Checklist for Hospital Investigation for COVID-19

* Identify if patient arrived by personal vehicle, EMS, or other means (If EMS, will need to reach out to service for contacts and PPE/IPC measures used)
* Identify all healthcare personnel (HCP) who have had contact with patient or in patient room since admission
	+ Providers, nurses, medical assistants, patient care techs, EVS, dietary services, radiology staff, contracting staff (who removes sharps containers, etc), security officers, chaplains, behavioral therapists, clerks, other ancillary staff with access to patients. Include laboratory staff who have processed patient specimens
		- Consider time stamps on entrance, triage, move to room, admit or transfer to floor to narrow list and identify all
		- Consider security footage review for areas of patient movement to ensure all HCP identified
	+ Determine exposure risk of all identified HCP (if capacity allows)
		- Identify staff/POC to perform HCP risk assessments
		- Use HCP risk assessment tool: attached
		- Use CDC interim HCP guidance to determine risk category: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
	+ Determine your policy for work restriction of HCP based on risk-assessment
		- Identify staff/POC for HCP to communicate work restriction policy and recommendations
		- CDC provides best practice recommendations for Medium or High Risk exposures to be work restricted
		- CDC also provides allowances for return to work of Medium or High Risk HCP who are asymptomatic if these individuals are needed to continue facility functions. (See table below)
			* This is specific for areas with community transmission, which is currently ongoing in Chicago.
		- CDC provides best practice guidance on symptom monitoring with delegated supervision
			* In Chicago, this can involve entry of HCP names and contact information into a RedCap Database which will then provide twice daily email symptoms monitoring
			* **All HCP regardless of exposure should be screened for symptoms before shifts to ensure that no HCP work if they have fever or respiratory symptoms**
			* Send email list of occupational health staff performing monitoring to CDPH for access to RedCap database and to enroll exposed HCP. CDPH will provide Standard Operating Procedure as well
	+ If HCP reports symptoms, call HCP to review to determine if testing is indicated. Call the HCP’s local health department to review and make determination.
	+ If HCP becomes a PUI during monitoring, HCP should be isolated at home until testing can be performed. Facility can contact HCPs local health department to obtain authorization code (or use a commercial laboratory). Facility should lead testing logistics, CDPH will facilitate.
	+ If a patient becomes a PUI and has negative testing for COVID-19, their original recommendations for work restriction (if implemented) will resume based on their risk assessment and initial instructions.
	+ Occupational health staff should monitor RedCap entries to ensure HCP are completing. Local health departments have access to this
* Identify patients with potential exposure to patients with COVID-19
	+ This can include those in emergency or clinic waiting rooms, in shared spaces such as non-private patient rooms, physical therapy areas, radiology areas
		- Consider using time stamps for ED entry, triage, room assignment, appointment times, etc.
		- Consider security footage to identify other patients within close proximity to patients with COVID-19
	+ Patients should be instructed to monitor for fever or respiratory symptoms for 14 days from last exposure and to call their healthcare provider to discuss if testing indicated.
* Return to work policies
	+ Healthcare facility staff/POC should communicate return to work processes to HCP.

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| **Table: Considerations for HCP Return-to-Work**  |
| **Exposure, Illness, & Work Exclusion**  | **Return-to-work Recommendations**  |
| **HCP exposed to known case (hospital or community)**  | **HCP symptomatic**  | **Work Exclusion**  | **When can HCP return to work?**  | **Additional Considerations**  |
| Yes, and HCP not tested  | No  | No – but symptom monitor for 14 days after last exposure.  | Immediately as long as asymptomatic.  | CDPH does not recommend that asymptomatic HCP be tested for COVID-19; they should be allowed to work as long as symptom monitoring is ongoing through occupational health.  |
| Yes, and HCP not tested  | Yes  | Yes  | Whichever is longer: 14 days from exposure **or** 7 days after symptom onset **and** 72 hours after recovery\*  | The longer 14-day period accounts for sequential respiratory illness or co-infection. Existing sick policies should be used for determining time from symptom resolution to potential return to work. Symptom screen should occur before return to work.  |
| Yes, and HCP COVID-19 test is positive  | Yes/No  | Yes  | Whichever is longer: 7 days after symptom onset **and** 72 hours after recovery\*  | Symptom screen should occur before return to work.  |

\*recovery is defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath). Lingering cough should not prevent a case from being released from isolation.