GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

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DEPARTMENT ON DISABILITY SERVICES
PROTOCOLS AND STRATEGIES FOR ACTION STEPS TO BE TAKEN
FOR PEOPLE WITH COVID-19 EXPOSURE OR DIAGNOSIS (INCLUDING PROVIDER STAFF)

The purpose of these protocols and strategies is to set forth the specific actions, applicable time periods, and staff to be utilized by the Department on Disability Services (DDS), and its Developmental Disabilities Administration (DDA) and Quality Assurance and Performance Management Administration (QAPMA), and the residential provider community, in addressing a person's close contact exposure to the novel coronavirus 2019 (COVID-19) or diagnosis with COVID-19 in the home setting and, where applicable, in the hospital setting. These protocols and strategies are premised on and require strict compliance with, at minimum, the following: Mayor's Order 2020-045 dated March 11, 2020 (Declaration of Public Emergency: Coronavirus (COVID-19)); Mayor's Order 2020-046 dated March 11, 2020 (Declaration of Public Health Emergency: Coronavirus (COVID-19)); Mayor's Order 2020-050 dated March 20, 2020 (Extensions of Public Emergency and Public Health Emergency: Coronavirus (COVID-19)); Mayor's Order 2020-054 dated March 30, 2020 (Stay at Home Order); Mayor's Order 2020-063 dated April 15, 2020 (Extensions of Public Emergency and Public Health Emergency and Measures to Protect Vulnerable Populations During the COVID-19 Public Health Emergency); and Mayor's Order 2020-066 dated May 13, 2020 (Extensions of Public Emergency and Public Health Emergency and Preparation for Washington, DC Reopening). Significant portions of these COVID-19 protocols and strategies are included in DDS Transmittal No. 20-01 dated April 24, 2020 (Protocols Required at All Residences and Facilities to Comply with Mayor's Order 2020-063), which outlines the minimum requirements necessary for residential providers to comply with the referenced Mayor's order at residential facilities and community-based residences, and serves as a DDS emergency policy until notified otherwise.

The intent of these COVID-19 protocols and strategies is to significantly slow the spread of COVID-19 for people supported by DDA and the staff who support them; to reduce COVID-19 virus infections, COVID-19 illness, and death caused by COVID-19 and its complications; and to protect the health, safety, and welfare of these District of Columbia residents, and the staff who support them in Washington, DC and the greater metropolitan area in the various residential settings and in their natural homes. DDS has developed these COVID-19 protocols and strategies to support the residential provider network, the staff who are in the homes, and the people they support during this global pandemic. These protocols and strategies include monitoring the health of the people we support who have been exposed or diagnosed with the virus, monitoring people who have had an exposure to someone who lives or works with them who have tested positive for the virus, and what must be happening in both the home and hospital settings in each of these circumstances. DDS will continue to develop resources and technical assistance to

provider nurses and direct support professionals (DSP) working to mitigate the spread of the virus. The strategies are multi-focal and are identified below.

PROTOCOLS AND STRATEGIES

These protocols and strategies are set forth primarily in the context of the residential setting and are designed in conjunction with the applicable Mayor's Orders, DC Health guidance, DDS policies and procedures, and DDS transmittals with the objective of helping to prevent, mitigate or address a person's COVID-19 close contact exposure or diagnosis. The action steps by both the residential provider and the DDS staff and consultants should be seen as cumulative. Communication by and among the various parties will be critical.

I. ROLES AND RESPONSIBILITIES OF DDS STAFF AND CONSULTANTS

DDS staff and consultants shall have the following roles and responsibilities in the agency's and the residential provider's response to COVID-19 close contact exposure or diagnosis:

Service Coordinators – The Service Coordinators will continue to amend ISPs, authorize services, and monitor ISP services according to the existing schedule. The Service Coordinators are responsible for communicating as needed with the assigned Nurse Practitioner to ensure supports are in place prior to discharge. The Service Coordinators are also expected to attend all discharge planning meetings. As set forth more fully herein, the Service Coordinators must consult with the DDS Deputy General Counsel in circumstances involving hospitalization where end-of-life planning, the withholding of medical interventions, or the hospital's ethics committee are involved. The Service Coordinators are responsible for communicating as needed with the assigned Nurse Consultant to ensure supports are in place post-hospitalization.

