**Coronavirus (COVID-19) Toolkit**  
**A Resource for Long Term Care Facilities**

**Table of Contents**

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Screening Toolkit</td>
<td>3-4</td>
</tr>
<tr>
<td>Hospital-to-Facility Transfer Form</td>
<td>5</td>
</tr>
<tr>
<td>Post-Acute Care and Behavioral Health to Hospital Transfer Form</td>
<td>6</td>
</tr>
<tr>
<td>NEW CDC Guidance on Use of Masks, Gowns and Eye Protection to Conserve Supplies</td>
<td>7-11</td>
</tr>
<tr>
<td>CMS &amp; DHSS Guidance</td>
<td>12-41</td>
</tr>
<tr>
<td>SLCR Guidance on Residents Leaving the Facility REVISED</td>
<td>13</td>
</tr>
<tr>
<td>DHSS PPE Resource Request Process</td>
<td>14</td>
</tr>
<tr>
<td>DHSS Guidance for Hospice Care in Long Term Care Facilities</td>
<td>15</td>
</tr>
<tr>
<td>CMS Memo: REVISED QSO-20-14-NH</td>
<td>16-21</td>
</tr>
<tr>
<td>Communal Dining Approaches</td>
<td>22-23</td>
</tr>
<tr>
<td>CMS Memo: QSO-20-17-ALL (Industrial Respirators)</td>
<td>24-26</td>
</tr>
<tr>
<td>CMS Memo: QSO-20-12-ALL (Suspension of Survey Activities)</td>
<td>27-38</td>
</tr>
<tr>
<td>CMS Memo: QSO-20-09-ALL (Information for HCF on 2019-nCoV)</td>
<td>39-41</td>
</tr>
<tr>
<td>CMS Issues Waivers of 3-day Stay and Spell of Illness</td>
<td>42-43</td>
</tr>
<tr>
<td>Implement Environment Infection Control – Cleaning and Disinfection</td>
<td>44-45</td>
</tr>
<tr>
<td>COVID Medicare FFS and Medicare Advantage Guidance</td>
<td>46-47</td>
</tr>
<tr>
<td>Communications to Residents, Families, and Vendors</td>
<td>48-50</td>
</tr>
<tr>
<td>Template Letter for Residents, Families, Visitors</td>
<td>49</td>
</tr>
<tr>
<td>Template Letter to Vendors</td>
<td>50</td>
</tr>
<tr>
<td>Employee Screening Resources</td>
<td>51-53</td>
</tr>
<tr>
<td>Template Letter to Employees</td>
<td>52</td>
</tr>
<tr>
<td>Employee Screening Tool</td>
<td>53</td>
</tr>
<tr>
<td>Impacted and Non-Impacted Facilities</td>
<td>54-62</td>
</tr>
<tr>
<td>Media Statement and Talking Points – Impacted Facility</td>
<td>55-58</td>
</tr>
<tr>
<td>Media Statement and Talking Points – Non-Impacted Facility</td>
<td>59-62</td>
</tr>
<tr>
<td>Signage/Infographics</td>
<td>63-67</td>
</tr>
<tr>
<td>Stop the Spread of Germs Infographic</td>
<td>64</td>
</tr>
<tr>
<td>What to Do If You Are Sick Infographic</td>
<td>65</td>
</tr>
<tr>
<td>Hand Washing Infographic</td>
<td>66</td>
</tr>
<tr>
<td>Coronavirus Precautions</td>
<td>67</td>
</tr>
<tr>
<td>OSHA Guidance on Preparing Workplaces for COVID-19</td>
<td>68-102</td>
</tr>
<tr>
<td>Guide on Communications During an Emergency</td>
<td>103-109</td>
</tr>
<tr>
<td>Acknowledgement</td>
<td>110</td>
</tr>
</tbody>
</table>
Coronavirus (COVID-19) Toolkit  
A Resource for Long Term Care Facilities  
Introduction

The top priority at this point with COVID-19 is to prevent the virus from entering your nursing home given the high case fatality rate in the elderly, which preliminary data shows it at 15% or greater. Evaluations from prior viral epidemics that spread like COVID-19 found that actions taken early in outbreaks (such as social distancing, restricting interaction with others, washing hands) can significantly reduce the spread of the virus. Waiting until the virus is spreading in the community is often too late.

As such, AHCA strongly recommends five actions to help prevent the entry of COVID-19 into your facilities whether or not it has been found in your surrounding community.1

1. Allow entry to only individuals who need entry.
2. Restrict activities and visitors with potential for exposure.
3. Actively screen individuals entering the building and restrict entry to those with respiratory symptoms or possible exposure to COVID-19.
4. Require all individuals entering the building to wash their hands at entry.
5. Set up processes to allow remote communication for residents and others.

For additional resources and ongoing updates on COVID-19, visit the MHCA dedicated coronavirus web page at https://www.mohealthcare.com/covid-19-resources.

Centers for Medicare & Medicaid (CMS) and Department of Health & Senior Services (DHSS) Resources

Both CMS and DHSS are constantly providing updated information as it becomes available. We have included the most current information from CMS & DHSS in this toolkit.

Visitor Screening and Criteria

Each nursing facility should designate staff members, trained in screening protocols. In this toolkit you will find the following:

- Template letter for residents, family members and visitors, educating them about COVID-19 and policies of the nursing home to prevent its spread (Attachment 1);
- Template communication to vendors requested they not enter the nursing facility if they are potentially at risk of carrying the COVID-19 virus (Attachment 2);

Employee Screening

Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work. Any staff who develop signs and symptoms of a respiratory infection while on the job, should:

- Immediately stop work, put on a facemask, and self-isolate at home;
- Inform the facility’s infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and
- Contact and follow the local health department recommendations for next steps (e.g., testing, locations for treatment).
- Refer to the CDC guidance for exposures that might warrant restricting at risk, yet asymptomatic healthcare personnel from reporting to work.
Tools to Develop Staff Screening Protocols:
- Sample letter to educate staff on steps implemented to help reduce the potential for the virus to enter the nursing home (Attachment 6); and
- Employee screening tool (Attachment 7).

How to Deal with the Media and Community
It is important to be prepared for possible questions from both the general population of your community and the media. Attached are statements and talking points for both facilities with coronavirus (attachment 8) and facilities without coronavirus (attachment 9).

Posting Information
It is important to post educational information that reminds employees and visitors to follow precautions to protect residents from the COVID-19. Attached are sample signage/infographics for facility use:
- Methods to Stop the Spread of Germs (Attachment 10);
- What to do if you are sick (Attachment 11);
- Hand Washing How-To (Attachment 12); and
- Coronavirus (COVID-19) Precautions to displayed at all entrances to your nursing home (Attachment 13).

*The information and materials provided in this toolkit are designed to serve as a best practice to support facilities’ COVID-19 prevention activities. Facilities should consult their legal and clinical teams when developing and implementing any company-specific procedures and protocols.
HOSPITAL TO FACILITY TRANSFER — COVID-19

INSTRUCTIONS: All hospitalized patients should be assessed for COVID-19 prior to transfer to a post-acute care facility. This tool should be used to document an individual’s medical status related to COVID-19 and to facilitate communication between the hospital and the receiving facility during patient transfers. This document must be signed-off by the physician, APRN, or PA who completes the clinical assessment. A copy of the form should be provided to the EMS provider.

CHECK THE BOX FOR EACH OF THE CRITERIA APPROPRIATE TO THE PATIENT’S STATUS:

Patient Name: ____________________________________________________________

Transferring Facility: ___________________________________________ Accepting Facility: ___________________________________________

Has patient been laboratory tested for COVID-19?

COVID-19 Testing criteria for elderly/medically frail patients — Updated 3/23/2020
- Patients age 65 and older or patients with serious underlying medical conditions AND
- Patient presents with new onset fever 100.4 or greater AND cough OR other respiratory signs including shortness of breath

☐ YES, Patient tested for COVID-19
   Date of test __________________________
   What was the indication for testing?

☐ NO, Test NOT INDICATED per CDC criteria OR,
   in patient with COVID diagnosis, no fever for the last 72 hours without fever reducing medications and improvement in respiratory symptoms AND at least 7 days have passed since symptoms first appeared.

   MAY TRANSFER

☐ Travel/Exposure in the past 14 days, has the patient been to any of the restricted travel areas, traveled internationally, traveled on a cruise ship, exposed to a person who has been lab tested positive for COVID-19, or is an immunocompromised person.

☐ Positive test
   Does patient meet criteria outlined in CDC Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

   ☐ YES
   ☐ NO

☐ Negative test
   Transfer to facility with appropriate staff, PPE and space

   ☐ POSITIVE TEST

☐ Respiratory Signs/symptoms of a respiratory illness (cough, sneezing, fever>100.4, shortness of breath, sore throat).

☐ Patient greater than 14 days since travel/exposure
   ☐ MAY TRANSFER

☐ Patient less than 14 days since travel/exposure

Clinical Assessment Completed by (signature) __________________________

Date/Time __________________________

Reported to (name of facility staff) ____________________________________________

Date/Time __________________________
Post-Acute Care and Behavioral Health to Hospital Transfer — COVID-19

It is critical for all Post-Acute and Behavioral Health Facilities to notify EMS and hospital emergency departments PRIOR TO TRANSFER of the Resident/Patient’s COVID-19 status. This tool should be used to document the Resident/Patient’s current clinical and COVID-19 status.

INSTRUCTIONS: CHECK THE BOX FOR EACH OF THE CRITERIA APPLICABLE TO THE RESIDENT/PATIENT STATUS.
FOLLOW THE DIRECTIVE FOR USE OF A STANDARD MASK ON THE PATIENT.

A copy of the form should be provided to the EMS provider.

Facility ______________________________ Date ______________________________
Contact Information ______________________________ Time ______________________________
Resident/Patient Name ______________________________ Date of Birth ______________________________

Reason for resident transfer and any input from the sending Physician/Practitioner

QUESTION 1:
Has the resident/patient been tested for COVID-19? If yes, date of test

☐ Negative
☐ Positive

QUESTION 2:
Has the facility had a patient that was suspected or confirmed to have COVID-19?

☐ YES
☐ NO

QUESTION 3:
Has the transferring facility implemented COVID-19 Screening of Residents, Staff, Visitors and Vendors for the PAST 14 DAYS or more?

☐ YES
☐ NO

QUESTION 4:
Has the patient or a member of the facility staff been lab tested positive for COVID-19, or in the past 14 days, been a Person Under Investigation (PUI) for COVID-19, traveled through an airport, traveled on a cruise ship, or had a respiratory illness that was NOT evaluated for COVID-19?

☐ NO
☐ YES

QUESTION 5:
Does the resident/patient have a respiratory illness (cough, sneezing, fever>100.4, shortness of breath, or sore throat?) Or is the resident/patient immunocompromised?

☐ YES
☐ NO

PATIENT MASK IS NOT REQUIRED DURING TRANSPORT

Report called to: ______________________________ Date/time ______________________________

Form updated as of 3/23/2020

Missouri Hospital Association
NEW CDC Guidance on Use of Masks, Gowns, and Eye Protection to Conserve Supplies

CDC issued today new guidance on the use of masks, gowns and face shields including suggestions on what to do if in crises shortages (which most all of you are in) and when your supplies are exhausted (see below for summary).

As all of you are coming to realize first-hand, the country does not have enough masks and gowns to meet the needs of health care providers, particularly if this pandemic persists for the weeks that experts predict. In order to significantly conserve masks and gowns, nursing homes and assisted living communities need to implement significant conservation steps right now by reviewing the crises capacity strategies in the new guidance issued today by CDC. We strongly urge you to start today in order to extend availability of your remaining PPE until such time as production and supply improves or we can obtain masks and gowns from other health care sectors and manufacturing.

To help long term care providers take such actions, the Centers for Disease Control & Prevention's (CDC) new guidance will be helpful. These recommendations continue to protect from droplet exposure (which is how COVID-19 and most other respiratory viruses are spread). We believe these recommendations help preserve PPE supply given the dire shortage.

We understand that many of you are very close to running out of PPE and that any supplies you receive from your state or federal stockpile need to bridge the time until more masks and gowns become available. Therefore, we urge you to adopt these new guidelines from CDC as soon as possible and for some, that may mean coming up with more creative ways to use or make your own PPE.

Highlights from the new CDC guidance on PPE use are below.

**MASK SUMMARY**

- **Implement extended use of facemasks** which allows the wearing the same facemask for repeated close contact encounters with several different patients, without removing the facemask between patient encounters.
- **Restrict facemasks to use by HCP, rather than patients for source control.** Have patients with symptoms of respiratory infection use tissues or other barriers to cover their mouth and nose.
• **Implement limited re-use of facemasks**, which is the practice of using the same facemask by one HCP for multiple encounters with different patients but removing it after each encounter. Discarded if soiled, damaged, or hard to breathe through.

• **Prioritize facemasks for selected activities**, such as:
  - For provision of essential surgeries and procedures
  - During care activities where splashes and sprays are anticipated
  - During activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable
  - For performing aerosol generating procedures, if respirators

**GOWNS SUMMARY**

• **Shift gown use towards cloth isolation gowns**
• **Consider the use of coveralls**
• **Extended use of isolation gowns** (disposable or cloth), such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact (such as Clostridium difficile) among patients. If the gown becomes visibly soiled, it must be removed and discarded as per usual practices.
• **Re-use of cloth isolation gowns among multiple patients in a patient cohort area** without laundering in between.
• **Prioritization of gowns** for the following activities:
  - During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures
  - During the high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care
  - **When No Gowns Are Available** consider pieces of clothing as a last resort, preferably with long sleeves and closures (snaps, buttons) that can be fastened and secured, particularly for care of COVID-19 patients as single use. Other options include:
    - Disposable laboratory coats
    - Reusable (washable) patient gowns
    - Reusable (washable) laboratory coats
    - Disposable aprons
    - Combinations of pieces of clothing can be considered for activities that may involve body fluids and when there are no gowns available:
      - Long sleeve aprons in combination with long sleeve patient gowns or laboratory coats
- Open back gowns with long sleeve patient gowns or laboratory coats
- Sleeve covers in combination with aprons and long sleeve patient gowns or laboratory coats

Reusable patient gowns and lab coats can be safely laundered according to routine procedures

**EYE PROTECTION SUMMARY**

- **Implement extended use of eye protection** is the practice of wearing the same eye protection dedicated to one HCP for repeated close contact encounters with several different patients, without removing eye protection between patient encounters including for disposable and reusable devices.
  - Eye protection should be removed and reprocessed if it becomes visibly soiled or difficult to see through.
  - If HCP touches or adjusts their eye protection they must immediately perform hand hygiene.
- **Prioritize eye protection for selected activities** such as: During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures or prolonged face-to-face or close contact with a potentially infectious patient is unavoidable.
- **Consider using safety glasses (e.g., trauma glasses) that have extensions to cover the side of the eyes**
- **Designate convalescent HCP for provision of care to known or suspected COVID-19 patients**
- **Selected options for Reprocessing and clean Eye Protection are provided.**

---

**CMS National Conference Call Today at 4:30 pm EST**

*(This call will be recorded.)*

The Centers for Medicare and Medicaid Services (CMS) will host a call on COVID-19 on Wednesday, March 18 for nursing home organizations. CMS leadership will discuss 1135 waivers and the agency’s latest telehealth guidance. There will be audience Q&A, and the call will be recorded if you are unable to join. The call-in information is as follows:

**Wednesday, March 18**
4:30 – 5:00 PM EST
888-455-1397 Access Code: 5854574
CMS Issues Guidance Expanding Telehealth

Yesterday, CMS expanded telehealth for Medicare. Medicare will temporarily pay clinicians to provide telehealth services for beneficiaries for a wider range of services. CMS Under the new waiver, Medicare can pay for office, hospital, and other telehealth visits. For the duration of the COVID-19 Public health Emergency, Medicare will make payment for professional services to beneficiaries in all areas of the country in all settings.

If you do not currently have telehealth arrangements, you may want to explore such arrangements, but it also may not be technically possible and necessary depending on your facility, physician coverage, or other circumstances.

CMS Waives 3-Day Stay for Admission and for SNF Long-Stay Residents

On March 14, CMS issued a nationwide waiver of the 3-Day Stay requirement. This waiver means that SNF care will be covered by Medicare without a 3-day inpatient hospital stay required. CMS has told us that this applies to all Medicare beneficiaries during this national emergency, regardless of diagnoses or relationship to the coronavirus, however, CMS has not provided written specifics on this.

AHCA has created this FAQ to help address your questions.

Additional Waivers Available

CMS has also authorized certain Medicaid flexibilities; their FAQ on this is available here.

On March 17, CMS released the first Medicaid Section 1135 to the State of Florida. The waiver focuses exclusively on Medicaid and has no direct impacts on Medicare. AHCA/NCAL has created an overview of this waiver.
We cannot thank you and your staff enough for the dedication and diligence in doing all that you can for the residents in your centers and communities. We will continue to do all that we can to support you during this pandemic.

Please email COVID19@ahca.org for additional questions, and visit www.ahcancal.org/coronavirus or https://www.mohealthcare.com/page/covid-19-resources for additional information and resources.
The following updates have been provided by the Centers for Medicare and Medicaid (CMS) and Department of Health and Senior Services (DHSS) on Guidance for Infection Control and Prevention of Coronavirus Disease 2019:

- SLCR Guidance on Residents Leaving the Facility *(REVISED)*
- DHSS PPE Resource Request Process
- DHSS Guidance for Hospice Care in Long Term Care Facilities
- Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes *(REVISED)*
  - Communal Dining Approaches to Implement
- Guidance for use of Certain Industrial Respirators by Health Care Personnel
- Suspension of Survey Activities
- Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV)

Visit www.mohealthcare.com/covid-19-resources for ongoing updates and resources.
SLCR Guidance on Residents Leaving the Facility

Updated March 17, 2020 (additions in red text)

This is guidance from SLCR; it is not a mandate but rather provides facilities with an avenue to protect the health and safety of residents.

It is appropriate for facilities to ask residents not to leave the facility, unless for a necessary medical reason that cannot be addressed in the facility. For those insistent on taking residents out of the facility, SLCR recommends the following:

- Only legally authorized persons may remove a resident from the facility. This may be a durable power of attorney for healthcare (if the DPOA has been enacted), a legal guardian or the resident themselves.
- Before a resident leaves, the facility should follow the discharge regulations to the extent possible so that the resident receives appropriate care while away from the facility.
- Upon leaving the facility, the resident, their legal representative and all those required by regulation should be given a *written emergency discharge notice*. It is imperative that the notice contain the required elements stated in regulation, including the reason for discharge (as permitted in regulation) and the location to which the resident is being discharged.
- Those taking the resident out of the facility are to be informed that the resident will not be permitted to return until the restrictions currently in place are lifted. When appropriate, residents may be required to obtain clearance from their medical provider which may include proof of a negative COVID-19 screening.

