HAWAI'I COVID-19 PUBLIC HEALTH RECOVERY TASK FORCE

Summary Report

May 15, 2020

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- Dr. Tarquin Collis, Kaiser Permanente
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- Dr. Sarah Park, DOH
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- Mark Wasielewski, Diagnostic Laboratory Services (DLS)
- Dr. Brian Wu, HMSA

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- Lieutenant Colonel Jonathan Ishikawa, Hawaii Army National Guard
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Consultants

Karen Smith, MD, MPH – former director of the California Department of Public Health. She is currently participating in Santa Clara County's COVID-19 response and recovery efforts.

Boston Consulting Group – BCG is a leading business strategy advisor currently assisting California, New York, Washington, and Massachusetts in developing COVID-19 recovery plans.

Introduction

Aloha.

As representatives of Hawai'i's government, business, healthcare, and non-profit sectors, we understand the immediate health risks caused by COVID-19, as well as the long-term economic impacts it will cause. When we talk about reopening our state, we understand the risks of reopening too quickly, but also the negative effects of waiting too long.

That's why we've all been working together as part of this public-private partnership, with experts in every sector, especially our health system partners, to get it right. The partnership's recovery plan uses scientific evidence and draws on best practices from around the world.

This will inform us when to phase out some restrictions, what each sector must do to reopen safely, and how to prepare us for any new surge of infection.

This requires a unified strategy, and a solid infrastructure for screening, testing, tracing, and quarantine, as well as Personal Protective Equipment (PPE) and other supplies required to keep our state safe.

We look forward to the discussion to finalize our plans to bring our economy back while ensuring protection of Hawai'i's public health.

We believe that working together under a strong, transparent, and unified strategy we can restore our island home to health and economic well-being.

Mahalo.

– ***Hawai'i COVID-19 Public Health Recovery Task Force***
May 15, 2020

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Purpose of this Summary

This document is the culmination of the Hawai'i COVID-19 Public Health Recovery Task Force ("Task Force") efforts and serves as a point-in-time reference for the Task Force outcomes.

Background and Overview

The House Select Committee on COVID-19 Economic and Financial Preparedness ("House Select Committee") was established (per House Resolution 54) to work with representatives from local and state government, private industry, and nonprofit agencies and organizations to inform the House of Representatives on the State's economic and financial preparedness through the COVID-19 pandemic. The House Select Committee is tasked with examining economic and financial issues including:

1) Identifying the potential economic and financial impact to the State;
2) Developing short-term and long-term mitigation plans; and
3) Monitoring COVID-19 conditions and outcomes.

Through the leadership of The House Select Committee's co-chairs House Speaker Scott Saiki and Peter Ho, the Hawai'i COVID-19 Public Health Recovery Task Force ("Task Force") was formed as a public-private partnership for the singular purpose of safeguarding the well being – health and livelihoods – of our community deeply affected by the COVID-19 pandemic.

The Task Force convened over a four-week period with the vision of a statewide public health framework and a strong disease containment infrastructure to support a carefully planned economic recovery.

Task Force Statement of Purpose

The Hawai'i COVID-19 Public Health Recovery Task Force is a coalition of leaders and organizations from government, business, healthcare, and nonprofit sectors. It also includes health advisers from across the islands and the U.S. mainland.

The Task Force's purpose is to generate a strategic, unified, and evidence-based approach to measure and manage a phased recovery to a "new normal" as Hawai'i faces the unprecedented challenge of COVID-19.

To help ensure public transparency and confidence in the effort, an alert model of clear, concise, and multi-dimensional measures and responses will be maintained to help everyone stay apprised of community health status.

We will work together to provide public and private leaders throughout the state with scientifically supported data and relevant medical perspectives to ensure public health and community well being.

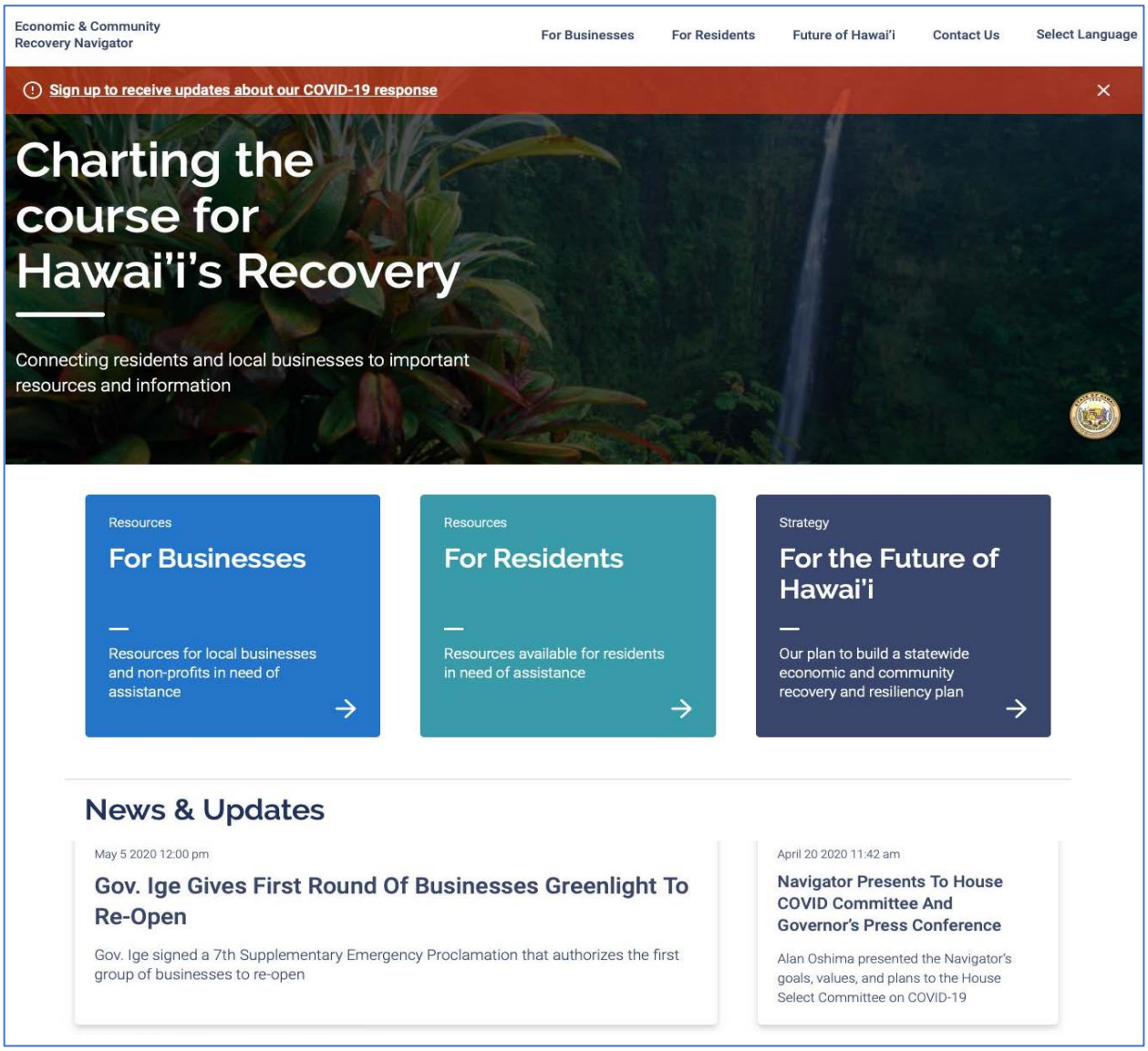
Coordination and Alignment

Significant coordination among Task Force members and organizations led to alignment of purpose, activities, and outcomes.

Reopening Hawai‘i’s Economy

The Task Force’s work informs the Hawai‘i Economic and Community Recovery & Resiliency Plan led by Governor David Ige, Major General Kenneth Hara, and Navigator Alan Oshima. This Plan will provide Hawai‘i’s businesses and residents clear and specific guidelines and dates to safely reopen the kama‘āina economy and visitor industry.

The Economic & Community Recovery Navigator’s website has available resources for residents and local businesses. Included in the business section are sample reopening guidelines for approximately 15 industry sectors.

