

COVID-19 Outbreak Response in Non-Medical Congregate Settings

Provider/Facility Guide

January 13, 2021

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Purpose

To help providers plan and implement appropriate responses when COVID-19 cases occur in non-medical congregate settings (e.g., group homes, residential care homes, treatment facilities, etc.). Level of state support to the setting may vary depending upon size of facility, scope of outbreak, and availability of in-house expertise. May include onsite assistance, targeted service support, or remote consultation, as necessary.

Process

When a positive COVID-19 case in either residents or staff is reported at a non-medical congregate facility, the provider should complete the attached Outbreak Response Checklist. The checklist corresponds to the attached Outbreak Response Manual with detailed information in each area. If further support is required in any of the response categories, the provider should contact the state's COVID community support team (DPH.CommunitySupport@ct.gov), the local public health entity, and the appropriate state agency lead if one exists (i.e., the lead from the state agency that primarily funds the program) for an outbreak assessment and discussion of next steps.

Definitions

Cleaning and Disinfection: Cleaning is the process of physically removing dirt and pathogens. Disinfection is the process of killing pathogens.

Close contact¹: Within 6 feet of someone with confirmed or probable COVID-19 during their infectious period for a cumulative total of 15 minutes or more over a 24-hour period. The infectious period for COVID-19 starts from 2 days before illness onset (or, for asymptomatic individuals, 2 days prior to positive test specimen collection) until the criteria for lifting isolation has been met.² Isolation is lifted when the individual is no longer infectious to others.

Cohort, cohorting: placing residents and providing services to residents separated by COVID status; usually known COVID infected and potentially infectious residents are physically separated from other residents not thought to be infected at all times. Cohorting both staff and residents (not just residents) is most effective for outbreak control, if possible.

Confirmed COVID-19 case: A finding of a positive SARS-CoV-2 diagnostic test result (antigen or molecular/PCR, not antibody) in an individual with or without signs and symptoms.

¹ <https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact>

² <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>

Contact tracing: The process of informing people who have been identified as having close contact with someone who has tested positive for COVID-19 that they might have been exposed and that they should quarantine.

Face mask: A facial covering, meant to be worn over the nose and mouth. There are differences in recommended use between cloth face coverings, surgical face masks, and N95 respirators.

Facility: The physical location where the outbreak is happening.

High risk: Individuals are defined as at high risk for severe illness from COVID-19 if they are 65+ years old, pregnant, or have certain underlying medical conditions.³

Infection control: Measures to prevent and control the spread of infections (e.g., masks for source control, PPE, hand hygiene, environmental cleaning, physical separation).

Isolation: Separation of infectious individuals with COVID-19 from individuals who are not infected. Isolation for COVID-19 lasts⁴:

- At least 10 days have passed since symptoms first appeared AND
- At least 24 hours has passed without fever without the use of fever-reducing medications AND
- Improvement of symptoms.

After this period, the individual is no longer considered infectious.

Non-medical congregate living setting: A setting in which people stay overnight together and medical care is not routinely provided. Examples may include: group homes, residential care homes, substance use treatment facilities, halfway houses, homeless shelters, and youth camps.

Outbreak in a congregate living setting: In a congregate living setting, a single case of COVID-19 among a staff or resident should be considered an outbreak and trigger an outbreak response. An outbreak ends when 2 incubation periods (28 days total for COVID-19) has passed without a new-onset case of COVID-19 among residents or staff.

Personal protective equipment (PPE): Equipment worn to protect the wearer from exposure to hazards that cause serious workplace injuries and illnesses (e.g., masks, gloves, gowns, eye protection).

Person Under Investigation (PUI) for COVID-19: An individual who has symptoms suggestive of COVID-19, whether or not they had significant known exposure to the virus.

Provider: The party responsible for managing the facility.

Quarantine: Separation and restriction of movement of people potentially exposed to COVID to see if they become sick. Lasts for 14 days.

Resident: Someone staying overnight in a facility in order to receive services offered there.

³ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>

⁴ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>

SARS-CoV-2 aka COVID-19: Severe acute respiratory syndrome coronavirus 2, the strain of coronavirus that causes coronavirus disease 2019 (also referred to as COVID-19).

Staff: Any person working at the facility full time, part time, or on contract.

Staffing shortage contingency or crisis capacity strategies⁵: Strategies for a facility experiencing shortages of *essential* on-site staff to ensure continued resident safety and supports. These are not without risk.

Levels of Support

The following levels of support may be considered based on the outbreak assessment: remote consultation, targeted service support, onsite outbreak management. The determination of the appropriate level of state support will be made by the state community support team, in consultation with the requesting provider and the appropriate state agency.

Remote Consultation

A provider may be connected with subject matter experts in the response areas in need of support for remote consultation (email, telephone, or teleconference).

Targeted Service Support

A provider may be connected with an Outbreak Rapid Response Team or subject matter experts, as appropriate, to deliver onsite targeted support in identified areas of need. For instance, a provider may only need short-term testing support to begin the cohorting process or may primarily need connection to short-term replacement staff to address shortages.

Onsite Outbreak Management

A contracted Outbreak Rapid Response Team may be deployed to provide full onsite outbreak management. Support could include onsite assessment, clinical expertise, testing support, and service coordination. The team may provide some combination of supports, as appropriate:

- Rapid testing (usually antigen-type testing)
- Molecular (e.g., PCR) testing
- Staff to collect specimens and/or administer tests
- Medical provider responsible for ordering testing and reporting results to public health authorities
- Staff to provide infection control consultation and assist in organizing implementation of recommendations (e.g., isolation/quarantine, contact tracing, environmental cleaning, etc.)
- Staff to coordinate and make connections to additional supports as needed (e.g., direct care, wraparound services, care coordinators, ongoing testing providers, transportation, environmental cleaning, other local supports)

⁵ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

In extraordinary circumstances, the state community support team may support providers in accessing offsite isolation (more information provided in the manual). The community support team may also consider requests for funding for costs associated with managing an outbreak.

Agency Leads

If a residential setting requires support in any of the checklist categories (below/attached), the facility should contact three parties simultaneously for an outbreak assessment and discussion of next steps:

- the state community support team (DPH.CommunitySupport@ct.gov) AND
- the local public health authority (find yours here: <https://portal.ct.gov/DPH/Local-Health-Admin/LHA/Local-Health-Administration---Site-Map>) AND
- if the facility is funded by or affiliated with a state agency, the appropriate lead below.

Agency	Lead	Email	Phone
DMHAS	Nancy Navarretta	Nancy.navarretta@ct.gov	860-418-6952
	Mary Kate Mason	Mary.mason@ct.gov	860-418-6839
DDS	Katie Rock-Burns	Kathryn.rock-burns@ct.gov	860-418-8762
DCF	Linda Dixon	linda.dixon@ct.gov	860 550-6383
DSS	Nicole Godburn	Nicole.godburn@ct.gov	860-424-5390
	Krista Pender	Krista.pender@ct.gov	
DOH	Steve DiLella	Steve.dilella@ct.gov	860-205-0981
Judicial	Mary Phalstaf	Mary.phalstaf@jud.ct.gov	860-368-4343

Outbreak Response Checklist *(for providers)*

This checklist should be used to identify whether a facility experiencing an outbreak might require additional support. Reviewing this checklist *before and outbreak happens* can help prepare facilities to appropriately respond to an outbreak. See Attachment A for a printable format.

Each section corresponds to further detail in the Outbreak Response Manual below. If there is further need for support in any area, the provider should contact the contact the state community support team (DPH.CommunitySupport@ct.gov) and appropriate state agency lead for an outbreak assessment.

Testing

- Can testing be administered or arranged **IMMEDIATELY** after a single case of COVID-19 is found among a resident or staff member?
- Can rapid testing be administered or arranged to help with resident cohorting?
- Can molecular (e.g., PCR) testing be administered or arranged, either as a primary testing strategy or a follow-up testing strategy where indicated after rapid testing?
- Can testing be administered or arranged on an at-least-weekly basis until 14 days without new-onset staff or resident cases?

