FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

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

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

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

October 6 2020: The Public Health Emergency has been extended another 90 days or January 21, 2021. Extending the emergency declaration allows providers to continue to use waivers and flexibilities issued to assist in responding to the COVID-19 pandemic.
https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx

Home Health and Hospice Waivers continue to be in effect until the end of the Public Health Emergency unless otherwise stated in the waiver.

CMS announces resumption of normal survey activities by state agencies is encouraged while also addressing the backlog of surveys postponed during the PHE. Recommended prioritization of surveys in descending order include

- **Revisit surveys for past non-compliance that do not qualify for a desk review**
- **Complaint surveys triaged as non-IJ level or higher that have not been completed,**
- **Initial Surveys of new providers**
- **Past-due recertification surveys with a statutorily required survey interval (HHA & Hospice)**
- **Past-due recertification surveys without a statutorily required survey interval.**

Memo to state agencies here: https://www.cms.gov/files/document/qso-20-35-all.pdf

A

Assisted and Independent Living Facility Access:

Check your state to determine if the governor or health department has mandated staff COVID-19 testing for ALFs. Home health and hospice staff can be included as you represent staff coming into the facility, a 'vendor'. Weekly or bi-weekly COVID 19 testing may be required. CHAP recommends contacting the ALF administration for information about possibly obtaining the tests from the same vendor and using the same lab. Clarify is screening tests are acceptable – see under "Testing'.

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

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

CHAP Community Health Accreditation Partner

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

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

- Additionally, hospice and HHA personnel should participate in any facility required screening.
- If access is restricted, hospices and HHAs should communicate with the facility administration, including the State or local health department when indicated, about the nature of the restriction and gaining access to hospice or home care patients.
- HOSPICE DISCHARGE: Communication should also occur with the hospice patient's family or representative. If after reasonable attempts have been made and documented in the patient's record, and the hospice continues to be unable to access the patient *in-person*, the hospice would 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-and-intermediate-care-facilities-individuals-intellectual.pdf June 2020 Pages 9-13
- If an HHA is refused access, document the situation in the patient's record and advise the patient's physician. https://www.cms.gov/files/document/qso-20-18-hha-revised.pdf

(March 10 Memo Revised April 23, 2020. Note the HHA reference to ALF/ILF access on page 6)

October 6, 2020: Airborne Transmission or Spread of COVID 19:

There is evidence that under certain conditions, people with COVID-19 infect others who are more than 6 feet away. The transmissions occur within enclosed spaces with inadequate ventilation. In some instances, the person with COVID 19 was breathing heavily or singing, exercising, or shouting.

- 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 called "airborne transmission" and is the same as for TB, for example.
- Again, try to avoid crowded indoor spaces when providing care/services, educate family and caregivers that well ventilated spaces for the patient or client is 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 6, 2020

CHAP Community Health Accreditation Partner

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

C

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 <21 years old
Children and COVID-19-A Summary from the Children's Hospital Association and the American Academy of Pediatrics: https://downloads.aap.org/AAP/PDF/AAP%20and%20CHA%20-%20Children%20and%20COVID-19%20State%20Data%20Report%209.10.20%20FINAL.pdf Sep 10/2020

- Children represent 10% of all COVID 19 cases, not MISC C but COVID 19.
- NY and NJ: 3.5% are children, top 5 states: TN, SC, AZ, MS, LA

MISC-C: Multisystem Inflammatory Syndrome in Children:

Multisystem inflammatory syndrome in children (MIS-C) is a condition where different body parts can become inflamed, including the heart, lungs, kidneys, brain, skin, eyes, or gastrointestinal organs. Children with MIS-C may have a fever and various symptoms, including abdominal (gut) pain, vomiting, diarrhea, neck pain, rash, bloodshot eyes, or feeling extra tired. The cause of MIS-C is not known. However, children with the disease test positive for COVID-19 or have been in the presence of a positive COVID-19 patient.

The latest CDC information as of 9/3/2020:

- CDC has received reports of 792 confirmed cases of MIS-C and 16 deaths (2%)
- 99% of cases (783) 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.
- Most cases are in children between the ages of 1 and 14 years, the highest number of cases are among children aged 5-9, *with the average age of 8*.
- More than 70% of reported cases have occurred in children who are Hispanic/Latino (276 cases) or Non-Hispanic Black (230 cases).
- Slightly more than half (54%) of reported cases were male.

MISC has been identified in 42 states and DC: Top States for incidence are:

- California, Arizona, Florida, Louisiana, Maryland, Massachusetts, New York, New Jersey, Pennsylvania
- Followed by: Georgia, Illinois, Michigan, North Carolina https://www.cdc.gov/mis-c/cases/?deliveryName=USCDC_2067-DM37553 Sep 3 2020

CHAP Community Health Accreditation Partner

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

The common symptoms of MIS-C:

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

NOTE: Not all children will have all the same symptoms.

Emergency care should be sought for a child with any of the following symptoms or other concerning signs:

- Trouble breathing
- Pain or pressure in the chest that does not go away
- New confusion
- Inability to wake or stay awake
- Bluish lips or face
- 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)

The CDC and the American Academy of Pediatrics continue to work together to inform pediatric practices about risk factors, pathogenesis, clinical course, and treatment for MIS-C.

- CDC is requesting healthcare providers who have cared or are caring for patients younger than 21 years of age who meet the MIS-C criteria to report suspected cases to their local or state health department.
  - For additional information, please contact CDC's 24-hour Emergency Operations Center at 770-488-7100. After hour phone numbers for health departments are available at the Council of State and Territorial Epidemiologists website (https://resources.cste.org/epiafterhoursexternal icon).
- **Case Definition for Multisystem Inflammatory Syndrome in Children (MIS-C)** Provided to Pediatric Practices:
  - An individual aged <21 years presenting with fever ≥100.4F for ≥24 hours, or report of subjective fever lasting ≥24 hours; laboratory evidence of inflammation, and evidence of clinically severe illness requiring hospitalization, with multisystem (≥2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic or neurological); *AND*
  - No alternative plausible diagnoses; *AND*
  - Positive for current or recent SARS-CoV-2 infection by RT-PCR serology or antigen test; or COVID-19 exposure within the 4 weeks prior to the onset of symptoms: https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html (May 29, 2020)

CHAP Community Health Accreditation Partner

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

Clinical Study Findings of US COVID 19 Patients:

Study Findings from the first 100,000 COVID 19 US Cases:

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

Fever (83–99%)	Cough (59–82%)	Sputum production (28–33%)
Anorexia (40–84%)	Fatigue (44–70%)	Shortness of breath (31–40%)
Myalgias (11–35%)		

    - Headache, confusion, rhinorrhea, sore throat, hemoptysis, vomiting, and diarrhea have also been reported but are less common (<10%).[1,4-6]
    - Older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms.[10,11]
    - *Monitor patients with risk factors for severe illness* closely given the possible risk of *progression to severe in the second week after symptom onset*.[5,6,10,11]
- Patients on ACE inhibitors or ARBs may have increased risk of SARS-CoV-2 infection and COVID-19 severity.[45]The American Heart Association (AHA), the Heart Failure Society of America (HFSA), and the American College of Cardiology (ACC) released a statement recommending continuation of these drugs for patients already receiving them for heart failure, hypertension, or ischemic heart disease.[4]
- Additional information about clinical presentation, including hypercoagulability can be found at the website that follows.

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

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

- Aged 65 and older continues as a risk for severe illness. 65 and older make up 31% of cases in US as of June 2020, 50% of hospitalizations, about half of those admitted to ICUs and about 80% of those who died
- People of any age with the following conditions **are at increased risk** of severe illness. **This list** only **includes conditions with sufficient evidence to draw conclusions as of this date:**
    - Cancer
    - Chronic kidney disease
    - COPD

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

- **October 6 2020: Heart conditions such as heart failure, coronary artery disease or cardio myopathies.**
- Immunocompromised (weakened immune system) state post solid organ transplant
- **October 6 2020: Obesity, defined as a body mass index (BMI) of 30 but <40.**
- **October 6, 2020: Severe obesity, BMI of >40.**
    - There are adult, teen and child BMI calculators at: https://www.cdc.gov/healthyweight/assessing/bmi/index.html
- Sickle cell disease,
- **October 6 2020 -Children who have the following conditions might be at increased risk for severe COVID 19 illness: obesity, medical complexity, severe genetic disorders, severe neurologic disorders, inherited metabolic disorders, 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/need-extra-precautions/people-with-medical-conditions.html **October 6 2020.**
- **October 6, 2020- Smoking**
- Type 2 Diabetes – Poor blood sugar control impairs immunity and has been associated with worse outcomes, including higher mortality among diabetic patients with COVID-19. Supporting people with diabetes in effective self-management during the pandemic is an important measure to aid in mitigating the effects of SARS-CoV-2 infection.