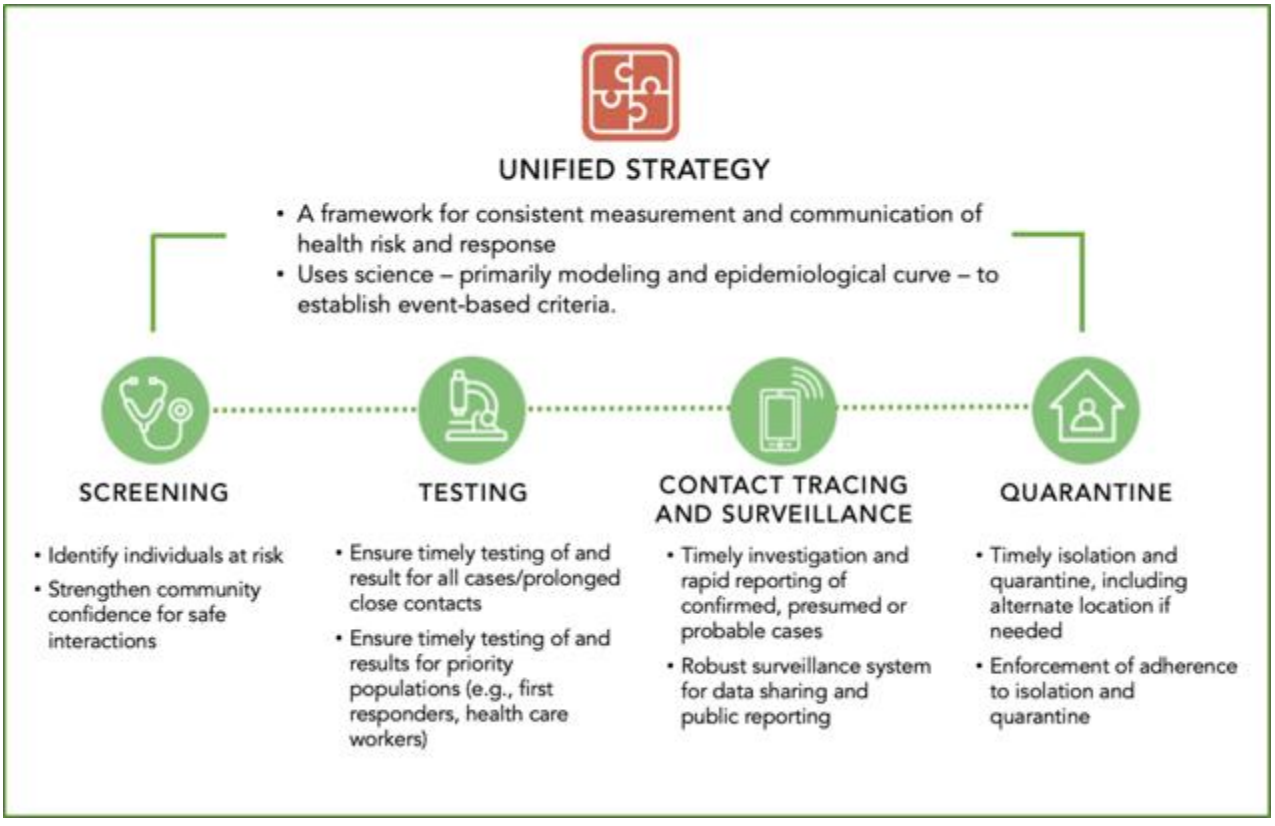


Homepage of Navigator website.

Task Force Approach

The Task Force's effort focused on three major areas:

1. **A unified strategy** – required to bridge public health determinants with individual and economic responses. This is a foundational step to reopening sectors of the Hawai'i economy.
2. **A strong public health infrastructure** – to effectively support a unified strategy and ensure disease containment. To that end, four pillars of public health are: Screening, Testing, Contact Tracing and Surveillance, and Quarantine. Each function requires additional support of people, process, technology, and funding.
3. **Clarity and effective coordination and communication of a unified strategy** – important for public understanding, trust, and confidence. State and county decisions are reached in the best interest of community well-being, and are coordinated, timely, and balanced – health and safety with economic viability.

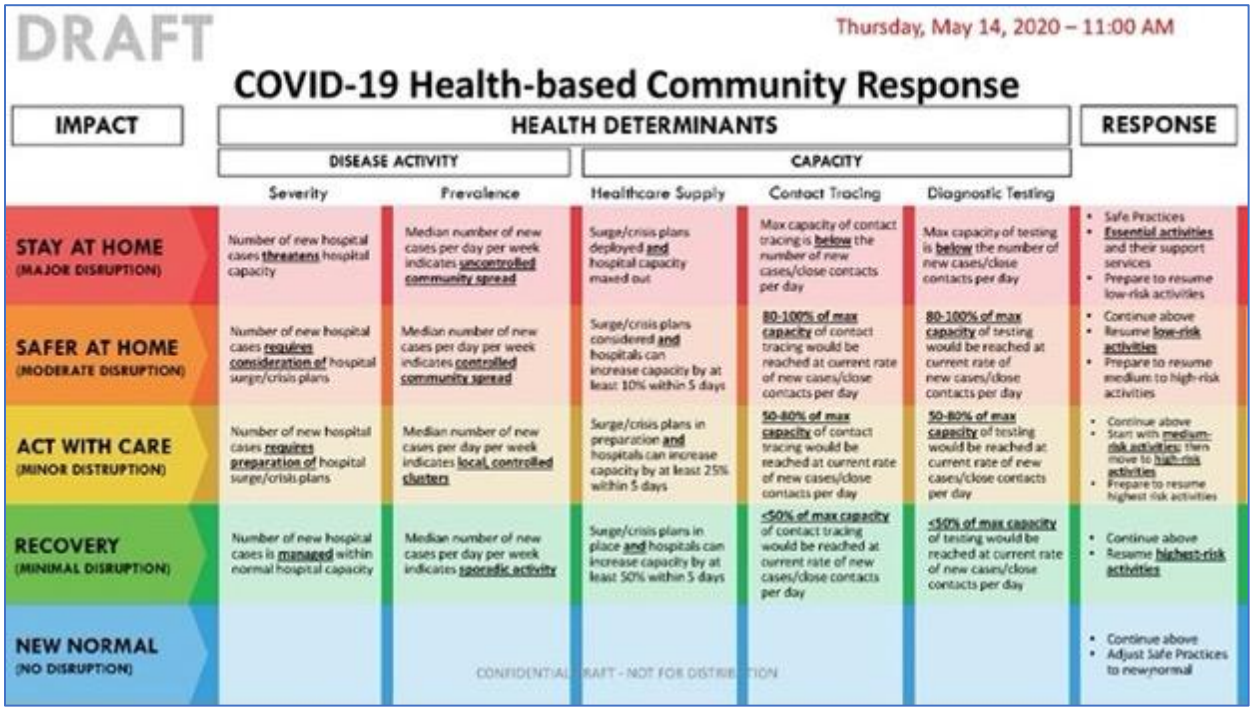


Unified Strategy

The Unified Strategy is illustrated in a framework designed to protect public health, with corresponding responses to individual responsibility and economic activity (i.e., social restrictions, business protocols, etc.). The goal is to use science, data and epidemiological modeling, and event-based criteria to measure health risk at the state and county levels. The color-coded guidance is based on New Zealand's COVID-19 Alert Level model (See New Zealand COVID-19 Alert Levels in appendix.) Other invaluable resources including the National Governors Association *State-By-State Summary of Public Health Criteria in Reopening Plans,* and *Utah Leads Together, Plan for a Health and Economic Recovery*.

The Unified Strategy Team developed a proposed Alert Model and shared valuable insights from their industry point of view (see appendix). Their endorsement of the first version of the model led to extensive collaboration with members of the Governor's office, County Mayors, officials from Hawaii Emergency Management Agency (HI-EMA), the Hawaii Economic and Community Recovery and Resiliency Navigator, State Department of Health, and the State Disaster Recovery Coordinator.

Following an iterative process and multiple draft version, this collaboration resulted in the final version below, approved by Governor Ige on May 14. It is planned for later public release.



