FAQs: COVID 19 Conference Calls

Updated February 18, 2021

The following FAQs are listed by topic in alphabetical order for quick reference. They include website links as information changes quickly. The dates 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!!

The Federal Public Health Emergency has been extended to likely throughout 2021. Importantly the Biden Administration letter to the governors advised that 60-day notice will be given when the PHE will end. Extending the emergency declaration allows providers to continue to use waivers and flexibilities issued to assist in responding to the COVID-19 pandemic. **https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf Jan 22 2021**

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 are included in mandated testing as home care or hospice staff are a 'vendor'. Weekly or bi-weekly COVID 19 testing may be required.

CMS addresses Home Health Agency (HHA) and Hospice access to assisted (ALF) and independent living facilities (ILF) and when Hospices should Discharge Patients if Restricted or No Access

- ALFs and ILFs are not subject to federal regulation, rather state authority.
- Hospice and HHA personnel are expected to participate in any facility required screening.
- If access is restricted, hospices and HHAs should communicate with the facility administration about the nature of the restriction and gaining access to hospice or home care patients.
- *HOSPICE DISCHARGE:* If after reasonable attempts are made to access hospice patients in person and documented in the patient's record, the hospice is expected to 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-faqs-non-long-term-care-facilities-andintermediate-care-facilities-individuals-intellectual.pdf June 2020 Pages 9-13 • If an HHA is refused in-person 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 the HHA reference to ALF/ILF access on page 6)

C

COVID-19:

Airborne Transmission or Spread of COVID 19:

Under certain conditions, people with COVID-19 can infect others who are more than 6 feet away. Scientists believe that in these situations' infectious smaller droplets and particles from the COVID-19 positive person are concentrated enough to spread the virus to other people in the same space during the same time or shortly after the person with COVID-19 left.

- This spread is "airborne transmission" and is the same as for TB, for example.
- Try to avoid crowded indoor spaces when providing care, educate family and caregivers that well ventilated spaces is the safest for everyone, bring in outdoor air as much as possible.

COVID-19 spreads less commonly through contact with contaminated surfaces

- Respiratory droplets can also land on surfaces and objects. It is possible that a person could get COVID-19 by touching a surface or object that has the virus on it and then touching their mouth, nose, or eyes. However, touching surfaces is not a common way that COVID-19 spreads.

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html Oct 20, 2020

Disinfectants effective with COVID-19 – EPA website Made Easier to Use Table N

- Video and infographic on how to use EPA product Table N.

https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19

COVID 19 Variants: 3 Known Variants of the COVID 19 virus all confirmed in the US.

- Identified as from UK (B.1.1.7), South Africa (B1.351), Brazil (P.1)
- To date evidence is that the variants result in easier spread of the virus, no evidence that the variants results in more serious illness or death, or that that current vaccines do not work. The UK variant confirmed in over half of the states (primarily California and Florida), and South African and Brazilian variants also confirmed in US.
  https://www.cdc.gov/coronavirus/2019-ncov/transmission/variant-cases.html Feb 2, 2021

CDC Clinician On-Call Center is a hotline with trained CDC clinicians available to answer COVID-19 questions daily 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 17 yrs. old and Younger-Update:

- Jan 7, 2.9M cases in children (17yrs or younger) representing 12.5% of all COVID cases, -about 4% increase from Aug 2020.

- 0.2 to 3.1% of cases resulted in hospitalization; mortality 0-0.20% among reporting states, no change over reporting the past two quarters.
- Top 5 states in order where children are >15% of state's COVID cases: WY, AL; SC; TN; NM; ND • Top 5states in order by Number of Children's COVID Cases: CA, IL, TN, FL, AZ, https://downloads.aap.org/AAP/PDF/AAP%20and%20CHA%20%20Children%20and%20COVID19%20State%20Data%20Report%201.7.21%20FINAL.pdf Jan 7 2020

Two diseases added to Conditions of who Children who are at increased risk for severe COVID 19 illness: obesity, medical complexity, severe genetic disorders, severe neurologic disorders, inherited metabolic disorders, **sickle cell disease, chronic kidney disease**, congenital (since birth) heart disease, diabetes, asthma and other chronic lung disease, and immunosuppression due to malignancy or immune-weakening medications. https://www.cdc.gov/coronavirus/2019-ncov/needextra-precautions/people-with-medicalconditions.html December 29, 2020

MISC-C: Multisystem Inflammatory Syndrome in Children:

Multisystem inflammatory syndrome in children (MIS-C) is a rare, serious condition where different body parts become inflamed, including the heart, lungs, kidneys, brain, skin, eyes, or gastrointestinal organs. The cause of MIS-C is not known. Children with the disease test positive for COVID-19 or have been around someone with COVID-19.

Update: CDC information about MIS-C:

- CDC has received reports of **1288** confirmed cases of MIS-C and **28** deaths (2%)
- Reported in all states except West Virginia, Vermont, and Maine. Most cases reported in California, Texas, Louisiana, New York, and Florida.
- In 99% of cases (1269) the child tested positive for SARS CoV-2, the virus that causes COVID-19. The remaining 1% were around someone with COVID-19.
- Most children developed MIS-C 2-4 weeks after infection with SARS-CoV-2.
- The highest number of cases are among children aged 5-9, *with the average age of 8*.
- 76% of reported cases occurred in children who are Hispanic/Latino or Non-Hispanic Black
- 56% of reported cases are male. https://www.cdc.gov/misc/cases/?deliveryName=USCDC_2067DM37553 Dec 7, 2020

Common Symptoms of MIS-C:

Fever	Neck Pain
Abdominal Pain	Rash
Vomiting	Bloodshot eyes
Diarrhea	Feeling extra tired

NOTE: Not all children have all the same symptoms.

Emergency care is needed for a child with any of the following signs or symptoms:

Trouble breathing	Inability to wake or stay awake
Pain or pressure in the chest that does not resolve	Bluish lips or face
New confusion	Severe abdominal pain

The latest MIS-C 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)

Updated Clinical Study Findings of US COVID 19 Patients:

- The incubation period continues to extend to 14 days, with a median time of 4-5 days from exposure to symptoms onset.
- The signs and symptoms of COVID-19 present at illness onset vary but over the course of the disease they include the following:
  https://www.cdc.gov/coronavirus/2019ncov/symptomstesting/symptoms.html December 22, 2020

Fever or chills	**Cough**	**Headache**
Myalgia	**Sore Throat**	**Shortness of Breath**
Fatigue	**Congestion or Runny Nose**	**Nauseas ***
Diarrhea*	**New loss of smell and taste ****	**Vomiting***

*People increasingly reporting GI symptoms such as nauseas, vomiting or diarrhea sometimes prior to having a fever and lower respiratory tract signs and symptoms.
** Lost of taste and smell may persist for weeks or months after recovery and need not delay the end of isolation. https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/endhomeisolation.html *Dec 1, 2020*

COVID 19 Illness severity can range from mild to critical:

- Mild to moderate (mild symptoms up to mild pneumonia): 81%
- Severe (dyspnea, hypoxia, or more than 50% lung involvement on imaging): 14%
- Critical (respiratory failure, shock, or multiorgan system dysfunction): 5%
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html Dec 8, 2020

Study of Home Health COVID 19 Patients Risk for Rehospitalization: Among patients with COVID-19 admitted to home health care, comorbid conditions associated with rehospitalization or death included heart failure, diabetes, chronic pain, and cognitive impairment.
Bowles *et al*. *Surviving COVID-19 after hospital discharge: Symptom, functional, and adverse outcomes of home health recipients*, Annals of Internal Medicine (November 24, 2020).

Update and Addition of a Condition to COVID-19 VULNERABLE POPULATION by Condition Making Them Priority for Vaccine Access:

Adults of any age with the following underlying medical conditions are at risk of severe illness from COVID -19:

Cancer	Obesity: (BMI 30kg/m but < 40 kg/m)
Chronic Kidney Disease	Severe Obesity (BMI ≥ 40kg/m
COPD	Pregnancy
Heart conditions such as heart failure, CAD, cardiomyopathies	Sickle Cell Disease
Type 2 Diabetes	Immune compromised from solid organ transplant
Smoking	**Down Syndrome**

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medicalconditions.html Dec 29 2020

COVID-19 VULNERABLE POPULATION by Age by Risk for Hospitalization and Death

Age Range	Hospitalization	Death
18-29 yrs.	Comparison Group	Comparison Group
30-39 yrs.	2X higher	4X -higher
40-49 yrs.	3X higher	10X higher
50-64 yrs.	4X higher	30X higher
65-74 yrs.	5X higher	90X higher
75-84 years	8X higher	220X higher
85+ years	13X higher	630X higher

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html Nov 27, 2020

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/

D

Disaster Shelters and COVID 19

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.
- 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-DisasterSheltersCOVID19.pdf

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/interimrecommendations-intake-companion-animals-households-humans-COVID-19-arepresent

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/covid19/prepare-for-hurricane.html

If your patient will be evacuating and staying with another family, and so in closer quarters than usual see information for specific populations: https://emergency.cdc.gov/groups.asp

DMEPOS

Prior Authorization for Specific DMEPOS 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.

- 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-andSystems/Monitoring-Programs/MedicareFFSCompliancePrograms/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 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-faqs.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.

