Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

The Joint Commission Journal on Quality and Patient Safety 2020; 46:483–488

COMMENTARY

Communication with Patients and Families Regarding Health Care–Associated Exposure to Coronavirus 2019: A Checklist to Facilitate Disclosure

Karthik Sivashanker, MD, MPH, CPPS; Mallika L. Mendu, MD, MBA; Paige Wickner, MD, MPH; Tricia Hartley, MBA, MPH; Sonali Desai, MD, MPH; Karen Fiumara, PharmD; Andrew Resnick, MD, MBA[1]*; Hojjat Salmasian, MD, MPH, PhD*[1]

As the novel coronavirus 2019 (COVID-19) pandemic unfolds, health care institutions will need to grapple with the challenge of notifying patients and their family members about possible or known exposures to the virus. This task will become increasingly monumental as the virus rapidly multiplies within communities. It will be critical for health care organizations to use a standardized, robust, and clear communication strategy to notify and guide patients in the ambulatory setting. Each organization will need to identify a disclosure team with the capacity to respond rapidly to clinical questions about symptoms and prognosis; to instruct patients on containment strategies; to provide supportive responses to emotional distress; to help patients and their families connect with resources they need in order to adhere to recommendations such as wearing masks, self-quarantine, and diagnostic testing; and to systematically track and notify at-risk patients and those proximally associated with them.

We have developed a pragmatic COVID-19 exposure disclosure checklist (Table 1) to standardize the disclosure process and ensure that all key areas are considered in every conversation. There are five core competencies that are critical to facilitating an effective COVID-19 exposure disclosure conversation: clinical, infectious disease, risk management, language, and psychosocial (Table 2). Skill in cultural sensitivity, clear communication, and emotional intelligence is also helpful.

These competencies are embedded in the checklist, which is simultaneously a list of reminders, a sequence of steps to facilitate a natural flow of information, a diagnostic tool to assess risk, and a treatment of prescribed next steps based on current best practices. This checklist is intended to facilitate a clear and consistent disclosure process that reduces inconsistencies and, hopefully, improves patient safety and outcomes.[1] Facilitators should be quickly trained in the use of this checklist and can lean on the sample scripted language to respond to patients and families in a sensitive manner. For more complicated situations, domain experts can fill in gaps in knowledge or skills.

Given variation in personnel across institutions, it is important to establish which departments (for example, occupational health, infection prevention and control, quality and safety, human resources) will be responsible for communicating with and supporting patients and families that have potentially been exposed. As a first step, a system for tracking exposed patients and family members should be created, and staff should be assigned to investigate the details of the actual exposure. These details should then be entered into the tracker to facilitate a smooth disclosure process. Key elements to include regarding the exposed patient or family member are their name, phone number, date of birth, medical record number, demographic information, preferred language, contact information, history of prior COVID-19 exposure, and documented or reported COVID-19 testing and results. For the source of the exposure, elements to include are the individual's title/role and the date he or she was identified as positive. Information should be tracked regarding the location and the date of the exposure event and the last day of the incubation period. Finally, all aspects of the outreach process should be tracked and then documented in the electronic health record, from the time of first outreach, to the modality used (for example, e-mail, phone), to the final outcome. At our institution, to avoid further exposure and facilitate rapid disclosure (that is, within 24 hours of the exposure), phone calls are the preferred means of communication. Use of interpreters, notification of the patients' primary care physician, activation of social work, and any other interactions with other services should also be noted.

When communicating health care–associated exposures to COVID-19, standard disclosure principles and practices apply.[2–5] The goal of the disclosure process is to encourage open dialogue and a safe space for venting, conflict, and resolution, with appropriate use of mediation and apology. To illustrate how the checklist might be used in the context of

[1] Co-senior authors.