DRAFT

Thursday, May 14, 2020 – 11:00 AM

COVID-19 Health-based Community Response

IMPACT	HEALTH DETERMINANTS					RESPONSE
	DISEASE ACTIVITY		CAPACITY			
	Severity	Prevalence	Healthcare Supply	Contact Tracing	Diagnostic Testing	
STAY AT HOME (MAJOR DISRUPTION)	Number of new hospital cases **threatens** hospital capacity	Median number of new cases per day per week indicates **uncontrolled community spread**	Surge/crisis plans deployed **and** hospital capacity maxed out	Max capacity of contact tracing is **below** the number of new cases/close contacts per day	Max capacity of testing is **below** the number of new cases/close contacts per day	• Safe Practices • **Essential activities** and their support services • Prepare to resume low-risk activities
SAFER AT HOME (MODERATE DISRUPTION)	Number of new hospital cases **requires consideration of** hospital surge/crisis plans	Median number of new cases per day per week indicates **controlled community spread**	Surge/crisis plans considered **and** hospitals can increase capacity by at least 10% within 5 days	**80-100% of max capacity** of contact tracing would be reached at current rate of new cases/close contacts per day	**80-100% of max capacity** of testing would be reached at current rate of new cases/close contacts per day	• Continue above • Resume **low-risk activities** • Prepare to resume medium to high-risk activities
ACT WITH CARE (MINOR DISTRUPTION)	Number of new hospital cases **requires preparation of** hospital surge/crisis plans	Median number of new cases per day per week indicates **local, controlled clusters**	Surge/crisis plans in preparation **and** hospitals can increase capacity by at least 25% within 5 days	**50-80% of max capacity** of contact tracing would be reached at current rate of new cases/close contacts per day	**50-80% of max capacity** of testing would be reached at current rate of new cases/close contacts per day	• Continue above • Start with **medium-risk activities**; then move to **high-risk activities** • Prepare to resume highest risk activities
RECOVERY (MINIMAL DISRUPTION)	Number of new hospital cases is **managed** within normal hospital capacity	Median number of new cases per day per week indicates **sporadic activity**	Surge/crisis plans in place **and** hospitals can increase capacity by at least 50% within 5 days	**<50% of max capacity** of contact tracing would be reached at current rate of new cases/close contacts per day	**<50% of max capacity** of testing would be reached at current rate of new cases/close contacts per day	• Continue above • Resume **highest-risk activities**
NEW NORMAL (NO DISRUPTION)						• Continue above • Adjust Safe Practices to newnormal

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Implementation

In implementing this framework, the Governor of the State of Hawai'i and County Mayors will provide specific direction to residents and businesses through the COVID-19 alert levels and response. Each level is color-coded and guided by rigorous measurement and evaluation of current conditions so policymakers can clearly determine health risk, when to move to a different level under appropriate circumstances, and consider the impact to economic viability and social indicators (i.e. incidences of suicide, domestic violence and mental health service requests). The measures below are taken collectively, to provide focus and discipline to make the right decisions that yield the most benefit.

Each level protects public health and drives the response for individual responsibility and economic activity as outlined in the *Hawai'i Economic and Community Recovery & Resiliency Plan*, in coordination with HI-EMA and County Mayors. With constant (daily) monitoring, escalating risk requires a 48-72-hour public notification; de-escalating risk requires a 10-14-day transition period. Communication and transparency of levels will bolster confidence that community well-being (health and economic viability) is safeguarded.

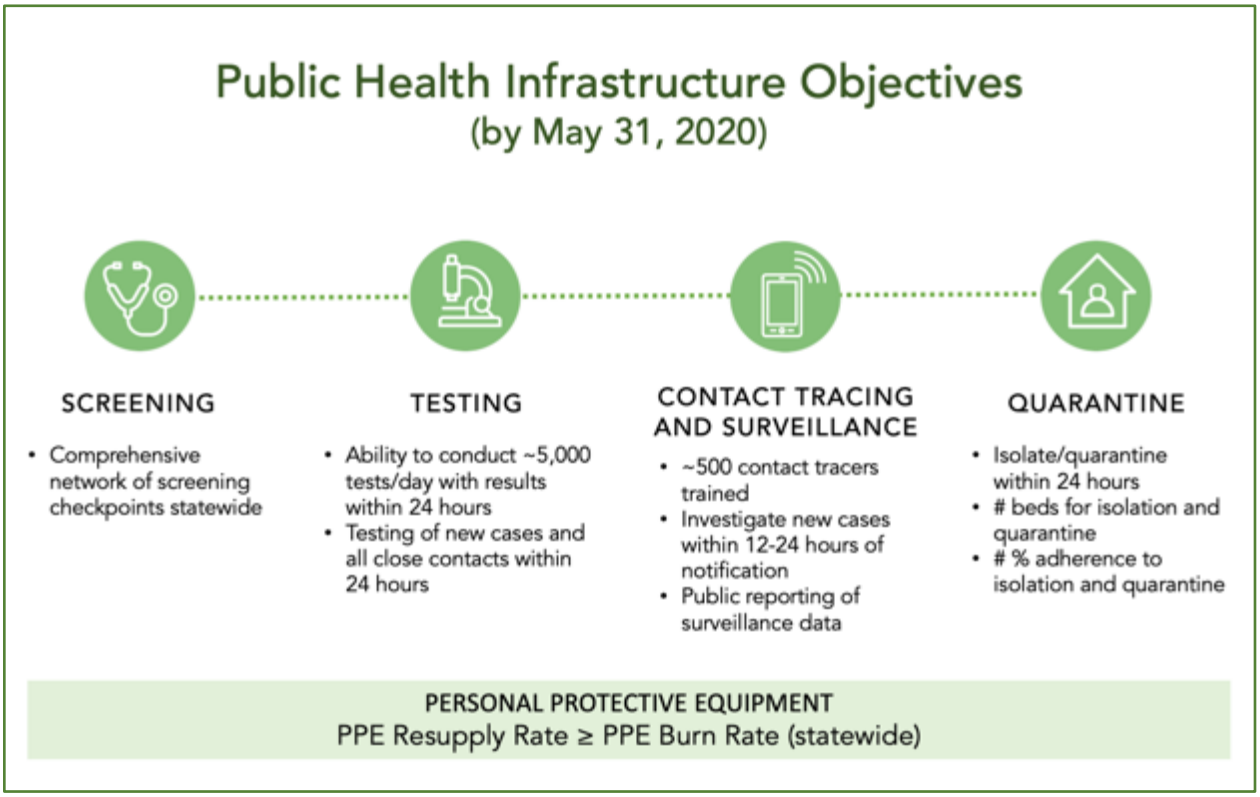
Relevant Data Points:

MEASUREMENT		**RESOURCES**
Disease Activity	Severity	Healthcare Association of Hawaii (HAH) and Hospitals
	Prevalence	Department of Health (DOH)
Capacity	Healthcare Supply	HAH and Hospitals
	Contact Tracing	DOH, HI-EMA
	Diagnostic Testing	State and Private Labs
Response	Personal and Economic Activities	Economic Recovery and Resilience Navigator HI-EMA Adjutant General Key Stakeholders

Definitions and data points for each group of measures in the framework, as well as a sample dashboard are provided in the appendix.

Public Health Infrastructure Objectives

To help ensure that Hawai'i is prepared to reopen and remain open, the Task Force established key objectives for a strong public health infrastructure to enable disease containment: Screening, Testing, Contact Tracing and Surveillance, and Quarantine. This infrastructure requires an adequate supply of medical resources, PPE, as well as staff and funding.



Each component of the infrastructure was led by a designated coordinator and committee. Committee members are subject matter experts and industry leaders who participated in the development of workplans to enable successful implementation.

A summary of the Unified Strategy and Public Health Infrastructure Committee reports are provided in the following section.

Committee Conclusions and Recommendations

This series of reports are from the working meetings of the Unified Work Team, Screening, Testing, Contact Tracing and Surveillance, and Quarantine Work Groups, as of May 9, 2020.

Unified Strategy Work Group Report

Objective

To provide framework for consistent measurement and communication of health risk and response based on thoughtful, evidence-based approach, combined with knowledge of industry risks and best practices.

Meeting & Feedback Summary

- Overall, **positive endorsement** from the participants. **Uniform levels** of reopening are essential, with county-level application.
- Framework should be **clear, simple, easy to understand** and in **layman's terms.** Consistent communication is critical for public understanding and trust.
- **Reinforce** the careful, stepwise approach between levels.
- **Businesses need to know the plan, with lead time** to prepare for reopening.
- Small business is the backbone of our economy. **Rapid implementation** of a plan is critical.
- **Inter-dependencies** among industries are an important consideration.
- DOH affirmed **contact tracing is sufficient**. Acknowledged the need to work on surveillance. Current rate of testing is 1,000/day, with capacity to do more.
- Concern over **readiness and scaling up** of public health capacity with increase in passenger arrivals.
- Consider challenges for county specific Alert Levels for businesses that operate statewide.

For Discussion and Resolution

- Agreement on, and adoption of a statewide, unified strategy for measurement of health risk and response. This strategy is based on the premise of reopening the Hawaii economy, through the effective containment (rather than elimination) COVID-19.
- Enable coordinated and well-communicated implementation.
- Consensus on level of transparency of public health determinants.
- Focus on strengthening the public health infrastructure.

Alert Model Framework

An Alert Model framework was proposed by the Unified Strategy Team for consideration by the other state organizations. It is included in the Appendix.

Screening Work Group Report

Overview

Screening efforts are critical to help identify those who have potentially been exposed to or infected by COVID-19, even if they are showing no symptoms. Screening may include questionnaires, temperature checks or other non-invasive methods.

If those infected are showing symptoms, it's important to get them immediate testing and care, and prevent them from entering or re-entering the larger population, whether that's a workforce, community or even the state itself.