Isolation/Quarantine/Cohorting

- Can residents be cohorted to adequately quarantine/isolate within the facility?
 - If yes, are there enough staff to maintain appropriate care for each cohort?
 - If no, is there access to an offsite quarantine/isolation facility? Is there enough staff to maintain appropriate care in both facilities?
- Is there access to diagnostic testing with a rapid (less than a day) turn-around-time to inform effective cohorting?
- Do staff understand the concept of cohorting and how to do so effectively?

Contact Tracing

- Are facility leadership/staff aware of the latest guidelines for who is considered a [close contact](#)? (within 6 feet of an infected person for a cumulative total of 15 minutes or more of a 24-hour period starting from 2 days before illness onset)
- Are knowledgeable staff available to conduct contact tracing or support the local health department/state contact tracing staff through communications with residents and staff, supplying information on facility layout and room assignments, and rosters of residents and staff participating in group sessions and any set mealtimes?

Staffing

- What percentage of staff are currently unable to work on-site? This may include staff out due to infection/isolation, exposure/quarantine, or other matters.
 - What percentage of your staff have been identified as exposed?

- Have return-to-work dates been determined?⁶
- Are all exposed staff able to quarantine for 14 days, or must [contingency or crisis capacity strategies to mitigate staffing shortages](#) be implemented (not without risk)?
- Can alternate housing be offered to staff who are working at the facility?
- Is there a mechanism to quickly bring on additional staffing (e.g., contract with a temp service, agreements between providers, etc.) should it be needed?

Environmental Cleaning

- Has a cleaning and disinfection plan been developed?⁷
- Have staff been trained in adequate cleaning and disinfection protocols?
- Are disinfectants effective against COVID-19 from EPA List N available?⁸
- Have high-touch surfaces been identified?

Personal Protective Equipment (PPE)

- Have staff been trained in appropriate *choice* of PPE and how to safely put it on and take it off (*donning and doffing*)?⁹
- Is appropriate PPE in sufficient quantities onsite for staff working with residents with COVID-19 or PUIs? (eye protection, N95 respirators, gowns, gloves)
- Is there access to the appropriate PPE for the duration of the outbreak? See definition of “outbreak”: until 28 days have passed without a new-onset case among residents or staff.
- Have staff been fit tested for N95 respirators? Have they been fit-tested for the respirator models on-hand? If not, can you arrange for fit testing? (Please note: N95s should be used in the context of a facility’s OSHA-compliant respiratory protection plan)
- Are there the appropriate hand hygiene and cleaning supplies onsite?

If the facility will be requesting an outbreak assessment, the provider should be prepared to provide the following additional information to the state agency lead.

Facility Information

- Provider name
- Facility name and address
- Contact list
 - Contact information
 - Responsibilities by person
 - Identification of primary outbreak lead
- Type of facility
 - Size
 - Mission

⁶ https://portal.ct.gov/-/media/DPH/HAI/COVID19-Provider-Memo-RTW_11242020.pdf

⁷ <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>

⁸ <https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19>

⁹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>

- Type of rooms (i.e., dorm, single rooms, shared rooms)
- General layout (shared space, bathrooms, etc.)
- Total number of residents
- Total number of staff
- Outbreak description
 - Residents:
 - # total residents (census)
 - # COVID-positive, along with date(s) of symptom onset and specimen collection date(s)
 - # in isolation and description of isolation location (ok to room multiple residents with COVID-19 together)
 - # hospitalized with COVID-19
 - # of deaths associated with COVID-19
 - # recovered¹⁰
 - Staff:
 - # total staff, including roles
 - # COVID-positive, along with date(s) of symptom onset and specimen collection date(s)
 - # in isolation and description of isolation location
 - # hospitalized with COVID-19
 - # of deaths associated with COVID-19
 - # recovered¹⁰

Program Information

- List of direct care/supports provided onsite (e.g., ADLs, medication administration, behavioral health support, specialized medical support, specialized clinical support)
- Number of hours per day setting is staffed
- Licenses required for staff
- Facility/agency licenses (e.g., with DPH FLIS)
- List of ancillary services provided onsite (e.g., food preparation, telehealth, case management)

¹⁰ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>

Outbreak Response Manual (*for providers*)

Testing

Once a single positive case has been identified at your facility, staff should report this to the local health department.

