify options for telecommuting.
- Emergency staffing plans may be activated if staffing levels are significantly affected.
 - Each facility Superintendent/designee will determine essential posts to be staffed and essential functions to be accomplished.
 - Emergency staffing should be implemented in accordance with local emergency management plans.

In the event of active or suspected cases of COVID-19 are present at the facility, the following are examples of actions that should occur:

- Facilities should use predesignated isolation/quarantine areas for affected incarcerated individuals to be housed.

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- Cellmates of sick individuals will be isolated until it is determined that those individuals are free of COVID-19 symptoms.
- Restricted/limited movement of incarcerated individuals should be implemented to reduce the possibility of additional exposures.
- Visitation will be closed while on COVID-19 infection control protocols to prevent further potential exposures. Notification to the public should be made.
- All programming will be suspended (such as education, self-help, industries, and work programs).
- Meals will be served in the dining halls, when possible, to the unaffected population. Movement to and from the dining facilities will be operated to provide social distancing from those who are sick and those who are not.
- Meals for infected incarcerated individuals will be served in their assigned cells/medical facilities.
- Personal Protective Equipment (PPE) will be utilized by both staff and incarcerated individuals.

Social Distancing

- While facilities are on limited/restricted movement, internal program restrictions will be enforced.
- Incarcerated individuals pending transfer to another facility will be moved to the designated isolation unit for 72 hours prior to transfer. Transfer will be cancelled should the individual become symptomatic.
- Incarcerated Individuals being received by the facility will be maintained in the designated isolation unit for 72 hours prior to release into the general population.
- Incarcerated individuals scheduled for release will be placed into the isolation unit for 72 hours prior to release.
- Gatherings of staff and incarcerated individuals will be limited to prevent possible exposure.
- Volunteer managed programs will be cancelled while COVID-19 infection control protocols are in effect.
- Facility tours should be suspended.

Additional COVID-19 Resources

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Local Health Jurisdictions](#)

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- [Workplace and Employers](#)
- [Persons Who are at Higher Risk for Serious Illness](#)
- [Communities and Community Organizations](#)
- [Stigma Reduction](#)
- [How Can I Be Prepared for a COVID-19 Outbreak?](#)

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Recommendations for Jails and Detention Facilities with Onsite Medical during COVID-19 Outbreak

The Washington State Department of Health developed guidance to assist jails and detention facilities with onsite medical care in response to the 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, individuals over 60 years of age, immune compromised people, and those with chronic medical conditions may be at higher risk for severe illness from COVID-19. Jails and detention facilities have experience managing respiratory infections and outbreaks among residents and staff and should apply the same outbreak management principles to COVID-19. Additional resources on how long-term care facilities can prepare for and manage COVID-19 can be found here: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html>

Stay up-to-date.

Assign one person to monitor public health updates from:

- [Local Public Health Department](#)
- [Washington State Department of Health](#)
- [Centers for Disease Control and Prevention Situation Summary](#)

Make a plan.

Review and update your infection control plan and/or infectious disease response plans. If you do not have a plan, use the following checklist tool as a guide to develop preparedness plans: <https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf>

For COVID-19, we recommend your plan include the following:

- A policy for when direct care staff should use personal protective equipment for residents with symptoms of respiratory infection.
- A plan for implementing respiratory hygiene throughout the facility. (See “Communicate with staff, residents, and visitors.”)
- A plan for grouping symptomatic residents using one or more of the following strategies:
 - Confining symptomatic residents and exposed roommates to their rooms.
 - Placing symptomatic residents together in one area of the facility.
 - Closing units where symptomatic and asymptomatic residents reside.
 - Assigning staff on either affected or non-affected units to prevent transmission between units.
 - Closing communal dining halls, instead consider delivering meals to residents.

- Canceling events where many people come together.
- Cleaning and disinfecting frequently touched surfaces with EPA-registered disinfectant with a label indicating effectiveness against human coronavirus or emerging viral pathogens.
- Criteria and protocols for enforcing visitor limitations and how you will communicate those limitations.
 - Screen visitors for respiratory illness symptoms.
 - Consider screening visitors for recent travel to area with COVID-19 transmission.
 - Ask visitors and family members not to visit the facility if they are experiencing respiratory symptoms. Suggest other options such as visiting by phone if possible.
- A proactive sick leave policy to address the needs of staff including:
 - Advising staff, caregivers, or volunteers who have respiratory symptoms that they should not report to work and to immediately report their symptoms to an identified manager.
 - Provide staff members with information about symptoms so they can self-assess before reporting for duty. (See “Communicate with staff, residents, and visitors.”)
 - A plan for what to do if staff develop symptoms while at work.
 - When staff can return to work after having a diagnosis of COVID-19. (As of February 29, public health requires confirmed cases to have two negative tests before isolation can be discontinued. This guidance may change as the situation evolves.)
 - Plans to accommodate staff who need to care for ill family members.
 - Identifying staff who may be at higher risk for severe COVID-19 disease and assigning them to unaffected units, if possible.
- Contingency staffing and patient placement plans:
 - Identify minimum staffing needs for essential facility operations.
 - Prioritize critical and non-essential services based on residents’ health status, functional limitations, and disabilities.
 - In collaboration with the local health department, identify facility space that could be adapted for use as an isolation area for symptomatic individuals.
 -
- A plan for grouping symptomatic residents or groups using one or more of the following strategies:
 - Confining symptomatic residents and exposed roommates to their rooms.
 - Placing symptomatic residents together in one area of the facility.
 - Restricting access to units where symptomatic and asymptomatic residents reside.
 - Assigning staff on either affected or non-affected units to prevent transmission between units.
 - Closing communal dining halls.
 - Canceling events in the facility where many people come together.

- Cleaning and disinfecting high touch surfaces with EPA-registered disinfectant with label claim of effectiveness against human coronavirus or emerging viral pathogens.

Identify and contact partners to coordinate.

Identify public health and professional resources in the table below.

Contact Name	Phone	Email
Local Health		
State Department of Health		

Identify contacts for local, regional or state emergency preparedness groups, especially communicable disease and emergency management representatives in the table below.

Contact Name	Phone	Email
Local		
Regional		
State		
Other		

Contact local hospitals to learn who to coordinate with if one of your residents needs to be hospitalized or is being discharged from the hospital. ([List of hospitals in Washington state.](#))

- **Residents referred to the hospital:** If a resident is referred to a hospital, you will need to coordinate transport with the hospital, local health department, and medical transport service/emergency medical service to ensure that the resident can be safely transported and received by the hospital.
- **Residents discharged from the hospital:** When your resident is ready to be discharged, coordinate with the hospital regarding transportation and continued care needs, including any precautions to take in your facility. As the outbreak spreads, having open beds in hospitals is vitally important.

Hospital Contacts

Name	Phone	Email

Communicate with staff, residents, and visitors.

- Educate staff, residents, and family members of residents about COVID-19. Make sure they know the potential risks for residents and basic prevention measures, such as:
 - Wash hands often with soap and water or use alcohol-based hand sanitizer. (For staff tips, see [Clean Hands Count for Healthcare Providers](#).)
 - Cough and sneeze into elbow or into a tissue. Throw away the tissue immediately after use and wash hands. (For staff tips, see [Respiratory Hygiene/Cough Etiquette in Healthcare Settings](#).)
 - Frequently clean and disinfect surfaces.
 - Ask staff to use of Personal Protective Equipment (PPE). PPE recommended when caring for COVID-19 patients, includes a gown, gloves, mask (or respirator), and eye protection. (See [Sequence for putting on Personal Protective Equipment \(PPE\)](#) for more information.)
 - Staff and visitors should remain home if they are sick with cough, sneezing and/or fever. Inform staff about sick leave policies and/or the ability to work from home, if possible.
- Post signs at the entry, the reception area, and throughout the facility to help visitors, staff, and volunteers self-identify relevant symptoms and travel history. (See the [Novel Coronavirus Factsheet](#), available in 11 languages. Check for travel history information on CDC's [Coronavirus 2019 Information for Travel](#) page.)
- Let visitors know about any new policies or procedures in your preparedness plan and how they will impact their visits.
- Communicate with family members of residents to share information the measures you are taking to protect your residents from COVID-19.
- Communicate with staff about any new policies and procedures in your preparedness plan that will impact how they do their work and what to do when they are sick.

Watch for respiratory infection and COVID-19 symptoms in residents and staff.

Observe your residents and staff to detect respiratory infections.

- Use and modify the resources below to monitor and track of influenza-like-illness (ILI) among residents and staff:
 - [Respiratory Tract Infection Worksheet](#)
 - [Infection and Antibiotics Use Tracking Tool](#) and [Instructions](#)
- Assess incoming residents with respiratory [symptoms](#) including coughing, fever or shortness of breath for:
 - Travel to an area with COVID-19 transmission in 14 days prior to illness onset
 - Any diagnostic testing for COVID-19

In the case a resident has symptoms of COVID-19 or a known exposure:

Immediately contact your local health department. Your local health department will help assess the situation and provide guidance for further actions.

Prevention Strategies

- Admission coordinators will evaluate new residents for COVID-19 symptoms
- Anyone admitted under these circumstances will be placed in droplet precautions for 14 days unless otherwise cleared
- Staff will strictly adhere to infection control practices and use personal protective equipment as appropriate
- If single room is not available, combine laboratory-confirmed incarcerated individuals
- Educate incarcerated individuals and staff on infection control measures
- Exposed workers should notify their employer immediately and should not report for work
- Keep close contact with state and local health authorities
- Enforce respiratory hygiene (wash your hands, cover your cough, and stay home when you are sick)

Mitigation Strategies

All of the prevention strategies listed above, including the following:

- Patients presenting with fever or respiratory symptoms should perform hand hygiene, wear masks if possible, and /or be placed in a unit with the door closed and a special precautions sign posted
- All personnel entering facility or containment areas will wear appropriate personal protective equipment, such as gowns, gloves and masks.
- Use of social distancing and isolation will be initiated in coordination with local health recommendations
- Limit points of entry to facility
- Limit visitors to those essential for facility support.
- Screen all persons entering the facility for fever and respiratory symptoms
- Implement system for detecting and reporting signs and symptoms of staff reporting for duty
- Symptomatic employees will be screened regarding fit for duty
- Entry logs will be at all facility entrances to document all who enter the unit
- Personnel assigned to combined patient care units should not float to other areas
- If transportation of symptomatic person is necessary, have individual wear mask to contain respiratory secretions
- Consider canceling events at the facility where many people come together

- Facilities should utilize pre-designated isolation/quarantine areas for affected incarcerated individuals to be housed
- Cellmates of sick individuals will be isolated until it is determined that those individuals are free of COVID-19 symptoms
- Restrict/limit movements of incarcerated individuals to reduce the possibility of additional exposures
- Limit or suspend programming (such as: education, self-help, industries, work programs, and volunteer programs)
- Consider limiting exposure during meals, for example restricting/slowing movement to and from the dining facilities to provide social distancing or serving meals in cells/rooms
- Meals for incarcerated individuals who are sick will be served in their assigned cells/medical facilities
- Transfers from county to state facilities when residents are symptomatic should be limited, prudent, and reviewed by receiving facilities medical team
- If feasible, maintain incoming incarcerated individuals in a designated isolation unit for 14 days prior to release into the general population
- Arrange appropriate aftercare for incarcerated individuals who are sick and scheduled for release in collaboration with their local health department
- Facility tours should be suspended

Additional COVID-19 Resources

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Workplace and Employers](#)
- [Persons Who are at Higher Risk for Serious Illness](#)
- [Communities and Community Organizations](#)
- [Stigma Reduction](#)
- [How Can I Be Prepared for a COVID-19 Outbreak?](#)

Recommendations for Homeless Shelter Facilities during a COVID-19 Outbreak

Homeless Shelters

The Washington State Department of Health has developed this guidance to assist homeless shelter facilities in response to the 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, at this time we believe that people over 60, immune-compromised people and those with chronic medical conditions may be at higher risk for severe illness from COVID-19.

Stay up-to-date.

Monitor public health updates from:

- [Local Public Health Department](#)
- [Washington State Department of Health](#)
- [Centers for Disease Control and Prevention Situation Summary](#)

What you can do to protect staff and clients

Educate staff and clients about COVID-19. Make sure they know the potential risks and basic prevention measures, such as:

- Wash hands often with soap and water for 20 seconds or use alcohol-based hand sanitizer.
- Avoid touching your face with unwashed hands especially your eyes, nose, or mouth
- Cough and sneeze into elbow or into a tissue. Throw away the tissue immediately after use and wash hands. (For staff tips, see [Respiratory Hygiene/Cough Etiquette in Healthcare Settings](#).)
- Consider providing N95 masks to sick people and staff.
- Maintain a minimum of six feet of distance between yourself and others when feasible.
- Frequently clean and disinfect high contact surfaces like doorknobs, tables, furniture, shared bathrooms, and countertops.
- Ensure adequate supplies of soap, hand sanitizers, and tissues are readily available.

Post signs sharing how staff and guests can protect themselves and others at the facility. Consider posting signs at entrances and in bathrooms.

- [DOH Coronavirus Factsheet](#)
- [DOH Education Material](#)

Facilities providing sleeping accommodations should attempt to **increase the distance between people**, where feasible. Offering individual rooms for groups or families is ideal, but not

typically available. In shared spaces, a “head-to-toe” sleeping arrangement with a minimum of six feet of distance between beds is recommended.

Encourage guests to report illnesses and exposure to COVID-19 to staff prior or upon entry to the facility. Reassure clients that they will not be denied or lose a bed if they report symptoms.

Separate sick clients from those without symptoms. Facilities with a single room should assign sick clients to one side and clients without symptoms to the opposite side.

Encourage staff and volunteers to remain home if they are sick with cough, sneezing and/or fever. Inform them about sick leave policies. For more information, review [DOH’s Resources for Workplaces and Employers](#).

If you have a guest (or an outbreak of several guests) exhibiting symptoms and you would like further guidance you should contact:

- Your local health department:
<https://www.doh.wa.gov/AboutUs/PublicHealthSystem/LocalHealthJurisdictions>
- Or the state coronavirus hotline at 1-800-525-0127 and press #. Note: The hotline may be experiencing high traffic and may be temporarily unavailable, and keep trying.

Additional COVID-19 Resources

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Workplace and Employers](#)
- [Persons Who are at Higher Risk for Serious Illness](#)
- [Communities and Community Organizations](#)
- The [National Health care for the Homeless Council](#). Although this document focuses on influenza, much of the principals apply to Coronavirus.
- [The U.S. Department of Housing and Urban Development](#)
- [Stigma Reduction](#)
- [How Can I Be Prepared for a COVID-19 Outbreak?](#)

Recommendations for Community-Based Facilities during a COVID-19 Outbreak

Juvenile and Behavior Rehabilitation Facilities

The Washington State Department of Health has developed this guidance to assist community-based facilities in response to the 2019 novel coronavirus disease (COVID-19) outbreak. While the situation is evolving, at this time we believe that those over 60, immune-compromised or those with chronic medical conditions may be at higher risk for severe illness from COVID-19. Community-based facilities have experience managing respiratory infections and outbreaks among residents and staff and should apply the same outbreak management principles to COVID-19.

Additional resources on how community-based care facilities can prepare for and manage COVID-19 can be found at [CDC's Resources for Healthcare Facilities](#) webpage. (Note: This webpage is for long-term care facilities, which follow many of the same recommendations.)

Stay up-to-date:

Assign one person to monitor public health updates from:

- [Local Public Health Department](#)
- [Washington State Department of Health](#)
- [Centers for Disease Control and Prevention Situation Summary](#)

Make a plan:

Review and update your infection control plan preparedness plan. If you do not have a plan, a planning guide can be found at <https://www.cdc.gov/flu/pandemic-resources/pdf/longtermcare.pdf>.

For COVID-19, we recommend your plan include the following:

- A policy for when direct care staff should use standard, droplet, and contact precautions for residents with symptoms of respiratory infection.
 - Standard: <https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html>
 - Droplet and Contact: <https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html>
- A plan for implementing respiratory hygiene throughout the facility. (See “Communicate with staff, residents, and visitors.”)

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.

- A plan for grouping symptomatic residents using one or more of the following strategies:
 - Confining symptomatic residents and exposed roommates to their rooms.
 - Placing symptomatic residents together in one area of the facility.
 - Limit access to where symptomatic and asymptomatic residents reside.
 - Assigning staff on either affected or non-affected units to prevent transmission between units.
 - Closing communal dining halls, instead consider delivering meals to residents.
 - Canceling events where many people come together.
 - Cleaning and disinfecting frequently touched surfaces with [EPA-registered disinfectant](#) with a label indicating effectiveness against human coronavirus or emerging viral pathogens.
- Criteria and protocols for enforcing visitor limitations and how you will communicate those limitations.
 - Screen visitors for respiratory illness symptoms.
 - Consider screening visitors for recent travel to an area with COVID-19 transmission.
 - Ask visitors and family members not to visit the facility if they are experiencing respiratory symptoms.
- A proactive sick leave policy to address the needs of staff including:
 - Advising staff, caregivers, or volunteers who have respiratory symptoms that they should not report to work and to immediately report their symptoms to an identified manager.
 - Provide staff members with information about symptoms so they can self-assess before reporting for duty. (See “Communicate with staff, residents, and visitors.”)
 - A plan for what to do if staff develop symptoms while at work.
 - When staff can return to work after having a diagnosis of COVID-19. (As of February 29, public health requires confirmed cases to have two negative tests, 24 hours apart, before isolation can be discontinued. This guidance may change as the situation evolves.)
 - Plans to accommodate staff who need to care for ill family members.
 - Identifying staff who may be at higher risk for severe COVID-19 disease and assigning them to unaffected units, if possible.
- Contingency staffing and resident placement plans:
 - Identify minimum staffing needs and prioritize critical and non-essential services based on residents’ health status, functional limitations, disabilities, and essential facility operations.
 - Contact your healthcare coalition for guidance on altered standards of care in case residents need acute care and hospital beds are not available.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 ([Washington Relay](#)) or email civil.rights@doh.wa.gov.

- Strategize about how your facility can help increase hospital bed capacity in the community.
- Criteria and protocols for closing units or the entire facility to new admissions when COVID-19 has been identified in the facility. Notify lead state DCYF/DSHS contact about these preparations in order to support alternate accommodations.

Identify and contact partners to coordinate:

Identify public health and professional resources in the table below.

Contact Name	Phone	Email
Local Health		
Department of Health		
State Long-Term Professional Trade Association		

Identify contacts for local, regional, or state emergency preparedness groups, especially bioterrorism/communicable disease coordinators in the table below.

Name	Phone	Email
Local		
Regional		
State		

Contact local hospitals to learn who to coordinate with if one of your residents needs to be hospitalized or is being discharged from the hospital. ([List of hospitals in Washington State.](#))

- **Residents referred to the hospital:** If a resident is referred to a hospital, you will need to coordinate transport with the hospital, local health department, and medical transport service/emergency medical service to ensure that the resident can be safely transported and received by the hospital.
- **Residents discharged from the hospital:** When your resident is ready to be discharged, coordinate with the hospital regarding transportation and continued care needs, including any recommended precautions to take in your facility. As the outbreak spreads, having open beds in hospitals is vitally important.

Hospital Contacts

Name	Phone	Email

Communicate with staff, residents, and visitors:

- Educate staff, residents, and family members of residents about COVID-19. Make sure they know the potential risks for residents and basic prevention measures, such as:
 - Wash hands often with soap and water or use alcohol-based hand sanitizer. (For staff tips, see [Clean Hands Count for Healthcare Providers](#).)
 - Refrain from handshakes and instead use elbow-bumps as greetings.
 - Cough and sneeze into the elbow or into a tissue. Throw away the tissue immediately after use and wash hands. (For staff tips, see [Respiratory Hygiene/Cough Etiquette in Healthcare Settings](#).)
 - Frequently clean and disinfect surfaces.
 - Ask staff to use Personal Protective Equipment (PPE). PPE recommended when caring for COVID-19 patients, includes a gown, gloves, mask (or respirator), and eye protection. (See [Sequence for putting on Personal Protective Equipment \(PPE\)](#) for more information.)
 - Staff and visitors should remain home if they are sick with cough, sneezing and/or fever. Inform staff about sick leave policies and/or the ability to work from home, if possible.
- Post signs at the entry, the reception area, and throughout the facility to help visitors, staff, and volunteers self-identify relevant symptoms and travel history. (See the [Novel Coronavirus Factsheet](#), available in 11 languages. Check for travel history information on CDC's [Coronavirus 2019 Information for Travel](#) page.)
- Let visitors know about any new policies or procedures in your preparedness plan and how they will impact their visits.
- Communicate with family members of residents to share information the measures you are taking to protect your residents from COVID-19.
- Communicate with staff about any new policies and procedures in your preparedness plan that will impact how they do their work and what to do when they are sick.

Watch for respiratory infection and COVID-19 symptoms in residents and staff:

- Observe your residents and staff to detect respiratory infections.
 - Use and modify the resources below to monitor and track of influenza-like-illness among residents and staff:
 - [Respiratory Tract Infection Worksheet](#)
 - [Infection and Antibiotics Use Tracking Tool](#) and [Instructions](#)
 - Assess incoming residents with respiratory [symptoms](#) including coughing, fever or shortness of breath for:

- Travel to an area with COVID-19 transmission in 14 days prior to illness onset.
- Any diagnostic testing for COVID-19.
- This is a possible mitigation point for community-based facilities – consider your refusal policies and if there are exceptions to this policy. Also, consider the impacts to the system as a whole if admission is not accepted.
- Sputum and oral swab specimens for COVID-19 should not be collected in the facility unless you have a procedure that has been cleared by your local health department.

In the case a resident has symptoms of COVID-19 or a known exposure:

- Immediately contact your local health department. Your local health department will help assess the situation and provide guidance for further actions.
- Contact family or guardian of a resident who meets exposure and symptom criteria to inform them of their loved ones' status and steps being taken to address their wellbeing.

Additional COVID-19 Resources:

- [DOH Coronavirus \(COVID-19\) webpage](#) – updated information and resources daily
- [Workplace and Employers](#)
- [Persons Who are at Higher Risk for Serious Illness](#)
- [Communities and Community Organizations](#)
- [Stigma Reduction](#)
- [How Can I Be Prepared for a COVID-19 Outbreak?](#)



Non-Pharmaceutical Interventions (NPI) Implementation Guide

NPIs are mitigation strategies to limit and prevent exposure to disease. These include personal protective steps for everyday use, community containment, and environmental measures to control viral disease outbreaks and pandemics.

This guide will help you decide what NPIs to consider implementing in an outbreak. Public health officials will need to determine the appropriate set of interventions to implement in combination for a given incident.

This guide is intended for an Incident Management Team, the Department of Health, multi-agency coordination policy groups, and local health officers.

FEBRUARY 2020

Contents

- 1** Intervention Overview, Implementation, and Operational Guidance
- 2** Staffing Models and Work Assignments
- 3** Logistics and Resources Required

NPIs

This guide lists 13 interventions to mitigate the spread of a contagious disease, such as a novel virus. It is part of the state's Communicable Disease and Pandemic Response plan and includes personal, community, and environmental methods of control.

Its purpose is to help public health officials and partners choose which mitigation strategies to implement to limit and prevent the spread of novel respiratory diseases of concern.

The interventions included are:

1. Increase handwashing and use of alcohol-based sanitizer
2. Respiratory hygiene and cough etiquette
3. Keep distance from others (> 6 feet)
4. Frequently clean and disinfect surfaces
5. Remain home during a respiratory illness
6. Voluntary isolation of sick persons
7. Voluntary quarantine of contacts of sick persons
8. Involuntary isolation of sick persons
9. Involuntary quarantine of contacts of sick persons
10. Recommend or order cancellation of major public and large private gatherings
11. Recommend or order closure of schools, child care facilities, workplaces, and public buildings
12. Prevent non-emergency travel outside of the home
13. Establish cordon sanitaire

Table 1 lists expected results on the spread of disease if each intervention were to be used, and gives examples of how each of the interventions can be done.

Transmissibility, Severity

Each intervention lists a scaled measure of transmissibility and a scaled measure of clinical severity as identified by the CDC.

- **Transmissibility** is a scale of 1 to 5, with 5 being the most contagious
- **Clinical severity** is a scale of 1 to 7, with 7 being the most severe in terms of number of cases, number of hospitalizations, and fatality ratio.

The complexity of the interventions increases as transmissibility and clinical severity increase. **Table 1** connects these scales to each intervention and **Table 2** defines them.

ESF-8 Supporting Agencies

These Emergency Support Function 8 (ESF-8) supporting agencies contribute to public health response efforts, including community mitigation strategies, in collaboration with the Department of Health as the lead agency for ESF-8.

- Department of Agriculture
- Department of Ecology
- Department of Enterprise Services
- Department of Fish and Wildlife
- Department of Labor and Industries
- Department of Licensing
- Department of Social and Health Services
- Department of Transportation
- Washington Military Department
- Washington State Health Care Authority
- Washington State Patrol
- Washington State Pharmacy Association
- Washington State Office of the Attorney General
- Washington State Hospital Association
- Washington State Pharmacy Association
- Washington State Disaster Medical Advisory Committee
- Northwest Healthcare Response Network
- Local Health Officers
- Local Emergency Management Agencies
- Tribal Governments

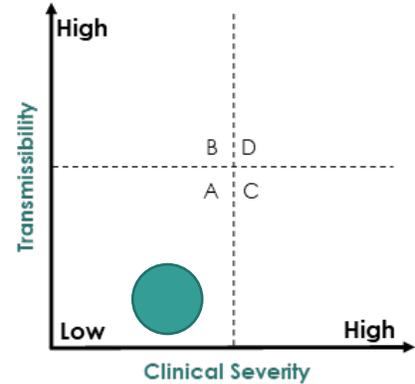
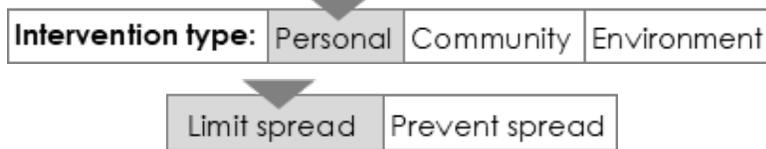
This guide was developed from the Communicable Disease and Pandemic Response Plan, Risk Matrix and Recommendations Table of Annex 4. ([Document link](#) — WA Emergency Management Division)

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.

Intervention 1: Increase Handwashing and Use of Alcohol-Based Hand Sanitizer

Reduce probability of direct and indirect transmission of the disease by handwashing regularly with soap and water or using hand sanitizer.

Transmissibility (1-5)	1
Clinical severity (1-7)	1-4
Recommend implementing at	A, B, C, D



Rationale for Use as Public Health Strategy

Hand hygiene reduces the transmission of viruses that occurs when one person touches another with a contaminated hand, or when a person touches an object or surface that’s been contaminated and then touches their own nose or face with that hand before washing it.

Success Factors: Success depends on public education effectiveness, public compliance, and access to handwashing facilities and sanitizing stations.

Possible Drawbacks: None anticipated, although there is a potential concern about the supply chain for hand sanitizer and soap.

Possible Benefits: Quick and easy to implement; effective at reducing illness due to direct/indirect contact.

Settings and Use

- Personal non-pharmaceutical interventions (NPIs) are everyday preventive actions that can help keep someone from getting and spreading respiratory illnesses transmitted by droplet routes.
- Use at homes, child care facilities, schools, workplaces, houses of worship, public transit, and other settings where people regularly gather.

Jurisdictional Authority and Key Decision Makers

Local

Key Decision Makers: Local health officer and local board of health, with the required assistance of health care providers have authority to control and prevent spread of contagious or infectious diseases within their jurisdiction and to inform the public about the nature of the disease and prevention methods.

Applicable Law(s):

- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [WAC 246-100-021 – Responsibilities and duties – Health care providers](#)
- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)

State

Key Decision Makers: The Secretary of Health has the same authority as a local health officer (LHO) to control and prevent the spread of disease (under RCW 43.70.130), and may exercise the authority in an emergency, when LHOs agree, or when LHOs fail or are unable to act, per RCW 43.70.130(7). This includes the authority to promote public health activities and educational campaigns.

Applicable Law(s):

- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

Decisional Objectives/Key Decision Points

- Determine financial responsibility for providing handwashing stations and/or hand sanitizer.
- Research/discuss resource procurement needs:
 - Local/state/national partners
 - Private/public partners
- Develop communication strategies and communication plans.
- Engage community partnerships to promote message.

