IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

2019 Novel Coronavirus (COVID-19)
Stakeholder Situational Update
June 17, 2020

Webinar Recording Link


IHFS
ILLINOIS DEPARTMENT OF
Healthcare and
Family Services
ONLINE SCREENING
SELF-CARE AT HOME
REMOTE PATIENT MONITORING PROFESSIONAL HEALTH ASSISTANCE
HEALTH & WELLNESS KITS
ILLINOIS COVID-19 VIRTUAL CARE PROGRAM
www.coronavirus.illinois.gov/s/telehealth
Culturally Competent Care
1-800-889-3931
Text CARE_Zip Code to 36363
Assistance Available
Food
Housing
Other
Insecurities
Advocate Health Care
OSF HEALTHCARE
SIU SCHOOL of MEDICINE
Connecting you to virtual screening and self-isolation care.

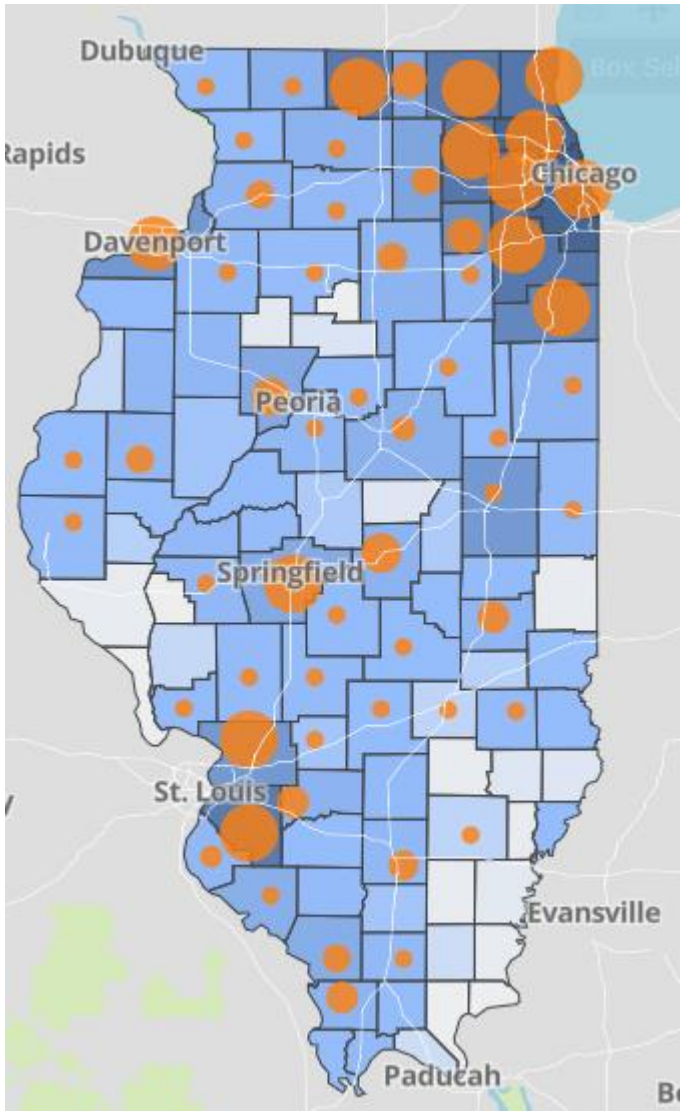
COVID-19 in Illinois

133,639 Cases

6,398 Deaths

1,228,341 specimens tested

93% recovery rate



As of 6/1/2020

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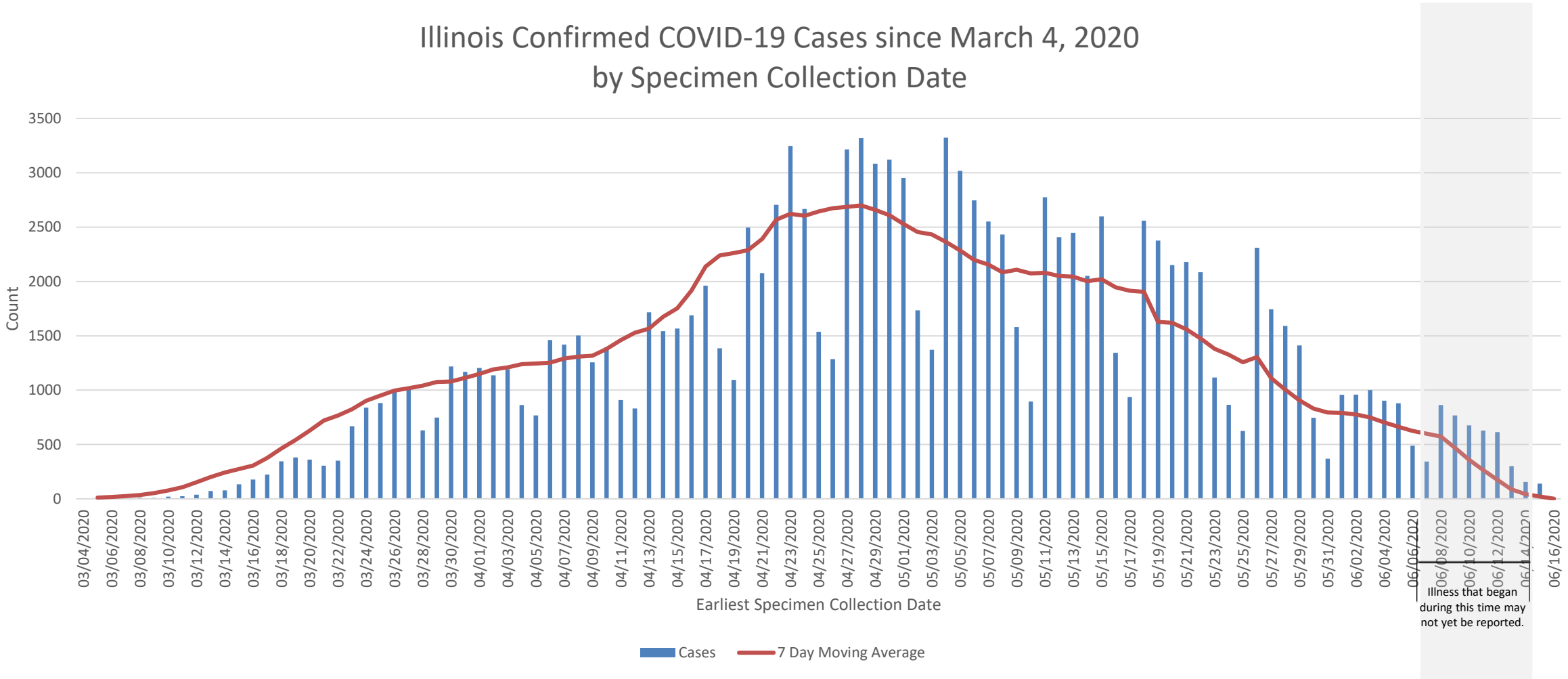
COVID-19 Cases