Risk factors for COVID-19-related mortality in people with type 1 and type 2 diabetes in England: A population-based cohort study **Holman *et al.* Lancet Diabetes & Endocrinology (August 13, 2020).**

October 6, 2020: Possible conditions that may place adults of any age at increased risk for severe illness from COVID 19 based on what CDC knows at this time:

- **Asthma (moderate-to-severe)**
- **Cerebrovascular disease (affects blood vessels and blood supply to the brain)**
- **Cystic fibrosis**
- **Hypertension or high blood pressure**
- **Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines**
- **Neurologic conditions, such as dementia**
- **Liver disease**
- **Overweight (BMI > 25 kg/m^2, but < 30 kg/m^2)**
- **Pregnancy**
- **Pulmonary fibrosis (having damaged or scarred lung tissues)**
- **Thalassemia (a type of blood disorder)**
- **Type 1 diabetes mellitus**

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

October 6, 2020: NOTE: The above lists of underlying conditions are meant to inform clinicians to help them provide the best care possible for patients, and to inform individuals as to what their level of risk may be so they can make individual decisions about illness prevention.

CoPs (Conditions of Participation): HOSPICE Emergency Plan Requirements and COVID 19

- **Hospice - CFR §418.113:** The hospice must comply with all applicable Federal, State and local emergency preparedness requirements. The hospice must establish and maintain a comprehensive emergency preparedness program that meets these requirements. The emergency preparedness program must include, but not be limited to, the following elements:
  (a) Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every two years. The plan must do all the following:
  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
  (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.
  (3) Address patient/family population, including, but not limited to, persons at-risk; the type of services the hospice can provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
  (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or an emergency.

- **Hospice Policies and Procedures**: Facilities]must develop and implement emergency preparedness policies and procedures, based upon the emergency plan set forth in paragraph(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:
  (1) Procedures to follow up with on duty staff and patients to determine services that are needed, if there is an interruption in services during, or due to an emergency. The hospice must inform state and local officials of any on-duty staff or patients that they are unable to contact.
  (2) The procedures to inform State and local emergency preparedness officials about homebound Hospice patients in need of evacuation from their residences at any time due to an emergency based on the patient's medical and psychiatric condition and home environment.
  (3) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.
  (4) The use of hospice employees in an emergency or other staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency
  (5) The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.
  (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:

(i) A means to shelter in place for patients, hospice employees who remain in the hospice
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include but are not limited to the following:
(A) Food, water, medical and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(C) Sewage and waste disposal.
(iv) The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other locations.

Hospice Communication Plan: The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all the following:

(1) Names and contact information of the following:
- Staff
- Entities providing services under arrangement
- Patient's physicians
- Other hospices

(2) Contact information for the following:
- Federal, State, Tribal, regional, and local emergency preparedness staff
- Other sources of assistance

(3) Primary and alternate means for community with:
- Staff
- Federal, state, tribal, regional, and local emergency management agencies.

(4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.
(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii)

Hospice Communication Plan (continued)
(6) A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4)
(7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center or designee

Hospice Emergency Plan Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this Section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

(1) Training. The hospice must do all the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii)Provide emergency preparedness training at least *every 2 years*.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

(2) Emergency Plan Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community-based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) if the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) Second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C)A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

Hospice COPs Emergency Plan Regulations (Continued)

statements, directed messages, or prepared questions designed to challenge an emergency plan.

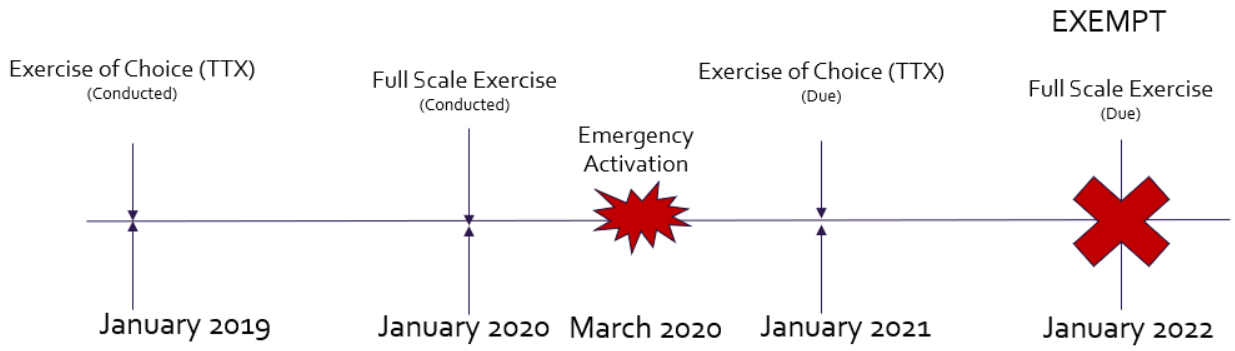
October 6, 2020 - QSO Memo published September 25, 2020 with subject: Guidance related to the Emergency Testing Exercise Requirements – Coronavirus Disease 2019 (COVID-19)

The emergency preparedness regulations allow an exemption for providers or suppliers that experience a natural or man-made event requiring activation of their emergency plan. On Friday, March 13, 2020, the President declared a national emergency due to COVID-19 and subsequently many providers and suppliers have activated their emergency plans in order to address surge and coordinate response activities. **Facilities that activate their emergency plans are exempt from the next required full-scale community-based or individual, facility-based functional exercise.** Facilities must be able to demonstrate, through written documentation, that they activated their program due to the emergency.

Documentation of emergency plan implementation could include but not be limited to:

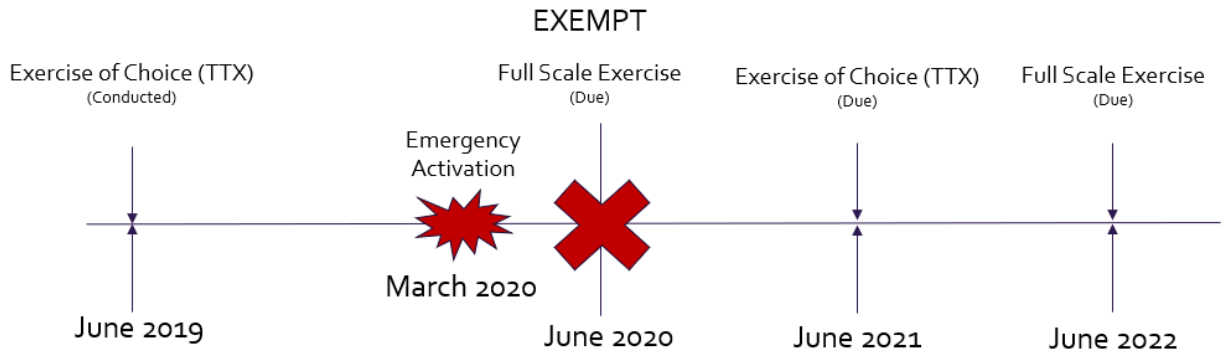
- Notice of activation to staff via electronic systems (alerts);
- Proof of patient transfers and changes in daily operations based on the emergency;
- Initiation of additional safety protocols, for example, mandate for use of personal protective equipment (PPE) for staff, visitors and patients as applicable;
- Coordination with state and local emergency officials;
- Minutes of board/facility meetings;
- 1135 Waiver (individual or use of blanket flexibilities); or,
- Incident command system related reports, such as situation reports or incident action plans.

Scenario one: In the following scenario, since the organization had conducted a full scale in 2020 prior to the initiation of the public health emergency, they are exempt from completing the next full-scale exercise due in 2022.



FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

Scenario Two: In the following scenario, a full-scale exercise was due in 2020 as in the previous example but had not been conducted before the public health emergency. Therefore, the organization would be exempt from conducting the 2020 full scale and will conduct the 2022 full scale exercise.