Once a positive case is reported, the facility should support testing for all residents and staff.

- Facility-wide testing of all clients and staff is recommended where a case of COVID-19 has been identified.
 - Work with partners to offer diagnostic testing as soon as possible to all clients and staff who were at the site during the time period from 48 hours before symptom onset of the person diagnosed with COVID-19 until they were isolated.
 - It may not be possible to provide testing to every individual who might have been exposed, but the intent is to broadly offer testing to anyone who might have been exposed.
- Repeat testing of all previously negative or untested clients and staff (e.g., once a week) is recommended until the testing identifies no new cases of COVID-19 over at least 14 days since the most recent positive result.
- Follow-up testing is recommended for anyone who was not tested or tested negative if they develop symptoms of COVID-19 at any time.

The sooner testing is completed for all residents in the facility, the faster the outbreak can be contained. Rapid testing is encouraged when molecular testing turn-around-times is longer than 48 hours.

Type and Frequency of Testing

There are two primary types of COVID-19 diagnostic tests:

- **Molecular tests (i.e., PCR tests):** these tests are highly accurate as they detect viral RNA, but most at this time must be lab processed, so they take longer to produce a result.
- **Antigen tests:** these tests detect viral antigens and are often read onsite, so they produce rapid results, but may be less sensitive. Particularly in an outbreak setting, positive results are considered to be accurate, but negative results may miss infectious cases. When prevalence is low (pretest probability is low), positive antigen test results may need to be confirmed with a molecular test.

Recommendations on testing frequency may vary depending upon the circumstance. Once someone tests positive, they should not be retested for 3 months unless *new* symptoms develop.

Offsite Testing

If possible, residents and staff may be transported to offsite community-based testing sites. See CT 211 for testing sites:

www.211ct.org/covidtesting

Follow guidelines on safely transporting residents and staff to testing sites.

- Transport residents from each cohort separately.
- Provide as much space between riders as possible (ideally, at least 6 feet).
- Increase the number of vehicles and the frequency of trips to limit the number of people in a vehicle.
- All passengers and drivers should wear face coverings when in the vehicle.
- All passengers and drivers should use hand sanitizer before entering the vehicle and when arriving at destination.

See CDC guidelines for cleaning and disinfecting transport vehicles:

<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/disinfecting-transport-vehicles.html>

See job aide for carpooling tips: <https://www.cdc.gov/coronavirus/2019-ncov/downloads/community/organizations/carpooling-fs.pdf>

Onsite Testing

Contact the state community support team (DPH.CommunitySupport@ct.gov) and appropriate state agency lead if you need assistance with procurement and implementation of onsite testing. Various factors may impact onsite testing options available for your facility, including:

- Availability of ordering provider
- CLIA Certificate of Waiver for the facility (for rapid testing)
- Availability of staff to facilitate onsite sample collection
- Ability to comply with reporting requirements

Isolation/Quarantine/Cohorting

General cohorting guidelines

Residents should cohort by their COVID-19 status:

- **Group 1 (Individuals that are infectious with COVID-19):** Residents that are COVID-19 positive, whether they have symptoms or not, can be isolated together during their infectious period.¹¹ Individuals who have recovered from COVID-19 are unlikely to be re-infected in the following 3

¹¹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>

months, and can share a room with *any* of the resident groups if needed during the 3-month period following infection.