Nurse Consultants – The ten Nurse Consultants are responsible for communicating with their assigned residential provider nurses when a person or group of persons has been exposed to a housemate, staff, or others who have tested positive for COVID-19. The Nurse Consultants shall work to ensure that the provider staff are taking the most current DC Health guideline steps to mitigate the spread of the virus, monitoring the health of the people exposed, and reporting changes to the primary care physician (PCP) of record. The Nurse Consultants shall document in MCIS on a weekly basis for positive COVID-19 cases without hospitalization and for people who are being monitored for COVID-19 close contact exposure. The Nurse Consultants shall track positive COVID-19 cases until there are at least two negative tests more than 24 hours apart or the person has been cleared by their PCP as having recovered. The Nurse Consultants shall monitor COVID-19 close contact exposures for at least 14 to 21 days post-exposure and the person has shown no symptoms, or a long as is necessary relative to their pre-existing conditions or current state of health.

Quality Resource Specialists – The two Supervisory Quality Resource Specialists and twelve Quality Resource Specialists (QRS) are responsible for staying in near constant contact with their assigned residential providers and ensuring that providers have the resources and staffing necessary to adequately respond to the COVID-19 public health emergency and meet the person-centered needs of the people they support. In addition, the QRS teams are responsible for tracking and monitoring provider staff who are diagnosed with COVID-19 and their return to work. The QRS teams are responsible for assisting residential providers with mitigation strategies and working with the provider to modify staffing plans as needed. The QRS teams reach out to residential providers on at least a weekly basis to verify that they are complying with Mayor's Order 2020-063 and obtaining entrance and temperature logs on a weekly basis through upload into MCIS in provider documents. To the extent possible, consistent with current agency mandates regarding work in the community, the QRS teams are conducting environmental reviews of each residential provider by site. The QRS teams are performing virtual inspections of potential respite placements for people who may need to temporarily relocate for quarantine or other purposes.

Nurse Practitioners – If the person is hospitalized, one of two DDS Nurse Practitioners are assigned by one of the two Supervisory Community Health Nurses, who daily review the report of serious reportable incidents (SRIs), to follow up with the hospital staff and begin planning transition. The two Nurse Practitioners follow all people who are hospitalized and those who are in natural home settings who had been diagnosed with COVID-19 or had a close contact exposure to a person who has tested positive for the virus. The Nurse Practitioners must engage with hospital staff within one (1) business day of an admission and document all contacts with hospital staff, guardians, family members, Service Coordinators, and others. For a COVID-19 hospitalization, contact during the admission must occur daily and be documented for the first week and, thereafter, weekly and as needed. As set forth more fully herein, the Nurse Practitioners must consult with the DDS Deputy General Counsel and the Physician Consultant in circumstances involving hospitalization where end-of-life planning, the withholding of medical interventions, or the hospital's ethics committee are involved. Upon discharge, the Nurse Practitioners must engage the assigned Nurse Consultant for the follow-along post-hospitalization. This transition from the Nurse Practitioners to the Nurse Consultants must be documented in MCIS within two (2) business days.

Supervisory Community Health Nurses – The two Supervisory Community Health Nurses supervise the work of the two Nurse Practitioners and the ten Nurse Consultants. As indicated above, the Supervisory Community Health Nurses review the daily SRI report, make assignments, and follow all emergency inpatient hospitalizations. The Supervisory Community Health Nurses are responsible for communicating daily with the two Nurse Practitioners on all hospitalized cases of COVID-19, sharing findings with the DDA Deputy Director, and ensuring that support for tracking of these cases is documented in MCIS and the tracking log accordingly. The Supervisory Community Health Nurses shall coordinate with residential provider agency

nurses on COVID-19 testing of persons served, including serving as the point of contact for use of the Department of Forensic Services Public Health Laboratory.

Physician Consultant – The use of the Physician Consultant, Dr. Ernest Brown, is governed by the DDS REFERRAL PROTOCOL: Consulting for People with Complex Medical Needs and Transitioning from Hospitals and/or Long-Term Acute Care Facilities dated August 2, 2019, whereby the Service Coordinator, the Nurse Practitioner, a provider, or a person or his or her representative may seek a referral in ten identified circumstances. As it relates specifically to referrals for COVID-19 cases, the Physician Consultant shall be engaged for consultation where the person:

(a) is experiencing a change in status as an in-patient and requiring transfer to a higher intensity of service (*i.e.* to the Critical Care Unit or Intensive Care Unit);
(b) is experiencing an in-patient hospital stay with a length over two weeks;
(c) is experiencing a decline in function which impacts critical organ system, *e.g.*, cardio-vascular, etc.;
(d) is being admitted to hospice or being considered for hospice admission (and, for COVID-19 cases, for any discussions related to end-of-life planning);
(e) has conflicting recommendations by two or more specialists (in which circumstances, prior to referral, ensure that the PCP has been made aware and that there are continued concerns or delays in decision-making, or delays in interventions); or
(f) has medical needs, in the sole discretion of the DDA Deputy Director, that warrant a referral.

