Ohio | Department of Developmental Disabilities

DODD Companion Guidance for Using Long-Term Services and Supports Pre-Surge Planning Toolkit

The Ohio Department of Developmental Disabilities (DODD), Department of Health, Department of Medicaid, and Department of Aging have collaborated to create a Long-Term Services and Supports (LTSS) Pre-Surge Planning Toolkit that includes concept diagrams and tools related to coronavirus (COVID-19).

This DODD companion guidance is intended to help DODD providers understand the information in the LTSS Pre-Surge Planning Toolkit. Please do not try to use this companion document on its own. It is only to be used to assist with understanding the LTSS Pre-Surge Planning Toolkit.

The information in this toolkit includes essential guidance from the Centers for Disease Control and Prevention (CDC) distilled into a more simplified format.

It is at this critical time, before stay-at-home orders are lifted, that all providers evaluate and reevaluate their needs and their capacity to address future quarantines of people who have been exposed, isolation of people who are tested or presumed positive, and planning for critical shortages of personal protective equipment (PPE).

By completing Pre-Surge Planning using the tools in this kit, providers will be better prepared to act rather than react to future COVID-19 outbreaks.

LTSS: Long-Term Services and Supports is a term representing all nursing facilities, intermediate care facilities, DODD-licensed facilities, DODD waiver services, and other DODD residential services. This does not include Adult Day Support services.

Not all diagrams or tools in the LTSS Pre-Surge Planning Toolkit will be applicable to all LTSS provider settings.

Support Setting Classification

Nursing Facility/Congregate Care Settings (NF/CC) (pages 5 to 7): Congregate care settings will include ICF or other licensed developmental disabilities facilities **only if** the setting can provide the level of nursing care described in the Patient/Resident Journey in NF/CC care settings diagrams.

ICF facilities that are not able to provide a NF/CC level of nursing care will follow the guidance pages for Community Settings.

Community Settings (pages 8 and 9): Includes personal family homes and homes where waiver supports are provided.

There are agencies that provide congregate care in some locations and support for people in community settings in other locations. The determination of setting classification is about where the person currently lives, not about the agency's services at large.

Each LTSS Pre-Surge Planning Toolkit diagram links to the applicable document or form, which is noted with the magnifying glass symbol (🔍①). If the documents are used in a printed format, tools are numbered to allow for choosing the printed tool that is referenced in the document.

Below is a brief list of terms used in the diagrams/tools and an explanation of the purpose of each diagram/tool.

Quarantine vs. Isolation

Quarantine: A designated living space where people who have been exposed avoid contact with people who have no exposure, no symptoms, and are not diagnosed with COVID-19. **It is during quarantine periods when people who have been exposed are monitored for symptoms.** From quarantine, people are either escalated to COVID-19 isolation, or, after the specified number of quarantined days, they are determined to have no symptoms and leave quarantine.

Isolation: A designated living space where symptomatic people who have been told by their primary care physician, advanced practice nurse practitioner, or local health department that they have a positive test or meet the symptomatic criteria to presume they have COVID-19,

PPE Status

This PPE guidance accounts for the contingency planning that organizations must do to optimize the supply of PPE. (page 2)

PPE: Personal protective equipment.

Contingency PPE: These are recommendations of what PPE can be used when the typically preferable PPE is in short supply or entirely unavailable.

Crisis PPE: These are recommendations for PPE that can be used when contingency-level PPE supplies are in short supply or entirely unavailable.

Other Terminology

Aerosol-generating procedures: Procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways, nebulized breathing treatments)

ABHS: Alcohol-based hand sanitizer.

Assess and Stratify (Using NEWS2 to Assess and Stratify Clinical Level of Severity): The use of symptoms and risk factors to determine if care can be continued in the current living setting or if transfer to a more advanced care setting is needed.

Cleaning: Refers to the removal of germs, dirt, and impurities from surfaces. It does not kill germs, but by removing them, it lowers their numbers and the risk of spreading infection.

Clean Environment: A living area where no exposed, presumed or confirmed cases have been known to have spent time.

Clinician: Physician, advanced practice nurse practitioner, or local health department representative with the ability to identify suspected COVID-19 and to direct COVID-19-related testing treatment.

Cohort: A group of people in home/facility or care settings who all have the same COVID-19 status: 1.) No Symptoms/No Exposure (diagrams show this status as green); 2.) Exposed (orange); or, 3.) COVID-19 Presumed Positive or Diagnosed (purple).

