Letter of Introduction

Centers for Medicare and Medicaid Services (CMS)

- Guidance for Infection Prevention and Control of COVID-19 In Nursing Homes (Revised) (March 13, 2020)
- Medicare Coverage and Payment Related to COVID-19
- COVID-19 Emergency Declaration Health Care Providers Fact Sheet
- Findings Concerning Section 1812(f) of the Social Security Act in Response to The Effects of the COVID-19 Outbreak
- Suspension of Survey Activities
- Guidance for Use of Certain Industrial Respirators by Health Care Personnel
- Guidance for Infection Control and Prevention concerning COVID-19: FAQs and Considerations for Patient Triage, Placement and Hospital Discharge
- Guidance for Infection Prevention and Control of COVID-19 In Nursing Homes (March 4, 2020)
- Guidance for Infection Prevention and Control of COVID-19 In Nursing Homes (Revised) (March 9, 2020)
American Health Care Association/National Center for Assisted Living (AHCA/NCAL)

- AHCA NCAL COVID-19 screening checklist-Recommendation for SNF visitors
- Taking Reasonable Efforts to Prevent COVID-19 from Entering Your Assisted Living Community
- Taking Reasonable Efforts to Prevent COVID-19 From Entering Your Skilled Nursing Center
- Guidance for SNFs On Admissions from and Discharges to Hospitals Relating to COVID-19 (as of March 13, 2020)
- STATEMENT & TALKING POINTS FOR FACILITIES WITH CORONAVIRUS Infection Prevention and Control in Skilled Nursing and Assisted Living Communities Updated: March 2, 2020
- STATEMENT & TALKING POINTS FOR FACILITIES WITHOUT CORONAVIRUS- Infection Prevention and Control in Nursing Homes and Assisted Living Communities Updated: March 9, 2020
- Information to families: Reason We are Restricting Individuals from Entering our Building
- Template Letter for Residents and Family Members on Center Letterhead **Please Tailor as Needed**
- Template Letter to Employees on Center Letterhead **Please Tailor as Needed**
- Variations between AHCA & CMS revised guidance for visitation during COVID-19
- Emergency Preparedness Communications Plan
New Jersey Department of Health (DOH)

- 2019 Novel Coronavirus Information Sheet
- COVID-19 Health Care Personnel Exposure Checklist
- COVID-19 Fever and Symptom Monitoring Log for Health Care Personnel
- HealthCare Personnel Exposure to Confirmed COVID-19 Case Risk Algorithm
- Retrospective Assessment Tool for Health Care Personnel Potentially Exposed to COVID-19

Centers for Disease Control and Prevention (CDC)

- Checklist for HealthCare Facilities: Strategies for Optimizing the Supply of N95 Respirators During the COVID-19 Response
- CDC Education Tools: workplace-school-home-guidance
- Stop the Spread of Germs
- Symptoms for Coronavirus Disease 2019
- What You Need to Know About Coronavirus Disease 2019
- What to Do If You Are Sick with Coronavirus Disease 2019
- CERC In an Infectious Disease Outbreak
- Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission
Additional Resources

- Employee Screening Tool
- Visitor Screening Tool
- DMAHS-Coping with The Emotional Impact of Public Health Emergencies (brochure)
- PHENS LINCS preferred email Contact List by County
- Directory of Local Health Departments in New Jersey
- EPA’s Registered Antimicrobial Products for Use Against Novel Coronavirus-SARS-CoV-2 the cause of COVID-19
- Grainger Products available for purchase to provide potential solutions for converting single resident rooms or hallways into negative pressure isolation environments.
- The Society for Post Acute and Long Term Care Medicine: COVID-19 in PALTC Settings
Dear Member:

There have been many directives issued regarding how to manage COVID-19. This is a stressful time for everyone and information changes daily. The enclosed toolkit and resource document provide information and guidance from several sources including: Centers For Disease Control and Prevention (CDC), New Jersey Department of Health (DOH), American Health Care Association/National Center for Assisted Living (AHCA/NCAL), and the Centers for Medicare and Medicaid Services (CMS).

This toolkit includes a visitor screening tool and template letters for facilities to use to communicate with resident families and center staff as well as monitoring tools from DOH for use in screening center personnel for signs and symptoms of COVID-19. We have also included contact information for the local Boards of Health. Additionally, CDC (www.cdc.gov) offers information on hand hygiene, infection prevention and control guidelines, and mitigation strategies in both healthcare and community settings.

We also suggest:

• While staff and visitors are a concern, residents in some settings, such as assisted living communities, will want to continue to leave the building as they choose. It is important to educate all residents about the risks of contracting and spreading COVID-19 to others in their home.
• When reviewing leave policies with staff and residents, consider including that all sign out and identify where they are going.
  o This information will be important if there is a need to report information to the Boards of Health.
  o Upon the resident’s return, ensure that they have washed their hands in accordance with CDC guidelines.
• Investigate whether physicians can provide telehealth visits in lieu of onsite office appointments.
• When reviewing your policies and procedures be sure you have considered pharmacy deliveries and medication requirements.
• Have a plan for how/where delivered medications will be received, especially late evening deliveries and deliveries to residents who self-administer their medications and receive deliveries from local pharmacies.
• Ensure your back-up medications are fully stocked in the event there are any medication supply problems.
• Inventory your medical equipment supplies to be sure you have adequate supplies of items to properly and safely care for all residents.
While specific to COVID-19, this toolkit has many resources that can be used for any infectious outbreaks in long term care centers. Tailor the information provided to make it specific for your center and in alignment with your infection control policies and procedures and outbreak response plans. As new information is received, update this guide as needed to ensure the most current information is available.

Please frequently check the following web sites for updates:

- [www.ahcancal.org/coronavirus](http://www.ahcancal.org/coronavirus)
- [www.cms.gov](http://www.cms.gov)
- [www.nj.gov/health/cd/topics/ncov.shtml](http://www.nj.gov/health/cd/topics/ncov.shtml)

We must protect our elders from contracting this virus to the best of our abilities. This will require ongoing monitoring of staff and residents, education of staff, residents, and families, communication and updates to staff, residents and families, and management oversite from all departments to ensure staff compliance. Together, we will weather this crisis. As always, HCANJ is available to assist with your questions and concerns.
CMS INFORMATION

• Guidance for Infection Prevention and Control of COVID-19 In Nursing Homes (Revised) (March 13, 2020)

• Medicare Coverage and Payment Related to COVID-19

• COVID-19 Emergency Declaration Health Care Providers Fact Sheet

• Findings Concerning Section 1812(f) of the Social Security Act in Response to The Effects of the COVID-19 Outbreak

• Suspension of Survey Activities

• Guidance for Use of Certain Industrial Respirators by Health Care Personnel

• Guidance for Infection Control and Prevention concerning COVID-19: FAQs and Considerations for Patient Triage, Placement and Hospital Discharge

• Guidance for Infection Prevention and Control of COVID-19 In Nursing Homes (March 4, 2020)

• Guidance for Infection Prevention and Control of COVID-19 In Nursing Homes (Revised) (March 9, 2020)
DATE: March 13, 2020

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED)

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.

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. 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:**
- Review CDC guidance for Infection Prevention and Control Recommendations for
- 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, 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
adopt this new code for such tests. HCPCS code (U0002) generally describes 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets). The Medicare claims processing system will be able to accept these codes on April 1, 2020 for dates of service on or after February 4, 2020.

Vaccines

Medicare Part B pays for certain preventive vaccines (influenza, pneumococcal, and Hepatitis B) and coinsurance and deductible do not apply to preventive vaccines. Medicare Part B also pays for other vaccines directly related to medically necessary treatment of an injury or direct exposure to a disease or condition. For example, Medicare would cover a tetanus vaccine for a beneficiary who steps on a rusty nail. For these other medically necessary vaccines, beneficiary coinsurance and deductible would apply.

Inpatient Hospital Care Services

Medicare Part A covers medically necessary inpatient hospital care. This coverage includes semi-private rooms, meals, general nursing, imaging, drugs as well as other hospital services and supplies as part of inpatient hospital treatment. Inpatient hospital treatment includes care from acute care hospitals, critical access hospitals, inpatient rehabilitation facilities, long-term care hospitals, inpatient care as part of a qualifying clinical research study, and inpatient mental health care given in a psychiatric hospital or psychiatric unit within a hospital.

Medicare beneficiaries may pay a deductible for hospital services. Under Original Medicare, for hospital inpatient services, beneficiaries pay a deductible of $1,408 and no coinsurance for days 1–60 of each benefit period. Beneficiaries pay a coinsurance amount of $352 per day for days 61–90 of each benefit period. There is a coinsurance amount per “lifetime reserve day” after day 90 of each benefit period (up to 60 days over a beneficiary’s lifetime). Beneficiaries pay all costs for each day after all the lifetime reserve days are used. In addition, inpatient psychiatric care in a freestanding psychiatric hospital is limited to 190 days in a beneficiary’s lifetime.

Inpatient Hospital Quarantines

There may be times when beneficiaries with the virus need to be quarantined in a hospital private room to avoid infecting other individuals. These patients may not meet the need for acute inpatient care any longer but may remain in the hospital for public health reasons. Hospitals having both private and semiprivate accommodations may not charge the patient a differential for a private room if the private room is medically necessary. Patients who would have been otherwise discharged from the hospital after an inpatient stay but are instead remaining in the hospital under quarantine would not have to pay an additional deductible for quarantine in a hospital.
If a Medicare beneficiary is a hospital inpatient for medically necessary care, Medicare will pay hospitals the diagnosis-related group (DRG) rate and any cost outliers for the entire stay, including any the quarantine time when the patient does not meet the need for acute inpatient care, until the Medicare patient is discharged. The DRG rate (and cost outliers as applicable) includes the payments for when a patient needs to be isolated or quarantined in a private room.

**Ambulatory Services in a Hospital or Other Location**

Medicare Part B covers medically necessary ambulatory services, including doctors’ services, hospital outpatient department services, home health services, durable medical equipment, mental health services, and other medical services. Coinsurance and deductible would generally apply depending on the service.

In the event a patient is quarantined in an ambulatory setting, the existing Medicare payments for medically necessary services apply.

**Telehealth and Other Communication-Based Technology Services**

Beneficiaries can communicate with their doctors or certain other practitioners without necessarily going to the doctor’s office in person for a full visit.

Since 2018, Medicare pays for “virtual check-ins” for patients to connect with their doctors without going to the doctor’s office. These brief, virtual check-in services are for patients with an established relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The patient must verbally consent to using virtual check-ins and the consent must be documented in the medical record prior to the patient using the service. The Medicare coinsurance and deductible would apply to these services.

Doctors and certain practitioners may bill for these virtual check-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

Medicare also pays for patients to communicate with their doctors without going to the doctor’s office using online patient portals. The individual communications, like the virtual check ins, must be initiated by the patient; however, practitioners may educate beneficiaries on the availability of this kind of service prior to patient initiation. The communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable. The Medicare coinsurance and deductible would apply to these services.
In addition, Medicare beneficiaries living in rural areas may use communication technology to have full visits with their physicians. The law requires that these visits take place at specified sites of service, known as telehealth originating sites, and receive services using a real-time audio and video communication system at the site to communicate with a remotely located doctor or certain other types of practitioners. Medicare pays for many medical visits through this telehealth benefit. Certain beneficiaries, such as those needing a monthly end-stage renal disease visit or those needing treatment for substance use disorders or co-occurring mental health disorder may access telehealth services from their home without traveling to an originating site. The Medicare coinsurance and deductible would apply to these services.

Medicare also pays doctors for certain non-face-to-face care management services and remote patient monitoring services. The Medicare coinsurance and deductible would apply to these services.

**Requests for Prescription Refills**

For Part B drugs, when considering whether to pay for a greater-than-30-day-supply of drugs, in general, Medicare and its contractors, known as Medicare Administrative Contractors or MACs, will, on a case-by-case, basis, consider each request and make decisions locally.

In general, local Medicare contractors will take into account the nature of the particular Part B drug (including Part B immunosuppressive drugs), the patient’s diagnosis, the extent and likely duration of disruptions to the drug supply chain during an emergency, and other relevant factors that would be applicable when making a determination as to whether, on the date of service, an extended supply of the drug was reasonable and necessary.

**Emergency Ambulance Transportation**

Medicare covers ground ambulance transportation when beneficiaries need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services when transportation in any other vehicle could endanger the beneficiary’s health. A ground ambulance emergency transportation may temporarily stop at a doctor’s office without affecting the coverage status of the transport in certain circumstances, however, in general the physician’s office is not a covered destination. Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if the beneficiaries needs immediate and rapid ambulance transportation that ground transportation can’t provide.

Should a facility which would normally be the nearest appropriate facility be unavailable during an emergency, Medicare may pay for transportation to another facility so long as that facility is the nearest facility that is available and equipped to provide the needed care for the illness or injury involved.
In some cases, Medicare may pay for limited, medically necessary, nonemergency ambulance transportation if the doctor writes an order stating that ambulance transportation is medically necessary. For example, beneficiaries may need a medically necessary nonemergency ambulance transport to a dialysis facility when they have End-Stage Renal Disease. There is a current Medicare model testing prior authorization for individuals receiving scheduled, non-emergency ambulance transportation for 3 or more round trips in a 10-day period or at least once a week for 3 weeks or more in certain states.

The Medicare coinsurance and deductible would apply to these Part B services.

