



## **Healthcare Evaluation and Protection of HCP**

- **All healthcare workers need to protect themselves** and expect heightened demands on the healthcare system that will require a healthy and intact workforce. All providers should review and practice protocols for handling patients with respiratory disease and suspected COVID-19 infection: identify suspect patients upon arrival, apply surgical facemasks to such patients to prevent/reduce exposure of healthcare workers and other patients, and triage to an exam room where suspected cases are segregated from other patients.
- Exercise clinical judgement in evaluating patients with respiratory illness. If testing is indicated, influenza testing and nucleic acid testing with multiplex PCR respiratory pathogens are both widely available. If a patient is lab test (+) on these tests, we are currently considering COVID-19 as a remote possibility and not recommending further diagnostics specific for the COVID-19 virus. Exceptions for severely ill patients with atypical clinical presentation may be warranted.
- Currently laboratory testing for the COVID-19 virus is limited, but is expected to become widely available in the coming days. Until commercial COVID-19 testing is readily available, providers who believe testing is indicated based on presence of travel history or epidemiologic risk factors or clinical presentation should contact a local or state health department for assistance.
- Patients with serious respiratory illness with (-) laboratory results for influenza and other respiratory pathogens are potential candidates for COVID-19 testing. This led to the identification of a COVID-19 (+) patient in northern California. Contact a local/state health department to discuss testing/case management.
- Once commercial COVID-19 lab tests become available, providers should error on the side of testing to facilitate identification and isolation of COVID-19 infected patients.
- It is **CRITICALLY IMPORTANT** that staff responsible for collecting nasopharyngeal (NP) swabs be thoroughly trained and strictly compliant with specimen collection protocols. Failure to collect a proper specimen could result in a FALSE NEGATIVE test which could have major consequences for controlling COVID-19. Please work with staff responsible for NP specimen collection to be sure they are thoroughly trained and compliant with specimen collection protocols. A training video can be found here: <https://www.youtube.com/watch?v=hXohAo1d6tk>
- Long term care facilities such as nursing homes and assisted living facilities are an area of special concern given close living quarters and a population highly vulnerable to COVID-19 complications. The outbreak unfolding at a Washington care facility over the weekend warrants the attention of those responsible for the care and safety of residents at Nebraska care facilities such as this. Please review CDC guidance for these types of facilities:  
<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>

Please see an update and interim guidance from CDC below. To help contain the potential outbreak, in addition to countries listed by CDC as *Alert Level 2* or *Warning Level 3*, Nebraska DHHS Division of Public Health is also assessing and monitoring travelers from countries listed by CDC in *Watch Level 1* or as *Other Destinations with Risk of Community Spread*. For the most up-to-date list of countries, go to CDC's website:

<https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>

Public health personnel are committed to rapid identification of suspected cases, with prompt isolation and laboratory confirmation, along with identification and quarantine of contacts. Any patient suspected of COVID-19 infection should immediately be reported to a local or state public health authority ([www.dhhs.ne.gov/lhd](http://www.dhhs.ne.gov/lhd)).

**We continue to encourage attention to the following situations:**

- 1) Travelers who have known exposure to a confirmed patient or who have returned to Nebraska in the last 14 days from countries where transmission is known to be occurring (i.e., mainland China, South Korea, Iran, Italy, Japan, Hong Kong, Singapore, Taiwan, and Thailand [please refer to the above-cited CDC website for updates]).  
**and**  
who have fever  $\geq 100.4$  **or** respiratory symptoms should immediately be reported to public health for evaluation/diagnostic workup.
- 2) **Asymptomatic travelers from mainland China** are of particular concern and are requested to self-report to the Nebraska public health on-line tracking system (<https://cip-dhhs.ne.gov/redcap/surveys/?s=JKHEPR4DPR>) and to self-isolate for 14 days.
- 3) **Asymptomatic travelers from South Korea, Iran, Italy, Japan, Hong Kong, Singapore, Taiwan, and Thailand** are requested to self-report to the Nebraska public health on-line tracking system (see above). Based on travel history, there could be risk for coronavirus infection and transmission. At the least, please self-monitor for fever, cough or shortness of breath twice daily.

**This is an official**

# **CDC HEALTH UPDATE**

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February 28, 2020, 15:05 ET (3:05 PM ET)  
CDCHAN-0428

## **Update and Interim Guidance on Outbreak of Coronavirus Disease 2019 (COVID-19)**

### **Summary**

The Centers for Disease Control and Prevention (CDC) continues to closely monitor and respond to the COVID-19 outbreak caused by the novel coronavirus, SARS-CoV-2.

This CDC Health Alert Network (HAN) Update provides updated guidance on evaluating and testing persons under investigation (PUIs) for COVID-19. It supersedes guidance provided in CDC's HAN 427 distributed on February 1, 2020.

The outbreak that began in Wuhan, Hubei Province, has now spread throughout China and to 46 other countries and territories, 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. CDC has updated travel guidance to reflect this information (<https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html>).

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 working together to investigate this case and are identifying contacts with whom this individual interacted.

