COVID-19 Testing Decision Matrix
Persons Under Investigation (PUIs) for Testing at IDPH Laboratories

CLINICAL PRESENTATION:

Fever and/or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)

AND

any of the following epidemiologic or other factors:

CONTACT	TRAVEL	CONGREGATE LIVING / HEALTHCARE FACILITY	MEDICAL RISK FACTORS	PUBLIC HEALTH CONCERN	HOSPITALIZED +
Any person, including health care workers, who has had **close contact with a laboratory-confirmed COVID-19 patient** within 14 days of symptom onset	A history of **travel from affected geographic areas** within 14 days of symptom onset (currently China, South Korea, Iran, Italy, parts of Europe, and Japan)[1]	The individual is from a **congregate living** or **health care facility (staff and/or patient/resident) with clusters of infection not due to influenza and suspected to be due to SARS-CoV-2**, as determined in collaboration with public health authorities	The patient is at **higher risk for complications** from SARS-CoV-2 and for whom **rapid test results are more likely to impact clinical care/outcomes** (e.g. older adults (age ≥ 65 years)) **OR** is an individual with **chronic medical conditions and/or an immunocompromised state** that may put them at higher risk for poor outcomes[2]	Other situations involving patients that clinicians have thoroughly evaluated and are deemed **high priority after consultation with public health OR** are **part of a situation of concern as determined by public health**	**Hospitalized patients with unexplained[3] pneumonia** where a physician (infectious disease or pulmonary specialist, if feasible) has evaluated the patient and is concerned about SARS-CoV-2 infection[4, 5]

Patients who do not meet any of the above criteria for COVID-19 testing by IDPH laboratories should be managed as clinically indicated.
Providers may determine to proceed with testing at a commercial or clinical laboratory.

1. https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
2. Examples include but are not limited to diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease.
3. Patient has had negative influenza and respiratory panel testing.
4. Exposure source may be unknown or not identified.
5. Radiologic studies should also be reviewed with an expert (e.g. chest radiologist) to help make this determination.

3/13/2020

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

HEALTH ALERT

JB Pritzker, Governor | Ngozi Ezike, MD, Director

Summary and Action Items

- To provide information on the availability of commercial lab testing for SARS-CoV-2
- To clarify what testing will be prioritized through IDPH Public Health Laboratories
    1. To clarify which persons under investigation should be reported to local health departments

Background

SARS-CoV-2 testing is now available through a limited number of commercial laboratories and availability through hospital and reference labs will continue to grow. Expected turn-around time (TAT) at commercial laboratories is 1 to 4 days but may be longer. In contrast, testing at IDPH laboratories can usually be performed with a 1 to 2-day TAT. IDPH has limited capacity/reagents to perform SARS-CoV-2 testing and will target its testing to higher priority specimens (see IDPH Public Health Laboratory Testing section on page 2). This will enable higher risk patients to be identified sooner, assist with care of patients with more severe illness, and inform response efforts, including critical infection control decisions.

Reference Laboratory Testing

The first commercial laboratories to offer testing is LabCorp. IDPH recommends that facilities set up accounts with a commercial laboratory for testing of lower priority specimens (see below). This will preserve IDPH's limited supply of reagents and allow the IDPH laboratories to offer rapid TAT for high priority specimens.

Lab	Start date	Website
LabCorp	March 5, 2020	https://ir.labcorp.com/news-releases/news-release-details/labcorp-launches-test-coronavirus-disease-2019-covid-19

As additional laboratories begin offering testing, IDPH will update this list on its COVID-19 website. IDPH does not endorse any commercial lab; laboratories will be listed in alphabetical order.

All specimens should be collected as directed by the laboratory where specimens are being submitted, using appropriate precautions. Clinicians must implement the most recently recommended infection prevention and control practices for testing and care if a patient is suspected of having COVID-19. Based on current CDC guidance:

When collecting diagnostic respiratory specimens (e.g., nasopharyngeal swab) from a possible COVID-19 patient, the following should occur:

- *HCP in the room should wear an N-95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown.*
- *The number of HCP present during the procedure should be limited to only those essential for patient care and procedure support. Visitors should not be present for specimen collection.*

- *Specimen collection should be performed in a normal examination room with the door closed.*
- *Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control below.*

Improper specimen collection procedures may have negative consequences, including exposure of health care workers, and false negative results. In addition, cross contamination of specimen collection materials may cause false positive results. Collection of NP specimens should be done by individuals who have been trained and, ideally, have demonstrated competency. This video from NEJM on NP swab collection can be used for instruction. Always read the instructions for the test kit and transport media being used.

Individuals tested for SARS-CoV-2 should be instructed to restrict their activity based on their exposure risk category and risk classification as outlined in Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Cases. **Instruct non-hospitalized patients being tested for COVID-19 to self-isolate. Patients should follow home care instructions** until their test result is negative or until they are told by public health officials or their health care provider that they are no longer infectious.

IDPH Public Health Laboratory Testing

Pre-authorization of a specimen is required for testing at the IDPH laboratory. IDPH is prioritizing use of its laboratory for SARS-CoV-2 testing for the following situations:

- Medium and high-risk contacts to a laboratory-confirmed case of COVID-19, who have a clinically compatible illness.
- Travelers with a clinically compatible illness AND a history of travel within the past 14 days to an affected geographic area without an alternative explanatory diagnosis (e.g., influenza).
- Hospitalized patients with unexplained pneumonia where a physician (infectious disease or pulmonary specialist, if feasible) has evaluated the patient and is concerned about SARS-CoV-2 infection. Radiologic studies should also be reviewed with an expert (e.g. chest radiologist) to help make this determination.
- Individuals from congregate or health care facilities (staff and/or patients) with clusters of infection not due to influenza and suspected to be due to SARS-CoV-2, as determined in collaboration with public health authorities. As a reminder, clusters of respiratory illness are reportable to the local health department by phone with 24 hours.
- People at higher risk for complications from SARS-CoV-2, for whom rapid test results are more likely to impact clinical care/outcomes (e.g. older adults (age ≥ 65 years) and individuals with chronic medical conditions and/or an immunocompromised state that may put them at higher risk for poor outcomes (e.g., diabetes, heart disease, receiving immunosuppressive medications, chronic lung disease, chronic kidney disease).
- Other situations of concern as identified by public health authorities.
- Other situations involving patients that clinicians have thoroughly evaluated and are deemed high priority after consultation with public health.

