

FAQs: COVID 19 Conference Calls – Updated Week of July 23, 2020

The following FAQs are listed by topic in alphabetical order for quick reference. They include website links as information changes quickly. The dates in parenthesis () following each link refer to the last time the link was known to be updated.

Unless otherwise noted, the recommendations relate to a home health, hospice, private duty, infusion, palliative care or DMEPOS provider. **Weekly updates made to topics or websites are noted in red with the corresponding week noted to make it easier to see changes week to week.**

If you have questions or comments, please send them to education@chapinc.org Thank you!!

July 23 – the Public Health Emergency that officially ends July 25 has been extended for another 90 days. Extending the emergency declaration allows providers to continue to use waivers and flexibilities issued to assist in responding to the COVID-19 pandemic.

A

Assisted and Independent Living Facility Access:

Check your state to determine if the governor or health department has mandated staff COVID-19 testing for ALFs. Home health and hospice staff can be included as you represent staff coming in to provide care – called ‘vendors. To date weekly or bi-weekly COVID 19 mandated testing is reported. CHAP recommends contacting the ALF administration for information about possibly obtaining the tests from the same vendor and using the same lab.

CMS addresses Home Health Agency (HHA) and Hospice access to assisted (ALF) and independent living facilities (ILF) in an updated memorandum you can access via the link at the end of this section.

- Both ALFs and ILFs are not subject to federal regulation, rather state authority. However, CMS states

HHAs and hospices serve an important role in providing essential healthcare services in a variety of community-based settings, including assisted and independent living facilities and should be granted access as long as their staff meet the CDC guidelines for healthcare workers.

- Additionally, hospice and HHA personnel should participate with any screening activity that the facility requires.
- If access is restricted, hospices and HHAs should communicate with the facility administration, including the State or local health department when indicated, on the nature of the restriction and timing for gaining access to hospice or home care patients.
- HOSPICE DISCHARGE: Communication should also occur with the hospice patient’s family or representative. If after reasonable attempts have been made and documented in the patient’s record and the hospice continues to be unable to access the patient *in-person*, the hospice would have to

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discharge the patient as “outside of the hospice’s service area” (Medicare Benefit Policy Manual, chapter 9, 20.2.3):

- Additionally, a hospice must forward to the patient’s attending physician a copy of the hospice discharge summary and patient’s clinical record if requested.
 - <https://www.cms.gov/files/document/covid-fags-non-long-term-care-facilities-and-intermediate-care-facilities-individuals-intellectual.pdf> June 2020 Pages 9-13
- Note that a State or Local health department can issue a directive restricting access to a specific ALF/ILF that can result in no access, however this should be an exception.
- If the HHA is refused access, document the situation in the patient’s record and advise the patient’s physician. <https://www.cms.gov/files/document/qso-20-18-hha-revised.pdf>
(March 10 Memo Revised April 23, 2020 note HHA reference to ALF/ILF access on page 6 of 10)

C

CDC Clinician On-Call Center is a hotline with trained CDC clinicians standing by to answer COVID-19 questions daily from healthcare personnel on a wide range of topics, such as diagnostic challenges, clinical management, and infection prevention and control. To reach this service, call 800-CDC-INFO (800-232-4636) and ask for the Clinician On-Call Center.

Children -Pediatric Patients <21 years old

- **MISC-C: Multisystem Inflammatory Syndrome in Children.** Over 250 cases have been reported in children primarily aged 2-15 years. Different body parts can become inflamed, including the heart, lungs, kidneys, brain, skin, eyes, or gastrointestinal organs. The CDC does not yet know what causes MIS-C. MIS-C can be serious, even deadly, but most children who were diagnosed with this condition have gotten better with medical care. Pediatrician offices have been alerted nationwide.

The latest symptoms and information for parents can be found at:

<https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/children/mis-c.html> (May 20, 2020)

There is limited information currently available about risk factors, pathogenesis, clinical course, and treatment for MIS-C.

- Patients with MIS-C have presented with a persistent fever and a variety of signs and symptoms including multiorgan (e.g., cardiac, gastrointestinal, renal, hematologic, dermatologic, neurologic) involvement, and elevated inflammatory markers.
- Not all children will have the same symptoms, and some children may have symptoms not listed above.

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- MIS-C may begin weeks after a child is infected with SARS-CoV-2. The child may have been asymptotically infected, and, in some cases, the child and their caregivers may not even know they had been infected.
- CDC is requesting healthcare providers who have cared or are caring for patients younger than 21 years of age who meet the MIS-C criteria to report suspected cases to their local or state health department.
 - For additional information, please contact CDC’s 24-hour Emergency Operations Center at 770-488-7100. After hour phone numbers for health departments are available at the Council of State and Territorial Epidemiologists website (<https://resources.cste.org/epiafterhoursexternal> icon).
- Case Definition for Multisystem Inflammatory Syndrome in Children (MIS-C) Provided to Pediatric Practices:
 - An individual aged <21 years presenting with fever $\geq 100.4^{\circ}\text{F}$ for ≥ 24 hours, or report of subjective fever lasting ≥ 24 hours; laboratory evidence of inflammation, and evidence of clinically severe illness requiring hospitalization, with multisystem (≥ 2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic or neurological); AND
 - No alternative plausible diagnoses; AND
 - Positive for current or recent SARS-CoV-2 infection by RT-PCR, serology, or antigen test; or COVID-19 exposure within the 4 weeks prior to the onset of symptoms: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html> (May 29, 2020)

Clinical Study Findings of US COVID 19 Patients:

- Study Findings from the first 100,000 COVID 19 US Cases:
 - The incubation period continues to extend to 14 days, with a median time of 4-5 days from exposure to symptoms onset.¹⁻³ 97.5% of COVID-19 infected persons who develop symptoms, do so within 11.5 days of infection.³
 - The signs and symptoms of COVID-19 present at illness onset vary, but over the course of the disease, most persons with COVID-19 will experience the following^{1,4-9}:

| | | |
|-------------------|------------------|------------------------------|
| Fever (83–99%) | Cough (59–82%) | Sputum production (28–33%) |
| Anorexia (40–84%) | Fatigue (44–70%) | Shortness of breath (31–40%) |
| Myalgias (11–35%) | | |
 - Headache, confusion, rhinorrhea, sore throat, hemoptysis, vomiting, and diarrhea have also been reported but are less common (<10%).^{1,4-6}
 - Older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms.^{10,11}
 - Patients with risk factors for severe illness should be monitored closely given the possible risk of progression to severe in the second week after symptom onset.^{5,6,10,11}
 - Patients on ACE inhibitors or ARBs may increase the risk of SARS-CoV-2 infection and COVID-19 severity.⁴⁵The American Heart Association (AHA), the Heart Failure Society of America (HFSA), and the American College of Cardiology (ACC) released a statement recommending

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continuation of these drugs for patients already receiving them for heart failure, hypertension, or ischemic heart disease.⁴

- Additional information about clinical presentation, including Hypercoagulability can be found at the website that follows.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html> May 20, 2020

NEW VULNERABLE POPULATION DISEASE RISK FACTORS: Continued study of individuals who tested positive for COVID 19 has identified the strongest and most consistent evidence of factors of the populations that are most vulnerable for severe illness from COVID-19.

- Aged 65 and older continues as a risk for severe illness. 65 and older make up 31% of cases in US as of June 2020, 50% of hospitalizations, about half of those admitted to ICUs and about 80% of those who died
- People of any age with the following conditions **are at increased risk** of severe illness:
 - Chronic kidney disease
 - COPD
 - Immunocompromised state post solid organ transplant
 - Obesity, defined as a body mass index (BMI) of 30 or above, increases your risk of severe illness from COVID-19. There are adult, teen and child calculators at:
<https://www.cdc.gov/healthyweight/assessing/bmi/index.html>
 - Serious heart conditions, such as heart failure about 10% of cases, coronary artery disease, or cardiomyopathies
 - Sickle cell disease, and
 - Type 2 Diabetes

It is Important to consider the multiplier effect of age and condition, particularly if these conditions are not well controlled and self-managed.

Children who are medically complex, who have neurologic, genetic, metabolic conditions, or who have congenital heart disease are at higher risk for severe illness from COVID-19 than other children.

Conditions of Participation: Emergency Plan Requirements

- **Hospice - CFR §418.113:** The hospice must comply with all applicable Federal, State and local emergency preparedness requirements. The hospice must establish and maintain a comprehensive emergency preparedness program that meets these requirements. The emergency preparedness program must include, but not be limited to, the following elements:
 - **(a) Emergency Plan.** The Hospice must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every two years. The plan must do all of the following:
 - (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.

