


 Newsletter

July 9, 2020

No

69

Community Care Foster Family Home Program



Aloha CCFFH Operators,

Up to this point you needed to complete an Adverse Event form for any potential or confirmed COVID-19 exposure.

Starting today, please do **NOT** fill out an adverse event form. Instead, you **ARE** required to report all potential and confirmed COVID-19 cases using the attached new **COVID-19 Reporting Form**.

The first thing you are now being required to do when you become aware of any potential or confirmed case of COVID-19 is to report it to the Department of Health Disease Outbreak Division Reporting Line at **808-586-4586**. You will then fill out the new form and fax it to CTA.

You will also need to call all client's case management agencies.

The form can be found on the CTA website forms page. It is fillable and needs to be printed from the website.

<http://comties.com/HIforms/COVID-19%20Reporting%20Form.pdf>

Here is a picture of what it looks like. The form is a total of 3 pages.

COVID-19 Reporting Form


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ABOUT COMMUNITY TIES OF AMERICA, INC.

Community Ties of America, Inc. provides licensure and certification on behalf of the State of Hawaii, Office of Health Care Assurance

Our website address to find forms, information and helpful tools:

<http://comties.com/HIforms.html>

OHCA website for posted surveys

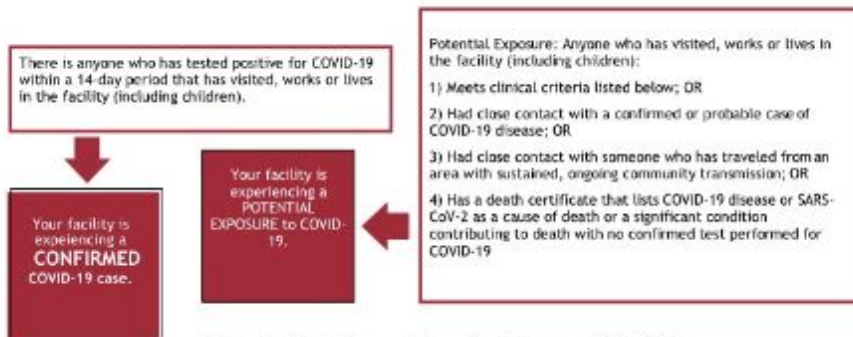
<http://health.hawaii.gov/ohca/inspection-reports/>

REPORTING COVID-19 CASES

To report a confirmed positive test case of COVID-19 you must immediately contact the Department of Health Disease Outbreak Control Division (DOCD), Disease Reporting Line at 808-586-4586.

To report a potential exposure and/or confirmed positive COVID-19 case, you must complete this form and send it via fax to CTA at 808-234-5470.

How to determine if your facility has a **Potential Exposure** or **Confirmed COVID-19 case**:



Clinical Criteria for reporting potential cases of COVID-19

The individual must have one of the following **AND** no alternative diagnosis that is more likely (an individual's physician needs to be contacted prior to completing a report form)

- At least two of the following symptoms: fever (measured or subjective (the person feels like they are running a fever even if it can't be measured as one), chills (with or without a fever), rigors (shivering and feeling cold followed by feeling warm), myalgia (muscle or body aches), headache, fatigue, sore throat, new loss of olfactory (smell) or taste, congestion or runny nose; Nausea or vomiting, or diarrhea.
-OR-
- At least one of the following symptoms: cough, shortness of breath, or difficulty breathing
-OR-
- Severe respiratory illness with at least one of the following:
 - Clinical or x-ray evidence of pneumonia, or
 - Acute respiratory distress syndrome (ARDS)

Note: Older adults may experience different symptoms, so facilities are encouraged to consult with that individual's physician. If COVID-19 is circulating locally, and several clients, students, caregivers and/or household members develop acute respiratory illness with a fever within a short period of time, COVID-19 should be suspected until proven otherwise.

Close Contact: defined by the Centers for Disease Control as someone who was within 6 feet of an infected person for at least 15 minutes starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to specimen collection) until the time that patient is isolated. Brief interactions are less likely to result in transmission, however, symptoms and the type of interaction (e.g., did the person cough directly into the face of the individual) remain important.

