

# COVID-19 Frequently Asked Questions

*A resource prepared for members of LeadingAge Ohio*

Last updated: [April 9](#), 2020. This version of our FAQs includes additions from the March 20 all-member call, as well as significant reorganization and renumbering of items, to improve readability. Additions and changes from the previous version are underlined and in red.

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## Personal Protective Equipment (PPE)

### PPE1. Q. Our facility is nearing exhaustion of certain PPE. Who should we reach out to?

**PPE1. A.** On April 3, ODH provided a Resource Request Guidance document that directs facilities to request supplies from the county EMA. The EMA will request the following information: Details about the incident/situation • The gap between existing resources and what is needed to handle the incident/situation • Details about how you have tried to fill that gap locally (asked for volunteers; reached out to the local business community, attempts to purchase goods, etc.). Utilize the Ohio County EMA Directory to find the respective county's contact information.

On April 7, ODH created a new request for information (RFI) survey. The changes to this survey will allow accurate projections and allocations of PPE and supplies to occur. The survey will go out daily through the EIDC system and other mechanisms. For this first survey ODH is requesting results by Thursday April 9, 2020 at 5:00pm. The survey at this time is voluntary. ODH has stressed the importance of doing this survey every day. The link will remain the same each day. <https://www.surveymonkey.com/r/88R2KSD>

In addition, the CDC has a webpage specific for healthcare that provides guidance on [Optimizing the Supply of Personal Protective Equipment and Equipment.](#)

*Last updated 4/7/20*

### PPE2. Q. I haven't had success in finding PPE resources with my local department of health or EMA. What should I do next?

**PE2. A.** Ensure you are reaching out to the correct EMA contact which can be found in this [Emergency Management Agency \(EMA\) Directory](#). Some [LeadingAge Ohio](#) members have had success with outside-of-the-box solutions, like the [University of Wisconsin's Maker Space](#), which has made available to the public the specs for fabrication of face shields, and connected buyers with manufacturers nationwide.

Finally, both Value First and LinkAge have remained engaged in the sourcing supplies for members. Please reach out to Annette Hutchins ([AHutchins@linkageconnect.com](mailto:AHutchins@linkageconnect.com)) or Denise May ([dmay@leadingagewi.org](mailto:dmay@leadingagewi.org)) for information on various supplies.

Utilizing the Battelle N95 decontamination system will also assist in conserving of supplies. A facility can set up this contract by going to the [Battelle website](#). A facility just needs to complete the [Contact a Battelle COVID19 Expert](#) questionnaire. The facility will then receive all the info they need in an email to initiate the contract.

*Last updated 4/7/20*

### PPE 3. Q. Do you have a brief document that explains whether the use of standard masks is acceptable as long as breathing treatments are not being administered?

**PPE 3. A.** The Ohio Department of Health’s Guidance for Utilizing and Optimizing Person Protective Equipment instructs staff to wear surgical/medical facemask while working to avoid asymptomatic transmission of COVID-19 to residents and other staff. was released on April 1 in a Health Alert. The alert also recommends using the CDC Strategies for Optimizing the Supply of PPE and Equipment.

The CDC Strategies for Optimizing the Supply of N95 Respirators provides the following guidance: HCP should be educated on the use of N95 respirators when caring for patients managed with airborne precautions, and other instances for respirator use, such as the performance of aerosol generating procedures.

*Last updated 4/7/20*

**PPE4. Q. Is there a formula to use to calculate your PPE utilization rate?**

**PPE4. A.** On March 24, the CDC provided a Personal Protective Equipment (PPE) Burn Rate Calculator. This tool assists healthcare facilities in planning and optimizing the use of PPE for response to coronavirus disease 2019 (COVID-19). A good practice is to identify one or two people to manage and distribute supplies.

*Last updated 4/7/20*

**PPE5. Q. Staff are concerned about protection without N95 masks if we have a suspected COVID-19 patient. They feel without this it’s like “sending a firefighter into a fire dressed in a bikini.” I’ve reviewed the guidance on conserving PPE but I’m struggling with this when I see the drive thru testing facilities with the workers in overall hoods and a full mask. Please advise.**

**PPE5. A.** The World Health Organization on March 3, warned of the PPE shortage and called on industry and governments to increase manufacturing by 40% to meet demand. One of the best ways to protect staff is to know your inventory, utilization, and availability of PPE. The Ohio Department of Health and the Ohio Hospital Association [sent a letter to providers](#) on March 12, recommending for the immediate actions for the conservation of PPE. The CDC has a webpage on [strategies on optimizing the supply of PPE](#). Strategies such as reducing face-to-face encounters, limiting non-essential personnel, and utilizing telemedicine will conserve PPE, allowing it to be available for the direct care staff.

Also refer to the April 3, ODH Resource Request Guidance document that directs facilities to request supplies from the county EMA.

*Last updated 4/7/20*

**PPE6. Q. How are you advising organizations whose staff typically wear masks during their daily roles in the building. Are members allowing for cloth/reusable masks?**

**PPE6. A.** Homemade cloth/sewn masks are not a substitute for procedure/surgical masks but can be used when those masks are unavailable. The CDC provides optimization strategies for crisis management with PPE, including: *In “Settings where facemasks are not available, HCP might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort.”*

*Last updated 4/7/20*

**PPE9. Q. Are staff supposed to wear surgical masks during the entire shift?**

**PPE9. A.** Yes, according to [guidance from the Ohio Department of Health](#), it is recommended that all staff in long-term care facilities wear a surgical/medical facemask while working to avoid asymptomatic transmission of COVID-19 to residents and other staff. **This includes facilities not known to be affected by COVID-19.** • ODH provides guidance for when facemasks are not available. Healthcare personnel (HCP) might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort. However, homemade masks are not considered PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option. Homemade masks should ideally be used in combination with a face shield that covers the entire front (that extends to the chin or below) and sides of the face.

The CDC speaks to this in the [Strategies for Optimizing the Supply of PPE](#). Facemasks should be discarded if soiled.

*Last updated 4/7/20*

**PPE10. Q. What is the recommendations on reuse of disposable surgical masks?**

**PPE10. A.** We encourage you to review the contingency strategy on the [CDC website](#), which includes recommendations related to multiple patient encounters, as well as what steps health care personnel should take to extend the life of a mask. In the [additional documents sent to nursing homes by ODH on April 1](#), there is guidance on how to maintain the masks as to not contaminate other areas, storing it in a paper bag between uses.

*Last updated 4/6/20*

## Infection Control

**IC1. Q. I have not seen a clear answer on the policy for employees returning to work who have come in contact with someone in the community who is being tested for COVID-19. I've seen policies for health care personnel who have come in contact with patients who are being tested, but what about an employee who says their friend that they spent time with five days ago is now being tested?**

**IC1. A.** The interim guidance for [healthcare personnel with potential exposure](#) by the CDC assists healthcare facilities in making work restrictions based on a risk assessment. The local health department also needs to be contacted in this situation. The local health department will have information on testing criteria and the current community spread situation and will provide guidance accordingly.

*Last updated 4/7/20*

**IC2. Q. Should employees that have traveled out of state be allowed to return to work?**

**IC2. A.** [The Ohio Department of Health Stay at Home Order requires an individual who has traveled out of state to self quarantine for 14 days.](#)

*Last updated 4/7/20*

**IC3. Q. We currently do not have any suspected or known COVID19 residents. However, in the event that we experience this in the future, we would like to know if there are any recommendations regarding how to isolate them.**

**IC3. A.** Utilize the [Preparing for COVID-19](#) guidance which state:

If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community,

- Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
- Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement.
- Facilities should notify the health department immediately and follow the [Interim Infection Prevention and Control Recommendations for Patients with COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings](#), which includes detailed information regarding recommended PPE.