- **Group 2 (Individuals who may develop COVID-19 during 14-day period after exposure):** Residents exposed to COVID-19, but do not show symptoms, tested negative or have not yet been tested, should quarantine away from others.
 - Ideally, people who are quarantining should not share rooms. Having 2 or more individuals who are quarantining together in a room or bathroom is not without risk, even if they shared an exposure. One of the roommates may develop COVID-19, while the other may not.
 - If someone who is quarantining must share a bathroom with others, bathroom surfaces should be wiped down between uses, and only one person should be allowed in the bathroom if masks must come off (for example, when brushing teeth).
 - When a resident from this group develops symptoms consistent with COVID-19, they should be isolated (like Group 1) and tested as soon as possible.
- **Group 3 (unexposed individuals):** Residents not exposed to COVID-19 and not showing symptoms can remain together with no need for isolation or quarantine. Infection control measures such as physical distancing, frequent hand washing, and wearing a face covering over the nose and mouth should be maintained as much as possible. When a resident becomes symptomatic, they should be isolated away from others and tested as soon as possible.

Additional control measures may include increasing ventilation, scheduled staggered use of common areas, or others. See CDC's guidance for Households Living in Close Quarters:

<https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/living-in-close-quarters.html>

When residents are symptomatic

Isolate symptomatic residents, whether or not they have been tested for COVID-19.

- Symptomatic residents should be isolated and tested for COVID-19. While awaiting test results and ongoing if results are positive:
 - Residents who are being tested or who test positive should not leave the facility.
 - Arrange for the safe delivery/provision of food, medications, and other supports onsite.
- Rapidly move residents with any COVID-19 symptoms into a designated isolation area that is separated from the rest of the facility, if possible.
 - It should be a separate building, room, or designated area, away from asymptomatic residents, ideally with a separate bathroom.
 - Place clear signage outside all isolation areas indicating that it is the isolation space for COVID+ residents.
 - If there is no way for symptomatic clients to reside in separate rooms or buildings, partitions (e.g., linen, dressers, etc.) should be constructed to create as much of a barrier as possible.
- A designated restroom should be identified and reserved for use by symptomatic individuals only. If this is not possible, cleaning after the room has been used by a symptomatic person is essential.
- If symptomatic residents need to move through common areas, they should wear a mask and minimize the time in these areas.

- Symptomatic/COVID positive residents should eat meals separately from residents without symptoms.
 - If dining space must be shared, stagger meals so symptomatic residents are not eating with asymptomatic residents and clean after use by each group.
- Mobile screens (or other ways to form partitions – linens, etc.) should be used to encourage compliance with separation in shared spaces.
- Minimize the number of staff members who have face-to-face interactions with residents with symptoms and cohort these staff away from other residents if possible. Provide instructions to all staff to prevent disease spread, including hygiene, appropriate PPE, and housekeeping best practices.
- Resident isolation may be discontinued when the following conditions are met:
 - At least 10 days have passed since symptoms first appeared AND
 - At least 24 hours has passed without fever without the use of fever-reducing medications AND
 - Improvement of symptoms.
- Staff should keep a daily log of all residents in isolation to monitor symptoms and determine termination of isolation.¹²
- If a symptomatic resident fits into a high-risk group, encourage them to call or facilitate a call to their primary care provider if their symptoms worsen or notify a staff member to call 911. When calling 911, staff members must notify the dispatcher that this person has COVID-19 symptoms or has tested positive.

Seek immediate medical attention by calling 911 for any of these COVID-19 emergency warning signs:

- Trouble breathing
- Persistent pain or pressure in the chest
- New confusion or inability to arouse
- Bluish lips or face

When staff are symptomatic

- Staff should monitor their symptoms at least daily and be encouraged to stay home if they are ill. If rapid testing is available onsite, test prior to departure. If symptoms occur offsite, staff should not come to the facility.
- Staff with symptoms of COVID-19 should be provided with home isolation instructions and instructed to stay home (if symptoms begin offsite) or go home (if symptoms begin onsite) to self-isolate and to notify their healthcare provider. If staff is tested offsite, they should notify the facility of the result.

When staff are exposed

Quarantine exposed residents who have come in close contact with a symptomatic person.

