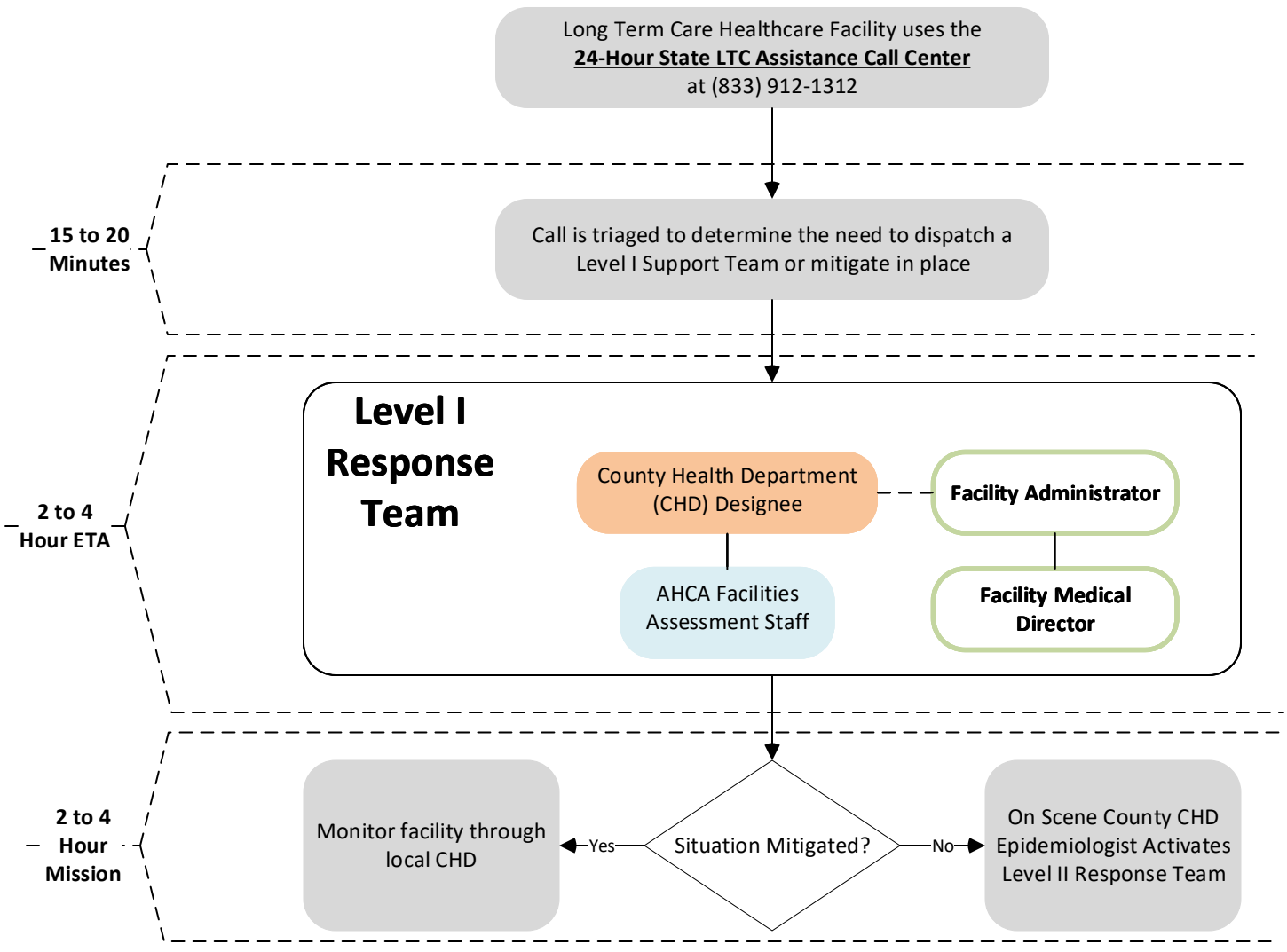
24-Hour Long Term Care Call Center and Rapid Emergency Support Team for COVID-19 Outbreak