Once the health care provider has performed an initial evaluation, if it is evaluated to be of high priority (or possibly high priority), contact the local health department regarding testing at the IDPH laboratory. If turn-around-time for alternative diagnoses is time prohibitive, please discuss these patients with your LHD.

If testing at IDPH laboratory is not approved, the clinician can order testing if she/he remains concerned about COVID-19 illness via a private laboratory. If the clinician cannot access commercial laboratory testing, please inform such patients that they cannot be tested yet, but that commercial testing is ramping up. Please tell them to isolate themselves at home away from other household members until 3 days (72 hours) after complete resolution of symptoms. As an example, if the patient has symptoms that last for 7 days, they would self-isolate at home for 10 days total.

For lower priority testing performed elsewhere, notification of public health that a test has been ordered is not required, unless requested by your local health department. IDPH will receive test results from commercial laboratories electronically.

Patients should not be referred directly to the local health department or to the IDPH COVID-19 hotline for decision making about testing.

Contact

For other testing questions, additional information or other questions, please contact your local health department. If they are not available, please contact the IDPH Communicable Disease Section at 217-782-2016. For information after hours, please contact your local health department. If they cannot be reached, use the IDPH after hours number 800-782-7860. Local health departments should contact IDPH for consultations on PUIs.

Additional Resources

IDPH website: Coronavirus Disease 2019 (COVID-19)

CDC Resources: Information for Healthcare Professionals

Target Audience

Local Health Departments, Infectious Disease Physicians, Hospital Emergency Departments, Infection Preventionists, Health Care Providers, Long Term Care Facilities and Laboratories

Date Issued:

March 10, 2020

Author:

Communicable Disease Section

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
IDPH
PROTECTING HEALTH, IMPROVING LIVES

Recommended Guidance For Healthcare Workers

JB Pritzker, Governor **Ngozi O. Ezike, MD, Director**

Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)

Summary of Recent Changes

Update: This Interim Guidance was updated on March 7, 2020 to make the following changes:

- **Updating recommendations regarding HCP contact tracing, monitoring, and work restrictions in selected circumstances. These include allowances for asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. (See Additional Considerations and Recommendations at the end of the document)**
- **Removed requirement under "self monitoring with delegated supervision" for healthcare facilities to actively verify absence of fever and respiratory symptoms when healthcare personnel (HCP) report for work. This is now optional.**
- **Simplified risk exposure categories based on most common scenarios with focus on presence/absence of source control measures; use of personal protective equipment (PPE) by HCP; and degree of contact with the patient (i.e., prolonged versus brief)**
- **Added language advising HCP to inform their occupational health program if they have travel or community-associated exposures as defined in Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease (COVID-19) Exposure in Travel-associated or Community Settings.**

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

825 North Rutledge Street • Springfield, Illinois 62702-4910 • www.dph.illinois.gov

MEMORANDUM

TO: Local Health Departments & Regional Offices of the Illinois Department of Public Health (IDPH), Hospital Laboratories, Hospital Administrators, PIOs, ED Personnel, Nursing Directors, EMS Staff, Laboratory Staff, ID/INEDSS, EMS Partners and IL Local EMAs

FROM: E. Matt Charles
Chief, Division of Laboratories

DATE: March 13, 2020

SUBJECT: COVID-19 Sample Submission to IDPH

The Illinois Department of Public Health (IDPH) Division of Laboratories is now testing for COVID-19 at all three of its laboratories located in Carbondale, Chicago and Springfield. **Effective 3/13/20, IDPH will only test NP swabs for initial patient screening.** Below contains updated guidance for specimen testing at IDPH Laboratories. **PLEASE READ CAREFULLY**

Specimens to be Collected:
As of 3/12/2020, the CDC updated guidance to recommend collecting only the nasopharyngeal (NP) swab. Collecting both NP and oropharyngeal (OP) is no longer recommended. **Please only send one (1) NP swab per patient.** This recommendation only applies when samples are tested with the CDC Emergency Use Authorization (EUA) assay, CDC 2019-Novel Coronavirus Real-Time PCR Diagnostic panel. This is the assay used by the Illinois Public Health Laboratories. When using other laboratories or other assays, please consult recommendations for specimen types and handling that are specific to those assays. If the patient is positive on the initial screening performed at the IDPH Laboratories, additional specimens may be requested, such as sputum and serum. Please do not send these samples until requested.

Forms to Include with Specimens:
All submissions require approval from the Local Health Department which will provide a patient-specific authorization number. Each specimen should have its own Communicable Disease Laboratory Test Requisition Form. Prior to submission, ensure all sections of the form are complete as missing fields may delay testing. The authorization code should be placed at the top of the form.

Laboratory Turn Around Time (TAT):
The published TAT is 3 days for this test. Currently, IDPH labs are able to provide results for most specimens 1-2 days after specimen receipt. The laboratories are performing testing Monday through Saturday. Sunday testing is only permitted if a critical need arises.

Please refer to prior guidance from IDPH regarding appropriate swabs, storage temperatures and shipping. If you have specific questions relating to the content of this communication, please contact

Kristin Goldesberry (Springfield Laboratory Manager) at 217-524-6228, Chris Vogt (Carbondale Supervisor) at 618-457-5131 or Dr. Mohammad Nasir (Chicago Laboratory Manager) at 312-793-4760. Contact your Local Health Department to discuss any Persons Under Investigation.

