DRAFT FOR PILOT

Infection Prevention and Control Assessment Tool (Tele-ICAR)

Attached is an infection control assessment and response tool (ICAR) that can be used to help nursing homes prepare for COVID-19. This tool may also contain content relevant for assisted living facilities. The items assessed support the key strategies of:

- Keeping COVID-19 out of the facility
- Identifying infections as early as possible
- Preventing spread of COVID-19 in the facility
- Assessing and optimizing personal protective equipment (PPE) supplies
- Identifying and managing severe illness in residents with COVID-19

The areas assessed include:

- Visitor restriction
- Education, monitoring, and screening of healthcare personnel (HCP)
- Education, monitoring, and screening of residents
- Ensuring availability of PPE and other supplies
- Ensuring adherence to recommended infection prevention and control (IPC) practices
- Communicating with the health department and other healthcare facilities

Findings from the assessment can be used to target specific IPC preparedness activities that nursing homes can immediately focus on while continuing to keep their residents and HCP safe.

Additional Information:

- The assessment includes a combination of staff interviews and direct observation of practices in the facility and can be conducted in-person or remotely (e.g., Tele-ICAR via phone or video conferencing). Provide a copy of the tool to the facility before completing the Tele-ICAR and encourage nursing home staff to take their own notes as you conduct the assessment.
- Background information in the grey boxes above each section being assessed provides context for the ICAR user. This information does not need to be read during the assessment process but can be referred to for additional information.
- Assessments can be conducted by state or local health department (HD) staff, or a designee such as a volunteer or student, even if they do not have an extensive IPC background. The goal is to convey key messages to nursing homes and identify COVID-19 specific preparedness needs. IPC questions and concerns can be noted and addressed after the ICAR is completed.
    - Individuals completing the assessment should be given a brief introduction to COVID-19, nursing homes, and how to use of the tool. Resources are available on the CDC website, including current guidance, a nursing home pre-recorded webinar, and additional tools.
    - Engage state HD HAI/AR Program leads for additional support and technical assistance if required for the facility.
- Assessment activities provide an opportunity for dialogue and information sharing.
    - Discuss the purpose of the assessment and emphasize that it is not a regulatory inspection and is designed to ensure the facility is prepared to quickly identify and prevent spread of COVID-19.

    - Promote discussion by asking additional questions to prompt or probe. Use this opportunity to address concerns and offer available resources.
    - In an effort to help volunteers and health department staff facilitate conversations with facilities, sample questions are provided in italics above each element being assessed. These do not need to be asked, however, they offer suggestions to help continue the discussion.
- Be aware of applicable federal, state, county, or city rules, regulations such as CMS requirements for nursing homes and life safety code, and state government proclamations that may affect implementation of recommended practices.
- Provide feedback or a high-level summary immediately after the assessment including elements in place and areas for improvement.
    - Consider scanning and providing a copy of your assessment tool or a brief summary with feedback, answers to the facility's questions, and recommended next steps directly to the facility within 2-3 days.
- Schedule a follow-up call with the facility, such as within the next week, after the assessment findings are shared.

Investigator: _____ Date: _____

Good morning/afternoon. My name is _____ and I am calling from the _____ Department of Health. May I speak with someone who is in charge of infection prevention and control (IPC) at your facility?

Greetings, ____. My name is _____ and I am calling to discuss infection prevention and control (IPC) preparedness activities that your facility can immediately put into place to combat COVID-19 while continuing to keep your residents and healthcare personnel safe. I would like to go through an IPC consultation with you and your team, that is non-regulatory in nature and meant to be helpful. Is now a good time to talk? If not, when would work best?

Great. As background, infection control assessment and response surveys, also referred to as ICARs (eye-cars), were developed by CDC to help health departments assess IPC practices and guide quality improvement activities. ICARs are particularly useful for stopping the spread of pathogens during outbreaks. ICAR findings will be shared between the health department's Healthcare Associated Infections Program and CDC.

Before we begin, may I get your name and contact information. Is there another person at your facility who would be the primary contact for the health department? If yes, can I get their information also?

Demographics:

Facility POC Name: _____

Facility POC Title: _____

POC Phone: _____

POC E-mail Address: _____

Facility Name: _____

Facility County: _____

- Number of beds in the facility: _____
- Total number of residents in the facility: _____
- Total number of staff in the facility: _____
- Total number of units: _____
  - Specialty Units (check all that apply): ☐ Vent/trach ☐Dialysis ☐Dementia/Memory ☐Skilled Nursing ☐ Subacute Rehab ☐ Psychiatric care

    These units have residents at higher risk for poor outcomes. Vent/trach units provide respiratory support and dementia/memory units are often secured, and limit resident movement to other locations.