COVID-19 | March 20, 2020

This document provides the framework and call guidelines for COVID-19 Rapid Emergency Support Teams (REST). A REST is a scalable team of response professionals that can include (but is not limited to) representatives from the Department of Health (DOH), the Agency for Healthcare Administration (AHCA), the Department of Elder Affairs (DOEA), infection prevention (ICP) experts, clinical team members, Florida Infectious Disease Transportation Network (FIDTN) Teams and local EMS/Fire/Rescue units/personnel. Response missions will center on providing support, assessment, training, clinical care, transportation, infection prevention, and decontamination of long term care facilities that have critical situations associated with COVID-19 patients in their facility. A REST team is a multi-disciplinary multi-agency approach to combating an outbreak in a high risk facility. There are three levels of response with a REST team.



CHD Designee: This position is responsible for the coordination of the initial epidemiological investigation and is the response leader in a Level I response. This position in conjunction with AHCA and the facility administrator will conduct an assessment of the facility to determine the next action steps. The position will determine the need to activate a Level II Response Team or manage the incident with current resources

AHCA Field Assessment Staff: The AHCA field staff will assist in providing a facility assessment to insure a safe environment exists for the remaining residents. AHCA representatives are regionally disbursed and may be the first on scene to coordinate with the local CHD.

Case definition for Level I activation:

1) A laboratory confirmed case of COVID-19 among a staff member or resident of the facility; (note: DOH will likely already be aware of this via electronic laboratory reporting) -or-

2) A facility resident or staff member determined to be a close contact of a laboratory confirmed case of COVID-19. Note: close contact is household member or someone in close proximity (<6 feet) for more than 10 minutes -or-

3) Any cluster of 3 or more residents/staff identified within a 72 hour period, with influenza like illness (ILI), pneumonia, or severe respiratory illness requiring further evaluation -or-

4) Any deaths among residents/staff due to respiratory illness.

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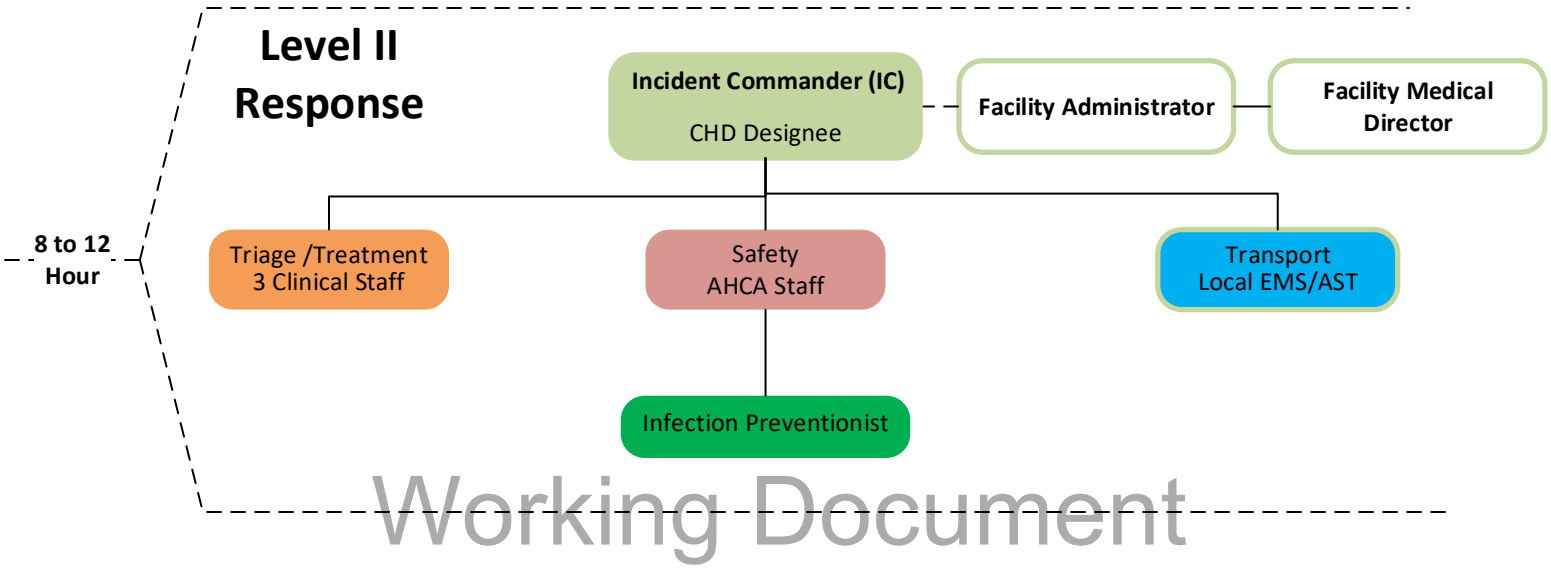
A level II response will be requested by the local CHD Designee. This response converts the scene of the facility to a mass casualty response with triage/treatment, safety, and transport sections. In addition, an infection preventionist is added to the safety section to assist the IC/CHD Designee and AHCA staff with infection control activities.