State of Illinois
Illinois Department of Public Health

Communicable Diseases Laboratory Test Requisition

Authorization Code:_____
(If applicable)

REQUISITION MUST BE FILLED OUT COMPLETELY

Laboratory Specimen Number (FOR PUBLIC HEALTH USE ONLY)

Type or use indelible dark ink and print legibly with capital letters

Outbreak #:

SUBMITTER INFORMATION:

_____
Submitting Institution

_____ _____ _____ _____
Submitter Address (Street Number, Name of Street) | City | State | ZIP Code

_____ _____ _____ _____
Contact Person/Clinician's Last Name | Telephone Number | FAX | E-mail Address

PATIENT INFORMATION:

_____ _____ _____
Patient's Last Name | First Name | Middle Name

_____ _____
Street Address | Apartment/Suite Number

_____ _____ _____
City | State | ZIP Code

_____ _____ _____
Telephone Number | Birthday (mm/dd/yyyy) | Age

Sex
❑ Male
❑ Female

Race
❑ White
❑ African American/ Black
❑ Native American
❑ Asian/Pacific Islander
❑ Other/Unknown

Ethnicity
❑ Hispanic
❑ Non-Hispanic

Patient ID # (optional)_____ Medicaid Recipient ID # _____

TEST REQUEST INFORMATION

When sending acute and convalescent serology specimens, use one test requisition. Complete collection information immediately below for acute specimen and complete collection information for convalescent specimen in the "Source/Specimen Type" box.

_____ _____:_____ ( ) a.m. _____ Initials of Person _____ Initials of Person _____
Date Collected (mm/dd/yyyy) | Time collected ( ) p.m. | Date of Onset | Collecting Specimen | Completing Form

TEST		SOURCE/ SPECIMEN TYPE (one source type per form)		REASON
❑ Arbovirus Panel	❑ MTBC – PCR (Resp. spec. only)	❑ Blood - Film	❑ Serum – Acute	❑ Carrier
❑ B. Strep (Gp A)	❑ MTB Genotyping only	❑ Blood - Serum	❑ Serum - Convalescent	❑ Confirmation
❑ B. Strep (Gp B)	❑ Norovirus	❑ Blood - Whole	❑ Skin	❑ Contact
❑ Bacillus anthracis	❑ Orthopox virus	❑ Body Fluid (Specify Below**)	❑ Smear	❑ Diagnosis
❑ Brucella	❑ Pertussis PCR	❑ Bronchial Alveolar Lavage "BAL"	❑ Spinal Fluid	❑ Foodborne Illness
❑ Burkholderia	❑ Respiratory Panel	❑ Bronchial Washing	❑ Stool/Feces	❑ Immunity
❑ COVID-19	❑ Salmonella	❑ Fecal Swab	❑ Sputum	❑ Outbreak
❑ Cyclospora	❑ Shiga-toxin producing E. coli or E. coli O157	❑ Genital Swab	❑ Tissue Culture Fluid	❑ Post Vaccination
❑ Cryptosporidium	❑ Shigella	❑ Nasal Aspirate	❑ Tissue (Specify Below**)	❑ Release Specimen
❑ Francisella	❑ Staphylococcus aureus	❑ Nasopharyngeal Swab	❑ Throat Swab	❑ Routine Screening
❑ Gonorrhea Culture	❑ Varicella-zoster	❑ O&P Kit	❑ Urine	❑ Rule Out Threat Agent
❑ Giardia	❑ Yersinia	❑ Oropharyngeal Swab	❑ Vaginal Swab	❑ Symptomatic
❑ Legionella	❑ Yersinia pestis	❑ Pharyngeal Swab	❑ Other (Specify Below**)	❑ Treatment
❑ Malaria	❑ Vibrio	❑ Rectal Swab	❑ Other Swab (Specify Below**)	❑ Typing
❑ Measles PCR	❑ Other (Specify Below*)	❑ Referred/Isolated Culture		❑ Other (Specify Below***)
❑ Mumps PCR				
❑ MTBC Smear, Cult, ID & Sens				

_____ _____
*OTHER TEST | **SOURCE

_____
***REASON(S)

OVER- For Referred Cultures and Instructions

State of Illinois
Illinois Department of Public Health

Communicable Diseases Laboratory Test Requisition

REFERRED CULTURE INFORMATION

Agent Suspected _____

Morphology _____

Carbohydrate Reactions _____

Other Biochemical Reaction _____

Commercial Kit Used _____

Tentative Identification _____

Other Pertinent Information

INSTRUCTIONS

The Illinois Department of Public Health laboratory requisition form titled, "Communicable Diseases Laboratory Test Requisition," is designed to accompany the specimens submitted to the Department's laboratories by approved submitters for communicable diseases testing, including parasitology, bacteriology, enterics and virus.

DEFINITION - Submitter - Entity that sends specimens to be tested.

SUBMITTER INFORMATION - Enter the name of the organization/hospital OR submitter code (if you have one) requesting the test, the ordering contact person/clinician's last name (important so that test results may be routed correctly), the address of the organization/hospital requesting the test, and the complete submitter's phone number and FAX, including area code.

PATIENT INFORMATION - Print the patient's full name. The patient's ID# is an optional field for a locally assigned patient number completed at the discretion of the submitter. If applicable, enter the patient's Medicaid identification number. Enter the patient's date of birth, if known. If the date of birth is entered, the age may be left blank. Enter sex, race, ethnicity as indicated by the patient. Enter the patient's complete address including apartment or suite number, city/town, state and five digit ZIP code.

TEST REQUEST INFORMATION - Enter the date the specimen was collected. This is a REQUIRED field. If applicable, enter the date of patient's illness onset. Please print the initials of person completing the requisition form and the initials of person collecting the specimen. Enter specimen collection time.

To request a test, fill in appropriate box. Fill in box for source and reason. If not listed, use "other" and write appropriate test, source or reason.