F

Flu versus COVID-19:

Symptom: Many symptoms of the Flu and COVID-19 are similar and may vary by degree of severity.

• Fatigue - more common in flu	• GI symptoms, nausea/vomiting/diarrhea -more common in children
• Cough – More common in both	• Headaches
• Aches and pain – more common in flu	• Shortness of breath
• Runny or stuffy nose	• Sore throat

COVID-19 symptoms include new loss of taste and/or smell.

Symptom Onset

- COVID-19 – Gradual Onset
- Flu – Abrupt onset

Incubation Period

- COVID-19 – 2-14 Days with contagious period 2 days prior to symptom onset and up to 10 days • Flu – 1-4 days with contagious period 1 day prior to symptom onset and typically 3-4 days of illness but can be contagious as long as 7.
-

Reduce Risk of Infection COVID and the Flu: Both are respiratory illnesses spread by person to person by close contact or through respiratory droplets when an infected person coughs, sneezes or talks. The preventive measures for the pandemic also help in decreasing the spread of flu:

- Social Distancing
- Mask
- Hand Hygiene

Flu vaccination and COVID resource - https://www.cdc.gov/vaccines/pandemic-guidance/index.html

- *Individuals with a positive COVID test* but are asymptomatic – defer the flu vaccination for 10 days from the positive test result date.
- *Individuals who are symptomatic or with suspected/confirmed COVID-19,* defer vaccination until:
  - 10 days after symptom onset AND ○ 24 hours with no fever without the use of fever reducing medications AND ○ Improvement of COVID-19 symptoms AND
  - No longer moderately or severely ill.
- *Individuals with known COVID exposure* should not seek the flu vaccine until their 14-day quarantine period has ended.

Flu Vaccination effectiveness: Approximately two weeks after vaccination for protection against the flu.
COVID Vaccination effectiveness: Approximately one-two weeks after all required doses.

Flu resources for patients and staff:

- 2020 Vaccine Storage and Handling Toolkit:

https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/index.html

- Vaccine Administration and storage and handling one page resource guide: https://www.cdc.gov/vaccines/hcp/admin/downloads/vacc-admin-storage-guide.pdf
- Take Three Actions to Fight Flu Infographic (English): https://www.cdc.gov/flu/resourcecenter/freeresources/graphics/infographic-fight-flu.htm
- Take Three Actions to Fight Flu Infographic (Spanish): https://www.cdc.gov/flu/pdf/freeresources/graphics/take3-fight-flu-infographic-sp.pdf
- Flu fact sheet in multiple languages: https://www.cdc.gov/flu/resourcecenter/freeresources/multilanguage-factsheets.html

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-cov2covid-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.

Home Cleaning: 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.
- 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/

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.

- **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/

N

Nursing Home CMS Regulations for Testing – Including Hospice and Home Care Staff

CMS has authority over the Medicare Skilled Nursing beds (SNF) and Medicaid nursing facilities. August 26, 2020 CMS released new federal testing regulations for SNFs and ICFs *effective immediately.*

Each facility must have one or more staff identified as an Infection Preventionist or IP who is responsible for the infection control program.

The federal regulations addressing testing scope and frequency are in addition to any state required testing and any facility-specific testing. CMS' June outreach to nursing homes regarding testing was recommendation, these regulations mandate testing.
https://www.cms.gov/files/document/qso-20-38-nh.pdf Aug 27, 2020

The following summarizes key elements of the regulation as it relates to your team entering these facilities:

- All residents and "facility staff" are subject to testing. Facility staff are defined by CMS as employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents.
    - Facility testing frequency can be applied to those who enter at least weekly. It remains the choice of the facility to establish testing requirements for those 'staff' who enter less often.
- Facilities are required to test residents and staff based on parameters and a frequency set forth by the HHS Secretary.

  The frequency of testing staff and residents – up to two times per week - is based on a *new* HHS database that presents % nursing home positive rates in the county that the LTC facility is located.

https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg

- Each facility is required to monitor the database and test resident and staff per the frequency in Table 2: https://www.cms.gov/files/document/qso-20-38-nh.pdf Aug 27 2020 ○ Each facility must report all positive and negative results to database at the frequency and detail defined by CMS.
    - **NOTE: If your organization tests your staff and provides the results to the facility, clarify what data they will need, how you will be advised of the frequency, and how to report it.**
    - CMS is following CDC guidelines that any facility staff who previously tested positive for COVID-19 do not need to be retested within the 3 months following the positive test.
- To enforce mandated federal reporting requirements an LTC facility found not to be reporting is subject to Civil Monetary Penalties, the first offense is $1000.

Approved Nursing Home Testing:

- Two types of testing approved by CMS:
    - **Molecular (RT-PCR) tests that detect the virus's genetic material** – diagnostic testing. The test used should be able to detect SARS-CoV2 virus with >95% sensitivity and >90% specificity, and results obtained within 48 hrs.
    - **Antigen tests or Point of Care (POC) testing** that detect specific proteins on the surface of the virus or an active infection before symptoms may appear.

NOTE for important details about POC or Antigen testing, scroll to "Testing" in the following Section on Operations under "O".

CMS Regulation for Nursing Home Access by Hospice and Home Health Staff: CMS is addressing how visiting residents can occur acknowledging concerns about physical, mental, and emotional health of residents in prolonged isolation. CMS advises precautions can be taken for visits outdoors, in resident rooms, dedicated visitation spaces, and for circumstances beyond typical compassionate care situations https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicyand-memos-states-and/nursing-home-visitation-covid-19 September 17, 2020

Indoor visitation: CMS states that facilities should accommodate and support indoor visitation, considering the following as well as other factors stated in the memo above:

- There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing (resident or staff testing positive in past 72 hrs.).
- Also consider use of the COVID-19 county positivity rate, found on the COVID-19 Nursing Home Data site as additional information in determining when to facilitate indoor visitation:

Please note the scope of "compassionate care situations" definitions stated by CMS. Consider these in presenting to nursing homes the importance of your care to support access to your patients=note that

CMS uses the phrase: " signs of distress that visitors may be able relieve or reduce" CMS includes the following:

- A resident struggling with the change in environment having previously lived with a family.
- A resident grieving after a friend or family member recently died.
- A resident who needs cueing and encouragement with eating or drinking, which was previously provided by family and/or caregiver(s), is now experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

NOTE for Hospice and Home Health Staff: A facility can identify a way to allow for personal contact, if following all appropriate infection prevention guidelines, and for a limited amount of time.

Facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v). Failure to do so can constitute a potential violation of 42 CFR 483.10(f)(4), and the facility would be subject to citation and enforcement actions.

Workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, social workers, clergy etc., must be permitted to come into the facility if they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened. All staff must comply with COVID-19 testing requirements.

Nursing Homes Required to Advise Residents and Their Representative of COVID 19 Infection:
https://www.cms.gov/files/document/nursing-home-reopening-recommendations-state-andlocalofficials.pdf (May 18, 2020)

- 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 who have new onset of respiratory symptoms within 72 hours. Updates to residents and their representatives must be provided weekly or each subsequent infection outbreak. Facilities must include information on action taken to prevent or reduce the risk of transmission, including if normal operations in the nursing home are altered. The information must be reported in accordance with existing privacy. regulations and statute.

O

Operational Changes Under COVID-19:

CDC Recommendations for Staff Diagnostic COVID-19 Testing: NOTE the following recommendations were made by the CDC Updated December 14, 2020. The recommendations apply to Healthcare Personnel (HCP)

Diagnostic testing is to be prioritized for:

1. The staff member who has ***signs or symptoms*** consistent with COVID-19
    a. Due to the extensive and close contact HCP have with vulnerable populations, even mild signs or symptoms (e.g., sore throat) of possible COVID-19 should prompt consideration for testing. Clinicians will need to utilize their judgement in making that determination.
2. ***Asymptomatic staff with high-risk exposures*** to SARS-CoV-2
    a. Higher risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure. The CDC recommendation would be that the exposed HCP be excluded from work for 14 days following the exposure.
    b. For HCP with higher risk exposures CDC recommends testing initially and if negative, again about 5-7 days post exposure to more quickly identify pre-symptomatic or asymptomatic HCP who could contribute to transmission in the community. Even if testing is not positive, those with higher exposures should be excluded from work for 14 days unless staffing shortages determine the need to shorten the quarantine period.
        a. In situations of staffing shortages, the following options to shorten quarantine.
            1. Quarantine can end after Day 10 without testing if no symptoms have been reported during daily monitoring (post quarantine transmission risk is estimated to be about 1% - 10%)
            2. When diagnostic testing resources are sufficient and available, then quarantine can end after day 7 if a diagnostic specimen tests negatives and no symptoms were reported during daily monitoring. The specimen may be collected and tested within 48 hours before the time of planned quarantine discontinuation, but quarantine cannot be discontinued any earlier than day 7. (post quarantine transmission risk is estimated to be 5-12%) https://www.cdc.gov/coronavirus/2019ncov/more/scientific-briefoptions-to-reduce-quarantine.html
    c. At risk exposure is contact for 15 minutes or more within 6 feet of the confirmed positive individual without the appropriate PPE. Any duration should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.
    d. 15 minutes exposure includes 15 minutes total over 24 hours.

