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Louisiana Department of Health
Health Standards Section

TO: <u>**All**</u> Hospitals and Critical Access Hospitals

FROM: Cecile Castello, RN, Deputy Assistant Secretary, Health Standards Section

SUBJECT: Guidance for Infection Control and Prevention *of* Coronavirus Disease COVID-19) *in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs)*

DATE: April 1, 2020

The Louisiana Department of Health/Health Standards Section encourages all ESRD providers to monitor the CDC website for updated information and resources and contact the Louisiana Office of Public Health when needed (CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html)

<u>Guidance</u>

Hospitals*, psychiatric hospitals, and CAHs* should monitor the Centers for Disease Control and Prevention's (CDC) website (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html) for up-to-date information and resources *for the mitigation of transmission of COVID-19 for both inpatient and outpatient facilities.* They should contact their local health department if they have questions or suspect a patient or healthcare provider has COVID-19. Hospitals*, psychiatric hospitals, and CAHs* should have plans for monitoring healthcare personnel with exposure to patients with known or suspected COVID-19. Also, in light of limited staffing options, there should be a plan for how exposed or infected healthcare personnel may return to work. Additional information about monitoring healthcare personnel *and returning to work* is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html; https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

Hospital, Psychiatric Hospital, and CAH Capacity for Acute Inpatient Care and Excluded Psychiatric and Rehabilitation Units

CMS has waived a number of requirements under Section 1135 for all hospitals including CAHs and psychiatric hospitals. Current information on 1135 waivers available to all hospitals/CAHs and psychiatric hospitals can be found at: https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-

providers-fact-sheet.pdf and *https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page*

Guidance for *Mitigating Transmission and Preparing for Community Spread* of COVID-19 Addressing Patient Triage, Placement of Patients with known or suspected COVID-19, *Mitigation of Staffing Shortages (due to COVID-19 patient surges and/or staff becoming infected) and Expanded Visitation Recommendations*

If healthcare personnel have been exposed or infected with COVID-19, when can they return to work to prevent staffing shortages?

According to CDC, in hospitals where testing is available, it is suggested that test-based strategies are preferred.

1. *Test-based strategy. Personnel should be excluded from work until:*
   - *Resolution of fever without the use of fever-reducing medications, **and***
   - *Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and***
   - *Negative results of an FDA Emergency Use Authorized molecular assay for COVID-19 from at least two consecutive nasopharyngeal swab specimens collected ≥24 hours apart (total of two negative specimens)[1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).*
2. *Non-test-based strategy. Personnel should be excluded from work until:*
   - *At least 3 days (72 hours) have passed since recovery, defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,*
   - *At least 7 days have passed since symptoms first appeared.*

If healthcare personnel were never tested for COVID-19 but have an alternate diagnosis such has having tested positive for influenza, criteria for return to work should be based on existing guidance for that diagnosis.

Are there special considerations for previously exposed or infected healthcare personnel when returning to the workplace?
Before returning to work, exposed healthcare personnel should:
   - *Consult with their occupational health program, be monitored for symptoms, and seek re-evaluation from occupational health if fever and/or respiratory symptoms recur or worsen.*

For more information on self-monitoring please see:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Healthcare personnel with confirmed or suspected COVID-19 should consult with their occupational health program and follow the CDC Interim guidance on return to work.
https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html

What additional measures should a hospital, psychiatric hospital, or CAH consider for the mitigation of transmission in outpatient settings?

- *Reschedule non-urgent outpatient visits as necessary.*
- *Consider reaching out to patients who may be at a higher risk of COVID-19-related complications such as the elderly, those with medical co-morbidities, and potentially other persons who are at higher risk for complications from respiratory diseases, such as pregnant women to ensure adherence to current medications and therapeutic regimens, confirm they have sufficient medication refills, and provide instructions to notify their provider by phone if they become ill.*
- *Consider accelerating the timing of high priority screening and intervention needs for the short-term, in anticipation of the possible need to manage an influx of COVID-19 patients in the weeks to come.*
- *Symptomatic patients who need to be seen in a clinical setting should be asked to call before they leave home, so staff are ready to receive them using appropriate infection control practices, including providing a mask for the potentially infectious patient before or immediately upon entry into the healthcare facility, and personal protective equipment for the healthcare personnel.*

What additional measures should a hospital, psychiatric hospital or CAH consider for the mitigation of transmission in inpatient settings?