Implementation Methods

- **Create an inclusive public messaging campaign**
 - Work with communications team to create messages that:
 - Are culturally competent and at an appropriate reading level.
 - Are translated into the most spoken languages in the affected area.
 - Are relevant to the changing nature of the incident/outbreak.
 - Communicate on multiple platforms appropriate to the affected communities.
 - Connect with community leaders or representatives for advice and buy-in.
 - Provide messages to LHJs and other partners to share with their constituents.
 - Provide consistent messaging throughout the state via media outreach.
 - Encourage workplaces to make handwashing a priority among employees.

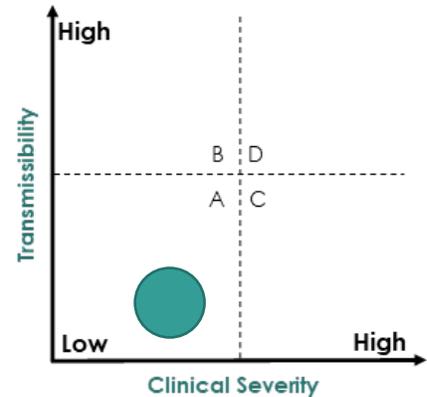
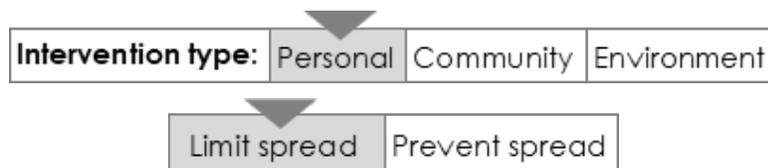
- **Create and distribute accessible, public messaging**
 - Display culturally appropriate messaging in public places.
 - Consider transit centers, health care facilities, schools, shopping centers, entertainment arenas, fitness centers, houses of worship, or other places as appropriate to the communities affected by the outbreak.
 - Connect with community leaders or representatives for advice.
 - Publications should be culturally competent, translated as needed, and at an appropriate reading level, and should include pictures/illustrations.

- **Place hand-washing or hand sanitizer stations in accessible areas**
 - Deploy disinfectant stations in the following or similar locations: Bus stations, transit centers, transportation hubs, health care facilities, schools, shopping centers, entertainment venues, workplaces
 - Prioritize areas of known exposure or at increased risk of exposure.

Intervention 2: Respiratory Hygiene/Cough Etiquette

Reduce probability of droplet transmission of the disease by reducing the range of respiratory droplets and aerosols from coughs, sneezes, and other sources.

Transmissibility (1-5)	1
Clinical severity (1-7)	1-4
Recommend implementing at	A, B, C, D



Rationale for Use as Public Health Strategy

Respiratory etiquette is widely supported in literature and by studies, and is recommended by experts as a way to control the spread of disease. Droplets from those who do not cover their coughs or sneezes can travel up to six feet. Studies of influenza transmission and practical experience in controlling influenza outbreaks reinforce that respiratory hygiene is an important factor in infection control.

Success Factors: Success depends on public education effectiveness and public compliance.

Possible Drawbacks: None anticipated. There could be potential concerns about supply chain for tissues/alcohol-based hand sanitizer.

Possible Benefits: Quick and easy to implement; effective at reducing illness due to droplet transmission.

Settings and Use

- Personal non-pharmaceutical interventions (NPIs) such as covering a cough are everyday preventive actions that can help keep persons from getting and spreading respiratory illnesses transmitted by droplets.
- Use at homes, child care facilities, schools, workplaces, houses of worship, public transit, and other settings where people regularly gather.

Jurisdictional Authority and Key Decision Makers

Local

Key Decision Makers: Local health officer and local board of health, with the required assistance of health care providers have authority to control and prevent spread of contagious or infectious diseases within their jurisdiction and to inform the public about the nature of the disease and prevention methods.

Applicable Law(s):

- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [WAC 246-100-021 – Responsibilities and duties – Health care providers](#)
- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)

State

Key Decision Makers: The Secretary of Health also has the same authority as local health officers (LHO) to control and prevent the spread of disease (under RCW 43.70.130), and may exercise the authority in an emergency or when LHO(s) agree or fail or are unable to act, per RCW 43.70.130(7). This includes the authority to promote public health activities and educational campaigns.

Applicable Law(s):

- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

Decisional Objectives/Key Decision Points

- Determine financial responsibility for providing tissues, handwashing stations, and/or hand sanitizer.
- Research/discuss resource procurement needs:
 - Local/state/national partners
 - Private/public partners
- Develop communication strategies and communication plan.
- Engage community partnerships to promote key messages.

Implementation Methods

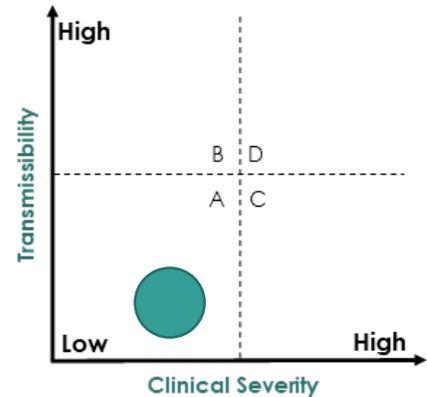
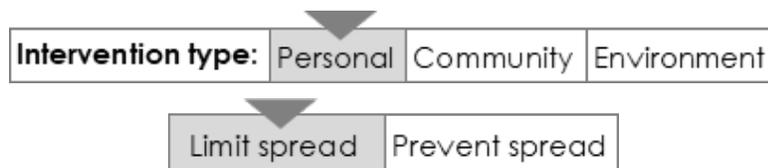
- **Create an inclusive public messaging campaign**
 - Work with communications team to create messages that:
 - Are culturally competent and at an appropriate reading level.
 - Are translated into the most spoken languages in the affected area.
 - Are relevant to the changing nature of the incident/outbreak.

- Communicate on multiple platforms appropriate to the affected communities
- Connect with community leaders or representatives for advice and buy-in.
- Provide messages to LHJs and other partners to share with their constituents.
- Provide consistent messaging throughout the state via media outreach.
- **Create and distribute accessible, public messaging**
 - Display culturally appropriate messaging in public places.
 - Consider transit centers, health care facilities, schools, shopping centers, entertainment arenas, fitness centers, houses of worship, or other places as appropriate to the communities affected by the outbreak.
 - Connect with community leaders or representatives for advice.
 - Publications should be culturally competent, translated as needed, and at an appropriate reading level, and should include pictures/illustrations.
 - Flyers should be translated into locally appropriate languages.
- **Provide respiratory hygiene stations in accessible areas.**
 - Provide tissues and waste receptacle at every public hand sanitizer station in accessible areas.
 - Consider bus stations, transit centers, transportation hubs, health care facilities, schools, shopping centers, entertainment venues, etc.
 - Prioritize areas of known exposure or at increased risk of exposure.

Intervention 3: Keep distance from others (> 6 feet)

Reduce probability of direct and droplet transmission by reducing the number of interpersonal contacts.

Transmissibility (1-5)	1
Clinical severity (1-7)	1-4
Recommend implementing at	A, B, C, D



Rationale for Use as Public Health Strategy

Keeping distance from others is the most basic form of social distancing that reduce opportunities for person-to-person virus transmission and can help delay and slow the exponential growth of disease spread. It's a common-sense approach to limit disease spread by limiting contact and possible exposures. Droplets from those who do not cover their coughs or sneezes can travel up to six feet. Keeping distance from others if you are sick or from others who may be sick is limits possible spread.

Other more restrictive forms of social distancing are discussed in later interventions and include closure of buildings, isolation and quarantine. The optimal strategy may be to implement several social distancing measures simultaneously where groups of people gather.

Success Factors: Success depends on public education effectiveness and public compliance.

Possible Drawbacks: Certain cultural and religious groups may be unwilling or unable to comply due to conflict with cultural/religious norms or practices. Persons may feel anxious, worried, or fearsome due to being socially distant from others.

Possible Benefits: Quick and easy to implement; effective at reducing illness due to droplet transmission.

Settings and Use

- Personal NPIs such as keeping distance from others who may be sick are everyday preventive actions that can help keep persons from getting and spreading respiratory illnesses transmitted by droplets. Diseases are transmitted by direct contact, indirect contact, droplet, and/or airborne routes. Ill persons can spread illness everywhere they go and surfaces they touch.
- Use at homes, child care facilities, schools, workplaces, houses of worship, public transit, and other settings where people regularly gather.
- Examples that reduce in-person contact include: telecommuting instead of meeting in-person, staggering work hours, spacing workers further apart at the worksite, limiting non-essential travel, and avoiding close contact with people who are sick.

Jurisdictional Authority and Key Decision Makers

Local

Key Decision Makers: Local health officer and local board of health, with the required assistance of health care providers have authority to control and prevent spread of contagious or infectious diseases within their jurisdiction and to inform the public about the nature of the disease and prevention methods.

Applicable Law(s):

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Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

Implementation Methods

- **Create an inclusive public messaging campaign**
 - Work with communications team to create messages that:
 - Are culturally competent and at an appropriate reading level.
 - Are translated into the most spoken languages in the affected area.
 - Are relevant to the changing nature of the incident/outbreak.
 - Communicate on multiple platforms appropriate to the affected communities
 - Connect with community leaders or representatives for advice and buy-in.
 - Provide messages to LHJs and other partners to share with their constituents.
 - Provide consistent messaging throughout the state via media outreach.
- **Create and distribute accessible, public messaging**
 - Display culturally appropriate messaging in public places.
 - Consider transit centers, health care facilities, schools, shopping centers, entertainment arenas, fitness centers, houses of worship, or other places as appropriate to the communities affected by the outbreak.
 - Connect with community leaders or representatives for advice.
 - Publications should be culturally competent, translated as needed, and at an appropriate reading level, and should include pictures/illustrations.
 - Flyers should be translated into locally appropriate languages.

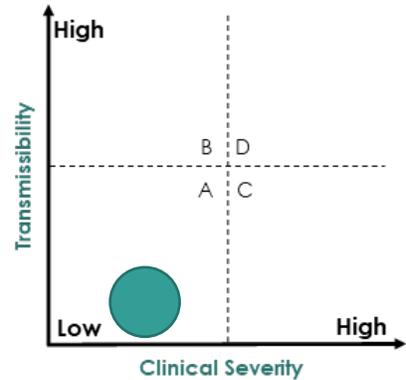
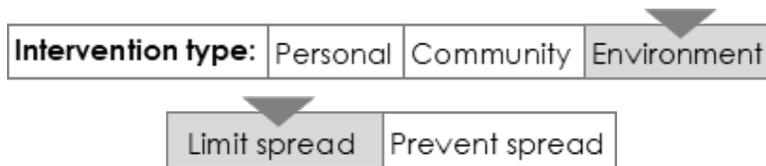
Decisional Objectives/Key Decision Points

- Communication strategies and communication plan
 - Outreach to major employers
 - Community and faith-based partners
 - Schools, child care facilities, and other settings where people regularly gather
- Social distancing on public transit
- Social distancing for ill persons or the public at large

Intervention 4: Frequently Clean and Disinfect Personal Surfaces

Reduce probability of indirect transmission of the disease by disinfecting fomites, or objects that can carry infection. This includes doorknobs, phones, keyboards, etc.

Transmissibility (1-5)	1
Clinical severity (1-7)	1-4
Recommend implementing at	A, B, C, D



Rationale for Use as Public Health Strategy

Contact transmission (i.e., hand transfer of virus from contaminated objects to the eyes, nose, or mouth) is a recognized route of virus spread. The routine use of disinfection measures that eliminate viruses from contaminated surfaces might reduce the spread of viruses.

Success Factors: Success depends on public education effectiveness, public compliance, and access to appropriate disinfectants at home.

Possible Drawbacks: Lack of available cleaning supplies.

Possible Benefits: Environmental disinfection is effective at reducing illness due to indirect contacts (fomites).

Settings and Use

- Environmental NPIs include routine disinfection of surfaces that helps to eliminate viruses from frequently touched surfaces and objects, such as phones, toys, keyboards, desks, and doorknobs.
- Disinfect homes, child care facilities, schools, workplaces, houses of worship, other settings where people regularly gather, and all frequently touched surfaces with a disinfectant labeled to kill viruses and bacteria.

Jurisdictional Authority and Key Decision Makers

Local

Key Decision Makers: Local health officer and local board of health, with the required assistance of health care providers have authority to control and prevent spread of contagious or infectious diseases within their jurisdiction and to inform the public about the nature of the disease and prevention methods.

Applicable Law(s):

- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [WAC 246-100-021 – Responsibilities and duties – Health care providers](#)
- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)

State

Key Decision Makers: The Secretary of Health also has the same authority as local health officers (LHO) to control and prevent the spread of disease (under RCW 43.70.130), and may exercise the authority in an emergency or when LHO(s) agree or fail or are unable to act, per RCW 43.70.130(7). This includes the authority to promote public health activities and educational campaigns.

Applicable Law(s):

- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

Decisional Objectives/Key Decision Points

- Determine communication strategies and communication plan.
 - Outreach to major employers
 - Community and faith-based partners
- Research/discuss resource procurement needs, including fiscal responsibility:
 - Local/state/national partners
 - Private/public partners
- Engage business and community partnerships to implement and promote messages.

Implementation Methods

- **Create an inclusive public messaging campaign**
 - Work with communications team to create messages that:
 - Are culturally competent and at an appropriate reading level.
 - Are translated into the most spoken languages in the affected area.
 - Are relevant to the changing nature of the incident/outbreak.
 - Communicate on multiple platforms appropriate to the affected communities
 - Connect with community leaders or representatives for advice and buy-in.
 - Provide messages to LHJs and other partners to share with their constituents.
- **Create and distribute accessible, public messaging**
 - Display culturally appropriate messaging in public places.
 - Consider transit centers, health care facilities, schools, shopping centers, entertainment arenas, fitness centers, houses of worship, or other places as appropriate to the communities affected by the outbreak.

- Connect with community leaders or representatives for advice.
- Publications should be culturally competent, translated as needed, and at an appropriate reading level, and should include pictures/illustrations.
- **Distribute disinfectant in accessible locations**
 - Deploy disinfectant stations in the following locations: Bus stations, transit centers, transportation hubs, health care facilities, schools, shopping centers, grocery stores, entertainment venues, and other areas where community members gather.
 - Prioritize areas of known exposure or increased risk of exposure.

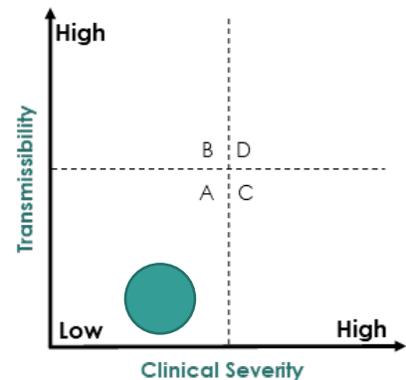
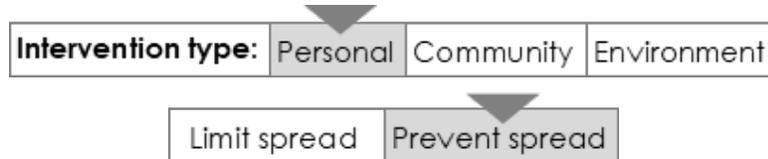
Decisional Objectives/Key Decision Points

- Determine communication strategies and communication plan.
 - Outreach to major employers
 - Community and faith-based partners
- Research/discuss resource procurement needs, including fiscal responsibility:
 - Local/state/national partners
 - Private/public partners
- Engage business and community partnerships to implement and promote messages.

Intervention 5: Remain Home When Sick with Respiratory Illness

Reduce probability of transmission by preventing contacts between well and sick people.

Transmissibility (1-5)	1
Clinical severity (1-7)	1-4
Recommend implementing at	A, B, C, D



Rationale for Use as Public Health Strategy

Staying home while sick will prevent spreading illness to others in your community. You can also create social distance at home and prevent spreading the illness to others in your household by staying in a specific room and away from your household members as much as possible and using a separate bathroom (if available).

Success Factors: Success depends on the individual’s willingness and ability to stay home from work/school/events including access to paid sick leave.

Possible Drawbacks: Many members of the public will be reluctant to stay home due to risk of lost wages and limited or no access to paid sick leave.

Possible Benefits: This is a form of voluntary isolation which is extremely effective in reducing the spread of illness if ill persons comply consistently.

Settings and Use

- Diseases are transmitted by direct contact, indirect contact, droplet, and/or airborne routes. Ill persons can spread illness everywhere they go and surfaces they touch.
- This NPI is used at home to stop spread of disease in public places. It can also be used by employers to request sick employees not come to work.

Jurisdictional Authority and Key Decision Makers

Local

Key Decision Makers: Local health officer and local board of health, with the required assistance of health care providers have authority to control and prevent spread of contagious or infectious diseases within their jurisdiction and to inform the public about the nature of the disease and prevention methods.

Applicable Law(s):

- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [WAC 246-100-021 – Responsibilities and duties – Health care providers](#)
- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)

State

Key Decision Makers: The Secretary of Health also has the same authority as local health officers (LHO) to control and prevent the spread of disease (under RCW 43.70.130), and may exercise the authority in an emergency or when LHO(s) agree or fail or are unable to act, per RCW 43.70.130(7). This includes the authority to promote public health activities and educational campaigns.

Applicable Law(s):

- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

Decisional Objectives/Key Decision Points

- Communication strategies and communication plan.
 - Communicate with major employers.
 - Perform outreach to community and faith-based partners.
- Reference available guidance on duration of illness.
- Evaluate economic impact of ill persons without paid sick leave.

Implementation Methods

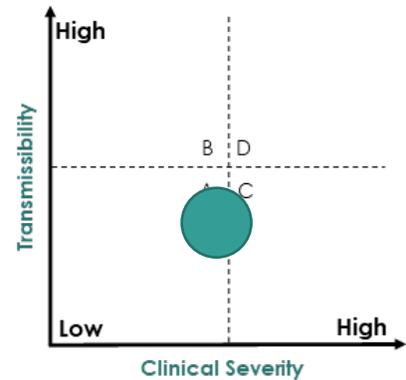
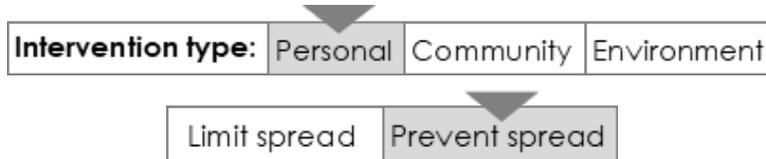
- **Create an inclusive public messaging campaign**
 - Work with communications team to create messages that:
 - Are culturally competent and at an appropriate reading level.
 - Are translated into the most spoken languages in the affected area.
 - Are relevant to the changing nature of the incident/outbreak.
 - Communicate on multiple platforms appropriate to the affected communities
 - Connect with community leaders or representatives for advice and buy-in.
 - Provide messages to LHJs and other partners to share with their constituents.
 - Provide consistent messaging throughout the state via media outreach.
- **Create and distribute accessible, public messaging**
 - Display culturally appropriate messaging in public places.
 - Consider transit centers, health care facilities, schools, shopping centers, entertainment arenas, fitness centers, houses of worship, or other places as appropriate to the communities affected by the outbreak.
 - Connect with community leaders or representatives for advice.
 - Publications should be culturally competent, translated as needed, and at an appropriate reading level, and should include pictures/illustrations.
 - Co-locate messaging or publications with sanitizer stations and tissues.
- **Work with employers**
 - Have employers review and communicate their sick leave policies, flexible leave policies, and alternate work schedules with employees to encourage sick employees to stay home and prevent the spread of illness at work.
 - Use current relationships with employers to ask employees to stay home if they are ill.

- Suggest allowing employees to work from home. If this is already an option, consider working with HR to be more flexible and inclusive.
- Consider an emergency/temporary change in sick leave policy; allowing an employee to use sick leave proactively and earn it back retroactively.
 - This can decrease the hesitancy on the employees' part to stay home and increase participation in voluntary quarantine.

Intervention 6: Voluntary Isolation of Sick Persons

Reduce probability of transmission by preventing contact between well and sick people.

Transmissibility (1-5)	2
Clinical severity (1-7)	2-5
Recommend implementing at	A, B, C, D



Rationale for Use as Public Health Strategy

Personal non-pharmaceutical interventions are everyday preventive actions that can help keep persons from getting and spreading respiratory illnesses transmitted by droplets. Voluntary isolation is a form of social distancing and prevents a sick person from infecting other people outside of their isolation location. Historically, isolation measures can help prevent the spread of infectious diseases by stopping the person-to-person spread of virus via contaminated droplets generated by coughs and sneezes, and have been shown to delay the peak of an influenza pandemic.

Success Factors: Effective education and ability to comply with request. Material routine support and services (e.g. laundry, food) and working with the employer may help compliance.

Possible Drawbacks: Non-compliance with voluntary isolation increases risk of disease transmission; isolation is difficult to enforce.

Possible Benefits: Isolation is extremely effective in consistently reducing the spread of illness. Voluntary isolation is “less restrictive” and more acceptable to the public.

Settings and Use

- Voluntary isolation of a sick person involves remaining home, at a health care facility, or at another designated isolation facility.
- Isolation is used for persons infected with a contagious disease to separate them from people who are not sick.
- For isolation and quarantine measures, state law requires making reasonable efforts to obtain voluntary compliance unless doing so would create a risk of serious harm (WAC 246-100-040(1)(a)). It is good public health policy, and it’s also legally required.

Jurisdictional Authority and Key Decision Makers

Local

Key Decision Makers:

Local health officer and local board of health, with the required assistance of health care providers have authority to control and prevent spread of contagious or infectious diseases within their jurisdiction and to inform the public about the nature of the disease and prevention methods.

Local health officers (and the Secretary of Health under the circumstances outlined in RCW 43.70.130(7)) have the authority to request isolation or quarantine under WAC 246-100-040. The health officer can authorize which people can enter the isolation or quarantine facility to provide medical care and/or meet the needs of the sick person. Any person who enters an isolation or quarantine facility without authorization is subject to quarantine by the health officer.

Applicable Law(s):

- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [WAC 246-100-021 – Responsibilities and duties – Health care providers](#)
- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)
- [WAC 246-100-040 – Procedures for isolation or quarantine](#)
- [WAC 246-100-045 - Conditions and principles for isolation or quarantine](#)
- [WAC 246-100-050 - Isolation or quarantine premises](#)
- [WAC 246-100-055 - Relief from isolation or quarantine](#)

State

In an emergency or when a local health officer consents or does not act, the Secretary of Health may exercise the same authority as a local health officer to control and prevent disease and issue isolation and quarantine orders. The Secretary also has authority to investigate disease outbreaks and advise local health officers on measures to be taken in response.

The State Board of Health (SBOH) has broad power to "adopt rules for the imposition and use of isolation and quarantine" (RCW 43.20.050(2)(e)). Local Health Officers and the Secretary of Health can issue isolation and quarantine orders based on SBOH rules.

Applicable Law(s):

- [RCW 43.20.050 - Powers and Duties of the State Board of Health](#)
- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#) (can be exercised by Secretary)
- [WAC 246-101-105 – Duties of the healthcare provider](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

Federal

The diseases subject to quarantine under federal law are determined by Executive Order. The most recent order published in the [Federal Register](#) includes severe acute respiratory syndromes and provides the basis for federal quarantine.

Applicable Law(s):

- [42 U.S.C. § 264 - Regulations to control communicable diseases](#)
- [42 C.F.R. Part 70 - Interstate Quarantine](#)
- [42 C.F.R. Part 71 - Foreign Quarantine](#)
- [Public Law 113-5 – Pandemic and All Hazards Preparedness Reauthorization Act](#)
- [42 U.S.C. § 201 et seq. – Public Health Service Act](#)

Decisional Objectives/Key Decision Points

- Create communication strategies and plan for:
 - Health care providers
 - Major employers
 - Community and faith-based partners
- Create guidance and/or education resources for patients and health care providers, including monitoring forms.
- Identify isolation facility for individual(s).
- Determine need for material support and services to meet essential needs (food, laundry, utilities, prescription medication, social support, etc.) and who will authorize providing services.
- Movement plan for sick persons to a health care facility (if needed)
- Personal Protective Equipment (PPE) needed for persons providing support to sick persons in isolation.
- Determine type of monitoring:
 - Self-monitoring (what will be monitored, frequency, reporting)
 - Active monitoring (phone, video, or in-person; frequency; responsible staff)
 - Other type
- Plan the logistics for specimen collection and providing other medical services, if needed.
- Determine when to release from isolation and process for notification.

Implementation Methods

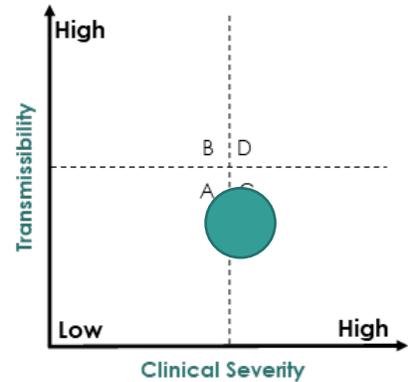
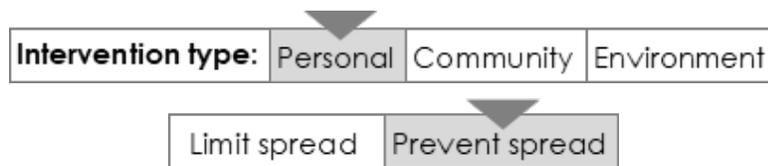
- **Health officer requests that a patient self-isolate**
 - Letter should be on official department letterhead, with a wet or electronic signature from the health officer. While a wet signature may be more impactful, it is not a legal requirement. It may be more efficient and avoid delay to use an e-signature under certain circumstances.
 - Letter should include additional information resources for providers, including phone numbers, websites, and other relevant resources.

- **Instruct health care providers to educate patients**
 - Work with communications teams to distribute a health alert to all providers in Washington.
 - Attach information or a publication to the alert that can be printed and displayed in waiting areas and treatment rooms.
 - Distribute a health alert to all relevant providers about the health officer's request.
- **Engage community organizations and faith-based organizations**
 - Work within already established relationships with community and faith-based partners.
 - If faith-based and community partners receive your health alerts, consider creating a separate alert for them with relevant information to the communities and individuals they serve.
 - Be willing to speak to their leadership/elders/members regarding the situation (within reason) and why we are making this ask.

Intervention 7: Voluntary Quarantine of Contacts of Sick Persons

Reduce probability of transmission in the event that the contact becomes contagious before symptoms developed.

Transmissibility (1-5)	2
Clinical severity (1-7)	2-5
Recommend implementing at	A, B, C, D



Rationale for Use as Public Health Strategy

Quarantine refers to the separation and restriction of movement of persons who, while not yet ill, have been exposed to an infectious agent and therefore may become ill. Quarantine of exposed persons is a public health mitigation strategy intended to stop the spread of infectious disease. It is effective in protecting the public from disease.

Certain infected (but not yet symptomatic) individuals may spread illness and could unknowingly infect friends, neighbors, and others in the community before symptoms begin. Therefore, all contacts exposed to a sick person could be asked to voluntarily stay home for a specified period of time to assess for early signs of infection. If other household members of the contact become ill during this period, then the time for voluntary home quarantine may be extended for another incubation period. Quarantine at a designated facility (in lieu of home setting) also can be considered.

Success Factors: Effective contact tracing and individual ability to comply with request. Material support with material routine support and services (e.g. laundry, food) and working with the employer may help to encourage compliance.

Possible Drawbacks: Non-compliance increases risk of disease transmission.

Possible Benefits: Quarantine may allow quick identification of a suspect case and helps to prevent exposures early in the course of illness.

Settings and Use

- To avoid potential spread of the disease, consider use of voluntary quarantine for contacts who are exposed to a sick person but are not showing symptoms.
- Settings: At home or at a designated facility.
- For isolation and quarantine measures, state law requires making reasonable efforts to obtain voluntary compliance unless doing so would create a risk of serious harm (WAC 246-100-040(1)(a)). It is good public health policy, and it's also legally required.

Jurisdictional Authority and Key Decision Makers

Local

Key Decision Makers: Local health officer and local board of health, with the required assistance of health care providers have authority to control and prevent spread of contagious or infectious diseases within their jurisdiction and to inform the public about the nature of the disease and prevention methods.

Local health officers (and the Secretary of Health under the circumstances outlined in RCW 43.70.130(7)) have the authority to request isolation or quarantine under WAC 246-100-040. The health officer can authorize which people can enter the isolation or quarantine facility to provide medical care and/or meet the needs of the sick person. Any person who enters an isolation or quarantine facility without authorization is subject to quarantine by the health officer.