Public awareness is critical to this step to help identify individuals who should be screened, and to motivate them to voluntarily request testing and other services. We also need to make plans for large-scale screening checkpoints in key locations such as airports, harbors or stadiums. This will require ramp-up to address staffing needs, PPE supplies, other medical equipment, and transport. It may also require the creation of a database or other tools to maintain and appropriately share screening information.

Goals

While unknown, but likely, a large portion of our population has had known contact with a confirmed or probable case, which means the risk factor for transmission remains high. Knowing that the presence of the virus will continue to exist in our community for the foreseeable future, it is important to provide reasonable safety measures that are balanced in their approach of public health and community recovery.

The strength of screening is increased vigilance, raising awareness, serving as a triage tool, and providing community comfort. As such, the goals for screening include:

- Prevent those who likely have COVID-19 from entering public areas and identify them at the earliest point at which they've entered the public domain
- Identify symptomatic individuals and those with recent contact with confirmed or probable cases of COVID-19 so they can be tested and placed in isolation or quarantine as appropriate (for those not captured through contact tracing or other methods of identification)
- Raise awareness within the community
- Data source for early identification of hot spots and contact tracing

Objectives

- Questionnaire: By MM/DD/YY, establish a set of standardized questionnaires that can be utilized in different settings based on risk, foot traffic, etc. Questionnaires can be deployed

through different modalities; written, verbal, etc. Utilization can occur at checkpoints, online, or at a place of business.

- Screening Sites: By MM/DD/YY, establish a network of screening stations so that a person leaving their home or accommodation is highly likely to pass through a screening point every 1-3 days. Guidelines will be developed for screening plans correlated to the appropriate alert level and for specific industries, such as reduction of entry points for office buildings and/or thermal temperature tracking for all arrivals at a port of entry. Additionally, screening processes will be variable based on the type, size, and reasonable deployment, so as not to unreasonably impact any entity or person. Screening stations would coordinate with the appropriate government agencies to provide information for enforcement and medical services.
- Workflow Integration: By MM/DD/YY, establish process to integrate with other workstreams to help transition patients/data that can assist their efforts. Examples would be co-location of a screening station with a testing station, so that anyone screened and found to be symptomatic may proceed directly to testing. Contact tracing and surveillance could then be available to immediately intake information for their respective efforts.

Meeting & Feedback Summary

- **High level of engagement** among participants, with interest on implementation.
- **Establish a baseline** of what screening is and when it is necessary. Screening should happen in high contact areas. Industry-specific guidance is already released and being followed.
- Expressed need for a **network of screening checkpoints** that can capture a vast majority of population movement.
- Question whether screening is **mandated or whether a softer touch** is more effective.
- Consider the cost/benefit of implementing screening. It is especially difficult for small businesses as extra staffing will likely be required.
- Consider **additional time and staff** needed to sanitize areas
- Assume the burden will be on small businesses; and question the **role of public health**/DOH function. DOH considers screening of low value in relation to other public health functions.
- Concern on PPE as **supplies are limited and expensive,** support will be needed for businesses required to screen.
- Question what is **realistic** to implement in a short amount of time.
- Concern over **liability and protection** for businesses. They are not health professionals.
- AlohaTrace.org is a technology platform to enable implementation.
- There is no process and database system in place to **support monitoring and enforcement of incoming arrivals,** including clearance of exempt travelers (e.g. off-island construction workers on assignment)

Agreed to by the Work Group

- All the Areas of Work were directionally correct, and no areas were missing.

For Discussion and Resolution

- Mandate general public health measures and basic pre-entry requirements be posted in all public establishments.
- Screening is a safety protocol to enhance public confidence. This step should be coordinated with DOH and not considered a low-value activity. Processes and systems are required for effective screening, monitoring and enforcement.
- Places of public interaction can manage contact intensity within their space to ensure safety, balanced with practical implementation. Industries can adopt/adapt guidance on health and safety criteria published by the CDC, with support from DOH.
- Consider defining criteria for screening points on airports, malls/shopping centers with daily visitors greater than "X", attractions/public places with daily visitors greater than "X", restaurants with greater than "X" seats, schools/universities with daily attendance greater than "X".
- Financial support is required to implement screening protocols in high-contact intensity industries.
- Enable coordinated and well-communicated implementation.

Testing Work Group

Overview

Testing is a cornerstone of response to the threat of COVID-19. Our recommended approach is therefore wide- and far-reaching.

Specific objectives of tests-per-day will be established in each of these areas to ensure comprehensiveness and success.

Other key steps include assessing current testing capabilities, determining specific testing goals, identifying test locations and partners, expediting test results, and gathering all data to monitor progress and optimize ongoing efforts.

Testing Goals

To prevent transmission of COVID-19 in the community by:

- Identifying cases of COVID-19 by testing all individuals with symptoms consistent with COVID-19 infection
- Ensuring all first responders, healthcare workers, and those seeking health care receive the recommended number of diagnostic testing (i.e., may be more than one test) in a timely manner
- Ensuring rapid and comprehensive testing for any identified clusters of cases (e.g., dormitories) or outbreaks
- Conducting broad, community-based surveillance testing of non-symptomatic individuals, particularly once serologic testing becomes more widely available

Testing Objective

- By MM/DD/YY, the expected testing capacity with a turnaround of 24 hours for results is approximately 4,875 tests per day (DLS 1,700 tests per day, Clinical Labs 2,425 tests per day, Kaiser 750 tests per day).

Meeting & Feedback Summary

- DOH direction: CDC guidelines should be what clinicians follow, rather than a workplan. Clinical guidance dictates who is tested, rather than a target number. Number of tests conducted should be in relation to the amount of disease we have.
- DOH has outlined clinical programs, surveillance programs, public health assessments for purposes of federal funding and grant requests.
- Test accuracy of 90% is not sufficient. **Predictive values would be a better target.**
- DLS update:
    - Currently below 50% of capacity. Capability to support a surge up to 1,500 tests per day.
    - Need to develop **criteria for using tests in the screening process for elective procedures**.
    - Population is demanding serology tests.
    - In a surge, expect a supply allocation based on need.
- Clinical Labs – agree with DLS, and
    - Going live with ITG on 4/30/20. Public can choose to take it (self-pay).
- Secure necessary supplies (reagents, swabs) to meet demand at Level 4/Red.

Agreed to by the Work Group

- By May 15, 2020, the expected testing capacity with a turnaround of 24 hours for results is approximately 4,875 tests per day (DLS 1,700 tests per day, Clinical Labs 2,425 tests per day, Kaiser 750 tests per day).
- All the Areas of Work were directionally correct, and no areas were missing.

For Discussion and Resolution:

The Work Group was not able to come to a consensus on whether asymptomatic people should have a PCR test done:

- Some on the committee believe that testing all asymptomatic close contacts and all those arriving from COVID epicenters are beneficial since stopping the transmission of even just one person is important due to the highly contagious nature of the disease. In particular, testing asymptomatic close contacts is preferable to only isolating them because early identification of another new case would trigger contact tracing of that person's close contacts and ensure quicker containment. Testing asymptomatic people is currently being done by Hawaii hospitals for admitted patients, being done in California and Utah, recommended by national experts (Dr. Zeke Emmanuel and former CDC Director Tom Frieden), and suggested should done on April 8th by Lt. Gov Josh Green. In addition the CDC does allow testing of "persons without symptoms who are prioritized by health departments or clinicians, for any reason, including but not limited to: public health monitoring, sentinel surveillance or screening of other asymptomatic individuals according to state and local plans".
- DOH and other committee members do not believe we should test asymptomatic people, even close contacts of confirmed cases or those arriving from COVID epicenters, since CDC only allows testing of persons without symptoms if prioritized by health departments or clinicians.

(URLs for noted hyperlinks above can be found in the Appendix.)

Task Force Leadership Recommendation:

- Since the last meeting of the Testing Committee, we've reached an agreement on nearly all issues raised in the Task Force sub-committees.
- The key exceptions are within the Testing Sub-Committee, where there is disagreement on 1) whether to test all asymptomatic close contacts of COVID-19 positive patients, and 2) testing arriving passengers from epicenters of COVID-19 where there is wide community spread.
- Based on agreement by the majority of the Task Force Leadership, it is **strongly recommended that we test all asymptomatic close contacts of COVID-19 positive patients and test arriving passengers from epicenters of COVID-19 where there is wide community spread.**

Contact Tracing & Surveillance Work Group

Overview

Contact Tracing and Surveillance are related – yet distinct – efforts important to addressing the threat and spread of COVID-19.