- *Reschedule elective surgeries, procedures, and other visits as necessary.*
- *Shift elective urgent inpatient diagnostic and surgical procedures to outpatient settings, when feasible.*
- *Maintain social distancing of at least six feet during group therapy interactions.*
- *Limit visitors to COVID-19 positive patients and persons under investigation (PUI).*
- *Plan for a surge of critically ill patients and identify additional space to care for these patients. Include options for:*
  - *Using alternate and separate spaces in the ER, ICUs, and other patient care areas to manage known or suspected COVID-19 patients.*
  - *Separating known or suspected COVID-19 patients from other patients ("cohorting").*
  - *Identifying dedicated staff to care for COVID-19 patients.*

Can an acute care inpatient be admitted to an excluded psychiatric unit to temporarily expand bed capacity?

Yes, CMS will allow acute care hospitals/CAHs with excluded distinct part psychiatric units that need to relocate acute care inpatients to excluded distinct part psychiatric units to provide care for overflow due to COVID-19 patients.

Can an acute care inpatient be admitted to an excluded rehabilitation unit to temporarily expand bed capacity?

Yes, CMS will allow acute care hospitals/CAHs with excluded distinct part inpatient rehabilitation units that need to relocate acute care inpatients to excluded distinct part rehabilitation units in order to provide care for overflow due to COVID-19 patients. The distinct part unit's bed must be appropriate for the acute care inpatient.

Can an inpatient of an excluded rehabilitation unit be admitted to an acute care inpatient unit to temporarily expand bed capacity?

Yes, CMS will allow acute care hospitals/CAHs with excluded distinct part inpatient rehabilitation units that relocate their inpatients to an acute care bed and unit units to provide care for overflow due to COVID-19 patients. This waiver may be utilized where the hospital/CAH's acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

Can an excluded unit psychiatric inpatient be admitted to an acute care inpatient unit to expand bed capacity?

Yes, CMS will allow acute care hospitals/CAHs with excluded distinct part inpatient psychiatric units to relocate their inpatients to an acute care bed and unit to provide care for overflow due to COVID-19 patients. This waiver may be used when the hospital/CAH's acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others receive safe and appropriate care.

Which patients are at risk for severe disease for COVID-19?
Based upon CDC data *https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html*, older adults and those with underlying chronic medical conditions or immunocompromised state may be most at risk for severe outcomes. This should be considered in the decision to monitor the patient as an outpatient or inpatient.

How should facilities screen visitors and patients for COVID-19?

Hospitals*, psychiatric hospitals, and CAHs* should identify visitors and patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility. They should ask patients about the following:
1. *Signs or symptoms of a respiratory infection, such as a fever, cough, or difficulty breathing.*
2. *Contact with a person who is positive for COVID-19 or with someone who is considered a PUI or someone who is ill with respiratory illness.*
3. *Travel within the last 14 days to areas with widespread or ongoing COVID-19 community spread. For updated information on countries and restricted areas*

within the U.S., visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html.
4. *Residence or working in a community where community-based spread of COVID-19 is occurring. For more information on mitigation plans for communities identified to be at risk, visit: https://www.cdc.gov/coronavirus/2019-ncov/community/index.html.*

For patients, implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient's nose and mouth if that has not already been done) and isolate the patient in an examination room with the door closed. If the patient cannot be immediately moved to an examination room, ensure they are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for COVID-19. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC COVID-19 website. *For more specific guidance see resource links.*

Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, facemasks, and tissues at healthcare facility entrances, waiting rooms, patient check-ins, etc.

How should facilities monitor or restrict healthcare facility staff?

The same screening performed for visitors should be performed for hospital*, psychiatric hospital, and CAH* staff.
- Healthcare providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:
    - Immediately stop work, put on a facemask, and self-isolate at home.
    - Inform the hospital*, psychiatric hospital, or CAH*'s infection *control professional/*preventionist and include information on individuals, equipment, and locations the person came in contact with.
    - Contact and follow the local health department recommendations for next steps such as testing and locations for treatment.
- Refer to the CDC guidance for exposures that might warrant restricting asymptomatic healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019- ncov/hcp/guidance-risk-assesment-hcp.html).