As of 6/16/2020

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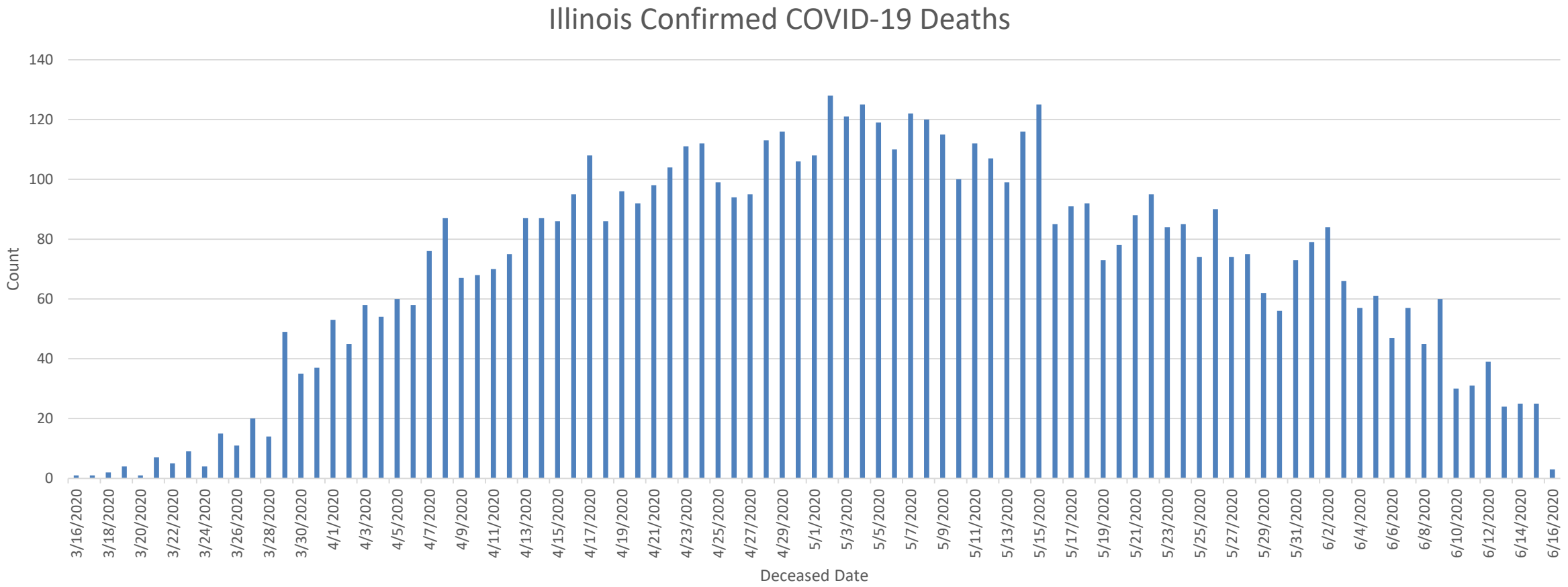
COVID-19 Deaths