Illinois Department of Public Health
Division of Laboratories
2121 W. Taylor Street
Chicago, IL 60612
312-793-4760

Illinois Department of Public Health
Division of Laboratories
825 N. Rutledge Street
Springfield, IL 62702
217-782-6562

Illinois Department of Public Health
Division of Laboratories
1155 South Oakland Avenue
Carbondale, IL 62901
618-457-5131

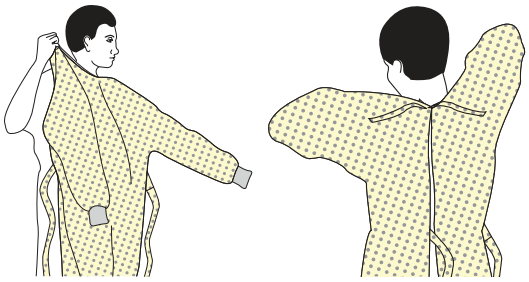
IL 482-1039
Printed by the Authority of the State of Illinois
P.O.#5513245 100M 10/14
IOCI 15-413

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

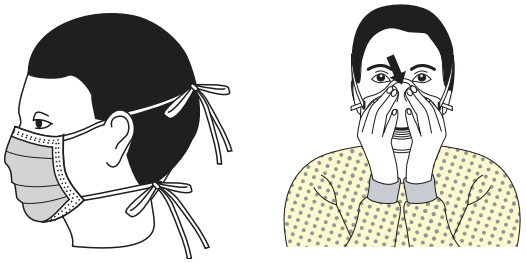
1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

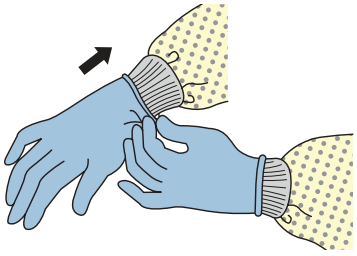


3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

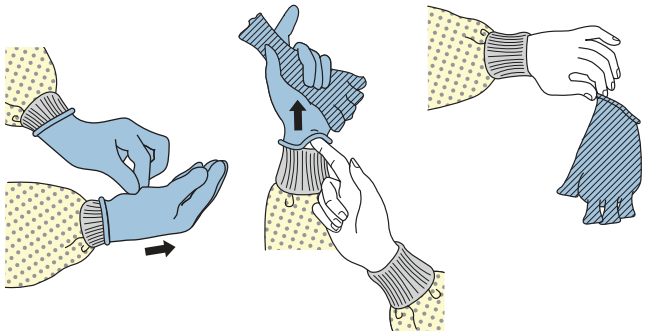
CS250672-E

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container

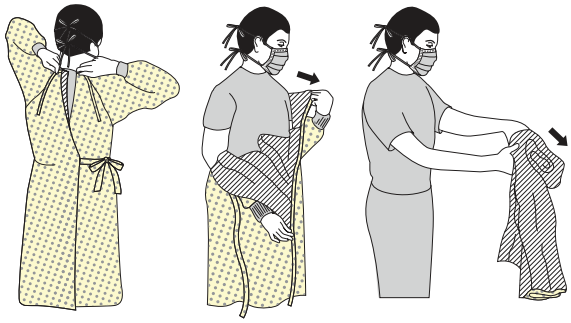


2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

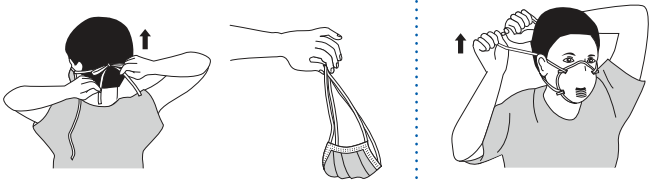
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

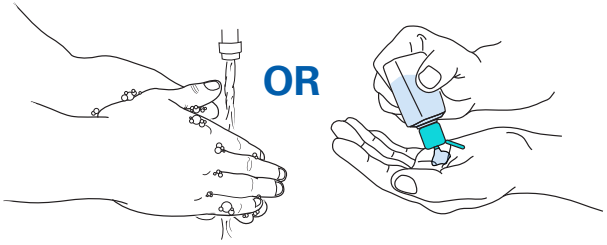


4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

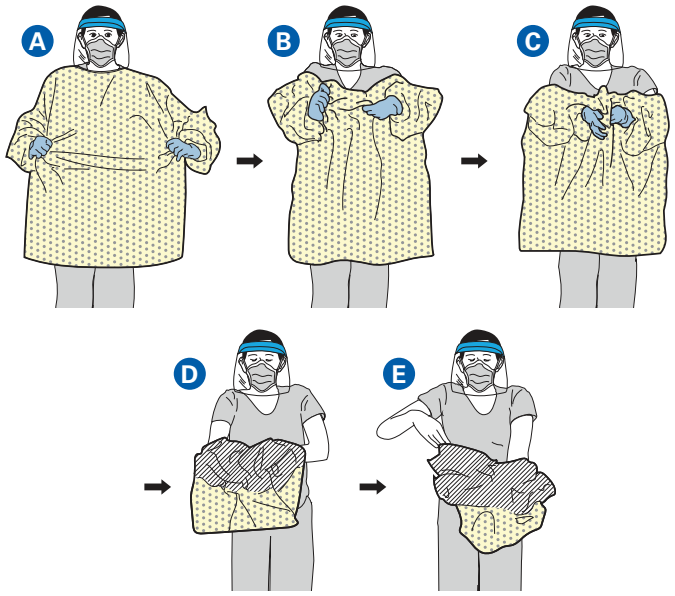
CS250672-E

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 2

Here is another way to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GOWN AND GLOVES

- Gown front and sleeves and the outside of gloves are contaminated!
- If your hands get contaminated during gown or glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp the gown in the front and pull away from your body so that the ties break, touching outside of gown only with gloved hands
- While removing the gown, fold or roll the gown inside-out into a bundle
- As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container

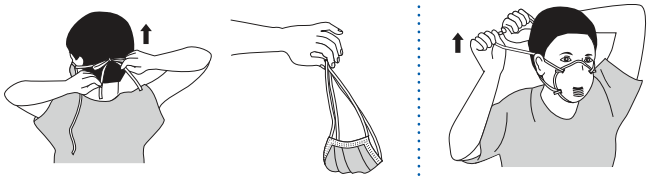


2. GOGGLES OR FACE SHIELD

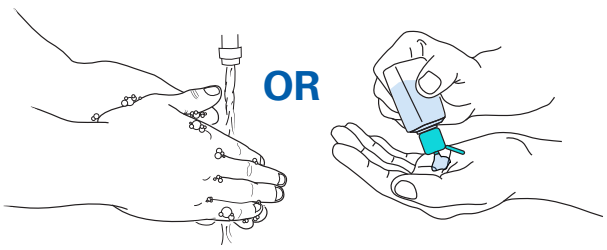
- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band and without touching the front of the goggles or face shield
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

3. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



4. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CS250672-E

COVID-19 Healthcare Planning Checklist

Hover over form fields for instructions

Planning for a potential emerging infectious disease pandemic, like COVID-19, is critical to protecting the health and welfare of our nation. To assist state, local, tribal, and territorial partners in their planning efforts, the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response has developed the following checklist. It identifies specific activities your jurisdiction can do now to prepare for, respond to, and be resilient in the face of COVID-19. Many of the activities in this checklist are specific for COVID-19, however many, pertain to any public health emergency.

This checklist is adapted from a variety of HHS Pandemic Influenza Pandemic Planning resources. It is not intended to set forth mandatory requirements by the Federal government. Each jurisdiction should determine for itself whether it is adequately prepared for disease outbreaks in accordance with its own laws and authorities. We strongly encourage continued review of HHS' Centers for Disease Control (CDC) COVID-19 guidance which is available on their website for the most current information.

1. **Safety / Infection Control Activities**

Completed	In Progress	Not Started	Activities
○	○	○	1.1 Develop a pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.2 Develop an agency/facility pandemic safety plan and appoint a safety officer to modify as required.
○	○	○	1.3 Provide staff education about COVID-19 infection control and update polices as required.
○	○	○	1.4 Support N95 respirator fit-testing for all agency/facility employees and just-in-time education on recommended infection control precautions including fit checking, applying simple mask to patients with cough, and hand hygiene.
○	○	○	1.5 Monitor availability of N95 respirators/powered air purifying respirators (PAPRs) and other supplies including alcohol-based hand disinfectants, gloves, etc., and watch and alert coalition members to supply shortages. Make recommendations on possible alternatives.
○	○	○	1.6 Prepare guidelines for conservative and re-use of N95 respirators/PAPRs if severe shortages are imminent (ideally regionally and in conjunction with local public health, occupational safety, and infection prevention providers and agencies - for example, consider use by only the highest-risk staff, re-use in selected situations, continued use while working on cohorted units, etc.).
○	○	○	1.7 Plan contingencies if appropriate levels of respiratory protection are unavailable.
○	○	○	1.8 Develop guidance for staff monitoring for signs of illness (including self-reporting, self-quarantine, and start/end of shift evaluation) and create a mechanism for reporting both illness and absenteeism.
○	○	○	1.9 Develop a return to work post illness policy for health care workers. This should be as consistent as possible across the coalition.
○	○	○	1.10 Encourage HCFs to plan for staff access to medical care for themselves and their families; determine whether illness will be handled as workers' compensation or personal insurance depending on situation/criteria and share best practices.
○	○	○	1.11 Determine contingency plan for at-risk staff (e.g., pregnant, other defined risk groups) including job expectations and potential alternate roles and locations.
○	○	○	1.12 Evaluate the need for family support to enable staff to work (e.g., childcare, pet care). Provide information for family care plans.

2. EMS Activities

Completed	In Progress	Not Started	Activities
○	○	○	2.1 Determine coordination mechanisms, scope, and likely authorities between coalition EMS agencies including information sharing, resource monitoring/assistance, and policy coordination. Work with local intelligence fusion centers to assist with information sharing and coordination.
○	○	○	2.2 Determine actions that the state EMS agency is likely to take including: • Suspension or modification of operational requirements for EMS agencies • Specific emergency orders or actions that may limit liability and/or expand scope of operations
○	○	○	2.3 Determine local ordinances or laws that may affect EMS disaster operations and the authorities or ability to suspend or modify if needed to support non-traditional operations.
○	○	○	2.4 Evaluate available indicators that may be needed for planning or by other partners and how to track them, e.g., EEI such as number of transports, number of potential COVID-19 cases, staff illness/absenteeism.
○	○	○	2.5 Evaluate indicators that have effects on EMS and coordinate access through the health care coalition (e.g., status of emergency departments, alternate care sites, epidemiologic information/ forecasting, weather (e.g., snowstorms), availability of staff, availability of supplies).
○	○	○	2.6 Determine vulnerable supplies and coordinate with vendors and the health care coalition to develop contingency plans/allocation plans.
○	○	○	2.7 Develop public messages that emphasize using 911 only for life-threatening emergencies and coordinate with the joint information system.
○	○	○	2.8 Develop information sharing process both for internal staff and between EMS agencies.
○	○	○	2.9 Develop just-in-time education for EMS personnel relative to infection prevention and control, self-care, transmission and family protection, and normal stress responses.
○	○	○	2.10 Pre-identify strategies and resources to ensure behavioral health support for staff to mitigate adverse stress and grief and loss reactions.
○	○	○	2.11 Determine virtual coordination mechanisms that will enable remote engagement of senior staff to prevent exposures and maximize ability to engage in both daily and incident operations.
○	○	○	2.12 Determine how agency/regional EMS incident action plans will be managed.
○	○	○	2.13 Prepare to initiate auto-answer/recorded answering of 911 calls including diversion of information or non-emergency calls to another call center (e.g., public health hotline). Consider activating a community hotline if such a call center does not exist.
○	○	○	2.14 Evaluate protocols for conducting call screening to recognize COVID-19 -like symptoms (e.g., cough and fever) and advise the responding EMS personnel of a potentially infectious patient.