Contact Tracing follows specific infections of individuals, any close contact with others, and further outreach to those contacts. Those who may have been exposed may need to be interviewed, tested, and considered for further monitoring to help mitigate wider spread of the disease. This effort requires focused investigation of each case, as well as identifying those who may need to be quarantined. Surveillance focuses on the wide view of community-by-community infection through data collection and evaluation, and on communicating results quickly and effectively to leaders and the public.

These endeavors require a complex operational and communications framework to help determine the appropriate courses of action to prevent the spread of COVID-19, as public health recovery begins and until immunization is widely available. All of these activities must be conducted in consideration of appropriate individual privacy protections.

Contact Tracing Goals

To prevent, slow down, or containing transmission of COVID-19 in the community by:

- Rapid reporting of confirmed and probable cases of COVID-19 to Hawai'i DOH by all healthcare providers and labs
- Immediate investigation and isolation of every confirmed and probable case
- Notification and quarantine of all Close Contacts (i.e., those with face-to-face exposure at less than 6 feet for 10-30 minutes or longer), including downstream contacts of Close Contacts
- Post monitoring of all confirmed/probable cases and Close Contacts (if test positive)
- Development of a unified Incident Management system for data sharing and reporting across Hawai'i DOH, healthcare providers, labs, private payers, and other stakeholders

Contact Tracing Objective

Objectives to measure progress toward defined goals are:

- By MM/DD/YY, establish the ability, across the entire state, to identify, test, and isolate new cases within 12 hours and contact trace and quarantine all Close Contacts of every confirmed and probable case of COVID-19 within 24 hours.

Contact Tracing Meeting & Feedback Summary

- DOH has plans in place to handle contact tracing and surveillance. Incorporate the activities identified in Section 3. Disease, Surveillance & Investigation Report ("Report").
- Given the incremental approach in the DOH document, consider if we should begin staffing within DOH now for the likely scenarios in which the epidemic will grow. [Reference: Dr. Brown's response and Dr. Karen Smith's observations]
- Public health education and communication is lacking.
- Interest expressed in technological aspects of contact tracing and surveillance. DOH has a new technology application – Health Space, which is utilized nationwide.
- Need to ensure implementation of policies and procedures are effective, and where needed, enforced.
- Ensure that any process and outcomes metrics be publicly available for the general public as well as decision makers.
- Proactivity in addressing legal issues in quarantine and isolation, including those that relate to mobile technologies and applications.
- DOH indicated the median number of close contacts for each new case is two.
- For the neighbor island clusters, complete contact tracing took weeks rather than days.

Agreed to by the Work Group

- Identify, test, and isolate new cases within 12 hours and contact trace and quarantine all close contacts of every confirmed and probable case of COVID-19 within 24 hours.
- All the Areas of Work were directionally correct. One Area of Work that was added was "Technology Solutions" to create a process to evaluate technologies that could facilitate contact tracing.

For Discussion and Resolution:

- The Work Group was not able to come to a consensus on whether we need more contact tracers currently in anticipation of a surge, particularly when we re-open Hawai'i to travelers:
    - DOH indicated they have sufficient contact tracers, even for surges of new cases, due to their "surge from within" ability (Civil Beat).
    - Others on committee were a little more concerned that we do not have sufficient contact tracers, such as Dr. Tim Brown, as well as national organizations (National Association of County and City Health Officials) which recommends 30 contact tracers per 100,000 during a pandemic as other states have mentioned (NPR). In addition, the median number close contacts (two per DOH) seemed unusually low to some on the committee as people do not typically live this way, especially in Hawai'i. Finally, it

appears that DOH was not able to identify all close contacts in a timely fashion (weeks instead of days) on the neighbor islands despite DOH's ability to ensure an adequate number of contact tracers.

- There was also not a consensus, as noted under the Testing section above, on whether asymptomatic close contacts should be tested.

(URLs for noted hyperlinks above can be found in the Appendix.)

Resolved post-meeting:

- Since the last meeting of the Contact Tracing and Surveillance Committee, the University of Hawaii (in partnership with DOH) committed to training 300 contact tracers over the next couple of months. This will enable DOH to eventually have access to approximately 400 contact tracers (including 100 from DOH) available for use which is closer to the recommended 30 contact tracers per 100,000 needed during a pandemic. However, this requires quick mobilization and training of this new contact tracing workforce to ensure more timely isolation (days instead of weeks), particularly when the median number of close contacts grows to a much larger number than two when we reopen Hawaii to travelers.

Surveillance Goals

To monitor and prevent the spread of COVID-19 in the community by:

- Developing and implementing a multi-faceted surveillance system for tracking COVID-19 in Hawai'i by incorporating localized information and new types of data
- Defining a set of early signs/trigger events that will inform decision making
- Establishing communication plan and reporting structure

Surveillance Objective

- By MM/DD/YY, design and implement a multifaceted surveillance system and reporting structure that helps to prevent the spread of COVID-19 as recovery begins and restrictions relax.

Meeting & Feedback Summary

- DOH has plans in place to handle contact tracing and surveillance. Incorporate the activities identified in Section 3. Disease, Surveillance & Investigation Report ("Report").
- Given the incremental approach in the DOH document, consider if we should begin staffing within DOH now for the likely scenarios in which the epidemic will grow.
  [Reference: Dr. Brown's response and Dr. Karen Smith's observations]
- Public health education and communication is lacking.
- Interest expressed in technological aspects of contact tracing and surveillance. DOH has a new technology application – Health Space utilized nationwide.
- Need to ensure implementation of policies and procedures are effective, and where needed, enforced.
- Ensure that any process and outcomes metrics be publicly available for the general public as well as decision makers.

- Proactivity in addressing legal issues in quarantine and isolation, including those that relate to mobile technologies and applications.
- DOH indicated the median number of close contacts for each new case is two.
- For the neighbor island clusters, complete contact tracing took weeks rather than days.

Agreed to by the Work Group

- All the Areas of Work were directionally correct, and no areas were missing.

Quarantine Work Group

Overview

As the economy opens up and there is more community interaction, there will be a growing need to appropriately isolate or quarantine confirmed and probable cases of the disease.

Quarantine may be required based on an individual's close contact with the disease, those who have traveled from a place with widespread infection or other risk factors.

Depending on the severity of risk and individual circumstance, isolation may include quarantine-at-home, providing designated spaces for those with housing restrictions or needs, and support services and resources during quarantine. Monitoring efforts to enforce compliance will also need to be implemented.

Defining criteria, triage and measures for isolation and quarantine will need to be developed and may vary to address different populations in our islands.

Quarantine Goals

To prevent transmission of COVID-19 in the community by:

- Isolating all confirmed and probable cases;
- Quarantining people in prolonged close contact with a confirmed and probable case
- Quarantining those who traveled from a state or country with widespread community infection
- Quarantining those who can't self-quarantine (first responders, housing challenges, etc.) in a designated space
- Providing support structure and resources for diverse community members to ensure isolation/quarantine is effective and safe.

Quarantine Objectives

Objectives to measure progress toward defined goals are:

- By May 31, 2020, establish the ability for each county to be able to isolate and quarantine people who are unable to do so at their own residence or place of lodging.

Meeting & Feedback Summary

- Discussion with HI-EMA
    - They have been involved in planning for isolation and quarantine by identifying and securing potential sites in each county for people who require a designated location (e.g., healthcare workers not wanting to expose family) for isolation or quarantine.
    - The goal is for people to isolate and quarantine at their own residence. Have looked into quarantine/isolation for large number of people but requires a significant amount of money.
    - For people that are identified at the airport, it is the Department of Transportation that is responsible for ensuring people are isolated and quarantined.
    - For people found through contact tracing, it is the responsibility of the Department of Health.
    - Resources and enforcement are delegated first to the county level and only if additional support is needed, counties would ask HI-EMA or the Sate for assistance.
    - Within 12 hours, HI-EMA could set up a field hospital with 50 beds for isolation and/or quarantine
    - Need to ensure security of those at a designated location, people are safe and healthy and that they are getting the needed services (i.e., wrap around services).
- Differentiated, risk-based quarantine rules (e.g., those traveling from non-community spread locations).
- Need to proactively address the legal issues around isolation and quarantine.
- Ensure enforcement of isolation and quarantine while under the emergency proclamation

Agreed to by the Work Group

- All the Areas of Work were directionally correct, and no areas were missing (reviewed by Dr. Bronstein of HI-EMA)

For Discussion and Resolution

- Will need to discuss with county-level leads of emergency operation command centers and DOH to determine timing of isolation and quarantine, plans for availability of designated locations and compliance of isolation and quarantine.

APPENDICES

APPENDIX A: COVID-19 Health-Based Community Response – Measures

Disease Activity – Severity

Definition: The severity of COVID-19 is measured by the impact of new hospital cases and its cumulative effect on hospital capacity at the county level. Hospital capacity is measured by the total number of licensed beds, ICU beds and ventilators by hospital. Hospital capacity is also measured by clinician staffing and available PPE.