As of 6/16/2020

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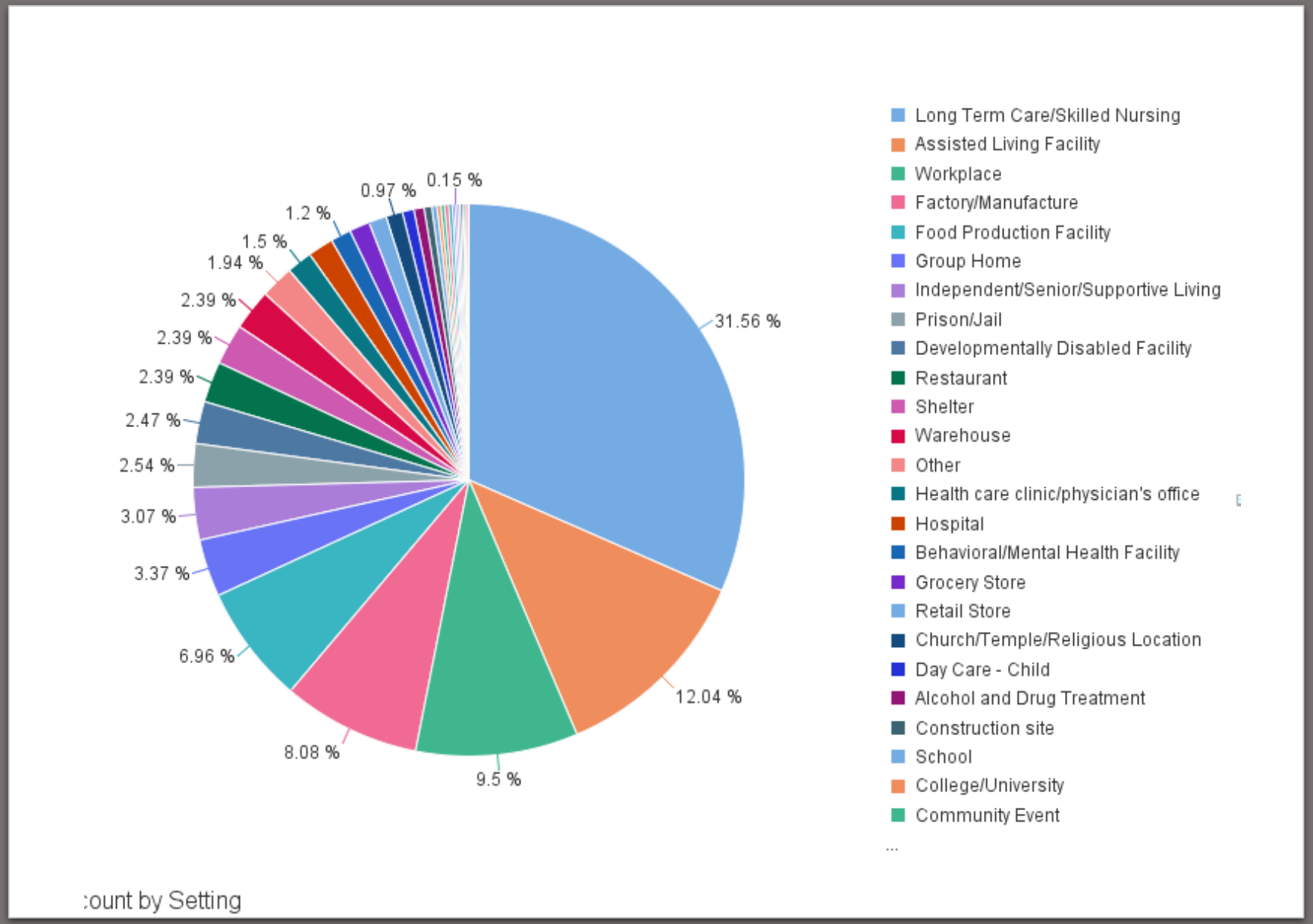
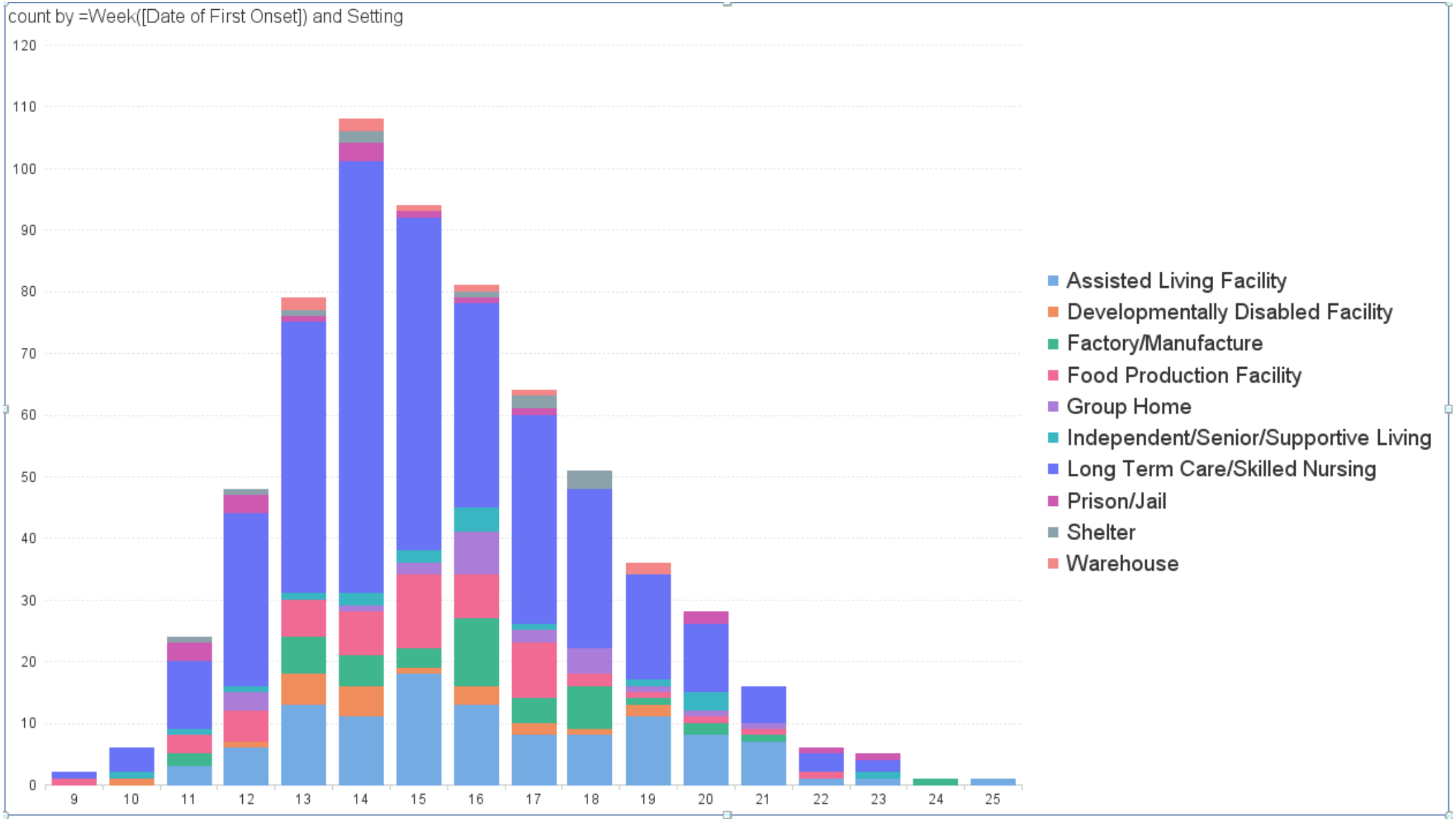


Outbreaks; total outbreaks = 1,337

In LTC/DD:
75% Residents;
25% Staff

Top 10 Outbreak Categories by Week of First Onset & # Lab Confirmed is > 5



Analysis of COVID-19 Patients in Illinois Long-Term Care Facilities
→ As of 16 June 2020

Statistic Name	Statistic Value	As a Percent of Total LTC Cases	As a Percent of Statewide Totals
Total LTC Cases	18,343	--	14 (n=133,639)
Fatal LTC Cases	3,517	19	55 (n=6,398)
Hospitalized LTC Cases	5,190	28	--
Mean Hospital Length of Stay (days)*	9.2		

*Patients with a discharge date

Statewide: Case Positivity and Test Positivity

Case Positivity (daily and 7-day rolling avg)
(Confirmed cases / total tests) * 100