Additionally, LeadingAge Ohio encourages members to consider designating a space/wing in their facility for caring for COVID-19 patients. Doing so will further reduce likelihood of transmission and help to conserve precious PPE.

*Last updated 3/27/20*

**IC4. Q. What are the recommendations in regard to mailed packages and personal items dropped off at nursing facilities and assisted living for residents?**

**IC4. A.** On March 17, the United States Postal Service put out a statement saying there was no evidence COVID-19 is being spread through the mail. The message was based on CDC, WHO, and the Surgeon General's guidance. The statement included the following CDC, "in general, because of poor survivability of these coronaviruses on surfaces, there is likely very low risk of spread from products or packaging that are shipped over a period of days or weeks at ambient temperatures. Coronaviruses are generally thought to be spread most often by respiratory droplets."

Facilities should develop a drop off protocol that allows the staff member to stay six feet away from the person delivering mail or packages.

LeadingAge Ohio encourages organizations to remind staff to wash their hands after handling the mail. Organizations may choose, as an added precaution, to have staff handle mail using gloves. Additional consideration should be given to the availability of PPE.

*Last updated 3/27/20*

**IC5. Q. Is it okay to disinfect packages prior to them entering a nursing facility?**

**IC5. A.** There has been no guidance on this point to date, and processing packages in this way may be seen as tampering with mail. One strategy is to limit the number of individuals who touch a package and more importantly, stay six feet away from the person delivering the package, as COVID-19 is mostly likely to be spread by droplets.

*Last updated 3/27/20*

**IC6. Q. Do we know how long the virus lives on different surfaces?**

**IC6. A.** The National Institutes of Health in their March 17 news release addressed how long coronavirus is stable on surfaces. The release stated: the virus that causes coronavirus disease 2019 (COVID-19) is stable for several hours to days in aerosols and on surfaces, according to a new study from National Institutes of Health, CDC, UCLA and Princeton University scientists in The New England Journal of Medicine. The scientists found that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

was detectable in aerosols for up to three hours, up to four hours on copper, up to 24 hours on cardboard and up to two to three days on plastic and stainless steel.

*Last updated 3/27/20*

**IC7. Q. Is there an approved sanitizer/cleaner to put in carpet extractors for cleaning carpets in hallways, other care areas?**

**IC7. A.** The CDC provides the following guidance: For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. The CDC provides [environmental cleaning and disinfection recommendations](#). The above guidance on soft surfaces can be found in the [Interim Guidance for Environmental Cleaning and Disinfection for U.S. Households with Suspected or Confirmed Coronavirus Disease 2019](#).

*Last updated 3/27/20*

**IC8. Q. Is alcohol 70% or greater (like isopropyl alcohol 70% to 99%) approved for long-term care use for COVID-19? Also, is there a wet time indicated for alcohol 70% or greater? Our research is that alcohol based hand sanitizers indicate that 20 seconds of rubbing the hand sanitizer on hands is effective, but it would be nice to find an approved providing guidance for isopropyl alcohol on a cotton ball or cotton pad.**

**IC8. A.** Alcohol-based hand rub with 60% ethanol or 70% isopropanol is effective and approved for long-term care. The CDC has provided [hand sanitation and Alcohol Based Hand Rub guidance](#) for healthcare personnel. Healthcare Personnel should perform hand hygiene by using ABHR or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR. This guidance is in [the interim Infection Prevention and Control Recommendations for Patients with confirmed or suspected Coronavirus \(COVID-19\) in Healthcare Settings](#)

*Last updated 3/27/20*

**IC9. Q. Is there any guidance you can offer on using china versus carryout containers?**

**IC9. A.** Nursing homes are already held to a high food sanitation standard in the [Requirements of Participation](#). The purpose of this high standard is to assume all dishes are potentially contaminated and Universal Precautions should be maintained. Using china will hold food to the correct temperature. The use of china also creates a dignified dining/meal experience. Review your organizations dish washing policy to ensure it meets the following F-tag 812 requirements:

- Machine Washing and Sanitizing - Dishwashing machines use either heat or chemical sanitization methods. Manufacturer's instructions must always be followed. The following are general recommendations according to the U.S.

Department of Health and Human Services, Public Health Services, Food and Drug Administration Food Code for each method.

- High Temperature Dishwasher (heat sanitization):
  - Wash - 150-165 degrees F; Final Rinse - 180 degrees F; (160 degrees F at the rack level/dish surface reflects 180 degrees F at the manifold, which is the area just before the final rinse nozzle where the temperature of the dish machine is measured); or 165 degrees F for a stationary rack, single temperature machine.
- Low Temperature Dishwasher (chemical sanitization):
  - Wash - 120 degrees F; and Final Rinse - 50 ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse.
- The chemical solution must be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines.

*Last updated 3/27/20*

**IC10. Q. Are there best practices for communicating if a **resident** is diagnosed with COVID19? We want to be prepared for if/when this situation arises.**

**IC10. A.** LeadingAge has prepared this for a media statement when a resident is diagnosed, which providers may use in communication with the media:

*“Earlier today (**ORGANIZATION NAME**) discovered that one of our residents has contracted the COVID-19 Virus (Coronavirus). As the safety and well-being of the residents and patients is our foremost priority, we immediately isolated the resident to ensure essential medical treatment, and notified the State Department of Public Health of this finding. We have also notified residents, family members and staff of this discovery, and are working closely with state officials to determine that all necessary steps are taken, including potential testing of residents and staff. The patient is currently being treated at **XXX (name of facility)**, and medical officials on-site at (**ORGANIZATION NAME**) are working to determine if any other residents there have been impacted. Any other media inquiries regarding this particular patient should be referred to the State Department of Public Health.”*

*Last Updated 4/6/20*

**IC11. Q. Our local health department has indicated they no longer want to be contacted regarding suspected cases, only confirmed cases. If we have a suspected case, and the doctor doesn't want to test, what actions should we take?**



**IC11. A.** There are [three key components](#) to managing a suspected case of COVID-19. First, limit the spread by reducing physical interactions. Utilize alternative methods of communicating such as through a telephone. Use telemedicine for any scheduled follow-up appointments. Second, if in a facility, isolate the suspected person in a well ventilated private room with door closed and a private bathroom. If in a private home, have them self-isolate. Lastly, educate staff on hand hygiene and PPE, in a facility, identify cohort residents, and limit the number of staff caring for this individual.

*Last updated 3/27/20*

**IC12. Q. Should anything be done differently for new hospital admissions that do not have COVID-19, but may have come from a hospital that has positive cases?**

**IC12. A.** [The ODH provided guidance on utilizing transmission-based precautions which includes guidance on an individual coming from the hospital. The Guidance for Discontinuing Transmission-Based instructs to utilize a non-tested based strategy. The CDC provides the additional guidance Preparing for COVID-19: Long-term Care Facilities, Nursing Homes which includes guidance on managing residents with respiratory symptoms.](#)

*Last updated 4/7/20*

**IC13. Q. How long does alcohol have to be left on non-critical patient equipment to be effective?**

**IC13. A.** It can be effective after one minute, but there is concern of it being ineffective in different scenarios such as coronavirus that is in a substance (like feces), because it is harder to kill and therefore, CDC's guidance is to use an [EPA-registered product to clean non-critical patient care items](#).