CHD Designee: This position in a Level II response is responsible for incident command plus the coordination of the epidemiological investigation. This position works in conjunction with an infection preventionist to conduct assessments and provide training to facility staff on appropriate infection control practices.

Clinical Team Members: The clinical team members will include a combination of nurses, physicians, paramedics, and EMTs to assist with clinical care. The clinical team members will perform health assessments of residents and assume clinical care for a brief period while staff members are being evaluated and trained on proper infection control technics.

AHCA Field Assessment Staff: The AHCA field staff will assume the role as Safety Officer and perform a facility assessment to ensure a safe environment exists for the remaining residents. AHCA is regionally disbursed and may be the first on scene to coordinate with the local CHD.

Infection Preventionist: The infection preventionist works in conjunction with the CHD Designee and reports to the Safety Officer. The IP will identify and report any unsafe practices to the Safety Officer and document improvements to be made. The IP is also responsible for training facility staff on proper infection prevention strategies.

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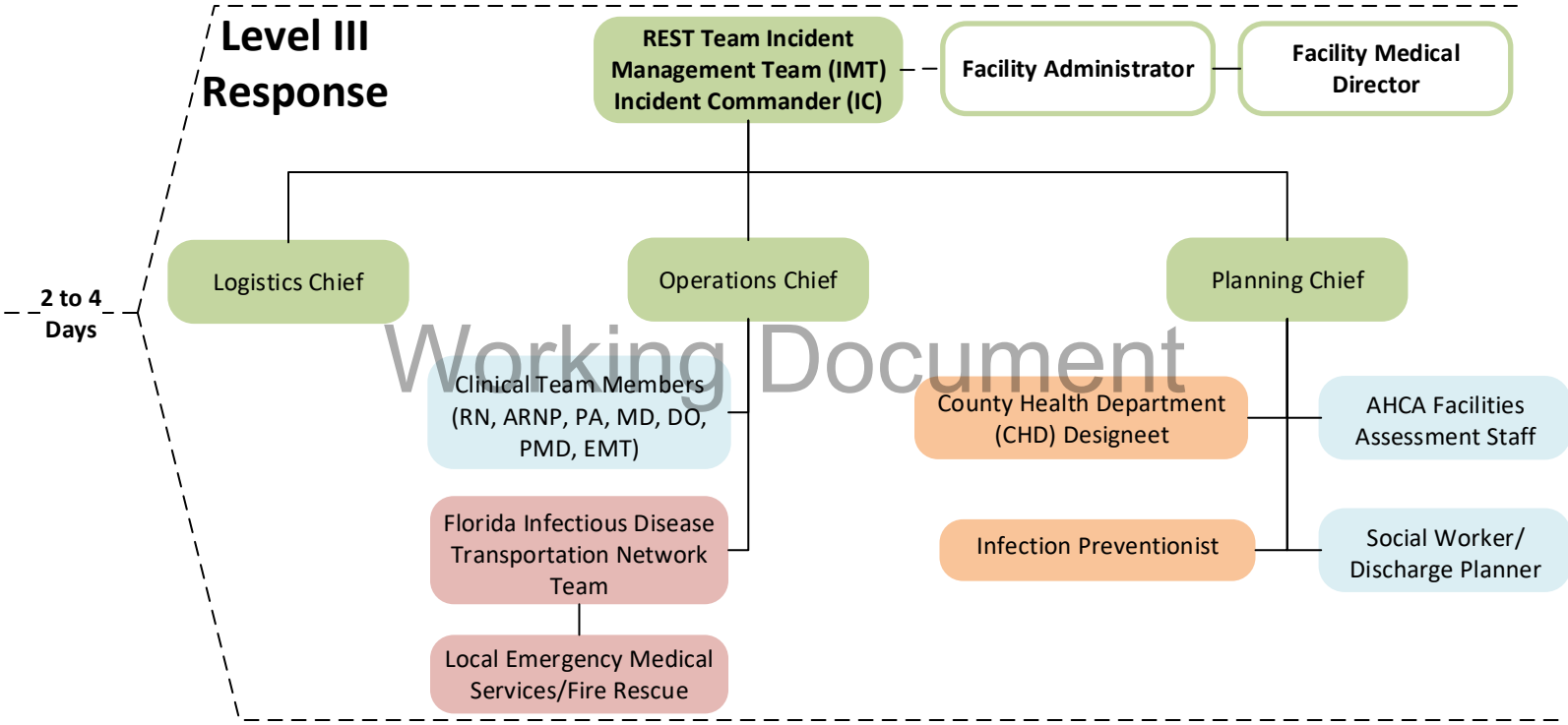
A level III response includes an Incident Management Team (IMT) that follows common Incident Command System (ICS) principles. This level of response will be activated by the CHD Designee from a Level II response or by the State Emergency Operations Center (SEOC). This level of response includes a full complement of representatives from the Department of Health (DOH), the Agency for Healthcare Administration (AHCA), the Department of Elder Affairs (DOEA), infection prevention (IP) experts, clinical team members, Florida Infectious Disease Transportation