If an exercise of choice is due in 2020, documentation must show that the exercise was conducted. The exercise could be one of the following:

- Another full-scale exercise
- Individual facility-based functional exercise
- Mock disaster drill
- A tabletop exercise (TTX) or workshop

Agencies may choose to conduct a table-top exercise (TTX) which could assess the facility's response to COVID-19. This may include but is not limited to, discussions surrounding availability of personal protective equipment (PPE); isolation and quarantine areas for screening patients; or any other activities implemented during the activation of the emergency plan. The emergency preparedness provisions require that facilities assess and update their emergency program as needed. Therefore, lessons learned, and challenges identified in the TTX may allow a facility to adjust its plans accordingly.
https://www.cms.gov/files/document/qso-20-41-all.pdf

(3) **Emergency Plan Testing for hospices that provide inpatient care directly.** The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

(i)Participate in an annual full-scale exercise that is community-based; or

(A)When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or

(B)If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

(ii)Conduct an additional annual exercise that may include, but is not limited to the following:

(A) Second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii)Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

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

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

CoPs: Conditions of Participation for Home Health Emergency Preparedness Regulations

Home Health - CFR §484.102: The home health agency must comply with all applicable Federal, State, and local emergency preparedness requirements. The agency must establish and maintain a comprehensive emergency preparedness program that meets these requirements. The emergency preparedness program must include, but not be limited to, the following elements:

(**a) Emergency Plan**. The Home Health must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every two years. The plan must do all the following:

(1) Be based on and include a documented, agency-based, and community-based risk assessment, utilizing an all-hazards approach.
(2) Include strategies for addressing emergency events identified by the risk assessment.

(3) Address patient population, including, but not limited to, persons at-risk; the type of services the agency can provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and situation.

(b) **Policies and Procedures**: [Facilities]must develop and implement emergency preparedness policies and procedures, based upon the emergency plan set forth in paragraph(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:

(1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55.
(2) The procedures to inform State and local emergency preparedness officials about Home Health Agency patients in need of evacuation from their residences at any time due to an emergency based on the patient's medical and psychiatric condition and home environment.
(3) The procedures to follow up with on-duty staff and patients to determine services that are needed, if there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact.
(4) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.
(5) The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.

(c) Communication Plan: The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all the following:

(1) Names and contact information of the following:
- Staff
- Entities providing services under arrangement
- Patient's physicians
- volunteers

(2) Contact information for the following:
- Federal, State, Tribal, regional, and local emergency preparedness staff
- Other sources of assistance

(3) Primary and alternate means for community with:
- Staff
- Federal, state, tribal, regional, and local emergency management agencies.

(4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care.
(5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii)

(6) A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4)
(7) A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center or designee

(d) **Home Health Emergency Plan Training and Testing.** The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

(1) Training program. The [facility] must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.

(2) Testing. The [*facility*] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:

(i) Participate in a full-scale exercise that is community-based *every 2 years; or*

*(A) W*hen a community-based exercise is not accessible, *conduct a facility-based functional exercise every 2 years; or*
(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in *its next required* community-based or individual, facility-based *functional* exercise following the onset of the actual event.

(ii) Conduct an additional exercise *at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted,* that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based *functional exercise*; *or*
(B) *A mock disaster drill; or*
(C) A tabletop exercise *or workshop* that *is* led by a facilitator *and includes a group discussion* using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed

October 6, 2020 - QSO Memo published September 25, 2020 with subject: Guidance related to the Emergency Testing Exercise Requirements – Coronavirus Disease 2019 (COVID-19)

CHAP Community Health Accreditation Partner

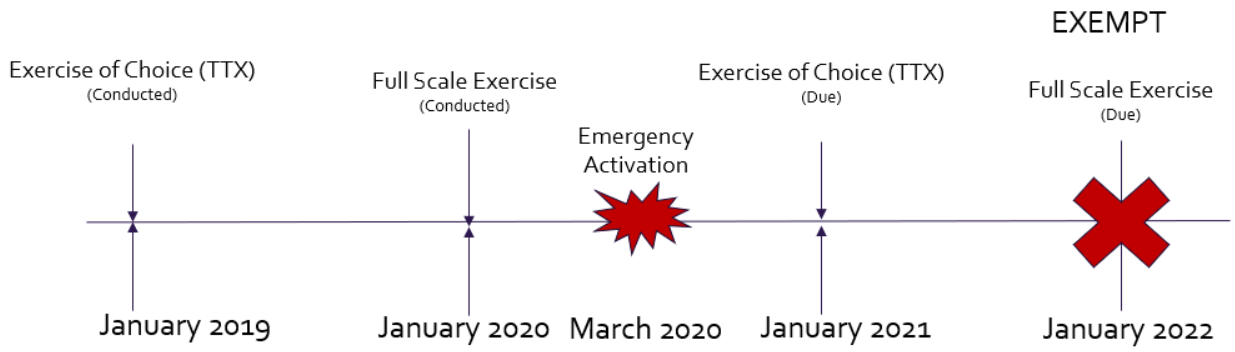
FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

The emergency preparedness regulations allow an exemption for providers or suppliers that experience a natural or man-made event requiring activation of their emergency plan. On Friday, March 13, 2020, the President declared a national emergency due to COVID-19 and subsequently many providers and suppliers have activated their emergency plans in order to address surge and coordinate response activities. **Facilities that activate their emergency plans are exempt from the next required full-scale community-based or individual, facility-based functional exercise.** Facilities must be able to demonstrate, through written documentation, that they activated their program due to the emergency.

Documentation of emergency plan implementation could include but not be limited to:

- Notice of activation to staff via electronic systems (alerts);
- Proof of patient transfers and changes in daily operations based on the emergency;
- Initiation of additional safety protocols, for example, mandate for use of personal protective equipment (PPE) for staff, visitors and patients as applicable;
- Coordination with state and local emergency officials;
- Minutes of board/facility meetings;
- 1135 Waiver (individual or use of blanket flexibilities); or,
- Incident command system related reports, such as situation reports or incident action plans.

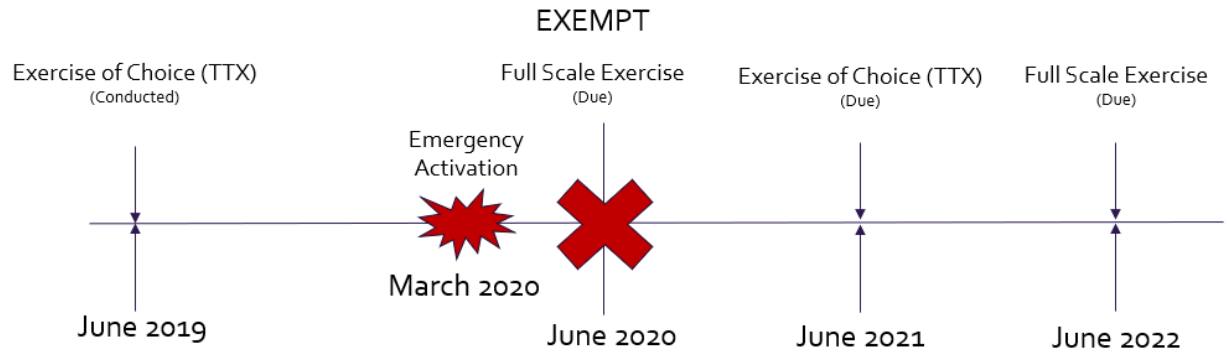
Scenario one: In the following scenario, since the organization had conducted a full scale in 2020 prior to the initiation of the public health emergency, they are exempt from completing the next full-scale exercise due in 2022.



Scenario Two: In the following scenario, a full-scale exercise was due in 2020 as in the previous example but had not been conducted before the public health emergency. Therefore, the organization would be exempt from conducting the 2020 full scale and will conduct the 2022 full scale exercise.

CHAP Community Health Accreditation Partner

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020



If an exercise of choice is due in 2020, documentation must show that the exercise was conducted.
The exercise could be one of the following:

- Another full-scale exercise
- Individual facility-based functional exercise
- Mock disaster drill
- A tabletop exercise (TTX) or workshop

Agencies may choose to conduct a table-top exercise (TTX) which could assess the facility's response to COVID-19. This may include but is not limited to, discussions surrounding availability of personal protective equipment (PPE); isolation and quarantine areas for screening patients; or any other activities implemented during the activation of the emergency plan. The emergency preparedness provisions require that facilities assess and update their emergency program as needed. Therefore, lessons learned, and challenges identified in the TTX may allow a facility to adjust its plans accordingly.
https://www.cms.gov/files/document/qso-20-41-all.pdf

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

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and complies [with the program].