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- (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice’s ability to provide care.
 - (3) Address patient/family population, including, but not limited to, persons at-risk; the type of services the hospice has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
 - (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.
- **Policies and Procedures:** Facilities]must develop and implement emergency preparedness policies and procedures, based upon the emergency plan set forth in paragraph(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:
 - (1) Procedures to follow up with on duty staff and patients to determine services that are needed, in the event that there is an interruption in services during, or due to an emergency. The hospice must inform state and local officials of any on-duty staff or patients that they are unable to contact.
 - (2) The procedures to inform State and local emergency preparedness officials about homebound Hospice patients in need of evacuation from their residences at any time due to an emergency situation based on the patient’s medical and psychiatric condition and home environment.
 - (3) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.
 - (4) The use of hospice employees in an emergency or other staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency
 - (5) The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.
 - (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
 - (i) A means to shelter in place for patients, hospice employees who remain in the hospice
 - (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance
 - (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include but are not limited to the following:
 - (A) Food, water, medical and pharmaceutical supplies.
 - (B) Alternate sources of energy to maintain the following:

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- (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
 - (2) Emergency lighting.
 - (C) Sewage and waste disposal.
 - (iv) The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.
 - (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other locations.
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- (c) **Communication Plan:** The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:
 - (1) Names and contact information of the following:
 - Staff
 - Entities providing services under arrangement
 - Patient's physicians
 - Other hospices
 - (2) Contact information for the following:
 - Federal, State, Tribal, regional, and local emergency preparedness staff
 - Other sources of assistance
 - (3) Primary and alternate means for community with:
 - Staff
 - Federal, state, tribal, regional, and local emergency management agencies.
 - (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.
 - (5) A means , in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii)
 - (6) A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4)
 - (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center or designee
- (d) **Training and testing.** The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at

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paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

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- **(1) Training.** The hospice must do all of the following:
 - (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
 - (ii) Demonstrate staff knowledge of emergency procedures.
 - (iii) Provide emergency preparedness training at least *every 2 years*.
 - (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
 - (v) *Maintain documentation of all emergency preparedness training.*
 - (vi) *If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.*
- **(2) Testing** for hospices that provide care in the patient’s home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
 - (i) Participate in a full-scale exercise that is community based every 2 years; or
 - (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
 - (B) if the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
 - (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
 - (A) second full-scale exercise that is community-based or a facility based functional exercise; or
 - (B) A mock disaster drill; or
 - (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
- **(3) Testing for hospices that provide inpatient care directly.** The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
 - (i) Participate in an annual full-scale exercise that is community-based; or

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- (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or*
- *(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.*
- (ii) Conduct an additional annual exercise that may include, but is not limited to the following:*
 - (A) second full-scale exercise that is community-based or a facility based functional exercise; or*
 - (B) A mock disaster drill; or*
 - (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.*
- (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.*

(e) Integrated healthcare systems. If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:] (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

- (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.
- (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program].
- (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:
 - (i) A documented community-based risk assessment, utilizing an all-hazards approach.
 - (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
- (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

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- **Home Health - CFR §484.102:** The home health agency must comply with all applicable Federal, State and local emergency preparedness requirements. The agency must establish and maintain a comprehensive emergency preparedness program that meets these requirements. The emergency preparedness program must include, but not be limited to, the following elements:
 - (a) Emergency Plan. The Home Health must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every two years. The plan must do all of the following:
 - (1) Be based on and include a documented, agency-based and community-based risk assessment, utilizing an all-hazards approach.
 - (2) Include strategies for addressing emergency events identified by the risk assessment.
 - (3) Address patient population, including, but not limited to, persons at-risk; the type of services the agency has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
 - (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation.
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 - (b) **Policies and Procedures:** [Facilities] must develop and implement emergency preparedness policies and procedures, based upon the emergency plan set forth in paragraph(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:
 - (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55.
 - (2) The procedures to inform State and local emergency preparedness officials about Home Health Agency patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.
 - (3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact.
 - (4) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.
 - (5) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

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- **(c) Communication Plan:** The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:
 - (1) Names and contact information of the following:
 - Staff
 - Entities providing services under arrangement
 - Patient’s physicians
 - volunteers
 - (2) Contact information for the following:
 - Federal, State, Tribal, regional, and local emergency preparedness staff
 - Other sources of assistance
 - (3) Primary and alternate means for community with:
 - Staff
 - Federal, state, tribal, regional, and local emergency management agencies.
 - (4) A method for sharing information and medical documentation for patients under the [facility’s] care, as necessary, with other health providers to maintain the continuity of care.
 - (5) A means , in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii)
 - (6) A means of providing information about the general condition and location of patients under the [facility’s] care as permitted under 45 CFR 164.510(b)(4)
 - (7) A means of providing information about the [facility’s] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center or designee
- **(d) Training and testing.** The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.
 - (1) Training program. The [facility] must do all of the following:
 - (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
 - (ii) Provide emergency preparedness training at least every 2 years.
 - (iii) Maintain documentation of all emergency preparedness training.
 - (iv) Demonstrate staff knowledge of emergency procedures.
 - (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.
 - (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:
 - (i) Participate in a full-scale exercise that is community-based every 2 years; or

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- (A) When a community-based exercise is not accessible, *conduct a facility-based functional exercise every 2 years; or*
 - (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in *its next required* community-based or individual, facility-based *functional* exercise following the onset of the actual event.
 - (ii) Conduct an additional exercise *at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted*, that may include, but is not limited to the following:
 - (A) A second full-scale exercise that is community-based or individual, facility-based *functional exercise; or*
 - (B) *A mock disaster drill; or*
 - (C) A tabletop exercise *or workshop that is led by a facilitator and includes a group discussion* using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
 - (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed
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- (e) **Integrated healthcare systems.** If a [facility] is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the [facility] may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must- [do all of the following:]
 - (1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.
 - (2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.
 - (3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance [with the program].
 - (4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:
 - (i) A documented community-based risk assessment, utilizing an all-hazards approach.
 - (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
 - (5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

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Pandemic Considerations for Emergency Preparedness Plan Development

- Community-based considerations in risk assessment :
 - Prevalence of the virus
 - Ability to staff to meet community need
 - Continual monitoring of changes in risk level
- Facility-based considerations in risk assessment
 - Availability of PPE
 - Ability to social distance within the facility
 - The need to implement remote work
 - Number of employees at high risk
- Addition of other emergent events to the COVID crisis, (natural disasters)
 - Evaluate the need for the agency to include this possibility in their risk assessment – 2 emergencies at once
 - Prepare staff and patients with emergency plans that will meet the CDC recommendation of no more than 50 people in a shelter
 - Plan ahead
- Addressing patient population and ability to provide services
 - Discuss methods to address patient/family fears causing refusals to be seen in-person
 - Work with facilities to educate them on the staff's precautions to ease their anxiety about giving access
 - Consider which types of patient needs you are and are not able to meet in the midst of the pandemic
- Continuity of operations
 - Ensure appropriate staffing to meet patient needs even if staff are out
 - Are staff cross trained to allow for continuing operations smoothly if one is out such as the administrator or clinical manager.
- Process for collaboration with emergency officials
 - Is the contact information easily accessible for the appropriate emergency officials: public health department, other resources for information such as state associations?

Pandemic Considerations for the Communication Plan

- (1) Contact information employees/contract/physicians
 - Update the employee listing with each new employee and each employee who left
 - Update the patient list with physician numbers . Keep the list current to include new admissions and removal of discharges
- (2) Contact information for emergency management and other assistance
 - Keep in mind that the assistance might be physical need, supplies, or current information
 - Currently the national and state home health and hospice associations are resources, as well as, CDC updates, and CMS helpline
- (3) Means for primary and alternate communication

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- Emergency management personnel is a good resource to ask about what would be beneficial in the agency location for alternate communication
 - Possibilities include CB radio, walkie-talkies- or satellite phones
- (4) A method for sharing documentation for patients under your care and as necessary with other health providers
- (5) a means to release patient information in case of evacuation
- (6) a means of providing information about the general condition of the patient
 - Consider at this time with the use of telehealth and uncertainty of who will be able to work on any given day, what process will be used to ensure that coordination of care is occurring not only between service lines, but also between like disciplines.
 - How is documentation being maintained to reflect the current status of the patient so if someone needed to fill in, they understand what the patient needs?
- (7) means to provide information to those having jurisdiction
 - What process is in place so the agency knows on a continual basis, any needs they have and whether they would be able to lend assistance if needed.

Pandemic Considerations related to Policy and Procedures:

- **Policies related to on-duty staff address**
 - screening processes of both staff and patients
 - of follow up if a staff member becomes ill during the work day
- **Procedure to inform officials of patients in need of evacuation from their residences**
 - this may be in relation to patients who become COVID positive and need to be moved to another care environment to have their needs met OR
 - patients whose caregivers become ill and there is needed assistance for the patient that the caregiver is unable to give
 - also keep in mind the potential impact of a natural disaster such as hurricane, floods or fire on top of the COVID actions
- **A system of medical documentation that preserves patient information, protects confidentiality of patient information, secures and maintains availability of records.**
 - Pandemic considerations here include the method of providing key information to receiving facilities in cases of patient transfer and to the receiving physician in cases of patient discharge.
 - Agencies may need to utilize contract staff and if they have not done so before, have a need to develop a process for sharing information, especially if documentation is late or the electronic documentation is not accessible to the contract staff.
 - When using telecommunication methods, a process for ensuring protection of patient information during the session needs to be followed
- **The use of volunteers/employees in an emergency or other staffing strategies to address surge needs**

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- The hiring of contract staff is one strategy, another is utilizing telecommunication methods whenever appropriate to be able to use typical travel time on visits.
- Developing processes to deal with COVID positive or Persons Under Investigation is also a key staffing strategy, some examples that have been shared by providers include assigning particular clinicians to provide care to COVID patients, using high risk employees in other positions such as provision of telehealth, determining how to address health care personnel who have been exposed but remain asymptomatic.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_z_emergprep.pdf

Condition of Participation: Infection Control

- **Hospice – CFR §418.60:** The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.
 - (a) Standard: Prevention
 - The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
 - (b) Standard: Control
 - The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that—
 - (1) Is an integral part of the hospice's quality assessment and performance improvement program; and
 - (2) Includes the following:
 - A method of identifying infectious and communicable disease problems; and
 - A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.
 - (c) Standard: Education
 - The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.