Factors to consider when defining close contact include proximity, the duration of exposure and whether the individual has symptoms.

CALL 911: Look for emergency warning signs and seek emergency medical care immediately if someone is showing any of the following signs

Trouble Breathing - Persistent pain or pressure in chest - New confusion - Inability to wake or stay awake - Bluish lips or face

COVID-19 Report Form

Date of report: <input type="checkbox"/> Initial report <input type="checkbox"/> Updated report		You must complete both pages of this form. If not applicable leave blank
Status (see definitions above; check only one): <input type="checkbox"/> Potential COVID-19 case <input type="checkbox"/> Confirmed COVID-19 case		
Facility Information (all CMAs, CCFPHs, ADCCs and NATCEP are facilities for reporting purposes)		
PCG, ADCC, CMA, NATCEP name on certificate:		Type of facility (check only one): <input type="checkbox"/> Case Management Agency <input type="checkbox"/> Adult Day Care Center <input type="checkbox"/> Community Care Foster Family Home <input type="checkbox"/> Nurse Aide Training and Competency Program
Address:		
City:	Zip:	
Client Information		
Client (people who are not staff, students, caregivers or household members at the facility)		
Number of clients in facility (census):		
Number of clients with respiratory illness (using outlined clinical criteria):		
Date first client became ill with respiratory symptoms:	Was there testing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Testing		
Number of clients tested for COVID-19:	Number of clients who tested positive for COVID-19:	
Date first COVID-19 positive client became ill:	Number of clients who have probable COVID-19 (not tested / test pending / negative test without alternate diagnosis):	
Number of client who tested negative for COVID-19:		
Number of clients tested for influenza:	Number of clients who tested positive for influenza:	
Number of clients tested for RSV:	Number of clients who tested positive for RSV:	
Number of clients tested for another respiratory illness (e.g., with other testing):	Number of clients who tested positive for another respiratory illness:	
What other illnesses were identified (if applicable)?		
Outcomes		
Number of hospitalized clients who tested positive for COVID-19:	Number of hospitalized clients with probable COVID-19 (not tested / test pending / negative test without alternate diagnosis):	
List where clients have been transferred:		
Number of deaths among clients who have tested positive for COVID-19:	Number of deaths among clients with probable COVID-19 (not tested / test pending / negative test without alternate diagnosis):	
DETAILS (You must provide all names of clients affected and their case management agencies. Describe what is being done for quarantine, isolation and infection control.) Use a separate piece of paper if necessary.		

COVID-19 Report Form

Staff (for reporting purposes this includes employees, students, caregivers, and household members (including children))	
Number of people that work/live at the facility:	
Number of these people with respiratory illness (using outlined clinical criteria):	
Date first person became ill:	
Ill with respiratory symptoms:	Was there testing? <input type="checkbox"/> Yes <input type="checkbox"/> No
Testing	
Number of staff tested for COVID-19:	Number of staff who tested positive for COVID-19:
Date first COVID-19 positive staff member became ill:	Number of staff who have probable COVID-19 (not tested/test pending/negative test without alternate diagnosis):
Number of staff who tested negative for COVID-19:	
Number of staff tested for influenza:	Number of staff who tested positive for influenza:
Number of staff tested for RSV:	Number of staff who tested positive for RSV:
Number of staff tested for another respiratory illness (e.g., with other testing):	Number of staff who tested positive for another respiratory illness:
What other illnesses were identified (if applicable)?	
Outcomes	
Number of hospitalized staff who tested positive for COVID-19:	Number of hospitalized staff with probable COVID-19 (not tested/test pending/negative test without alternate diagnosis):
List where staff have been transferred:	
Number of deaths among staff who have tested positive for COVID-19:	Number of deaths among staff with probable COVID-19 (not tested/test pending/negative test without alternate diagnosis):
DETAILS (provide any other information regarding staff exposure/illness including names of those affected, what is being done for quarantine, isolation and infection control). Use a separate piece of paper if necessary.	

Reporter Information	
Person reporting:	Title of person reporting:
Facility Name:	Agency phone:

Updated June 30, 2020

We appreciate your commitment and dedication to keeping everyone safe while continuing to provide quality care.

Mahalo,

Angel England, RN
Operations Manager



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