2. EMS Activities (cont'd)

Completed	In Progress	Not Started	Dispatch Activities
○	○	○	2.15 Adjust response configurations to allow flexibility including: • Prioritization of calls for service (for services that do not currently use priority dispatch systems) including basic algorithms for non-medically trained dispatchers or referring calls to recorded information, nurse triage hotlines, public health information lines, or other technology-based systems • Recommending self-transport or referral to primary care if appropriate (may need to triage calls to medical provider to evaluate if this capability is available) • Assignment of less than usual resources (e.g., assign law enforcement only on injury accidents unless and until clear information that non-ambulatory/critical injuries a represent) • Assignment of non-traditional resources (e.g., using 'jump' cars, community paramedicine, and other responses) • Diversion to an alternate care site • Increasing interpretive service assistance
Completed	**In Progress**	**Not Started**	**Response Activities**
○	○	○	2.16 Develop triggers for implementing closest hospital transport - ideally done regionally.
○	○	○	2.17 Develop triggers for implementing 'batch' transports (e.g., answering another call immediately if your current patient is stable) - ideally regionally.
○	○	○	2.18 Determine indicators and triggers for changing staff shifts and crew configuration - ideally this should be implemented consistently in the region.
○	○	○	2.19 Provide criteria for patient assessment and emphasis on cough/respiratory and hand hygiene as well as strict adherence to appropriate infection control precautions per Centers for Disease Control and Prevention (CDC) guidance.
○	○	○	2.20 Develop criteria for on-scene denial of transport by EMS personnel for COVID-19 -like illness and other patients - with or without on-line medical control - ideally regional rather than agency-based criteria and process.
○	○	○	2.21 Develop/provide patient information sheets on homecare for COVID-19 -like illness including usual clinical symptoms and course, infection prevention, treatment, and when to seek additional medical care.
○	○	○	2.22 Develop/provide patient information sheets for other conditions that may be left without transport if the service volume suggests a relevant need (e.g., minor injuries).
○	○	○	2.23 Determine alternate transport resources and triggers to utilize them, e.g., private ambulance, wheelchair, contract/courier, for hire vehicles, military assets, buses.
○	○	○	2.24 Evaluate available staff vs. available transport units to determine ability to meet other non-transport missions (e.g., community paramedicine, EMS personnel staffing alternate care locations or providing hospital support).
○	○	○	2.25 Determine necessary changes to record-keeping including use of templates.

3. Hospitals and Health Care Activities

Completed	In Progress	Not Started	Coordination Regulatory Activities
○	○	○	3.1 Determine coordination mechanisms, scope, and likely authorities between coalition hospitals and health care systems including information sharing, resource monitoring/assistance, and policy coordination. This should include the role of the coalition to engage with vendors of PPE, pharmaceuticals, and other medical supplies that may be in shortage. Conduct a coordination conference call with healthcare facilities to ensure awareness and consistency.
○	○	○	3.2 Determine mechanism to engage outpatient settings (homecare, ambulatory care) in information sharing and policy/response coordination.
○	○	○	3.3 Determine mechanisms to engage skilled nursing facilities in information sharing and policy/ response coordination.
○	○	○	3.4 Determine actions that the state of emergency management or public health agency is likely to take that affect health care including: • Suspension or modification of requirements for hospitals or clinics • Specific emergency orders or actions that may limit liability or expand scope of operations (for facilities and providers, including volunteers) • Requests for 1135 waivers from the Centers for Medicare & Medicaid Services (CMS) • Crisis standards of care activation • Issuance of clinical guidelines for care and resource allocation • 'Taking powers' of the state relative to medical materials and staff (i.e., does the state have ability to commandeer resources under their emergency powers and does this include medical materials?) • Promulgation or enforcement of legal obligations of medical staff to provide care
○	○	○	3.5 Evaluate available indicators that may be needed for planning or by other partners and how to track them, e.g., number ED visits available beds, available ventilators, number of potential COVID-19 cases, staff illness/absenteeism.
○	○	○	3.6 Evaluate indicators that have effects on hospitals and coordinate access through the health care coalitions (e.g., status of EMS agencies, alternate care sites, epidemiologic information/ forecasting, availability of supplies).
○	○	○	3.7 Determine a process for expedited credentialing of supplemental staff and for the orientation/ mentoring of supplemental or shared staff.
○	○	○	3.8 Determine threshold for use and priority list for supplemental staff (e.g., first shared health care system staff, then similarity credentialed and licensed staff, then Medical Reserve Corps, etc.)
○	○	○	3.9 Determine indicators and potential triggers for implementation of alternate care systems in conjunction with public health.
○	○	○	3.10 Develop public messages that emphasize using emergency departments only for life-threatening emergencies and coordinate with the joint information system. Be prepared to manage the expectations of the public relative to scarce resources (what is the shortage, what is being done, who are the priority groups, etc.).
○	○	○	3.11 Determine common visitor policies for coalition hospitals.
○	○	○	3.12 Develop just-in-time education for health care personnel relative to COVID-19 transmission, clinical course, at-risk populations, complications, treatment prevention and control, self-care, transmission and family protection, and normal stress responses.

Completed	In Progress	Not Started	Coordination Regulatory Activities
○	○	○	3.13 Pre-identify strategies and resources to ensure behavioral health support for staff to mitigate adverse stress and grief and loss reactions.
○	○	○	3.14 Determine how facility/regional hospital incident action plans will be managed.
○	○	○	3.15 Determine how awareness of retail pharmacy stocks will be maintained and shared with ambulatory/emergency care workers.
○	○	○	3.16 Determine behavioral health support plan that includes use of individual HCF staff as well as local, regional, state and federal assistance for meeting patients and staff needs (including those in a leadership role.)
○	○	○	3.17 Determine direction for tracking response cost and lost revenue implications associated with response.