- *Report cases of illness to their supervisor, employee health service, and/or occupational health clinic. Employees should also consult their healthcare provider if they are experiencing signs/symptoms consistent with COVID-19*

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

Can hospitals continue to procure organs for organ donation?

Yes. Ensuring that individuals have continued access to life-saving organs is critical. We understand that hospitals are preparing for a surge in COVID-19 patients; however, we would ask that donor hospitals continue with normal operations in regards to allowing organ procurement coordinators into hospitals to discuss organ donation with families wherever possible. Hospital and Organ Procurement Organization (OPO) leadership should communicate on risk assessments in their communities and any potential impacts for organ recovery operations.

What are recommended infection prevention and control practices, including considerations for patient placement, when evaluating and care for patients with known or suspected COVID-19?

Recommendations for patient placement and other detailed infection prevention and control recommendations regarding hand hygiene, Transmission-Based Precautions, environmental cleaning and disinfection, managing visitors, and monitoring and managing healthcare personnel are available in the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons under Investigation for COVID-19 in Healthcare Settings.

Do all patients with known or suspected COVID-19 infection require hospitalization?

No. Patients may not require hospitalization and can be managed at home if they are able to comply with monitoring requests. More information is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

Are there specific considerations for patients requiring diagnostic or therapeutic interventions?

Patients with known or suspected COVID-19 should continue to receive the intervention appropriate for the severity of their illness and overall clinical condition. Because some procedures such as intubation create high risks for transmission additional precautions include: 1) HCP should wear all recommended *personal protective equipment (PPE),* 2) the number of HCP present should be limited to essential personnel, and 3) the room should be cleaned and disinfected in accordance with environmental infection control guidelines.

Additional information about performing aerosol-generating procedures is available here: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Please note that CDC has issued updated strategies for optimizing the use of facemasks. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html.

When is it safe to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19?

The decision to discontinue Transmission-Based Precautions for hospitalized patients with COVID-19 should be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. This decision should consider disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in respiratory specimens. More detailed information about criteria to discontinue Transmission-Based Precautions are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized- patients.html.

What are the considerations for discharge to a subsequent care location for patients with COVID-19?
The decision to discharge a patient from the hospital*, psychiatric hospital, or CAH* should be made based on the clinical condition of the patient. If Transmission-Based Precautions must be continued in the subsequent setting, the receiving facility must be able to implement all recommended infection prevention and control recommendations.

Although COVID-19 patients with mild symptoms may be managed at home, the decision to discharge to home should consider the patient's ability to adhere to isolation recommendations, as well as the potential risk of secondary transmission to household members with immunocompromising conditions. *Special consideration should be given to patients with psychiatric or cognitive disabilities to ensure they are able to adhere to the COVID-19 discharge recommendations and fully comprehend the significance of the precautions, or they have a family member or significant other involved to assist with these restrictions.* More information is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

What are the implications of the Medicare Hospital, *psychiatric hospital, Psychiatric Hospital, and CAH* Discharge Planning Regulations for Patients with COVID-19?

Medicare's Discharge Planning Regulations (which were updated in November 2019) require that *the* hospital*, psychiatric hospital, or CAH* assess the patient's needs for post-hospital*, psychiatric hospital or CAH* services, and the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any post-acute service provider. For COVID-19 patients, this must be communicated to the receiving service provider prior to the discharge/transfer and to the healthcare transport personnel.

Can hospitals*, psychiatric hospital, and CAHs* restrict visitation of patients?