On page 26 of the May 2019 update of the [Guideline for Disinfection and Sterilization in Healthcare](#), it states:

*Because the SARS coronavirus is stable in feces and urine at room temperature for at least 1–2 days, surfaces might be a possible source of contamination and lead to infection with the SARS coronavirus and should be disinfected. Until more precise information is available, environments in which SARS patients are housed should be considered heavily contaminated.*

*Last updated 3/27/20*

The CDC has provided an updated list ([List N: Disinfectants for Use Against SARS-CoV-2](#)) on March 19 for products to use for COVID-19. This list includes products and the contact times. This list represents what should be used to disinfect surfaces.

List N includes products that meet EPA's criteria for use against SARS-CoV-2, the novel coronavirus that causes the disease COVID-19.

CDC has provided the [Coronavirus Disease 2019 \(COVID-19\) Preparedness Checklist for Nursing Homes and other Long-Term](#) that includes the following recommendations for cleaning of supplies:

*Facility ensures HCP have access to EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. 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.*

*Last updated 3/27/20*

**IC14. Q. Where can I find the infection Control Survey that was developed by CMS and CDC to perform a voluntary self-assessment? This document may be requested by surveyors.**

**IC14. A.** CMS released the [QSO 20-20-All](#) memo on March 20 directing State Agencies to focus surveys on infection control and advise nursing homes to complete the self assessment that is included in the memo. This document can also be found on the LeadingAge Ohio [COVID-19 HUB](#) on our website.

*Last updated 3/27/20*

**IC15. Q. Has the temperature threshold changed to lower than 100.4?**

**IC15. A.** Yes, it is 100.0. ODH sent a bulletin to all providers on March 26 with a packet of information titled "ODH Assessment Tools, PPE, and Guidance 3.26.20." The information contained in this packet utilizes a temperature threshold of 100.0 rather than previously-identified 100.4. The CDC provides further explanation on temperature monitoring in the [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease \(COVID-19\)](#):

*Fever is either measured temperature >100.0 F or subjective fever. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of patients in such*

*situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<100.0oF) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) based on assessment by public health authorities.*

*Last updated 3/27/20*

## Caring for Individuals with COVID-19

### **CA1. Q. What actions should a provider take if they have a suspected or confirmed case of COVID-19?**

**CA1. A.** ODH wants providers to immediately call the local health department after they contact the physician. The local health department has received guidance and will advise the provider on next steps.

The Centers for Disease Control & Prevention has [released Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes](#) on when a patient is confirmed or suspected with COVID-19 in a healthcare setting.

Additionally, the CDC has long-term care-specific guidance available to help nursing homes: [Preparing for COVID-19: Long-term Care Facilities, Nursing Homes.](#)

Place a patient with known or suspected COVID-19 in a single-person room with the door closed. The patient should have a dedicated bathroom.

LeadingAge Ohio encourages members to consider designating a portion of their facility to care for COVID-19 patients. This will be an important step in conserving PPE and limiting transmission within your facility.

Additionally, nursing facilities with excess space (for example, a vacant wing or a skilled unit that has seen decreased referrals), are encouraged to reach out to their local health departments, that may soon be identifying facilities that can be dedicated to caring for COVID-19 patients, OR for patients that would have otherwise been cared for in a hospital, in order to free up hospital capacity.

*Last updated 3/20/20*

### **CA2. Q. We have residents that are exhibiting symptoms consistent with COVID-19. How do we access test kits?**

**CA2. A.** ODH has clarified that the first call should be to the resident's physician, who would write the order for the testing. The local health department should be the next call. That person will direct the provider on the current status in terms of where to access the test and/or whether to test or to self-quarantine.

*Last updated 3/20/20*

### **CA3. Q. Our nursing facility does not have a reverse-pressure isolation room equipped to care for individuals with COVID-19. What should we do if we identify a likely case?**

**CA3. A.** Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.

Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement.

Facilities should notify the local health department immediately and follow the [Interim Infection Prevention and Control Recommendations for Patients with COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings](#), which includes detailed information regarding recommended PPE.

*Last updated 3/20/20*

**CA4. Q. Other states have begun to develop triage protocols which identify whether COVID-19 patients are eligible for life-sustaining treatment. Has Ohio begun to have these discussions?**

**CA4. A.** LeadingAge Ohio is aware that across the country, other states and health system leadership have begun to develop these clinical protocols to determine how to allocate scarce equipment and resources. To date, these discussions have not been part of policy discussions at the state level in Ohio.

*Last updated 3/27/20*

**CA5. Q. What changes have been put in place related to handling of deceased positive COVID cases or potential COVID cases? Regarding removal from home? Transport to funeral homes?**

**CA5. A.** We have not heard anything on this at this point. We will definitely add this to the process map. More information on this will be added to the LeadingAge Ohio COVID-19 HUB on our website.

Best Practice from the State of Washington shared on the CMS call - recommended facilities have a communication plan completed in advance and ready for notification of health department; EMS providers; Hospitals, transport companies; and funeral homes.

*Last updated 3/27/20*

**CA6. Q. What is the current policy for administering CPR to a COVID positive resident?**

**CA6. A.** The American Heart Association has [issued interim guidance for administering CPR to COVID-19 positive individuals.](#)

*Last updated 4/6/20*

**CA7. Q. Is there a list of facilities that are COVID-19 facilities? Currently can a facility refuse admission of COVID-19 patient?**

**CA7. A.** Currently there is not a list of facilities dedicated to the care of COVID-19-positive patients. LeadingAge Ohio has joined the Departments of Health, Medicaid and Aging in developing a clinical protocol for transferring these individuals between settings (home, nursing homes, hospitals). Meanwhile, we understand that in some parts of the state, the regional healthcare coalitions have identified facilities that can be dedicated to caring for this patient population. Guidance is still forthcoming on how these facilities will be used, and how referrals/admissions will be accepted.

To date, the Ohio Department of Health has not issued a mandate that nursing homes accept COVID-19-positive individuals. In CDC guidance on the [Discontinuation of Transmission Precautions](#), it states:

*If discharged to a long-term care or assisted living facility, AND*

- *Transmission-Based Precautions are still required, they should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be placed in a location designated to care for COVID-19 residents.*
- 

LeadingAge Ohio encourages members to consider whether they have sufficient staffing and PPE to care for COVID-19 patients safely before admitting them.

*Last updated 4/6/20*

**CA8. Q. Our local hospital has asked us to admit an individual but is refusing to conduct a COVID-19 test. What steps can I take?**

**CA8. A.** Work with the hospital to determine if this referral meets the definition of person under investigation. The CDC provides in the [Preparing for COVID-19: Long-term Care Facilities, Nursing Homes](#) webpage that assists facilities in preparing for persons under investigation and recommendations with patient placement that includes suggestions such as admitting the resident into a private room.

*Last updated 4/6/20*

## Staffing & Workforce

**SW1. Q. If we have a suspected or confirmed case of COVID-19, should we quarantine staff? If a staff member presents at the nursing home and they have a fever, what actions should a provider take?**

**SW1. A.** The CDC have provided **very** specific [guidance for staff potential exposure](#). Note, in particular, the final two paragraphs copied below speak to the fact that employees who believe they may be symptomatic should leave work immediately.

