

December 5, 2022

Health Notice for District of Columbia Health Care Providers
COVID-19 Outbreak Investigation and Reporting Requirements
for Healthcare Facilities

SUMMARY

It has been nearly three years since the beginning of the COVID-19 pandemic, and every district resident has been affected in some way. While cases of COVID-19 have been steadily declining, outbreak investigation and reporting will remain a vital tool in our ongoing response. This Health Notice provides information on 1) The definition of a COVID-19 outbreak in the long-term care setting 2) The definition of a COVID-19 outbreak in the hospital setting 3) The definition of a COVID-19 outbreak in the outpatient setting, 4) The infection control recommendations to mitigate the outbreak, and 5) Reporting thresholds.

BACKGROUND

The thresholds and outbreak definition presented below reflect the local epidemiology of COVID-19 and are based on available scientific resources and expert opinion. The information provided here does not replace reporting of COVID-19 as part of routine COVID-19 surveillance to DC Health, the Centers for Medicare & Medicaid Services (CMS) requirements for Nursing Homes to report to the National Healthcare Safety Network (NHSN) or the Health and Human Services Protect data reporting. Thresholds for reporting are intended to expedite facilities' investigation of COVID-19 cases and reporting to DC Health, thus ensuring early detection of possible outbreaks and timely intervention to prevent the virus' spread. Healthcare facilities should consult DC Health if they have questions at coronavirus.hai@dc.gov.

An outbreak response or investigation may take many forms depending on the characteristics of the outbreak and healthcare setting. It can involve site visits and facility assessments conducted by DC Health, collection of additional data that are not captured in standard case investigation or contact tracing, lab-testing of potentially exposed patients and HCP, guidance related to infection control practices including cohorting, and other forms of technical assistance and phone-based consultations involving the affected facility. DC Health may also collaborate with healthcare facilities to inform the public and potentially exposed patients, residents, facility visitors and HCP through public notification.

DEFINITIONS

Healthcare Personnel (HCP): HCP includes all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients/residents or infectious materials; this includes part-time and full-time contractors, agency workers, and vendors. Examples of HCP include emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students, trainees, clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel.

Epi-linkage among patients: An overlapping admission on the same unit or ward, or having the potential to have been cared for by common HCP within a 10-day time period of each other. DC Health may determine epi-linkages, weighing evidence whether patients had a common source of exposure or not.

Epi-linkage among HCP: Having the potential to have been within 6 feet for a cumulative total of 15 minutes or more over a 24-hour while working in the facility during the 10 days prior to the onset of symptoms; for example, worked on the same unit during the same shift. DC Health may determine epi-linkages, weighing evidence whether transmission took place in the facility or not, accounting for likely sources of exposure outside the facility.

Confirmed case: A person who meets confirmatory laboratory evidence. Confirmatory laboratory evidence is detection of SARS-CoV-2 ribonucleic acid (RNA) in a clinical specimen or post-mortem respiratory swab using a diagnostic molecular amplification test performed by a CLIA-certified provider, OR detection SARS-CoV-2 by genomic sequencing.

Probable case: A person meeting presumptive laboratory evidence AND either clinical criteria OR epidemiologic evidence. Presumptive laboratory evidence includes the detection of SARS-CoV2 specific antigen in a clinical or post-mortem specimen using a diagnostic test performed by a CLIA-certified provider. Readmissions occurring within 24 hours will be considered a single admission.

Suspect case: A person meeting supportive laboratory evidence OR meeting vital records criteria with no confirmatory or presumptive laboratory testing performed for COVID-19. Supportive laboratory evidence includes the detection of SARS-CoV-2 specific antigen by immunocytochemistry OR detection of SARS-CoV-2 RNA or specific antigen using a test performed without CLIA oversight.

Facility-acquired COVID-19 infection in a hospital: An inpatient with onset of laboratory-confirmed COVID-19 occurring 10 or more days after admission for a condition other than COVID-19; A person meeting clinical criteria starting 10 or more days after admission for a condition other than COVID-19 AND epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19.

Facility-acquired COVID-19 infection in a long-term care resident: A confirmed diagnosis 14 days or more after admission for a non-COVID condition, without an exposure during the previous 14 days to another setting where an outbreak was known or suspected to be occurring.

Identifying information: Includes full name, date of birth, full address including city/state and zip code, primary state of residence (if different), daytime and evening telephone number, and email address (if available).