Home Health – CFR §484.70: The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases.

- (a) Standard: Prevention
 - The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.
- (b) Standard: Control.

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- The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include:
 - (1) A method for identifying infectious and communicable disease problems; and
 - (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention.
- (c) Standard: Education.
 - The HHA must provide infection control education to staff, patients, and caregiver(s).

Pandemic Considerations of Infection Control

- **Infection Prevention:** Six (6) standard precautions identified by the Center for Disease Control and Prevention healthcare infection control practices committee should apply during any episode of care and they include:
 1. **Hand Hygiene:** - our pandemic considerations here are to ensure everyone has the education to know how and when to conduct appropriate hand hygiene in relation to the spread of COVID-19.
 2. **Environmental Cleaning and Disinfection;** We have discussed pandemic considerations in relation to cleaning and disinfecting frequently touched areas and the use of appropriate disinfectant when doing so.
 3. **Injection and Medication Safety.**
 4. **Appropriate Use of Personal Protective Equipment;** pandemic consideration related to PPE are varied from the agency having an adequate supply of PPE, to ensuring staff have sufficient individual supplies, to ensuring all employees are using appropriate PPE correctly, to teaching patients and family about when to wear masks and the correct way to do so.
 5. **Minimizing Potential Exposures;** pandemic considerations here include how to address high risk staff, determining the safest way to provide care to each individual patient, ensuring appropriate ongoing screening of staff, patients, family and visitors
 6. **Reprocessing of reusable medical equipment between each patient and when soiled.** An initial consideration is whether to carry any equipment into the home. If equipment is used patient to patient, ensuring appropriate disinfection with an approved disinfectant is key.
- **Infection Control:**
 1. Evaluation of staff competence in donning and doffing PPE appropriately
 2. Ongoing screening of staff and patients
 3. Ability to respond quickly in cases where either patients or staff become symptomatic or test positive
 4. Ensuring appropriate PPE for all staff...external and internal
 5. Monitoring contacts of each staff to enable contact tracing if needed

Education

1. Reinforce the importance of maintaining PPE and ongoing screening

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2. Provide patients and family members information regarding screening and symptoms to watch for
3. Patients who become positive or have a potential COVID family member need information regarding isolation, masks, care of frequently touched surfaces and disinfection

COVID-19 Symptom List

- The list of symptoms of COVID-19 infection has been expanded. See CHAP document titled: “COVID-19: Updated Information Related to Symptoms and Protection” on education website at <https://education.chapling.org/>

CMS Survey Status:

CHAP resumed regular survey activity for Home Health and Hospice Surveys the week of June 8, 2020. This means that accredited organizations can expect a re-certification visit or a focus visit associated with a previous site visit. Site visits for deemed organizations remain unannounced. Initial site visits will continue to be scheduled based on readiness. Re-accreditation visits for all other organizations will be scheduled per our usual process.

- The scheduling of CHAP site visits will be based on a state’s re-opening criteria.

CHAP site visitors will be assessing compliance with standards acknowledging:

- Current federal blanket waivers for home health and hospice regulations - if your organization obtained a specific waiver, please have that available at the time of your site visit.
 - State Medicaid waivers, and
 - Applicable state executive orders.
- If you have questions, please contact your Director of Accreditation. We appreciate your continued dedication to the delivery of quality patient during this pandemic.

DMEPOS: The CMS AO suspension of surveys has expired. CHAP has resumed initial and renewal surveys. If you have questions, please contact your Director of Accreditation, Jackie King.

D

Disaster Shelters

CDC Guidelines for Disaster Shelters During the Pandemic: The CDC has released guidelines for state and county governments when opening shelters due to disasters (e.g. hurricanes, flooding, etc.).

- 50 or less people in a shelter to support social distancing.
- Daily symptom screening.
- The CDC preference is that vulnerable individuals *are not* moved to a shelter, but to remain at home.

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- Medical support shelters and functional needs shelters may be available for the more vulnerable populations during disasters.
<https://www.cdc.gov/coronavirus/2019-ncov/downloads/Guidance-for-Gen-Pop-Disaster-Shelters-COVID19.pdf>

Due to the pandemic, hospitals or SNFs that previously would take patients/clients who had medical needs and had to be evacuated may be unable to take these patients/clients due to COVID-19 risk.

- If the area you serve typically faces disasters (e.g. hurricanes, floods, etc.) and with this information in mind, is there anything you may need to change in patient/client classification for evacuation?
- Companion animals are not preferred in animal shelters during disasters. If the pet is coming from the home of a positive COVID 19 patient/client, please advise a shelter.

<https://www.avma.org/resources-tools/animal-health-and-welfare/covid-19/interim-recommendations-intake-companion-animals-households-humans-COVID-19-are-present>

July 23 2020: Additional CDC Disaster Planning Resources for Use During Pandemic

https://www.cdc.gov/disasters/disaster_resources.html (July 1 2020)

Includes hurricanes, storms and extreme heat

<https://www.cdc.gov/disasters/hurricanes/covid-19/prepare-for-hurricane.html>

If the patient will be evacuating and staying with another family, and so in closer quarters than usual.

Info for specific populations: <https://emergency.cdc.gov/groups.asp>

COVID-19 and Cooling Centers:

- Cooling centers (a cool site or air-conditioned facility designed to provide relief and protection during extreme heat) are used by many communities to protect health during heat events
- NOTE that the use of cooling centers can result in congregating of groups of at-risk people, such as older adults or those with respiratory diseases, and potentially provide a route for the transmission of the SARS COV-2 virus and subsequent development of COVID-19 disease among both visitors and staff. Poor air circulation is the risk, patients who are vulnerable better if at home.
- If patients must go to a cooling centers, advise them to expect verbal screening or temperature checks before being admitted to the cooling center. There is no guarantee that the center will be able to separate those individuals that develop COVID 19 symptoms during the emergency.
- The recommendation for vulnerable populations is to seek utility assistance, such as the low-income home energy assistance program (LIHEAP) or similar methods that provide financial assistance for home air conditioner use or gain access to air conditioning with avoiding the risk of cooling centers
<https://www.cdc.gov/coronavirus/2019-ncov/php/cooling-center.html> April 2020

DMEPOS

July 23, 2020: Prior Authorization Resumes August 3, 2020, regardless of the status of the public health emergency. CMS will resume full operations for the prior authorization program for certain DMEPOS items.

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- For Power Mobility Devices and Pressure Reducing Support Surfaces that require prior authorization as a condition of payment, claims with an initial date of service on or after August 3, 2020, must be associated with an affirmative prior authorization decision to be eligible for payment.
- For an updated list of items that require prior authorization please visit:
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-CompliancePrograms/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf.

Prior authorization will be required for certain LLPs Lower Limb Prosthetic Devices (Healthcare Common Procedure Coding System codes L5856, L5857, L5858, L5973, L5980, and L5987), with dates of service on or after September 1, 2020, in California, Michigan, Pennsylvania, and Texas – this is the new date change from May 11 2020 pre-COVID 19

- On December 1, 2020, prior authorization for these codes will be required in all of the remaining states and territories- this is the pre-COVID new date change from Oct 8 202 pre-COVID 19.

<https://www.cms.gov/files/document/provider-burden-relief-fags.pdf> July 2020

DME Signature Requirement at Delivery Waived: (effective 3/1/2020)

- The patient’s signature is waived for those Part B drugs and Durable Medical Equipment (DME) covered by Medicare requiring proof of delivery and/or a beneficiary’s signature.
 - Suppliers should document in the patient record the delivery date and that a signature was not able to be obtained because of COVID-19.

Contractor Flexibility in Requirements for DMEPOS Replacement (effective 3/1/20)

- If durable medical equipment, a prosthetic, orthotic or supply is lost, destroyed, or irreparably damaged or otherwise rendered unusable, contractors can waive replacement requirements such as the face-to-face requirement, new physician’s order, and medical necessity documentation.
 - Suppliers must continue to include a narrative description on the claim explaining why the DMEPOS must be replaced, and maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable due to the Public Health Emergency. www.cms.gov/files/document/covid-dme.pdf

DME Retail Closure If a shelter-in-place order is declared:

- DMEPOS is considered an essential service in most states. “Essential service” is defined by each state. Whether you stay open is a business decision, and if you can meet social distancing and infection precautions in the retail space. Decide what you will do and document it, including start date.
 - If the retail portion of the company had patients come to the office for CPAP setups, oxygen tank pickup, purchase walkers or canes, you need a process to continue to meet those patients’ needs. Document how you do this, and how you let patients know – the bottom line is meeting patient need.