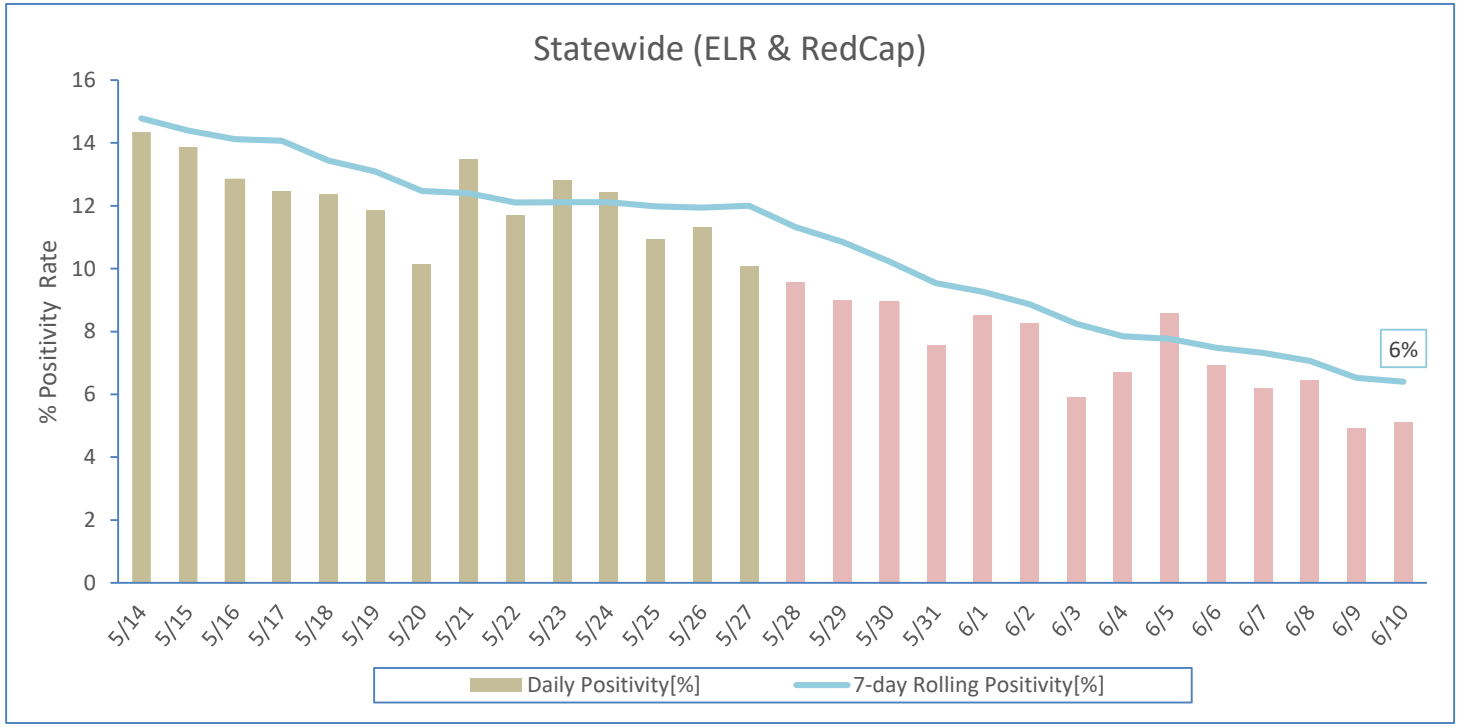
Helps us understand whether changes in the number of confirmed cases is due to more testing or due to more infections.

Metric	Date	Case Positivity (case/total tests)
Most recent day	June 12, 2020	3.1%
Current 7-day rolling	June 06 - June 12	3.4%
Most Recent 28 Days	May 16 - June 12	6.5%

Test positivity rate (daily and 7-day rolling avg)

(Positive tests / total tests)*100

Allows us to account for repeated testing and understand how the virus is spreading in the population over time.



Statewide (ELR & RedCap)	Date	Total Test	Positive Test	Positivity [%]
Most Recent Day	June 12, 2020	21,844	1,093	5%
Current 7-day Rolling	June 06 - June 12	146,897	8,178	6%
Cumulative (recent 28 days)	May 16 - June 12	628,620	58,307	9%

Morbidity and Mortality Weekly Report (*MMWR*)

CDC

Coronavirus Disease 2019 Case Surveillance — United States, January 22 –May 30, 2020

Early Release / June 15, 2020 / 69

Erin K. Stokes, MPH[1,*]; Laura D. Zambrano, PhD[1,*]; Kayla N. Anderson, PhD[1]; Ellyn P. Marder, DrPH[1]; Kala M. Raz, MPH[1]; Suad El Burai Felix, MPH[1]; Yunfeng Tie, PhD[1]; Kathleen E. Fullerton, MPH[1] (View author affiliations)

- As of May 30, 2020, among COVID-19 cases, the most common underlying health conditions were cardiovascular disease (32%), diabetes (30%), and chronic lung disease (18%).
- Hospitalizations were six times higher and deaths 12 times higher among those with reported underlying conditions compared with those with none reported.
- Reported cumulative incidence in the case surveillance population among persons aged ≥20 years is notably higher than that among younger persons.
  - The lower incidence in persons aged ≤19 years could be attributable to undiagnosed milder or asymptomatic illnesses among this age group that were not reported.
  - Incidence in persons aged ≥80 years was nearly double that in persons aged 70–79 years.
- Among cases with known race and ethnicity, 33% of persons were Hispanic (18% of total population), 22% were black (18% of total population), and 1.3% were AI/AN (.7% of total population); disproportionately affected by the COVID-19 pandemic

https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e2.htm?s_cid=mm6924e2_w

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Morbidity and Mortality Weekly Report (*MMWR*)

CDC

Public Attitudes, Behaviors, and Beliefs Related to COVID-19, Stay-at-Home Orders, Nonessential Business Closures, and Public Health Guidance — United States, New York City, and Los Angeles, May 5–12, 2020

Early Release / June 12, 2020 / 69

Mark É. Czeisler[1,2]; Michael A. Tynan[3]; Mark E. Howard, MBBS, PhD[1,2,4]; Sally Honeycutt, MPH[3]; Erika B. Fulmer, MHA[3]; Daniel P. Kidder, PhD[3]; Rebecca Robbins, PhD[5,6]; Laura K. Barger, PhD[5,6]; Elise R. Facer-Childs, PhD[1]; Grant Baldwin, PhD[3]; Shantha M.W. Rajaratnam, PhD[1,5,6]; Charles A. Czeisler, MD, PhD[5,6] (View author affiliations)

- Respondents who were male, employed, or essential workers were significantly more likely to report having been in public areas in the past week.
- Among respondents who had been in public areas during the preceding week, significantly higher percentages of women, adults aged ≥65 years, retired persons, and those living in urban areas reported wearing cloth face coverings.
- A significantly higher percentage of adults aged ≥65 years and nonessential workers reported maintaining 6 feet of physical distance between themselves and others and abiding by the recommendation to avoid gatherings of 10 or more persons than did others.
- Adherence to recommendations to maintain 6 feet of physical distance and limit gatherings to fewer than 10 persons also differed significantly by employment status and race, respectively, with employed persons less likely than were retired persons to have maintained 6 feet of distance and black persons less likely than were white or Asian persons to have limited gatherings to fewer than 10 persons.

https://www.cdc.gov/mmwr/volumes/69/wr/mm6924e1.htm?s_cid=mm6924e1_e&deliveryName=USCDC_921-DM30460

Overview of Testing for SARS-CoV-2
Revised June 13, 2020
https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html