Medicare pays for ambulance transports under the Ambulance Fee Schedule. This payment amount includes a base rate payment (level of service provided) plus a separate payment for mileage to the nearest appropriate facility and also cover both the transport of the beneficiary to the nearest appropriate facility and all medically necessary covered items and services (such as oxygen, drugs, extra attendants, and electrocardiogram testing) associated with the transport.

**Medicare Advantage (Part C) and Part D**

Medicare Advantage (also known as “Part C”) is an “all in one” alternative to Original Medicare. Medicare Advantage plans cover Medicare Part A and Part B services, and usually prescription drugs covered under Medicare Part D. These plans also may offer extra benefits Original Medicare doesn’t cover. Medicare Part D, also called the Medicare prescription drug benefit, is an optional federal-government program to help Medicare beneficiaries pay for prescription drugs not covered under Part B through prescription drug insurance.

**Medicare Advantage Coverage**

Medicare Advantage plans must cover all medically necessary Part A and B services covered under Original Medicare for all enrollees. Medicare Advantage plans can also cover items and services beyond those covered by Original Medicare, such as vision, dental, and over-the-counter products, among other things. These items and services are typically referred to as “supplemental benefits.”

**Medicare Advantage Cost Sharing - “Surprise Billing”**

Medicare Advantage plan enrollees are generally protected from “surprise billing” which is when an enrollee receives unexpected bills from out-of-network providers. Surprise billing most commonly occurs when patients either receive care from an out-of-network provider they had reasonably assumed was in-network or received out-of-network care in an emergency when they had limited, if any, ability to choose their provider. When Medicare Advantage enrollees obtain plan-covered services (e.g., covered under the plan’s normal rules, or when an HMO
arranges for or directs out of network care) in an HMO, PPO, or Regional PPO, they may not be charged or held liable for more than plan-allowed cost-sharing.

Additionally, CMS advises Medicare Advantage (MA) organizations that they may waive or reduce enrollee cost-sharing for Novel Coronavirus (COVID-19) laboratory tests effective immediately provided that MA organizations waive or reduce cost-sharing for all plan enrollees on a uniform basis. Specifically, CMS will exercise its enforcement discretion regarding the administration of MA organizations benefit packages as approved by CMS in conjunction with implementing a voluntary waiver or reduction of cost-sharing for COVID-19 laboratory tests as described. CMS consulted with the Office of Inspector General (OIG) and OIG advised that should an MA organization choose to voluntarily waive or reduce enrollee cost-sharing for COVID-19 laboratory tests, as approved by CMS in this advisory, such waivers or reductions would satisfy the safe harbor to the Federal anti-kickback statute set forth at 42 CFR 1001.952(l).

Nothing in this guidance speaks to the arrangements between MA organizations and their contracted providers or facilities.

**Telehealth and other Communication Based Technology Services**

Medicare Advantage plans may provide their enrollees with access to Medicare Part B services via telehealth in any geographic area and from a variety of places, including beneficiaries’ homes. With this flexibility, it is possible that beneficiaries in Medicare Advantage plans can receive clinically appropriate services for treatment of COVID-19 via telehealth.

**Part D Coverage**

Each Part D Sponsor that offers prescription drug coverage must provide a standard level of coverage to ensure beneficiaries have adequate access to Part D drugs. Many Part D Sponsors offer plans with different levels of coverage many of which exceed CMS’s minimum requirements.

**Vaccines**

Under current law, once a vaccine becomes available for COVID-19, Medicare will cover the vaccine under Part D. All Part D plans will be required to cover the vaccine.

**Prior Authorization**

Consistent with flexibilities available to Medicare Advantage Organizations and Part D Sponsors with respect to other items and services, MAOs and Part D Sponsors may choose to waive plan prior authorization requirements that otherwise would apply to tests or services related to COVID-19.
COVID-19 Emergency Declaration
Health Care Providers Fact Sheet

The Trump Administration is taking aggressive actions and exercising regulatory flexibilities to help healthcare providers combat and contain the spread of 2019 Novel Coronavirus Disease (COVID-19). In response to COVID-19, CMS is empowered to take proactive steps through 1135 waivers and rapidly expand the Administration’s aggressive efforts against COVID-19. As a result, the following blanket waivers are available:

- **Skilled Nursing Facilities**
  CMS is waiving the requirement at Section 1812(f) of the Social Security Act for a 3-day prior hospitalization for coverage of a skilled nursing facility (SNF) stay provides temporary emergency coverage of (SNF services without a qualifying hospital stay, for those people who need to be transferred as a result of the effect of a 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.

  Second, CMS is waiving 42 CFR 483.20 to provides relief to SNFs on the timeframe requirements for Minimum Data Set assessments and transmission.

- **Critical Access Hospitals**
  CMS is waiving the requirements that Critical Access Hospitals limit the number of beds to 25, and that the length of stay be limited to 96 hours.

- **Housing Acute Care Patients In Excluded Distinct Part Units**
  CMS is waiving requirements to allow acute care hospitals to house acute care inpatients in excluded distinct part units, where the distinct part unit’s beds are appropriate for acute care inpatient. The Inpatient Prospective Payment System (IPPS) hospital should bill for the care and annotate the patient’s medical record to indicate the patient is an acute care inpatient being housed in the excluded unit because of capacity issues related to the disaster or emergency.

- **Durable Medical Equipment**
  Where Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) is lost, destroyed, irreparably damaged, or otherwise rendered unusable, contractors have the flexibility to waive replacements requirements such that the face-to-face requirement, a new physician’s order, and new medical necessity documentation are not required. Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged or otherwise rendered unusable or unavailable as a result of the emergency.
• **Care for Excluded Inpatient Psychiatric Unit Patients in the Acute Care Unit of a Hospital**

CMS is waiving to allow acute care hospitals with excluded distinct part inpatient psychiatric units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part psychiatric unit to an acute care bed and unit. The hospital should continue to bill for inpatient psychiatric services under the Inpatient Psychiatric Facility Prospective Payment System for such patients and annotate the medical record to indicate the patient is a psychiatric inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the hurricane. This waiver may be utilized where the hospital’s acute care beds are appropriate for psychiatric patients and the staff and environment are conducive to safe care. For psychiatric patients, this includes assessment of the acute care bed and unit location to ensure those patients at risk of harm to self and others are safely cared for.

• **Care for Excluded Inpatient Rehabilitation Unit Patients in the Acute Care Unit of a Hospital**

CMS is waiving requirements to allow acute care hospitals with excluded distinct part inpatient Rehabilitation units that, as a result of a disaster or emergency, need to relocate inpatients from the excluded distinct part rehabilitation unit to an acute care bed and unit. The hospital should continue to bill for inpatient rehabilitation services under the inpatient rehabilitation facility prospective payment system for such patients and annotate the medical record to indicate the patient is a rehabilitation inpatient being cared for in an acute care bed because of capacity or other exigent circumstances related to the disaster or emergency. This waiver may be utilized where the hospital’s acute care beds are appropriate for providing care to rehabilitation patients and such patients continue to receive intensive rehabilitation services.

CMS is waiving requirements to allow IRFs to exclude patients from the hospital’s or unit’s inpatient population for purposes of calculating the applicable thresholds associated with the requirements to receive payment as an IRF (commonly referred to as the “60 percent rule”) if an IRF admits a patient solely to respond to the emergency and the patient’s medical record properly identifies the patient as such. In addition, during the applicable waiver time period, we would also apply the exception to facilities not yet classified as IRFs, but that are attempting to obtain classification as an IRF.

• **Supporting Care for Patients in Long-Term Care Acute Hospitals (LTCH)s**

Allows a long-term care hospital (LTCH) to exclude patient stays where an LTCH admits or discharges patients in order to meet the demands of the emergency from the 25-day average length of stay requirement which allows these facilities to be paid as LTCHs.

• **Home Health Agencies**

Provides relief to Home Health Agencies on the timeframes related to OASIS Transmission. Allows Medicare Administrative Contractors to extend the auto-cancellation date of Requests for Anticipated Payment (RAPs) during emergencies.
• **Provider Locations**
  Temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid.

• **Provider Enrollment**
  - Establish a toll-free hotline for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges
  - Waive the following screening requirements:
    - Application Fee - 42 C.F.R 424.514
    - Criminal background checks associated with FCBC - 42 C.F.R 424.518
    - Site visits - 42 C.F.R 424.517
  - Postpone all revalidation actions
  - Allow licensed providers to render services outside of their state of enrollment
  - Expedite any pending or new applications from providers

• **Medicare appeals in Fee for Service, MA and Part D**
  - Extension to file an appeal
  - Waive timeliness for requests for additional information to adjudicate the appeal;
  - Processing the appeal even with incomplete Appointment of Representation forms but communicating only to the beneficiary;
  - Process requests for appeal that don’t meet the required elements using information that is available.
  - Utilizing all flexibilities available in the appeal process as if good cause requirements are satisfied.

**Medicaid and CHIP**

When the President declares an emergency through the Stafford Act or National Emergency Act, and the Secretary declares a Public Health Emergency, the Secretary is authorized to waive certain Medicare, Medicaid and Children’s Health Insurance Program (CHIP) authorities under Section 1135 of the Social Security Act.

There is no specific form or format that is required to submit the request for a Section 1135 waiver, but the state should clearly state the scope of the issue and the impact. States and territories may submit a Section 1135 waiver request directly to Jackie Glaze, CMS Acting Director, Medicaid & CHIP Operations Group Center for Medicaid & CHIP Services by e-mail (Jackie.Glaze@cms.hhs.gov) or letter.
The following are examples of flexibilities that states and territories may seek through a Section 1135 waiver request:

- Waive prior authorization requirements in fee-for-service programs
- Permits providers located out of state/territory to provide care to another state’s Medicaid enrollees impacted by the emergency
- Temporarily suspend certain provider enrollment and revalidation requirements to increase access to care.
- Temporarily waive requirements that physicians and other health care professionals be licensed in the state in which they are providing services, so long as they have an equivalent licensing in another state, and
- Temporarily suspend requirements for certain pre-admission and annual screenings for nursing home residents
- States and territories are encouraged to assess their needs and request these available flexibilities, which are more completely outlined in the Medicaid and CHIP Disaster Response Toolkit. For more information and to access the toolkit, visit: https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html.

For questions please email: 1135waiver@cms.hhs.gov
TO: The Secretary
Through: DS____
COS____
ES____

FROM: Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Findings Concerning Section 1812(f) of the Social Security Act in Response to the Effects of the 2019-Novel Coronavirus (COVID-19) Outbreak

These findings are based on the public health emergency that you declared under Section 319 of the Public Health Service Act as a result of the consequences of the above-captioned emergency, and are effective with respect to the timeframes and geographic areas specified in the waiver(s) issued under section 1135 of the Social Security Act (the Act) in response to that emergency. Accordingly, both the effective date(s) and expiration date(s) for these temporary emergency policies are the same as those specified pursuant to the corresponding section 1135 waiver(s).

Section 1861(i) of the Act permits Medicare payment for skilled nursing facility (SNF) care only when a beneficiary first has an inpatient hospital stay of at least 3 consecutive days. Section 1812(f) of the Act allows Medicare to pay for SNF services without a 3-day qualifying stay if the Secretary of Health and Human Services 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. I find that covering SNF care without a 3-day inpatient hospital stay only for beneficiaries affected by the above-captioned emergency (with respect to the timeframes and geographic areas specified in the waiver(s) issued under section 1135 of the Act as a result of that emergency) would not increase total payments made under the Medicare program and would not change the essential acute-care nature of the Medicare SNF benefit. Therefore, SNF care without a 3-day inpatient hospital stay will be covered for beneficiaries who experience dislocations or are otherwise affected by the emergency, such as those who are (1) evacuated from a nursing home in the emergency area, (2) discharged from a hospital (in the emergency or receiving locations) in order to provide care to more seriously ill patients, or (3) need SNF care as a result of the emergency, regardless of whether that individual was in a hospital or nursing home prior to the emergency.

In addition, we will recognize 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 non-institutional setting for at least 60 days). However, the dislocations resulting from the emergency (including emergency-related measures that could result in discharge delays) may delay or prevent such beneficiaries from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal
circumstances. Accordingly, I find that covering additional SNF care without requiring a break in the spell of illness for those beneficiaries in connection with the above-captioned emergency would not increase total payments made under the Medicare program and would not change the essential acute-care nature of the Medicare SNF benefit. Therefore, we are also utilizing the authority under section 1812(f) of the Act to provide renewed coverage for extended care services which will not first require starting a new spell of illness for such beneficiaries, who can then receive up to an additional 100 days of SNF Part A coverage for care needed as a result of the above-captioned emergency. This policy will apply only for those beneficiaries who have been delayed or prevented by the emergency itself from commencing or completing the process of ending their current benefit period and renewing their SNF benefits that would have occurred under normal circumstances.

Any patients discharged from a hospital to the SNF or admitted directly from home to the SNF should be managed in accordance with the latest CMS or CDC guidance.

Seema Verma
Administrator
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_basics.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 complete 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.
DATE: March 10, 2020

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for use of Certain Industrial Respirators by Health Care Personnel

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 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:


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:  

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 (RNHClis)
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:
- Strategies for Optimizing the Supply of N95 Respirators:  
• CDC Updates: https://www.cdc.gov/coronavirus/2019-ncov/whats-new-all.html

FDA Resources:
• Emergency Use Authorizations: https://www.fda.gov/medical-devices/emergency-situations-medical-devices/emergency-use-authorizations

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: Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge

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.

- **Coordination with the Centers for Disease Control (CDC) and local public health departments** - We encourage all hospitals 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)).