As set forth more fully herein, the Physician Consultant must consult with the DDS Deputy General Counsel in circumstances involving hospitalization where end-of-life planning, the withholding of medical interventions, or the hospital's ethics committee are involved.

Incident Management and Enforcement Unit – Residential providers are required to adhere to the requirements in DDS Transmittal No. 20-01 dated April 24, 2020, with respect to submitting reportable incidents (RIs) and serious reportable incidents (SRIs), as appropriate, to the Incident Management and Enforcement Unit (IMEU) to report COVID-19 close contact exposure and diagnoses as follows:

(a) Reportable Incident / COVID-19 (DDA Person): For a person served who has been diagnosed and tested positive (Non-Hospitalization). The description for this incident needs to be as detailed as possible and include names and relations of people that they have come in direct contact with if available. The description should also contain details regarding the notification to DC Health and the instructions given.
(b) Reportable Incident / COVID-19 (Person Exposed): For a person served who has been in direct contact with someone diagnosed (Non-Hospitalization) of person served. The

description for this incident needs to be as detailed as possible and include names and relations of people that they have come in direct contact with. The description should also contain details regarding the notification to DC Health and the instructions given. Please note that this category does not include staff that they have had contact with that have tested positive for COVID-19 (for which please see paragraph (c) below for how to enter those interactions).

(c) Reportable Incident / COVID-19 (Staff-Specific-ONLY): There are two RIs for staff. One is for staff with direct contact with people served and one is for staff without direct contact with people served as follows:

(1) For staff with direct contact with people served, and if a member of a provider's staff tests positive for COVID-19, or the member is alerted to or has strong suspicions that they have come into direct contact with someone who has COVID-19, then a separate RI should be entered for every person served that they are assigned to or have direct contact with. The RI description should be as detailed as possible but **must not** include the staff's name when reported.

(2) For staff without direct contact with people served, and if a member of a provider's staff tests positive for COVID-19 and they had no direct contact with the people supported, then you must select "Provider Staff (Internal) – COVID19" from the Person selection options to enter this incident. (This is a new category to only track staff with no contact with the people). You will then select REPORTABLE / COVID-19 (Staff Specific-ONLY). The RI description should be as detailed as possible and it **must not** include the staff's name, but the dates of diagnosis, and details regarding job assignments. There should also be indication if that person has come into direct contact with other staff.

(d) Serious Reportable Incident / COVID-19 (Person Supported - EIH) – An SRI for an emergency in-patient hospitalization (EIH) should be entered for anyone admitted to the hospital only when their primary reason for hospitalization is related to COVID-19. If they are admitted for any other reason (*e.g.*, heart failure not related to COVID-19, diabetic issues not related to COVID-19, trauma, kidney failure, etc.), but also test positive for COVID-19, then an SRI/EIH should be entered for the reason they are hospitalized not related to COVID-19 and then a separate RI should be entered for the same person indicating that they have been diagnosed with COVID-19, as required above.

Office of the General Counsel – The DDS Office of the General Counsel (specifically, the Deputy General Counsel or her designee) must be consulted by the Service Coordinator, the Nurse Practitioner, and the Physician Consultant for a person hospitalized with a COVID-19 diagnosis or suspected of having COVID-19 to the extent a hospital or other acute care facility engages the support team: (a) in any discussion about end-of-life planning; (b) where the withholding of life-saving or other medical interventions is being considered in the absence of an

advanced directive or contrary to the person's or their substitute decision-maker's wishes; or (c) in any discussion that involve the hospital's Ethics Committee (or similar committee).

II. COVID-19 PREVENTION IN THE RESIDENIAL SETTING

What action steps must be taken by residential providers and DDS staff and consultants to help slow the spread of COVID-19 for people supported by DDA and the staff who support them; to reduce COVID-19 virus infections, COVID-19 illness, and death caused by COVID-19 and its complications; and to protect the health, safety, and welfare of these District of Columbia residents, and the staff who support them in Washington, DC and the greater metropolitan area in the various residential settings and in their natural homes?