Infection Control for DMEPOS suppliers providing equipment to patients in the home:

- Delivery and instruction by your technicians involves the same precautions for staff of home health, hospice, and private duty. All the staff recommendations in these FAQs apply to your staff, as well as

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any additional instructions from manufacturers for cleaning equipment returned from a home with a known or suspected COVID 19 patient.

H

Home Cleaning and Disinfecting During the Pandemic: The CDC recommends cleaning and disinfection of households to limit the survival of COVID 19 virus. These recommendations can be made to homemakers, aides and other employees who assist with basic cleaning, laundry, etc. and to families of vulnerable patients.

- Studies continue to show transmission of coronavirus occurs more commonly through airborne respiratory droplets than droplets on furniture, clothing, utensils, etc.
- Current evidence also suggests that COVID 19 may remain viable for hours to days on surfaces made from a variety of materials. Therefore, CDC is recommending the two-step process of cleaning and disinfecting frequently touched areas.
 - **Cleaning** refers to the removal of germs, on visibly dirty surfaces with soap and water or detergents. This does not kill germs but lowers their numbers and the risk of spreading infection such as COVID 19 and other respiratory viral illnesses.
 - **Disinfecting** refers to using chemicals, preferred EPA-approved products, to kills germs on surfaces.
<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19> (May 14,2020)
- Disinfecting does not necessarily clean dirty surfaces or remove all germs but killing germs with a disinfectant on a surface *after* cleaning, further lowers the risk of spreading infection. Be sure to let the disinfectant dry, unless stated otherwise in directions.

Frequently touched areas needing cleaning and disinfecting include tables, hard backed chairs, doorknobs, light switches, phone screens, handles, desks, toilets, faucets, sinks.

- **Floors drapes, rugs** use your usual cleaning process, and if soiled with fluids or secretions, recommendation to use a product from the EPA list on the link above.
- **Electronics** including tablets and touch screens, follow the manufacturer’s instructions for all cleaning and disinfection products.
 - Consider use of wipeable covers for electronics. If no manufacturer guidance is available,
 - Consider the use of alcohol-based wipes or spray containing at least 70% alcohol to disinfect touch screens.
 - Dry surfaces thoroughly to avoid pooling of liquids which can damage electronics

PPE and Cleaning and Disinfecting Surfaces:

- Wear disposable gloves when cleaning and disinfecting surfaces. Gloves should be discarded after each cleaning.

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- If reusable gloves are used, those gloves should be dedicated for cleaning and disinfection of surfaces for COVID-19 and should not be used for other purposes. Consult the manufacturer’s instructions for cleaning and disinfection products used.
- Clean hands immediately after gloves are removed.

Laundry: If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry from an ill person, including COVID-19 positive patients can be washed with other people’s items.

- Wearing disposable gloves when handling dirty laundry from an ill person is optional. Clean hands immediately after gloves are removed. If not using gloves, wash hands afterwards.
- Clothes hampers: Clean and disinfect hampers using guidance above for surfaces. Consider placing a bag liner that is either disposable (can be thrown away) or can be laundered.
- Trash: Wash hands after handling or disposing of trash.

<https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cleaning-disinfection.html>

(May 27, 2020)

L

Licensure-Professionals Ability to Work Across State Lines:

- **Are clinicians (RNs, LPNs, PTs, PTAs, OTR, COTA, CNAs) able to cross state lines to perform skilled care?** The recognition of licensure in each state to facilitate care across state lines is a state decision. States may implement recognition of other state licensure during a public health emergency. However, the process can be different in each state.
 - Right now, under the nurse licensure compact (NLC), state boards of nursing may issue registered nurses (RNs) and licensed practical nurses (LPNs) with a multistate license, which allows them to practice both in the state where they legally reside and in all other compact states. More information at: <https://nurseslabs.com/nurse-licensure-compact/>
 - There is also compact state licensure for physical therapists and PTAs, more information at <http://ptcompact.org/>

Licensure: Licensed Practitioners

- **State Nursing Boards are initiating approval of Nurse Practitioners to authorize home health and other services.** Some states are doing so with a letter confirming the extended scope of practice to coincide with the CARES Act law which also recognizes NPs and PAs at the federal level. CHAP encourages you to contact your state Nursing Board or state association to assess progress in your state.

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- **Nurse Practitioners (NP) State Scope of Practice:** CMS' recent approval for licensed practitioners to order and certify patients' eligibility for home health during public health emergency also requires that you understand that the NP providing orders is acting within the scope of their practice in each state. You can use the following website for more information:
<https://www.aanp.org/advocacy/state/state-practice-environment>
- **Physician Assistants (PA) State Scope of Practice:** PAs are also licensed practitioners who can order and certify home health. Like NPs, the scope of their practice varies by state. To understand what is required of PAs in your state to provide a valid order for home health, you can use the following website for more information: <http://scopeofpracticepolicy.org/practitioners/physician-assistants/>

State Licensure:

- **California: Hospice Initial Licensure Waiver-(April 23,2020):**
 - Initial licensure using CHAP: HSC sections 1747 (a) and (b) A hospice that has applied for initial licensure may begin providing care prior to undergoing the initial licensure survey for CDPH.
 - If you have selected CHAP for initial licensure, the waiver allows you to admit patients and advise CHAP of readiness for survey without the preceding licensure survey. CHAP will conduct a survey that meets Medicare hospice Certification requirements as well as CDPH initial licensure requirements.
- **New Jersey: CHAP HCSF licensure, Division of Consumer Affairs (DCA) advises:**
 - In home plan of care evaluation: Division of Consumer Affairs (NJ) waiver (3/25/2020): Temporary waiver of N.I.A.C. 13:45B-14.9(g) requiring on-site, in home plan of care evaluations; permits required plan of care evaluations by nursing supervisors to be completed by electronic means.
<https://www.njconsumeraffairs.gov/COVID19/Documents/DCA-W-2020-02.pdf>

N

Nursing Home Access for Hospice:

State-Based Nursing home mandated COVID-19 testing of hospice and home health staff:

CMS has authority over the Medicare Skilled Nursing beds and Medicaid nursing facilities and sent a communication to state health departments and state surveyors to formulate a COVID 19 testing plan. At a minimum CMS is *recommending* that each state mandate:

- a. Testing all residents for COVID 19 as a baseline.
- b. Testing all residents should any staff test positive or any resident- including a resident with COVID symptoms -and continue to test weekly until all residents test negative.
- c. Test all nursing home staff, including external staff, for baseline testing and then weekly – weekly testing can be adjusted by the state based on transmission in the area.

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- d. Written screening protocols for all staff, including those entering to provide care, visitors and residents.
- e. Arrangement with labs to process tests. The test used should be able to detect SARS-CoV2 virus with >95% sensitivity and >90% specificity, and results obtained within 48 hrs.
- f. Use Universal Control: All visitors and residents wear a cloth mask or a surgical mask. If a visitor is unwilling, restrict their entrance, as well as small children. Require that all visitors wash hands upon entry.
- g. PPE requirements and only approve use of contingency policies per CDC as necessary – CDC’s Strategies to Optimize the Supply of PPE and Equipment. Crisis strategy is not acceptable.
- h. All staff must wear face mask and administrative personnel can wear cloth masks.

Many governors are or have responded with executive orders. Expect variation as these are only CMS *recommendations*: To date, we are aware of state orders for Arizona, California-state overruled LA county, Delaware, Florida, Illinois, Massachusetts, Minnesota, New Jersey, New York, Pennsylvania, South Dakota, Tennessee, Texas, West Virginia,

Anticipate that corporate-owned SNFs and nursing homes may standardize their approach across states which may include contracts with labs and acquiring tests. They may be looking for partners-likely across states. Also, in some states, health departments have preferred labs listed.

<https://www.cms.gov/files/document/qso-20-30-nh.pdf> June 2020

CMS nursing home memorandum supports hospice access to residents. The CMS memorandum (QSO-20-14-NH (Revised)) states that health care workers who do not work in a nursing home, as long as external staff meet state guidelines for health care workers – screened for symptoms and wearing appropriate PPE. You may access the memorandum at <https://www.cms.gov/files/document/qso-20-28-nh.pdf> (April 24, 2020), in particular see Question No. 6 in the FAQs.

CMS is using its authority over Medicare skilled nursing facilities (SNF), and Medicaid nursing facilities to issue guidance on restricting access and determining essential external providers of care. CMS:

- CMS encourages communication with external health care providers to identify those critical to the care of residents on a case by case basis, and to provide for their access to deliver care. CMS specifically cites residents receiving hospice care including access to a resident who is not enrolled in hospice, but their health status is declining and can benefit from hospice care.
 - CMS states in these circumstances it is necessary to ensure precautions are taken to conduct visits as safely as possible, and that external health care staff be subject to the same screening as facility employees before entering to provide care.
 - CMS also encourages the use of telehealth whenever possible to support the care of residents.

NOTE: Before bringing in your equipment (e.g. BP cuff, stethoscope, etc.) into the facility, check if you will need to use the facility’s equipment. CMS has directed that each facility designates vital sign equipment (including blood pressure cuff) to use either with individual residents or in specific wings or units with COVID 19 patients. Facilities are directed to clean and disinfect this equipment appropriately

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according to manufacturers' instructions using an Environmental Protection Agency (EPA)-registered hospital-grade disinfectant.