Having a fever would fall under potential communicable disease and them not coming in. With COVID-19, ODH is recommending ruling out any other underlying cause. So having their primary physician do a health assessment and definitely an influenza swab would be important.

*While contact tracing and risk assessment, with appropriate implementation of HCP work restrictions, of potentially exposed HCP remains the recommended strategy for identifying and reducing the risk of transmission of COVID-19 to HCP, patients, and others, it is not practical or achievable in all situations. Community transmission of COVID-19 in the United States has been reported in multiple areas. This development means some recommended actions (e.g., contact tracing and risk assessment of all potentially exposed HCP) are impractical for implementation by healthcare facilities. In the setting of community transmission, all HCP are at some risk for exposure to COVID-19, whether in the workplace or in the community. Devoting resources to contact tracing and retrospective risk assessment could divert resources from other important infection prevention and control activities. Facilities should shift emphasis to more routine practices, which include asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection and not report to work when ill. Facilities should develop a plan for how they will screen for symptoms and evaluate ill HCP. This could include having HCP report absence of fever and symptoms prior to starting work each day.*

*Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. **If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work.***

*Last updated 3/20/20*

**SW2. Q. What supports are available for non-essential staff that we have had to lay off? What supports are available for individuals who are sent home to self-quarantine, in terms of unemployment?**

**SW2. A.** The DeWine Administration waived the one-week wait period to receive unemployment benefits from the state of Ohio, and has made unemployment compensation available to employees who are quarantined due to signs/symptoms or a positive test for COVID-19. More information is available at [www.unemployment.ohio.gov](http://www.unemployment.ohio.gov).

Additionally, on March 18, President Trump signed the Families First Coronavirus Response Act, which made [significant changes](#) to FMLA policies and sick leave policy.

*Last updated 3/20/20*

**SW3. Q. What do we do if a clinical employee (STNA, Nurse) refuses to provide care to a resident/patient that has been exposed to COVID19 and/or has tested positive for it?**

**SW3. A.** Given appropriate policies/procedures and PPE for employees, there should not be any reason that an employee can choose not to care for an individual that is infected with COVID-19. If they refuse to take care of the individuals on the assignment, we would encourage employers to utilize their disciplinary protocols for the refusal to care for an individual with an infectious disease. Employees must perform their assignments within the structure of their job descriptions. (Guidance provided by Benesch, 3/16/20)

*Last updated 3/20/20*

**SW4. Q. Currently, we are screening all employees for COVID-19 symptoms and exposure at the beginning of each shift, but in the future, as more people are tested or exposed, how will we continue to manage our workforce?**

**SW4. A.** Your local health department is still the best source for the most current information for your county and for guidance in the event of COVID-19 exposure or positive test. Additionally, the CDC has provided [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease](#).

*Last updated 3/20/20*

**SW5. Q. To what extent can we use volunteers?**

**SW5. A.** Providers should be utilizing only personnel who are absolutely necessary for the operations. Emergency Preparedness plans should be implemented. For nursing



homes, if a volunteer is needed to meet an operational need, implement according to SOM Appendix Z E-24.

During a call with ODH on March 17, they learned that many homes are utilizing volunteers to screen employees because of smaller staff. Providers need to make sure they are conducting the same screening for that volunteer as they do for staff.

*Last updated 3/20/20*

**SW6. Q. We are thinking of using nursing students as aides in our nursing facility. Do you know of any additional documentation needed to do this?**

**SW6. A.** The CMS blanket waivers granted on March 30 provided additional flexibility regarding who can be employed as a nurse aide in nursing homes. CMS waived training and certification requirements for nurse aides during the pandemic, allowing more individuals to serve in this capacity. However, the formal state-tested nursing assistant (STNA) licensure requirements are still in rule, and a nursing student could become a licensed STNA under the criteria in [OAC 3701-17-07.1](#) , which permits nursing students to serve as a nursing assistant. The OAC rule states:

(6) The individual is enrolled in a prelicensure program of nursing education approved by the board of nursing or by an agency of another state that regulates nursing education, has provided the long-term care facility with a certificate from the program indicating that the individual has successfully completed the courses that teach basic nursing skills including infection control, safety and emergency procedures and personal care, and has successfully completed the competency evaluation program; or

(7) The individual has the equivalent of twelve months or more of full-time employment in the preceding five years as a hospital aide or orderly and has successfully completed a competency evaluation program.

*Last updated 4/7/20*

**SW7. Q. Does the March 30 blanket waiver that waived nurse aide training requirements mean that individuals do not have to be test-ready? We could train anyone as long as they have demonstrated competency?**

**SW7. A.** ODH has affirmed that blanket waivers granted by CMS on March 30 mean that so long as an individual passes other hiring screenings, like background checks, and can demonstrate competency in performing nurse aide tasks, they may be hired. This

could be an individual who went through NATCEP training, and didn't pass the written or skills part.

For individuals who are seeking to ultimately function as an STNA, the waiver does not preclude individual requirements to obtain an STNA licensure. While severely limited by closures, STNA testing does continue in Ohio.

Last updated 4/7/20

**SW9. Q. With the nurse aide waiver, can we use our residential nursing assistants that work in assisted living in the nursing home if we test for competency on tasks they don't normally perform? What about training office staff?**

**SW9. A. Yes, you can use existing staff, so long as they are competent to provide nurse aide tasks. It is very important for providers to document this competency.**

Last updated 4/7/20

**SW10. Q. For onsite training would we have to use certified trainers?**

**SW10. A. No. A certified trainer is not required. The CMS waivers did not proscribe who would perform nurse aide training. [The Ohio Board of Nursing](#) offers the following guidance, in terms of delegation of authority:**

*In general, nurses are authorized to delegate a nursing task to an unlicensed person or teams of unlicensed persons, provided the task is not prohibited (such as unauthorized medication administration), the nurse has obtained verification that the unlicensed person is educated and competent in the safe performance of the task, and the task does not require complex observations or critical decisions be to be made during the performance of the task. Nurses may delegate to persons who have existing authority to administer medications, including MA-Cs certified by the Board of Nursing or medication aides certified by the Ohio Department of Developmental Disabilities. RNs and LPNs may not delegate to an unlicensed person, the administration of medications with the exception of over the counter topical medications applied to intact skin, over the counter eye drop, ear drops, suppository medications, foot soak treatments, and enemas.*

LeadingAge Ohio recommends that a nurse be the one to assess the competency of the individual aide, before nursing tasks can be delegated.

Last updated 4/7/20

**SW11. Q. Does your facility have to be a NATCEP-approved provider or can any facility provide the training? What about a facility that previously had their NATCEP approval suspended?**

**SW11. A.** A facility does not have to be an approved NATCEP training program. Any facility can develop training programs and competency evaluations.

The nurse aide blanket waiver doesn't address nurse aide training programs that have had sanctions. Rather, since standardized training is not required during the state of emergency to perform nurse aide tasks, nursing facilities can offer a condensed nurse training program to enable people to move very quickly to the front line.

*Last updated 4/7/20*

**SW13. Q.** If we train someone to be an aide do they still need to go through training and testing to be on the registry of nursing assistants?

**SW13. A.** Across Ohio, many NATCEP testing centers have been closed, making it difficult for STNAs to sit for their tests. Once the state/national emergency is lifted, we anticipate testing will resume at full pace and STNAs will need to complete all the requirements previously in place.

*Last updated 4/7/20*

**SW14. Q.** We have had requests from facilities to help with feeding patients. Can nursing home social workers help to feed patients in facilities?