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include the following:

- (i) A documented community-based risk assessment, utilizing an all-hazards
- approach.
- (ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan, and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

Pandemic Considerations for Emergency Preparedness Plan Development

- Community-based considerations included in the Emergency Plan risk assessment:
  - Prevalence of the virus
  - Ability to staff to meet community need
  - Continual monitoring of changes in infection risk level
- Operational considerations in Emergency Plan risk assessment
  - Availability of PPE
  - Ability to social distance in the office setting
  - The need to implement remote work
  - Number of employees who are at high risk
- Other emergent events in addition to the COVID pandemic (natural disasters).
  - Evaluate the need for your organization to include this possibility in the risk assessment – 2 emergencies at once
  - Prepare staff and patients with emergency plans that meet the CDC recommendation of no more than 50 people in a shelter and appropriate distancing and use of masks
- Addressing the patient population and your organization's ability to provide services
  - Discuss methods to address patient/family fears causing refusals to be seen in-person
  - Work with facilities to educate them about the staff's monitoring and precautions to ease the facility's anxiety about giving access
  - Identify which types of patient needs you are and are not able to meet during the pandemic or a period of surge in your community
- Continuity of organization operations
  - Ensure appropriate staffing to meet patient needs even if staff are out
  - Cross-train staff to support continuing operations if the administrator or clinical manager is out.
- Access to emergency officials
  - Is the contact information easily accessible for the appropriate emergency officials: public health department, other resources for information such as state associations?

Pandemic Considerations for the Emergency Preparedness Communication Plan

- Contact information for the employees/contracted staff/physicians

  - Update the employee listing with each new employee and remove each employee who left
  - Update the patient list with their physician's contact numbers. Keep the list current to include new admissions and remove patients discharged.
- Contact information for emergency management and other assistance
  - Keep in mind that the assistance needed might be a physical need, supplies, or current information
  - National and state home health and hospice associations may be resources, as well as CDC updates, and the CMS helpline
- Primary and alternate communication
  - Emergency management personnel are a resource to ask what is beneficial for the organization to use for alternate communication
    - Possibilities include CB radio, walkie-talkies- or satellite phones
- Identify a method to share patient information with others who will be assuming care responsibility during the disaster, including the general condition of the patient.
- Identify a means to access, maintain and release patient information in case of office evacuation so a staff member unfamiliar with a patient knows the patient status and care plan.
- What process is in place to identify patient needs and how to access their assistance if needed.
- What process is used to ensure coordination of care/

Pandemic Considerations for Emergency Preparedness Policy and Procedure:

- Policies related to on-duty staff address how screening of both staff and patients occur, including follow-up if a staff member becomes ill during the workday
- Procedure to inform officials of patients in need of evacuation from their residence.
  - This may be in relation to patients who become COVID positive and need to be moved to another care environment for care OR
  - Patients whose caregivers become ill and needed patient assistance is not available, keeping in mind the potential impact of a natural disaster such as hurricane, floods, or fire in addition to reducing the risk for COVID-19 infection.
  - How documentation of care and services provided is sustained that also preserves patient information, protects confidentiality, as well as secures and maintains availability of records.
  - Pandemic considerations include the method of providing key information to receiving facilities in cases of patient transfer, and to the receiving community physician in cases of patient discharge.
  - Consider that you may need to utilize contract staff and if the organization has not done so before, a process for sharing information will be needed, especially if the electronic documentation is not accessible to the contract staff.
  - A policy defining a process to protect patient confidentiality when using telecommunication.
  - Staffing shortage:
    - The use of volunteers/employees in an emergency or other staffing strategies to address surge needs
    - Hiring contracted staff,
    - Utilizing telecommunication whenever appropriate.

- Developing processes to limit staff exposure to COVID positive or Persons Under Investigation patients. Examples shared include assigning clinicians to provide care to COVID patients and using high risk staff in other roles such as providing telehealth. https://www.cms.gov/Regulations-and Guidance/Guidance/Manuals/downloads/som107ap_z_emergprep.pdf

CoPs (Condition of Participation: Infection Control)
Hospice – CFR §418.60: The hospice must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.

CoPs (Condition of Participation: Infection Control) Hospice
(a) Standard: Prevention
The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
(b) Standard: Control
The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that—

(1) Is an integral part of the hospice's quality assessment and performance improvement program; and
(2) Includes the following:

- A method of identifying infectious and communicable disease problems; and
- A plan for implementing the appropriate actions that are expected to result in improvement and disease prevention.

(c)Standard: Education

- The hospice must provide infection control education to employees, contracted providers, patients, and family members and other caregivers.

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

- The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.

(b) Standard: Control.

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

(c) Standard: Education.

- The HHA must provide infection control education to staff, patients, and caregiver(s).

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

Pandemic Considerations for Infection Control

- **Infection Prevention**: Six (6) standard precautions identified by the Center for Disease Control and Prevention (CDC) apply during any episode of care and include:
    1. **Hand Hygiene**: - Pandemic considerations are to ensure everyone knows how and when to conduct appropriate hand hygiene.
    2. **Environmental Cleaning and Disinfection**: Cleaning and disinfecting frequently touched areas and using an appropriate disinfectant.
    3. **Injection and Medication Safety**.
    4. **Appropriate Use of Personal Protective Equipment (PPE).** Pandemic considerations relate primarily to your organization having an adequate supply chain of FDA and NIOSH approved

Pandemic Considerations for Infection Control (Continued)

PPE, and to teach patients and family when to wear masks in the home and the correct way to do so.

5. **Minimizing Potential Exposures**: Pandemic considerations include how to identify staff at high risk; considering the needs of each patient and the safest means to provide the care to reduce exposure risk for the patient and for staff; and ongoing screening of staff, patients, family and visitors for signs and symptoms of COVID 19.
6. **Cleaning and disinfecting reusable medical equipment between each patient.** One consideration is if staff will carry any equipment into the home, or each patient is given their own equipment (e.g. BP cuff, stethoscope) to be maintained in the home. If equipment is used patient-to-patient, define the protocol for cleaning and disinfecting and provide the related supplies

- **Infection Control:**
    1. Evaluation of staff competence in donning and doffing PPE appropriately
    2. Ongoing screening of staff and patients
    3. Ability to respond quickly in cases where either patients or staff become symptomatic or test positive
    4. Ensuring appropriate PPE for all staff…external and internal
    5. Monitoring contacts of each staff to enable contact tracing if needed

Education

1. Reinforce to staff the importance of maintaining PPE and ongoing self-screening of symptoms per your policy.
2. Provide patients and family members information regarding symptoms of COVID-19 and when to report and act.
3. Patients who test COVID positive or advise that they have a potential positive COVID family member in the house, are provided information regarding isolation, masks, as well as cleaning and disinfection in the home. See Home Cleaning and Disinfecting in a following Section.

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 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.chaplinq.org/

CMS Survey Status:

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

CHAP site visitors are assessing compliance with standards acknowledging:

- Current federal blanket waivers for home health and hospice regulations - if your organization obtained a specific waiver, please have that available at the time of your site visit.
- State Medicaid waivers, and
- Applicable state executive orders.

- If you have questions, please contact your Director of Accreditation. We appreciate your continued dedication to the delivery of quality patient during this pandemic.

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

D

Disaster Shelters 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-Disaster-Shelters-COVID19.pdf

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

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

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

Additional CDC Disaster Planning Resources for Use During Pandemic
https://www.cdc.gov/disasters/disaster_resources.html (July 1, 2020)
Includes hurricanes, storms, and extreme heat
https://www.cdc.gov/disasters/hurricanes/covid-19/prepare-for-hurricane.html

If 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

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

DMEPOS

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/Medicare-FFS-ComplianceProgram s/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.

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

- Delivery and instruction by your technicians involve the same precautions for staff of home health, hospice, and private duty. All the staff recommendations in these FAQs apply to your staff, as well as any additional instructions from manufacturers for cleaning equipment returned from a home with a known or suspected COVID 19 patients.

H

Home Cleaning and Disinfecting During the Pandemic: The CDC recommends cleaning and disinfection of households to limit the survival of COVID 19 virus. These recommendations can be made to

homemakers, aides and other employees who assist with basic cleaning, laundry, etc. and to families of vulnerable patients.

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

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

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

PPE and Cleaning and Disinfecting Surfaces:

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

State Organization Licensure:

- **California: Hospice Initial Licensure Waiver-(April 23,2020):**
  - Initial licensure using CHAP: HSC sections 1747 (a) and (b) A hospice that has applied for initial licensure may begin providing care prior to undergoing the initial licensure survey for CDPH.
  - If you have selected CHAP for initial California licensure, the waiver allows you to admit patients and advise CHAP of readiness for survey without the preceding licensure survey. CHAP will conduct a survey that meets Medicare hospice Certification requirements as well as CDPH initial licensure requirements.