Risk assessment: A tool developed to assess infection control practices, identify gaps, and guide quality improvement activities. Infection control practices that may be assessed include, but are not limited to, appropriate management of close contacts with an infectious agent (e.g., cohorting), appropriate use of personal protective equipment (PPE) per specific environment or circumstance (e.g., correct eye protection, facemask versus respirator), and evaluation of future transmission risk to the facility and community.

Vital Records Criteria: A death certificate that lists COVID-19 disease, SARS-CoV-2 or an equivalent term as an underlying cause of death or a significant condition contributing to death.

Skilled nursing facilities, assisted living facilities and long-term acute care hospitals

Threshold for additional investigation by facility:

- ≥ 1 suspect, probable or confirmed COVID-19 case in a resident or HCP;
- ≥ 3 cases of acute illness compatible with COVID-19 in residents with onset within a 72h period.

Threshold for required reporting to DC Health:

- ≥ 1 probable or confirmed COVID-19 case in a resident or HCP;
- ≥ 3 cases of acute illness compatible with COVID-19 in residents with onset within a 72h period.

An outbreak is defined as:

- ≥ 1 case in a resident ≥ 14 days after admission/readmission;

- ≥ 1 case in staff

An outbreak in the facility will result in:

- Return to Outbreak Initiation Phase or as directed by DC Health;
- Additional risk assessment(s) to identify exposed close contacts as directed by DC Health;
- Outbreak testing of residents and staff as directed by DC Health;
- Working with and providing information to DC Health as requested;
- Additional activities deemed necessary to mitigate spread of COVID-19 as part of outbreak/facility specific recommendations.

Acute care hospitals

Threshold for additional investigation by facility:

- ≥ 1 case of probable or confirmed COVID-19 in a patient 4 or more days after admission for a non-COVID-19 condition;
- ≥ 1 case of suspect, probable, or confirmed COVID-19 in Healthcare Personnel (HCP).

Threshold for required reporting to DC Health:

- ≥ 2 cases of probable or confirmed COVID-19 in a patient ≥ 4 days after admission for a non-COVID-19 condition;
- ≥ 3 cases of confirmed COVID-19 in HCP with epi-linkage.

An outbreak is defined as:

- ≥ 2 cases of probable or confirmed COVID-19 in a patient ≥ 4 days after admission for a non-COVID-19 condition, with epi-linkage;
- ≥ 3 cases of suspect, probable or confirmed COVID-19 in HCP on the same unit/location/department within 10 days with epi-linkage AND no other more likely sources of exposure for at least 2 of the cases.;

An outbreak in the facility will result in:

- Additional risk assessment(s) to identify exposed close contacts as directed by DC Health;
- Submitting outbreak-specific line lists to DC Health within 24 hours of notification and whenever new or updated information becomes available;
 - Line lists must include identifying information for all positive cases associated with the outbreak, identifying information for all individuals exposed to each known case that is associated with the outbreak, location(s) of all individuals associated with the outbreak, and all additional information that is relevant to the investigation as determined by DC Health.
- Testing of patients and staff on the affected unit and providing up-to-date documentation of testing efforts and outcomes to DC Health. Testing frequency will be specified by DC Health;
- Reporting infection control interventions that were implemented in response to the possible or confirmed outbreak to DC Health;
- Working with and providing information to DC Health as requested;
- Additional activities deemed necessary to mitigate spread of COVID-19 as part of outbreak/facility specific recommendations.

Intermediate care facilities/Community Residence Facilities (Ch. 34/35)

Threshold for additional investigation by facility:

- ≥ 1 suspect, probable or confirmed COVID-19 case in a person supported or HCP;
- ≥ 1 case of acute illness compatible with COVID-19 in person supported.

Threshold for required reporting to DC Health:

- ≥ 1 probable or confirmed COVID-19 case in a person supported or HCP;
- ≥ 2 cases of acute illness compatible with COVID-19 in person supported with onset within a 72h period.

An outbreak is defined as:

- ≥ 1 case in a person supported ≥ 10 days after admission/readmission;
- ≥ 3 cases in staff within 10 days.

An outbreak in the facility will result in:

- Additional risk assessment(s) to identify exposed close contacts as directed by DC Health;
- Testing of persons supported and staff in the residence as directed by DC Health;
- Increased monitoring of persons supported and staff for symptoms of COVID-19;
- Working with and providing information to DC Health as requested;
- Additional activities deemed necessary to mitigate spread of COVID-19 as part of outbreak/facility specific recommendations.