Residential Providers – DDS Transmittal No. 20-01 dated April 24, 2020 (Protocols Required at All Residences and Facilities to Comply with Mayor's Order 2020-063), outlines the minimum requirements necessary for residential providers to comply with Mayor's Order 2020-063 at residential facilities and community-based residences, and serves as a DDS emergency policy until notified otherwise. Residential providers are required to:

(a) implement exclusion and screening protocols for employees and essential visitors at each residence and facility;
(b) implement screening and quarantine or isolation instructions from DC Health at each residence and facility;
(c) implement, post, distribute, and share information found in DC Health guidance;
(d) ensure a clean environment at each residence and facility;
(e) continuously update their comprehensive emergency preparedness plans (CEPPs); and
(f) report COVID-19 infections and transmissions to IMEU as RIs or SRIs as appropriate.

DSPs and Qualified Developmental Disability Professionals (QDDPs) have daily contact with the people served and should be the eyes and ears for both the residential provider and DDS as we move forward together. Residential providers should continue to participate in the weekly provider forums held by DDS for additional up-to-date information and to share best practices with DDS and the provider community.

Requirement for Testing – Under current DC Health guidelines as of May 15, 2020, the following groups of people and staff are considered high priority for testing: (a) the people who we support or staff who are symptomatic; (b) the people we support who are in congregate settings and the staff who support them to the extent they have had a COVID-19 close contact exposure; and (c) the people we support who are at high risk (*i.e.* over 65 years of age or underlying chronic conditions) to the extent they have had a COVID-19 close contact exposure. DDS is requiring that anybody receiving DDA supports and services in these three groups **must**

be tested for COVID-19. Residential providers are responsible for ensuring that staff adhere to the requirements in Mayor's Order 2020-063 for testing and return to work.

Capability for Testing – DDS has been in daily communication with DC Health to ensure adequate testing capacity exists, to include forging a relationship with the Department of Forensic Services (DFS) Public Health Laboratory (PHL). The Health and Wellness Nurse Consultants conducted a survey of assigned providers to assess the ability of provider network nurses ability, willingness, and personal protective equipment (PPE) availability to obtain specimens using kits ordered from DFS, an understanding of the chain of custody of the specimens, and adequate storage capacity based on DFS requirements. Additionally, DDA has worked with the provider network to assess the capacity to use provider-based medical directors, primary care physicians (PCPs), and community-based resources to obtain specimens and testing. Working with DC Health, DDS has ensured that resources are developed that consider the unique needs of the DDA network.

DDS's Action Steps Per Roles and Responsibilities for COVID-19 Prevention – The Service Coordinators will continue to amend ISPs, authorize services, monitor ISP services according to the existing schedule, and have at least monthly contact. The Nurse Consultants will work to ensure that the provider staff are taking the most current DC Health guideline steps to prevent or mitigate the spread of the virus. The QRS teams are responsible for staying in near constant contact with their assigned residential providers and monitoring whether the providers have the resources and staffing necessary to adequately respond to the COVID-19 public health emergency and meet the person-centered needs of the people they support. The QRS teams will continue to reach out to residential providers on at least a weekly basis to verify that they are complying with Mayor's Order 2020-063 and obtaining entrance and temperature logs on a weekly basis through upload into MCIS in provider documents. To the extent possible, the QRS teams are conducting environmental reviews of each residential provider by site, consistent with DDS agency guidance regarding social distancing and community-based work. The QRS teams are performing virtual inspections of potential respite placements for people who may need to temporarily relocate for quarantine or other purposes.

Additional Resources – The DDS/DDA Nurse Educator has developed an online training that serves as a resource to all residential providers to ensure staff, including nurses and DSPs, have the latest information on mitigation and support to people served.

III. COVID-19 CLOSE CONTACT EXPOSURE IN THE RESIDENIAL SETTING

What additional action steps must the residential provider and DDS staff and consultants take to the extent that there is a COVID-19 close contact exposure in the facility or residence?

Residential Providers – The residential provider is required to report COVID-19 infection and transmissions to IMEU as RIs or SRIs as appropriate. Quarantine or isolation is indicated for anybody who has had a COVID-19 close contact exposure. A person with such an exposure should be treated with Universal Precautions and as if they have a positive COVID-19 diagnosis. Testing should be conducted as indicated above.

