UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ENZO COSTA, *et al.*, Plaintiffs, v. BARBARA BAZRON, *et al.*, Defendants.	Civil Action No. 19-3185 (RDM)

DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER

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INTRODUCTION

Plaintiffs seek a temporary restraining order (TRO) against the District of Columbia, Department of Behavioral Health Director Barbara Bazron and Saint Elizabeths Hospital CEO Mark Chastang (collectively, the District), requiring that specific measures be implemented at Saint Elizabeths Hospital (Saint Elizabeths, or the Hospital) in response to the COVID-19 pandemic. In short, the majority of the measures plaintiffs seek are already in place. In light of this fact, plaintiffs cannot demonstrate irreparable harm absent a TRO, which would not significantly alter current operations at the Hospital. In addition, plaintiffs are unlikely to succeed on the merits of their claims under the Due Process Clause or the Americans with Disabilities Act (ADA), and they have not shown that the balance of the equities and the public interest weigh in their favor.

Throughout this pandemic, Saint Elizabeths has implemented a variety of patient-protection protocols amid a fast-moving informational landscape and evolving recommendations from public health experts nationwide. Given that the Hospital is already implementing the majority of the measures plaintiffs seek, there is no preliminary relief appropriate for this Court to grant. Plaintiffs' motion for a TRO should be denied.

BACKGROUND

I. COVID-19 in the District of Columbia

On March 7, 2020, officials announced the District's first confirmed case of COVID-19, an infectious respiratory illness caused by the novel coronavirus that has

spread rapidly across the globe since its first detection in humans in late 2019. *See* Press Release, Gov't of the District of Columbia, DC Department of Health Confirms First Coronavirus Case (March 7, 2020), available at https://coronavirus.dc.gov/release/dc-department-health-confirms-first-coronavirus-case; D.C. Health, COVID-19 FAQs, available at https://coronavirus.dc.gov/node/1464356. Although the virus's sufferers have exhibited a range of symptoms or none at all, severe cases have been known to cause shortness of breath, pneumonia and even death. *Id.* The World Health Organization (WHO) has declared the spread of COVID-19 a global pandemic. *See* "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, March 11, 2020, available at https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020.

Since early March 2020, U.S. cities and states have ordered the closure of schools and non-essential businesses, banned large gatherings and recommended that individuals who do not live in the same household abide by now-familiar "social distancing" measures where feasible. *See, e.g.*, Jesse McKinley and Michael Gold, *Ban on Large Gatherings in N.Y. as Coronavirus Cases Rise Sharply*, N.Y. Times, March 12, 2020, available at https://www.nytimes.com/2020/03/12/nyregion/coronavirus-nyc-event-ban.html; Dominic Fracassa, *SF bans large gatherings as nation moves to confront pandemic*, San Francisco Chronicle, March 11, 2020, available at

https://www.sfchronicle.com/bayarea/article/Mayor-London-Breed-bans-all-large-gatherings-15123312.php. The District is no exception. On February 28, 2020, more than a week before the District recorded its first case of COVID-19, Mayor Muriel Bowser issued an order preemptively activating the District's Emergency Operations Center and requiring all District agencies to ensure they had up-to-date plans for emergency operations. *See* Mayor's Order 2020-035, February 28, 2020, available at https://dchealth.dc.gov/sites/default/files/dc/sites/doh/page_content/attachments/2020-035-District-Government-Preparation-for-the-Coronavirus-COVID-19.pdf.

While the District prepared in earnest, events unfolded quickly. By March 11, 2020, Mayor Bowser issued a Declaration of Public Emergency and a Declaration of Public Health Emergency based on the WHO declaration of a pandemic, as well as on the outbreaks seen in other cities throughout the world. *See* Mayor's Order 2020-045, March 11, 2020, available at https://mayor.dc.gov/sites/default/files/dc/sites/mayormb/release_content/attachments/MO.DeclarationofPublicEmergency03.11.20.pdf; Mayor's Order 2020-046, March 11, 2020, available at https://mayor.dc.gov/sites/default/files/dc/sites/mayormb/release_content/attachments/MO.DeclarationofPublicHealthEmergency03.11.20.pdf. Both Declarations have since been extended through at least May 15, 2020, and the District remains under a stay-at-home order. *See* Mayor's Order 2020-063, April 15, 2020, available at https://coronavirus.dc.gov/sites/default/files/dc/sites/coronavirus/publication/attachments/MayorsOrder2020.063.pdf.

Despite federal, state and local government efforts across the country, COVID-

19 has continued to spread rapidly, generating immense demand for protective face masks, gloves, hand sanitizer and other products used to limit transmission of pathogens; a shortage of all these items has resulted. *See* United States Conference of Mayors, "Shortages of COVID-19 Emergency Equipment in U.S. Cities: A Survey of the Nation's Mayors," March 27, 2020, available at https://www.usmayors.org/issues/covid-19/equipment-survey/ (noting, for example, that 91.5% of cities surveyed do not have an adequate supply of face masks for their first responders). This case arises in the context of an unprecedented response to an unprecedented situation.

II. COVID-19 Response at Saint Elizabeths Hospital

Saint Elizabeths Hospital, overseen by the District of Columbia Department of Behavioral Health (DBH), is the District's only public psychiatric facility for individuals with serious and persistent mental illness requiring intensive inpatient care to support their recovery. Declaration of Philip Candilis (Candilis Decl.), Ex. 1 ¶ 2. The Hospital is licensed to house 292 patients in 12 different units, with an average daily patient census of approximately 275. Declaration of Rich Gontang (Gontang Decl.) Ex. 2 ¶ 6. Each unit at the Hospital generally houses no more than 27 patients, and has bedrooms, common living areas, bathrooms and showering facilities, and dining areas. *Id.*

Assigned to each unit is a designated treatment team consisting of a variety of professionals devoted to the care of each patient in that unit. Gontang Decl. ¶ 11. Each treatment team consists of a clinical administrator that is responsible for

coordinating all care, a psychiatrist responsible for psychiatric treatment and medication, a social worker responsible for discharge planning, and a registered nurse responsible for daily nursing care. *Id.* Each unit also has a general medical officer or nurse practitioner to assist with medical issues, and a psychologist. *Id.* Other specialists such as neurologists are available throughout the Hospital as needed. *Id.*

Saint Elizabeths generally admits three categories of patients: (1) pre-trial patients; (2) post-trial patients adjudicated not guilty by reason of insanity (NGBRI) in criminal court proceedings; and (3) civilly committed patients admitted through the civil commitment process. Candilis Decl. ¶ 6. Since Mayor Bowser declared a District-wide public health emergency on March 11, 2020, the population at Saint Elizabeths has been significantly reduced; the population stands at 226 patients as of April 20, 2020, down from 277 on February 1, 2020. Declaration of Martha Pontes (Pontes Decl.), Ex. 3, ¶ 4. This reduction has been the result of both reduced admissions and increased patient discharges to the community. *See* Candilis Decl. ¶ 7; Gontang Decl. ¶ 7.

Saint Elizabeths is unique among healthcare facilities in that it is foremost a psychiatric treatment facility but also houses pre-trial defendants and shares similarities with long-term nursing facilities. Gontang Decl. ¶ 5. COVID-19 has thus presented the Hospital with unique challenges. Hospital officials have been continuously evaluating Saint Elizabeths's policies and practices, and as the Centers for Disease Control and Prevention (CDC) and the District of Columbia Department

of Health (DOH) have issued new guidance related to the pandemic, the Hospital's policies and practices have evolved to comply. *See* DBH Administrative Issuance #2020-001, Ex. 3 (effective date January 29, 2020, and updated no fewer than five times to provide additional guidance on managing the COVID-19 epidemic). For example, in just this past week, the CDC issued new guidance on the recommended standards of care for patients in healthcare settings and long term care facilities, including new recommendations on face coverings and visitor screenings.[1] Then, on April 14, 2020, DOH issued similar guidance recommending for the first time that face masks be worn by everyone—patients, visitors and personnel—in facilities such as Saint Elizabeths. *See* District of Columbia Department of Health, Letter to Long Term Care Facilities Administrators (April 14, 2020), available at https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/DC_Health_COVID-19_LTCF_Coverings_and_Masks_2020.04.14.pdf (April 14 DOH Letter). The following day, Mayor Bowser issued Order 2020-063 mandating that specific precautions be taken at Saint Elizabeths to protect the health of patients and staff. *See* Mayor's Order 2020-063, April 15, 2020, available at

[1] *See* Centers for Disease Control and Prevention, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (April 13, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html (CDC Healthcare Settings Recommendations); Centers for Disease Control and Prevention, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes, available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (Preparing for COVID-19).

https://coronavirus.dc.gov/release/mayor-bowser-extends-public-health-emergency-stay-home-order-and-closure-non-essential. The Hospital has worked expeditiously to ensure its policies and procedures conform to these new best practices and meet the Hospital's obligation to provide patient care in the least restrictive setting possible.[2] Current practices and policies at Saint Elizabeths include the following.

A. New Patient Admissions

Saint Elizabeths provides critical services to some of the District's most vulnerable residents, and the need for these services has not stopped during the current public health emergency. Gontang Decl. ¶ 5. The Hospital has implemented thorough procedures to allow for the continued admissions of limited new patients during the pandemic, while also protecting the patients already in its care.

Saint Elizabeths limits admissions to court-ordered pre-trial individuals and only those referred through the civil commitment process for whom (1) admission to the Hospital is medically necessary, and (2) no less restrictive treatment option is available. *See* Candilis Decl. ¶ 5. Since March 11, 2020, the Hospital admissions have been lower than the Hospital's pre-COVID-19 average. *Id.* ¶ 7.

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[2] On April 17, 2020, physicians from the CDC and DOH visited the Hospital and toured several different units to see the COVID-19 response measures. The CDC was complimentary of the Hospital's efforts and stated no negative findings. Tu Decl. ¶ ___. The physicians offered the following verbal recommendations for continued improvement in operations: (1) prioritizing usage of PPE; (2) optional usage of head and shoe coverings; (3) minimizing staff rotation among units whenever possible; (4) minimizing groups of staff eating in the breakroom; (5) continuing to provide training on correct usage of PPE; and (6) encouraging staff to make on-the-spot corrections when staff are not using PPE appropriately. *Id.* ¶¶ 9-10.

Before arriving at Saint Elizabeths, most patients admitted through the civil commitment process will have first received treatment at other area hospitals from which they are being transferred. Candilis Decl. ¶ 8. At the time of transfer, the patient will generally have been monitored in acute hospital care for over two weeks, which allows Saint Elizabeths to fully assess the need for admission and that the patient was properly screened for COVID-19 and is not exhibiting any symptoms. *Id.* ¶¶ 8-9. Further, after arriving at the Hospital but before being placed on a unit, each patient is screened again for COVID-19 by Hospital staff. *Id.* ¶ 9.

Pre-trial patients also receive careful screening. Because pre-trial patients often arrive directly from the community and not from another healthcare provider, Saint Elizabeths is now requesting that the court order the District of Columbia Department of Corrections (DOC) to test pretrial patients for COVID-19 prior to their arrival at the Hospital. Declaration of Martha Pontes (Pontes Decl.) Ex. 4 ¶ 15. The results of their test will then dictate which unit they are placed into as described below.[3]

B. Screening and Testing for COVID-19

Saint Elizabeth adheres to all CDC and DOH guidance on how to screen patients and staff for COVID-19.[4] On March 30, 2020, the Hospital implemented

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[3] Since March 23, 2020, only one pretrial defendant has been ordered to the Hospital for a competency evaluation. *Id.* ¶ 7. That patient has been tested for COVID-19 by DOC and will be housed accordingly pending the results of the test. *Id.* ¶ ___.

[4] *See* CDC Healthcare Settings Recommendations; Preparing for COVID-19.

DOH's Administrative Issuance 2020-001 requiring that every individual entering the Hospital—staff, contractors and visitors—be screened before admission.[5] Declaration of Yi-Ling Elaine Tu (Tu Decl.) Ex. 5 ¶ 13; DOH Admin. Issuance 2020-001. Current screening includes a temperature check using a no-touch infrared thermometer and, beginning April 20, 2020, a questionnaire to determine whether the individual is at risk of having COVID-19. *See* Tu Decl. Ex. 5 ¶ 14. Any individual whose temperature reading exceeds 100 degrees Fahrenheit or whose answers suggest they may have COVID-19 is denied entry into the Hospital. *Id.*

Pursuant to CDC and DOH recommendations, all Saint Elizabeths patients receive a daily screen for COVID-19 symptoms, which includes a check of the patient's vital signs. Pontes Decl. ¶ 14. Patients are evaluated for testing pursuant to CDC and DOH guidelines, which do not recommend general testing of asymptomatic patients. *Id.*. Any patient exhibiting COVID-19 symptoms that meet the guidelines for testing is screened, provided a mask if needed, transferred to a "person under investigation" (PUI) unit and tested. *Id.* Using test sample collection kits on-site, Hospital staff collect a swab from the patient and send the sample to the District of Columbia Department of Forensic Services laboratory for testing. *Id.* Results are returned within 24 to 48 hours. *Id.* The patient remains in the PUI unit while awaiting test results.

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[5] As of April 15, 2020, visitors allowed into the Hospital are generally limited to attorneys and interpreters. See Mayor's Order 2020-063, April 15, 2020, available at https://coronavirus.dc.gov/sites/default/files/dc/sites/coronavirus/publication/attachments/MayorsOrder2020.063.pdf.

C. Isolation and Cohorting

In response to the pandemic, Saint Elizabeths has implemented "cohorting" practices—housing COVID-positive patients together in units isolated from other patients—as recommended by the CDC. Tu Decl. ¶ 7; *see also* CDC Healthcare Settings Recommendations. On top of the patient units previously in operation, on April 15, 2020, the Hospital converted an auxiliary programming wing called the Therapeutic Learning Center (TLC) into an additional housing unit to facilitate the cohorting process. Gontang Decl. ¶ 7. Currently, the hospital has two dedicated isolation units housing only patients who have tested positive for COVID-19. Tu Decl. ¶ 7. In addition, the Hospital has one PUI unit where patients awaiting test results are housed. *Id.* Nursing and medical staff assigned to the isolation units minimize contact with patients and staff members throughout the rest of the Hospital. *Id.* As of today, the remaining nine units do not house any patients that have tested COVID-positive, are awaiting test results, or are suspected of COVID based on their symptoms. *Id.*

D. Patient Protections

1. Social Distancing

Because COVID-19 is believed to spread mainly from person to person, the CDC recommends that everyone practice social distancing. *See* Centers for Disease Control and Prevention, *Social Distancing, Quarantine and Isolation*, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing

.html. To promote social distancing and reduce contact between patients, the Hospital has suspended group therapies and other communal activities which previously took place in the TLC, and, as explained above, converted the TLC into an auxiliary housing unit. Gontang Decl. ¶ 17. Meal practices have been modified to reduce the number of patients present in the dining hall at any given time, including staggering meals and allowing patients to eat meals in their rooms. Pontes Decl. ¶ 9.

All staff have been trained to practice and enforce social distancing, and staff do as much as they can to ensure patients practice distancing safely. *Id.* For example, when receiving medication at their unit's medication window, each patient is instructed to approach the window one at a time to ensure patient privacy and, now, to maintain social distancing. *Id.* ¶ 10. If another patient approaches, staff will redirect the patient and remind them to maintain safe spacing. *Id.* While the physical space in the various units is more than sufficient for patients to practice social distancing, patient response to the social distancing guidance from staff has been mixed, and it can be difficult to enforce without impinging on patient autonomy. *Id.*

2. Face Masks

On April 14, 2020, DOH issued new guidance recommending all patients be provided with a facemask when possible. *See* April 14 DOH Letter. As plaintiffs note, all patients currently have access to facemasks. Pontes Decl. ¶ 13; Guzman Decl. [33-9] ¶ 3. The Hospital has a sufficient inventory of surgical masks and receives regular replenishments, which are then made available to patients who request them. Pontes Decl. ¶ 13; Declaration of Renee Bivins (Bivins Decl.) Ex. 6 ¶ 8. In addition, the

Hospital's Department of Recreation has made and distributed cloth masks for patients that can be washed and reused. Pontes Decl. ¶ 13. Staff members all wear different levels of face protection depending on the unit in which they are providing care and according to CDC guidelines and recommendations. *Id.* ¶ 11. At minimum, as of April 21, 2020, each staff member wears a face mask and a face shield. *Id.*

3. Hand Hygiene

All patients have access to soap and sinks in the bathrooms to wash their hands as needed.[6] Bivins Decl. ¶ 8. Housekeeping checks the bathrooms daily to ensure that there is an adequate supply of soap and paper towels. *Id.* Patients can also ask for soap at nurses' stations in their units. *Id.* In addition, hand sanitizer is available on all units, though on certain units, patients are required to ask nursing staff to dispense the sanitizer for them.[7] *Id.*

4. Additional Cleaning Measures

All parts of Saint Elizabeths, including patient rooms and bathrooms, are cleaned by professional cleaning staff throughout each day between 6:00 a.m. and 11:30 p.m. Bivins Decl. ¶¶ 5- 6. The Hospital has also hired an additional ten cleaning contractors to increase the frequency of cleaning. *Id.* ¶ 6. In addition to regular housekeeping practices, cleaning staff now focus on cleaning and sanitizing "high touch areas" such as rails and doorknobs. *Id.*

E. Provision of Psychiatric and Medical Treatment

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6 Plaintiffs' own evidence confirms this. *See* Rose Decl. [39-10] ¶ 5.

7 Plaintiffs' evidence confirms this, too. Guzman Decl. ¶ 3 ; Rose Decl. ¶ 5.

Patients receive a variety of treatment while they reside at Saint Elizabeths, much of which remains unchanged during the COVID-19 health emergency. While group therapies have been suspended based on CDC social distancing guidance, patients at the hospital continue to receive the psychiatric treatment, medicine and other services they received prior to the health emergency. Gontang Decl. ¶ 11. Each patient has a treatment team on the unit where they reside that consists of a clinical administrator that is responsible for coordinating all care, a psychiatrist responsible for psychiatric treatment and medication, a social worker responsible for discharge planning, and a registered nurse responsible for daily nursing care. *Id.* In addition, each unit has a general medical officer or nurse practitioner to assist with medical issues, and a psychologist. *Id.* Patients continue to receive appropriate and individualized psychiatric treatment, including medications, psychological support, nursing and social work services, as well as other specialty services they require. *Id.* There has also been a documented reduction in the incidents of aggressive behavior by patients in the last month. *See* Gontang Decl. ¶ 14 (below average instances of "unusual incidents of physical assault" and "unusual incidents of aggressive behavior" in last 30 days).

Although most group therapies and activities have been suspended during the pandemic, Hospital staff are working to expand their telemedicine capabilities to facilitate continuity of care for patients with outside providers and are monitoring patients to ensure these changes do not negatively affect each patient's psychological stability. *Id.* ¶ 12. Currently, the Hospital has provided each unit with a computer

and access to WebEx teleconferencing software that patients can use for teletherapy and telemedicine with outside practitioners. *Id.* On April 17, 2020, the Hospital received 14 new WebEx enabled devices to expand its telemedicine capabilities. *Id.* ¶ 13.

F. Individualized Patient Assessments

Saint Elizabeths regularly conducts individualized assessments of all patients, "identifying potential for treatment in the least restrictive environment." Gontang Decl. ¶ 7. This is the core function of the Hospital's Department of Social Work at all times, including during the current COVID-19 pandemic. *Id.* The Hospital has completed individual assessments of each patient during the COVID-19 health emergency, assessing both their fitness for discharge and whether Saint Elizabeths remains the least restrictive setting for their continued care. *See id.* ¶¶ 7-10.

In response to a recent motion filed in Superior Court, Saint Elizabeths completed individual evaluations of all pre-trial patients charged with misdemeanors and made recommendations to the court. *Id.* ¶ 7; *see also* D.C. Code § 24-531.06. As of April 17, 2020, the court has ordered the discharge of 14 patients as a result. *See Id.* Saint Elizabeths has also completed individual assessments for post-trial patients. *Id.* ¶ 8. The Hospital, however, is required by statute to consider public safety and the risk of dangerousness and recidivism when evaluating post-trial patients for community release, and the Hospital cannot release any post-trial patient without Superior Court approval. *Id.*; *see* D.C. Code § 24-501(e). Finally, the Hospital has completed individualized assessments for all civilly committed patients. *See*

Gontang Decl. ¶ 9. While some individuals were found eligible to receive treatment in the community, barriers such as the unavailability of safe and stable housing stand in the way of discharge for many. *Id.* ¶ 10. For example, most patients are not able to live independently immediately upon discharge, and admissions to group homes or nursing homes are severely curtailed because of COVID-19. *Id.* DBH generally recommends against discharge into homeless shelters, which may not have the necessary support services for successful community transition. *Id.* Successful community discharge instead typically involves close coordination with a community-based mental health services provider called a Core Services Agency (CSA). *Id.* But because CSAs cannot always provide services to a patient without stable housing, the lack of stable housing presents a barrier discharge. *Id.*

Discharge into the community is even more difficult during the pandemic because the threat of COVID-19 exists everywhere. Gontang Decl. ¶ 10. For example, group homes pose the risk of exposure among asymptomatic roommates, guardians and others that are free to travel in and out of the home. *Id.* A vulnerable patient that does not have the mental capacity to adhere to social distancing, cough etiquette, hand washing and other COVID-19 precautions in the community may be safer in an environment with ready access to mental health, medical and nursing care. *Id.* Saint Elizabeths nonetheless continues to evaluate patients for the possibility of community transition.

G. Staffing

Throughout the pandemic, the Hospital has maintained adequate staffing to ensure patients receive adequate care and treatment. Pontes Decl. ¶ 4. The nursing department maintains a staffing matrix to ensure the proper number of nurses, nurses assistants and behavioral health technicians are present in each unit based on the patient census on any given day. *Id.* ¶ 6. The Hospital has 760 staff, 83 of which are currently out because they are COVID-positive or symptomatic. *Id.* ¶ 4. To assist while staff members are unavailable, the Hospital has brought in 31 additional nursing staff, and increased the number of contract medical personnel at the Hospital. *Id.* ¶ 7. All contract medical personnel participate in a three-day orientation and onboarding process to ensure they are familiar with the platforms and procedures of the Hospital. *Id.*

H. Personal Protective Equipment

The Hospital has adequate personal protective equipment (PPE) to comply with CDC guidelines and recommendations, Pontes Decl. ¶ 11, and receives deliveries of PPE several times per week. *Id.* ¶ 12. In accordance with CDC and DOH guidance, staff are required to wear facemasks at all times when they are present on patient units. *Id.* ¶ 11. As of April 20, 2020, staff also don face shields whenever they interact with patients on general units. For PUI units, staff utilize gown, N95 mask, goggles, gloves and shoe covers *Id.*. On isolation units, a respirator or "PAPR mask" is required. *Id.* The Hospital has conducted WebEx trainings with all staff on appropriate PPE levels and how to don and doff each type of PPE safely according to CDC guidelines, and has issued written guidance. *Id.*

III. Plaintiffs' Allegations and Procedural History

Plaintiffs' operative complaint only contains allegations pertaining to a temporary water outage that occurred at Saint Elizabeths in the fall of 2019. *See* Compl. [1] ¶¶ 1-4. Plaintiffs filed this putative class action on October 23, 2019, asserting two counts: a substantive due process claim under 42 U.S.C. § 1983 and a disability discrimination claim under the ADA, 42 U.S.C. § 12131, *et seq. Id.* ¶¶ 97-110. Plaintiffs sought declaratory and injunctive relief. *See id.* ¶¶ 111-17. The Hospital began restoring normal water usage the same day the Complaint was filed, and on December 16, 2019, the District moved to dismiss the case as moot. *See* Mot. to Dismiss [21]. In response to the motion to dismiss, plaintiffs moved for jurisdictional discovery on December 20, 2019, *see* Pls.' Mot. for Jurisdictional Discovery [23], and the District opposed on January 3, 2020, *see* District's Opp'n to Mot. for Jurisdictional Discovery [27]. After oral argument on January 22, 2020, the Court granted plaintiffs' requests in part and plaintiffs served discovery requests on January 29, 2020. The District provided responses on February 28, 2020. Plaintiffs' response to the District's motion to dismiss is due 14 days after the District produces the requested documents.

Then, on April 16, 2020, plaintiffs moved for an emergency hearing and leave to file an amended complaint, alleging that the District has not been taking proper measures at Saint Elizabeths to mitigate the risks of COVID-19 to patients. *See* Pl.'s

Mot. For Emergency Hearing [36]; Proposed Am. Compl. [36-1] ¶¶ 37-122.[8] The Proposed Amended Complaint includes new factual allegations related to the current COVID-19 global pandemic and the District's response. *See* Proposed Am. Compl. ¶¶ 37-122. On April 16, the Court granted plaintiffs' request for an emergency hearing and the Parties appeared telephonically on April 17, 2020. The Court set an expedited briefing schedule for plaintiffs' motion for leave to file an amended complaint, and plaintiffs' request for emergency relief. Pursuant to that schedule, plaintiffs filed a motion for a temporary restraining order on April 18, 2020, and the District opposed by 4:00 p.m. on April 21, 2020. Any reply is due by 12:00 p.m. on April 22, 2020. A hearing is scheduled for 3:30 p.m. on April 23, 2020.

LEGAL STANDARD

A temporary restraining order "is 'an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief.'" *Sherley v. Sebelius*, 644 F.3d 388, 393 (D.C. Cir. 2011) (quoting *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008)). "The same standards apply for both temporary restraining orders and preliminary injunctions." *Experience Works, Inc. v. Chao*, 267 F. Supp. 2d 93, 96 (D.D.C. 2003).

A plaintiff seeking a TRO must establish that: (1) "he is likely to succeed on the merits"; (2) "he is likely to suffer irreparable harm in the absence of preliminary relief"; (3) "the balance of equities tips in his favor"; and (4) "an injunction is in the

[8] The District has opposed plaintiffs' motion for leave to amend their Complaint. *See* District's Opp'n to Pls.' Mot. for Leave to Amend [40]. In addressing plaintiffs' new allegations and proposed claims below, the District does not waive the arguments made in that opposition.

public interest." *Sherley*, 644 F.3d at 392. Because injunctive relief is an extraordinary remedy, a plaintiff seeking such relief must prove all four prongs of the standard before relief can be granted. *In re Navy Chaplaincy*, 738 F.3d 425, 428 (D.C. Cir. 2013); *Winter*, 555 U.S. at 22. The plaintiff bears the burden of doing so. *Davis v. Pension Benefit Guar. Corp.*, 571 F.3d 1288, 1292 (D.C. Cir. 2009).

"The usual role of a preliminary injunction is to preserve the status quo pending the outcome of litigation." *Cobell v. Norton*, 455 F.3d 301, 314 (D.C. Cir. 2006) (quoting *Dist. 50, United Mine Workers of Am. v. Int'l Union, United Mine Workers of Am.*, 412 F.2d 165, 168 (D.C. Cir. 1969)); *see also Chaplaincy of Full Gospel Churches v. England*, 454 F.3d 290, 297 (D.C. Cir. 2006) (*CFGC*) (same).

ARGUMENT

I. Plaintiffs Fail To Show They Will Suffer Irreparable Harm.

A TRO is fundamentally about establishing the need for immediate relief. For that reason, the "failure to demonstrate irreparable harm is grounds for refusing to issue a [TRO], even if the other three factors … merit such relief." *Nat'l Mining Ass'n v. Jackson*, 768 F. Supp. 2d 34, 50 (D.D.C. 2011) (citation and internal quotation marks omitted); *see also CFGC*, 454 F.3d at 297 (observing that there is "a high standard for irreparable injury"). "[P]roving irreparable injury is a considerable burden, requiring proof that the movant's injury is certain, great and actual—not theoretical—and imminent, creating a clear and present need for extraordinary equitable relief to prevent harm." *Power Mobility Coal. v. Leavitt*, 404 F. Supp. 2d 190, 204 (D.D.C. 2005) (citations and internal quotation marks omitted). If a party fails to make a sufficient showing of irreparable injury, a court may deny a motion

for preliminary relief without considering the other factors. *CityFed Fin. Corp. v. Office of Thrift Supervision*, 58 F.3d 738, 747 (D.C. Cir. 1995).

The specific relief plaintiffs have requested makes clear that they will not suffer irreparable harm absent a TRO. The primary reason is straightforward: Saint Elizabeths is already taking the overwhelming majority of the measures plaintiffs request. Treatment teams already monitor patients individually for potential new issues and needed changes to their treatment plans, *see* Pls.' Proposed Order ¶¶ 2, 9; Gontang Decl. ¶ 11, and have been evaluating patients for the possibility of community placement, recommending individuals for release where appropriate, *see* Pls.' Proposed Order ¶¶ ; Gontang Decl. ¶¶ 7-9. Medical staff already monitor patients for symptoms of COVID-19 and conduct tests according to CDC and DOH guidelines, isolate and quarantine individuals appropriately, and provide necessary PPE for symptomatic individuals. *See* Pls.' Proposed Order ¶ 5; Tu Decl. ¶ 7, 11; Pontes Decl. ¶ 5. All patients already have consistent access to soap, hand sanitizer, and running water, and regular cleaning and disinfecting services are provided daily—and sometimes hourly—throughout the facility. *See* Pls.' Proposed Order ¶ 6; Bivins Decl. ¶¶ 8. Patients are already appropriately housed in isolation units, PUI units, and general housing units based on the likelihood of whether they have contracted the virus. *See* Pls.' Proposed Order ¶ 7; Pontes Decl. ¶ 14. And staff already educate patients on COVID-19 symptoms and prevention measures through individual handouts, one-on-one conversations, coordination with the Patient Advocates Group and the Patient Advisory Counsel, and previously through community meetings. *See*

Pls.' Proposed Order ¶ 8; Tu Decl. ¶ 5.

Two requests for relief remain: an order directing Saint Elizabeths to cease new patient admissions and another directing Saint Elizabeths to provide the Court with daily reports reflecting its ongoing compliance with specified measures and updated information about the patient population. *See* Pls.' Proposed Order ¶¶ 1, 10. As to the first of these, even assuming the District could prevent the Superior Court from referring new patients (which it cannot), new patient arrivals are already well below normal, and the new-patient screening procedures currently in place ensure the separation of positive and suspected COVID-19 cases from the general patient population. *See* Pls.' Proposed Order ¶ 1; Pontes Decl. ¶ 15; Candilis Decl. ¶¶ 7-9. Plaintiffs have sufficient space to engage in social distancing at all times and will not be housed in a situation that exposes them to an unreasonable risk of contracting the virus. Pontes Decl. ¶¶ 9-10. As to the second, and based on the evidence presented, plaintiffs will suffer no harm if the Court does not order Saint Elizabeths to issue reports on what it is already doing.

No harm will come to plaintiffs, let alone irreparable harm that is certain and imminent, if the Court denies their request for a TRO and Saint Elizabeths continues to carry out the measures it has put in place. This alone suffices to deny plaintiffs' request for a TRO. *See Nat'l Mining Ass'n*, 768 F. Supp. 2d at 50.[9]

[9] On April 20, 2020, Mayor Bowser also announced she had appointed a team of "health and operational experts from" the District government to "review, scrutinize, and, when appropriate, recommend changes to the policies and practices in place at … Saint Elizabeths." *See* Government of the District of Columbia, Coronavirus (COVID-19) Situational Update Monday, April 20, 2020, at 6, available at

II. Plaintiffs Cannot Show a Likelihood of Success on the Merits.

Demonstrating a likelihood of success on the merits is a free-standing requirement, *Sherley*, 644 F.3d at 393, and the failure to meet the burden on this prong "is alone sufficient to defeat" a motion for emergency injunctive relief, *Smith v. Henderson*, 944 F. Supp. 2d 89, 96 (D.D.C. 2013). The Court need not conclude that plaintiffs will definitely lose on the merits, only that they have not met the demanding burden of showing a clear entitlement to immediate, extraordinary relief. *Sweis v. U.S. Foreign Claims Settlement Comm'n*, 950 F. Supp. 2d 44, 48 (D.D.C. 2013). To overcome this burden, it must be shown not merely that success is a "possibility" but that it is "likely." *Winter*, 555 U.S. at 20-22. Plaintiffs raise two claims for relief in their Complaint but ultimately fail to show a likelihood of success on the merits for either one.

A. Plaintiffs' Due Process Claim Is Not Likely To Succeed.

The record and plaintiffs' own framing of the law show they are unlikely to succeed on their due process claim. *See* Proposed Am. Compl. ¶¶ 218-24. The Constitution prohibits the government from depriving people of life, liberty or property without due process of law. U.S. Const., amend. V.[10] This includes the guarantee of "substantive" due process, or the protection from "unjustified intrusions on personal security." *Ingraham v. Wright*, 430 U.S. 651, 673 (1977). Although such

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https://coronavirus.dc.gov/sites/default/files/dc/sites/coronavirus/release_content/attachments/Situational%20Update%20Presentation_new-04202020.pdf. Plaintiffs' request for ongoing reporting is especially unnecessary in light of this announcement.

[10] The Due Process Clause of the Fifth Amendment applies to the District. *See Bolling v. Sharpe*, 34 U.S. 497, 498 (1954).

conduct "usually takes the form of affirmative state action," the failure to act by government officials can also implicate the due process clause in some circumstances. *Estate of Phillips v. District of Columbia*, 455 F.3d 397, 403 (D.C. Cir. 2006).

A well-established line of authority analyzes due process in circumstances such as these. In *Youngberg v. Romeo*, 457 U.S. 307 (1982), the Supreme Court recognized that the Due Process Clause imposes on the government a "duty to provide certain services and care" to "a person [who] is institutionalized—and wholly dependent on the State." *Id.* at 317. These include duties "to provide adequate food, shelter, clothing, and medical care," and "reasonable safety for all residents and personnel within the institution." *Id.* at 324. Plaintiffs' charge here falls under the rubric of *Youngberg*, to the extent they allege inadequate care.[11] But their challenge cannot succeed for two reasons.

First, although plaintiffs identify isolated components of care that have been modified or interrupted during the COVID-19 pandemic, plaintiffs do not (and cannot) show that they are being denied "adequate" care or "reasonable safety." *See Youngberg*, 457 U.S. at 324. The record supports that Saint Elizabeths is providing residents with adequate accommodations, medical and psychiatric care, and the

[11] Plaintiffs incorrectly attempt to frame this case under the legal standards applicable to cases involving affirmative actions by state officials. *See* Pls.' Mem. at 18-19 (citing *Kingsley v. Hendrickson*, 135 S. Ct. 2466, 2475 (2015)). The key case they cite, *Kingsley*, addresses "the appropriate standard for a pretrial detainee's excessive force claim" under the Due Process Clause. *See id.* at 2473. Plaintiffs here, however, do not allege excessive force, nor do they raise claims based on any affirmative acts taken by government officials. They instead allege inadequate care during their involuntary commitment to a District-run psychiatric facility—in other words, a claim based on the failure to act.

items they need to protect themselves from COVID-19 according to current public health guidelines. The Hospital has taken broad precautions related to the virus, such as making face masks readily available to all patients and separating residents into dedicated units based on the likelihood of whether they have contracted the virus. *See* Pontes Decl. ¶¶ 13-14; Tu Decl. ¶¶ 7-8. Treatment teams continue to provide patients with individualized care, including psychiatric and medical care. Gontang Decl. ¶ 11. Although some therapy services have been paused based on CDC guidance to minimize in-person gatherings, *id.*, hospital staff have set up computers and tablets for patients to take part in virtual individualized therapy sessions with outside providers, *id.* ¶¶ 12-13.[12] Plaintiffs cannot show that they are being subjected to inadequate care, an unreasonable risk to their health and safety, or a deficiency of any other rights to which they are entitled under the Constitution.

Second, even if there were a deficiency in their care, plaintiffs are incorrect that this alone would establish a violation of their due process rights. The Fifth Amendment does not establish a negligence regime by which any pre-trial detainee can show a due process violation when any actions taken against that individual "are objectively unreasonable." *See* Pls.' Mem. at 18-19. In numerous cases (including *Kingsley*, the key authority on which plaintiffs rely), the Supreme Court has emphasized just the opposite: that constitutional due process violations require more than mere negligence by government actors. *See Kingsley*, 135 S. Ct. at 2472

[12] Plaintiff Smith, for example, states that she has had "remote therapy via telemedicine" once a week for the last two weeks. *See* Smith Decl. [39-8] ¶ 10.

("[L]iability for *negligently* inflected harm is categorically beneath the threshold of constitutional due process" (Court's emphasis)); *Davidson v. Cannon*, 474 U.S. 344, 347 (1986) ("[T]he Due Process Clause of the Fourteenth Amendment is not implicated by the lack of due care of an official causing unintended injury to life, liberty or property."); *DeShaney v. Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 202 (1989) (Fourteenth Amendment Due Process Clause "does not transform every tort committed by a state actor into a constitutional violation").[13]

When, as here, a plaintiff alleges a deprivation arising from the failure to act, authority is split on how to establish a due process violation. Under one line of authority, applicable to plaintiffs in the government's custody generally, a plaintiff must first establish that officials exhibited "deliberate indifference." *See Farmer v. Brennan*, 511 U.S. 825 (1994). Under the other, applicable specifically to involuntarily committed medical or psychiatric patients, a plaintiff must show that the professionals entrusted with care made a decision that was "such a substantial

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[13] Were excessive force at issue here, the Court in *Kingsley* held that an official may be held liable under the Due Process Clause only where "the use of force [was] deliberate—*i.e.*, purposeful or knowing." 135 S. Ct. at 2472. The official's affirmative, physical action must have been carried out deliberately, but the official need not have intended the force itself be excessive as long as the level of force was "objectively unreasonable." *Id.* at 2473. At most, *Kingsley* stands for the proposition that excessive force can rise to a due process violation even absent any intent to inflict punishment. That, however, is not at issue here because plaintiffs allege neither an affirmative action nor that anyone intended to (or did) punish them.

Plaintiffs also cite a Second Circuit case, *Darnell v. Pineiro*, 849 F.3d 17 (2d Cir. 2017). Leaving aside whether a plaintiff can establish a likelihood of success on the merits by pointing to an out-of-circuit legal standard, *Darnell* nevertheless still requires a showing that the official in question either "acted intentionally" or "recklessly failed to act with reasonable care." *Id.* Either one would require a plaintiff to show more than negligence.

departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such judgment." *Youngberg*, 457 U.S. at 323. *See Jordan v. District of Columbia*, 161 F. Supp. 3d 45, 57 (D.D.C. 2016) (collecting cases showing split across circuits on which standard to apply). Although the D.C. Circuit has not resolved which one applies in each scenario, *see Harvey v. District of Columbia*, 798 F.3d 1042, 1051-52 (D.C. Cir. 2015), courts have generally applied the professional judgment standard to cases of civilly committed psychiatric patients. *See, e.g.*, *Jordan*, 161 F. Supp. 3d at 58. Plaintiffs, however, cannot establish a due process violation under either standard.

1. The District Has Not Exhibited Deliberate Indifference.

Of the two possible standards, deliberate indifference presents a higher bar for plaintiffs to clear. *See Jordan*, 161 F. Supp. 3d at 57. Deliberate indifference occurs where an official has "subjective knowledge of the plaintiff's serious medical need and recklessly disregards the excessive risk to the plaintiff's health or safety from that risk." *Harvey*, 798 F.3d at 1052 (alterations adopted) (internal quotation marks omitted) (quoting *Baker v. District of Columbia*, 326 F.3d 1302, 1306 (D.C. Cir. 2003)). Deliberate indifference cannot be established by pointing to facts only known with the benefit of hindsight; the key inquiry is whether the officials in question disregarded excessive risk to the plaintiffs "at the time the decisions were made." *Kaucher v. Cnty. of Bucks*, 455 F.3d 418, 428 (3d Cir. 2006); *see also id.* (finding no deliberate indifference toward risk of MRSA outbreak in jail where facts showed that "[w]hen defendants recognized an increased number of MRSA infections, they took

various remedial and preventative measures, including isolating and treating infected inmates and distributing information to staff and inmates").

The record demonstrates that the District has not recklessly disregarded any risk to the plaintiffs amid the pandemic. Saint Elizabeths began taking thorough precautions against COVID-19 as early as January 29, 2020, when the Hospital disseminated its first administrative issuance notifying staff of COVID-19. *See* January 29, 2020 Admin. Issuance4. The Hospital has since implemented "cohorting," establishing separate wards for those who have tested positive, those exhibiting symptoms without yet testing positive, and all others. Tu Decl. ¶ 7; Pontes Decl. ¶ 14. Outside visitors have been significantly curtailed, and all remaining visitors, as well as all staff and contractors, get screened by having their temperature taken and filling out a questionnaire, both of which must meet specified standards before entry into the facility. Tu Decl. ¶ 14. Saint Elizabeths has hired extra cleaning contractors and has lined up extra nursing staff to ensure adequate staffing levels. Bivins Decl. ¶ 6; Pontes Decl. ¶7. Residents have access to a steady supply of soap that is checked daily so they can take proper handwashing precautions. Bivins Decl. ¶ 8; Rose Decl. [39-10] ¶ 5. As plaintiffs themselves describe, residents have access to hand sanitizer upon request. *See* Guzman Decl. ¶ 3; Rose Decl. ¶ 5. Residents and staff have consistent access to appropriate PPE—which plaintiffs themselves confirm. *See* Guzman Decl. ¶ 3a (patients in quarantine unit "were given new masks every day," and "[a]ll staff wore masks and full protective suits"); *Id.* ¶ 3c (in non-quarantine unit "[i]f a patient asks for a mask, and if a mask is available, the staff will provide the

patient with a mask," "[a]ll staff members wear masks every day," and "[s]ome staff members wear gowns"). Residents and staff receive education on precautions such as handwashing and social distancing. Tu Decl. ¶¶ 4-5. And staff ensure residents have ample space available to practice social distancing, even though some residents may choose not to heed this guidance. Pontes Decl. ¶ 10.

Although Saint Elizabeths has suspended group therapy and other programming normally conducted in communal spaces, it has done so based on CDC recommendations that healthcare facilities minimize opportunities for communal gathering—not out of any kind of disregard for patients' needs. *See* Gontang Decl.¶ 18. The hospital has taken measures to ensure patients can continue meeting virtually with therapy providers. Gontang Decl ¶¶ 12-13. Saint Elizabeths continues to admit new patients—as required by court orders—with proper screening measures in place. Pontes Decl. ¶ 15; Candilis Decl. ¶¶ 8-9. With a current patient population of 226, and a rate of new admissions far lower than usual, hospital officials have concluded it is still safe to accept new patients who require psychiatric care and might otherwise have nowhere to receive the care they need. Gontang Decl. ¶ 5.

Saint Elizabeths has undertaken all of these measures precisely because of the serious risks posed by COVID-19. The District does not dispute that the pandemic is a serious matter. Plaintiffs' argument instead depends on factual assertions that are simply not correct. Saint Elizabeths is not "housing symptomatic and COVID-19 positive individuals together with asymptomatic individuals," has not "failed to isolate and quarantine individuals with the virus or suspected of having the virus,"

and is not "failing to provide basic sanitation appropriate to the situation—in this case, ample soap and hand sanitizer, increased cleaning and disinfection of areas." Pls.' Mem. at 20. It is no surprise that plaintiffs provide no citations for these assertions. They are inaccurate and, as described above, contradicted by many of plaintiffs' own proffered facts. Their lone citation for the general assertion that the District has disregarded the risks posed by COVID-19 is to the declaration of someone who claims no personal knowledge of conditions in the Hospital and who has formed her opinion based only on the allegations in plaintiffs' Proposed Amended Complaint and declarations that are themselves not based on personal knowledge. *See* Pls.' Mem. at 24 (citing Jones Decl. ¶ 16). Plaintiffs simply cannot show deliberate indifference in light of the numerous measures the District has taken. *See Kaucher*, 455 F.3d at 428.

Several cases plaintiffs point to as examples of deliberate indifference present circumstances not present here. In *Feliciano v. Gonzales*, 13 F. Supp. 2d 151 (D.P.R. 1998), for instance, the court indeed found deliberate indifference toward the unmitigated spread of various diseases in Puerto Rico prisons—but did so based on a finding that "[t]he prison system in Puerto Rico … lacks isolation facilities," *id.* at 174, and based on an absence of equipment necessary to conduct screening for certain illnesses, such as X-ray machines needed to screen for tuberculosis, *id.* at 179. Similarly, in *Joy v. Healthcare C.M.S.*, 534 F. Supp. 2d 482 (D. Del. 2008), the court observed that the prison medical contractor "[did] not have a policy in place to examine inmates [for disease] before placing them into general population." *Id.* at

485. As described above, however, Saint Elizabeths screens new patients and ensures that COVID-19 testing occurs consistent with CDC guidelines. *See* Pontes Decl. ¶ 14-15. Other cases plaintiffs point to simply state—correctly—that deliberate indifference is the requisite standard for assessing an alleged due process violation and can be established by certain factual showings. *See Shimon v. Dep't of Corr. Servs. for the State of New York*, Civil Action No. 93-3144, 1996 WL 15688, at *3 (S.D.N.Y. 1996) (due process liability possible "[i]f plaintiff can prove that [official] had notice of a tuberculosis 'epidemic' and failed, with deliberate indifference, to take appropriate actions to prevent or address the problem"); *Joy*, 534 F. Supp. 2d at 485 (liability possible upon showing that prison officials were "acting with deliberate indifference" when exposing prisoners to substantial risk of harm). Although true, that is not applicable given the facts here.

Plaintiffs cannot show deliberate indifference by the District and fall well short of showing a likelihood of success on the merits.

2. No Action by the District Has Departed from Accepted Professional Judgment, Practice or Standards.

Plaintiffs cannot make out a due process claim even under the lower of the two standards, the professional judgment standard. Under this rubric, in cases involving those involuntarily committed to the state's care, due process "only requires that the courts make certain that professional judgment in fact was exercised" by appropriate staff, without mandating that any specific judgment should have been made. *Youngberg*, 457 U.S. at 321. "[E]vidence establishing mere departures from the applicable standard of care is insufficient to show a constitutional violation." *Patten*

v. Nichols, 274 F.3d 829, 845 (4th Cir. 2001). Rather, "decisions made by the appropriate professional are entitled a presumption of correctness unless it is established that the person responsible did not base the decision on accepted professional judgment." *Terrance v. Northville Regional Psychiatric Hosp.*, 286 F.3d 834, 849 (6th Cir. 2002) (citing *Youngberg*, 457 U.S. at 323); *see also Cameron v. Tomes*, 990 F.2d 14, 20 (1st Cir. 1993) ("Nothing in the Constitution mechanically gives controlling weight to one set of professional judgments."). This deference to facility administrators is derived from the requirement that courts must "balance[] the plaintiff's liberty interests against any relevant state interests, including fiscal constraints and administrative burdens." *LaShawn A. v. Dixon*, 762 F. Supp. 959, 994 (D.D.C. 1991) (citing *Youngberg*, 457 U.S. at 321); *see also P.C. v. McLaughlin*, 913 F.2d 1033, 1043 (2d Cir. 1990) (no substantive due process violation in institutional placement of mentally disabled individual with violent history where state's "decision was prompted by the total lack of any viable alternative, and compelled by the necessity to provide him with food, shelter, clothing and medical care").

Plaintiffs focus on the risk COVID-19 poses in general, *see* Pls.' Mem. at 22-23, but do not specify any particular decisions they believe fall below *Youngberg*'s threshold. To establish a substantive due process violation, plaintiffs must show that a "decision by [a] professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible *actually did not base the decision on such a judgment*." *Youngberg*, 457 U.S. at 323 (emphasis added). They have not done so, and the record shows that the

various procedures and protocols Saint Elizabeths officials have implemented in light of the pandemic have in fact been based on sound professional judgments, balancing the need to provide appropriate care with the need to protect patients from the risks of COVID-19. *See LaShawn*, 762 F. Supp. at 994; *McLaughlin*, 913 F.2d at 1043.

Plaintiffs cannot point to any decisions that were not based on a professional judgment. As described above, Saint Elizabeths has made the decisions it has made—some of them difficult—based on the need to balance competing considerations relevant to providing appropriate patient care. Even under this lower standard, plaintiffs cannot succeed on the merits of their substantive due process claim.

B. Plaintiffs Are Not Likely To Succeed on Their ADA Claim.

Plaintiffs also cannot show a likelihood of success on their ADA claim. *See* Proposed Am. Compl. ¶¶ 225-31 (citing 42 U.S.C. § 12131). Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

A plaintiff must generally make a showing of three elements to succeed in claiming that a public entity violated the ADA: "(1) that the plaintiff is a qualified individual with a disability; (2) that the public entity denied him the benefits of or prohibited him from participating in the entity's services, programs or activities; and (3) that denial or prohibition was 'by reason of' his disability." *Jackson v. District of Columbia*, 826 F. Supp. 2d 109, 125-26 (D.D.C. 2011) (quoting 42 U.S.C. § 12132). An

ADA claim generally takes one of three forms: disparate treatment, disparate impact, or failure to make a reasonable accommodation. *Seth v. District of Columbia*, Civil Action No. 18-1034 (BAH), 2018 WL 4682023, at *10 (D.D.C. Sept. 28, 2018). A fourth category, known as "unjustified isolation," emerged after the Supreme Court's decision in *Olmstead v. Zimring*, 527 U.S. 581 (1999). Under this theory, the ADA calls for institutionalized individuals to be placed in community settings "when (1) the State's treatment professionals have determined that community placement is appropriate, (2) the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and (3) the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Brown v. District of Columbia*, 928 F.3d 1070, 1077 (D.C. Cir. 2019) (quoting *Olmstead*, 527 U.S. at 587). Plaintiffs, however, cannot show a likelihood of success on the merits of their ADA claim.

1. Plaintiffs Have Not Raised a Cognizable Theory of ADA Discrimination.

Plaintiffs contend that during the COVID-19 outbreak, the District failed "to reasonably modify its system to reduce the segregation of Plaintiffs with disabilities from their communities of non-disabled peers during emergencies that threaten the physical and mental health and safety of Plaintiffs and undermine the clinical justification for such confinement." Proposed Am. Compl. ¶ 228; Pls.' Mem. at 25. This appears to allege an ADA claim under the theory of unjustified isolation. *See Brown*, 928 F.3d at 1077. But the facts on the ground do not support that theory. During the COVID-19 pandemic, Saint Elizabeths has been continually assessing patients and

considered, among other things, which patients might be appropriately placed into community settings. Gontang Decl. ¶¶ 13-16. In fact, a number of patients have been discharged into the community since the pandemic began. *Id.* ¶ 13.

Plaintiffs highlight only one consideration, some confirmed cases of COVID-19 among the Saint Elizabeths patient population, in concluding that "continued segregation and institutionalization of plaintiffs is not reasonable." Pls.' Mem. at 25. But that is not the legal standard. Community placement is appropriate only where "the State's treatment professionals have determined that community placement is appropriate," "the transfer from institutional care to a less restrictive setting is not opposed by the affected individual," and "the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." *Brown*, 928 F.3d at 1077. Plaintiffs' assertion that COVID-19 renders their continued hospitalization unreasonable ignores this standard, within which are embedded numerous appropriate considerations about whether community placement will in fact be in any given patient's best interest. As the record demonstrates, Saint Elizabeths has evaluated and continues to evaluate patients for appropriate transfers to community-based placements, Gontang Decl. ¶¶ 7-9, despite ongoing limitations such as a shortage of available spots in nursing homes for elderly patients and the low availability of in-person community care, *id.* ¶ 16. Plaintiffs have no basis for asserting an unjustified isolation theory of ADA discrimination and cannot succeed on the merits of their claim.

Plaintiffs' motion does not raise the second ADA theory stated in their Proposed Amended Complaint, which alleges that the District has "discriminated against class members by repeatedly utilizing methods of administration that deprive Plaintiffs of equal access to the benefits of the mental health services provided by Defendants that other individuals in the community are receiving." Proposed Am. Compl. ¶ 229. That theory, however, would fare no better.

Although couched as attacks on the Hospital's "methods of administration," these measures amount to challenges to the adequacy of services provided—grievances that are not cognizable under the ADA. The ADA does not "impose[] on the States a standard of care for whatever medical services they render," nor does it "require[] States to provide a certain level of benefits to individuals with disabilities." *Olmstead*, 527 U.S. at 603 n.14. All the ADA requires is that states "adhere to the ADA's nondiscrimination requirement with regard to the services they in fact provide." *Id.*

In any case, plaintiffs' own proffered evidence alleges that even during the pandemic, plaintiffs have continued receiving many services, such as individual therapy, albeit in modified form. *See* Smith Decl. [39-8] ¶ 10 (Plaintiff Smith receiving teletherapy once a week). In-person services, especially those involving group gatherings, have of course been modified or suspended to facilitate social distancing. *See* Gontang Decl. ¶ 11. But communal gatherings, including group meetings, have been curtailed throughout the broader community—a fact true for disabled and non-disabled people alike. *See, e.g.*, Julia Pinney, "As 12-Step Meetings Halt In Person

Due to the Coronavirus, Recovery Goes Online," Street Sense Media (April 16, 2020), available at https://www.streetsensemedia.org/article/12-step-meetings-coronavirus-recovery-online/#.Xp0DZZkpBPY (Alcoholics Anonymous groups no longer meeting in person in the District because of pandemic). Plaintiffs cannot succeed on an ADA claim challenging the adequacy of services where they cannot show actual discrimination. *See Doe v. Pfrommer*, 148 F.3d 73, 84 (2d Cir. 1998) (rejecting ADA claim where plaintiff's challenge to state-run vocational education program for the disabled challenged "not illegal discrimination against the disabled, but the substance of the services provided to him through [the program]"); *Buchanan v. Maine*, 469 F.3d 158, 175 (1st Cir. 2006) (individual shot by police could not sue state under ADA despite years of state-sponsored mental health treatment where "claim was not about discriminatory denial of services, but rather about the adequacy of treatment"). This is not a cognizable ADA claim and cannot succeed on the merits.

2. Even if Their Claims Are Otherwise Cognizable, Plaintiffs Have Not Shown a Deprivation "By Reason Of" Their Disabilities.

An ADA plaintiff must show "sufficient facts to establish that the complained-of discrimination was due to his disability." *Seth*, 2018 WL 4682023, at *11 (internal quotation marks omitted) (quoting *Howell v. Gray*, 843 F. Supp. 2d 49, 59 (D.D.C. 2012)). It is a plaintiff's burden to allege "that the disability actually played a role in the decision making process and had a determinative influence on the outcome." *Id.* (internal quotation marks omitted). Simply put, the plaintiff must "show that the complained-of discrimination was based on, or based solely on, [the plaintiff's] disability." *Id.*

Regardless of the services Saint Elizabeths has had to modify during the pandemic, plaintiffs cannot show that the District deprived them of anything "by reason of" their disabilities. Plaintiffs' own allegations make clear that all relevant actions taken by Saint Elizabeths were implemented as reasonable responses to an emergency situation. Plaintiffs have not shown any other plausible reason for the measures imposed. Nothing in the record or even alleged in the Proposed Amended Complaint suggests that the District took the actions it did because of plaintiffs' disabilities.

C. Plaintiffs Have Not Argued They Are Likely To Succeed on Their Claims Based on Any Facts About the Fall 2019 Water Outage.

As noted above, the legal claims laid out in plaintiffs' Proposed Amended Complaint allege actions from two separate events: the COVID-19 pandemic, and a temporary water outage that occurred in the Fall of 2019. *See* Proposed Am. Compl. In their motion for a TRO, however, plaintiffs argue they are likely to succeed on the merits only based on the events of the pandemic. *See generally* Pls.' Mem. They do not include any arguments or factual proffers about the water outage. Without raising any arguments about these events, plaintiffs cannot show they are likely to succeed on the merits based on any facts relating to the water outage.

III. The Balance of Equities and Public Interest Counsel Against the Preliminary Relief at Issue.

Even if plaintiffs could show a likelihood of success on the merits and that irreparable harm would result without a TRO, they must additionally show both that "the balance of equities tips in their favor," and that "an injunction is in the public

interest." *Sherley*, 644 F.3d at 392; *In re Navy Chaplaincy*, 738 F.3d at 428 (plaintiffs cannot use strong showing on some factors to make up for weak showing on others). These two factors "merge when the Government is the opposing party" and are thus analyzed together. *Guedes v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 920 F.3d 1, 10 (D.C. Cir. 2019) (citation and internal quotation marks omitted). "[W]here the Court has a less intrusive means" of ensuring legal compliance, "the public interest would weigh towards choosing such options, especially where … the plaintiffs seek a mandatory ('do this') rather than prohibitory ('don't do this') injunction." *Garnett v. Zeilinger*, 313 F. Supp. 3d 147, 160 (D.D.C. 2018).

Because Saint Elizabeths is already doing most of what plaintiffs seek from a TRO, the only question is whether the balance of the equities and the public interest favor the remaining two items: ceasing all admissions of new patients, and providing the Court and plaintiffs' counsel "with daily reports to ensure that the measures laid out in the Court's order are being followed." Pls.' Proposed Order ¶¶ 1, 10. As discussed above, the screening and isolation measures the Hospital has imposed adequately mitigate the risks of continuing new admission, especially at their slow pace. Candilis Decl. ¶¶ 7-9; Pontes Decl. ¶ 15. In any case, ceasing admissions—assuming Saint Elizabeths could do this—would not be in the public interest. The Hospital already limits admissions to court-ordered pretrial defendants and only those civil commitments that are medically necessary and where no less restrictive treatment option is available. Candilis Decl. ¶ 5. Courts commit individuals to Saint Elizabeths to receive care they likely could not receive anywhere other than a public

hospital dedicated to the intensive care of those with psychological disabilities. *See* Gontang Decl. ¶ 5. Denying these individuals admission would force them either to stay at home—for those who have homes—without any care, or to be placed into another kind of facility such as an acute care hospital. As plaintiffs themselves observe, hospitals and other healthcare facilities face a crisis of capacity trying to treat an influx of COVID-19 patients. *See* Pls.' Mem. at 10. In addition, those who would otherwise be placed into Saint Elizabeths pre-trial might instead be put in jail where the resources do not exist to provide the same level of psychiatric care Saint Elizabeths provides. Neither of these alternatives would be in the public interest and weigh decidedly against an order halting all new patient admissions.

The same is true for the detailed reporting requirement plaintiffs propose. There is a well-established public interest in permitting the government to carry out its authorized functions where doing otherwise would needlessly upend its operations. *See Benisek v. Lamone*, 138 S. Ct. 1942, 1945 (2018) (finding lower court could have reasonably concluded that ordering redrawing of electoral district map would have contravened public interest where "injunction might have worked a needlessly chaotic and disruptive effect upon the electoral process" (citation and internal quotation marks omitted)); *Garnett*, 313 F. Supp. 3d at 160 (public interest "would disfavor the Court's interference" in legal process of administering food stamp benefits "in light of [federal agency's] expertise and role" in carrying it out). This is especially true for a public hospital attempting to adjust its patient care to fluid public health guidance amid an ongoing pandemic. In addition to being unnecessary,

imposing onerous reporting requirements would require Saint Elizabeths to divert significant resources away from patient care and ensuring the general functioning of the hospital.

The balance of the equities and the public interest weigh in the District's favor and counsel against granting a TRO.

CONCLUSION

For the foregoing reasons, the Court should deny plaintiffs' motion for a temporary restraining order.

Dated: April 21, 2020.

Respectfully submitted,

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EXHIBIT 1

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ENZO COSTA, *et al.*, Plaintiffs, v. BARBARA BAZRON, *et al.*, Defendants.	Civil Action No. 19-3185 (RDM)

DECLARATION OF PHILIP CANDILIS, MD

I, Philip Candilis, MD, declare and state as follows:

1. I am over the age of eighteen (18) years, competent to testify to the matters contained in this declaration, and testify based on my personal knowledge acquired in the course of my official duties.

2. I am the Director of Medical Affairs for Saint Elizabeths Hospital, the District of Columbia's only public psychiatric facility for individuals with serious and persistent mental illness requiring intensive inpatient care to support their recovery. Saint Elizabeths is overseen by the District of Columbia Department of Behavioral Health (DBH).

3. I have worked at Saint Elizabeths Hospital since 2014. As a life-long public sector physician, I have served in a variety of roles, including Director of the Forensic Psychiatry Fellowship here at Saint Elizabeths, the program providing advanced training for physicians in psychiatry and the law. I assumed the role of Director of Medical Affairs in late October 2017. I am Professor of Psychiatry at

George Washington University School of Medicine, Clinical Professor of Psychiatry at Howard University College of Medicine, and Adjunct Professor of Psychiatry at the Uniformed Services University of Health Sciences. I also serve as President of the Washington Psychiatric Society. I am board-certified in both general and forensic psychiatry, have practiced psychiatry for over 25 years, and have had my work published extensively in a number of academic journals and texts.

4. As Director of Medical Affairs at Saint Elizabeths, I oversee medical and psychiatric care and am familiar with the Hospital's daily operations, including measures that protect patients and staff from COVID-19.

5. Saint Elizabeths Hospital's policy generally limits admissions to court-ordered pre-trial individuals and only those referred through the civil commitment process for whom (1) admission to the Hospital is medically necessary, and (2) no less restrictive treatment option is available. The Hospital rigorously screens all new patients to prevent the introduction of a positive COVID-19 patient from outside the hospital.

6. Patients admitted to Saint Elizabeths fall into three categories: pre-trial patients, post-trial patients deemed not guilty by reason of insanity (NGBRI), and civilly committed patients. Pre-trial and post-trial patients are often referred to as "forensic patients" because they are admitted by order of the D.C. Superior Court through criminal justice matters. Civilly committed patients are individuals hospitalized under D.C. Code § 21-501, *et seq.* upon being deemed a danger to themselves or others as a result of mental illness. The Hospital's current screening

procedures for new admission vary depending on the category of patient being admitted because each presents different risks for COVID-19 exposure.

7. Since March 11, 2020, the Hospital has admitted three (3) civilly committed patients, compared to an average 6-7 patients per month pre-COVID-19.

8. The civil admission process includes robust screening measures. Civil patients are rarely admitted directly from the community. Rather, a civilly committed patient will normally receive treatment first at a local emergency room or the Department of Behavioral Health Comprehensive Psychiatric Emergency Program (CPEP) for one or two days and then transfer to a local area hospital for continued acute psychiatric treatment. After 14 days that include medical monitoring and treatment, the hospital treating the patient may request a transfer to Saint Elizabeths Hospital. This occurs only in rare cases as most patients can be discharged directly back into the community.

9. Since the COVID-19 pandemic began, I have been personally involved in the screening of civil admissions to ensure that patients have been properly screened at the local hospital, are asymptotic for COVID-19 and not experiencing respiratory symptoms. I make this assessment by speaking with the patient's treating physician. If the patient is symptomatic, the Hospital will decline the referral. In addition, before any patient is admitted, a Saint Elizabeths general medical officer or nurse practitioner conducts a thorough assessment to screen for any possible COVID-19 symptoms. The Hospital will follow this protocol for all subsequent requests for civil admissions from acute care hospitals during COVID-19.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

April 21, 2020
DATED

Philip J. Candilis, MD, DFAPA
Director of Medical Affairs
Professor of Psychiatry, George Washington University School of Medicine
President, Washington Psychiatric Society

EXHIBIT 2

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ENZO COSTA, *et al.*, Plaintiffs, v. BARBARA BAZRON, *et al.*, Defendants.	Civil Action No. 19-3185 (RDM)

DECLARATION OF RICHARD GONTANG, PH.D

I, Richard Gontang, Ph.D, declare and state as follows:

1. I am over the age of eighteen (18) years, competent to testify to the matters contained in this declaration, and testify based on my personal knowledge acquired in the course of my official duties.

2. I am the Chief Clinical Officer for Saint Elizabeths Hospital (Saint Elizabeths), the District of Columbia's only public psychiatric facility for individuals with serious and persistent mental illness requiring intensive inpatient care to support their recovery. Saint Elizabeths is overseen by the District of Columbia Department of Behavioral Health (DBH).

3. I have worked at Saint Elizabeths Hospital since March 2008. I have served in a variety of roles at Saint Elizabeths, including Director of Psychology Training and Director of Psychology. I assumed the role of Chief Clinical Officer in April of 2016.

4. As the Chief Clinical Officer, I am in charge of the non-medical and non-nursing clinical disciplines at Saint Elizabeths, including psychology, social work, rehabilitation services, clinical administrators, volunteer services, and the Therapeutic Learning Centers. Through my position, I am aware of Saint Elizabeths Hospital operations on a daily basis to protect patients and staff from COVID-19.

5. Saint Elizabeths is unique among healthcare facilities in that it is foremost a psychiatric treatment facility but also houses pre- and post-trial patients and shares similarities with long-term care nursing facilities. The Hospital provides critical services to some of the District's most vulnerable residents, and the need for these services has not stopped during the current public health emergency. The Hospital has implemented thorough screening procedures to allow for the continued admission of a limited number of new patients during the pandemic, while also protecting the patients already in its care.

6. Saint Elizabeths Hospital has the capacity to house 292 patients. Pre-COVID-19, the Hospital's population census averaged 275 patients. On February 1, 2020, the Hospital census was 277. Since the COVID-19 outbreak, the Hospital has substantially reduced its census. As of April 21, 2020, the Hospital census is 221. Each unit at the Hospital generally houses no more than 27 patients, and has bedrooms, common living areas, bathrooms and showering facilities, and dining areas.

7. For patients currently in Saint Elizabeths' care, the Hospital has always maintained an individualized assessment on all patients to identify potential

for treatment in the least restrictive environment. This is a core function of the Hospital's Department of Social Work. During the COVID-19 pandemic, the Hospital has individually assessed each patient to determine whether the patient can be safely discharged from the Hospital. The Hospital's authority to discharge patients depends upon their category. Pre-trial and post-trial patients are referred by the D.C. Superior Court amid ongoing criminal proceedings. In response to a motion filed in Superior Court, Saint Elizabeths completed individual evaluations of all pretrial forensic patients charged with misdemeanors and made recommendations to the court. Since March 1, 2020, the D.C. Superior Court has ordered 39 pretrial patients released from the Hospital. The D.C. Superior Court ordered 5 patients discharged on April 15, 2020, and 9 on April 17, 2020, and continues to hear individual motions from pre-trial patients for release.

8. Saint Elizabeths has also completed individual assessments for post-trial patients, individuals who were found Not Guilty By Reason of Insanity (NGBRI) and committed to the Hospital by court order. By law, the Hospital is required to consider public safety and the risk of dangerousness and recidivism in evaluating NGBRI patients for community release. The Hospital has evaluated all NGBRI patients for discharge, including the named plaintiffs in this case.

9. Civilly committed patients are those hospitalized after being deemed a danger to themselves or others as a result of mental illness. We have completed individualized assessments for all civilly committed patients.

10. A patient's ability to safely live in the community remains a long-standing challenge to discharging. Many of our patients do not have secure housing available to them. Options such as homeless shelters lack adequate services and supports for our patients and may lead to a return to inpatient setting. Successful community discharge generally requires close coordination with a community-based mental health provider called a Core Services Agency, or CSA. CSAs typically provide in-home services, but this is difficult to provide if the discharged patient lacks safe and stable housing. An additional concern is that the threat of COVID-19 is prevalent in the community as well. For example, a patient residing in a group home risks exposure to asymptomatic roommates, guardians, and others that are free to travel in and out of the home creating risk of exposure. A vulnerable patient that does not have the mental capacity to adhere to social distancing, cough etiquette, hand washing, and other COVID-19 precautions in the community may not be any safer when compared to the Hospital, with ready access to mental health, medical and nursing care.

11. Some of our mental health treatment has been modified because of the pandemic. All group therapy has been suspended because of CDC guidance on minimizing group interactions. However, group therapy is just one method of delivering one aspect of mental health treatment in the Hospital. Every patient has a treatment team that consists of a clinical administrator that is responsible for coordinating all care, a psychiatrist responsible for psychiatric treatment and medications, a social worker responsible for discharge planning, and a registered

nurse responsible for daily nursing care. In addition, each unit has a general medical officer or nurse practitioner for medical issues and a psychologist for psychological services. Individual patients may also have other individual needs, such as rehabilitation, interpreter services (both in-person and remote), neurology, and access to external medical care. The Hospital has a neurology department with an on-site neurologist who provides services to patients that require that level of care. While groups are temporarily suspended, all patients continue to receive appropriate and individualized psychiatric treatment, including medications, medical, nursing, and social work services, and any other specialty services that they require.

12. The Hospital has provided WebEx accounts for staff to conduct individual telehealth consultations with patients for those that require individual one-to-one therapy. Each patient unit has a shared computer, cleaned and sanitized regularly, that is dedicated to this purpose. Saint Elizabeths Hospital is monitoring patients to ensure this change does not negatively affect patients' psychological stability.

13. In the last 30 days, the Hospital has used its telehealth technology to conduct treatment planning meetings, individual therapy, discharge planning meetings, legal visits and court appearances for Mental Observation and Mental Health Commission hearings. To increase its telehealth capacity, on April 17, 2020, the Hospital received 14 more devices that will be used for telehealth.

14. In the last 30 days, there has been a documented reduction in aggressive and assaultive behavior among patients at Saint Elizabeths. Prior to COVID-19, the

hospital averaged 43 unusual incidents of physical assault and 69 unusual incidents of aggressive behavior by patients. Since mid-March, the Hospital reported 24 unusual incidents involving physical assault and 63 unusual incidents of aggressive behavior.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

4/21/2020

DATED

RICHARD GONTANG, PH.D

EXHIBIT 3

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Administrative Issuance -#2020-001

Department of Behavioral Health, Saint Elizabeths Hospital Administrative Issuance

SUBJECT: Prevention and Management of COVID-19 (Coronavirus)
EFFECTIVE DATE: January 29, 2020
UPDATED: 3/5/2020, 3/20/2020, 4/1/2020, 4/2/2020, 4/3/2020

PURPOSE AND AUTHORITY

This Administrative Issuance provides Saint Elizabeths Hospital employees guidance on managing patients or staff who are suspected of Pneumonia of Unknown Etiology (PUE) and specifically COVID-19. The situation is evolving; therefore, this Issuance will be updated as more information becomes available.

DEFINITION

2019-nCo V/COVID-19: A novel coronavirus that is causing an outbreak of pneumonia-like illness.

TRANSMISSION AND PRECAUTIONS

Transmission and Precaution: CDC currently recommends a cautious approach to patients under investigation for COVID-19.

1) Patients at risk or with symptoms of COVID-19 shall be asked to wear a surgical mask as soon as they are identified, and shall be evaluated in a private room with the door closed. Ideally, this should be an airborne infection isolation room if available, pending transfer out to an acute care hospital.
2) SEH staff entering the room of affected patients shall use standard precautions, contact precautions, airborne precautions, and use eye protection (e.g., PAPR, gloves, gown). See guidelines set in the Infection Control Recommendations on page 2 of this Issuance.
3) For staff who return to work after traveling abroad or who exhibit potential symptoms, an assessment shall be completed using Appendix 2.

Notification: GMOs/NPs, supervisors identifying a newly admitted patient, or staff meeting these criteria, shall immediately notify the SEH Infection Control Coordinator and Department of Health if a patient/staff meets criteria of suspected cases-

1) DC Health by calling 202-576-1117 (during business hours) or 844-493-2652 (after business hours) or by sending an email to doh.epi@dc.gov.
2) SEH's Infection Control Coordinator via yi-ling .tu@dc.gov or by calling 202-465-5529.

Personal Protective Equipment (PPE): PPE may be obtained from the unit Nurse Manager or Supervisor. Additional PPEs may be obtained from the supply room. PPE includes: gloves, gowns, shoe protectors, face masks, and face shields.

- Nurse Managers or Department Supervisor shall utilize the SiteFM system to request additional or replacement PPEs.
- Nurse Managers/Department Supervisors should throughout the day periodically check supplies quantities, and seek feedback from their frontline staff on conditions/status of supplies.
- All frontline staff (e.g., nursing, social work, clinical administrators, house-keeping) shall be trained on proper use of PPEs, including how and when to wear PPE (see Appendix 6:2TR PPE Requirement). Staff seeking more training/information should contact their supervisor.

Visitors to SEH and Patients: As of the date of this Administrative Issuance, visitation by patient's family, guardians, and friends has been suspended. Patients and their family/friends/others are encouraged to continue communicating via telephone. The Hospital has established the following guidelines for visits by case management providers and patient's attorneys:

- Case Management Providers: On-site visitation by case management providers has been suspended, with the exception of the day of discharge when case managers aid our individuals with their return to the community.
- Legal Visits: We strongly encourage attorneys to contact clients via telephone or videoconference, whenever possible, since outside visitors pose the greatest infection risk to our individuals in care. All legal visitors will be screened for COVID-19 at the Intensive entrance to the Hospital. All legal visitors must arrive between 9:00 AM and 4:00 PM, Monday through Friday, for screening prior to being permitted to enter the building, and visits must be completed by 6:00 PM. If you do not arrive in time for the screening, the visit will need to be postponed to the next business day.

Screening of Visitors: All visitors are required to enter through the Intensive-side of the Hospital to be screened. Staff conducting the screening shall compete the form in Appendix 8: Screening Questions for COVID-19 Visitor.

SURVEILLANC BY THE HOSPITAL

Screening of Patients: Clinical screening criteria for COVID-19 should be based on DC Health Notice and CDC recommendations. Newly admitted patients, or patients exhibiting potential symptoms shall be screened by using Appendix 1 of this issuance.

Screening of Staff: As of April 1, staff from Housekeeping, Nursing, Facilities and Environment, and Nutritional Services will receive screening for COVID-19 prior to reporting for duty. Staff from these departments must report to the Intensive-side of the building to receive temperature and other screening prior to reporting for duty. Any employee that shows risks and/or symptoms of COVID-19 shall be directed to go to their primary care physician for further testing. Staff may not return to work until they are cleared by their primary care physician.

- Screening for all other remaining staff will start on or before the week of April 6.
- The criteria for staff screening are the same as for newly admitted patients; and shall also be used for new hires, when staff return from international travel, and/or exhibit respiratory symptoms. Staff shall also be guided by the attached Appendix 2 (DC Health Issuance dated February 28, 2020) and Appendix 3 (DCHR Memorandum dated March 2, 2020).

COVID-19 Screening Tools: Conduct screening of COVID-19 by using Travel History Questions for 2019-nCoV (Coronavirus), per Appendix 1 for patients and Appendix 2 for staff. When suspected cases are identified, healthcare providers should-

- Apply facemask to patient/staff.
- Isolate patient/staff in a room with door closed. Affix the "Isolation Unit" signage on the entry doors (see Appendix 10).
- Call 911 to send patient/staff out to an acute care hospital.

Testing of Patients for COVID-19: Patients returning from an outside provider, courts, or community hospitals that may present with risks or symptoms for COVID-19 shall be screened and evaluated by a GMO/NP. Based on the screening/evaluation results (e.g., patient symptoms), the GMO/NP will determine if further COVID-19 testing will be required (see Appendix 9: Notice to GMO/NPs on COVID-19 (Coronavirus) Testing, and Department of Forensic Sciences: COVID-19 Specimen Submission Guidelines; and associated forms and instructions).

Infection Control Recommendations: Saint Elizabeths Hospital follows DC Health's and CDC's latest recommendations to develop infection control and prevention strategies outlined below:

1) Follow DC Human Resources policy as it pertains to leave or other HR matters (see Appendix 3: DCHR Memorandum dated March 29, 2020, https://edpm.dc.gov/issuances/human-resources-guidance-covid-19-emergency/)
2) Use proper Cough Etiquette as outlined in Appendix 5 (Cough Etiquette)
3) Perform frequent hand hygiene per Infection Control Policy 11.0 Hand Hygiene. (https://tinyurl.com/vdwfkb4)
4) Housekeeping staff shall implement cleaning and disinfecting practices per Appendix 7: Guidelines for Facilities During Outbreaks of Norovirus/Gastroenteritis: Recommendations and Precautions.
5) Saint Elizabeths Hospital will provide additional hand sanitizers and facemask for visitors.

Monitoring Guidelines for Staff Who Were Exposed to a Confirmed COVID-19 Staff: Staff shall be notified if they were exposed to another employee who has had a confirmed COVID-19 test. These exposed staff shall (see Appendix 11)-

1) Monitor their temperature and absence of symptoms each day prior to starting work.
2) Wear a facemask while at work for the 14 days after the exposure.
3) Adhere to hand hygiene protocols.
4) NOT work with high risk patient populations (such as in units 1A & 1B)
5) Self-monitor for symptoms at all times, and seek re-evaluation from your primary care doctor if respiratory symptoms occur.
6) If they develop symptoms (even mild symptoms) while at work, IMMEDIATELY cease patient care activities. Staff shall don a facemask (if not already wearing), isolate themselves, and notify their supervisor.

Process for Staff Requesting Leave Due to COVID-19 and/or as a Result of Experiencing Symptoms of COVID-19 (see Appendix 12)

- **Leave Review and Recommendations**
  1) All requests for leave shall be emailed to Dr. Potter for review.
  2) Dr. Potter will review and provide his recommendations to the DBH Risk Manager (Mary Campbell) and Elaine Tu who will be tracking employees and their symptoms.
  3) Recommendation will also be sent to the employee's supervisor; who will notify the employee on the recommendations (i.e., to test and quarantine).
  4) Mary will notify Ms. Wheeler of the leave request and recommendations; and Ms. Wheeler will inform the supervisor if the employee should get administrative leave (or any other type of leave).
- **Employee Responsibilities**
  1) All employees are required to share their contact information with Elaine/Mary. Mary will conduct daily calls with the employee until they return.
  2) All employees are required to share medical information related to COVID 19 illness.
  3) All employees must present a medical clearance before returning to work.
- **Tracking of Employee Leave**
  1) Mary/Elaine will track all employee COVID19 tests and test results.
  2) Mary will track employees requesting FMLA, ADA, or other underlying health issues.

Staff having questions related to human resources-related issues should contact SEH's HR Department:

- Debra Allen-Williams at 299-5212 or debra.allen-williams@dc.gov
- Andrea Bentley at 299-5231 or andrea.bentley@dc.gov

Working in Areas/Units Identified as "Quarantined" or "Isolation": Staff shall use proper Personal Protective Equipment.

- As of March 31, 2020; ALL STAFF WORKING ON UNIT 2TR MUST wear Powered Air Purify Respiratory (PAPR), gown, eye protector or faces shield, gloves and shoe protectors when providing patient-care within 6 feet of the patients (see Appendix 6: 2TR PPE Requirement).
- PAPR is not needed when staff is not in close contact with patients, for example when in the Nursing Station, working within the confines of the Medication Room, and when maintaining more than a 6 foot distance in the milieu or common areas. However, face shield, face mask, gown, gloves, and shoe protector should be worn while working on 2TR.
- Staff shall use contact and droplet precaution when providing patient care as appropriate (see Appendix 6: 3M Air-Mate Powered Air Purifying Respirator Instructions for Use).

The following chart provides guidance for when to use PPE and PAPR equipment (see Appendix 6:2TR PPE Requirement). Staff may request further training on the proper use of this equipment from their supervisor.

Areas	Protection
Quarantined (2TR)	Gown, Face Mask, Face Shield, Gloves, Shoe Protectors
Isolation	Zipped-up Suit, White Hood, PAPR, Gloves, Shoe Protectors
All Other Areas	Standard droplet precautions when providing care

Communicating the Hospital's Plan to Patients and their Family/Guardians: Executive leadership has been meeting with the patients and the Patient Advisory Council to share with them the Hospital's plans for keeping them safe. Leadership has also provided and continues to provide updates to patient's family/guardians. Executive leadership are available to speak with patients as needed. Please notify your supervisor if your unit requests a meeting or more information.

Approval:

Edger Potter, MD
Supervisory General Medical Officer

Yi-ling Elaine Tu, MSN, RN, WCC
Infection Control Coordinator

Approved:

Mark Chastang, MPA, MBA, FACHE
Chief Executive Officer

Saint Elizabeths
SHINING THE LIGHT SINCE 1855

Screening Questions for COVID-19 (Coronavirus)
PATIENT

PATIENT NAME:	HOSPITAL #:
ADMISSION DATE:	UNIT:

These criteria are intended to serve as a guide for evaluation and are subject to change as additional data become available. Testing may be considered for deceased persons who otherwise meet the PUI criteria. Patients who meet the following criteria should be reported to DC Health for evaluation as a PUI*:

Temperature: _____F NA ☐

Clinical Features and Epidemiologic Risk			
Clinical Features	**&**	**Epidemiologic Risk**	**Action**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) ○ Yes ○ NO	**AND**	**Any person, including health care personnel[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).**
Fever[1] AND signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath) AND tested negative for influenza[5] ○ Yes ○ NO	**AND**	**A history of travel to a country with a Level 2 or 3 Travel Advisory OR an area with confirmed ongoing community transmission, within 14 days of symptom onset. (check CDC for daily update)** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND without an alternative explanatory diagnosis ○ Yes ○ NO	**AND**	**A history of residing in a nursing home or long-term care facility within 14 days of symptom onset** ○ Yes ○ NO	**If Yes, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the**

SEH Travel History Questions for 2019-nCoV (Coronavirus)
SEH 320.03.50

APPENDIX 1

COVID-19 (Coronavirus).

1 Fever may be subjective or confirmed.
2 For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
3 Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
4 Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
5 Includes rapid and confirmatory influenza testing

If patient meets one of the above, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of covid-19(Coronavirus) and contact the DC Health Division of Epidemiology–Disease Surveillance and Investigation at:

202-576-1117 (8:15am-4:45pm)

844-493-2652 (after-hours, healthcare providers only)

Fax: 202-442-8060 | Email: doh.epi@dc.gov

Evaluator (sign):

Print Name: _____ **GMO** ☐ **NP** ☐ **RN** ☐

Signature: _____ **Date:** _____

The guidelines above will continue to be updated as the outbreak evolves. Please visit the DC Health and CDC websites regularly for the most current information.

Saint Elizabeths
SHINING THE LIGHT SINCE 1855

Screening Questions for COVID-19 (Coronavirus)
EMPLOYEE

EMPLOYEE NAME:	TRAVEL DESTINATION:
RETURN DATE:	DEPARTMENT/UNIT:

Does Employee Meet DCHR Self Quarantine Criterion According to DC Government Continuing Operations in Response to COVID-19 (Effective March 16, 2020- March 31, 2020).

You must notify your immediate supervisor of any foreign travel in the last 14 days to areas designated by CDC as Level 2 or 3.

Self-Quarantine: ☐ Yes ☐ No Temperature: _____F ☐ NA

These criteria are intended to serve as a guide for evaluation and are subject to change as additional data become available. Testing may be considered for deceased persons who otherwise meet the PUI criteria. Employees who meet the following criteria should be reported to DC Health for evaluation as a PUI*:

Clinical Features and Epidemiologic Risk			
Clinical Features	**&**	**Epidemiologic Risk**	**Action**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) ○ Yes ○ NO	**AND**	**Any person, including health care personnel[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of COVID-19 (Coronavirus).**
Fever[1] AND signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath) AND tested negative for influenza[5] ○ Yes ○ NO	**AND**	**A history of travel to a country with a Level 2 or 3 Travel Advisory OR an area with confirmed ongoing community transmission, within 14 days of symptom onset. (check CDC for daily update)** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND without	**AND**	**A history of residing in a nursing home or long-term care facility within 14 days of symptom onset**	**If Yes to both, follow infection control measures on Administrative**

APPENDIX 2

an alternative explanatory diagnosis

- Yes
- NO

- Yes
- NO

Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).

1 Fever may be subjective or confirmed.
2 For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
3 Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
4 Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
5 Includes rapid and confirmatory influenza testing

If employee meets one of the above, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of covid-19(Coronavirus) and contact the DC Health Division of Epidemiology–Disease Surveillance and Investigation at:

202-576-1117 (8:15am-4:45pm)

844-493-2652 (after-hours, healthcare providers only)

Fax: 202-442-8060 | Email: doh.epi@dc.gov

Evaluator (sign):

Print Name: _____ **GMO** ☐ **NP** ☐ **RN** ☐

Signature: _____ **Date:** _____

The guidelines above will continue to be updated as the outbreak evolves. Please visit the DC Health and CDC websites regularly for the most current information.

HTTPS://edpm.dc.gov/issuances/human-resources-guidance-covid-19-emergency/

Human Resources Guidance for the COVID-19 Emergency (March 26 Update)

I-2020-8

Effective Date:
March 29, 2020

Expiration Date:
Dec. 31, 2020

Chapters:
12 16

Contents »

Overview

On March 11, 2020, the Mayor declared both a public emergency and a public health emergency due to the Coronavirus Disease 2019 (COVID-19). Following the Mayor's declarations, on March 17, 2020, the Council passed the COVID-19 Response Emergency Amendment Act of 2020 providing broad authority to address the critical needs of District residents and businesses.

The Department of Human Resources (DCHR) is releasing this guidance to assist agencies and employees in understanding personnel management changes that are in effect during the COVID-19 emergency. In this issuance, we are making updates to administrative leave provisions, which supersede and replace the provisions contained in Issuance No. 2020-6.

For the most up to date information on COVID-19 in Washington, DC, please visit https://coronavirus.dc.gov/.

Hiring and Promotions

During the public health emergency, District government agencies have several flexible hiring options available if it becomes necessary to quickly hire new employees. Agencies under the Mayor's personnel authority shall work with DCHR's recruitment specialists to identify the right hiring tools for agencies' hiring needs to implement and effectuate these temporary assignments.

Details

An employee may be temporarily detailed to another position to meet the immediate needs of the agency or another agency to address the COVID-19 emergency. Details may be made within agencies and between agencies. If an agency needs assistance meeting a staffing need, the agency should reach out to their assigned Specialist at DCHR for assistance. Details may be made for up to 240 days. Details in excess of 240 days must be approved by DCHR.

Emergency Appointments

With DCHR's approval, agencies may make non-competitive emergency Career Service appointments of up to 30 days to provide for maintenance of essential services to respond to a natural disaster or other similar emergency situations. Agencies cannot extend emergency appointments and may not promote, convert, transfer, or otherwise move the employee into a permanent position within the District government.

Non-Competitive Appointments

During the COVID-19 emergency, DCHR may authorize non-competitive appointments. Non-competitive appointments will be authorized when rapid appointment is reasonably necessary to respond to the COVID-19 emergency. DCHR may waive any applicable residency requirements, but these waivers must be approved in writing and contained in any offer letter.

Special Appointments

DCHR may authorize agencies to make special, non-competitive appointments to fill professional, scientific, or technical expert or consultant positions. These appointments are in the Excepted Service. For the duration of the COVID-19 emergency, the applicable residency requirement is suspended. After the emergency ends, appointees will have 180 days to relocate into the District or to compete internally for a position in a different service. There is no limit to the number of special appointments that can be made, and they are in addition to the Mayor's allotted Excepted Service positions under D.C. Official Code § 1-609.03.

Temporary / Term Appointments

APPENDIX 3

Agencies may make temporary appointments to the Career, Education, and Management Supervisory Services to meet immediate, time-limited operational needs. During the COVID-19 emergency, and with DCHR's approval, agencies may make these appointments non-competitively above grade 12. However, once the emergency ends, any appointments above grade 12 must be competed.

Additionally, agencies may extend any temporary or term appointment for up to 90 days without pre-authorization. Any extensions beyond 90 days must be approved by DCHR.

Promotions

DCHR may authorize the promotion of employees either on a temporary or permanent basis without competition to meet immediate operational needs. Time limits for temporary promotions are suspended during the COVID-19 emergency.

Reassignments

For front-line agencies that are experiencing talent shortages, agencies may choose to reassign existing employees. If an agency has specific hiring needs with which it needs assistance, please contact the assigned Specialist at DCHR for assistance.

Residency Requirements

For the duration of the COVID-19 emergency, DCHR may suspend any residency requirements for positions to meet immediate operational needs to provide critical services or support for the COVID-19 emergency. All waivers by DCHR must be in writing and must include the scope and duration of the waiver. Agencies must supply a corresponding notice to the applicable candidate or employee.

Selection Certificates

Typically, selection certificates for vacancies may last no longer than 90 days. During the pendency of the COVID-19 emergency, and with the approval of DCHR, agencies may rely on certificates that are more than 90 days old.

Scheduling and Deployment

Childcare

The District government recognizes the difficulty of acquiring childcare during the COVID-19 emergency. As such, employees directed to telework may work from home and supervise their children during this emergency. Agencies may also consider alternative work hours and schedules for impacted employees. For example, agencies may authorize employees to work 12 hours shift for 4 days to allow time for both work and child supervision.

However, due to the critical nature of the jobs performed by employees who cannot telework or who are ordered to a duty station, these employees must find alternative arrangements for childcare. Only if operations permit may agencies approve at their discretion, leave for employees who cannot telework or who are ordered to a duty station but cannot physically report to work.

Commuter Delays

Metro has reduced services and updates its operating status frequently. For the current operational status, please visit Metro's COVID-19 Operational Status webpage.

With the reduced service, employees will likely experience unexpected commuting delays when using Metro bus and rail service. Agencies should remain flexible and understanding when employees encounter commuting challenges. Employees should notify their supervisor immediately if they are impacted by commuting delays and will be unable to arrive at work as scheduled. Employees should receive pay only for those hours actually worked. If an employee arrives late due to commuting delays, a supervisor may approve an employee to work later than scheduled to make up the lost time.

Duties

Agencies may modify employees' assigned duties as needed to support the COVID-19 response. Agencies may also modify employees' assigned duties to accommodate remote and telework arrangements.

Duty Stations

Agencies may modify an employee's duty station as appropriate to meet operational or service needs during the COVID-19 emergency.

Employee Scheduling

Agencies may modify employees' work schedules as needed to adequately manage the city's COVID-19 response and maintain critical services. This includes changing workdays and times, adding additional workdays, expanding worktimes, and ordering overtime. When modifying an employees' schedule, agencies should provide employees at least 24 hours' notice of the schedule change, except when the need for the schedule change was unforeseeable.

Employees who are exempt from the FLSA overtime provisions may be eligible to accrue exempt time off at the discretion of their agency. At this time, FLSA-exempt employees are not eligible for overtime pay. For additional guidelines on overtime and compensatory time (comp time), refer to Issuance 2020-2, *Overtime*.

Previously Approved Leave (Rescinding)

Agencies shall rescind any previously approved leave granted to an employee if the employee's absence would impede the city's COVID-19 response. An agency, at its discretion, may authorize the reimbursement of any actual financial loss suffered by an employee as a direct consequence of a recension of previously approved leave. For example, an agency may reimburse an employee for any travel change fees but not the entirety of the employee's itinerary. Reimbursements will be made from centralized funding and will not impact agencies budgets.

Meetings

Agencies' gatherings and in-person meetings shall be limited to fewer than 10 people at a time, when feasible; agencies are encouraged to use tele-conferencing, video-conferencing and other electronic options to the greatest extent possible. For more information, visit https://remote.dc.gov/.

Reporting Time

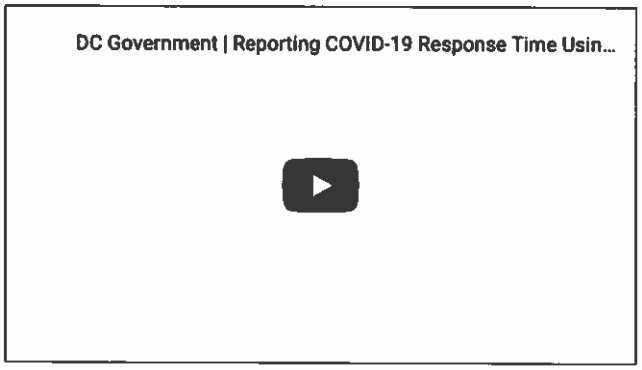
During the COVID-19 emergency, employees, and timekeepers for those agencies whose timekeepers enter employees' time, will continue to enter work hours on their timesheets. Generally, time will be entered as usual. However, to properly account for new operating models, accurate time reporting is critical.

Telework

Employees who are working from home must use the Situational Telework Time Reporting Code (TRC). This TRC is: "Telework (Situational) – STTW".

Recording COVID-19 Tasks

Employees who perform any work due to COVID-19 should use the new "Task" field in PeopleSoft in addition to the appropriate TRC ("Telework (Situational) – STTW", "Regular Pay - REG," etc.). Employees should use the "Task" field to report regular work related to COVID-19 (work requiring you to report to a physical duty station), telework related COVID-19, and any COVID-19 related overtime. For more information on reporting COVID-19 tasks, please see Issuance 2020-7, COVID-19 Timekeeping and watch the following video for instructions on how to report COVID-19 related tasks.



Employee Protections and Requirements

Administrative Leave

Employees who are ordered or recommended to self-quarantine or quarantine may telework from home. However, an agency head may authorize administrative covering a 14-day period following the employee's last day of work at a government worksite if the employee is unable to telework due to COVID-19 (see also Declaration-of-Emergency Leave). For employees who self-quarantine or quarantine, agencies shall require a doctor's note prior to returning to the workplace clearing the employee to return.

DCHR is currently reviewing recently enacted federal legislation that may impact employees' eligibility for paid time off. This section will likely be revised in the coming week.

Colds, Flus or other Communicable Illnesses

Employees suffering or who appear to be suffering from an acute respiratory illness (e.g., cough, fever, shortness of breath) at work shall be separated from other employees and sent home immediately. Employees shall not come to work until they are free of a fever (100.4°F or greater using an oral thermometer), signs of a fever, and any other symptoms for at least 24 hours without the use of symptom altering medicines.

An employee who has a cold, flu, or other communicable disease or illness shall consult their supervisors about flexible leave usage policies and any situational telework options. Prior to returning to the workplace, agencies shall require a doctor's note clearing the employee to return. In rare cases, employees returning from leave or situational telework following an illness may be asked to undergo a fitness for duty evaluation. However, such evaluations may only be ordered with DCHR's approval. (For more information on fitness for duty evaluations, please refer to 6-B DCMR § 2005.)

Declaration-of-Emergency Leave (DC Family and Medical Leave Act)

An employee who is unable to work because of the COVID-19 emergency may be entitled to declaration-of-emergency (DOE) leave under the DC Family Medical Leave Act during the emergency. To be eligible for DOE leave, an employee must receive proper certification of their eligibility.

The following shall constitute acceptable certification of the need for DOE leave: a recorded order or recommendation from (1) the Mayor, (2) any District or federal agency, or (3) a medical professional that the employee self-quarantine. In the case of a government mandated quarantine or isolation, the declaration of public health emergency shall serve as certification of the need for such leave.

At their option, employees eligible for DOE leave may choose to telework from home instead of taking leave. Otherwise, employees may use any of their accrued leave (annual leave, sick leave, or both) during their absence from work and may receive advanced leave if their accrued leave does not cover the duration of their absence. Employees taking DOE leave due to self-quarantine must supply their agencies a doctor's note clearing their return.

Telework

Situational telework is when employees work remotely from a secure location, usually from home, to address an immediate situation. Situational telework is appropriate to address a declared emergency and for responding to COVID-19. Time spent in a situational telework status must be recorded in PeopleSoft using the Time Reporting Code "Telework (Situational)." All employees who have been directed to work from home during the COVID-19 emergency shall use this time reporting code on their timesheets. Employees who are not teleworking and are reporting to a duty station outside of their home should continue to use their normal time codes.

Employees must execute an application to telework and sign a telework agreement, have the necessary equipment to work remotely, and the agency head must approve the telework agreement. As part of any telework agreement, employees must agree to respond to phone calls and emails within 30 minutes and must have the ability to report to any duty station within the District of Columbia within 2 hours if directed to do so unless otherwise approved by the agency.

Telework Mandated

The Mayor has ordered that employees telework to the greatest extent possible during the COVID-19 emergency. For purposes of addressing COVID-19:

- **All employees shall be considered for telework** regardless of whether they are probationary, temporary, term, or permanent, and regardless of any performance problems (including whether they were rated a marginal performer or lower for the last fiscal year or currently subject to a Performance Improvement Plan).
- Agencies may not suspend public-facing services as part of their telework policy without approval from the Mayor or the Mayor's designee.

Assessing Telework Options

Each agency shall continue to assess the positions in their agency and determine those positions that are eligible to telework. Below are general guidelines on situational telework based on the viability of telework given the nature of agencies' operations.

Fully Telework Capable Agencies

Employees shall telework if they work at agencies where the entire workforce is capable of teleworking without disruption to District government services.

Please refer to coronavirus.dc.gov for the current operating status of each agency.

Partially Telework Capable Agencies

As part of the city's response to COVID-19, some agencies will have a mix of jobs within their workforce, where telework is not practical for some employees but other employees are capable of teleworking without significant disruption to District government services.

Please refer to coronavirus.dc.gov for the current operating status of each agency.

Agencies Without Telework Capabilities

Certain agencies whose primary missions focus on public safety and/or health emergency response may not exercise expanded telework options during the city's COVID-19 response as these agencies have been deemed by the Mayor to be, in whole, essential to public well-being.

Please refer to coronavirus.dc.gov for the current operating status of each agency.

Teleworking Securely

Given the possibility of a larger percentage of District government network users (employees and contractors) working from home, the Office of the Chief Technology Officer (OCTO) is doing everything possible to make remote work as secure as possible. Remember, bad actors may know this is a vulnerable moment to try to access the District government network.

Ideally, everyone working remotely will be using a government issued device, such as a laptop, tablet, or mobile phone. These devices should have an OCTO-approved image installed, including updated antivirus, and each user should have a secure VPN account to access the same environment they normally access when at work.

In addition to these practices, all employees and contractors must help in protecting our network and data during this response. OCTO has put together guidance for agency leadership to allow agencies to work remotely in the most secure way possible. Use the following link to learn more about remote work options and remote work guidance.

Leave

Requesting Leave

Employees are required to request approval to take leave from their immediate supervisor or, if the immediate supervisor is unavailable, from another supervisor within the employee's chain of command. To the greatest extent possible, employees who require unscheduled leave must contact their supervisor no later than two hours prior to the start of their scheduled tour of duty. All leave requests shall continue to be made according to existing policies.

Sick Leave

An employee is entitled to use an unlimited amount of their accrued sick leave when they are unable to perform their duties due to physical or mental illness or are symptomatic due to a disease. Employees are entitled to use sick leave to care for family members who are symptomatic due to a quarantinable communicable disease. Please refer to 6-B DCMR § 1242.1 for other permissible uses of sick leave. For sick leave absences in

excess of three consecutive workdays, and until further notice, employees must supply a medical release from their health care provider clearing their return to work. No agency shall permit an employee to return to the workplace without such a release unless this requirement is waived by DCHR.

Leave Without Pay (LWOP)

Leave Without Pay (LWOP) is a temporary non-pay status and absence from duty granted at the employee's request or as otherwise authorized by regulations. The permissive nature of LWOP distinguishes it from absences without official leave (AWOL), which is unauthorized leave that may subject an employee to corrective or adverse action. Agencies may approve a maximum of 52 calendar weeks of LWOP. Except as provided by D.C. FMLA, authorizing LWOP shall be a matter of administrative discretion.

Absence Without Leave (AWOL)

Notwithstanding COVID-19, if employees need to take unscheduled leave, they must continue to inform their supervisor, or if their supervisor is not available, another supervisor or manager within their chain of command. Except when authorized by a supervisor, employees who do not arrive to their duty station at the start of their scheduled tour of duty may be considered AWOL. An employee whose leave request is denied and who fails to report for duty as scheduled is also considered AWOL. An employee can be charged with AWOL regardless of whether the employee has accrued leave.

If it is later determined that the absence was excusable, or that the employee was ill, agencies may change the charge to AWOL to a charge against annual leave, compensatory time, restored leave, sick leave, leave without pay, or another leave type as appropriate. See 6-B DCMR § 1268 for additional details.

Unless directed otherwise, all District employees must continue to report to work as scheduled and take leave in accordance with District personnel regulations, the policies outlined in this issuance and any existing agency-specific leave policies. To the extent there is a conflict between the leave policies in this issuance and existing regulations and agency policies, the provisions of this guidance shall control.

Advanced Sick leave and Annual Leave

If an employee exhausts their accrued annual leave, sick leave, or both, agencies may advance leave to the employee.

Agencies may advance annual leave to eligible employees up to the amount of annual leave expected to be earned during the balance of the current leave year or the remainder of the employee's time-limited appointment, whichever is sooner. For more information on advancing annual leave, please refer to 6-B DCMR § 1237.

In cases of serious disability or ailments, agencies may advance up to a maximum of 240 hours of sick leave to employees who have exhausted all their accumulated sick leave except when the agency has reason to believe that the employee may not be able to repay the advanced leave. For term and temporary employees, agencies may advance only up to the total sick leave the employee would earn during the remainder of the time-limited appointment. For more information on advancing sick leave, please refer to 6-B DCMR § 1243.

Workforce Management

Corrective and Adverse Actions

If an employee faces corrective or adverse actions as part of the progressive discipline process located in 6-B DCMR § 1600 *et seq.*, employees are entitled to certain rights. Specifically, 6-B DCMR §1602.3 (a) states that a corrective or adverse action must be initiated no more than 90 business days after an agency knew or should have known about the performance or conduct supporting the action.

However, during the COVID-19 emergency, the 90-business day limit is suspended. No days during the emergency shall be considered business days for purpose of 6-B DCMR § 1602.3(a). This suspension is necessary to avoid the diversion of critical resources to administrative investigations, and the practical challenges involved in investigating and taking corrective or adverse action while many employees are working remotely.

Fitness for Duty Evaluations

The DC Health recommends that all non-urgent medical procedures be "postposed to preserve health care capacity ... [and] ... to flatten the epidemic curve." Fitness for duty evaluations are considered non-urgent. Accordingly, in compliance with DC Health's recommendation, DCHR will not process any fitness for duty until DC Health recommends that non-urgent medical services should resume.

Travel for Government Purposes

Travel for government purposes falls into two categories: essential and non-essential. The category determines what restrictions and guidance apply.

Essential Government Travel

Essential government travel is domestic travel critical to the continued operations of the District government, or travel that is required by law. For example, travel for the purpose of testifying on behalf of the District of Columbia government before an administrative or judicial court is considered essential government travel. However, the District is following the CDC guidance as it relates to restricted travel to those areas where a travel ban is in place. All essential government travel must be approved by the agency head.

Non-Essential Government Travel

Non-essential government travel is all international travel as well as domestic, government-related travel that does not qualify as "essential" travel. This includes, among other purposes, travel for conferences and training.

Non-essential government travel commencing after March 11, 2020, is permitted only when the travel was approved and determined by the agency's director or equivalent, or the relevant Deputy Mayor that the travel is in the best interest of the District of Columbia.

International travel and travel not otherwise permitted by this section is suspended until May 1, 2020, or as otherwise directed by the Mayor.

Human Resources Management

Supersession

The provisions of this issuance supersede any provisions within previous issuances, a collective bargaining agreement, or the District personnel regulations to the extent there is a conflict.

Time Limits

The personnel authority may authorize different time limits than that explicitly outlined in this issuance to appropriately respond to the COVID-19 emergency.

Updates

In the absence of the Director of the D.C. Department of Human Resources, the Associate Director for Policy and Compliance is authorized to make any required amendments to this issuance.

References

1. *Declaration of Public Emergency,* Mayor's Order 2020-045 (Mar. 11, 2020)
2. *Declaration of Public Health Emergency,* Mayor's Order 2020-046 (Mar. 11 2020)
3. *COVID-19 Response Emergency Amendment Act of 2020,* Act 23-0246 (Mar. 17, 2020)
4. *Hours of Work, Legal Holidays and Leave,* Chapter 12, Title 6-B of the DCMR (Eff. Mar. 1, 2020)
5. *Compressed, Flexible, and Telework Schedules,* Issuance No. 12-58 (Sept. 28, 2016)

Attachments

1. Attachment 1 - COVID-19 FAQ
2. Attachment 2 - COVID-19 Personnel Time Tracking
3. Attachment 3 - Checklist for Identifying Critical Staffing Shortages
4. Attachment 4 - Administrative Leave Notice

Issued by Ventris C. Gibson, Director D.C. Department of Human Resources on March 29, 2020, midnight

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Center for Policy, Planning and Evaluation
Division of Epidemiology–Disease Surveillance and Investigation

March 13, 2020

Health Notice for District of Columbia Health Care Providers
Coronavirus Disease 2019 (COVID-19): Update on Testing and Personal Protective Equipment Recommendations

Summary

On March 10, 2020 the Centers of Disease Control and Prevention (CDC) updated its Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html).

- To the extent possible, providers should use telemedicine or telephonic communications to evaluate patients and avoid unnecessary visits to healthcare facilities.
- Based on the scientific evidence to date about how COVID-19 is transmitted, newly released infection prevention guidance from CDC, and given shortages of N95 respirators, **DC Health advises that collection of nasopharyngeal (NP) and oropharyngeal (OP) swab specimens for COVID-19 testing using contact and droplet precautions with a face mask is appropriate. Eye protection should always be used.**
- Specimen collection may be performed in an examination room with the door closed. Severely ill patients who will be transferred to a higher level of care should not be tested in an outpatient setting. Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients undergoing aerosol-generating procedures.
- **It is critical that outpatient providers continue to ensure that any patients presenting with respiratory symptoms are immediately given a facemask for source control. If the patient is tested for COVID-19 then provide them with guidance to self-quarantine at home until test results are available to inform next steps.**
- Now that COVID-19 testing is available at commercial and hospital labs, providers can choose to pursue testing through the DFS Public Health Laboratory that meet the DC Health testing criteria, or to send specimens to commercial or hospital-based labs.

Background

As of March 12, 2020, there have been 1,215 confirmed cases of COVID-19 within the United States, including 36 deaths. To date, there have been 10 DC residents who have tested positive for COVID-19. The epidemiology and spread of COVID-19 internationally and within the United States is rapidly evolving and guidance is continuously being released. We encourage you to regularly review the DC Health (https://coronavirus.dc.gov/) and CDC (https://www.cdc.gov/coronavirus/2019-ncov/index.html) websites for the most up-to-date situational information.

APPENDIX 4

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Important Points When Evaluating Potential COVID-19 PUIs

- Review CDC guidance, including on infection control, and the DC Health website regularly and develop internal processes for managing the assessment and notification to DC Health about potential PUIs
    - Infection control recommendations vary by facility and activity type and are important to maintain in order to prevent spread within a healthcare facility: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html)
- Please **do not direct patients to call DC Health directly** to determine if they should be tested for COVID-19. Healthcare providers should conduct a clinical assessment and then on the basis of the assessment and the PUI criteria described below, contact us if they suspect the patient may have COVID-19
- Please do the appropriate clinical evaluation on your patients based on their symptoms to assess ALL possible diagnoses (e.g. influenza, Strep throat), not just COVID-19
- When contacting DC Health, please leave a voicemail with a **direct** phone number if we do not answer so that we can call you back. We currently have a large call volume so may receive multiple calls at the same time, but return calls as soon as possible to healthcare providers.

Criteria on Evaluation and Testing of PUIs for COVID-19 (including updates about commercial testing)

Healthcare provider criteria for the evaluation of Persons Under Investigation (PUI) was expanded on March 4, 2020 to include a wider group of symptomatic patients (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html). Now that COVID-19 testing is available at commercial and hospital labs, providers can choose to pursue testing through the DFS Public Health Laboratory that meet the DC Health testing criteria, or to send specimens to commercial or hospital-based labs. Test results should be reported to the patient by their healthcare provider as per their usual protocols.

Patients who meet the following criteria will be prioritized for testing through the DFS PHL. Others will be considered on a case-by-case basis:

Clinical Features		**Epidemiologic Risk**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including health care personnel[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset
Fever[1] AND signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND tested negative for influenza[5]	AND	A history of travel to a country with a Level 2 or 3 Travel Advisory OR an area with confirmed ongoing community transmission, within 14 days of symptom onset
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND without an alternative explanatory diagnosis	AND	A history of residing in a nursing home or long-term care facility within 14 days of symptom onset

[1] Fever may be subjective or confirmed.
[2] For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
[3] Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – *or* – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
[4]Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
[5]Includes rapid and confirmatory influenza testing

Specimen Collection Guidelines

- Guidelines on collecting, handling and testing of clinical specimens from PUIs for COVID-19 can be found on the DFS PHL website
- PPE guidance for different healthcare settings can be found the above respective sections.
- Collection of an NP swab (in Viral Transport Media (VTM) or universal transport media (UTM)), OP swab (VTM or UTM) is recommended for initial diagnostic testing for SARS-CoV-2. Lower respiratory specimens can be tested if available and for patients who develop a productive cough, a sputum specimen can be collected. However, this significantly increases the risk to the HCP and should only be done if absolutely necessary.
- Please label specimens appropriately with patient's full name, date of birth, date and time of specimen collection, and unique patient identifier (medical record number or PUI number).
- Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset
- If approved for testing by DC Health, please complete the following forms, which are available on the DFS PHL website:
    - DC DFS PHL External Chain of Custody (CoC)
    - DC DFS PHL Test Requisition Form
    - CDC 50.34 Test Requisition Form
- Detailed instructions about specimen testing and forms will also be provided via email once testing is approved. Incorrectly labeled or missing information on forms and specimens will result in testing delays or specimen rejection.
- Please contact the PHL for any questions pertaining to testing:
    - Phone: 202-727-8956 (Monday-Friday from 8:30am-5:30pm), 202-868-6561 (after-hours calls), Email: dc.phl@dc.gov

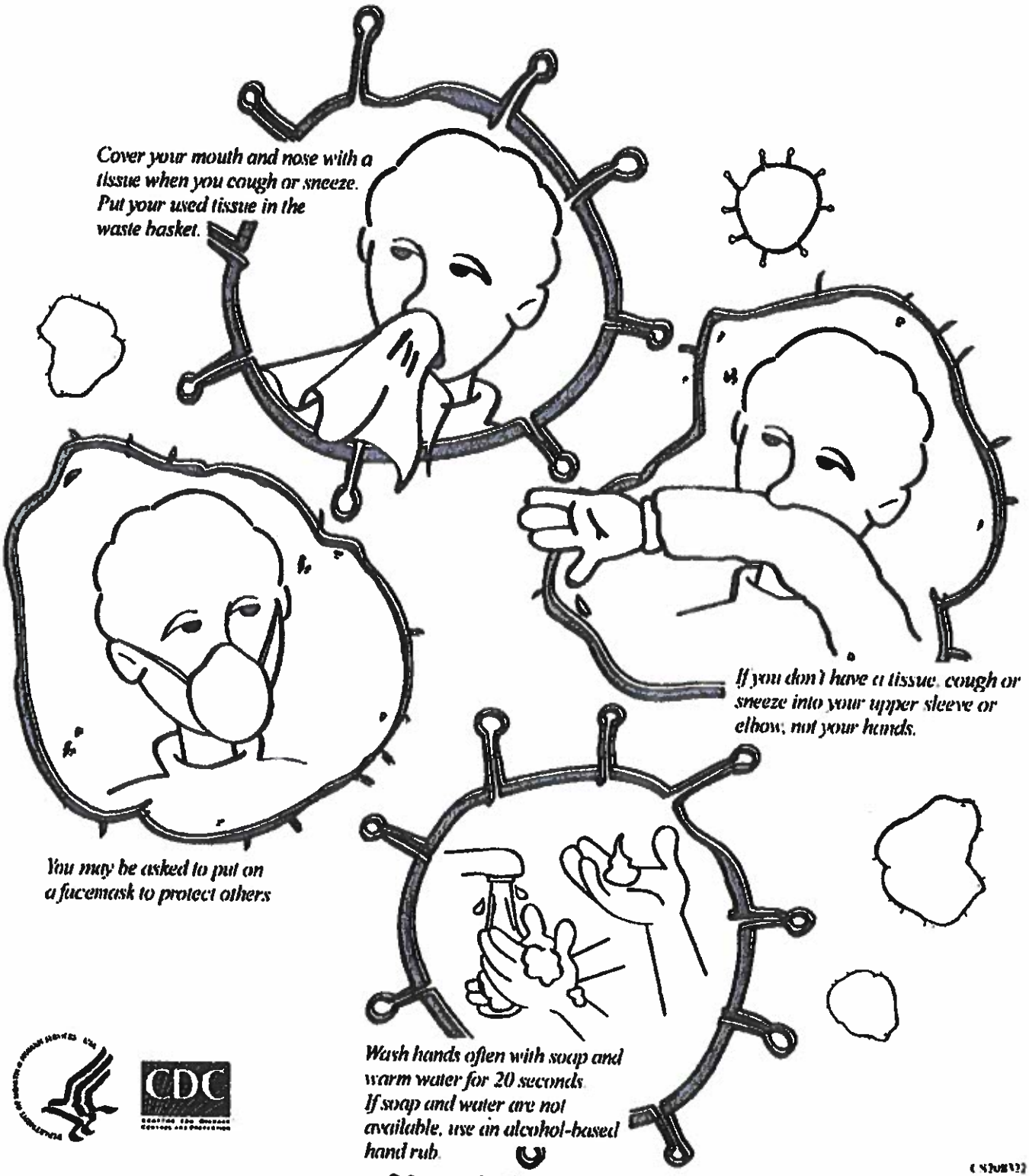
- If the test result is negative then the patient can stop self-quarantine and nothing needs to be reported to DC Health (as long as no prior conversations about this patient were initiated)
- If the test result is positive for COVID-19 then immediately report the case to DC Health through the 'Notifiable Disease and Condition Case Report Form' https://redcap.doh.dc.gov/surveys/index.php/surveys/?s=DHNA4X8LJC

The guidelines above will continue to be updated as the outbreak evolves. Please visit the DC Health and CDC websites regularly for the most current information.

Please contact the DC Health Division of Epidemiology–Disease Surveillance and Investigation at:
202-576-1117 (8:15am-4:45pm)
844-493-2652 (after-hours, healthcare providers only)
Fax: 202-442-8060 | Email: doh.epi@dc.gov

Cover your Cough

Stop the spread of germs that can make you and others sick!



CDC

APPENDIX 5

2TR PPE REQUIREMENT

If you are Providing Care to Quarantined Patients on 2TR:

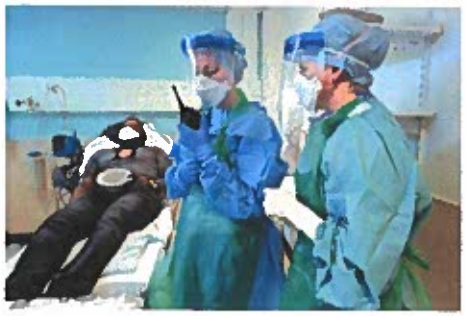
Face Mask

Face Shield

Gown

Gloves

Shoe Protectors



If you are Providing Care to Isolated Patients:

White Hood

PAPR

Gown

Gloves

Shoe Protectors

Please make sure PAPR IS CHARGED AS MUCH AS POSSIBLE
Wipe PAPR between uses with Oxivir
Adhere to Hand Hygiene Policy
Clean and disinfect high-touch surfaces

APPENDIX - 6

SEH Infection Control

3M Air-Mate Powered Air Purifying Respirator (PAPR) Instructions for Use

Durham Regional Hospital
Safety Office
470-6161

1. Unplug the PAPR from the cord connecting it to the battery charger and electrical outlet.

2. Inspect the airflow tube for cracks. Pay close attention to the end that connects to the head cover.

3. Check to ensure that the airflow tube is securely connected to the PAPR. Look for any signs of damage.

4. Remove the tissue paper covering the clear plastic face mask.

5. Turn the PAPR on by Pressing the Black Rubber Button.

6. To check the airflow, place the "egg float" into the upright end of the airflow tube.

APPENDIX 6

7. The lower band will rise above the edge of the airflow tube if the air supply is adequate.

8. Connect the airflow tube to the plastic circle at the back of the head cover.

9. Place the PAPR (with airflow tube up) against your lower back and fasten the belt buckle.

10. Guide the airflow tube upward behind you and put the head cover on. There are headbands inside the head cover that fit snugly on your head.

11. Adjust the head cover so that the elasticized edge of the face seal fits under your chin. It is now safe to enter the isolation room.

12. Remove PAPR in a non-contaminated area. Disconnect the head cover from the airflow tube with care by firmly grasping both pieces by the hard plastic parts that connect them. Gently but firmly pull them apart.

Care and Storage

For Patients on Airborne Precautions:

- Head covers can be re-used by the same employee for the same patient as long as they are clean and intact.
- Write your name on it.
- On the nursing units the head covers can be stored in the anterooms.
- Reconnect the PAPR to the battery charger.

For Patients on Airborne Precautions and Contact Isolation:

- Discard the head cover. *Do not reuse head covers when caring for a patient on Contact Isolation.*
- Disinfect the OUTSIDE of the PAPR unit with hospital-grade disinfectant after use.
- Reconnect the PAPR to the battery charger.

- If airflow is inadequate, the PAPR malfunctions, or there are cracks in the airflow tube, call Clinical Engineering at 470-8184.
- New head covers can be ordered from Central Stores 470-4250.

GUIDELINES FOR FACILITIES DURING OUTBREAKS OF NOROVIRUS/ GASTROENTERITIS: RECOMMENDATIONS AND PRECAUTIONS

- Encourage frequent hand washing with soap and warm water.
- Provide and encourage use of alcohol based (62%) waterless hand sanitizers when entering facility.
- Reinforce strict hand washing policy among staff.
- Do not allow symptomatic staff to work in facility.
- Assure glove use for handling of all ready-to-eat foods and eating utensils.
- Increase frequency for cleaning/sanitizing "high touch" surfaces, e.g., door handles, light switches, handrails, faucets, ice machine, etc. (see next page for facility specific recommendations)
- Use disposable cleaning cloths; use a new cloth for each room/area cleaned.
- Dispose of vacuum cleaner bags between uses. *Note: if area is visibly soiled with fecal spillage or vomit do not vacuum—either steam clean or use hot water and detergent.*
- Do not enter food service area with items soiled with vomit or fecal spillage.

The following cleaning agents are recommended for use during an outbreak:

Suggested Uses	Suggested Cleaning Method	How to Make (1 cup = 240ml)	Strength (parts per million)
Porous surfaces such as wood floors or surfaces visibly soiled with vomit/feces	Chlorine bleach*	1 ⅓ cup bleach in 1 gallon water	5000ppm (1:10 dilution)
Non-porous surfaces such as: handrails, tile floors, counter-tops, sinks, toilets, doorknobs and other commonly handled items. *See facility specific section for suggested items.*	Chlorine bleach*	1/3 cup bleach in 1 gallon water	1000ppm (1:50 dilution)
Food/mouth contact items, stainless steel and toys mouthed by children	Chlorine bleach* then rinsed with water OR dishwasher at 170°F	1 Tbsp. bleach in 1 gallon water	200ppm (1:250 dilution)
Carpet & upholstered fabrics visibly soiled with vomit or fecal spillage. Do not dry vacuum as viruses can become airborne.	Hot water and detergent OR Steam clean	NA	NA

*Bleach solution must: contain 5.25% Sodium Hypochlorite; be prepared fresh daily; have 10-20 minute surface contact time. Use unopened bleach for outbreak-related sanitization (open bottles lose effect after 30 days). EPA-registered disinfectants may also be used although effectiveness in outbreaks has not been evaluated.

Warnings:

1. Cleaning staff should wear protective equipment when handling chemicals.
2. Food preparation/food contact areas must be washed, rinsed and sanitized using standard protocol after cleaning with the stronger bleach solutions listed above.

Additional Recommendations for Healthcare/Assisted Living Facilities:

- Reinforce proper glove use when giving patient/resident care. Remove gloves before leaving ill patient's/resident's room and wash hands immediately.
- Do not "float" staff between units with ill patients/residents and units with non-ill patients/ residents.
- Assign staff members to care for only ill group or only non-ill group to help prevent transmission.
- Exclude non-essential personnel from units with ill patients/residents.
- Discontinue new admissions to the facility until the outbreak has ended.
- Confine ill patients/residents to their rooms until 72 hours after their symptoms end.
- Do not allow patients/residents from outbreak-affected units to enter/transfer to unaffected units, unless medically urgent to do so, until end of outbreak.
- Discontinue group activities (communal dining, etc.) until outbreak has ended.
- Limit visitation until outbreak has ended.
- Store and launder contaminated soiled linens separately from non-contaminated soiled linens.

Last Updated: 2/26/2010

APPENDIX 7

Facility-specific List of Suggested Items to Sanitize with 1000ppm bleach solution (1/3 cup bleach in 1 gallon water)

This is a list of suggested items to sanitize in order to reduce the number of illnesses during a gastroenteritis outbreak. This list is not exhaustive and your facility may have additional items in need of sanitation.

General:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, countertops, light switches, and other common items shared among staff/patrons.

Restaurants/Food Service:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, countertops, light switches, common telephones, menus, table placards, folders for credit cards, trays, tray stands, baskets, salt & pepper shakers, table bottle of ketchup and other condiments, sugar packet dispensers, booths, tables, exposed parts of buffet line, sneeze guards, and other common items shared among staff/patrons.

Healthcare Facilities:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, bedrails, countertops, common telephones, cards/games in common room, common craft materials, TV remote controls, computer keyboards, drawer/cabinet pulls, light/lamp switches, recliner chair handles, dining hall tables and chairs, dining hall salt/pepper shakers, walkers, wheelchair handles, any physical therapy shared items, and other common items shared among staff/patients/residents.

Schools/Childcare Facilities:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, countertops, light switches, common telephones, shared games/books/toys, playground equipment, diaper changing table, diaper changing pad, locker hardware, shared classroom equipment (microscopes, musical instruments, computer keyboards), physical education shared equipment, cafeteria tables and chairs, cafeteria salt/pepper shakers, and other common items shared among staff/students.
- Cloth items unable to withstand bleach sanitization (plush toys, pillows, etc.) should be laundered in hot water or discarded if laundering/sanitization not possible.

CONTACT THE LOCAL HEALTH DEPARTMENT IF YOU SUSPECT AN OUTBREAK IN YOUR FACILITY.

References:

http://www.cdc.gov/ncidod/dhqp/id_norovirusFS.html
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5009a1.htm
http://www.michigan.gov/documents/Guidelines_for_Environmental_Cleaning_125846_7.pdf
http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5633a2.htm
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5839a2.htm

Saint Elizabeths
SHINING THE LIGHT SINCE 1855

Screening Questions for COVID-19 (Coronavirus)
VISITOR

VISITOR NAME:	TRAVEL DESTINATION:
DATE OF VISIT:	VISITING UNIT/IIC/STAFF:

Visitors must be screened for COVID-19 prior to entering Saint Elizabths Hospital. If you have traveled to a country designated by the CDC as Level 2 or above in the last 14 days, you will not be able to visit.

Travel: Yes ☐ No ☐ Temperature: _____F NA

These criteria are intended to serve as a guide for evaluation and are subject to change as additional data become available. Testing may be considered for deceased persons who otherwise meet the PUI criteria.

Visitors who meet the following criteria should be reported to DC Health for evaluation as a PUI*:

Clinical Features and Epidemiologic Risk			
Clinical Features	**&**	**Epidemiologic Risk**	**Action**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) ○ Yes ○ NO	**AND**	**Any person, including health care personnel[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of COVID-19 (Coronavirus).**
Fever[1] AND signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath) AND tested negative for influenza[5] ○ Yes ○ NO	**AND**	**A history of travel to a country with a Level 2 or 3 Travel Advisory OR an area with confirmed ongoing community transmission, within 14 days of symptom onset. (check CDC for daily update)** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND without an alternative explanatory diagnosis ○ Yes	**AND**	**A history of residing in a nursing home or long-term care facility within 14 days of symptom onset** ○ Yes	**If Yes to both, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the**

SEH Travel History Questions for 2019-nCoV (Coronavirus)
SEH 320.03.50

APPENDIX 8

o NO

o NO

COVID-19 (Coronavirus).

1 Fever may be subjective or confirmed.
2 For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
3 Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
4 Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
5 Includes rapid and confirmatory influenza testing

If visitor meets one of the above, he or she is not allowed to visit.

Evaluator (sign):

Print Name: _____ **GMO** ☐ **NP** ☐ **RN** ☐

Signature: _____ **Date:** _____

The guidelines above will continue to be updated as the outbreak evolves. Please visit the DC Health and CDC websites regularly for the most current information.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Department of Behavioral Health, Saint Elizabeths Hospital

SUBJECT: Notice to GMO/NPs on COVID-19 (Coronavirus) Testing

EFFECTIVE DATE: April 1, 2020

Background

The clinical spectrum of COVID-19 varies from asymptomatic or paucisymptomatic forms to clinical conditions characterized by respiratory failure that necessitates mechanical ventilation and support in an intensive care unit (ICU), to multiorgan and systemic manifestations in terms of sepsis, septic shock, and multiple organ dysfunction syndromes (MODS) (Cascella, Rajnik, Cuomo, Dulebohn,& Di Napoli, 2020).

The first 425 cases recorded in Wuhan, data indicate that the patients' median age was 59 years, with a range of 15 to 89 years. There were no significant gender differences (56% male). Of note, the fatal cases were primarily elderly patients, in particular those aged ≥ 80 years (about 15%), and 70 to 79 years (8.0%). Approximately half (49.0%) of the critical patients and affected by preexisting comorbidities such as cardiovascular disease, diabetes, chronic respiratory disease, and oncological diseases, died (Cascella, Rajnik, Cuomo, Dulebohn,& Di Napoli, 2020). The authors of the Chinese CDC report divided the clinical manifestations of the disease by their severity:

- Mild disease: non-pneumonia and mild pneumonia; this occurred in 81% of cases.
- Severe disease: dyspnea, respiratory frequency ≥ 30/min, blood oxygen saturation (SpO2) ≤ 93%, PaO2/FiO2 ratio or P/F [the ratio between the blood pressure of the oxygen (partial pressure of oxygen, PaO2) and the percentage of oxygen supplied (fraction of inspired oxygen, FiO2)] < 300, and/or lung infiltrates > 50% within 24 to 48 hours; this occurred in 14% of cases.
- Critical disease: respiratory failure, septic shock, and/or multiple organ dysfunction (MOD) or failure (MOF); this occurred in 5% of case.

The COVID-19 may present with mild, moderate, or severe illness. Among the severe clinical manifestations, there are severe pneumonia, ARDS, sepsis, and septic shock. The clinical course of the disease seems to predict a favorable trend in the majority of patients. Among patients who developed severe disease, the medium time to dyspnea ranged from 5 to 8 days, the median time to acute respiratory distress syndrome (ARDS) ranged from 8 to 12 days, and the median time to ICU admission ranged from 10 to 12 days. Clinicians should be aware of the potential for some patients to rapidly deteriorate one week after illness onset (CDC, 2020). The initial 5 to 8 days

APPENDIX 9

after symptom development is a significant determinate in sending the patient to an acute care facility immediately.

Testing

Indication

Patients who are found to have met the criteria for having symptoms consistent with COVID-19 by the covering general medical officer (GMO) or Nurse Practitioner (NP) will be sent out to the emergency room for initial diagnosis and management. Testing for COVID-19 will be done in the treating facility. Whereas the patient is returned to SEH and testing for COVID-19 has not been done, if reasonable suspicion remains, then the test will be performed at SEH.

Protocol

Patients who have met the criteria for testing in SEH will be tested on their unit.

The examiner will don full PPE and collect the specimen in accordance with the DC Department of Forensic Sciences (DFS) guidelines.

The examiner will complete the Covid-19 case report form which is designed to collect key information on COVID-19 case-patients, including:

- Demographic, clinical, and epidemiologic characteristics
- Exposure and contact history
- Course of clinical illness and care received

The specimen will be processed through the DC DFS public health laboratory (PHL) through DC Health.

Results will be received by the GMO or NP through DC Health, timeframe to be determined by DC Health.

Disposition of Patient

Patients who are suspected by the GMO or NP to have been infected with the COVID-19 virus and have been tested in the community or at SEH will be sent to unit 2TR and remain in contact precautions to await results. Once results have been received then the following will occur:

Negative results – patient will immediately be returned to the sending unit.

Positive results – patient will remain on 2TR 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.

Additional Information

Uncomplicated (mild) Illness

These patients usually present with symptoms of an upper respiratory tract viral infection, including mild fever, cough (dry), sore throat, nasal congestion, malaise, headache, muscle pain, or malaise. Signs and symptoms of a more serious disease, such as dyspnea, are not present. Compared to previous HCoV infections, non-respiratory symptoms such as diarrhea are challenging to find.

Moderate Pneumonia

Respiratory symptoms such as cough and shortness of breath (or tachypnea in children) are present without signs of severe pneumonia.

Severe Pneumonia

Fever is associated with severe dyspnea, respiratory distress, tachypnea (> 30 breaths/min), and hypoxia (SpO2 < 90% on room air). However, the fever symptom must be interpreted carefully as even in severe forms of the disease, it can be moderate or even absent. Cyanosis can occur in children. In this definition, the diagnosis is clinical, and radiologic imaging is used for excluding complications.

Acute Respiratory Distress Syndrome (ARDS)

The diagnosis requires clinical and ventilatory criteria. This syndrome is suggestive of a serious new-onset respiratory failure or for worsening of an already identified respiratory picture. Different forms of ARDS are distinguished based on the degree of hypoxia. The reference parameter is the PaO2/FiO2:

- Mild ARDS: 200 mmHg < PaO2/FiO2 ≤ 300 mmHg. In not-ventilated patients or in those managed through non-invasive ventilation (NIV) by using positive end-expiratory pressure (PEEP) or a continuous positive airway pressure (CPAP) ≥ 5 cmH2O.
- Moderate ARDS: 100 mmHg < PaO2/FiO2 ≤ 200 mmHg.
- Severe ARDS: PaO2/FiO2 ≤ 100 mmHg.

References:

Marco Cascella; Michael Rajnik; Arturo Cuomo; Scott C. Dulebohn; Raffaela Di Napoli. *Features, Evaluation and Treatment Coronavirus (COVID-19).* Stat Pearls. March 20, 2020. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK554776/

US Department of Health and Human Services, CDC. *Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)* March 14, 2020. Retrieved from https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

DISTRICT OF COLUMBIA
DFS
DEPARTMENT OF FORENSIC SCIENCES

COVID-19 Specimen Submission Guidelines

Specimen Collection

Please review guidelines recommended by the Centers for Disease Control and Prevention to ensure the appropriate infection control precautions are in place **before** collecting any specimens.

Acceptable specimen types for collection:

1. **Upper Respiratory Specimens**
   a. The following are acceptable upper respiratory specimens for submission:

      i. **Nasopharyngeal (NP) swab** only in viral transport media (VTM) or Universal Transport Media (UTM)

      OR

      ii. **Combined NP swab** and **Oropharyngeal (OP) swab** in VTM or UTM. Once the NP swab is collected, place it in VTM/UTM, swirl it in the media for a few seconds and break off the shaft. Next, collect the OP swab, place it in the same VTM as the NP swab, swirl it for a few seconds and break off the shaft. Please screw of the lid of the vial tightly.

Please see the video for additional instructions on NP swab collection:
https://www.youtube.com/watch?v=DVJNWefmHjE

Swab specimens should be collected using only swabs with a synthetic tip, such as nylon or Dacron, and an aluminum or plastic shaft. Calcium alginate swabs are unacceptable and swabs with cotton tips and wooden shafts are not recommended.

ESwabs in Amies media are not a valid specimen type for COVID-19 testing. A hospital or clinic that requires swabs or UTM should contact the DC DFS PHL via email (DFS-COVID19@dc.gov).

2. **Lower Respiratory Specimens**

   a. ***Sputum***- Have the patient rinse the mouth with water and then expectorate deep cough directly into a sterile, leak-proof, screw-cap sputum collection cup or a sterile dry container.

   b. ***Bronchoalveolar lavage (BAL)*** - Collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.
   Additional specimens may be requested on a case by case basis.

DISTRICT OF COLUMBIA
DFS
DEPARTMENT OF FORENSIC SCIENCES

Specimen Storage

All specimens must be refrigerated (2-8°C) promptly after collection and couriered/shipped on cold packs within 72 hours. Specimens being held for >72 hours must be stored at -70°C and couriered/shipped on dry ice.

Paperwork

Any specimen being sent through the DC DFS PHL must have the following paperwork accommodating the specimen:

1. DC DFS PHL External Chain of Custody (CoC)
2. DC DFS PHL Test Requisition Form

All paperwork can additionally be found on DC DFS PHL's website under forms and documents:
https://dfs.dc.gov/publication/phl-forms-and-documents

Additionally, a person under investigation (PUI) form must be completed by the requesting healthcare provider for all COVID-19 testing, and must be completed to receive results. All forms will be provided to the requesting health care provider by the epidemiologist at the time of approval.

Only one DC DFS PHL test requisition form (example provided below) and one chain of custody for each set of specimens is required for testing.

Please ensure that all specimens submitted and their respective test requisition form has the following information on it:

- Full name of patient
- Date of birth
- Unique patient identifier (e.g., medical record number, patient ID, PUI #)
- Date and time of specimen collection

Incorrectly labeled requisitions and specimens will result in testing delays.

Courier Request

Once specimens are ready for pick up and the appropriate paperwork is completed, please email DFS-COVID@dc.gov to request a courier. An address (including the room number), PUI number, point-of-contact name and phone number and the specimen storage temperature will be required to dispatch a courier for specimen pick-up. Do NOT include patient identifiers in the body of the email. Please call the main laboratory line in the event of an emergency (202-727-8956).

Please contact the DC Department of Forensic Sciences Public Health Laboratory for any questions pertaining to testing:
Phone: 202-727-8956 (Monday-Friday from 8:30am-5:30pm) | 202-868-6561 (after-hours calls) Fax: 202-481-3936 | Email: dc.phl@dc.gov

DFS DEPARTMENT OF FORENSIC SCIENCES

District of Columbia • Department of Forensic Sciences • Public Health Laboratory
401 E Street SW • 4th Floor • Washington, DC 20024 • Phone (202) 727-8956 • Fax (202) 481-3464

General Laboratory Services Request Form
PHL Director: Anthony Tran, DrPH, MPH, D(ABMM)
CLIA#: 09D0968273

Patient Information

***Required Information**

Last Name*	First Name*	Middle Initial	Suffix
Date of Birth* (MM/DD/YYYY)	Sex* ☐ Male ☐ Female ☐ Other	If Female, Pregnant ☐ Yes ☐ No ☐ Unknown	
Address	City*	State*	ZIP
Sample ID (Lab ID, Outbreak#, Zika#, etc.)*	Medical Record Number		

Submitter Information

Name of Submitting Hospital, Laboratory, or other Facility*		Healthcare Provider NPI #*		
Health Care Provider	Last Name*	First Name*		
Address (include room)*		City*	State*	Zip*
Primary Contact (If not the Health Care Provider)	Last Name	First Name		
Telephone #* (primary)	Secure Fax #**	Email		
** Final report will be sent to the fax number above				

Specimen Information

Date of Collection* (MM/DD/YYYY): Time of Collection*: ☐ AM ☐ PM

Reason for Submission*
☐ Diagnostic ☐ Outbreak ☐ DC Health Request: DC Health Contact:_____

Specimen Type (check all that apply)*
☐ Blood Culture Bottle ☐ Isolate ☐ Cary-Blair ☐ ESwab™ ☐ Swab ☐ Slide ☐ Sterile Container ☐ UTM ☐ VTM
☐ Blood Tube (Plasma, Serum or Whole Blood)_____ ☐ Other (specify)_____

Specimen Source*
☐ Abscess ☐ Blood ☐ Bronchoalveolar Lavage ☐ Bronchial Wash ☐ Buccal ☐ CSF ☐ Endocervical ☐ Nasopharynx (NP)
☐ Oropharynx (OP) ☐ NP/OP ☐ Plasma ☐ Rectal ☐ Serum ☐ Sputum, expectorated ☐ Sputum, induced ☐ Stool ☐ Throat
☐ Tissue ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other (specify)_____

Test Request (✓ requested tests)

BT RULE-OUT§	MOLECULAR
☐ *r/o B. anthracis*	☐ Ebola (PCR)+
☐ *r/o Brucella sp.*	☐ Novel Influenza (PCR)+
☐ *r/o Burkholderia sp.*	☐ Norovirus (PCR)
☐ *r/o F. tularensis*	☐ Middle East Respiratory Syndrome (MERS-CoV) (PCR)+
☐ *r/o Y. pestis*	☐ *Chlamydia trachomatis* and *Neisseria gonorrhoeae* (TMA)
☐ Other(specify):_____	☐ Mumps (PCR)+
MICROBIOLOGY/GENERAL BACTERIOLOGY	☐ Measles Virus (PCR)+
☐ OCME	☐ Arbovirus Detection Panel (chikungunya, dengue and Zika) (PCR)+
☐ Referred Isolates	**SEROLOGY**
	☐ Measles Virus (IgG)+
	☐ Zika Virus (IgM)+
	VIRAL CULTURE
	☐ Respiratory DFA with Reflex to Viral Culture (Adenovirus, Respiratory Syncytial Virus, Influenza A, Influenza B, Parainfluenza 1, 2 & 3)
OTHER TESTS	
☐ Test Name (specify)_____	

+ DC Health must approve testing prior to sending any isolate or specimen to the Public Health Laboratory
§ Call the Public Health Laboratory prior to sending any suspected isolate or specimen

Last updated: 12/20/2019

DISTRICT OF COLUMBIA
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Example of PHL Test Requisition Form

DFS DEPARTMENT OF FORENSIC SCIENCES

District of Columbia • Department of Forensic Sciences • Public Health Laboratory
401 E Street SW • 4th Floor • Washington, DC 20024 • Phone (202) 727-8956 • Fax (202) 481-3464
General Laboratory Services Request Form
PHL Director: Anthony Tran, DrPH, MPH, D(ABMM)
CLIA#: 09D0968273

★ ★ ★

Patient Information *Required Information

Last Name*	First Name*	Middle Initial	Suffix
Date of Birth* (MM/DD/YYYY)	Sex* ☐ Male ☐ Female ☐ Other	If Female, Pregnant ☐ Yes ☐ No ☐ Unknown	
Address	City*	State*	ZIP
Sample ID (Lab ID, Outbreak#, Zika#, etc.)*	Medical Record Number		

PUI ID given by DC Health

Health care provider with same NPI number requesting testing

Submitter Information

Name of Submitting Hospital, Laboratory, or other Facility*		Healthcare Provider NPI #*		
Health Care Provider	Last Name*	First Name*		
Address (include room)*		City*	State*	Zip*
Primary Contact (if not the Health Care Provider)		First Name		
Telephone #* (primary)	Secure Fax #**	Email		

** Final report will be sent to the fax number above

Results will be faxed to this number
Critical values will result in a phone call

Specimen Information

Date of Collection* (MM/DD/YYYY): Time: ☐ AM ☐ PM

Reason for Submission*
☑ Diagnostic ☐ Outbreak ☐ DC Health Request: DC Health Contact:

Specimen Type (check all that apply)
☐ Blood Culture Bottle ☐ Isola... ☑ Sterile Container ☑ UTM ☑ VTM
☐ Blood Tube (Plasma, Serum or Whole Blood) ☐ Other (specify)

Specimen Source*
☐ Abscess ☐ Blood ☑ Bronchoalveolar Lavage ☑ Bronchial Wash ☐ Buccal ☐ CSF ☐ Endocervical ☑ Nasopharynx (NP)
☑ Oropharynx (OP) ☑ NP/OP ☐ Plasma ☐ Rectal ☐ Serum ☑ Sputum, expectorated ☑ Sputum, induced ☐ Stool ☐ Throat
☐ Tissue ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other (specify)

Nasopharynx (NP) swabs and Oropharynx (OP) swabs must be placed in either UTM or VTM

Sputum, Bronchial Wash and Bronchoalveolar Lavage specimens

All specimen sources approved for testing are highlighted

...uested tests)

BT RULE-OUT§	MOLECULAR
☐ *r/o B. anthracis*	☐ Ebola (PCR)*
☐ *r/o Brucella sp.*	☐ Novel Influenza (PCR)*
☐ *r/o Burkholderia sp.*	☐ Norovirus (PCR)
☐ *r/o F. tularensis*	☐ Middle East Respiratory Syndrome (MERS-CoV) (PCR)*
☐ *r/o Y. pestis*	☐ *Chlamydia trachomatis* and *Neisseria gonorrhoeae* (TMA)
☐ Other(specify):	☐ Mumps (PCR)*
MICROBIOLOGY/GENERAL BACTERIOLOGY	☐ Measles Virus (PCR)*
☐ OCME	☐ Arbovirus Detection Panel (chikungunya, dengue and Zika) (PCR)*
☐ Referred Isolates	**SEROLOGY**
	☐ Measles Virus (IgG)*
	☐ Zika Virus (IgM)*
	VIRAL CULTURE
	☐ Respiratory DFA with Reflex to Viral Culture (Adenovirus, Respiratory Syncytial Virus, Influenza A, Influenza B, Parainfluenza 1, 2 & 3)
	OTHER TESTS
	☑ Test Name (specify) 2019-nCoV PCR

+ DC Health must approve testing prior to sending any isolate or specimen to the Public Health Laboratory
§ Call the Public Health Laboratory prior to sending any suspected isolate or specimen

Last updated: 12/20/2019

DFS DEPARTMENT OF FORENSIC SCIENCES

District of Columbia • Department of Forensic Sciences • Public Health Laboratory
401 E Street SW • 4th Floor • Washington, DC 20024 • Phone (202) 727-8956 • Fax (202) 481-3464
General Laboratory External Chain of Custody
PHL Director: Anthony Tran, DrPH, MPH, D(ABMM)
CLIA#: 09D0968273

Specimen Submitted by:

Hospital/Clinic_____
Point-of-Contact Name_____
Phone_____
Fax_____
E-mail _____
Signature_____
Date _____ **Time**_____

Specimen Received By:

Courier Name_____
Date_____ **Time**_____
Initials_____

#	Unique Specimen Identifier (e.g., MRN, sample ID)	Sample type (e.g. serum, tissue, isolate)	Date of Birth	Collection Date	Comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

This section is for DC PHL use only

Specimens received by _____ Date/Time_____ Storage Temp_____

ISOLATION UNIT

AUTHORIZED EMPLOYEES ONLY

S.E.H Infection Control Coordinator

APPENDIX-10

Monitoring Guidelines for Staff Exposed to a Confirmed COVID-19 Staff

1. **Monitor your temperature and absence of symptoms each day prior to starting work.**
2. **Wear a facemask while at work for the 14 days after the exposure.**
3. **Adhere to hand hygiene protocols.**
4. **DO NOT work with high risk patient populations (such as in units 1A & 1B)**
5. **Self-monitor for symptoms at all times, and seek re-evaluation from your primary care doctor if respiratory symptoms occur.**
6. **If you develop symptoms (even mild symptoms) while at work, IMMEDIATELY cease patient care activities. Don a facemask (if not already wearing), isolate yourself, and notify your supervisor.**

Reference: DC Health Notice: Coronavirus 2019 (COVID-19): Guidance for Healthcare Personnel Monitoring, Restriction and Return to Work.

Please reach out to your supervisor with questions regarding staying out of work.

APPENDIX 11

REQUESTING LEAVE DUE TO COVID 19

Process for SEH employees requesting leave due to COVID-19 and/or as a result of experiencing symptoms of COVID-19.

Review and Recommendations

1. All requests for leave shall be sent to Dr. Potter for review.
2. Dr. Potter will review and provide his recommendations to the DBH Risk Manager (Mary Campbell) and Elaine Tu who will be tracking symptoms.
3. Recommendation will also be sent to the employee's supervisor; who will notify the employee on the recommendations (i.e., to test and quarantine).
4. Mary will notify Ms. Wheeler of the leave request and recommendations; and Ms. Wheeler will inform the supervisor if the employee should get administrative leave (or any other type of leave).

Employee Responsibilities

1. All employees are required to share their contact information with Elaine/Mary. Mary will conduct daily calls with the employee until they return.
2. All employees are required to share medical information related to COVID-19 illness.
3. All employees must present a medical clearance before returning to work.

Tracking of Employee Leave

1. Mary/Elaine will track all employee COVID-19 tests and test results.
2. Mary will track employees requesting FMLA, ADA, or other underlying health issues.

Appendix 12

04/03/2020

REQUESTING LEAVE DUE TO COVID 19

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Appendix 12

04/03/2020

EXHIBIT 4

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ENZO COSTA, *et al.*, Plaintiffs, v. BARBARA BAZRON, *et al.*, Defendants.	Civil Action No. 19-3185 (RDM)

DECLARATION OF MARTHA PONTES, R.N.

I, Martha Pontes, R.N. declare and state as follows:

1. I am over the age of eighteen (18) years, competent to testify to the matters contained in this declaration, and testify based on my personal knowledge acquired in the course of my official duties.

2. I am the Chief Nurse for Saint Elizabeths Hospital. I have worked at Saint Elizabeths Hospital since January 2009. I have served in a variety of roles, including Risk Manager, Assistant Director of Nursing, Director of Nursing Performance Improvement, and Interim Chief Nurse Executive. I assumed the role of the Interim Chief Nurse Executive on April 13, 2020.

3. As the Chief Nurse Executive, I am responsible for providing guidance, leadership and direction for all professional nurses and paraprofessional nursing staff within the framework of established psychiatric, medical and administrative policies and procedures. This includes the responsibility for the planning, development, implementation, coordination, review and evaluation of all nursing

service and nursing-related training programs. Through my position, I am aware of Saint Elizabeths Hospital operations on a daily basis to protect patients and staff from COVID-19.

4. The Hospital has a sufficient number of staff members working each shift to ensure the safety and well-being of patients. The Hospital has 760 staff. Approximately half are nursing staff, including registered nurses and behavioral health technicians. Currently, 83 staff are out for COVID-19 symptoms or positive test results. This temporary reduction in available staff is mitigated by the 18% drop in the patient population, from 277 on February 1, 2020, to 221 on April 21, 2020.

5. Saint Elizabeths follows CDC and DC Health guidelines on testing for COVID-19. Pursuant to CDC and DC Health guidelines, the Hospital's staff can be tested at the United Medical Center drive-up test site or their primary care provider if they experience symptoms. Hospital employees that have potential COVID-19 symptoms are sent home with instructions to get tested and are placed on administrative leave. Employees who test negative are permitted to return to work as long as it is determined they are medically fit to do so. As of April 20, 2020, 22 employees formerly placed on administrative leave for COVID-19-related precautions have been cleared and returned to work.

6. The Saint Elizabeths nursing department maintains a staffing matrix to identify the staff needed each day for each unit, based upon the patient population census and patient acuity (individualized medical or mental health needs of one or more the patients on a unit). The Hospital also tracks whether the units are meeting

the staffing requirements each day. While some staff have had to miss work during the COVID-19 emergency, the Hospital has continued to provide adequate staff on each unit each day to ensure patients receive adequate care and treatment.

7. Saint Elizabeths has brought in 31 extra nursing staff, registered nurses and certified nursing assistants, from a nurse staffing agency, to augment the full-time staff during the pandemic to ensure adequate staffing levels on each unit. The additional contracted nursing staff are provided a scheduled three-day training and orientation provided by the nursing education department that includes primers on COVID-19 precautions, the Saint Elizabeths patient population, the Hospital's medical equipment, the electronic record system, the medication administration system and a high-level review of Hospital nursing procedures.

8. Staff, including nursing contractors, are continuously apprised of new policies and information through the Hospital's intranet system and e-mails. Nursing staff also learn of new policies and procedures from nurse managers who meet with them whenever there is a Health Notice from CDC or DC Health. Moreover, nurse managers meet with staff on an individual or small group basis, to review new policies and procedures and to encourage staff to ask questions, so that the nurse managers can ensure that staff understand the new policies and procedures.

9. All staff have been trained to practice and enforce social distancing. The Hospital has suspended in-person group therapy sessions and classes during the emergency in accordance with CDC guidelines on reducing the spread of COVID-19. All treatment is conducted on patients' units. The Hospital has modified meal

practices in the communal dining rooms that can normally seat 16. We now limit entry to 8 patients at a time so they can sit at a safe distance from one another. Residents may also eat their meals in common areas such as day rooms and in their individual bedrooms provided they are not especially at risk for choking. Meals are served on the units and patients eat in shifts to maintain appropriate social distancing.

10. At Saint Elizabeths, there is sufficient space in the common areas, private rooms, and dining areas for each patient to practice social distancing if he or she chooses to do so. Staff do as much as they can to ensure patients practice social distancing. Sometimes this is difficult to enforce without impinging on patient autonomy. For instance, patients are supposed to walk up to medication windows one by one to receive their medication in order to maximize each individual's privacy. If a patient attempts to get too close, staff will redirect the patient to maintain safe spacing.

11. The Hospital has adequate personal protective equipment (PPE) to comply with CDC guidelines and recommendations. The Hospital has three levels of PPE procedures for staff and has established written procedures for each. *See* Appendix 1. The highest level of PPE is a Powered Air Purifying Respirator (PAPR), which is used for procedures that involve prolonged contact with positive patients on the COVID-19 positive isolation units 1B and 2A. The middle level of PPE involves a gown, N95 mask, goggles, gloves, and shoe covers. Mid-level PPE is used on the Person Under Investigation (PUI) Unit (2TR), where patients are exhibiting

symptoms and awaiting COVID-19 test results. The lowest level of PPE is a facemask. This is used, at a minimum, by all staff in the hospital on all units at all times. In addition, as of April 20, 2020, staff on general units will also wear a face shield any time they interact with a patient. The Hospital has conducted WebEx trainings with all staff on what level of PPE is appropriate and how to don and doff each type of PPE safely according to CDC guidelines. Written guidance has also been issued to staff.

12. The Hospital receives deliveries of PPE several times per week. The PPE is placed in bags and distributed daily to each unit. If staff need additional PPE, they can call the nursing office or place requests in the Hospital's computerized ordering system.

13. All patients have access to face masks as needed, including replacement masks, upon request from the nursing station. Some patients choose to wear masks, others do not. Staff work to educate patients on COVID-19 and encourage safe infection control practices, such as hand hygiene, social distancing, and the use of face masks. The Hospital's Department of Recreation is making cloth masks for patients that can be laundered and reused. The Hospital has enough facemasks for all patients if they want to wear one, and everyone is encouraged to change their mask when soiled or damaged.

14. The Hospital follows CDC and DC Health recommendations on the monitoring and isolation of patients based upon COVID-19 risks. The Hospital operates two units with positive COVID-19 patients, 1B and 2A. The Hospital screens all patients every day. This process includes taking each patient's vital signs and

checking for signs for COVID-19. Any patient that exhibits COVID-19 symptoms will be immediately transferred to the PUI unit and tested. The patient will remain in the PUI until the DC Forensic Laboratory provides the test results, normally within 24-48 hours. If the patient tests positive, the patient will be transferred to 1B or 2A. If the patient tests negative, the patient will return to his or her unit.

15. New patients are also screened prior to being placed on units. Screening depends on how the patient was referred to Saint Elizabeths. Civilly committed patients are screened both by staff at the community hospital from which they are arriving and then again by Saint Elizabeths staff upon arrival. Only one pretrial patient has been ordered to Saint Elizabeths since March 23, 2020. That patient was tested for COVID-19 by the District of Columbia Department of Corrections (DOC) prior to admission. As of the date of this declaration, he has not yet transferred to the Hospital. Upon admission, he will be medically screened by the Hospital staff. No post-trial patients have been referred to Saint Elizabeths since March 23, 2020. Saint Elizabeths will continue to request that newly referred pre-trial and post-trial patients in the future be tested by DOC before arrival at Saint Elizabeths.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

Apr. 21. 2020
DATED

MARTHA PONTES, R.N.

EXHIBIT 5

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ENZO COSTA, *et al.*, Plaintiffs, v. BARBARA BAZRON, *et al.*, Defendants.	Civil Action No. 19-3185 (RDM)

DECLARATION OF YI-LING ELAINE TU, RN

I, Yi-Ling Elaine Tu, RN, declare and state as follows:

1. I am over the age of eighteen (18) years, competent to testify to the matters contained in this declaration, and testify based on my personal knowledge acquired in the course of my official duties.

2. I am the Infection Control Coordinator for Saint Elizabeths Hospital. I have worked at Saint Elizabeths Hospital since August, 2008. I have a Master's Degree in Nursing Education, and have worked for 20 years in the field of nursing. After joining the Hospital in 2008, I spent six years as the Nurse Manager in a geriatric unit. I have been the Infection Control Coordinator since 2014.

3. As Infection Control Coordinator at Saint Elizabeths, I am responsible for working across disciplines in coordinating the Hospital's efforts in infection control issues. This includes updating the Hospital on the Centers for Disease Control and Prevention (CDC) and District Department of Health (DOH) COVID-19 guidance and new infection-related issues, assisting the Hospital's effort in strategizing

infection prevention plans, monitoring Hospital infections, and providing education to all disciplines on infection prevention.

4. As part of my job, I have been involved in educating patients and staff about COVID-19 precautions. This includes proper hand washing, social distancing and proper cough etiquette. In February 2020, I began trainings to various departments on proper hand-hygiene, informing housekeeping staff of recommendations for the frequent cleaning and disinfecting of high touch surfaces, and providing staff trainings on the proper use of Powered Air Purifying Respirator (PAPR) in anticipation of possible COVID-19 infections that could occur in the Hospital.

5. Along with other Saint Elizabeths staff, I have disseminated COVID-19-related information to patients in a number of ways. We have provided patients with DOH handouts about the importance of social distancing, and frequent and proper hand-washing, and have reminded patients one-on-one about both of these. We have also informed patients verbally of the availability of face masks and recommended they be worn at all times when patients are present in shared spaces. We have disseminated information to patients through the Hospital's Patient Advocates Group and Patient Advisory Council.

6. Since the Hospital's first case of COVID-19 on April 1, 2020, I have been in frequent communication with epidemiologists at DOH, in consultation regarding the Hospital's COVID-19 prevention and quarantine efforts.

7. "Cohorting" is the CDC-approved process for health care providers to house COVID-positive patients together, and away from asymptomatic patients. Currently, all of the Hospital's known positive COVID-19 cases are cohorted in two specific units, 1B and 2A. Patients in these isolation units are closely monitored by medical staff to ensure their conditions do not worsen. To the extent possible, staff on isolation units do not travel to or from other units. When staff rotations are necessary, the staff change their personal protective equipment (PPE) to avoid cross-unit contamination. Patients who exhibit symptoms of COVID-19 infection are referred to as Patients Under Investigation (PUI). The Hospital has a dedicated PUI unit—2TR—for patients suspected of having COVID-19 and awaiting test results. If the test is positive, the patient is moved to one of the COVID-positive isolation units. If the test is negative, the patient can return to his or her unit.

8. There are no known positive cases of COVID-19 on the remaining nine units. To date, three patients have recovered from COVID-19 and have been placed back into general housing units after medical staff determined they were no longer at risk of infecting others. There are also three patients at local hospitals that have recovered and will return to Saint Elizabeths pending final negative tests.

9. On April 7, 2020, the Hospital requested that the CDC and DOH visit the Hospital and review its infection control measures. On April 17, 2020, a team of physicians and infectious disease experts from each jointly visited the Hospital. The teams toured a cohorting isolation unit, the PUI unit, three general units, and the

Therapeutic Learning Center, and also reviewed the Hospital's infection control program and operations.

10. During the exit conference, which I participated in, the CDC was complimentary of the Hospital's efforts and stated no negative findings. They made the following verbal recommendations, which the Hospital is implementing: (1) prioritize usage of PPE; (2) use of head and shoe coverings are optional; (3) minimize staff rotation whenever possible; (4) minimize staff eating in the breakroom at the same time due to the small size of the room; (5) continue to provide training on correct usage of PPE; and (6) encourage staff to make on-the-spot corrections when staff are not using PPE appropriately.

11. Since April 6, 2020, Saint Elizabeths has had and continues to have a supply of COVID-19 tests on-site. Pursuant to CDC and DOH guidelines, Hospital staff evaluate patients exhibiting possible COVID-19 symptoms, and when appropriate, collect a nasal swab sample for testing. The sample is sent to the District of Columbia Department of Forensic Services lab, and results are returned within 24-48 hours. The Hospital has tested 31 patients since April 6, 2020. The CDC and DOH do not recommend the general testing of asymptomatic patients.

12. On January 29, 2020, the Hospital implemented Administrative Issuance 2020-00, Prevention and Management of the 2019-nCoV "Coronavirus," which provided guidance on managing patients suspected of being COVID-positive. Based on the Issuance, staff were required to: (1) use PPE in treating any patient suspected of COVID-19; (2) ask affected patients to wear a face mask; (3) notify the

Hospital Infection Control Coordinator and DOH if a patient met the criteria for possible infection; (4) screen patients for additional risk factor; and (5) transfer any patient exhibiting COVID-19 symptoms and with a risk of exposure to an acute care hospital for testing. *See* Appendix 1.

13. On March 4, 2020, the Hospital updated Administrative Issuance 2020-001, to require assessments for Hospital staff. The updated policy included specific forms and questionnaires to screen both patients and staff for travel to affected countries and symptoms. *See* Appendix 2. In addition, the Hospital published DC Health posters throughout the Hospital and on the Hospital intranet, educating the staff and patients on COVID-19 and proper handwashing and cough etiquette. Copies of the posters are attached as Appendix 3.

14. On March 30, 2020, the Hospital further updated Administrative Issuance 2020-001 to suspend all social visitations at Saint Elizabeths and require mandatory screening for all staff and legal or professional visitors. *See* Appendix 4. Before entering the Hospital, each person's temperature is taken using a no-touch infrared thermometer. No one exhibiting a temperature above 100 degrees Fahrenheit is permitted to enter the Hospital. Staff and visitors also receive a questionnaire with inquiries about symptoms and possible exposure. Staff members conducting screening deny entry to anyone whose answers suggest they might have COVID-19. We have had to turn away at least three employees and one visitor due to fever.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

4/21/2020
DATED

YI-LING ELAINE TU

ATTACHMENT 1

GOVERNMENT OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF BEHAVIORAL HEALTH

Administrative Issuance - #2020-001

Department of Behavioral Health, Saint Elizabeths Hospital Administrative Issuance

SUBJECT: Prevention and Management of the 2019-nCoV "Coronavirus"

EFFECTIVE DATE: January 29, 2020

PURPOSE AND AUTHORITY

This policy provides Saint Elizabeths Hospital employees guidance in managing patients who are suspected of Pneumonia of Unknown Etiology (PUE) and specifically the 2019-nCoV (i.e., Coronavirus). The situation is evolving; therefore, this issuance will be updated as more information becomes available.

DEFINITION

2019-nCoV: A novel coronavirus is causing an outbreak of pneumonia illness in the city of Wuhan, Hubei Province, China.

TRANSMISSION AND PRECAUTIONS

Transmission and Precaution: Although the transmission dynamics have yet to be determined, CDC currently recommends a cautious approach to patients under investigation for 2019 Novel Coronavirus.

1) Such patients shall be asked to wear a surgical mask as soon as they are identified and shall be evaluated in a private room with the door closed, ideally, an airborne infection isolation room if available.
2) SEH employees entering the room of affected patients shall use standard precautions, contact precautions, airborne precautions, and use eye protection (e.g., goggles or a face shield).
3) Employees shall immediately notify the Infection Control Coordinator and Department of Health if a patient meets criteria of possibly being infected (see information in the subsection titled "Notification").

Personal Protective Equipment (PPE): PPE may be obtained from the PPE organizer inside the nurses' station. PPE stored inside the organizers include: gloves, gowns, shoe protectors, face masks, and face shields. Additional PPEs may be obtained from the supply room.

SURVEILLANC BY THE HOSPITAL

Assessment: The CDC clinical criteria for a 2019-nCoV patient under investigation has been developed based on what is known about MERS-CoV and SARS-CoV, and are subject to change as additional information becomes available. GMOs/NPs shall obtain a detailed travel history for patients being evaluated with fever and acute respiratory illness. The following criteria shall be used to evaluate patients for the 2019-nCoV (Coronavirus):

1) Fever AND symptoms of lower respiratory illness (e.g., cough, shortness of breath); and in the last 14 days before symptom onset, history of travel from Wuhan City China, or close contact with a person who is under investigation for 2019-nCOV while that person was ill.

ORIGINAL ADMINISTRATIVE ISSUANCE

2) Fever OR symptoms of lower respiratory illness (e.g., cough, shortness of breath) and in the last 14 days before symptom onset, close contact with an ill laboratory-confirmed 2019-nCoV patient.

Notification: GMOs/NPs shall report patients who have severe respiratory symptoms; have traveled to Wuhan China since December 1, 2019; who became ill within two weeks of returning; and who do not have another known diagnosis that would explain their illness.

GMOs/NPs identifying a newly admitted patient meeting these criteria, shall immediately notify-

1) DC Health by calling 202-442-9370 (during business hours) or 844-493-2652 (after business hours) or by sending an email to doh.epi@dc.gov.
2) SEH's Infection Control Coordinator via yi-ling.tu@dc.gov or by calling 202-465-5529.

Specimen Collection Guidelines: Multiple respiratory tract specimens shall be collected from persons with infections suspected to be associated with this cluster, including nasopharyngeal, nasal, and throat swabs. Patients with severe respiratory disease shall also have lower respiratory tract specimens collected, if possible. Consider saving urine, stool, serum, and respiratory pathology specimens (if available).

Infection Control Recommendations: Although the etiology and mode of transmission are unknown, CDC currently recommends the following precautions for symptomatic patients with a history of travel to Wuhan City since December 1, 2019:

1) Patients shall be asked to wear a surgical mask as soon as they are identified or? patients shall be evaluated in a private room with the door closed.
2) Employees entering the room to evaluate the patient shall use contact and airborne precautions. The Powered air purifying respirators (PAPR) must be worn at all time when managing a suspected patient.
3) For patients admitted for inpatient care, contact and airborne isolation precautions are recommended as of January 22, 2020. Thus, **any patient with suspected symptoms and history shall be transferred via 911 to an acute care hospital, for further testing.**

Cleaning and Disinfecting: After a patient with suspected symptoms and history leaves the area, housekeeping staff shall clean the area by following cleaning and disinfecting procedures. While cleaning the area housekeepers shall use proper PPEs and PAPR until all tasks are completed. All PPE shall be disposed of into regular trash, and PAPR shall be wiped with Oxivir wipes.

Approval: Elaine Tu.
Yi-ling Elaine Tu, MSN, RN, WCC
Infection Control Coordinator

Approval:
Michelle Blake-Smith, JD, MPH, CHC
Compliance and Performance Improvement Officer

Approved:
Mark Chastang, MPA, MBA, FACHE
Chief Executive Officer

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Center for Policy, Planning and Evaluation
Division of Epidemiology–Disease Surveillance and Investigation

January 28, 2020

Health Notice for District of Columbia Health Care Providers
Update and Interim Guidance: Novel Coronavirus (2019-nCov) Outbreak

SUMMARY
An outbreak of pneumonia of unknown etiology in Wuhan City was initially reported to the World Health Organization (WHO) on December 31, 2019. Chinese health authorities have now confirmed hundreds of infections with a novel coronavirus (2019-nCoV) as the cause of the outbreak. The first case in the United States (US) was identified in Washington state on January 21, 2020. As of January 27, 2020, a total of 5 positive cases have been reported in the US .The Centers for Disease Control and Prevention and Prevention (CDC) Health Advisory released on January 17, 2020 provides guidance as of that date, however the situation is continuously evolving. This Health Notice provides updated situational awareness and guidance for evaluation of patients under investigation (PUI) for 2019-nCoV, prevention and infection control guidance, including the addition of an eye protection recommendation, and additional information on specimen collection.

BACKGROUND
Coronaviruses are a large family of viruses, including SARS and MERS, which spread by person-to-person transmission via respiratory droplets. The growing number of 2019-nCoV cases suggests person-to-person transmission is occurring, however, details on how this virus is transmitted are still being investigated. Limited information is available to characterize the spectrum of clinical illness associated with 2019-nCoV. No vaccine or specific treatment for 2019-nCoV infection is currently available; care for infected persons is supportive.

CDC is closely monitoring this situation and issued a level 3 travel notice ("Avoid Nonessential Travel") for this destination (https://wwwnc.cdc.gov/travel/notices/watch/pneumonia-china).
We recommend that in addition to the guidance below, healthcare providers regularly review the CDC website (https://www.cdc.gov/coronavirus/2019-nCoV/index.html) for the most updated information.

DC Health Recommendations for Healthcare Providers

1) **Criteria to Guide Evaluation of Patients Under Investigation (PUI) for 2019-nCoV**
   Clinical criteria for a 2019-nCoV PUI are based on MERS-CoV and SARS-CoV and are subject to change as additional information becomes available. Patients who meet the following criteria should be reported to DC Health for evaluation as a PUI:
   1) Fever[1] AND symptoms of lower respiratory illness (e.g. cough, shortness of breath) AND in the last 14 days before symptom onset,
      - History of travel from Wuhan City, China* OR
      - Close contact[2] with a person who is under investigation for 2019-nCOV while that person was ill

SOURCE DOCUMENT:
APPENDIX FOR ORIGINAL ADMINISTRATIVE

2) Fever[1] OR symptoms of lower respiratory illness (e.g. cough, shortness of breath) AND in the last 14 days before symptom onset,
   - Close contact[2] with an ill laboratory-confirmed 2019-nCoV patient

*This will be updated as the situation changes

[1] Fever may not be present in some patients, such as those who are very young, elderly, immunosuppressed, or taking certain fever-lowering medications. Clinical judgment should be used to guide testing of patients in such situations

[2] Close contact is defined as-

a) being within approximately 6 feet (2 meters), or within the room or care area, of a 2019-nCoV case for a prolonged period of time while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection); close contact can include caring for, living with, visiting, or sharing a healthcare waiting area or room with a 2019-nCoV case.
– or –

b) having direct contact with infectious secretions of a 2019-nCoV case (e.g., being coughed on) while not wearing recommended PPE.

Please try to collect the following information before notifying DC Health about a PUI:

1. State of residence
   - If the patient is a Maryland or Virginia resident, please contact the Maryland or Virginia Departments of Health, respectively
2. Detailed symptom history with symptom onset date
3. Contact with ill persons
   - Was the patient in contact with a person who was ill OR a person suspected or confirmed to have 2019-nCoV?
   - Was the contact ill while the patient was around them?
   - Type of contact between patient and contact (for example, stayed in the same house or shared a meal together at a restaurant)
   - Date(s) patient was exposed to ill person
4. Detailed travel history (countries, cities, dates including any layovers or additional stops)
   - Mode of travel between locations (i.e. train, plane, bus)
5. Details about wearing a facemask at any time before, during or after the travel
6. History of being a healthcare provider OR being in a healthcare facility (as a patient, worker or visitor) in China
7. If there is high suspicion the patient meets the criteria for a PUI, the mode of transport to your healthcare facility

2) **Immediate notification to DC Health**

- Healthcare providers should **immediately** notify their infection control personnel and then contact DC Health immediately in the event of a PUI for 2019-nCoV by calling 202-442-9370 (during business hours) or 844-493-2652 (after business hours).
- If the case does not meet the current case definition but is **highly suspicious**, please contact DC Health for consultation.

Infection Control Recommendations

- Patients should be asked to wear a surgical mask as soon as they are identified and be evaluated in a private room with the door closed (airborne isolation room if available)

- **Personnel entering the room to evaluate the patient should use standard precautions, contact precautions, airborne precautions and eye protection (e.g. goggles or a face shield)**
- **For inpatient care, contact and airborne isolation precautions are recommended in addition to standard precautions.**

Specimen Collection Guidelines

- **Routine testing for respiratory pathogens can be performed at clinical or public health labs, however viral isolation should not be attempted from 2019-nCoV PUIs**
- **Collection of an NP swab (in Viral Transport Media; VTM), OP swab (VTM) and sputum (sterile container) specimen is recommended at this time for testing at CDC**
    - **Save urine, stool, serum, and respiratory pathology specimens if available; collection of these samples should not delay respiratory specimen collection**
- **Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset**
- **If approved for testing by CDC, please complete the following forms:**
    - **CDC 50.34 (for each specimen)**
    - **DC Public Health Laboratory External Chain of Custody form (https://dfs.dc.gov/publication/phl-forms-and-documents)**
    - **Patient Under Investigation (PUI) form**
- **Detailed instructions about specimen testing and forms will be provided once testing is approved.**
- **Any specimens submitted without complete CDC 50.34 forms will result in significant delays in testing and may be rejected for testing.**

The guidelines above will continue to be updated as the outbreak evolves. Please reach out to DC Health at doh.epi@dc.gov with any questions regarding 2019-nCoV or PUIs. For the current CDC recommendations, including detailed infection control and specimen collection guidance, please see the following website (https://www.cdc.gov/coronavirus/2019-nCoV/index.html).

Please contact the DC Health Division of Epidemiology–Disease Surveillance and Investigation at:
Phone: 202-442-9370 (8:15am-4:45pm) | 844-493-2652 (after-hours calls)
Fax: 202-442-8060 | Email: doh.epi@dc.gov

ATTACHMENT 2

GOVERNMENT OF THE District Of Columbia

DEPARTMENT OF BEHAVIORAL HEALTH

Administrative Issuance -#2020-001

Department of Behavioral Health, Saint Elizabeths Hospital Administrative Issuance

SUBJECT: Prevention and Management of COVID-19 (Coronavirus)

EFFECTIVE DATE: January 29, 2020; Updated March 4, 2020

PURPOSE AND AUTHORITY

This policy provides Saint Elizabeths Hospital employees guidance in managing patients who are suspected of Pneumonia of Unknown Etiology (PUE) and specifically COVID-19. The situation is evolving; therefore, this issuance will be updated as more information becomes available.

DEFINITION

2019-nCo V/COVID-19: A novel coronavirus that is causing an outbreak of pneumonia-like illness.

TRANSMISSION AND PRECAUTIONS

Transmission and Precaution: Although the transmission dynamics have yet to be determined, CDC currently recommends a cautious approach to patients under investigation for COVID-19.

1) Such patients shall be asked to wear a surgical mask as soon as they are identified and shall be evaluated in a private room with the door closed; ideally, this should be an airborne infection isolation room if available, pending transfer out to an acute care hospital.
2) SEH employees entering the room of affected patients shall use standard precautions, contact precautions, airborne precautions, and use eye protection (e.g. PAPR, gloves, gown, etc.).
3) Employees shall immediately notify the Infection Control Coordinator and Department of Health if a patient meets criteria of suspected cases (see DC Health Notice from February 28, 2020).
4) For staff who return to work after traveling abroad or who exhibit potential symptoms, an assessment shall be completed using Appendix 2.

Personal Protective Equipment (PPE): PPE may be obtained from the PPE organizer inside the nurses' station. PPE stored inside the organizers include gloves, gowns, shoe protectors, face masks, and face shields. Additional PPEs may be obtained from the supply room.

SURVEILLANC BY THE HOSPITAL

Assessment for Patients: Clinical screening criteria for COVID-19 should be based on DC Health Notice and CDC recommendations. Newly admitted patients, or patients exhibiting potential symptoms shall be evaluated by using Appendix 1 of this issuance.

Assessment for Staff: The criteria for staff assessment are the same as for newly admitted patients. It is used when they return from international travel or exhibit respiratory symptoms. Staff shall also be guided by the attached Appendix 3 (DCHR Memorandum dated March 2, 2020) and the attached Appendix 4 (DC Health Issuance dated February 28, 2020).

AMENDED ADMINISTRATIVE ISSUANCE - PROPOSED

Notification: GMOs/NPs and supervisor identifying a newly admitted patient or staff meeting these criteria, shall immediately notify-

1) DC Health by calling 202-576-1117 (during business hours) or 844-493-2652 (after business hours) or by sending an email to doh.epi@dc.gov.
2) SEH's Infection Control Coordinator via yi-ling .tu@dc.gov or by calling 202-465-5529.

Specimen Collection Guidelines: Multiple respiratory tract specimens shall be collected from persons with infections suspected to be associated with this cluster, including nasopharyngeal, nasal, and throat swabs. Patients with severe respiratory disease shall also have lower respiratory tract specimens collected, if possible. Consider saving urine, stool, serum, and respiratory pathology specimens (if available).

Infection Control Recommendations:

Saint Elizabeths Hospital should follow DC Health and CDC latest recommendations to develop infection control and prevention strategies outlined below:

1. Follow leave policy as outlined in Appendix 3 (DCHR Memorandum dated March 2, 2020)
2. Use proper Cough Etiquette as outlined in Appendix 5 (Cough Etiquette)
3. Perform frequent hand hygiene per Infection Control Policy 11.0 Hand Hygiene.
4. Use proper Personal Protective Equipment such as the Powered air purifying respirators (PAPR) when encounter suspected COVID-19 patients. Use standard, contact, and airborne precautions when providing patient care as appropriate. (See Appendix 6: 3M Air-Mate Powered Air Purifying Respirator Instructions for Use)
5. Implement cleaning and disinfecting practice by housekeeping staff by using Appendix 7: GUIDELINES FOR FACILITIES DURING OUTBREAKS OF NOROVIRUS/ GASTROENTERITIS: RECOMMENDATIONS AND PRECAUTIONS.
6. Conduct screening of COVID-19 by using Travel History Questions for 2019-nCoV (Coronavirus), per Appendix 1 for patients and Appendix 2 for staff. When suspected cases are identified, healthcare providers should-
   - Apply facemask to patient/staff
   - Isolate patient/staff in a room with door closed
   - Call 911 to send patient/staff out to an acute care hospital

   All staff in the immediate area MUST wear Powered Air Purify Respiratory (PAPR), gown, eye protector or faces shield, gloves and shoe protectors until patient/staff leaves the area.

   a. **Notification**
      - Immediately Contact Elaine Tu, Infection Control Coordinator: 202-465-5529 or yi-ling.tu@dc.gov
        AND
      - Contact DC Health Division of Epidemiology–Disease Surveillance and Investigation at: Phone: 202-576-1117 (8:15am-4:45pm) | 844-493-2652 (after-hours calls) Fax: 202-442-8060 | Email: doh.epi@dc.gov
7. Saint Elizabeths Hospital will provide additional hand sanitizers and facemask for visitors.
8. Information on protecting patients on the units will be provided to visitors.

Cleaning and Disinfecting: After a patient with suspected symptoms and history leaves the area, housekeeping staff shall clean the area by following cleaning and disinfecting procedures. While cleaning

the area, housekeepers shall use proper PPEs and PAPR until all tasks are completed. All PPE shall be disposed of into regular trash, and PAPR shall be wiped with Oxivir wipes.

Saint Elizabeths
SHINING THE LIGHT SINCE 1855

Travel History Questions for 2019-nCoV (Coronavirus)

PATIENT NAME:	HOSPITAL #:
ADMISSION DATE:	UNIT:

Clinical features and epidemiologic risk

Clinical Features	&	Epidemiologic Risk
Fever[1] or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including health care workers[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset
Fever[1] and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	AND	A history of travel from affected geographic areas[5] (see below) within 14 days of symptom onset • China • Iran • Italy • Japan • South Korea (as of 2/26/2020, CDC)
Fever[1] with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization[4] and without alternative explanatory diagnosis (e.g., influenza)[6]	AND	No source of exposure has been identified

These criteria are intended to serve as guidance for evaluation and are subject to change as data become available. Testing may be considered for deceased persons who otherwise meet the PUI criteria.

1 Fever may be subjective or confirmed.

2 For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

3 Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on) 3 If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

4 Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.

APPENDIX 1

5 Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. Current information is available in CDC's COVID-19 Travel Health Notices (https://www.cdc.gov/coronavirus/2019-ncov/travelers).
6 Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS (acute respiratory distress syndrome) of unknown etiology in which COVID-19 is being considered.

If answer is "Yes", follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the 2019-nCoV "Coronavirus".

Evaluator (sign):

Print Name: _____ **GMO** ☐ **NP** ☐ **RN** ☐

Signature: _____ **Date:** _____

Saint Elizabeths
SHINING THE LIGHT SINCE 1855

Travel History Questions for 2019-nCoV (Coronavirus)

EMPLOYEE NAME:	
RETURN DATE:	DEPARTMENT:

Clinical features and epidemiologic risk			
Clinical Features	**&**	**Epidemiologic Risk**	**Action**
Fever[1] or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) ○ Yes ○ NO	AND	Any person, including health care workers[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset ○ Yes ○ NO	If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the 2019-nCoV "Coronavirus".
Fever[1] and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization ○ Yes ○ NO	AND	A history of travel from affected geographic areas[5] (see below) within 14 days of symptom onset. (as of 2/26/2020, CDC) • China • Iran • Italy • Japan • South Korea ○ Yes ○ NO	If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the 2019-nCoV "Coronavirus".
Fever[1] with severe acute lower respiratory illness (e.g., pneumonia, ARDS) requiring hospitalization[4] and without alternative explanatory diagnosis (e.g., influenza)[6] ○ Yes ○ NO	AND	No source of exposure has been identified ○ Yes ○ NO	If Yes, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the 2019-nCoV "Coronavirus".

These criteria are intended to serve as guidance for evaluation and are subject to change as data become available. Testing may be considered for deceased persons who otherwise meet the PUI criteria.

SEH Travel History Questions for 2019-nCoV (Coronavirus)
SEH 320.03.20

APPENDIX 2

1 Fever may be subjective or confirmed.
2 For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
3 Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on) 3 If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
4 Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
5 Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. Current information is available in CDC's COVID-19 Travel Health Notices (https://www.cdc.gov/coronavirus/2019-ncov/travelers).
6 Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS (acute respiratory distress syndrome) of unknown etiology in which COVID-19 is being considered.

If answer is "Yes", follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the 2019-nCoV "Coronavirus".

Evaluator (sign):

Print Name: _____ **GMO** ☐ **NP** ☐ **RN** ☐

Signature: _____ **Date:** _____

dchr

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

MEMORANDUM

To: **District Employees**

From: **Ventris C. Gibson, Director, Department of Human Resources**

Date: **Monday, March 2, 2020**

Subject: **Coronavirus Update**

Coronavirus Disease 2019, also known as COVID-19, is a new respiratory virus that originated in Wuhan, Hubei Province, China. Since its emergence in December 2019, COVID-19 has been discovered across the globe and in the United States.

For the safety of our workforce, we want to keep you updated on the steps the District Government is taking to prepare for potential impacts related to the coronavirus. DC Health has confirmed there are no cases of coronavirus in Washington, DC.

On Friday, Mayor Muriel Bowser issued a Mayor's Order which named DC Health and the DC Homeland Security and Emergency Management Agency responsible for coordinating the District's emergency response planning for any potential impacts from coronavirus.

Since this is an emerging, rapidly evolving situation, DC Health is working closely with the Centers for Disease Control and Prevention (CDC) to provide updated information and education awareness on coronavirus as it becomes available.

As you prepare your home, family, and person, we encourage you to follow good hygiene practices for prevention of contagious diseases such as coronavirus or seasonal influenza. Help stop the spread of germs by:

- Staying home from work until you are free of fever, signs of a fever, and any other symptoms for at least 24 hours and without the use of fever-reducing or other symptom-altering medicants.
- Seeking medical attention – if you have reason to believe you have been exposed to coronavirus or influenza. Call your healthcare provider before visiting a healthcare facility.
- Washing your hands often with soap and water for at least 20 seconds, especially after going to the bathroom, before eating, and after blowing your nose, coughing, or sneezing.
- Avoiding close contact with people who are sick.
- Avoiding touching your eyes, nose and mouth with unwashed hands.
- Cleaning and disinfecting frequently touched objects and surfaces.
- Using an alcohol-based hand sanitizer with at least 60% alcohol, if you have symptoms of acute respiratory illness.

APPENDIX 3

If you have had close contact with someone infected with coronavirus, call your healthcare provider and tell them about your symptoms and your exposure to a patient with COVID-19. If you are impacted by COVID-19or seasonal influenza, promptly contact your immediate supervisor to request to be placed on sick or annual leave, leave without pay, or other earned leave (for example, restored leave or compensatory time).

Additionally, we recommend you and your household are prepared for the possible impact COVID-19 may have in our community:

- Have an adequate supply of nonprescription drugs and other health supplies on hand – pain relievers, stomach remedies, cough and cold medicines, fluids with electrolytes, and vitamins.
- Check on your regular prescription drugs to make sure you have an adequate supply, refill your prescriptions as needed.
- Have a thermometer, tissues, soap, and hand sanitizer.
- Have extra non-perishable food items at home.

Considering our responsibility to continue to provide high-quality, equitable service to our residents, this week, the District will begin sharing public messaging to stop stigma associated with coronavirus:

- **Coronavirus doesn't recognize race, nationality, or ethnicity.** Coronavirus (COVID-19) started in geographically in Wuhan, China. Having Chinese ancestry — or any other ancestry — does not make a person more vulnerable to this illness.
- **Wearing a mask does not mean a person is ill.** People wear masks for a variety of reasons, including to avoid pollen and air pollution and for cultural and social reasons. We should not judge someone for wearing a mask or assume they are sick.
- **Speak up if you hear, see, or read discriminatory comments**. Correct false information and remind the person that prejudiced language and actions make us all less safe. If discrimination occurs, report it to DC's Office of Human Rights at 202-727-4559.
- **Show compassion and support for those most closely impacted.** Listen to, acknowledge and, with permission, share the stories of people experiencing stigma, along with a message that bigotry is not acceptable in our community.

For more information about COVID-19, visit:

- dchealth.dc.gov/coronavirus
- cdc.gov/coronavirus/2019-ncov/index.html
- travel.state.gov/content/travel/en/traveladvisories/traveladvisories.html/

Agency human resources offices may contact the Department of Human Resources for additional health, safety, or leave management information.

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Center for Policy, Planning and Evaluation
Division of Epidemiology–Disease Surveillance and Investigation

February 28, 2020

Health Notice for District of Columbia Health Care Providers
Update and Interim Guidance: Coronavirus Disease 2019 (COVID-19)

SUMMARY

The DC Department of Health (DC Health) continues to monitor the Coronavirus Disease 2019 (COVID-19) outbreak caused by the novel coronavirus, SARS-CoV-2. Cases were initially reported in Wuhan City, Hubei Province, China but has now been detected in 50 locations internationally, including the United States. As of February 27, 2020 there were 78,497 reported cases in China and 3,797 cases in locations outside China. In addition to sustained transmission in China, there is evidence of community spread in several additional countries. The Centers of Disease Control and Prevention (CDC) has updated travel guidance to reflect this information (https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html).

This Health Notice provides updated guidance on evaluating and testing persons under investigation (PUIs) for COVID-19 in response to CDC's Health Alert Network Update released on February 28, 2020.

BACKGROUND

To date, there has been limited spread of COVID-19 in the United States. As of February 26, 2020, there were a total of 61 cases within the United States; 46 of these were among repatriated persons from high-risk settings. The other 15 cases were diagnosed in the United States; 12 were persons with a history of recent travel in China and 2 were persons in close household contact with a COVID-19 patient (i.e. person-to-person spread). One patient with COVID-19 who had no travel history or links to other known cases was reported on February 26, 2020, in California. The California Department of Public Health, local health departments, clinicians, and CDC are still working to investigate this case.

DC Health continues to work with partners to implement measures to identify COVID-19 in DC, and slow and contain transmission. These measures include assessing and monitoring per CDC guidelines, and working with healthcare providers to screen for possible COVID-19 PUIs. To date, five PUIs have tested negative in DC, and no cases have been confirmed.

Recognizing persons at risk for COVID-19 is a critical component of identifying cases and preventing further transmission. With expanding spread of COVID-19, additional areas of geographic risk are being identified and PUI criteria are being updated by CDC to reflect this spread. To prepare for possible additional person-to-person spread of COVID-19 in the United States, DC Health recommends that clinicians consider COVID-19 in patients with severe respiratory illness even in the absence of travel history to affected areas or known exposure to another case and notify health officials immediately when a case is suspected. The epidemiology of COVD-19 is rapidly evolving and guidance is continuously being released. We encourage you to review the DC Health and CDC websites for the most up-to-date situational information.

APPENDIX 4

Updated Recommendations for Healthcare Providers

1) **Criteria on Evaluation and Testing of Patients Under Investigation (PUI) for COVID-19**
Patients who meet the following criteria should be reported to DC Health for evaluation as a PUI*:

Clinical Features		Epidemiologic Risk
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including health care personnel[2], who has had close contact[3] with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset
Fever[1] AND signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) requiring hospitalization	AND	A history of travel from affected geographic areas[5], within 14 days of symptom onset
Fever[1] with severe acute lower respiratory illness (e.g., pneumonia, ARDS (acute respiratory distress syndrome) requiring hospitalization and without an alternative explanatory diagnosis (e.g., influenza)[6]	AND	No identified source of exposure

These criteria are intended to serve as guidance for evaluation and are subject to change as data become available. Testing may be considered for deceased persons who otherwise meet the PUI criteria.

[1] Fever may be subjective or confirmed.

[2] For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

[3] Close contact is defined as—

a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case

– or –

b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on)

If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
[4]Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
[5]Affected areas are defined as geographic regions where sustained community transmission has been identified. Relevant affected areas will be defined as a country with at least a CDC Level 2 Travel Health Notice. Current information is available in CDC's COVID-19 Travel Health Notices (https://www.cdc.gov/coronavirus/2019-ncov/travelers).
[6]Category includes single or clusters of patients with severe acute lower respiratory illness (e.g., pneumonia, ARDS (acute respiratory distress syndrome) of unknown etiology in which COVID-19 is being considered.

Special consideration should be given to healthcare personnel exposed in healthcare settings, as described in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).

Review of Recommendations for Healthcare Providers

1) Notification to DC Health

- Healthcare providers should **immediately** notify their infection control personnel and contact DC Health in the event of a PUI for COVID-19 by calling **202-576-1117 (during business hours)** or **844-493-2652 (after business hours)**.
- **Please try to collect the following information prior to notifying DC Health about a PUI:**
  1. State of residence
     - If the patient is a Maryland or Virginia resident, please contact the Maryland or Virginia Departments of Health as per your usual protocol
  2. Patient contact information and occupation
  3. Detailed symptom history with symptom onset date
  4. Contact with ill persons
     - Was the patient in contact with a person who was ill OR a person suspected or confirmed to have 2019-nCoV?
     - Was the contact ill while the patient was around them?
     - Type of contact between patient and contact (for example, stayed in the same house or shared a meal together at a restaurant)
     - Date(s) patient was exposed to ill person
  5. Detailed travel history (countries, cities, dates including any layovers or additional stops)
     - Mode of travel between locations (i.e. train, plane, bus)
  6. Details about wearing a facemask at any time before, during or after the travel
  7. History of being a healthcare provider OR being in a healthcare facility (as a patient, worker or visitor) in an affected country
  8. If there is high suspicion the patient meets the criteria for a PUI, the mode of transport to your healthcare facility
- If the case does not meet the current case definition but is **highly suspicious**, please contact DC Health for consultation.

2) **Infection Control Recommendations**
   - Infection control recommendations vary by facility and activity type and are important to maintain in order to prevent spread within a healthcare facility
   - Please review the CDC website to find the appropriate information for your facility: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html)

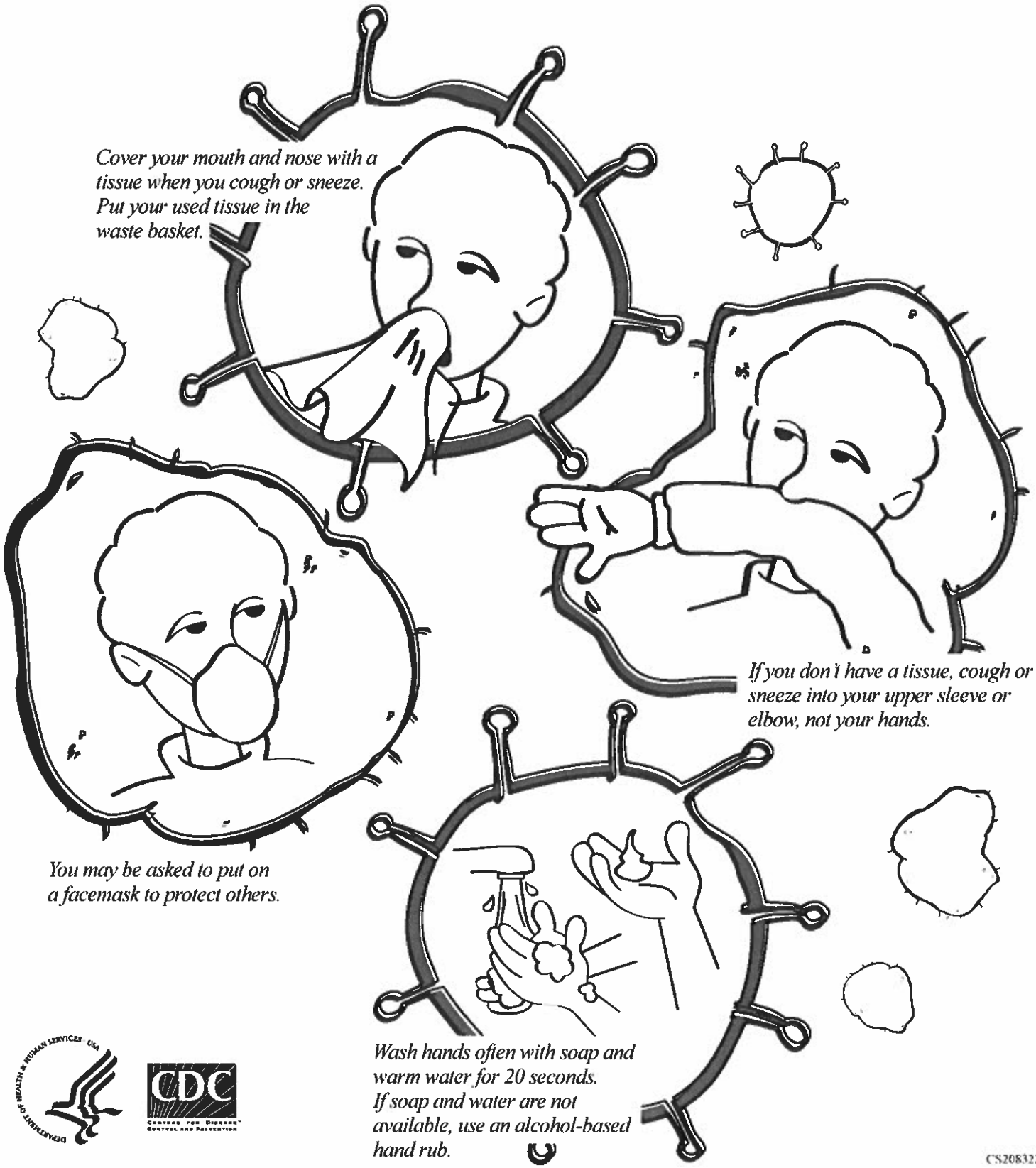
3) **Specimen Collection Guidelines**
   - For guidelines on collecting, handling and testing of clinical specimens from Patients Under Investigation(PUIs) for COVID-19(https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html)
   - Collection of an NP swab (in Viral Transport Media (VTM) or universal transport media (UTM)), OP swab (VTM or UTM) is recommended for initial diagnostic testing for SARS-CoV-2. Lower respiratory specimens can be tested if available and for patients who develop a productive cough, a sputum specimen can be collected
     - Induction of sputum is not recommended and should be collected in a sterile container if indicated
     - For patients for whom it is clinically indicated (e.g. those receiving invasive mechanical ventilation), a lower respiratory tract aspirate or bronchoalveolar lavage sample should be collected as lower respiratory tract specimen
     - Please label specimens appropriately
   - Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset
   - If approved for testing by CDC, please complete the following forms:
     - CDC 50.34 (for each specimen) (https://www.cdc.gov/laboratory/specimen-submission/form.html)
     - DC Public Health Laboratory External Chain of Custody form (https://dfs.dc.gov/publication/phl-forms-and-documents)
     - DC Public Health Laboratory Test Requisition form (https://dfs.dc.gov/publication/phl-forms-and-documents)
     - Patient Under Investigation (PUI) form (https://www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html)
   - Detailed instructions about specimen testing and forms will also be provided via email once testing is approved. **Any specimens submitted without complete CDC 50.34 forms will result in significant delays in testing and may be rejected**

The guidelines above will continue to be updated as the outbreak evolves. Please visit the DC Health (https://dchealth.dc.gov/coronavirus) and CDC COVID-19 websites (https://www.cdc.gov/coronavirus/2019-ncov/index.html) for the most current information.

Please contact the DC Health Division of Epidemiology–Disease Surveillance and Investigation at:
Phone: 202-576-1117 (8:15am-4:45pm) | 844-493-2652 (after-hours calls)
Fax: 202-442-8060 | Email: doh.epi@dc.gov

Cover your Cough

Stop the spread of germs that can make you and others sick!



Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.

If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.

You may be asked to put on a facemask to protect others.

Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.

CS208322

APPENDIX 5

3M Air-Mate Powered Air Purifying Respirator (PAPR) Instructions for Use

Durham Regional Hospital
Safety Office
470-6161

1. Unplug the PAPR from the cord connecting it to the battery charger and electrical outlet.

2. Inspect the airflow tube for cracks. Pay close attention to the end that connects to the head cover.

3. Check to ensure that the airflow tube is securely connected to the PAPR. Look for any signs of damage.

4. Remove the tissue paper covering the clear plastic face mask.

5. Turn the PAPR on by Pressing the Black Rubber Button.

6. To check the airflow, place the "egg float" into the upright end of the airflow tube.

APPENDIX 6

7. The lower band will rise above the edge of the airflow tube if the air supply is adequate.

8. Connect the airflow tube to the plastic circle at the back of the head cover.

9. Place the PAPR (with airflow tube up) against your lower back and fasten the belt buckle.

10. Guide the airflow tube upward behind you and put the head cover on. There are headbands inside the head cover that fit snugly on your head.

11. Adjust the head cover so that the elasticized edge of the face seal fits under your chin. It is now safe to enter the isolation room.

12. Remove PAPR in a non-contaminated area. Disconnect the head cover from the airflow tube with care by firmly grasping both pieces by the hard plastic parts that connect them. Gently but firmly pull them apart.

Care and Storage

For Patients on Airborne Precautions:

- Head covers can be re-used by the same employee for the same patient as long as they are clean and intact.
- Write your name on it.
- On the nursing units the head covers can be stored in the anterooms.
- Reconnect the PAPR to the battery charger.

For Patients on Airborne Precautions *and* Contact Isolation:

- Discard the head cover. *Do not reuse head covers when caring for a patient on Contact Isolation.*
- Disinfect the OUTSIDE of the PAPR unit with hospital-grade disinfectant after use.
- Reconnect the PAPR to the battery charger.

- If airflow is inadequate, the PAPR malfunctions, or there are cracks in the airflow tube, call Clinical Engineering at 470-8184.
- New head covers can be ordered from Central Stores 470-4250.

GUIDELINES FOR FACILITIES DURING OUTBREAKS OF NOROVIRUS/ GASTROENTERITIS: RECOMMENDATIONS AND PRECAUTIONS

- Encourage frequent hand washing with soap and warm water.
- Provide and encourage use of alcohol based (62%) waterless hand sanitizers when entering facility.
- Reinforce strict hand washing policy among staff.
- Do not allow symptomatic staff to work in facility.
- Assure glove use for handling of all ready-to-eat foods and eating utensils.
- Increase frequency for cleaning/sanitizing "high touch" surfaces, e.g., door handles, light switches, handrails, faucets, ice machine, etc. (see next page for facility specific recommendations)
- Use disposable cleaning cloths; use a new cloth for each room/area cleaned.
- Dispose of vacuum cleaner bags between uses. *Note: if area is visibly soiled with fecal spillage or vomit do not vacuum—either steam clean or use hot water and detergent.*
- Do not enter food service area with items soiled with vomit or fecal spillage.

The following cleaning agents are recommended for use during an outbreak:

Suggested Uses	Suggested Cleaning Method	How to Make (1 cup = 240ml)	Strength (parts per million)
Porous surfaces such as wood floors or surfaces visibly soiled with vomit/feces	Chlorine bleach*	1 ½ cup bleach in 1 gallon water	5000ppm (1:10 dilution)
Non-porous surfaces such as: handrails, tile floors, counter-tops, sinks, toilets, doorknobs and other commonly handled items. *See facility specific section for suggested items.*	Chlorine bleach*	1/3 cup bleach in 1 gallon water	1000ppm (1:50 dilution)
Food/mouth contact items, stainless steel and toys mouthed by children	Chlorine bleach* then rinsed with water OR dishwasher at 170°F	1 Tbsp. bleach in 1 gallon water	200ppm (1:250 dilution)
Carpet & upholstered fabrics visibly soiled with vomit or fecal spillage. Do not dry vacuum as viruses can become airborne.	Hot water and detergent OR Steam clean	NA	NA

*Bleach solution must: contain 5.25% Sodium Hypochlorite; be prepared fresh daily; have 10-20 minute surface contact time. Use unopened bleach for outbreak-related sanitization (open bottles lose effect after 30 days). EPA-registered disinfectants may also be used although effectiveness in outbreaks has not been evaluated.

Warnings:

1. Cleaning staff should wear protective equipment when handling chemicals.
2. Food preparation/food contact areas must be washed, rinsed and sanitized using standard protocol after cleaning with the stronger bleach solutions listed above.

Additional Recommendations for Healthcare/Assisted Living Facilities:

- Reinforce proper glove use when giving patient/resident care. Remove gloves before leaving ill patient's/resident's room and wash hands immediately.
- Do not "float" staff between units with ill patients/residents and units with non-ill patients/ residents.
- Assign staff members to care for only ill group or only non-ill group to help prevent transmission.
- Exclude non-essential personnel from units with ill patients/residents.
- Discontinue new admissions to the facility until the outbreak has ended.
- Confine ill patients/residents to their rooms until 72 hours after their symptoms end.
- Do not allow patients/residents from outbreak-affected units to enter/transfer to unaffected units, unless medically urgent to do so, until end of outbreak.
- Discontinue group activities (communal dining, etc.) until outbreak has ended.
- Limit visitation until outbreak has ended.
- Store and launder contaminated soiled linens separately from non-contaminated soiled linens.

APPENDIX 7

Facility-specific List of Suggested Items to Sanitize with 1000ppm bleach solution (1/3 cup bleach in 1 gallon water)

This is a list of suggested items to sanitize in order to reduce the number of illnesses during a gastroenteritis outbreak. This list is not exhaustive and your facility may have additional items in need of sanitation.

General:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, countertops, light switches, and other common items shared among staff/patrons.

Restaurants/Food Service:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, countertops, light switches, common telephones, menus, table placards, folders for credit cards, trays, tray stands, baskets, salt & pepper shakers, table bottle of ketchup and other condiments, sugar packet dispensers, booths, tables, exposed parts of buffet line, sneeze guards, and other common items shared among staff/patrons.

Healthcare Facilities:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, bedrails, countertops, common telephones, cards/games in common room, common craft materials, TV remote controls, computer keyboards, drawer/cabinet pulls, light/lamp switches, recliner chair handles, dining hall tables and chairs, dining hall salt/pepper shakers, walkers, wheelchair handles, any physical therapy shared items, and other common items shared among staff/patients/residents.

Schools/Childcare Facilities:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, countertops, light switches, common telephones, shared games/books/toys, playground equipment, diaper changing table, diaper changing pad, locker hardware, shared classroom equipment (microscopes, musical instruments, computer keyboards), physical education shared equipment, cafeteria tables and chairs, cafeteria salt/pepper shakers, and other common items shared among staff/students.
- Cloth items unable to withstand bleach sanitization (plush toys, pillows, etc.) should be laundered in hot water or discarded if laundering/sanitization not possible.

CONTACT THE LOCAL HEALTH DEPARTMENT IF YOU SUSPECT AN OUTBREAK IN YOUR FACILITY.

References:

http://www.cdc.gov/ncidod/dhqp/id_norovirusFS.html
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5009a1.htm
http://www.michigan.gov/documents/Guidelines_for_Environmental_Cleaning_125846_7.pdf
http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5633a2.htm
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5839a2.htm

ATTACHMENT 3

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Administrative Issuance -#2020-001

Department of Behavioral Health, Saint Elizabeths Hospital Administrative Issuance

SUBJECT: Prevention and Management of COVID-19 (Coronavirus)
EFFECTIVE DATE: January 29, 2020
UPDATED: 3/5/2020, 3/20/2020, 4/1/2020, 4/2/2020, 4/3/2020

PURPOSE AND AUTHORITY
This Administrative Issuance provides Saint Elizabeths Hospital employees guidance on managing patients or staff who are suspected of Pneumonia of Unknown Etiology (PUE) and specifically COVID-19. The situation is evolving; therefore, this Issuance will be updated as more information becomes available.

DEFINITION
2019-nCo V/COVID-19: A novel coronavirus that is causing an outbreak of pneumonia-like illness.

TRANSMISSION AND PRECAUTIONS
Transmission and Precaution: CDC currently recommends a cautious approach to patients under investigation for COVID-19.

1) Patients at risk or with symptoms of COVID-19 shall be asked to wear a surgical mask as soon as they are identified, and shall be evaluated in a private room with the door closed. Ideally, this should be an airborne infection isolation room if available, pending transfer out to an acute care hospital.
2) SEH staff entering the room of affected patients shall use standard precautions, contact precautions, airborne precautions, and use eye protection (e.g., PAPR, gloves, gown). See guidelines set in the Infection Control Recommendations on page 2 of this Issuance.
3) For staff who return to work after traveling abroad or who exhibit potential symptoms, an assessment shall be completed using Appendix 2.

Notification: GMOs/NPs, supervisors identifying a newly admitted patient, or staff meeting these criteria, shall immediately notify the SEH Infection Control Coordinator and Department of Health if a patient/staff meets criteria of suspected cases-

1) DC Health by calling 202-576-1117 (during business hours) or 844-493-2652 (after business hours) or by sending an email to doh.epi@dc.gov.
2) SEH's Infection Control Coordinator via yi-ling .tu@dc.gov or by calling 202-465-5529.

Personal Protective Equipment (PPE): PPE may be obtained from the unit Nurse Manager or Supervisor. Additional PPEs may be obtained from the supply room. PPE includes: gloves, gowns, shoe protectors, face masks, and face shields.

- Nurse Managers or Department Supervisor shall utilize the SiteFM system to request additional or replacement PPEs.
- Nurse Managers/Department Supervisors should throughout the day periodically check supplies quantities, and seek feedback from their frontline staff on conditions/status of supplies.
- All frontline staff (e.g., nursing, social work, clinical administrators, house-keeping) shall be trained on proper use of PPEs, including how and when to wear PPE (see Appendix 6:2TR PPE Requirement). Staff seeking more training/information should contact their supervisor.

Visitors to SEH and Patients: As of the date of this Administrative Issuance, visitation by patient's family, guardians, and friends has been suspended. Patients and their family/friends/others are encouraged to continue communicating via telephone. The Hospital has established the following guidelines for visits by case management providers and patient's attorneys:

- Case Management Providers: On-site visitation by case management providers has been suspended, with the exception of the day of discharge when case managers aid our individuals with their return to the community.
- Legal Visits: We strongly encourage attorneys to contact clients via telephone or videoconference, whenever possible, since outside visitors pose the greatest infection risk to our individuals in care. All legal visitors will be screened for COVID-19 at the Intensive entrance to the Hospital. All legal visitors must arrive between 9:00 AM and 4:00 PM, Monday through Friday, for screening prior to being permitted to enter the building, and visits must be completed by 6:00 PM. If you do not arrive in time for the screening, the visit will need to be postponed to the next business day.

Screening of Visitors: All visitors are required to enter through the Intensive-side of the Hospital to be screened. Staff conducting the screening shall compete the form in Appendix 8: Screening Questions for COVID-19 Visitor.

SURVEILLANC BY THE HOSPITAL

Screening of Patients: Clinical screening criteria for COVID-19 should be based on DC Health Notice and CDC recommendations. Newly admitted patients, or patients exhibiting potential symptoms shall be screened by using Appendix 1 of this issuance.

Screening of Staff: As of April 1, staff from Housekeeping, Nursing, Facilities and Environment, and Nutritional Services will receive screening for COVID-19 prior to reporting for duty. Staff from these departments must report to the Intensive-side of the building to receive temperature and other screening prior to reporting for duty. Any employee that shows risks and/or symptoms of COVID-19 shall be directed to go to their primary care physician for further testing. Staff may not return to work until they are cleared by their primary care physician.

- Screening for all other remaining staff will start on or before the week of April 6.
- The criteria for staff screening are the same as for newly admitted patients; and shall also be used for new hires, when staff return from international travel, and/or exhibit respiratory symptoms. Staff shall also be guided by the attached Appendix 2 (DC Health Issuance dated February 28, 2020) and Appendix 3 (DCHR Memorandum dated March 2, 2020).

COVID-19 Screening Tools: Conduct screening of COVID-19 by using Travel History Questions for 2019-nCoV (Coronavirus), per Appendix 1 for patients and Appendix 2 for staff. When suspected cases are identified, healthcare providers should-

- Apply facemask to patient/staff.
- Isolate patient/staff in a room with door closed. Affix the "Isolation Unit" signage on the entry doors (see Appendix 10).
- Call 911 to send patient/staff out to an acute care hospital.

Testing of Patients for COVID-19: Patients returning from an outside provider, courts, or community hospitals that may present with risks or symptoms for COVID-19 shall be screened and evaluated by a GMO/NP. Based on the screening/evaluation results (e.g., patient symptoms), the GMO/NP will determine if further COVID-19 testing will be required (see Appendix 9: Notice to GMO/NPs on COVID-19 (Coronavirus) Testing, and Department of Forensic Sciences: COVID-19 Specimen Submission Guidelines; and associated forms and instructions).

Infection Control Recommendations: Saint Elizabeths Hospital follows DC Health's and CDC's latest recommendations to develop infection control and prevention strategies outlined below:

1) Follow DC Human Resources policy as it pertains to leave or other HR matters (see Appendix 3: DCHR Memorandum dated March 29, 2020, https://edpm.dc.gov/issuances/human-resources-guidance-covid-19-emergency/)
2) Use proper Cough Etiquette as outlined in Appendix 5 (Cough Etiquette)
3) Perform frequent hand hygiene per Infection Control Policy 11.0 Hand Hygiene. (https://tinyurl.com/vdwfkb4)
4) Housekeeping staff shall implement cleaning and disinfecting practices per Appendix 7: Guidelines for Facilities During Outbreaks of Norovirus/Gastroenteritis: Recommendations and Precautions.
5) Saint Elizabeths Hospital will provide additional hand sanitizers and facemask for visitors.

Monitoring Guidelines for Staff Who Were Exposed to a Confirmed COVID-19 Staff: Staff shall be notified if they were exposed to another employee who has had a confirmed COVID-19 test. These exposed staff shall (see Appendix 11)-

1) Monitor their temperature and absence of symptoms each day prior to starting work.
2) Wear a facemask while at work for the 14 days after the exposure.
3) Adhere to hand hygiene protocols.
4) NOT work with high risk patient populations (such as in units 1A & 1B)
5) Self-monitor for symptoms at all times, and seek re-evaluation from your primary care doctor if respiratory symptoms occur.
6) If they develop symptoms (even mild symptoms) while at work, IMMEDIATELY cease patient care activities. Staff shall don a facemask (if not already wearing), isolate themselves, and notify their supervisor.

Process for Staff Requesting Leave Due to COVID-19 and/or as a Result of Experiencing Symptoms of COVID-19 (see Appendix 12)

- **Leave Review and Recommendations**
  1) All requests for leave shall be emailed to Dr. Potter for review.
  2) Dr. Potter will review and provide his recommendations to the DBH Risk Manager (Mary Campbell) and Elaine Tu who will be tracking employees and their symptoms.
  3) Recommendation will also be sent to the employee's supervisor; who will notify the employee on the recommendations (i.e., to test and quarantine).
  4) Mary will notify Ms. Wheeler of the leave request and recommendations; and Ms. Wheeler will inform the supervisor if the employee should get administrative leave (or any other type of leave).
- **Employee Responsibilities**
  1) All employees are required to share their contact information with Elaine/Mary. Mary will conduct daily calls with the employee until they return.
  2) All employees are required to share medical information related to COVID 19 illness.
  3) All employees must present a medical clearance before returning to work.
- **Tracking of Employee Leave**
  1) Mary/Elaine will track all employee COVID19 tests and test results.
  2) Mary will track employees requesting FMLA, ADA, or other underlying health issues.

Staff having questions related to human resources-related issues should contact SEH's HR Department:

- Debra Allen-Williams at 299-5212 or debra.allen-williams@dc.gov
- Andrea Bentley at 299-5231 or andrea.bentley@dc.gov

Working in Areas/Units Identified as "Quarantined" or "Isolation": Staff shall use proper Personal Protective Equipment.

- As of March 31, 2020; ALL STAFF WORKING ON UNIT 2TR MUST wear Powered Air Purify Respiratory (PAPR), gown, eye protector or faces shield, gloves and shoe protectors when providing patient-care within 6 feet of the patients (see Appendix 6: 2TR PPE Requirement).
- PAPR is not needed when staff is not in close contact with patients, for example when in the Nursing Station, working within the confines of the Medication Room, and when maintaining more than a 6 foot distance in the milieu or common areas. However, face shield, face mask, gown, gloves, and shoe protector should be worn while working on 2TR.
- Staff shall use contact and droplet precaution when providing patient care as appropriate (see Appendix 6: 3M Air-Mate Powered Air Purifying Respirator Instructions for Use).

The following chart provides guidance for when to use PPE and PAPR equipment (see Appendix 6:2TR PPE Requirement). Staff may request further training on the proper use of this equipment from their supervisor.

Areas	Protection
Quarantined (2TR)	Gown, Face Mask, Face Shield, Gloves, Shoe Protectors
Isolation	Zipped-up Suit, White Hood, PAPR, Gloves, Shoe Protectors
All Other Areas	Standard droplet precautions when providing care

Communicating the Hospital's Plan to Patients and their Family/Guardians: Executive leadership has been meeting with the patients and the Patient Advisory Council to share with them the Hospital's plans for keeping them safe. Leadership has also provided and continues to provide updates to patient's family/guardians. Executive leadership are available to speak with patients as needed. Please notify your supervisor if your unit requests a meeting or more information.

Approval:

Edger Potter, MD
Supervisory General Medical Officer

Yi-ling Elaine Tu, MSN, RN, WCC
Infection Control Coordinator

Approved:

Mark Chastang, MPA, MBA, FACHE
Chief Executive Officer

Saint Elizabeths
SHINING THE LIGHT SINCE 1855

Screening Questions for COVID-19 (Coronavirus)
PATIENT

PATIENT NAME:	HOSPITAL #:
ADMISSION DATE:	UNIT:

These criteria are intended to serve as a guide for evaluation and are subject to change as additional data become available. Testing may be considered for deceased persons who otherwise meet the PUI criteria. Patients who meet the following criteria should be reported to DC Health for evaluation as a PUI*:

Temperature: _____F NA ☐

Clinical Features and Epidemiologic Risk			
Clinical Features	**&**	**Epidemiologic Risk**	**Action**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) ○ Yes ○ NO	**AND**	**Any person, including health care personnel[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).**
Fever[1] AND signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath) AND tested negative for influenza[5] ○ Yes ○ NO	**AND**	**A history of travel to a country with a Level 2 or 3 Travel Advisory OR an area with confirmed ongoing community transmission, within 14 days of symptom onset. (check CDC for daily update)** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND without an alternative explanatory diagnosis ○ Yes ○ NO	**AND**	**A history of residing in a nursing home or long-term care facility within 14 days of symptom onset** ○ Yes ○ NO	**If Yes, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the**

APPENDIX 1

COVID-19 (Coronavirus).

1 Fever may be subjective or confirmed.
2 For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
3 Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
4 Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
5 Includes rapid and confirmatory influenza testing

If patient meets one of the above, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of covid-19(Coronavirus) and contact the DC Health Division of Epidemiology–Disease Surveillance and Investigation at:

202-576-1117 (8:15am-4:45pm)

844-493-2652 (after-hours, healthcare providers only)

Fax: 202-442-8060 | Email: doh.epi@dc.gov

Evaluator (sign):

Print Name: _____ **GMO** ☐ **NP** ☐ **RN** ☐

Signature: _____ **Date:** _____

The guidelines above will continue to be updated as the outbreak evolves. Please visit the DC Health and CDC websites regularly for the most current information.

Saint Elizabeths
SHINING THE LIGHT SINCE 1855

Screening Questions for COVID-19 (Coronavirus)
EMPLOYEE

EMPLOYEE NAME:	TRAVEL DESTINATION:
RETURN DATE:	DEPARTMENT/UNIT:

Does Employee Meet DCHR Self Quarantine Criterion According to DC Government Continuing Operations in Response to COVID-19 (Effective March 16, 2020- March 31, 2020).

You must notify your immediate supervisor of any foreign travel in the last 14 days to areas designated by CDC as Level 2 or 3.

Self-Quarantine: ☐ Yes ☐ No Temperature: _____F ☐ NA

These criteria are intended to serve as a guide for evaluation and are subject to change as additional data become available. Testing may be considered for deceased persons who otherwise meet the PUI criteria. Employees who meet the following criteria should be reported to DC Health for evaluation as a PUI*:

Clinical Features and Epidemiologic Risk			
Clinical Features	**&**	**Epidemiologic Risk**	**Action**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) ○ Yes ○ NO	**AND**	**Any person, including health care personnel[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of COVID-19 (Coronavirus).**
Fever[1] AND signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath) AND tested negative for influenza[5] ○ Yes ○ NO	**AND**	**A history of travel to a country with a Level 2 or 3 Travel Advisory OR an area with confirmed ongoing community transmission, within 14 days of symptom onset. (check CDC for daily update)** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND without	**AND**	**A history of residing in a nursing home or long-term care facility within 14 days of symptom onset**	**If Yes to both, follow infection control measures on Administrative**

APPENDIX 2

an alternative explanatory diagnosis

- Yes
- NO

- Yes
- NO

Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).

1 Fever may be subjective or confirmed.
2 For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
3 Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
4 Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
5 Includes rapid and confirmatory influenza testing

If employee meets one of the above, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of covid-19(Coronavirus) and contact the DC Health Division of Epidemiology–Disease Surveillance and Investigation at:

202-576-1117 (8:15am-4:45pm)

844-493-2652 (after-hours, healthcare providers only)

Fax: 202-442-8060 | Email: doh.epi@dc.gov

Evaluator (sign):

Print Name: _____ **GMO** ☐ **NP** ☐ **RN** ☐

Signature: _____ **Date:** _____

The guidelines above will continue to be updated as the outbreak evolves. Please visit the DC Health and CDC websites regularly for the most current information.

HTTPS://edpm.dc.gov/issuances/human-resources-guidance-covid-19-emergency/

Human Resources Guidance for the COVID-19 Emergency (March 26 Update)

I-2020-8

Effective Date:
March 29, 2020

Expiration Date:
Dec. 31, 2020

Chapters:
12 16

Contents »

Overview

On March 11, 2020, the Mayor declared both a public emergency and a public health emergency due to the Coronavirus Disease 2019 (COVID-19). Following the Mayor's declarations, on March 17, 2020, the Council passed the COVID-19 Response Emergency Amendment Act of 2020 providing broad authority to address the critical needs of District residents and businesses.

The Department of Human Resources (DCHR) is releasing this guidance to assist agencies and employees in understanding personnel management changes that are in effect during the COVID-19 emergency. In this issuance, we are making updates to administrative leave provisions, which supersede and replace the provisions contained in Issuance No. 2020-6.

For the most up to date information on COVID-19 in Washington, DC, please visit https://coronavirus.dc.gov/.

Hiring and Promotions

During the public health emergency, District government agencies have several flexible hiring options available if it becomes necessary to quickly hire new employees. Agencies under the Mayor's personnel authority shall work with DCHR's recruitment specialists to identify the right hiring tools for agencies' hiring needs to implement and effectuate these temporary assignments.

Details

An employee may be temporarily detailed to another position to meet the immediate needs of the agency or another agency to address the COVID-19 emergency. Details may be made within agencies and between agencies. If an agency needs assistance meeting a staffing need, the agency should reach out to their assigned Specialist at DCHR for assistance. Details may be made for up to 240 days. Details in excess of 240 days must be approved by DCHR.

Emergency Appointments

With DCHR's approval, agencies may make non-competitive emergency Career Service appointments of up to 30 days to provide for maintenance of essential services to respond to a natural disaster or other similar emergency situations. Agencies cannot extend emergency appointments and may not promote, convert, transfer, or otherwise move the employee into a permanent position within the District government.

Non-Competitive Appointments

During the COVID-19 emergency, DCHR may authorize non-competitive appointments. Non-competitive appointments will be authorized when rapid appointment is reasonably necessary to respond to the COVID-19 emergency. DCHR may waive any applicable residency requirements, but these waivers must be approved in writing and contained in any offer letter.

Special Appointments

DCHR may authorize agencies to make special, non-competitive appointments to fill professional, scientific, or technical expert or consultant positions. These appointments are in the Excepted Service. For the duration of the COVID-19 emergency, the applicable residency requirement is suspended. After the emergency ends, appointees will have 180 days to relocate into the District or to compete internally for a position in a different service. There is no limit to the number of special appointments that can be made, and they are in addition to the Mayor's allotted Excepted Service positions under D.C. Official Code § 1-609.03.

Temporary / Term Appointments

APPENDIX 3

Agencies may make temporary appointments to the Career, Education, and Management Supervisory Services to meet immediate, time-limited operational needs. During the COVID-19 emergency, and with DCHR's approval, agencies may make these appointments non-competitively above grade 12. However, once the emergency ends, any appointments above grade 12 must be competed.

Additionally, agencies may extend any temporary or term appointment for up to 90 days without pre-authorization. Any extensions beyond 90 days must be approved by DCHR.

Promotions

DCHR may authorize the promotion of employees either on a temporary or permanent basis without competition to meet immediate operational needs. Time limits for temporary promotions are suspended during the COVID-19 emergency.

Reassignments

For front-line agencies that are experiencing talent shortages, agencies may choose to reassign existing employees. If an agency has specific hiring needs with which it needs assistance, please contact the assigned Specialist at DCHR for assistance.

Residency Requirements

For the duration of the COVID-19 emergency, DCHR may suspend any residency requirements for positions to meet immediate operational needs to provide critical services or support for the COVID-19 emergency. All waivers by DCHR must be in writing and must include the scope and duration of the waiver. Agencies must supply a corresponding notice to the applicable candidate or employee.

Selection Certificates

Typically, selection certificates for vacancies may last no longer than 90 days. During the pendency of the COVID-19 emergency, and with the approval of DCHR, agencies may rely on certificates that are more than 90 days old.

Scheduling and Deployment

Childcare

The District government recognizes the difficulty of acquiring childcare during the COVID-19 emergency. As such, employees directed to telework may work from home and supervise their children during this emergency. Agencies may also consider alternative work hours and schedules for impacted employees. For example, agencies may authorize employees to work 12 hours shift for 4 days to allow time for both work and child supervision.

However, due to the critical nature of the jobs performed by employees who cannot telework or who are ordered to a duty station, these employees must find alternative arrangements for childcare. Only if operations permit may agencies approve at their discretion, leave for employees who cannot telework or who are ordered to a duty station but cannot physically report to work.

Commuter Delays

Metro has reduced services and updates its operating status frequently. For the current operational status, please visit Metro's COVID-19 Operational Status webpage.

With the reduced service, employees will likely experience unexpected commuting delays when using Metro bus and rail service. Agencies should remain flexible and understanding when employees encounter commuting challenges. Employees should notify their supervisor immediately if they are impacted by commuting delays and will be unable to arrive at work as scheduled. Employees should receive pay only for those hours actually worked. If an employee arrives late due to commuting delays, a supervisor may approve an employee to work later than scheduled to make up the lost time.

Duties

Agencies may modify employees' assigned duties as needed to support the COVID-19 response. Agencies may also modify employees' assigned duties to accommodate remote and telework arrangements.

Duty Stations

Agencies may modify an employee's duty station as appropriate to meet operational or service needs during the COVID-19 emergency.

Employee Scheduling

Agencies may modify employees' work schedules as needed to adequately manage the city's COVID-19 response and maintain critical services. This includes changing workdays and times, adding additional workdays, expanding worktimes, and ordering overtime. When modifying an employees' schedule, agencies should provide employees at least 24 hours' notice of the schedule change, except when the need for the schedule change was unforeseeable.

Employees who are exempt from the FLSA overtime provisions may be eligible to accrue exempt time off at the discretion of their agency. At this time, FLSA-exempt employees are not eligible for overtime pay. For additional guidelines on overtime and compensatory time (comp time), refer to Issuance 2020-2, *Overtime*.

Previously Approved Leave (Rescinding)

Agencies shall rescind any previously approved leave granted to an employee if the employee's absence would impede the city's COVID-19 response. An agency, at its discretion, may authorize the reimbursement of any actual financial loss suffered by an employee as a direct consequence of a recension of previously approved leave. For example, an agency may reimburse an employee for any travel change fees but not the entirety of the employee's itinerary. Reimbursements will be made from centralized funding and will not impact agencies budgets.

Meetings

Agencies' gatherings and in-person meetings shall be limited to fewer than 10 people at a time, when feasible; agencies are encouraged to use tele-conferencing, video-conferencing and other electronic options to the greatest extent possible. For more information, visit https://remote.dc.gov/.

Reporting Time

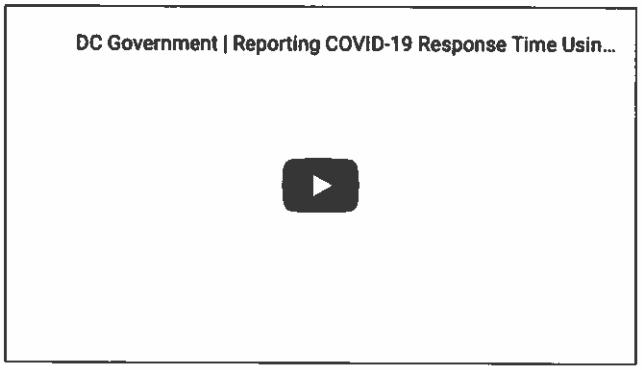
During the COVID-19 emergency, employees, and timekeepers for those agencies whose timekeepers enter employees' time, will continue to enter work hours on their timesheets. Generally, time will be entered as usual. However, to properly account for new operating models, accurate time reporting is critical.

Telework

Employees who are working from home must use the Situational Telework Time Reporting Code (TRC). This TRC is: "Telework (Situational) – STTW".

Recording COVID-19 Tasks

Employees who perform any work due to COVID-19 should use the new "Task" field in PeopleSoft in addition to the appropriate TRC ("Telework (Situational) – STTW", "Regular Pay - REG," etc.). Employees should use the "Task" field to report regular work related to COVID-19 (work requiring you to report to a physical duty station), telework related COVID-19, and any COVID-19 related overtime. For more information on reporting COVID-19 tasks, please see Issuance 2020-7, COVID-19 Timekeeping and watch the following video for instructions on how to report COVID-19 related tasks.



Employee Protections and Requirements

Administrative Leave

Employees who are ordered or recommended to self-quarantine or quarantine may telework from home. However, an agency head may authorize administrative covering a 14-day period following the employee's last day of work at a government worksite if the employee is unable to telework due to COVID-19 (see also Declaration-of-Emergency Leave). For employees who self-quarantine or quarantine, agencies shall require a doctor's note prior to returning to the workplace clearing the employee to return.

DCHR is currently reviewing recently enacted federal legislation that may impact employees' eligibility for paid time off. This section will likely be revised in the coming week.

Colds, Flus or other Communicable Illnesses

Employees suffering or who appear to be suffering from an acute respiratory illness (e.g., cough, fever, shortness of breath) at work shall be separated from other employees and sent home immediately. Employees shall not come to work until they are free of a fever (100.4°F or greater using an oral thermometer), signs of a fever, and any other symptoms for at least 24 hours without the use of symptom altering medicines.

An employee who has a cold, flu, or other communicable disease or illness shall consult their supervisors about flexible leave usage policies and any situational telework options. Prior to returning to the workplace, agencies shall require a doctor's note clearing the employee to return. In rare cases, employees returning from leave or situational telework following an illness may be asked to undergo a fitness for duty evaluation. However, such evaluations may only be ordered with DCHR's approval. (For more information on fitness for duty evaluations, please refer to 6-B DCMR § 2005.)

Declaration-of-Emergency Leave (DC Family and Medical Leave Act)

An employee who is unable to work because of the COVID-19 emergency may be entitled to declaration-of-emergency (DOE) leave under the DC Family Medical Leave Act during the emergency. To be eligible for DOE leave, an employee must receive proper certification of their eligibility.

The following shall constitute acceptable certification of the need for DOE leave: a recorded order or recommendation from (1) the Mayor, (2) any District or federal agency, or (3) a medical professional that the employee self-quarantine. In the case of a government mandated quarantine or isolation, the declaration of public health emergency shall serve as certification of the need for such leave.

At their option, employees eligible for DOE leave may choose to telework from home instead of taking leave. Otherwise, employees may use any of their accrued leave (annual leave, sick leave, or both) during their absence from work and may receive advanced leave if their accrued leave does not cover the duration of their absence. Employees taking DOE leave due to self-quarantine must supply their agencies a doctor's note clearing their return.

Telework

Situational telework is when employees work remotely from a secure location, usually from home, to address an immediate situation. Situational telework is appropriate to address a declared emergency and for responding to COVID-19. Time spent in a situational telework status must be recorded in PeopleSoft using the Time Reporting Code "Telework (Situational)." All employees who have been directed to work from home during the COVID-19 emergency shall use this time reporting code on their timesheets. Employees who are not teleworking and are reporting to a duty station outside of their home should continue to use their normal time codes.

Employees must execute an application to telework and sign a telework agreement, have the necessary equipment to work remotely, and the agency head must approve the telework agreement. As part of any telework agreement, employees must agree to respond to phone calls and emails within 30 minutes and must have the ability to report to any duty station within the District of Columbia within 2 hours if directed to do so unless otherwise approved by the agency.

Telework Mandated

The Mayor has ordered that employees telework to the greatest extent possible during the COVID-19 emergency. For purposes of addressing COVID-19:

- **All employees shall be considered for telework** regardless of whether they are probationary, temporary, term, or permanent, and regardless of any performance problems (including whether they were rated a marginal performer or lower for the last fiscal year or currently subject to a Performance Improvement Plan).
- Agencies may not suspend public-facing services as part of their telework policy without approval from the Mayor or the Mayor's designee.

Assessing Telework Options

Each agency shall continue to assess the positions in their agency and determine those positions that are eligible to telework. Below are general guidelines on situational telework based on the viability of telework given the nature of agencies' operations.

Fully Telework Capable Agencies

Employees shall telework if they work at agencies where the entire workforce is capable of teleworking without disruption to District government services.

Please refer to coronavirus.dc.gov for the current operating status of each agency.

Partially Telework Capable Agencies

As part of the city's response to COVID-19, some agencies will have a mix of jobs within their workforce, where telework is not practical for some employees but other employees are capable of teleworking without significant disruption to District government services.

Please refer to coronavirus.dc.gov for the current operating status of each agency.

Agencies Without Telework Capabilities

Certain agencies whose primary missions focus on public safety and/or health emergency response may not exercise expanded telework options during the city's COVID-19 response as these agencies have been deemed by the Mayor to be, in whole, essential to public well-being.

Please refer to coronavirus.dc.gov for the current operating status of each agency.

Teleworking Securely

Given the possibility of a larger percentage of District government network users (employees and contractors) working from home, the Office of the Chief Technology Officer (OCTO) is doing everything possible to make remote work as secure as possible. Remember, bad actors may know this is a vulnerable moment to try to access the District government network.

Ideally, everyone working remotely will be using a government issued device, such as a laptop, tablet, or mobile phone. These devices should have an OCTO-approved image installed, including updated antivirus, and each user should have a secure VPN account to access the same environment they normally access when at work.

In addition to these practices, all employees and contractors must help in protecting our network and data during this response. OCTO has put together guidance for agency leadership to allow agencies to work remotely in the most secure way possible. Use the following link to learn more about remote work options and remote work guidance.

Leave

Requesting Leave

Employees are required to request approval to take leave from their immediate supervisor or, if the immediate supervisor is unavailable, from another supervisor within the employee's chain of command. To the greatest extent possible, employees who require unscheduled leave must contact their supervisor no later than two hours prior to the start of their scheduled tour of duty. All leave requests shall continue to be made according to existing policies.

Sick Leave

An employee is entitled to use an unlimited amount of their accrued sick leave when they are unable to perform their duties due to physical or mental illness or are symptomatic due to a disease. Employees are entitled to use sick leave to care for family members who are symptomatic due to a quarantinable communicable disease. Please refer to 6-B DCMR § 1242.1 for other permissible uses of sick leave. For sick leave absences in

excess of three consecutive workdays, and until further notice, employees must supply a medical release from their health care provider clearing their return to work. No agency shall permit an employee to return to the workplace without such a release unless this requirement is waived by DCHR.

Leave Without Pay (LWOP)

Leave Without Pay (LWOP) is a temporary non-pay status and absence from duty granted at the employee's request or as otherwise authorized by regulations. The permissive nature of LWOP distinguishes it from absences without official leave (AWOL), which is unauthorized leave that may subject an employee to corrective or adverse action. Agencies may approve a maximum of 52 calendar weeks of LWOP. Except as provided by D.C. FMLA, authorizing LWOP shall be a matter of administrative discretion.

Absence Without Leave (AWOL)

Notwithstanding COVID-19, if employees need to take unscheduled leave, they must continue to inform their supervisor, or if their supervisor is not available, another supervisor or manager within their chain of command. Except when authorized by a supervisor, employees who do not arrive to their duty station at the start of their scheduled tour of duty may be considered AWOL. An employee whose leave request is denied and who fails to report for duty as scheduled is also considered AWOL. An employee can be charged with AWOL regardless of whether the employee has accrued leave.

If it is later determined that the absence was excusable, or that the employee was ill, agencies may change the charge to AWOL to a charge against annual leave, compensatory time, restored leave, sick leave, leave without pay, or another leave type as appropriate. See 6-B DCMR § 1268 for additional details.

Unless directed otherwise, all District employees must continue to report to work as scheduled and take leave in accordance with District personnel regulations, the policies outlined in this issuance and any existing agency-specific leave policies. To the extent there is a conflict between the leave policies in this issuance and existing regulations and agency policies, the provisions of this guidance shall control.

Advanced Sick leave and Annual Leave

If an employee exhausts their accrued annual leave, sick leave, or both, agencies may advance leave to the employee.

Agencies may advance annual leave to eligible employees up to the amount of annual leave expected to be earned during the balance of the current leave year or the remainder of the employee's time-limited appointment, whichever is sooner. For more information on advancing annual leave, please refer to 6-B DCMR § 1237.

In cases of serious disability or ailments, agencies may advance up to a maximum of 240 hours of sick leave to employees who have exhausted all their accumulated sick leave except when the agency has reason to believe that the employee may not be able to repay the advanced leave. For term and temporary employees, agencies may advance only up to the total sick leave the employee would earn during the remainder of the time-limited appointment. For more information on advancing sick leave, please refer to 6-B DCMR § 1243.

Workforce Management

Corrective and Adverse Actions

If an employee faces corrective or adverse actions as part of the progressive discipline process located in 6-B DCMR § 1600 *et seq.*, employees are entitled to certain rights. Specifically, 6-B DCMR §1602.3 (a) states that a corrective or adverse action must be initiated no more than 90 business days after an agency knew or should have known about the performance or conduct supporting the action.

However, during the COVID-19 emergency, the 90-business day limit is suspended. No days during the emergency shall be considered business days for purpose of 6-B DCMR § 1602.3(a). This suspension is necessary to avoid the diversion of critical resources to administrative investigations, and the practical challenges involved in investigating and taking corrective or adverse action while many employees are working remotely.

Fitness for Duty Evaluations

The DC Health recommends that all non-urgent medical procedures be "postposed to preserve health care capacity ... [and] ... to flatten the epidemic curve." Fitness for duty evaluations are considered non-urgent. Accordingly, in compliance with DC Health's recommendation, DCHR will not process any fitness for duty until DC Health recommends that non-urgent medical services should resume.

Travel for Government Purposes

Travel for government purposes falls into two categories: essential and non-essential. The category determines what restrictions and guidance apply.

Essential Government Travel

Essential government travel is domestic travel critical to the continued operations of the District government, or travel that is required by law. For example, travel for the purpose of testifying on behalf of the District of Columbia government before an administrative or judicial court is considered essential government travel. However, the District is following the CDC guidance as it relates to restricted travel to those areas where a travel ban is in place. All essential government travel must be approved by the agency head.

Non-Essential Government Travel

Non-essential government travel is all international travel as well as domestic, government-related travel that does not qualify as "essential" travel. This includes, among other purposes, travel for conferences and training.

Non-essential government travel commencing after March 11, 2020, is permitted only when the travel was approved and determined by the agency's director or equivalent, or the relevant Deputy Mayor that the travel is in the best interest of the District of Columbia.

International travel and travel not otherwise permitted by this section is suspended until May 1, 2020, or as otherwise directed by the Mayor.

Human Resources Management

Supersession

The provisions of this issuance supersede any provisions within previous issuances, a collective bargaining agreement, or the District personnel regulations to the extent there is a conflict.

Time Limits

The personnel authority may authorize different time limits than that explicitly outlined in this issuance to appropriately respond to the COVID-19 emergency.

Updates

In the absence of the Director of the D.C. Department of Human Resources, the Associate Director for Policy and Compliance is authorized to make any required amendments to this issuance.

References

1. *Declaration of Public Emergency,* Mayor's Order 2020-045 (Mar. 11, 2020)
2. *Declaration of Public Health Emergency,* Mayor's Order 2020-046 (Mar. 11 2020)
3. *COVID-19 Response Emergency Amendment Act of 2020,* Act 23-0246 (Mar. 17, 2020)
4. *Hours of Work, Legal Holidays and Leave,* Chapter 12, Title 6-B of the DCMR (Eff. Mar. 1, 2020)
5. *Compressed, Flexible, and Telework Schedules,* Issuance No. 12-58 (Sept. 28, 2016)

Attachments

1. Attachment 1 - COVID-19 FAQ
2. Attachment 2 - COVID-19 Personnel Time Tracking
3. Attachment 3 - Checklist for Identifying Critical Staffing Shortages
4. Attachment 4 - Administrative Leave Notice

Issued by Ventris C. Gibson, Director D.C. Department of Human Resources on March 29, 2020, midnight

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Center for Policy, Planning and Evaluation
Division of Epidemiology–Disease Surveillance and Investigation

March 13, 2020

Health Notice for District of Columbia Health Care Providers
Coronavirus Disease 2019 (COVID-19): Update on Testing and Personal Protective Equipment Recommendations

Summary

On March 10, 2020 the Centers of Disease Control and Prevention (CDC) updated its Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html).

- To the extent possible, providers should use telemedicine or telephonic communications to evaluate patients and avoid unnecessary visits to healthcare facilities.
- Based on the scientific evidence to date about how COVID-19 is transmitted, newly released infection prevention guidance from CDC, and given shortages of N95 respirators, **DC Health advises that collection of nasopharyngeal (NP) and oropharyngeal (OP) swab specimens for COVID-19 testing using contact and droplet precautions with a face mask is appropriate. Eye protection should always be used.**
- Specimen collection may be performed in an examination room with the door closed. Severely ill patients who will be transferred to a higher level of care should not be tested in an outpatient setting. Airborne Infection Isolation Rooms (AIIRs) should be reserved for patients undergoing aerosol-generating procedures.
- **It is critical that outpatient providers continue to ensure that any patients presenting with respiratory symptoms are immediately given a facemask for source control. If the patient is tested for COVID-19 then provide them with guidance to self-quarantine at home until test results are available to inform next steps.**
- Now that COVID-19 testing is available at commercial and hospital labs, providers can choose to pursue testing through the DFS Public Health Laboratory that meet the DC Health testing criteria, or to send specimens to commercial or hospital-based labs.

Background

As of March 12, 2020, there have been 1,215 confirmed cases of COVID-19 within the United States, including 36 deaths. To date, there have been 10 DC residents who have tested positive for COVID-19. The epidemiology and spread of COVID-19 internationally and within the United States is rapidly evolving and guidance is continuously being released. We encourage you to regularly review the DC Health (https://coronavirus.dc.gov/) and CDC (https://www.cdc.gov/coronavirus/2019-ncov/index.html) websites for the most up-to-date situational information.

APPENDIX 4

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

Important Points When Evaluating Potential COVID-19 PUIs

- Review CDC guidance, including on infection control, and the DC Health website regularly and develop internal processes for managing the assessment and notification to DC Health about potential PUIs
    - Infection control recommendations vary by facility and activity type and are important to maintain in order to prevent spread within a healthcare facility: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html)
- Please **do not direct patients to call DC Health directly** to determine if they should be tested for COVID-19. Healthcare providers should conduct a clinical assessment and then on the basis of the assessment and the PUI criteria described below, contact us if they suspect the patient may have COVID-19
- Please do the appropriate clinical evaluation on your patients based on their symptoms to assess ALL possible diagnoses (e.g. influenza, Strep throat), not just COVID-19
- When contacting DC Health, please leave a voicemail with a **direct** phone number if we do not answer so that we can call you back. We currently have a large call volume so may receive multiple calls at the same time, but return calls as soon as possible to healthcare providers.

Criteria on Evaluation and Testing of PUIs for COVID-19 (including updates about commercial testing)

Healthcare provider criteria for the evaluation of Persons Under Investigation (PUI) was expanded on March 4, 2020 to include a wider group of symptomatic patients (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html). Now that COVID-19 testing is available at commercial and hospital labs, providers can choose to pursue testing through the DFS Public Health Laboratory that meet the DC Health testing criteria, or to send specimens to commercial or hospital-based labs. Test results should be reported to the patient by their healthcare provider as per their usual protocols.

Patients who meet the following criteria will be prioritized for testing through the DFS PHL. Others will be considered on a case-by-case basis:

Clinical Features		**Epidemiologic Risk**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath)	AND	Any person, including health care personnel[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset
Fever[1] AND signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND tested negative for influenza[5]	AND	A history of travel to a country with a Level 2 or 3 Travel Advisory OR an area with confirmed ongoing community transmission, within 14 days of symptom onset
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND without an alternative explanatory diagnosis	AND	A history of residing in a nursing home or long-term care facility within 14 days of symptom onset

[1] Fever may be subjective or confirmed.
[2] For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
[3] Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – *or* – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
[4]Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
[5]Includes rapid and confirmatory influenza testing

Specimen Collection Guidelines

- Guidelines on collecting, handling and testing of clinical specimens from PUIs for COVID-19 can be found on the DFS PHL website
- PPE guidance for different healthcare settings can be found the above respective sections.
- Collection of an NP swab (in Viral Transport Media (VTM) or universal transport media (UTM)), OP swab (VTM or UTM) is recommended for initial diagnostic testing for SARS-CoV-2. Lower respiratory specimens can be tested if available and for patients who develop a productive cough, a sputum specimen can be collected. However, this significantly increases the risk to the HCP and should only be done if absolutely necessary.
- Please label specimens appropriately with patient's full name, date of birth, date and time of specimen collection, and unique patient identifier (medical record number or PUI number).
- Specimens should be collected as soon as possible once a PUI is identified regardless of time of symptom onset
- If approved for testing by DC Health, please complete the following forms, which are available on the DFS PHL website:
    - DC DFS PHL External Chain of Custody (CoC)
    - DC DFS PHL Test Requisition Form
    - CDC 50.34 Test Requisition Form
- Detailed instructions about specimen testing and forms will also be provided via email once testing is approved. Incorrectly labeled or missing information on forms and specimens will result in testing delays or specimen rejection.
- Please contact the PHL for any questions pertaining to testing:
    - Phone: 202-727-8956 (Monday-Friday from 8:30am-5:30pm), 202-868-6561 (after-hours calls), Email: dc.phl@dc.gov

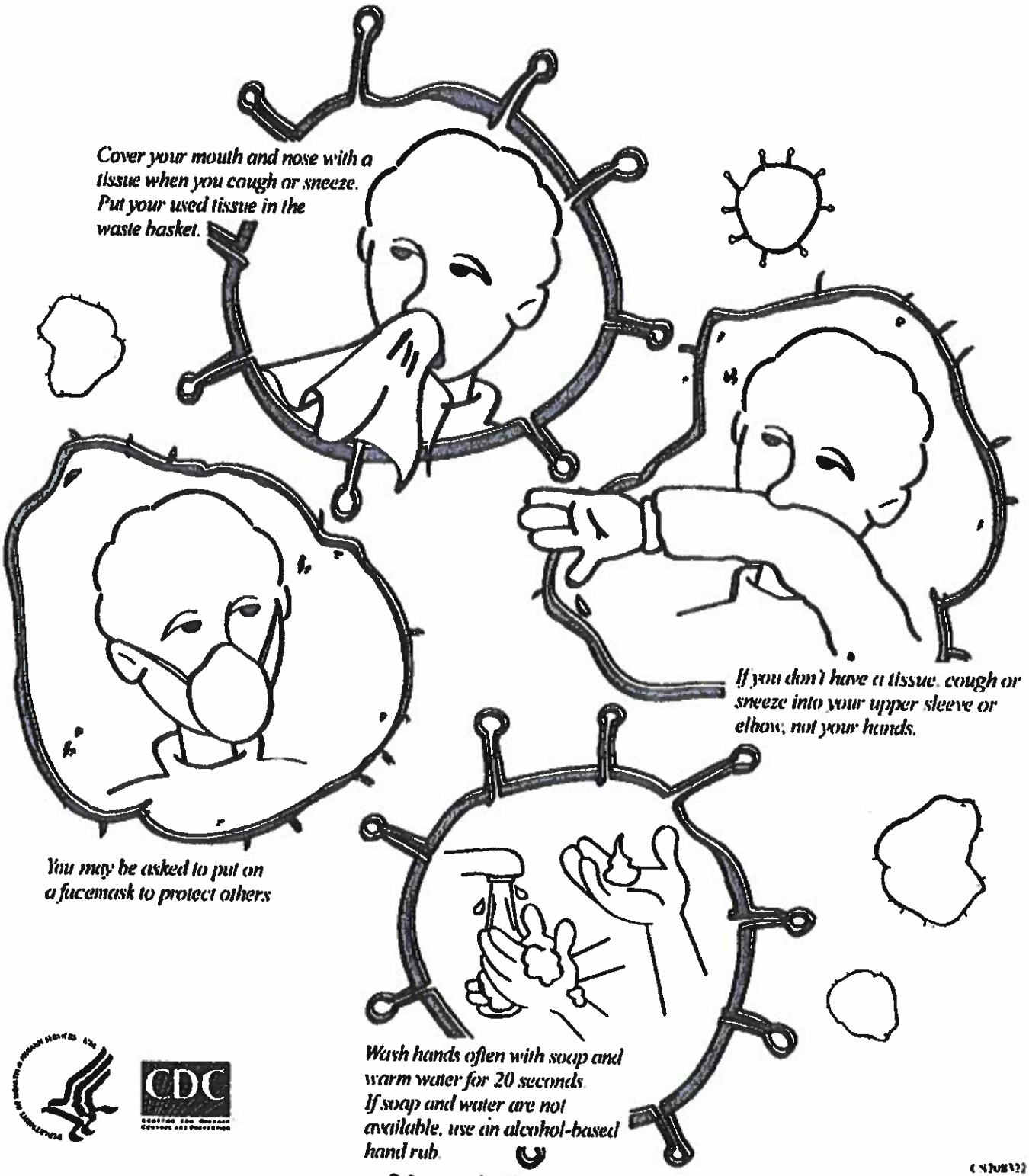
- If the test result is negative then the patient can stop self-quarantine and nothing needs to be reported to DC Health (as long as no prior conversations about this patient were initiated)
- If the test result is positive for COVID-19 then immediately report the case to DC Health through the 'Notifiable Disease and Condition Case Report Form' https://redcap.doh.dc.gov/surveys/index.php/surveys/?s=DHNA4X8LJC

The guidelines above will continue to be updated as the outbreak evolves. Please visit the DC Health and CDC websites regularly for the most current information.

Please contact the DC Health Division of Epidemiology–Disease Surveillance and Investigation at:
202-576-1117 (8:15am-4:45pm)
844-493-2652 (after-hours, healthcare providers only)
Fax: 202-442-8060 | Email: doh.epi@dc.gov

Cover your Cough

Stop the spread of germs that can make you and others sick!



Cover your mouth and nose with a tissue when you cough or sneeze. Put your used tissue in the waste basket.

If you don't have a tissue, cough or sneeze into your upper sleeve or elbow, not your hands.

You may be asked to put on a facemask to protect others

Wash hands often with soap and warm water for 20 seconds. If soap and water are not available, use an alcohol-based hand rub.

APPENDIX 5

2TR PPE REQUIREMENT

If you are Providing Care to Quarantined Patients on 2TR:

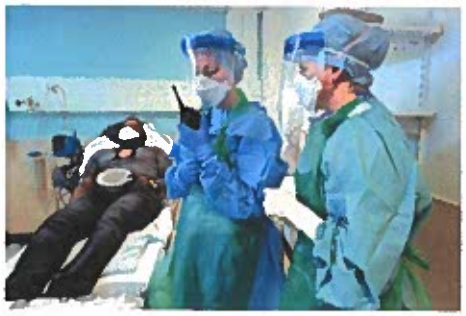
Face Mask

Face Shield

Gown

Gloves

Shoe Protectors



If you are Providing Care to Isolated Patients:

White Hood

PAPR

Gown

Gloves

Shoe Protectors

Please make sure PAPR IS CHARGED AS MUCH AS POSSIBLE
Wipe PAPR between uses with Oxivir
Adhere to Hand Hygiene Policy
Clean and disinfect high-touch surfaces

APPENDIX - 6

SEH Infection Control

3M Air-Mate Powered Air Purifying Respirator (PAPR) Instructions for Use

Durham Regional Hospital
Safety Office
470-6161

1. Unplug the PAPR from the cord connecting it to the battery charger and electrical outlet.

2. Inspect the airflow tube for cracks. Pay close attention to the end that connects to the head cover.

3. Check to ensure that the airflow tube is securely connected to the PAPR. Look for any signs of damage.

4. Remove the tissue paper covering the clear plastic face mask.

5. Turn the PAPR on by Pressing the Black Rubber Button.

6. To check the airflow, place the "egg float" into the upright end of the airflow tube.

APPENDIX 6

7. The lower band will rise above the edge of the airflow tube if the air supply is adequate.

8. Connect the airflow tube to the plastic circle at the back of the head cover.

9. Place the PAPR (with airflow tube up) against your lower back and fasten the belt buckle.

10. Guide the airflow tube upward behind you and put the head cover on. There are headbands inside the head cover that fit snugly on your head.

11. Adjust the head cover so that the elasticized edge of the face seal fits under your chin. It is now safe to enter the isolation room.

12. Remove PAPR in a non-contaminated area. Disconnect the head cover from the airflow tube with care by firmly grasping both pieces by the hard plastic parts that connect them. Gently but firmly pull them apart.

Care and Storage

For Patients on Airborne Precautions:

- Head covers can be re-used by the same employee for the same patient as long as they are clean and intact.
- Write your name on it.
- On the nursing units the head covers can be stored in the anterooms.
- Reconnect the PAPR to the battery charger.

For Patients on Airborne Precautions and Contact Isolation:

- Discard the head cover. *Do not reuse head covers when caring for a patient on Contact Isolation.*
- Disinfect the OUTSIDE of the PAPR unit with hospital-grade disinfectant after use.
- Reconnect the PAPR to the battery charger.

- If airflow is inadequate, the PAPR malfunctions, or there are cracks in the airflow tube, call Clinical Engineering at 470-8184.
- New head covers can be ordered from Central Stores 470-4250.

GUIDELINES FOR FACILITIES DURING OUTBREAKS OF NOROVIRUS/ GASTROENTERITIS: RECOMMENDATIONS AND PRECAUTIONS

- Encourage frequent hand washing with soap and warm water.
- Provide and encourage use of alcohol based (62%) waterless hand sanitizers when entering facility.
- Reinforce strict hand washing policy among staff.
- Do not allow symptomatic staff to work in facility.
- Assure glove use for handling of all ready-to-eat foods and eating utensils.
- Increase frequency for cleaning/sanitizing "high touch" surfaces, e.g., door handles, light switches, handrails, faucets, ice machine, etc. (see next page for facility specific recommendations)
- Use disposable cleaning cloths; use a new cloth for each room/area cleaned.
- Dispose of vacuum cleaner bags between uses. *Note: if area is visibly soiled with fecal spillage or vomit do not vacuum—either steam clean or use hot water and detergent.*
- Do not enter food service area with items soiled with vomit or fecal spillage.