CDC, state and local health departments, other federal agencies, and other partners have been implementing measures to slow and contain transmission of COVID-19 in the United States. These measures include assessing, monitoring, and caring for travelers arriving from areas with substantial COVID-19 transmission and identifying cases and contacts of cases in the United States.

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 to reflect this spread. To prepare for possible additional person-to-person spread of COVID-19 in the United States, CDC continues to recommend that clinicians and state and local health departments 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.

### **Criteria to Guide Evaluation and Testing of Patients Under Investigation (PUI) for COVID-19**

Local or state health departments, in consultation with clinicians, should determine whether a patient is a PUI for COVID-19. The CDC clinical criteria for COVID-19 PUIs have been developed based on available information about this novel virus, as well as what is known about Severe Acute Respiratory Syndrome (SARS) (<https://www.cdc.gov/sars/clinical/guidance.html>) and Middle East Respiratory Syndrome (MERS) (<https://www.cdc.gov/coronavirus/mers/interim-guidance.html#evaluation>). These criteria are subject to change as additional information becomes available.

Clinical Features		Epidemiologic Risk
Fever <sup>1</sup> <b>or</b> signs/symptoms of lower respiratory illness (e.g., cough or shortness of breath)	<b>AND</b>	Any person, including healthcare personnel <sup>2</sup> , who has had close contact <sup>3</sup> with a laboratory-confirmed <sup>4</sup> COVID-19 patient within 14 days of symptom onset
Fever <sup>1</sup> <b>and</b> signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath) requiring hospitalization	<b>AND</b>	A history of travel from affected geographic areas <sup>5</sup> , within 14 days of symptom onset
Fever <sup>1</sup> 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). <sup>6</sup>	<b>AND</b>	No identified source of exposure

These criteria are intended to serve as guidance for evaluation. In consultation with public health departments, patients should be evaluated on a case-by-case basis to determine the need for testing. Testing may be considered for deceased persons who would otherwise meet the PUI criteria.

<sup>1</sup>Fever may be subjective or confirmed.

<sup>2</sup> 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>).

<sup>3</sup>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.

Additional information is available in CDC’s updated Interim Healthcare Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings (<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>).

Data to inform the definition of close contact are limited. Considerations when assessing close contact include the duration of exposure (e.g., longer exposure time likely increases exposure risk) and the clinical symptoms of the person with COVID-19 (e.g., coughing likely increases exposure risk, as does exposure to a severely ill patient). 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-assessment-hcp.html>).

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

<sup>5</sup>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>).

<sup>6</sup>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.

### Recommendations for Reporting, Testing, and Specimen Collection

Clinicians should immediately implement recommended infection prevention and control practices (<https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>) if a patient is suspected of having COVID-19. They should also notify infection control personnel at their healthcare facility and their state or local health department if a patient is classified as a PUI for COVID-19. State health departments that have identified a PUI or a laboratory-confirmed case should complete a PUI and Case Report form through the processes identified on CDC's Coronavirus Disease 2019 website (<https://www.cdc.gov/coronavirus/2019-ncov/php/reporting-pui.html>). State and local health departments can contact CDC's Emergency Operations Center (EOC) at 770-488-7100 for assistance with obtaining, storing, and shipping appropriate specimens to CDC for testing, including after hours or on weekends or holidays. Currently, diagnostic testing for COVID-19 is being performed at state public health laboratories and CDC. Testing for other respiratory pathogens should not delay specimen testing for COVID-19.

For initial diagnostic testing for SARS-CoV-2, CDC recommends collecting and testing upper respiratory tract specimens (nasopharyngeal AND oropharyngeal swabs). CDC also recommends testing lower respiratory tract specimens, if available. For patients who develop a productive cough, sputum should be collected and tested for SARS-CoV-2. The induction of sputum is not recommended. 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 and tested as a lower respiratory tract specimen. Specimens should be collected as soon as possible once a PUI is identified, regardless of the time of symptom onset. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Patients Under Investigation (PUIs) for COVID-19 (<https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html>) and Biosafety FAQs for handling and processing specimens from suspected cases and PUIs (<https://www.cdc.gov/coronavirus/2019-ncov/lab/biosafety-faqs.html>).

### For More Information

More information is available at the COVID-19 website: <https://www.cdc.gov/coronavirus/2019-ncov/index.html>.

*The Centers for Disease Control and Prevention (CDC) protects people's health and safety by preventing and controlling diseases and injuries; enhances health decisions by providing credible information on critical health issues; and promotes healthy living through strong partnerships with local, national, and international organizations.*

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#### Categories of Health Alert Network messages:

<b>Health Alert</b>	Requires immediate action or attention; highest level of importance
<b>Health Advisory</b>	May not require immediate action; provides important information for a specific incident or situation
<b>Health Update</b>	Unlikely to require immediate action; provides updated information regarding an incident or situation
<b>HAN Info Service</b>	Does not require immediate action; provides general public health information

##This message was distributed to state and local health officers, state and local epidemiologists, state and local laboratory directors, public information officers, epidemiologists, HAN coordinators, and clinician organizations##