3. For ***lower risk exposures,*** HCP may continue to work; however, CDC recommends screening for symptoms prior to starting work each day and using source control measures.
4. Asymptomatic HCP without known or suspected exposure – testing as part of expanded screening.
    a. This process is currently only recommended in nursing homes.
    b. If resources are available, general guidance is as follows:
        a. Testing asymptomatic HCP without known exposure is most valuable when it is repeated frequently. Testing less than one per week increases the risk of missing HCP infected between scheduled tests.
        b. The presence of available resources should be considered before taking on this approach due to potential for false positives impacting staffing.
        c. This approach is most impactful when conducted on HCP who have regular close contact (within 6 feet) with large numbers of patients or who regularly care for persons with risk factors or medical conditions that increase the risk of severe illness.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html January 14, 2021
Staff are asked or referred to get diagnostic testing by their healthcare provider, local or state health department.

When tested, staff should self-quarantine/isolate at home pending test results.

Handling Exposures post vaccination.

Vaccinated persons with an exposure to someone with suspected or confirmed COVID-19 are not required to quarantine **if** they meet all of the following criteria:

- Are fully vaccinated (i.e., ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine)
- Are within 3 months following receipt of the last dose in the series.
- Have remained asymptomatic since the current COVID-19 exposure.

Those who meet the above criteria and do not quarantine should monitor themselves for potential symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they should be clinically evaluated for COVID-19

Those who do not meet all of the above criteria should continue to follow current quarantine guidance. https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#phrecs Feb 10, 2021

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 your community, positive tests among healthcare staff do not necessarily indicate transmission due to an exposure in the workplace.

CDC Identifies Two (2) Types of Testing:

***Definition of Diagnostic Testing* for SARS-CoV-2 intended to identify current acute infection in individuals (PT-**PCR) tests that detect the virus's genetic material.

Definition of Screening Testing or POC (Point of Care) Testing: intended to identify infected persons who are asymptomatic and without known or suspected exposure to SARS-CoV-2.

- *A screening testing is performed to identify persons who may be contagious so that measures can be taken to prevent further transmission*. Examples of screening include testing a long-term care facility or an assisted living facility. https://www.cdc.gov/coronavirus/2019-ncov/testing/diagnostic-testing.html#who-should-get-tested August 24, 2020

POC (Point of Care) Testing or Antigen Testing for SARS-CoV-2:

CDC General Guidance

The FDA has granted emergency use authorization (EUA) for antigen tests that can identify SARS-CoV-2. See FDA's list of In Vitro Diagnostic EUA. https://www.fda.gov/medical-devices/coronavirusdisease2019-covid-19-emergency-use-authorizations-medical-devices/vitro-diagnostics-euas Aug 28, 2020

Antigen Tests Used at the point-of-care (POC) to detect the presence of a specific viral antigen, which implies current viral infection. The currently authorized devices return results in approximately 15 minutes. The reliability of the test and any limitations associated with the test (e.g., if a rapid antigen test known to have false positives and negatives) or the diagnostic test) in writing from the manufacturer and the FDA. Most often the interpretation of the results requires consideration of infection spread in

Additional CDC Antigen Update:

- Antigen tests or point of care (POC) test perform best when the person is tested in the early stages of infection with SARS-CoV-2 when viral load is generally highest.
- *Antigen levels in specimens collected beyond 5-7 days of the onset of* symptoms may drop below the limit of detection of the test. This may result in a negative test result,

- Antigen or POC tests can be used for screening testing in high-risk congregate settings where repeat testing could quickly identify persons with a SARS-CoV-2 infection to support infection prevention and control measures, and prevent or reduce transmission.

  https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antigen-testsguidelines.html?deliveryName=USCDC_2067-DM37553 Sep 4, 2020

FDA Approved EUA Antigen Tests for use with a CLIA Waiver can be found at:
https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/vitro-diagnostics-euas#individual-antigen October 14, 2020 (Scroll to Individual Antigen tests)

POC or Antigen Testing Requires a CLIA Waiver:
FDA advises that an EUA authorized antigen point of care test is deemed CLIA-waived. For the duration of the PHE, these tests can be performed in any patient care setting that operates under a CLIA Certificate of Waiver or Certificate of Compliance/Certificate of Accreditation.
https://www.cdc.gov/csels/dls/locs/2020/fda_clarifies_clia-waived_status.html April 9, 2020

State Requirements to Conduct Antigen Testing Must Also be Checked and Vary: Contact your health department for interpretation of your organization's ability to conduct testing. List of state agencies:
https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIASA.pdf
If you need a CLIA waiver, use this website for CLIA application Quick Start Guide:
https://www.cms.gov/files/document/cms-clia-laboratory-quick-start-guide-remediated.pdf

POC Infection Control and Test Management: Maintain six feet of separation from the person whose specimen was collected. CDC recommends using Standard Precautions. Follow the manufacturer's guidelines. https://www.cdc.gov/coronavirus/2019-ncov/lab/point-of-care-testing.html Oct 14 2020

Discontinuing Isolation and Quarantine can be a State Decision:
NOTE: State health departments may decide not to follow CDC recommendation and issue their orders that apply to a State or region or municipality.

Symptom Based Strategy to Discontinue Transmission Based Precautions and Isolation:

- Most persons with COVID-19, can end isolation and precautions 10 days *after symptom onset*[1] and resolution of fever for at least 24 hours, without using fever reducing medications, and with improvement of other symptoms.
- *Symptom onset* is defined as the date on which symptoms first began, including non-respiratory symptoms. the hospital "Course of Clinical Care Summary" has dates of clinical tests in the hospital more often than the H&P.
- Note: Some persons with severe illness may produce replication-competent virus beyond 10 days that warrants extending duration of isolation and precautions for up to 20 days after symptom onset; consider consultation with an infection control expert.

Ending Quarantine of Asymptomatic People Testing Positive for COVID 19, Options

- **CDC's recommendation remains 14 days quarantine,** as this option maximally reduces risk of post quarantine transmission risk and is the strategy with the greatest collective experience at present.
- The following science and research cited quarantine duration options are offered to reduce burden on individuals with asymptomatic illness.

Options to CDC 14-day Quarantine That *Public Health Authorities May Put in Place:*

End Quarantine After Day 10 Without Testing	End Quarantine After Day 7 – D*iagnostic Testing Required*
• **No evidence of symptoms reported with daily monitoring from the start to day 10.** • **Post-quarantine transmission risk ranges from 1% to 10%** • **Symptom monitoring continues through day 14, any changes – self-isolate and be tested.** • **Consistent mask use and social distancing, hand cough hygiene, environmental disinfecting, adequate ventilation, avoid crowds.**	• **No evidence of symptoms reported with daily monitoring from the start to day 7.** • **End only by negative Pt-PCR testing, specimen may be collected and tested 48 hrs. before day 7, but quarantine cannot be ended before day 7.** • **Post-quarantine transmission risk is 5-12%** • **Required consistent mask use and social distancing, hand cough hygiene, environmental disinfecting, adequate ventilation, avoid crowds.**

https://www.cdc.gov/coronavirus/2019-ncov/more/scientific-brief-options-to-reduce-quarantine.html
Dec 2, 2020

- **For persons who develop new symptoms consistent with COVID-19 during the 3 months after the date of initial symptom onset**, and an alternative etiology cannot be identified by a provider, the CDC recommends consultation with an infectious disease or infection control expert and retesting may be indicated.
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/durationisolation.html?deliveryName=USCDC_2067-DM35559# Aug 16, 2020

- **Admitting COVID 19 Patients to home care:** COVID 19 patients continue to be referred to home health, private duty, and hospice organizations across the country. If you accept COVID-19 patients for care or services, please consider the following questions shared by call participants:
  - **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/2019ncov/hcp/ppestrategy/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 instances, hand hygiene is performed per OPIM after removing PPE. (Shared practice not endorsed by the CDC).

- **At referral 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.

- **Collection of COVID 19 Respiratory Specimens for Diagnostic Testing** ○ Nasopharyngeal swab is no longer the preferred method of specimen collection ○f 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

CDC Summary of Managing PPE Shortages at the CHAP Education Web Site:

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 –
        - When ordering N95 respirators have the model number of the masks fit-tested for your staff. If no model number, provide the manufacturer and year from a mask you have.

- **Update ASPR Regional Health Care Coalitions Areas and Contact Person for Resources**: Health care coalitions (HCC) are groups of health care and response organizations – such as acute care hospitals, emergency medical service (EMS) providers, emergency management agencies, public health agencies, and more – working in a defined geographic location to prepare for and respond to disasters and emergencies.

  HCCs collaborate to ensure each member has what it needs to respond to emergencies and planned events, including medical equipment and supplies, real-time information, communication systems, and education. Website now allows identification of the coalition serving your area and a contact person.

  ○ https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx February 2 2021

- **Maximizing PPE: –** the CDC website offer specific recommendations to maximize the use of 5 categories of PPE used in the home. 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.
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html (July 20, 2020)

PPE Burn Rate Calculator: Excel Spreadsheets, instruction video and guidance for each type of PPE.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

Eye Protection: (NOTE CDC recognizes Face Shields AND Goggles as Eye Protection

- **Conventional Capacity: Your Organization's Usual practice with an adequate supply (Goggles, Face Shield)**
  The purpose of eye protection is used to protect staff eyes from exposure to splashes, sprays, splatter, and respiratory secretions for all patient encounters when there is moderate to substantial community transmission of SARS-CoV-2).
  CDC recommends shifting eye protection supplies from disposable to reusable devices (i.e., reusable face shields or goggles).
    - Disposable eye protection (e.g., face shields and goggles, should be removed and discarded after use.
    - Re-useable eye protection should be cleaned and disinfected after each patient encounter.