- **New Jersey: CHAP HCSF licensure, Division of Consumer Affairs (DCA) advises:**
  - In home plan of care evaluation: Division of Consumer Affairs (NJ) waiver (3/25/2020): Temporary waiver of N.I.A.C. 13:45B-14.9(g) requiring on-site, in home plan of care evaluations; permits required plan of care evaluations by nursing supervisors to be completed by electronic means. https://www.njconsumeraffairs.gov/COVID19/Documents/DCA-W-2020-02.pdf

N

CMS Nursing Home 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.
    - **Rapid 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 Rapid 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-certificationsurveycertificationgeninfopolicy-and-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 passed away.

• 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 as long as 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-and-local-officials.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 with new onset of respiratory symptoms that occur within 72 hours. Updates to residents and their representatives must also be provided weekly, or each subsequent time. Facilities must include information on action taken to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered. The information must be reported in accordance with existing privacy regulations and statute.

O

Operational Changes Under COVID-19:

CDC Recommendations for Staff Diagnostic COVID-19 Testing: NOTE the following recommendations were made by the CDC August 24, 2020. The recommendations apply to staff as well other individuals.

Diagnostic testing is recommended for:

1. The staff member who has signs or symptoms consistent with COVID-19
2. Asymptomatic staff with known or suspected exposure to patients with confirmed SARS-CoV-2 or exposure to positive COVID individuals in their own household.
    a. At risk exposure is contact for more than 15 minutes within 6 feet of the confirmed positive individual without the appropriate PPE.

3. 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 and follow the advice of your health care provider.

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.

- *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 Rapid 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/coronavirus-disease-2019-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 being used, or the diagnostic test) are available in writing. Most often the interpretation of the results requires consideration of infection spread in the community and the clinical consideration of the staff's physical symptoms.

If your organization is considering use of a rapid antigen testing for screening staff entering facilities, ensure that it is FDA, EUA approved. Also go to the manufacturer's via their website where they are required by the FDA to present a summary of how the test occurs, how results are provided, and how to interpret those results for your knowledge as an employer:

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FAQs: COVID 19 Conference Calls Updated Week of October 6, 2020

Additional CDC Rapid Antigen Update:

- Rapid antigen tests or point of care (POC) tests per CMS, perform best when the person is tested in the early stages of infection with SARS-CoV-2 when viral load is generally highest. They also may be informative in diagnostic testing situations in which the person has a known exposure to a confirmed case of COVID-19.
- Rapid antigen or POC tests can be used for screening testing in high-risk congregate settings in which repeat testing could quickly identify persons with a SARS-CoV-2 infection to inform infection prevention and control measures, thus preventing transmission. In this case, there may be value in providing immediate results with antigen tests even though they may have lower sensitivity than RT-PCR tests, especially in settings where a rapid turnaround time is required.
- 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,

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

FDA approved EUA Rapid Antigen Test for use with a CLIA Waiver:

1. Abbot Labs: BinaxNow™ EUA Approved 8/26/2020
2. Azure Biotech: Assure COVID-19 IgG/IgM Rapid Test Device (finger stick) 9/2020
3. Lumira DX UK EUA Approved 8/18/2020
4. Becton Dickinson BD Veritor 7/2/2020
5. Quidel, Sofia SARS 5/2/2020

https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/vitro-diagnostics-euas#individual-antigen Sep 4 2020

POC or Rapid Antigen Testing Requires a CLIA Waiver:

FDA clarifies when it grants an Emergency Use Authorization (EUA) for a point-of-care test, that test is deemed to be CLIA-waived. For the duration of the national emergency declaration for COVID-19, such tests can be performed in any patient care setting that operates under a CLIA Certificate of Waiver or Certificate of Compliance/Certificate of Accreditation.
ttps://www.cdc.gov/csels/dls/locs/2020/fda_clarifies_clia-waived_status.html
More info: https://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/faqs-testing-sars-cov-2 Sep 4 2020

Rapid Antigen Tests being shipped to HHAs and Hospices:

HHA and hospice organizations began to receive shipments of the tests the week of Sept 20 2020. The tests are being provided at no cost. Currently, there is no specific mandate for staff testing in Home Health or Hospice Agencies. Larger organizations with a CLIA Waiver and within an area of higher COVID-19 prevalence are prioritized. Contact your Health Department for more details on distribution.

- The tests are intended for staff screening and not for testing of home health or hospice patients.
- The kits are being sent to either the Administrator of the Responsible person of record. Agencies may want to pass along this information to prevent confusion if your agency receives a shipment. The kits are being sent as a set of 50 and may come with an invoice for 10 thousand dollars. A separate letter is sent that explains the initial 50 are free.

Purpose of the Rapid Antigen Test: The use of the test is for screening of staff, not patients! The INTENT of the kits is to support HHAs and Hospices to meet the testing requirements for their staff to care for patients within SNFs and/or ICFs

- **Agency obligations to conduct testing**
  - CLIA Waiver
  - Those agencies without a waiver, need to obtain a waiver before being able to use the testing
  - Those with a waiver, need to check with their health department to determine if they require an addition to the waivers. (Some may and others may not)
  - Notify relevant public health authority on intent to run test. While in contact with the health department, ask the question: What reporting is expected and what is the process for that reporting. It seems the reporting requirements may vary from one location to another.
- **Training of staff:**
  - From Abbott: https://www.globalpointofcare.abbott/en/support/product-installation-training/navica-brand/navica-binaxnow-ag-training.html
    - According to the information site from Abbott (link provided in FAQ) educational documents including a product insert, procedure card, and fact sheets are supposed to be included.
    - Abbott has a 6-video training program. The first four videos addresses the preparation, quality control, specimen collection and handling, and patient testing. Each video is no longer than 5 minutes.
    - The remaining two videos speak to an APP called Navica.
      - Administrator APP for those who are conducting the testing: App links the test card to the “patient” staff being tested
      - Patient App which once linked to the test card being used allows electronic delivery of the test results.
  - Webinar conducted by HHS in conjunction with NAHC was presented on September 25, 2020. Recording not yet posted.
- **If your organization receives a test supply:**
  - To date tests have been sent to the attention of either, the Administrator or the responsible person of record.
  - The box may include an invoice – DON’T PANIC- There is no cost. A separate letter will follow explaining the kits are free. The process on how to obtain more kits is provided.

- Be aware there is literature indicating mandatory reporting to your public health department. Three (3) potential ways to report results depending on the health department:
  - send the data directly to state or local public health departments using existing reporting channels to allow rapid initiation of case investigations and concurrent reporting of results must be shared with ordering provider or patient.
  - Submit data through a centralized platform such as "Association of Public Health Laboratories' AIMS platform
  - Submit data through a state or regional Health Information Exchange (HIE) to the appropriate state or local public health department.

The CDC No Longer Recommending the Test Based Strategy to Discontinue Transmission-Based Precautions and Isolation:

The test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the strategy outlined as follows.

- Exception: Persons who are severely immunocompromised, a test-based strategy could be considered in consultation with infectious diseases experts
- NOTE: This is a CDC recommendation and organizations and state health departments may decide not to follow this recommendation.

Symptom Based Strategy to Discontinue Transmission Based Precautions and Isolation Updated:

- For most persons with COVID-19, isolation and precautions can generally be discontinued 10 days *after symptom onset*[1] and resolution of fever for at least 24 hours, without the use of 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. Course of Clinical Care Summary will have dates of clinical tests.
  - Note: A limited number of persons with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset; consider consultation with infection control experts.

- **For Patients Being Discharged Home from a Hospital: A c**onference call participant recommends requesting a hospital "Clinical Course of Care Summary" which most often includes all tests, dates and results so staff may establish when the patient was tested in order to assess the number of days to continue Transmission Precautions and Isolation.

- **For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days *after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.* The positive test is used as the symptom onset start date.**
- **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/duration-isolation.html?deliveryName=USCDC_2067-DM35559# Aug 16, 2020

- **Asymptomatic Exposure of a Staff Member to an individual with suspected or confirmed COVID-19: As** the pandemic and associated exposure risk continues, CHAP is recommending that you consider addressing asymptomatic exposure of a staff member to an individual with suspected or confirmed COVID 19 as part of your pandemic related policies. This is a recommendation and not a requirement for survey under CHAP standards. The Operational Guidelines are a separate attachment and include an example of a reporting form. The information can be found as an attachment on the CHAP education site.