Network (FIDTN) units/members, and local EMS/Fire Rescue units/personnel. Response missions are centered on providing support, assessments, training, clinical care, transportation, infection prevention, and decontamination of long term care facilities that have critical situations associated with COVID-19 patients in their facility.



CHD Designee: This position is responsible for the coordination of the epidemiological investigation with the local CHD and works in conjunction with other ICPs to conduct assessments and provide training to facility staff on appropriate infection control practices.

Clinical Team Members: The clinical team members will include a combination of nurses, physicians, paramedics, and EMTs to assist with clinical care. The clinical team members will perform health assessments of residents and assume clinical care for a brief period while staff members are being evaluated and trained on proper infection control technics.

AHCA Field Assessment Staff: The AHCA field Staff will assist in providing a facility assessment to insure a safe environment exist for the remaining residents. AHCA is regionally disbursed and may be the first on scene to coordinate with the local CHD.

Social Worker/Discharge Planner: The Department of Elder Affairs will work in partnership with the planning chief to assure each resident's needs are being met. This may include but not limited the coordination of discharge planning with family members to another healthcare facility or home of residents. This work may be completed virtually.

FIDTN Team: An FIDTN will be dispatch to the scene to transport any remaining residents that the REST determines a need to be removed from the facility. Additionally, the FIDTN will coordinate with the infection control preventionist to decontaminate patients rooms and other areas of the facility deemed necessary. The FIDTN may coordinate transports with a local EMS/Fire Rescue Service.