For residents, primarily in RCFs and ALFs, who leave the facility on a frequent basis, the facility will need to determine at what point those outings pose a risk to the health and safety of the residents in the facility. This includes, but is not limited to, the location the resident is going, whether there are positive COVID-19 cases in the community, whether there is community transmission of the virus, etc. This guidance does not require facilities to issue an emergency discharge notice every time a resident leaves a facility. The resident and their legal guardian, when applicable, should discourage outings, attempt to meet the needs of residents without them leaving the facility, clearly communicate the expectations to residents (including any screening required upon return) and work together should the need arise to give an emergency discharge notice.

For additional information, please visit the Department’s website at [health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/](http://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/). This site also contains a link specific to long-term care communities.
Missouri Department of Health and Senior Services Announces PPE Resource Request Process

- DHSS will begin receiving orders for PPE from our state cache assets effective Monday, March 16, 2020.
- The state cache asset has limited types of items, as well as limited models and sizes. The SNS Ordering Form delineates the types of items available from the state cache asset. See the top section on page 1 entitled “State Cache Assets”.
- All PPE resource requests must be submitted through your respective healthcare coalition. The information for submitting those requests to the healthcare coalition is in both the attached SNS Ordering Form and on page 2 of the Personal Protective Equipment Resource Request Process.
- Any orders sent directly to DHSS will be returned with no action and the requestor will be required to resubmit through the appropriate process.
- It is not a requirement that your facility or organization is involved with your respective healthcare coalition to place an order to receive PPE from the state cache assets.
- If you do not know which of the Missouri healthcare coalitions your facility or organization aligns with, please see the Healthcare Coalition Map.
- Attached are four documents, all of which you will be needed in order to place an order from the state cache assets.
  - Personal Protective Equipment Resource Request Process
  - SNS Ordering Form (Note: Do not be confused by the name, this is the ordering form you should use for resources from the state cache assets.)
  - Instructions for Completing SNS Ordering Form
  - DHSS COVID-19 Personal Protective Equipment Resource Request Approval Decision Process
  - Map of Missouri’s Healthcare Coalitions with points of contact
- Questions about the process may be directed to your healthcare coalition or to the SNS workstation in the DHSS Emergency Response Center at 573-526-5519. Please read the documents thoroughly before placing a phone call to ask a question.
TO: All Hospice Agencies and All Long-Term Care Facilities

FROM: Dean Linneman, DRL Director
Lisa Coots, Bureau Chief, Home Care and Rehabilitative Standards
Shelly Williamson, SLCR Administrator

DATE: March 20, 2020

RE: Guidance on Hospice Care in Long Term Care Facilities

There has been an influx of questions concerning the Centers for Medicare and Medicaid Services (CMS) QSO-20-14 NH Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (Revised), especially in regard to exceptions to restrictions for health care workers. Page two of the QSO memo states other health care workers, such as hospice workers, EMS personnel, or dialysis technicians that provide care to residents should be permitted to come into the facility as long as they meet the CDC guidelines for health care workers.

Our highest priority is to keep people safe. According to the Centers for Disease Control and Prevention, health care personnel who work in multiple locations may pose higher risk of transmission. To protect both the residents, as well as all the healthcare workers from both the hospice and long term care facility, we are offering the following guidance.

Of utmost importance is ensuring each resident receives appropriate care while limiting the number of people entering the facility. Hospice agencies and facilities need to work together to ensure resident needs are being met. These needs can hopefully be met by facility staff in coordination with offsite consultation and coordination with the hospice provider, such as virtual communications (phone, video-communication, etc.).

During compassionate care situations, such as when end of life is imminent, facilities should ensure residents receive appropriate care and may allow hospice staff, including non-essential health care personnel (such as clergy, hospice social workers, etc.) access during this time. Decisions about when to allow visitation during these end of life situations should be well coordinated and made on a case by case basis.

In this time of crisis, it is imperative the healthcare industry works together to provide patients and residents with the care they need, while making every effort to ensure their safety with the resources available.

DHSS encourages providers to view the information at the following link for the most up-to-date information:

https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/
Memorandum

Summary

• **CMS is committed** to taking critical steps to ensure America’s health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19.

• **Guidance for Infection Control and Prevention of COVID-19** - CMS is providing additional guidance to nursing homes to help them improve their infection control and prevention practices to prevent the transmission of COVID-19, including *revised guidance for visitation*.

• **Coordination with the Centers for Disease Control (CDC) and local public health departments** - We encourage all nursing homes to monitor the CDC website for information and resources and contact their local health department when needed (CDC Resources for Health Care Facilities: [https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html](https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html)).

**Background**
The Centers for Medicare & Medicaid Services (CMS) is responsible for ensuring the health and safety of nursing home residents by enforcing the standards required to help each resident attain or maintain their highest level of well-being. In light of the recent spread of COVID-19, we are providing additional guidance to nursing homes to help control and prevent the spread of the virus.

**Guidance**
Facility staff should regularly monitor the CDC website for information and resources (links below). They should contact their local health department if they have questions or suspect a resident of a nursing home has COVID-19. Per CDC, prompt detection, triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among residents, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent
monitoring for potential symptoms of respiratory infection as needed throughout the day. Furthermore, we encourage facilities to take advantage of resources that have been made available by CDC and CMS to train and prepare staff to improve infection control and prevention practices. Lastly, facilities should maintain a person-centered approach to care. This includes communicating effectively with residents, resident representatives and/or their family, and understanding their individual needs and goals of care.

Facilities experiencing an increased number of respiratory illnesses (regardless of suspected etiology) among patients/residents or healthcare personnel should immediately contact their local or state health department for further guidance.

In addition to the overarching regulations and guidance, we’re providing the following information about some specific areas related to COVID-19:

**Guidance for Limiting the Transmission of COVID-19 for Nursing Homes**

**For ALL facilities nationwide:**
Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In those cases, visitors will be limited to a specific room only. Facilities are expected to notify potential visitors to defer visitation until further notice (through signage, calls, letters, etc.). Note: If a state implements actions that exceed CMS requirements, such as a ban on all visitation through a governor’s executive order, a facility would not be out of compliance with CMS’ requirements. In this case, surveyors would still enter the facility, but not cite for noncompliance with visitation requirements.

For individuals that enter in compassionate situations (e.g., end-of-life care), facilities should require visitors to perform hand hygiene and use Personal Protective Equipment (PPE), such as facemasks. Decisions about visitation during an end of life situation should be made on a case by case basis, which should include careful screening of the visitor (including clergy, bereavement counselors, etc.) for fever or respiratory symptoms. Those with symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) should not be permitted to enter the facility at any time (even in end-of-life situations). Those visitors that are permitted, must wear a facemask while in the building and restrict their visit to the resident’s room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.

**Exceptions to restrictions:**
- **Health care workers:** Facilities should follow CDC guidelines for restricting access to health care workers found at [https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html). This also applies to other health care workers, such as hospice workers, EMS personnel, or dialysis technicians, that provide care to residents. They should be permitted to come into the facility as long as they meet the CDC guidelines for health care workers. Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals ([https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html](https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html)).
- **Surveyors:** CMS and state survey agencies are constantly evaluating their surveyors to ensure they don’t pose a transmission risk when entering a facility. For example, surveyors may have been in a facility with COVID-19 cases in the previous 14 days, but because they were wearing PPE effectively per CDC guidelines, they pose a low risk to
transmission in the next facility, and must be allowed to enter. However, there are circumstances under which surveyors should still not enter, such as if they have a fever.

Additional guidance:
1. Cancel communal dining and all group activities, such as internal and external group activities.
2. Implement active screening of residents and staff for fever and respiratory symptoms.
3. Remind residents to practice social distancing and perform frequent hand hygiene.
4. Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home.
5. For individuals allowed in the facility (e.g., in end-of-life situations), provide instruction, before visitors enter the facility and residents’ rooms, provide instruction on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the resident’s room. Individuals with fevers, other symptoms of COVID-19, or unable to demonstrate proper use of infection control techniques should be restricted from entry. Facilities should communicate through multiple means to inform individuals and non-essential health care personnel of the visitation restrictions, such as through signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls.
6. Facilities should identify staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19.
7. Facilities should review and revise how they interact vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), and other non-health care providers (e.g., food delivery, etc.), and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility. Have them dropped off at a dedicated location (e.g., loading dock). Facilities can allow entry of these visitors if needed, as long as they are following the appropriate CDC guidelines for Transmission-Based Precautions.
8. In lieu of visits, facilities should consider:
   a) Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).
   b) Creating/increasing listserv communication to update families, such as advising to not visit.
   c) Assigning staff as primary contact to families for inbound calls, and conduct regular outbound calls to keep families up to date.
   d) Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility’s general operating status, such as when it is safe to resume visits.
9. When visitation is necessary or allowable (e.g., in end-of-life scenarios), facilities should make efforts to allow for safe visitation for residents and loved ones. For example:
   a) Suggest refraining from physical contact with residents and others while in the facility. For example, practice social distances with no hand-shaking or hugging, and remaining six feet apart.
   b) If possible (e.g., pending design of building), creating dedicated visiting areas (e.g., “clean rooms”) near the entrance to the facility where residents can meet with
visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting.

c) Residents still have the right to access the Ombudsman program. Their access should be restricted per the guidance above (except in compassionate care situations), however, facilities may review this on a case by case basis. If in-person access is not available due to infection control concerns, facilities need to facilitate resident communication (by phone or other format) with the Ombudsman program or any other entity listed in 42 CFR § 483.10(f)(4)(i).

10. Advise visitors, and any individuals who entered the facility (e.g., hospice staff), to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the individuals of reported contact, and take all necessary actions based on findings.

When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital?
Nursing homes with residents suspected of having COVID-19 infection should contact their local health department. Residents infected with COVID-19 may vary in severity from lack of symptoms to mild or severe symptoms or fatality. Initially, symptoms may be mild and not require transfer to a hospital as long as the facility can follow the infection prevention and control practices recommended by CDC. Facilities without an airborne infection isolation room (AIIR) are not required to transfer the resident assuming: 1) the resident does not require a higher level of care and 2) the facility can adhere to the rest of the infection prevention and control practices recommended for caring for a resident with COVID-19.

Please check the following link regularly for critical updates, such as updates to guidance for using PPE: [https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html](https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html).

The resident may develop more severe symptoms and require transfer to a hospital for a higher level of care. Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident’s diagnosis, and precautions to be taken including placing a facemask on the resident during transfer. If the resident does not require hospitalization they can be discharged to home (in consultation with state or local public health authorities) if deemed medically and socially appropriate. Pending transfer or discharge, place a facemask on the resident and isolate him/her in a room with the door closed.

When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?
A nursing home can accept a resident diagnosed with COVID-19 and still under Transmission-Based Precautions for COVID-19 as long as the facility can follow CDC guidance for Transmission-Based Precautions. If a nursing home cannot, it must wait until these precautions are discontinued. CDC has released [Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19](https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html). Information on the duration of infectivity is limited, and the interim guidance has been
developed with available information from similar coronaviruses. CDC states that decisions to discontinue Transmission-based Precautions in hospitals will be made on a case-by-case basis in consultation with clinicians, infection prevention and control specialists, and public health officials. Discontinuation will be based on multiple factors (see current CDC guidance for further details).

**Note:** Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room).

**Other considerations for facilities:**
- Increase the availability and accessibility of alcohol-based hand rubs (ABHRs), *reinforce strong hand-hygiene practices*, tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, resident check-ins, etc.
  - Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms.
- Increase signage for vigilant infection prevention, such as hand hygiene and cough etiquette.
- Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility.
- Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse’s stations, phones, internal radios, etc.).

**Will nursing homes be cited for not having the appropriate supplies?**
CMS is aware of that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks and ABHR) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of ABHR, we expect staff to practice effective hand washing with soap and water. Similarly, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact the local and state public health agency to notify them of the shortage, follow national guidelines for [optimizing their current supply](https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html), or identify the next best option to care for residents. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the state agency should contact the CMS Branch Office.

**What other resources are available for facilities to help improve infection control and prevention?**
CMS urges providers to take advantage of several resources that are available:
**CDC Resources:**
- Infection preventionist training: [https://www.cdc.gov/longtermcare/index.html](https://www.cdc.gov/longtermcare/index.html)

**CMS Resources:**

**Contact:** Email DNH_TriageTeam@cms.hhs.gov

**NOTE:** The situation regarding COVID-19 is still evolving worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC) to change. Please monitor the relevant sources regularly for updates.

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright cc:

Survey and Operations Group Management
Communal Dining Guidance

CMS’s memo dated March 13, 2020 includes guidance to “cancel communal dining and all group activities” in your skilled nursing facility. (Please note: we also strongly encourage assisted living communities to abide by this recommendation.) Implementing this can be a challenge and will likely require changes in staffing patterns and enlisting other staff in the facility in order to accomplish.

Facilities should take all reasonably available steps to adhere, given the dire consequences of the spread of COVID-19 among our resident population. How this is implemented must be viewed on a facility-by-facility and day-to-day basis depending on physical plant, staff availability, and resident needs.

A key reason for the recommendation to cancel communal dining is linked to the concept of social distancing (e.g., limiting people being in close proximity to each other for periods of time; ideally people should keep about six [6] feet apart). Social distancing is recommended broadly across the public and recommended by CMS for facilities regarding resident interactions. Communal dinning is a common group activity that places residents in close proximity to each other. This can spread respiratory viruses.

The experience in the Seattle, Washington area suggests the spread may have been facilitated by group activities, including perhaps communal dinning.

This virus is now reported in 49 states. You should assume it is already in your surrounding community, whether or not it has been confirmed, due to lack of testing to-date.

Implement social distancing in your dining practices. Recommended approaches:

1. Provide in-room meal service for those that are assessed to be capable of feeding themselves without supervision or assistance.
2. Identify high-risk choking residents and those at-risk for aspiration who may cough, creating droplets. Meals for these residents should ideally be provided in their rooms; or the residents should remain at least six (6) feet or more from others if in a common area for meals, and with as few other residents in the common area as feasible during their mealtime. Staff should take appropriate precautions with eye protection and gowns given the risk for these residents to cough while eating.
3. If residents need to be brought to the common area for dining, do this in intervals to maintain social distancing.
   a. Attempt to separate tables as far apart as possible; at least six (6) feet if practicable.
   b. Increase the number of meal services or offer meals in shifts to allow fewer residents in common areas at one time.
   c. Ideally, have residents sit at tables by themselves to ensure that social distancing between residents can be maintained, or depending on table and room size.
   d. If necessary, arrange for meal sittings with only two (2) residents per table, focusing on maintaining existing social relationships and/or pairing roommates and others that associate with each other outside of mealtimes.
4. Residents who need assistance with feeding should be spaced apart as much as possible, ideally six (6) feet or more or no more than one person per table (assuming a standard four [4] person table). Staff members who are providing assistance for more than one resident simultaneously must perform hand hygiene with at least hand sanitizer each time when switching assistance between residents.
5. The CMS memo also emphasizes no visitation of non-essential health care personnel, unless for compassionate care visits (end-of-life). Facilities may need to consider use of volunteers or other paid personnel to accomplish food service, which can be viewed as essential and not as visitors. Note: they must undergo screening upon entry and adhere to frequent handwashing or use of alcohol-based hand rub.

In general, facility life will have to adjust significantly during this viral breakout with a primary focus on:
(1) necessary medical treatment;

(2) hygiene;

(3) hydration; and

(4) meal service

as these will take more, if not all of your staff’s time. As with all other guidance during the COVID-19 pandemic, handwashing and hygiene before, during and after meals is imperative.
Memorandum Summary

- The Centers for Medicare & Medicaid Services (CMS) CMS is committed to taking critical steps to ensure America’s health care facilities are prepared to respond to the threat of the Coronavirus Disease 2019 (COVID-19) and other respiratory illnesses.

- The memo clarifies the application of CMS policies in light of recent Centers for Disease Control and Prevention (CDC) and Food and Drug Administration (FDA) guidance expanding the types of facemasks healthcare workers may use in situations involving COVID-19 and other respiratory infections.

Background

CMS is committed to taking critical steps to ensure America’s health care facilities are prepared to respond to the threat of the COVID-19 and other respiratory illness. With this announcement, health care workers in providers and suppliers certified by CMS will have a more expansive range of options to protect themselves and those receiving their care. CMS will continue to explore flexibilities and innovative approaches within our regulations to allow health care entities to meet the critical health needs of the country.

Guidance

The Centers for Disease Control and Prevention (CDC) have updated their Personal Protective Equipment (PPE) recommendations for health care workers involved in the care of patients with known or suspected COVID-19. At this time, these recommendations will be considered by CMS surveyors to determine if Medicare and Medicaid providers and suppliers are complying with infection control protocols:

- Based on local and regional situational analysis of PPE supplies, facemasks are an acceptable temporary alternative when the supply chain of respirators cannot meet the demand. During this time, available respirators should be prioritized for procedures that are likely to generate respiratory aerosols, which would pose the highest exposure risk to Health Care Providers (HCP).
  - Facemasks protect the wearer from splashes and sprays.
  - Respirators, which filter inspired air, offer respiratory protection.

- When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for patients with known or suspected COVID-19. Facilities that do not currently have a

Ref: QSO-20-17-ALL
respiratory protection program, but care for patients infected with pathogens for which a respirator is recommended, should implement a respiratory protection program.

- Eye protection, medical gown, and gloves continue to be recommended.
  - If there are shortages of medical gowns, they should be prioritized for aerosol generating procedures, 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 HCP.

- Updated recommendations regarding the need for an airborne infection isolation room (AIIR).
  - Patients with known or suspected COVID-19 should be cared for in a single person room with the door closed. AIIRs should be reserved for patients undergoing aerosol-generating procedures.

- Updated information based on currently available information about COVID-19 and the current situation in the United States, which includes reports of cases of community transmission, infections identified in HCP, and shortages of facemasks, N95 filtering facepiece respirators (FFRs) (commonly known as N95 respirators), and gowns.

- Increased emphasis on early identification and implementation of source control (i.e., putting a face mask on patients presenting with symptoms of respiratory infection).

Additional information on CDC’s recommendations above can be found here: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Further, the FDA approved the CDC request for an emergency use authorization (EUA) to allow health care personnel to use certain industrial respirators during the COVID-19 outbreak in health care settings. The FDA concluded that respirators approved by the National Institute for Occupational Safety and Health (NIOSH), but not currently meeting the FDA’s requirements, may be effective in preventing health care personnel from airborne exposure, including COVID-19, which can cause serious or life-threatening disease, including severe respiratory illness.