- CDC does not currently recommend using antibody testing as the sole basis for diagnosis of acute infection, and antibody tests are not authorized by FDA for such diagnostic purposes.
- 5 Categories for SARS-CoV-2 Testing
  - Testing individuals with symptoms
    - Clinicians are encouraged to consider testing for other causes of respiratory illness, for example influenza, in addition to testing for SARS-CoV-2 depending on patient age, season, or clinical setting; detection of one respiratory pathogen (e.g., influenza) does not exclude the potential for co-infection with SARS-CoV-2.
  - Testing for asymptomatic individuals with recent known or suspected exposure to control transmission
    - Recommended for all close contacts
    - In certain settings, broader testing is recommended where potential for rapid and widespread dissemination (meat processing plants) or in which populations are at risk for severe disease (LTC, DD homes)

Overview of Testing for SARS-CoV-2
Revised June 13, 2020 (continued)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html

- Testing for asymptomatic individuals without known or suspected SARS-CoV-2 exposure for early identification in special settings
  - Settings that house vulnerable populations in close quarters for extended periods of time (e.g., long-term care facilities, correctional and detention facilities) and/or settings where critical infrastructure workers (e.g., healthcare personnel, first responders)
  - Approaches for early identification of asymptomatic individuals include:
    - Initial testing of everyone residing and/or working in the setting,
    - Regular (e.g., weekly) testing of everyone residing and/or working in the setting, and
    - Testing of new entrants into the setting and/or those re-entering after a prolonged absence (e.g., one or more days)
  - Settings for which these approaches could be considered include:
    - Long-term care facilities
    - Correctional and detention facilities
    - Homeless shelters
    - Other congregate work or living settings including mass care, temporary shelters, assisted living facilities, and group homes for individuals with intellectual disabilities and developmental disabilities
    - High-density critical infrastructure workplaces where continuity of operations is a high priority

Overview of Testing for SARS-CoV-2
Revised June 13, 2020 (continued)
https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-overview.html

- Testing to determine resolution of infection with SARS-CoV-2
  - This strategy could be considered in three situations (not necessarily preferred over symptoms-based approach):
    - Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings
    - Discontinuation of Isolation for Persons with COVID -19 Not in Healthcare Settings
    - Determining Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19
- Testing for public health surveillance for SARS-CoV-2
  - Viral tests are used in community, outpatient, and hospital-based surveillance systems to identify cases of SARS-CoV-2 infection. These data help identify areas of ongoing circulation (hot spots), determine trends in disease by location, provide insight into the impact of the disease over time and by location, and inform disease forecasts
  - Antibody tests to determine the proportion of a population previously infected with SARS-CoV-2.

Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case Is Identified

https://www.cdc.gov/coronavirus/2019-ncov/community/worker-safety-support/hd-testing.html

- Workers in critical infrastructure sectors may be permitted to work if asymptomatic after potential exposure to a confirmed case of coronavirus disease 2019 (COVID-19), provided that worker infection prevention recommendations and controls are implemented.
- When a confirmed case of COVID-19 is identified, interviewing and testing potentially exposed co-workers should occur as soon as possible to reduce the risk of further workplace transmission.
- Positive results indicate need for isolation and those living in close quarters with others, alternative housing should be considered
- Use a risk-based approach to testing co-workers based on likelihood of exposure
  - Examine the facility and operations work records, conduct a walk-through, consider layout and size of the room, the design and implementation of engineering controls, adherence to administrative controls, and movement of workers within the area, and employee interviews to categories employees into 3 tiers for testing priority.

Testing Strategy for Coronavirus (COVID-19) in High-Density Critical Infrastructure Workplaces after a COVID-19 Case Is Identified (Continued)

- Tier 1: close contacts within 48 hours before onset (same shift in same area, lunch together, car pool together or reside in same household)
  - strategy 1 is for exposed workers in Tier 1 to follow existing recommendations regarding exclusion from work with 14 day quarantine
  - Strategy 2 includes baseline testing and serial testing (i.e. re-testing) every 3 days until there are no more new cases detected in the Tier 1 cohort. Individual workers in Tier 1 who remain asymptomatic and have negative tests at baseline and Day 3 can return to work and should continue to be tested every 3 days after returning to work until there are no more new cases in the worker cohort. With this strategy some workers who are infected and return to work may begin to shed virus after Day 3.
  - Strategy 3, during critical staffing shortages, allows asymptomatic workers in Tier 1 to return to work after a baseline test is obtained. Under this strategy, it is recommended that return to work would follow a negative test result, but could occur while results were pending, provided other protections are in place.
- Tier 2: Same shift but in a different area or operation who may have had an exposure to the confirmed case
- Tier 3: Workers not in Tiers 1 or 2 who shared a common space (rest room, break room) with the case. Should especially consider if in an area with high rates of COVID transmission. If facility-wide testing is implement, managers should have a plan for staffing shortages in the likelihood that positives will be identified.

- For all these strategies, waiting for test results prior to returning to work is preferred to keep infected workers out of the workplace.

- Testing strategy should enhance existing disease prevention measures by augmenting ability to detect infection among asymptomatic or pre-symptomatic workers.

9 Critical Questions CDC will be addressing through collaborations with universities

- How can schools mitigate risk when reopening?
  - What metrics should prompt closure?
  - Role of children in transmission?
  - Best practices
- How can office settings mitigate risk when reopening?
  - What metrics should prompt closure?
  - Best practices and how to monitor; what should the screening criteria be?
- What is driving racial/ethnic disparities?
  - Why higher rates of severe disease and incidence rates?
  - Important risk factors for severe disease
  - Best practices for addressing
- How to prevent and control COVID in congregate settings?
  - Testing guidance (homeless shelters, jails)
- How to prevent infections in healthcare settings?
  - N95 masks, alternatives to N95, role of reusable masks
- Best practices for contact tracing?
  - Should asymptomatic contacts be tested and when?
  - Role of digital technologies?
- Are cloth face coverings protective?
- How can PH most effectively monitor reopenings?
  - In hotspots, what mitigation efforts should be ramped up?
- What can we say about immunity?
  - Durable immunity?
  - What role does it have in cocoon strategies.