- **Contingency Capacity –expected temporary expected shortage, begin implementing extended use.**
  Extended use of eye protection is a staff member wearing the same eye protection for repeated close contact with several *different patients, without removing eye protection between patient encounters.*
    - In an expected shortage, a disposable face shield or goggles should be dedicated to one staff member and cleaned and disinfected whenever visibly soiled or when removed and prior to putting it back on.

- Face shields or goggles should be discarded if damaged (e.g., face shield or goggles can no longer fasten securely to the provider, if staff cannot see clearly, and cleaning does not restore visibility).
- If staff touch their eye protection or adjust it, they must immediately perform hand hygiene.
- Staff should leave the patient care area if they need to remove their eye protection.

- **Crisis Capacity: Per CDC these practices do not meet US standards of care but are implemented during known periods of shortages of eye protection for staff.**
  - Use the face shield or goggles beyond manufacturer shelf-life date (most often found on the label of either)
  - Implement extended use for staff whose care activities require prolonged (more than 15 minutes) face-to-face or close contact with a *potentially infectious patient* for which eye protection is recommended.
  - As an alternative, CDC advises to consider using safety glasses (e.g., trauma glasses) that have extensions to cover the side of the eyes. However, if these have gaps between glasses and the face, they likely do not protect eyes from all splashes and sprays.
  - Exclude staff who are at risk for severe illness from COVID-19 infection from care of patients with *suspected or confirmed* infection.

Treat glasses and goggles like medical devices - Cleaning per manufacturer guidelines, use gloves to clean, and store in a clean or dirty area so staff know what is clean and what dirty for re-use.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/eye-protection.html Dec 22, 2020

Gloves

- **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.
https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/medical-gloves-covid-19 (September 3, 2020)

- **Conventional Capacity: Your Organization's Usual practice with an adequate supply**
  Continued use of FDA-cleared disposable medical gloves following standard and transmission-based and when indicated for other exposures such as handling cleaning chemicals.

- Reinforce indications and recommended practices for non-sterile disposable glove use, and how and where gloves are to be disposed.
- Remind staff about indications for gloves use, as well as common situations when gloves may *not* be needed. (conserve PPE)
- Prioritize medical gloves for handling chemotherapy agents (chemotherapy gloves) for staff handling chemotherapy and other hazardous drugs. Ensure staff and operations know which drugs meet this qualification to ensure adequate PPE.

- **Contingency Capacity –expected temporary expected shortage.**
  Use gloves past their manufacturer-designated shelf life for training activities
  Non-sterile disposable gloves cleared by FDA are not required to have expiration date labeling; however, some manufacturers choose to designate a shelf life.
  - If a manufactured date is noted, the FDA recommends not using the gloves if more than 5 years since that date.
  - CDC advises using disposable medical gloves that are *like* FDA-cleared 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 (December 23, 2020)

- **Crisis Capacity: Per CDC these practices do not meet US standards of care but are implemented during known periods of gloves shortage. Implement extended use.**
  - Use gloves past their manufacturer-designated shelf life.
  - Prioritize non-sterile disposable gloves for use to protect hands from contact with potentially hazardous substances, including blood and body fluids (e.g., wound care, aerosol generating procedures).
  - Extended use of disposable medical gloves by staff refers to the practice of wearing gloves without changing them between patients or tasks. Gloves can remain on but must be sanitized between patients.to prevent cross transmission from patient to patient.
  - *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 disposable medical gloves in a time of 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.

Discard disposable medical or examination gloves always after:

- Visible soiling or contamination with blood, respiratory or nasal secretions, or other body fluids.
- 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 (December 23, 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.

Updated NIOSH website: https://www.cdc.gov/niosh/npptl/respirators/testing/NonNIOSHresults.html
August 7, 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/emergencyconsiderationsppe.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.
    - 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, reuse 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 -

Face Masks

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/mask-fit-and-filtration.html

CDC recommendations for "double masking" is based on the widespread COVID-19 variants some of which appear to spread more quickly and easily than the COVID-19 virus identified in early 2020.

- CDC recommendation are based on 4 factors:
  - How well a mask fits around the nose and below the eyes, and on the sides.
  - How well it filters air.
  - How many layers it has, and?
  - What mask to wear when, for example around people you do or do not know.

- Cloth Masks: What to look for:
  - Look for a cloth mask that is made of multiple layers of tightly woven, breathable fabric.
  - Make sure the cloth mask blocks light from coming through the fabric if held up to a bright light.
  - Does it have gaps around the sides of the face or nose? If so, it fits poorly and can allow respiratory droplets containing the virus to leak in and out around the mask.

  What you can do: Layered a cloth mask on top of a medical procedure mask (forming a "double mask") for better fit and air filtration. Using a mask fitter or brace can also help to the improve fit of a cloth mask.

- **Surgical Masks sold as "disposable face masks" for 1-time community use: What to Look For**
  - Check the labels to ensure that they are made of *multi-layered,* non-woven material.
  - Look at the fit which is often poor fit as there are gaps around the nose and along the sides of the face, where respiratory droplets containing the virus can leak in and out.

  What You Can Do: A medical procedure mask can be layered underneath a cloth mask (forming a "double mask") for better fit and air filtration. NOTE: a surgical mask ***should not*** be layered underneath a surgical mask. A mask fitter or brace can also help to improve fit around the face.

- **KN95 Masks (also known as KN95 Respirators): What to Look For**

  KN95 masks are a type of filtering facepiece respirator that are commonly made and used in China. KN95 masks can be preferred mask to wear in situations that require prolonged close contact (less

than 6 ft, for longer than 15 minutes) with people who do not live in the same household, or for people who are at increased risk for severe illness from COVID-19.

- **NOTE: When fitting properly these masks filter up to 95% of particles. BUT!!** many counterfeit (fake) KN95 masks are available, and sometimes it is hard to tell if they meet the right requirements just by looking at them. At least 60% of the KN95 masks evaluated by NIOSH did not meet the requirements that they claim to meet.

What You Can Do: use a KN95 mask identified on the FDA Emergency Use Authorization List https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/personal-protective-equipment-euas#appendixasurgicalmasks 2/9/21

- **What Mask to Wear When:** Some situations have higher risk of exposure to COVID-19 than others, so the how much protection you need can vary.

Cloth masks or surgical masks work well for community use. Examples might include:

  - Talking with neighbors when you are outdoors and are at least six feet away.
  - Going to a park, as long as you can stay at least six feet away from people who do not live with you.

When you will be in close contact (less than 6 ft) with people who do not live with you, a mask that gives you more protection (improved fit and/or improved filtration) such as double masking or KN95 is important.
Examples include:

- Going to the grocery store
- Visiting the doctor
- Working where you are exposed to people who do not live with you and you are not always able to maintain at least six feet of distance from others
- Riding on planes, buses, trains, or other forms of public transportation, especially when you are not able to maintain at least 6 feet of distance from other people who do not live with you
- Taking care of someone who is sick with COVID-19.

People who are older or have conditions that make them more likely at risk for severe COVID-19 illness should consider using KN95 masks or double masking when around people they do not live with.

https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/mask-fit-and-filtration.html Feb 10, 2021

Surgical Mask Use:

- **Conventional Capacity: Your Organization's Usual practice with an adequate supply**
  Facemasks are used by healthcare staff for 2 general purposes:

- As PPE to protect their nose and mouth from exposure to splashes, sprays, splatter, and respiratory secretions. When used for this purpose, facemasks should be removed and discarded after each patient.
- When used to cover one's mouth and nose to prevent spread of respiratory secretions when talking, sneezing, or coughing, facemasks may be used until they become soiled, damaged, or hard to breathe through. They should be immediately discarded after removal.

FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

- **Contingency Capacity –expected temporary expected shortage – implement extended use.**

  Extended use of facemasks is the practice of staff wearing the same facemask during encounters with several different patients, without removing the facemask between.
  - The facemask is discarded whenever it is removed, and always at the end of each workday.
  - The facemask is removed and discarded if it is soiled, damaged, or hard to breathe through.
  - Staff must take care not to touch their facemask. If they touch or adjust it, they must immediately perform hand hygiene.

  - HCP should leave the patient care area if they need to remove the facemask.
  - Staff who wear a mask to cover one's mouth and nose to prevent spread of respiratory secretions when talking, sneezing, or coughing may use a cloth mask.
  - Instead of providing a facemask to patients not already wearing their own cloth mask for source control, have them use tissues or other barriers to cover their mouth and nose.

Crisis Capacity: Per CDC these practices do not meet US standards of care but are implemented during known periods of shortage. Implement limited re-use with extended use.

- Pairing limited re-use of facemasks with extended use is one staff member using the same facemask for multiple patient contacts but removing it after several contacts and redonning it for further patient contacts.
- Ensure that staff do not touch outer surfaces of the mask during care, and that mask removal and replacement be done in a careful and deliberate manner.
- There is not a known maximum number of uses (donning) of the same facemask.
- The facemask should be removed and discarded if soiled, damaged, or hard to breathe through.
- Facemasks that fasten to the face by using ties may not be able to be undone without tearing and should be considered only for extended use, not re-re-use.
- Facemasks with elastic ear hooks may be the best for re-use.