Disinfecting: Refers to using chemicals; for example, EPA-registered disinfectants, to kill germs on surfaces. This process does not necessarily clean dirty surfaces or remove germs, but by killing germs on a surface after cleaning, it can further lower the risk of spreading infection.

HCP: Health care professional, health care personnel. This can also refers to **direct support professionals (DSPs).**

LHD: Local health department.

Local Triage: This is when the person's clinician and LHD work together to determine the best course of action based on the person's health status and available resources for getting more advanced care. This allows a hospital to have capacity and to be prepared to receive a person coming to the hospital.

Malaise: Illness expressed as lack of energy, sadness, or other decreased capacity.

Patient/Resident: A person receiving support in their home or a licensed facility.

Physical Distancing: As much as possible, have people actively stay at least 6 feet from one another.

PPE: Personal protective equipment. **Non-PPE:** Refers to equipment that is not National Institute for Occupational Safety and Health (NIOSH)-approved as protection but is preferable to having no barrier when there is no supply of PPE.

Routine Precautions: The standard and universal precautions used to prevent the spread of infection while providing personal care routinely used prior to the COVID-19 outbreak.

Transfer: Specific precautions for moving a sick person to a hospital.

Zone Triage: When local hospitals determine the need for patients to be cared for at regional rather than their local hospital.

The Purpose of the Concept and System Flow Diagrams

Purpose and List of Diagrams and Tools (page 1): Quick reference to all the documents in the toolkit.

Introduction to Key Terms and Concepts (page 2): Explains levels of PPE capacity and a person's potential COVID-19 status.

Ohio's COVID19 Health Care Delivery Systems (page 3): A flow chart of health care settings addressing COVID-19 status and the flow into more intensive care settings. (C+ is exposed, presumed or diagnosed) (C- is non-exposed with no symptoms).

Long-Term Services and Supports (LTSS) Personal Protective Equipment (PPE) Contingency Planning (page 4): This diagram elaborates on the management of PPE supplies. Choosing between contingency and crisis level PPE use may vary for any given type of PPE depending on the provider's available supply and usage rate.

Patient/Resident Journey in Nursing Facilities/Congregate Care Settings (page 5): This illustrates how people who live in residential facilities who have either no symptoms, or who have been exposed, or are presumed/tested positive, are separated depending on their health status. It specifies the care each group needs and if/when a person moves from one group to another. It also includes tools for assessing the setting's population and personnel's individual risk for planning purposes (Tool #1 and Tool #2).

COVID-19 and Patient/Resident Journey into Higher Levels of Medical Care (page 6): This illustrates stratification of people with presumed/diagnosed COVID-19 into four levels of severity of symptoms. It further illustrates which levels of illness may require transfer to a hospital or other care center based on the guidance of the person's physician, local health department, and hospital partners regionally.

Staff Journey in Nursing Facilities/Congregate Care Settings (page 7): This diagram illustrates screening of personnel's health for ability to enter and work in the facility. It specifies the PPE personnel should use based on the status of the person, as well as the availability of recommended PPE. The choice to use contingency level PPE or crisis level PPE needs to be assessed by the provider, considering their current and anticipated supplies and/or shortages.

Patient/Resident Journey in Community Settings (page 8): This chart is followed when people receive supports in their home or in facilities that do not have nursing services at the level of a nursing facility/congregate care setting. Based on their COVID-19 health status, this chart outlines the care they may receive in their home, monitoring of their health status, and what to do if their severity of symptoms exceeds what can be provided in their home.

For each status (green, orange, or purple), it lists the recommended ideal use of PPE. It also includes tools for planning purposes to assess the setting's population and personnel's individual risk (Checklists 1 and 2).

The column of information titled "**If care exceeds ability to remain home**" is referring to the person's health status, not their quarantine or isolation status.

To prevent the spread of COVID-19, **people should remain at home unless their primary health care provider directs them to a hospital or testing site** (physician, advanced practice nurse practitioner, or local health department).

The exception to this is a staffing crisis that requires people to move because personnel are not available to go into the home and support people in their home.

It is important to minimize potential viral load (the amount of viral exposure) by not aggregating ill people in large groups (more than 6) if at all avoidable.