Applicable Law(s):

- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [WAC 246-100-021 – Responsibilities and duties – Health care providers](#)
- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)
- [WAC 246-100-040 – Procedures for isolation or quarantine](#)
- [WAC 246-100-045 - Conditions and principles for isolation or quarantine](#)
- [WAC 246-100-050 - Isolation or quarantine premises](#)
- [WAC 246-100-055 - Relief from isolation or quarantine](#)
- [WAC 246-101-105 – Duties of the healthcare provider](#)

State

In an emergency or when a local health officer consents or does not act, the Secretary of Health may exercise the same authority as a local health officer to control and prevent disease and issue isolation and quarantine orders. The Secretary also has authority to investigate disease outbreaks and advise local health officers on measures to be taken in response.

The State Board of Health (SBOH) has broad power to "adopt rules for the imposition and use of isolation and quarantine" (RCW 43.20.050(2)(e)). Local Health Officers and the Secretary of Health can issue isolation and quarantine orders based on SBOH rules.

Applicable Law(s):

- [RCW 43.20.050 - Powers and Duties of the State Board of Health](#)
- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#) (can be exercised by Secretary)
- [WAC 246-101-105 – Duties of the healthcare provider](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

Federal

The diseases subject to quarantine under federal law are determined by Executive Order. The most recent order published in the [Federal Register](#) includes severe acute respiratory syndromes and provides the basis for federal quarantine.

Applicable Law(s):

- [42 U.S.C. § 264 - Regulations to control communicable diseases](#)
- [42 C.F.R. Part 70 - Interstate Quarantine](#)
- [42 C.F.R. Part 71 - Foreign Quarantine](#)
- [Public Law 113-5 – Pandemic and All Hazards Preparedness Reauthorization Act](#)
- [42 U.S.C. § 201 et seq. – Public Health Service Act](#)

Decisional Objectives/Key Decision Points

- Definition of “close contact” (including length of exposure to ill person, travel history, etc.)
- Location(s) of quarantine facility (home, government facility, etc.)
- Length of quarantine
- Communication strategies and plan
- Determine need for material services to meet essential needs (food, laundry, utilities, prescription medication, social support, etc.) and who will authorize providing these services.
- Plan for moving persons under quarantine to a health care facility if they develop symptoms
- Determine type of monitoring:
 - Self-monitoring (what will be monitored, frequency, reporting)
 - Active monitoring (phone, video, or in-person; frequency; responsible staff)
 - Other type
- Plan the logistics for specimen collection and providing other medical services, if needed.
- Determine when to release from quarantine and process for notification.

Implementation Methods

- **Health officer request for person to self-quarantine**
 - Letter should be on official department letterhead, with a wet or electronic signature from the health officer. While a wet signature may be more impactful, it is not a legal requirement. It may be more efficient and avoid delay to use an e-signature under certain circumstances.
 - The letter should include additional resources for providers, including phone numbers, websites, and other relevant resources.
- **Engage community-based and faith-based organizations to support**
 - Work within already established relationships with community-based and faith-based partners.
 - Consider creating and sending a custom health alert for them with relevant information to the communities and individuals they serve.
 - Be willing to speak to their leadership/elders/members regarding the situation (within reason) and why we are making this ask.
- **Work with employers**
 - Use current relationships with employers to support employees in voluntary quarantine due to exposure to sick contacts.

- Suggest allowing employees to work from home. If this is already an option, consider working with human resources to be more flexible and inclusive.
- Consider an emergency/temporary change in sick leave policy; allowing an employee to use sick leave proactively and earn it back retroactively.
 - This can decrease the hesitancy on the employees' part to stay home and increase participation in voluntary quarantine.
- **Create a public messaging campaign**
 - Work with communications team to create messages that:
 - Are culturally competent and at an appropriate reading level.
 - Are translated into the most spoken languages in the affected area.
 - Are relevant to the changing nature of the incident/outbreak.
 - Communicate on multiple platforms appropriate to the communities of affected persons.
 - Provide messages to LHJs and other partners to share with their constituents.
 - Send a health alert to health care providers.

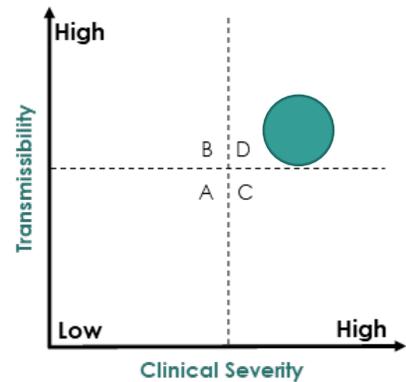
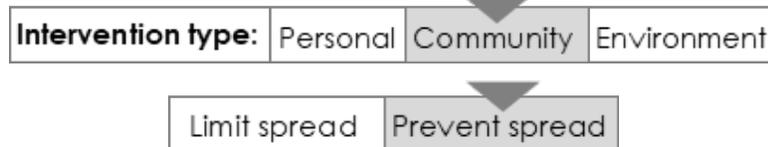
Special Considerations

- Consider dedicating a phone line to answer questions that may follow the request for quarantine.
- Work with communications staff to translate materials as needed for community-based and faith-based organizations, community partners, and employers.
- Sovereign tribal nations may decide their own criteria for quarantine.
- Consider use of telemedicine options and home assessment teams for medical support and backup. The idea that medical health is available may help reduce anxiety.

Intervention 8: Involuntary Isolation of Sick Persons

Reduce probability of transmission by preventing contact between well and sick people.

Transmissibility (1-5)	3
Clinical severity (1-7)	5-6.5
Recommend implementing at	D



Rationale for Use as Public Health Strategy

Isolation prevents a sick person from infecting others outside of their isolation location. Historically, isolation measures have helped to prevent the spread of infectious diseases, such as influenza, by stopping the person-to-person spread of virus via contaminated droplets from coughs and sneezes.

Success Factors: Success depends on health care facility and/or public health system ability to implement. Clearly communicate with affected communities about the rationale for use of isolation, and the responsibility for public officials to protect the safety and health of a community from communicable illnesses of high severity and high transmissibility.

Possible Drawbacks: Involuntary isolation is extremely restrictive and resource intensive. It limits personal liberties and can be controversial.

Possible Benefits: Isolation is effective in reducing the spread of illness. Use of involuntary isolation is a method to force compliance to the measure.

Settings and Use

- Isolation separates sick persons with a contagious disease from people who are not sick.
- Involuntary isolation is only recommended when an individual is not reliable or compliant with voluntary isolation for a disease that is highly severe and highly transmissible.
- For isolation and quarantine measures, state law requires making reasonable efforts to obtain voluntary compliance unless doing so would create a risk of serious harm (WAC 246-100-040(1)(a)). It is good public health policy, and it's also legally required.

Jurisdictional Authority and Key Decision Makers

Local, State

Key Decision Makers: The local health officer and/or Secretary of Health may issue a detention order for involuntary isolation when they have reason to believe the person is infected with a communicable disease and poses a serious and imminent risk to the health and safety of others if not isolated. The local health officer must first make reasonable efforts to obtain voluntary

compliance, unless doing so would create a risk of serious harm. An order directly from a local health officer may last for up to 10 days. A court may order a longer period of isolation. Violation of an isolation order is a misdemeanor for which individuals may be arrested, fined, and imprisoned up to 90 days.

Local health officers, and the Secretary of Health under the circumstances outlined in RCW 43.70.130(7), have the authority to request isolation or quarantine under WAC 246-100-040. The health officer can authorize which people can enter the isolation or quarantine facility to provide medical care and/or meet the needs of the sick person. Any person who enters an isolation or quarantine facility without authorization is subject to quarantine by the health officer.

The State Board of Health (SBOH) has broad power to "adopt rules for the imposition and use of isolation and quarantine" (RCW 43.20.050(2)(e)). Local Health Officers and the Secretary of Health can issue isolation and quarantine orders based on SBOH rules.

Applicable Law(s):

- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)
- [WAC 246-100-040 – Procedures for isolation or quarantine](#)
- [WAC 246-100-045 - Conditions and principles for isolation or quarantine](#)
- [WAC 246-100-050 - Isolation or quarantine premises](#)
- [WAC 246-100-055 - Relief from isolation or quarantine](#)
- [WAC 246-100-070 – Enforcement of local health officer orders](#)
- [WAC 246-101-105 – Duties of the healthcare provider](#)
- [RCW 43.20.050 - Powers and Duties of the State Board of Health](#)
- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)
- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [RCW 70.05.120\(4\) – Violations – Remedies - Penalties \(misdemeanor for violation of an order\)](#)

Forms (find all instructions and forms on [DOH's website](#)):

- [Emergency Involuntary Detention Order \(Word\)](#)
In addition to the form available at the link above, a COV-19 specific involuntary detention order is available. Please contact DOH for use.
- [Confidential Schedule \(Word\)](#)
A local health officer may issue an isolation order immediately. Such an order is subject to court challenge. A court order is required to isolate an individual for longer than 10 days. Law enforcement may arrest an individual for violating a local health officer's or a court order. A court order is also enforceable through contempt proceedings.

When no attempt is made to seek voluntary compliance due to the serious and imminent risk to the public, use the following forms:

- [Summons \(Word\)](#)
- [Detention ex parte petition \(Word\)](#)
- [Confidential schedule \(Word\)](#)
- [Declaration supporting ex parte detention petition \(Word\)](#)
- [Order ex parte for involuntary detention \(Word\)](#)

When voluntary compliance was sought, but the individual refused or otherwise indicated they would not comply, use the following forms:

- [Summons \(Word\)](#)
- [Detention ex parte petition when voluntary detention refused \(Word\)](#)
- [Confidential schedule \(Word\)](#)
- [Declaration supporting ex parte detention petition when voluntary detention refused \(Word\)](#)
- [Order ex parte when voluntary detention refused \(Word\)](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government. Tribal nations may decide their own criteria for isolation.

Federal

The diseases subject to quarantine under federal law are determined by Executive Order. The most recent order published in the [Federal Register](#) includes severe acute respiratory syndromes and provides the basis for federal quarantine.

Applicable Law(s):

- [42 U.S.C. § 264 - Regulations to control communicable diseases](#)
- [42 C.F.R. Part 70 - Interstate Quarantine](#)
- [42 C.F.R. Part 71 - Foreign Quarantine](#)
- [Public Law 113-5 – Pandemic and All Hazards Preparedness Reauthorization Act](#)
- [42 U.S.C. § 201 et seq. – Public Health Service Act](#)

Decisional Objectives/Key Decision Points

- Language for health officer order and involuntary detention court orders.
- Location(s) for isolation.
- Personal Protective Equipment (PPE) requirements for health care workers providing care for sick persons.
- Determine need for material services to meet essential needs (food, laundry, utilities, prescription medication, social support, etc.) and who will authorize providing these services.
- Plan of moving sick persons under isolation to treatment facility, if isolated outside of a health care facility.
- Plans and logistics for specimen collection or providing other medical services, if needed.
- Communication strategies and plan to communicate decisions
 - Affected individuals and community members
 - Public, media, public officials
- Due process: understand and prepare for the rights of the affected patient if due process is initiated. Communicate steps for due process, such as administrative hearings, court review, or notification of right to object. Protect patient rights to privacy and restrictions on who can and cannot be notified (e.g., family member, employer)
- Plan to manage non-compliance with isolation. Identify progressively restrictive steps, up to court-ordered detention. Identify decision point for ordering person to a more restrictive location. Identify who will issue order and transport process.
- Determine when to release from isolation and process for notification.

Implementation Methods

- **Health officer order for emergency detention**
 - Once the person is ordered into isolation, the local health officer should seek a court order and must consider individual rights to due process. Seeking a court order quickly is a good idea if isolation sought is more than 10 days.
 - The needs of a person isolated or quarantined must be addressed to the greatest extent possible in a systematic and competent fashion, including, but not limited to, providing adequate food, clothing, shelter, means of communication with those in isolation or quarantine and outside these settings, medication, and competent medical care. Cultural and religious beliefs should be considered in addressing their needs.
- **Standing orders within a hospital**
 - Work with the hospital facility or designated health care provider and the health officer to create standing orders for the care of individuals in involuntary isolation.

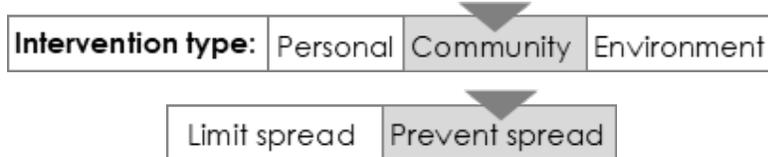
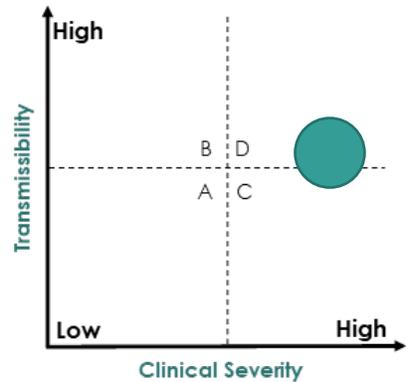
Special Considerations

- Food, water, basic needs, and other support services for isolated patients.
- This intervention requires detailed coordination between state and local government officials.
- Court orders for involuntary isolation may be required.
- Tribal nations may decide their own criteria for isolation.
- When the individual is released, consider providing them with a letter that recognizes their release so they will not be mistakenly reported as not complying with the isolation order.

Intervention 9: Involuntary Quarantine of Contacts of Sick Persons

Reduce probability of transmission in the event that the contact becomes contagious before symptoms developed.

Transmissibility (1-5)	3
Clinical severity (1-7)	5-6.5
Recommend implementing at	D



Rationale for Use as Public Health Strategy

Quarantine refers to the separation and restriction of movement of persons who, while not yet ill, have been exposed to an infectious agent and therefore may become infectious. Quarantine of exposed persons is a public health strategy intended to stop the spread of infectious disease. Quarantine is medically very effective in protecting the public from disease.

Certain infected but not yet symptomatic individuals may unknowingly infect friends, neighbors, and others in the community before becoming symptomatic.

In situations of highly transmissible and clinically severe infections where there are asymptomatic contacts who are not willing to quarantine, authorities may want to consider involuntary quarantine of contacts of sick persons to prevent possible disease spread, especially for novel pathogens of concern.

Success Factors: Success depends on health care facility and/or public health system ability to implement.

Possible Drawbacks: Involuntary quarantine is extremely restrictive and resource intensive.

Possible Benefits: Quarantine is extremely effective in reducing the spread of illness. Non-compliant persons can be prevented from spreading the disease.

Settings and Use

- Consider using involuntary quarantine for contacts who are not reliable or compliant and who were exposed to a sick person but are asymptomatic to avoid potential spread of disease.
- Involuntary quarantine at a designated facility is only recommended when an individual is not reliable or compliant.

Jurisdictional Authority and Key Decision Makers

Local, State

Key Decision Makers: The local health officer and/or Secretary of Health may issue a detention order for involuntary quarantine when they have reason to believe the person is, or is suspected

to be, infected with or exposed to a communicable disease and poses a serious and imminent risk to the health and safety of others if not quarantined. The local health officer must first make reasonable efforts to obtain voluntary compliance, unless doing so would create a risk of serious harm. An order directly from a local health officer may last for up to 10 days. A court may order a longer period of quarantine. Violation of a quarantine order is a misdemeanor for which individuals may be arrested, fined, and imprisoned up to 90 days.

Local health officers, and the Secretary of Health under the circumstances outlined in RCW 43.70.130(7), have the authority to request isolation or quarantine under WAC 246-100-040. The health officer can authorize which people can enter the isolation or quarantine facility to provide medical care and/or meet the needs of the sick person. Any person who enters an isolation or quarantine facility without authorization is subject to quarantine by the health officer.

The State Board of Health (SBOH) has broad power to "adopt rules for the imposition and use of isolation and quarantine" (RCW 43.20.050(2)(e)). Local Health Officers and the Secretary of Health can issue isolation and quarantine orders based on SBOH rules.

Applicable Law(s):

- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)
- [WAC 246-100-040 – Procedures for isolation or quarantine](#)
- [WAC 246-100-045 - Conditions and principles for isolation or quarantine](#)
- [WAC 246-100-050 - Isolation or quarantine premises](#)
- [WAC 246-100-055 - Relief from isolation or quarantine](#)
- [WAC 246-100-070 – Enforcement of local health officer orders](#)
- [RCW 43.20.050 - Powers and Duties of the State Board of Health](#)
- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)
- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [RCW 70.05.120\(4\) – Violations – Remedies - Penalties \(misdemeanor for violation of an order\)](#)

Forms (find all instructions and forms on [DOH's website](#)):

- [Emergency Involuntary Detention Order \(Word\)](#)
In addition to the form available at the link above, a COV-19 specific involuntary detention order is available. Please contact DOH for use.
- [Confidential Schedule \(Word\)](#)
- A local health officer may issue an isolation order immediately. Such an order is subject to court challenge. A court order is required to isolate an individual for longer than 10 days. Law enforcement may arrest an individual for violating a local health officer's or a court order. A court order is also enforceable through contempt proceedings.

When no attempt is made to seek voluntary compliance due to the serious and imminent risk to the public, use the following forms:

- [Summons \(Word\)](#)
- [Detention ex parte petition \(Word\)](#)
- [Confidential schedule \(Word\)](#)
- [Declaration supporting ex parte detention petition \(Word\)](#)

- [Order ex parte for involuntary detention \(Word\)](#)

When voluntary compliance was sought, but the individual refused or otherwise indicated that he or she would not comply, use the following forms:

- [Summons \(Word\)](#)
- [Detention ex parte petition when voluntary detention refused \(Word\)](#)
- [Confidential schedule \(Word\)](#)
- [Declaration supporting ex parte detention petition when voluntary detention refused \(Word\)](#)
- [Order ex parte when voluntary detention refused \(Word\)](#)

Federal

The diseases subject to quarantine under federal law are determined by Executive Order. The most recent order published in the [Federal Register](#) includes severe acute respiratory syndromes and provides the basis for federal quarantine.

Applicable Law(s):

- [42 U.S.C. § 264 - Regulations to control communicable diseases](#)
- [42 C.F.R. Part 70 - Interstate Quarantine](#)
- [42 C.F.R. Part 71 - Foreign Quarantine](#)
- [Public Law 113-5 – Pandemic and All Hazards Preparedness Reauthorization Act](#)
- [42 U.S.C. § 201 et seq. – Public Health Service Act](#)

Tribal

- Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government. Tribal nations may decide their own criteria for isolation.

Decisional Objectives/Key Decision Points

- Language for health officer order and involuntary detention court orders.
- Definition of “close contact” (including length of exposure to ill person, travel history, etc.)
- Location(s) of quarantine facility (home, government facility, etc.)
- Length of quarantine
- Communication strategies and plan
- Determine need for material services to meet essential needs (food, laundry, utilities, prescription medication, social support, etc.) and who will authorize providing these services.
- Plan to move persons under quarantine to a health care facility if they develop symptoms
- Plans and logistics for specimen collection or provision of other medical services, if needed.
- Active monitoring for persons under quarantine

Implementation Methods

- **Health officer order for emergency detention**
 - Once the person is ordered into quarantine, the local health officer should seek a court order and must consider individual rights to due process. Seeking a court order quickly is a good idea if isolation sought is more than 10 days.
 - The needs of a person isolated or quarantined must be addressed to the greatest extent possible in a systematic and competent fashion, including, but not limited to, providing adequate food, clothing, shelter, means of communication with those in isolation or

quarantine and outside these settings, medication, and competent medical care. Cultural and religious beliefs should be considered in addressing their needs.

- **Standing orders within a hospital**
 - Work with the hospital facility or designated health care provider and the health officer to create standing orders for the care of individuals in involuntary quarantine.

Special Considerations

- Food, water, basic needs, and other support services for quarantined individuals.
- This intervention will require detailed coordination between state and local government officials.
- Court orders for involuntary isolation may be required.
- Tribal nations may decide their own criteria for isolation.
- When the individual is released, consider providing them with a letter that recognizes their release so they will not be mistakenly reported as not complying with the quarantine order.

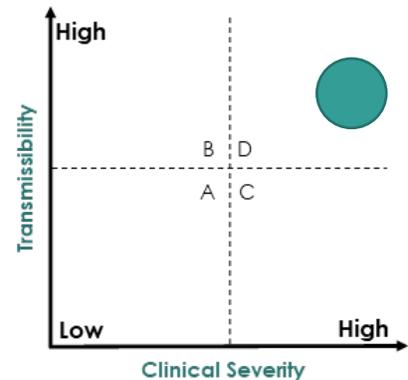
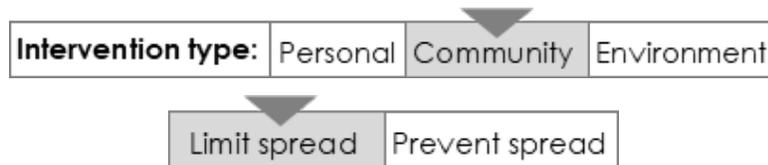
Decisional Objectives/Key Decision Points

- Language for health officer order and involuntary detention court orders.
- Definition of “close contact” (including length of exposure to ill person, travel history, etc.)
- Location(s) of quarantine facility (home, government facility, etc.)
- Length of quarantine
- Communication strategies and plan
- Determine need for material services to meet essential needs (food, laundry, utilities, prescription medication, social support, etc.) and who will authorize providing these services.
- Plan to move persons under quarantine to a health care facility if they develop symptoms
- Plans and logistics for specimen collection or provision of other medical services, if needed.
- Active monitoring for persons under quarantine

Intervention 10: Recommend or Order Cancellation of Major Public and Large Private Gatherings

Reduce probability of transmission by reducing the number of the interpersonal contacts.

Transmissibility (1-5)	4
Clinical severity (1-7)	5-7
Recommend implementing at	D



Rationale for Use as Public Health Strategy

Social distancing measures, such as cancellation or postponement of mass gatherings, reduce opportunities for person-to-person virus transmission and can help delay the spread and slow the exponential growth of disease spread. The optimal strategy is to implement these measures simultaneously in places where people gather.

Canceling mass gatherings, in combination with other social distancing measures (e.g., patient isolation, quarantine of exposed persons, and school closures), may help reduce virus transmission.

Success Factors: Success depends upon event sponsor compliance and authorities' ability to enforce effectively.

Possible Drawbacks: May result in revenue loss, public outrage, or political backlash, and may disproportionately affect certain cultural and community groups.

Possible Benefits: Reduces opportunities for widespread disease transmission by reducing interpersonal contacts and increasing social distance.

Settings and Use

- Social distancing measures can be implemented in a range of community settings, including public places where people gather (e.g., parks, houses of worship, theaters, sports arenas).
- Modifying, cancelling, or postponing events is an approach that might reduce face-to-face contact in community settings.

Jurisdictional Authority and Key Decision Makers

Local

Key Decision Makers: Local health officer and local board of health have authority to control and prevent spread of contagious or infectious diseases within their jurisdiction and to inform the public about the nature of the disease and prevention methods. This includes issuing orders to cancel events.

Intervention 10: Recommend or Order Cancellation of Major Public and Large Private Gatherings

Last updated: 2/28/2020

Key Stakeholders: Decision should be made in coordination with local elected officials (such as mayor, city council, county council, and/or county executive), emergency managers, local law enforcement, impacted businesses, proprietors, cultural and religious leaders, event sponsors and event organizers.

Applicable Law(s) for Decision Makers:

- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)
- [WAC 246-100-070 – Enforcement of local health officer orders](#)

State

Key Decision Makers: In an emergency or when a local health officer consents or does not act, the Secretary of Health may exercise the same authority as a local health officer to control and prevent disease and issue orders to cancel events. The Secretary of Health also has the authority to promote public health activities and educational campaigns.

The Governor has broad authority to proclaim a state of emergency in order to preserve life, health, property, or the public peace ([RCW 43.06.220](#)). A governor declared emergency could trigger limitations such as curfews, prohibitions of people on streets and open areas, limit use of streets, highways or public ways; or other broad restrictions outlined by the law, such as prohibiting travel.

Washington’s laws against discrimination are outlined in RCW 49.60. Public officials should consider how communities may be impacted and take action to remove stigma that may marginalize or discriminate against groups.

Applicable Law(s):

- [RCW 43.06.220 – State of emergency – powers of governor pursuant to proclamation](#)
- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#) (can be exercised by Secretary)
- [RCW 49.60 – Discrimination – Human Rights Commission](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government. They may decide their own criteria for canceling large gatherings.

Federal

Key Decision Makers: The federal government has independent authority when emergencies cross state and national borders.

Applicable Law(s):

- [42 U.S.C. § 247d – Public health emergencies](#)
- [42 U.S.C. § 264 - Regulations to control communicable diseases](#)
- [28 CFR Part 35 – Nondiscrimination on the Basis of Disability in State and Local Government Services](#)

Decisional Objectives/Key Decision Points

- Establish guidance/requirements needed to request or order the cancellation of gatherings.
- Identify affected events and disproportionately impacted communities.
 - Research upcoming cultural and religious holidays, observances, and events.
 - Assess economic impact for both individuals and larger communities (loss of wages, tourism revenue)
- Plan community engagement efforts, methods, and approaches that are responsive to the needs, preferences, and values of the community.
- Develop strategies to gain buy-in from event organizers and leadership
- Plan for enforcement of cancellations
 - Partner with trusted community leaders
 - Assess need, benefit, and potential unintended consequences of working with law enforcement/security personnel.
 - Create mitigation strategies, as needed, to address any real, potential, or perceived issues or consequences of enforcement activities.
- Determine whether events should be pre-emptively canceled.
- Proactively address unintended consequences that inequitably impact historically marginalized individuals and communities may further erode trust with governmental systems needed for overall public health and future response efforts.
- Ensure all strategies, communications, and engagement are culturally and linguistically appropriate and meet readability and accessibility guidelines.

Healthcare Considerations

- Consider impact on the healthcare system and their current capacity and if the intervention would reduce or increase burden.
- Determine if implementation would mitigate burden on health care system to maintain essential medical services, especially for underserved populations.
- Identify if this would decrease or increase absenteeism among health care workers.
- Potential legal and ethical issues involving altered standards of care.

Implementation Methods

- **Health officer order or request that major government-sponsored events/gatherings be cancelled or postponed.**
 - Meet with event organizers, committees and employees.
 - Explain the situation
 - Offer alternatives, if any, including new location, rescheduling the event, or changing entrance rules.
 - Government-sponsored events or gatherings may be affected anyway due to the Continuity of Operations Plan.
 - Work with public information officers/communication teams to get the information out with relevant Q&As and FAQs
- **Create and distribute accessible, public messaging about closures**
 - General messaging about why these measures are being taken.

- Work with communications team to create messages that:
 - Meet readability and accessibility guidelines.
 - Are culturally and linguistically relevant.
 - Are translated into the most spoken languages in the affected area.
 - Are relevant/adaptable to the changing nature of the incident/outbreak.
- Communicate through multiple platforms and channels appropriate to the affected communities
- Engage with community leaders or representatives for advice and buy-in.
- Provide messages to LHJs and other partners to share with their constituents.
- Provide consistent messaging throughout the state via media outreach.
- Develop tailored messaging for disproportionately impacted communities.
- Specific messaging about the cancellation of specific events.
 - Display appropriate messaging in places where attendees may see them.
 - Work with event organizers and to use their communication methods.

Special Considerations

- Requires excellent and effective communication mechanisms to notify community of details and rationale. Communications must be culturally relevant and in a language and format that the audience can understand to be effective.
- Any attempts to implement social distancing in cultural & religious gatherings should be informed by cultural & religious leaders.
- Canceling events could affect civic participation and social cohesion. It could also create an opportunity for discrimination if only certain events are closed.
- Postponing the event may benefit or negatively impact employees as well as attendees or participants, depending on the event and the individual's role.
- This intervention will require detailed coordination between state, local government officials, and community organizations/leaders/groups.
- This intervention will require detailed coordination with the event organizers and planners.
- Cancellation of large events may affect individual income, revenue, employment, economic opportunity, and commerce.
- Coordination with the Office of the Governor and/or local government leadership may be needed.
- There should be consistency in which events are cancelled. Cancellation should not be based on the communities likely to attend or work at the event.
- Culturally and religiously diverse communities may be disproportionately impacted.
- Families on the brink of housing insecurity may be disproportionately impacted by loss of wages, potentially increasing risk of missing rent payments, potentially increasing risk of eviction and homelessness. Homeless individuals already experience barriers to health care, services, and information.
- Unintended consequences that inequitably impact historically marginalized individuals and communities may further erode trust with governmental systems needed for overall public health and future response efforts.