**SW14. A.** Yes, social workers can assist with eating, provided they are trained and assessed for competency in performing the tasks you will have them do. Nursing homes should document the training, as well as any evaluation to demonstrate competency in the tasks assigned.

ODH has also offered a suggestion that a nursing facility that does not have a dining training program could utilize the dining assistant program which is available for download [Dining Assistants Program Standards and Guidelines](#). ODH has also stated they are approving and reactivating formal dining assistant programs if a nursing facility desires to do so. A nursing facility is not required to have an "approved" dining assistant program through ODH in order to do dining training.

*Last updated 4/7/20*

**SW15. Q.** Will test ready staff that exceed the four months be tested once testing sites are back up and running?

**SW15. A.** Guidance has not been provided as of this date regarding testing once the waiver is removed.

*Last updated 4/7/20*

## **Pandemic Childcare**

### **CH1. Q. If childcare centers close, what options are available to our staff who need childcare in order to keep working?**

**CH1. A.** On March 18, the Ohio Department of Job & Family Services announced a new “pandemic childcare center” license available to any licensed childcare center in the state of Ohio. Providers are encouraged to reach out to the childcare centers used by their employees and ask them to consider applying to become a pandemic childcare center.

At this point in time, ODJFS is not permitting long-term care providers to offer on-site childcare, if they did not operate a child care center previously.

Last updated 3/20/20

### **CH2. Q. Will there be a list of “approved” daycare providers who have been approved as Pandemic childcare centers that we can partner with to provide childcare for our staff members?**

**CH2. A.** Yes. ODJFS will be compiling a list of licensed pandemic child care centers, and posting to its [Pandemic Child Care Center website](#). LeadingAge Ohio anticipates it will have a complete list by the time they announce closing of childcare centers.

Last updated 3/20/20

### **CH3. Q. Can you run a daycare center in your facility or would the children be in violation of the no visitor restriction?**

**CH3. A.** You can have a childcare center on your campus but not in contiguous proximity of where residents are living. Separation requirements will have to continue to prevent transmission of infection. You will need to avoid violating the ban on visitors to the healthcare facility. The children and the workers in the pandemic child care center would not be considered visitors. There will need to be dedicated space as to not violate the requirements.

Last updated 3/20/20

### **CH4. Q. No license required until you are watching seven or fewer children?**

**CH4. A.** The State of Ohio does not license childcare centers providing care to fewer than 7 children, so providers wanting to set up a babysitting service for employees are not prohibited from doing so.

**CH5. Q. In a SNF/AL can we provide child care for our staff only without the special license? Or is a license required for all pandemic child care centers?**

**CH5. A.** In Ohio, a license is required for entities providing childcare to more than seven children at a time. ODJFS has stated

”The temporary license is available for existing providers and those new organizations that want to set up short-term child care services. In our transmittal letter we did highlight that buildings with current building certificates of occupancy and fire inspections will be the most expeditious. This would include but not be limited to: hospitals, churches, schools, Boys and Girls clubs, YMCA/YWCA.”

Last updated 3/20/20

**CH6. Q. Can churches apply for the TPCCC license?**

**CH6. A.** Yes. See CH5.

Last updated 3/20/20

**CH7. Q. How are pandemic childcare centers paid for? Will the individual employee be responsible, the employer, or is it a government program?**

**CH7. A.** At this point there is no subsidy provided for the pandemic child care center. LeadingAge Ohio has advocated for funding to offset the increased costs of childcare for essential personnel.

Last updated 3/20/20

**CH8. Q. Has there been any discussion of subsidizing the costs of childcare for affected workers, particularly those who have school-age children?**

**CH8. A.** LeadingAge Ohio has advocated to the Ohio Department of Job and Family Services for relief for frontline healthcare workers who have unanticipated childcare costs due to school closures, but no details are yet available as to whether this relief will be granted.

Last updated 3/20/20

## Background Checks

**BC1. Q. Background checks for new hires have been suspended by the entity we rely on to complete background checks. How do we move forward with getting new hires on board if we're unable to complete the mandated fingerprinting for health care workers?**

**BC1. A.** This is an issue that LeadingAge Ohio has raised, both as it relates to nursing homes being unable to “staff up” for the anticipated surge, as well as for childcare workers who are essential to enable health care personnel to continue reporting to work. [On April 1, the Ohio Department of Health shared the bulletin ODH Guidance on Fingerprinting which reinforced that background check requirements remain in effect, and how healthcare providers can access fingerprinting if their typical provider is unavailable.](#)

[Additionally,](#) LeadingAge Ohio has identified members across the state who have offered their webcheck to other members in an effort to expedite hiring. If your organization either has webcheck capability or is in need of background checks, please email Karen Lowe at [klowe@leadingageohio.org](mailto:klowe@leadingageohio.org), who is connecting members.

[Last updated 4/6/20](#)

## Telehealth

### TH1. Q. What services are approved to be delivered via telehealth, in light of the COVID-19 pandemic?

TH1. A. Medicare has [issued guidance](#) on those services which may be delivered via telehealth, noting three different types of visits: Medicare Telehealth Visits, Virtual Check-Ins, and E-visits.

For more information, review the [Medicare Telemedicine Health Care Provider Fact Sheet](#) and [Frequently Asked Questions](#).

In addition, the Ohio Department of Medicaid [filed an emergency rule](#) which expands the professional services, originating sites, and mode of delivery of services via telehealth.

[In addition to the guidance provided above, CMS has issued guidance on the use of telehealth in home health and hospice.](#)

*Last updated 4/6/20*

### TH2. Q. Are dietary and nutrition services included in the current waivers & emergency rules related Medicaid telehealth?

TH2. A. In the Ohio Department of Medicaid [emergency telehealth rule](#), dietitians as defined in Chapter 4759 of the Revised Code are one of the billable services under telehealth.

Last updated 3/20/20

### TH3. Q. Can nursing facilities bill for services delivered via telehealth?

TH3. A. Yes, nursing facilities can be an [originating site of service for telehealth](#) for professional services delivered there.

Last updated 3/20/20

### TH4. Q. Can the initial history & physical be done through telehealth?

TH4. A. Yes. For both [Medicare](#) and [Medicaid](#), the first-visit requirements were waived, and care can be started via telehealth.

Last updated 3/20/20

### TH5. Q. Can we complete Part B visits for our community palliative care patients with telehealth?

**TH5. A.** If it is a practitioner (physician, APRN, PA, CNS) is doing those visits then the answer is yes, you should be able to bill for telehealth visits.

Last updated 3/20/20

**TH6. Q. Did I understand correctly that the 14 (or now 21 day) RN routine visit for hospice patients (including comprehensive assessment) can now be done by telehealth if both video and audio are available?**

**TH6. A.** CMS has clarified that all hospice Routine Home Care visits can be done via telehealth. However, with the nursing component of the comprehensive assessment CMS said it can be done via telehealth **“to the extent that telehealth can offer a full assessment of patient/caregiver needs in a way that enables you to develop an accurate care plan and deliver services.”**

*Last updated 4/6/20*

**TH7. Q. For a hospice visit to qualify as telehealth, does the video/visual component have to be used, or just be available?**

**TH7. A.** CMS clarified that hospice Routine Home Care visits can be done with a telephone with audio only. If a telehealth is done with a phone with audio/visual capabilities like Facetime is acceptable, and HIPAA guidelines have been waived to use these type of applications.