Staff Journey in Community Settings (page 9): This diagram illustrates screening of personnel's health for ability to enter and work in people's homes. It specifies the PPE personnel should use based on the status of the person as well as the availability of recommended PPE. The choice to use contingency level PPE or crisis level PPE needs to be assessed by the provider, considering their current and anticipated supplies and/or shortages.

Explanation of Tools

Tool #1 – Patient/Resident Population Assessment Checklist (page 10): This is an optional planning tool that may be used by providers to rate the risk factors of everyone's baseline health for conditions known to increase the risk of having more severe complications from COVID-19.

Tool #2 – Personnel Population Risk Assessment Checklist (page 11): This is an optional planning tool that may be used by providers to rate the risk factors of personnel's baseline health for conditions known to increase a risk of having more severe complications from COVID-19. This is to allow consideration of work assignments of highest risk personnel.

Tool #3 – Assessment of COVID19 and Clinical Level of Severity (NEWS2) (page 12): This patient assessment form is the National Early Warning Score. Used with C-2 (NEWS2 Scoring Matrix).

It uses key health status indicators to evaluate the recommended frequency of monitoring a person's health and guides escalation of health care to more advanced clinicians based on their combination of symptoms.

This is a tool to help track if people are becoming increasingly ill. In a NF/CC nurses and physicians would use this to guide clinical monitoring and the need to transfer to a hospital

Community settings may want to use this for determining a person's baseline health (before suspected illness), and for monitoring if health status is changing. In community settings, support personnel would report changes to the person's primary health care professional (HCP) and follow the HCP's direction for treatment or testing or transfer to hospital.

Tool #4 – Scoring Matrix for NEWS2 (page 13): Used to guide monitoring frequency and clinical response to the person's combination of symptoms.

Tool #5 – COVID-19 Symptom Monitoring Log (page 14): An optional checklist of symptoms that can be used for personnel screening and for monitoring and tracking people who have been exposed to COVID-19 during their time in quarantine status. (See DODD's "Sample Instructions for Personnel Daily Symptom Monitoring" form for determining when people can work or should not work.)

Tool #6 – Patient/Resident Transfer Checklist (Clinical Criteria for Transfer of Facility Residents to Hospital) (page 15): This checklist is intended to assist with communications when transferring COVID-19 residents to a hospital. It serves as an easy reference guide, ensuring details of care have been accurately relayed. It does not replace or supersede existing clinical, facility, or agency protocols, or the directions given by a person's HCP or LHD. Please check all that apply. This checklist does not have to be completed by a nurse.

Tool #7 – Hospital Discharge Criteria Checklist to Facility/Home (page 16): This checklist is intended to assist with communications when transferring COVID-19 residents from a hospital. It serves as an easy reference guide, ensuring details of care have been accurately relayed. It does not replace or supersede existing clinical or facility protocols. People returning from the hospital will be given specific instructions about how long they should stay in isolation or quarantine after they get home.

Tool #8 – Tips for Patient/Resident Social and Emotional Wellbeing (page 18): This an optional tool and should be adapted based on each resident's health status. Page 2 is titled "Tips for Engaging Nursing Facility and Congregate Care Residents."

Tool #9 – Tips for Staff Social and Emotional Wellbeing (page 20): This is an optional tool.

Tool #10 – Tips for Staff Attire and Personal Protective Equipment (PPE) (page 22): This guidance is provided to minimize inadvertent spread of COVID-19. It includes important information about personnel re-entry into their own homes after work.

Tool #11 – PPE Quick Guide – Contingency Capacity (page 23): A graphic depiction of the PPE used at contingency capacity.

Tool #12 – PPE Quick Guide – Crisis Capacity (page 24): A graphic depiction of the PPE used at crisis capacity.

Tool #13 – Tips for Cleaning and Disinfecting Homes and Congregate Care Settings (page 25): Guidance for cleaning and disinfecting.

Update: August 3, 2020

DODD Addendum to the June 19 edition of the Long Term Services and Supports Pre-surge, and Longer-Term Planning Toolkit: Return to Work guidance (page 31 of LTSS Tool)

The purpose of this document is to update the LTSS guidance for clearing personnel to return to work based on the Center for Disease Control's guidance updated July 17, 2020, and to clarify how to address symptoms as from a known cause differently than from an unknown cause.