COVID-19 Long Term Care Response Plan
Version 1.0

Long term care facilities are especially vulnerable to COVID-19 and require rapid multi-agency response to prevent outbreaks in long-term care settings. This tiered approach

1. County Health Departments or long-term care facilities report PUIs or newly detected cases in long-term care facilities to a 24/7 triage line at (833) 912-1312
    a. Triage center is staffed by ESF8 operations, epidemiology and AHCA personnel.
    b. The triage criteria is:
        i. Determine risk for COVID-19 in the facility:
            1. A laboratory confirmed case of COVID-19 among a staff member or resident of the facility; (note: DOH will likely already be aware of this via electronic laboratory reporting) -or-
            2. A facility resident or staff member determined to be a close contact of a laboratory confirmed case of COVID-19. Note: close contact is household member or someone in close proximity (<6 feet) for more than 10 minutes -or-
            3. Any cluster of 3 or more residents/staff identified within a 72-hour period, with influenza like illness (ILI), pneumonia, or severe respiratory illness requiring further evaluation -or-
            4. Any deaths among residents/staff due to respiratory illness.
        ii. Verify immediate infection control actions:
            1. Have symptomatic patients been isolated or transported out.
            2. Confirm isolation of any symptomatic patients
            3. Determine single room vs double room
            4. Are staff using PPE and do they have adequate supplies
2. If the situation meets any of the above criteria a Level 1 response team is deployed to the facility within 12- hours to **conduct an on-site infection control assessment and epidemiological investigation.** Should the phone triage determine infection control actions are not in pace a more rapid response will be initiated within 2 to 4 hours.
    a. The Level I team is made up of a representative of the county health department and AHCA field operations team.
    b. The team assesses the immediate safety of persons in the facility and determines the immediate need to transfer any patients from the facility or confirm the ability to safely isolate in place.
    c. If transfers are necessary, the Level 1 team will work with local EMS to transport a patient out of the facility.
    d. This team remains on-site for the time necessary to conduct the assessment and connect additional resources.
    e. If the Level 1 team determines that the facility is at increased risk for an outbreak, they trigger the deployment of the Level II team
3. The Level II activation converts the response from an assessment to a **mass casualty response with triage, treatment, safety and transport capabilities. This level also provides increased expertise in infection control.** The team arrives within 2 to 4 hours.
    a. The Level II team provides patient care with enhanced infection control expertise, trains facility staff on infection control practices, provides a cache, and transports patients to the hospital as necessary.
    b. Clincal staff more experienced in the use of PPE and infection control assume care for infected patients while facility staff receive additional training.

c. The team is designed to be onsite for 12 hours
d. If an outbreak is confirmed by the State Epidemiologist in a long-term care facility a Level III response is triggered.

4. The Level III activation **expands upon the clinical care established in the previous level and increase care facility wide to rapidly detect additional cases.**
    a. This team can be on-site within 12 to 24 hours and remain on-scene for two to four days.
    b. The team conducts temperature checks of other residents, provides patient care, transports patients to hospital as necessary

APPENDIX I - Long Term Care Facility (LTCF) Checklist

The following infection prevention and control assessment tool should be used to assist nursing homes with preparing to care for residents with COVID-19. Elements should be assessed through a combination of interviews with staff and direct observation of practices in the facility.

The assessment focuses on the following priorities, which should be implemented by all LTCF.