Completed	In Progress	Not Started	Health Care Facility Activities
○	○	○	3.18 Determine incident management activation/configuration based on impact (phased approach) as well as incident action plan cycle and development process.
○	○	○	3.19 Identify SMEs to inform operational decisions and potential resource allocation decisions.
○	○	○	3.20 Determine methods for patient/family information provision including alternate languages/ interpretive services.
○	○	○	3.21 Determine staff communication mechanisms and redundant information management process.
○	○	○	3.22 Determine indicators and potential triggers for changing services provided (e.g., limit elective services).
○	○	○	3.23 Determine strategies to maintain services for at-risk patients during outbreak period (e.g., pregnant, dialysis) but unrelated to COVID-19.
○	○	○	3.24 Determine likely resource shortages and identify relevant vendor, cache, and coalition options for managing shortages.
○	○	○	3.25 Develop service restriction plans in case of staff shortages or increased demand (e.g., respiratory care, nutritional support, pharmacy, laboratory, radiology, elective surgeries/ procedures).
○	○	○	3.26 Develop/update crisis standard of care language in emergency operations plan including the potential for triage decision-making (who, process, communication, considerations) and staff management (how will staff expertise be maximally utilized vs. add additional training for some staff.
○	○	○	3.27 Evaluate the plan for providing just-in-time staff education via electronic and other non-classroom means including information about the COVID-19, transmission, infection prevention measures, usual clinical symptoms and course, risk factors, and complications.
○	○	○	3.28 Establish connection with homecare and long-term care partners to facilitate rapid discharge process from the hospital.

Completed	In Progress	Not Started	
○	○	○	3.29 Develop indicators and possible triggers for implementing alternate systems of care (including phone and web-based assessments as well as in-person care) including establishing health care system-based alternate care sites (e.g., on-site or managed completely by health care entity at owned and re-purposed site).
○	○	○	3.30 Develop indicators and possible triggers for establishing community alternate care sites in conjunction with public health and emergency management including what support may be required from the health care system.
○	○	○	3.31 Develop demand staffing plans for all categories of staff. Modify staff responsibilities and shifts as required (supervisory staff work clinically, suspend most education and other administrative burdens, determine where less-trained staff can safely provide support and the extent of family member support).
○	○	○	3.32 Engage union/labor leaders in relevant discussions of staff responsibilities and hours during pandemics.
○	○	○	3.33 Anticipate supply shortages and coordinate with vendors, the health care coalition, and emergency management to coordinate resource supply, distribution, and scarce resource strategies.
○	○	○	3.34 Develop a plan for implementing a supplemental facility security/controlled access plan (which may be phased) particularly during the peak pandemic weeks to assure controlled campus ingress and egress and monitoring.
○	○	○	3.35 Provide patients and staff with information about stress responses, resilience, and available professional mental health resources. Develop staff monitoring for those exposed to high levels of cumulative stress or specific severe stressors (death of co-worker, etc.).
○	○	○	3.36 Consider ways to maintain staff resilience and morale when congregate gatherings and close physical contact are discouraged. This may need to include memorial services for staff members.
○	○	○	3.37 Determine if the fatality management plan is sufficient for an increased volume of decedents at the facility.
○	○	○	3.38 Develop procedure for notifying the state agency for healthcare administration if licensed bed availability/capacity changes as a result of COVID-19.
Completed	**In Progress**	**Not Started**	**Emergency Department Activities**
○	○	○	3.39 Determine screening process and location (e.g., curb side screening prior to entry, supplemental screening at intake, etc.).
○	○	○	3.40 Determine how suspect cases will be isolated from other waiting patients and during ED care.
○	○	○	3.41 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.42 Develop referral plans for patients that do not need emergency care.

Completed	In Progress	Not Started	
○	○	○	3.59 Develop care plans that reduce the number of staff caring for suspect/confirmed cases and protocolize care.
○	○	○	3.60 Adjust daily nursing expectations/duties as required to meet demand.
○	○	○	3.61 Develop environmental services room decontamination and waste stream plans.
○	○	○	3.62 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.
○	○	○	3.63 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.64 Develop palliative care plans for implementation when needed.
Completed	**In Progress**	**Not Started**	**Outpatient Services/Community Health Centers/Free Standing Health Facilities Activities**
○	○	○	3.65 Develop staffing plan to allow for expanded service hours when needed. Determine if outpatient locations and services should remain open if the threat is too great to staff and patients.
○	○	○	3.66 Determine screening process and location (e.g., curbside screening prior to entry, supplemental screening at intake, separate well/ill clinics, etc.).
○	○	○	3.67 Develop telemedicine service plan for use for patients with special needs or general population.
○	○	○	3.68 Develop a plan to expedite medication refills, obstetrician visits, and other office visits prior to the arrival of COVID-19 cases in the community. The practice should have days to weeks to pre-emptively manage its workload in anticipation of limited elective services during the outbreak period.
○	○	○	3.69 Develop a process for screening and triage of phone and email requests for care to limit office visits to those that require an in-person provider evaluation.
○	○	○	3.70 Develop a process to limit/cancel non-essential visits which can 'flex' with the demands of the COVID-19 outbreak.
○	○	○	3.71 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies. Develop patient movement and transportation route plans.
○	○	○	3.72 Evaluate maximal use of space. Convert specialty clinics to acute care, extend hours, etc.
○	○	○	3.73 Consider which clinics may be converted into in-patient units (e.g., surgicenters).
○	○	○	3.74 Develop referral/deferral plans for patients that do not need acute care (e.g., perform virtual/telephone medication management, automate prescription refills).
○	○	○	3.75 Assure administrative engagement in decision-making/use of incident management to assure continuity and consistency between providers and agencies/facilities.

Completed	In Progress	Not Started	
○	○	○	3.76 Develop infection prevention plan for the clinic specific to COVID-19 and conduct education and develop signage and other necessary materials.
○	○	○	3.77 Create templated charts for COVID-19 patients including discharge instructions and prescriptions.
○	○	○	3.78 Create 'fast-track' or other methods for rapid evaluation and prescribing for minor illness.
○	○	○	3.79 Determine how suspect cases will be isolated from other patients in the clinic space.
○	○	○	3.80 Consider specific clinics designated for suspect cases, or specific hours for acute illness clinics.
○	○	○	3.81 Develop care plans that reduce the number of staff caring for suspect/confirmed cases and protocolize care.
○	○	○	3.82 Determine at-risk and functional needs populations that may be impacted and assure access to care.
○	○	○	3.83 Plan to provide just-in-time staff education via electronic and other non-classroom means including information about COVID-19 transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.
○	○	○	3.84 Determine potential indicators/triggers for alternate care systems (including telephone prescribing/encounters and early evaluation and treatment locations as needed).
○	○	○	3.85 Provide or develop patient resources on COVID-19 including transmission, prevention, usual clinical course, risks for more severe disease, and when to seek medical care. These materials should also encourage patients to have at least a 30 day supply of usual medications on hand.
○	○	○	3.86 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.87 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.