Amish Community COVID Response

- Build trust and work with key leaders and engage in planning and delivery of the response
- Understand the strong work ethic may deter compliance with quarantine and not financial incentive
- Use words like Postpone church and not Don’t hold church
- Social distancing is a hard concept due to the strong and cohesive nature of the community; use physical distancing
- Consider timing of testing clinics for better uptake; e.g., avoid dates that are common dates for weddings.
- Weddings are very large and social events; most Illinois cases have revolved around a wedding or reunion out of state
- Adherence to prevention measures, e.g., masking is not an individual decision, but based on a community leader decision

Testing Guidelines for Nursing Homes

Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel

Print Page

Updated June 13, 2020

Related Pages

Summary of Changes:

Revisions were made on June 13, 2020, to reflect the following:

- Reorganized recommendations to address:
  - Viral testing of healthcare personnel (HCP)
  - Viral testing of residents
  - Viral testing in response to an outbreak
- Changed "baseline" testing to "initial" testing, although these terms are interchangeable
- Added the following recommendations:
  - Testing the same individual more than once in a 24-hour period is not recommended.
  - Clinicians are encouraged to consider testing symptomatic residents for other causes of respiratory illness, for example influenza, in addition to testing for SARS-CoV-2.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

Additional Changes Under "Viral Testing in Response to an Outbreak" Section

- *"A single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected… "*
  - IDPH definition is not changing. A single case should prompt investigation and response, to include testing.

- *"Continue repeat viral testing of all previously negative residents [and HCP], generally between every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result."*
  - Previously said "(e.g., weekly)". Need to consider logistics of testing, ability to implement infection control measures in between testing.

New CDC FAQs for COVID-19 Testing in Nursing Homes

Should residents or HCP who have a positive antibody test for SARS-CoV-2 be tested as part of facility-wide testing?

- "Yes... We do not know yet if having antibodies to the virus that causes COVID-19 can protect someone from getting infected again or, if they do, how long this protection might last. Therefore, antibody tests should not be used to diagnose COVID-19 and should not be used to inform infection prevention actions."

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html

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Do residents or healthcare personnel (HCP) who previously had COVID-19 confirmed by viral testing (e.g., reverse-transcriptase polymerase chain reaction, RT-PCR) and who have recently recovered need to be re-tested as part of facility-wide testing?

Whether residents or HCP who previously had COVID-19 confirmed by viral testing need to be re-tested depends on: 1) how much time has passed since their initial illness; 2) what strategy the facility is using to determine when residents can discontinue isolation and HCP can return to work; and 3) whether the individual has developed symptoms after initial recovery.

- Most individuals who recently recovered from COVID-19 are likely no longer infectious even if they continue to have a positive viral test (e.g., persistently or recurrently detectable viral RNA). When an individual has a positive test result <6 weeks after they met criteria for discontinuation of Transmission-Based Precautions or Home Isolation, it can be difficult to determine if they have been re-infected or if they still have detectable viral RNA from their previous infection.
- Residents and HCP who had a positive viral test in the past 6–8 weeks and are now asymptomatic may not need to be retested as part of facility-wide testing unless the facility is using a test-based strategy to determine if residents can discontinue isolation or HCP can return to work. Residents and HCP who had a positive viral test over 8 weeks ago should be retested as part of facility-wide testing, regardless of symptoms.
- Residents and HCP who had a positive viral test at any time and become symptomatic after recovering from the initial illness should be re-tested and placed back on the appropriate Transmission-Based Precautions or excluded from work, respectively.

This guidance may be updated as we learn more information on viral persistence and risk for reinfection.

CDC FAQ

How should facilities approach residents who decline testing?

- Consider less invasive swab (e.g., anterior nares), encourage through discussion of the reason for testing.
  - **Resident has COVID-19-like symptoms** -->Transmission-Based Precautions until meet symptom-based criteria for discontinuation.
  - **Resident is asymptomatic** --> decisions on placing resident on TBPs or providing usual care should be based on whether facility has evidence suggesting SARS-CoV-2 transmission (i.e., confirmed infection in HCP or nursing-home onset infection in a resident).
  - Only residents who have a confirmed positive viral test should be moved to COVID-19-designated units or facilities.

CDC FAQ

How should facilities approach HCP who decline testing?

- **HCP with COVID-19-like symptoms** --> should be presumed to have COVID-19 and excluded from work.
  - Return to work decisions should be based on COVID-19 return to work guidance at the discretion of the facility's occupational health program.

- **Asymptomatic HCP** -->work restriction, if any, should be determined by the facility's occupational health and local jurisdiction policies.
  - All staff should be trained in proper use of personal protective equipment, including universal facemask policies, hand hygiene, and other measures needed to stop transmission of SARS-CoV-2.

CDC FAQ

If HCP work at multiple facilities, do they need to receive a viral test at each facility?

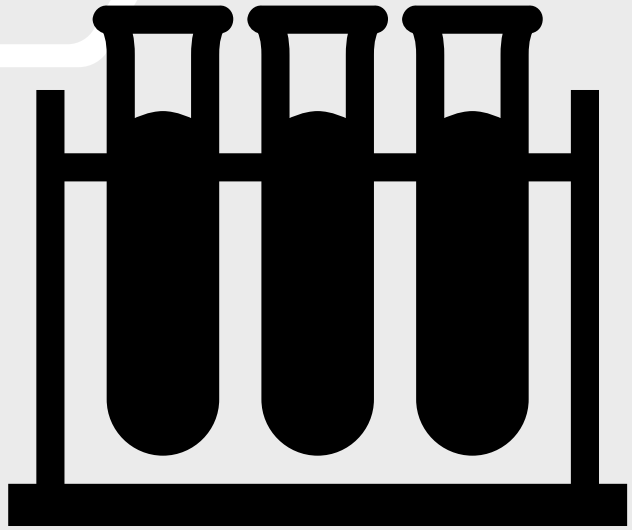
- No. Documentation should be provided to each facility.
- Each facility should maintain appropriate documentation of test results and have a plan to evaluate and manage HCP.
- HCP should be encouraged to tell facilities if they have had exposures at other facilities with recognized COVID-19 cases.