¹² https://portal.ct.gov/-/media/DPH/HAI/COVID19-Provider-Memo-RTW_11242020.pdf

- Close contact is defined as contact within 6 feet of someone with COVID-19 (symptomatic or asymptomatic) for a total of 15 minutes or more over the course of 24 hours starting from two days before illness onset until the time of isolation.
- Residents who have been exposed should quarantine for 14 days after last exposure.
 - Do not allow resident to leave the facility.
 - Arrange for the safe delivery/provision of food, medications, and other supports onsite.
- Anyone who had contact with body fluids and/or secretions of someone infectious with COVID-19 (they were coughed on/sneezed on, shared utensils or saliva) or provided direct clinical care to someone with infectious COVID-19 without wearing full PPE (mask, gloves, gown, eye protection), also needs to quarantine.
- The contact may have been with a staff or resident of the facility or with someone outside the facility (family, community, etc.).
- The contact may have occurred while the infected person was symptomatic OR up to 48 hours (two days) BEFORE the infected person showed symptoms (or within 2 days prior to specimen collection date of COVID-positive specimen if the person showed no symptoms).
- Self-quarantine should be for 14 days from last contact with someone with COVID-19.
 - If a resident begins to show symptoms during the quarantine period, consider the person to be a presumptive positive case even if not tested or testing negative, and the guidelines for isolation described above apply. The resident's isolation period should be counted from the start of symptoms rather than the start of their quarantine period.

Quarantine exposed staff who have come in close contact with symptomatic residents or staff.

- Staff who have been exposed should be sent home to quarantine or placed in onsite quarantine for 14 days.
- The guidelines for staff quarantine are the same as those for residents (above).
- **However**, in times of extreme workforce shortage, asymptomatic staff who were exposed *can* continue to work PROVIDED there are additional protective measures in place:
 - Surgical face mask **MUST** be worn *appropriately* over mouth and nose at all times while at work for 14 days.
 - Symptom monitoring (including fever) occurs at least twice daily. An acceptable practice would be to monitor symptoms and take temperature once before coming to work and approximately twelve hours later.
 - Frequent handwashing. Internal auditing of handwashing and other control strategies.

Return from quarantine guidelines:

- If resident or staff member never experiences symptoms or tested positive:
 - May return after 14 days.
 - Shortened quarantine is not recommended in congregate living settings, particularly in settings where high-risk individuals are housed.
- If resident or staff member never experiences symptoms but tests positive (asymptomatic positive):
 - May discontinue isolation when at least 10 days have passed since the date of their positive COVID-19 diagnostic test and if they continue to have no symptoms.
 - During staffing crises, those who are asymptomatic and COVID-positive may need to work. Use CDC strategies for mitigating staffing shortages:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

- If resident or staff member develops symptoms:
 - At least 10 days have passed since symptoms first appeared AND
 - At least 24 hours has passed without fever without the use of fever-reducing medications AND
 - Improvement of symptoms.

When offsite isolation space is needed

Every effort should be made to maintain the residents onsite using the isolation/quarantine/cohorting guidance presented above, particularly when wraparound services or treatments are available at the facility. If onsite isolation/quarantine/cohorting is impossible, consider the needs of the specific population. For example:

1. Residents who have alternative housing and could be served by telehealth-based treatment and delivery of other basic needs if available.
2. Residents who lack alternative housing but could be well served by telehealth-based treatment and delivery of other basic needs if housing could be provided.
3. Residents who lack alternative housing but have limited treatment needs and could be well served with housing and delivery of basic needs.
4. Residents who have support needs of such depth that onsite care is necessary.

Contact the state community support team (DPH.CommunitySupport@ct.gov) and appropriate state agency lead to access available resources for the specific needs of the population.

Contact Tracing

Close contact for COVID-19 is defined as contact:

- Within 6 feet of someone infectious with COVID-19
- For a cumulative total of 15 minutes or more over a 24-hour period
- Starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the end of the isolation period.