Intervention 10: Recommend or Order Cancellation of Major Public and Large Private Gatherings

- Social distancing measures, such as cancellation or postponement of mass gatherings, reduce opportunities for person-to-person virus transmission and can help delay the spread and slow the exponential growth of disease spread. The optimal strategy is to implement these measures simultaneously in places where people gather, and to do so strategically in ways that maximize the benefit of reducing interpersonal contacts, particularly for people at increased risk, while also working to minimize the burden on society resulting from the intervention.

Thresholds for Considering Implementation:

- **Threshold 1:** Unmitigated or uncontained community transmission is occurring in several or many major US cities but there may not be evidence of community transmission in WA yet. In such a circumstances, authorities should consider initiating minimally restrictive/burdensome but effective mitigation measures.
- **Threshold 2:** Evidence that unmitigated or uncontained community transmission is occurring in WA State, but only in one or two jurisdictions, that cannot be contained.
- **Threshold 3:** Evidence that unmitigated or uncontained community transmission of disease is occurring across WA State (in more than 2 large jurisdictions).

Rationale for Use as Public Health Strategy

Recommending or ordering cancellation of mass gatherings, in combination with other social distancing measures (e.g., patient isolation, quarantine of exposed persons, and public site closures), may help reduce virus transmission.

General assumptions: COVID-19 is known to cause more severe disease illness in individuals with known underlying medical conditions as well as in older individuals (60 years of age and greater), COVID-19 symptoms are currently believed to be relatively mild or almost non-existent in younger populations, and as of 2/27/2020, COVID-19 is spreading now in 47 countries outside of the United States with known community transmission occurring in 10 countries.

Success Factors: Success depends upon event sponsor compliance and authorities' ability to enforce effectively. All non-pharmaceutical interventions have the greatest effect when implemented early and effectively.

Possible Drawbacks: May result in revenue loss, public outrage, or political backlash, and may disproportionately affect certain cultural and community groups. For these reasons, working with communities and event organizers to voluntarily cancel events and gatherings is strongly preferred.

Possible Benefits: Reduces opportunities for widespread disease transmission by reducing interpersonal contacts and increasing social distance. The larger the event and the closer the

interpersonal interactions/contact expected at each event, the more benefit can be derived through canceling the event

Settings and Use

Social distancing measures can be implemented in a range of community settings, including public places where people gather (e.g., parks, houses of worship, theaters, sports arenas). Modifying, cancelling, or postponing events is an approach that might reduce face-to-face contact in community settings.

Operational Strategies for Threshold 1:

- Recommend and implement voluntary event cancellations for large gatherings.
 - Specifically, recommend postponing or canceling events with large numbers of high risk individuals (older adults or individuals with known health conditions).
- For events that will be ongoing, consider:
 - Review and implement NPI 1-5 strategies at venue sites to assure adequate precautions are in place, including:
 - Screening at point of entry for symptomatic persons, including taking temperatures, at events for exclusion.
 - Ensure that hand hygiene stations are available for all attendees.
 - Address social distancing recommendations through site setup strategies.
 - Communicate with high risk groups the importance of staying home and non-attendance for major gatherings.
 - Address re-imbursement policy for attendees who are ill or in high risk group.

Operational Strategies for Threshold 2:

- Continue efforts under Threshold 1.
- Stronger recommendations for event cancellations for areas impacted.
- Voluntary recommendations for non-high risk geographic areas in WA State.

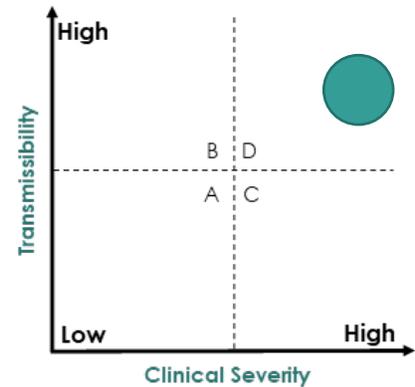
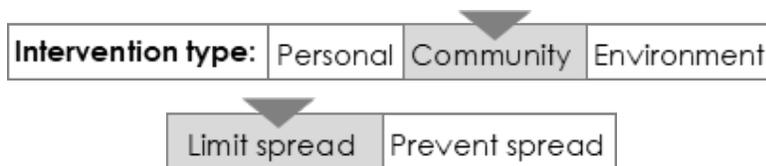
Operational Strategies for Threshold 3:

- Continue efforts under Thresholds 2.
- Ordering of event cancellations statewide.

Intervention 11: Recommend or Order Closure of Public or Private Sites within impacted communities

Viruses quickly and easily spread in places where people gather in close contact, such as schools, child care facilities, workplaces, and public buildings. Dismissing or closing such facilities may be considered to limit disease spread by reducing the number of interpersonal contacts.

Transmissibility (1-5)	4
Clinical severity (1-7)	5-7
Recommend implementing at	D



Rationale for Use as Public Health Strategy

Social distancing measures, including closure of buildings, reduce opportunities for person-to-person virus transmission and can help delay the spread and slow the exponential growth of disease spread. If disease spread is occurring in a school, child care facility or public building, dismissing students, staff, or the public from these locations or closing the locations early can limit further spread. The optimal strategy may be to implement several social distancing steps simultaneously where large groups of people gather.

Success Factors: Early implementation of dismissals or closures to limit spread. Facility compliance and authorities’ ability to enforce effectively.

Possible Drawbacks: May result in missed school days, revenue loss, public outrage, or political backlash. It may disproportionately affect certain cultural and community groups. Low income and other vulnerable communities may be put at risk for non-outbreak related harm if they are unsupervised, don’t have access to an adult caretaker, or cannot communicate with the outside world if there is an emergency. It may cause disruption for families and communities. Adults may experience missed work and loss of income from their workplace closure or to stay home to care for children.

Possible Benefits: Reduces opportunities for widespread disease transmission by reducing interpersonal contacts and increasing social distance.

Settings and Use

Specific priority settings include schools, child cares, workplaces, meetings, and other places where people gather (e.g., parks, religious institutions, theaters, and sports arenas).

Early dismissal or closing facilities is a social distancing measure that may reduce face-to-face contact in community settings to reduce the spread of diseases transmitted by contact, droplets, or air. Choose social distancing measures depending on the severity of the disease.

School or child care: Examples of social distancing, closures and dismissals could include:

- Dismissing or cancelling classes and use web-based distance learning instead
- Pre-emptive, coordinated school closures or dismissals at child care facilities, K–12 schools, and institutions of higher education.
- Canceling school concerts, after-school programs, or sporting events.

Workplaces and public buildings: Many work settings involve shared work space, equipment, and face-to-face contact. Public buildings can bring many people into close contact. Examples of social distancing for these settings include telecommuting and remote-meeting options in workplaces.

Jurisdictional Authority and Key Decision Makers

Local

Key Decision Makers: Local health officer and local board of health have authority to control and prevent spread of contagious or infectious diseases within their jurisdiction and to inform the public about the nature of the disease and prevention methods.

When there is a potential for an outbreak within a school or childcare center, local health officers have the authority to order school superintendents and childcare center administrators to close their facilities, cancel events, and/or exclude students, staff, and volunteers.

Key Stakeholders: Decision should be made in coordination with school superintendents, boards of education, local elected officials (such as mayor, city council, county council, and/or county executive), child care administrators, private sector, emergency managers, local law enforcement, impacted businesses, proprietors, event sponsors and event organizers.

Applicable Law(s):

- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [WAC 246-100-021 – Responsibilities and duties – Health care providers](#)
- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)
- [WAC 246-100-070 – Enforcement of local health officer orders](#)
- [WAC 246-110-020 – Control of contagious disease \(schools and childcare centers\)](#)

State

Key Decision Makers: In an emergency or when a local health officer consents or does not act, the Secretary of Health may exercise the same authority as a local health officer to control and prevent disease. The Secretary of Health also has the authority to promote public health activities and educational campaigns.

Applicable Law(s):

- [RCW 43.70.020\(3\) – Department of Health created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)
- [RCW 70.05.070 – Local health officer – powers and duties \(can be exercised by Secretary\)](#)

- [RCW 49.60 – Discrimination – Human Rights Commission](#)

Tribal

- Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government. They may decide their own criteria for canceling school, child care, and tribal facilities.

Federal

Key Decision Makers: The federal government has independent authority when emergencies cross state and national borders.

Applicable Law(s):

- [42 U.S.C. § 247d – Public health emergencies](#)
- [42 U.S.C. § 264 - Regulations to control communicable diseases](#)
- [28 CFR Part 35 – Nondiscrimination on the Basis of Disability in State and Local Government Services](#)

Decisional Objectives/Key Decision Points

- Scale of closures (e.g. specific schools, districts, ages, geographic regions)
- Identify affected facilities
- Determine whether closure is limited to certain at-risk groups or applies to the general public.
- Length of closure
- Determine building cleaning protocols, if needed.
- Personal Protective Equipment (PPE), if any, for persons cleaning closed facilities
- Communication strategies and plan
- How to get employer engagement and buy-in

Healthcare Considerations

- Consider impact on the healthcare system and their current capacity and if the intervention would reduce or increase burden.
- Determine if implementation would mitigate burden on health care system to maintain essential medical services, especially for underserved populations.
- Increase in absenteeism among health care workers if schools and childcare are closed.
- Potential legal and ethical issues involving altered standards of care.

Implementation Methods

- **Local health officials and local school administrators work closely together in decision making to implement closures and dismissals.**
 - Include communication to parents and the public in case of school or child care closure.
 - Include communication to employees in case of a workplace closure.
- **Communicate to the media, partners, and the public about any facility or building closure.**
 - Create culturally relevant publications in all needed languages.
 - Work through the building or organization’s communication channels.
 - Communicate on multiple platforms appropriate to the affected communities

- Provide consistent messaging throughout the state via media outreach.

Special Considerations

- Local health policies and risk communication strategies should take into account community attitudes and acceptance of preventive behaviors related to social distancing, which might differ across racial/ethnic, cultural, and economic groups.
- Strategies can be used in settings like schools (e.g., closure), workplaces (e.g., phone conferences instead of in-person meetings), and mass gatherings (e.g., postponement or cancellation) to reduce spread and infections. Multiple social distancing measures can be implemented simultaneously.
- Regarding school and child care closures, public officials should make decisions that balance local benefits and potential harms and consider timing, flexibility, and modifications to intervention based on the severity of local conditions.
- Requires advanced planning and preparation, as well as political leadership; collaboration between public health and emergency management agencies; coordination with schools, child care, businesses, nongovernmental organizations, and community- and faith-based organizations; and clear communication with the public.
- Cancelling school, child care facilities, workplaces, and public buildings would reduce income for staff working in those locations. Additionally, this could impact the income of working parents left without childcare and school and impact the ability for students to learn.
- Consider options for students who receive free or reduced-price student lunches to continue receiving meals during missed school days. Families experiencing housing insecurity or homelessness may need additional and proactive planning to ensure children are able to access alternative meals during closures.
- Unintended consequences that inequitably impact historically marginalized individuals and communities may further erode trust with governmental systems needed for overall public health and future response efforts.
- Ensure all strategies, communications, and engagement are culturally and linguistically appropriate and meet readability and accessibility guidelines.

Intervention 11: Recommend or Order of Schools, Child Care Facilities, Workplaces, and Public Buildings

- Viruses quickly and easily spread in places where people gather in close contact, such as community centers, VFWs, senior centers, assisted living centers, long term care facilities, schools, child care facilities, workplaces, and public buildings. Dismissing or closing such facilities may be considered to limit disease spread by reducing the number of interpersonal contacts. In cases where closure is impossible, limiting access to visitors, symptom screening prior to entry, and other measures may be considered to reduce risk of disease introduction into a congregate care or living setting.
- This intervention should be done in alignment with all other NPI strategies (1-10).

Thresholds for Implementation:

- Threshold 1: Unmitigated or uncontained community transmission is occurring in several or many major US cities but there may not be evidence of community transmission in WA yet. In such a circumstances, authorities should consider initiating minimally restrictive/burdensome but effective mitigation measures.
- Threshold 2: Evidence that unmitigated or uncontained community transmission is occurring in WA State, but only in one or two jurisdictions, that cannot be contained.
- Threshold 3: Evidence that unmitigated or uncontained community transmission of disease is occurring across WA State (in more than 2 large jurisdictions).

Rationale for Use as Public Health Strategy

Social distancing measures, including closure of buildings, reduce opportunities for person-to-person virus transmission and can help delay the spread and slow the exponential growth of disease spread. If disease spread is occurring in a school, child care facility or public building, dismissing students, staff, or the public from these locations or closing the locations early can limit further spread. The optimal strategy may be to implement several social distancing steps simultaneously where large groups of people gather.

General assumptions: COVID-19 is known to cause more severe disease illness in individuals with known underlying medical conditions as well as older individuals (60 years of age or greater), COVID-19 symptoms are currently believed to be relatively mild or almost non-existent in younger populations, and as of 2/27/2020 COVID-19 is spreading now in 47 countries outside of the United States with known community transmission occurring in 10 countries.

Success Factors: Early implementation of dismissals or closures to limit spread. Facility compliance and authorities' ability to enforce effectively.

Possible Drawbacks: May result in missed school days, revenue loss, public outrage, or political backlash. It may disproportionately affect certain cultural and community groups. Low income and other vulnerable communities may be put at risk for non-outbreak related harm if they are

unsupervised, don't have access to an adult caretaker, or cannot communicate with the outside world if there is an emergency. It may cause disruption for families and communities. Adults may experience missed work and loss of income from their workplace closure or to stay home to care for children.

Possible Benefits: Reduces opportunities for widespread disease transmission by reducing interpersonal contacts and increasing social distance.

Settings and Use

Facility quarantine or closing facilities is a social distancing measure that may reduce face-to-face contact in community settings to reduce the spread of diseases transmitted by contact, droplets, or air. Choose social distancing measures depending on the severity of the disease.

Operational Strategies for Threshold 1:

- Recommend worksite telecommuting options.
- Strengthen public messaging around “if sick stay home.”
- Work with employers to relax/extend sick leave benefits for employees, and encourage or require employees to remain at home if they are sick
- Provide additional guidance for high risk population movement restrictions or protection measures.
 - Make recommendations for limiting visitation hours at Long Term Care (LTC) facilities or provide guidance on appropriate protection for any visitors.
 - Assure appropriate guidance is given to assisted living centers and retirement communities to mitigate potential transmission of disease at these sites. Recommend residents be vigilant at identifying their symptoms and contact local public health jurisdictions and their healthcare provider when symptoms present and isolating at home.
 - Recommend the continued use of NPI 1-5 measures at community centers, correctional centers, and other highly frequented community gathering locations especially those where high risk individuals may congregate (i.e. VFWs).
 - Provide recommendations for the exclusion of school age children with known underlying medical conditions.
 - Strengthen recommendations for social distancing within worksites that must maintain operations.
 - Increase general messaging on NPIs 1-5 for the community at wide and develop strategically directed messages for potentially high risk populations within the state.

Operational Strategies Threshold 2:

- Continue all strategies under Level 1 activation
- Enhance recommendations directed to the impacted jurisdictions, to include:
 - Recommend closure of community centers, senior recreational centers, VFWs, ELKS clubs, etc.

- Consider closure of businesses:
 - Businesses identify all non-essential functions that could be stood down.
 - Ask all business partners to transition eligible staff to telework.
- Consider closure of schools and universities activities and events.
- Consider closures of schools, child care centers, and universities.
- Consider closure of mass transit.
- Recommend or order closures of mass community gathering locations such as bowling alleys, malls, movie theatres.
- Message across the state the potential risk to travel to impacted jurisdictions.

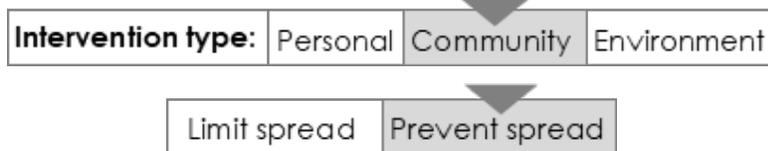
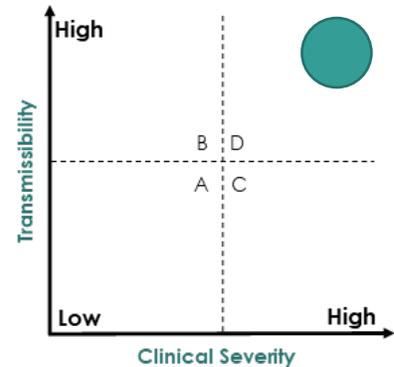
Operational Strategies Threshold 3:

- Continue all strategies under Level 2 activation
- Enhance mass messaging to the population across the state on NPI 1-7.
- Increase span of recommendations under level 2 for the entire state:
 - Recommend closure of community centers, senior recreational centers, VFWs, ELKS clubs, etc.
 - Consider closure or businesses
 - Recommend businesses identify all non-essential functions.
 - Ask all business partners to transition eligible staff to telework.
 - Consider or order closure of schools and universities activities and events.
 - Consider or order closures of schools, child care centers, and universities.
 - Consider or order closure of mass transit.
 - Recommend or order closures of mass community gathering locations such as bowling alleys, malls, movie theatres.

Intervention 12: Prevent Non-Emergency Travel Outside the Home

Limiting travel outside of the home will reduce probability of the transmission by reducing the numbers of the interpersonal contacts. Travel should be restricted to emergency use only.

Transmissibility (1-5)	5
Clinical severity (1-7)	5.5-7
Recommend implementing at	D



Rationale for Use as Public Health Strategy

This intervention is a more extreme measure of social distancing, which reduces occasions for person-to-person virus transmission to help delay the spread and slow the exponential growth of a pandemic.

Success Factors: Success depends upon compliance and authorities’ ability to enforce effectively.

Possible Drawbacks: Will prevent the operation of public entities and private businesses; the effect will be felt economically by employees as loss of income, and the public as lack of commodity availability. Revenue loss; public outrage; and political backlash are possible. Travel restrictions may disproportionately affect certain cultural and community groups.

Possible Benefits: Reduces opportunities for direct or indirect disease spread, and may prevent a disease from entering new geographical region.

Settings and Use

- Travel restrictions are conditionally recommended during an early stage of a localized and extraordinarily severe pandemic for a limited period of time. Before implementing, consider cost, acceptability and feasibility, as well as ethical and legal considerations, in relation to this measure.
- This intervention should be considered when less-restrictive interventions have failed or to prevent disease introduction into new geographical areas.

Jurisdictional Authority and Key Decision Makers

Local, State

Key Decision Makers: Local governments have police power to protect the public health under the U.S. Constitution’s 10th Amendment, granting authority to implement restrictions on private rights for the sake of public welfare, order, and security. It also includes reasonable regulations to protect public health and safety. Under the 10th Amendment, police powers resides with state and local authorities unless specifically delegated to federal government. Local governments

may need to collaborate with state and federal partners as the complexity of the emergency increases. Local governments may request support from the state.

The Governor has broad authority to proclaim a state of emergency in order to preserve life, health, property, or the public peace ([RCW 43.06.220](#)). A governor declared emergency could trigger limitations such as curfews, prohibitions of people on streets and open areas, limit use of streets, highways or public ways; or other broad restrictions outlined by the law, such as prohibiting travel.

Washington's laws against discrimination are outlined in RCW 49.60. Public officials should consider how communities may be impacted and take action to remove stigma that may marginalize or discriminate against groups.

Key Stakeholders: Decision should be made in coordination with local elected officials (such as mayor, city council, county council, and/or county executive), private sector, emergency managers, local law enforcement, school superintendents, boards of education, health care, and transportation agencies.

Applicable Law(s):

- [RCW 43.06.220 – State of emergency – powers of governor pursuant to proclamation](#)
- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)
- [RCW 70.05.060 – Powers and duties of local board of health](#)
- [RCW 70.05.070 – Local health officer – powers and duties](#)
- [RCW 49.60 – Discrimination – Human Rights Commission](#)
- [WAC 246-100-021 – Responsibilities and duties – Health care providers](#)
- [WAC 246-100-036 – Responsibilities and duties – Local health officers](#)
- [WAC 246-100-070 – Enforcement of local health officer orders](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

Federal

Key Decision Makers: The federal government has independent authority when emergencies cross state and national borders.

Applicable Law(s):

- [42 U.S.C. § 201 et seq. – Public Health Service Act](#)
- [42 U.S.C. § 247d – Public health emergencies](#)
- [42 U.S.C. § 264 - Regulations to control communicable diseases](#)
- [28 CFR Part 35 – Nondiscrimination on the Basis of Disability in State and Local Government Services](#)
- [Public Law No. 116-22 – 2019 Pandemic and All-Hazards Preparedness and Advancing Innovation Act \(PAHPAIA\)](#)
- [Public Law 113-5 – Pandemic and All Hazards Preparedness Reauthorization Act](#)

Decisional Objectives/Key Decision Points

- Define “essential travel”
- Define geographic location for ban on non-essential travel and length of ban.
- Communication strategies and communication plan
- Enforcement plan in coordination with law enforcement
 - Personal Protective Equipment (PPE) needed for enforcement officials
- Movement plan for individuals with essential travel needs
- Consider support of elected officials in issuing the order
- Consider how individual or community will access emergency services, if needed, during the restriction period
- Determine need for material support and services to meet essential needs (food, laundry, utilities, prescription medication, social support, etc.) and who will authorize providing services.
- Plans and logistics for specimen collection or providing other medical services, if needed.

Healthcare Considerations

- Consider impact on the healthcare system and their current capacity and if the intervention would reduce or increase burden.
- Determine if implementation would mitigate burden on health care system to maintain essential medical services, especially for underserved populations.
- Increase in absenteeism among health care workers if schools and childcare are closed.
- Potential legal and ethical issues involving altered standards of care.

Implementation Methods

- Health officer order to the public to cease all non-essential travel.
- Work with law enforcement agencies to enforce.
 - Enforcement must be feasible and within the capabilities of the agency.
- Distribute messaging to help the public understand the reason for the measure and what to do.
 - Ensure messaging is culturally and linguistically appropriate for any groups disproportionately affected by the travel restriction. Ensure messaging is accessible for individuals with disabilities and available in alternative formats.

Special Considerations

- Consider obtaining support of elected officials in issuing such a restrictive order.
- This intervention will require detailed coordination between state and local government officials.
- Law enforcement will be necessary to enforce the travel ban.
- Schools, transit services, and places of work will be affected.
- Sovereign tribal nations may decide their own criteria for non-emergency travel.
- Consider possible impacts to the health care system, such as an increase in people seeking care.
- Plan in advance any services needed to support the community during the restriction period.

Intervention 12: Prevent Non-Emergency Travel Outside the Home

Last updated: 2/24/2020

- Unintended consequences that inequitably impact historically marginalized individuals and communities may further erode trust with governmental systems needed for overall public health and future response efforts.
- Ensure all strategies, communications, and engagement are culturally and linguistically appropriate and meet readability and accessibility guidelines.

Intervention 12: Prevent Non-Emergency Travel Outside the Home

- Limiting travel outside of the home will reduce probability of the transmission by reducing the numbers of the interpersonal contacts. Travel should be restricted to emergency use only.
- Intervention 12 should not be done without Intervention 10-11 strategies also being implemented.

Thresholds for Implementation:

- Threshold 1: Unmitigated or uncontained community transmission is occurring in several or many major US cities but there may not be evidence of community transmission in WA yet. In such a circumstances, authorities should consider initiating minimally restrictive/burdensome but effective mitigation measures.
- Threshold 2: Evidence that unmitigated or uncontained community transmission is occurring in WA State, but only in one or two jurisdictions, that cannot be contained.
- Threshold 3: Evidence that unmitigated or uncontained community transmission of disease is occurring across WA State (in more than 2 large jurisdictions).
- Threshold 4: Health care system is significantly impacted and/or we have clear evidence that the case hospitalization and case fatality rate are higher than previously thought.

Rationale for Use as Public Health Strategy

This intervention is a more extreme measure of social distancing, which reduces occasions for person-to-person virus transmission to help delay the spread and slow the exponential growth of a pandemic.

General assumptions: COVID-19 is known to cause more severe disease illness in individuals with known underlying medical conditions as well as older individuals (60 years of age or greater), COVID-19 symptoms are currently believed to be relatively mild or almost non-existent in younger populations, and COVID-19 is spreading now in 47 countries outside of the United States with known community transmission occurring in 10 countries.

Success Factors: Success depends upon compliance and authorities' ability to enforce effectively.

Possible Drawbacks: Will prevent the operation of public entities and private businesses; the effect will be felt economically by employees as loss of income, and the public as lack of commodity availability. Revenue loss; public outrage; and political backlash are possible. Travel restrictions may disproportionately affect certain cultural and community groups. Includes community impacts such as food/groceries, gas station fuel, utilities.

Possible Benefits: Reduces opportunities for direct or indirect disease spread, and may prevent a disease from entering new geographical region.

Settings and Use

Travel restrictions are conditionally recommended during an early stage of a localized and extraordinarily severe pandemic for a limited period of time. Before implementing, consider cost, acceptability and feasibility, as well as ethical and legal considerations, in relation to this measure. This intervention should be considered when less-restrictive interventions have failed or to prevent disease introduction into new geographical areas.

Operational Strategy for Threshold 1:

- Strengthen public health messaging and communication efforts on NPI 1-11.
- Communicate CDC travel restrictions to WA State residents and make recommendations for limiting travel outside of the state.
 - Include enhanced messaging on traveler monitoring of symptoms for WA state residents.

Operational Strategy for Threshold 2:

- Continue efforts for messaging on NPI 1-11 as appropriate.
- Maintain communication locally on CDC travel restrictions and expand messaging to include local travel restrictions within highly impacted jurisdictions.
- Strengthen guidance for staying at home for non-emergent situations for impacted jurisdictions with 2nd generation spread of disease.
 - Additionally, consider closure of additional community businesses, closure of schools, child care centers, and other locations where people congregate within the impacted community.
 - Consider postponing or cancelling non-emergent travel for older adults and those with chronic medical conditions.

Operational Strategy for Threshold 3:

- Continue efforts under Threshold 2.
- Expand recommendation for staying at home for non-emergent situations,
 - Consider wider closure of additional community businesses, closure of schools, child care centers, and other locations where people congregate across the state.
 - Consider expanding travel restrictions for older adults and those with chronic medical conditions.
 - Including identification for alternative access to medical care/treatment that would limit need for emergency travel outside a home or facility environment.

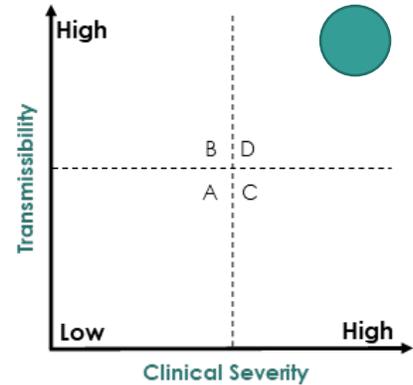
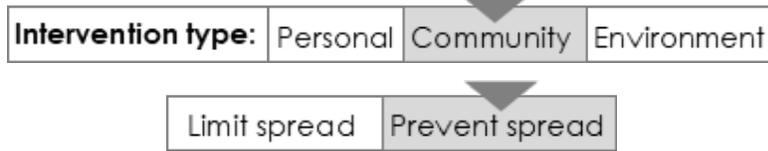
Operational Strategy for Threshold 4:

- Continue all efforts under threshold 3
- If no state of emergency has been declared, consider a declaration for non-emergency use of roadways to transport of sick persons.

Intervention 13: Establish a Cordon Sanitaire

Contains a communicable disease within specific geographical boundaries. Legally enforceable order that restricts movement into or out of an area of quarantine to reduce spread in and to persons outside affected area.

Transmissibility (1-5)	5
Clinical severity (1-7)	5.5-7
Recommend implementing at	D



Rationale for Use as Public Health Strategy

A cordon sanitaire is the restriction of movement of people in or out of the defined geographic area in order to contain disease within specific geographical boundaries. It is created around an area experiencing an outbreak or disease to prevent spread. This is a form of isolation and quarantine when applied to all inhabitants of an area as a sanitary barrier.

Success Factors: Success depends upon compliance and authorities’ ability to enforce effectively. It also depends on engaging affected people to communicate the reason for the measure and gain their support for complying.