1. All personnel should continue to be screened for the most common symptoms of COVID-19 before working daily.

    a. The daily screening includes questions about the presence of some symptoms that may also be symptoms of a known origin such as chronic coughs, asthma, seasonal allergies, or clinically validated infections. When symptoms are identified as being from a known cause, the symptom does not exclude personnel from working or require quarantine or isolation precautions.

    b. On the LTSS Return to Work guidance document "Contingency and Crisis Facility Staffing Guidance" (graph on page 31) the reference to symptoms only refers to symptoms of **unknown origin**. Any symptoms of a known origin such as those noted above would not be applied to this analysis as a COVID symptom. When a person's symptoms are from a known cause that is not COVID they would be considered negative for symptoms.

2. On the LTSS Return to Work guidance document "Contingency and Crisis Facility Staffing Guidance", (graph on page 31) the "10/3/3" criteria has been updated to a "10/1/Improvement" metric.
    a. *Personnel with mild to moderate illness who are not severely immunocompromised may return to work when:*

        i. At least 10 days have passed *since symptoms first appeared* **and**
        ii. At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
        iii. Symptoms (e.g., cough, shortness of breath) have improved

    b. *Personnel with severe to critical illness or who are severely immunocompromised may return to work when:*
        i. At least 20 days have passed *since symptoms first appeared* ***and***
        ii. At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
        iii. Symptoms (e.g., cough, shortness of breath) have improved

    c. Personnel who are **severely immunocompromised** but who were **asymptomatic** throughout their infection may return to work when at least 20 days have passed since the date of their first positive viral diagnostic test was collected.

3. Test-Based Strategies should not be used to evaluate for Return to Work.
    a. If a person has already tested positive for the COVID-19 virus they should not be tested again in less than 90 days
    b. Time and Symptom-Based criteria should be used to determine the end of isolation, quarantine, and ability to return to work

Coronavirus Disease 2019: Contingency and Crisis Facility Staffing Guidance

Ohio Department of Health

Covid-19 Test Status		Staff Symptoms		Staff Exposure (by Contact Tracing)		Infection Control Guidance	Return to Work (RTW) Guidance	Subject to Staff Mitigation Tier
Test		Symptoms		Exposed				
+		+		N/A		**Isolation* x 10 days (10/3/3 rule)**	**After 10 days from date of first symptoms (10/3/3 rule)**	3
+			–	N/A		**Isolation* x 10 days from date + test collected**	**After 10 days from date + test collected**	3
	–	+		+		**Begin quarantine* x 14 days** from date of last known exposure; Self-monitor **Arrange for medical evaluation** for potential alternate diagnosis/ symptom management **Consider a repeat test in 5 days**, particularly if symptoms persist or are not explained by another diagnosis	**After 14 days of quarantine** (if no repeat testing done) **If repeat testing done:** • If test negative, may RTW when symptoms resolved per HR policies (as for non-COVID conditions) • If test positive, RTW 10 days from date of first symptoms (10/3/3 rule) • Mask for 14 days from first symptoms (during breaks, etc, to protect other employees)	3
	–	+			–	**Quarantine-like monitoring* x 10 days from date of first symptom**; Self-monitor **Arrange for medical evaluation** for potential alternate diagnosis/symptom management **Consider a repeat test in 5 days**, particularly if symptoms persist or are not explained by another diagnosis	**After 10 days of quarantine-like monitoring** (if no repeat testing done) **If repeat testing done:** • If test negative, may RTW when symptoms resolved per HR policies (as for non-COVID conditions) • If test positive, RTW 10 days from date of first symptoms (10/3/3 rule) • Mask for 14 days from first symptoms (during breaks, etc, to protect other employees)	3
	–		–	+		**Quarantine x 14 days, but may work if remains asymptomatic**	Follow policies for universal employee screening and mask use and diligent handwashing Mask for 14 days after exposure event (during breaks, etc, to protect other employees)	2
	–		–		–	**No quarantine required**	Follow policies for universal employee screening and mask use and diligent handwashing	1

Note: Asypmtomatic personnel may work while awaiting test results. Repeat testing assesses if first test was a false negative or done during incubation period. This guidance is relevant for all Health Care Personnel and potentially exposed staff and individuals not directly involved in patient care e.g. (clerical, food & laundry service) as described by cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html. Please note: Potential exposures can occur when personnel come within 6 feet of an infected person for at least 15 minutes or during performance of an aerosol-generating procedure or from direct contact with infectious secretions while not wearing recommended PPE.