CDC FAQ

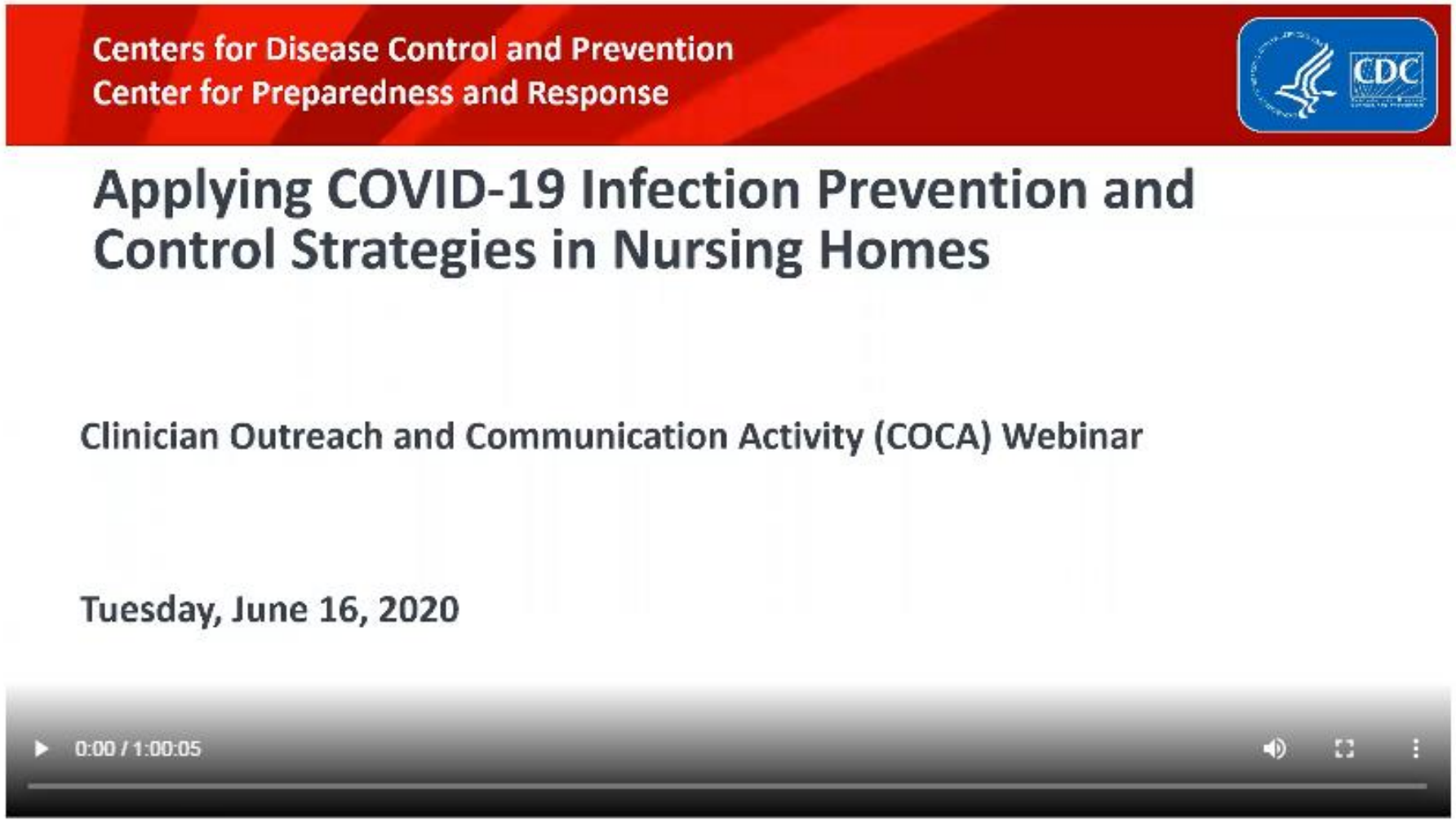
How long should facilities continue serial testing of HCP?

- **For COVID-19 outbreaks** --> serially test all previously negative residents and HCP until no new cases identified ≥14 days since most recent positive result.

- **For reopening process -->** decision to serially test HCP should be made in context of local incidence.



Applying COVID-19 Infection Prevention and Control Strategies in Nursing Homes



https://emergency.cdc.gov/coca/calls/2020/callinfo_061620.asp

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RESTORE ILLINOIS

A Public Health Approach To Safely Reopen Our State

Workplace Safety Guidelines

Phase 3 - Recovery

ILLINOIS

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Restore Illinois

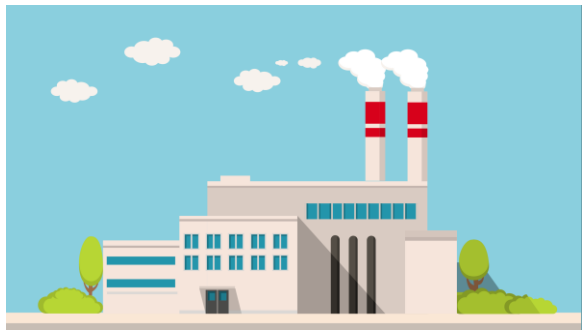
- Five-phased plan to reopen Illinois guided by health metrics.
    - Each phase permits distinct business, education, and recreation activities with IDPH-approved safety guidance in place.
    - Based upon regional healthcare availability – the impact of COVID-19 per region and hospital capacity. Movement between Phases dependent on health metrics.
    - Initial framework will be updated as research and science develop.
- IDPH has regions that traditionally guide its public health work. For Restore IL, four health regions established: NE IL, N-Central IL, Central IL, and S-IL.
- More Information on Restore Illinois.

ILLINOIS

Phase 3 - Recovery

- Illinois is in Phase 3 as of May 29th. Some activities permitted to resume with IDPH-approved safety guidance in place.
  - **Gatherings** of 10 people or fewer
  - **Travel** should follow IDPH and CDC guidance
  - **Health Care** are all opened with IDPH safety guidance
  - **Education and Child Care** remote learning for P-12 and higher ed; limited child care and summer programs open with IDPH guidance
  - **Outdoor Recreation** permitted with groups of 10 or fewer with social distancing; State parks open
  - **Businesses** reopening spans ten categories

Phase 3 - Recovery



Businesses permitted to reopen under Phase 3 with IDPH-approved safety guidance:

- Manufacturing
- Offices
- Retail
- Service Counters
- Youth Sports
- Health and Fitness Centers
- Personal Care Services
- Outdoor Recreation
- Day Camps
- Restaurants and Bars (outdoor dining and drinking)

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Phase 3 – Business Toolkit

- The State of Illinois provides a Phase 3 Business Toolkit to ensure activities are conducted in accordance with latest public health recommendations.
- Describes common guidelines for all Phase 3 permitted business operations and activities.
- Includes signage, training checklists, and other resources.
- Illinois encourages these guidelines be followed among all employers and activity types, as well as workplace and program-specific guidelines.
- Guidelines for all Phase 3 Businesses and Operations can be found in the Phase 3 Business Toolkit.

Phase 3 Guidelines for Reopening Business and Returning People to Work Safely

- Each set of Phase 3 guidelines includes common standards that are expected and encouraged among all employers and activity types, as well as workplace and program-specific guidelines.
- Industry definition and workplace and program-specific guidelines can be found at DCEO's website.
  - This information provides guidelines and a toolkit per industry in order to help businesses open safely and protect the health and safety of their employees and customers.

Goal of Workplace Guidelines to Mitigate Key Risk Factors

Proximity

How physically close are workers to others?

Duration

How long does a typical interaction last?