Possible Drawbacks: Controversial because it infringes on personal freedom of movement. May lead to feeling isolated or result in the isolation of an entire community. People could be stranded without support. Commerce will be heavily compromised. Revenue loss, public outrage, and political backlash are possible. It may disproportionately affect certain cultural and community groups, low-income families, rural and under-resourced communities, and individuals with un-related acute, chronic, or severe medical needs. May be difficult to solicit cooperation.

Possible Benefits: May contain a disease within the boundaries of the cordon. Reduces need for urgent evaluation of large numbers of potential contacts to determine indications for activity restrictions. May reduce transmission among groups without explicit activity restrictions.

Settings and Use

This strategy can be used when extensive transmission is occurring, a significant number of cases lack identifiable epidemiologic links at the time of evaluation, and/or restrictions placed on persons known to have been exposed are insufficient to prevent further spread.

Consider this intervention with highly transmissible and clinically severe disease that has requires geographic containment. This could apply to diseases that are easily transmitted

human-to-human via contact, droplet, and/or airborne routes when less-restrictive interventions have failed, or to prevent introduction into new geographical areas.

Jurisdictional Authority and Key Decision Makers

Local, State

Key Decision Makers: Local governments have police power to protect the public health under the US Constitution's 10th Amendment, granting authority to implement restrictions on private rights for the sake of public welfare, order, and security. It also includes reasonable regulations to protect public health and safety. Under the 10th Amendment, police powers resides with state and local authorities unless specifically delegated to federal government. Local governments may need to collaborate with state and federal partners as the complexity of the emergency increases. Local governments may request support from the state.

The Governor has broad authority to proclaim a state of emergency in order to preserve life, health, property, or the public peace ([RCW 43.06.220](#)). A governor declared emergency could trigger limitations such as curfews, prohibitions of people on streets and open areas, limit use of streets, highways or public ways; or other broad restrictions outlined by the law, such as prohibiting travel.

Washington's laws against discrimination are outlined in RCW 49.60. Public officials should consider how communities may be impacted and take action to remove stigma that may marginalize or discriminate against groups.

Applicable Law(s):

- [RCW 43.06.220 – State of emergency – powers of governor pursuant to proclamation](#)
- [RCW 43.70.020\(3\) – Department created](#)
- [RCW 43.70.130 – Powers and duties of the Secretary of Health](#)
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- [WAC 246-100-070 – Enforcement of local health officer orders](#)

Tribal

Tribal governments have the authority and responsibility to control communicable disease on tribal lands and are expected to do so according to the laws, rules, and regulations of the tribal government.

Federal

Key Decision Makers: The federal government has independent authority when emergencies cross state and national borders. HHS Secretary may declare a public health emergency under 42 USC sec. 247, which is a way to get Congress to fund a public health emergencies account, but declarations are often made receiving without associated Congressional funding.

The diseases subject to quarantine under federal law are determined by Executive Order. The most recent order published in the [Federal Register](#) includes severe acute respiratory syndromes and provides the basis for federal quarantine.

Applicable Law(s):

- [42 U.S.C. § 201 et seq. – Public Health Service Act](#)
- [42 U.S.C. § 247d – Public health emergencies](#)
- [42 U.S.C. § 264 - Regulations to control communicable diseases](#)
- [28 CFR Part 35 – Nondiscrimination on the Basis of Disability in State and Local Government Services](#)
- [42 C.F.R. Part 70 - Interstate Quarantine](#)
- [42 C.F.R. Part 71 - Foreign Quarantine](#)
- [Public Law No. 116-22 – 2019 Pandemic and All-Hazards Preparedness and Advancing Innovation Act \(PAHPAIA\)](#)
- [Public Law 113-5 – Pandemic and All Hazards Preparedness Reauthorization Act](#)

Decisional Objectives/Key Decision Points

- Geographic location and timeframe of cordon sanitaire.
- Communication strategies and communication plan, including:
 - How affected community will receive updates
 - Whether to set up a call center
- Work with law enforcement to determine an enforcement strategy, including non-compliance.
 - Personal Protective Equipment (PPE) for officials enforcing the cordon sanitaire
- Movement of individuals and essential personnel into and out of the cordoned area for health and safety reasons
- Movement of materials (e.g. food, medical supplies/services, waste management) into and out of the cordoned area and providing essential services (e.g. utilities and water), and who will authorize providing services.
- Plan for health and emergency services in the cordoned area, such as mental health support, telehealth, and emergency medical transport
- Plans and logistics for specimen collection or providing other medical services, if needed.
- Identify communities that will be disproportionately impacted or burdened.
- Plan community engagement efforts, methods, and approaches that are responsive to the needs, preferences, and values of the community.
- Proactively address unintended consequences that inequitably impact historically marginalized individuals and communities may further erode trust with governmental systems needed for overall public health and future response efforts.
- Ensure all strategies, communications, and engagement are culturally and linguistically appropriate and meet readability and accessibility guidelines.

Implementation Methods

- **Health officer orders a cordon for a specific geographic area.**
 - Work with local health officer to determine best geographic area; work with the Washington State Department of Transportation and other transportation partners to transport cases and/or contacts to or from a geographic area.
- **Work with law enforcement agencies to enforce the cordon.**

- Determine law enforcement needs and whether the agencies need additional officers.
- **Create and distribute accessible, public messaging,**
 - General messaging about why these measures are being taken.
 - Work with communications team to create messages that:
 - Meet readability and accessibility guidelines.
 - Are culturally and linguistically relevant.
 - Are translated into the most spoken languages in the affected area.
 - Are relevant/adaptable to the changing nature of the incident/outbreak.
 - Communicate through multiple platforms and channels appropriate to the affected communities
 - Engage with community leaders or representatives for advice and buy-in.
 - Provide messages to LHJs and other partners to share with their constituents.
 - Provide consistent messaging throughout the state via media outreach.
 - Develop tailored messaging for disproportionately impacted communities.

Special Considerations

- Requires excellent communication mechanisms to notify community of details and rationale.
- Low-income families, immigrant/refugee communities, communities of color, and individuals with criminal records may be disproportionately impacted by enforcement activities.
- Requires plans/protocols for providing essential services. Plan movement of materials (e.g., food, medical supplies/services, and waste management) into and out of the cordoned area and essential services (e.g., utilities and water) to avoid additional public health issues.
- Requires detailed coordination between state, local government officials, and community organizations/leaders/groups.
- Requires law enforcement to enforce travel restrictions and maintain security at borders, but their involvement may create stress, trauma/re-traumatization, and fear for certain communities.
- Heavily affects individual income, revenue, employment, economic opportunity, and commerce.
- Limits transportation for persons requiring medical evaluation, with appropriate infection control precautions. Consider use of telehealth resources to support this need, but that telehealth may not be an accessible resource for all individuals and communities in need.
- May disproportionately impact individuals with other, non-related chronic, severe, and acute medical conditions that require ongoing/follow-up treatment or management.
- Requires plan to divert flow of critical infrastructure supplies and materials that normally move through the cordoned area.
- Requires plan to provide mental health support.
- Risk of noncompliance, particularly as length of time increases. May require enforcement for noncompliance.
- When an entire community is involved, requires cooperation with neighboring jurisdictions that may not be using a similar intervention, particularly in situations where persons live in one city and work in another and only one locale is affected by the intervention.
- Coordination with the Office of the Governor and/or local government leadership may be needed.
- Tribal nations may decide their own criteria for cordoning and any relevant security concerns.
- Families on the brink of housing insecurity may be disproportionately impacted by loss of wages, potentially increasing risk of missing rent payments, potentially increasing risk of eviction and

Intervention 13: Establish a Cordon Sanitaire

Last updated: 2/24/2020

homelessness. Homeless individuals already experience barriers to health care, services, and information.

- Unintended consequences that inequitably impact historically marginalized individuals and communities may further erode trust with governmental systems needed for overall public health and future response efforts.
- Ensure all strategies, communications, and engagement are culturally and linguistically appropriate and meet readability and accessibility guidelines.

Intervention 13: Establish a Cordon Sanitaire

- Contains a communicable disease within specific geographical boundaries. Legally enforceable order that restricts movement into or out of an area of quarantine to reduce spread in and to persons outside affected area. A less restrictive cordon sanitaire can also be imposed that allows essential travel and supplies into and out of the cordon as well as limited nonemergency travel.
- Intervention 13 should not be done without also considering interventions 10-12 strategies also being implemented.

Thresholds for Considering Implementation:

- Threshold 1: Second or Third generation of spread in a narrowly defined geographic region within the state or clusters of geographic transmission in defined pockets within the state.

Rationale for Use as Public Health Strategy

A cordon sanitaire is the restriction of movement of people in or out of the defined geographic area in order to contain disease within specific geographical boundaries. This is a form of combined isolation and quarantine when applied to all inhabitants of an area as a sanitary barrier.

General assumptions: COVID-19 is known to cause more severe disease illness in individuals with known underlying medical conditions as well as elderly individuals (60 years or greater), COVID-19 symptoms are currently believed to be relatively mild or almost non-existent in younger populations, and COVID-19 is spreading now in 47 countries outside of the United States with known community transmission occurring in 10 countries.

Success Factors: Success depends upon compliance and authorities' ability to enforce effectively.

Possible Drawbacks: Controversial because it infringes on personal freedom of movement. May lead to feeling isolated or result in the isolation of an entire community. People could be stranded without support. Commerce will be heavily compromised. Revenue loss, public outrage, and political backlash are possible. It may disproportionately affect certain cultural and community groups, low-income families, under-resourced communities, and individuals with un-related acute, chronic, or severe medical needs. May be difficult to solicit cooperation.

Possible Benefits: May contain a disease within the boundaries of the cordon. Reduces need for urgent evaluation of large numbers of potential contacts to determine indications for activity restrictions. May reduce transmission among groups without explicit activity restrictions.

Settings and Use

This strategy can be used when extensive transmission is occurring, a significant number of cases lack identifiable epidemiologic links at the time of evaluation, and/or restrictions placed on persons known to have been exposed are insufficient to prevent further spread.

Consider this intervention with highly transmissible and clinically severe disease that has requires geographic containment. This could apply to diseases that are easily transmitted human-to-human via contact, droplet, and/or airborne routes when less-restrictive interventions have failed, or to prevent introduction into new geographical areas.

Operational Strategy for Threshold 1:

- Refer to 13.1

TABLE 1. Non-pharmaceutical Interventions Matrix

Assessment*		Intervention	Expected Result	Example Implementation	Begin NPI use	NPI Type
Transmissibility	Clinical Severity					
1	1-4	1. Increase handwashing and use of alcohol-based sanitizer	Reduce probability of direct and indirect transmission of the disease by disinfecting hands	Conduct public messaging and media campaigns to encourage and educate the public and to promote enhanced hygiene and social distancing measures. Targeted messaging to major employers may be beneficial in encouraging the enhance behaviors in the workplace.	Y N	Personal
1	1-4	2. Respiratory Hygiene/Cough Etiquette	Reduce probability of droplet transmission of the disease by reducing the range of respiratory droplets and aerosols		Y N	
1	1-4	3. Keep distance from others (>6 feet)	Reduce probability of direct and droplet transmission by reducing the number of interpersonal contacts		Y N	Community
1	1-4	4. Frequently clean and disinfect personal surfaces (doorknobs, phones, keyboards, etc.)	Reduce the probability of indirect transmission by disinfecting fomites		Y N	Environmental
1	1-4	5. Remain home through the duration of respiratory illness	Reduce probability of transmission by preventing contacts between well and sick people		Y N	Personal
2	2 - 5	6. Voluntary isolation of sick persons	Reduce probability of transmission by preventing contacts between well and sick people	Y N		
2	2 - 5	7. Voluntary quarantine of contacts of sick persons	Reduce probability of transmission in the event that the contact becomes contagious before symptoms developed.	Health officers, medical providers, and public health personnel provide direct education to cases and contacts asking that they remain home for an established period of time.	Y N	Community
3	5 – 6.5	8. Involuntary isolation of sick persons	Reduce probability of transmission by preventing contacts between well and sick people	Health officers issue emergency detention orders or seek court orders for involuntary detention in order to involuntarily isolate or quarantine those who are uncooperative	Y N	
3	5 - 6.5	9. Involuntary quarantine of contacts of sick persons	Reduce probability of transmission in the event that the contact becomes contagious before symptoms develop		Y N	
4	5 - 7	10. Order cancellation of major public and large private gatherings	Reduce probability of transmission by reducing the number of the interpersonal contacts	Health officer orders to suspend all gatherings above a certain size with the intention to reduce risk of disease transmission if a subset of that population may be sick	Y N	
4	5 - 7	11. Order closure of schools, childcare facilities, workplaces, and public buildings	Reduce probability of transmission by reducing the number of the interpersonal contacts		Y N	
5	5.5 - 7	12. Prevent non-emergency travel outside of the home	Reduce probability of transmission by reducing the number of the interpersonal contacts	Health officer orders to halt non-emergency travel and remain indoors in order to protect those not yet sick.	Y N	Community
5	5.5 - 7	13. Establish a cordon sanitaire	Contain the disease within specific geographical boundaries.		Y N	

*Assessment levels are based on the following table (Table 2).

TABLE 2. Refined assessment: scaled measures of influenza virus transmissibility and clinical severity							
Measures of transmissibility and clinical severity	Scale						
	1	2	3	4	5	6	7
Transmissibility (scale of 1-5)							
Symptomatic attack rate, community	≤ 10%	11% - 15%	16% - 20%	21% - 24%	≥ 25%	-	-
Symptomatic attack rate, school	≤ 20%	21% - 25%	26% - 30%	31% - 35%	≥ 36%	-	-
Symptomatic attack rate, workplace	≤ 10%	11% - 15%	16% - 20%	21% - 24%	≥ 25%	-	-
Household secondary attack rate, symptomatic	≤ 5%	6% - 10%	11% - 15%	16% - 20%	≥ 21%	-	-
R ⁰ : basic reproductive number	≤ 1.1	1.2 – 1.3	1.4 – 1.5	1.6 – 1.7	≥ 1.8	-	-
Peak percentage of outpatient visits for influenza-like illness	1% - 3%	4% - 6%	7% - 9%	10% - 12%	≥ 13%	-	-
Clinical severity (scale of 1 – 7)							
Case-fatality ratio	<0.02%	0.02% - 0.05%	0.5% - 0.1%	0.1% - 0.25%	0.25% -0/5%	0.5% -1%	>1%
Case-hospitalization ratio	<0.5%	0.5% - 0.8%	0.8% - 1.5%	1.5% - 3%	3% - 5%	5% - 7%	>7%
Deaths-hospitalizations ratio	≤3%	4% - 6%	7% - 9%	10% - 12%	13% - 15%	16% - 18%	>18%

Source: Reed C, Biggerstaff M, Finelli L, et al. Novel framework for assessing epidemiologic effects of influenza epidemics and pandemics. *Emerg Infect Dis* 2013; 19:85-91

This chart transcribed from the CDCs MMWR, Community Mitigation Guidelines to Prevent Pandemic Influenza-United States, 2017

ADDITIONAL SUPPLEMENTAL DOCUMENTS

- 10.1S Supplemental Guidance for Intervention 10: Recommend or Order Cancellation of Major Public and Large Private Gatherings
- 11.1S Supplemental Guidance for Intervention 11: Recommend or Order of Schools, Child Care Facilities, Workplaces, and Public Buildings
- 12.1S Supplemental Guidance for Intervention 12: Prevent Non-Emergency Travel Outside the Home
- 13.1S Supplemental Guidance for Intervention 13: Establish a Cordon Sanitaire

Intervention 10: Recommend or Order Cancellation of Major Public and Large Private Gatherings

- Social distancing measures, such as cancellation or postponement of mass gatherings, reduce opportunities for person-to-person virus transmission and can help delay the spread and slow the exponential growth of disease spread. The optimal strategy is to implement these measures simultaneously in places where people gather, and to do so strategically in ways that maximize the benefit of reducing interpersonal contacts, particularly for people at increased risk, while also working to minimize the burden on society resulting from the intervention.

Thresholds for Considering Implementation:

- **Threshold 1:** Unmitigated or uncontained community transmission is occurring in several or many major US cities but there may not be evidence of community transmission in WA yet. In such a circumstances, authorities should consider initiating minimally restrictive/burdensome but effective mitigation measures.
- **Threshold 2:** Evidence that unmitigated or uncontained community transmission is occurring in WA State, but only in one or two jurisdictions, that cannot be contained.
- **Threshold 3:** Evidence that unmitigated or uncontained community transmission of disease is occurring across WA State (in more than 2 large jurisdictions).

Rationale for Use as Public Health Strategy

Recommending or ordering cancellation of mass gatherings, in combination with other social distancing measures (e.g., patient isolation, quarantine of exposed persons, and public site closures), may help reduce virus transmission.

General assumptions: COVID-19 is known to cause more severe disease illness in individuals with known underlying medical conditions as well as in older individuals (60 years of age and greater), COVID-19 symptoms are currently believed to be relatively mild or almost non-existent in younger populations, and as of 2/27/2020, COVID-19 is spreading now in 47 countries outside of the United States with known community transmission occurring in 10 countries.

Success Factors: Success depends upon event sponsor compliance and authorities' ability to enforce effectively. All non-pharmaceutical interventions have the greatest effect when implemented early and effectively.

Possible Drawbacks: May result in revenue loss, public outrage, or political backlash, and may disproportionately affect certain cultural and community groups. For these reasons, working with communities and event organizers to voluntarily cancel events and gatherings is strongly preferred.

Possible Benefits: Reduces opportunities for widespread disease transmission by reducing interpersonal contacts and increasing social distance. The larger the event and the closer the

interpersonal interactions/contact expected at each event, the more benefit can be derived through canceling the event

Settings and Use

Social distancing measures can be implemented in a range of community settings, including public places where people gather (e.g., parks, houses of worship, theaters, sports arenas). Modifying, cancelling, or postponing events is an approach that might reduce face-to-face contact in community settings.

Operational Strategies for Threshold 1:

- Recommend and implement voluntary event cancellations for large gatherings.
 - Specifically, recommend postponing or canceling events with large numbers of high risk individuals (older adults or individuals with known health conditions).
- For events that will be ongoing, consider:
 - Review and implement NPI 1-5 strategies at venue sites to assure adequate precautions are in place, including:
 - Screening at point of entry for symptomatic persons, including taking temperatures, at events for exclusion.
 - Ensure that hand hygiene stations are available for all attendees.
 - Address social distancing recommendations through site setup strategies.
 - Communicate with high risk groups the importance of staying home and non-attendance for major gatherings.
 - Address reimbursement policy for attendees who are ill or in a high-risk group.
- Consider partnering with the following organizations to inform decision making:
 - Event venues, city officials and planners, law enforcement organizations, local emergency management, industry associations, faith and community based organizations, etc.
- Weigh the health, economic, and cultural impacts of canceling or postponing the event.

Operational Strategies for Threshold 2:

- Continue efforts under Threshold 1.
- Stronger recommendations for event cancellations for areas impacted.
- Consider a public messaging campaign to ensure attendees are aware of the potential risks of attending.
- Can you hold the event remotely (via teleconference)? At a different location?
- Voluntary recommendations for non-high risk geographic areas in WA state.

Operational Strategies for Threshold 3:

- Continue efforts under Thresholds 2.
- Ordering of event cancellations statewide.
- Develop and implement a messaging campaign to ensure attendees are aware the event is cancelled.

Intervention 11: Recommend or Order of Schools, Child Care Facilities, Workplaces, and Public Buildings

- Viruses quickly and easily spread in places where people gather in close contact, such as community centers, VFWs, senior centers, assisted living centers, long term care facilities, schools, child care facilities, workplaces, and public buildings. Dismissing or closing such facilities may be considered to limit disease spread by reducing the number of interpersonal contacts. In cases where closure is impossible, limiting access to visitors, symptom screening prior to entry, and other measures may be considered to reduce risk of disease introduction into a congregate care or living setting.
- This intervention should be done in alignment with all other NPI strategies (1-10).

Thresholds for Implementation:

- Threshold 1: Unmitigated or uncontained community transmission is occurring in several or many major US cities but there may not be evidence of community transmission in WA yet. In such a circumstances, authorities should consider initiating minimally restrictive/burdensome but effective mitigation measures.
- Threshold 2: Evidence that unmitigated or uncontained community transmission is occurring in WA State, but only in one or two jurisdictions, that cannot be contained.
- Threshold 3: Evidence that unmitigated or uncontained community transmission of disease is occurring across WA State (in more than 2 large jurisdictions).

Rationale for Use as Public Health Strategy

Social distancing measures, including closure of buildings, reduce opportunities for person-to-person virus transmission and can help delay the spread and slow the exponential growth of disease spread. If disease spread is occurring in a school, child care facility or public building, dismissing students, staff, or the public from these locations or closing the locations early can limit further spread. The optimal strategy may be to implement several social distancing steps simultaneously where large groups of people gather.

General assumptions: COVID-19 is known to cause more severe disease illness in individuals with known underlying medical conditions as well as older individuals (60 years of age or greater), COVID-19 symptoms are currently believed to be relatively mild or almost non-existent in younger populations, and as of 2/27/2020 COVID-19 is spreading now in 47 countries outside of the United States with known community transmission occurring in 10 countries.

Success Factors: Early implementation of dismissals or closures to limit spread. Facility compliance and authorities' ability to enforce effectively.

Possible Drawbacks: May result in missed school days, revenue loss, public outrage, or political backlash. It may disproportionately affect certain cultural and community groups. Low income and other vulnerable communities may be put at risk for non-outbreak related harm if they are unsupervised, don't have access to an adult caretaker, or cannot communicate with the outside world if there is an emergency. It may cause disruption for families and communities. Adults may experience missed work and loss of income from their workplace closure or to stay home to care for children.

Possible Benefits: Reduces opportunities for widespread disease transmission by reducing interpersonal contacts and increasing social distance.

Settings and Use

Facility quarantine or closing facilities is a social distancing measure that may reduce face-to-face contact in community settings to reduce the spread of diseases transmitted by contact, droplets, or air. Choose social distancing measures depending on the severity of the disease.

Operational Strategies for Threshold 1:

- Recommend worksite telecommuting options.
 - Encourage employers to update continuity of operations plans to address telework and other ways to meet mission essential functions.
- Strengthen public messaging around “if sick stay home.”
 - Ensure there is clear and consistent messaging about symptoms that should be monitored.
- Work with employers to relax/extend sick leave benefits for employees, and encourage or require employees to remain at home if they are sick.
 - Consider revising state paid sick leave regulations to improve access for impacted individuals. This could include, for example, revising the requirement for a physician's certification in order to alleviate burden on the health care system and ensure impacted individuals receive benefits in a timely manner.
- Provide additional guidance for high risk population movement restrictions or protection measures.
 - Make recommendations for limiting visitation hours at Long Term Care (LTC) facilities or provide guidance on appropriate protection for any visitors.
 - Assure appropriate guidance is given to assisted living centers and retirement communities to mitigate potential transmission of disease at these sites. Recommend residents be vigilant at identifying their symptoms and contact local public health jurisdictions and their healthcare provider when symptoms present and isolating at home.
 - Recommend the continued use of NPI 1-5 measures at community centers, correctional centers, and other highly frequented community gathering locations especially those where high risk individuals may congregate (i.e. VFWs).

- Build networks of communication with relevant partners so that specific messaging can be quickly and effectively disseminated.
- Provide recommendations for the exclusion of school age children with known underlying medical conditions.
- Strengthen recommendations for social distancing within worksites that must maintain operations.
- Increase general messaging on NPIs 1-5 for the community at wide and develop strategically directed messages for potentially high risk populations within the state.

Operational Strategies Threshold 2:

- Continue all strategies under Level 1 activation
- Enhance recommendations directed to the impacted jurisdictions, to include:
 - Recommend closure of community centers, senior recreational centers, VFWs, ELKS clubs, etc.
 - Consider closure of businesses:
 - Businesses identify all non-essential functions that could be stood down.
 - Ask all business partners to transition eligible staff to telework.
 - Consider closure of schools and universities activities and events.
 - Consider closures of schools, child care centers, and universities.
 - Consider closure of mass transit.
 - Recommend or order closures of mass community gathering locations such as bowling alleys, malls, movie theatres.
 - Message across the state the potential risk to travel to impacted jurisdictions.

Operational Strategies Threshold 3:

- Continue all strategies under Level 2 activation
- Enhance mass messaging to the population across the state on NPI 1-7.
- Increase span of recommendations under level 2 for the entire state:
 - Recommend closure of community centers, senior recreational centers, VFWs, ELKS clubs, etc.
 - Consider closure or businesses
 - Recommend businesses identify all non-essential functions.
 - Ask all business partners to transition eligible staff to telework.
 - Consider or order closure of schools and universities activities and events.
 - Consider or order closures of schools, child care centers, and universities.
 - Consider or order closure of mass transit.
 - Provide transportation options for AFN populations and mission essential workers.
 - Strategies to reduce the impact of increased traffic due to single occupancy vehicles could include:

Intervention 11 Supplement: Recommend or Order Closure of Schools, Child Care Facilities, Workplaces, and Public Buildings

Last updated: 2/27/2020

- Decrease tolling;
 - Delay construction projects; and
 - Limit HOV lanes to public safety and mission essential workers.
- Recommend or order closures of mass community gathering locations such as bowling alleys, malls, movie theatres.

Intervention 12: Prevent Non-Emergency Travel Outside the Home

- Limiting travel outside of the home will reduce probability of the transmission by reducing the numbers of the interpersonal contacts. Travel should be restricted to emergency use only.
- Intervention 12 should not be done without Intervention 10-11 strategies also being implemented.

Thresholds for Implementation:

- Threshold 1: Unmitigated or uncontained community transmission is occurring in several or many major US cities but there may not be evidence of community transmission in WA yet. In such a circumstances, authorities should consider initiating minimally restrictive/burdensome but effective mitigation measures.
- Threshold 2: Evidence that unmitigated or uncontained community transmission is occurring in WA State, but only in one or two jurisdictions, that cannot be contained.
- Threshold 3: Evidence that unmitigated or uncontained community transmission of disease is occurring across WA State (in more than 2 large jurisdictions).
- Threshold 4: Health care system is significantly impacted and/or we have clear evidence that the case hospitalization and case fatality rate are higher than previously thought.

Rationale for Use as Public Health Strategy

This intervention is a more extreme measure of social distancing, which reduces occasions for person-to-person virus transmission to help delay the spread and slow the exponential growth of a pandemic.

General assumptions: COVID-19 is known to cause more severe disease illness in individuals with known underlying medical conditions as well as older individuals (60 years of age or greater), COVID-19 symptoms are currently believed to be relatively mild or almost non-existent in younger populations, and COVID-19 is spreading now in 47 countries outside of the United States with known community transmission occurring in 10 countries.

Success Factors: Success depends upon compliance and authorities' ability to enforce effectively.

Possible Drawbacks: Will prevent the operation of public entities and private businesses; the effect will be felt economically by employees as loss of income, and the public as lack of commodity availability. Revenue loss; public outrage; and political backlash are possible. Travel restrictions may disproportionately affect certain cultural and community groups. Includes community impacts such as food/groceries, gas station fuel, utilities.

Possible Benefits: Reduces opportunities for direct or indirect disease spread, and may prevent a disease from entering new geographical region.

Settings and Use

Travel restrictions are conditionally recommended during an early stage of a localized and extraordinarily severe pandemic for a limited period of time. Before implementing, consider

cost, acceptability and feasibility, as well as ethical and legal considerations, in relation to this measure. This intervention should be considered when less-restrictive interventions have failed or to prevent disease introduction into new geographical areas.

Operational Strategy for Threshold 1:

- Strengthen public health messaging and communication efforts on NPI 1-11.
- Communicate CDC travel restrictions to WA State residents and make recommendations for limiting travel outside of the state.
 - Include enhanced messaging on traveler monitoring of symptoms for WA state residents.

Operational Strategy for Threshold 2:

- Continue efforts for messaging on NPI 1-11 as appropriate.
- Maintain communication locally on CDC travel restrictions and expand messaging to include local travel restrictions within highly impacted jurisdictions.
- Strengthen guidance for staying at home for non-emergent situations for impacted jurisdictions with 2nd generation spread of disease.
 - Additionally, consider closure of additional community businesses, closure of schools, child care centers, and other locations where people congregate within the impacted community.
 - Consider postponing or cancelling non-emergent travel for older adults and those with chronic medical conditions.

Operational Strategy for Threshold 3:

- Continue efforts under Threshold 2.
- Expand recommendation for staying at home for non-emergent situations,
 - Consider wider closure of additional community businesses, closure of schools, child care centers, and other locations where people congregate across the state.
 - Consider expanding travel restrictions for older adults and those with chronic medical conditions.
 - Including identification for alternative access to medical care/treatment that would limit need for emergency travel outside a home or facility environment.