Staff should leave patient care area if they need to remove the facemask. It should be carefully folded so that the outer surface is inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean sealable paper bag or breathable container.

When no Facemasks are Available:

- Use a face shield that covers the entire front (that extends to the chin or below) and sides of the face with no facemask.
- If neither respirators nor facemasks are available, staff might use cloth masks as a last resort for care of patients with suspected or confirmed diagnosis for which facemask or respirator use is normally recommended. Caution should be exercised when considering this option. Cloth masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html November 23, 2020

FDA Surgical Face Masks:

The FDA issued an umbrella emergency use authorization (EUA) for certain disposable, single-use surgical masks that meet certain performance requirements for use in any healthcare settings when used by staff to provide a physical barrier to fluids and particulate materials to prevent exposure to respiratory droplets and large particles.

Surgical masks that have been confirmed by the FDA as meeting criteria under the EUA are included in Appendix A as authorized surgical masks and the list is updated regularly.

https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/personal-protective-equipment-euas **February 1, 2021**

Gowns: CDC recommending Use of Disposable and Cloth Isolation Gowns

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.

Conventional Capacity: Usual practice with anticipated adequate supply of gowns

The CDC encourages employers to consider several fluid-resistant and impermeable protective clothing options.

- Nonsterile *disposable patient isolation gowns* used for routine patient *care are appropriate for use by staff when caring for patients with suspected or confirmed COVID-19.*
- *Reusable (i.e., washable) gowns are also accepted for routine* use, and typically made of polyester or polyester-cotton fabrics. Gowns made of these fabrics can be safely laundered after each use according to routine procedures and reused.
    - Routinely inspect gowns for rips or being too thin.
    - Ensure clean gowns stored so clean gowns are easily identifiable.

Emergency Use Authorization for Isolation Gowns: Using ANSI/AAMI PB70 standard disposal gowns: Level 1 or 2 gowns (non-surgical isolation gowns) is recommended when there is low risk of contamination. https://www.fda.gov/media/138326/download May 20, 2020

Contingency Capacity – Temporary, expected shortage of gown, implement extended use.

Limit the use of isolation gowns:

- *To patients with suspected or confirmed SARS-CoV-2 infections during aerosol generating procedures;* and
- *during patient activities that involve close and prolonged contact with the patient or their immediate environment* (e.g., dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, and wound care).

  NOTE: use of surgical gowns as isolation gowns requires changing gowns between patients and consideration of which surgical gown is used as they provide different levels of protection https://www.cdc.gov/niosh/npptl/topics/protectiveclothing/

Crisis Capacity: The practices are known not to meet US standards of care but are implemented in the care of patients during known periods of shortages.

- Extend the use of isolation gowns (disposable or reusable) *by having staff wear the same gown when interacting with more than one patient housed in the same location and known to be infected with the same infectious disease (e.g., all COVID 19 patients).*
  - *Re-use of the same gown with >1 patient can be considered **only** if there* are no additional *co-infectious diagnoses that can be transmitted by contact* (such as *Clostridioides difficile, Candida auris*).
  - A gown being used becomes visibly soiled, it must be removed and discarded or changed.
- Per the CDC, in situations of severely limited or no available isolation gowns, the following clothing can be considered *as a last resort for care of COVID-19 patients as single use*. None of these options can be considered PPE, since their capability to protect HCP is unknown. CDC recommends using this clothing if it has long sleeves and closures (snaps, buttons) that can be fastened and secured.
  - Disposable laboratory coats
  - Reusable (washable) patient gowns
  - Reusable (washable) laboratory coats
  - Disposable aprons
  - Combinations of pieces of clothing can be considered for activities that may involve high amounts of body fluids and when there are no gowns available.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html Jan 21, 2021

Ongoing FDA Hand Sanitizer Alert: All alcohol-based hand sanitizers from Mexico on national import alert - 84% of the samples analyzed by the FDA from April through December 2020 did not comply with the FDA's regulations and over half contained methanol and/or other toxic elements.

- 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.
- The FDA list to check if your hand sanitizer is a product you should use:

https://www.fda.gov/consumers/consumer-updates/your-hand-sanitizer-fdas-list-products-you-should-not-use

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Q

Quality Reporting as of July 1, 2020

CAHPS Data Submission After July 1, 2020

The CAHPS® Home Health Survey will be required for the third quarter of 2020 and onward. The Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS) requirements for the Annual Payment Update (APU) run from April through the following March. For the CY 2022 APU, HHAs are required to submit monthly lists to their HHCAHPS- approved survey vendors for the months of April 2020 through March 2021. Due to the COVID exceptions, agencies are not required to submit data for the second quarter of 2020, which is April 2020 through June 2020. The HHCAHPS-approved survey vendors are required to submit survey data on the third Thursday in the months of January, April, July, and December. The HHCAHPS- approved survey vendors are required to submit HHCAHPS survey data on July 16, 2020, and onward.

OASIS AND HH QRP

Starting with Q3 that begins July 1, 2020, CMS expects providers to report their quality data, which means that for all assessment time points with a **M0090 date of July 1, 2020, or later,** CMS expects the assessments to be submitted following the QRP requirements. CMS continues to waive the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE; however, the submission must be completed before submitting a final claim.

If an organization submitted data for Q1 and Q2 2020 to include the data for public reporting starting with Q3 2020 data, we will not include any of those data for purposes of calculating whether you meet HH QRP Requirements impacting CY 2022 payments. =
https://www.cms.gov/files/document/hhqrp-covid19phetipsheet-july2020.pdf

PHE Quality Reporting Exemptions on Public Reporting – Sept 2020

For Q1 2020 and Q2 2020, providers were excepted from data submissions. For this reason, CMS will hold the data constant (i.e., freeze the data) following the October 2020 refresh. The affected Compare site refreshes that were scheduled to contain CY 2020 COVID-19 data (Q1 2020, and Q2 2020) include:

- January 2021
- April 2021
- July 2021
- October 2021

After the October 2021 refresh, CMS plans to resume public reporting. Figure 2 provides a summary.

Quarter Refresh	Home Health Compare OASIS – Assessment-Based Measures Claims-Based Measures	Home Health Compare CAHPS®
October 2020	Normal refresh (includes Q4 2019 data)	Normal refresh (includes Q4 2019 data)
January 2021	Freeze	Freeze
April 2021	Freeze	Freeze
July 2021	Freeze	Freeze
October 2021	Freeze	Freeze
January 2022	Public reporting resumes*	Public reporting resumes*
April 2022	Normal refresh	Normal refresh

***To account for missing PHE -excepted data (Q1 2020 and Q2 2020) when public reporting resumes, any potential change in measure calculation methodology will be subject to notice-and-comment rulemaking.**

https://www.cms.gov/files/document/hhqrp-pr-tip-sheet081320final-cx-508.pdf

Home Health Flexibilities related to QRP due to the PHE.

CMS is delaying the release of the updated version of OASIS needed to support the Transfer of Health. (TOH) Information quality measures and new or revised Standardized Patient Assessment Data Elements (SPADES) to provide maximum flexibilities for providers of HHAs to respond to the COVID-19 PHE. The release of the updated version of the OASIS will be delayed until January 1 of the year that is at least 1 full calendar year after the end of the COVID-19 PHE.

CMS is providing relief to HHAs on the timeframes related to OASIS transmission through the following: (1) extending the 5-day completion requirement for the comprehensive assessment to 30 days; and (2) waiving the 30-day OASIS submission requirement. Delayed submission is permitted during the PHE. We are now allowing 30 days for the completion of the comprehensive assessment. HHAs must submit OASIS data prior to submitting their final claim to receive Medicare payment.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/Home-Health-Quality-Reporting-Training.

Hospice Quality Reporting

In the March 27, 2020, Medicare Learning Network (MLN) memo, CMS announced temporary relief for hospices and other providers in quality reporting programs in response to COVID-19 PHE. These temporary exemptions due to this PHE lifted the requirements to report data to assist hospice providers

while they directed their resources toward caring for their patients and ensuring the health and safety of patients and staff. Specific quarters for which hospices are exempted from reporting of CAHPS® Hospice Survey and HIS assessment and discharge data for calendar years (CYs) 2019 and 2020 are listed below and end on June 30, 2020:

- October 1, 2019–December 31, 2019 (Q4 2019)
- January 1, 2020–March 31, 2020 (Q1 2020)
- April 1, 2020–June 30, 2020 (Q2 2020)

CAHPS Submission after July 1, 2020
The CAHPS® Hospice Survey will start July 1 with July deaths.

HIS Data Submission
All new HIS admission records and any HIS discharge records that occur on or after July 1, 2020. Timely submission and acceptance of HIS data are unchanged. Data submission must occur for all patients within 30 days of admission and discharge at least 90 percent of the time. It is recommended that hospices submit HIS data within 14-days to ensure acceptance by the 30-day deadline.