- **Hospital Guidance and Actions** - CMS regulations and guidance support hospitals taking appropriate action to address potential and confirmed COVID cases and mitigate transmission including screening, discharge and transfers from the hospital, and visitation.

Background
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. This memorandum responds to questions we have received and provides important guidance for hospitals and critical access hospitals (CAH’s) in addressing the COVID-19 outbreak and minimizing transmission to other individuals. Specifically, we address FAQs related to optimizing patient placement, with the goal of addressing the needs of the individual patient while protecting other patients and healthcare workers.

Guidance
Hospitals should monitor the CDC website ([https://www.cdc.gov/coronavirus/2019-ncov/index.html](https://www.cdc.gov/coronavirus/2019-ncov/index.html)) for up to date information and resources. They should contact their local health department if they have questions or suspect a patient or healthcare provider has COVID-19. Hospitals should have plans for monitoring healthcare personnel with exposure to patients with known or suspected COVID-19. Additional information about monitoring healthcare personnel...

Guidance for Addressing Patient Triage and Placement of Patients with known or suspected COVID-19

Which patients are at risk for severe disease for COVID-19?
Based upon CDC data, older adults and those with underlying chronic medical conditions or immunocompromised state may be most at risk for severe outcomes. This should be considered in the decision to monitor the patient as an outpatient or inpatient.

How should facilities screen visitors and patients for COVID-19?
Hospitals should identify visitors and patients at risk for having COVID-19 infection before or immediately upon arrival to the healthcare facility. They should ask patients about the following:

1. Fever or symptoms of a respiratory infection, such as a cough and sore throat.
2. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
3. Contact with someone with known or suspected COVID-19.

For patients, implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the patient’s nose and mouth if that has not already been done) and isolate the patient in an examination room with the door closed. If the patient cannot be immediately moved to an examination room, ensure they are not allowed to wait among other patients seeking care. Identify a separate, well-ventilated space that allows waiting patients to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. In some settings, medically-stable patients might opt to wait in a personal vehicle or outside the healthcare facility where they can be contacted by mobile phone when it is their turn to be evaluated.

Inform infection prevention and control services, local and state public health authorities, and other healthcare facility staff as appropriate about the presence of a person under investigation for COVID-19. Additional guidance for evaluating patients in U.S. for COVID-19 infection can be found on the CDC COVID-19 website.

Provide supplies for respiratory hygiene and cough etiquette, including 60%-95% alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, facemasks, and tissues at healthcare facility entrances, waiting rooms, patient check-ins, etc.

How should facilities monitor or restrict health care facility staff?
The same screening performed for visitors should be performed for hospital staff.

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that 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 hospital’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 asymptomatic
healthcare personnel from reporting to work (https://www.cdc.gov/coronavirus/2019-

Hospitals should contact their local health department for questions, and frequently review the
CDC website dedicated to COVID-19 for health care professionals

**What are recommended infection prevention and control practices, including
considerations for patient placement, when evaluating and care for a patients with known
or suspected COVID-19?**

Recommendations for patient placement and other detailed infection prevention and control
recommendations regarding hand hygiene, Transmission-Based Precautions, environmental
cleaning and disinfection, managing visitors, and monitoring and managing healthcare personnel
are available in 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.

**Do all patients with known or suspected COVID-19 infection require hospitalization?**
Patients may not require hospitalization and can be managed at home if they are able to comply
with monitoring requests. More information is available

**Are there specific considerations for patients requiring diagnostic or therapeutic
interventions?**
Patients with known or suspected COVID-19 should continue to receive the intervention
appropriate for the severity of their illness and overall clinical condition. Because some
procedures create high risks for transmission (e.g., intubation) additional precautions include: 1) HCP should wear all recommended PPE, 2) the number of HCP present should be limited to
essential personnel, and 3) the room should be cleaned and disinfected in accordance with
environmental infection control guidelines.

Additional information about performing aerosol-generating procedures is available
here: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-
recommendations.html

**When is it safe to discontinue Transmission-based Precautions for hospitalized patients
with COVID-19?**
The decision to discontinue Transmission-Based Precautions for hospitalized patients with
COVID-19 should be made on a case-by-case basis in consultation with clinicians, infection
prevention and control specialists, and public health officials. This decision should consider
disease severity, illness signs and symptoms, and results of laboratory testing for COVID-19 in
respiratory specimens.
More detailed information about criteria to discontinue Transmission-Based Precautions are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

**Can hospitals restrict visitation of patients?**
Medicare regulations require a hospital to have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation. CMS sub-regulatory guidance identifies infection control concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital setting (for example, among patients, staff, and visitors) as well as between the hospital and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals should work with their local, State, and Federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

**What are the considerations for discharge to a subsequent care location for patients with COVID-19?**
The decision to discharge a patient from the hospital should be made based on the clinical condition of the patient. If Transmission-Based Precautions must be continued in the subsequent setting, the receiving facility must be able to implement all recommended infection prevention and control recommendations.

Although COVID-19 patients with mild symptoms may be managed at home, the decision to discharge to home should consider the patient’s ability to adhere to isolation recommendations, as well as the potential risk of secondary transmission to household members with immunocompromising conditions. More information is available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html

**What are the implications of the Medicare Hospital Discharge Planning Regulations for Patients with COVID-19?**
Medicare’s Discharge Planning Regulations (which were updated in November 2019) require that hospital assess the patient’s needs for post-hospital services, and the availability of such services. When a patient is discharged, all necessary medical information (including communicable diseases) must be provided to any post-acute service provider. For COVID-19 patients, this must be communicated to the receiving service provider prior to the discharge/transfer and to the healthcare transport personnel.
concern as an example of when clinical restrictions may be warranted. Patients must be informed of his/her visitation rights and the clinical restrictions or limitations on visitation.

The development of such policies and procedures require hospitals to focus efforts on preventing and controlling infections, not just between patients and personnel, but also between individuals across the entire hospital setting (for example, among patients, staff, and visitors) as well as between the hospital and other healthcare institutions and settings and between patients and the healthcare environment. Hospitals should work with their local, State, and Federal public health agencies to develop appropriate preparedness and response strategies for communicable disease threats.

Important CDC Resources:


CDC Updates:

CMS Resources
CMS has additional guidance which may be beneficial to hospitals related to EMTALA requirements and other topics surrounding the health and safety standards during emergencies. The document Provider Survey and Certification Frequently Asked Questions (FAQs), Declared Public Health Emergency All-Hazards are located at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/All-Hazards-FAQs.pdf. These FAQs are not limited to situations involving 1135 Waivers, but are all encompassing FAQs related to public health emergencies and survey activities and functions.

Contact: Questions about this memorandum should be addressed to QSOG_EmergencyPrep@cms.hhs.gov. Questions about COVID-19 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 R. Wright
cc: Survey and Operations Group Management
DATE: March 4, 2020

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes

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.

- **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**

CMS is responsible for ensuring the health and safety of nursing homes 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’re providing additional guidance to nursing homes to help control and prevent the spread of the virus.

**Guidance**

Facilities should 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 patients are essential to prevent unnecessary exposures among patients, 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 patients, patient 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 (Frequently Asked Questions) about some specific areas related to COVID-19:

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

**How should facilities monitor or limit visitors?**
Facilities should screen visitors for the following:

1. International travel within the last 14 days to restricted countries. For updated information on restricted countries visit: [https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html](https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html)
2. Signs or symptoms of a respiratory infection, such as a fever, cough, and sore throat.
3. Has had contact with someone with or under investigation for COVID-19.

If visitors meet the above criteria, facilities may restrict their entry to the facility. Regulations and guidance related to restricting a resident’s right to visitors can be found at 42 CFR §483.10(f)(4), and at F-tag 563 of [Appendix PP of the State Operations Manual](https://www.cdc.gov/coronavirus/2019-ncov/Long-Term-Care/appendix-pp-guidance.html). Specifically, a facility may need to restrict or limit visitation rights for reasonable clinical and safety reasons. This includes, “restrictions placed to prevent community-associated infection or communicable disease transmission to the resident. A resident’s risk factors for infection (e.g., immunocompromised condition) or current health state (e.g., end-of-life care) should be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious (e.g., 24 hours after resolution of fever without antipyretic medication).”

**How should facilities monitor or restrict health care facility staff?**
The same screening performed for visitors should be performed for facility staff (numbers 1, 2, and 3 above).

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that 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).
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).

**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 maybe 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 patient assuming: 1) the patient 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. (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 patient 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 patient 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 patient diagnosed with COVID-19 and still under Transmission-based Precautions for COVID-19 as long as it 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. 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.

**Other considerations for facilities:**

- Increase the availability and accessibility of alcohol-based hand sanitizer (ABHS), tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, patient check-ins, etc.
Ensure ABHS 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.).

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

**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
DATE: March 9, 2020

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes (REVISED)

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**
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 (Frequently Asked Questions) about some specific areas related to COVID-19:

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

**How should facilities monitor or restrict visitors?**
If visitors meet the criteria below, facilities may restrict their entry to the facility. Regulations and guidance related to restricting a resident’s right to visitors can be found at 42 CFR §483.10(f)(4), and at F-tag 563 of Appendix PP of the State Operations Manual. Specifically, a facility may need to restrict or limit visitation rights for reasonable clinical and safety reasons. This includes, “restrictions placed to prevent community-associated infection or communicable disease transmission to the resident. A resident’s risk factors for infection (e.g., chronic medical conditions) or current health state (e.g., end-of-life care) should be considered when restricting visitors. In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious.”

Facilities should actively screen and restrict visitation by those who meet the following criteria:
1. Signs or symptoms of a respiratory infection, such as fever, cough, shortness of breath, or sore throat.
2. In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or under investigation for COVID-19, or are ill with respiratory illness.
3. International travel within the last 14 days to countries with sustained community transmission. For updated information on affected countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
4. Residing in a community where community-based spread of COVID-19 is occurring.

For those individuals that do not meet the above criteria, facilities can allow entry but may require visitors to use Personal Protective Equipment (PPE) such as facemasks (see expanded guidance below).

**Limiting visitors and individuals: Expanded recommendations:**
CMS is providing the following expanded guidance to prevent the spread of COVID-19 (in addition to the information above about restricting visitors).
- **Restricting** means the individual should not be allowed in the facility at all, until they no longer meet the criteria above.
• **Limiting** means the individual should not be allowed to come into the facility, except for certain situations, such as end-of-life situations or when a visitor is essential for the resident’s emotional well-being and care.

• **Discouraging** means that the facility allows normal visitation practices (except for those individuals meeting the restricted criteria), however the facility advises individuals to defer visitation until further notice (through signage, calls, etc.).

1. **Limiting or Discouraging visitation:**
   a) **Limiting:** For facilities that are in counties, or counties adjacent to other counties where a COVID-19 case has occurred, we recommend limiting visitation (except in certain situations as indicated above). For example, a daughter who visits her mother every Monday, would cease these visits, and limit her visits to only those situations when her mom has a significant issue. Also, during the visit, the daughter would limit her contact with her mother and only meet with her in her room or a place the facility has specifically dedicated for visits.

   b) **Discouraging:** For all other facilities (nationwide) not in those counties referenced above, we recommend discouraging visitation (except in certain situations). See below for methods to discourage visitation. Also see CDC guidance to “stay at home” https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/high-risk-complications.html#stay-home.

2. Facilities should increase visible signage at entrances/exist, offer temperature checks, increase availability to hand sanitizer, offer PPE for individuals entering the facility (if supply allows). Also, provide instruction, before visitors enter the facility and residents’ rooms, 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. Signage should also include language to discourage visits, such as recommending visitors defer their visit for another time or for a certain situation as mentioned above.

3. In addition to the screening visitors for the criteria for restricting access (above), facilities should ask visitors if they took any recent trips (within the last 14 days) on cruise ships or participated in other settings where crowds are confined to a common location. If so, facilities should suggest deferring their visit to a later date. If the visitor’s entry is necessary, they should use PPE while onsite. If the facility does not have PPE, the facility should restrict the individual’s visit, and ask them to come back at a later date (e.g., after a 14 days with no symptoms of COVID-19).

4. In cases when visitation is allowable, facilities should instruct visitors to limit their movement within the facility to the resident’s room (e.g., reduce walking the halls, avoid going to dining room, etc.)

5. Facilities should review and revise how they interact with volunteers, vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), other practitioners (e.g., hospice workers, specialists, physical therapy, 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 as long as they are following the appropriate CDC guidelines for
Transmission-Based Precautions. For example, hospice workers can enter a facility when using PPE properly.

6. In lieu of visits (either through limiting or discouraging), facilities can 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.

7. When visitation is necessary or allowable, facilities should make efforts to allow for safe visitation for residents and loved ones. For example:
   a) Suggest limiting 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. If in-person access is allowable, use the guidance mentioned above. 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).

8. Visitor reporting:
   a) Advise exposed visitors (e.g., contact with COVID-19 resident prior to admission) to monitor for signs and symptoms of respiratory infection for at least 14 days after last known exposure and if ill to self-isolate at home and contact their healthcare provider.
   b) Advise visitors to report to the facility any signs and symptoms of COVID-19 or acute illness within 14 days after visiting the facility.

How should facilities monitor or restrict health care facility staff?
The same screening performed for visitors should be performed for facility staff.

- Health care providers (HCP) who have signs and symptoms of a respiratory infection should not report to work.
- Any staff that 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).
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).

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.