Operational Strategy for Threshold 4:

- Continue all efforts under threshold 3
- If no state of emergency has been declared, consider a declaration for non-emergency use of roadways to transport of sick persons.
 - Consider finding alternative ways to use mass transit to provide transportation for impacted individuals.

Intervention 13: Establish a Cordon Sanitaire

- Contains a communicable disease within specific geographical boundaries. Legally enforceable order that restricts movement into or out of an area of quarantine to reduce spread in and to persons outside affected area. A less restrictive cordon sanitaire can also be imposed that allows essential travel and supplies into and out of the cordon as well as limited nonemergency travel.
- Intervention 13 should not be done without also considering interventions 10-12 strategies also being implemented.

Thresholds for Considering Implementation:

- Threshold 1: Second or third generation of spread in a narrowly defined geographic region within the state or clusters of geographic transmission in defined pockets within the state.

Rationale for Use as Public Health Strategy

A cordon sanitaire is the restriction of movement of people in or out of the defined geographic area in order to contain disease within specific geographical boundaries. This is a form of combined isolation and quarantine when applied to all inhabitants of an area as a sanitary barrier.

General assumptions: COVID-19 is known to cause more severe disease illness in individuals with known underlying medical conditions as well as elderly individuals (60 years or greater), COVID-19 symptoms are currently believed to be relatively mild or almost non-existent in younger populations, and COVID-19 is spreading now in 47 countries outside of the United States with known community transmission occurring in 10 countries.

Success Factors: Success depends upon compliance and authorities' ability to enforce effectively.

Possible Drawbacks: Controversial because it infringes on personal freedom of movement. May lead to feeling isolated or result in the isolation of an entire community. People could be stranded without support. Commerce will be heavily compromised. Revenue loss, public outrage, and political backlash are possible. It may disproportionately affect certain cultural and community groups, low-income families, under-resourced communities, and individuals with un-related acute, chronic, or severe medical needs. May be difficult to solicit cooperation.

Possible Benefits: May contain a disease within the boundaries of the cordon. Reduces need for urgent evaluation of large numbers of potential contacts to determine indications for activity restrictions. May reduce transmission among groups without explicit activity restrictions.

Settings and Use

This strategy can be used when extensive transmission is occurring, a significant number of cases lack identifiable epidemiologic links at the time of evaluation, and/or restrictions placed on persons known to have been exposed are insufficient to prevent further spread.

Consider this intervention with highly transmissible and clinically severe disease that has requires geographic containment. This could apply to diseases that are easily transmitted human-to-human via contact, droplet, and/or airborne routes when less-restrictive interventions have failed, or to prevent introduction into new geographical areas.

Operational Strategy for Threshold 1:

- The following partners are essential to implement cordon sanitaire:
 - Local emergency management, state emergency management, local law enforcement, first responders, local and state officials, waste management companies, critical infrastructure partners, Department of Transportation, Washington Military Department, etc.
- Consider how essential supplies (food, medical supplies, etc.) and workers will get in and out of the cordon.
- Develop and implement a public information campaign to ensure those inside and outside of the cordon receive regular updates.

Please send specimen(s) to: New York State Department of Health, Wadsworth Center
David Axelrod Institute, 120 New Scotland Avenue, Albany, NY 12208
Rabies Lab only: 5668 State Farm Rd, Slingerlands, NY 12159

For more information about the Infectious Diseases laboratories at the Wadsworth Center, go to:
<https://www.wadsworth.org/programs/idi>

Patient Demographics and Requesting Provider				*required information	
Last name*	First name*	MI	DOB*	<input type="checkbox"/> Male	<input type="checkbox"/> Other
			/ /	<input type="checkbox"/> Female	
Permanent Street Address	Facility of Residence (if applicable)	City	State	Zip Code	
NYS County of Residence*	Patient Reference Number	NYS DOH Outbreak Number OMS202015920	CDESS Case Number		

Name and National Provider Identifier (NPI) for Health Care Provider: _____ Phone: () -

Submitting Facility (Laboratory report will be sent to this address)		*required information
Name*	Laboratory PFI	
Address*	NPI	
Contact Person*	Phone* () -	

Specimen Information			*required information
Collection Date*: / /	Time Collected (if applicable):	Date of Symptoms Onset: / /	<input type="checkbox"/> Autopsy
Specimen Collected	Specimen submitted on/in (specify media/preservative/cell line)	Submitter's Specimen Identifier(s)	
NP Swab	<input type="checkbox"/> Isolate <input type="checkbox"/> Primary		
	<input type="checkbox"/> Isolate <input type="checkbox"/> Primary		
	<input type="checkbox"/> Isolate <input type="checkbox"/> Primary		

Laboratory Examination Requested	
<input type="checkbox"/> Confirmation <input type="checkbox"/> Identification/Detection	Submitter Lab Findings: Smear/Stain/Other: _____
Suspect Organism/Agent	Suspect Organism/Agent
<input type="checkbox"/> Bacterial	<input type="checkbox"/> Parasitic
<input type="checkbox"/> Antimicrobial Resistance Laboratory Network Susceptibility	<input type="checkbox"/> Malaria Drug Susceptibility
<input type="checkbox"/> Other Susceptibility (please specify): _____	<input type="checkbox"/> Serology
<input type="checkbox"/> Fungal	<input type="checkbox"/> Viral**Circle Test(s) Requested: COVID-19
<input type="checkbox"/> Antimicrobial Resistance Laboratory Network Susceptibility	<input type="checkbox"/> Viral Encephalitis PCR Panel on CSF
<input type="checkbox"/> Other Antifungal Susceptibility	<input type="checkbox"/> Influenza Antiviral Susceptibility
<input type="checkbox"/> Mycobacterial	<input type="checkbox"/> Other

Clinical History	
Relevant Exposure:	<input type="checkbox"/> Travel <input type="checkbox"/> Animal <input type="checkbox"/> Arthropod <input type="checkbox"/> Contact w/ Known Case <input type="checkbox"/> Food/Water
Exposure Detail:	Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital Name: _____
Diagnosis:	Pregnant (trimester): _____ Fever (max): _____ CSF: Glu _____ Prot _____ RBC _____ WBC _____
Relevant Treatment:	Date: / / Relevant Immunization: _____ Date: / /

****Symptoms** (check all applicable): Acute Chronic Other Symptoms _____

Cardiovascular	Central Nervous System	Rash	Respiratory	Miscellaneous
<input type="checkbox"/> Endocarditis	<input type="checkbox"/> Altered Mental Status	<input type="checkbox"/> Hemorrhagic	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Arthralgia
<input type="checkbox"/> Myocarditis	<input type="checkbox"/> Encephalitis	<input type="checkbox"/> Maculopapular	<input type="checkbox"/> Cough	<input type="checkbox"/> Conjunctivitis
<input type="checkbox"/> Pericarditis	<input type="checkbox"/> Headache	<input type="checkbox"/> Petechial	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Hepatitis
	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Vesicular	<input type="checkbox"/> Upper Respiratory	<input type="checkbox"/> Hepatomegaly
	<input type="checkbox"/> Paralysis			<input type="checkbox"/> Immunocompromised
				<input type="checkbox"/> Lymphadenopathy
				<input type="checkbox"/> Malaise
				<input type="checkbox"/> Myalgia
				<input type="checkbox"/> Splenomegaly

From: John Unger <john.unger@wvsenate.gov>
Sent: Sunday, March 22, 2020 9:53 AM
To: Slemp, Cathy C <Cathy.C.Slemp@wv.gov>
Cc: Crouch, Bill J <Bill.J.Crouch@wv.gov>
Subject: [External] Fwd: OSHA compliant

CAUTION: External email. Do not click links or open attachments unless you verify sender.

Thank you for all your hard work under increasingly difficult challenges.

Please see email message below. I wanted to bring this matter to your attention and ask what, if anything, we can do to address it.

Please call on me if I can assist you in your emergency operations.

Blessings and peace,

John

Begin forwarded message:

From: [REDACTED]
Date: March 22, 2020 at 9:36:41 AM EDT
To: John Unger <john.unger@wvsenate.gov>
Subject: FW: OSHA compliant

Dear Sir,

I'm sending you this letter from OSHA. [REDACTED] employs around 2,000 at this facility. My daughter works there. They are not being protected. I have reached out to the governor with no response. I have spoken to a staff member from Senator Joe Manchin's office. I watched the governor's news conference, clearly his speech was not informative. **Please we need to protect our citizens.**

[REDACTED]

From: [OSHA Area Office Charleston](#)
Sent: Thursday, March 19, 2020 12:38 PM
To: [REDACTED]
Subject: OSHA compliant

ATTN: [REDACTED]

Please see attached letter that was sent to [REDACTED]

U.S. DOL-OSHA
[REDACTED]



**HOUSE OF DELEGATES
WEST VIRGINIA LEGISLATURE**

BUILDING 1, ROOM 230-E
1900 KANAWHA BLVD., EAST
CHARLESTON, WV 25305-0470
PHONE (304) 340-3900
EMAIL: DANIELLE.WALKER@WVHOUSE.GOV

DELEGATE DANIELLE M. WALKER

Committees:

Government Organization
Health and Human
Resources
Political Subdivisions
Prevention and Treatment
of Substance Abuse
Technology and Infrastructure

Dear Secretary Crouch,

Thanks for being present at the press conferences and keeping ALL West Virginians informed about the precautions, testing, and awareness around COVID-19. I have received several calls, texts, and emails relating to testing, exposure and assistance. Even though the message is keeping calm, the reality is life is different for every person. I have a couple of questions which seem to be recurring in many of the communications I am receiving.

First, how are we handling visitation between kinship and foster care children and their biological families? Many home health agencies or direct care agencies have eliminated face to face contact. For example, Kepro assessments will be done by phone. Many kinship and foster care parents are concerned continuing face-to-face visits, especially since many cross county lines, could spread illness between many individuals which could be prevented by following guidance to limit gatherings between households.

Secondly, if any state program recipient had a scheduled face to face meeting in any DHHR office, will a phone option be available? With a National and State Emergency being declared, will applicants be able to apply online for services such as SNAP, TANF, or Medicaid? Do we have any



**HOUSE OF DELEGATES
WEST VIRGINIA LEGISLATURE**

BUILDING 1, ROOM 230-E
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DELEGATE DANIELLE M. WALKER

Committees:

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of Substance Abuse
Technology and Infrastructure

emergency application process where folks will not need to wait 10-30 days for approval?

In addition, many utilities have placed a moratorium on shut off notices. Will DHHR receive more funding for LIEP programs and will water utilities be included?

Lastly, reporting abuse and the safety of investigators are very concerning. Neglect and abuse seems to rise in high stressful situations. The majority of reporting comes from schools. Can you please inform is there's a decline in calls to central intake. We have a shortage of workers and I know all state employees need to be safe. What is the plan for of calls reporting abuse or neglect?

Please advise any policies or updates.

Sincerely,

Delegate Danielle Walker



State of West Virginia
Office of the Attorney General

Patrick Morrissey
Attorney General

(304) 558-2021
Fax (304) 558-0140

March 11, 2020

**NOTICE TO ALL HEALTHCARE FACILITIES FROM THE WEST VIRGINIA
MEDICAID FRAUD CONTROL UNIT (“MFCU”)**

The Office of the West Virginia Attorney General’s Medicaid Fraud Control Unit (“MFCU”) is mindful of the concerns, confusion, and questions that all healthcare facilities and caregivers are currently experiencing in response to the 2019-Novel Coronavirus (“2019-nCoV”) outbreak, also known as COVID-19. Additionally, pursuant to 42 C.F.R. 1007.11(b), West Virginia MFCU is a designated health oversight agency that is authorized by law to investigate and prosecute abuse, neglect, and misappropriation of funds or property in West Virginia’s Medicaid program, whether the healthcare provider is publicly or privately operated.

Therefore, the Attorney General, through the West Virginia MFCU, asks that every healthcare facility and caregiver educate themselves to be better able to understand and respond to the COVID-19 virus, including the nature of the virus itself and the best practices to prevent the spread of the virus. To that end, the Attorney General wants to work with healthcare facilities and provide the most accurate and real-time information possible. If you have questions or concerns about what you should do as a healthcare facility and/or as a caregiver, please use the following links:

Centers for Disease Control and Prevention (“CDC”):
www.cdc.gov/coronavirus/2019-ncov

CDC - Information for Healthcare Professionals:
www.cdc.gov/coronavirus/2019-nCoV/hcp

West Virginia Department of Health & Human Resources (“DHHR”):
www.coronavirus.wv.gov

Should you have any healthcare concerns, you should call:

West Virginia DHHR Bureau for Public Health at 1-800-887-4304

Should you have any information, complaints, or concerns about healthcare facilities and/or caregivers that are neglecting to use the recommended care or best practices promulgated by the CDC or WV DHHR in response to COVID-19 virus, you should call:

West Virginia MFCU at (304) 558-1858

West Virginia MFCU is committed to the education and protection of patients and residents in the State of West Virginia from the spread of this infectious disease. While the MFCU is charged with the power and duty to investigate and refer for prosecution allegations of healthcare fraud committed against the Medicaid program and allegations of abuse, neglect, or financial exploitation of patients of Medicaid-funded healthcare providers, the purpose of this transmission is to begin a collaboration with the healthcare facilities in our state to mitigate the risk of the spread of coronavirus. Please let us know if you have any questions.

Sincerely,



Patrick Morrissey
Attorney General of West Virginia

STATE OF WEST VIRGINIA

EXECUTIVE DEPARTMENT

At Charleston

EXECUTIVE ORDER NO. 9-20

By the Governor

WHEREAS, a State of Emergency was declared on the Sixteenth Day of March, Two Thousand Twenty for all counties in West Virginia (the “State of Emergency Declaration”), to allow agencies to coordinate and create necessary measures to prepare for and respond to the outbreak of respiratory disease caused by a novel coronavirus now known as COVID-19; and

WHEREAS, Chapter 15, Article 5, Section 6 of the Code of West Virginia authorizes the Governor to, among other things, control ingress and egress to and from a disaster area or an area where large-scale threat exists, the movement of persons within the area, and the occupancy of premises therein; and

WHEREAS, Executive Order 2-20, Executive Order 3-20, Executive Order 6-20, and Executive Order 8-20 have ordered closed or otherwise limited occupancy of businesses and establishments such as casinos, restaurants, bars, fitness centers, gymnasiums, recreation centers, barber shops, nail salons, hair salons, state park lodges, and the Hatfield McCoy Trail, all to protect public health, safety, and welfare; and

WHEREAS, further measures are necessary to protect the health, safety, and welfare of the public, to disrupt the spread of the virus, and to mitigate the impact of COVID-19, including the closure of additional businesses and facilities throughout the state; and

WHEREAS, the Centers for Disease Control and Prevention (“CDC”) and the West Virginia Department of Health and Human Resources have recommend the public practice of social distancing, meaning staying home whenever possible and otherwise maintaining a six feet distance from other individuals, to minimize the transmission of COVID-19; and

WHEREAS, locations where people congregate unnecessarily and/or fail to follow adequate social distancing practices are therefore areas of large-scale threat and emergency; and

WHEREAS, businesses that are to remain open will need to reduce their operations to continue with minimum contact with members of the public and only essential employees, and must require proper social distancing at all times; and

WHEREAS, these measures relating to the closure of certain businesses and to limit the operation of non-essential businesses are necessary because of the propensity of the COVID-19 virus to spread via personal interactions and because of physical contamination of property due to its ability to remain on surfaces for prolonged periods of time; and

WHEREAS, it is the duty of every West Virginian to practice proper social distancing and to comply with these measures in order to protect our people, our families, and each other, against this terrible epidemic.

NOW, THEREFORE, I, JIM JUSTICE, pursuant to the authority vested in me pursuant to the provisions of Chapter 15, Article 5, Section 6 and Chapter 15, Article 5, Section 1 of the Code of West Virginia, hereby **DECLARE** and **ORDER**, effective as of 8:00 PM, Eastern Standard Time, on the Twenty-fourth day of March, Two Thousand Twenty, as follows:

1. **Stay at home or your place of residence.** To preserve public health and safety, and to ensure the healthcare system in West Virginia is capable of serving all citizens in need, especially those at high risk and vulnerable to COVID-19, all individuals within the State of West Virginia are under a general stay-at-home order and are directed to stay at home or their place of residence unless performing an essential activity. An activity is essential if the purpose of the activity is one of the following:

- a. Obtaining food, medicine, and other similar goods necessary for the individual or a family member of the individual.
- b. Obtaining non-elective medical care and treatment and other similar vital services for an individual or a family member of the individual.
- c. Going to and from an individual's workplace if such workplace and/or work is included in the definition of Essential Businesses and Operations as outlined in Section 3, below.
- d. Going to and from the home of a family member.
- e. Going to and from the home of another individual who, under the terms of a parenting plan or similar agreement, is entitled to visitation with or the care of a child.
- f. Going to and from an individual's place of worship.
- g. Engaging in outdoor activity, provided that individuals at all times and as much as reasonably possible maintain social distancing of six feet from one another and abide by a 10-person limitation on gathering size.

2. **Non-essential businesses and operations must temporarily cease operations.** In addition to those businesses directed to close or limit occupancy pursuant to previous executive orders, all businesses and operations in West Virginia, except Essential Businesses and Operations as defined below, are required to cease all activities within the state except for such minimum basic operations as are necessary to maintain the value of the business's inventory, preserve the condition of the business's physical plant and equipment, ensure security, process payroll and employee benefits, or related functions, and the minimum necessary activities to facilitate employees of the business being able to continue to work remotely from their residences. Businesses such as home-based businesses may continue to operate, so long as any employees or contractors of such businesses perform activities from their own residences. Further, small businesses that do not invite in the general public and which have five or less employees in the office may continue to operate, but must ensure that proper social distancing and hygiene practices are maintained.

3. **Essential businesses and operations shall continue to operate.** Essential Businesses and Operations, as described below, shall remain open, and individuals may leave their

residence to provide any services or to perform any work necessary to offer, provision, supply, operate, maintain, and/or repair Essential Businesses and Operations. The term “Essential Businesses and Operations” includes those industries and workers described in the U.S. Department of Homeland Security’s Cybersecurity and Infrastructure Security Agency’s March 19, 2020, *Memorandum on Identification of Essential Critical Infrastructure Workers During COVID-19 Response* and its “Guidance on the Essential Critical Infrastructure Workforce: Ensuring Community and National Resilience in COVID-19 Response” attached thereto (the “CISA Guidance”). In addition to those industries and workers identified in the CISA Guidance, the following industries, businesses, and/or workers employed in such industries and businesses are specifically included as Essential Businesses and Operations under this Order:

- a. Healthcare, public health operations, and health insurance companies.**

Healthcare, public health operations, and healthcare insurance companies include without limitation hospitals, clinics, dental offices, pharmacies, public health entities, including those that compile, model, analyze, and communicate public health information, pharmaceutical, pharmacy, medical device and equipment, and biotechnology companies (including operations, research and development, manufacture, and supply chain), managed care organizations and related entities and attendant or related services, Medicaid providers, healthcare insurers, organizations collecting blood, platelets, plasma, and other necessary materials (including organizations hosting blood drives, provided that appropriate precautions are taken, including proper social distancing and hygiene measures during any such drive), obstetricians and gynecologists, eye care centers, including those that sell or provide glasses and contact lenses, home healthcare providers, mental health and substance use providers, other healthcare facilities and suppliers and providers of any related and/or ancillary healthcare services, and entities that transport and dispose of medical materials and remains. This includes manufacturers, technicians, logistics, and warehouse operators and distributors of medical equipment, personal protective equipment, medical gases, pharmaceuticals, blood and blood products, vaccines, testing materials, laboratory supplies, cleaning, sanitizing, disinfecting, or sterilization supplies, and tissue and

paper towel products. This category of industry shall be construed very broadly to avoid any impacts to the delivery of healthcare, broadly defined. Healthcare and public health operations does not include fitness and exercise gyms, spas, salons, barber shops, tattoo parlors, and similar facilities limited or closed under previous executive order.

b. Grocery stores and pharmacies. Grocery stores, pharmacies, farmers' markets, farm and produce stands, supermarkets, convenience stores, and other establishments engaged in the retail sale of groceries, canned food, dry goods, frozen foods, fresh fruits and vegetables, pet supplies, fresh meats, fish, and poultry, prepared food, alcoholic and non-alcoholic beverages, any other household consumer products (such as cleaning and personal care products), specifically including their supply chain and administrative support operations. This includes stores that sell groceries, medicine, including over-the-counter medication not requiring a medical prescription, and also those that sell other non-grocery products, and products necessary to maintaining the safety, sanitation, and essential operation of residences and Essential Businesses and Operations.

c. Food, beverage, and agriculture. Food and beverage manufacturing, production, processing, and cultivation, including farming, livestock, seed and feed stores, fishing, baking, and other production agriculture, including cultivation, marketing, production, and distribution of animals and goods for consumption, and businesses that provide food, shelter, and other necessities of life for animals, including animal shelters, rescues, shelters, kennels, and adoption facilities. Restaurants and other facilities that prepare and serve food and/or drinks, but only for consumption off-premises, through such means as take-away, delivery, or drive-through/drive in. Schools and other entities that typically provide food services to students or members of the public may continue to do so under this Order on the condition that the food is provided to students or members of the public on a pick-up or take-away basis only. Schools and other entities that provide food services under this exemption shall not permit the food to be eaten at the site where it is provided, or at any other gathering site due to the virus's propensity to physically impact surfaces and personal property.

- d. Essential governmental functions.** For purposes of this Order, all first responders, emergency management personnel, emergency dispatchers, legislators, judges, court personnel, jurors and grand jurors, law enforcement and corrections personnel, hazardous materials responders, child protection and child welfare personnel, housing and shelter personnel, military, and other governmental employees working for or to support Essential Businesses and Operations, and all state governmental employees deemed essential employees by their respective agency head, are categorically exempt from this Order. Essential government functions means all services provided by the State or any municipality, township, county, political subdivision, board, commission, or agency of government and needed to ensure the continuing operation of the government agencies or to provide for or support the health, safety, and welfare of the public, and including contractors performing such essential government functions. Each government body shall determine its essential government functions and identify employees and/or contractors necessary to the performance of those functions. This Order does not apply to the United States government. Nothing in this Order shall prohibit any individual from performing or accessing essential government functions.
- e. Human services organizations and childcare facilities and providers.** Human services operations includes without limitation long-term care facilities, day care centers, day care homes, group day care homes, residential settings and shelters for adults, seniors, children, and/or people with developmental disabilities, intellectual disabilities, substance use disorders, and/or mental illness, transitional facilities, home-based settings to provide services to individuals with physical, intellectual, and/or developmental disabilities, seniors, adults, and children, field offices that provide and help determine eligibility for basic needs including food, cash assistance, medical coverage, child care, vocational services, rehabilitation services, development centers, adoption agencies, businesses that provide food, shelter, and social services, and other necessities of life for economically disadvantaged individuals, individuals with physical, intellectual, and/or developmental disabilities, or otherwise needy individuals, and child care centers, day care centers, and those engaged in caretaking for children.

- f. Essential infrastructure.** Businesses, entities, or workers engaged in food production, distribution, fulfillment centers, storage facilities, preparation, and sale, construction (including without limitation construction required in response to this public health emergency, hospital construction, construction of long-term care facilities, public works construction, school construction, essential business construction, and housing construction), business management and maintenance, airport operations, operation, maintenance, and supply of utilities, including water, sewer, and gas, electrical (including power generation, distribution, and production of raw materials including without limitation coal and oil and natural gas), distribution centers, oil and biofuel refining, roads, highways, railroads, and public transportation, cyber and other security operations and services, flood control, solid waste and recycling collection and removal, and internet, video, and telecommunications systems (including the provision of global, national, and local infrastructure for computing services, business infrastructure, communications, and web-based services) and telecommunications workers. Essential infrastructure shall be construed broadly to avoid any impacts to essential infrastructure, broadly defined.
- g. Coal mining and coal-fired electric generation facilities.** Coal mining and coal-fired electric generation facilities, as well as all ancillary and support functions ranging from transportation, maintenance, equipment, and supply vendors.
- h. Manufacture, distribution, and supply chain for critical products and industries.** Manufacturing companies, distributors, and supply chain companies producing and supplying essential products and services in and for industries such as pharmaceutical, technology, biotechnology, healthcare, chemicals and sanitization, waste pickup and disposal, agriculture, food and beverage, transportation, energy, iron ore, steel and steel products, aluminum and aluminum products, petroleum, propane, and fuel, mining, construction, national defense, communications, as well as products used by other Essential Businesses and Operations including without limitation filters and filtration products and services.
- i. Transportation and travel related businesses and gas stations.** Travel related businesses facilitating access to or provision of essential activities or any Essential

Businesses and Operations, including without limitation , airlines, taxis, transportation network providers (such as Uber and Lyft), vehicle rental services, paratransit, and other private, public, and commercial transportation and logistics providers, travel or transport of agricultural products, foodstuffs, or related items, or other governmental travel needs, and gas stations and automobile dealers and other suppliers, auto repair, farm equipment, construction equipment, and related facilities and related facilities.

j. Financial and insurance institutions. Banks and banking services including without limitation ATM services, currency exchanges, consumer lenders, credit unions, appraisers, title companies, financial markets, trading and futures exchanges, payday lenders, affiliates of financial institutions, professional debt collectors and related creditor service workers, workers engaged in payment clearing and settlement, wholesale funding, and capital markets activities, entities that issue bonds, related financial institutions, institutions selling financial products, insurance companies, underwriters, agents, brokers, and related insurance claims and agency services.

k. Hardware and supply stores. Hardware and supply stores and businesses that sell construction, electrical, plumbing, and heating materials.

l. Critical trades. Building and construction tradesmen and tradeswomen, and other trades including without limitation plumbers, electricians, exterminators, filtration technicians, cleaning and janitorial staff for commercial and governmental properties, security staff, operating engineers, HVAC engineers, painting, moving, and relocation services, and other service providers who provide services that are necessary to maintain the safety, sanitation, and essential operation of residences, essential activities, and Essential Businesses and Operations.

m. Mail, post, shipping, logistics, delivery, and pick-up services. Post offices and other businesses that provide shipping and delivery services, and businesses that ship or deliver groceries, food, alcoholic and non-alcoholic beverages, goods, vehicles, or services to end users or through commercial channels.

n. Religious entities. Religious facilities, entities, and groups and religious gatherings, including weddings and funerals; provided that such gatherings should

still practice proper social distancing of six feet between persons to the greatest extent possible.

o. Educational institutions. Educational institutions including public and private pre-K-12 schools, colleges, and universities for purposes of facilitating distance learning, performing critical research, or performing essential functions including providing for the delivery or pick-up of food for school age children; provided that proper social distancing of six feet between persons is maintained to the greatest extent possible.

p. Laundry services. Laundromats, dry cleaners, industrial laundry services, and laundry service providers.

q. Supplies to work from home. Businesses that sell, manufacture, or supply products needed for people to work from home, including IT and telecommunications services and product companies.

r. Supplies for Essential Businesses and Operations. Businesses that sell, manufacture, or supply other Essential Businesses and Operations with the support of materials necessary to operate, including computers, audio and video electronics, household appliances, IT and telecommunications equipment, cybersecurity software or services, hardware, paint, flat glass, electrical, plumbing, and heating material, sanitary equipment, personal hygiene products, food, food additives, ingredients, and components, medical and orthopedic equipment, optics and photography equipment, diagnostics, food and beverages, chemicals, soaps and detergents, tent and other temporary structure suppliers, and firearm and ammunition suppliers and retailers.

s. Home-based care and services. Home-based care for adults, seniors, children, and/or people with developmental disabilities, intellectual disabilities, substance use disorders, and/or mental illness, including caregivers such as nannies who may travel to the child's home to provide care, and other in-home services including meal delivery.

t. Residential facilities and shelters. Residential facilities and shelters for adults, seniors, children, pets, and/or people with developmental disabilities, intellectual disabilities, substance use disorders, and/or mental illness.

u. Professional services. Professional services, such as legal services, accounting services, insurance services, real estate services (including appraisal and title services).

v. Media and first amendment protected speech. Newspapers, television, radio, and other media services.

w. Hotels and motels. Hotels and motels, to the extent used for lodging and delivery or carry-out food delivery.

x. Funeral services. Funeral, mortuary, cremation, burial, cemetery, and related services; provided that proper social distancing of six feet between persons is maintained to the greatest extent possible.