*Last updated 4/6/20*

**TH8. Q. Can you please clarify for me, if telehealth visits are able to replace routine nursing visits and satisfy the skilled nurse frequency?**

**TH8. A.** Yes, you are able to do telehealth visits for hospice routine home care visits. You need to make sure the telehealth visits are incorporated into your plan of care and appropriate for the patient/family.

*Last updated 4/6/20*



## Regulatory Relief & Flexibility

### RR1. Q. Will survey and oversight visits be suspended for nursing homes, assisted living, and other healthcare providers & housing operators?

RR1. A. Currently, the following survey and oversight activities are suspended:

Nursing home and assisted living:

- All standard recertification surveys.
- Residential care facility surveys, except for two-day complaint surveys.
- Ombudsman visits. Ombudsman will continue to work with families and residents via phone.
- MDS Exception Reviews in nursing homes.

Home health and hospice:

- Targeted probe and educate (TPE) audits
- Post-payment review, including:
  - SMRC Audits
  - RAC Audits
- Review Choice Demonstration may be paused, but may be subject to ADR at a later date

Housing:

- REAC Inspections to HUD properties

Furthermore, LeadingAge Ohio is anticipating in the near future, CMS will suspend all recertification surveys except for those involving immediate jeopardy citations, but this had not been released as of the last update of this document.

*Last updated 4/7/20*

### RR2. Q. Do hospices still need to perform:

- **An in-person face-to-face visit for recertification or can they use telehealth?**
- **An in-person nurse visit every 15 days for the completion of the comprehensive assessment for the update to the plan of care?**
- **5% volunteer level of activity?**

RR2. A. CMS has issued a significant number of blanket waivers for [home health and hospice](#) providers. Please see the attached documents that outline these relief efforts.

These include:

- A waiver of the face-to-face visit for both home health and hospice;

- [A waiver of volunteer service requirements for hospices, and](#)
- [And extension of the timeframe for the completion of the hospice comprehensive assessment, from 15 to 21 days.](#)

*Last updated 4/6/20*

**RR3. Q. Can our nursing facility admit a Medicare Part A resident without a 3-day hospital stay?**

**RR3. A.** Yes. This was a blanket waiver announced by CMS on March 14, which states do not need to apply for. According to a [recent memo](#):

Section 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a SNF stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).

*Last updated 3/27/20*

**RR4. Q. Has there been discussion of waiving the nursing home bed tax payment, or other financial relief for providers that are seeing escalating costs related to the pandemic?**

**RR4. A.** LeadingAge Ohio joined the Ohio Healthcare Association in a letter requesting a 25% increase to Medicaid payments to offset the escalating costs of PPE, staffing, and other pandemic-associated expenses, but to date has not received feedback on ODM's strategy to support providers.

*Last updated 4/6/20*

**RR5. Q. Will you please clarify what changes are occurring with quality measures during this time?**

**RR5. A.** CMS announced relief to providers on the quality reporting programs on March 22 in a [press release](#). In the release, CMS stated they are granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs.:

**[RR6. Q. Where do I find more information about the waivers granted by CMS related to coronavirus?](#)**

**RR6. A.** All of the information related to coronavirus-related waivers are housed on the CMS Coronavirus Waiver website, including resources listing provider-specific waivers for nursing homes, home health, and hospice.

*Last updated 4/6/20*

**RR7. Q. Where can we find information about accelerated and advanced payments?**

**RR7. A.** CMS is authorized to provide accelerated or advance payments during the period of the public health emergency to any Medicare provider/supplier who submits a request to the appropriate Medicare Administrative Contractor (MAC) and meets the required qualifications. Each MAC will work to review requests and issue payments within seven calendar days of receiving the request.

Traditionally repayment of these advance/accelerated payments begins at 90 days, however for the purposes of the COVID-19 pandemic, CMS has extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment. Providers can get more information on this process in a [Fact Sheet developed by CMS.](#)

*Last updated 4/6/20*

## Screening & Access to Nursing Homes

**AC1. Q. Where can I find guidance that has been issued on nursing home access?**

**AC1. A. The latest guidance on nursing home access was released on April 3 from the Ohio Department of Health (ODH).**

*Last updated 4/8/20*

**AC2. Q. What personnel and contracted staff should be permitted access to a nursing facility?**

**AC2. A. The Directors' order limits access to nursing homes to those personnel who are absolutely necessary for the operation of the home, including staff, contracted and emergency healthcare providers, contractors conducting critical on-site maintenance, and governmental representatives and regulators and their contractors. Long-term care facilities should screen these personnel in accordance with guidance from the U.S. Centers for Disease Control, Centers for Medicare and Medicaid Services (CMS) and the Ohio Department of Health.**

*Last updated 4/8/20*

**AC3. Q. What are the requirements for screening individuals (visitors, suppliers, personnel, etc.) entering a nursing home or assisted living facility?**

**AC3. A. On March 7, the Centers for Disease Control & Prevention (CDC) [issued updated guidance](#) for screening healthcare personnel.**

This same guidance should be applied for visitors during compassionate care/end-of-life situations.

*Last updated 3/13/20*

**AC4. Q. Are hospice staff considered “absolutely necessary,” in light of the Governor’s order? **What does ODH guidance say about end-of-life visits?****

**AC4. A. In the April 3 letter sent to nursing home administrators, Ohio Department of Health (ODH) clarified after screening, necessary personnel should be permitted to enter the building if they do not meet the criteria for exclusion under the guidance. This includes contracted healthcare providers like hospice workers who may need to provide care to a resident multiple times daily. It is important that the healthcare needs of your residents continue to be met during this critical time.**

While the amended order restricts normal visitation to residents, it makes an exception for end-of life situations. Visitation would be limited to any resident who is facing imminent death as determined by a medical professional acting within their scope of practice. The facility should screen visitors prior to entry and restrict any visitor who does not pass screening. There are additional recommendations for visitors in the most recent CMS guidance.

*Last updated 4/8/20*

**AC5. Q. How should assisted living treat home care companion services that are paid privately by a resident?**

**AC5. A.** See AL3.

*Last updated 3/13/20*

**AC6. Q. Does the nurse aide training waiver, which could allow a family member to be trained to deliver services, conflict with the no visitor policy?**

**AC6. A.** Remember staff are not visitors. ODH defined staff in the Director of Health's [Order Limit Access to Ohio's Nursing Homes and Similar Facilities](#). The order explains that no visitors of residents shall be allowed. Ensure anyone being trained to be a staff member is being screened the same as you are currently screening current staff. Each facility will need to evaluate who and how many their essential staff members are based on resident acuity and operations of the organization.

*Last Updated 4/6/20*

## Visitation to Nursing Homes

### VI1. Q. Should a nursing home restrict all resident visitation?

VI2. A. According to the April 3 ODH Letter, the order restricts normal visitation to residents, it makes an exception for end-of life situations. Visitation would be limited to any resident who is facing imminent death as determined by a medical professional acting within their scope of practice. The facility should screen visitors prior to entry and restrict any visitor who does not pass screening. There are additional recommendations for visitors in the most recent CMS guidance.

*Last updated 4/8/20*

### VI2. Q. How should we counsel residents and families who are accustomed to leaving the facility on a regular basis, for example, to go out to eat?

VI2. A. The Joint Directors' order does not restrict individuals' rights to move freely in and out of nursing facilities or assisted living. It is advised and considered best practice to discourage residents from leaving, and/or to encourage them to choose times and venues that would present a lower risk. For example, visiting with one friend versus attending a family gathering.

A facility is permitted to have a policy which outlines screening residents who leave and come back. ODH has not provided guidance on whether a nursing facility would be able to subsequently place an individual in isolation or discharge an individual who has left a facility and returned for non-medical reasons.

*Last updated 3/20/20*

### VI3. Q. Can families be permitted into a nursing facility to receive training for patients being discharged to home? Training would include tube feeding, transfers, IV training etc.

VI3. A. ODH has clarified that training necessary for safe discharge is considered essential, and should be permitted. These family visitors should be screened similarly to staff, and to mitigate the risk, a nursing home could designate a separate area for that training.

*Last updated 3/20/20*

## Gatherings & Congregate Dining

### **DI1. Q. Has anything been released in regards to cancelling Resident Council Meetings till further notice?**

**DI1. A.** On March 16, President Trump that nationwide, there would be a ban on gatherings of 10 or more individuals. LeadingAge Ohio encourages members to consider facilitating Resident Council meetings via technology or limiting the size of Resident Council meetings and set up meetings in such a way that individuals are seated at a safe social distance (6ft) from one another. Another option is holding more than one resident council meeting, for example, by neighborhood, which would allow for smaller gatherings.

*Last updated 3/20/20*

### **DI2. Q. If communal dining is no longer permitted, should nursing facilities/assisted living close their dining rooms?**

**DI2. A.** The elimination of communal dining does not mean dining rooms need to be closed, of course, but it is important to maintain six feet social distance.

Here are ideas for nursing facility/assisted living:

- Moving tables in the nursing area so they are six feet apart and placing one person per table (i.e. social distancing). Meal hours likely extended, as a result of the limitation on the number of residents that could be served at one time with this method. Prompting for those residents that need it and assisting by staff would have to be maintained.
- Meal delivery to rooms for all. Seems very challenging for those that need the prompting/assisting.
- Giving residents a choice: asking residents if they want the social distancing option OR meal delivery.

Here are ideas for residents in independent living:

- Arranging a meal pick-up time with staggered times by last name (i.e. A's – F's: 5:30 – 5:45; G's – L's 5:45 -- 6:00; M's – S's 6:15, etc.)
- Limiting menu options to facilitate meal delivery to all

*Last updated 3/20/20*

## Returning & Admitting Patients to Nursing Facilities

### **AD1. Q. What protocol should be in place for patients returning from a hospitalization?**

**AD1. A.** Residents be allowed to return to a facility following a hospital discharge. The individual should be screened according to the criteria provided, and if there is an indication of illness, placed in isolation according to protocol described in [CMS guidance](#).

*Last updated 3/20/20*

### **AD2. Q. Should a facility continue to admit new residents?**

**AD2. A.** None of the recent guidance restricts a nursing home or assisted living from admitting new residents. New residents should be screened according to the protocol described in Q3 as part of the admission assessment.

Nursing homes have an important role in ensuring the health care system does not become overwhelmed. It is critically important that nursing homes continue admission practices, caring for those individuals who are most appropriate to this level of care.

*Last updated 3/20/20*

### **AD3. Q. How should a facility accommodate individuals & families who are requesting tours of a facility, in anticipation of admission?**

**AD3. A.** An advisable practice would be to use technology to provide a virtual tour of the facility.

*Last updated 3/13/20*



## RCF/Assisted Living Questions

**AL1. Q. If a family member sets up a resident's medication, are they allowed to enter and do that medication set-up?**

**AL1. A.** No. The Ohio Department of Health has shared that an RCF should complete any tasks that can be done by staff. Alternatively, the facility nurse could take the medications to the family, meet them at the entrance, and then the family could fill the pillbox at home, and then deliver them back to the RCF.

ODH has shared that if a family member normally does any kind of task, but it is a task that RCF staff can do, then the RCF should take over this task for the time being. This includes catheter change, dressing change, and medication administration, as well as housekeeping, laundry, dusting and other duties.

*Last updated 3/20/20*

**AL2. Q. If a resident dies, are the family allowed to come in and remove belongings (both in Nursing Home and RCF)?**

**AL2. A.** Yes. The family would be allowed to remove belongings following an individual's death. Similarly, if an individual is being admitted, the family is permitted to move furniture and personal items in.

*Last updated 3/13/20*

**AL3. Q. How should assisted living treat home care companion services that are paid privately by a resident?**

**AL3. A.** ODH has since clarified that any services that a residential care facility *can* provide, it *should* provide. This includes assistance with any activities of daily living which may have previously been provided by a private duty caregiver or family member.

Ask the question "Is our facility able to provide the service?"

- If yes, then the family/volunteer is not essential.
- If no, a nurse is not onsite and family is able to do the service, then yes it is essential.

For example, if an RCF does not have a nurse when an RCF resident needs to have a specific care or services that would be provided by a nurse, but the family is able to do it, then this would be considered essential. This is an example when the RCF did not have a nurse during that time.

*Last updated 3/13/20*

## Hospice & Home Health

**HH1. Q. Can you guide us as to what are essential hospice services and what are not? Also, what language should be in care plans?**

**HH1. A.** For hospice, the Core Services are: nurse, social worker, chaplain and physician as well as medications, durable medical equipment and supplies. The non-core services are volunteer, hospice aides, therapies and alternative therapies. At a minimum, in order to bill for hospice services, a registered nurse has to complete a comprehensive assessment every 21 days.

If certain disciplines are not able to make visits to patients at this time (for example, volunteers are not visiting), then you should write a hold order for those discipline visits. Sample order language could be: "Volunteer visit on hold due to the COVID-19 pandemic and visit orders will be resumed once the pandemic restrictions have been lifted."

*Last Updated: 4/7/20*

**HH2. Q. Are there specific guidelines for the number of family members permitted in facilities and IPUs, and how next of kin is defined?**

**HH2. A.** Nursing facilities have been given the directive to not allow any visits in the facilities, unless it is a compassionate care visit/end-of-life visit, but the guidance is not specific to the number of family members that should be permitted. LeadingAge Ohio strongly encourages all of its members to work to educate families to minimize visits to the greatest extent possible.

In the Ohio statute, next of kin is defined as the individual's spouse, adult living children, siblings, nieces/nephews/aunts/uncles or other relatives.

*Last updated 4/8/20*

**HH3. Q. Our hospice has severely limited patient visitation for social workers and chaplains, instead we are having them contact patients and families via a zoom platform, in coordination with the nurse case manager. Is this sufficient to meet requirements for the comprehensive assessment regularly updating the plan of care?**

**HH3. A.** CMS has issued guidance that hospice routine home care visit can be performed via telehealth. CMS has clarified that telephone/audio only visits are sufficient for routine home care visits. What you described sounds like a great way to get involvement from the social worker and chaplain. Remember that social worker phone calls are to be reported on the claim.

*Last updated 4/9/20*

**HH4. Q. Can a home health face-to-face visit be done via telehealth for both Medicare and Medicaid?**

**HH4. A.** Yes, a home health face-to-face visit can be done via telehealth for both Medicare and Medicaid recipients. The National Association for Home Care & Hospice has shared resources for both [Medicaid](#) and [Medicare](#) requirements.

*Last updated 3/27/20*

**HH5. Q. For hospice staff that need their annual competencies completed, can we note in the personnel file that the annual competency wasn't completed timely due to COVID19 restrictions?**

**HH5. A.** Hospice providers need to reach out to their accrediting body representative to ask about annual competencies during this public health emergency. Annual competencies for hospice staff are not regulated by state or federal regulatory bodies.