- **Keep COVID-19 from entering your facility:**
  - No visitors except for compassionate care situations (e.g., end of life).
  - Restrict all volunteers and non-essential healthcare personnel (HCP), including consultant services (e.g., barber, construction worker).
  - All who enter the facility must wear a facemask.
  - Actively screen all HCP for fever and respiratory symptoms before starting each shift and upon ending each shift; ask them to put on a facemask and send them home if they are ill. Have a delegated person at the facility whom HCP will report to if they develop symptoms off-shift.
  - Contract HCP should be notified by LTC staff and told to self-monitor for fever or respiratory symptoms (e.g., shortness of breath, new or change in cough, and sore throat) daily, and inform both the LTC staff and their employing agency if they have symptoms. They should also **NOT** report to work if they develop symptoms.
  - Cancel all field trips outside of the facility.
  - Have residents who must regularly leave the facility for medically necessary purposes (e.g., residents receiving hemodialysis) wear a facemask whenever they leave their room, including for procedures outside of the facility.
  - Staff should identify and maintain a list of the names, contact information, and services provided for all contract staff/HCP, in case they need to be alerted about suspected or confirmed COVID-19 cases in the facility.
- **Identify infections early:**
  - Actively screen all residents at least daily for fever and respiratory symptoms; immediately isolate anyone who is symptomatic.
    - Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 if it is circulating in the community.
  - Notify the health department if: one resident or HCP develops symptoms – new onset cough, fever and shortness of breath, or individuals with known or suspected COVID-19 are identified.
- **Prevent spread of COVID-19:**
  - Cancel all group activities and communal dining.
  - Enforce social distancing among residents. Restrict all residents to their room. Identify an informal leader amongst residents and utilize the individual to reinforce importance of the prevention measures that are being implemented at the facility. Implement universal facemask use by all (source control) when they enter the facility;
    - If facemasks are in short supply, they should be prioritized for direct care personnel. All HCP should be reminded to practice social distancing when in break rooms or common areas.
  - **If there is any resident with known or suspected COVID-19 identified in the facility,** consider HCP wear all recommended PPE for resident care. Refer to strategies for optimizing PPE when shortages exist.
    - Recent experience suggests that a substantial proportion of long-term care residents with COVID-19 do not demonstrate symptoms.
  - In times of PPE shortages

        - Gowns only used during aerosol-generating procedures such as nebulization; care activities where splashes and sprays are anticipated; during high-contact resident care activities. **The same gown and gloves may NOT be used for more than one resident.**
        - The same facemask and eye protection may be used during the care of more than one resident. The mask must be discarded when:
            - Damp, damaged or hard to breathe through
            - If used during an aerosol generating procedures such as nebulization
            - If contaminated with blood or other body fluids
        - Eye protection must be replaced (can be reused after cleaning and disinfection) when:
            - Damaged or hard to see through
            - If used during an aerosol generating procedures such as nebulization
            - If contaminated with blood or other body fluids
    - Strengthen hand hygiene adherence. **Place alcohol-based hand rubs in every resident room to facilitate hand hygiene by staff.** Keep sinks stocked with soap and water.
    - Check if disinfectants in use are EPA-registered, hospital-grade with a claim against the virus are available for frequent cleaning of high-touch surface areas and shared resident care equipment. See EPA list N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
    - Evaluation of housekeeping or cleaning services should include the use of appropriate protection for persons providing these services. If facility policies, procedures and products for environmental cleaning and disinfection for healthcare settings are not in place, at a minimum the "Interim Recommendations for US Households with Suspected/Confirmed Coronavirus Disease 2019" https://www.cdc.gov/coronavirus/2019-ncov/prepare/cleaning-disinfection.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcommunity%2Fhome%2Fcleaning-disinfection.html including the use EPA-registered disinfectants https://www.americanchemistry.com/Novel-Coronavirus-Fighting-Products-List.pdf
    - Non-dedicated, non-disposable resident care equipment should be cleaned and disinfected after each use.
- **Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply:**
    - Maintain inventory and strict access controls on your PPE stores due to risk of inappropriate use or theft.
    - For more guidance on extended use of facemasks and eye protection or prioritization of gowns for certain resident care activities
        - https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
- **Identify and manage severe illness:**
    - Facility performs appropriate monitoring of ill residents (including taking vitals and documentation of pulse oximetry) twice a shift to quickly identify residents who require transfer to a higher level of care.
    - As residents are not showing typical symptoms and time from symptom onset to clinical deterioration can be short, monitor vitals for all asymptomatic residents (including pulse oximetry) at least once a shift.
    - **Call 911 for any resident in acute distress.**
- **Communicate**
    - Communicate to residents and families advising them about actions that the facility is taking in response to COVID-19. This could include
        - informing about visitor restrictions to the families and residents.
    - Communicate to residents about what they need to do – such as social distancing, informing personnel immediately if they feel ill, importance of hand hygiene and cough etiquette
    - Communicate to residents about other changes that will take place with regards to their care such as higher frequency of monitoring of symptoms
    - ALF staff could create notices that are distributed to each resident room as a notification for contract HCP and for residents, and emphasize the message to avoid visitors.