Re-Opening and Reporting Rules for Nursing Homes: <https://www.cms.gov/files/document/nursing-home-reopening-recommendations-state-and-local-officials.pdf> (May 18, 2020)

- Nursing homes must report residents or staff with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or staff with new-onset respiratory symptoms within 72 hours of each other through the CDC's National Health Safety Network (NHSN) system.
- Nursing homes must advise residents and their representatives within 12 hrs. of a single occurrence of a confirmed COVID-19 infection, or of 3 or more residents or staff with new onset of respiratory symptoms that occur within 72 hours. Updates to residents and their representatives must also be provided weekly, or each subsequent time. Facilities must include information on action taken to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered. The information must be reported in accordance with existing privacy regulations and statute.
- Hospices caring for patients in nursing homes are encouraged to be proactive to address these new requirements, and any contract or coordination issues that may result to avoid situations that could interrupt continuity of care.
<https://www.cms.gov/files/document/qso-20-26-nh.pdf> (April 19, 2020)
- For patient care purposes, remember that you can use telehealth or face time to work with a facility nurse to assess the patient and their symptoms.
- Should you be denied entry, remember to advise the patient's doctor and for hospice patients, the medical director, of the inability to deliver care and document this in the patient record.

O

Operational Changes Under COVID-19:

The CDC recommendation for Healthcare personnel (HCP) COVID-19 Testing in four (4) Situations.

1. The staff member has signs or symptoms consistent with COVID-19
 - a. Because HCP often have extensive and close contact to vulnerable populations, even mild signs or symptoms (e.g., sore throat) of possible COVID-19 should prompt consideration for testing.
2. Asymptomatic staff with known or suspected exposure to SARS-CoV-2 -including exposure to positive COVID individuals in their own household.
3. Asymptomatic staff without known or suspected exposure to SARS-CoV-2 for early identification in special settings (e.g., governor orders for care in nursing homes or ALFs).

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4. Healthcare staff who have been diagnosed with SARS-CoV-2 infection to determine when they are no longer infectious. Note: symptom-based testing is also acceptable, see details later in this Section.

When testing staff, the CDC recommends viral tests (from respiratory system-nasal swabs) to test for acute infection. Aim for rapid turnaround times after testing (i.e., less than 24 hours) to facilitate effective interventions. The CDC does not recommend testing the same individual more than once in a 24-hour period.

The CDC also recommends providing information to the staff that you want tested. As the spread of infection increases, this give you a standardized response to staff.

The information CDC recommends be provided to staff who are requested to be tested for COVID 19 includes:

- the purpose of the test
- the reliability of the test and any limitations associated with the test (are you using the fast test-known to have false positives, or the viral test which is sent to the lab as preferred by the CDC)
- who will pay for the test and how is the test performed
- how to interpret results and any next steps related to the results
- who will receive the results – CHAP recommends when you receive the results as an employer that they are placed in the staff member’s health record
- how the results may be used
- any consequences for declining testing

Remember there are CDC recommended options for asymptomatic staff to continue working while awaiting test results. These include:

- Staff with higher risk exposures can continue to work during their 14-day post-exposure period when testing is readily available. Performing testing during the 14-day post-exposure period can be considered to more quickly identify pre-symptomatic or asymptomatic HCP who could contribute to SARS-CoV-2 transmission.
- Healthcare staff with lower risk exposures, can continue recommended symptom screening and source control measures while at work.

Testing Timing: Testing only identifies the presence of virus at the time of the test. Repeat testing could be considered. Timing of symptoms can be 2-10 days after exposure.

Note: If you request that staff be tested when there is widespread SARS-CoV-2 transmission occurring in the community, positive tests among healthcare staff do not necessarily indicate transmission due to an exposure in the workplace.

- **Asymptomatic Exposure of a Staff Member to an individual with suspected or confirmed COVID-19:** As the pandemic and associated exposure risk continues, CHAP is recommending that you consider addressing asymptomatic exposure of a staff member to an individual with suspected or confirmed

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COVID 19 as part of your pandemic related policies. This is a recommendation and not a requirement for survey under CHAP standards. The Operational Guidelines are a separate attachment and include an example of a reporting form. The information can be found as an attachment on the CHAP education site.

- **The national declaration of a public health emergency extends through July 26, 2020 and is expected to be renewed.** However, CMS expects the organization’s office of record to be open and staffed during the business hours stated on the CMS 855. The office can be closed for periods of time with signage reflecting this and how to reach someone in your organization. During a pandemic office closure is based on local guidance. Long term remote work could be a problem if the office is not staffed during stated office hours. CMS expects that surveyors can conduct a survey of the provider.
- **Letters for Staff as They Travel:** Nationwide home care and hospice staff are being stopped and asked for reason why they are traveling when there are shelter-in-place orders. Their ID badge is often not enough. We recommend a short letter on your company’s letterhead. The letter can be short, an example follows.

(Name of company) is providing healthcare services. (Name of staff member) is currently assigned to provide these services to one of our patients in their home. They are carrying an ID badge issued by our company. If you have questions, you can reach us at (insert a 24/7 number if your staff could be out at any time). Thank you.

Signed by an Administrator or Director of Nurses (make it someone in management). Add the CHAP Logo if currently accredited.

- **Assessing Readiness for Admitting COVID 19 Patients:** COVID 19 patients are being referred to home health, private duty, and hospice organizations across the country. Will your organization accept COVID-19 patients?
If yes, the following questions were shared by call participants as helpful in deciding how many COVID 19 patients they can care for.
 - **Ask staff who agrees to care for a COVID 19 patient.** Organizations report that not all staff will, and some staff have resigned rather than face the prospect.
 - **How much PPE do you have and need** (e.g. face shields, gloves, gowns, N95 masks)? CDC offers a PPE ‘burn rate calculator: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html> (April 7, 2020)
 - **Will staff see only COVID 19 patients each day, or mixed with those who are not suspected or confirmed COVID 19?** This decision impacts your PPE inventory. Organizations report two current practices: 1) leave the N95 mask, face shield and gown after use in the patient’s home (if not soiled or possibly contaminated, and still ‘sound’-not torn, and still fitting appropriately) and place these in a paper bag and the bag inside a box-with cautions for access by pets and children; or 2) staff removes PPE and places the N95 mask in a paper bag in a box in their trunk, and only uses when they see the next COVID 19 patient. In both

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- instances, hand hygiene is performed per OPIM after removing PPE. (Shared practice not endorsed by the CDC).
- In view of the **nationwide recommendation, and in some areas a governor’s or health department order that the public wear masks**, CHAP recommends that staff wear masks when entering the home of those without confirmed or suspected COVID-19. Staff will likely be within 6 ft of the patient or others in the home.
 - **Organizations also share that when possible they don PPE upon entry to the apartment or house** to avoid issues for the patient and family if donned on a porch or in the hallway. PPE is for protection at the bedside with the infected patient, and usually the patient is at least 6ft away when putting on PPE inside the residence (Shared practice).
 - In the following “PPE”, there is a variety of information to manage your inventory.
- **Referral acceptance, request the COVID 19 status of each patient/client:** CHAP recommends adding the question about each patient’s COVID 19 status (confirmed, pending testing results, COVID symptoms) to your referral acceptance process – it is critical to the health of the patient, their family and your staff.
 - If the patient has confirmed or suspected COVID 19, remember to get orders for any specific symptom monitoring or intervention for the COVID 19 diagnosis, as well as care for other chronic illnesses.
 - Obtain information how long transmission-based precautions must be maintained or how you will know that the patient/client is no longer considered infectious. **Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.**

The decision to **Discontinue Transmission-Based Precautions** is made using a test-based strategy or non-test-based process (i.e., time-since-illness-onset and time-since-recovery strategy).

- **Test-based Strategy for those with symptoms:** Note a combination of: -
 - Resolution of fever without the use of fever-reducing medications **and**
 - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
 - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens) [1]. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html). (May 22, 2020 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html> (May 29,2020)
- **Symptom-Based Strategy (previously known as Non-test-based strategy); recognizing the limitations for testing includes a combination of:**
 - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and**
 - improvement in respiratory symptoms (e.g., cough, shortness of breath); **and,**

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- At least 10 days have passed *since symptoms first appeared* (Revised 4/30/2020 and changed the number of days from the first symptoms to 10 rather than 7 days <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html> (May 29, 2020))
- **Test Based strategy for those without symptoms but tested positive:**
 - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens)
- **Time Based Strategy for those without symptoms but tested positive:**
 - At least 10 days have passed since the date of their first positive COVID-19 test assuming they have not subsequently developed symptoms since their test. If they develop symptoms, then either the symptom-based or test-based strategy should be used. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html> (May 29, 2020)
- **Collection of COVID 19 Respiratory Specimens for Testing**
 - Nasopharyngeal swab is no longer the preferred method of specimen collection
 - Additional approved methods include oropharyngeal, nasal mid-turbinate. Anterior nares swab or nasopharyngeal wash/aspirate/nasal wash
 - The type of specimen collection is not as important as following proper collection guidelines. The following link provides detailed instruction in the collection guidelines of each method of specimen collection:
 - <https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html> (May 22, 2020)

P

PPE:

- **Accessing PPE, the National Declaration of an Emergency distributes PPE via two (2) sources:**
 - **The county and state health departments** – access to the national supply stockpile is distributed from health departments on a governor’s requests:
 - Contact your state or local health department to request supplies.
 - Also contact your state associations for information about accessing supplies – state associations have been able to identify the process which could be formal request (forms to be completed) or requests e-mailed to the health department or local, regional or national suppliers with inventory.
 - For N95 respirators, be ready with the model number of which masks have been fit tested for your staff. If no model number, provide the manufacturer and year from a mask you have.
- **ASPR Health Care Coalitions as sources of PPE for home care and hospice:** The following site includes a list of organizations that have come together to ensure that providers have what is needed in an

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emergency. Use the Interactive map in the web location below. Note, those who respond may not have immediately thought of home and community-based care, persist!