- **Infrastructure employees** (receptionist, janitorial, etc.) could continue to work as long as they remain asymptomatic. Strategies include:
    - Conduct pre-screening with measuring the employee's temperature and assessing symptoms prior to the start of the workday
    - Regular self-monitoring if there are no symptoms or a temperature present
    - The employee should always wear a face mask for 14 days post exposure while in the workplace. A surgical face mask would be best but in the event of a shortage, then cloth face coverings at a minimum
    - Maintain social distancing of 6 feet
    - Disinfect and clean workspaces such as offices, bathrooms, common areas, shared electronic equipment routinely.
    - If the employee becomes sick during the day:
        - They are sent home immediately.
        - Workplace surfaces are cleaned and disinfected
        - Those who had contact with the individual at the time of symptoms appearing and 2 days prior should be informed.
        - Exposure of others would be those who had been within 6 feet of the employee
    - Additional Considerations include:
        - Employees should not share headsets or other objects that are near mouth or nose.
        - Employers should increase the frequency of cleaning commonly touched surfaces
        - Employees and employers should consider pilot testing the use of face masks to ensure they do not interfere with work assignments.
        - Employers should work with facility maintenance staff to increase air exchanges in offices.
        - Employees should physically distance when they take breaks together. Stagger breaks and don't congregate in the break room.
        - Don't share food or utensils

https://www.cdc.gov/coronavirus/2019-ncov/downloads/critical-workers-implementing-safety-practices.pdf

CHAP Community Health Accreditation Partner

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

- **Letters for Staff as They Travel:** When stay-at-home orders are in place anticipate that staff will be stopped and asked the reason why they are traveling. Your staff are considered essential health workers in most states. Their ID badge is often not enough. We recommend a short letter on your company's letterhead. The letter can be short, an example follows.

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

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

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

- **Referral acceptance, request the COVID 19 status of each patient/client:** CHAP recommends adding the question about each patient's COVID 19 status (confirmed, pending testing results, COVID symptoms) to your referral acceptance process – it is critical to the health of the patient, their family and your staff.
  - If the patient has confirmed or suspected COVID 19, remember to get orders for any specific symptom monitoring or intervention for the COVID 19 diagnosis, as well as care for other chronic illnesses.

- Obtain information how long transmission-based precautions must be maintained or how you will know that the patient/client is no longer considered infectious. Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.

- **Collection of COVID 19 Respiratory Specimens for Diagnostic Testing**
  - Nasopharyngeal swab is no longer the preferred method of specimen collection
  - Additional approved methods include oropharyngeal, nasal mid-turbinate. Anterior nares swab or nasopharyngeal wash/aspirate/nasal wash
  - The type of specimen collection is not as important as following proper collection guidelines. The following link provides detailed instruction in the collection guidelines of each method of specimen collection:
  - https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html (May 22, 2020)

P

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 – state associations have been able to identify the process which could be formal request (forms to be completed) or requests e-mailed to the health department or local, regional or national suppliers with inventory.
    - 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.

- **ASPR Health Care Coalitions as sources of PPE for home care and hospice**: The following site includes a list of organizations that have come together to ensure that providers have what is needed in an emergency. Use the Interactive map in the web location below. Note, those who respond may not have immediately thought of home and community-based care, persist!
  - https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx (March 24, 2020)

- **Maximizing PPE: –** the CDC website below offers 5 categories of PPE-specific recommendations to maximize the use of PPE. Note: information is often written with the inpatient setting in mind. Not

all categories will apply to care in the home, but many do. Anticipate how to make these protections work in the home care setting.

- Eye protection
- Gowns
- Face Masks
- N95 respirators – includes fit testing, training on use of respirators, alternative respirators
- How to calculate your PPE "burn rate" https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html (**April 7 2020**)

https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html **(April 3, 2020)**

Eye Protection -Face Shield Update, FDA anticipates a Shortage (Aug 11, 2020):

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

- Protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays. CDC update July 15, 2020
- CHAP recommends using the Harvard Global Institute online risk rating by county to identify 'moderate to sustained' COVID 19 transmission, namely the areas rated 'red' or 'orange'. The dated is updated weekly and utilizes a standardized rating. You can find the data for your county or counties at: https://globalepidemics.org/key-metrics-for-covid-suppression/
- Goggles: provide barrier protection for the eyes. Should fit tightly over and around the eyes or prescription glasses
- Limited availability:
    - Extended use for one staff delivering care to use on multiple patients with COVID-19.
    - Reuse strategy should allow that the eye protection is dedicated to one HCW
    - As able, reprocessing should occur when visibly soiled or removed. See link for reprocessing directions: https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/emergency-considerations-ppe.html (May 5, 2020)
    - No Availability of eye protection: Potential alternative includes safety glasses that have side barriers to protect from droplets and splashes

Face Shields:

Face shields provide barrier protection to the facial area and related mucous membranes and are considered an alternative to goggles

August 11 CDC reaffirms face shields are not meant to function as primary respiratory protection and should be used concurrently with a mask.

- As an exception, CDC recommends considering the use of a face shield for those who cannot use a mask, understanding that it offers some protection to the patient as well as protection to caregivers
- CDC advises that although evidence on face shields is limited, not all face shields are equal. The available data suggest that the following face shields may provide better source control than others:
    - Face shields that wrap around the sides of the wearer's face and extend below the chin are the most effective, as well as considering use of hooded face shields.
    - CDC reminder of precautions when a face shield is used to wash hands before and after removing the face shield and avoid touching eyes, nose and mouth when removing it.
- Disposable vs. One Time Use Face Shields
    - Some face shields can only be worn for a single use and disposed of according to manufacturer instructions.
    - Reusable face shields should be cleaned and disinfected after each use according to manufacturer instructions or by following CDC face shield cleaning instructions .
    - Plastic face shields for newborns and infants are NOT recommended.
- https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html Aug 7, 2020

Anticipated Face Shield Shortage: FDA-Issued Emergency Use Authorization (EUA) for Face Shields –

- WHEN ORDERING, what you should see on any FDA approved face shield:
    - e product is labeled accurately to describe the product as a face shield *for medical purposes* and includes a list of the body contacting materials
    - The product is not integrated (combined) with any other article of PPE such as a face mask, but rather is for use as a standalone face shield.
    - Labeling describes the product as intended for either a single user, single use, or for multiple uses by the same user, and includes instructions for recommended cleaning and/or disinfection materials and processes, if applicable.

https://www.fda.gov/media/136842/download#:~:text=Face%20shields%20can%20be%20intended%20for%20medical%20or,FDA%20under%2021%20CFR%20878.4040%20%E2%80%93%20Surgical%20apparel

Gloves and Re-Use When There is an Inadequate Supply

- Understanding your glove utilization is critical to anticipating PPE burn. In considering which gloves to buy, it is important to know that gloves vary in use and ability to re-use in a crisis. The CDC is providing information to support improved access to gloves as well as re-use.
- **Glove types:** There are two (2) primary types are used in health care, sterile surgical gloves and disposable medical gloves or Patient Examination gloves, referenced as "Examination" gloves most often.

- Home health, home care (private duty), palliation, hospice and home infusion use non-sterile disposable examination gloves. 'Specialty' examination gloves often are chemotherapy gloves, which have been tested with chemotherapy agents.
- Glove product codes represent the material used in manufacturing; the following is per the FDA:

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

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

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

- CDC advises you may consider using disposable medical gloves that are *like* FDA-cleared surgical and examination gloves and approved under other U.S. or international standards. Examples are shown in the table at the following website. You would be looking for 'Examination' gloves. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/gloves.html (April 30, 2020)

- The use of gloves by staff when it is reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin could occur is not being waived.
    - *During a glove supply crisis gloves, can be used up to 4 hours continuously, but must be cleaned between patients to prevent cross transmission from patient to patient.*

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

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

Discard disposable medical or examination gloves always after:

- Visible soiling or contamination with blood, respiratory or nasal secretions, or other body fluids occurs.
- Any signs of damage (e.g., holes, rips) or degradation are observed; and
- Maximum of four (4) hours of continuous use.
- Doffing. Previously removed gloves should not be re-donned as the risk of tearing and contamination increases. Disposable glove "re-use" should not be performed.

- After removing gloves for any reason, hand hygiene should be performed with alcohol-based hand sanitizer or soap and water.
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/gloves.html (April; 30, 2020)

Masks with Exhalation Valves or Vents Not Recommended for Source Control

Awareness for patient's families and others: CDC warns that masks with one-way valves or vents allow air to be exhaled through a hole in the material, and therefore can result in expelled respiratory droplets that can reach others. This type of mask does not prevent the person wearing the mask from transmitting COVID-19 to others.

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/emergency-considerations-ppe.html (May 5, 2020)
    - Respirators should be removed (doffed) and discarded before activities such as meals and restroom breaks.

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

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

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

Discard: N95 respirators if:

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

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

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

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

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

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

Surgical Masks – Shortage Fall 2020 Anticipated:
The FDA issued an umbrella emergency use authorization (EUA) for certain disposable, single-use surgical masks in response to concerns about insufficient supply and availability of such masks.

The EUA authorizes the emergency use of surgical masks that meet certain performance requirements for use in healthcare settings by health care personnel as personal protective equipment to provide a

physical barrier to fluids and particulate materials to prevent exposure to respiratory droplets and large particles during surgical mask shortages resulting from the COVID-19 pandemic.

Surgical masks that have been confirmed by the FDA to meet the criteria under the EUA are included below in Appendix A as authorized surgical masks.

Note for health care personnel: https://www.fda.gov/media/140895/download

https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/personal-protective-equipment-euas#appendixasurgicalmasks August 5

PPE Resource: Project N-95 – A national critical clearinghouse for personal protective and critical equipment. Organization conducts sourcing due diligence on all suppliers and products to accelerate supply access. https://www.projectn95.org/

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. Examples of high-contact patient care activities requiring gown use include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, or wound care.

- Re-usable gowns are available instead of disposable single use gowns – but also require the laundering process.
- **Using ANSI/AAMI PB70 standard disposal gowns**: Level 1 or 2 gowns (non-surgical isolation gowns) are recommended when there is low risk of contamination. Level 3 or higher for high risk of contamination.
  https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html (April 9, 2020)
- **Limited Gown Availability:**
  - Extended use: One staff member uses the gown with multiple patients with COVID-19 over a single shift. This emergency strategy should be prioritized over the use of alternatives.
  - Reusable gown should be laundered per the guidance at the following link: **https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/emergency-considerations-ppe.html** (May 5, 2020)
- **No Gowns Available: potential alternatives:**
  - Disposable aprons
  - Disposable laboratory coats
  - Washable patient gowns and/or laboratory coats
  - Combinations of clothing such as sleeve covers in combination with aprons and long sleeve patient gowns or laboratory coats.

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

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

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

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Q

Quality Reporting as of July 1, 2020
Home Health Quality Reporting

Temporary HH QRP Exception Due to COVID-19 PHE
In the March 27, 2020, Medical Learning network (MLN) memo, CMS announced temporary relief for HHAs and other providers in QRPs in response to COVID-19 PHE. These temporary exceptions due to this PHE lifted the requirements to report data to assist HHAs while they directed their resources toward caring for patients and ensuring the health and safety of patients and staff.
Specific quarters for which HHAs are exempted from reporting of CAHPS® Home Health Survey and OASIS 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 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

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FAQs: COVID 19 Conference Calls Updated Week of October 6, 2020

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

CMS Strategy for Excepted Data

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.

FAQs: COVID 19 Conference Calls Updated Week of October 6, 2020

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.

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FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

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 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/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
    - 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.

R

Religious Nonmedical Healthcare Institutions - RNHCI

- **These facilities** provide nonmedical care to beneficiaries who choose to rely solely upon a religious method of health and for whom acceptance of medical services would be inconsistent with their religious beliefs.
- **Staff provide for the physical needs** of these nonmedical patients: 1) assist with activities of daily living; 2) assistance in moving, positioning and ambulation; 3) address nutritional needs; and 4) provide comfort and support measures on a 24-hour basis.
- **RNHCI facilities** are required to monitor CMS and CDC websites for guidance to protect their patients from the spread of infectious disease.
- **Emergency Preparedness Plan Implementation** should be fully in place with processes to address emerging infectious disease. All infection control practices as outlined by the CDC should be implemented. Availability of PPE should be in place prior to needing it for a patient who is positive.
- **Screening of patients** for COVID-19 symptoms is expected to be done on an ongoing basis; reporting anyone with potential COVID-19 symptoms to their management; reporting of incidents of COVID-19 symptoms to their public health department; and utilizing source control for those with symptoms by use of a face mask.
- **Screening of staff** is expected to be ongoing and anyone who has signs and symptoms of a respiratory infection should not report to work. If symptoms develop while working, the personnel should stop work, put on a facemask, and self-isolate. Management needs to be aware of who the employee has had contact with for the 48 hours prior to the development of symptoms and to contact the public health department for testing.
- **RNHCI Patients who test positive** are to be isolated with staff using appropriate PPE. A separate bedroom and bath are preferred as well as identification of the room housing a COVID-19 patient room so all staff who might have direct contact with the patient are aware of the COVID-19 status. If a patient requires and desires transfer to a hospital setting, the transport personnel and receiving facility are to be provided information about the patient. Pending the transfer, a facemask is placed on the patient prior to travel.
- **Facility actions to provide protection** include the screening of visitors in addition to the screening of staff and patients; limiting the entry points into the facility; requiring appropriate PPE for those who enter; restricting access to communal areas and implementation of appropriate disinfection processes.

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

S

Staff Stress and Compassion Fatigue:

Healthcare Personnel Coping with Stress During the COVID-19 Pandemic
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.

CHAP Community Health Accreditation Partner

FAQs: COVID 19 Conference Calls
Updated Week of October 6, 2020

In a Pandemic the 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-life-coping/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!)

Employers, Supervisors: Communicate with your coworkers, supervisors, and employees about job stress.

- Talk openly about how the pandemic is affecting your work.
- Identify factors that cause stress and work together to identify solutions. get a workgroup not only can address a problem and establish connections with coworkers.
- Recognize your team's performing a crucial role in fighting this pandemic and they are doing the best you can with the resources available. Celebrate successes – how many COVID 19 patients you have cared for at home, call the local paper about a story about home care and hospice nurses supporting COVID 19 patients at home - where folks go when they come out of the hospital or to quarantine-it's home and you are there.
- Mourn sorrows with co-workers.
- Present how to access mental health resources in your workplace.
- 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'll 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.

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

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

Staff Symptoms: COVID 19 Processes to Address the Following:

- **How you monitor staff health status** for the presence of the COVID 19 symptoms-fever, coughing, shortness of breath. Staff should also report if two of the following symptoms are present: chills, repeated shaking with chills, muscle pain, headache, sore throat, new loss of taste or smell. https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html May 13, 2020
  - CHAP conference call participants shared ways that they screen: having staff contact supervisors daily with a health status report; and, leaving a voice message, or an e-mail about their health status (shared practice).
- **Staff Feeling Ill.** The CDC recommends staff feeling ill go home and contact a doctor for care and/or testing.
- **How patients, families and other staff are notified of staff health status.** Designate who will advise patients, families, or other staff that a staff member is ill, and what action they should take awaiting information if the staff member will be tested for COVID 19 and when results are received.
- **Advise patients and caregivers how you monitor staff health status and ask their cooperation in telling you if any member of the household or visitor is confirmed COVID-19 or is awaiting results.**

Staff Exposure: 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 close contact with a patient, visitor or HCP with confirmed COVID-19 AND did not wear appropriate PPE which would include respirator or face mask, eye protection, and HCP not wearing all recommended PPE whiled performing an aerosol-generating procedure
    - Exclude from work 14 days after last exposure

        - Advise HCP to self-monitor for fever or other symptoms of COVID-19
        - Any HCP who develops symptoms should arrange for medical evaluation and testing.
    - LOWER RISK EXPOSURE – any HCP who had exposure without the high risk noted above
        - No work restrictions
        - Continue wearing facemask for source control while at work
        - Do not report to work if ill
        - Any HCP who develops symptoms consistent with COVID-19 should immediately self-isolate and arrange for medical evaluation and testing.
- Prolonged exposure is determined as 15 or more minutes of close contact

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

T

Telehealth:

- **Use of telehealth in CHAP accredited private duty nurse evaluations for patients receiving skilled care:**

  For organizations accredited using the CHAP Private Duty standards-PDII.5, d1 - the in-person nurse evaluation may be conducted by telehealth -Skype, face time, if the patient refuses the nurse's entry. CHAP would look to see documentation of the patient's or client's refusal, the results of evaluation and how it was done (e.g. facetime, etc.)