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.
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, 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
CMS Resources:


Contact: Email [DNH_TriageTeam@cms.hhs.gov](mailto: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
AHCA/NCAL INFORMATION

- AHCA NCAL COVID-19 screening checklist-Recommendation for SNF visitors
- Taking Reasonable Efforts to Prevent COVID-19 from Entering Your Assisted Living Community
- Taking Reasonable Efforts to Prevent COVID-19 From Entering Your Skilled Nursing Center
- Guidance for SNFs On Admissions from and Discharges to Hospitals Relating to COVID-19 (as of March 13, 2020)
- STATEMENT & TALKING POINTS FOR FACILITIES WITH CORONAVIRUS
  Infection Prevention and Control in Skilled Nursing and Assisted Living Communities Updated: March 2, 2020
- STATEMENT & TALKING POINTS FOR FACILITIES WITHOUT CORONAVIRUS
  Infection Prevention and Control in Nursing Homes and Assisted Living Communities Updated: March 9, 2020
- Information to families: Reason We are Restricting Individuals from Entering our Building
- Template Letter for Residents and Family Members on Center Letterhead
  **Please Tailor as Needed**
- Template Letter to Employees on Center Letterhead
  **Please Tailor as Needed**
- Variations between AHCA & CMS revised guidance for visitation during COVID-19
- Emergency Preparedness Communications Plan
Prevent COVID-19:
Screening Checklist – Recommendations for SNF Visitors
ALL individuals (employees, family, visitors, government officials) entering the building should be asked the following questions:

1. Has this individual washed their hands or used alcohol-based hand rub (ABHR) on entry?  
   - Yes  
   - No – please ask them to do so.

2. Ask the individual if they have any of the following respiratory symptoms?  
   - Fever (checking for temperature is not necessary)  
   - Sore throat  
   - Cough  
   - New shortness of breath  

   If YES to any, ask them to not enter the building. They may or may not have COVID-19, and the potential consequences to COVID-19 entering the building is serious enough to ask them to not enter even though they may not have it. Many populations outside of the elderly do not show any symptoms but are able to transmit the virus to others.

   If NO to all proceed to question #3.

3. Ask the individual if they have  
   - Travelled internationally within the last 14 days to areas where COVID-19 cases have been confirmed  
   - Worked in another health care setting that has confirmed COVID-19 cases (this may change as COVID spreads in the community)

   If YES to any, ask them to not enter the building  

   If NO to all, proceed to question #4

4. Ask the visitor the purpose for their visit/entry  
   - Employees and contractors involved in meeting the resident’s needs or maintaining the operations of the facility should be allowed  
   - Immediate family members, approved by the resident or resident’s representative, who do not screen positive for #2 or #3 above, should be allowed  
   - Immediate family members visits for critical or time sensitive reasons such as hospice related visits, complete medical authorizations, etc. should be allowed but need to use mask, gown and gloves.  
   - Routine social visits should be strongly discouraged  

   NOTE: This is not a complete ban on all visitors, but routine social visits are discouraged. The rationale of should be explained, and alternative methods of communications offered.

   RATIONALE: COVID-19 is extremely dangerous for SNF residents with early estimates of at least a 15% mortality rate for older adults 80+ years old. Many populations outside of the elderly do not show any symptoms but are able to transmit the virus to others. The risk of entering the building is large enough to ask them to not enter.

5. Remind the individual to  
   - Wash their hands or use ABHR throughout their time in the building  
   - Not shake hands with, touch or hug individuals during their visit

Note: Assisted Living Providers can use this checklist as feasible for their community. 3/9/2020
Taking Reasonable Efforts to Prevent COVID-19 From Entering Your Assisted Living Community  
(as of March 9, 2020)

The top priority at this point with COVID-19 is to prevent the virus from entering your assisted living community given the high case fatality rate in elderly over the age of 80 with preliminary data showing it at 15% or greater. Evaluations from prior viral epidemics that spread like COVID-19 found that actions taken early in outbreaks can significantly reduce the spread of the virus. Waiting until the virus in spreading in the community is often too late.

As such, AHCA/NCAL strongly recommends the following actions to help prevent the entry of COVID-19 into your facilities regardless of whether your surrounding community has confirmed cases.1

1. Limit entry to only individuals who need entry.
2. Restrict activities and visitors with potential for exposure.
3. Restrict individuals who have respiratory symptoms or potential COVID-19 exposure out of an abundance of caution.
4. Require all staff entering the building to wash their hands upon entry and encourage all essential visitors do so as well.
5. Set up process to allow remote communication for residents and others.

We recognize that assisted living communities are committed to providing a home-like environment for their residents, many of whom are high functioning, mostly independent individuals. In addition, assisted living settings vary in size, scope of care, and policies. In certain assisted living communities, residents are able to enter and exit the building freely and family members may have unlimited access to the community to visit at any time. We also recognize that many assisted living communities have multiple entrances without any receptionist or a receptionist at limited times, which may make it challenging to monitor entry at all entrances and at certain times of day.

However, due to the very serious impact COVID-19 will continue to have on our elderly population and those with underlying conditions, we are recommending that you evaluate your current visitation policies to determine whether some of these best practices could be implemented at your communities. Because of the diverse nature of assisted living, each community must focus on steps they are able to enact now to mitigate COVID-19 in their communities, taking into account their state regulations, local health department guidance, staffing capabilities, residents’ rights and family concerns.

#1 Limit entry to only individuals who need entry, such as:
- Facility employees, contractors, consultants who need to keep the operations running and assure the residents’ needs are met.
- Government officials who in their capacity require entry (e.g., CDC or public health staff).

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1 These recommendations build upon what CMS and CDC currently recommend. We urge members to adopt these additional best practices when possible based on the growing data about the high mortality rate among the elderly over the age of 80 with chronic disease (estimated at 15%), who comprise the majority of our residents. Waiting until the virus starts to spread in the community, has been shown in prior viral epidemics to be too late. (Note the case fatality rate in the Kirkland, WA skilled nursing facility was over 50% based on data available on King County Health Departments website as of 3-7-20). To date, nearly all the deaths in the United States have been in individuals over the age of 70.
• Immediate families or friends who need to visit for critical or time sensitive reasons such as hospice-related visits, complete medical authorizations, etc.

Exceptions: AHCA/NCAL’s recommendation is NOT for a complete ban on all visitors. The circumstances for the reason for entry need to be taken into consideration, particularly for immediate family members (e.g. spouse or sons/daughters), but routine social visits are discouraged. The rationale should be explained, and alternative methods of communications offered. We strongly recommend that the resident (or the resident representative) be consulted to determine if a resident wants or needs a specific visitor, including immediate family members, and allow entry if they do not meet any of the screening exclusion criteria in #2 below.

Some best practices that may be possible in your facility include:

• Post signage clearly in your facility. The CDC provides sample signage for your use to ensure that all those entering or exiting your buildings are aware of the risks associated with COVID-19 and the recommended precautions they should take.
• Notify all residents, family members and other loved ones. Ask your residents to strongly encourage their family members and friends to not visit for the time being.
• Establish specific visiting hours. Specifically, consider limiting visitors to only daytime hours (e.g., 9:00 a.m. to 7:00 p.m.) when staff can more closely monitor a visitor entrance.
• Close more than one entry point in accordance with life safety regulations. Consider having one central entry location (e.g., main entrance).
• Enact a sign-in policy to encourage all visitors to check in with staff and conduct possible screening for COVID-19.

#2 Restrict activities or individuals with potential for exposure, including:

• Visitors, when there are any COVID-19 confirmed cases in the surrounding community. This does not apply to workforce needed to keep the operations going and to meet resident needs.
• Other visitors for routine social visits, tours with prospective residents or their families, and outside group activities (e.g., school groups or bands, etc.) should be restricted.
• Cancel activities that take residents into the community to public places particularly with large gatherings, such as mall, movies, etc. (Note: this does NOT apply to residents who need to leave the building for medical care such as dialysis, medical visits, etc.).
• Internal group activities should be restricted, especially if: a) the facility has residents with respiratory symptoms (who should be in contact isolation per CDC guidance); b) if COVID-19 is in the surrounding community; and/or c) the ability to restrict visitors is challenging in the facility.

Facilities should also continue to use CDC recommended signage reminding people that anyone with symptoms of respiratory illness should not enter the facility, including employees, government officials and contractors.

#3 Restrict individuals who have respiratory symptoms or potential COVID-19 exposure out of an abundance of caution, including employees, contractors, volunteers, visitors, new admissions, government officials, and health care professionals. Post notices for individuals to assess their risk which would include any individuals with:

• Respiratory symptoms (fever, sore throat, cough and new shortness of breath); and
As of March 9, taking temperatures is not included in any CDC or CMS recommendations and AHCA/NCAL is not recommending taking temperatures. Extenuating circumstances should be taken into consideration, but in these cases, individuals should use gown, mask and gloves during their visit.

- International travel within the last 14 days to areas where COVID-19 cases have been confirmed.
- Anyone who has worked in another health care setting with confirmed COVID-19 cases (this may change as COVID-19 spreads in your community).

Anyone who is symptomatic for respiratory illness or has traveled within the last 14 days to areas where a COVID-19 outbreak has been confirmed, including communities in the United States that are exhibiting community spread should not enter the community (extenuating circumstances may be taken into consideration; but those individuals must wear mask, gown and gloves to reduce the risk of spreading any viruses).

**#4 Require all staff entering the building to wash their hands upon entry and encourage all essential visitors do so as well.**

- If possible, set up hand washing and/or alcohol-based hand rub (ABHR) stations immediately inside all entryways with signage reminding people to wash before entering.
- Ask each person who enters the community to immediately wash their hands or use hand sanitizer before they do anything else.
- Encourage them to wash their hands or use ABHR throughout their time in the building and in accordance with CDC recommendations. CDC recommendations include increasing the access to ABHR.
- Clean and disinfect frequently touched objects and surfaces following manufacturer’s directions.
- Remind people to not shake hands or hug each other, staff or residents during this epidemic.

**#5 Set up a process to allow remote communication for residents and others.**

- Ensure emergency contact information for family members and the resident representative is up to date.
- Develop alternative means of communications for residents to visit and talk with loved ones, such as video chat, telephone, texting or social media.
- Inform residents or their representatives of these changes using clear, concise, jargon-free messages that express empathy for their situation while simply explaining the policy.
- Ensure proactive communication with residents, loved ones, contractors, volunteers, etc. to make them aware of these restrictions and to keep them up to date.
- Develop a process for family members to communicate with the facility with questions.

**Frequently Asked Questions**

**Who should NOT enter your assisted living community?**

- Anyone who has symptoms of respiratory illness or has traveled within the last 14 days to areas where a COVID-19 outbreak has been confirmed.
• Anyone who has traveled internationally within the last 14 days to areas where COVID-19 cases have been confirmed.
• Anyone who has worked in another health care setting with confirmed COVID-19 cases (this may change as COVID-19 spreads in your community). This does not apply to workforce needed to keep the operations going and to meet resident needs.

How do I inform people about entry restrictions?

• Post signage at all entries, CDC and others have posters that you may consider using.
• Communicate with your residents and their families
• Communicate with your vendors, contractors, consultants, etc.

What if a person refuses and tries to enter?

• Explain the rationale for the restriction and need to keep all the residents safe.
• Offer them an alternate way to communicate with the person they want to see.
• Talk with the resident or person they want to see, to make sure they want to see the person and explain that person’s request.
• Use best judgement and assess extenuating circumstances for entry.

Resources to Facilitate Communication

AHCA/NCAL offers a number of communication resources on our coronavirus website (www.ahcancal.org/coronavirus), including:

• Template letters for families and residents
• Template letters for employees
• Template statement and talking points for impacted and non-impacted facilities
• A guide on communication plans during an emergency

AHCA/NCAL strongly recommends all long term care facilities review the CDC guidance on COVID-19 by checking the CDC website frequently as guidance and recommendations are continuing to rapidly evolve.

Please email COVID19@ahca.org with any questions.

For additional information and resources on the virus, visit our dedicated website on this issue: www.ahcancal.org/coronavirus.
Taking Reasonable Efforts to Prevent COVID-19 From Entering Your Skilled Nursing Center  
(as of March 9, 2020)

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.

#1 Restrict entry to only individuals who need entry, such as:

- Facility employees, contractors and consultants who are needed to keep the operations running and assure the residents' needs are met.
- Government officials who in their capacity require entry (e.g., CDC or public health staff).
- Immediate families or friends who need to visit for critical or time sensitive reasons such as hospice-related visits, complete medical authorizations, etc. These visitors should be instructed to limit their movement within the facility.

Visitor Exceptions: AHCA/NCAL's recommendation is NOT for a complete ban on all visitors. The circumstances for the reason for entry need to be taken into consideration, particularly for immediate family members (e.g. spouse or sons/daughters) but routine social visits are strongly discouraged. The rationale for this best practice should be explained, and alternative methods of communications offered. We recommend that the resident (or the resident representative) be consulted to determine if a resident wants or needs a specific visitor, including immediate family members, and to allow entry if they do not meet any of the screening exclusion criteria in #3 below.

#2 Restrict activities and individuals with potential for exposure, including:

- Visitors, when there are any confirmed COVID-19 cases in the surrounding community. This does not apply to workforce needed to keep the operations going and to meet resident needs.