Any residents or staff meeting these criteria should be notified and directed to quarantine, as defined above, and get tested. Contact tracing should be initiated as soon as the positive case is known and no later than 48 hours after. Local health and/or state contact tracers will be activated by the positive test results. The facility should be prepared to partner with the contact tracers as they conduct their work.

Community Outreach Specialists (COS's) are available to conduct the contact tracing if residents speak Spanish, Portuguese, Haitian Creole, or Polish, or if the facility residents include vulnerable populations (e.g., people experiencing homelessness, individuals in recovery from substance use, individuals with developmental disabilities, individuals living in group homes, etc.)

To request COS support or general contact tracing support, the facility manager should contact the state community support team (DPH.CommunitySupport@ct.gov) and appropriate state agency lead.

Staffing

Outbreaks can have a significant impact on staffing in non-medical congregate settings. If positive cases are handled appropriately early, it can reduce further spread within the facility and improve staffing. Facilities should also plan for emergency staff, including recruiting former or retired employees, temporary staffing agencies, furloughed staff from other programs, working with local public health to identify any local staffing resources, or others.

In times of extreme workforce shortage, asymptomatic staff who were exposed can continue to work PROVIDED they wear a surgical mask at all times while at work for 14 days and other control measures are in place (as mentioned above). Asymptomatic staff who were exposed and continue to work should self-monitor for symptoms of COVID-19. They should self-monitor for symptoms twice daily – once before coming to work and approximately twelve hours later.

For additional CDC guidance on contingency and crisis capacity staffing measures during staffing shortages, please see: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

Contact the state community support team (DPH.CommunitySupport@ct.gov) and appropriate state agency lead if you need assistance with a staffing shortage.

Environmental Cleaning

Facilities should have a plan to ensure proper cleaning and disinfection of environmental surfaces (including high touch surfaces such as light switches, bed rails, bedside tables, etc.) and equipment in the patient room.

- All staff with cleaning responsibilities should understand the contact time for the cleaning and disinfection products used in the facility (check containers for specific guidelines).
- Ensure shared or non-dedicated equipment is cleaned and disinfected after use according to the manufacturer's recommendations.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19.
 - For a list of EPA-registered disinfectants that have qualified for use against COVID-19 go to: <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>
- Set a protocol to terminally clean rooms after a resident is discharged from the facility. If a known COVID-19 resident is discharged or transferred, staff should refrain from entering the room until sufficient time has elapsed for enough air exchanges to take place (more information on air exchanges at <https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb6>)

See CDC Cleaning Guidelines Here:

- <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html>
- <https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html>

Personal Protective Equipment (PPE)

Non-medical congregate settings should establish protocols about proper use of personal protective equipment (PPE). In general, staff and residents (as possible) should wear a facemask at all times while they are in the facility.

- Regular in-servicing, emphasizing the potential to self-contaminate when doffing (taking off) PPE, can improve appropriate PPE use.
- When available, facemasks are generally preferred over cloth face coverings for staff as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others.
- **Cloth face coverings should NOT be worn by staff instead of a respirator or facemask if PPE is required.**
- Masks with exhalation valves or vents should not be used as they do not provide adequate source control for respiratory droplets.

While staff not providing physical care to patients should maintain distance and wear a facemask, according to the CDC, the PPE recommended when providing physical care for a patient with known or suspected COVID-19 includes:

- **Respirator or Facemask covering nose and mouth (need to follow OSHA standards to use respirators, such as “N95s”)**
- **Eye Protection** (i.e., face shield that covers the front and sides of the face OR goggles)
- **Gloves**
- **Isolation Gown**

Staff should be trained and have practiced prior to caring for a resident, including attention to correct use of PPE and prevention of contamination of clothing, skin, and environment during the process of removing such equipment.

See CDC guidance on PPE here:

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

Additionally, Hand and Respiratory Hygiene strategies should be implemented.