- <https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx>
(March 24, 2020)
- **Maximizing PPE:** – the CDC website below offers 5 categories of PPE-specific recommendations to maximize the use of PPE. Note: information is often written with the inpatient setting in mind. Not all categories will apply to care in the home, but many do. Anticipate how to make these protections work in the home care setting.
 - Eye protection
 - Gowns
 - Face Masks
 - N95 respirators – includes fit testing, training on use of respirators, alternative respirators
 - How to calculate your PPE “burn rate” <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html> (April 7 2020)
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html> (April 3, 2020)

Eye Protection:

As of July 9, CDC recommends the universal use of eye protection (in addition to a facemask) for HCP working in facilities located in communities with moderate to sustained SARS-CoV-2 transmission is intended to ensure HCP eyes, nose, and mouth are all protected during patient care encounters.
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html> July 9 2020

- CHAP recommends using the Harvard Global Institute on line risk rating by county to identify ‘moderate to sustained’ COVID 19 transmission, namely the areas rated ‘red’ or ‘orange’. The dated is updated weekly and utilizes a standardized rating. You can find the data for your county or counties at:
<https://globalepidemics.org/key-metrics-for-covid-suppression/>
- Goggles: provide barrier protection for the eyes. Should fit tightly over and around the eyes or prescription glasses
- Face shields: provide barrier protection to the facial area and related mucous membranes and are considered an alternative to goggles but not meant to function as primary respiratory protection and should be used concurrently with a mask.
- Limited availability:
 - Extended use for one HCW to use on multiple patients with COVID-19.
 - Reuse strategy should allow that the eye protection is dedicated to one HCW
 - As able, reprocessing should occur when visibly soiled or removed. See link for reprocessing directions:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/emergency-considerations-ppe.html> (May 5, 2020)
 - No Availability of eye protection: Potential alternative includes safety glasses that have side barriers to protect from droplets and splashes

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Gloves and Re-Use When There is an Inadequate Supply

- Understanding your glove utilization is critical to anticipating PPE burn. In considering which gloves to buy, it is important to know that gloves vary in use and ability to re-use in a crisis. The CDC is providing information to support improved access to gloves as well as re-use.
- **Glove types:** There are two (2) primary types are used in health care, sterile surgical gloves and disposable medical gloves or Patient Examination gloves, referenced as “Examination” gloves most often.
- Home health, home care (private duty), palliation, hospice and home infusion use non-sterile disposable examination gloves. ‘Specialty’ examination gloves often are chemotherapy gloves, which have been tested with chemotherapy agents.
- Glove product codes represent the material used in manufacturing; the following is per the FDA:

| | | |
|-----------------|-------------------|---------------------------|
| Latex – (LYY) | Vinyl – (LYZ) | Synthetic Polymer – (LZA) |
| Nitrile – (LZA) | Specialty – (LZC) | Finger Cot – (LZB) |

Surgical gloves have a product code (NGO) to avoid ordering the wrong product when not needed.

Expiration dates on boxes of gloves are not required by the FDA, only voluntary. If a manufactured date is noted, the FDA recommends not using the gloves if more than 5 years since that date.

- CDC advises you may consider using disposable medical gloves that are *similar to* FDA-cleared surgical and examination gloves and approved under other U.S. or international standards. Examples are shown in the table at the following website. You would be looking for ‘Examination’ gloves. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/gloves.html> (April 30, 2020)
- The use of gloves by staff when it is reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin could occur is not being waived.
 - *During a glove supply crisis gloves, can be used up to 4 hours continuously, but must be cleaned between patients to prevent cross transmission from patient to patient.*

CDC offers two (2) means for re-use of medical, examination gloves in a time of crisis and inadequate supply.

- 1) **Alcohol-based Hand Sanitizer (ABHS):** If not visibly soiled, disposable latex and nitrile glove brands maintain their integrity when disinfected for up to six (6) applications of ABHS or until the gloves become otherwise contaminated or ineffective (wear, tears, etc.). Follow hand hygiene guidance for proper application of ABHS.
- 2) **Soap and water** can be used to clean donned, disposable medical gloves between tasks or patients. Long-cuffed surgical gloves are recommended as washing may be impractical for short cuffed gloves where water may become trapped inside the worn gloves which then must be discarded. Disposable medical gloves can be cleaned with soap and water up to 10 times or until the gloves become otherwise contaminated or ineffective. Follow hand hygiene guidance for proper soap and water hand hygiene procedures.

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Discard disposable medical or examination gloves always after:

- Visible soiling or contamination with blood, respiratory or nasal secretions, or other body fluids occurs.
- Any signs of damage (e.g., holes, rips) or degradation are observed; and
- Maximum of four (4) hours of continuous use.
- Doffing. Previously removed gloves should not be re-donned as the risk of tearing and contamination increases. Disposable glove “re-use” should not be performed.
- After removing gloves for any reason, hand hygiene should be performed with alcohol-based hand sanitizer or soap and water.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/gloves.html> (April; 30, 2020)

N95 Masks - Particulate filtering facepiece respirators

- There are two types of respirators, standard N95 and surgical N95. When trying to access, you need only N95 or equivalent.
- Respirators are for healthcare staff who need protection from both: 1) airborne droplets and 2) fluid as the close fit is to avoid permeation of both.

KN95 NIOSH (National Institute of Occupational Safety) Sampling identifies KN95 Masks that do not meet basic filtering standards, and in some cases are counterfeit.

- NIOSH developed tests to assess the filter efficiency and penetration (>95%) of a sample of respirators represented as certified by an international certification authority. NIOSH states that usual testing was not done previously due to the respirator shortage associated with COVID-19.
- NIOSH samples identified products that failed filtering tests.
- NIOSH has provided a table at the link below to identify the manufacturer and filtering test results. The table is regularly updated, even daily.
 - NIOSH warns of respirator masks with an ear loop design. NIOSH-approved N95s typically have head bands. Limited assessment of ear loop designs indicate difficulty achieving a proper fit.
 - NIOSH advises that while the manufacturer listed in the table at the link below is the manufacturer of record, NIOSH has been informed that some of these are counterfeit products. Some products with legitimate manufacturer names, showing poor filter penetration results (<95%), are counterfeit products.

<https://www.cdc.gov/niosh/npptl/respirators/testing/NonNIOSHresults.html> (June 11, 2020)

Conserving Inventory of Respirator Masks: Two (2) Ways to Approach

- **Respirator Extended use:** wearing the same respirator mask for repeated close contact encounters with patients, the maximum recommended extended use period is 6 hrs.

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/emergency-considerations-ppe.html> (May 5, 2020)

- Respirators should be removed (doffed) and discarded before activities such as meals and restroom breaks.
- **Respirator Re-Use:** using the same respirator by one staff member for multiple encounters with different patients but removing it (i.e. doffing) after each encounter.

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- Data suggest limiting the number of reuses to no more than 5 uses per device to ensure an adequate safety margin.¹
- One CDC example is to issue 5 respirators to each staff member. Each respirator is used on a day and stored in a breathable paper bag until the next week.
 - This can result in each staff member requiring a minimum of five respirators if they put on, take off, care for them, and store them properly each day. The respirators may need to be stored in the staff's trunk vs. the home.
 - The amount of time between uses should exceed the 72-hour expected survival time for COVID-19 virus.³ Healthcare staff should still treat the respirator as though it is still contaminated and follow the precautions.
- **Note that each re-use of N95 respirators requires 2 pair of gloves**, a clean pair of gloves when donning or adjusting a previously worn N95 respirator. Then discarding these gloves and performing hand hygiene after the N95 respirator is donned or adjusted and using a new pair of gloves for care.
- **Use of a cleanable face shield or facemask over the respirator** can extend respirator use as it reduces/prevents contamination of the N95 respirator.
- Reuse can also be extended by putting a surgical mask on the patient.

Staff reuse of N95 Masks with presumptive or confirmed COVID-19 patients: Two sources of information on reuse:

- CDC: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html> (April 22, 2020)
- NIOSH the National institutes of Occupational Safety <https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html> (March 27,2020)
 - Inpatient staff recommendations are based on wearing the same staff wearing N-95 masks patient-to-patient for several hours. Using inpatient criteria and applying it to the home, re-use is typically limited by
 - hygienic concerns (the respirator is contaminated with blood, respiratory or nasal secretions, or other patient bodily fluids, or
 - the respirator is damaged or crushed and no longer meets fit test requirements.