¹ These recommendations build upon what CMS and CDC currently recommend. We urge members to adopt these additional best practices when possible based on the growing data about the high mortality rate among the elderly over the age of 80 with chronic disease (estimated at 15%), who comprise the majority of our residents. Waiting until the virus starts to spread in the community, has been shown in prior viral epidemics to be too late. (Note the case fatality rate in the Kirkland WA SNF was over 50% based on data available on King County Health Departments website as of 3-7-20). To date, nearly all the deaths in the United States have been in individuals over the age of 70.
• Other visitors for routine social visits, tours with prospective residents or their families, and outside group activities (e.g., school groups or bands, etc.) should be restricted.
• Cancel activities that take residents into the community to public places particularly with large gatherings, such as mall, movies, etc. (note: this does NOT apply to residents who need to leave the building for medical care such as dialysis, medical visits, etc).
• Internal group activities should be restricted, especially if: a) the facility has residents with respiratory symptoms (who should be in contact isolation per CDC guidance); b) if COVID-19 is in the surrounding community; and/or c) the ability to restrict visitors is challenging in the facility.

Facilities should also continue to use CDC recommended signage reminding people that anyone with symptoms of respiratory illness should not enter the facility, including employees, government officials and contractors.

#3 Actively try to screen all individuals entering the building, including employees, contractors, volunteers, visitors, new admissions, government officials, and health care professionals. The screening process\(^2\) should include asking individuals for:
• Respiratory symptoms (fever, sore throat, cough and new shortness of breath);
  [Please note: As of March 7, taking temperatures is not included in any CDC or CMS recommendations and AHCA/NCAL is not recommending taking temperatures. Extenuating circumstances should be taken into consideration, but in these cases, individuals should use gown, mask and gloves during their visit.]
• International travel within the last 14 days to areas where COVID-19 cases have been confirmed.
• Anyone who has worked in another health care setting with confirmed COVID-19 cases (this may change as COVID-19 spreads in your community)

#4 Require all individuals entering the building to wash their hands at entry.
• If technically possible, set up hand washing and/or alcohol-based hand rub (ABHR) stations immediately inside all entryways with signage reminding people to wash before entering.
• Have each person who enters the center immediately wash their hands or use hand sanitizer before they do anything else.
• Encourage them to wash their hands or use ABHR throughout their time in the building and in accordance with CDC recommendations. CDC recommendations includes increasing the access to ABHR.
• Clean and disinfect frequently touched objects and surfaces following manufacturer’s directions.
• Remind people to not shake hands or hug with each other, staff or residents during this epidemic.

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\(^2\) See AHCA screening tool available on AHCA/NCAL COVID19 website.
#5 Set up a process to allow remote communication for residents and others.

- Ensure emergency contact information for family members and the resident representative is up to date.
- Develop alternative means of communications for residents to visit and talk with loved ones, such as video chat, telephone, texting or social media.
- Inform residents or their representatives of these changes using clear, concise, jargon-free messages that express empathy for their situation while simply explaining the policy.
- Ensure proactive communication with residents’ families, loved ones, contractors, volunteers, etc. to make them aware of these restrictions; and to keep them up to date.
- Develop a process for family members to communicate with the facility to get answers to their questions.

**Frequently Asked Questions**

**Who should NOT enter your center?**

- Anyone who has symptoms of respiratory illness or has traveled internationally within the last 14 days to areas where a COVID-19 outbreak has been confirmed.
- If COVID-19 is confirmed in your surrounding community, visitors should be restricted. This does not apply to the facility workforce or contractors.
- Any one has worked in another healthcare setting with COVID-19 patients (this may change as COVID-19 spreads in your community)

**Who should be screened?**

- Anyone who is entering your center including staff, visitors, contractors and government employees.

**How do I conduct a respiratory symptom screen?**

- Ask and observe for signs or symptoms of acute respiratory: (cough or sneezing or shortness of breath).
- Ask for symptoms of fever, sore throat, cough, shortness of breath.
  - Please note: As of March 7, taking temperatures is not recommended.

**What if a person refuses and tries to enter?**

- Explain the rationale for the restriction and need to keep all the residents safe.
- Offer them an alternate way to communicate with the person they want to see.
- Talk with the resident or person they want to see, to make sure they want to see the person and explain that person’s request.
- Use best judgement and assess extenuating circumstances for entry.
  [Note: this guidance is not a ban on all visitors and SNFs cannot be expected to physically restrain individuals from entering but should do what is feasible to explain the rationale for the restriction. Federal regulations permit SNFs to limit visitation if it poses a clinical or safety risk].
Resources to Facilitate Communication

AHCA/NCAL offers a number of communication resources on our coronavirus website (www.ahcancal.org/coronavirus), including:

- Screening tool for visitors
- Template letters for families and residents
- Template letters for employees
- Template statement and talking points for impacted and non-impacted facilities
- A guide on communication plans during an emergency

AHCA/NCAL strongly recommends all centers review the CDC guidance on COVID-19 by checking the CDC website frequently as guidance and recommendations are continuing to rapidly evolve.

Please email COVID19@ahca.org with any questions.

For additional information and resources on the virus, visit our dedicated website on this issue: www.ahcancal.org/coronavirus.
Guidance to SNFs on Admissions from and Discharges to Hospitals Relating To COVID-19 
(as of March 13, 2020)

This document answers some common questions regarding how to transfer patients with a confirmed COVID-19 diagnosis, when to accept or not accept COVID-19 patients from the hospital, and what to do about other patients who do not have a COVID-19 diagnosis.

Please note: this guidance may be used in the assisted living setting as well. Recognizing that assisted living communities vary across the country, refer to state-based requirements and level of care capabilities within the assisted living community.

**When should nursing homes consider transferring a resident with suspected or confirmed infection with COVID-19 to a hospital?**

Consistent with CMS memo of March 9, 2020:

- 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.
- 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.

Please check the CDC website on Recommendations for Patients with Suspected or Confirmed Coronavirus in Healthcare Settings regularly for critical updates, such as updates to guidance for using PPE.

Please also check the CDC website for Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes for additional updates for long-term care facilities.
When should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital?

Consistent with CMS memo of March 9, 2020:

- 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 infection prevention and control guidance, including proper precautions.
  - Consult with local and/or state health department before accepting resident as they may have different or more specific guidance based on latest developments.
- If a nursing home cannot follow transmission-based precautions, it must wait until these precautions are discontinued.
  - AMDA guideline notes that based on experience with similar viruses, people with severe illness will shed more virus and for a longer period of time than those with mild COVID-19 infection. People with severe illness may continue to shed virus even 12 days after symptom onset. The decision of when people no longer require isolation precautions should be made on a case-by-case basis and in consultation with public health officials. Such a decision will need to take into account the severity of the illness, comorbid conditions, resolution of fever, and clinical status of the individual.
- CDC has released Interim Guidance for Discontinuing Transmission-Based Precautions or In-Home Isolation for Persons with Laboratory-confirmed COVID-19. 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 Interim Guidance for further details).

AMDA recommends that nursing homes accept patients recovering from COVID-19 only after consultation with the local and/or state health department and referring facility. If limited resources make this impracticable, AMDA recommend that nursing homes should accept residents with a known COVID-19 infection when that individual can be placed in a private room with a closed door and when there is sufficient and adequately trained staff to care for that individual.

**When should a nursing home not accept a resident with known or suspected COVID-19?**

If any of the following conditions exist in the nursing home that would not allow for proper Transmission-Based Precautions to be implemented, do not admit a person with known COVID-19:
• No PPE for proper precautions (facemask, isolation gown, gloves, goggles or disposable face shield) or limited to extent that PPE is not readily available. Consider N95 or other respirators where indicated.
• Unable to restrict resident with COVID-19 to their room
• Unable to ensure resident with COVID-19 will wear facemask or cover mouth and nose with tissues if they must leave the room
• Unable to cohort resident with COVID-19 with other residents who have been diagnosed with COVID-19 or provide single person room with door closed and dedicated bathroom.
• Unable to dedicate health care providers to work only on unit where resident with COVID-19 will reside

How should a nursing home respond to a request to admit a person who:
• has unknown COVID-19 status;
• is in a hospital that has COVID-19 cases;
• resides in the community with COVID-19 cases with community spread; or
• resides in the community with COVID-19 cases without community spread?

Prior to accepting for admission, perform screening including:
• Fever or symptoms of respiratory infection (e.g., cough, sore throat, or shortness of breath);
• Contact with an individual with COVID-19;
• International travel within the last 14 days to affected countries. Information on high-risk countries is available on CDC’s COVID-19 travel website.

If suspected of COVID-19, follow process above for “when should a nursing home not accept a resident with known or suspected COVID-19” and “when should a nursing home accept a resident who was diagnosed with COVID-19 from a hospital”.

March 13, 2020
PRESS STATEMENT:

“We are doing everything we can to ensure we stop the spread of this within our facility/community. We are in very close communication with 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, and we have asked family and visitors to not visit our facility until the virus has been eradicated.”

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.
- [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 limiting contractors and visitors, including family members. Family can visit by using Skype or calling, texting or checking in on social media.

OR

- We are not permitting visitors and outside contractors per the direction of the local health department. Family can visit by using Skype or calling, texting or checking in on social media.
COMMON MEDIA QUESTIONS:

Should families who are worried move their loved ones out of skilled nursing centers 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 center or assisted living residents?
  - Just like the flu, 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?
  - Long term care providers are having some of the same difficulties as other health care providers getting masks and gowns. Providers should contact their state and local health departments if they are unable to place orders for equipment they need. It’s important to note that CDC does not recommend masks for the general public at this point.

BACKGROUND:

- To decrease the risk of viral outbreaks in long term care centers, 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 centers (or any health care facility) include:
  - Keeping all ill individuals from visiting the facility, including family, volunteers and employees.
  - 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 centers and require each nursing
  center 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 center 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.

- AHCA/NCAL has recommended several steps to help decrease the risk of future viral outbreaks in nursing centers:
  - AHCA/NCAL has offered to provide our certificate course for free to those centers who provide care to high risk individuals (e.g. pediatrics, ventilators, HIV, transplants, and ESRD).
  - State health departments should ensure each nursing center 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).
PRESS STATEMENT:

“We are acting now and have reviewed 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 remind all employees who are sick to stay home and ask all family members and volunteers to avoid visiting our [center/community] 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 center, to minimize the spread to anyone else.
- [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.
- 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 asking non-essential visitors, including family members, contractors, and volunteers to avoid visiting our facility for the time being. Loved ones can communicate with residents by using video chat, calling, texting, or checking in on social media.
- 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 centers 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 center or assisted living residents?
  - We know that the frail and elderly are very susceptible to this virus. That’s why we are limiting 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]. We 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.

BACKGROUND:

- To decrease the risk of viral outbreaks in long term care centers, 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 centers (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:
  o 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.
  o Regular and frequent internal monitoring systems of hand hygiene with regular feedback to staff.
  o Visual reminders that hand hygiene helps residents stay healthy.
  o 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).
  o Use of masks on residents with symptoms if they need to leave their rooms, which should be severely restricted.
  o Use of personal protective equipment by staff and visitors for droplet protection.
  o 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 centers and require each nursing center to have an infection control plan that must describe:
  o 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;
  o 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 center 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 centers who provide care to high risk individuals (e.g. pediatrics, ventilators, HIV, transplants, and ESRD).

State health departments should ensure each nursing center 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).
Reason We are Restricting Individuals from Entering our Building

The current COVID-19 outbreak situation means that it is critical that we take every precaution possible. We must prevent this virus from entering our center. Protecting our residents’ health and safety is our top priority.

The CDC has done a careful review of the death rate in the elderly, especially those with dementia or chronic diseases. Experts are recommending we take action to limit individuals from entering our building and to ensure sick employees stay home.

Early data shows that
- The mortality rate for people over 80 in the general population is 15% in China.
- The World Health Organization report estimates the mortality rate at 21.9% for those over 80.
- At the nursing home in Washington state, there have been 50 residents who have tested positive for the COVID-19 virus. As of March 9, 2020, 19 of those have died. This is a high death rate.

There is a risk that people who appear healthy will enter nursing homes and infect residents. Studies of past viral epidemics where recommending prevention was delayed were not effective. These studies show that the sooner we limit interactions with each other and wash your hands frequently virus spreads more slowly.

These facts have led many to recommend severe limitations on visitors. This describes why we have taken this action now.

We hope this explains to you why we are asking people to limit their visits. This may prevent you from physically seeing your family member or friend. Our residents’ health and safety are our top concern. We are committed to doing everything we can to protect them.

Please feel free to contact [ABC Nursing Home] with any questions. Please make sure we have your latest contact information. Thank you for supporting these efforts.

Sincerely,

[ENTER NAME/CONTACT INFO FOR FACILITY]
**Template Letter for Residents and Family Members on Center Letterhead**

**Please Tailor as Needed**

To Our Residents and Family Members:

We know many of you are concerned about the spread of COVID-19 (the new coronavirus) and how it may impact us here at [FACILITY NAME]. Ensuring residents are cared for in a safe and healthy environment is our first priority. At this time, we don’t have any cases in our [CENTER/COMMUNITY]. The Centers for Disease Control and Prevention (CDC) have recommended a variety of steps that we are implementing to help reduce the potential for the virus to enter our building. However, we need your help in battling COVID-19. Below are some examples of how you can help protect the residents, as well as prevent the spread throughout the community.

At this time, we request that family and friends do not visit the center. Out of an abundance of caution, we are limiting all visitors to our facility unless absolutely necessary. We are posting signs on our entryway doors to notify visitors of this policy and actively screening individuals, including staff, who need to come into the building.

We understand that connecting with your loved ones is incredibly important, and there are a variety of other ways you might consider communicating with them. These may include telephone, email, text, video chat or social media. If you believe a visit to the center is necessary, we request that you contact [POINT OF CONTACT AND CONTACT INFO] prior to your arrival.