1553-7250/$-see front matter

https://doi.org/10.1016/j.jcjq.2020.04.010

Table 1. COVID-19 Exposure: Checklist for Patients, Families, and/or Workers[1]

Step	Checklist Questions	Additional Guidance*
1. Identify disclosure team.	**Which department(s) will you include in outreach to patients?** [ ] Quality/Safety/Risk [ ] Patient Relations or Experience [ ] Social Work [ ] Case Management [ ] Other_____ **Disclosure training provided to staff?** [ ] Yes [ ] No	Verify that the people selected to be on the disclosure team have undergone prior training. Consider using a "see one, do one" approach by pairing senior staff members to lead and junior staff members to observe and then practice.
2. Initiate disclosure.	**Patient's preferred language confirmed in health record?** [ ] Yes [ ] No [ ] Unknown **Interpreter services activated?** [ ] Yes [ ] No [ ] Not applicable **Patient and/or family member successfully contacted?** [ ] Yes [ ] No, unable to reach (_____ attempt #)	Provide a transparent, open disclosure to the patient and/or visitor. The general location and date of the exposure may be shared, but specific identifying information regarding the affected provider should be kept confidential. Ensure that the disclosure is performed in the patient's primary language, with medical interpreters available, at the appropriate literacy level, as necessary. Offer reassurance that you are here to help them navigate through the best next steps, and to connect them with the resources they need. If unable to reach the patient, stop checklist and document the attempt in the medical record. We recommend at least three documented attempts spaced at least 24 hours apart before terminating outreach efforts. Suggested communication: *"My name is _____ and I'm calling from _____. I want to make you aware that an employee who cared for you/your loved one on [Date/Time] has tested positive for COVID-19. Because you were in close contact with this person for more than 15 minutes, there is the potential that you were exposed. To assist you with the next steps, we have information, resources, and support tools available to ensure that you and your loved ones have the support you need."*
3. Review symptomology.	**COVID-19 symptoms reviewed?** [ ] Yes [ ] No **Confirm if patient and/or visitor is experiencing symptoms, with level of severity identified?** [ ] Yes [ ] No **Non-symptomatic patient and/or visitor recommendations reviewed?** [ ] Yes [ ] No	Review known COVID-19 symptoms with the patient and/or visitor, keeping in mind that health literacy levels vary significantly. Ensure understanding by having the individual repeat back the symptoms they should be looking out for and encouraging them to raise any questions or concerns. Ask about others who joined the visit or who live at home who may be at risk. Symptoms include: • Fever (temperature greater than 100°F) • Cough • Shortness of breath • Sore throat • Running nose • Sore muscles • Loss of taste or smell Depending on whether the patient and/or visitor reports having experienced any symptoms, and to which degree of severity, next steps may vary. Suggested communication: *"COVID-19 symptoms can vary. Have you been experiencing any symptoms of a viral respiratory infection, such as fever, coughing, sore throat, or sore muscles?"* *[If yes]* *"I'm sorry to hear you aren't feeling well. I'm here and I'm going to help you."* *[If no]* *"That is good to hear. Even if you are not currently experiencing any symptoms, you should continue taking your temperature twice daily and pay attention to any changes to your health, such as a cough or shortness of breath."*

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Table 1. (*continued*)

Step	Checklist Questions	Additional Guidance*
4. Provide testing and isolation guidelines[1] if no symptoms or mild symptoms (skip if not applicable).	**Isolation guidelines reviewed?** [ ] Yes [ ] No [ ] Not applicable **Relevant testing information provided?** [ ] Yes [ ] No [ ] Not applicable **Available resources offered?** [ ] Yes [ ] No	If patients are not experiencing any symptoms or only mild symptoms (sore throat, cough, fever, etc.), emphasize the importance of isolating themselves for the next 14 days. This includes protecting family members from exposure: • Staying physically away (6 to 8 feet) from others as much as possible • Using a separate bedroom and bathroom if possible • Using separate household items (such as towels, utensils, and personal items) whenever possible • Limiting contact with pets • Avoiding personal household items • Cleaning "high-touch" surfaces daily • Checking temperature twice daily and self-monitoring for symptoms Assess the home situation for overcrowding and the presence of elderly, immunocompromised, and other individuals at high risk of harm if exposed. For some patients, it is not possible to practice physical distancing in their living space (for example, those living in crowded homes). Patients should consider relocating to a temporary residence, such as a rental or hotel, if they can afford it or if provided by their employer or other source. On the other hand, keep in mind that isolation may present a significant financial and social burden to some patients. Be sure to ask if there are any resources the patients need to ensure that they can safely and effectively quarantine themselves. If yes, direct them to resources outlined in Step 6. Explain that, should the patient become symptomatic, they may need to be tested for the virus. Depending on the health care system communicating the disclosure, instructions on testing may vary. If, during the disclosure, the patient or family member informs you that they have already tested positive for the virus, ensure that they understand the isolation guidelines prescribed earlier and that they are referred to a primary care physician for further management. Most importantly, make sure the instructions are clear, and the patient has the resources they need, such as transportation, for testing to take place, and access to primary care, if necessary. If the patient does not have the resources required, direct them to the resources listed in Step 6. Suggested communication: *"To be extra careful, there are several steps you can take to help limit the spread of this disease. The most important is isolating yourself as much as possible for the next 14 days. This means staying physically away from others, including your pets, using a separate bedroom and bathroom than others in your household, avoiding personal household items, and cleaning surfaces in your house that you touch routinely daily.* *"If you develop any of the symptoms we discussed, we recommend that you get tested. Please write down this number, _____, to order and set up a time for you to get tested. The testing site is located at X."* *[If tested positive]* *"I'm sorry to hear you have tested positive. In addition to the guidelines I described earlier on how best to prevent the spread of disease, I also recommend you connect with a primary care doctor, so they can assist you with management. Would you like me to reach out to your primary care doctor on your behalf?"*

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Table 1. (*continued*)

Step	Checklist Questions	Additional Guidance*
5. If severe symptoms[1] (skip if not applicable)	**Emergency department contact information provided?** [ ] Yes [ ] No **Contact made to emergency department on incoming patient?** [ ] Yes [ ] No [ ] Unable to reach **Available resources offered?** [ ] Yes [ ] No	If the patient or family member is experiencing severe symptoms (shortness of breath, fever, etc.), ensure that the patient can be transported to the closest emergency department. Suggested communication: *"We recommend that you be seen at the nearest emergency department. Do you have someone who can drive you there? If not, would you like us to call Emergency Medical Services for you?"*
6. Provide resources.	**All patient's concerns/questions addressed?** [ ] Yes [ ] No [ ] No **Available resources offered?** [ ] Yes **Social work referral made if needing more help?** [ ] Yes [ ] No	Have prepared a list of local resources that may be able to assist patients with a variety of needs. Should a patient/visitor voice a concern related to any of the items below, be sure to communicate how they are best able to access the resources they need. Consider having the contact information for your institution's Social Work and/or Care Coordination Department available for additional assistance. • Food security • Housing security • Transportation assistance • Caretaking/caretaker support • Psychological distress • Persons with disabilities • Intimate partner violence or domestic abuse • Primary care • Other Suggested communication: *"Are there any resources you need (or are at risk of losing) that may affect your ability to follow our recommendations? We can help connect you with available resources. If you would like, I am happy to have a social worker reach out to you in the next 24 hours [M–F] to help."*
7. Provide additional contact information.	**Additional contact information provided?** [ ] Yes [ ] No **Alerted primary care provider?** [ ] Yes [ ] No	Provide patient and/or visitor with direct contact information or hotline for the health care institution should any additional questions or concerns arise. Suggested communication: *"If any other questions or concerns arise, you can always call X for more information and support. We'd also like to contact your primary care provider to update them."*

References

1. Centers for Disease Control and Prevention. Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19. (Updated: May 19, 2020.) Accessed May 21, 2020. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html.

2. Liang BA. A system of medical error disclosure. Qual Saf Health Care. 2002;11:64–68.

*Guidance provided by the World Health Organization and Centers for Disease Control and Prevention may evolve over time and should be referenced for updates.

a flexible conversation, consider the following hypothetical and generic COVID-19 disclosure.

After the initial introduction, staff should be ready to answer the most commonly asked questions (for example, "What's my risk of dying?"), to empathically hold patients' and their families' anxiety (for example, "We're in this together and we're going to do everything we can to walk you through this process"), to apologize when appropriate (for example, "I'm so sorry that this happened in the course of receiving care with us"), to give clear instructions on next steps (for example, "For your safety and others, we recommend that you isolate yourself. . . . I'm going to explain what this means and how to do it"), to ask about psychosocial needs (for example, "Are there any resources you need, or are at risk of losing, that may make it difficult to follow our recommendations?"), to ask about other at-risk individuals in the home (for example, "Are there any older or immunocompromised people in the house?"), to assess for overcrowding (for example, "Do you have space in your household to stay six feet away from others at all times?"),

Table 2. Core Competencies Required for Effective COVID-19 Exposure Disclosure Conversations

Responsibility	Description
Clinical	**Knowledge required:** • COVID-19 symptoms, risk factors, and prognosis • Recommendations for symptom management and monitoring **Skills required:** • Health literacy
Infectious disease	**Knowledge required:** • Best practices, indications, and protocols for prevention, isolation, self-quarantine, and COVID-19 testing • Public health tracking and reporting requirements **Skills required:** • Database management for case tracking
Risk management	**Knowledge required:** • Best practices for non–error disclosure conversations • Health Insurance Portability and Accountability Act (HIPAA) • Patient rights to privacy and confidentiality vs. public health requirements and mandates • Medicolegal risks **Skills required:** • Dexterity in using reporting systems and processes
Language	**Knowledge required:** • Patient preferences for language **Skills required:** • Ability to speak patient's preferred language and/or efficiently engage interpreter services
Psychosocial	**Knowledge required:** • Resources available to patients for housing, food, transportation, and other basic needs • Socioeconomic and inequity risk factors for nonadherence with COVID-19 precautions **Skills required:** • Cultural sensitivity • De-escalation • Container-building for psychological safety • Empathic communication

and to offer resources when indicated (for example, "A social worker will be reaching out in the next 24 hours to talk about available resources").

Early on in the disclosure process, organizations should consider assigning the role to more senior staff members who can use their experience to examine strategies and navigate the unexpected. There is no checklist that can account for the wide-ranging variation of human reactions to stress. In their responses, patients and their families may be suspicious (for example, "I think hospitals are deliberately infecting patients"), hostile (for example, "You can't make me do anything!"), or even flippant (for example, "This will all blow over soon"). Patients may also raise unique challenges that have no clear answers—such as how they can avoid exposing their young children if they are the sole caregivers and have no support, or how they can self-isolate in a crowded household with no alternatives for housing. It will be important for staff to observe how more experienced facilitators move on and off script in mediating these situations through improvisation, de-escalation, redirection, and other techniques.

Developing and training a team to perform disclosures ensures a more consistent and reliable process than having the providers who have cared for the patient do the outreach. Although the therapeutic relationship of the latter may be of some benefit, it is critical that accurate information is conveyed and that all questions are correctly answered. This is in contrast to patients admitted to the hospital where it makes more sense for the patient's providers to perform the disclosure rather than having an unknown person interrupt the continuum of care. The disclosure team should still consider offering guidance to the inpatient team to encourage a consistent process. This may be particularly helpful when the disclosure involves surrogate decision-makers and other complexities.

Organizations should prioritize public health, transparency, and equity over concerns for medicolegal risks to the organization. Although it is possible that some complaints may emerge from this crisis related to health care organizations exposing patients to COVID-19, there is a broad consensus that this is a highly transmissible disease that may be difficult to contain, even with strict adherence to best practices and protocols. Patients and staff will almost certainly get infected in the course of delivering and receiving health care. It is the responsibility of health care institutions to prioritize prevention efforts and to be fully transparent with patients when transmission occurs to maintain the public trust. It is the responsibility of patients and their families to take this pandemic seriously and to protect themselves, their loved ones, and their providers by following the recommendations of their providers and public health officials.

LIMITED ENGLISH PROFICIENCY

Staff should be prepared to use an interpreter based on the patient and his or her family's language preference, with consideration for health literacy (for example, "I'm calling with an interpreter on the line. Is it okay if we continue, or do you prefer another language?"). Written instructions in the preferred language may also be handed to the patient (inpatient) or mailed/e-mailed (outpatient). Although language preferences are not always reliably recorded in the medical record, checking the medical record before calling the patient may save time. Use of bilingual staff may also be considered, depending on availability of staff and the patient population.

UNDOCUMENTED AND IMMIGRANT PATIENTS

US health care institutions should pay special attention to reassuring undocumented and immigrant patients that their information is protected and that their exposure status will not be communicated to Immigrations and Customs Enforcement (ICE) by health care officials. This population of patients may disenroll from health services and other government programs from fear that the government might deny their green card or visa application (public charge rule).[7] Most individuals in this population do not need to worry about the public charge rule and should be encouraged to seek medical care for covid-19 and to utilize available services when indicated.[6]

OTHER POPULATIONS WITH SPECIFIC NEEDS

Appreciating the wide variability among health care institutions and the populations they serve in the United States and abroad, organizations will need to adapt the checklist to their needs. For example, an organization caring for people with disabilities may spend more time asking about possible disruptions in their disability services. A mental health organization may instead focus on whether patients are able to get their prescription psychotropic medications. Yet, for both of these organizations, asking about psychosocial needs and offering resources are critical and cannot be overlooked.

CONCLUSION

The steps outlined in this checklist were developed based on consensus expert opinion and are currently being employed at our institution. We are using an ongoing patient tracking and contact program that will inform the utility of the checklist. Although the checklist has not been formally studied with respect to impact on outcomes, we believe it can serve as a blueprint for other institutions tackling the spread of COVID-19.

Conflicts of Interest. All authors report no conflicts of interest.

Karthik Sivashanker, MD, MPH, CPPS, is Medical Director of Quality, Safety, and Equity, Department of Quality and Safety and Department of Employee Diversity, Inclusion & Experience, Brigham and Women's Hospital (BWH), Boston.**Mallika L. Mendu, MD, MBA**, is Medical Director for Quality and Safety, Department of Quality and Safety, and Director for Quality Improvement, Division of Renal Medicine, Department of Medicine, BWH.**Paige Wickner, MD, MPH**, is Medical Director for Quality and Safety, Department of Quality and Safety, and Program Director, Division of Allergy and Clinical Immunology, Department of Medicine, BWH.**Tricia Hartley, MBA, MPH**, is Patient Safety Program Manager, Department of Quality and Safety, BWH.**Sonali Desai, MD, MPH**, is Medical Director of Ambulatory Patient Safety, Department of Quality and Safety, and Medical Director of Quality, Division of Rheumatology, Department of Medicine, BWH.**Karen Fiumara, PharmD**, is Executive Director of Patient Safety, Department of Quality and Safety, BWH.**Andrew Resnick, MD, MBA**, is Senior Vice President and Chief Quality and Safety Officer, Department of Quality and Safety, Department of Surgery, BWH.**Hojjat Salmasian, MD, MPH, PhD**, is Medical Director of Data Science and Analytics, Department of Quality and Safety, and Instructor of Medicine, Division of General Internal Medicine, BWH. Please address correspondence to Karthik Sivashanker, ksivashanker@bwh.harvard.edu.

REFERENCES

1 Gawande A. The Checklist Manifesto: How to Get Things Right. New York: Metropolitan Books, 2010.
2 Wu AW, et al. Disclosing adverse events to patients: international norms and trends. J Patient Saf. 2017;13:43–49.
3 Cantor MD. Telling patients the truth: a systems approach to disclosing adverse events. Qual Saf Health Care. 2002;11:7–8.
4 American Society for Healthcare Risk Management Disclosure: what works now and what can work even better. J Healthc Risk Manag. 2004;24:19–26.
5 Boyle D, et al. Disclosing errors and adverse events in the intensive care unit. Crit Care Med. 2006;34:1532–1537.
6 Immigrant Legal Resource Center. Public Charge Outreach Toolkit, Aug 19, 2019. Accessed May 21, 2020. https://www.ilrc.org/public-charge-outreach-toolkit.