Discard: N95 respirators if:

- contaminated with patient blood, respiratory or nasal secretions, or other bodily fluids.
- obviously damaged or becomes hard to breathe through; or
- inadvertent contact is made with the inside of respirator.

NOTE: Respiratory pathogens on the respirator surface can potentially be transferred by touch to the wearer's hands, increasing the risk of causing infection through subsequent touching of the mucous membranes of the face -

Surgical Mask Use: Fluid-resistant, disposable, and loose-fitting protection devices that create a physical barrier between the mouth and nose of the wearer.

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- Surgical masks do not seal tightly to the wearer’s face, and therefore do not provide a reliable level of protection from inhaling infectious aerosols.
- Healthcare staff can continue to wear the same surgical mask until obviously soiled or torn-no longer providing protection.
- **Limited Supply strategies**
 - **Extended use** – the use of by one HCW on multiple patients (not recommended by the CDC but if adopted):
 - If the mask is removed for taking a break or completing a shift, it should be removed using appropriate technique and disposed of.
 - The potential number of hours of extended use would be dependent on local and individual factors such as humidity and shift length but in practice should be a maximum of 6 hours.
 - ***This emergency strategy (extended use) should be prioritized over reuse or other approaches. If applicable to the circumstances.***
 - **Reuse** of surgical masks would allow reprocessing and reusing the mask for one HCW to use on multiple patients with COVID-19 for a limited time (multiple shifts)
 - This method would be difficult with a typical surgical mask with ties as they quickly deteriorate.
 - It is important to closely inspect the mask prior to each reuse due to the likelihood of quick deterioration.
- **No Surgical Masks Available:**
 - Potential Alternatives:
 - A face shield only or a combination of a cloth face mask and a face shield
 - **Note: Non-medical fabric masks are not considered PPE and their ability to protect HCW is currently unknown. Do not fall into a false sense of protection.**
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/emergency-considerations-ppe.html> (May 5, 2020)

Gowns: should be worn for aerosol-generating procedures such as suctioning, nebulizer treatments, and other care activities where splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers. Examples of high-contact patient care activities requiring gown use include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, or wound care.

- Re-usable gowns are available instead of disposable single use gowns – but also require the laundering process.
- **Using ANSI/AAMI PB70 standard disposal gowns:** Level 1 or 2 gowns (non-surgical isolation gowns) are recommended when there is low risk of contamination. Level 3 or higher for high risk

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of contamination. https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html
(April 9, 2020)

- **Limited Availability:**
 - Extended use:
 - One HCW uses the gown with multiple patients with COVID-19 over a single shift
 - This emergency strategy should be prioritized over the use of alternatives.
 - Reusable gown is laundered per the guidance at the following link:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/emergency-considerations-ppe.html> (May 5, 2020)
- **No Gowns Available: potential alternatives:**
 - Disposable aprons
 - Disposable laboratory coats
 - Washable patient gowns and/or laboratory coats
 - Combinations of clothing such as sleeve covers in combination with aprons and long sleeve patient gowns or laboratory coats.

July 23 2020: Increase in Toxic Methanol Hand Sanitizers-FDA Site Lists Dangerous Products: The FDA is aware of reports of adverse events due to methanol contamination associated with hand sanitizer products.

- **The FDA encourages health care professionals, consumers and patients to report adverse events or quality problems experienced with the use of hand sanitizers to FDA’s [MedWatch Adverse Event Reporting](#) program (please provide the agency with as much information as possible to identify the product):**
- **A current list of FDA known methanol hand sanitizers by name can be found at:**
<https://www.fda.gov/drugs/drug-safety-and-availability/fda-updates-hand-sanitizers-methanol#products>

R

Religious Nonmedical Healthcare Institutions - RNHCI

- **These facilities** provide nonmedical care to beneficiaries who choose to rely solely upon a religious method of health and for whom acceptance of medical services would be inconsistent with their religious beliefs.
- **Staff provide for the physical needs** of these nonmedical patients: 1) assist with activities of daily living; 2) assistance in moving, positioning and ambulation; 3) address nutritional needs; and 4) provide comfort and support measures on a 24-hour basis.
- **RNHCI facilities** are required to monitor CMS and CDC websites for guidance to protect their patients from the spread of infectious disease.

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- **Emergency Preparedness Plan Implementation** should be fully in place with processes to address emerging infectious disease. All infection control practices as outlined by the CDC should be implemented. Availability of PPE should be in place prior to needing it for a patient who is positive.
- **Screening of patients** for COVID-19 symptoms is expected to be done on an ongoing basis; reporting anyone with potential COVID-19 symptoms to their management; reporting of incidents of COVID-19 symptoms to their public health department; and utilizing source control for those with symptoms by use of a face mask.
- **Screening of staff** is expected to be ongoing and anyone who has signs and symptoms of a respiratory infection should not report to work. If symptoms develop while working, the personnel should stop work, put on a facemask, and self-isolate. Management needs to be aware of who the employee has had contact with for the 48 hours prior to the development of symptoms and to contact the public health department for testing.
- **RNHCI Patients who test positive** are to be isolated with staff using appropriate PPE. A separate bedroom and bath are preferred as well as identification of the room housing a COVID-19 patient room so all staff who might have direct contact with the patient are aware of the COVID-19 status. If a patient requires and desires transfer to a hospital setting, the transport personnel and receiving facility are to be provided information about the patient. Pending the transfer, a facemask is placed on the patient prior to travel.
- **Facility actions to provide protection** include the screening of visitors in addition to the screening of staff and patients; limiting the entry points into the facility; requiring appropriate PPE for those who enter; restricting access to communal areas and implementation of appropriate disinfection processes.

<https://www.cms.gov/files/document/gso-20-18-hha-revised.pdf> (4/23/2020)

S

Antibody Testing and Staff Status: The CDC advises that an antibody test should NOT be used to determine if someone can return to work: Currently there is not enough information to say whether someone is immune and protected from reinfection by COVID 19 if they have antibodies to the virus.

- Anyone who has had a positive antibody test should continue to take steps to protect themselves and others, including staying at least 6 feet away from other people outside of their home (social distancing) and wearing masks.
- <https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests.html> (May 28, 2020)

Staff Symptoms: COVID 19 Processes to Address the Following:

- **How you monitor staff health status** for the presence of the COVID 19 symptoms-fever, coughing, shortness of breath. Staff should also report if two of the following symptoms are present: chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell.
<https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html> May 13, 2020

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- CHAP conference call participants shared ways that they screen: having staff contact supervisors daily with a health status report; and, leaving a voice message, or an e-mail about their health status (shared practice).
- **Staff Feeling Ill.** The CDC recommends staff feeling ill go home and contact a doctor for care and/or testing.
- **How patients, families and other staff are notified of staff health status.** Designate who will advise patients, families, or other staff that a staff member is ill, and what action they should take awaiting information if the staff member will be tested for COVID 19 and when results are received.
- **Advise patients and caregivers how you monitor staff health status and ask their cooperation in telling you if any member of the household or visitor is confirmed COVID-19 or is awaiting results.**

Staff Exposure: When to restrict the employee from work

- CDC provided guidance for asymptomatic HCP who were exposed to individuals with confirmed COVID-19. Higher risk exposures involve exposure of HCP eyes, nose or mouth to material potentially containing SARS-Cov-2, especially if the interaction involved aerosol-generating procedures.
 - HIGH RISK EXPOSURE - HCP who had prolonged close contact with a patient, visitor or HCP with confirmed COVID-19 AND did not wear appropriate PPE which would include respirator or face mask, eye protection, and HCP not wearing all recommended PPE while performing an aerosol-generating procedure
 - Exclude from work 14 days after last exposure
 - Advise HCP to self-monitor for fever or other symptoms of COVID-19
 - Any HCP who develops symptoms should arrange for medical evaluation and testing.
 - LOWER RISK EXPOSURE – any HCP who had exposure without the high risk noted above
 - No work restrictions
 - Continue wearing facemask for source control while at work
 - Do not report to work if ill
 - Any HCP who develops symptoms consistent with COVID-19 should immediately self-isolate and arrange for medical evaluation and testing.
- Prolonged exposure is determined as 15 or more minutes of close contact

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html#4> (May 29, 2020)

T

Telehealth:

- **Use of telehealth in CHAP accredited private duty nurse evaluations for patients receiving skilled care:** For organizations accredited using the CHAP Private Duty standards-PDII.5, d1 - the in-person nurse evaluation may be conducted by telehealth -Skype, face time, if the patient refuses the nurse's entry. CHAP would look to see documentation of the patient's or client's refusal, the results of evaluation and how it was done (e.g. facetime, etc.)
- **Use of telehealth by Medicare Certified home health agencies or by hospices.**

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- **Home Health:** Home Health Agencies (HHAs) can provide more services to beneficiaries using telecommunications technology within the 30-day period of care, so long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. We acknowledge that the use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care. Telecommunications technology can include, for example: remote patient monitoring; telephone calls (audio only and TTY); and 2-way audio-video technology that allows for real-time interaction between the clinician and patient.
 - However, only in-person visits can be reported on the home health claim.
 - The required face-to-face encounter for home health can be conducted via telehealth (i.e., 2-way audio-video telecommunications technology that allows for real-time interaction between the physician/allowed practitioner and the patient).