Please make sure we have your most current, emergency contact information. We want to make sure we efficiently communicate with you should there be any new developments. Please reach out to [POINT OF CONTACT AND CONTACT INFO] with your updated contact information.

Residents [AND PATIENTS], please help prevent the spread of infection by exercising proper hand washing hygiene as well as coughing and sneezing etiquette. We offer hand washing and alcohol-based hand sanitizer stations throughout the building, which you are welcome to use. Please also avoid shaking hands and hugs with any individual. If you are experiencing a cough, fever, sore throat, runny nose, and/or shortness of breath, please let a staff member know immediately.

Our [CENTER/COMMUNITY] is following the recommendations of the CDC on prevention steps, including following strict handwashing procedures, and in many circumstances, wearing gowns and gloves when interacting with residents who present symptoms. We also are staying up to date with the CDC recommendations as they may continue to change. In addition, our [CENTER/COMMUNITY] is in close contact with the local and state health department, and we are following their guidance.

We will notify you if any residents or staff are diagnosed with COVID-19. Should you have any questions, please feel free to contact our center at: [PLEASE FILL IN YOUR CENTER’S CONTACT INFORMATION AND TAILOR TO MEET YOUR CENTER’S NEEDS.]

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

Sincerely,

[FILL IN YOUR CENTER INFORMATION]
To Our Employees:

We know some of 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. At this time, we don’t have any cases in our [CENTER/COMMUNITY]. The Centers for Disease Control and Prevention (CDC) have recommended a variety of steps that we are implementing to help reduce the potential for the virus to enter our building. However, we need your help in battling COVID-19. Below are some examples of how you can help protect yourselves and our residents, as well as prevent the spread throughout the community.

1. **Sick employees should stay home.** At this time, we request that you stay home if you have any symptoms of respiratory illness. Those symptoms include: cough, fever, sore throat, runny nose, and/or shortness of breath.

2. **Notify us if you develop respiratory symptoms while at work.** These include: cough, fever, sore throat, runny nose, and/or shortness of breath.

3. **Practice proper hand washing 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.

4. **Cover your mouth and nose with a tissue when coughing or sneezing.** Please review the CDC’s information on coughing and sneezing etiquette.

5. **Perform routine environmental cleaning.** Routinely clean all frequently touched surfaces in the workplace, such as workstations, countertops, and doorknobs. Use the cleaning agents that are usually used in these areas and follow the directions on the label. No special cleaning is necessary for COVID-19.

Our [CENTER/COMMUNITY] is following the recommendations of the CDC on using basic contact precautions to prevent the spread, which includes wearing gowns and gloves when interacting with residents who present symptoms—as we always do. We also are staying up to date with the CDC recommendations as they may continue to change. In addition, our [CENTER/COMMUNITY] is in close contact with the local and state health department and are following their guidance.

We are asking all non-essential visitors to avoid coming to the building unless absolutely necessary, and actively screening individuals—including staff—who enter. We are posting signs on our entryway doors to notify visitors of this policy and request that they not enter the building.

We will notify you if any residents or staff are diagnosed with COVID-19. 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.

Sincerely,

[FILL IN YOUR CENTER INFORMATION]
## Variations between AHCA Recommendations and CMS Revised Guidance on for Visitation during COVID-19

The new guidance issued by CMS on 3/9/2020 has the same goals and instructions for preventing COVID-19 from entering facilities as AHCA’s guidance, with a few areas of slight variation.

### Areas of slight variation in guidance

<table>
<thead>
<tr>
<th>Screening Protocol:</th>
<th>AHCA</th>
<th>CMS</th>
<th>Variation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory symptoms</td>
<td>Yes</td>
<td>Yes</td>
<td>AHCA does not recommend temperature checks; CMS mentions “offering” them but does not require. Temperature checks will pull nurses off the floor.</td>
</tr>
<tr>
<td>Anyone who has worked in another health care setting with confirmed COVID-19 cases</td>
<td>Yes</td>
<td>No</td>
<td>CMS does not specifically mention this; AHCA notes that this recommendation may need to change if COVID-19 is widespread in the community</td>
</tr>
<tr>
<td>In the last 14 days, has had contact with someone with a confirmed diagnosis of COVID-19, or under investigation for COVID-19, or are ill with respiratory illness</td>
<td>No</td>
<td>Yes</td>
<td>Slightly different wording: AHCA does not mention contact, but recommends restricting all visitors when there are any confirmed COVID-19 cases in the surrounding community</td>
</tr>
<tr>
<td>Been on a cruise or in another setting with confined crowds in the last 14 days</td>
<td>No</td>
<td>Yes</td>
<td>Both CMS and AHCA guidance is to allow visitors if absolutely necessary – CMS also specifies either restricting visitors who have been on a cruise or large crowds, or asking them to wear masks</td>
</tr>
</tbody>
</table>

| Require all individuals to wash hands at entry | Yes | No | CMS does not specifically require but suggests providing instruction on hand hygiene |
| Create “clean rooms” and disinfect after use | No | Yes | CMS suggests this as best practice for visitors to meet with residents; AHCA does not as it may not be feasible |
| Restrict interaction with other stakeholders (volunteers, vendors, suppliers) | No | Yes | CMS suggest suppliers leave supplies outside; AHCA recommends screening everyone at entry and limit for essential visits |
| Recommends restricting gatherings in the community (outside the facility) | Yes | No | AHCA notes obvious exception for health care visits outside the facility |
| Recommends restricted activities inside the facility (internal group activities) | Yes | No | |

## Both AHCA and CMS recommend

- Recommend further restrictions or limitations to visitation and, generally, discourage visitation at this time
- Screen for international travel within the last 14 days to areas where COVID-19 cases have been confirmed
- Encourage other methods of communication for residents interacting with their loved ones
- Update emergency contact info with families
- Encourage restricted movement when visitation occurs
- Social distancing practices, such as no hand shaking or hugging
- Recommend [signage](#) at entry, and elsewhere, and education on other infection control strategies (hand hygiene, social distancing)
- Recommend visitors use PPE
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.

Serious considerations must be made regarding the executive director/administrator. 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 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**
NJDOH INFORMATION

- 2019 Novel Coronavirus Information Sheet
- COVID-19 Health Care Personnel Exposure Checklist
- COVID-19 Fever and Symptom Monitoring Log for Health Care Personnel
- HealthCare Personnel Exposure to Confirmed COVID-19 Case Risk Algorithm
- Retrospective Assessment Tool for Health Care Personnel Potentially Exposed to COVID-19
What is a novel coronavirus?

Novel (meaning “new”) coronavirus is a virus strain that has only spread in people since December 2019. Health experts are concerned because little is known about this new virus and it has the potential to cause severe illness in some people.

How does novel coronavirus spread?

Health experts are still learning the details about how this new coronavirus spreads. Other coronaviruses spread from an infected person to others through:

- The air by coughing and sneezing
- Close personal contact, such as touching or shaking hands
- Touching an object or surface with the virus on it, then touching your mouth, nose, or eyes
- In rare cases, contact with feces (poop)

How severe is novel coronavirus?

Health experts are still learning about the illness caused by the new virus. People infected have had illness that has ranged from mild (like a common cold) to severe pneumonia that requires medical care in a hospital. So far, deaths have been reported mainly in older adults who had other health conditions.

What are the symptoms?

People who have been diagnosed with novel coronavirus have symptoms that may appear in as few as two days or as long as 14 days after exposure to the virus. Symptoms may include fever, cough, and shortness of breath.
Who is at risk for novel coronavirus?

Currently, there is a widespread outbreak in Wuhan, China. At this time, the risk in the U.S. to the general public is low. At this time, there are a small number of cases in the U.S. To limit the risk of spread, health officials are working with healthcare providers to promptly identify and evaluate anyone they think may have the virus. Travelers to and from certain areas of the world may be at increased risk. See wwwnc.cdc.gov/travel for the latest travel guidance from the CDC.

How can I prevent from getting novel coronavirus?

If you are traveling overseas (to China, but also to other places) follow the CDC’s guidance at wwwnc.cdc.gov/travel.

Right now the novel coronavirus has not been spreading widely in the United States, so there are no additional precautions recommended for the general public. Steps you can take to prevent spread of flu and the common cold will also help prevent coronavirus:

- Wash hands often with soap and water. If not available, use hand sanitizer.
- Avoid touching your eyes, nose, or mouth with unwashed hands
- Avoid contact with people who are sick
- Stay home while you are sick and avoid contact with others
- Cover your mouth and nose with a tissue or sleeve when coughing or sneezing

Currently there are no vaccines available to prevent novel coronavirus infections.

How is novel coronavirus treated?

There is no specific treatment for coronavirus. Most people with mild coronavirus illness will recover on their own by drinking plenty of fluids, resting, and taking pain and fever medications. However, some people develop pneumonia and need medical care or treatment in a hospital.

For more information: https://www.nj.gov/health/cd/topics/ncov.shtml

Follow the New Jersey Department of Health on Twitter @njdeptofhealth, Facebook /njdeptofhealth and Instagram@njdeptofhealth.
Background

COVID-19 is a new and emerging public health concern that originated in Wuhan City, Hubei Province, China in late 2019. COVID-19 is caused by SARS-CoV-2, a novel coronavirus. Coronaviruses are a large family of viruses that are common in many different species of animals, including camels, cattle, cats, and bats. Coronaviruses can also regularly infect humans and are a frequent cause of the common cold.

Early reports suggest that COVID-19 most often is spread during close exposure to a person who is ill with the disease, although asymptomatic spread might be possible before people show symptoms. Person-to-person spread is thought to occur mainly via respiratory droplets produced when an infected person coughs, similar to other respiratory pathogens. These droplets can land in the mouth, nose, or eyes of people who are nearby, or possibly be inhaled into the lungs. While much is still to be learned, touching a contaminated surface and then touching the mouth, nose, or eyes, might also contribute to transmission.

As the spread of COVID-19 has been confirmed throughout the United States, including in New Jersey, it is important to keep updated on the most recent information and guidance. For up-to-date case counts or and other information please visit the Centers for Disease Control and Prevention (CDC) COVID-19 webpage at [https://www.cdc.gov/coronavirus/2019-nCoV/index.html](https://www.cdc.gov/coronavirus/2019-nCoV/index.html) or the New Jersey Department of Health COVID webpage at [https://www.nj.gov/health/cd/topics/ncov.shtml](https://www.nj.gov/health/cd/topics/ncov.shtml).

Purpose

Due to their often extensive and close contact with vulnerable individuals in healthcare settings, NJDOH recommends a conservative approach to HCP monitoring and restrictions from work to quickly identify early symptoms and prevent transmission from potentially contagious HCP to patients, HCP, and visitors. Healthcare facilities (HCFs) should have a low threshold for evaluating symptoms and testing symptomatic HCP, particularly those who fall into the high- and medium-risk categories described in this guidance. HCFs, in consultation with public health authorities, should use clinical judgment as well as the principles outlined in this guidance to assign risk and determine need for work restrictions.
NOTE: CDC has defined HCP as all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this guidance, HCP does not include clinical laboratory personnel.

Lastly, HCP who are returning travelers or exposed in a community setting while NOT providing care to patients in a healthcare setting with confirmed COVID-19 infection should be assessed using the traveler and community guidance previously released by NJDOH.

**Supplemental Tools**

To help HCFs document and assess HCP risk and exposure, NJDOH has developed the below series of tools and checklists:

1. **“NJDOH Healthcare Personnel (HCP) Exposure to Confirmed COVID-19 Case Risk Algorithm”**
   - This document can be used to assess the type of potential exposure HCP may have experienced while caring for the COVID-19 patient and assign risk level (High, Medium, Low or No Risk). It also provides guidance on the management of exposed HCP.

2. **“Retrospective Assessment Tool for Healthcare Personnel Potentially Exposed to COVID-19”**
   - This tool can be used to assess HCP exposure risk prior to the patient being identified as having COVID-19.

   - This tool can be used to monitor and assess the appropriate use of personal protective equipment (PPE) for HCP caring for the COVID-19 patient after they have been identified in the facility.

4. **“NJDOH COVID-19 Fever and Symptom Monitoring Log for Healthcare Personnel”**
   - This tool can be used by a HCF or local health department (LHD) to assist HCP with daily symptom monitoring.

The guidance outlined below will assist HCFs and public health partners in determining COVID-19 exposure risk of HCP and which appropriate course of action to take in their management.

**Role of the HCF and Public Health Officials**

Central to this guidance are the roles of the HCF and collaboration with the state and local health departments. For the purposes of this guidance, NJDOH recommends HCFs determine their internal capacity to assess HCP exposure and monitor for symptoms of COVID-19.

- Healthcare providers or facilities who have an infrastructure (e.g., occupational health, infection prevention, administration) to support risk assessment and monitoring will be responsible for assessing risk exposure, initiating and tracking symptom monitoring if warranted, conduct contact tracing, make decisions about furlough from work and complete any associated documentation.
- HCFs should include their occupational health program if applicable in the assessment and management of risk
- Decisions to furlough HCP based on risk should be done in accordance with current CDC and NJDOH guidance for management of HCP exposed to COVID-19
  - Facilities who require assistance with the above tasks may reach out to their LHDs for support and guidance in managing any exposed HCP. LHDs may assist with or manage any of the above tasks.
  - If active monitoring is being conducted and managed by the HCF, LHDs should be notified for situational awareness purposes.

Below is guidance for assessing and managing HCP who may have been exposed to patients with confirmed COVID-19. HCFs and LHDs may choose to adapt and use this in accordance with their own policies and procedures.

NJDOH guidance is based on currently available data about COVID-19 and guidance from CDC. Guidance and Recommendations may be subject to change as new information becomes available.

**HCP Exposures to Confirmed COVID-19 Case(s)**

HCP who are working in facilities where they may be exposed to confirmed cases of COVID-19 should be educated on potential risk and the appropriate infection control measures for preventing exposure. Should an exposure occur, the facility should have the capacity to evaluate exposure risk and notify HCP. HCFs, with support of the LHDs if needed, may conduct active or passive monitoring, make decisions on work furlough, and provide follow up and resources to HCP who develop symptoms.

1. **HCP Exposure Risk Assessment:** When caring for COVID-19 patients, HCFs should have policies and procedures in place that align with CDC’s Interim Infection Control Guidance for COVID-19. This guidance provides direction for facilities on the appropriate use of PPE, isolation, identifying breaches in PPE, and tracking HCP movement in and out of isolation rooms. HCP with exposure to confirmed COVID-19 cases should be identified and an appropriate risk assessment completed to determine if they have a high, medium, low, or no identifiable risk exposure (including breaches in PPE). Documentation should be done by the facility for those HCP with identified risk. This can be done by the department(s) of infection prevention, occupational health or another designee. The facility may request assistance from the LHD at any time to assist with these tasks. Exposure assessment can be done using the tools developed by NJDOH, described above.

2. **Active or Passive Symptom Monitoring:** The decision to initiate active or passive symptom monitoring for 14 days after last exposure should be made based on the level of HCP exposure risk. The facility will conduct appropriate monitoring with associated documentation using internal processes previously developed or the *NJDOH COVID-19 Fever and Symptom Monitoring Log for Healthcare Personnel.*
3. Management of symptomatic HCP with known COVID-19 exposure: HCFs and LHDs who are conducting active monitoring should have a plan in place if HCP develop symptoms during their 14-day symptom monitoring period. Facilities should consider developing an individualized plan in conjunction with employee health, administration, infection prevention, LHDs and the HCF. All HCP who undergo symptom monitoring should be made aware of where to seek care should symptoms develop. This may include their personal healthcare provider, occupational health, the HCF where they currently work or other designated provider. This should be discussed at the start of the monitoring process. In general, HCP who are exposed to a confirmed case of COVID-19 and develop symptoms (fever, cough, shortness of breath) should:
   a. Isolate themselves from others in the home (if home monitoring is in place)
   b. Alert their employer (HCF) and/or designee who is monitoring their symptoms and receive guidance on where to seek additional advice or care if needed. If care is needed emergently the HCP should be advised to call 911 and alert dispatch that they are currently being monitored for COVID-19.
   c. The HCF and/or designee responsible for monitoring should notify the LHD immediately to determine if the HCP requires testing.
   d. If the symptomatic HCP becomes a confirmed COVID-19 case, management and clearance for return to work should be done in accordance with the available evidence and guidance from CDC and NJDOH. Clearance for return to work should be made in collaboration with LHD, the HCP and the HCF management/occupational health.

4. Management of asymptomatic HCP and guidance for return to work: HCP who complete their 14-day symptom monitoring period and remain asymptomatic should have complete and accurate documentation for LHD or NJDOH review, if requested. Individuals who remain asymptomatic should be allowed to return to work after their 14-day monitoring period is complete.

Guidance on Furlough/Work Restriction of HCP and Return to Work

Current guidance from CDC indicates that HCP with high- and medium-risk exposures should be restricted from work and undergo active monitoring for 14 days. However, the guidance also states that the decision to furlough workers may be left to the discretion of the HCF and is dependent on nature of exposure, the symptoms of HCP and the needs of the facility. Given the likelihood of community spread, restriction of all HCP with COVID-19 exposures may not be feasible particularly if HCP are exposed outside of the HCF. Personnel resources and the needs of the HCF should be considered when determining the need for work restriction or furlough. NJDOH recommends that HCFs review their internal work restriction/furlough and HCP exposure policies and update them as needed to address any questions about COVID-19 exposures and work restrictions. Guidance for HCP who are exposed to COVID-19 and not restricted from work can be found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html.

HCP with high- or medium-risk exposure and are furloughed or restricted from work, may return to work if they are asymptomatic at the end of their 14-day monitoring period. Those HCP who become
symptomatic and are diagnosed with COVID-19 may return to work in consultation with their employer. The employer/HCF should determine appropriateness for return to work using the available CDC guidance and consultation with NJDOH and LHD if necessary.

**Exposure Risk Categories for HCP Caring for Confirmed COVID-19 Patients**

CDC and NJDOH recommend the following risk-based stratification of asymptomatic HCP and corresponding monitoring, movement and work restriction guidance. NJDOH has developed an algorithm to assist with the identification of risk (see NJDOH Healthcare Personnel (HCP) Exposure to Confirmed COVID-19 Case Risk Algorithm). Additional guidance on conducting an appropriate HCP risk assessment can be found on the CDC website.

**High-risk exposures** generally refer to HCP who have had prolonged close contact with patients with COVID-19 who were not wearing a facemask while HCP nose and mouth were unprotected. CDC provides the example of a HCW who is present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on patients with COVID-19 when the HCP eyes, nose, or mouth were not protected, would be considered high-risk.

**Medium-risk exposures** generally include exposures in which HCP had prolonged close contact with patients with COVID-19 who were wearing a facemask while HCP nose and mouth were unprotected. Some low-risk exposures could be upgraded to medium-risk depending on the type of care activity performed. CDC provides the example of HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure, instead of a low-risk exposure.

**HCP in the high- or medium-risk category** should undergo active monitoring, including restriction from work in any healthcare setting until 14 days after their last exposure. The distinction between high- and medium-risk exposures is the same in terms of recommendations for active monitoring and work restrictions. CDC created these risk categories to align with risk categories in the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease 2019 (COVID-19) Exposures: Geographic Risk and Contacts of Laboratory-confirmed Cases (https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html).

**Low-risk exposures** generally refer to brief interactions with patients with COVID-19 or prolonged close contact with patients who were wearing a facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection, in addition to a facemask or respirator would further lower the risk of exposure.

**HCP in the low-risk category** should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. Asymptomatic HCP in this category are not restricted from work. They should check their temperature twice daily and remain alert for respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat). HCP should ensure they are afebrile and asymptomatic before leaving home and reporting for work.
**No identifiable risk:** HCP with no direct patient contact and no entry into active patient management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have no identifiable risk.)

**NOTE:** Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, CDC recommends HCP should still perform self-monitoring with delegated supervision, the same as low-risk exposures.

If HCP become symptomatic such as developing any fever (measured temperature >100.0°F or subjective fever) OR respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat) they should immediately self-isolate (separate themselves from others) and notify their LHD or NJDOH and HCF for further evaluation.

Currently, this guidance applies to HCP with potential exposure in a healthcare setting to patients with confirmed COVID-19. However, HCP exposures could involve a PUI who is awaiting testing. Implementation of monitoring and work restrictions described in this guidance could be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. A record of HCP exposed to a PUI should be maintained and HCP should be encouraged to perform self-monitoring while awaiting test results. If the results will be delayed more than 72 hours or the patient is positive for COVID-19, then the monitoring and work restrictions described in this document should be followed.

**Resources**

- NJDOH – COVID-2019 (Novel Coronavirus, Wuhan, China)
  - [https://www.nj.gov/health/cd/topics/ncov.shtml](https://www.nj.gov/health/cd/topics/ncov.shtml)
- CDC – Coronavirus Disease 2019 (COVID-19)
- CDC – Interim Guidance for Implementing Home Care of People Not Requiring Hospitalization for Coronavirus Disease 2019 (COVID-19)
- NJDOH – Local Health Department Directory
  - [www.localhealth.nj.gov](http://www.localhealth.nj.gov)
- CDC – Interim Guidance for Preventing the Spread of Coronavirus Disease 2019 (COVID-19) in Homes and Residential Communities
- 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
**NJDOH COVID-19 Healthcare Personnel (HCP) Exposure Checklist**

Facility Name: ___________________________    Unit:___________________ Date: ____/___/________  Shift:__________________

Directions: Place a ✓ where appropriate for each staff encounter with COVID-19 patient. To determine HCP exposure risk, use information in checklist and refer to **NJDOH HCP Exposure to Confirmed Case Risk Algorithm**.

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*Example of prolonged close contact with patient is being within 6 feet of patient for over 1-2 minutes
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(1) Name: ________________________ Age (yrs): _______ Sex: M F

(2) Street address: ________________________ City, State: ________________________ Telephone number: ________________________

(3) Exposure Level (High or Medium) ________________________ Furloughed from work? ________________________

(4) Case ID number (from contact listing form): _______________ Contact number (from contact listing form): _______________

(5) Facility where the contact occurred case occur: ________________________

Date of last contact with the case (mm/dd/yyyy): _______________
NJDOH Healthcare Personnel (HCP)\(^\star\) EXPOSURE to Confirmed COVID-19 Case Risk Algorithm

HCP who have PROLONGED CLOSE CONTACT with patient (e.g. within 6 feet for over 1-2 minutes) OR having UNPROTECTED DIRECT CONTACT WITH INFECTIOUS SECRETIONS OR EXCRETIONS of the patient

HCP who had brief interactions with a patient such as conversations at triage, briefly entering patient room but not having direct contact with the patient or patient’s secretions/excretions, or entering patient room immediately after discharge

HCP who walk by a patient or who have no direct contact with the patient or their secretions/excretions and no entry into the patient room

See back for monitoring and work restriction recommendations
**For this guidance, CDC defines HCP as all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.**

**Procedures likely to generate higher concentrations of respiratory secretions or aerosols include, but are not limited to, cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, or sputum induction.**

*If during monitoring the person develops any fever (measured temperature $\geq 100.0^\circ F$ or subjective fever) OR respiratory symptoms consistent with the 2019 Novel Coronavirus infection (e.g. cough, shortness of breath, sore throat) they should immediately self-isolate (separate themselves from others) and promptly notify their local or state public health authority and healthcare facility for further evaluation.**

**In situations of suspected community transmission 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 immediately and don a facemask.**


### Risk Exposure Category | Recommended Monitoring* | Work Restrictions for Asymptomatic HCP**
--- | --- | ---
**HIGH RISK** | ACTIVE Monitoring until 14 days after the last potential exposure | Exclude from work for 14 days after last exposure
**MEDIUM RISK** | ACTIVE Monitoring until 14 days after the last potential exposure | Exclude from work for 14 days after last exposure
**LOW RISK** | SELF-MONITORING with delegated supervision until 14 days after the last potential exposure | NONE
**NO IDENTIFIABLE RISK** | NONE | NONE

---

^For this guidance, CDC defines HCP as all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.

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Retrospective Assessment Tool for Healthcare Personnel (HCP) Potentially Exposed to COVID-19

Directions: For each confirmed COVID-19 case, maintain a line list of HCP and complete a tracking form for each potentially exposed HCP (e.g., nurses, physicians, respiratory therapists, environmental services, others). Upon completion, please refer to NJDOH Healthcare Personnel Exposure to Confirmed COVID-19 Case Risk Algorithm to determine risk level for each date exposed. Use additional sheets if necessary. The overall risk level should be determined from the highest risk level of all dates exposed. If monitoring is indicated, monitoring should begin on the most recent date of MEDIUM or HIGH-risk exposure and continue for 14 days as per CDC and NJDOH guidance.

PLEASE NOTE: This form is designed for retrospective assessment of potential exposures. For current or ongoing HCP exposures, please refer to the NJDOH Healthcare Personnel (HCP) COVID-19 Exposure Checklist.

<table>
<thead>
<tr>
<th>Employee ID:</th>
<th>Facility Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Sex:</td>
</tr>
<tr>
<td>Address (street, city, county, state):</td>
<td>Age (Years):</td>
</tr>
<tr>
<td>Phone Number(s):</td>
<td>Employee Position:</td>
</tr>
</tbody>
</table>

Risk Level Determined: __________________________________________

Active or Passive Monitoring: ________________________________

Employee Signature ____________________________  Date _____/______/_______
Dates the patient was in the facility:
Please enter Y (yes) or N (no) in each box based on the exposure question and the date specified.
Please describe any exposures requested in this column here. Please use a separate sheet of paper if you need more space.