Outpatient facilities

Outpatient facility guidelines are divided into two subcategories:

- **Emergency Department, Urgent Care, Primary Care**
 - Threshold for additional investigation by facility:
 - ≥ 1 suspect, probable, or confirmed COVID-19 case in a HCP.
 - Threshold for required reporting to DC Health:
 - ≥ 3 cases of suspect, probable, or confirmed COVID-19 cases in HCP within 10 days, with epi- linkage.
 - An outbreak is defined as:
 - ≥ 3 cases of confirmed COVID-19 cases in patients or HCP within 10 days, with epi-linkage,
AND
 - No other likely sources of exposure for at least 2 of the cases.

- **Ambulatory Specialty Settings** (e.g., dialysis centers, dental clinic, ENT, endoscopy, ambulatory surgical centers, pain clinics, antibiotic infusion centers, ophthalmology, oncology infusion centers, speech therapy clinics)
 - Threshold for additional investigation by facility:
 - ≥ 1 suspect, probable, or confirmed COVID-19 case in a HCP,
OR
 - When notified of ≥ 1 suspect, probable, or confirmed COVID-19 case in a patient without other significant source of exposure.
 - Threshold for required reporting to DC Health:
 - ≥ 3 cases of suspect, probable or confirmed COVID-19 in HCP within 10 days with epi-linkage.
 - ≥ 3 cases of probable or confirmed COVID-19 cases in patients, with epi-linkage, **AND** without other significant sources of exposure
 - An outbreak is defined as:
 - ≥ 3 cases of probable or confirmed COVID-19 cases in patients, with epi-linkage,
AND no other more likely sources of exposure for at least 2 of the cases.

- ≥ 3 cases of suspect, probable or confirmed COVID-19 cases in HCP within 10 days, with epi-linkage, **AND** no other more likely sources of exposure for at least 2 of the cases.

An outbreak in **any outpatient facility** will result in:

- Additional risk assessment(s) to identify exposed close contacts as directed by DC Health;
- Testing of staff as directed by DC Health;
- Any patients identified as being exposed in this outbreak should be advised to follow DC Health guidance for exposure AND reported to DC Health (please report all patient to DC Health regardless of their state of residence); please see the 'Reporting Requirements' section below;
- Patient and staff notifications;
- Working with and providing information to DC Health as requested;
- Additional activities deemed necessary to mitigate spread of COVID-19 as part of outbreak/facility specific recommendations.

Reporting Requirements

Any identified outbreak must be reported to DC Health in accordance with DCMR Chapter [22B 208.2](#), [22B 201.1\(ff\)](#) and [201.1 \(gg\)](#), [D.C. Official Code § 7-139](#). Unless already reporting through a DC Health approved process, all health care facilities must report a confirmed or suspected outbreak to coronavirus.hai@dc.gov within 24 hours.

Any patients or residents transferred to another facility while under empiric transmission-based precautions or during their isolation period must be reported to DC Health within 24 hours, however, notifications prior to transfer are preferred to ensure expedited connection with contact tracers.

- The following minimum information must be provided: First Name, Last Name, Date of Birth, Full Address, Phone, Discharge Date, Discharge Location, and date of last known exposure or date of last day of isolation.

Please visit dchealth.dc.gov/page/covid-19-reporting-requirements for more information about routine COVID-19 reporting to DC Health.

References:

- **HHS reporting guidance:** hhs.gov/sites/default/files/covid-19-faqs-hospitals-hospital-laboratory-acute-care-facility-data-reporting.pdf
- **CMS's testing guidelines for nursing homes:** cms.gov/files/document/qso-20-38-nh-revised.pdf
- **CORHA/CSTE Thresholds and outbreak definitions for COVID-19:** corha.org/wp-content/uploads/2022/08/COVID-19-HC-Outbreak-Definition-Guidance-8-10-22.pdf

The guidelines above will continue to be updated as the outbreak evolves. Please visit coronavirus.dc.gov/ and the DC Health - Health Notices website (dchealth.dc.gov/page/health-notices) regularly for the most current information.

Please contact DC Health regarding COVID-19 at:
Phone: 202-576-1117 | Fax: 202-442-8060 | Email: coronavirus@dc.gov