- Hand hygiene (HH) – washing hands with soap and water or using hand sanitizer – should be supported for staff and residents.
- Staff members should perform HH before and after ALL resident encounters and should also use HH at the beginning of their shifts, before and after eating, after using the restroom, and at other times throughout the day.
- Make sure HH supplies, such as soap and water or alcohol-based hand sanitizer, are readily accessible, including in areas where PPE is removed.
- Sinks should be well-stocked with soap and paper towels. Hand sanitizers should be replaced as needed.
- Facilities should have a process for auditing adherence to recommended HH practices by staff.

- Respiratory hygiene/cough etiquette – covering mouth and nose with a tissue when coughing, disposing of tissue, performing HH – should be supported for residents and staff.

Attachment A: Outbreak Response Checklist *(for providers – print format)*

This checklist should be used to identify whether a facility experiencing an outbreak might require additional support. Reviewing this checklist *before and outbreak happens* can help prepare facilities to appropriately respond to an outbreak. See Attachment A for a printable format.

Each section corresponds to further detail in the Outbreak Response Manual below. If there is further need for support in any area, the provider should contact the contact the state community support team (DPH.CommunitySupport@ct.gov) and appropriate state agency lead for an outbreak assessment.

Testing

- Can testing be administered or arranged **IMMEDIATELY** after a single case of COVID-19 is found among a resident or staff member?
- Can rapid testing be administered or arranged to help with resident cohorting?
- Can molecular (e.g., PCR) testing be administered or arranged, either as a primary testing strategy or a follow-up testing strategy where indicated after rapid testing?
- Can testing be administered or arranged on an at-least-weekly basis until 14 days without new-onset staff or resident cases?

NOTES:

Isolation/Quarantine/Cohorting

- Can residents be cohorted to adequately quarantine/isolate within the facility?
 - If yes, are there enough staff to maintain appropriate care for each cohort?
 - If no, is there access to an offsite quarantine/isolation facility? Is there enough staff to maintain appropriate care in both facilities?
- Is there access to diagnostic testing with a rapid (less than a day) turn-around-time to inform effective cohorting?
- Do staff understand the concept of cohorting and how to do so effectively?

NOTES:

Contact Tracing

- Are facility leadership/staff aware of the latest guidelines for who is considered a [close contact](#)? (within 6 feet of an infected person for a cumulative total of 15 minutes or more of a 24-hour period starting from 2 days before illness onset)
- Are knowledgeable staff available to conduct contact tracing?
- Are you prepared to support the local health department/state contact tracing staff through communications with residents and staff, supplying information on facility layout and room assignments, and rosters of residents and staff participating in group sessions and any set mealtimes?

NOTES:

Staffing

- What percentage of staff are currently unable to work on-site? This may include staff out due to infection/isolation, exposure/quarantine, or other matters.
 - What percentage of your staff have been identified as exposed?
 - Have return-to-work dates been determined?
 - Are all exposed staff able to quarantine for 14 days, or must [contingency or crisis capacity strategies to mitigate staffing shortages](#) be implemented (not without risk)?
- Can alternate housing be offered to staff who are working at the facility?
- Is there a mechanism to quickly bring on additional staffing (e.g., contract with a temp service, agreements between providers, etc.) should it be needed?

NOTES:

Environmental Cleaning

- Has a cleaning and disinfection plan been developed?
- Have staff been trained in adequate cleaning and disinfection protocols?
- Are disinfectants effective against COVID-19 from EPA List N available?
- Have high-touch surfaces been identified?

NOTES:

Personal Protective Equipment (PPE)

- Have staff been trained in appropriate *choice* of PPE and how to safely put it on and take it off (*donning and doffing*)?
- Is appropriate PPE in sufficient quantities onsite for staff working with residents with COVID-19 or PUIs? (eye protection, N95 respirators, gowns, gloves)
- Is there access to the appropriate PPE for the duration of the outbreak? See definition of “outbreak”: until 28 days have passed without a new-onset case among residents or staff.
- Have staff been fit tested for N95 respirators? Have they been fit-tested for the respirator models on-hand? If not, can you arrange for fit testing? (Please note: N95s should be used in the context of a facility’s OSHA-compliant respiratory protection plan)
- Are there the appropriate hand hygiene and cleaning supplies onsite?

NOTES: