FAQs: COVID 19 Conference Calls – Updated Week of June 30, 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!!

A

Assisted and Independent Living Facility Access:

June 30, 2020: 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 in the orders as you represent staff coming in to provide care – called 'vendors. To date we are seeing weekly or bi-weekly COVID 19 mandated testing. CHAP recommends contacting the ALF administration for information about possibly obtaining the tests from the same vendor and using the same lab.

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

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

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

- Additionally, hospice and HHA personnel should participate with any screening activity that the facility requires.
- If access is restricted, hospices and HHAs should communicate with the facility administration, including the State or local health department when indicated, on the nature of the restriction and timing for gaining access to hospice or home care patients.
- HOSPICE DISCHARGE: Communication should also occur with the hospice patient's family or representative. If after reasonable attempts have been made and documented in the patient's record and the hospice continues to be unable to access the patient *in-person*, the hospice would have to 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
- Note that a State or Local health department can issue a directive restricting access to a specific ALF/ILF that can result in no access, however this should be an exception.
- If the HHA is refused access, document the situation in the patient's record and advise the patient's physician. https://www.cms.gov/files/document/qso-20-18-hha-revised.pdf
  (March 10 Memo Revised April 23, 2020 note HHA reference to ALF/ILF access on page 6 of 10)

C

Children -Pediatric Patients <21 years old

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

The latest symptoms and information for parents can be found at:
https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/children/mis-c.html (May 20, 2020)

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

- Patients with MIS-C have presented with a persistent fever and a variety of signs and symptoms including multiorgan (e.g., cardiac, gastrointestinal, renal, hematologic, dermatologic, neurologic) involvement, and elevated inflammatory markers.
- Not all children will have the same symptoms, and some children may have symptoms not listed above.
- MIS-C may begin weeks after a child is infected with SARS-CoV-2. The child may have been asymptomatically infected, and, in some cases, the child and their caregivers may not even know they had been infected.
- CDC is requesting healthcare providers who have cared or are caring for patients younger than 21 years of age who meet the MIS-C criteria to report suspected cases to their local or state health department.
  - For additional information, please contact CDC's 24-hour Emergency Operations Center at 770-488-7100. After hour phone numbers for health departments are available at the Council of State and Territorial Epidemiologists website (https://resources.cste.org/epiafterhoursexternal icon).

- Case Definition for Multisystem Inflammatory Syndrome in Children (MIS-C) Provided to Pediatric Practices:
  - An individual aged <21 years presenting with fever ≥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)

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]
  - Persons with COVID-19 experienced gastrointestinal symptoms such as diarrhea and nausea prior to developing fever and lower respiratory tract infection
  - Older adults and persons with medical comorbidities may have delayed presentation of fever and respiratory symptoms.[10,11]
    - Among 1,099 hospitalized patients, fever was present in only 44% at hospital admission but later developed in 89% during hospitalization.[1]
  - Patients with risk factors for severe illness should be monitored closely given the possible risk of progression to severe in the second week after symptom onset.[5,6,10,11]
  - Patients on ACE inhibitors or ARBs may increase the risk of SARS-CoV-2 infection and COVID-19 severity.[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.[46]
  - Additional information about clinical presentation, including Hypercoagulability can be found at the website that follows.

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

COVID-19 Symptom List

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

CMS Survey Status:

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

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

CHAP site visitors will be assessing compliance with standards acknowledging:

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

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

June 30: DMEPOS: The CMS AO suspension of surveys has expired. CHAP is resuming initial and renewal surveys. If you have questions, please contact your Director of Accreditation, Jackie King.

D

Disaster Shelters

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

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

DMEPOS

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

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

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

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

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

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

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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/

Licensure: Licensed Practitioners

June 30: 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 Licensure:

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

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

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N

Nursing Home Access for Hospice:

June 30, 2020: Nursing home mandated COVID-19 testing of hospice and home health staff:
CMS has authority over the Medicare Skilled Nursing beds and Medicaid nursing facilities and has sent a communication to leaders in state health departments and state surveyors to formulate a COVID 19 testing plan. At a minimum CMS is recommending that each state mandate:

a. Testing all residents for COVID 19 as a baseline.
b. Testing all residents should any staff test positive or any resident- including a resident with COVID symptoms -and continue to test weekly until all residents test negative.
c. Test all nursing home staff, including external staff, for baseline testing and then weekly – weekly testing can be adjusted by the state based on transmission in the area.
d. Written screening protocols for all staff, including those entering to provide care, visitors and residents.
e. Arrangement with labs to process tests. The test used should be able to detect SARS-CoV2 virus with >95% sensitivity and >90% specificity, and results obtained within 48 hrs.
f. Use of Universal Control: All visitors and all residents wear a cloth mask or a surgical mask. If a visitor is unwilling, restrict their entrance, as well as small children. Require that all visitors wash hands upon entry.

g. PPE requirements and only approve use of contingency policies per CDC as necessary – CDC's Strategies to Optimize the Supply of PPE and Equipment. Crisis strategy is not acceptable.
h. All staff must wear face mask and administrative personnel can wear cloth masks.

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

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

https://www.cms.gov/files/document/qso-20-30-nh.pdf

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

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

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

NOTE: Before bringing in your equipment (e.g. BP cuff, stethoscope, etc.) into the facility, check if you will need to use the facility's equipment. CMS has directed that each facility designates vital sign equipment (including blood pressure cuff) to use either with individual residents or in specific wings or units with COVID 19 patients. Facilities are directed to clean and disinfect this equipment appropriately according to manufacturers' instructions using an Environmental Protection Agency (EPA)-registered hospital-grade disinfectant.

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

- Nursing homes must report residents or staff with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or staff with new-

onset respiratory symptoms within 72 hours of each other through the CDC's National Health Safety Network (NHSN) system.

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

O
Operational Changes Under COVID-19:

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 on the CHAP education site.

Office Opening: The public health emergency is expected to continue through July 2020. However, CMS expects the organization's office of record to be open and staffed during the business hours stated on the CMS 855. It is usually fine to close the office for short periods of time with signage reflecting this and how to reach someone with the organization. During a pandemic remaining closed is based on local guidance. Long term remote work could be a problem if the office is not staffed during stated office hours. CMS expects that the surveyors are can conduct a survey of the provider.

- Letters for Staff as They Travel: Nationwide home care and hospice staff are being stopped and asked for reason why they are traveling when there are shelter-in-place orders. Their ID badge is often not enough. We recommend a short letter on your company's letterhead. The letter can be short, an example follows.

  (Name of company) is providing healthcare services. (Name of staff member) is currently assigned to provide these services to one of our patients in their home. They are carrying an ID badge issued by

our company. If you have questions, you can reach us at (insert a 24/7 number if your staff could be out at any time). Thank you.

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

- Assessing Readiness for Admitting COVID 19 Patients: COVID 19 patients are being referred to home health, private duty, and hospice organizations across the country. Will your organization accept COVID-19 patients?
  If yes, the following questions were shared by call participants as helpful in deciding how many COVID 19 patients they can care for.
  - Ask staff who agrees to care for a COVID 19 patient. Organizations report that not all staff will, and some staff have resigned rather than face the prospect.
  - How much PPE do you have and need (e.g. face shields, gloves, gowns, N95 masks)? CDC offers a PPE 'burn rate calculator: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html (April 7, 2020)
  - Will staff see only COVID 19 patients each day, or mixed with those who are not suspected or confirmed COVID 19? This decision impacts your PPE inventory. Organizations report two current practices: 1) leave the N95 mask, face shield and gown after use in the patient's home (if not soiled or possibly contaminated, and still 'sound'-not torn, and still fitting appropriately) and place these in a paper bag and the bag inside a box-with cautions for access by pets and children; or 2) staff removes PPE and places the N95 mask in a paper bag in a box in their trunk, and only uses when they see the next COVID 19 patient. In both instances, hand hygiene is performed per OPIM after removing PPE. (Shared practice not endorsed by the CDC).
  - In view of the nationwide recommendation, and in some areas a governor's or health department order that the public wear masks, CHAP recommends that staff wear masks when entering the home of those without confirmed or suspected COVID-19. Staff will likely be within 6 ft of the patient or others in the home.
  - Organizations also share that when possible they don PPE upon entry to the apartment or house to avoid issues for the patient and family if donned on a porch or in the hallway. PPE is for protection at the bedside with the infected patient, and usually the patient is at least 6ft away when putting on PPE inside the residence (Shared practice).
  - Below under PPE, there is a variety of information to manage your inventory.

- Referral acceptance, requesting COVID 19 status of each patient/client:

- CHAP recommends adding the question about each patient's COVID 19 status (confirmed, pending testing results, COVID symptoms) to your referral acceptance process – it is critical to the health of the patient, their family and your staff.

- If the patient has confirmed or suspected COVID 19, remember to get orders for any specific symptom monitoring or intervention for the COVID 19 diagnosis, as well as care for other chronic illnesses.
- Obtain information how long transmission-based precautions must be maintained or how you will know that the patient/client is no longer considered infectious. Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for discharge.

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

- Test-based Strategy for those with symptoms: Note a combination of: -.
  - Resolution of fever without the use of fever-reducing medications and
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), and
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) [1]. See
  - Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). (May 22, 2020 https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html (May 29,2020)

- Symptom-Based Strategy (previously known as Non-test-based strategy); recognizing the limitations for testing includes a combination of:
  - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications and
  - improvement in respiratory symptoms (e.g., cough, shortness of breath); and,
  - At least 10 days have passed *since symptoms first appeared* (Revised 4/30/2020 and changed the number of days from the first symptoms to 10 rather than 7 days https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html (May 29, 2020)
- Test Based strategy for those without symptoms but tested positive:
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens)
- Time Based Stratetgy for those without symptoms but tested positive:
  - At least 10 days have passed since the date of their first positive COVID-19 test assuming they have not subsequently developed symptoms since their test. If they develop symptoms, then either the symptom-based or test-based strategy should be used. https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-patients.html (May 29, 2020)
- **Collection of COVID 19 Respiratory Specimens for Testing**
  - Nasopharyngeal swab is no longer the preferred method of specimen collection
  - Additional approved methods include oropharyngeal, nasal mid-turbinate. Anterior nares swab or nasopharyngeal wash/aspirate/nasal wash

- The type of specimen collection is not as important as following proper collection guidelines. The following link provides detailed instruction in the collection guidelines of each method of specimen collection:
- https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html (May 22, 2020)

P

PPE:

- Accessing PPE, the National Declaration of an Emergency distributes PPE via two (2) sources:
  - The county and state health departments – access to the national supply stockpile is distributed from health departments on a governor's requests:
    - Contact your state or local health department to request supplies.
    - Also contact your state associations for information about accessing supplies – state associations have been able to identify the process which could be formal request (forms to be completed) or requests e-mailed to the health department or local, regional or national suppliers with inventory.
    - For N95 respirators, be ready with the model number of which masks have been fit tested for your staff. If no model number, provide the manufacturer and year from a mask you have.

- ASPR Health Care Coalitions as sources of PPE for home care and hospice: The following site includes a list of organizations that have come together to ensure that providers have what is needed in an 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)

Gloves and Re-Use When There is an Inadequate Supply

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

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

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

- Expiration dates on boxes of gloves are not required by the FDA, only voluntary. If a manufactured date is noted, the FDA recommends not using the gloves if more than 5 years since that date.
- CDC advises you may consider using disposable medical gloves that are *similar to* FDA-cleared surgical and examination gloves and approved under other U.S. or international standards. Examples are shown in the table at the following website. You would be looking for 'Examination' gloves. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/gloves.html (April 30, 2020)

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

- CDC offers two 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)

N95 Masks - Particulate filtering facepiece respirators

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

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

- NIOSH developed tests to assess the filter efficiency and penetration (>95%) of a sample of respirators represented as certified by an international certification authority. NIOSH states that usual testing was not done previously due to the respirator shortage associated with COVID-19.
- NIOSH samples identified products that failed filtering tests.
- NIOSH has provided a table at the link below to identify the manufacturer and filtering test results. The table is regularly updated, even daily.
  - NIOSH warns of respirator masks with an ear loop design. NIOSH-approved N95s typically have head bands. Limited assessment of ear loop designs indicate difficulty achieving a proper fit.
- NIOSH advises that while the manufacturer listed in the table at the link below is the manufacturer of record, NIOSH has been informed that some of these are counterfeit products. Some products with legitimate manufacturer names, showing poor filter penetration results (<95%), are counterfeit products.
  https://www.cdc.gov/niosh/npptl/respirators/testing/NonNIOSHresults.html (June 11, 2020)

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

- Respirator Extended use: wearing the same respirator mask for repeated close contact encounters with patients, the maximum recommended extended use period is 6 hrs.
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/emergency-considerations-ppe.html (May 5, 2020)
  - Respirators should be removed (doffed) and discarded before activities such as meals and restroom breaks.
- Respirator Re-Use: using the same respirator by one staff member for multiple encounters with different patients but removing it (i.e. doffing) after each encounter.
  - Data suggest limiting the number of reuses to no more than 5 uses per device to ensure an adequate safety margin.[1]

  - One CDC example is to issue 5 respirators to each staff member. Each respirator is used on a day and stored in a breathable paper bag until the next week.
    - This can result in each staff member requiring a minimum of five respirators if they put on, take off, care for them, and store them properly each day. The respirators may need to be stored in the staff's trunk vs. the home.
    - The amount of time between uses should exceed the 72-hour expected survival time for COVID-19 virus.[3] Healthcare staff should still treat the respirator as though it is still contaminated and follow the precautions.
- Note that each re-use of N95 respirators requires 2 pair of gloves, a clean pair of gloves when donning or adjusting a previously worn N95 respirator. Then discarding these gloves and performing hand hygiene after the N95 respirator is donned or adjusted and using a new pair of gloves for care.
- Use of a cleanable face shield or facemask over the respirator can extend respirator use as it reduces/prevents contamination of the N95 respirator.
- Reuse can also be extended by putting a surgical mask on the patient.

- Staff reuse of N95 Masks with presumptive or confirmed COVID-19 patients: Two sources of information on reuse:
  - CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html (April 22, 2020)
  - NIOSH the National institutes of Occupational Safety https://www.cdc.gov/niosh/topics/hcwcontrols/recommendedguidanceextuse.html (March 27,2020)
    - Inpatient staff recommendations are based on wearing the same staff wearing N-95 masks patient-to-patient for several hours. Using inpatient criteria and applying it to the home, re-use is typically limited by
      - hygienic concerns (the respirator is contaminated with blood, respiratory or nasal secretions, or other patient bodily fluids, or
      - the respirator is damaged or crushed and no longer meets fit test requirements.

Discard: N95 respirators if:

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

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

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

- 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.

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

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

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

- Re-usable gowns are available instead of disposable single use gowns – but also require the laundering process.
- Using ANSI/AAMI PB70 standard disposal gowns: Level 1 or 2 gowns (non-surgical isolation gowns) are recommended when there is low risk of contamination. Level 3 or higher for high risk of contamination. https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/default.html (April 9, 2020)
- Limited Availability:

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

Eye Protection

- Goggles: provide barrier protection for the eyes. Should fit tightly over and around the eyes or prescription glasses
- Face shields: provide barrier protection to the facial area and related mucous membranes and are considered an alternative to goggles but not meant to function as primary respiratory protection and should be used concurrently with a mask.
- Limited availability:
  - Extended use for one HCW to use on multiple patients with COVID-19.
  - Reuse strategy should allow that the eye protection is dedicated to one HCW
    - As able, reprocessing should occur when visibly soiled or removed. See link for reprocessing directions: https://www.cdc.gov/coronavirus/2019-ncov/hcp/non-us-settings/emergency-considerations-ppe.html (May 5, 2020)
  - No Availability of eye protection:
    - Potential alternative includes safety glasses that have side barriers to protect from droplets and splashes

R

Religious Nonmedical Healthcare Institutions - RNHCI

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

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

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

S

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

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

Staff Symptoms: COVID 19 Processes to Address the Following:

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

  - 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 test results.

Staff Exposure: When to restrict the employee from work

- CDC provided guidance for asymptomatic HCP who were exposed to individuals with confirmed COVID-19. Higher risk exposures involve exposure of HCP eyes, nose or mouth to material potentially containing SARS-Cov-2, especially if the interaction involved aerosol-generating procedures.
    - HIGH RISK EXPOSURE - HCP who had prolonged close contact with a patient, visitor or HCP with confirmed COVID-19 AND did not wear appropriate PPE which would include respirator or face mask, eye protection, and HCP not wearing all recommended PPE 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.)

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- 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 as long as it is part of the patient's plan of care and does not substitute for in-person visits as ordered on the plan of care.
  - **Plan of care** should be modified as the type of visits change. The plan of care should reflect which visits will be made in person and which visits will be conducted 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 if and when telehealth can be provided and if it is billable.

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

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

Telehealth options:

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

Getting Started:

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

Virtual Visit Etiquette

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

Telehealth Resources:

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

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

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

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

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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.

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

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

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

Thank you for your dedication and be well!