DDS's Action Steps Per Roles and Responsibilities to the Extent of COVID-19 Close Contact Exposure – Additional action steps by the Nurse Consultants must be taken to the extent of a COVID-19 close contact exposure. Specifically, the Nurse Consultants shall (a) document in MCIS on a weekly basis for people who are being monitored for a COVID-19 close contact exposure; (b) monitor COVID-19 close contact exposures for at least 14 to 21 days post-exposure and the person has shown no symptoms, or a long as is necessary relative to their pre-existing conditions or current state of health; and (c) track placements that have had an exposure from provider network staff, family members, or housemates/roommates diagnosed with COVID-19 and provide technical assistance on measures to isolate people who have tested positive and mitigate the spread of the virus. This information is shared with DDS leadership.

IV. COVID-19 DIAGNOSIS IN THE RESIDENTIAL SETTING

What additional action steps must the residential provider and DDS staff and consultants take to the extent there is a COVID-19 diagnosis in the facility or residence?

Residential Providers – The residential provider is required to report COVID-19 infection and transmissions to IMEU as RIs or SRIs as appropriate. Quarantine or isolation is indicated for anybody who has had a COVID-19 close contact exposure or diagnosis. Testing should be conducted as indicated above. The residential provider must follow DC Health guidance in terms of appropriate medical next steps for the person, as well as all steps necessary to limit any transmission of the virus to other residents or staff in the home

DDS's Action Steps Per Roles and Responsibilities to the Extent of a COVID-19 Diagnosis – The following additional action steps must be taken by the Nurse Consultants and the QRS team to the extent of a COVID-19 diagnosis. The Nurse Consultants shall (a) document in MCIS on a weekly basis for positive COVID-19 cases without hospitalization and for people who are being monitored for a COVID-19 close contact exposure; and (b) shall track positive COVID-19 cases until there are at least two negative tests more than 24 hours apart or the person has been cleared by their PCP as having recovered. The Nurse Consultants also provide technical assistance on measures providers must take to isolate people who have tested positive and mitigate the spread of the virus. The QRS teams are responsible for (a) tracking and monitoring provider staff who are diagnosed with COVID-19 and their return to work; and (b) assisting residential providers with mitigation strategies and working with the provider to modify staffing plans as needed. The QRS teams are reaching out to the provider network assessing

need for PPE, tracking staff exposed or testing positive for the virus, and tracking needs as reported. All of this information is shared with DDS leadership.

V. COVID-19 HOSPITALIZATION

What additional action steps must the residential provider and DDS staff and consultants take to the extent there is a COVID-19 hospitalization?

Residential Providers – The residential provider is required to report COVID-19 infection, transmissions, and hospitalizations to IMEU as RIs or SRIs as appropriate. Residential providers are reminded that a person's DSP may be authorized to provide necessary supports in the hospital setting during the COVID-19 under the approved Appendix K. To the extent there are issues with the hospital, they should be reported through the Service Coordinator and the Nurse Practitioner, and if necessary, brought to the attention of the DDS Office of the General Counsel for assistance.

DDS's Action Steps Per Roles and Responsibilities to the Extent of COVID-19 Hospitalization – The following additional action steps must be taken by DDS staff and consultants to the extent of a COVID-19 hospitalization:

(a) ***Service Coordinators*** – The Service Coordinators are responsible for communicating as needed with the assigned Nurse Practitioner to ensure supports are in place prior to discharge as well as attendance at all discharge planning meetings. The Service Coordinators must consult with the DDS Deputy General Counsel in circumstances involving hospitalization where end-of-life planning, the withholding of medical interventions, or the hospital's ethics committee are involved.

(b) ***Nurse Practitioners*** – To the extent the person is hospitalized, there is a referral to one of two DDS Nurse Practitioners to follow up with the hospital staff and begin planning transition. The two Nurse Practitioners follow all people who are hospitalized and those who are in natural home settings who have been diagnosed with COVID-19 or had a close contact exposure to a person who has tested positive for the virus. The Nurse Practitioners must engage with hospital staff within one (1) business day of an admission and document all contacts with hospital staff, guardians, family members, Service Coordinators, and others. For a COVID-19 hospitalization, contact during admission must occur daily and be documented during the first week and, thereafter, weekly and as needed. The Nurse Practitioners must consult with the DDS Deputy General Counsel and the Physician Consultant in circumstances involving hospitalization where end-of-life planning, the withholding of medical interventions, or the hospital's ethics committee are involved.

(c) ***Supervisory Community Health Nurses –*** The two Supervisory Community Health Nurses supervise the work of the two Nurse Practitioners and the ten Nurse Consultants.