Number of contacts

How many interactions with people occur daily?

Nature of contact

Do workers touch common surfaces/ items?

Screening and removal

Is there screening to catch contagious people?

Ventilation

Do workers breathe same air in confined space?

Workplace Mitigation Guidelines Categorized Across 8 Dimensions

All employers risk mitigation

General health guidelines
(e.g., recommendations on PPE, hand-washing, social distancing)

HR and travel policies
(e.g., offering paid time off for sick employees, eliminate non-essential travel)

Health monitoring
(e.g., implement testing/screening)

Consistent across all workplaces

Workplace-specific risk mitigation

Physical workspace
(e.g., spatial configuration, limiting interactions)

Disinfecting/cleaning procedures
(e.g., cleaning frequency, process)

Staffing and attendance
(e.g., jobs that be adapted to WFH, new staffing protocols)

External interaction
(e.g., format of interactions, external constituent screening as possible)

Customer behaviors
(e.g., requirements for customers if business is customer-facing)

Customized for individual workplace archetypes

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General Guidelines For All Employers

General health

- Minimum guidelines
  - All employees who can work from home should continue to do so
  - Employees should wear face coverings over their nose and mouth when within 6-ft. of others (cloth masks preferred). Exceptions may be made where accommodations are appropriate – see IDHR's guidance.
  - Social distance of at least 6-ft. should be maintained between non-household individuals unless participating in activities permitted under Phase III guidelines
  - Employer should provide hand washing capability or sanitizer to employees and if applicable, customers
  - Frequent hand washing by employees, and an adequate supply of soap/ paper towels and/or disinfectant/ hand sanitizer should be available

HR and travel policies

- Minimum guidelines
  - All employees should complete health and safety training related to COVID-19 when initially returning to work. Resources to design a training are posted on the DCEO Restore Illinois guidelines website
  - Employers should continue to limit all non-essential business travel
    - > If employee must travel, employee should follow CDC considerations to protect themselves and others during trip
  - Employees should not report to, or be allowed to remain at, work if sick or symptomatic (with cough, shortness of breath or difficulty breathing, fever of 100.4 degrees or above, chills, muscle pain, headache, sore throat, new loss of taste or smell, or other CDC-identified symptoms), and sick or symptomatic employees should be encouraged to seek a COVID-19 test at a state or local government testing center, healthcare center or other testing locations
- Encouraged best practices
  - Provide reasonable accommodation for COVID-19-vulnerable employees, including but not limited to work from home (if feasible), reduced contact with others, use of barriers to ensure minimum distance between others whenever feasible or other accommodations that reduce chances of exposure

Health monitoring

- Minimum guidelines
  - Employers should make temperature checks available for employees and encourage their use. Employers should post information about the symptoms of COVID-19 in order to allow employees to self-assess whether they have any symptoms and should consider going home
  - All employers should have a wellness screening program. Resources outlining screening program best practices are posted on the DCEO Restore Illinois guidelines website
    - > Employer should conduct in-person screening of employees upon entry into workplace and mid-shift screening to verify no presence of COVID-19 symptoms
  - If employee does contract COVID-19, they should remain isolated at home for a minimum of 10 days after symptom onset and can be released after feverless and feeling well (without fever-reducing medication) for at least 72 hours OR has 2 negative COVID-19 tests in a row, with testing done at least 24 hours apart
  - If an employee is identified as being COVID-19 positive by testing, CDC cleaning and disinfecting should be performed as soon after the confirmation of a positive test as practical
  - Where appropriate, notify employees who have been exposed
  - Any employee who has had close contact[1] with co-worker or any other person who is diagnosed with COVID-19 should quarantine for 14 days after the last/most recent contact with the infectious individual and should seek a COVID-19 test at a state or local government testing center, healthcare center or other testing locations. All other employees should be on alert for symptoms of fever, cough, or shortness of breath and taking temperature if symptoms develop

1 Close contacts include household contacts, intimate contacts, or contacts within 6-ft. for 10 minutes or longer

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Workplace Specific Guidelines Have Similar Principles Among Workplace Archetypes

Physical workspace

- Minimum guidelines
  - Desks in offices, recreation stations, personal care stations must be spaced out or closed to allow for 6-ft. of space; impermeable barriers recommended
  - Display signage with social distancing guidelines at point of entry, in multiple languages as needed
  - Remove shared items (e.g., magazines) from waiting areas and configure any seating to be 6-ft apart to allow for social distancing
    - > Any surfaces in waiting area (e.g., seats) touched by customers should be disinfected after use
- Encouraged best practices
  - Display visual markers 6-ft. apart at any queue points (e.g., elevators, building entrances)
  - Touchless transactions/ check-ins

Disinfecting / cleaning

- Minimum guidelines
  - Cleaning/ disinfecting of premises must be conducted in compliance with CDC protocols weekly
  - Clean and disinfect common areas (e.g., restrooms, cafeterias) and surfaces which are touched by multiple people (e.g., entry/exit doorknobs, stair railings) frequently; every 2 hours recommended for high-traffic areas
  - Sanitization stations should be easily accessible to all employees and customers
  - Shared equipment should be disinfected before being used by another employee
- Encouraged best practices
  - Provide each employee with disinfecting/ cleaning materials to be used at his/her workstation

Staffing and attendance

- Minimum guidelines
  - Maximum capacity limits based on 50% of building capacity OR 5 customers per 1000 sq. ft. of space
  - Design a plan to allow for social distancing within the workplace and if needed, designate employee(s) to monitor capacity limits and social distancing
  - Limit the occupancy of common areas/ break rooms to allow for social distancing of 6-ft. or greater by removing/ decommissioning furniture or staggering break times; this guideline is not intended to diminish employees break time requirements
- Encouraged best practices
  - Stagger shift start and end times to minimize congregation of employees during changeovers

External interactions

- Minimum guidelines
  - Before allowing entrance, businesses must ask whether external suppliers/ visitors are currently exhibiting COVID-19 symptoms
  - Log kept with info of all suppliers/ visitors who enter
  - Suppliers and other visitors should wear face coverings over their nose and mouth when entering premises (exceptions can be made for people with medical conditions or disabilities that prevent them from safely wearing a face covering)
- Encouraged best practices
  - Limited contact with suppliers/ visitors

Customer behaviors

- Minimum guidelines
  - Reservations only, no walk-ins (excluding Retail/ Service counter)
  - Customers should wear face coverings over their nose and mouth (exceptions can be made for people with medical conditions or disabilities that prevent them from safely wearing a face covering)
- Encouraged best practices
  - Customers wait for services off premises
  - Screening of customers if possible

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THANK YOU

Questions?