*Last updated 4/9/20*

**HH6. Q. I am a Hospice Social Worker and haven't read any recommendations regarding visit restrictions. Do we follow the same guidelines as nurses? i.e. telehealth, phone calls, etc.?**

**HH6. A.** Hospice social workers can follow the same visit guidelines as nurses in regards to telehealth visits and phone calls. The only difference is, hospice social worker phone calls can be documented on the hospice claim in 15 minutes increments. CMS determined social worker phone calls could be documented as a contact on the claim several years ago, so it is not new guidance. All visits, either face to face or telehealth should be documented in the clinical record and the type of visit should be noted in the record.

*Last updated 4/6/20*

**HH7. Q. Have any of the HIS requirements been waived during this pandemic?**

**HH7. A.** Both the HIS and Hospice CAHPS have been suspended until the pandemic threat is over.

CMS issued a recent Memo that provided clearer guidance related to HQRP reporting exemptions. See following excerpt:

CMS is granting an exemption to the Hospice Quality Reporting Program (QRP) reporting requirements. Medicare-certified Hospices are exempt from the reporting of data on measures, Hospice Item Set (HIS) data and Consumer

Assessment of Healthcare Providers and Systems (CAHPS) surveys, required under Hospice QRP for calendar years (CYs) 2019 and 2020 for the following quarters. For HIS, the quarters are based on submission of HIS admission or discharge assessments. For CAHPS, the quarters are based on patient deaths in 2019 and 2020.

Hospice QRP: o October 1, 2019–December 31, 2019 (Q4 2019) o January 1, 2020–March 31, 2020 (Q1 2020) o April 1, 2020–June 30, 2020 (Q2 2020).

Last updated 4/6/20

**HH8. Q. To clarify for the Hospice Aide supervisory visits, these can be done via phone with audio only or does this also require visual? Also - there was no extension to when this needs to be completed (still needs to be completed every 14 days).**

**HH8. A. Aide supervisory visits for both home health and hospice can be done via telephone with audio capabilities only. This visit requires the nurse or therapist asking the patient/family their perception of how the aide is meeting their needs. That can be done with just a phone call that is not to be documented on the claim.**

Last updated 4/6/20

**HH9. Q. Is the telephonic comprehensive assessment only to be used for hospice patients who are COVID positive or suspicious of COVID, or can all visits in COVID planning be used via telephonic use?**

**HH9. A. All hospice routine home visits can be done via telehealth, not just COVID-19 positive or suspicious patients.**

Last updated 4/9/20

**HH10. Q. Can an admission visit assessment also be completed telephonically for hospice?**

**HH10. A. Yes, an initial comprehensive assessment can be completed telephonically for a hospice start of care. CMS clarified an assessment visit can be done via telehealth “to the extent that telehealth can offer a full assessment of patient/caregiver needs in a way that enables you to develop an accurate care plan and deliver services.”**

Last updated 4/9/20

**HH11. Q. Has PASSPORT loosened any regulations surrounding aide supervisory visits for traditional PASSPORT waiver services and/or Enhanced Community Living services?**

**HH11. A.** The State will permit PASSPORT providers to perform supervisory visit(s) telephonically if a supervisory visit is required by the waiver service.

i. The modified supervisory schedule must be documented in the individual's service plan by the provider's nurse supervisor.

ii. The provider shall notify the case manager if they elect to perform the supervisory visit telephonically.

Note: These protocols are also being implemented in the Ohio Home Care Waiver and MyCare Ohio.

*Last updated 4/6/20*

**HH12. Q.** Can hospice still get reimbursed for telehealth visits since we get a per diem rate per day we'll still get that rate, correct?

**HH12. A.** Hospice is paid on a per diem basis, so therefore, telehealth visits are not reimbursable beyond the per diem payment.

*Last updated 4/9/20*

**HH13. Q.** Is telehealth allowed for a recertification visit?

**HH13. A.** Yes, on 4.7.20 CMS clarified on their Office Hours call that, "Telehealth can be used for routine home care visits to the extent the technology can offer a full assessment of patient/caregiver needs in a way that enables you to develop an accurate care plan and deliver services."

*Last updated 4/9/20*

**HH14. Q.** How should telehealth visits be listed on the claim?

**HH14. A.** Palmetto reached out to CMS who clarified that hospice telehealth visits do should not be on the hospice claims at this time. Palmetto has asked CMS for further guidance related to telehealth visits on hospice claims.

*Last updated 4/9/20*

**HH15. Q.** Does telehealth mean that it is audio and visual?

**HH15. A.** CMS has clarified on their 4/7/20 Office Hours call that hospice routine homecare visits can be performed via telephone, audio only, for all disciplines and further explained that, “Telehealth can be used to the extent the technology can offer a full assessment of patient/caregiver needs in a way that enables you to develop an accurate care plan and deliver services.”

Last updated 4/9/20

**HH16. Q. Can a Nurse Practitioner do all Face to Face recertification visits via telehealth?**

**HH16. A.** Yes, all recertification face to face encounters can be done by a physician or nurse practitioner by telehealth. For F2F visits technology with audio and visual capabilities is necessary to complete the visit. Telephones with an app with both audio and visual capabilities is acceptable as HIPAA regulations have been lifted during the public health emergency.

Last updated 4/9/20

**HH17. Q. What if a patient will not allow a hospice nurse to visit a minimum of every 21 days?**

**HH17. A.** Palmetto reached out to CMS to ask what happens if a patient will not allow a hospice patient to visit a minimum of every 21 days. CMS responded with the following guidance: If a hospice provider cannot complete a comprehensive assessment at a minimum of 21 days, a provider will need to discharge the patient because per the Hospice: CMS Flexibilities to Fight COVID-19 it states, “hospices must continue to complete the required assessments and updates, however, the timeframes for updating the assessment may be extended from 15 to 21 days.” Therefore, if a the comprehensive assessment cannot be done in 21 days, they do not meet the requirements.

Last updated 4/9/20

**HH18. Q. If the LUPA Threshold was met, could the home health recertification visit be done via telehealth?**

**HH18. A.** In recent **CMS guidance** states, Home Health Agencies (HHAs) can provide more services to beneficiaries using telehealth within the 30 day episode of care, so long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. We acknowledge that the use of such technology may result

in changes to the frequency or types of in-person visits outlined on existing or new plans of care.

*Last updated 4/9/20*

## Housing

**HO1. Q. Has anyone heard from HUD if their freezing recertifications or extending them to protect office managers and our residents?**

**HO1. A.** HUD has not yet suspended recertifications, but LeadingAge has made this request. Our understanding is that doing so would require congressional action, so it is not something that HUD can do on its own.

*Last updated 3/20/20*

**HO2. Q. Will housing staff be included as “essential staff” for pandemic childcare centers?**

**HO2. A.** LeadingAge Ohio has asked the DeWine Administration to include housing property managers, maintenance staff, and service coordinators to be included among essential staff, so that they may continue to support the older adults residing in their communities.

*Last updated 3/27/20*

**HO3. Q. Has HUD issued any guidance related to visitation in HUD 202 or multifamily settings?**

**HO3. A.** HUD has not issued guidance related to restricting visitation to individuals residing in subsidized housing. LeadingAge Ohio has asked Governor DeWine to directly address older Ohioans in senior living communities, asking them to restrict visits by friends and family to reduce the likelihood of transmission of COVID-19.

*Last updated 3/27/20*