The following cleaning agents are recommended for use during an outbreak:

Suggested Uses	Suggested Cleaning Method	How to Make (1 cup = 240ml)	Strength (parts per million)
Porous surfaces such as wood floors or surfaces visibly soiled with vomit/feces	Chlorine bleach*	1 ½ cup bleach in 1 gallon water	5000ppm (1:10 dilution)
Non-porous surfaces such as: handrails, tile floors, counter-tops, sinks, toilets, doorknobs and other commonly handled items. *See facility specific section for suggested items.*	Chlorine bleach*	1/3 cup bleach in 1 gallon water	1000ppm (1:50 dilution)
Food/mouth contact items, stainless steel and toys mouthed by children	Chlorine bleach* then rinsed with water OR dishwasher at 170°F	1 Tbsp. bleach in 1 gallon water	200ppm (1:250 dilution)
Carpet & upholstered fabrics visibly soiled with vomit or fecal spillage. Do not dry vacuum as viruses can become airborne.	Hot water and detergent OR Steam clean	NA	NA

*Bleach solution must: contain 5.25% Sodium Hypochlorite; be prepared fresh daily; have 10-20 minute surface contact time. Use unopened bleach for outbreak-related sanitization (open bottles lose effect after 30 days). EPA-registered disinfectants may also be used although effectiveness in outbreaks has not been evaluated.

Warnings:

1. Cleaning staff should wear protective equipment when handling chemicals.
2. Food preparation/food contact areas must be washed, rinsed and sanitized using standard protocol after cleaning with the stronger bleach solutions listed above.

Additional Recommendations for Healthcare/Assisted Living Facilities:

- Reinforce proper glove use when giving patient/resident care. Remove gloves before leaving ill patient's/resident's room and wash hands immediately.
- Do not "float" staff between units with ill patients/residents and units with non-ill patients/ residents.
- Assign staff members to care for only ill group or only non-ill group to help prevent transmission.
- Exclude non-essential personnel from units with ill patients/residents.
- Discontinue new admissions to the facility until the outbreak has ended.
- Confine ill patients/residents to their rooms until 72 hours after their symptoms end.
- Do not allow patients/residents from outbreak-affected units to enter/transfer to unaffected units, unless medically urgent to do so, until end of outbreak.
- Discontinue group activities (communal dining, etc.) until outbreak has ended.
- Limit visitation until outbreak has ended.
- Store and launder contaminated soiled linens separately from non-contaminated soiled linens.

Last Updated: 2/26/2010

APPENDIX 7

Facility-specific List of Suggested Items to Sanitize with 1000ppm bleach solution (1/3 cup bleach in 1 gallon water)

This is a list of suggested items to sanitize in order to reduce the number of illnesses during a gastroenteritis outbreak. This list is not exhaustive and your facility may have additional items in need of sanitation.

General:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, countertops, light switches, and other common items shared among staff/patrons.

Restaurants/Food Service:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, countertops, light switches, common telephones, menus, table placards, folders for credit cards, trays, tray stands, baskets, salt & pepper shakers, table bottle of ketchup and other condiments, sugar packet dispensers, booths, tables, exposed parts of buffet line, sneeze guards, and other common items shared among staff/patrons.

Healthcare Facilities:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, bedrails, countertops, common telephones, cards/games in common room, common craft materials, TV remote controls, computer keyboards, drawer/cabinet pulls, light/lamp switches, recliner chair handles, dining hall tables and chairs, dining hall salt/pepper shakers, walkers, wheelchair handles, any physical therapy shared items, and other common items shared among staff/patients/residents.

Schools/Childcare Facilities:

- Doorknobs, water fountains, bathroom stall and sink hardware, paper towel dispenser, soap dispenser, handrails, countertops, light switches, common telephones, shared games/books/toys, playground equipment, diaper changing table, diaper changing pad, locker hardware, shared classroom equipment (microscopes, musical instruments, computer keyboards), physical education shared equipment, cafeteria tables and chairs, cafeteria salt/pepper shakers, and other common items shared among staff/students.
- Cloth items unable to withstand bleach sanitization (plush toys, pillows, etc.) should be laundered in hot water or discarded if laundering/sanitization not possible.

CONTACT THE LOCAL HEALTH DEPARTMENT IF YOU SUSPECT AN OUTBREAK IN YOUR FACILITY.

References:

http://www.cdc.gov/ncidod/dhqp/id_norovirusFS.html
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5009a1.htm
http://www.michigan.gov/documents/Guidelines_for_Environmental_Cleaning_125846_7.pdf
http://www.cdc.gov/hicpac/pdf/guidelines/Disinfection_Nov_2008.pdf
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5633a2.htm
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5839a2.htm

Saint Elizabeths
SHINING THE LIGHT SINCE 1855

Screening Questions for COVID-19 (Coronavirus)
VISITOR

VISITOR NAME:	TRAVEL DESTINATION:
DATE OF VISIT:	VISITING UNIT/IIC/STAFF:

Visitors must be screened for COVID-19 prior to entering Saint Elizabths Hospital. If you have traveled to a country designated by the CDC as Level 2 or above in the last 14 days, you will not be able to visit.

Travel: Yes ☐ No ☐ Temperature: _____F NA

These criteria are intended to serve as a guide for evaluation and are subject to change as additional data become available. Testing may be considered for deceased persons who otherwise meet the PUI criteria.

Visitors who meet the following criteria should be reported to DC Health for evaluation as a PUI*:

Clinical Features and Epidemiologic Risk			
Clinical Features	**&**	**Epidemiologic Risk**	**Action**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) ○ Yes ○ NO	**AND**	**Any person, including health care personnel[2], who has had close contact[3] with a laboratory-confirmed[4] COVID-19 patient within 14 days of symptom onset** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of COVID-19 (Coronavirus).**
Fever[1] AND signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath) AND tested negative for influenza[5] ○ Yes ○ NO	**AND**	**A history of travel to a country with a Level 2 or 3 Travel Advisory OR an area with confirmed ongoing community transmission, within 14 days of symptom onset. (check CDC for daily update)** ○ Yes ○ NO	**If Yes to both questions, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the COVID-19 (Coronavirus).**
Fever[1] OR signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) AND without an alternative explanatory diagnosis ○ Yes	**AND**	**A history of residing in a nursing home or long-term care facility within 14 days of symptom onset** ○ Yes	**If Yes to both, follow infection control measures on Administrative Issuance 2020-001: Prevention and Management of the**

APPENDIX 8

o NO

o NO

COVID-19 (Coronavirus).

1 Fever may be subjective or confirmed.
2 For healthcare personnel, testing may be considered if there has been exposure to a person with suspected COVID-19 without laboratory confirmation. Because of their often extensive and close contact with vulnerable patients in healthcare settings, even mild signs and symptoms (e.g., sore throat) of COVID-19 should be evaluated among potentially exposed healthcare personnel. Additional information is available in CDC's Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html).
3 Close contact is defined as— a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case – or – b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on). If such contact occurs while not wearing recommended personal protective equipment (PPE) (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.
4 Documentation of laboratory-confirmation of COVID-19 may not be possible for travelers or persons caring for COVID-19 patients in other countries.
5 Includes rapid and confirmatory influenza testing

If visitor meets one of the above, he or she is not allowed to visit.

Evaluator (sign):

Print Name: _____ **GMO** ☐ **NP** ☐ **RN** ☐

Signature: _____ **Date:** _____

The guidelines above will continue to be updated as the outbreak evolves. Please visit the DC Health and CDC websites regularly for the most current information.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF BEHAVIORAL HEALTH

Department of Behavioral Health, Saint Elizabeths Hospital

SUBJECT: Notice to GMO/NPs on COVID-19 (Coronavirus) Testing

EFFECTIVE DATE: April 1, 2020

Background

The clinical spectrum of COVID-19 varies from asymptomatic or paucisymptomatic forms to clinical conditions characterized by respiratory failure that necessitates mechanical ventilation and support in an intensive care unit (ICU), to multiorgan and systemic manifestations in terms of sepsis, septic shock, and multiple organ dysfunction syndromes (MODS) (Cascella, Rajnik, Cuomo, Dulebohn,& Di Napoli, 2020).

The first 425 cases recorded in Wuhan, data indicate that the patients' median age was 59 years, with a range of 15 to 89 years. There were no significant gender differences (56% male). Of note, the fatal cases were primarily elderly patients, in particular those aged ≥ 80 years (about 15%), and 70 to 79 years (8.0%). Approximately half (49.0%) of the critical patients and affected by preexisting comorbidities such as cardiovascular disease, diabetes, chronic respiratory disease, and oncological diseases, died (Cascella, Rajnik, Cuomo, Dulebohn,& Di Napoli, 2020). The authors of the Chinese CDC report divided the clinical manifestations of the disease by their severity:

- Mild disease: non-pneumonia and mild pneumonia; this occurred in 81% of cases.
- Severe disease: dyspnea, respiratory frequency ≥ 30/min, blood oxygen saturation (SpO2) ≤ 93%, PaO2/FiO2 ratio or P/F [the ratio between the blood pressure of the oxygen (partial pressure of oxygen, PaO2) and the percentage of oxygen supplied (fraction of inspired oxygen, FiO2)] < 300, and/or lung infiltrates > 50% within 24 to 48 hours; this occurred in 14% of cases.
- Critical disease: respiratory failure, septic shock, and/or multiple organ dysfunction (MOD) or failure (MOF); this occurred in 5% of case.

The COVID-19 may present with mild, moderate, or severe illness. Among the severe clinical manifestations, there are severe pneumonia, ARDS, sepsis, and septic shock. The clinical course of the disease seems to predict a favorable trend in the majority of patients. Among patients who developed severe disease, the medium time to dyspnea ranged from 5 to 8 days, the median time to acute respiratory distress syndrome (ARDS) ranged from 8 to 12 days, and the median time to ICU admission ranged from 10 to 12 days. Clinicians should be aware of the potential for some patients to rapidly deteriorate one week after illness onset (CDC, 2020). The initial 5 to 8 days

APPENDIX 9

after symptom development is a significant determinate in sending the patient to an acute care facility immediately.

Testing

Indication

Patients who are found to have met the criteria for having symptoms consistent with COVID-19 by the covering general medical officer (GMO) or Nurse Practitioner (NP) will be sent out to the emergency room for initial diagnosis and management. Testing for COVID-19 will be done in the treating facility. Whereas the patient is returned to SEH and testing for COVID-19 has not been done, if reasonable suspicion remains, then the test will be performed at SEH.

Protocol

Patients who have met the criteria for testing in SEH will be tested on their unit.

The examiner will don full PPE and collect the specimen in accordance with the DC Department of Forensic Sciences (DFS) guidelines.

The examiner will complete the Covid-19 case report form which is designed to collect key information on COVID-19 case-patients, including:

- Demographic, clinical, and epidemiologic characteristics
- Exposure and contact history
- Course of clinical illness and care received

The specimen will be processed through the DC DFS public health laboratory (PHL) through DC Health.

Results will be received by the GMO or NP through DC Health, timeframe to be determined by DC Health.

Disposition of Patient

Patients who are suspected by the GMO or NP to have been infected with the COVID-19 virus and have been tested in the community or at SEH will be sent to unit 2TR and remain in contact precautions to await results. Once results have been received then the following will occur:

Negative results – patient will immediately be returned to the sending unit.

Positive results – patient will remain on 2TR 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.

Additional Information

Uncomplicated (mild) Illness

These patients usually present with symptoms of an upper respiratory tract viral infection, including mild fever, cough (dry), sore throat, nasal congestion, malaise, headache, muscle pain, or malaise. Signs and symptoms of a more serious disease, such as dyspnea, are not present. Compared to previous HCoV infections, non-respiratory symptoms such as diarrhea are challenging to find.

Moderate Pneumonia

Respiratory symptoms such as cough and shortness of breath (or tachypnea in children) are present without signs of severe pneumonia.

Severe Pneumonia

Fever is associated with severe dyspnea, respiratory distress, tachypnea (> 30 breaths/min), and hypoxia ($SpO2 < 90\%$ on room air). However, the fever symptom must be interpreted carefully as even in severe forms of the disease, it can be moderate or even absent. Cyanosis can occur in children. In this definition, the diagnosis is clinical, and radiologic imaging is used for excluding complications.

Acute Respiratory Distress Syndrome (ARDS)

The diagnosis requires clinical and ventilatory criteria. This syndrome is suggestive of a serious new-onset respiratory failure or for worsening of an already identified respiratory picture. Different forms of ARDS are distinguished based on the degree of hypoxia. The reference parameter is the PaO2/FiO2:

- Mild ARDS: $200 \text{ mmHg} < PaO2/FiO2 \leq 300 \text{ mmHg}$. In not-ventilated patients or in those managed through non-invasive ventilation (NIV) by using positive end-expiratory pressure (PEEP) or a continuous positive airway pressure (CPAP) ≥ 5 cmH2O.
- Moderate ARDS: $100 \text{ mmHg} < PaO2/FiO2 \leq 200 \text{ mmHg}$.
- Severe ARDS: $PaO2/FiO2 \leq 100 \text{ mmHg}$.

References:

Marco Cascella; Michael Rajnik; Arturo Cuomo; Scott C. Dulebohn; Raffaela Di Napoli. *Features, Evaluation and Treatment Coronavirus (COVID-19).* Stat Pearls. March 20, 2020. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK554776/

US Department of Health and Human Services, CDC. *Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)* March 14, 2020. Retrieved from https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

DISTRICT OF COLUMBIA
DFS
DEPARTMENT OF FORENSIC SCIENCES

COVID-19 Specimen Submission Guidelines

Specimen Collection

Please review guidelines recommended by the Centers for Disease Control and Prevention to ensure the appropriate infection control precautions are in place **before** collecting any specimens.

Acceptable specimen types for collection:

1. **Upper Respiratory Specimens**
   a. The following are acceptable upper respiratory specimens for submission:

      i. **Nasopharyngeal (NP) swab** only in viral transport media (VTM) or Universal Transport Media (UTM)

      OR

      ii. **Combined NP swab** and **Oropharyngeal (OP) swab** in VTM or UTM. Once the NP swab is collected, place it in VTM/UTM, swirl it in the media for a few seconds and break off the shaft. Next, collect the OP swab, place it in the same VTM as the NP swab, swirl it for a few seconds and break off the shaft. Please screw of the lid of the vial tightly.

Please see the video for additional instructions on NP swab collection:
https://www.youtube.com/watch?v=DVJNWefmHjE

Swab specimens should be collected using only swabs with a synthetic tip, such as nylon or Dacron, and an aluminum or plastic shaft. Calcium alginate swabs are unacceptable and swabs with cotton tips and wooden shafts are not recommended.

ESwabs in Amies media are not a valid specimen type for COVID-19 testing. A hospital or clinic that requires swabs or UTM should contact the DC DFS PHL via email (DFS-COVID19@dc.gov).

2. **Lower Respiratory Specimens**

   a. ***Sputum***- Have the patient rinse the mouth with water and then expectorate deep cough directly into a sterile, leak-proof, screw-cap sputum collection cup or a sterile dry container.

   b. ***Bronchoalveolar lavage (BAL)*** - Collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container.
      Additional specimens may be requested on a case by case basis.

DISTRICT OF COLUMBIA
DFS
DEPARTMENT OF FORENSIC SCIENCES

Specimen Storage

All specimens must be refrigerated (2-8°C) promptly after collection and couriered/shipped on cold packs within 72 hours. Specimens being held for >72 hours must be stored at -70°C and couriered/shipped on dry ice.

Paperwork

Any specimen being sent through the DC DFS PHL must have the following paperwork accommodating the specimen:

1. DC DFS PHL External Chain of Custody (CoC)
2. DC DFS PHL Test Requisition Form

All paperwork can additionally be found on DC DFS PHL's website under forms and documents:
https://dfs.dc.gov/publication/phl-forms-and-documents

Additionally, a person under investigation (PUI) form must be completed by the requesting healthcare provider for all COVID-19 testing, and must be completed to receive results. All forms will be provided to the requesting health care provider by the epidemiologist at the time of approval.

Only one DC DFS PHL test requisition form (example provided below) and one chain of custody for each set of specimens is required for testing.

Please ensure that all specimens submitted and their respective test requisition form has the following information on it:

- Full name of patient
- Date of birth
- Unique patient identifier (e.g., medical record number, patient ID, PUI #)
- Date and time of specimen collection

Incorrectly labeled requisitions and specimens will result in testing delays.

Courier Request

Once specimens are ready for pick up and the appropriate paperwork is completed, please email DFS-COVID@dc.gov to request a courier. An address (including the room number), PUI number, point-of-contact name and phone number and the specimen storage temperature will be required to dispatch a courier for specimen pick-up. Do NOT include patient identifiers in the body of the email. Please call the main laboratory line in the event of an emergency (202-727-8956).

Please contact the DC Department of Forensic Sciences Public Health Laboratory for any questions pertaining to testing:
Phone: 202-727-8956 (Monday-Friday from 8:30am-5:30pm) | 202-868-6561 (after-hours calls) Fax: 202-481-3936 | Email: dc.phl@dc.gov

DFS DEPARTMENT OF FORENSIC SCIENCES

District of Columbia • Department of Forensic Sciences • Public Health Laboratory
401 E Street SW • 4th Floor • Washington, DC 20024 • Phone (202) 727-8956 • Fax (202) 481-3464

General Laboratory Services Request Form
PHL Director: Anthony Tran, DrPH, MPH, D(ABMM)
CLIA#: 09D0968273

Patient Information

***Required Information**

Last Name*	First Name*	Middle Initial	Suffix

Date of Birth* (MM/DD/YYYY)	Sex* ☐ Male ☐ Female ☐ Other	If Female, Pregnant ☐ Yes ☐ No ☐ Unknown

Address	City*	State*	ZIP

Sample ID (Lab ID, Outbreak#, Zika#, etc.)*	Medical Record Number

Submitter Information

Name of Submitting Hospital, Laboratory, or other Facility*		Healthcare Provider NPI #*		
Health Care Provider	Last Name*	First Name*		
Address (include room)*		City*	State*	Zip*
Primary Contact (If not the Health Care Provider)	Last Name	First Name		
Telephone #* (primary)	Secure Fax #**	Email		
** Final report will be sent to the fax number above				

Specimen Information

Date of Collection* (MM/DD/YYYY):	Time of Collection*: ☐ AM ☐ PM

Reason for Submission*
☐ Diagnostic ☐ Outbreak ☐ DC Health Request: DC Health Contact:_____

Specimen Type (check all that apply)*
☐ Blood Culture Bottle ☐ Isolate ☐ Cary-Blair ☐ ESwab™ ☐ Swab ☐ Slide ☐ Sterile Container ☐ UTM ☐ VTM
☐ Blood Tube (Plasma, Serum or Whole Blood)_____ ☐ Other (specify)_____

Specimen Source*
☐ Abscess ☐ Blood ☐ Bronchoalveolar Lavage ☐ Bronchial Wash ☐ Buccal ☐ CSF ☐ Endocervical ☐ Nasopharynx (NP)
☐ Oropharynx (OP) ☐ NP/OP ☐ Plasma ☐ Rectal ☐ Serum ☐ Sputum, expectorated ☐ Sputum, induced ☐ Stool ☐ Throat
☐ Tissue ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other (specify)_____

Test Request (✓ requested tests)

BT RULE-OUT§	MOLECULAR
☐ *r/o B. anthracis*	☐ Ebola (PCR)+
☐ *r/o Brucella sp.*	☐ Novel Influenza (PCR)+
☐ *r/o Burkholderia sp.*	☐ Norovirus (PCR)
☐ *r/o F. tularensis*	☐ Middle East Respiratory Syndrome (MERS-CoV) (PCR)+
☐ *r/o Y. pestis*	☐ *Chlamydia trachomatis* and *Neisseria gonorrhoeae* (TMA)
☐ Other(specify):_____	☐ Mumps (PCR)+
MICROBIOLOGY/GENERAL BACTERIOLOGY	☐ Measles Virus (PCR)+
☐ OCME	☐ Arbovirus Detection Panel (chikungunya, dengue and Zika) (PCR)+
☐ Referred Isolates	**SEROLOGY**
	☐ Measles Virus (IgG)+
	☐ Zika Virus (IgM)+
	VIRAL CULTURE
	☐ Respiratory DFA with Reflex to Viral Culture (Adenovirus, Respiratory Syncytial Virus, Influenza A, Influenza B, Parainfluenza 1, 2 & 3)
OTHER TESTS	
☐ Test Name (specify)_____	

+ DC Health must approve testing prior to sending any isolate or specimen to the Public Health Laboratory
§ Call the Public Health Laboratory prior to sending any suspected isolate or specimen

Last updated: 12/20/2019

DISTRICT OF COLUMBIA
DFS
DEPARTMENT OF FORENSIC SCIENCES

Example of PHL Test Requisition Form

DFS DEPARTMENT OF FORENSIC SCIENCES

District of Columbia • Department of Forensic Sciences • Public Health Laboratory
401 E Street SW • 4th Floor • Washington, DC 20024 • Phone (202) 727-8956 • Fax (202) 481-3464
General Laboratory Services Request Form
PHL Director: Anthony Tran, DrPH, MPH, D(ABMM)
CLIA#: 09D0968273

★ ★ ★

Patient Information *Required Information

Last Name*	First Name*	Middle Initial	Suffix
Date of Birth* (MM/DD/YYYY)	Sex* ☐ Male ☐ Female ☐ Other	If Female, Pregnant ☐ Yes ☐ No ☐ Unknown	
Address	City*	State*	ZIP
Sample ID (Lab ID, Outbreak#, Zika#, etc.)*	Medical Record Number		

PUI ID given by DC Health

Health care provider with same NPI number requesting testing

Submitter Information

Name of Submitting Hospital, Laboratory, or other Facility*		Healthcare Provider NPI #*		
Health Care Provider	Last Name*	First Name*		
Address (include room)*		City*	State*	Zip*
Primary Contact (if not the Health Care Provider)		First Name		
Telephone #* (primary)	Secure Fax #**	Email		

** Final report will be sent to the fax number above

Results will be faxed to this number
Critical values will result in a phone call

Specimen Information

Date of Collection* (MM/DD/YYYY): Time: ☐ AM ☐ PM

Reason for Submission*
☑ Diagnostic ☐ Outbreak ☐ DC Health Request: DC Health Contact:

Specimen Type (check all that apply)
☐ Blood Culture Bottle ☐ Isola... ☑ Sterile Container ☑ UTM ☑ VTM
☐ Blood Tube (Plasma, Serum or Whole Blood) ☐ Other (specify)

Specimen Source*
☐ Abscess ☐ Blood ☑ Bronchoalveolar Lavage ☑ Bronchial Wash ☐ Buccal ☐ CSF ☐ Endocervical ☑ Nasopharynx (NP)
☑ Oropharynx (OP) ☑ NP/OP ☐ Plasma ☐ Rectal ☐ Serum ☑ Sputum, expectorated ☑ Sputum, induced ☐ Stool ☐ Throat
☐ Tissue ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other (specify)

Nasopharynx (NP) swabs and Oropharynx (OP) swabs must be placed in either UTM or VTM

Sputum, Bronchial Wash and Bronchoalveolar Lavage specimens

All specimen sources approved for testing are highlighted

...uested tests)

BY RULE-OUT§	MOLECULAR
☐ *r/o B. anthracis*	☐ Ebola (PCR)+
☐ *r/o Brucella sp.*	☐ Novel Influenza (PCR)+
☐ *r/o Burkholderia sp.*	☐ Norovirus (PCR)
☐ *r/o F. tularensis*	☐ Middle East Respiratory Syndrome (MERS-CoV) (PCR)+
☐ *r/o Y. pestis*	☐ *Chlamydia trachomatis* and *Neisseria gonorrhoeae* (TMA)
☐ Other(specify):	☐ Mumps (PCR)+
MICROBIOLOGY/GENERAL BACTERIOLOGY	☐ Measles Virus (PCR)+
☐ OCME	☐ Arbovirus Detection Panel (chikungunya, dengue and Zika) (PCR)+
☐ Referred Isolates	**SEROLOGY**
	☐ Measles Virus (IgG)+
	☐ Zika Virus (IgM)+
	VIRAL CULTURE
	☐ Respiratory DFA with Reflex to Viral Culture (Adenovirus, Respiratory Syncytial Virus, Influenza A, Influenza B, Parainfluenza 1, 2 & 3)
	OTHER TESTS
	☑ Test Name (specify) 2019-nCoV PCR

+ DC Health must approve testing prior to sending any isolate or specimen to the Public Health Laboratory
§ Call the Public Health Laboratory prior to sending any suspected isolate or specimen

Last updated: 12/20/2019

District of Columbia • Department of Forensic Sciences • Public Health Laboratory
401 E Street SW • 4th Floor • Washington, DC 20024 • Phone (202) 727-8956 • Fax (202) 481-3464
General Laboratory External Chain of Custody
PHL Director: Anthony Tran, DrPH, MPH, D(ABMM)
CLIA#: 09D0968273

Specimen Submitted by:

Hospital/Clinic_____
Point-of-Contact Name_____
Phone_____
Fax_____
E-mail _____
Signature_____
Date _____ **Time**_____

Specimen Received By:

Courier Name_____
Date_____ **Time**_____
Initials_____

#	Unique Specimen Identifier (e.g., MRN, sample ID)	Sample type (e.g. serum, tissue, isolate)	Date of Birth	Collection Date	Comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

This section is for DC PHL use only

Specimens received by _____ Date/Time_____ Storage Temp_____

ISOLATION UNIT

AUTHORIZED EMPLOYEES ONLY

S.E.H Infection Control Coordinator

APPENDIX-10

Monitoring Guidelines for Staff Exposed to a Confirmed COVID-19 Staff

1. **Monitor your temperature and absence of symptoms each day prior to starting work.**
2. **Wear a facemask while at work for the 14 days after the exposure.**
3. **Adhere to hand hygiene protocols.**
4. **DO NOT work with high risk patient populations (such as in units 1A & 1B)**
5. **Self-monitor for symptoms at all times, and seek re-evaluation from your primary care doctor if respiratory symptoms occur.**
6. **If you develop symptoms (even mild symptoms) while at work, IMMEDIATELY cease patient care activities. Don a facemask (if not already wearing), isolate yourself, and notify your supervisor.**

Reference: DC Health Notice: Coronavirus 2019 (COVID-19): Guidance for Healthcare Personnel Monitoring, Restriction and Return to Work.

Please reach out to your supervisor with questions regarding staying out of work.

APPENDIX 11

REQUESTING LEAVE DUE TO COVID 19

Process for SEH employees requesting leave due to COVID-19 and/or as a result of experiencing symptoms of COVID-19.

Review and Recommendations

1. All requests for leave shall be sent to Dr. Potter for review.
2. Dr. Potter will review and provide his recommendations to the DBH Risk Manager (Mary Campbell) and Elaine Tu who will be tracking symptoms.
3. Recommendation will also be sent to the employee's supervisor; who will notify the employee on the recommendations (i.e., to test and quarantine).
4. Mary will notify Ms. Wheeler of the leave request and recommendations; and Ms. Wheeler will inform the supervisor if the employee should get administrative leave (or any other type of leave).

Employee Responsibilities

1. All employees are required to share their contact information with Elaine/Mary. Mary will conduct daily calls with the employee until they return.
2. All employees are required to share medical information related to COVID-19 illness.
3. All employees must present a medical clearance before returning to work.

Tracking of Employee Leave

1. Mary/Elaine will track all employee COVID-19 tests and test results.
2. Mary will track employees requesting FMLA, ADA, or other underlying health issues.

Appendix 12

04/03/2020

REQUESTING LEAVE DUE TO COVID 19

Process for SEH employees requesting leave due to COVID-19 and/or as a result of experiencing symptoms of COVID-19.

Review and Recommendations

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1. Mary/Elaine will track all employee COVID-19 tests and test results.
2. Mary will track employees requesting FMLA, ADA, or other underlying health issues.

Appendix 12

04/03/2020

VIRUSES DON'T DISCRIMINATE, AND NEITHER SHOULD WE

CORONAVIRUS AND STIGMA

Coronavirus doesn't recognize race, nationality, or ethnicity.

Coronavirus (COVID-19) started in Wuhan, China. That's just geography. Having Chinese ancestry — or any other ancestry — does not make a person more vulnerable to this illness.

Wearing a mask does not mean a person is ill.

People wear masks for a variety of reasons, including to avoid pollen and air pollution and for cultural and social reasons. We should not judge someone for wearing a mask or assume they are sick.

Stop stigma by sharing accurate information.

Avoid spreading misinformation. Stay informed through reputable, trusted sources:

- Centers for Disease Control and Prevention (CDC)
- DC Department of Health (DC Health)

Speak up if you hear, see, or read discriminatory comments.

Gently correct the false information and remind the person that prejudiced language and actions make us all less safe. If discrimination occurs, report it to DC's Office of Human Rights, 202-727-4559.

Show compassion and support for those most closely impacted.

In the schools and workplaces, create learning opportunities for students and staff that dispel racist and misniformed ideas. Listen to, acknowledge and, with permission, share the stories of people experiencing stigma, along with a message that bigotry is not acceptable in our community.

coronavirus.dc.gov

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

WE ARE WASHINGTON DC
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

STOP THE SPREAD OF GERMS!

Hãy ngăn chặn vi khuẩn lây lan

- Ở nhà khi bị bệnh
- Dùng giấy lau che miệng khi hắt hơi hoặc ho
- Vứt giấy lau vào thùng rác ngay sau khi dùng
- Nếu không có giấy lau hãy ho hay hắt hơi vào phía trên cánh tay
- Rửa tay bằng xà phòng và nước trong ít nhất 20 giây
- Tránh đưa tay chưa rửa lên mắt, mũi, miệng

- **Stay home when sick**
- **Cover your cough or sneeze with a tissue**
- **Dispose of tissue after use**
- **If you don't have a tissue, cough or sneeze into your upper sleeve**
- **Wash hands with soap and water for at least 20 seconds**
- **Avoid touching eyes, nose, and mouth with unwashed hands**

Arrêter la propagation des germes

- Restez à la maison lorsque vous êtes malade
- Couvrez votre toux ou éternuements avec un mouchoir
- Jetez le mouchoir après utilisation
- Si vous n'avez pas de mouchoir, toussez ou éternuez dans votre manche supérieure
- Lavez vos mains avec de l'eau et du savon pendant au moins 20 secondes
- Évitez de toucher les yeux, le nez et la bouche avec les mains non lavées

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- በሚታመሙበት ጊዜ ቤት ይቆዩ
- በሚያስነጥሱበት ወይም በሚስሉበት ጊዜ በቲሹ ይሸፍኑ
- የተቀሙበትን ናፕኪን ይጣሉ/ያስወግዱ
- በሚስሉበት ወይም በሚያስነጥሱበት ጊዜ ቲሹ ከሌለ የላይኛው እጅጌዎን ይጠቀሙ
- ቢያንስ ለ 20 ሰከንዶች ያህል እጅዎን በሳሙና ይታጠቡ
- ባልታጠበ እጅ አይን ፣ አፍንጫ እና አፍ ከመንካት ይቆጠቡ

阻止細菌傳播

- 生病時待在家裡
- 用衛生紙遮掩咳嗽和噴嚏
- 丟棄使用過的衛生紙
- 若無衛生紙，以袖子上方遮掩咳嗽和噴嚏
- 以肥皂和清水洗手至少20秒
- 避免眼 ,鼻和嘴巴碰觸未清洗的手

세균을 퍼뜨리는 것을 멈춰주세요

- 아프면 집에서 쉬세요
- 기침이나 재채기를 할 때, 휴지로 막아주세요
- 사용한 휴지는 버려주세요
- 휴지가 없다면, 소매 윗부분에 기침이나 재채기를 하세요
- 비누와 물로 손을 20초 이상 닦으세요
- 씻지 않은 손으로 눈,코,입을 만지지 마세요

Detenga la propagación de gérmenes

- Quédese en casa cuando esté enfermo
- Cubra su boca y nariz con un pañuelo desechable al toser o estornudar
- Tire a la basura el pañuelo desechable después de usarlo.
- Si no tiene un pañuelo desechable, al toser o estornudar cúbrase la boca y nariz con la parte interior de su codo.
- Lávese las manos con agua y jabón durante al menos 20 segundos
- Evite tocarse los ojos, la nariz y la boca si no se ha lavado las manos.

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MURIEL BOWSER, MAYOR

STOP THE SPREAD OF GERMS!

Stay home when sick

Cover your cough or sneeze with a tissue

Dispose of tissue after use

If you don't have a tissue, cough or sneeze into your upper sleeve

Wash hands with soap and water for at least 20 seconds

Avoid touching eyes, nose, and mouth with unwashed hands

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MURIEL BOWSER, MAYOR

ATTACHMENT 4

EXHIBIT 6

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ENZO COSTA, *et al.*, Plaintiffs, v. BARBARA BAZRON, *et al.*, Defendants.	Civil Action No. 19-3185 (RDM)

DECLARATION OF RENEE BIVINS

I, Renee Bivins, declare and state as follows:

1. I am over the age of eighteen (18) years, competent to testify to the matters contained in this declaration, and testify based on my personal knowledge acquired in the course of my official duties.

2. I am the Director of Hospital Operations for Saint Elizabeths Hospital, the District of Columbia's only public psychiatric facility for individuals with serious and persistent mental illness requiring intensive inpatient care to support their recovery. Saint Elizabeths is overseen by the District of Columbia Department of Behavioral Health (DBH).

3. I have worked at Saint Elizabeths Hospital since May 2008. I have served in a variety of roles, including supervisory inventory management specialist and logistics officer. I assumed the role of Director of Hospital Operations on January 18, 2017.

4. As the Director of Hospital Operations, I am in charge of housekeeping, materials management, transportation, nutrition services, facilities and the safety department. Through my position, I am aware of Saint Elizabeths Hospital's daily housekeeping operations to protect patients and staff from COVID-19.

5. The Hospital is cleaned by professional cleaning staff. This staff consists of 40 housekeepers, three housekeeper foremen and one supervisor. All rooms are cleaned at least daily including patient rooms, bathrooms, showers, treatment room, multi-purpose room, laundry room, day room, comfort room, medication room, linen room, storage room, nurses' station and administration offices according to a task specific checklist.

6. Housekeeping staff work in overlapping shifts from 6:00 a.m. until 11:30 p.m. each day. Since the pandemic began, the Hospital has hired an additional ten cleaning contractors to increase the frequency with which cleaning and sanitizing occurs. On an hourly basis, these contract cleaners sanitize "high touch" areas, such as, rails, door knobs, doors, countertops, nursing stations, furniture, fixtures, light switches, and other commonly touched surfaces, and record the cleaning on a daily tracking sheet.

7. Housekeeping cleans and sanitizes patient rooms and bathrooms daily.

8. All patients have access to soap and sinks to wash their hands as needed. Housekeeping checks bathrooms daily to ensure that there is an adequate supply of soap, toilet tissue, and paper towels. Also, patients can ask for additional

supplies including soap, hand sanitizer or a mask at the nurse's station. There has not been a shortage of soap at Saint Elizabeths during the COVID-19 pandemic.

I declare under the penalty of perjury that the foregoing is true and correct to the best of my knowledge, information, and belief.

April 21, 2020
DATED

RENEE BIVINS
Director of Hospital Operations