Completed	In Progress	Not Started	**Homecare Activities**
○	○	○	3.88 Determine incident management process and authorities; assure administrative engagement and support.
○	○	○	3.89 Establish prioritization process for homecare intake or ongoing services including denial and referral to other services. Adjust home visit schedules and responsibilities as required.
○	○	○	3.90 Establish liaison process with hospitals to share information on current and projected capacity and needs.
○	○	○	3.91 Establish liaison process with health care coalition to provide updates on capacity and assist with resource and staffing issues including the process for requesting additional resources from coalition partners or emergency management.

Completed	In Progress	Not Started	
○	○	○	3.92 Determine contingency staffing plan.
○	○	○	3.93 Address staff transportation-related issues that may be anticipated such as reduced access to fuel.
○	○	○	3.94 Develop/provide education to homecare professionals about COVID-19 transmission, and complications (in addition to infection control/staff safety information as outlined above).
○	○	○	3.95 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.96 Develop/provide just-in-time training to staff taking on non-traditional roles as required to maintain critical services. Coordinate with health care coalition to determine potential options.
○	○	○	3.97 Obtain or develop printed materials (including at appropriate reading level and in relevant languages) for clients including information about COVID-19 (including infection prevention measures and clinical disease), service modifications due to COVID-19, and resources. These materials should encourage patients to have at least a 30 day supply of usual medications on hand.
○	○	○	3.98 Determine how volunteer/other staff could contribute to homecare activities.
○	○	○	3.99 Establish telephone/virtual support for clients to provide information and 'check in' status.
○	○	○	3.100 Monitor clients for mental health related issues and provide information on normal stress responses.
○	○	○	3.101 Provide just-in-time staff education via electronic and other non-classroom means including information about COVID-19, transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.
○	○	○	3.102 Assure that at-risk individuals serviced (e.g., on home oxygen, dialysis patients, etc.) have ongoing access to appropriate services and are listed in an agency database for easy reference.
○	○	○	3.103 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.

Completed	In Progress	Not Started	**Long-term Care/Skilled Nursing Activities**
○	○	○	3.104 Determine incident management process and authorities; assure administrative engagement and support.
○	○	○	3.105 Liaison with the health care coalition/hospitals to assure maximal available residential beds.
○	○	○	3.106 Determine potential supply shortages and work with vendors and the health care coalition if resource availability is limited.
○	○	○	3.107 Develop a process to address shortages of supplies at the facility level including administration, nursing, medical direction, and subject matter expert input - ideally this can be a regional construct rather than at each facility.

Completed	In Progress	Not Started	
○	○	○	3.108 Develop a plan for more advanced care at the facility if hospital capacity is unavailable. This should involve nursing, medical direction, administrative representatives, and include consideration of telemedicine.
○	○	○	3.109 Determine any potential regulatory relief (CMS 1135 or other waivers, state regulations relief, staffing requirements, etc.) that may be needed to effectively respond to COVID-19 as well as issues regarding staff licensure/certification.
○	○	○	3.110 Determine with medical director and nursing director changes in thresholds for emergency department referral. These may vary across the period according to demand.
○	○	○	3.111 Evaluate potential staffing and responsibility changes and how less-trained staff and families could contribute to operations.
○	○	○	3.112 Evaluate potential staffing and responsibility changes and how less-trained staff and families could contribute to operations.
○	○	○	3.113 Develop a process for rapid credentialing and training of non-facility supplemental health care staff.
○	○	○	3.114 Develop infection detection process at the facility to promptly detect and isolate residents and staff with suspected COVID-19 and monitor their close contacts.
○	○	○	3.115 Emphasize hand and respiratory hygiene and other infection prevention techniques through education, policies, signage, and easy availability of supplies.
○	○	○	3.116 Develop visitor policies designed to minimize potential exposures (ideally consistent across the coalition) and communicate via physical (signs at entrances and on units) and electronic means. Determine if visitation should be restricted or stopped if threat is too high for patients and staff.
○	○	○	3.117 Communicate any change in services or policies to staff, residents, families, and the health care coalition.
○	○	○	3.118 Designate a point of contact for the health care coalition.
○	○	○	3.119 Designate a point of contact for family/resident information or questions.
○	○	○	3.120 Develop infection control/isolation plan for ill suspect or confirmed cases.
○	○	○	3.121 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.
○	○	○	3.122 Assure fatality management plans are appropriate to address potentially increased numbers of deaths during a COVID-19 outbreak.
○	○	○	3.123 Plan for providing just-in-time staff education via electronic and other non-classroom means including information about COVID-19 , transmission, infection prevention measures, usual clinical symptoms and course, treatment, risk factors, and complications.

Completed	In Progress	Not Started	Alternate Care Site/System Activities
○	○	○	3.124 Assure integration with public health and other health systems regarding consistent scripts for web and telephone based nurse triage lines/9-1-1 public safety answering points/ poison control centers/locally generated "apps" and integration with additional telephone/virtual prescribing - particularly for at-risk populations.
○	○	○	3.125 Determine support needed from the health care system for 'flu clinics' for early screening and treatment as planned by public health.
○	○	○	3.126 Understand/assist with plan for alternate care site(s) for hospital overflow - roles, responsibilities, authorities, staffing, material resources, criteria, level of clinical care (understanding that this may not be feasible if staff absenteeism is high at the hospitals).
○	○	○	3.127 Assure the specific needs of pediatric and at-risk populations are addressed in surge capacity planning.
○	○	○	3.128 Assure enough staff, supplies, prophylaxis, and logistical support are on hand before opening the site.
○	○	○	3.129 Provide patients and families with information about stress responses, resilience, and available professional mental health/behavioral health resources.

Comments: