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May 4, 2020

Senate's Special Committee on COVID-19
415 S Beretania St
Honolulu, HI 96813

Subject: Reply to Senate's Special Committee on COVID-19 conducted on April 28, 2020

Dear Senators:

The following answers are provided to your inquiries contained in your letter dated April 29, 2020.

1. Under HRS 325-8, "Infected Persons and Quarantine", Department of Health (DOH) has the authority to obtain orders for mandatory quarantine. Currently, there are no mandatory quarantine orders issued under HRS 325-8.

2. Under current conditions, due to the Governor's Emergency Proclamations, HRS-325-8 is under defacto suspension. The Governor, under HRS 127A has determined that HRS 325-8 is inadequate to address the COVID-19 situation and therefore has ordered the 14-Day Emergency Self Quarantine in conjunction with the airport screening process.

3. The mass quarantine operation upon review by the Attorney General's Office was found to be "legally problematic". There were several issues revolving around the rights and civil liberties of travelers being quarantined upon entering the state. Enclosure (1) was provided to Director Hara regarding this. Director Hara did acknowledge the issues with civil liberties and directed HI-EMA to conduct the following:

a. Modify and or improve the procedures of the existing 14-Day Emergency Self Quarantine to meet all legal questions and publish a complete standing operate procedure.

b. For the purpose of contingency planning, determine the conditions, both medical and legally, when an en masse quarantine operation can be executed.

4. Department of Transportation (DOT) Airports Division is the lead agency on enforcing the 14-day quarantine requirements. Hawaii Emergency Management Agency (HI-EMA) offered planning support to assist them in developing a standard operating procedure, but DOT-Airports decided to write their own procedure.

5. The following planning estimates are the staffing and resource requirements for enforcing the 14-day quarantine based upon the following assumptions:

- Average cost of the minimum wage worker of $81 a day to O-3 CPT $266 a day. Average $173 a day per single Support Staff.
- CONUS and International Passenger arrival is maintained at 539 per day
- Average based on Month of April
- Law Enforcement staff numbers includes AG office for investigations of violators of 14-day Self-Quarantine in Honolulu and County law enforcement for Maui, Kauai, and Hawaii. (Numbers confirmed by Wayne Anno SLEC)
- HTA Staff numbers include call center

Total Passenger arrival and Support Staff for Airport Screening and Security			
		Per Day	
Passenger	Staff Support	Ratio of Passengers:Support Staff	
539.0345	229	0.424	**[1:2.5]**

Passengers	Staff Support	Cost (per day)
1000	424	$ 73,352.00
2000	848	$ 146,704.00
3000	1272	$ 220,056.00
4000	1696	$ 293,408.00
5000	2120	$ 366,760.00
10000	4240	$ 733,520.00
15000	6360	$ 1,100,280.00
20000	8480	$ 1,467,040.00
25000	10600	$ 1,833,800.00
30000	12720	$ 2,200,560.00

6. HI-EMA is not working on specific plans for opening restaurants and other facilities as arriving passengers increases. HI-EMA is providing the Governor's Office and the Counties with recommendations on how to conduct a phased re-opening. The two draft documents are: *Menu of Essential and Phase 1 and 2 Reopen Risk Levels-Guidelines* and *Beyond Recovery Presentation*. These will be used to continue the conversation about what sectors to open across the State of Hawaii.

7. Covidexemption@hawaii.gov is the "official" state of Hawaii's site for communicating possible exemptions to any COVID-19 restrictions. Additionally, all six emergency proclamations outline the rules, regulations and restrictions. HI-EMA makes recommendations to the Governor's office on certain exemptions. Enclosure (2) was provided to Director Hara on the issue of opening florists for Mother's Day.

8. The following answer was provided by Emergency Support Function 7 (Logistics) regarding personal protective equipment (PPE) to Department of Health (DOH).

"HI-EMA has not received a specific Request For Assistance from DOH to provide PPE for State Food inspectors or Nursing and Long Term Care Facilities. However, State Departments engaged in activities that expose employees to heighten risk to infection will be provided PPE pursuant to OSHA regulations by their cognizant agency.

The PPE requirements of Acute Care, Nursing, and Long-Term Care Facilities are evaluated and characterized by the Department of Health. The Department of Health develops a PPE forecast that includes non-hospital medical providers. Non-hospital medical providers that experience PPE shortages can request assistance from the HHEM or directly from the DOH which in-turn provides PPE from its SNS received PPE inventory or PPE purchased by the State of Hawaii."

9. Department of Health (DOH) is currently refining the state's COVID-19 testing strategy. DOH provided enclosure (3) "Disease Surveillance and Investigation" as part of their updated "Infectious Disease Emergency Response Plan" (April 2020).

If you have any questions or require additional information, please contact me.

Sincerely,

SHAWN P. GRZYBOWSKI
Planner, Hawaii Emergency Management Agency

DAVID A. LOPEZ
Executive Officer, Hawaii Emergency Management Agency

LUKE P. MEYERS
Administrator, Hawaii Emergency Management Agency

Enclosures:
(1) Memo sent to Director Hara titled "Mandatory Quarantine of Travelers"
(2) Letter to Director Hara discussing the florist exemption
(3) Department of Health's "Disease Surveillance and Investigation"

To: Director Hara and Administrator Meyers

From: Future Operations Section

SUBJECT: MANDATORY QUARANTINE OF TRAVELERS

REFERENCES:

a. US Constitution (Fourth, Fifth, and Fourteenth Amendment)
b. Hawaii Constitution (Art 1, Section 8)
c. Governor's Emergency Proclamation (4 March 20)
d. Hawaii Revised Statues (HRS) 127A-13 "Additional Powers in an Emergency Period"
e. Hawaii Revised Statues (HRS) 325-8 "Infected Persons and Quarantine"
f. Second Supplementary Proclamation ordering an Emergency 14 Day Self Quarantine for persons entering the state. (21 March 20)
g. Fourth Supplementary Proclamation ordering an Emergency 14 Day Self Quarantine for persons traveling between islands. (31 March 20)
h. Hawaii DoT: SOP Airport Screening

BLUF: Rights and civil liberties that cannot be suspended in a Governor's Proclamation are Constitutional limitations (U.S. or Hawaii Constitution) and / or Federal statutes and administrative rules (Supremacy Clause conflicts). Mandatory Quarantine of Travelers en masse appears to have several questions of constitutionality and is a legal liability.

BACKGROUND:

1. <u>Quarantine</u>
   a. Legal authority: HRS 325-8
      - Origin of authority: Department of Health
      - Basic authority for the state to quarantine an individual
   b. Elements of the quarantine
      - DoH must provide probable cause
      - The individual in question is believed to have been exposed or infected to a contagious disease
      - Quarantine is necessary to protect public health
      - Quarantine will be administered to respect the dignity of the individual
      - Quarantine will be administered by the least restrictive means necessary
   c. Due Process
      - DoH has to establish probable cause to quarantine
      - DoH petitions the court of jurisdiction for an ex parte order
      - Court will grant ex parte order if probable cause exists
      - Order is provided to the quarantined individual
      - Order is accompanied with a notification of an individual's right to a hearing to contest the ex parte order

2. <u>Emergency 14 Day Self Quarantine</u>:
   a. Legal authority: HRS 127A-13(a)(1):

- Origin of Authority: Governor
    i. Under a declared emergency the governor may provide for and require quarantine
    ii. if he believes the current Public Health Statutes (HRS 325) are not adequate to provide protection to the public for the conditions of the emergency.
- Governor's Emergency Proclamation (4 March 20)
- Second Supplementary Proclamation ordering an Emergency 14 Day Self Quarantine for persons entering the state. (21 March 20)
- Fourth Supplementary Proclamation ordering an Emergency 14 Day Self Quarantine for persons traveling between islands. (31 March 20)

b. Elements:
    - Declared state of emergency by the government
    - Statutes under normal conditions are inadequate to protect public health or safety in the emergency environment
    - In bound persons must be found not residing in their stated quarantine location
    - Vacated the quarantine for reason other medical or an emergency
    - Is not performing emergency response or critical infrastructure functions

c. Due Process:
    - De facto suspension of HRS 325-8
    - Airport screening SOP
    - Government verification fails three times
    - Government dispatches Police to investigate, locate and identify the person
    - Police arrest, issue citation under 127A
    - Court Hearing

ISSUE/PROBLEM: The Future Ops Cells has been asked to develop a plan for the State to conduct mass quarantine of travelers entering the state.

MANDATORY QUARANTINE Operation: Considering limited Director's guidance, existing documents and guidance from the current airport screening operations and discussion with the AG's office the following legal / constitutional concerns have been raised:

Per guidance issued by the AG: **Mandatory Quarantine** is defined in Orders issued by the court via a magistrate approved petition of order by DoH and meets a standard of probable cause described in HRS 325-8.

This operation, by definition, would have to be compliant with HRS 325-8. Using the assumption that this operation would be enacted under 127A as is the current Emergency 14 Day Self Quarantine, is legally problematic because the conditions of the emergency and the quarantine procedure have significantly changed.

Under the Emergency Proclamation, the Emergency 14 Day Self Quarantine is based on the unknown facts of a lethal, highly contagious disease that was spreading through the world. HRS 325-8 was

inadequate to deal with the rapid and mass quarantine required to contain the spread among the population in Hawaii.

The Emergency 14 Day Self Quarantine allowed for the control of the disease and also allows for the quarantine to be carried out in a manner conducive to the elements of HRS 325-8:

- Quarantine will be administered to respect the dignity of the individual,
- Quarantine will be administered by the least restrictive means necessary.

The significant changes in conditions and procedure of Mandatory Quarantine are:

1. The medical environment has changed, the mainland is controlling the disease / outbreaks to the point of lifting restrictions and reopening the economy. Hawaii is also developing a reopening and recovery plan. Hawaii has the lowest fatality rate in the country, one of the lowest case rates per capita of transmission, one of the lowest transmission rates, and the medical criteria to approve requests for FEMA assets does not exist at this time.

2. The nature and procedure of the quarantines have changed; where the 14 Day Self Quarantine allows for traveler choice (voluntary), greater freedom of movement, and maintaining of personal belongings; the Mandatory Quarantine restricts choice, restricts movement, seizes baggage and may subject travelers to medical screening ordered by the state.

The following are the legal questions raised based on operational guidance of the Mandatory Quarantine:

1. Travelers entering the state:
    - Legal issue to authority of the state to mass quarantine (Restrict the freedom of movement)
    - Probable cause to detain, petition for order (travelling, in and of itself, is not prima facie evidence that someone is contagious or likely to have been
    - Due process issues, the quarantine order
    - Right to redress (court hearing)

2. Airport Processing of Travelers
    - Information collection, storage, dissemination are still issues
    - Medical screening; if it exceeds the current temperature and medical screening
3. Baggage Plan
    - The governments right to seize baggage without warrant or probable cause
    - Will this then lead to a warrantless search upon entering a quarantine facility?
4. Movement plan from airport
    - Detaining and transporting citizens without probable cause, warrant, or orders
5. Quarantine Site
    - Detainment
    - Seizure
    - Search
6. Medical checkup, branch plan for ill, clearance procedures
    - What type of medical check up can the government order a citizen to undertake?

- Can the government order a citizen to undergo medical treatment for an illness?
- How invasive is any checkup, treatment etc., does the government have the right to take samples?

Lastly, as in the current Emergency 14 Day Self-Quarantine, the Mandatory Quarantine would require several agencies to develop complex procedures to ensure uniformity of operations and that other legal requirements are met. Currently, it is very difficult to get well written procedures from departments, like DoT or DoH, both who have responsibilities in the current quarantine and in the proposed quarantine.

RECOMMENDATIONS:

1. Discontinue planning efforts based on the AG opinions that the operation is not legal.

2. Modify and or improve the procedures of the existing Emergency 14 Day Self Quarantine to meet all legal questions and publish a complete standing operate procedure. This should include all agencies who have statutory authorities to include transition plans for employees and operations as the medical and economical environment changes.

3. Determine the conditions, both medical and legally, when an en masse quarantine operation can be executed. Ensure the name of the operation or activity is different from existing legal processes to avoid confusion of definitions, legal classes, and origins of authority and responsibility.

Encl (1)

Director Hara and Administrator Meyers,

BLUF: The florist exemption raises many issues and granting an exemption has the possibility of creating legal issues within all subsections of industry ranging from the business owners and employees to the labor unions. There are right to work issues and such exemptions should first have policy developed on solid legal grounds to prevent greater issues in the legal environment.

- The Orders are in place to prevent / reduce the spread of COVID 19, while allowing critical societal functions to continue to operate.

- Allowing certain business to be exempted based on a holiday raises questions about preferences of exemptions ranging from governmental preferred treatment of specific businesses to preferences based on religion.

- Currently, there is no defined standard about who and why an exemption would be considered or granted; which reduces the strength of any exemption granted in the face of opposition.

However, for the immediate question of this exemption:

Option 1: Disapprove the exemption based on:

1) A holiday, in a relation to the risk of the disease and reason for the Orders, does not in itself, significantly reduce the risk to allow non-essential services to be temporarily restored. In fact, a holiday increases risk by allowing the circulation of more people.

2) The services a florist offers do not reduce risk, nor does it provide or enhance a lifesaving, emergency, or other critical service as defined by the Orders.

Option 2: Approve the exemption under the following guidelines:

1. The Governor has set up a team or group to grant exemptions to COVID 19 Orders. This group will retain the autonomy to grant such exemptions to maintain uniformity in the decision-making process and to clarify any limitations of the exemption.

2. Any businesses the Governor exempts will be required to operate under the same established provisions that an essential service or business is required to follow. This is the minimum requirement allowing most essential services to operate under the Orders in the current COVID 19 environment.

Encl (a)

3. Allow time for the business to adequately prepare (spin-up) when determining the effective dates of the exemption (from – to) to also allow for the wind down of their operations to meet the original restrictions under the current Orders.

   For Example: Florists are considered "essential services" and can begin operations immediately until May 13th using the same social distancing procedures essential services and businesses are currently operating under.

4. Counties retain the right to proscribe more stringent conditions on operations IAW their respective County Orders, however, they may not lower the minimum standard set by the State. In lieu of any written state or county protocols regarding COVID 19, business will use the CDC guidelines.

Further Considerations:

By allowing this exemption, the State will set a very low standard of criteria for the granting of business exemptions:

- The conditions around the exemption request is a holiday.
- The reason for the request is for the business to be able take advantage of the holiday to increase profits.
- This reasoning negates the purpose of the Orders in their entirety and will bring about more scrutiny and possible loss of public confidence in the government.
- Under this reasoning all business should be exempt. In this case, why should florists be able to open but not candy stores? And if candy stores are allowed to open, then why not Hallmark stores? And if Hallmark stores can open, why not jewelry stores?

This exemption will further raise questions about who has the right and is allowed to work under these Orders in both the public and private sectors.

- These Orders have limited the citizens in their ability to work.
- An exemption will grant certain citizens the privilege of work over others.
- These questions will have to be answered: Which citizens are excluded from the privilege to work? By Whom? By Whom and How will it be enforced?

Encl (a)

Hawaii State Department of Health

Section 3. Disease Surveillance and Investigation

Objective

This section describes the authorities and activities used in Hawaii to detect and characterize diseases caused by pathogens of national and global concern, as well as generate epidemiologic information to inform public health measures to control and prevent transmission.

Assumptions

HAR §11-156 (Communicable Diseases) directs all healthcare providers and laboratories to report, by the methods described in the chapter, any diseases and agents declared by the Director of Health to be "communicable and dangerous to the public health." This reporting requirement includes "any communicable disease not [specifically] listed...occurring beyond usual frequency, or of unusual etiology." Further, reporting is required whether a healthcare provider has definitively diagnosed a patient or suspects a diagnosis "in the absence of definitive test results for confirmation."

HRS §321-29 (Epidemiologic Investigations) states that HDOH will "conduct investigations to determine the nature and extent of diseases and injuries deemed by the department to threaten the public health and safety." Every person or entity with information relevant to HDOH epidemiologic investigations is therefore required under this authority to provide that information when requested by HDOH.

DOCD, under the direction of the State Epidemiologist or designee, is responsible for leading and coordinating all epidemiologic surveillance for and investigations of diseases that pose a public health threat or emergency. All information collected by HDOH as part of epidemiologic investigations is "kept strictly confidential, except as the director determines is necessary to protect the public health and safety." Access to confidential information is restricted to authorized HDOH personnel and others deemed necessary to protect the public's health. Generally, only non-identifying information may be released to the public.

Procedures

DOCD will conduct the following actions as described with surge capacity support as needed and possible.

Surveillance

- Communicate with other states, federal colleagues, and other relevant public health partners to monitor the disease activity occurring outside the State, especially that which may have direct and indirect implications for the State's response and public health.
- Monitor surveillance reports (e.g., from CDC or the World Health Organization [WHO]) to better understand and prepare for any potential impacts on the State
- Adopt the Council of State and Territorial Epidemiologists (CSTE) surveillance case definition[1] once established to ensure appropriate standardized identification and

[1] https://cdn.ymaws.com/www.cste.org/resource/resmgr/2020ps/interim-20-id-01_covid-19.pdf

reporting.

- Maintain routine surveillance activities to detect and monitor for the pathogen of concern and disease threat:
  - Monitor and verify disease reports from clinical providers.
  - Monitor and analyze data received via the electronic laboratory reporting (ELR).
  - For a respiratory pathogen such as influenza, SARS-CoV, or MERS-CoV, use the influenza surveillance framework:
    - Influenza-like illness (ILI)[2] sentinel surveillance network[3]—type of syndromic surveillance[4]
      - Monitor weekly numerator data of all ILI visits and denominator data of total all-cause visits provided by volunteer clinical providers located throughout the state; may suggest burden of disease activity.
      - Specimens from ILI visits directed to State Laboratories Division (SLD) for respiratory pathogen panel (RPP) testing to detect routine respiratory pathogens; testing for pathogen of concern (e.g., COVID-19) will be added; findings may suggest geographic scope of disease activity.
    - ILI cluster surveillance—monitor for and investigate any reports of ILI cluster occurring in any long-term care facilities (LTCFs) or school; all required to report any ILI cluster (persons with ILI around the same time and place).
    - Pneumonia & influenza mortality (P&I) surveillance—pneumonia serves as proxy for the pathogen of interest, whether flu or COVID-19; monitor for any increase in mortality compared with average of previous 5 and possibly 10 years to identify potentially increasing severity of disease.
    - Surveillance for severe, unexplained illness—monitor for any reports regarding emergency department or intensive care unit patients with severe, unexplained respiratory illness for specimen testing at SLD (RPP, testing for pathogen of concern [e.g., COVID-19]).
    - International air traveler passive surveillance—current federal law requires commercial airlines to report incoming ill passengers from international origins to port of entry; since October 2005, HDOH has collaborated with CDC Honolulu Quarantine Station, HNL medical group, Department of Transportation/Airports, and U.S. Customs and Border Protection to obtain clinical, epidemiologic, and contact information as well as collect specimens, on voluntary basis, from travelers meeting ILI

[2] Fever or history of fever of 38°C (100.4°F) or greater plus sore throat or cough; definition of ILI is being discussed.
[3] https://www.cdc.gov/flu/weekly/overview.htm (2. Outpatient Illness Surveillance); https://health.hawaii.gov/docd/about-us/programs/hawaiis-influenza-surveillance-program/ (How can clinical providers help contribute to Hawaii's Influenza Surveillance Program?); see also Appendix 2
[4] Refers to methods relying on detection, in near real time or real time, of individual and population health indicators that are discernible before confirmed diagnoses are made.

clinical criteria; all specimens tested at SLD by RPP; testing for pathogen of concern (e.g., COVID-19) will be added; therefore monitor for potential introductions of concern.

- Employ enhanced surveillance activities as needed to gain more accurate or complete understanding of potential disease activity entering or occurring in the State. Examples of such activities include:
    - Port of entry surveillance—to further monitor for potential introductions of concern; this type of surveillance is only surveillance, not a means to identify and capture all infected persons as those in the incubation phase may not be identified; this type of surveillance may not be pursued or prioritized once pathogen recognized to circulate widely within the State as staffing and resources refocused then on community-wide mitigation efforts and incoming travel likely to be limited.
        - Air. While active screening of all air passengers poses many challenges (e.g., many staff, adequate space, resources, etc.), this type of surveillance may be modified from the routine passive surveillance system (noted above) and/or expanded (e.g., to include all airports as well as domestic flights) to facilitate identifying introduction of pathogen of concern in Hawaii.
        - Water. Current federal law requires all ships to report any health issues to the Coast Guard in advance of arriving at the intended seaport. Further, passenger ships must report disease activity to CDC (international) or the US Food and Drug Administration (FDA; interstate). If needed, a similar surveillance to that described above with air partners may be employed under similar circumstances.
    - Hospital admission and emergency department surveillance—syndromic surveillance to determine the general pattern of disease activity through collection of hospital admission and emergency department visit data based on defined set of symptoms and/or criteria; previously engaged each respective healthcare facility's infection preventionist (IP); will pursue establishing electronic syndromic surveillance system (i.e., CDC ESSENCE[5]) to more efficiently collect necessary data.
    - Emergency medical services encounters surveillance—syndromic surveillance for transports of persons with ILI-type illness to determine potential pattern of disease activity, especially if increased; collaboration of Disease Outbreak Control Division with the Emergency Medical Services System and Injury Prevention Branch.
    - LTCF surveillance—expansion of routine surveillance as needed; monitor for illness clusters via active monitoring of illness among healthcare workers (HCWs) and staff in LTCFs; illness among LTCF residents may be subtle and not readily detected, therefore call and inquire with all LTCF IPs regularly, with focus

[5] https://www.cdc.gov/nssp/biosense/index.html

especially on high priority (i.e., at risk) LTCFs based on Centers for Medicaid and Medicare Services indicators; low threshold to test patients and staff where signs suggest a potential concern; review case data to determine other potential signs that may serve as indicators of concern to prompt testing.

- Serological surveillance—should an FDA approved and CDC validated serological (i.e., antibody) assay become available, consider a statewide serosurvey between pandemic waves to contribute to determining scope of disease spread caused by the immediately previous pandemic wave. Methodology for serosurvey may be determined according to guidance to states from CDC, and at the very least should involves sampling on all islands targeting especially vulnerable population and where the population is most dense.
- Nontraditional data sources—monitor internet and social media activity to gauge areas of public concern and potential gaps in public information.

Investigation

- Use known information to establish criteria or use the established CSTE case definition to identify suspect cases for investigation and determine conditions for risk of exposure.
- When the pathogen of concern has not yet been introduced or is not yet widely circulating in the State, follow-up every reported suspect and confirmed case in person, by phone, and/or electronically as appropriate to:
  - Verify and confirm potential disease activity.
  - Identify potential case contacts who may be at risk—i.e., contact tracing.
  - Use digital application (i.e., HealthSpace, see Appendix 1) to augment contact tracing and monitoring efforts
  - If HCWs identified as cases, work with the affected healthcare facility to provide technical guidance regarding infection control and support or delegate contact tracing and monitoring of affected HCWs, staff, and patients under DOCD supervision
  - Identify persons who require isolation (i.e., confirmed cases) and those who require quarantine (i.e., close contacts[6] exposed to the confirmed case)
  - If the possibility exists for the pathogen or disease to involve an environmental vehicle, determine potential environmental exposures that may need to be considered for control (e.g., product embargo).
  - Determine scope of pathogen transmission and/or disease activity.
- When the pathogen or disease of concern is circulating in the State:
  - As long as feasible with current and available surge (see below) staff, continue investigations and contact tracing, especially if community mitigation measures (e.g., extreme social distancing measures such as shelter in place) have been engaged to support slowing disease spread

[6] For COVID-19, defined as being within 6 feet for a period of 10 minutes to 30 minutes or more depending upon the exposure. In healthcare settings, this may be defined as exposures of greater than a few minutes or more. Data are insufficient to precisely define the duration of exposure that constitutes prolonged exposure and thus a close contact.

- When disease spread continues to increase such that the median cases per day continues to at least double each week for 2 maximum incubation periods of the disease of concern, consider limiting investigations to focus on potential introduction in new areas of the State (e.g., island with no previous activity) and/or characterize a large or unusual outbreak of the disease (e.g., affecting a specific population subset). At this point, disease control should focus primarily on strict community-wide mitigation measures.

Surge staffing

- When disease threat is indicated as imminent, review, monitor, and mobilize all DOCD staff as needed to determine surge support from other program areas of DOCD.
- When call (i.e., inquiries for general information) volume for the Officer of the Day or Standby Officer exceeds normal weekly call volume (2019: 0–24/wk, median 10/wk) such that DOCD is receiving greater than 50 calls/wk, activate call support from 2-1-1.
- If calls to DOCD continue to increase despite 2-1-1 activation and/or burden of disease investigation of suspect cases is such that assignments to DOCD[7] investigators including those from other areas of DOCD exceed 5 new case assignments/investigator/day, request surge staffing from within DOH, starting with the Public Health Nursing (PHN) Branch and then the STD/HIV Program.
  - Surge staff will be arranged in a hub and spoke model, such that DOCD and STD/HIV (once oriented and experienced) Epidemiological Specialists will be the hubs, coordinating the spokes, i.e., Epidemiological Specialist Extenders (e.g., PHNs).
  - Theoretically, each hub may have a maximum of 5–7 Extenders, but ideally 3.
- The same hub-spoke model would be used for the Infection Control and Prevention Team for contact tracing in healthcare facilities when cases among healthcare workers identified.
  - Hubs: DOCD Healthcare Associated Infection and Antimicrobial Resistance Epidemiologists with potential surge support from other Surveillance Epidemiologists.
  - Spokes: Immunization Branch RN, PHNs, student nurses, medical residents, etc.
- If the pace of new case assignments per day continues at 5/investigator for >1 week or increases, seek surge staffing outside the Department.
  - Initially may use volunteers via the Medical Reserve Corps and universities (e.g., student nurses, medical residents, etc.)
  - Federal or other emergency funds anticipated to support response
  - Rapid hire staff (e.g., via The Research Corporation of the University of Hawaii, contract staffing) identified through the University of Hawaii Community Health Worker program
  - Number of maximum investigations and monitoring staff (including DOCD and DHOs—i.e., statewide)

[7] Including District Health Office (DHO) investigators

- Epidemiological Specialists, including surge staffing from STD/HIV Program: up to 23
- Plus, ideal number of Extenders: 69
- If maximum number of Extenders: 115–161

- Consider, surging up to the maximum staffing would mean handling up to 920 new cases per day, a rate not actually tenable to try to achieve disease control only by contact tracing as very likely ICU and bed capacity would have been surpassed long before that point. At 200 or even 50 new cases per day, strict social distancing measures will be required to more effectively curtail the disease activity.

Hawaii State Department of Health

Appendix 1. New Tool for Digital Monitoring of COVID-19 Contacts

Overview

The Hawaii State Department of Health (HDOH) is implementing a new tool to expand existing contact tracing and monitoring capacity. During routine investigation of COVID-19 cases, any close contacts, who are identified as being at risk of infection, are monitored with daily phone calls from disease investigators or public health nurses. Using this new digital health monitoring tool, the contacts of cases can now provide their health information through a secure link that will direct them to a cloud-based survey and transmit their responses directly to HDOH. The tool will also serve as a secure portal allowing HDOH to protect individual's privacy while utilizing non-HDOH staff. Volunteers acting as surge capacity staff (e.g., public health nurses) can be given limited permission accounts allowing them to only access and manage information for the contacts assigned to them. This tool leverages cloud technology to significantly increase the reach and capacity of HDOH disease investigators and their surge capacity extenders by identifying new cases and monitoring all close contacts of these cases and thereby augments the State's effort to track and prevent the spread of disease.

Process

When a person has been identified as a close contact by a COVID-19 case the contact will receive an initial phone call from an HDOH investigator or public health nurse to explain they are at risk of COVID-19 disease, are required to remain at home for 14 days, and will need to monitor their health. The contact of the case will provide an email or cell phone number to automatically receive a daily survey. The survey will ask if they have a fever, cough, shortness of breath, or other symptoms that could be signs of COVID-19. Anyone can opt-out of receiving these messages if they prefer, and an investigator or nurse will call them to collect their health information.

- Contacts who respond NO to all questions will continue to receive surveys every 24 hours until their risk period has ended.
- Contacts who respond YES to any of the questions will receive a follow-up call to assess their health and determine if they meet criteria for a probable case or potentially warrant testing.
- Contacts who opt out by responding "STOP" or who fail to respond to the survey in 48 hours will receive a follow-up call.

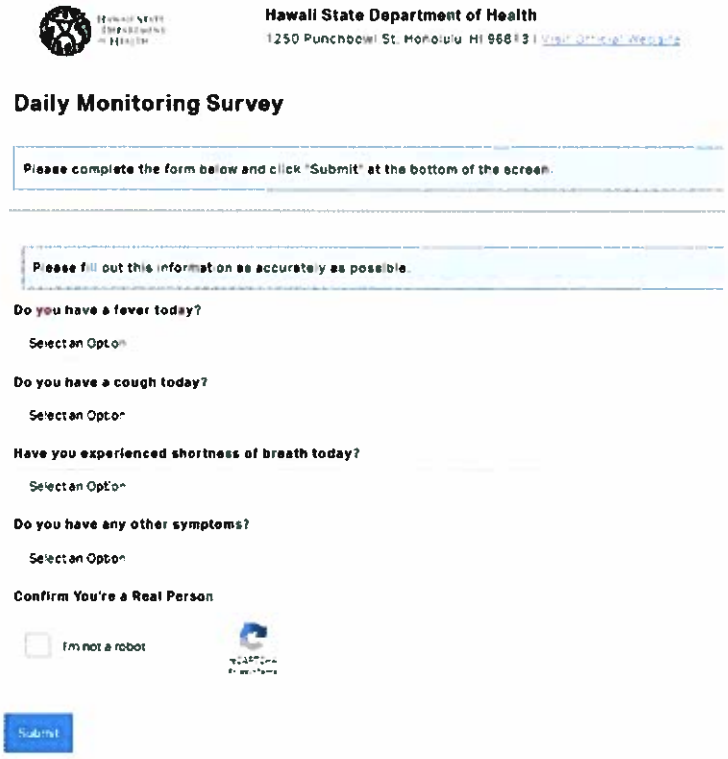

Image: daily monitoring survey for close contacts of COVID-19 cases

FAQs

1. Privacy
    - The survey does not collect location information
    - Survey responses can only be viewed by HDOH investigators and are not shared
2. Security
    - Data are encrypted using 256-bit SSL and stored on data servers that are certified HIPAA-compliant
3. Costs/Barriers to Users
    - The application does require the user has access to a smartphone or email and internet access. People who are unable to complete the survey using these modes will be contacted by telephone.
    - Unlike many app-based solutions, the tool does not require the user to download any third-party applications and can be accessed from any device that has an internet connection and browser.
    - There are no costs to the end-user associated with receiving the text message or completing the survey
4. What company or organization is being used to run the platform?
    - We have contracted with HealthSpace, a cloud-based platform with more than 20 years of experience in offering data solutions to local and state public health agencies in the US and Canada.
    - HealthSpace has contracts with over 500 health departments, and their platform is being used for the COVID-19 response in many of these jurisdictions.
    - All data collected is the sole and exclusive property of HDOH.
    - HealthSpace has signed a confidentiality and non-disclosure agreement to ensure protection of all data collected and stored using the application.

Appendix 2. ILINet/COVID Sentinel Surveillance

The U.S. Outpatient ILI Surveillance Network, or ILINet, is a nationwide network of healthcare providers that report information on outpatient visits for ILI to CDC. Data reported by these sentinel providers in combination with other surveillance data provide a national picture of influenza, COVID, and ILI activity in Hawaii and the United States. ILINet sentinel providers report the number of patient visits for ILI by age group (0–4 yrs, 5–24 yrs, 25–49 yrs, 50–64 yrs, and 65+ years) each week throughout the year. Clinical providers including physicians and nurses in most clinical practice settings are eligible.

In addition to reporting ILI patient numbers, sentinel providers submit respiratory specimens from patients with ILI symptoms to the Hawaii Department of Health (HDOH) free of charge. Most sentinel providers submit patient specimens to a clinical laboratory for initial testing, which are then forwarded to SLD for further confirmatory testing and surveillance purposes. Because of the recent change (i.e., beginning of March 2020) in the healthcare landscape (e.g., telemedicine), HDOH has also recently started offering the assistance of "swab teams" to collect specimens of sentinel provider patients at their homes to then be tested directly at SLD. Specimens forwarded through a clinical laboratory or received directly from a sentinel provider are tested within one business day. SLD offers free RT-PCR influenza A/B testing and typing, respiratory pathogen panel (RPP), and COVID testing. Testing of COVID specimens as a part of sentinel surveillance is one of the surveillance components that can help HDOH identify cases of community transmission, clusters, and disease spread and activity.

Hawaii's ILINet program has sentinel providers enrolled from all counties in the state. Practice types of participating sentinel providers include family practice, internal medicine, pediatricians, student health, urgent care, and emergency medicine. Among registered sentinel providers, there are 17 in Honolulu county, six in Hawaii county, five in Maui county, and four in Kauai county. Sentinel providers are located in various cities in each county. An increase in the reported ILI numbers and/or COVID positive results from a provider or area may help us identify clusters or community transmission.

Although Hawaii has a range of dedicated providers, there may be some areas and populations not represented by a sentinel provider. HDOH has been actively reaching out to our community healthcare partners and Federally Qualified Health Centers (FQHC) and recruiting more sentinel providers into our ILINet program for the surveillance of ILI and COVID. Once they are enrolled in ILINet, they can immediately begin to report their numbers and send specimens to SLD for testing.