Data Point	Resource
Number of new COVID-19 hospital cases (daily)	Healthcare Association of Hawaii (HAH) and HI-EMA
Number of total licensed beds by county (May 2020): • Honolulu – 2,082 • Maui – 247 • Kaua'i – 111 • Hawai'i – 333	HAH & HI-EMA
Number of total ICU beds by county • Honolulu – 276 (includes 97 pediatric ICU) • Maui – 29 • Kaua'i – 9 • Hawai'i – 24	HAH & HI-EMA
Number of total ventilators by county • Honolulu – 366 (including 99 pediatric vents) • Maui – 28 • Kaua'i – 15 • Hawai'i – 50	HAH & HI-EMA
Hospital surge/crisis operational plans	Hospitals
Hospital staffing Supply & PPE levels at least for two months at 70% occupancy rates	Hospitals

Disease Activity - Prevalence

Median number of new cases per day per week indicates **uncontrolled community spread**

Median number of new cases per day per week indicates **controlled community spread**

Median number of new cases per day per week indicates **local, controlled clusters**

Median number of new cases per day per week indicates **sporadic activity**

Definition: The prevalence of COVID-19 is measured by the median number of new cases per day per week and monitoring of community spread/cluster activity. The World Health Organization (WHO) provides the following definitions for transmission scenarios[1]:

1. No cases
2. **Sporadic Cases**: one or more cases, imported or locally detected.
3. **Clusters of Cases**: clusters in time, geographic location, or common exposure. Most cases of local transmission are linked to chains of transmission.
4. **Community Transmission**: larger outbreaks of local transmission with the inability to relate confirmed cases through chains of transmission for a large number of cases, or by increasing positive tests through sentinel samples (routine systematic testing of respiratory samples from established laboratories

The intensity of community spread is tracked geographically as an indication of rising or declining transmission rates.

Data Point	Resource
Median number of new cases per day per week	DOH
Intensity and pervasiveness of community spread	DOH, HI-EMA
Cluster activity	DOH
Disease containment activity	DOH

[1] https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/critical-preparedness-readiness-and-response-actions-for-covid-19

Capacity – Healthcare Supply

Surge/crisis plans deployed **and** hospital capacity maxed out

Surge/crisis plans highly considered **and** hospitals can increase capacity by at least 10% within 5 days

Surge/crisis plans in preparation **and** hospitals can increase capacity by at least 25% within 5 days

Surge/crisis plans in place **and** hospitals can increase capacity by at least 50% within 5 days

Definition

Hospital utilization is a critical measurement to protect vulnerable populations and support front-line healthcare workers who provide care. To ensure the availability of hospital resources (total beds, ICU beds, ventilators, clinical staffing and PPE), disease demand must not exceed healthcare supply.

Hospitals' ability to appropriately adjust census is contingent upon constant communication and awareness of current conditions in each county as well as statewide for appropriate transfers to referral centers.

Data Point	**Resource**
Surge/crisis operational plans with trigger points at each level	Hospitals
Ability to adjust hospital census within five days	Hospitals
Clinical and support staffing	Hospitals
Preparation of adequate supply of PPE	Hospitals

Capacity – Contact Tracing

Max capacity of contact tracing is **below** the number of new cases/close contacts per day

80-100% of max capacity of contact tracing would be reached at current rate of new cases/close contacts per day

50-80% of max capacity of contact tracing would be reached at current rate of new cases/close contacts per day

<50% of max capacity of contact tracing would be reached at current rates of new cases/close contacts per day

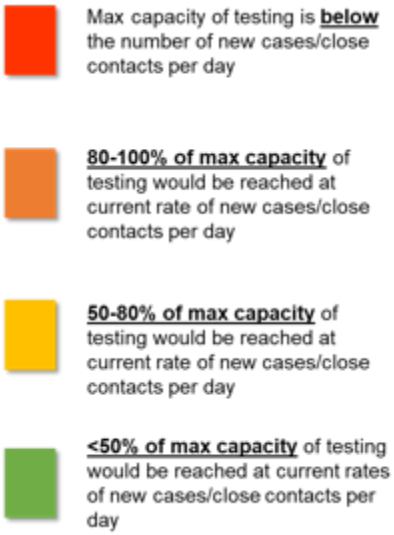
Definition

Contact tracing is a key public health strategy to contain the spread of the COVID-19 and prevent outbreaks. Contact tracing keeps the virus in check by having teams of public health workers — epidemiologists, nurses, trained individuals — identify and test each new positive case, track down their contacts and help both the sick person and those who were exposed isolate or quarantine themselves.

Rapid contact tracing effectively limits the rate of transmission. Capacity to scale up prior to the need is particularly important for the state's visitor industry, as it enables real time containment of disease from imported cases.

Data Point	Resource
Contact tracing total capacity based on benchmarks issued by the National Association of County and City Health Officials: • ~250 – Baseline (normal): 15 health workers per 100,000 people • ~500 – Pandemic: 30 contact tracers per 100,000 people	DOH
Current state population: 1.4M (2019 estimates) Current Kaua'i County population: 72k Current Honolulu County population: 975k Current Maui County population: 167k Current Hawai'i County population: 202k	DBEDT
Estimated visitors on any given day based on historical arrivals and travel patterns: 250K https://www.hawaiinewsnow.com/2020/01/31/hawaii-saw-more-than-m-visitors-last-year-not-everyone-is-celebrating/	Hawaii News Now UHERO (supplement)

Capacity – Diagnostic Testing



Definition

Diagnostic testing is a key public health strategy to identify, treat and contain the spread of COVID-19. It is critically important to scale up testing in anticipation of visitor arrivals.

Currently, the most reliable and effective method is molecular (PCR) tests. Tests are conducted based on the following criteria (consistent with the CDC, WHO, and leading practices):

- All symptomatic individuals;
- Non-symptomatic individuals with prolonged close contact to COVID-19+ individuals;
- First responders
- Clusters/outbreaks; rapid and comprehensive testing response
- Broad, community-based surveillance testing of non-symptomatic individuals when serologic testing is widely available.

Scaling up of testing capability is dependent on funding, the supply of test kits, reagents and swabs available for state and private laboratories, as well as the ability of private practitioners, clinics and testing sites to conduct FDA-approved tests safely with PPE. (https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations#covid19ivd)

Data Point	Resource
Testing total capacity is currently estimated at 5,000/day through state and private labs	DOH, DLS and Clinical Labs
Supply availability (test kits, reagents and swabs)	DOH, DLS and Clinical Labs
PPE availability for safe testing protocols	DOH

Response

- Safe practices
- **Essential activities** and their support services
- Prepare to resume low-risk activities

- Continue above
- Resume **low-risk activities**
- Prepare to resume medium to high-risk activities

- Continue above
- Start with **medium-risk activities**; then move to **high-risk activities**
- Prepare to resume highest risk activities

- Continue above
- Resume **highest-risk activities**

- Continue above
- Adjust Safe Practices to new normal

Definition

Responses are inextricably linked to each health level and are critically important for the risk assessment of increased disease transmission balanced against risks to the health and well-being of the public, society, and the economy.

Guidance on mitigation measures and risk assessments is outlined in the Johns Hopkins Public Health Principles for a Phased Reopening During COVID-19: Guidance for Governors.

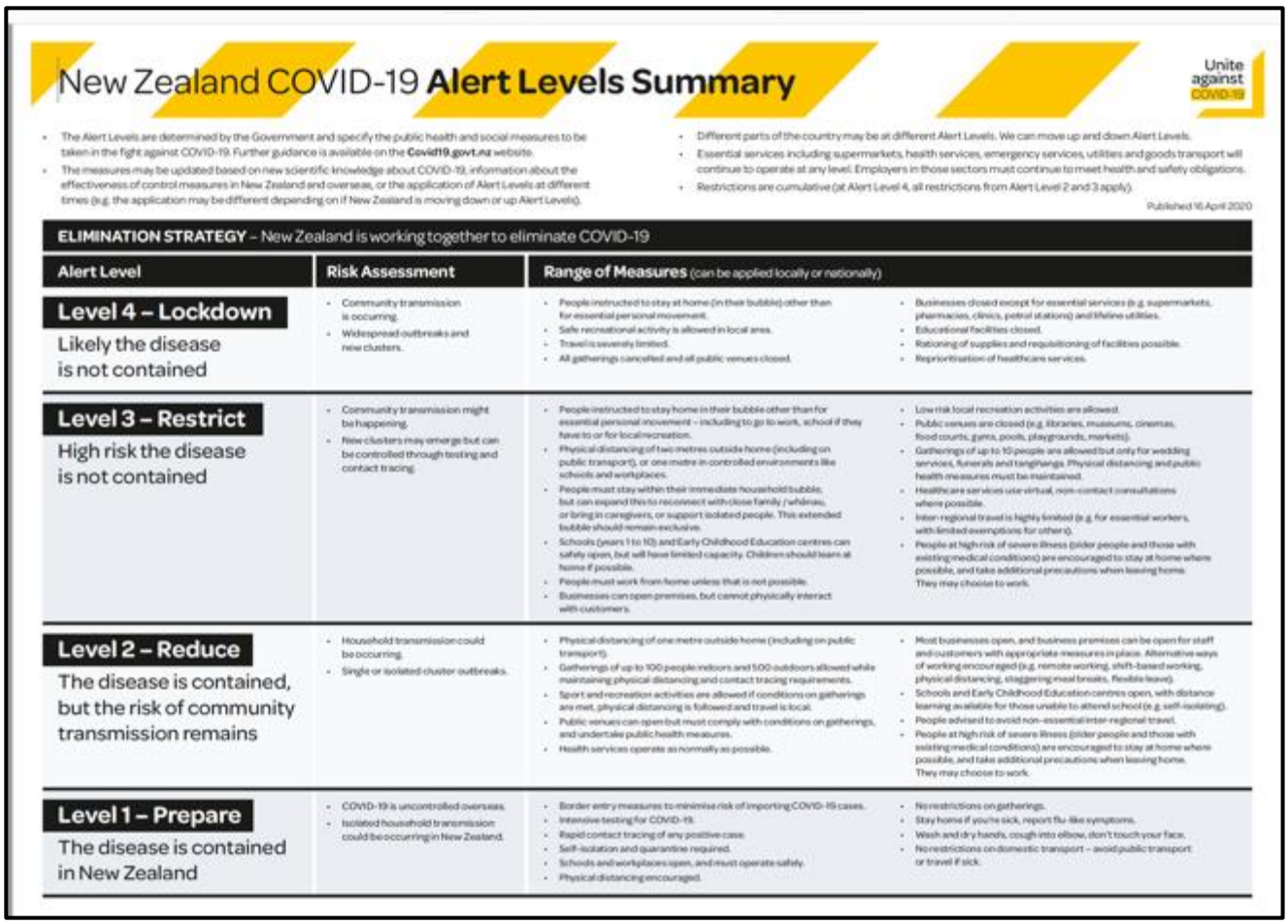
General health measures are recommended to mitigate the risk of infection to protect individuals – regardless of business-specific considerations:

- Use of nonmedical cloth masks
- Incorporating engineering controls such as physical barriers where possible
- Reconfiguring space to enable people to be located apart (ideally 6 feet)
- Supporting and enabling employees to remain at home if they are unwell or have been in close contact with someone who is sick.

Risk assessments are provided by category, contact intensity and the number of contacts in a setting at the same time. Contact intensity is a function of the contact type (ranging from close to distant) and duration (ranging from brief to prolonged). High contact intensity activities involve prolonged close contact. High number of contacts is presumed to be riskier. Categories of activities and businesses are ranked on this scale of high, medium, and low risk of contact intensity. Allowable personal and commercial activities are matched to each health level, in consultation with stakeholders and government leaders.

Specific industry guidance is provided on the State Recovery Navigator's website at https://recoverynavigator.hawaii.gov. Additional guidance can be found on the John Hopkins website at https://www.centerforhealthsecurity.org/our-work/publications/public-health-principles-for-a-phased-reopening-during-covid-19-guidance-for-governors.

APPENDIX B: New Zealand COVID-19 Alert Levels



New Zealand COVID-19 **Alert Levels Summary**

Unite against COVID-19

- The Alert Levels are determined by the Government and specify the public health and social measures to be taken in the fight against COVID-19. Further guidance is available on the **Covid19.govt.nz** website.
- The measures may be updated based on new scientific knowledge about COVID-19, information about the effectiveness of control measures in New Zealand and overseas, or the application of Alert Levels at different times (e.g. the application may be different depending on if New Zealand is moving down or up Alert Levels).
- Different parts of the country may be at different Alert Levels. We can move up and down Alert Levels.
- Essential services including supermarkets, health services, emergency services, utilities and goods transport will continue to operate at any level. Employers in those sectors must continue to meet health and safety obligations.
- Restrictions are cumulative (at Alert Level 4, all restrictions from Alert Level 2 and 3 apply).

Published 16 April 2020

ELIMINATION STRATEGY – New Zealand is working together to eliminate COVID-19

Alert Level	Risk Assessment	Range of Measures (can be applied locally or nationally)	
Level 4 – Lockdown Likely the disease is not contained	• Community transmission is occurring. • Widespread outbreaks and new clusters.	• People instructed to stay at home (in their bubble) other than for essential personal movement. • Safe recreational activity is allowed in local area. • Travel is severely limited. • All gatherings cancelled and all public venues closed.	• Businesses closed except for essential services (e.g. supermarkets, pharmacies, clinics, petrol stations) and lifeline utilities. • Educational facilities closed. • Rationing of supplies and requisitioning of facilities possible. • Reprioritisation of healthcare services.
Level 3 – Restrict High risk the disease is not contained	• Community transmission might be happening. • New clusters may emerge but can be controlled through testing and contact tracing.	• People instructed to stay home in their bubble other than for essential personal movement – including to go to work, school if they have to or for local recreation. • Physical distancing of two metres outside home (including on public transport), or one metre in controlled environments like schools and workplaces. • People must stay within their immediate household bubble, but can expand this to reconnect with close family / whānau, or bring in caregivers, or support isolated people. This extended bubble should remain exclusive. • Schools (years 1 to 10) and Early Childhood Education centres can safely open, but will have limited capacity. Children should learn at home if possible. • People must work from home unless that is not possible. • Businesses can open premises, but cannot physically interact with customers.	• Low risk local recreation activities are allowed. • Public venues are closed (e.g. libraries, museums, cinemas, food courts, gyms, pools, playgrounds, markets). • Gatherings of up to 10 people are allowed but only for wedding services, funerals and tangihanga. Physical distancing and public health measures must be maintained. • Healthcare services use virtual, non-contact consultations where possible. • Inter-regional travel is highly limited (e.g. for essential workers, with limited exemptions for others). • People at high risk of severe illness (older people and those with existing medical conditions) are encouraged to stay at home where possible, and take additional precautions when leaving home. They may choose to work.
Level 2 – Reduce The disease is contained, but the risk of community transmission remains	• Household transmission could be occurring. • Single or isolated cluster outbreaks.	• Physical distancing of one metre outside home (including on public transport). • Gatherings of up to 100 people indoors and 500 outdoors allowed while maintaining physical distancing and contact tracing requirements. • Sport and recreation activities are allowed if conditions on gatherings are met, physical distancing is followed and travel is local. • Public venues can open but must comply with conditions on gatherings, and undertake public health measures. • Health services operate as normally as possible.	• Most businesses open, and business premises can be open for staff and customers with appropriate measures in place. Alternative ways of working encouraged (e.g. remote working, shift-based working, physical distancing, staggering meal breaks, flexible leave). • Schools and Early Childhood Education centres open, with distance learning available for those unable to attend school (e.g. self-isolating). • People advised to avoid non-essential inter-regional travel. • People at high risk of severe illness (older people and those with existing medical conditions) are encouraged to stay at home where possible, and take additional precautions when leaving home. They may choose to work.
Level 1 – Prepare The disease is contained in New Zealand	• COVID-19 is uncontrolled overseas. • Isolated household transmission could be occurring in New Zealand.	• Border entry measures to minimise risk of importing COVID-19 cases. • Intensive testing for COVID-19. • Rapid contact tracing of any positive case. • Self-isolation and quarantine required. • Schools and workplaces open, and must operate safely. • Physical distancing encouraged.	• No restrictions on gatherings. • Stay home if you're sick, report flu-like symptoms. • Wash and dry hands, cough into elbow, don't touch your face. • No restrictions on domestic transport – avoid public transport or travel if sick.