4. Prohibited activities. All places of public amusement, whether indoors or outdoors, including but not limited to locations with amusement rides, carnivals, zoos, museums, arcades, fairs, pool halls, bingo halls, malls (except where stores in a mall that have a direct outdoor entrance and exit that provide essential services and products under the terms of this Order), children's play centers, playgrounds, bowling alleys, movie and other theaters, concert and music halls, adult entertainment venues, racetracks, social clubs, and other similar businesses shall be closed.

5. Avoid social gatherings. All public and private gatherings of any number of people occurring outside a single household or living unit are prohibited, except for the limited purposes permitted by this Order. Any gathering of more than 10 people is prohibited unless exempted by this Order. Nothing in this Order prohibits the gathering of members of a household or residence.

6. Intent of this Order. The intent of this Order is to ensure that the maximum number of people self-isolate in their places of residence to the maximum extent feasible, while enabling essential services to continue, to slow the spread of COVID-19 to the greatest extent possible. When people need to leave their places of residence, whether to perform essential activities, or to otherwise facilitate authorized activities necessary for continuity of social and commercial life, they should at all times and as much as reasonably possible properly socially distance themselves from others. All provisions of this Order should be interpreted and implemented to effectuate this intent.

7. **Enforcement.** This Order may be enforced by State and local law enforcement and by state and local regulatory and/or licensing bodies to the extent possible under West Virginia law.
8. **Duration.** The provisions of this Order, and all previous executive orders relating to COVID-19, are effective until terminated by subsequent executive order.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of West Virginia to be affixed.



DONE at the Capitol in the City of Charleston, State of West Virginia, this Twenty-third day of March, in the year of our Lord, Two Thousand Twenty in the One Hundred Fifty-seventh year of the State.

A handwritten signature in blue ink, which appears to be "Randolph" followed by a stylized flourish.

GOVERNOR

By the Governor

A handwritten signature in blue ink, which appears to be "Mpe Warner".

SECRETARY OF STATE

Robinson, Bill C

From: Ouellette, Audra (FTA) <audra.ouellette@dot.gov> on behalf of Garcia Crews, Terry (FTA) <theresa.garciacrews@dot.gov>
Sent: Tuesday, March 3, 2020 4:58 PM
To: List-FTA-TRO-3-All
Cc: Tarone, Tony (FTA); Berrillo, Katherine (FTA); NOTIFYTRO3
Subject: [External] Coronavirus Info Gathering Request (Bcc: CEO's)
Importance: High

CAUTION: External email. Do not click links or open attachments unless you verify sender.

Dear Colleagues:

In preparation for the COVID-19 (Coronavirus) event, FTA is determining what, if any action has been taken by transit agencies across the country. Please provide responses as concise bullets by close of business (COB) Thursday March 5, 2020:

1. Action taken for employees (Internal communications)
2. Action taken for the riding public (External communications) If there are no activities planned, please let me know that as well.
3. Type of action (i.e. website, flyers, social media etc.)

Please send your responses to this request to NOTIFYTRO3@dot.gov and copy Anthony Tarone, Tony.Tarone@dot.gov . If you have updates to the steps you are taking, please send this updated information to the same email address.

Thank you in advance for your expeditious response. If you need additional clarification or assistance, please contact myself or Katherine Berrillo at (215) 656-7257 or Katherine.Berrillo@dot.gov .

If you need any additional assistance or guidance, please let us know.

Best Regards,

Theresa "Terry" Garcia Crews
Regional Administrator
United States Department of Transportation
Federal Transit Administration-Region III
1835 Market Street, Suite 1910
Philadelphia, PA 19103
Telephone: 215.656.7263
Cell phone: 267.353.4970

Taking Reasonable Efforts to Prevent COVID-19 From Entering Your Skilled Nursing Center (as of March 9, 2020)

The top priority at this point with COVID-19 is to prevent the virus from entering your nursing home given the high case fatality rate in the elderly, which preliminary data shows it at 15% or greater. Evaluations from prior viral epidemics that spread like COVID-19 found that actions taken early in outbreaks (such as social distancing, restricting interaction with others, washing hands) can significantly reduce the spread of the virus. Waiting until the virus is spreading in the community is often too late.

As such, AHCA strongly recommends five actions to help prevent the entry of COVID-19 into your facilities whether or not it has been found in your surrounding community.¹

1. Allow entry to only individuals who need entry.
2. Restrict activities and visitors with potential for exposure.
3. Actively screen individuals entering the building and restrict entry to those with respiratory symptoms or possible exposure to COVID-19.
4. Require all individuals entering the building to wash their hands at entry.
5. Set up processes to allow remote communication for residents and others.

#1 Restrict entry to only individuals who need entry, such as:

- Facility employees, contractors and consultants who are needed to keep the operations running and assure the residents' needs are met.
- Government officials who in their capacity require entry (e.g., CDC or public health staff).
- Immediate families or friends who need to visit for critical or time sensitive reasons such as hospice-related visits, complete medical authorizations, etc. These visitors should be instructed to limit their movement within the facility.

Visitor Exceptions: AHCA/NCAL's recommendation is NOT for a complete ban on all visitors. The circumstances for the reason for entry need to be taken into consideration, particularly for immediate family members (e.g. spouse or sons/daughters) but routine social visits are strongly discouraged. The rationale for this best practice should be explained, and alternative methods of communications offered. We recommend that the resident (or the resident representative) be consulted to determine if a resident wants or needs a specific visitor, including immediate family members, and to allow entry if they do not meet any of the screening exclusion criteria in #3 below.

#2 Restrict activities and individuals with potential for exposure, including:

- Visitors, when there are any confirmed COVID-19 cases in the surrounding community. This does not apply to workforce needed to keep the operations going and to meet resident needs.

¹ These recommendations build upon what CMS and CDC currently recommend. We urge members to adopt these additional best practices when possible based on the growing data about the high mortality rate among the elderly over the age of 80 with chronic disease (estimated at 15%), who comprise the majority of our residents. Waiting until the virus starts to spread in the community, has been shown in prior viral epidemics to be too late. (Note the case fatality rate in the Kirkland WA SNF was over 50% based on data available on King County Health Departments website as of 3-7-20). To date, nearly all the deaths in the United States have been in individuals over the age of 70.

- Other visitors for routine social visits, tours with prospective residents or their families, and outside group activities (e.g., school groups or bands, etc.) should be restricted.
- Cancel activities that take residents into the community to public places particularly with large gatherings, such as mall, movies, etc. (note: this does NOT apply to residents who need to leave the building for medical care such as dialysis, medical visits, etc).
- Internal group activities should be restricted, especially if: a) the facility has residents with respiratory symptoms (who should be in contact isolation per CDC guidance); b) if COVID-19 is in the surrounding community; and/or c) the ability to restrict visitors is challenging in the facility.

Facilities should also continue to use [CDC recommended signage](#) reminding people that anyone with symptoms of respiratory illness should not enter the facility, including employees, government officials and contractors.

#3 Actively try to screen all individuals entering the building, including employees, contractors, volunteers, visitors, new admissions, government officials, and health care professionals. The screening process² should include asking individuals for:

- Respiratory symptoms (fever, sore throat, cough and new shortness of breath);
[Please note: As of March 7, taking temperatures is not included in any CDC or CMS recommendations and AHCA/NCAL is not recommending taking temperatures. Extenuating circumstances should be taken into consideration, but in these cases, individuals should use gown, mask and gloves during their visit.]
- International travel within the last 14 days to areas where COVID-19 cases have been confirmed.
- Anyone who has worked in another health care setting with confirmed COVID-19 cases (this may change as COVID-19 spreads in your community)

#4 Require all individuals entering the building to wash their hands at entry.

- If technically possible, set up hand washing and/or alcohol-based hand rub (ABHR) stations immediately inside all entryways with signage reminding people to wash before entering.
- Have each person who enters the center immediately wash their hands or use hand sanitizer before they do anything else.
- Encourage them to wash their hands or use ABHR throughout their time in the building and in accordance with CDC recommendations. CDC recommendations includes increasing the access to ABHR.,
- Clean and disinfect frequently touched objects and surfaces following manufacturer's directions.
- Remind people to not shake hands or hug with each other, staff or residents during this epidemic.

² See AHCA [screening tool](#) available on [AHCA/NCAL COVID19 website](#).

#5 Set up a process to allow remote communication for residents and others.

- Ensure emergency contact information for family members and the resident representative is up to date.
- Develop alternative means of communications for residents to visit and talk with loved ones, such as video chat, telephone, texting or social media.
- Inform residents or their representatives of these changes using clear, concise, jargon-free messages that express empathy for their situation while simply explaining the policy.
- Ensure proactive communication with residents' families, loved ones, contractors, volunteers, etc. to make them aware of these restrictions; and to keep them up to date.
- Develop a process for family members to communicate with the facility to get answers to their questions.

Frequently Asked Questions

Who should NOT enter your center?

- Anyone who has symptoms of respiratory illness or has traveled internationally within the last 14 days to areas where a COVID-19 outbreak has been confirmed.
- If COVID-19 is confirmed in your surrounding community, visitors should be restricted. This does not apply to the facility workforce or contractors.
- Any one has worked in another healthcare setting with COVID-19 patients (this may change as COVID-19 spreads in your community)

Who should be screened?

- Anyone who is entering your center including staff, visitors, contractors and government employees.

How do I conduct a respiratory symptom screen?

- Ask and observe for signs or symptoms of acute respiratory: (cough or sneezing or shortness of breath).
- Ask for symptoms of fever, sore throat, cough, shortness of breath.
 - *Please note: As of March 7, taking temperatures is not recommended.*

What if a person refuses and tries to enter?

- Explain the rationale for the restriction and need to keep all the residents safe.
- Offer them an alternate way to communicate with the person they want to see.
- Talk with the resident or person they want to see, to make sure they want to see the person and explain that person's request.
- Use best judgement and assess extenuating circumstances for entry.
[Note: this guidance is not a ban on all visitors and SNFs cannot be expected to physically restrain individuals from entering but should do what is feasible to explain the rationale for the restriction. Federal regulations permit SNFs to limit visitation if it poses a clinical or safety risk].

Resources to Facilitate Communication

AHCA/NCAL offers a number of communication resources on our coronavirus website (www.ahcancal.org/coronavirus), including:

- [Screening tool for visitors](#)
- [Template letters for families and residents](#)
- [Template letters for employees](#)
- Template statement and talking points for [impacted](#) and [non-impacted](#) facilities
- [A guide on communication plans during an emergency](#)

AHCA/NCAL strongly recommends all centers review the [CDC guidance on COVID-19](#) by checking the CDC website frequently as guidance and recommendations are continuing to rapidly evolve.

Please email COVID19@ahca.org with any questions.

For additional information and resources on the virus, visit our dedicated website on this issue: www.ahcancal.org/coronavirus.



*NGA Center for Best Practices Learning Collaborative on
Strengthening Substance Use Disorder Systems of Care*

Request for Applications

- Purpose:** To support up to five states in developing and implementing coordinated approaches for strengthening statewide substance use disorder (SUD) systems of care.
- Opportunity:** Through the learning collaborative, teams from up to five states will:
- 1) Attend a virtual kick-off meeting and action planning sessions, attend a one-and-a-half-day in-person convening in Virginia in Fall 2020, as well as participate in regular conference calls, webinars, or other virtual convenings.
 - 2) Develop and implement a strategic action plan to strengthen and improve coordination across the continuum of prevention, treatment, and recovery services for substance use disorders.
 - 3) Receive ongoing technical assistance from National Governors Association (NGA) in support of project goals, which may include a site visit by the NGA team and other experts.
- RFA Release Date:** February 19, 2020
- Applications Due:** March 19, 2020 – Please contact [Elaine Chhean](#) if you require an extension. We will allow extensions due to the focus of states on responding to covid-19.
- Selection Announcement:** Early-April
- Project Period:** June 2020 – March 2021
- Virtual Kick-off Meeting:** May/June 2020
- In-person convening:** Proposed for Fall 2020 in Richmond, Virginia
- NGA Contact(s):** *Elaine Chhean*
Senior Policy Analyst, NGA Health | echhean@nga.org | (202) 624-5344
- Lauren Wood*
Policy Analyst, NGA Health | lwood@nga.org | (202) 624-8839

Overview

The National Governors Association Center for Best Practices is launching a learning collaborative to support governor's offices and other state officials in improving coordination across the continuum of prevention, treatment, and recovery services for opioid use disorders (OUD) and other substance use disorders (SUD). This learning collaborative will support governors with developing and implementing evidence-based interventions to



link individuals with SUDs to treatment, facilitate care coordination and transitions throughout the continuum of care, and build a sustainable treatment infrastructure that reduces barriers to access for high-quality treatment and recovery supports.

An NGA learning collaborative is an opportunity to share successes and exchange ideas with different model jurisdictions, while developing and executing an action plan based on the governor's identified goals. Participating states will work with the NGA Health and Homeland Security and Public Safety Divisions to produce and implement a state action plan informed by the best practices in expanding access to high quality SUD treatment and recovery support and tailored to the unique needs of the state. For this project, the NGA Center will engage national experts, state and local officials, and people with lived experience to share key principles and strategies for developing robust systems of care.

Through participation in this learning collaborative, NGA will support state teams in identifying, developing, and implementing targeted strategies that meet the unique prevention, treatment, and recovery needs of their state. These strategies may include:

- Developing and beginning to execute a coordinated statewide vision for a robust SUD continuum of care
- Expanding public health, behavioral health, public safety, and first responder partnerships and programs to identify key intervention points and link individuals to treatment (e.g. diversion programs, first responders and connections to treatment, MAT and corrections, supervision, emergency departments, crisis continuum, community based providers, etc.)
- Increasing access to evidence-based treatment practices, such as medication-assisted treatment (MAT), care coordination, and meaningful care transitions through payment and delivery reform.
- Building a sustainable treatment infrastructure that addresses barriers to access for high-quality treatment, such as limits in provider capacity.

In response to concerns about travel related to coronavirus, this project will begin in late May or early June with a short, virtual, opening meeting to introduce states to the project. In addition, NGA will conduct virtual strategic action planning sessions with each state to identify state goals, next steps, and technical assistance needs, as well as conduct regular monthly webinars to learn from experts and connect with peers on key topics. Later this year, NGA will host a 1.5-day meeting to bring participating states together to learn from one another and state and national experts. NGA Center staff, along with a faculty of experts and practitioners, will provide ongoing support to state teams and assist states in developing and implementing their action plans. NGA Center will also work with an outside consultant to provide subject matter expertise and robust technical assistance to all state teams. The NGA Center will arrange for teams of up to five individuals from up to five selected states to travel to Virginia for the learning collaborative once travel is deemed safe for state participants, with a target date in September 2020. Travel and lodging expenses for team members participating in the in-person meeting will be covered by NGA. This project is made possible through a grant from the Centers for Disease Control and Prevention.

Background

As the opioid overdose epidemic continues to evolve with increasing challenges related to the rising prevalence of illicit opioids, stimulants, and polysubstance use, states must continue to make progress in addressing barriers to access for high-quality substance use disorder treatment and linkages to care.¹ In 2017, 7.6% of the nation's

¹ Centers for Disease Control and Prevention. 2018 Annual Surveillance Report of Drug-Related Risks and Outcomes — United States. Surveillance Special Report. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2018. Accessed [date] from <https://www.cdc.gov/drugoverdose/pdf/pubs/2018-cdc-drug-surveillance-report.pdf>



population age 12 or older had a need for SUD treatment in the past year; however, only 1.5% of the population was able to receive treatment.² Medicaid beneficiaries are disproportionately impacted by SUD, and many individuals with SUD continue to face barriers to high-quality treatment such as stigma, lack of coverage, and a limited provider workforce.³ Access to quality evidence-based treatment and recovery supports is limited, with substantial variation in state prescribing rates of MAT. Recent statistics show that less than half of those on Medicaid who have OUD received any form of SUD treatment.⁴ To compound these challenges, the delivery of SUD services often lacks care coordination, treatment for co-occurring physical or behavioral health needs, or wrap around services (e.g. housing, employment) to support individuals they transition through levels of care and into community-based recovery.

To address these challenges, many Governors and senior health officials are focused on modernizing addiction treatment systems, and are actively working to strengthen and improve coordination across the continuum of care. Given the heterogeneity of state challenges related to substance use and treatment system infrastructure, there is no one-size fits all model for expanding access to high-quality services. However, by using a variety of strategies to strengthen SUD interventions, linkages, and coordination across levels of care, governors and their state agencies can continue to make progress in addressing current gaps and barriers to access within the treatment system.

Specific strategies, models, and interventions that learning collaboratives teams may focus on through participation in the project include:

- Developing and beginning to execute a coordinated statewide vision for a robust SUD continuum of care to better align priorities, resources, and collaboration across agencies and stakeholders. Learning collaborative states will learn from peer states that have undertaken efforts to build a statewide continuum of care, addressing issues such as braiding of state and Federal funding, leveraging data to identify treatment gaps, engaging high priority populations (e.g. pregnant and parenting women, justice-involved populations, people who inject drugs), and building linkages and coordination of services through intervention, treatment, and community-based recovery.
- Expanding public health, behavioral health, public safety, and first responder partnerships and programs to identify key intervention points and link individuals to treatment (e.g. diversion programs, first responders and connections to treatment, MAT and corrections, supervision, crisis response systems, community providers, etc.). Public health and public safety partnerships can be leveraged to support early interventions, connections to wrap around support services, and linkages to care.
- Increasing access to evidence-based treatment practices, such as medication-assisted treatment (MAT), care coordination, and meaningful transitions of care through payment and delivery reform. Payment and delivery reforms that align Medicaid, as well as other funding streams, can help states build innovative models that support quality care, build capacity, and expand access to evidence-based SUD services.
- Building a sustainable treatment infrastructure that addresses barriers to access for high-quality treatment, including innovative state approaches for addressing provider workforce challenges, lack of parity in coverage of behavioral health services, and stigma.

² Assistant Secretary for Planning and Evaluation. (September 2019). Needs Assessment Methodologies in Determining Treatment Capacity for Substance Use Disorders: Final Report. Retrieved from: <https://aspe.hhs.gov/report/needs-assessment-methodologies-determining-treatment-capacity-substance-use-disorders-environmental-scan-final-report>

³ Office of the Assistant Secretary for Planning and Evaluation, “Best Practices and Barriers to Engaging People with Substance Use Disorders in Treatment”, (March 2019), retrieved from <https://aspe.hhs.gov/system/files/pdf/260791/BestSUD.pdf>.

⁴ Medicaid and CHIP Payment and Access Commission, “Report to Congress: Utilization Management of Medication-Assisted Treatment in Medicaid”, (October 2019), retrieved from <https://www.macpac.gov/wp-content/uploads/2019/10/Report-to-Congress-Utilization-Management-of-Medication-Assisted-Treatment-in-Medicaid.pdf>.



Learning Collaborative Expectations and Activities

During this learning collaborative, the NGA Center will work with selected state teams to move beyond vision statements and preliminary plans to developing and implementing action plans. States must identify a core team of up to five people who can drive and support, activities needed for actionable progress around improving their SUD treatment system in support of broader state health goals. The core team will be expected to participate in the kick-off, as well as monthly check-in calls, and will be responsible for ensuring continuation of the work in the state throughout the project period.

The learning collaborative will require active participation from selected states. States participating can expect to:

- 1.) **Attend virtual kick-off meeting(s):** NGA Center will host a virtual kick-off meeting in late May or early June 2020 to introduce state teams to the project. Over the next several months, NGA will conduct strategic action planning sessions with each state team to solidify state goals, next steps, and technical assistance needs, as well as conduct regular monthly webinars to learn from experts and connect with peers on key topics.
- 2.) **Attend an in-person Meeting in Virginia:** Selected states will send teams to Virginia in Fall 2020 for a one-and-a-half-day meeting to learn from experts and peers to discuss plans related to state goals in strengthening their SUD system of care. The NGA Center is targeting September 2020 for this convening and will pay for travel and accommodations for up to five state team members.
- 3.) **Develop and Implement an Action Plan:** States will develop a high-level action plan for strengthening their SUD treatment system with key strategies, specific action steps, team member responsibilities, and timelines for completing work during the project period.
- 4.) **Communicate Technical Assistance Needs and Participate in Monthly Calls:** NGA Center will provide ongoing technical assistance throughout the learning collaborative with the support of an outside consultant. Such assistance could include telephone consultation, facilitated conversations with other states and experts, presentations and other best practices research. At the invitation of the state, the NGA Center can facilitate one site visit* for each state team to advance their goals. Travel decisions will be made on a case by case basis for the next several months. In the meantime, NGA will be prepared to support state teams virtually as much as possible.

The NGA Center will also be hosting an expert roundtable in late fall/early Winter in Washington, DC to discuss challenges and strategies for addressing public health and safety challenges related to the increasing prevalence of stimulant and polysubstance use. Learning Collaborative states will be invited to send one team member to attend this roundtable discussion.

Project Timeline

The following presents a tentative timeline for the learning collaborative:

Date	Activity
March 19, 2020	Proposals Due (However, please let us know if you need an extension)
Early April	State Selection Announcement
April 2020	Project Kick-Off Call with Selected States



Late May/Early June 2020	Learning Collaborative Virtual Kick-Off Meeting
Fall 2020	In-person Convening
June 2020 – March 2021	Ongoing Technical Assistance

Required Application Content

To apply, states should submit the following required materials:

•**Letter from the Governor.** The letter must include the state’s interest in and expected outcomes related to the learning collaborative opportunity. The letter should indicate whom the governor is designating as the team lead and who will serve as the main point of contact between NGA Health and the state.

•**Brief Narrative.** The narrative should not exceed four pages (11-point font, single-spaced) and should include the following elements:

- **Assessment of Current Landscape (40 points)**
 Applicants should provide a brief description of the current landscape, addressing the following questions as they apply to the state’s proposed scope of work:
 - At a high level, describe the continuum of care for substance use disorders in your state. What are some of the challenges the state is facing in meeting demand for high-quality treatment and recovery support for individuals with SUDs?
 - What initiatives, strategies, or partnerships have been successful in linking individuals to treatment and expanding access to care?
 - What data sources is the state currently using to assess treatment needs and evaluate progress in achieving its goals?
 - What structures, processes, or plans are in place to coordinate state agencies and funding to support SUD treatment and recovery?
 - How is the state currently leveraging flexibility in the Medicaid program to expand access to quality SUD care?

- **Description of Preliminary Goals and Expected Outcomes (40 points)**
 Applicants should provide an overview of the state’s goals, expected outcomes, and approach to measuring success in this learning collaborative. Applicants should describe how they envision using this technical assistance opportunity to meet state goals and overcome challenges and provide an assessment of the state’s readiness to adopt new strategies. Please also describe any related technical assistance programs in which the state is participating and plans for coordinating with those efforts.

- **Learning Collaborative Team (20 points)**
 Applicants should provide a brief statement describing the anticipated cross-agency core team that will participate in the learning collaborative, including the reason for each member and agency’s participation. Five members of the core team are expected to travel to Virginia for the kick-off meeting on May 20-21, 2020. If there are other individuals who are instrumental to completing the state’s goals, but who will not be part of the core team, please describe how these individuals will be involved in the work. For each team member, please provide the individual’s name, title, and contact information. Finally, state applications must include the name and contact information of



an administrative staff person who is connected to the team lead and can help schedule conference calls and team logistics.

State teams should include senior representatives such as:

- Governors' health policy advisors
- State health secretaries or senior health agency leadership
- Directors of Single State Agencies (SSAs) for substance abuse services, or other behavioral health leadership
- State Opioid Coordinators or Directors of Drug Control Policy
- Medicaid agency leads
- State public safety leadership (e.g. governor's criminal justice policy advisor, state administering agency director for criminal justice, state public safety secretary, senior state public safety official, local public safety official)
- Chief Data Officers

Selection Process

The NGA Center will score state applications. States that have applied will be notified about their award status in early April. Due to a potentially high number of applicants, NGA will not be able to inform applicants of their status in the review process until final decisions are made.

Submission Information and Deadline

The scheduled deadline for applications is **5:00 p.m. ET on March 19, 2020**. However, please contact us if you need an extension or other accommodations. Applications must be submitted through the governor's office. Only one application per state will be accepted. Please combine all application materials into a single document and email to Elaine Chhean at echhean@nga.org.

This project is made possible through a collaborative grant with the Centers for Disease Control & Prevention.

This request for application (RFA) is not binding on the NGA, nor does it constitute a contractual offer. Without limiting the foregoing, the NGA reserves the right, in its sole discretion, to reject any or all applications; to modify, supplement, or cancel the RFA; to waive any deviation from the RFA; to negotiate regarding any proposal; and to negotiate final terms and conditions that may differ from those stated in the RFA. Under no circumstances shall NGA be liable for any costs incurred by any person in connection with the preparation and submission of a response to this RFA.



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Medical Services

Bill J. Crouch
Cabinet Secretary

Cynthia E. Beane
Commissioner

MEMORANDUM

TO: WV Medicaid Providers

FROM: Cynthia Beane, MSW, LCSW 
Commissioner

DATE: March 17, 2020

SUBJECT: Telehealth Modality

Due to the World Health Organization declaring Coronavirus disease (COVID-19) a pandemic, the West Virginia Bureau for Medical Services (BMS) is allowing all existing telehealth services listed in the BMS policy manual, and the telehealth services temporarily approved during the COVID-19 pandemic, referenced in BMS release memos, to use live video conferencing or telephonic service in the member's home. Place of service 02 for HCFA-1500 or CPT plus -GT modifier combination for UB04s should be utilized on all telehealth billings.

BMS will continue to monitor the situation and work closely with our state and federal partners gathering further information and directives and will provide further notification if an extension is received.

From: Lopez, John V <John.V.Lopez@wv.gov>

Sent: Friday, March 20, 2020 7:51 AM

To: Samples, Jeremiah <Jeremiah.Samples@wv.gov>; Crouch, Bill J <Bill.J.Crouch@wv.gov>; Watts, Linda <Linda.M.Watts@wv.gov>

Subject: Fw: [External] FW: travel restrictions

Please review my response below and let me know if it's ok to send.

██████████

Thank you for contacting the West Virginia Department of Health and Human Resources (DHHR). Cabinet Secretary, Bill Crouch has referred your inquiry to our office for review and response. We are pleased to assist you.

I read your email below and I recognize your concerns.

Please know that the health and well-being of our staff, clients, and the children we serve is of the utmost importance to us. Therefore, we have been exploring several options to be able to conduct normal business in the safest manner possible. The DHHR is putting plans in place to ensure our ability to sustain operations and continue to provide services to those in need. Many of our providers are restricting on-site visitation at this time to prevent the exposure of other children and staff in the facilities to the COVID-19 virus. The policies vary from facility to facility and the DHHR is working with the providers to encourage other means of communication that do not require a physical presence. The same is true with visitation between kinship and foster care children and their biological families. This is being handled on a case by case basis depending on the health of the child and vulnerability of others in the home. The Department will continue to ensure the safety of the vulnerable adults and children in our care. Some of our DHHR leadership team are currently working on a plan with Administrative staff of the State Supreme Court concerning visits of this nature. We are hopeful to have something in place later today.

Thanks,

From: Crouch, Bill J <Bill.J.Crouch@wv.gov>

Sent: Friday, March 20, 2020 6:37 AM

To: Samples, Jeremiah <Jeremiah.Samples@wv.gov>

Cc: Lopez, John V <John.V.Lopez@wv.gov>; Watts, Linda <Linda.M.Watts@wv.gov>

Subject: Re: [External] FW: travel restrictions

Jeremiah...can this only be stopped by a court order? If so, I can call the Chief Justice. If not, I can Doak to the Governor. I agree, they should not be traveling.

Bill

On Mar 20, 2020, at 2:43 AM, Samples, Jeremiah <Jeremiah.Samples@wv.gov> wrote:

This is being worked on with the Courts. In discussions with Linda, she is likely to order a two week hiatus on all such visitations and has been working with Cindy Hill to prepare the Court. We are looking

at alternatives like Skype and other communication media to maintain the connections between children and families.

I have a similar question from Senator Weld. Just tell them we have been working on it with the Courts and look to have guidance today.

Jeremiah Samples
Deputy Secretary
West Virginia Department of Health and Human Resources
[1 Davis Square, Suite 100E](#)
[Charleston, WV 25301](#)
[304-356-5405](#) (office phone)
[304-380-5944](#) (cell phone)
Jeremiah.samples@wv.gov

Montani Semper Liberi

NOTE: The information contained in this electronic message is legally privileged and confidential under applicable state and federal law and is intended for the individual named above. If the recipient of the message is not the above-named recipient, you are hereby notified that any distribution, copy or disclosure of this communication is strictly prohibited. All communications to DHHR staff are internal and deliberative in nature and should not be shared. If you have received this communication in error, please notify Jeremiah Samples, West Virginia Department of Health and Human Resources, and discard this communication immediately without making any copy or distribution.