Medicare regulations require a hospital*, psychiatric hospital, or CAH* to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital*, psychiatric hospital, or CAH* may need to place on such rights and the reasons for the clinical restriction or limitation. CMS sub-regulatory guidance identifies infection control concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital*, psychiatric hospital, and CAH* setting (for example, among patients, staff, and visitors) as well as between the hospital*, psychiatric hospital, and CAH* and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals*, psychiatric hospitals, and CAHs* should work with their local, state, and federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

Limiting visitors and individuals: Expanded recommendations:

CMS is providing the following expanded guidance for hospitals, psychiatric hospitals, and CAHs located in States with COVID-19 cases are present to prevent the spread of COVID-19:

   a) *Visitors should receive the same screening as patients, including whether they have had:*
   - *Fever or symptoms of a respiratory infection, such as a cough and difficulty breathing.*
   - *International travel within the last 14 days to CDC Level 3 risk countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html and for considerations after recent international travel visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html*
   - *Recent trips (within the last 30 days) on cruise ships. For updated information on recent cruise ship travel, visit the CDC website: https://wwwnc.cdc.gov/travel/page/covid-19-cruise-ship*
   - *Contact with someone with known or suspected COVID-19 or ill with respiratory illness.*
   - *Travel in the last 14 days within the United States to restricted areas. Information and guidance on restricted areas within the US, visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-in-the-us.html*

b) *Healthcare facilities should set limitations on visitation. For example, limitations may include restricting the number of visitors per patient, or limiting visitors to only those that provide assistance to the patient, or limiting visitors under a certain age.*

c) *Facilities must ensure patients have adequate and lawful access to chaplains or clergy in conformance with the Religious Freedom Restoration Act and Religious Land Use and Institutionalized Persons Act.*

d) *Healthcare facilities should provide signage at entrances for screening individuals, provide temperature checks/ ask about fever, and encourage frequent hand washing and use of hand sanitizer before entering the facility and before and after entering patient rooms*

e) *If visiting and not seeking medical treatment themselves, individuals with fevers, cough, difficulty breathing, body aches or runny nose or those who are not following infection control guidance should be restricted from entry.*

f) *Facilities should instruct visitors to limit their movement within the facility by reducing such things as walking the halls or trips to the cafeteria.*

g) *Facilities should establish limited entry points for all visitors and/or establish alternative sites for screening prior to entry.*

h) *Facilities can implement measures to:*
   - *Increase communication with families (phone, social media, etc.)*
   - *Potentially offer a hotline with a recording that is updated at set times so families can stay current on the facility's general status.*
   - *If appropriate, consider offering telephonic screening of recent travel and wellness prior to coming in for scheduled appointments. This may help limit the amount of visitor movement throughout the organization and congestion at entry points.*

i) *Consider closing common visiting areas and encouraging patients to visit with loved ones in their patient rooms.*

CDC Resources:
- *Coronavirus Disease 2019 (COVID-19) Hospital Preparedness Assessment Tool https://www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.html*
- CDC Resources for Health Care Facilities: https://www.cdc.gov/coronavirus/2019- ncov/healthcare-facilities/index.html
- CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html
- CDC FAQ for COVID-19**:** https://www.cdc.gov/coronavirus/2019-ncov/infection- control/infection-prevention-control-faq.html
- CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID19) or Persons Under Investigation for COVID-19 in Healthcare Settings.: https://www.cdc.gov/coronavirus/2019- ncov/infection-control/controrecommendations.html?CDC_AA_refVal=. https%3A%2F%2Fwww.c dc.gov%2Fcoronavirus%2F2019-ncov%2Fhcp%2Finfection-control.html
- Health Department Directories: https://www.naccho.org/membership/lhd-directory

CDC Updates:

https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html

Mental Health Resources:
SAMHSA has developed guidelines for Psychiatric Hospitals which can be found here:
https://www.samhsa.gov/sites/default/files/covid19-interim-considerations-for-state-psychiatric-hospitals.pdf

CMS Resources:
CMS has additional guidance which may be beneficial to hospitals*, psychiatric hospitals, and CAHs* related to *screening patients for COVID in alternate locations, Emergency Medical Treatment and Labor Act (EMTALA)* requirements and other topics surrounding the health and safety standards during emergencies:
https://www.cms.gov/files/document/qso-20-15-hospitalcahemtala.pdf

The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency All-Hazards are located at https://www.cms.gov/Medicare/Provider- Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

Effective Date: Immediately.

Please contact the Health Standards Section with any questions you may have regarding the regulatory responsibilities regarding these guidances. You may call the main desk at 225-342-0138 or email your questions to the applicable program manager for this provider type.

Also, please contact the Office of Public Health should you have any questions regarding the management of COVID-19. That number is 800-256-2748.