<https://www.cms.gov/files/document/covid-home-health-agencies.pdf> (5/15/2020)

Home Health FAQ Telehealth Answers and Expectations:

- On an interim basis, costs of telecommunication technology can be reported on the HHA **cost report** as allowable administrative and general costs by identifying the costs using a subscripts between line 5.01 through line 5.19
- If “**PRN**” telecommunication may be needed, it is permissible to use a PRN order as long as it is accompanied by a description of the beneficiary's medical signs and symptoms that would occasion the visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained. Orders for care may indicate a specific range in frequency of visits to ensure that the most appropriate level of services is furnished. If range of visits is ordered the upper limit of the range is considered the specific frequency.
- Comprehensive Assessments and update to the comprehensive assessment
 - Can be completed through audio only or two-way audio-video telecommunication as long as it is part of the patient's plan of care and does not substitute for in-person visits as ordered on the plan of care.
 - **Plan of care** should be modified as the type of visits change. The plan of care should reflect which visits will be made in person and which visits will be conducted via telecommunication technology
- Expectations:
 - **Education** of patients as to the processes the agency has in place to protect patients as well as home care staff.
 - Not everything can be accomplished per telecommunication when skilled care is required.
 - The agency should work closely with the patient to determine what would reassure them that in-person visits with the agency staff are safe.
 - If the **patient continues to refuse** any in-person visits as per the plan of care, the agency will have to determine if the patient's medical, nursing, rehabilitation and social needs can be met in their place of residence. Per §484.60

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<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf> (page 57) Updated 6/2/2020

- **Hospice:** Hospice providers can provide services to a Medicare patient receiving routine home care through telecommunications technology (e.g., remote patient monitoring; telephone calls (audio only and TTY); and 2-way audio-video technology), if it is feasible and appropriate to do so. Only in-person visits are to be recorded on the hospice claim.
 - Face-to-face encounters for purposes of patient recertification for the Medicare hospice benefit can now be conducted via telehealth (i.e., 2-way audio-video telecommunications technology that allows for real-time interaction between the hospice physician/hospice nurse practitioner and the patient).

<https://www.cms.gov/files/document/covid-hospices.pdf> (5/15/2020)

Hospice FAQ Telehealth Answers and Expectations:

- Billing
 - Service intensity add-on payments – only in-person visits by RN or SW provided during routine home care during the last seven days of life are eligible
 - On the hospice cost report, hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as “other patient care services” using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as “PHE
- Initial and Comprehensive Assessments
 - Due to the role of the assessment as the foundation of the plan of care and crucial to establishing the hospice-patient relationship, the expectation is that in most situations, the initial and comprehensive assessments would be done in person. Especially for assessment of skin/wound care, uncontrolled pain/symptoms, effective teaching of patient/caregiver medication administration, etc.)
 - It would be up to the clinical judgment of hospice as to whether such technology can meet the patient’s/caregiver’s/family’s needs and the use of technology should be included on the plan of care for the patient and family.

<https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf> Page 68 (Updated 6/2/2020)

- **Medicaid and Private Insurance**

- The ability to bill for home health/hospice is dependent upon the state flexibilities and the program itself. Research should be conducted to determine if and when telehealth can be provided and if it is billable.

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- **Paid telehealth visits by licensed practitioners.** As of March 6, 2020, Medicare pays for office, hospital visits or visits to a patient’s home furnished via telehealth. These visits can be conducted by doctors, nurse practitioners, clinical psychologists, licensed clinical social workers, and other licensed practitioners.
<https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>
(March 17, 2020)

Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for these practitioners to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Telehealth options:

- **Types of telehealth communications:**
 - Telehealth: refers to a broader scope of remote health care services than telemedicine as in addition to remote clinician services between a provider and patient/client, it also refers to remote non-clinical services such as clinician to clinician consults, patient education services, and interprofessional care team communications
 - Telemedicine: practice of delivering medicine using technology to deliver care at a distance. A physician/clinician in one location uses a telecommunications infrastructure to deliver care to a patient at a distant site. This is a subset of telehealth
 - Remote patient monitoring refers to using technology to gather patient data outside of the traditional health care setting to monitor a patient’s condition while they are at home. This is also a subset of telehealth and includes such devices as glucometers and digital scales
 - mHealth: is abbreviated for mobile health and refers to the subset of telehealth that uses mobile technologies. Examples include apps and peripheral devices designed for use on smart phones and tablet. Can be used for videoconferencing, gathering patient data, or providing patient education.

Getting Started:

- What is the state requirement related to patient consent to use telehealth?
 - If verbal consent is obtained, a witness is appropriate, and the consent should be documented within the clinical record.
- What payers does the organization provide service under who may allow telehealth billing?
- How will telehealth be provided?
- Develop protocols for the delivery of telehealth visits
 - How will the type of interaction be determined?
 - How will education be provided to patients/family related to the visits?
 - Who is responsible for scheduling and does a link need to be sent?
 - How will the visit documentation be done?
 - How will emergency/on call needs be addressed?

Virtual Visit Etiquette

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- Start the visit by confirming the screen is set up correctly and the patient/family can see and hear. Then make a clear transition to the start of the clinical visit. Such as “How are you doing?”
- Let the patient/family know that it is ok to interrupt if they need to pause or make adjustments during the visit.
- Confirm that you will call them in the event that sound, or video is lost during the visit
- For the first telehealth visit with the patient/family, provide an overview of the visit.
 - The amount of time for the visit
 - The interventions to be accomplished during the visit
 - Discussion of any concerns or symptoms being experienced
 - Review of medications and need for refills
 - The plan for the next visit
- If responding from home, the clinician should find a quiet location with a neutral background and good lighting
- Always dress appropriately, and wear plain clothes as patterns can cause nausea
- Speak slowly and clearly, and check every so often to ensure that you are being heard
- Remember to look at the camera on your own device (not at the screen that has the patient’s video)
- Call wrap up: Let the patient/family know when 5-10 minutes is left and ask if there is information they want to make sure to cover.
- End the visit by summarizing what you heard, what the plan is, reviewing medication needs.
 - Provide information on what will be needed to facilitate the next visit
 - Inform the patient if the next visit will be a virtual or in-person visit.

Telehealth Resources:

Northwest Regional Telehealth Resource Center

<https://www.nrtrc.org/covid-19-detail-117>

<https://www.nrtrc.org/content/blog-post-files/NRTRC-Telehealth-Start-Up-Checklist-handout-4-15-2020.pdf>

Health and Human Services

<https://telehealth.hhs.gov/providers/getting-started/>

Mid Atlantic Telehealth Resource Center

<https://www.matrc.org/matrc-telehealth-resources-for-covid-19/>

- **HIPAA and Telehealth:** Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.
<https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html> (March 23, 2020)

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Waivers:

Types of 1135 waivers are issued during the Public Health Emergency (PHE). All waivers are effective March 1, 2020. The provisions of each waiver end effective when the President officially ends the Public Health Emergency. NOTE: HHS Secretary Azar can extend that date by 60 days to offer health care providers additional time in ‘ramping up’.

- **Federal Blanket Waivers:** Publicly announced by CMS and applicable to all providers by Medicare benefit type. Examples include the home health and hospice waivers.
- **State Medicaid waivers:** States may request waivers of Medicaid regulations by contacting CMS. Over 48 states have requested waivers. To the following website, find your state, click on what is a letter to the state, scroll past the letter and you will find the details of the waiver.
<https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/entry>
- **Individual provider or company waivers:** One provider or an association or a company with multiple locations can request a specific waiver of regulation related to the delivery of care. These waivers are not made public unless the requesting organization does so. Example, some state hospital associations have provided copies of their approved waiver that included provisions for home care or hospice. You may find guidelines for an individual waiver at : website (<https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities>)

Send your individual or company waiver request to the specific Regional Office with oversight for your state:

ROATLHSQ@cms.hhs.gov (Atlanta RO): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

RODALDSC@cms.hhs.gov (Dallas RO): Arkansas, Louisiana, New Mexico, Oklahoma, and Texas.

ROPHIDSC@cms.hhs.gov (Northeast Consortium): Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia, New York, New Jersey, Puerto Rico, Virgin Islands, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

ROCHISC@cms.hhs.gov (Midwest Consortium): Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin, Iowa, Kansas, Missouri, and Nebraska.

ROSFOSO@cms.hhs.gov (Western Consortium): Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming, Alaska, Idaho, Oregon, Washington, Arizona, California, Hawaii, Nevada, and the Pacific Territories.

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Please continue to join CHAP on our Weekly COVID 19 Conference Calls:

- Tuesday 10:30 – 11:30AM ESDT Call in: 646-307-1479/toll-free 877-304-9269 with • Participant code: 246854#

- Thursdays 3 -4:00 PM ESDT Call in: 646-307-1479, or toll-free 877-304-9269 • Participant code: 246854#

Thank you for your dedication and be well!