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

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

Home Health FAQ Telehealth Answers and Expectations:

On an interim basis, costs of telecommunication technology can be reported on the HHA **cost report** as allowable administrative and general costs by identifying the costs using a subscript between line 5.01 through line 5.19

- If **"PRN"** telecommunication may be needed, it is permissible to use a PRN order as long as it is accompanied by a description of the beneficiary's medical signs and symptoms that would occasion the visit and a specific limit on the number of those visits to be made under the order before an additional physician order would have to be obtained. Orders for care may indicate a specific range in frequency of visits to ensure that the most appropriate level of services is furnished. If range of visits is ordered the upper limit of the range is considered the specific frequency.
- Comprehensive Assessments and update to the comprehensive assessment
  - Can be completed through audio only or two-way audio-video telecommunication if it is part of the patient's plan of care and does not substitute for in-person visits as ordered on the plan of care.
  - **Plan of care** should be modified as the type of visits change. The plan of care should reflect which visits will be made in person and which visits will be conducted 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:

- Billing
  - Service intensity add-on payments – only in-person visits by RN or SW provided during routine home care during the last seven days of life are eligible
  - On the hospice cost report, hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as "other patient care services" using Worksheet A, cost center line 46, or a subscript of line 46 through 46.19, cost center code 4600 through 4619, and identifying this cost center as "PHE

- Initial and Comprehensive Assessments
  - Due to the role of the assessment as the foundation of the plan of care and crucial to establishing the hospice-patient relationship, the expectation is that in most situations, the initial and comprehensive assessments would be done in person. Especially for assessment of skin/wound care, uncontrolled pain/symptoms, effective teaching of patient/caregiver medication administration, etc.)
  - It would be up to the clinical judgment of hospice as to whether such technology can meet the patient's/caregiver's/family's needs and the use of technology should be included on the plan of care for the patient and family.

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

- **Medicaid and Private Insurance**
  - The ability to bill for home health/hospice is dependent upon the state flexibilities and the program itself. Research should be conducted to determine 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-fact-sheet (March 17, 2020)

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

Telehealth options:

- **Types of telehealth communications:**
  - Telehealth: refers to a broader scope of remote health care services than telemedicine as in addition to remote clinician services between a provider and patient/client, it also refers to

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

Getting Started:

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

Virtual Visit Etiquette

- Start the visit by confirming the screen is set up correctly and the patient/family can see and hear. Then make a clear transition to the start of the clinical visit. Such as "How are you doing?"
- Let the patient/family know that it is ok to interrupt if they need to pause or adjust during the visit.
- Confirm that you will call them if sound, or video is lost during the visit
- For the first telehealth visit with the patient/family, provide an overview of the visit.
  - The amount of time for the visit
  - The interventions to be accomplished during the visit
  - Discussion of any concerns or symptoms being experienced
  - Review of medications and need for refills
  - The plan for the next visit
- If responding from home, the clinician should find a quiet location with a neutral background and good lighting
- Always dress appropriately, and wear plain clothes as patterns can cause nausea

- Speak slowly and clearly, and check every so often to ensure that you are being heard
- Remember to look at the camera on your own device (not at the screen that has the patient's video)
- Call wrap up: Let the patient/family know when 5-10 minutes is left and ask if there is information, they want to make sure to cover.
- End the visit by summarizing what you heard, what the plan is, reviewing medication needs.
    - Provide information on what will be needed to facilitate the next visit
    - Inform the patient if the next visit will be a virtual or in-person visit.

Telehealth Resources:

Northwest Regional Telehealth Resource Center
https://www.nrtrc.org/covid-19-detail-117
https://www.nrtrc.org/content/blog-post-files/NRTRC-Telehealth-Start-Up-Checklist-handout-4-15-2020.pdf

Health and Human Services
https://telehealth.hhs.gov/providers/getting-started/

Mid Atlantic Telehealth Resource Center
https://www.matrc.org/matrc-telehealth-resources-for-covid-19/

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

TOP TEN Deficiencies in Home Health and Hospice during the pandemic April 1-July 31, 2020

CHAP Standard	CFR	Home Health Topic
PCC.2.I.M1	484.50(c) (7-8)(10)	Patient rights related to the provision of written information
APC.7.I.M2	484.60(a)(2)	Required elements of the plan of care
APC.8.I.M3	484.60(e) (1-2)	Provision of written visit schedule, medication schedule
CDT.7.I.M2	484.75(b)(3)	Skilled Professionals follow the plan of care
CDT.7.I.M7	484.80(g)(2)	Aides not following the plan of care
APC.6.I.M1	484.55(c)(5)	Review of Medications as a component of the comprehensive assessment.
IPC.3.I.M1	484.70(a)	Infection control – hand hygiene and bag technique.
APC.7.I.M7	484.60(a)(1)	Plan of care includes measurable patient specific goals and the physician is coordinated with for approval and modifications for evaluation visits that occur following the approval of the original plan of care

PCC.3.I.M3	**484.50(a)(2)**	**Provision of rights/responsibilities and transfer/discharge policies to a patient-selected representative within 4 business days of the initial evaluation visit**
APC.9.I.M3	**484.60(c)(1)**	**Alerting physician of changes in the patient's condition or needs**

CHAP Standard	CFR	Hospice Topic
HCDT.16. I	**418.76(g)(2)/L627**	**Provision of care by the hospice aide**
HCPC.21. I	**418.56(c)/L545**	**Elements of the plan of care**
HCPC.19. I	**418.56(b)/L543**	**IDG services follows the plan of care. RN oversees**
HSIM.3. I	**418.104(a)(1)**	**Elements of the clinical record**
HCPC.18. I	**418.56/L538**	**POC for each patient and addresses patient needs**
HCPC.15. I	**418.54(c)(6)**	**Comprehensive assessment includes drug review**
HCPC.22. I	**418.56(d)**	**IDG meets at least every 15 days and revises the plan of care**
HCPC.9. I	**18.54(b)/L523**	**Comprehensive assessment completed within 5 calendar days**
HCDT.15. I	**418.76(g) (1_/L625**	**Written instructions are prepared by an RN for the aide**
HCPC.17. I	**418.54(d)/L533**	**Update of the Comprehensive Assessment**

Potential Pandemic Effects for Home Health and Hospice

(discussion during our conference calls or through questions submitted by email indicate the following potential effects)

- Inability to conduct comprehensive assessment in relation to the use of telecommunications and/or shortened visits length to decrease potential exposure.
- Changes in visit pattern occur in relation to patient's willingness to accept in-person visits
- Less in-person contact decreases the ability to provide patients and caregivers with required written information
- Organizations may have not standardized their altered care processes to evaluate the effect on the patient/caregiver

Tips for Success:

- Conduct focused audits related to changes in care provision practices to evaluate any potential negative effects on patients
- Ensure plans of care include telecommunications if staff are conducting visits in this manner.
- Ensure orders are obtained to reflect any changes in care
- If utilizing shortened visits or telecommunication, a checklist will aid the clinician to remember the needs of the visit as they deal with providing care in a different manner

See the updated "TOP TEN" for Home Health and Hospice which includes more detailed tips for success for each individual finding in each table. https://chapinc.org/services/readiness/

V

Vaccinator COVID 19 Identification – CDC is reaching out to State Health Departments and Departments of Senior Services in an effort to begin to identify partners in administering the COVID-19 vaccine when

it becomes available and to ensure processes and training to effectively and safely deliver vaccine, and collecting reliable vaccination data.

CDC is providing a COVID-19 Vaccination Program Provider Agreement and a COVID-19 Vaccination Program Provider Profile Form. The forms do not be need to be completed at this time, fillable PDF versions are being created and will be shared as soon as available via the state health departments or Departments of Senior Services. Be prepared to identify your organizations under "other" and as home care or hospice provider. Also expect to complete a survey of the geographic areas that you can cover in the state.

W

Waivers:

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

- **Federal Blanket Waivers**: Publicly announced by CMS and applicable to all providers by Medicare benefit type. Examples include the home health and hospice waivers.

- **State Medicaid waivers**: States may request waivers of Medicaid regulations by contacting CMS. Over 48 states have requested waivers. To the following website, find your state, click on what is a letter to the state, scroll past the letter and you will find the details of the waiver. https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/entry

- **Individual provider or company waivers**: One provider or an association or a company with multiple locations can request a specific waiver of regulation related to the delivery of care. These waivers are not made public unless the requesting organization does so. Example, some state hospital associations have provided copies of their approved waiver that included provisions for home care or hospice. You may find guidelines for an individual waiver at : website (https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Resources/Waivers-and-flexibilities

  Send your individual or company waiver request to the specific Regional Office with oversight for your state:
  ROATLHSQ@cms.hhs.gov (Atlanta RO): Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee.

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

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

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

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

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

- **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!