On Mar 19, 2020, at 6:43 PM, Lopez, John V <John.V.Lopez@wv.gov> wrote:

Please refer to the emails below – Do you have any information you want me to share in my response ?

From: Erikka Storch <erikka.storch@wvhouse.gov>
Sent: Thursday, March 19, 2020 3:10 PM
To: Lopez, John V <John.V.Lopez@wv.gov>
Subject: [External] FW: travel restrictions

CAUTION: External email. Do not click links or open attachments unless you verify sender.

Can you help me with this, please?

Thanks,
Erikka

From: mike trabert [REDACTED]
Sent: Thursday, March 19, 2020 12:39 PM
To: DHHRSecretary@wv.gov; governor@wv.state.us; Ryan Weld <ryan.weld@wvsenate.gov>; William Ihlenfeld <William.Ihlenfeld@wvsenate.gov>; Shawn Fluharty <shawn.fluharty@wvhouse.gov>; Erikka Storch <erikka.storch@wvhouse.gov>
Subject: travel restrictions

I want to let you know that [REDACTED], the workers are expected to take the ladies to their homes all over the state on weekend visits. With the coronavirus, this is the most ludicrous thing to do at this time. I was advised that this a policy of the office of the DHHR. Someone needs to put a stop to this travel immediately. Who knows what is going on in those areas and homes they are to take these girls to? The girls and/or the workers could bring something back to the facility and contaminate everyone else working and living there. Again, this travel needs to postponed immediately for the safety of everyone. Either Bill Crouch or Jim Justice needs to give a directive to all DHHR offices to stop all of the home visits until it is safe for everyone.



To: Mountain Health Employees

From: Susan Beth Robinson, Chief Human Resources Officer, Mountain Health Network

Re: COVID-19 Update

Date: March 19, 2020

Human Resources
Employee Question & Answers (Vol. 2)

REMINDER: Please wear ID badges at all times. With screenings at Hospital entrances, screeners will need to distinguish staff from visitors.

1. I heard the St. Mary's Wellness Center is closing. Will my payroll deductions stop?

Answer: Effective March 19, 2020, the Wellness Center has closed until further notice for employees and Cardiac Rehab patients. Payroll will be removing the Wellness Center deduction starting with the next pay on March 27 (for the pay period ending on March 22).

2. I have payroll deductions for the Huntington YMCA / MU Rec Center / Brown Dog Yoga and they have closed operations or have reduced hours. I would like to stop my payroll deductions.

Answer: Staff must contact their wellness facility directly to see if they will allow suspension or cancellation of your membership.

3. How do I schedule a time to discuss my 401(k) with the Principal (CHH) or my 403(b) with VALIC (SMMC)?

Answer:

Principal: CHH employees may continue to receive 401(k) assistance and investment advice by calling RBC Wealth Management at the Huntington office (304) 697-2030 or the Charleston office (304) 345-3752.

VALIC: SMMC employees may continue to receive 403(b) assistance and investment advice by calling Valic at 304-526-8784 or by going to SMMC's Intranet clicking on the Valic icon and setting up a phone appointment with a Valic representative.

4. Does Highmark Blue Cross Blue Shield have campus hours currently?

Answer: In lieu of onsite meetings with a representative from Highmark BCBS, we will provide a conference room to hold telephone meetings to discuss medical plan questions. Email reminders will be sent as the date approaches and will contain detailed instructions for scheduling these appointments. As always, staff may contact Highmark BCBS Member Services (877) 770-6991 at any time to receive assistance.

5. If I am caring for a patient suspected of COVID-19 and their test later becomes positive, am I sent home to quarantine and for how long?

Answer: An employee should treat any suspected COVID-19 patient as a confirmed COVID-19 patient and wear appropriate PPE and follow all infection prevention protocols. Staff will not be quarantined just because they cared for a COVID-19 patient. If they cared for a patient not in isolation and did not wear the appropriate PPE, then Employee Health will determine the exposure category related to the employees exposure and recommend appropriate monitoring based on the CDC's guidance.

6. What do we do about the workstations on wheels (WOW) for the patient with COVID-19 suspected and or positive?

Answer: The WOW should be wiped down with a gray top Sani-Cloth germicidal disposable wipe per the manufacture disinfection instructions: Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for three (3) minutes. Let air dry.

7. When and what type of isolation mask and personnel protective equipment should you wear when entering a patient's room or caring for a patient with suspected or confirmed COVID-19?

Answer: At this time the CDC generally suggests that only healthcare workers who are in close contact with people with influenza or COVID-19 wear masks. People should only wear a mask at all times if their doctor recommends it. As a guideline, the education departments at CHH and SMMC have developed a **PPE algorithm for suspected or confirmed cases of COVID-19** that will be available on both intranet sites. The algorithm states in the **clinical setting for a patient with Suspected or Confirmed Cases of COVID-19** if you are performing a routine patient assessment and exam, and the patient is in Standard + Droplet + Contact Isolation, wear a surgical mask, eye shield, gown and gloves. If the patient is critically ill or aerosol generating procedures are being performed and the patient is in Airborne + Contact + Eye Shield Isolation, wear N95/PAPR/CAPR, eye shield if N95, gown, and gloves. Aerosol generating procedures are intubation, noninvasive ventilation, CPR, bronchoscopy, open suction, NT suction, nebs, Chest PT, NP and SWAB collection. Aerosol generating procedures do not require a negative pressure room.



State of Washington
 Department of Health
PUBLIC HEALTH LABORATORIES
 1610 N.E. 150th Street
 Shoreline, Washington 98155-9701
 Phone: (206) 418-5400
 Fax: (206) 364-0072
 MTS #1327 CLIA #50D0661453

FOR PHL USE ONLY

Lab Number

Date/Time Received

[Http://doh.wa.gov/PHLForms](http://doh.wa.gov/PHLForms)

Please Print Clearly

COVID-19 Sample Submission Form

SUBMITTER

SUBMITTER NAME	AREA CODE & PHONE # () -	CLINICIAN
	FAX # () -	CLINICIAN PHONE #

DIAGNOSTIC SPECIMEN

CONFIRMATORY SPECIMEN

SPECIMEN TYPE: NASOPHARYNGEAL SWAB SPUTUM OTHER UPPER RESPIRATORY (SPECIFY) _____

OTHER LOWER RESPIRATORY (SPECIFY) _____

DATE COLLECTED: MO DAY YR TIME OF DAY : AM PM DATE OF ONSET MO DAY YR

PATIENT INFORMATION

(LAST) (FIRST) (MIDDLE)

ADDRESS CITY STATE ZIP CODE COUNTY

MALE FEMALE DATE OF BIRTH MO DAY YR CHART OR PATIENT ID NUMBER SPECIMEN ID NUMBER

FOR PHL USE ONLY

Preliminary Results:

Date/Time Reported:

Final Results:

Date/Time Reported:

Submitter Comments:

PHL Comments:

GENERAL INSTRUCTIONS:

- **PLEASE PRINT LEGIBLY.**
- **Please fill out the requisition form COMPLETELY. Delays in processing the specimen or reporting results may occur if information is incomplete.**
- **Each specimen submitted to the Public Health Laboratories (PHL) must be clearly marked with at least two unique identifiers for positive identification.**
- **Send specimens to the PHL as soon as possible to help ensure valid test results.**
- **All specimens being shipped must meet DOT(Department of Transportation) and US Postal Service regulations. It is the shippers responsibility to ensure that packages being shipped meet these regulations. Specimens mailed with insufficient postage will not be delivered by the Postal Service.**
- **This form replaces:**

Microbiology	Form Number DOH 302-013
--------------	--
- **Using the incorrect form may delay processing of the specimen.**
- **To obtain additional collection kits, please contact the PHL Mail Room at (206) 418-5579 .**



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

James A. Dodrill
Insurance Commissioner

MARCH 2020

WEST VIRGINIA INSURANCE BULLETIN

No. 2020 – 01

The following Insurance Bulletin is issued by the West Virginia Offices of the Insurance Commissioner to inform and educate the reader on the specified issue. It is not an evaluation of any specific facts or circumstances, but rather the Insurance Commissioner's guidance on a general issue or interpretation of an existing statute or rule.

To: All insurers writing health insurance or health benefit plan coverage in West Virginia, Insurance Trade Associations, Insurance producers and Other Interested Persons

From: James A. Dodrill, Insurance Commissioner

Re: Coronavirus (COVID-19)

Date: March 9, 2020

Coronavirus 2019 (COVID-19) is a respiratory illness caused by a novel coronavirus designated SARS-CoV-2. The outbreak of COVID-19 originated in December 2019 in Wuhan City, Hubei Province, China. Since then, thousands of confirmed cases have been reported in a rapidly growing number of countries worldwide. As of March 9, 2020, the West Virginia Department of Health and Human Resource's Bureau for Public Health has reported that there are no confirmed cases of COVID-19 in West Virginia. However, as the number of national cases grow, the risk of a confirmed case and community spread in West Virginia appears more likely.

Accordingly, this matter is of urgent importance to public health and, in order to protect the public health, the Commissioner is asking insurers to take all practical steps to identify and remove barriers to testing and treatment for COVID-19. Specifically, the Commissioner is asking insurers providing coverage through health benefit plans to West Virginia residents to take the following immediate measures related to the potential impact of COVID-19.

1. **Preparedness.** Insurers should review their internal processes and operations to ensure that they are prepared to address COVID-19 cases, including by providing insureds with information and timely access to all medically necessary covered health care services. As the situation continues to evolve, insurers should continually assess their readiness and make any necessary adjustments.



2. **Information Access.** Access to accurate information and avoiding misinformation are critical. Insurers are asked to inform insureds of available benefits, quickly respond to insured inquiries, and consider revisions needed to streamline responses and benefits for insureds. Insurers should make all necessary and useful information available on their websites and staff their nurse-help lines accordingly.
3. **Testing for COVID-19.** The Commissioner asks insurers to waive cost-sharing for COVID-19 laboratory tests to reduce or eliminate barriers to access testing. In addition, insurers are also asked to waive cost-sharing for an in-network provider office visit, in-network urgent care center visit and emergency room visit when testing for COVID-19.
4. **Telehealth Delivery of Services.** Given that COVID-19 is a communicable disease, some insureds may be using telehealth services instead of in-person health care services. Insurers are asked to review and ensure their telehealth programs with participating providers are robust and will be able to meet any increased demand.
5. **Network Adequacy and Access to Out-of-Network Services.** Insurers are asked to verify their provider networks are adequate to handle a potential increase in the need for health care services in the event COVID-19 cases are diagnosed in West Virginia. If an insurer does not have a health care provider in its network with the appropriate training and experience to meet the particular health care needs of an insured, health insurers are asked to provide access to an out-of-network provider at the in-network cost-sharing.
6. **Utilization Review.** Timely decision making is essential to responding appropriately to COVID-19, and it is particularly important with respect to utilization review. Health insurers are reminded that utilization review decisions must be made in the timeframes required by law. Health insurers should not use preauthorization requirements as a barrier to access necessary treatment for COVID-19, and health insurers should be prepared to expedite utilization review and appeal processes for services related to COVID-19 when medically appropriate.
7. **Immunizations.** A vaccine is not currently available for COVID-19, but it has been reported to be in development. In the event an immunization becomes available, the Commissioner requests that health insurers cover the immunization at no cost-sharing for all covered members.
8. **Access to Prescription Drugs.** Insurers are asked, where appropriate, to make expedited formulary exceptions if the insured is suffering from a health condition that may seriously jeopardize the insured's health, life, or ability to regain maximum function or if the insured is undergoing a current course of treatment using a non-formulary prescription drug.
9. **Information Sharing.** To ensure that public health officials and the public are adequately informed about what the health insurance industry is doing in response to COVID-19, the Commissioner asks that health carriers provide information on the steps they are taking in response to this Bulletin. Health carriers may send that information to Erin Hunter, Deputy Commissioner and General Counsel at Erin.K.Hunter@wv.gov.

Health insurers must be prepared to address COVID-19 cases in West Virginia and the Offices of the Insurance Commissioner extends its gratitude to health insurers working with the state to address this significant public health challenge. Insurers should continually assess their readiness and be prepared to make any necessary adjustments.

Insurers may contact Ellen Potter, Director of Health Policy, at (304) 414-8480 with questions regarding this Bulletin.

Additionally, the West Virginia Department of Health and Human Resources has established a tollfree information hotline to address public and medical provider questions concerning COVID-19. The number for the hotline is 1-800-887-4304.

For the most current information, please visit coronavirus.wv.gov or cdc.gov/COVID19.



James A. Dodrill
Insurance Commissioner

From: Boggs, Mara (Manchin) <Mara_Boggs@manchin.senate.gov>
Sent: Wednesday, March 18, 2020 1:21 PM
To: Slemp, Cathy C <Cathy.C.Slemp@wv.gov>; Crouch, Bill J <Bill.J.Crouch@wv.gov>; james.a.hoyer.mil@mail.mil
Cc: Marsh, Clay <cbmarsh@hsc.wvu.edu>; Cantrell, Phillip R CSM USARMY NG WVARNG (USA) <phillip.r.cantrell.mil@mail.mil>
Subject: [External] West Virginians requesting a test

CAUTION: External email. Do not click links or open attachments unless you verify sender.

Dr. Slemp, Dr. Crouch, and General Hoyer,

Thank you for all that you are doing for our state.

In the past 12 hours, the Senator and our staff have been hearing constantly from West Virginians who are fearful they have Corona, but have been turned down because of testing protocols or various reasons.

The first patient in this situation that we passed along yesterday was [REDACTED]
[REDACTED] We greatly appreciate you following up on her husband's test so quickly, as he indeed was a positive case.

Our staff has talked with each constituent who has called. Attached is a consolidated roster with contact information, a brief description of the issue and where each person is from. There are 35 West Virginians on this list who want a test. Please note that number 27 is an [REDACTED] who is not getting better with the medicine prescribed.

Senator Manchin would like me to get this information to you on a daily basis in an effective manner so that these West Virginians are tested.

Would you let me know if this is the best system to get you this information on a daily basis, and to get these West Virginians tested?

Thank you,
Mara

Mara Boggs
State Director
U.S. Senator Joe Manchin III
304-342-5855 (o)
202-679-5585 (c)





Human Infection with 2019 Novel Coronavirus (COVID-19)
Person Under Investigation (PUI) and Case Report Form

PUIs and Cases of COVID-19 are immediately reportable to the Local health department. Providers and Local health departments should submit this report to the Division of Infectious Disease Epidemiology by fax at 304-558-8736.

Reporting jurisdiction _____ Reporting health department _____
State case ID (PUI ID) _____ NNDSS loc. rec. ID/Case ID _____ Contact ID _____

Example - The format for the WV PUI ID is WV2020MMDDYY. (WV2020 followed by patient's date of birth (MM/DD/YY)).

COVID-19 specimen testing is being conducted through: Private laboratory [] State public health laboratory (Prior approval required) []

PATIENT DEMOGRAPHICS

Name: (last, first, middle): _____

Address (mailing): _____

Address (physical): _____

City/State/Zip: _____

County of Residence: _____

Phone (home): _____ Phone(work/cell): _____

Email: _____

Alternate contact: [] Parent/Guardian [] Spouse [] Other
Name: _____ Phone: _____

Birth date: ___/___/___ Age: _____

Sex: [] Male [] Female [] Unknown [] Other

Residency:

[] US resident

[] Non-US resident, country _____

Ethnicity: [] Not Hispanic or Latino

[] Hispanic or Latino [] Not specified

Race: [] White [] Black/African American

(Mark all that apply) [] Native Hawaiian/ Pacific Islander

[] American Indian/Alaskan Native

[] Asian [] Unknown [] Other, specify _____

INTERVIEWER INFORMATION

Investigation Start Date: ___/___/___ Interviewer name: _____ Telephone: _____

Affiliation/Organization: _____ Email: _____

REPORT SOURCE/HEALTH CARE PROVIDER (HCP)

Report Source: [] Laboratory [] Hospital [] Private Provider [] Public Health Agency [] Other - Specify _____

Reporter Name: _____ Reporter Phone: _____

Primary HCP Name: _____ Primary HCP Phone: _____

Report date to the Local health dept. (MM/DD/YYYY): ___/___/___ Report date to State health dept. (MM/DD/YYYY): ___/___/___

Report date of PUI to CDC (MM/DD/YYYY): ___/___/___ Report date of case to CDC (MM/DD/YYYY): ___/___/___

PATIENT INFORMATION - CASE STATUS AND SYMPTOMS

What is the current status of this person?

- [] PUI, testing pending
[] PUI, tested negative
[] Laboratory-confirmed case

Symptoms present during course of illness:

- [] Symptomatic [] Asymptomatic [] Unknown
If symptomatic, onset date (MM/DD/YYYY): ___/___/___ [] Unknown

If symptomatic, date of symptom resolution (MM/DD/YYYY): ___/___/___

- [] Still symptomatic [] Unknown symptom status
[] Symptoms resolved, unknown date

PATIENT INFORMATION - CLINICAL

Date of first positive specimen collection (MM/DD/YYYY): ___/___/___ [] Unknown [] N/A

Did the patient develop pneumonia?

[] Yes [] No [] Unknown

Did the patient have acute respiratory distress syndrome?

[] Yes [] No [] Unknown

Did the patient have another diagnosis/etiology for their illness?

[] Yes [] No [] Unknown

Did the patient have an abnormal chest X-ray?

[] Yes [] No [] Unknown

Was the patient hospitalized: [] Yes [] No [] Unknown

If yes, admission date 1: (MM/DD/YYYY): ___/___/___

If yes, discharge date 1: (MM/DD/YYYY): ___/___/___

Was the patient admitted to an intensive care unit (ICU)?

[] Yes [] No [] Unknown

Did the patient receive mechanical ventilation (MV)/intubation?

[] Yes [] No [] Unknown

If yes, total days with MV (days): _____

Did the patient receive ECMO? [] Yes [] No [] Unknown

Did the patient die as a result of this illness? [] Yes [] No [] Unknown

Date of death (MM/DD/YYYY): ___/___/___ [] Unknown date of death

PATIENT INFORMATION - EPIDEMIOLOGIC

Is the patient a health care worker in the United States? Yes No Unknown

Does the patient have a history of being in a healthcare facility (as a patient, worker or visitor) in China? Yes No Unknown

In the 14 days prior to illness onset, did the patient have any of the following exposures (check all that apply):

- Travel to Wuhan
- Travel to Hubei
- Travel to mainland China
- Travel to other non-US country

Specify: _____

Household contact with another lab-confirmed COVID-19 case-patient

If the patient had contact with another COVID-19 case, was this person a U.S. case?

Yes, nCoV ID of source case: _____ No Unknown N/A

Community contact with another lab-confirmed COVID-19 case-patient

Any healthcare contact with another lab-confirmed COVID-19 case-patient

If yes, Patient Visitor Health care worker Animal exposure

Exposure to a cluster of patients with severe acute lower respiratory distress of unknown etiology

Unknown Other, specify _____

Under what process was the PUI or first case identified? (check all that apply): Clinical evaluation leading to PUI determination

Contact tracing of case patient Routine surveillance Epi-X notification of travelers; if checked, DGMQID _____

Unknown Other, specify: _____

SYMPTOMS, CLINICAL COURSE, PAST MEDICAL HISTORY AND SOCIAL HISTORY

COLLECTED FROM (CHECK ALL THAT APPLY): PATIENT INTERVIEW MEDICAL RECORD REVIEW

During this illness, did the patient experience any of the following symptoms?	Symptom Present?		
Fever >100.4F (38C) ^c	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Subjective fever (felt feverish)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Chills	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Muscle aches (myalgia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Runny nose (rhinorrhea)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Sore throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cough (new onset or worsening of chronic cough)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Shortness of breath (dyspnea)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Nausea or vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Headache	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Diarrhea (≥3 loose/looser than normal stools/24hr period)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Other, specify: _____

PRE-EXISTING MEDICAL CONDITIONS? Yes No Unknown

Chronic Lung Disease (asthma/emphysema/COPD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Diabetes Mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Cardiovascular disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic Renal disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Chronic Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Immunocompromised Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Neurologic/neurodevelopmental/intellectual disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
Other chronic diseases	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, specify) _____
If female, currently pregnant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	(If YES, due date __/__/____)
Current smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Former smoker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	
Other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	

RESPIRATORY DIAGNOSTIC TESTING

Test	Positive	Negative	Pending	Not done
Influenza rapid Ag <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza PCR <input type="checkbox"/> A <input type="checkbox"/> B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RSV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. metapneumovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parainfluenza (1-4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adenovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhinovirus/enterovirus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus (OC43, 229E, HKU1, NL63)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
M. Pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Pneumoniae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPECIMENS FOR COVID-19 TESTING

COVID-19 specimen testing is being conducted through:

Private laboratory , Name of Laboratory _____

State public health laboratory (West Virginia Office of Laboratory Services) (*Prior approval required*)

Test	Specimen ID	Date Collected	State Lab Tested	State Lab Result
NP Swab	_____	__/__/__	<input type="checkbox"/>	_____
OP Swab	_____	__/__/__	<input type="checkbox"/>	_____
Sputum	_____	__/__/__	<input type="checkbox"/>	_____
Other, Specify:	_____	__/__/__	<input type="checkbox"/>	_____
_____	_____	_____	_____	_____

Additional State/local Specimen IDs: _____

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74 Atlanta, Georgia 30333; ATTN PRA (0920-1011).



STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF INSPECTOR GENERAL
WV CARES

Bill J. Crouch
Cabinet Secretary

408 Leon Sullivan Way, Suite 110
Charleston, West Virginia 25301
Telephone: (304) 558-2018 Fax: (304) 957-0190

Jolynn Marra
Interim Inspector General

March 20, 2020

Dear Provider:

Please be advised West Virginia Clearance for Access: Registry and Employment Screening (WV CARES) has been developing alternative procedures for the criminal background check process during the Coronavirus Disease (COVID-19) declaration of a national state of emergency.

At this time, providers are to continue with the prescreening process using the WV CARES system as described in *W. Va. Code R. §69-10-3*. If a potential candidate for employment does not receive a negative finding from prescreening, that individual may begin work as a provisional employee.

We are aware that due to social distancing and public health concerns IDEMIA fingerprinting locations are closing and unavailable. Each facility shall maintain a currently updated list through this time period of those provisional employees that have not been fingerprinted. Fingerprinting requirements will be expected to be met no later than July 1, 2020.

All provisions related to provisional employees will apply, aside from the need to be fingerprinted prior to beginning work as a provisional employee. See, *W. Va. Code R. §69-10-6*. Specifically, provisional employees must affirm, in a signed statement, that he or she has not committed a disqualifying offense, and acknowledge that a disqualifying offense shall constitute good cause for termination. *W. Va. Code R. §69-10-6.3*.

WV CARES will issue additional guidance for providers regarding these emergency policies and procedures as it becomes available and necessary. As always, WV CARES is available for questions from providers and can be contacted by telephone and email.

Sincerely,

Jolynn Marra

Jolynn Marra
Interim Inspector General

JM:dlc



TO: West Virginia Healthcare Providers, Hospitals and Other Healthcare Facilities

**FROM: Catherine Slemp, MD, MPH, Commissioner and State Health Officer
Bureau for Public Health
West Virginia Department of Health and Human Resources (WVDHHR)**

DATE: January 31, 2020

LOCAL HEALTH DEPARTMENTS: Please distribute to community health providers, hospital-based physicians, infection control preventionists, laboratory directors, and other applicable partners.

OTHER RECIPIENTS: Please distribute to association members, staff, etc.

Summary and Action Items

- All patients with fever and/or lower respiratory illness should be asked for travel history from December 1, 2019 to present. Healthcare providers should be on the lookout for people who recently traveled from China and have fever and respiratory symptoms or for individuals with such symptoms who have been in close contact with a confirmed case of 2019-nCoV.
- All patients meeting specific criteria recommended by the Centers for Disease Control and Prevention (CDC) and WVDHHR should be evaluated as a patient under investigation (PUI) in association with the outbreak of novel coronavirus and in partnership with public health.
- Emerging infectious diseases are reportable to the local health department within 24 hours per the West Virginia Reportable Disease Rule (64CSR-7). Healthcare providers should **immediately** report all PUI for this outbreak to their local health department.
- Please note this is an evolving situation and guidance will likely change based on new findings and observations. Providers should stay attuned to new information and updated recommendations.

Background

There is a rapidly expanding outbreak in China of respiratory illness caused by a novel (new) coronavirus abbreviated “2019-nCoV”. This virus is spreading from person-to-person in China and exported cases have been detected in a growing number of countries internationally. Imported cases of 2019-nCoV infection in people have been detected in the US. While limited person-to-person spread among close contacts has been detected in the US, there is currently no evidence that 2019-nCoV is actively spreading across US communities.

Healthcare providers should obtain a detailed travel history for patients being evaluated with fever and acute respiratory illness. Be on the lookout for people with recent travel history to China, especially Hubei province, who also have fever and respiratory symptoms or meet other criteria outlined below.

Infection Prevention and Control Recommendations

Although transmission dynamics have yet to be determined, the CDC currently recommends a cautious approach to PUI for 2019-nCoV. Such patients should be asked to wear a surgical mask as soon as they are

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Categories of Health Alert messages:

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Health Advisory: Provides important information for a specific incident or situation. May not require immediate action.

Health Update: Provides updated information regarding an incident or situation. Unlikely to require immediate action.

identified and be evaluated in a private room with the door closed, ideally an airborne infection isolation room if available. Healthcare personnel entering the room should use standard precautions, contact precautions, airborne precautions, and use eye protection (e.g., goggles or a face shield). As additional information becomes available, guidelines for infection prevention and control are subject to change. Healthcare providers are urged to check back regularly for the most up-to-date guidelines at <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/infection-control.html>.

Clinical Presentation and Evaluation

Limited information is available to characterize the spectrum of clinical illness associated with 2019-nCoV; reported illnesses have ranged from infected people with little to no symptoms to people being severely ill and dying. Symptoms can include fever, cough and shortness of breath; the incubation period is estimated at 5 days (range of 2-14 days). No vaccine or specific treatment for 2019-nCoV infection is available; care is supportive.

Clinical criteria are subject to change as additional information becomes available. Healthcare providers are urged to check back on these criteria regularly at <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>.

As of January 31, 2020, patients who meet one of the following classifications should be evaluated as a PUI for 2019-nCoV:

1. Fever or signs/symptoms of lower respiratory illness (e.g., cough, difficulty breathing) **AND**
 - History of **close contact with a laboratory confirmed 2019-nCoV patient** within 14 days of symptom onset
2. Fever and signs/symptoms of lower respiratory illness (e.g., cough, difficulty breathing) **AND**
 - History of travel from **Hubei Province, China** within 14 days of symptom onset
3. Fever and signs/symptoms of lower respiratory illness (e.g., cough, difficulty breathing) requiring **hospitalization AND**
 - History of travel from **mainland China** within 14 days of symptom onset

These criteria are intended to serve as guidance for evaluation. Patients should be evaluated and discussed with public health on a case-by case basis if their clinical presentation or exposure history is uncertain. For the most up-to-date information visit: <https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

Reporting

Clinicians should **immediately** notify both infection control at their healthcare facility and their local health department in the event of a person under investigation for 2019-nCoV. Emerging infectious diseases are reportable to the local health department within 24 hours per the West Virginia Reportable Disease Rule (64CSR-7). Contact information for West Virginia local health departments can be found at <http://www.dhhr.wv.gov/localhealth/pages/map.aspx>.

Specimen Collection

To increase the likelihood of detecting 2019-nCoV infection, lower respiratory, upper respiratory, and serum specimens should be collected from PUI. Additional specimen types (e.g., stool, urine) may be collected and stored. Healthcare providers should wait for shipping instructions for collected specimens. Testing for other respiratory pathogens should not delay reporting or specimen shipping. The Division of Infectious Disease Epidemiology will work with the local health department and CDC to report PUI and coordinate specimen shipping and testing. At this time, diagnostic testing is only being conducted at CDC and all PUI specimens must be routed through the West Virginia Office of Laboratory Services.

For more information, contact the West Virginia Office of Epidemiology and Prevention Services (OEPS), Division of Infectious Disease Epidemiology at (304) 558-5358, extension 1 or the 24/7 answering service at (304) 347-0843.

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West Virginia Health Alert Number 164-01-31-2020



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