Which of the following situations apply to the facility? (Select all that apply)

□ No cases of COVID-19 currently reported in their community
□ Cases reported in their community
□ Sustained transmission reported in their community
□ Cases identified in their facility (either among HCP or residents)

How many days supply does the facility have of the following PPE and alcohol-based hand sanitizer (ABHS)?

Facemasks:
N-95 or higher-level respirators:
Isolation gowns:
Eye protection:
Gloves:
ABHS:

Visitor restrictions		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility restricts all visitation except certain compassionate care situations, such as end of life situations. Decisions about visitation during an end of life situation are made on a case by case basis: • Potential visitors are screened prior to entry for fever or respiratory symptoms. Those with symptoms are not permitted to enter the facility. • Visitors that are permitted inside, must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. They are also reminded to frequently perform hand hygiene.		
Facility has sent a communication (e.g., letter, email) to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations, and that alternative methods for visitation (e.g., video conferencing) will be facilitated by the facility.		
Facility has provided alternative methods for visitation (e.g., video conferencing) for residents.		
Facility has posted signs at entrances to the facility advising that no visitors may enter the facility.		
Education, monitoring, and screening of healthcare personnel (HCP)		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility has provided education and refresher training to HCP (including consultant personnel) about the following: • COVID-19 (e.g., symptoms, how it is transmitted) • Sick leave policies and importance of not reporting or remaining at work when ill • Adherence to recommended IPC practices, including: ○ Hand hygiene,		

○ Selection and use including donning and doffing PPE, https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf ○ Cleaning and disinfecting environmental surfaces and resident care equipment • Any changes to usual policies/procedures in response to PPE or staffing shortages		
Facility keeps a list of symptomatic HCP.		
Facility screens all HCP (including consultant personnel) at the beginning of their shift for fever and respiratory symptoms (actively takes their temperature and documents absence of shortness of breath, new or change in cough, and sore throat). • If they are ill, they are instructed to put on a facemask and return home.		
Non-essential personnel including volunteers and non-essential consultant personnel (e.g., barbers) are restricted from entering the building.		
Education, monitoring, and screening of residents		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility has provided education to residents about the following: • COVID-19 (e.g., symptoms, how it is transmitted) • Importance of immediately informing HCP if they feel feverish or ill • Actions they can take to protect themselves (e.g., hand hygiene, covering their cough, maintaining social distancing) • Actions the facility is taking to keep them safe (e.g., visitor restrictions, changes in PPE, canceling group activities and communal dining)		
Facility assesses residents for fever and symptoms of respiratory infection upon admission and at least daily throughout their stay in the facility. • Residents with suspected respiratory infection are immediately placed in appropriate Transmission-Based Precautions. • Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 if it is circulating in the community.		
Facility performs appropriate monitoring of ill residents (including documentation of pulse oximetry) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.		
Facility keeps a list of symptomatic residents.		