Which of the following situations apply to the facility? (Select all that apply)

□ No cases of COVID-19 currently reported in the surrounding community
□ Cases reported in the surrounding community
□ Sustained transmission reported in the surrounding community
□ Cases identified in their facility (either among HCP and/or residents). If yes, please specify the number of cases among residents ____ and among HCPs _____
□ Cluster of ILI in facility (either among HCP and/or residents).
Among residents ____ Among HCPs _____

Have you received any prior information specific to prevention transmission of COVID-19? (Select all that apply)

□ No
□ Yes, from the health department
□ Yes, from Centers for Medicare and Medicaid Services (CMS)
□ Yes, from another source

Visitor restrictions and non-essential person restrictions:

Both CDC and CMS recommend restricting all visitors to nursing homes to prevent COVID-19 from entering the facility. Exceptions for compassionate care, such as end-of-life situations, may be considered on a case-by-case basis. All visitors should first have temperature and symptom screening (e.g., cough, shortness of breath, sore throat, muscle aches) to safeguard residents. Ill visitors should not enter. Visitors who are granted access should perform frequent hand hygiene, wear a cloth face covering (for source control), and conduct their visit in a location designated by the facility such as the resident's room. Additional best practices include designating a single entrance for visitors, posting signage at entrances to the facility, and providing communication to residents and families.

Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**
What is your current policy for visitors? **Facility restricts all visitation except for certain compassionate care situations, such as end-of-life situations.**		
Are there any exceptions to your visitation policy? What are those exceptions? **Decisions about visitation are made on a case-by-case basis.**		
If visitors are allowed in, what screening occurs? **Potential visitors are screened prior to entry for fever or symptoms of COVID-19. Those with symptoms are not permitted to enter the facility.**		
Are there any restrictions or requirements on visitors once they enter? Do you provide them with any additional information on hand hygiene? **Visitors that are permitted inside, must wear a cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. They are also reminded to frequently perform hand hygiene.**		
What is your policy for volunteers or non-medical service providers like a beautician, barber, or massage therapist?		

Non-essential personnel including volunteers and non-medical service providers (e.g., salon, barbers) are restricted from entering the building		
What has your facility done to communicate with family members of residents? What have you told family members about visiting? **Facility has sent a communication (e.g., letter, email) to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end-of-life, and that alternative methods for visitation such as video conferencing will be made available by the facility.**		
Is the facility offering alternative means of communication instead of visits? What are those? **Facility has provided alternative methods for visitation such as video conferencing for residents.**		
Are there signs to prevent entrance into the facility (e.g., no visitors)? **Facility has posted signs at entrances to the facility advising that no visitors may enter the facility.**		
Education, monitoring, and screening of healthcare personnel (HCP) ***Education*** *of HCP (including consultant personnel) should explain how the IPC measures protect residents, themselves, and their loved ones, with an emphasis on hand hygiene, PPE, and* ***monitoring*** *of their symptoms. Consultant personnel are individuals who provide specialized care or services (for example, wound care or podiatry) to residents in the facility on a periodic basis. They often work at multiple facilities in the area and should be included in education and screening efforts as they can be exposed to or serve as a source of pathogen transmission. If HCP work while ill, they can serve as a source of pathogen transmission within the facility. HCP should be reminded not to report to work when ill. All HCP should self-monitor when they are not at work and be* ***actively screened*** *upon entering the facility. Ideally, this would occur at the entrance to the facility, before they begin their shift. Screening includes temperature check and asking about symptoms like subjective fever, new or worsening cough, difficulty breathing, sore throat, and muscle aches. If they have a fever of 100.0 F or higher or symptoms, they should be masked and sent home. Because symptom screening will not identify individuals who are infected but otherwise asymptomatic or pre-symptomatic, facilities should also implement universal source control policies requiring anyone in the facility to wear a facemask or cloth face covering. When available, facemasks are generally preferred over cloth face coverings for HCP 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 instead of a respirator or facemask if more than source control is required.*		
Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**
Have you provided any in-service training or education to the staff due to COVID-19? What was included in those? **Facility has provided education and refresher training to HCP (including consultant personnel) about the following:** • **COVID-19 (e.g., symptoms, how it is transmitted)** • **Sick leave policies and importance of not reporting to or remaining at work when ill** • **New policies for source control while in the facility**		

Do you ever audit or record performance of things like hand hygiene? Selection and use of personal protective equipment? Environmental cleaning? **Facility monitors HCP adherence to recommended IPC practices, including:** • **Hand hygiene** • **Selection and use of PPE; have HCP demonstrate competency with putting on and removing PPE** • **Cleaning and disinfecting environmental surfaces and resident care equipment**		
Have you made any changes to the policies at your facility in light of COVID? What has your facility done? **Any changes to usual policies/procedures in response to PPE.**		
What is your current staffing capacity? **Facility is aware of staffing needs and has a plan in the event of staffing shortages.**		
What is the current policy for facemasks for staff inside the facility? What do you tell staff about wearing facemasks in common work areas with only co-workers present? If you are running low on facemasks, do you have a plan for when and which staff might use cloth face coverings for source control instead (those not providing direct care)? **Facility has implemented universal use of facemasks or cloth face coverings for HCP (for source control) while in the facility.** **Facility has provided staff with education to use facemask or respirator if more than source control is required.** If there are shortages of facemasks, facemasks should be prioritized for HCP and then for residents with symptoms of COVID-19 (as supply allows). Cloth face coverings are not considered PPE and should not be worn instead of a respirator or facemask if more than source control is required.		
What is the facility encouraging for staff in terms of social distancing? **All HCP are reminded to practice social distancing when in break rooms and common areas.**		
Have you started staff screening or check-ins? How does that work? Is this kept in a log? What do you do if someone has a fever or symptoms? **All HCP (including ancillary staff such as dietary and housekeeping and consultant personnel) are screened at the beginning of their shift for fever and symptoms of COVID-19 (actively records their temperature and documents absence of shortness of breath, new or change in cough, sore throat, and muscle aches).** • **If they are ill, they are instructed to keep their cloth face covering or facemask on and leave the facility. HCP with**		

suspected or confirmed COVID-19 should notify their supervisor at any facility where they work.		
Has your facility had any symptomatic staff? How are they tracked or monitored? **Facility keeps a list of symptomatic HCP**		

Education, monitoring, and screening, and cohorting of residents

Education of residents and their loved ones should include an explanation of steps the facility is taking to protect them and how visitors can serve as a source of pathogen transmission. The facility should ask residents to report if they feel feverish or have respiratory symptoms. They should actively monitor all residents upon admission and at least daily for fever and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If they have a fever (temperature of 100.0 F or higher) or symptoms, they should be restricted to their room and put into appropriate Transmission-Based Precautions. Group activities such as communal meals, religious gatherings, classes, and field trips should be stopped to promote social distancing (residents remaining at least 6 feet apart from one another).

Facilities should plan to dedicate space to care for residents with COVID-19 before they have an active case. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19 and would have dedicated HCP to deliver care within this space. Another consideration is how to manage new admissions or readmissions when COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected. If an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved from their rooms to this location while undergoing evaluation.

All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn by HCP when PPE is indicated.

Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**
Have you provided any education to your residents on ways they can protect themselves (like washing hands, visitor restriction, social distancing)? **Facility has provided education to residents about the following:** • **COVID-19 (e.g., symptoms, how it is transmitted)** • **Importance of immediately informing HCP if they feel feverish or ill** • **Actions they can take to protect themselves (e.g., hand hygiene, covering their cough, maintaining social distancing)** • **Actions the facility is taking to keep them safe (e.g., visitor restrictions, changes in PPE use, canceling group activities and communal dining)**		
Are you screening residents? How are you screening them/what questions are you asking them? How often? What is included?		

Facility assesses residents for fever and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches) upon admission and at least daily throughout their stay in the facility. • **Residents with suspected COVID-19 are immediately placed in appropriate Transmission-Based Precautions.** *Note*: Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.		
Are you keeping track of residents who are symptomatic? How? **Facility keeps a list of symptomatic residents (link to respiratory infection surveillance tool):** https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf)		
Has your facility made any changes to group activities (e.g., communal dining, religious activities [mass at Catholic facilities], gyms) or field trips? **Facility has stopped group activities inside the facility and field trips outside of the facility.**		
How are residents receiving meals? Has anything changed with communal dining? **Facility has stopped communal dining.**		
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) *What is happening with resident movement in the facility? Are residents advised to stay in their rooms? Are they required to wear a facemask if they leave their rooms?* **Residents are encouraged to remain in their rooms.** • **If there are cases in the facility, residents are restricted (to the extent possible) to their rooms except for medically necessary purposes.** • **If residents leave their rooms, they wear a cloth face covering or facemask, perform hand hygiene, limit movement in the facility, and perform social distancing.**		
What is being done to try and limit the number of people entering resident rooms, particularly if you have any symptomatic residents? **Facility bundles resident care and treatment activities to minimize entries into resident rooms, for example, by having clinical staff clean and disinfect high-touch surfaces when in a room.**		

How are ill residents monitored? How often are they monitored? What is included (e.g., symptoms, vitals, temp, SpO2, respiratory exam)? • **The facility monitors ill residents at least 3 times daily including evaluating symptoms, vital signs, oxygen saturation via pulse oximetryto identify and quickly manage clinical deterioration.**		
If there is a case within the facility in the future, have you made a plan for where the resident with COVID-19 will be placed? **Facility has dedicated a space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.** *How will this dedicated space be staffed?* **Facility has dedicated a team of primary HCP staff to work only in this area of the facility.**		
What is your plan for handling a resident who may have COVID-19? What is your plan for movement? What is your plan for testing? **Facility has a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive).** Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them.		
What is your plan for managing new admission or readmissions when the resident's COVID-19 status is unknown? What PPE will be worn when caring for residents who have unknown COVID-19 status and are under observation? **Facility has a plan for managing new admissions and readmissions whose COVID-19 status is unknown.**		
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community **Facility uses all recommended PPE for the care of all residents on affected units (or facility wide depending on the situation).** Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained		

transmission in the community. The health department can assist with decisions about testing of asymptomatic residents.		
Availability of PPE and Other Supplies *Major distributors in the United States have reported shortages of PPE. Shortages of alcohol-based hand sanitizers and refills and certain disinfectants have also been reported. Facilities should assess their current supplies of PPE and other critical materials as soon as possible and begin implementing strategies to optimize their current supply of PPE (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html). Examples of strategies described in those documents include extended use of facemasks and eye protection, which allow the same facemask and eye protection to be worn for the care of more than one resident. Gowns could be prioritized for select activities such as activities where splashes and sprays are anticipated (including aerosol generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP. If a facility anticipates or has a shortage, they should engage their health department and healthcare coalition for assistance.* ▪ *Link to identifying your state HAI coordinator: https://www.cdc.gov/hai/state-based/index.html* ▪ *Link to healthcare coalition/preparedness: https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx* *Disinfectants used at a facility should be EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2. List N on the EPA website lists products that meet EPA's criteria for use against SARS-CoV-2 (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2)*		
Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**
How is your current supply of: facemasks and respirators; gowns; gloves; eye protection? Does your facility have enough supply of facemasks and respirators (gowns, gloves, etc.) for the next 1-2 weeks? **Facility has assessed current supply of PPE and other critical materials (e.g., alcohol-based hand sanitizer, EPA-registered disinfectants, tissues). (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html)**		
What is your facility doing to try and conserve PPE? Are you aware of the recommendations to conserve PPE? Do you have a backup plan if you don't have enough? **If PPE shortages are identified or anticipated, facility has engaged their health department and/or healthcare coalition for assistance.**		
Facility has implemented measures to optimize current PPE supply (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html).		
Where is your PPE located? Is it readily available for staff that need it? **PPE is available in resident care areas including outside resident rooms.** • **PPE here includes: gloves, gowns, facemasks, N-95 or higher-level respirators (if facility has a respiratory protection program and HCP are fit-tested) and eye protection (face shield or goggles).**		

How much disinfectant does your facility have on hand? Do you expect a shortage? **EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2 are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.**		
Are trash cans accessible throughout the facility? What about tissues? **Tissues and trash cans are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.**		

Infection Prevention and Control Practices

Alcohol-based hand sanitizer (ABHS) is the preferred method of hand hygiene; however, sinks should still be stocked with soap and paper towels. Hand hygiene should be performed in the following situations: before resident contact, even if PPE is worn; after contact with the resident; after contact with blood, body fluids, or contaminated surfaces or equipment; before performing aseptic tasks; and after removing PPE.

Recommended PPE when caring for residents with suspected or confirmed COVID-19 includes gloves, gown, N-95 or higher-level respirator (or facemask if respirators are not available or HCP are not fit-tested), and eye protection (face shield or goggles). PPE should be readily available outside of resident rooms, although the facility should consider assigning a staff member to shepherd supplies and encourage appropriate use.

All EPA-registered, hospital-grade disinfectants have a contact time which is required to kill or inactivate pathogens. Environmental surfaces must remain wet with the product for the entire contact time duration to work appropriately. Contact times range from 30 seconds to 10 minutes. Keeping a surface wet for 10 minutes is seldom accomplished. It is important for facilities to know that their product is appropriate (List N as above) and is being used for the entire contact time. Also, it is helpful for the facility to assign responsibility for cleaning and disinfection of specific surfaces and equipment (who cleans what).

Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**
When, during patient care, is hand hygiene expected? **HCP perform hand hygiene in the following situations:** • **Before resident contact, even if gloves will be worn** • **After contact with the resident** • **After contact with blood, body fluids, or contaminated surfaces or equipment** • **Before performing an aseptic task** • **After removing PPE**		
What does your facility recommend for hand hygiene? Is there a preference for soap and water or alcohol-based hand sanitizer? **Facility has preference for alcohol-based hand sanitizer over soap and water**		

What PPE is being used by HCP caring for anyone with suspected or confirmed COVID-19 **HCP wear the following PPE when caring for residents with suspected or confirmed COVID-19** • **Gloves** • **Isolation gown** • **N-95 or higher-level respirator (or facemask if a respirator is not available)Eye protection (goggles or face shield)** •		
How are staff taught to remove PPE? **PPE are removed in a manner to prevent self-contamination and hand hygiene is performed.**		
What product do you use for alcohol-based hand sanitizer – do you know the alcohol percentage? Are you experiencing any shortages in alcohol-based hand sanitizer? If so, how are you addressing? **Hand hygiene supplies are available in all resident care areas.** • **Alcohol-based hand sanitizer* with 60-95% alcohol is available in every resident room and other resident care and common areas.** ***If there are shortages of alcohol-based hand sanitizer, hand hygiene using soap and water is still expected.**		
Do you ever audit or record performance of things like hand hygiene? Selection and use of personal protective equipment? What do you do if you see someone not washing their hands appropriately? **Hand hygiene and PPE compliance are audited.**		
How often are shared equipment like blood pressure cuffs/machines cleaned? These need to be cleaned after every patient use. Who is responsible for that? Are you able to dedicate equipment to residents that may be symptomatic or a case like thermometers, BP cuffs, and stethoscopes? **Non-dedicated, non-disposable resident care equipment is cleaned and disinfected after each use.**		

What disinfectant is used at your facility? Is this ready-to-use (premixed) or does it need to be diluted by your staff? Have you checked to see if that product is effective for coronavirus (EPA List N)? **EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim* against SARS-CoV-2 are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.** • ***See EPA List N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2** • **Name of EPA-registered disinfectant used in facility:** **_____**		
What is the contact time for the product? Remember that the contact time is how long a disinfectant needs to remain on a surface for it to be effective. The surface needs to be wet the entire time. Contact times can range from 30 seconds to 10 minutes; often the product is dry after 1-2 minutes so this means reapplying more until that contact time is met. [If they have a 10 minute product] Please make sure your staff are aware of that time and use it appropriately or consider changing to another product with a shorter time. **Facility is aware of the contact time for the EPA-registered disinfectant and shares this information with HCP.**		
Are disinfectants ready-to-use or do you have to mix/dilute them at the facility? How are they mixed/diluted? **EPA-registered disinfectants are prepared and used in accordance with label instructions.**		
Communication *Communicating is essential during an outbreak—with HCP, residents, families, the health department, transport personnel, and receiving facilities. Facilities should notify the health department about any resident with severe respiratory infection resulting in hospitalization or death, any resident or HCP with suspected or confirmed COVID-19, or if the facility identifies 3 or more cases of respiratory illness among residents and/or HCP in 72 hours. These situations should prompt further investigation and testing for SARS-CoV-2. Should a higher level of care be indicated for a resident with suspected or confirmed COVID-19, the facility should communicate this information with transport personnel, the receiving facility, and the health department.*		
Elements to be assessed	**Assessment (Y/N)**	**Notes/Areas for Improvement**

Have you ever talked to the health department before for your facility? Why? Moving forward, what would make you reach out to the health department now? You should reach out if you have a known or suspected case in a resident or healthcare provider; if you have a resident with a severe respiratory infection; or a cluster of new-onset respiratory symptoms among residents and or staff. Generally, we say 3 or more over the course of three days. **Facility notifies the health department about any of the following:** • **COVID-19 is suspected or confirmed in a resident or HCP** • **A resident has severe respiratory infection resulting in hospitalization or death** • **A cluster of new-onset respiratory symptoms among residents or HCP (≥3 cases over 72 hours)**		
If you have known or suspect cases of COVID-19, how do you plan to communicate this with staff? With residents? With family members? **Facility has process to notify residents, families, and staff members about COVID-19 cases occurring in the facility.**		
What about if you transfer a known or suspect case to the hospital, do you have a way to communicate their status to EMS; outpatient facility like dialysis or transfusion clinic; hospital? **Facility communicates information about known or suspected residents with COVID-19 to appropriate personnel (e.g., transport personnel, receiving facility) before transferring them to healthcare facilities such as dialysis and acute care facilities.**		

Duration of call: _____