The Supervisory Community Health Nurses review the daily SRI report, make assignments, and follow all emergency inpatient hospitalizations. The Supervisory Community Health Nurses are responsible for communicating daily with the two Nurse Practitioners on all hospitalized cases of COVID-19, sharing findings with the DDA Deputy Director, and ensuring that support for tracking of these cases is documented in MCIS and the tracking log accordingly. The Supervisory Community Health Nurses shall coordinate with residential provider agency nurses on COVID-19 testing of persons served, including serving as the point of contact for use of the Department of Forensic Services Public Health Laboratory.

(d) ***Physician Consultant*** – The use of the Physician Consultant, Dr. Ernest Brown, is governed by the DDS REFERRAL PROTOCOL: Consulting for People with Complex Medical Needs and Transitioning from Hospitals and/or Long-Term Acute Care Facilities dated August 2, 2019, and the Service Coordinator, the Nurse Practitioner, the residential provider, and the person or his or her representative may seek a referral in those ten circumstances. As it relates specifically to referrals for COVID-19 cases, the Physician Consultant shall be engaged for consultation where the person meets any of the six circumstances identified above. The Physician Consultant must consult with the DDS Deputy General Counsel in circumstances involving hospitalization where end-of-life planning, the withholding of medical interventions, or the hospital's ethics committee are involved.

(e) ***Office of the General Counsel*** – The Deputy General Counsel or her designee shall consult with the Service Coordinator, the Nurse Practitioner, and the Physician Consultant for a person hospitalized with a COVID-19 diagnosis or suspected of having COVID-19 to the extent a hospital or other acute care facility engages the support team in discussion about end-of-life planning, the withholding of medical interventions, or discussions with the hospital's ethics committee as more fully described above.

VI. COVID-19 POST-HOSPITALIZATION

What additional action steps must the residential provider and DDS staff and consultants take to the extent there of COVID-19 post-hospitalization?

Residential Providers – Residential providers are reminded that a person must be permitted to return to the residential setting post-hospitalization consistent with Mayor's Order 2020-063 and DDS Transmittal 20-01. To the extent there are any issues with returning the person to the residential setting post-hospitalization (*e.g.*, lack of adequate facilities to ensure appropriate infection control in the setting), they should be reported through the Service Coordinator and the Nurse Practitioner.

DDS's Action Steps Per Roles and Responsibilities to the extent of COVID-19 Post-Hospitalization – The following additional action steps must be taken by DDS staff and consultants to the extent of COVID-19 post-hospitalization:

(a) ***Service Coordinators*** – The Service Coordinators are responsible for communicating as needed with the assigned Nurse Practitioner to ensure supports are in place prior to discharge as well as attendance at all discharge planning meetings. The Service Coordinators are responsible for communicating as needed with the assigned Nurse Consultant to ensure supports are in place post-hospitalization.

(b) ***Nurse Consultants*** – The Nurse Consultants shall document in MCIS on a weekly basis for positive COVID-19 cases without hospitalization and for people who are being monitored for a COVID-19 close contact exposure. The Nurse Consultants shall track positive COVID-19 cases until there are at least two negative tests more than 24 hours apart or the person has been cleared by their PCP as having recovered.

(c) ***Nurse Practitioners*** – Upon discharge, the Nurse Practitioners must engage the assigned Nurse Consultant for the follow-along post-hospitalization. This hand-off from the Nurse Practitioners to the Nurse Consultants must be documented in MCIS within two (2) business days.

(d) ***Supervisory Community Health Nurses*** – The Supervisory Community Health Nurses supervise the work of the Nurse Practitioners and the Nurse Consultants. The Supervisory Community Health Nurses are responsible for communicating daily with the two Nurse Practitioners on all hospitalized cases of COVID-19, sharing findings with the DDA Deputy Director, and ensuring that support for tracking of these cases is documented in MCIS and the tracking log accordingly.

VII. ENFORCEMENT

DDS will enforce these protocols and strategies as indicated through frequent compliance checks and other mechanisms conducted by the Service Coordination and Planning Division, the Health and Wellness Unit, the QRS team, and the Incident Management and Enforcement Unit. Failure to comply with any of these provisions may result in the issuance of DDA provider sanctions against residential provider agencies. Please note that Mayor's Order 2020-063 specifically states that knowing violations of the Order may subject the individual or entity to civil, criminal, and administrative penalties authorized by law. Individuals are requested to call 311 to report any suspected violations of any Mayor's Order related to the COVID-19 public health emergency.