Facility has taken action to stop group activities inside the facility and field trips outside of the facility.		
Facility has taken action to stop communal dining.		
Facility has residents who must regularly leave the facility for medically necessary purposes (e.g., residents receiving hemodialysis or chemotherapy) wear a facemask whenever they leave their room, including for procedures outside of the facility. • Consider having HCP wear all recommended PPE (gown, gloves, eye protection, N95 respirator (or facemask if not available)) for the care of these residents, regardless of presence of symptoms (if PPE supply allows). Refer to strategies for optimizing PPE when shortages exist.		
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) • Residents are encouraged to remain in their room. If there are cases in the facility, residents are restricted (to the extent possible) to their rooms except for medically necessary purposes. If residents leave their room, they wear a facemask, perform hand hygiene, limit movement in the facility and perform social distancing. • Consider implementing protocols for cohorting ill residents with dedicated HCP.		
Availability of PPE and Other Supplies		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility has assessed current supply of PPE and other critical materials (e.g., alcohol-based hand rub, EPA-registered disinfectants, tissues).		
If PPE shortages are identified or anticipated, facility has engaged their healthcare coalition for assistance. https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx		
Facility has implemented measures to optimize current PPE supplies, which include options for extended use, reuse, and alternatives to PPE. For example, under extended use, the same facemask and eye protection may be worn during the care of more than one resident. Gowns could be prioritized for select activities such as activities where splashes and sprays are anticipated (including aerosol generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP.		

Additional options and details are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html		
Hand hygiene supplies are available in all resident care areas. • Alcohol-based hand sanitizer* with 60-95% alcohol is available in every resident room and other resident care and common areas. • Sinks are stocked with soap and paper towels. *If there are shortages of ABHS, hand hygiene using soap and water is still expected.		
PPE is available in resident care areas (e.g., outside resident rooms). PPE includes: gloves, gowns, facemasks, N-95 of higher-level respirators (if facility has a respiratory protection program and HCP are fit-tested) and eye protection (face shield or goggles).		
EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2 are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. *See EPA List N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2		
Tissues are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.		
Infection Prevention and Control Practices		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
HCP perform hand hygiene in the following situations: • Before resident contact, even if PPE is worn • After contact with the resident • After contact with blood, body fluids or contaminated surfaces or equipment • Before performing sterile procedure • After removing PPE		
HCP wear the following PPE when caring for residents with undiagnosed respiratory illness unless the suspected diagnosis required Airborne Precautions (e.g., tuberculosis): • Gloves • Isolation gown • Facemask • Eye protection (e.g., goggles or face shield) If COVID-19 is suspected, an N-95 or higher-level respirator is preferred, if available and the facility has a respiratory protection program with fit-tested HCP; facemasks are an acceptable alternative.		

PPE are removed in a manner to prevent self-contamination, hand hygiene is performed, and new PPE are put on after each resident except as noted below.		
Additional actions when COVID-19 is identified in the community (some facilities may choose to implement these earlier) • Facility has implemented universal use of facemasks for HCP (for source control) while in the facility. If facemasks are in short supply, they are prioritized for direct care personnel. All HCP are reminded to practice social distancing when in break rooms or common areas.		
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) • Consider having HCP wear all recommended PPE (gown, gloves, eye protection, N95 respirator (or facemask if not available)) for the care of all residents, regardless of presence of symptoms. This is done (if PPE supply allows) when COVID-19 is identified in the facility. Refer to strategies for optimizing PPE when shortages exist. This approach is recommended to account for residents who are infected but not manifesting symptoms. Recent experience suggests that a substantial proportion of long-term care residents with COVID-19 do not demonstrate symptoms.		
Non-dedicated, non-disposable resident care equipment is cleaned and disinfected after each use.		
EPA-registered disinfectants are prepared and used in accordance with label instructions.		
Communication		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility communicates information about known or suspected COVID-19 patients to appropriate personnel (e.g., transport personnel, receiving facility) before transferring them to healthcare facilities.		
Facility notifies the health department about any of the following: • COVID-19 is suspected or confirmed in a resident or healthcare provider • A resident has severe respiratory infection • A cluster (e.g., ≥ 3 residents or HCP with new-onset respiratory symptoms over 72 hours) of residents or HCP with symptoms of respiratory infection is identified.		