This action allows the NIOSH-approved respirators not currently regulated by the FDA to be used in a health care setting by health care personnel during the COVID-19 outbreak, thereby maximizing the number of respirators available to meet the needs of the U.S. health care system.

**PLEASE NOTE: Due to the updated CDC guidance and current supply demands of these devices (and the discards associated with testing), CMS is directing surveyors not to validate the date of the last FIT test for health care workers in Medicare and Medicaid certified facilities, until further notice.**

The press release announcing FDA and CDC action to increase access to respirators, including N95s, for health care personnel, can be found at: https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-andcdc-take-action-increase-access-respirators-including-n95s

The EUA letter can be found at https://www.fda.gov/media/135763/download

- Appendix A: A list of approved Filtering Facepiece Respirators (FFRs) eligible for coverage under this EUA are posted on the FDA’s website: https://www.fda.gov/media/135764/download

- Appendix B: A list of NIOSH-approved FFRs authorized under this EUA can be found here: https://www.fda.gov/media/135921/download

Therefore, any CMS guidance that explicitly, or by reference, indicates N-95 or PPE usage will automatically incorporate any FFRs authorized under this EUA and any guidance issued by the CDC. This memo is effective for all Medicare and Medicaid provider and certified supplier types:
1. Hospitals
2. Religious Nonmedical Health Care Institutions (RNHCIs)
3. Ambulatory Surgical Centers (ASCs)
4. Hospices
5. Psychiatric Residential Treatment Facilities (PRTFs)
6. Program of All-Inclusive Care for the Elderly (PACE)
7. Transplant Centers
8. Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)
9. Intermediate Care Facilities for Individuals with Intellectual Disabilities - ICF/IID
10. Home Health Agencies (HHAs)
11. Comprehensive Outpatient Rehabilitation Facilities (CORFs)
12. Critical Access Hospitals (CAHs)
13. Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
14. Community Mental Health Centers (CMHCs)
15. Organ Procurement Organizations (OPOs)
16. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
17. End-Stage Renal Disease (ESRD) Facilities

In addition, we’re providing the following information about some specific areas related to COVID-19 and this EUA:

CDC Resources:

FDA Resources:

Contact: Questions about this document should be addressed to QSOG_EmergencyPrep@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

cc: Survey and Operations Group Management
DATE: March 4, 2020

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Suspension of Survey Activities

Memorandum Summary

- CMS is committed to taking critical steps to ensure America’s health care facilities are prepared to respond to the threat of the 2019 Novel Coronavirus (COVID-19).
- The Centers for Medicare & Medicaid Services (CMS) CMS is committed to taking critical steps to ensure America’s health care facilities are prepared to respond to the threat of the COVID-19 and other respiratory illnesses.

Background
CMS is committed to taking critical steps to ensure America’s health care facilities and clinical laboratories are prepared to respond to the threat of the COVID-19 and other respiratory illness. Specifically, CMS is suspending non-emergency inspections across the country, allowing inspectors to turn their focus on the most serious health and safety threats like infectious diseases and abuse. This shift in approach will also allow inspectors to focus on addressing the spread of the coronavirus disease 2019 (COVID-19). CMS is issuing this memorandum to State Survey Agencies to provide important guidelines for the inspection process in situations in which a COVID-19 is suspected.

Discussion
Effective immediately, survey activity is limited to the following (in Priority Order):
- All immediate jeopardy complaints (cases that represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and allegations of abuse and neglect;
- Complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illnesses;
• Statutorily required recertification surveys (Nursing Home, Home Health, Hospice, and ICF/IID facilities);
• Any re-visits necessary to resolve current enforcement actions;
• Initial certifications;
• Surveys of facilities/hospitals that have a history of infection control deficiencies at the immediate jeopardy level in the last three years;
• Surveys of facilities/hospitals/dialysis centers that have a history of infection control deficiencies at lower levels than immediate jeopardy.

Due to the dynamic nature of this situation, we will be posting updated FAQs in real-time at the following website: https://www.cms.gov/medicare/quality-safety-oversight-general-information/coronavirus

For survey of facilities with Complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illness, please refer to the attached (Attachment A- Survey Planning in Facilities with Active or Suspected Cases of COVID-19 Cases; Attachment B- Infection Prevention, Control & Immunizations).

Contact: Questions about this document should be addressed to QSOG_EmergencyPrep@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

Attachment A- Survey Planning in Facilities with Active or Suspected Cases of COVID-19 Cases
Attachment B- Infection Prevention, Control & Immunizations

cc: Survey and Operations Group Management
Attachment A- Survey Planning in Facilities with Active or Suspected Cases of COVID-19 Cases

I. Protocols for Coordination and Investigation of Facilities with Actual or Suspected COVID-19 Cases

When a COVID-19 confirmed case or presumptive positive case (e.g., positive local test but pending confirmatory test), is identified in a Medicare/Medicaid certified provider or supplier, State Survey Agencies and Accrediting Organizations (AO) are requested to do the following:

- Notify the appropriate CMS Regional Office (if they are not already aware) of the facility and date of patient/resident COVID-19 or presumptive respiratory illness or confirmed status;
- Coordinate on initiating any Federal complaint or recertification survey of the impacted facility until CDC (and any other relevant Federal/State/Local response agencies) have cleared the facility for survey. The CMS Regional Office will then authorize a survey, if necessary;
- Ensure surveyors have all necessary Personal Protective Equipment (PPE) appropriate to allow a survey of the facility; Refer to CDC Infection Control resources for the most up to date guidance.
- Suspend any Federal enforcement action for any deficiencies identified until reviewed and approved by the CMS Regional Office to ensure consistent and appropriate action.

These protocols will be updated as circumstances warrant. We are asking Accrediting Organizations to copy their CMS AO liaison on any communications with the CMS Regional Office.

II. Focused Surveying – Prioritizing Threats

In all cases, concerns of Immediate Jeopardy (IJ) (cases that represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and cases of abuse and neglect allegations from complaints will continue to receive high priority for survey. Non-emergency surveys will be suspended.

III. Survey Planning in Facilities with Active or Suspected Cases of COVID-19 Infection

Introduction: Under What Circumstances Will CMS Authorize an On-site Survey/Investigation of a Facility With Persons who are Known or Suspected of Being COVID-19 Positive

When a COVID-19 confirmed case or presumptive positive case (e.g., positive local test but pending confirmatory test), is identified in a Medicare/Medicaid certified provider or supplier,
State Survey Agencies and Accrediting Organizations must notify the appropriate CMS Regional location (if they are not already aware) of the facility and date of patient/resident COVID-19 presumptive or confirmed status.

Before initiating any Federal complaint or recertification survey of the impacted facility, CMS will coordinate with the CDC (and any other relevant Federal/State/Local response agencies) to approve the facility for survey.

The CMS Regional locations will authorize an on-site survey if reported conditions at the facility are triaged at immediate jeopardy. Immediate jeopardy means there are conditions at the facility that are causing or are likely to cause on or more recipients of care to suffer serious injury, harm, impairment or death. CMS Regional locations will also authorize on-site surveys where the complaint or facility reported incident involves infection control concerns in the facility.

If conditions at such facilities do not rise to the immediate jeopardy level, then desk audits will be performed, and on-site investigations may be authorized once all active or suspected cases of COVID-19 have been cleared from the facility.

I. Before Survey Entry

Determine survey team composition for minimal but optimal number of surveyors required to efficiently and effectively conduct the onsite observations required. Generally, one to two surveyors for an abbreviated complaint survey focusing on the COVID-19 infection control and/or quality of care issues would be sufficient. Do not include any surveyors who are currently ill or have underlying health conditions that may make them particularly vulnerable to COVID-19.

A. Personal Protective Equipment Considerations

Ensure survey team members have needed personal protective equipment (PPE) that may be required onsite to observe resident care in close quarters. If the facility has gowns, gloves, face shields or other eye protection that may be used by surveyors, such PPE may be used onsite by surveyors. However, if observation of care provided to symptomatic patients/residents who are confirmed or presumed to be COVID-19 positive is anticipated, then survey agencies and accrediting organizations should refer to the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.

This guidance indicates, “Respirator use must be in the context of a complete respiratory protection program in accordance with Occupational Safety and Health Administration (OSHA) Respiratory Protection standard 29 CFR 1910.134). Staff should be medically cleared and fit-tested if using respirators with tight-fitting face-pieces (e.g., a NIOSH-certified disposable N95) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use...” More information on the use of respirators may be found here: https://www.osha.gov/SLTC/etools/respiratory/respirator基本原则.html.
B. Offsite Planning Considerations
Conduct offsite planning based on available information from: (1) facility-reported information; (2) CDC information and guidance from its onsite visit before the SA/CMS investigation; (3) available hospital information regarding patients transferred to the hospital; and/or (4) complaint allegations. Determine and prioritize key observations that should be conducted. Compile a preliminary list of the likely interviews with various facility staff and the types of records, policies or other documents that may be needed. This may be revised after onsite observations and interviews, which may lead to additional areas of investigation.

II. Onsite Survey Activities

Upon entry, notify the facility administrator of the limited nature of the planned survey. Coordinate with the facility staff a plan and timeline for conducting the needed observations. Plan to conduct as many observations on the entry day. If by the end of the first day, the surveyors were not able to completed necessary observations, coordinate with the facility when the observations may be completed by the next day. Unless there are extenuating circumstances, plan to complete all onsite observations and corresponding interviews within two days. When possible during observations, if symptomatic patients/residents are able to tolerate wearing face masks, this will reduce the need for surveyors to wear respirator masks.

Coordinate with the facility on how to gather medical record information, with the goal to conduct as much record review offsite as possible. If the facility has an electronic health record (EHR) system that may be accessed remotely, request remote access to the EHR to review needed records for a limited period of time. If this is not an option, discuss with the facility the best options to get needed medical record information, such as fax, secure website, encrypted email, etc.

Adhere to Standard, Contact and Airborne Precautions and refer to the CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings.

During onsite observation and investigation, focus on concerns with:
- Improper transmission precautions procedures
- Lack of staff knowledge of transmission precautions
- Improper staff use of PPE and/or inadequate hand hygiene
- High-risk, significant environmental cleaning issues
- Ineffective and/or improper laundering of linens
- Possible IC surveillance program issues - also consider how influenza & pneumococcal programs are managed

Conduct concurrent interviews of staff with observations during or directly after observations as appropriate. Conduct needed interviews with patients/residents onsite, as these may be difficult to obtain offsite. Patients may be discharged. Residents may have a difficult time responding to questions by telephone. While onsite, if there are periods of time when no observations can be made, attempt to conduct other needed interviews and review medical records.
For nursing home investigations, use the LTC investigative protocols for infection control (IC) and the environment:

**III. Complete Survey Offsite**

Except for interviews that should be conducted concurrently with observations, conduct other interviews offsite with staff by telephone. If any patient/resident interviews could not be conducted while onsite, then attempt to conduct those by telephone.

After coordinating with the facility and determining what medical record review may be conducted offsite, complete as much of the record review offsite as possible. Request facility policies and procedures for review offsite.

In addition, consider investigating Governing Body and Quality Assurance Performance Improvement requirements that may relate to infection control or care issues offsite through telephone interviews and additional record review.

After completing all investigative procedures, determine compliance status and conduct any survey exit discussion with the facility by telephone. Draft the CMS-2567 offsite.

**III: Enforcement Activities**

Surveys resulting in deficiencies will have the imposition of some type of enforcement action ranging from request for corrective action plans to termination depending on the circumstances surrounding deficiencies.
**Infection Prevention & Control Program (IPCP)**

- **Infection Control:** This facility task must be used to investigate compliance at F880, F881, and F883. For the purpose of this task, “staff” includes employees, consultants, contractors, volunteers, and others who provide care and services to residents on behalf of the facility. The Infection Prevention and Control Program (IPCP) program must be facility-wide and include all departments and contracted services. If a specific care area concern is identified, it should be evaluated under the specific care area, such as for pressure ulcers, respiratory care, catheter care, and medication pass observations which include central lines, peripheral IVs, and oral/IM/respiratory medications.

**Coordination:**

- One surveyor coordinates the facility task to review for:
  - The overall Infection Prevention and Control Program (IPCP);
  - The annual review of the IPCP policies and practices;
  - The review of the surveillance and antibiotic stewardship programs; and
  - Tracking influenza/pneumococcal immunization of residents.

- Team assignments must be made to include the review of:
  - Laundry services;
  - A resident on transmission-based precautions, if any;
  - Five sampled residents for influenza/pneumococcal immunizations; and
  - Other care-specific observations if concerns are identified.

- Every surveyor assesses IPCP compliance throughout the survey and communicates any concerns to the team.

**Hand Hygiene:**

- Staff implement standard precautions (e.g., hand hygiene and the appropriate use of personal protective equipment (PPE)).
- Appropriate hand hygiene practices are followed.
- Alcohol-based hand rub (ABHR) is readily accessible and placed in appropriate locations. These may include:
  - Entrances to resident rooms;
  - At the bedside (as appropriate for resident population);
  - In individual pocket-sized containers by healthcare personnel;
  - Staff work stations; and
  - Other convenient locations.

- Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected C. difficile infection (CDI) or norovirus during an outbreak, or if endemic rates of CDI are high. ABHR is not appropriate to use under these circumstances.

- Staff perform hand hygiene (even if gloves are used) in the following situations:
  - Before and after contact with the resident;
After contact with blood, body fluids, or visibly contaminated surfaces or other objects and surfaces in the resident’s environment;
- After removing personal protective equipment (e.g., gloves, gown, facemask); and
- Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care).

☐ When being assisted by staff, resident hand hygiene is performed after toileting and before meals.
☐ Interview appropriate staff to determine if hand hygiene supplies are readily available and who they contact for replacement supplies.
☐ Soap, water, and a sink are readily accessible in appropriate locations including, but not limited to, resident care areas, food and medication preparation areas.

1. Did staff implement appropriate hand hygiene?  ☐ Yes  ☐ No F880

**Personal Protective Equipment (PPE):**

☐ Determine if staff appropriately use and discard PPE including, but not limited to, the following:
- Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
- Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin;
- Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;
- A gown is worn for direct resident contact if the resident has uncontained secretions or excretions;
- A facemask is worn if contact (i.e., within 3 feet) with a resident with new acute cough or symptoms of a respiratory infection (e.g., influenza-like illness);
- Appropriate mouth, nose, and eye protection (e.g., facemasks, face shield) is worn for performing aerosol-generating and/or procedures that are likely to generate splashes or sprays of blood or body fluids;
- PPE is appropriately discarded after resident care, prior to leaving room, followed by hand hygiene; and
- Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, therapy rooms).

☐ Interview appropriate staff to determine if PPE supplies are readily available and who they contact for replacement supplies.

2. Did staff implement appropriate use of PPE?  ☐ Yes  ☐ No F880

**Transmission-Based Precautions:**

☐ Determine if appropriate transmission-based precautions are implemented, including but not limited to:
- PPE use by staff (i.e., don gloves and gowns before contact with the resident and/or his/her environment while on contact precautions; don facemask within three feet of a resident on droplet precautions; don a fit-tested N95 or higher level respirator prior to room entry of a resident on airborne precautions;
Infection Prevention, Control & Immunizations

- Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then equipment is cleaned and disinfected according to manufacturers’ instructions using an EPA-registered disinfectant prior to use on another resident;
- The least restrictive TBP possible under the circumstances;
- Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare use at least daily and when visibly soiled.
- Interview appropriate staff to determine if they are aware of processes/protocols for transmission-based precautions and how staff is monitored for compliance.
- If concerns are identified, expand the sample to include more residents with transmission-based precautions.

3. Did the staff implement appropriate transmission-based precautions? □ Yes □ No F880 □ NA

Laundry Services:
- Determine whether staff handle, store, and transport linens appropriately including, but not limited to:
  - Using standard precautions (i.e., gloves) and minimal agitation for contaminated linen;
  - Holding contaminated linen and laundry bags away from his/her clothing/body during transport;
  - Bagging/containing contaminated linen where collected, and sorted/rinsed only in the contaminated laundry area (double bagging of linen is only recommended if outside of the bag is visibly contaminated or is observed to be wet on the outside of the bag);
  - Transporting contaminated and clean linens in separate carts; if this is not possible, the contaminated linen cart should be thoroughly cleaned and disinfected per facility protocol before being used to move clean linens. Clean linens are transported by methods that ensure cleanliness, e.g., protect from dust and soil;
  - Ensuring mattresses, pillows, bedding, and linens are maintained in good condition and are clean (Refer to F584); and
  - If a laundry chute is in use, laundry bags are closed with no loose items.
- Laundry Rooms – Determine whether staff:
  - Maintain/use washing machines/dryers according to the manufacturer’s instructions for use;
  - If concerns, request evidence of maintenance log/record; and
  - Use detergents, rinse aids/additives, and follow laundering directions according to the manufacturer’s instructions for use.

4. Did the facility store, handle, transport, and process linens properly? □ Yes □ No F880
### Infection Prevention, Control & Immunizations

**Policy and Procedure:**
- The facility established a facility-wide IPCP including written IPCP standards, policies, and procedures that are current and based on national standards.
- The policies and procedures are reviewed at least annually.
- Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.

5. **Did the facility develop and implement an overall IPCP including policies and procedures that are reviewed annually?**
   - Yes
   - No F880

**Infection Surveillance:**
- The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of infections.
- The plan includes early detection, management of a potentially infectious, symptomatic resident and the implementation of appropriate transmission-based precautions.
- The plan uses evidence-based surveillance criteria (e.g., CDC NHSN Long-Term Care or revised McGeer Criteria) to define infections and the use of a data collection tool.
- The plan includes ongoing analysis of surveillance data and review of data and documentation of follow-up activity in response.
- The facility has a process for communicating the diagnosis, antibiotic use, if any, and laboratory test results when transferring a resident to an acute care hospital or other healthcare provider; and obtaining pertinent notes such as discharge summary, lab results, current diagnoses, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals.
- The facility has a current list of reportable communicable diseases.
- Staff can identify to whom and when communicable diseases, healthcare-associated infections (as appropriate), and potential outbreaks must be reported.
- Prohibiting employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit disease.
- Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

6. **Did the facility provide appropriate infection surveillance?**
   - Yes
   - No F880

**Antibiotic Stewardship Program:**
- Determine whether the facility has an antibiotic stewardship program that includes:
Infection Prevention, Control & Immunizations

- Written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics;
- Protocols to review clinical signs and symptoms and laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made and identify what infection assessment tools or management algorithms are used for one or more infections (e.g., SBAR tool for urinary tract infection (UTI) assessment, Loeb minimum criteria for initiation of antibiotics);
- A process for a periodic review of antibiotic use by prescribing practitioners: for example, review of laboratory and medication orders, progress notes and medication administration records to determine whether or not an infection or communicable disease has been documented and whether an appropriate antibiotic has been prescribed for the recommended length of time. Determine whether the antibiotic use monitoring system is reviewed when the resident is new to the facility, when a prior resident returns or is transferred from a hospital or other facility, during each monthly drug regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic drug regimen review as requested by the QAA committee;
- Protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic;
- A system for the provision of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data, and prescribing practices for the prescribing practitioner.

7. Did the facility conduct ongoing review for antibiotic stewardship?  □ Yes  □ No F881

Influenza and Pneumococcal Immunizations:
□ Select five residents in the sample to review for the provision of influenza/pneumococcal immunizations.
□ Document the names of residents selected for review.
□ Give precedence in selection to those residents whom the survey team has selected as sampled residents.
□ Review the records of the five residents sampled for documentation of:
  • Screening and eligibility to receive the vaccine;
  • The provision of education related to the influenza or pneumococcal immunizations (such as the benefits and potential side effects);
  • The administration of pneumococcal and influenza vaccine, in accordance with national recommendations. Facilities must follow the CDC and ACIP recommendations for vaccines; and
  • Allowing a resident or representative to refuse either the influenza and/or pneumococcal vaccine. If not provided, documentation as to why the vaccine was not provided.
□ For surveys occurring during influenza season, unavailability of the influenza vaccine can be a valid reason why a facility has not implemented the influenza vaccine program, especially during the early weeks of the influenza season. Ask the facility to demonstrate that:
  • The vaccine has been ordered and the facility received a confirmation of the order indicating that the vaccine has been shipped or that the product is not available but will be shipped when the supply is available; and
  • Plans are developed on how and when the vaccines are to be administered.
Infection Prevention, Control & Immunizations

As necessary, determine if the facility developed influenza and pneumococcal vaccine policies and procedures, including the identification and tracking/monitoring of all facility residents’ vaccination status.

8. Did the facility provide influenza and/or pneumococcal immunizations as required or appropriate? □ Yes □ No F883
DATE: February 6, 2020

TO: State Survey Agency Directors

FROM: Director
Quality Safety and Oversight Group

SUBJECT: Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV)

The Centers for Medicare & Medicaid Services (CMS) is committed to the protection of patients and residents of healthcare facilities from the spread of infectious disease. Every Medicare participating facility in the Nation’s healthcare system must adhere to standards for infection prevention and control in order to provide safe, high quality care. As concerns arise with the emerging 2019 Novel Coronavirus (2019-nCoV) threat, CMS encourages all healthcare facilities to carefully review the information provided by our partners at the U.S. Centers for Disease Control and Prevention (CDC). CDC has issued an updated interim Health Alert Network (HAN) Advisory, information about CDC’s response to 2019-nCoV as well as recommendations for healthcare facilities. Because coronavirus infections can rapidly appear and spread, facilities must take steps to prepare, including reviewing their infection control policies and practices to prevent the spread of infection.

CMS recognizes the need to consider “emerging infectious diseases” in a provider’s emergency preparedness plans as required by the 2016 Emergency Preparedness Final Rule (81 FR 63860, 63862, September 16, 2016). Recent public health events such as the Ebola virus, 2009 pandemic H1N1 influenza, and Zika outbreaks highlight the critical need for providers to be prepared by planning for infectious disease response within their organizations. In February 2019, CMS updated guidance to emphasize the need for preparation and now we are seeing the importance of this effort. Patients expect quality care from their healthcare providers and part of that means being ready for emergency situations that might arise. Understanding all of the
various hazards to prepare for emergencies, such as 2019-nCoV, improves patient outcomes and provides protection to patients, family members as well as staff in healthcare settings.

To ensure health and safety, CMS also expects healthcare staff and surveyors (contractors, Federal, State, and Local) to comply with basic infection control practices. For 2019 novel coronavirus, CDC is currently advising adherence to Standard, Contact, and Airborne Precautions, including the use of eye protection (for more information, see CDC’s Interim Infection Control Recommendations for 2019-nCoV). Healthcare staff should also adhere to CDC recommendations on standard hand hygiene practices, using alcohol-based hand rub/hand sanitizer (ABHR/ABHS) as the preferred method of hand hygiene in most clinical situations. If hands are visibly soiled, wash with soap and water for at least 20 seconds. Healthcare facilities should ensure that hand hygiene supplies are readily available see CDC Hand Hygiene in Healthcare Settings for more detailed information.

In addition to the review of CDC information by healthcare facilities, we encourage the review of appropriate personal protective equipment (PPE) use and availability, such as gloves, gowns, respirators, and eye protection. CMS regularly observes these infection control practices as part of the normal survey process and notes that applying the basic principles of hand hygiene and using appropriate PPE protects lives. Medicare participating healthcare facilities should also have PPE measures and protocols within their emergency plans, especially in the event of potential surge situations.

To assist facilities in self-assessment and review of their own practices, CMS provides several resources listed below including online courses developed in conjunction with CDC, focusing on universal infection control practices.

CMS continues to work diligently with CDC, Accrediting Organizations (AO) and State Survey Agencies to clarify, emphasize, and ensure that healthcare facility infection control programs meet minimum health and safety standards. This collaboration will support the CDC Clean Hands Count campaign which aims to improve healthcare provider adherence to hand hygiene recommendations. Additionally, during surveys in 2020, CMS and AO acute care surveyors will be alert to healthcare staff hand hygiene practices, including the use of ABHR/ABHS, in an effort to raise awareness of the need for hand hygiene and improve compliance. We know that adherence to basic infection control and prevention practices such as hand hygiene can help reduce the risk of infectious disease spread in all healthcare settings.

In light of the 2019-nCoV outbreak, the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services has issued guidance to serve as a reminder of the ways that patient information may be shared so that the protections of the HIPAA Privacy Rule are not set aside during an emergency: https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf

CMS will continue to monitor the 2019-nCoV situation and support efforts of our partners at the CDC. For the most current information please refer to the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/index.html
Additional information related to CMS requirements and training are located at the following links:

CMS Emergency Preparedness Website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep


CMS Nursing Home Infection Preventionist Training: https://www.train.org/cdctrain/training_plan/3814

Nursing Home Infection Control Worksheet: https://qsep.cms.gov/data/252/A_NursingHome_InfectionControl_Worksheet11-8-19508.pdf


Questions about this memorandum should be addressed to QSOG_EmergencyPrep@cms.hhs.gov. Questions about the 2019-nCoV guidance/screening criteria should be addressed to the State Epidemiologist or other responsible state or local public health officials in your state.

**Effective Date:** Immediately. This policy should be communicated with all survey and certification staff, their managers, and the State/Regional Office training coordinators immediately.

/s/
David Wright

cc: Survey & Certifications Group Management
CMS Issues Waivers of 3-Day Stay and Spell of Illness

On March 14, the Centers for Medicare and Medicaid Services (CMS) issued two waivers to aid skilled nursing facilities in addressing the national COVID-19 outbreak. CMS is waiving both the 3-Day Stay and Spell of Illness requirements – nationally.

These waivers mean that skilled nursing facility (SNF) care without a 3-day inpatient hospital stay will be covered for beneficiaries who experience dislocations or are affected by the COVID-19 outbreak. Due to the current crisis, CMS also is utilizing the authority under section 1812(f) providing renewed SNF coverage to beneficiaries without starting a new spell of illness and allowing them to receive up to an additional 100 days of SNF Part A coverage. More detail and background information are provided below.

Overview

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the U.S. Department of Health and Human Services (DHHS) Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to regular authorities. For example, under section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of beneficiaries. Today, DHHS has waived the critical SNF provisions.

3-Day Stay Waiver

Section 1861(i) of the Act permits Medicare payment for SNF care only when a beneficiary first has an inpatient hospital stay of at least three consecutive days. Section 1812(f) of the Act allows Medicare to pay for SNF services without a 3-day qualifying stay if the Secretary finds that doing so will not increase total payments made under the Medicare program or change the essential acute-care nature of the SNF benefit. Based upon the President’s actions and the Secretary’s authority under Section 1135 and Section 1812(f), SNF care without a 3-day inpatient hospital stay will be covered for beneficiaries who experience dislocations or are affected by the emergency.

Spell of Illness Waiver

In addition, CMS is recognizing special circumstances for certain beneficiaries who, prior to the current emergency, had either begun or were ready to begin the process of ending their spell of illness after utilizing all of their available SNF benefit days. Existing Medicare regulations state that these beneficiaries cannot receive additional SNF benefits until they establish a new benefit period (i.e., by breaking the spell of illness by being discharged to a custodial care or
noninstitutional setting for at least 60 days). Due to the current crisis, CMS also is utilizing the authority under section 1812(f) providing renewed SNF coverage to beneficiaries without starting a new spell of illness and allowing them to receive up to an additional 100 days of SNF Part A coverage. The policy applies only for those beneficiaries who have been delayed or prevented by the emergency itself from beginning or completing the process of ending their current benefit period and renewing their SNF benefits.

For More Information

To view the CMS information regarding these waivers, click here.

Please continue to email questions to COVID19@ahca.org and check www.ahcancal.org/coronavirus for the latest information and resources.
Implement Environmental Infection Control - Cleaning & Disinfection

Preventing and mitigating the spread of COVID-19 in long term care centers is the top priority. Environmental infection control practices are essential to reduce the risk of the virus entering nursing centers and assisted living communities.

Detailed information on environmental infection control in health care settings can be found on the CDC website: Guidelines for Environmental Infection Control in Health-Care Facilities and Guidelines for Isolation Precautions.

The following environmental infection control practices should be implemented immediately:

- Hand washing stations or alcohol-based hand rubs should be immediately available at all entryways.
- Dedicated medical equipment should be used for patient care, when possible.
- Between each use, non-disposable medical equipment should be cleaned and disinfected.
- This should be done according to manufacturer's instructions and facility policies.
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
- Environmental cleaning and disinfection procedures should be supervised. This ensures that proper procedures are followed consistently and correctly.

Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. These products can be identified by the following claim:

- "[Product name] has demonstrated effectiveness against viruses similar to COVID-19 on hard nonporous surfaces. Therefore, this product can be used against COVID-19 when used in accordance with the directions for use against [name of supporting virus] on hard, nonporous surfaces."

This claim will be made only through communication outlets such as:

- Technical literature distributed to health care facilities, physicians, nurses, and public health officials
- "1-800" consumer information services
- Social media sites
- Company websites

Specific claims for "COVID-19" will not appear on the product or master label. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.
See additional information about EPA-approved emerging viral pathogens claims [here](#).

A template handout for housekeeping staff on cleaning protocol is available [here](#). You can modify as needed for your facility's needs.
CMS Releases COVID-19 Medicare FFS and Medicare Advantage Plan Guidance

The Centers for Medicare & Medicaid Services (CMS) has released COVID-19 Medicare fee-for-service (FFS) and third-party payer guidance - specifically to Medicare Advantage plans. A summary of each is below, as well as hyperlinks to CMS materials. Additionally, America's Health Insurance Plans (AHIP) and the Association for Community Affiliated Plans (ACAP) have both posted plan-by-plan information on their members' COVID-19 coverage changes.

Medicare FFS COVID-19 Testing Reimbursement
Medicare Part B covers medically necessary clinical diagnostic laboratory tests when a doctor or other practitioner orders them. CMS developed two Healthcare Common Procedure Coding System (HCPCS) codes to bill Medicare Part B for COVID-19 testing: U0001 and U0002. Medicare claims processing systems will accept both codes beginning April 1, 2020, for dates of service on or after February 4, 2020.

It is important to note that local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. A longer discussion of Medicare FFS COVID-19 reimbursement is available here.

CMS Guidance to Medicare Advantage Plans
CMS yesterday issued guidance to Medicare Advantage (MA) and Part D plans outlining plan options and plan requirements. New and current flexibilities available to plans are intended to break down barriers to beneficiary access to care.

1. Plans may offer access to Medicare Part B services via telehealth in any geographic location and from a variety of places including a beneficiaries' home.
2. Plans may choose to waive plan prior authorization requirements that otherwise would apply to test or services related to COVID-19 at any time.

The CMS memo also reviews the special requirements MA plans must adhere to in a disaster or emergency, including:

1. Cover plan benefits furnished at non-contracted facilities (e.g. out-of-network providers);
2. Waive, in full, requirements for gatekeeper referrals where applicable;
3. Provide same cost sharing for the enrollee as if services were received in a contracted facility; and
4. Make changes that benefit the beneficiary without the 30-day notification requirement (such changes could include reductions in cost).

Lastly, CMS reminded MA plans that under a specific emergency waiver authority (known as a Katrina Waiver), the agency may authorize MACs to pay for Part C covered services furnished to beneficiaries enrolled in MA plans and retrospectively seek reimbursement from the MA plan.
for those services. Providers should check with their participating MA plans to understand which flexibilities the plan offers. The CMS guidance memo is available here.

**Health Plan Information**

On Tuesday, AHIP issued an industry response statement to COVID-19. It has also compiled a helpful list of specific health insurance plans' responses to COVID-19 regarding services and benefits: [Health Insurance Providers Respond to Coronavirus (COVID-19) - AHIP](#). The responses may differ among health plans and include measures such as:

- Waiving co-pays for diagnostic testing related to COVID-19;
- Waiving co-pays and out-of-pocket costs for emergency and urgent care services;
- No-cost telemedicine visits;
- Waiving some prior authorization requirements;
- Waiving prescription refill limits; and
- Providing additional stress and anxiety support services.

AHIP has also developed a [COVID-19 Resource Center](#). AHCA/NCAL recommends providers contact each of their health insurance plans for policies and procedures (or changes to existing policies and procedures) for COVID-19 related and non-related admissions and residents.

Finally, as mentioned, ACAP (the not-for-profit Medicaid and Medicare-Medicaid health plan association) also has posted an array of COVID-19 resources on plan coverage. No other health plan associations have posted coverage information to-date.

AHCA/NCAL will provide weekly COVID-19 reimbursement and market coverage updates. Please email [COVID19@ahca.org](mailto:COVID19@ahca.org) with any questions or comments.
The following tools are provided to assist with developing visitor screening protocols:

• Template letter for residents, family members and visitors educating them about COVID-19 and policies of the nursing center to prevent its spread (*Attachment 1*)

• Template communication to vendors requested they not enter the nursing center if they potentially carry the COVID-19 virus (*Attachment 2*)
To Our Residents and Family Members:

We know you are concerned about the spread of COVID-19 (the new coronavirus) and how it may impact us at [FACILITY NAME]. Making sure residents are cared for in a safe and healthy environment is our top priority.

CMS and the Missouri Department of Health and Senior Services has directed that we restrict all visitors and volunteers from visiting the facility. This includes family and friends. This restriction is in effect until further notice. We are posting signs in entryways to notify visitors and actively screening individuals, including staff, who do need to enter the building.

We may only allow visitors for compassionate care reasons, such as end-of-life situations. This will be handled on a case-by-case basis. We will actively screen anyone who must visit for this purpose. Protective measures will be followed during these visits. If visitors have respiratory symptoms such as a fever, they will be restricted from entering the building.

We understand connecting with your loved ones is incredibly important. There are a variety of other ways to consider communicating including telephone, email, text, video chat or social media. We are happy to facilitate these methods of communication. Please contact [POINT OF CONTACT AND CONTACT INFO] if you need assistance in using these alternative communication methods.

We will stay up to date on the Federal and State governments’ recommendations as they may continue to change. Our [FACILITY/COMMUNITY] is in close contact with the local and state health department and are also following their guidance.

Should you have any questions, please contact our center at: [PLEASE FILL IN YOUR FACILITY’S CONTACT INFORMATION AND TAILOR TO MEET YOUR FACILITY’S NEEDS.]

For more information, please visit the CDC’s coronavirus disease information page.

Sincerely,

[FILL IN YOUR FACILITY INFORMATION]
To Our Vendors/Business Partners:

We know you are concerned about the spread of COVID-19 (the new coronavirus) and how it may impact us here at [FACILITY NAME]. Ensuring our staff and residents are in a safe and healthy environment is our first priority. Per guidance from CMS and the Missouri Department of Health and Senior Services, we are implementing new measures including:

1. **Restricting all visitors, volunteers and non-essential health care personnel** from visiting the facility, except for compassionate reasons such as end-of-life situations.
2. **Actively screening** all health care personnel for respiratory symptoms including actively checking temperatures for a fever at the beginning of each shift. Anyone with these symptoms will not be permitted to enter the facility at any time.

In an effort to protect [FACILITY NAME] residents and staff from COVID-19, we are asking vendors and business partners to not visit the facility. If this is going to inhibit any of our vendors or business partners from rendering services to [FACILITY NAME], please contact [POINT OF CONTACT AND CONTACT INFO]. We appreciate your understanding as we ensure the health and well-being of our residents and staff.

We will stay up to date with the CMS and DHSS recommendations as they may continue to change. In addition, our [FACILITY/COMMUNITY] is in close contact with the local public health department and are following their guidance.

For additional information, please visit the CDC’s coronavirus disease information page.

Thank you for your commitment and dedication to our residents and staff.

Sincerely,

[FILL IN YOUR FACILITY INFORMATION]
Employee Screening Resources

The following tools are provided to assist with developing employee screening protocols:

- Sample letter to educate staff on steps implemented to help reduce the potential for the virus to enter the nursing facility (*Attachment 3*)

- Employee screening tool (*Attachment 4*)

Visit [www.mohealthcare.com/covid-19-resources](http://www.mohealthcare.com/covid-19-resources) for ongoing updates and resources
To Our Employees:

We know you are concerned about the spread of COVID-19 (the new coronavirus) and how it may impact us here at [FACILITY NAME]. Ensuring our staff and residents are in a safe and healthy environment is our first priority. Per guidance from CMS and the Missouri Department of Health and Senior Services, we are implementing new measures including:

1. **Restricting all visitors, volunteers and non-essential health care personnel** from visiting the facility, except for compassionate reasons such as end-of-life situations.
2. **Actively screening** all health care personnel for respiratory symptoms including actively checking temperatures for a fever at the beginning of each shift. Anyone with these symptoms will not be permitted to enter the facility at any time.

We need your help:

1. **Sick employees need to stay home.** If you have any symptoms, stay home and notify your supervisor. Those symptoms include: cough, fever, sore throat, and/or shortness of breath.
2. **Notify us if you develop respiratory symptoms while at work.** These include: cough, fever, sore throat and/or shortness of breath.
3. **Let us know** if you work in other health care settings or have any exposure to other facilities with suspected or confirmed COVID-19 cases.
4. **Practice proper hand hygiene.** All employees should wash their hands for at least 20 seconds or use alcohol-based hand sanitizer that contains at least 60-95% alcohol upon entering the building and before and after interaction with residents. Soap and water should be used preferentially if hands are visibly dirty.

We will stay up to date with the federal government’s recommendations as they may continue to change. In addition, our [FACILITY/COMMUNITY] is in close contact with the local and state health department and are following their guidance.

Should you have any questions, please feel free to contact [POINT OF CONTACT AND CONTACT INFO].

For additional information, please visit the CDC’s coronavirus disease information page.

Thank you for your commitment and dedication to our residents as well as coworkers.

Sincerely,

[FILL IN YOUR FACILITY INFORMATION]
### Employee Screening Tool

**Name of Employee:**

<table>
<thead>
<tr>
<th>Date of Screening:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you traveled by plane or cruise ship within and/or outside the United States in the last 14 days?</td>
</tr>
<tr>
<td>Fever (&gt;99.6°F) or history of fever within the last 14 days?</td>
</tr>
<tr>
<td>Sore throat</td>
</tr>
<tr>
<td>Cough</td>
</tr>
<tr>
<td>Runny nose</td>
</tr>
<tr>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Diarrhea</td>
</tr>
<tr>
<td>Exposure to individuals with cold or flu-like symptoms within the last 14 days?</td>
</tr>
<tr>
<td>Education and/or Materials Provided?</td>
</tr>
<tr>
<td>□ Hand hygiene, including return demonstration</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Date of Screening:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you traveled by plane or cruise ship within and/or outside the United States in the last 14 days?</td>
</tr>
<tr>
<td>Fever (&gt;99.6°F) or history of fever within the last 14 days?</td>
</tr>
<tr>
<td>Sore throat</td>
</tr>
<tr>
<td>Cough</td>
</tr>
<tr>
<td>Runny nose</td>
</tr>
<tr>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Diarrhea</td>
</tr>
<tr>
<td>Exposure to individuals with cold or flu-like symptoms within the last 14 days?</td>
</tr>
<tr>
<td>Education and/or Materials Provided?</td>
</tr>
<tr>
<td>□ Hand hygiene, including return demonstration</td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th>Date of Screening:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you traveled by plane or cruise ship within and/or outside the United States in the last 14 days?</td>
</tr>
<tr>
<td>Fever (&gt;99.6°F) or history of fever within the last 14 days?</td>
</tr>
<tr>
<td>Sore throat</td>
</tr>
<tr>
<td>Cough</td>
</tr>
<tr>
<td>Runny nose</td>
</tr>
<tr>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Diarrhea</td>
</tr>
<tr>
<td>Exposure to individuals with cold or flu-like symptoms within the last 14 days?</td>
</tr>
<tr>
<td>Education and/or Materials Provided?</td>
</tr>
<tr>
<td>□ Hand hygiene, including return demonstration</td>
</tr>
</tbody>
</table>
The following templates are provided to assist with the media and community for impacted and non-impacted facilities:

- Statement and talking points for an impacted facility with Coronavirus (*Attachment 5*)

- Statement and talking points for a non-impacted facility (*Attachment 6*)
STATEMENT & TALKING POINTS FOR FACILITIES WITH CORONAVIRUS
Infection Prevention and Control in Skilled Nursing and Assisted Living Communities
Updated: March 14, 2020
[TAILORED FOR YOUR USE]

PRESS STATEMENT:

“We are doing everything we can to ensure we stop the spread of this within our facility. We are in very close communication with our local and state health officials to ensure we are taking the appropriate steps at this time. Our staff and residents are following the recommended preventative actions; we have restricted visitors from entering our facility; and cancelled all group activities within the building until the virus has been eradicated.”

TALKING POINTS:

- Resident safety is a top priority for [FACILITY NAME]. Every resident should have a clean, safe living environment. We agree that the spread of this novel virus is a critical issue that requires attention.
- [FACILITY NAME] is in close contact with our local and state health departments, as well as the CDC, to stay up to date on the information to prevent and manage the spread of Coronavirus.
- Skilled nursing and assisted living providers will need to rely on local, state and federal resources to help prevent the spread of this virus.
  - Detailed technical assistance from CDC and other public health agencies is necessary to help track and prevent its spread.
- We have reviewed and updated our infection prevention and control plans and our emergency communication plan.
- We have reinforced to our staff that anyone who is sick should stay home.
- We are following the same basic procedures used during flu season: handwashing, using alcohol-based hand sanitizers and covering coughs.

DEPENDING ON THE LOCAL HEALTH DEPARTMENT RECOMMENDATIONS:

- We are restricting all non-essential personnel, per direction from local health department as well as the federal and state government.
- Family members can interact with their loved ones by using video chat, calling, texting or checking in on social media. [OUTLINE HOW FACILITY IS FACILITATING COMMUNICATION]

COMMON MEDIA QUESTIONS:

Should families who are worried move their loved ones out of skilled nursing facilities or assisted living communities?
• No. Moving the elderly or frail is risky and often has long-lasting impacts. Research around natural disasters and other emergency events has proven this over time. CDC does not currently recommend transferring residents either home or to the hospital.

**How concerned are you for skilled nursing facility or assisted living residents?**

• We know that the frail and elderly are especially susceptible to this virus. That’s why we are in close communication with our local health department, CDC and CMS to ensure we have the latest information and resources available.

**Are you having trouble getting things like masks and gowns?**

• We have heard that some long term care providers are having some of the same difficulties as other health care providers getting masks and gowns. In our facility, we [PROVIDE INFO ON YOUR SUPPLIES (e.g., conservation efforts)].

• We [have reached/are reaching] out to the state and local health departments and area hospitals/other health care providers when we are unable to place orders for equipment we need. - CUSTOMIZE BASED ON YOUR SITUATION

• It’s important to remind the public that the CDC does not recommend masks for the general public at this point, so we can prioritize this equipment for health care workers. We also urge members of the public to not hoard hand sanitizer, so we can make that available to residents and staff, who need to use it regularly.

**If staff have to stay home because they are sick/schools close, how are you ensuring that there are enough staff to care for your residents?**

• Our state and national associations are encouraging both federal and state governments to waive current licensing requirements that would hinder care professionals from working across state lines, so we can potentially address any shortages due to employees needing to stay home.

• Our state and national associations are also advocating for priority testing for our employees and residents, so we can quickly identify whether staff need to remain at home or if they can come back to work.  

• PROVIDE STEPS FACILITY IS TAKING

**BACKGROUND:**

• To decrease the risk of viral outbreaks in long term care facilities, two processes need to be in place.
  
  o First, efforts should focus on how to decrease the introduction of viruses into a facility.
  
  o Second, steps to decrease the spread of a virus between residents need to be in place and followed consistently.
  
  o Even then, outbreaks may still occur. Facilities should have a process to limit the spread of a virus and also treat individuals with an infection to decrease the risk of illness exacerbation, hospitalization, and in severe cases, death.

• Steps to help prevent the introduction of a virus into long term care facilities (or any health care facility) include:
  
  o Keeping all ill individuals from visiting the facility, including family, volunteers and employees.
  
  o Requiring individuals visiting a facility to wear a mask when viral infections are at increased levels in the community.
- Not applicable if visitors are not being permitted.
  - Encouraging frequent hand hygiene by making alcohol-based hand sanitizer dispensers readily available, in locations such as in or near each resident’s room as well as in the entry area and common areas.
  - Immunization of health care workers (e.g. influenza, measles, diphtheria, pertussis, chicken pox) or limiting health care workers physical interaction with residents when not immunized or using masks when such viral infections are found at increased levels in the community.

- Steps to help decrease the risk of viral spread within a facility include:
  - Ongoing hand hygiene at high levels. This can be achieved with: Readily available alcohol-based hand sanitizers in locations such as in or near each resident’s room, common areas, etc.
  - Regular and frequent internal monitoring systems of hand hygiene with regular feedback to staff.
  - Visual reminders that hand hygiene helps residents stay healthy.
  - Early identification of viral infections that cause upper respiratory illness (e.g. “colds”, “flu”, or “winter crud”) that lead to steps that prevent viral spread. Preventative measures include: Early contact isolation and droplet protection for individuals with flu-like symptoms before a definitive diagnosis is made. This includes: Keeping ill individuals away from healthy individuals (e.g. ideally by cohorting ill residents together, though cohorting may not be possible given the physical space and structure of facilities).
  - Use of masks on residents with symptoms if they need to leave their rooms, which should be severely restricted.
  - Use of personal protective equipment by staff and visitors for droplet protection.
  - Use of appropriate cleaning products on surfaces that are cytotoxic for common viral infections and changing these cleaning products when the harder to kill infectious agents are identified and requires special cleaning products, such as C. diff, norovirus and adenovirus, which should be readily available to the facility staff.

- CMS issued infection control regulations in November 2016. These regulations were designed to help decrease the risk of infectious outbreaks in nursing facilities and require each nursing facility to have an infection control plan that must describe:
  - An infection prevention and control program. The facility must establish an infection prevention and control program that includes an Antibiotic Stewardship Program and designate at least one Infection Preventionist;
  - A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
  - When and to whom possible incidents of communicable disease or infections should be reported;
  - Standard and transmission-based precautions to be followed to prevent spread of infections;
  - When and how isolation should be used for a resident; including but not limited to: the type and duration of the isolation, depending upon the infectious agent or organism involved, and;
  - A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
  - The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
  - The hand hygiene procedures to be followed by staff involved in direct resident contact.
• The CMS regulations also require each nursing facility to designate at least one employee to serve as an Infection Preventionist, who is both a clinician (e.g. nurse) and has received additional training and certification in infection control.
  o There are three training programs available including one designed by AHCA/NCAL. They all require approximately 20 to 25 hours of training.

• AHCA/NCAL has recommended several steps to help decrease the risk of future viral outbreaks in nursing facilities:
  o AHCA/NCAL has offered to provide our certificate course for free to those facilities who provide care to high risk individuals (e.g. pediatrics, ventilators, HIV, transplants, and ESRD).
  o State health departments should ensure each nursing facility has alcohol-based hand sanitizers that are readily available to each room and at entry to the facility as well as in common areas for staff and visitors.
  o State health departments should ensure all health care workers receive the influenza vaccine. If a worker chooses to decline the vaccine, during periods of time when there is an increase in influenza virus in the community, that individual should be required to wear a mask. If they are unable to wear a mask, they should not provide direct patient care. Several states and hospitals have adopted this type of approaches.
  o State health departments should assure health care facilities use appropriate cleaning supplies that are cytotoxic to common viruses and pathogens (per CDC and EPA labeling for claims against common viruses and pathogens). All health care facilities should have a supply of additional cleaning agents for hard to kill pathogens when such pathogens are identified or suspected (e.g. C. diff, adenovirus, norovirus).
STATEMENT & TALKING POINTS FOR FACILITIES
WITHOUT CORONAVIRUS
Infection Prevention and Control in Nursing Homes and Assisted Living Communities
Updated: March 14, 2020
[TAILOR FOR YOUR USE]

PRESS STATEMENT:

“We are acting now and have implemented our infection prevention and control policies and procedures, as this is key to preventing coronavirus and other common viruses. We are ensuring that our staff and residents are practicing proper hand hygiene, [FOR SNFs and ALs WITH PREVENTIONIST: and we have a trained infection preventionist who is taking the lead on facility risk assessment for this and other infections]. It’s critical that we follow direction from the federal/state government, which states that employees who are sick must stay home and that all non-essential personnel be restricted from entering our [facility] for the time being. We are in very close communication with local and state health officials to ensure we are taking the appropriate steps.”

TALKING POINTS:

• Resident safety is a top priority for [FACILITY NAME]. Every resident and family should have a clean, safe living environment. We agree that the spread of this novel virus is a critical issue that requires attention. Our goal is to try and keep the virus out and if it is found in the facility, to minimize the spread to anyone else.
• [FACILITY NAME] is in close contact with our local and state health departments, as well as monitoring guidance from the federal government, to stay up to date on the information to prevent and manage the spread of Coronavirus.
• We rely on local, state and federal resources to help prevent the spread of this virus, and we appreciate everything they’re doing at this time.
• We have reviewed and updated our infection prevention and control plans and our emergency communication plan.
• We have reinforced to our staff that anyone who is sick should stay home.
• We are following the same infection prevention procedures used during flu season: handwashing, using alcohol-based hand sanitizers, covering coughs, and disinfecting the environment.
• We are following guidance from the [federal/state] government that restricts non-essential individuals, including family members, contractors, and volunteers from visiting our facility for the time being. We will make accommodations for family members whose loved one is near end-of-life; however, it is critical that we do all that we can to protect our residents and patients from this virus.
  o Loved ones can communicate with residents by using video chat, calling, texting, or checking in on social media. [OUTLINE HOW FACILITY IS FACILITATING COMMUNICATION]
• We are also restricting group activities within our facility to help reduce the potential spread, including [OUTLINE SPECIFIC ACTIVITIES].
We need to make sure family members have given us the most current emergency contact information, so we can continue to keep them informed should there be any new developments.

COMMON MEDIA QUESTIONS:

Should families who are worried move their loved ones out of skilled nursing facilities or assisted living communities?

- No. Moving the elderly or frail is risky and often can cause other complications that have long-lasting impacts. Research around moving residents out of buildings because of natural disasters and other emergency events has proven this over time. CDC does not currently recommend transferring residents either home or to the hospital.

How concerned are you for skilled nursing facility or assisted living residents?

- We know that the frail and elderly are very susceptible to this virus. That’s why we are following the government’s guidance to restrict visitors, asking employees to stay home when ill, and in close communication with our local health department, CDC and CMS to ensure we have the latest information and resources available.

Are you having trouble getting supplies like masks and gowns?

- We have heard that some long term care providers are having some of the same difficulties as other health care providers getting masks and gowns. In our facility, we [PROVIDE INFO ON YOUR SUPPLIES (e.g., conservation efforts)].
- [CUSTOMIZE BASED ON YOUR SITUATION: We [have reached/are reaching] out to the state and local health departments and area hospitals when we are unable to place orders for equipment we need.]
- It’s important to remind the public that the CDC does not recommend masks for the general public at this point, so we can prioritize this equipment for health care workers. We also urge members of the public to not hoard hand sanitizer, so we can make that available to residents and staff, who need to use it regularly.

If staff have to stay home because they are sick/schools close, how are you ensuring that there are enough staff to care for your residents?

- Our state and national associations are encouraging both federal and state governments to waive current licensing requirements that would hinder care professionals from working across state lines, so we can potentially address any shortages due to employees needing to stay home.
- Our state and national associations are also advocating for priority testing for our employees and residents, so we can quickly identify whether staff need to remain at home or if they can come back to work.
- [SPECIFIC STEPS FACILITY IS TAKING]

BACKGROUND:

- To decrease the risk of viral outbreaks in long term care facilities, two processes need to be in place.
  - First, efforts should focus on how to decrease the introduction of viruses into a facility.
  - Second, steps to decrease the spread of a virus between residents need to be in place and followed consistently.
Even then, outbreaks may still occur. Facilities should have a process to limit the spread of a virus and also treat individuals with an infection to decrease the risk of illness exacerbation, hospitalization, and in severe cases, death.

- **Steps to help prevent the introduction of a virus into long term care facilities (or any health care facility) include:**
  - Limiting all non-essential visitors from entering the facility, including family, volunteers and contractors.
  - Requiring individuals visiting a facility to wear a mask when viral infections are at increased levels in the community (e.g., influenza). [Note: as of March 2 this is not recommended by the CDC]
  - Encouraging frequent hand hygiene by making alcohol-based hand sanitizer dispensers readily available, in locations such as in or near each resident’s room as well as in the entry area and common areas.
  - Immunization of health care workers (e.g. influenza, measles, diphtheria, pertussis, chicken pox) or limiting health care workers physical interaction with residents when not immunized or using masks when such viral infections are found at increased levels in the community.

- **Steps to help decrease the risk of viral spread within a facility include:**
  - Ongoing hand hygiene at high levels. This can be achieved with: Readily available alcohol-based hand sanitizers in locations such as in or near each resident’s room, entry ways, common areas, etc.
  - Regular and frequent internal monitoring systems of hand hygiene with regular feedback to staff.
  - Visual reminders that hand hygiene helps residents stay healthy.
  - Early identification of viral infections that cause upper respiratory illness (e.g., “colds”, “flu”, or “winter crud”) that lead to steps that prevent viral spread. Preventative measures include: Early contact isolation and droplet protection for individuals with flu-like symptoms before a definitive diagnosis is made. This includes: Keeping ill individuals away from healthy individuals (e.g., ideally by cohorting ill residents together, though cohorting may not be possible given the physical space and structure of facilities).
  - Use of masks on residents with symptoms if they need to leave their rooms, which should be severely restricted.
  - Use of personal protective equipment by staff and visitors for droplet protection.
  - Use of appropriate cleaning products on surfaces that are cytotoxic for common viral infections and changing these cleaning products when the harder to kill infectious agents are identified and requires special cleaning products, such as C. diff, norovirus and adenovirus, which should be readily available to the facility staff.

- **CMS issued infection control regulations for nursing homes in November 2016. These regulations were designed to help decrease the risk of infectious outbreaks in nursing facilities and require each nursing facility to have an infection control plan that must describe:**
  - An infection prevention and control program. The facility must establish an infection prevention and control program that includes an Antibiotic Stewardship Program and designate at least one Infection Preventionist;
  - A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
  - When and to whom possible incidents of communicable disease or infections should be reported;
Standard and transmission-based precautions to be followed to prevent spread of infections;
When and how isolation should be used for a resident; including but not limited to: The type and duration of the isolation, depending upon the infectious agent or organism involved, and;
A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
The hand hygiene procedures to be followed by staff involved in direct resident contact.

The CMS regulations also require each nursing facility to designate at least one employee to serve as an Infection Preventionist, who is both a clinician (e.g. nurse) and has received additional training and certification in infection control.
There are three training programs available including one designed by AHCA/NCAL. They all require approximately 20 to 25 hours of training.

Assisted living communities should refer to their state regulations on infection control requirements, but AHCA/NCAL is encouraging all assisted living communities to review guidance put forth by the CDC and AHCA/NCAL, as well as consult their local/state health department for COVID-19.

AHCA/NCAL has recommended several steps to help decrease the risk of future viral outbreaks in long term care facilities:
AHCA/NCAL has offered to provide our certificate course for free to those facilities who provide care to high risk individuals (e.g. pediatrics, ventilators, HIV, transplants, and ESRD).
State health departments should ensure each nursing facility has alcohol-based hand sanitizers that are readily available to each room and at entry to the facility as well as in common areas for staff and visitors.
State health departments should ensure all health care workers receive the influenza vaccine. If a worker chooses to decline the vaccine, during periods of time when there is an increase in influenza virus in the community, that individual should be required to wear a mask. If they are unable to wear a mask, they should not provide direct patient care. Several states and hospitals have adopted this type of approaches.
State health departments should assure health care facilities use appropriate cleaning supplies that are cytotoxic to common viruses and pathogens (per CDC and EPA labeling for claims against common viruses and pathogens). All health care facilities should have a supply of additional cleaning agents for hard to kill pathogens when such pathogens are identified or suspected (e.g. C. diff, adenovirus, norovirus).
It is important to post information educating and reminding employees and visitors on precautions to protect residents from COVID-19. This section includes sample signage, including:

- Methods to Stop the Spread of Germs (*Attachment 7*)
- What to do if you are sick (*Attachment 8*)
- Hand Washing How-To (*Attachment 9*)
- Coronavirus (COVID-19) Precautions [for display at facility entrance (*Attachment 10*)]

Visit [www.mohealthcare.com/covid-19-resources](http://www.mohealthcare.com/covid-19-resources) for ongoing updates and resources
STOP THE SPREAD OF GERMS

Help prevent the spread of respiratory diseases like COVID-19.

Avoid close contact with people who are sick.

Cover your cough or sneeze with a tissue, then throw the tissue in the trash.

Avoid touching your eyes, nose, and mouth.

Clean and disinfect frequently touched objects and surfaces.

Stay home when you are sick, except to get medical care.

Wash your hands often with soap and water for at least 20 seconds.

For more information: http://www.cdc.gov/COVID19
If you are sick with COVID-19 or suspect you are infected with the virus that causes COVID-19, follow the steps below to help prevent the disease from spreading to people in your home and community.

**Stay home except to get medical care**
You should restrict activities outside your home, except for getting medical care. Do not go to work, school, or public areas. Avoid using public transportation, ride-sharing, or taxis.

**Separate yourself from other people and animals in your home**

**People:** As much as possible, you should stay in a specific room and away from other people in your home. Also, you should use a separate bathroom, if available.

**Animals:** Do not handle pets or other animals while sick. See COVID-19 and Animals for more information.

**Call ahead before visiting your doctor**
If you have a medical appointment, call the healthcare provider and tell them that you have or may have COVID-19. This will help the healthcare provider's office take steps to keep other people from getting infected or exposed.

**Wear a facemask**
You should wear a facemask when you are around other people (e.g., sharing a room or vehicle) or pets and before you enter a healthcare provider’s office. If you are not able to wear a facemask (for example, because it causes trouble breathing), then people who live with you should not stay in the same room with you, or they should wear a facemask if they enter your room.

**Cover your coughs and sneezes**
Cover your mouth and nose with a tissue when you cough or sneeze. Throw used tissues in a lined trash can; immediately wash your hands with soap and water for at least 20 seconds or clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry. Soap and water should be used preferentially if hands are visibly dirty.

**Avoid sharing personal household items**
You should not share dishes, drinking glasses, cups, eating utensils, towels, or bedding with other people or pets in your home. After using these items, they should be washed thoroughly with soap and water.

**Clean your hands often**
Wash your hands often with soap and water for at least 20 seconds. If soap and water are not available, clean your hands with an alcohol-based hand sanitizer that contains at least 60% alcohol, covering all surfaces of your hands and rubbing them together until they feel dry. Soap and water should be used preferentially if hands are visibly dirty. Avoid touching your eyes, nose, and mouth with unwashed hands.

**Clean all “high-touch” surfaces every day**
High touch surfaces include counters, tabletops, doorknobs, bathroom fixtures, toilets, phones, keyboards, tablets, and bedside tables. Also, clean any surfaces that may have blood, stool, or body fluids on them. Use a household cleaning spray or wipe, according to the label instructions. Labels contain instructions for safe and effective use of the cleaning product including precautions you should take when applying the product, such as wearing gloves and making sure you have good ventilation during use of the product.

**Monitor your symptoms**
Seek prompt medical attention if your illness is worsening (e.g., difficulty breathing). Before seeking care, call your healthcare provider and tell them that you have, or are being evaluated for, COVID-19. Put on a facemask before you enter the facility. These steps will help the healthcare provider’s office to keep other people in the office or waiting room from getting infected or exposed.

Ask your healthcare provider to call the local or state health department. Persons who are placed under active monitoring or facilitated self-monitoring should follow instructions provided by their local health department or occupational health professionals, as appropriate.

If you have a medical emergency and need to call 911, notify the dispatch personnel that you have, or are being evaluated for COVID-19. If possible, put on a facemask before emergency medical services arrive.

**Discontinuing home isolation**
Patients with confirmed COVID-19 should remain under home isolation precautions until the risk of secondary transmission to others is thought to be low. The decision to discontinue home isolation precautions should be made on a case-by-case basis, in consultation with healthcare providers and state and local health departments.

For more information: www.cdc.gov/COVID19
Hand Washing How-To

**Does it matter how I wash my hands?**

You have to rub your hands for at least 20 seconds to get rid of harmful microorganisms. Follow these instructions:

1. **WET**
2. **SOAP**
3. **WASH**
   - 20 SECONDS
4. **RINSE**
5. **DRY**
6. **TURN OFF WATER WITH PAPER TOWEL**

Hand Sanitizer How-To

**How do I clean my hands with alcohol-based hand sanitizer?**

Use enough to cover all the surfaces of your hands. Air dry for 30 seconds. Follow these instructions:

1. **PLACE**
2. **RUB**
   - UNTIL DRY
   - 30 SECONDS
Coronavirus (COVID-19) Precautions

In order to protect our residents, we ask that you DO NOT visit the facility during this time if you have the following active symptoms:

- Fever
- Cough/Sneezing Cold Symptoms
- Difficulty Breathing

In order to keep our facility free of COVID-19 we will begin screening ALL visitors prior to visiting. Any visitors that show “active” signs will not be allowed to enter.

We appreciate your understanding during this time. If you have any questions/concerns, please don’t hesitate to call the facility.

Thank you for your understanding and cooperation.
Occupational Safety and Health Act of 1970

“To assure safe and healthful working conditions for working men and women; by authorizing enforcement of the standards developed under the Act; by assisting and encouraging the States in their efforts to assure safe and healthful working conditions; by providing for research, information, education, and training in the field of occupational safety and health.”

This guidance is not a standard or regulation, and it creates no new legal obligations. It contains recommendations as well as descriptions of mandatory safety and health standards. The recommendations are advisory in nature, informational in content, and are intended to assist employers in providing a safe and healthful workplace. The Occupational Safety and Health Act requires employers to comply with safety and health standards and regulations promulgated by OSHA or by a state with an OSHA-approved state plan. In addition, the Act’s General Duty Clause, Section 5(a)(1), requires employers to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm.

Material contained in this publication is in the public domain and may be reproduced, fully or partially, without permission. Source credit is requested but not required.

This information will be made available to sensory-impaired individuals upon request. Voice phone: (202) 693-1999; teletypewriter (TTY) number: 1-877-889-5627.
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>About COVID-19</td>
<td>4</td>
</tr>
<tr>
<td>How a COVID-19 Outbreak Could Affect Workplaces</td>
<td>6</td>
</tr>
<tr>
<td>Steps All Employers Can Take to Reduce Workers’ Risk of Exposure to SARS-CoV-2</td>
<td>7</td>
</tr>
<tr>
<td>Classifying Worker Exposure to SARS-CoV-2</td>
<td>18</td>
</tr>
<tr>
<td>Jobs Classified at Lower Exposure Risk (Caution): What to Do to Protect Workers</td>
<td>20</td>
</tr>
<tr>
<td>Jobs Classified at Medium Exposure Risk: What to Do to Protect Workers</td>
<td>21</td>
</tr>
<tr>
<td>Jobs Classified at High or Very High Exposure Risk: What to Do to Protect Workers</td>
<td>23</td>
</tr>
<tr>
<td>Workers Living Abroad or Travelling Internationally</td>
<td>25</td>
</tr>
<tr>
<td>For More Information</td>
<td>26</td>
</tr>
<tr>
<td>OSHA Assistance, Services, and Programs</td>
<td>27</td>
</tr>
<tr>
<td>OSHA Regional Offices</td>
<td>29</td>
</tr>
<tr>
<td>How to Contact OSHA</td>
<td>32</td>
</tr>
</tbody>
</table>
Introduction

Coronavirus Disease 2019 (COVID-19) is a respiratory disease caused by the SARS-CoV-2 virus. It has spread from China to many other countries around the world, including the United States. Depending on the severity of COVID-19’s international impacts, outbreak conditions—including those rising to the level of a pandemic—can affect all aspects of daily life, including travel, trade, tourism, food supplies, and financial markets.

To reduce the impact of COVID-19 outbreak conditions on businesses, workers, customers, and the public, it is important for all employers to plan now for COVID-19. For employers who have already planned for influenza pandemics, planning for COVID-19 may involve updating plans to address the specific exposure risks, sources of exposure, routes of transmission, and other unique characteristics of SARS-CoV-2 (i.e., compared to pandemic influenza viruses). Employers who have not prepared for pandemic events should prepare themselves and their workers as far in advance as possible of potentially worsening outbreak conditions. Lack of continuity planning can result in a cascade of failures as employers attempt to address challenges of COVID-19 with insufficient resources and workers who might not be adequately trained for jobs they may have to perform under pandemic conditions.

The Occupational Safety and Health Administration (OSHA) developed this COVID-19 planning guidance based on traditional infection prevention and industrial hygiene practices. It focuses on the need for employers to implement engineering, administrative, and work practice controls and personal protective equipment (PPE), as well as considerations for doing so.

This guidance is intended for planning purposes. Employers and workers should use this planning guidance to help identify risk levels in workplace settings and to determine any appropriate control measures to implement. Additional guidance may be needed as COVID-19 outbreak conditions change, including as new information about the virus, its transmission, and impacts, becomes available.


This guidance is advisory in nature and informational in content. It is not a standard or a regulation, and it neither creates new legal obligations nor alters existing obligations created by OSHA standards or the Occupational Safety and Health Act (OSH Act). Pursuant to the OSH Act, employers must comply with safety and health standards and regulations issued and enforced either by OSHA or by an OSHA-approved State Plan. In addition, the OSH Act’s General Duty Clause, Section 5(a)(1), requires employers to provide their employees with a workplace free from recognized hazards likely to cause death or serious physical harm. OSHA-approved State Plans may have standards, regulations and enforcement policies that are different from, but at least as effective as, OSHA’s. Check with your State Plan, as applicable, for more information.

About COVID-19

Symptoms of COVID-19

Infection with SARS-CoV-2, the virus that causes COVID-19, can cause illness ranging from mild to severe and, in some cases, can be fatal. Symptoms typically include fever, cough, and shortness of breath. Some people infected with the virus have reported experiencing other non-respiratory symptoms. Other people, referred to as asymptomatic cases, have experienced no symptoms at all.

According to the CDC, symptoms of COVID-19 may appear in as few as 2 days or as long as 14 days after exposure.
How COVID-19 Spreads

Although the first human cases of COVID-19 likely resulted from exposure to infected animals, infected people can spread SARS-CoV-2 to other people.

The virus is thought to spread mainly from person-to-person, including:

- Between people who are in close contact with one another (within about 6 feet).
- Through respiratory droplets produced when an infected person coughs or sneezes. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

It may be possible that a person can get COVID-19 by touching a surface or object that has SARS-CoV-2 on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the primary way the virus spreads.

People are thought to be most contagious when they are most symptomatic (i.e., experiencing fever, cough, and/or shortness of breath). Some spread might be possible before people show symptoms; there have been reports of this type of asymptomatic transmission with this new coronavirus, but this is also not thought to be the main way the virus spreads.

Although the United States has implemented public health measures to limit the spread of the virus, it is likely that some person-to-person transmission will continue to occur.

How a COVID-19 Outbreak Could Affect Workplaces

Similar to influenza viruses, SARS-CoV-2, the virus that causes COVID-19, has the potential to cause extensive outbreaks. Under conditions associated with widespread person-to-person spread, multiple areas of the United States and other countries may see impacts at the same time. In the absence of a vaccine, an outbreak may also be an extended event. As a result, workplaces may experience:

- **Absenteeism.** Workers could be absent because they are sick; are caregivers for sick family members; are caregivers for children if schools or day care centers are closed; have at-risk people at home, such as immunocompromised family members; or are afraid to come to work because of fear of possible exposure.

- **Change in patterns of commerce.** Consumer demand for items related to infection prevention (e.g., respirators) is likely to increase significantly, while consumer interest in other goods may decline. Consumers may also change shopping patterns because of a COVID-19 outbreak. Consumers may try to shop at off-peak hours to reduce contact with other people, show increased interest in home delivery services, or prefer other options, such as drive-through service, to reduce person-to-person contact.

- **Interrupted supply/delivery.** Shipments of items from geographic areas severely affected by COVID-19 may be delayed or cancelled with or without notification.

This illustration, created at the Centers for Disease Control and Prevention (CDC), reveals ultrastructural morphology exhibited by the 2019 Novel Coronavirus (2019-nCoV). Note the spikes that adorn the outer surface of the virus, which impart the look of a corona surrounding the virion, when viewed electron microscopically. This virus was identified as the cause of an outbreak of respiratory illness first detected in Wuhan, China.

*Photo: CDC / Alissa Eckert & Dan Higgins*
Steps All Employers Can Take to Reduce Workers’ Risk of Exposure to SARS-CoV-2

This section describes basic steps that every employer can take to reduce the risk of worker exposure to SARS-CoV-2, the virus that causes COVID-19, in their workplace. Later sections of this guidance—including those focusing on jobs classified as having low, medium, high, and very high exposure risks—provide specific recommendations for employers and workers within specific risk categories.

Develop an Infectious Disease Preparedness and Response Plan

If one does not already exist, develop an infectious disease preparedness and response plan that can help guide protective actions against COVID-19.

Stay abreast of guidance from federal, state, local, tribal, and/or territorial health agencies, and consider how to incorporate those recommendations and resources into workplace-specific plans.

Plans should consider and address the level(s) of risk associated with various worksites and job tasks workers perform at those sites. Such considerations may include:

■ Where, how, and to what sources of SARS-CoV-2 might workers be exposed, including:
  - The general public, customers, and coworkers; and
  - Sick individuals or those at particularly high risk of infection (e.g., international travelers who have visited locations with widespread sustained (ongoing) COVID-19 transmission, healthcare workers who have had unprotected exposures to people known to have, or suspected of having, COVID-19).

■ Non-occupational risk factors at home and in community settings.
Workers’ individual risk factors (e.g., older age; presence of chronic medical conditions, including immunocompromising conditions; pregnancy).

Controls necessary to address those risks.

Follow federal and state, local, tribal, and/or territorial (SLTT) recommendations regarding development of contingency plans for situations that may arise as a result of outbreaks, such as:

- Increased rates of worker absenteeism.
- The need for social distancing, staggered work shifts, downsizing operations, delivering services remotely, and other exposure-reducing measures.
- Options for conducting essential operations with a reduced workforce, including cross-training workers across different jobs in order to continue operations or deliver surge services.
- Interrupted supply chains or delayed deliveries.

Plans should also consider and address the other steps that employers can take to reduce the risk of worker exposure to SARS-CoV-2 in their workplace, described in the sections below.

**Prepare to Implement Basic Infection Prevention Measures**

For most employers, protecting workers will depend on emphasizing basic infection prevention measures. As appropriate, all employers should implement good hygiene and infection control practices, including:

- Promote frequent and thorough hand washing, including by providing workers, customers, and worksite visitors with a place to wash their hands. If soap and running water are not immediately available, provide alcohol-based hand rubs containing at least 60% alcohol.
- Encourage workers to stay home if they are sick.
- Encourage respiratory etiquette, including covering coughs and sneezes.
Provide customers and the public with tissues and trash receptacles.

Employers should explore whether they can establish policies and practices, such as flexible worksites (e.g., telecommuting) and flexible work hours (e.g., staggered shifts), to increase the physical distance among employees and between employees and others if state and local health authorities recommend the use of social distancing strategies.

Discourage workers from using other workers’ phones, desks, offices, or other work tools and equipment, when possible.

Maintain regular housekeeping practices, including routine cleaning and disinfecting of surfaces, equipment, and other elements of the work environment. When choosing cleaning chemicals, employers should consult information on Environmental Protection Agency (EPA)-approved disinfectant labels with claims against emerging viral pathogens. Products with EPA-approved emerging viral pathogens claims are expected to be effective against SARS-CoV-2 based on data for harder to kill viruses. Follow the manufacturer’s instructions for use of all cleaning and disinfection products (e.g., concentration, application method and contact time, PPE).

Develop Policies and Procedures for Prompt Identification and Isolation of Sick People, if Appropriate

Prompt identification and isolation of potentially infectious individuals is a critical step in protecting workers, customers, visitors, and others at a worksite.

Employers should inform and encourage employees to self-monitor for signs and symptoms of COVID-19 if they suspect possible exposure.

Employers should develop policies and procedures for employees to report when they are sick or experiencing symptoms of COVID-19.
Where appropriate, employers should develop policies and procedures for immediately isolating people who have signs and/or symptoms of COVID-19, and train workers to implement them. Move potentially infectious people to a location away from workers, customers, and other visitors. Although most worksites do not have specific isolation rooms, designated areas with closable doors may serve as isolation rooms until potentially sick people can be removed from the worksite.

Take steps to limit spread of the respiratory secretions of a person who may have COVID-19. Provide a face mask, if feasible and available, and ask the person to wear it, if tolerated. Note: A face mask (also called a surgical mask, procedure mask, or other similar terms) on a patient or other sick person should not be confused with PPE for a worker; the mask acts to contain potentially infectious respiratory secretions at the source (i.e., the person’s nose and mouth).

If possible, isolate people suspected of having COVID-19 separately from those with confirmed cases of the virus to prevent further transmission—particularly in worksites where medical screening, triage, or healthcare activities occur, using either permanent (e.g., wall/different room) or temporary barrier (e.g., plastic sheeting).

Restrict the number of personnel entering isolation areas.

Protect workers in close contact with (i.e., within 6 feet of) a sick person or who have prolonged/repeated contact with such persons by using additional engineering and administrative controls, safe work practices, and PPE. Workers whose activities involve close or prolonged/repeated contact with sick people are addressed further in later sections covering workplaces classified at medium and very high or high exposure risk.
Develop, Implement, and Communicate about Workplace Flexibilities and Protections

- Actively encourage sick employees to stay home.
- Ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.
- Talk with companies that provide your business with contract or temporary employees about the importance of sick employees staying home and encourage them to develop non-punitive leave policies.
- Do not require a healthcare provider’s note for employees who are sick with acute respiratory illness to validate their illness or to return to work, as healthcare provider offices and medical facilities may be extremely busy and not able to provide such documentation in a timely way.
- Maintain flexible policies that permit employees to stay home to care for a sick family member. Employers should be aware that more employees may need to stay at home to care for sick children or other sick family members than is usual.
- Recognize that workers with ill family members may need to stay home to care for them. See CDC’s Interim Guidance for Preventing the Spread of COVID-19 in Homes and Residential Communities: www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html.
- Be aware of workers’ concerns about pay, leave, safety, health, and other issues that may arise during infectious disease outbreaks. Provide adequate, usable, and appropriate training, education, and informational material about business-essential job functions and worker health and safety, including proper hygiene practices and the use of any workplace controls (including PPE). Informed workers who feel safe at work are less likely to be unnecessarily absent.
Work with insurance companies (e.g., those providing employee health benefits) and state and local health agencies to provide information to workers and customers about medical care in the event of a COVID-19 outbreak.

Implement Workplace Controls

Occupational safety and health professionals use a framework called the “hierarchy of controls” to select ways of controlling workplace hazards. In other words, the best way to control a hazard is to systematically remove it from the workplace, rather than relying on workers to reduce their exposure. During a COVID-19 outbreak, when it may not be possible to eliminate the hazard, the most effective protection measures are (listed from most effective to least effective): engineering controls, administrative controls, safe work practices (a type of administrative control), and PPE. There are advantages and disadvantages to each type of control measure when considering the ease of implementation, effectiveness, and cost. In most cases, a combination of control measures will be necessary to protect workers from exposure to SARS-CoV-2.

In addition to the types of workplace controls discussed below, CDC guidance for businesses provides employers and workers with recommended SARS-CoV-2 infection prevention strategies to implement in workplaces: www.cdc.gov/coronavirus/2019-ncov/specific-groups/guidance-business-response.html.

Engineering Controls

Engineering controls involve isolating employees from work-related hazards. In workplaces where they are appropriate, these types of controls reduce exposure to hazards without relying on worker behavior and can be the most cost-effective solution to implement. Engineering controls for SARS-CoV-2 include:

- Installing high-efficiency air filters.
- Increasing ventilation rates in the work environment.
- Installing physical barriers, such as clear plastic sneeze guards.
Installing a drive-through window for customer service.

Specialized negative pressure ventilation in some settings, such as for aerosol generating procedures (e.g., airborne infection isolation rooms in healthcare settings and specialized autopsy suites in mortuary settings).

**Administrative Controls**

Administrative controls require action by the worker or employer. Typically, administrative controls are changes in work policy or procedures to reduce or minimize exposure to a hazard. Examples of administrative controls for SARS-CoV-2 include:

- Encouraging sick workers to stay at home.
- Minimizing contact among workers, clients, and customers by replacing face-to-face meetings with virtual communications and implementing telework if feasible.
- Establishing alternating days or extra shifts that reduce the total number of employees in a facility at a given time, allowing them to maintain distance from one another while maintaining a full onsite work week.
- Developing emergency communications plans, including a forum for answering workers’ concerns and internet-based communications, if feasible.
- Providing workers with up-to-date education and training on COVID-19 risk factors and protective behaviors (e.g., cough etiquette and care of PPE).
- Training workers who need to use protecting clothing and equipment how to put it on, use/wear it, and take it off correctly, including in the context of their current and potential duties. Training material should be easy to understand and available in the appropriate language and literacy level for all workers.
**Safe Work Practices**

Safe work practices are types of administrative controls that include procedures for safe and proper work used to reduce the duration, frequency, or intensity of exposure to a hazard. Examples of safe work practices for SARS-CoV-2 include:

- Providing resources and a work environment that promotes personal hygiene. For example, provide tissues, no-touch trash cans, hand soap, alcohol-based hand rubs containing at least 60 percent alcohol, disinfectants, and disposable towels for workers to clean their work surfaces.
- Requiring regular hand washing or using of alcohol-based hand rubs. Workers should always wash hands when they are visibly soiled and after removing any PPE.
- Post handwashing signs in restrooms.

**Personal Protective Equipment (PPE)**

While engineering and administrative controls are considered more effective in minimizing exposure to SARS-CoV-2, PPE may also be needed to prevent certain exposures. While correctly using PPE can help prevent some exposures, it should not take the place of other prevention strategies.

Examples of PPE include: gloves, goggles, face shields, face masks, and respiratory protection, when appropriate. During an outbreak of an infectious disease, such as COVID-19, recommendations for PPE specific to occupations or job tasks may change depending on geographic location, updated risk assessments for workers, and information on PPE effectiveness in preventing the spread of COVID-19. Employers should check the OSHA and CDC websites regularly for updates about recommended PPE.

All types of PPE must be:

- Selected based upon the hazard to the worker.
- Properly fitted and periodically refitted, as applicable (e.g., respirators).
■ Consistently and properly worn when required.
■ Regularly inspected, maintained, and replaced, as necessary.
■ Properly removed, cleaned, and stored or disposed of, as applicable, to avoid contamination of self, others, or the environment.

Employers are obligated to provide their workers with PPE needed to keep them safe while performing their jobs. The types of PPE required during a COVID-19 outbreak will be based on the risk of being infected with SARS-CoV-2 while working and job tasks that may lead to exposure.

Workers, including those who work within 6 feet of patients known to be, or suspected of being, infected with SARS-CoV-2 and those performing aerosol-generating procedures, need to use respirators:

■ National Institute for Occupational Safety and Health (NIOSH)-approved, N95 filtering facepiece respirators or better must be used in the context of a comprehensive, written respiratory protection program that includes fit-testing, training, and medical exams. See OSHA’s Respiratory Protection standard, 29 CFR 1910.134 at www.osha.gov/laws-reggs/regulations/standardnumber/1910/1910.134.

■ When disposable N95 filtering facepiece respirators are not available, consider using other respirators that provide greater protection and improve worker comfort. Other types of acceptable respirators include: a R/P95, N/R/P99, or N/R/P100 filtering facepiece respirator; an air-purifying elastomeric (e.g., half-face or full-face) respirator with appropriate filters or cartridges; powered air purifying respirator (PAPR) with high-efficiency particulate arrestance (HEPA) filter; or supplied air respirator (SAR). See CDC/NIOSH guidance for optimizing respirator supplies at: www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy.
Consider using PAPRs or SARs, which are more protective than filtering facepiece respirators, for any work operations or procedures likely to generate aerosols (e.g., cough induction procedures, some dental procedures, invasive specimen collection, blowing out pipettes, shaking or vortexing tubes, filling a syringe, centrifugation).

Use a surgical N95 respirator when both respiratory protection and resistance to blood and body fluids is needed.

Face shields may also be worn on top of a respirator to prevent bulk contamination of the respirator. Certain respirator designs with forward protrusions (duckbill style) may be difficult to properly wear under a face shield. Ensure that the face shield does not prevent airflow through the respirator.

Consider factors such as function, fit, ability to decontaminate, disposal, and cost. OSHA’s Respiratory Protection eTool provides basic information on respirators such as medical requirements, maintenance and care, fit testing, written respiratory protection programs, and voluntary use of respirators, which employers may also find beneficial in training workers at: www.osha.gov/SLTC/etools/respiratory. Also see NIOSH respirator guidance at: www.cdc.gov/niosh/topics/respirators.

Respirator training should address selection, use (including donning and doffing), proper disposal or disinfection, inspection for damage, maintenance, and the limitations of respiratory protection equipment. Learn more at: www.osha.gov/SLTC/respiratoryprotection.

The appropriate form of respirator will depend on the type of exposure and on the transmission pattern of COVID-19. See the NIOSH “Respirator Selection Logic” at: www.cdc.gov/niosh/docs/2005-100/default.html or the OSHA “Respiratory Protection eTool” at www.osha.gov/SLTC/etools/respiratory.
Follow Existing OSHA Standards

Existing OSHA standards may apply to protecting workers from exposure to and infection with SARS-CoV-2.

While there is no specific OSHA standard covering SARS-CoV-2 exposure, some OSHA requirements may apply to preventing occupational exposure to SARS-CoV-2. Among the most relevant are:


- The General Duty Clause, Section 5(a)(1) of the Occupational Safety and Health (OSH) Act of 1970, 29 USC 654(a)(1), which requires employers to furnish to each worker “employment and a place of employment, which are free from recognized hazards that are causing or are likely to cause death or serious physical harm.” See: www.osha.gov/laws-regs/oshact/completeoshact.

OSHA’s Bloodborne Pathogens standard (29 CFR 1910.1030) applies to occupational exposure to human blood and other potentially infectious materials that typically do not include respiratory secretions that may transmit SARS-CoV-2. However, the provisions of the standard offer a framework that may help control some sources of the virus, including exposures to body fluids (e.g., respiratory secretions) not covered by the standard. See: www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030.
The OSHA COVID-19 webpage provides additional information about OSHA standards and requirements, including requirements in states that operate their own OSHA-approved State Plans, recordkeeping requirements and injury/illness recording criteria, and applications of standards related to sanitation and communication of risks related to hazardous chemicals that may be in common sanitizers and sterilizers. See: www.osha.gov/SLTC/covid-19/standards.html.

**Classifying Worker Exposure to SARS-CoV-2**

Worker risk of occupational exposure to SARS-CoV-2, the virus that causes COVID-19, during an outbreak may vary from very high to high, medium, or lower (caution) risk. The level of risk depends in part on the industry type, need for contact within 6 feet of people known to be, or suspected of being, infected with SARS-CoV-2, or requirement for repeated or extended contact with persons known to be, or suspected of being, infected with SARS-CoV-2. To help employers determine appropriate precautions, OSHA has divided job tasks into four risk exposure levels: very high, high, medium, and lower risk. The Occupational Risk Pyramid shows the four exposure risk levels in the shape of a pyramid to represent probable distribution of risk. Most American workers will likely fall in the lower exposure risk (caution) or medium exposure risk levels.
Very High Exposure Risk

*Very high exposure risk* jobs are those with high potential for exposure to known or suspected sources of COVID-19 during specific medical, postmortem, or laboratory procedures. Workers in this category include:

- Healthcare workers (e.g., doctors, nurses, dentists, paramedics, emergency medical technicians) performing aerosol-generating procedures (e.g., intubation, cough induction procedures, bronchoscopies, some dental procedures and exams, or invasive specimen collection) on known or suspected COVID-19 patients.

- Healthcare or laboratory personnel collecting or handling specimens from known or suspected COVID-19 patients (e.g., manipulating cultures from known or suspected COVID-19 patients).

- Morgue workers performing autopsies, which generally involve aerosol-generating procedures, on the bodies of people who are known to have, or suspected of having, COVID-19 at the time of their death.

High Exposure Risk

*High exposure risk* jobs are those with high potential for exposure to known or suspected sources of COVID-19. Workers in this category include:

- Healthcare delivery and support staff (e.g., doctors, nurses, and other hospital staff who must enter patients’ rooms) exposed to known or suspected COVID-19 patients. (Note: when such workers perform aerosol-generating procedures, their exposure risk level becomes *very high*.)

- Medical transport workers (e.g., ambulance vehicle operators) moving known or suspected COVID-19 patients in enclosed vehicles.

- Mortuary workers involved in preparing (e.g., for burial or cremation) the bodies of people who are known to have, or suspected of having, COVID-19 at the time of their death.
Medium Exposure Risk

Medium exposure risk jobs include those that require frequent and/or close contact with (i.e., within 6 feet of) people who may be infected with SARS-CoV-2, but who are not known or suspected COVID-19 patients. In areas without ongoing community transmission, workers in this risk group may have frequent contact with travelers who may return from international locations with widespread COVID-19 transmission. In areas where there is ongoing community transmission, workers in this category may have contact be with the general public (e.g., in schools, high-population-density work environments, and some high-volume retail settings).

Lower Exposure Risk (Caution)

Lower exposure risk (caution) jobs are those that do not require contact with people known to be, or suspected of being, infected with SARS-CoV-2 nor frequent close contact with (i.e., within 6 feet of) the general public. Workers in this category have minimal occupational contact with the public and other coworkers.

Jobs Classified at Lower Exposure Risk (Caution): What to Do to Protect Workers

For workers who do not have frequent contact with the general public, employers should follow the guidance for “Steps All Employers Can Take to Reduce Workers’ Risk of Exposure to SARS-CoV-2,” on page 7 of this booklet and implement control measures described in this section.

Engineering Controls

Additional engineering controls are not recommended for workers in the lower exposure risk group. Employers should ensure that engineering controls, if any, used to protect workers from other job hazards continue to function as intended.
Administrative Controls

- Monitor public health communications about COVID-19 recommendations and ensure that workers have access to that information. Frequently check the CDC COVID-19 website: www.cdc.gov/coronavirus/2019-ncov.
- Collaborate with workers to designate effective means of communicating important COVID-19 information.

Personal Protective Equipment

Additional PPE is not recommended for workers in the lower exposure risk group. Workers should continue to use the PPE, if any, that they would ordinarily use for other job tasks.

Jobs Classified at Medium Exposure Risk: What to Do to Protect Workers

In workplaces where workers have medium exposure risk, employers should follow the guidance for “Steps All Employers Can Take to Reduce Workers’ Risk of Exposure to SARS-CoV-2,” on page 7 of this booklet and implement control measures described in this section.

Engineering Controls

- Install physical barriers, such as clear plastic sneeze guards, where feasible.

Administrative Controls

- Consider offering face masks to ill employees and customers to contain respiratory secretions until they are able leave the workplace (i.e., for medical evaluation/care or to return home). In the event of a shortage of masks, a reusable face shield that can be decontaminated may be an acceptable method of protecting against droplet transmission. See CDC/NIOSH guidance for optimizing respirator supplies, which discusses the use of surgical masks, at: www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy.
Keep customers informed about symptoms of COVID-19 and ask sick customers to minimize contact with workers until healthy again, such as by posting signs about COVID-19 in stores where sick customers may visit (e.g., pharmacies) or including COVID-19 information in automated messages sent when prescriptions are ready for pick up.

Where appropriate, limit customers’ and the public’s access to the worksite, or restrict access to only certain workplace areas.

Consider strategies to minimize face-to-face contact (e.g., drive-through windows, phone-based communication, telework).

Communicate the availability of medical screening or other worker health resources (e.g., on-site nurse; telemedicine services).

**Personal Protective Equipment (PPE)**

When selecting PPE, consider factors such as function, fit, decontamination ability, disposal, and cost. Sometimes, when PPE will have to be used repeatedly for a long period of time, a more expensive and durable type of PPE may be less expensive overall than disposable PPE. Each employer should select the combination of PPE that protects workers specific to their workplace.

Workers with medium exposure risk may need to wear some combination of gloves, a gown, a face mask, and/or a face shield or goggles. PPE ensembles for workers in the medium exposure risk category will vary by work task, the results of the employer’s hazard assessment, and the types of exposures workers have on the job.

---

**High exposure risk** jobs are those with high potential for exposure to known or suspected sources of COVID-19.

**Very high exposure risk** jobs are those with high potential for exposure to known or suspected sources of COVID-19 during specific medical, postmortem, or laboratory procedures that involve aerosol generation or specimen collection/handling.
In rare situations that would require workers in this risk category to use respirators, see the PPE section beginning on page 14 of this booklet, which provides more details about respirators. For the most up-to-date information, visit OSHA’s COVID-19 webpage: www.osha.gov/covid-19.

Jobs Classified at High or Very High Exposure Risk: What to Do to Protect Workers

In workplaces where workers have high or very high exposure risk, employers should follow the guidance for “Steps All Employers Can Take to Reduce Workers’ Risk of Exposure to SARS-CoV-2,” on page 7 of this booklet and implement control measures described in this section.

Engineering Controls

- Ensure appropriate air-handling systems are installed and maintained in healthcare facilities. See “Guidelines for Environmental Infection Control in Healthcare Facilities” for more recommendations on air handling systems at: www.cdc.gov/mmwr/preview/mmwrhtml/rr5210a1.htm.
- CDC recommends that patients with known or suspected COVID-19 (i.e., person under investigation) should be placed in an airborne infection isolation room (AIIR), if available.
- Use isolation rooms when available for performing aerosol-generating procedures on patients with known or suspected COVID-19. For postmortem activities, use autopsy suites or other similar isolation facilities when performing aerosol-generating procedures on the bodies of people who are known to have, or suspected of having, COVID-19 at the time of their death. See the CDC postmortem guidance at: www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-postmortem-specimens.html. OSHA also provides guidance for postmortem activities on its COVID-19 webpage: www.osha.gov/covid-19.
Use special precautions associated with Biosafety Level 3 when handling specimens from known or suspected COVID-19 patients. For more information about biosafety levels, consult the U.S. Department of Health and Human Services (HHS) “Biosafety in Microbiological and Biomedical Laboratories” at www.cdc.gov/biosafety/publications/bmbl5.

**Administrative Controls**

If working in a healthcare facility, follow existing guidelines and facility standards of practice for identifying and isolating infected individuals and for protecting workers.

- Develop and implement policies that reduce exposure, such as cohorting (i.e., grouping) COVID-19 patients when single rooms are not available.
- Post signs requesting patients and family members to immediately report symptoms of respiratory illness on arrival at the healthcare facility and use disposable face masks.
- Consider offering enhanced medical monitoring of workers during COVID-19 outbreaks.
- Provide all workers with job-specific education and training on preventing transmission of COVID-19, including initial and routine/refresher training.
- Ensure that psychological and behavioral support is available to address employee stress.

**Safe Work Practices**

- Provide emergency responders and other essential personnel who may be exposed while working away from fixed facilities with alcohol-based hand rubs containing at least 60% alcohol for decontamination in the field.
Personal Protective Equipment (PPE)

Most workers at high or very high exposure risk likely need to wear gloves, a gown, a face shield or goggles, and either a face mask or a respirator, depending on their job tasks and exposure risks.

Those who work closely with (either in contact with or within 6 feet of) patients known to be, or suspected of being, infected with SARS-CoV-2, the virus that causes COVID-19, should wear respirators. In these instances, see the PPE section beginning on page 14 of this booklet, which provides more details about respirators. For the most up-to-date information, also visit OSHA’s COVID-19 webpage: www.osha.gov/covid-19.

PPE ensembles may vary, especially for workers in laboratories or morgue/mortuary facilities who may need additional protection against blood, body fluids, chemicals, and other materials to which they may be exposed. Additional PPE may include medical/surgical gowns, fluid-resistant coveralls, aprons, or other disposable or reusable protective clothing. Gowns should be large enough to cover the areas requiring protection. OSHA may also provide updated guidance for PPE use on its website: www.osha.gov/covid-19.

NOTE: Workers who dispose of PPE and other infectious waste must also be trained and provided with appropriate PPE.

The CDC webpage “Healthcare-associated Infections” (www.cdc.gov/hai) provides additional information on infection control in healthcare facilities.

Workers Living Abroad or Travelling Internationally

Employers with workers living abroad or traveling on international business should consult the “Business Travelers” section of the OSHA COVID-19 webpage (www.osha.gov/covid-19), which also provides links to the latest:
Employers should communicate to workers that the DOS cannot provide Americans traveling or living abroad with medications or supplies, even in the event of a COVID-19 outbreak.

As COVID-19 outbreak conditions change, travel into or out of a country may not be possible, safe, or medically advisable. It is also likely that governments will respond to a COVID-19 outbreak by imposing public health measures that restrict domestic and international movement, further limiting the U.S. government’s ability to assist Americans in these countries. It is important that employers and workers plan appropriately, as it is possible that these measures will be implemented very quickly in the event of worsening outbreak conditions in certain areas.

More information on COVID-19 planning for workers living and traveling abroad can be found at: www.cdc.gov/travel.

For More Information

Federal, state, and local government agencies are the best source of information in the event of an infectious disease outbreak, such as COVID-19. Staying informed about the latest developments and recommendations is critical, since specific guidance may change based upon evolving outbreak situations.

Below are several recommended websites to access the most current and accurate information:

- Occupational Safety and Health Administration website: www.osha.gov
- Centers for Disease Control and Prevention website: www.cdc.gov
- National Institute for Occupational Safety and Health website: www.cdc.gov/niosh
OSHA Assistance, Services, and Programs

OSHA has a great deal of information to assist employers in complying with their responsibilities under OSHA law. Several OSHA programs and services can help employers identify and correct job hazards, as well as improve their safety and health program.

Establishing a Safety and Health Program

Safety and health programs are systems that can substantially reduce the number and severity of workplace injuries and illnesses, while reducing costs to employers.

Visit www.osha.gov/safetymanagement for more information.

Compliance Assistance Specialists

OSHA compliance assistance specialists can provide information to employers and workers about OSHA standards, short educational programs on specific hazards or OSHA rights and responsibilities, and information on additional compliance assistance resources.

Visit www.osha.gov/complianceassistance/cas or call 1-800-321-OSHA (6742) to contact your local OSHA office.

No-Cost On-Site Safety and Health Consultation Services for Small Business

OSHA’s On-Site Consultation Program offers no-cost and confidential advice to small and medium-sized businesses in all states, with priority given to high-hazard worksites. On-Site consultation services are separate from enforcement and do not result in penalties or citations.

For more information or to find the local On-Site Consultation office in your state, visit www.osha.gov/consultation, or call 1-800-321-OSHA (6742).
Under the consultation program, certain exemplary employers may request participation in OSHA’s Safety and Health Achievement Recognition Program (SHARP). Worksites that receive SHARP recognition are exempt from programmed inspections during the period that the SHARP certification is valid.

**Cooperative Programs**

OSHA offers cooperative programs under which businesses, labor groups and other organizations can work cooperatively with OSHA. To find out more about any of the following programs, visit www.osha.gov/cooperativeprograms.

**Strategic Partnerships and Alliances**

The OSHA Strategic Partnerships (OSP) provide the opportunity for OSHA to partner with employers, workers, professional or trade associations, labor organizations, and/or other interested stakeholders. Through the Alliance Program, OSHA works with groups to develop compliance assistance tools and resources to share with workers and employers, and educate workers and employers about their rights and responsibilities.

**Voluntary Protection Programs (VPP)**

The VPP recognize employers and workers in the private sector and federal agencies who have implemented effective safety and health programs and maintain injury and illness rates below the national average for their respective industries.

**Occupational Safety and Health Training**

OSHA partners with 26 OSHA Training Institute Education Centers at 37 locations throughout the United States to deliver courses on OSHA standards and occupational safety and health topics to thousands of students a year. For more information on training courses, visit www.osha.gov/otiec.
OSHA Educational Materials

OSHA has many types of educational materials to assist employers and workers in finding and preventing workplace hazards.

All OSHA publications are free at www.osha.gov/publications and www.osha.gov/ebooks. You can also call 1-800-321-OSHA (6742) to order publications.

Employers and safety and health professionals can sign-up for QuickTakes, OSHA’s free, twice-monthly online newsletter with the latest news about OSHA initiatives and products to assist in finding and preventing workplace hazards. To sign up, visit www.osha.gov/quicktakes.

OSHA Regional Offices

Region 1
Boston Regional Office
(CT*, ME*, MA, NH, RI, VT*)
JFK Federal Building
25 New Sudbury Street, Room E340
Boston, MA 02203
(617) 565-9860 (617) 565-9827 Fax

Region 2
New York Regional Office
(NJ*, NY*, PR*, VI*)
Federal Building
201 Varick Street, Room 670
New York, NY 10014
(212) 337-2378 (212) 337-2371 Fax

Region 3
Philadelphia Regional Office
(DE, DC, MD*, PA, VA*, WV)
The Curtis Center
170 S. Independence Mall West, Suite 740 West
Philadelphia, PA 19106-3309
(215) 861-4900 (215) 861-4904 Fax
Region 4
Atlanta Regional Office
(AL, FL, GA, KY*, MS, NC*, SC*, TN*)
Sam Nunn Atlanta Federal Center
61 Forsyth Street, SW, Room 6T50
Atlanta, GA 30303
(678) 237-0400 (678) 237-0447 Fax

Region 5
Chicago Regional Office
(IL*, IN*, MI*, MN*, OH, WI)
John C. Kluczynski Federal Building
230 South Dearborn Street, Room 3244
Chicago, IL 60604
(312) 353-2220 (312) 353-7774 Fax

Region 6
Dallas Regional Office
(AR, LA, NM*, OK, TX)
A. Maceo Smith Federal Building
525 Griffin Street, Room 602
Dallas, TX 75202
(972) 850-4145 (972) 850-4149 Fax

Region 7
Kansas City Regional Office
(IA*, KS, MO, NE)
Two Pershing Square Building
2300 Main Street, Suite 1010
Kansas City, MO 64108-2416
(816) 283-8745 (816) 283-0547 Fax

Region 8
Denver Regional Office
(CO, MT, ND, SD, UT*, WY*)
Cesar Chavez Memorial Building
1244 Speer Boulevard, Suite 551
Denver, CO 80204
(720) 264-6550 (720) 264-6585 Fax
Region 9
San Francisco Regional Office
(AZ*, CA*, HI*, NV*, and American Samoa, Guam and the Northern Mariana Islands)
San Francisco Federal Building
90 7th Street, Suite 2650
San Francisco, CA 94103
(415) 625-2547 (415) 625-2534 Fax

Region 10
Seattle Regional Office
(AK*, ID, OR*, WA*)
Fifth & Yesler Tower
300 Fifth Avenue, Suite 1280
Seattle, WA 98104
(206) 757-6700 (206) 757-6705 Fax

*These states and territories operate their own OSHA-approved job safety and health plans and cover state and local government employees as well as private sector employees. The Connecticut, Illinois, Maine, New Jersey, New York and Virgin Islands programs cover public employees only. (Private sector workers in these states are covered by Federal OSHA). States with approved programs must have standards that are identical to, or at least as effective as, the Federal OSHA standards.

Note: To get contact information for OSHA area offices, OSHA-approved state plans and OSHA consultation projects, please visit us online at www.osha.gov or call us at 1-800-321-OSHA (6742).
How to Contact OSHA

Under the Occupational Safety and Health Act of 1970, employers are responsible for providing safe and healthful workplaces for their employees. OSHA’s role is to help ensure these conditions for America’s working men and women by setting and enforcing standards, and providing training, education and assistance. For more information, visit www.osha.gov or call OSHA at 1-800-321-OSHA (6742), TTY 1-877-889-5627.

For assistance, contact us. We are OSHA. We can help.
Emergency Preparedness requires a Communications Plan

Skilled Nursing and Post-Acute Care Centers, Assisted Living Communities, and Centers for Individuals with Intellectual or Developmental Disabilities
Emergency Preparedness requires a Communications Plan

Because the parts of an Emergency Preparedness plan are interrelated, having a comprehensive plan is essential. Yet one problematic area of emergency planning, especially in health care settings (skilled and post-acute care centers, assisted living communities, and ID/DD centers), is the Communications plan. Transparent and accurate communications with stakeholders, especially the media, during and after a crisis contributes to a successful resolution of the problem, including a positive evaluation by stakeholders and the public.

The Communications plan – consisting of policies, procedures, and an incident command structure -- is the primary tool management has to ensure employees follow protocols during an emergency in contacting stakeholders, the media, and others. The Media Outreach plan is an essential part of the Communications plan (see below).

To help set management on the right path to developing a communications plan, the following six-point outline can be a guide in the process of creating or modifying emergency preparedness communications procedures. Using these six steps will help management gauge when emergency preparedness is on solid footing.

Communications Plan: Scope and Severity

During an emergency (or “incident”), the Communications plan should govern all communications within an organization and with external stakeholders, including the media. However, the plan needs flexibility; an organization’s management may only need a portion of the incident command structure, depending on the scope and severity of the emergency, such as an elopement versus a natural disaster (hurricane, wildfires etc.). Irrespective of the emergency’s intensity, the organization’s emergency response team stays in a communications mode, appropriate to the situation, for the duration of the incident, as well as after, to ensure transparency throughout the process.

1. Form a Team

An early step in emergency preparedness is to designate an Emergency Communications Team (ECT), or person, as part of a broader Incident Management Team. Typically the ECT will consist of the organization’s leadership; with the Administrator or Executive Director, or CEO in the lead and designated “Commander.” But any staff can fill any position on the ECT. (For more on a typical chain of command see information on the Nursing Home Incident Command Structure.) The first goal of the ECT is to evaluate the scope and severity of the event, gather accurate information about it, and report back to the Commander and other ECT members.

In an emergency there may be limited or conflicting information about the event or its impact. “Facts” matter and may change several times as new information is available. Thus, the ECT
team needs training and practice in evaluating and communicating accurate details about the emergency.

Planning and practicing for typical scenarios and a variety of magnitudes of events is a keystone to a successful outcome in an actual emergency. When an emergency strikes, the organization’s staff responders and spokesperson should know instinctively what to do and how to report “up the chain of command.”

2. Plan Ahead

With the ECT in place, the incident Commander and spokesperson should quickly begin to develop communications, like a press statement or interview notes, that accurately address anticipated (or specific) questions from stakeholder groups, including the news media. In planning for emergencies, an important role for the ECT is to develop templates of materials to make outreach more efficient in the early stages of a crisis.

In an actual emergency, the ECT should have pre-existing template materials, modified to suit the situation at hand and tailored to various stakeholders (groups and individuals). The ECT needs to coordinate distribution of consistent messages across all stakeholder groups. This works well when a specific person is the designated the official spokesperson. He or she will work with the Commander to finalize internal and external comments related to the emergency to ensure accuracy and consistency of all messages. (See more under Media Outreach.)

To kick start the ECT in working on the Communications plan, here are a few initial projects members can do:

- Check records of resident relocation and staff contacts for accuracy
- Prepare a memo to update staff on the emergency preparedness plan
- Practice how to handle media inquiries, including social media
- Practice how to handle inquiries from families (who may be in a panic)
- Brainstorm possible scenarios/responses

3. Know the Stakeholders

As tempting as it may be, management should not rely exclusively on one way to communicate (e.g. telephone) their statements and messages. There should always be options in a plan for using alternate communications channels -- like text, wired telephone, cell phone, Internet, etc.

A key task of the ECT is to develop a priority list of stakeholders to contact in various scenarios, depending on the severity or scope of the event (e.g. elopement, hurricane).

- First responders (911, EMS, fire, police)
- Utility companies (power, water, gas)
- Residents and families
• Employees, volunteers, and families
• News media (print, broadcast, internet)
• Regulators (local/state/federal), elected officials, etc.
• Corporate management (up the chain of command)
• Neighbors living near the facility
• State health care associations and others

4. Know How to Contact Stakeholders
Have the ECT compile contact information for each stakeholder group and individuals; try to acquire multiple ways to contact them. The ECT should establish a policy schedule to update all lists. Other factors include:

• Keep duplicates in digital and hard copy form
• Copies of lists should be available at alternate evacuation sites along with other emergency resources
• Secure lists to protect confidential information and make it available only to authorized users

5. Communication Channels
One person should have final approval of all official statements. Ideally, that person is the Commander, working with the spokesperson. Following are typical channels to disseminate a statement or other communications to stakeholders:

• Press conference with press statement
• Interview with the media
• Telephone
  o Emergency hotline
  o Phone chain
  o Live interview
• Email
• In-facility briefing
• Social media (Facebook/Twitter/YouTube)
• Web site

6. Honor Confidentiality
Brief the ECT on HIPAA compliance and employment law to ensure confidentiality of covered information. Remind staff not to speculate or discuss an event, especially with media.
Conclusion

In an emergency, the need to react appropriately is immediate, followed by the need to communicate about it. An organization must know its stakeholders and how to communicate with them in advance of ever needing to actually do it. It is critical that organization leadership is prepared, and staff is empowered, to deal with a situation when it happens. There’s never any time to lose when trying to preserve life and property. Staff training is a necessity.

Lack of preparedness in an emergency has many markers, including:

- Emergency responses are slow and most likely inadequate
- Residents, patients and staff are unnecessarily harmed or stressed out
- Stakeholders, including families, are uninformed and probably agitated
- Local media outlets are out of the loop
- The crisis lingers long beyond the time required to bring it to a conclusion

For an organization identified as being unprepared, public opinion will drop and damage its good name (brand). To the public, poor performance in an emergency is a serious breach of an organization’s commitment to caring for people.

Preparing diligently for emergencies is serious business. It can save lives and property, enhances a community’s goodwill, and may even save your career.

Emergency Preparedness Today

The Media Plan

The key ingredient for dealing effectively with an emergency is through preparing, or updating, a Media plan as part of a Communications plan. There is not time to “figure it out” when an emergency strikes; it is critical to respond quickly and deal with the situation transparently and provide information and answers in a coherent, consistent way. As a rule of thumb, an organization’s leadership should release a statement in an hour or so of being contacted by the media about an emergency.

Developing the Media Plan

A media plan should include policies on how, when and who is designated to talk with the media (see section on “spokesperson”), the surrounding community, residents, families, and the staff. Everyone on staff should be aware of who the authorized spokesperson is and how and when to contact him or her. Disseminate the overall communications plan to all employees.

To develop a media plan, start with these basic steps:

1. To prepare, an organization needs to pre-draft emergency statements that incorporate relevant language or concepts from the organization’s mission statement (i.e. “importance of resident safety”); identify who to quote as part of this process. Just leave space to fill...
in specific details related to the emergency. Use these statements for any type or level of emergency or activity that generates media interest.

2. Make a comprehensive list of the radio, television, newspapers (weeklies and shoppers too!), senior publications and websites covering the profession in the area. Add the names and titles of key contacts and include web addresses, intranet sites, or other mass notification systems such as group e-mail lists, text messages, and social media as a way to distribute statements and updates.

3. Prepare several media “kits.” The kit should be in a folder containing a brief history of the organization and general information about the company. In an emergency, there won’t be time for anyone to prepare media materials from scratch.

**Identify Spokesperson**

The organization should identify at least two staff members to be a primary and substitute spokesperson. Ideally, spokespersons should be staff members who are, or can become, familiar with the organization’s operations, policies, procedures, and history.

Seriously consider that the executive director/administrator may not always be the best primary spokesperson. A top leader needs to manage a difficult environment and may not be available to properly handle the media or arrange interviews.

If a staff person is already involved with the media (e.g. community events), he, or she, may be best suited to fill the spokesperson’s role. After identifying and training spokespeople, post their contact information, such as office and cell phone numbers and e-mail addresses, in a place where staff can easily access it.

Task the spokesperson with gathering information about an emergency and to answer basic questions from the media and others regarding what is going on. To do this properly, and expeditiously, the spokesperson should:

- Have access to senior management to understand the situation and its ramifications
- Know basic statistics about the organization, and larger parent company, such as the number of residents, census data (number of beds, units, etc.), the number of employees, and a general outline of the company and its mission statement.
- Release information or clarifying points of fact; arrange for the release of a statement, or arrange interviews or tapings by the media.

If there is not a designated spokesperson, perceptions of the emergency may become a media circus; a crisis unto itself. If the organization fails to cooperate, such as stating “no comment” to questions about the emergency, assume that reporters will attempt to interview anyone, even residents, who may be willing to talk about of the situation without regard to accuracy.
In summary, the time to formulate an emergency communications plan is not when an emergency occurs; there just is not time to formulate an emergency preparedness plan. So prep the ECT in advance; compile and update media lists frequently; have several media kits prepared in advance; and make sure staff knows the correct procedures to follow.

**A Word about Today’s Media**

When writing a media plan be sure to include the internet and social media.

Consider the organization’s web page (“home page”) as a first step in the communications process. In an emergency, the media and the public will flock to a web site for news and basic information about the organization. So, make sure the mission statement is readily available, along with a brief history and current facts (total beds, staff, etc.) about the organization. Basically, be transparent about the organization.

Be sure the designated spokesperson regularly uses and updates all social media accounts, such as Facebook. It’s important to post information to social networks several times a week to keep followers engaged in the organization’s web site.

**The Bottom Line**

The bottom line is that with an Emergency Preparedness plan, along with a strong Communications and Media plan, any organization can deal with an emergency, preserve life and property, and possibly enhance its reputation in the public’s mind.

**END**
Acknowledgements

This toolkit was developed by the Missouri Health Care Association with information provided by the Centers for Disease Control (CDC), Centers for Medicare and Medicaid (CMS), Department of Health and Senior Services (DHSS), American Health Care Association/National Center for Assisted Living (AHCA/NCAL) and in cooperation with other state health care associations.

ABOUT THE MISSOURI HEALTH CARE ASSOCIATION
The Missouri Health Care Association (MHCA) is the largest long term care trade association in Missouri. MHCA serves the entire continuum of care with a diverse membership of skilled nursing facilities, intermediate care facilities, assisted living facilities, residential care facilities, adult day care, home health and hospice. With over 330 facility members, MHCA represents approximately two thirds of the long term care community and over 25,000+ long term care employees. MHCA is dedicated to ensuring and sustaining the high quality of care provided to Missouri’s vulnerable population in long term care facilities. For more information about the Missouri Health Care Association, visit www.mohealthcare.com.

# # #