The CY 2020 data used for meeting the HQRP requirements include July 1 through December 31, 2020, as Q1 and Q2 of 2020 (January 1-June 30, 2020) were exempted due to the COVID-19 PHE. This means that even if you submit HIS and CAHPS® Hospice Survey data for Q1 and Q2 2020, we will not include any of that data for purposes of calculating whether you meet HQRP requirements impacting FY 2022 payments.

https://www.cms.gov/files/document/hqrpcovid-19-phetipsheetjuly-2020508-compliant.pdf

Impact of Quality Reporting Exemptions on Public Reporting – September 2020
CMS Strategy for Exempted Data the Affected Compare site refreshes that were scheduled to include CY 2020 COVID-19 exempted data (Q1 2020 and Q2 2020) include: ·

- February 2021 ·
- May 2021 ·
- August 2021 ·
- November 2021

For these refreshes, CMS will hold the data constant (i.e., freeze the data). This means that following the November 2020 refresh, the data publicly reported will be the same data as the November 2020 data. Stated another way, the publicly reported data will be frozen through the November 2021 refresh. After the November 2021 refresh, CMS plans to resume public reporting. Figure 2 provides a summary.

Quarter Refresh	Hospice Compare HIS- Assessment Based Measures	Hospice Compare CAHPS®
November 2020	Normal refresh (includes Q4 2019 data)	Normal refresh (includes Q4 2019 data)
February 2021	Freeze	Freeze
May 2021	Freeze	Freeze
August 2021	Freeze	Freeze
November 2021	Freeze	Freeze
February 2022	Public reporting resumes*	Public reporting resumes*
May 2022	Normal refresh	Public reporting resumes*
August 2022	Normal refresh	Public reporting resumes*
November 2022	Normal refresh	Public reporting resumes*
February 2023	Normal refresh	Public reporting resumes*
May 2023	Normal refresh	Normal refresh

***To account for the PHE -excepted data (Q1 2020 and Q2 2020) when public reporting resumes, any potential change in measure calculation methodology will be subject to notice-and-comment rulemaking.**

https://www.cms.gov/files/document/hqrp-pr-tip-sheet081320final-cx-508.pdf

Quality Reporting Pandemic Considerations:

Current care practices implemented for Home Health and Hospice agencies to minimize virus exposure have potential to impact patient responses related to the CAHPS survey and clinician responses related to the OASIS or HIS data.

Examples of these practices include the use of PPE, shortening the visit length to reduce exposure time, use of telecommunication for the provision of care, and staffing shortages.

Considerations:
- PPE
  - use results in a barrier and the loss of "human touch" which facilitate relationship building
  - the loss of connection could impact patient answers to CAHPS questions such as: Were you listened to? Were you treated with respect? Did you receive confusing information?
  - Potential solutions:
    - Consider methods of care delivery that facilitate relationship building. If a patient is stressed overuse of telecommunications, the ability to connect clinician to patient is hindered.

- Allowing a patient/caregiver to "see" the face of their clinician through a window or by a picture may facilitate the "human touch."
- Minimizing length of visits ○ Shortening the length of visits requires alternate methods to provide the care of Using a combination of telecommunication and in-person visits to address patient needs will help ensure those needs are being met.
    - Potential solutions
        - Process to increase effectiveness of the shorter visit.
            - Possibly a checklist to stay on track.
            - Phone calls prior to or following the visit to obtain or verify information that does not require in-person contact.
            - Development of educational materials for patient review with the education conducted by telecommunication.
        - Use of Telecommunication for care delivery. Finding the optimum platform requires being able to validate the ability to conduct a comprehensive, effective visit that will meet the patient's needs. The same platform may not work for everyone.
    - Coordination of care provided remotely, and care provided in-person is key to ensure quality of patient care.
    - Potential solutions
        - Standardized written instruction for participating in a remote visit.
        - Encourage patients to have ready items needed for the remote visit.
            - Examples include supplies to conduct blood glucose testing, any new or changed medications, any logs that are being maintained by the patient.
- Needs identified during a remote visit require evaluation of whether an immediate in-person visit is needed or not.
    - Communication is key if the agency is unable to maintain consistent care providers for the patient. Being able to reflect coordination of the patient's care will emphasize the "team" caring for the patient.

During this challenging time, it is necessary to amend processes to provide quality care within the confines of infection control safety, and to also evaluate how those alternate processes may impact the patient's quality of care, their perception of their care experience and your publicly reported quality measures. Evaluate your processes broadly and think out of the box but within the Conditions of Participation.

S

Staff Stress and Compassion Fatigue:

Providing care to others during the COVID-19 pandemic can lead to stress, anxiety, fear, and other strong emotions. How you and your team cope with these emotions can affect your well-being, the care you give to others while doing your job, and the well-being of the people you care about outside of work.

In a Pandemic the Mental Health Issue is Duration: Experiencing or witnessing life threatening events impacts everyone differently. People may experience clinically significant distress or impairment, such as acute stress disorder, PTSD, or secondary traumatic stress (also known as vicarious traumatization). Compassion fatigue may also result from chronic workplace stress and exposure to traumatic events during the COVID-19 pandemic. **https://www.cdc.gov/coronavirus/2019-ncov/daily-lifecoping/managing-stress-anxiety.html** **July 1, 2020**

What You Can Do - First Identify It: Recognize the symptoms of stress

- Feeling irritation, anger, or denial
- Fear and worry about your own health and the health of your loved ones, your financial situation or job, or loss of support services you rely on
- Feeling uncertain, nervous, or anxious
- Feeling helpless or powerless
- Lacking motivation
- Feeling tired, overwhelmed, or burned out.
- Feeling sad or depressed
- Having trouble sleeping
- Having trouble concentrating

Learning to Manage Your Reactions:

Focus on 4 Core Components for Self-Management:

1) adequate sleep and rest
2) good nutrition, eat healthy meals,
3) regular physical activity and
4) active relaxation spend time outdoors relaxing when you can.

Talk to Yourself!

- Remind yourself that you are not the only one in an unusual situation with limited resources.
- Identify and accept those things which you do not have control over.
- Recognize that you are performing a crucial role in fighting this pandemic and that you are doing the best you can with the resources available. you share a sisterhood and brotherhood with caregivers like yourself across the world.

Take Control of Aspects of Your Daily Life:

- Keep a consistent daily routine when possible — as similar as you can to your schedule before the pandemic.
- Take breaks during your day to rest, stretch, or check in with *supportive* coworkers, friends, and family.
- Do things you enjoy during non-work hours – the importance of taking time away from work.
- Take breaks from watching, reading, or listening to news stories, including social media. Hearing about the pandemic repeatedly can be upsetting and mentally exhausting, especially since you work with people directly affected by the virus.
- Practice good daily hygiene-how like or unlike your daily routine are you now? Hair, shave, dress?
- 'Wash Up' at the end of the day, to 'put away' your work.
- Create individual ceremonies or rituals that allow you to focus your thoughts on letting go of stress or honoring a memory of something positive; seek moments of 'joy'.
- Practice your spiritual beliefs, anyone can pray.
- Engage in mindfulness techniques, such as breathing exercises and meditation. (there are apps for this!)
- If you feel you or someone you know may be misusing alcohol or other drugs (including prescriptions), ask for help or offer help.
- If you are being treated for a mental health condition, continue with your treatment, and talk to your provider if you experience new or worsening symptoms.

If concerned that you or someone in your household or you work with may harm themselves or someone else here are additional resources. If you share these, you never know when someone may use it.

- National Suicide Prevention Lifeline Toll-free number 1-800-273-TALK (1-800-273-8255)
  - The online Lifeline Crisis Chat is free and confidential. You will be connected to a skilled, trained counselor in your area.
- National Domestic Violence Hotline Call 1-800-799-7233 and TTY 1-800-787-3224
- Disaster Distress Hotline (SAMSHA) (Created for those working during disasters.
  - Call 1-800-985-5990 or text TalkWithUs to 6674.

Other sources American Institute of Stress https://www.stress.org has additional resources.

Staff Anxiety: Leadership, Manager and Supervision -What you can do:

Expect staff to demonstrate increased anxiety as the PHE continues, if only as a natural reaction to a sustained period of no predictability that can or does impact all parts of our lives. *As leaders you can take action to make a difference for your team! The following is excerpted studies of the impact of the pandemic on health care staff here in the US and the UK.*

1) Your leadership goal – reduce ambiguity for staff – they just want to know.

a. Double down on communication
b. Make it open and honest – their concern is financial security, physical safety, etc.

i. Tell them where the company is at, you are going forward, will expect and accept COVID 19 patients- yes or no and only if you have the supplies to care for them and for your team. (recommended guideline) ii. You are expected to keep wearing PPE. Tell them you have their backs, you have. PPE iii. Tell them that checking in with the symptom log is still expected, now it is critical to tracking.

c. Tell them what you learned from these seven months, reaffirm what worked and what will you do the same going forward. If something did not work, inform the staff group to address remember engaging folks offer hope which is based on taking action.
d. Clearly communicate the rationale behind changes you make going forward.

2) Acknowledge that you know that their job is stressful, and **they are** essential workers/heroes. Underscore the value of what they do -they let people stay at home-where we all want to be.
   a. What can you do to empower them, give them control over elements of what they do?
   b. Remind employees to take mental and physical breaks, exercise and participate in other non-work-related activities to reduce anxiety.
3) What roadblocks can you remove? They may have ideas.
4) Ensure that your team knows about mental health coverage as part of their benefits or access to these in the community (Noted at the end of the preceding information).
   a. If you have a wellness program use it for self-care, self-help virtual sessions with experts. Your goal is to reduce the stigma for asking for help.
   b. You may need to talk to some employees about seeking guidance.
5) So, what else is effective-in addition to clear communication about what is going on:
   a. Show how you care about the individual employee.
   b. Encourage supervisors and your management to check in with the team on about things other than work.
   c. Find more way to express appreciation.
   d. You are responsible to set a tone of respect.
   e. Resolve conflicts quickly.