For detail, see https://covid19.govt.nz/assets/resources/tables/COVID-19-alert-levels-summary.pdf

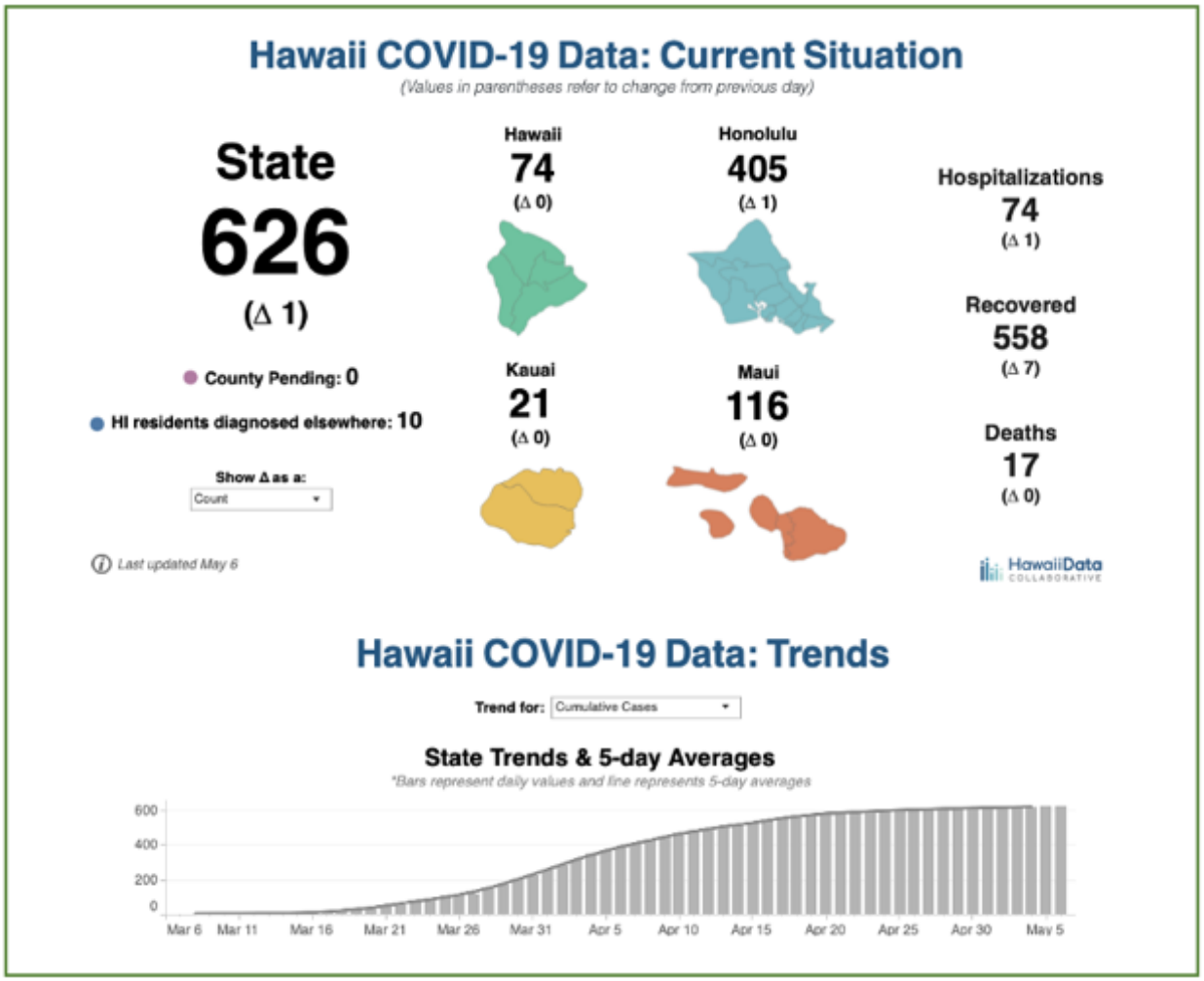
APPENDIX C: Sample Dashboard of Key Public Health Indicators

To help ensure public transparency and confidence in the effort, a dashboard of key public health indicators should be made public daily so that the public can stay apprised of accurate community health status.

This dashboard could be made available via a link or widget for consistent and identical formats on a wide array of platforms, including all relevant state and county websites, news media, business and industry sites, etc. The key is that all stakeholders remain aligned and informed.

A public dashboard might include all the key measures from the Alert Model, as well as trendlines over time.

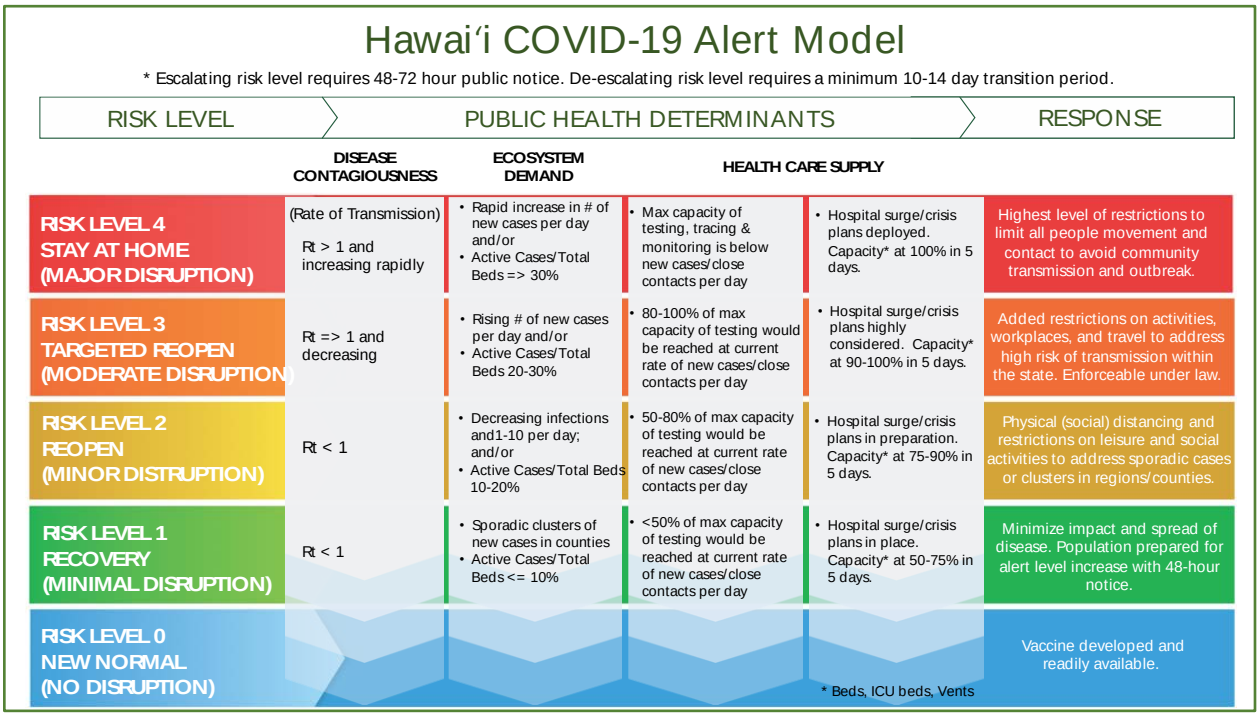
[Example for visual concept only. Source: Hawaii Date Collaborative]



APPENDIX D: Task Force Proposed Alert Model Framework

Proposed Alert Model Framework

For reference, the following framework was the Alert Model originally proposed by the Unified Strategy Team, first presented on 5/9/20. Since then, this framework has evolved through collaboration with other principals and stakeholders into the State's framework.



APPENDIX E: URLs for Work Group Hyperlinks

Testing Work Group

The following URL links are referenced in Testing Work Group – For Discussion and Resolution section:

- California: https://abcnews.go.com/Health/wireStory/mayor-la-1st-major-us-city-offering-residents-70418832
- Utah: https://kutv.com/news/local/testing-people-with-no-symptoms-utahs-next-steps-in-battling-covid-19
- Dr. Zeke Emmanuel: https://www.theatlantic.com/ideas/archive/2020/04/were-testing-the-wrong-people/610234/
- Tom Frieden: https://www.nytimes.com/2020/05/05/opinion/coronavirus-contact-tracing.html?smid=nytcore-ios-share
- Lt. Gov. Josh Green: https://www.staradvertiser.com/2020/04/08/hawaii-news/lt-gov-josh-green-calls-for-more-extensive-testing/
- CDC: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html
- CDC: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html

Contact Tracing & Surveillance Work Group

The following URL links are referenced in Contact Tracing & Surveillance Work Group – For Discussion and Resolution section:

- Civil Beat: https://www.civilbeat.org/2020/05/is-hawaii-ready-to-reopen-the-economy-some-experts-say-not-yet/
- Dr. Tim Brown: https://www.staradvertiser.com/2020/05/06/hawaii-news/health-experts-say-its-too-soon-to-reopen/
- National Association of County and City Health Officials: https://www.naccho.org/uploads/full-width-images/Contact-Tracing-Statement-4-16-2020.pdf
- NPR: https://www.npr.org/sections/health-shots/2020/04/28/846736937/we-asked-all-50-states-about-their-contact-tracing-capacity-heres-what-we-learne

Mahalo.