Folks need to know right now that someone cares about them and what they do.

Staff Work Status and Antibody Testing: The CDC advises that an antibody test should NOT be used to determine if someone can return to work:
https://www.cdc.gov/coronavirus/2019ncov/lab/resources/antibody-tests.html (May 28, 2020)

Staff COVID 19 Processes to Address the Following:

- Monitoring staff health status for symptoms of COVID 19 symptoms, https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html May 13, 2020
- Staff Feeling Ill go home and contact a doctor for care and/or testing. Per CDC.

- Designate who and how patients, families and other staff are notified that a staff member is ill, and what action they should take awaiting information is COVID 19 positive.
- 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 has confirmed COVID-19 or is awaiting results.

Staff Exposure: Restricting an 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-(15 min or more or 15 minutes over a 24-hr. period), close contact (within 6ft) 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, or HCP not wearing all recommended PPE while performing an aerosol-generating procedure**.** Exclude from work for 14 days**.** 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.

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

Staff Exposure post vaccination: Work Restriction?

Guidance related to when an individual has completed vaccination but been exposed to someone with suspected or confirmed COVID-19 may be applicable when considering work restrictions for fully vaccinated healthcare personnel with higher-risk exposures as a strategy to alleviate staffing shortages.

As of February 10th, 2021, an individual who has been fully vaccinated and had a subsequent exposure would not be required to quarantine if they meet all of the following criteria:

- Are fully vaccinated (i.e., ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine)
- Are within 3 months following receipt of the last dose in the series.
- Have remained asymptomatic since the current COVID-19 exposure.

Those who meet the above criteria and do not quarantine should monitor themselves for potential symptoms of COVID-19 for 14 days following an exposure. If they experience symptoms, they should be clinically evaluated for COVID-19

Organizations who are experiencing staffing shortages, may use these criteria to determine if those with higher-risk exposures could continue to work.

Those who do not meet all of the above criteria should continue to follow current quarantine guidance. https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#phrecs Feb 10, 2021

T

Telehealth:

Use of telehealth by Medicare Certified home health agencies.

- **A PRN telecommunication visit order** is permissible if it is accompanied by a description of the patient's medical signs and symptoms requiring the visit and a specific limit on the number of those visits to be made before an additional physician or allowed practitioner order is needed. Orders for care may indicate a specific range in frequency of visits to ensure that the most appropriate level of services is furnished. If a range of visits is ordered the upper limit of the range is considered the specific frequency.

- **Comprehensive Assessments and Updates to the Comprehensive Assessment**
  - Audio only or two-way audio-video telecommunication comprehensive assessment or an update to the assessment can be used if it is part of the patient's plan of care. Telecommunications cannot substitute for in-person visits as ordered on the plan of care.

- Plan of care should be modified as the type of visits change, noting which visits will be made in person and which visits will be conducted visa 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 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:

  - 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 when telehealth can be provided and if it is billable.

- **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-factsheet (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.
- 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

- Start the visit by confirming the patient/family can see and hear. Make a clear verbal transition to the start of the clinical visit. Such as "How are you doing?"
- Let the patient/family know they can interrupt if they need to pause or adjust during the visit. • Confirm that you will call them if sound, or video is lost during the visit
- For the 1st visit provide an overview of the visit.
    - The amount of visit time.
    - What is to be accomplished during the visit to○ Discuss any concerns or symptoms being experienced ○ Review of medications and need for refills. The plan for the next visit
- If responding from home, find a quiet location with a neutral background and good lighting.

- Always dress appropriately and wear plain clothes as patterns can cause nausea from the screen.
- 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. ○ 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-4152020.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: The HHS Office for Civil Rights (OCR) can waive penalties for HIPAA violations against health care providers serving patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 federal PHE. https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notificationenforcement-discretion-telehealth/index.html (March 23, 2020)

Tips for Success:

- Look for changes in care provision practices to evaluate any potential negative effects on patients.
- Ensure plans of care include telecommunications if staff are using.
- Ensure orders are obtained to reflect any changes in care including the use of telecommunications.
- If utilizing telecommunication, a checklist can aid the clinician to remember the needs of the visit as they provide care.

V

Vaccine Communication Toolkits

Essential Worker Toolkit: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/toolkits/essential-workers.html

Community-Based Organization Toolkit: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/toolkits/community-organization.html

The toolkits can be used to educate essential workers and/or community members about COVID-19 vaccines, raise awareness about the benefits of vaccination and address common questions and concerns.

Each kit includes an introductory letter about vaccination to be used with essential worker. As a healthcare provider, you need to educate your staff as an employer of essential workers and may want outreach to the community you serve. Toolkits include:

- A pdf Fact Sheet: What to Expect with vaccination in several languages.
- Posters, PowerPoint slide decks and social media messaging is also included.
- A document of key messages addresses:
    - Stop the pandemic by getting a COVID-19 vaccine, that is safe and effective.
    - COVID-19 vaccine will be free although the provider may bill for an administration fee.
    - After the vaccination, there may be some side effects that are normal signs of your body building protection.
    - The need to continue masking and social distancing after the vaccination.

Tips for Effective COVID-19 Vaccine Conversation with Patients Can be Found at:

https://www.cdc.gov/vaccines/covid-19/hcp/engaging-patients.html

Designated COVID 19 Vaccinator Status as a Community-Based Organizations

- An HHA or hospice do not need to take any action to administer and bill for the COVID-19 vaccination, either through individual claims or roster bill, you are considered a mass immunizer. You will need to apply and be approved by your state or local health department to receive the vaccine. Contact the Immunization Program Manager now at your health department.

- Medicare payment for administering vaccinations: **https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment** and, **https://www.cms.gov/files/document/covid-home-health-agencies.pdf** (Nov 5 2020)

- **How the vaccination is paid for:** Vaccine doses purchased with U.S. taxpayer dollars are given at no cost. Vaccination providers can charge administration fees for giving the shot.

  Vaccination providers can get the administration fee reimbursed by the patient's public or private insurance company or, for uninsured patients, by the Health Resources and Services Administration's Provider Relief Fund external icon.

February 18: Vaccinating HomeBound Patients – CDC Recommendations:

3 Elements Key to Vaccinating Homebound Patients in home health, hospice and home care (private duty). NOTE: Organizations administering vaccine at home do assume additional responsibility, if you do not routinely do this, contact your liability insurer.

- **Training:**

CDC recommends that healthcare professionals become familiar with the particular COVID 19 vaccine that will be administered to ensure it is stored, handled, prepared, and administered correctly.

- **Who Do You Train?** Check who is licensed to administer vaccines in your state. Some states may have changed with the pandemic in mind, issuing state waivers to increase the availability of staff.

- **Who needs to be trained:**
  - Experienced vaccinators
  - Vaccinators who haven't administered vaccines in the past 12 months or longer
  - Support staff (not licensed to administer vaccines) who can assist with vaccine preparation and cold chain management such as data reporting, distribution of required materials to vaccine recipients, etc.

  CDC COVID 19 vaccination training and core competencies can be found at https://www.cdc.gov/vaccines/covid-19/training.html Jan 27 2021

Pre-Plan for Home Vaccination-What is Involved? Estimate the number of doses needed as closely as possible by:

1. Contacting patients or their caregivers in advance to determine who wishes to be vaccinated.
2. Plan to use all doses in a vial -decide if a contingency plan of vaccinating caregivers, or other persons in the home can be used to avoid vaccine waste
3. Map out travel plans so vaccine is used in the time frames for vaccine use at different temperatures, including factoring in pre-vaccination preparation time, in-home time and post-vaccination observation.
4. Ensuring readiness to maintain, monitor, and report temperature of vaccine from the time the vaccine is picked up, during transportation, and up to the time that vaccine is administered, including who is monitoring and documenting on a temperature log. Consider using a digital data logger.
5. What is involved in transporting - it differs for each vaccine. Understand how you can get access to and use of a "packout" container specific for vaccines.
   More important detail can be found at the following website including about using cars for transport: https://www.cdc.gov/vaccines/hcp/admin/storage/toolkit/storage-handling-toolkit.pdf Feb 5 2021
6. What you need to ensure that staff bring with them and does it need to be in different languages? It needs to be specific to the vaccine you are administering (e.g. Moderna vs. Pfizer)

Vaccine Administration – A Series of Actions You Need to Consider in Estimating Time in Home:

1. Assessing patient vaccination status and screening for contraindications and precautions, use the CDC pre-vaccination checklist -even for the second dose,
   a. Observation of at least 15 minutes up to 30 minutes for persons with a history of an immediate allergic reaction (within 4 hours) of any severity to a vaccine or injectable therapy, and persons with a history of anaphylaxis due to any cause.
   b. CDC recommends vaccination providers have at least 3 doses of epinephrine on hand.
2. Educating patients and caregivers,
3. Preparing and administering vaccines properly, and

4. Documenting the person's consent to receive the vaccine and the administration in your medical record within 24 hours of administration and reporting data to the relevant system (i.e., immunization information system) no later than 72 hours after administration.

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/homebound-persons.html feb 11, 2021

Operational Questions for Vaccine Roll Out to Your Staff and Patients:

How are you positioning vaccination with your staff? Do you have expectations of how staff will respond to patients' questions about being vaccinated?

1) Are you making a recommendation to your staff about being vaccinated?
2) Do you have a forum or means for staff to ask questions and get answers, as well as bring questions to you that patients have asked, and they would like answers?

Consider a brief education piece to provide to patients and to staff, so that there is a common response to questions. One such CDC pdf is:
https://www.cdc.gov/coronavirus/2019ncov/vaccines/pdfs/321466-A_FS_What_Expect_COVID19_Vax_Final_12.13.20.pdf

Another good resource can be found at:
https://www.cdc.gov/vaccines/covid19/hcp/answeringquestions.html November 2, 2020

THE COVID-19 Vaccine - What Your Team Needs to Know about COVID-19 Vaccination:

A one- page summary for use by your staff is **available on the CHAP education website**. Your team has great influence on people's choices to be vaccinated, especially patients as vulnerable individuals.

FDA Approval of 2 Vaccines for Emergency Use Authorization:

- Pfizer FDA approves EUA for the 2-dose Pfizer vaccine.
- Moderna: FDA approves EUA for the 2 dose Moderna vaccine.
- More vaccines may request approval by the FDA.

Emergency Use Authorization (EUA) Approval: What It Means

- **Post vaccine EUA approval reporting**: A EUA approved vaccine must has a plan for active follow-up for safety, including deaths, hospitalizations, and other serious or clinically significant adverse events to rapidly detect safety problems. Follow-up includes VAERS and monitoring Medicare claims data.
- **Vaccine recipients are told about EUA authorization and option to refuse vaccination:**

The FDA Factsheet given with each vaccine is posted at: https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatoryandpolicy-framework/emergency-use-authorization#abouteuas Dec 9 2020

COVID 19 Vaccination Access Priority:

The CDC has made vaccination access recommendations to the States, the States have the final determination of distribution and access to the vaccine.

State Immunization Plans Draft Executive Summaries and access plans for the population.
https://www.cdc.gov/vaccines/covid-19/covid19-vaccination-guidance.html Dec 6, 2020

Information About COVID 19 Vaccines for Staff and for Patients:

The U.S. vaccine approval system ensures that vaccines are as safe as possible. Each vaccine must demonstrate that the benefits outweigh the risks. Find out more about how vaccine safety is ensured at: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety.html Dec 10, 2020

CDC has developed ***v-safe***, to increase the ability to rapidly detect safety issues with COVID-19 vaccines. V-safe is a smartphone-based, after-vaccination health checker for people who receive COVID19 vaccines. When you receive your vaccination, you find out how to register and you can report symptoms and be reminded of your next dose.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/vsafe.html Dec 10, 2020

- **Current vaccinations require more than one dose to get the most protection. You must take the 2nd dose to get the full COVID-19 protection. You may not be protected until 1-2 weeks after the 2nd shot.**

  - Pfizer vaccine - 2 doses and a second shot 3 weeks (21 days) after your first shot.
  - Moderna vaccine: 2 doses, the second shot is one month (28 days) after your first shot.
  - The same vaccine must be used for both doses.

CDC updates Interval between the first and Second Dose of Vaccine:

- CDC continues to recommend that people get their second dose of COVID-19 vaccine as close to the recommended interval as possible (3 weeks for Pfizer-BioNTech, and one month for Moderna).

- CDC's updated guidance allows for second dose administration up to 6 weeks (42 days) after the first *if it is not feasible* to adhere to the recommended interval. CDC is not advocating for people to delay getting their second dose, but the data from clinical trials support this range.
https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html Jan 21 2021

- **What to Expect When You Receive the Vaccine:** You should receive a vaccination card or printout that says which COVID-19 vaccine you received, the date you received it, and where you received it. Also, each COVID-19 vaccine has its own fact sheet with information about side effects, and when your second shot is needed. You should receive this on paper or electronically when you receive you first shot.

  - **Common Side Effects:** Side effects are normal signs that your body is building protection and responding to the vaccine. These side effects should go away in a few days. Note that side effects may occur after the first or second dose.

Pain at the injection site	Fever	Tiredness
Injection site swelling	Chills	Headache

- **Important: Masking and Social Distancing Continues even after Vaccination** until more of the population is vaccinated.

Allergic Reactions to Vaccine

Severe Allergic Reaction - anaphylaxis -after getting a COVID-19 vaccine.

- A severe allergic reaction results in an individual's needs to be treated with epinephrine or an EpiPen© or hospitalization.
- If an individual reports a severe allergic reaction to any ingredient in an mRNA COVID-**19 vaccine,**
  - they should not receive either of the currently available mRNA COVID-19 vaccines -do not try the other brand if a reaction has occurred to a mRNA COVID-19 vaccine.
  - CDC recommends that the individual should not get the second dose.

Immediate Allergic Reaction: to a COVID-19 vaccine

- Important definition*: immediate allergic reaction*: Within 4 hours of being vaccinated such as hives, swelling, and wheezing (respiratory distress).
- Anyone who has an immediate allergic reaction—even if it was not severe—to any ingredient in an mRNA COVID-19 vaccine, **the** CDC recommends that they should not get either of the currently available mRNA COVID-19 vaccines.
- **An individual who had an immediate allergic reaction after the first dose of an mRNA COVID-19 vaccine,** should not get the second **dose.** Their doctor may refer them to a specialist in allergies and immunology to provide more care or advice.

COVID 19 and Allergic Reactions to Other Types of Vaccines

If an individual has had an immediate allergic reaction—even if it was not severe—to *a vaccine or injectable therapy* for another disease, they should ask their doctor before getting a COVID-19 vaccine.

COVID 19 Vaccine and Allergies *Not* Related to Vaccines

- CDC recommends that people with a history of severe allergic reactions *not* related to vaccines or injectable medications—such as food, pet, venom, environmental, or latex allergies—get vaccinated.
- People with a history of allergies to oral medications or a family history of severe allergic reactions can also get vaccinated.

COVID 19 and previous allergic reaction to polyethylene glycol (PEG) or polysorbate

Polysorbate is not an ingredient in either mRNA COVID-19 vaccine but is closely related to PEG, which is in the vaccines. **People who are allergic to PEG or polysorbate should not get an mRNA COVID-19 vaccine.**
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/allergic-reaction.html Jan 22, 2021

Pfizer and Moderna Vaccines use new technology: both are mRNA vaccines:

- Most vaccines use weakened or inactive parts of a virus to stimulate the body's immune response to create antibodies and kill the virus.
- The Pfizer and Moderna vaccines do not contain a live virus, and do not have the risk of causing the disease. These vaccines use what is called mRNA that triggers the process in our cells to build immunity to the virus that causes COVID-19. This approach has been studied for over a decade.

https://www.cdc.gov/vaccines/covid-19/hcp/mrna-vaccine-basics.html November 24, 2020

Simple Presentation of How mRNA Vaccines Work:

- mRNA vaccines cannot give someone COVID-19 and do not use live virus.
- mRNA vaccines do not affect or interact with our DNA in any way.
    - mRNA never enters the nucleus of the cell, which is where our DNA (genetic material) is kept.
    - The cell breaks down and gets rid of the mRNA soon after it is finished using the instructions.

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mRNA.html?ACSTrackingID=USCDC_2067-DM47392&ACSTrackingLabel=Understanding%20mRNA%20COVID-19%20Vaccines%20%7C%20COVID-19&deliveryName=USCDC_2067-DM47392 Dec 18, 2020

Co-Vaccination

The COVID-19 vaccine series should routinely be administered alone, with a minimum interval of 14 days before or after administration with any other vaccine. If benefits of co-administration outweigh the Potential unknown risks of vaccine coadministration (e.g., tetanus), the interval could be shorter period.
https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html

TB testing and COVID-19 vaccination:

Not enough is yet known about the potential impact of mRNA vaccines on immune responses to know if the COVID-19 mRNA vaccine has a potential effect on TST or IGRA test results during the first 4 weeks after COVID-19 vaccination.

For healthcare personnel or patients who require baseline TB testing (at onboarding or entry to facilities) at the same time they are to receive a COVID-19 mRNA vaccine, CDC recommends:

- Perform TB symptom screening on all healthcare personnel or patients.
- If using IGRA, draw blood prior to COVID-19 mRNA vaccination.
- If using TST, place prior to COVID-19 mRNA vaccination.
- If COVID-19 mRNA vaccination has already occurred, defer TST or IGRA until 4 weeks after completion of 2-dose COVID-19 mRNA vaccination.

https://www.cdc.gov/tb/publications/letters/covid19-mrna.html#:~:text=For%20healthcare%20personnel%20or%20patients,to%20COVID%2D19%20mRNA%20vaccination

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W

Waivers:

Types of 1135 waivers are issued during the Public Health Emergency (PHE). All waivers are effective March 1, 2020 and end effective when the federal Public Health Emergency ends.

- **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-disasterresources/entry

Please continue to join CHAP on our Weekly COVID 19 Conference Calls in 2021:

- **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!