<table>
<thead>
<tr>
<th>Date/Shift</th>
<th>Notes:</th>
</tr>
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<tbody>
<tr>
<td>1 Did you work a shift on this day? (Y/N) If NO, STOP for this date</td>
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<tr>
<td>2 If yes, was this shift overnight? (Y/N)</td>
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</table>

**EXPOSURE QUESTIONS:**

3 Were you present in the room for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g. cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, or sputum induction)? (Y/N)
   If yes, list which procedures in notes column and SKIP to question 9

4 Did you have PROLONGED CLOSE CONTACT (e.g. within 6 feet for over 1-2 minutes)? (Y/N)

5 Did you have extensive body contact with the patient (e.g. rolling the patient)? (Y/N)

6 Did you have contact with the patient's secretions or excretions (Y/N)?
   If yes, please indicate if secretions/excretions contacted unprotected mouth, eyes, nose, or hands in notes column

7 Did you have brief interactions with the patient such as conversations at triage, briefly entering patient room, or entering patient room immediately after discharge? (Y/N, if yes describe in notes)

8 Did you walk by a patient without direct contact with the patient or their secretions/excretions AND did not enter the patient room? (Y/N)
   If YES, and questions 3-7 are NO, STOP for this date

**PERSONAL PROTECTIVE EQUIPMENT AND HAND HYGIENE QUESTIONS:**

9 Were you wearing gloves (Y/N)

10 Were you wearing a gown (Y/N)

11 Were you wearing respiratory protection as protective as a N95 Respirator or better (Y/N)

12 Were you wearing a mask (Y/N)

13 Were you wearing eye protection such as goggles or disposable face shield (Y/N)

14 Was the patient wearing a facemask? (Y/N)

**DAILY RISK LEVEL determined from NJDOH Healthcare Personnel Exposure to Confirmed COVID-19 Case Risk Algorithm**

OVERALL RISK LEVEL DETERMINED: ______________________________
CDC INFORMATION

- Checklist for HealthCare Facilities: Strategies for Optimizing the Supply of N95 Respirators During the COVID-19 Response
- CDC Education Tools: workplace-school-home-guidance
- Stop the Spread of Germs
- Symptoms for Coronavirus Disease 2019
- What You Need to Know About Coronavirus Disease 2019
- What to Do If You Are Sick with Coronavirus Disease 2019
- CERC In an Infectious Disease Outbreak
- Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission
Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response

Strategies for Optimizing the Supply of N95 Respirators offers a series of strategies or options on how healthcare facilities can optimize supplies of disposable N95 filtering facepiece respirators when there is limited supply availability. This checklist is intended to help healthcare facilities prioritize the implementation of the strategies following the prioritization used in the concept of surge capacity. The following strategies are categorized in a continuum of care and further organized according to the hierarchy of controls, as defined below.

Conventional Capacity Strategies consist of providing patient care without any change in daily practices

<table>
<thead>
<tr>
<th>Engineering Controls reduce exposures for healthcare personnel (HCP) by placing a barrier between the hazard and the HCP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolate patients in an airborne infection isolation room (AIIR)</td>
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<tr>
<td>Use physical barriers such as glass or plastic windows at reception areas, curtains between patients, etc.</td>
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<tr>
<td>Properly maintain ventilation systems to provide air movement from a clean to contaminated flow direction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative Controls refer to employer-dictated work practices and policies that reduce or prevent hazardous exposures.</th>
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<tbody>
<tr>
<td>Limit the number of patients going to hospitals or outpatient settings by screening patients for acute respiratory illness prior to non-urgent care or elective visits</td>
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<tr>
<td>Exclude all HCP not directly involved in patient care (e.g., dietary, housekeeping employees)</td>
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<td>Reduce face-to-face HCP encounters with patients (e.g., bundling activities, use of video monitoring)</td>
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<tr>
<td>Exclude visitors to patients with known or suspected COVID-19</td>
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<tr>
<td>Implement source control: Identify and assess patients who may be ill with or who may have been exposed to a patient with known COVID-19 and recommend they use facemasks until they can be placed in an AIIR or private room.</td>
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<tr>
<td>Cohort patients: Group together patients who are infected with the same organism to confine their care to one area</td>
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<tr>
<td>Cohort HCP: Assign designated teams of HCP to provide care for all patients with suspected or confirmed COVID-19</td>
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<tr>
<td>Use telemedicine to screen and manage patients using technologies and referral networks to reduce the influx of patients to healthcare facilities</td>
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*continue on next page*
cont.

- Train HCP on indications for use of N95 respirators
- Train HCP on use of N95 respirators (i.e., proper use, fit, donning and doffing, etc.)
- Implement just-in-time fit testing: Plan for larger scale evaluation, training, and fit testing of employees when necessary during a pandemic
- Limit respirators during training: Determine which HCP do and do not need to be in a respiratory protection program and, when possible, allow limited re-use of respirators by individual HCP for training and then fit testing
- Implement qualitative fit testing to assess adequacy of a respirator fit to minimize destruction of N95 respirator used in fit testing and allow for limited re-use by HCP

Personal Protective Equipment and Respiratory Protection should be used as part of a suite of strategies to protect personnel, complementing the use of engineering and administrative controls as needed.

- Use surgical N95 respirators only for HCP who need protection from both airborne and fluid hazards (e.g., splashes, sprays). If needed but unavailable, use faceshield over standard N95 respirator.
- Use alternatives to N95 respirators where feasible (e.g., other disposable filtering facepiece respirators, elastomeric respirators with appropriate filters or cartridges, powered air purifying respirators)

Contingency Capacity Strategies may change practices but may not have a significant impact on patient care or HCP safety

Administrative Controls
- Decrease length of hospital stay for medically stable patients with COVID-19 who cannot be discharged to home for social reasons by identifying alternative non-hospital housing

Personal Protective Equipment and Respiratory Protection
- Use N95 respirators beyond the manufacturer-designated shelf life for training and fit testing
- Extend the use of N95 respirators by wearing the same N95 for repeated close contact encounters with several different patients, without removing the respirator (i.e., recommended guidance on implementation of extended use)
- Implement re-use of N95 respirators by one HCP for multiple encounters with different tuberculosis patients, but remove it after each encounter
Crisis/Alternate Strategies are not commensurate with current U.S. standards of care but may need to be considered during periods of expected or known N95 respirator shortages.

### When N95 Supplies are Running Low

**Personal Protective Equipment and Respiratory Protection**

- Use respirators as identified by CDC as performing adequately for healthcare delivery beyond the manufacturer-designated shelf life
- Use respirators approved under standards used in other countries that are similar to NIOSH-approved N95 respirators but that may not necessarily be NIOSH-approved
- Implement limited re-use of N95 respirators for patients with COVID-19, measles, and varicella
- Use additional respirators identified by CDC as NOT performing adequately for healthcare delivery beyond the manufacturer-designated shelf life
- **Prioritize the use of N95 respirators and facemasks by activity type** with and without masking symptomatic patients

### When No Respirators Are Left

**Administrative Controls**

- Exclude HCP at higher risk for severe illness from COVID-19 from contact with known or suspected COVID-19 patients (i.e., those of older age, those with chronic medical conditions, or those who may be pregnant)
- Designate convalescent HCP for provision of care to known or suspected COVID-19 patients those who have clinically recovered from COVID-19 and may have some protective immunity to preferentially provide care

**Engineering Controls**

- Use an expedient patient isolation room for risk-reduction
- Use a ventilated headboard to decrease risk of HCP exposure to a patient-generated aerosol
- Personal Protective Equipment and Respiratory Protection
- Use masks not evaluated or approved by NIOSH or homemade masks as a last resort

www.cdc.gov/COVID19
Keeping the workplace safe
Encourage your employees to...

Practice good hygiene
- Stop handshaking – use other noncontact methods of greeting
- Clean hands at the door and schedule regular hand washing reminders by email
- Create habits and reminders to avoid touching their faces and cover coughs and sneezes
- Disinfect surfaces like doorknobs, tables, desks, and handrails regularly
- Increase ventilation by opening windows or adjusting air conditioning

Be careful with meetings and travel
- Use video conferencing for meetings when possible
- When not possible, hold meetings in open, well-ventilated spaces
- Consider adjusting or postponing large meetings or gatherings
- Assess the risks of business travel

Handle food carefully
- Limit food sharing
- Strengthen health screening for cafeteria staff and their close contacts
- Ensure cafeteria staff and their close contacts practice strict hygiene

Stay home if...
- They are feeling sick
- They have a sick family member in their home

What every American and community can do now to decrease the spread of the coronavirus
Keeping commercial establishments safe
Encourage your employees and customers to...

**Practice good hygiene**
- Stop handshaking – use other noncontact methods of greeting
- Clean hands at the door, and schedule regular hand washing reminders by email
- Promote tap and pay to limit handling of cash
- Disinfect surfaces like doorknobs, tables, desks, and handrails regularly
- Increase ventilation by opening windows or adjusting air conditioning

**Avoid crowding**
- Use booking and scheduling to stagger customer flow
- Use online transactions where possible
- Consider limiting attendance at larger gatherings

**For transportation businesses, taxis, and ride shares**
- Keep windows open when possible
- Increase ventilation
- Regularly disinfect surfaces

What every American and community can do now to decrease the spread of the coronavirus
Keeping the school safe
Encourage your faculty, staff, and students to...

Practice good hygiene
- Stop handshaking – use other noncontact methods of greeting
- Clean hands at the door and at regular intervals
- Create habits and reminders to avoid touching their faces and cover coughs and sneezes
- Disinfect surfaces like doorknobs, tables, desks, and handrails regularly
- Increase ventilation by opening windows or adjusting air conditioning

Consider rearranging large activities and gatherings
- Consider adjusting or postponing gatherings that mix between classes and grades
- Adjust after-school arrangements to avoid mixing between classes and grades
- When possible, hold classes outdoors or in open, well-ventilated spaces

Handle food carefully
- Limit food sharing
- Strengthen health screening for cafeteria staff and their close contacts
- Ensure cafeteria staff and their close contacts practice strict hygiene

Stay home if...
- They are feeling sick
- They have a sick family member in their home

What every American and community can do now to decrease the spread of the coronavirus
Keeping the home safe
Encourage your family members to...

All households
- Clean hands at the door and at regular intervals
- Create habits and reminders to avoid touching their face and cover coughs and sneezes
- Disinfect surfaces like doorknobs, tables, and handrails regularly
- Increase ventilation by opening windows or adjusting air conditioning

Households with vulnerable seniors or those with significant underlying conditions
*Significant underlying conditions include heart, lung, kidney disease; diabetes; and conditions that suppress the immune system*
- Have the healthy people in the household conduct themselves as if they were a significant risk to the person with underlying conditions. For example, wash hands frequently before interacting with the person, such as by feeding or caring for the person
- If possible, provide a protected space for vulnerable household members
- Ensure all utensils and surfaces are cleaned regularly

Households with sick family members
- Give sick members their own room if possible, and keep the door closed
- Have only one family member care for them
- Consider providing additional protections or more intensive care for household members over 65 years old or with underlying conditions

What every American and community can do now to decrease the spread of the coronavirus
Stay home when you are sick, except to get medical care.

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

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

Clean and disinfect frequently touched objects and surfaces.

Avoid close contact with people who are sick.

Avoid touching your eyes, nose, and mouth.

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: www.cdc.gov/COVID19
Patients with COVID-19 have experienced mild to severe respiratory illness.

Symptoms* can include:
- FEVER
- COUGH
- SHORTNESS OF BREATH

*Symptoms may appear 2-14 days after exposure.

Seek medical advice if you develop symptoms, and have been in close contact with a person known to have COVID-19 or if you live in or have recently been in an area with ongoing spread of COVID-19.

For more information: [www.cdc.gov/COVID19-symptoms](http://www.cdc.gov/COVID19-symptoms)
What is coronavirus disease 2019 (COVID-19)?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The virus that causes COVID-19 is a novel coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

Can people in the U.S. get COVID-19?

Yes. COVID-19 is spreading from person to person in parts of the United States. Risk of infection with COVID-19 is higher for people who are close contacts of someone known to have COVID-19, for example healthcare workers, or household members. Other people at higher risk for infection are those who live in or have recently been in an area with ongoing spread of COVID-19. Learn more about places with ongoing spread at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html#geographic.

Have there been cases of COVID-19 in the U.S.?


How does COVID-19 spread?

The virus that causes COVID-19 probably emerged from an animal source, but is now spreading from person to person. The virus is thought to spread mainly 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. It also may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads. Learn what is known about the spread of newly emerged coronaviruses at https://www.cdc.gov/coronavirus/2019-ncov/about/transmission.html.

What are the symptoms of COVID-19?

Patients with COVID-19 have had mild to severe respiratory illness with symptoms of

• fever
• cough
• shortness of breath

What are severe complications from this virus?

Some patients have pneumonia in both lungs, multi-organ failure and in some cases death.

How can I help protect myself?

People can help protect themselves from respiratory illness with everyday preventive actions.

• Avoid close contact with people who are sick.
• Avoid touching your eyes, nose, and mouth with unwashed hands.
• Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available.

If you are sick, to keep from spreading respiratory illness to others, you should

• Stay home when you are sick.
• Cover your cough or sneeze with a tissue, then throw the tissue in the trash.
• Clean and disinfect frequently touched objects and surfaces.

What should I do if I recently traveled from an area with ongoing spread of COVID-19?

If you have traveled from an affected area, there may be restrictions on your movements for up to 2 weeks. If you develop symptoms during that period (fever, cough, trouble breathing), seek medical advice. Call the office of your health care provider before you go, and tell them about your travel and your symptoms. They will give you instructions on how to get care without exposing other people to your illness. While sick, avoid contact with people, don’t go out and delay any travel to reduce the possibility of spreading illness to others.

Is there a vaccine?

There is currently no vaccine to protect against COVID-19. The best way to prevent infection is to take everyday preventive actions, like avoiding close contact with people who are sick and washing your hands often.

Is there a treatment?

There is no specific antiviral treatment for COVID-19. People with COVID-19 can seek medical care to help relieve symptoms.

For more information: 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. When working with your local health department check their available hours.

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
CERC in an Infectious Disease Outbreak

1. **Be First:** Quickly sharing information about a disease outbreak can help stop the spread of disease, and prevent and reduce illness and even death. People often remember the first information they hear in an emergency, so the first information they receive should come from health experts.
   - Even if the cause of the outbreak or specific disease is unknown, share facts that are available. This can help you stay ahead of possible rumors.
   - Share information about the signs and symptoms of disease, who is at risk, treatment and care options, and when to seek medical care.

2. **Be Right:** Accuracy establishes credibility. Information should include what is known, what is not known, and what is being done to fill in the information gaps.
   - Public health messages and medical guidance must complement each other. For example, public health officials should not widely encourage people to go to the doctors if doctors are turning people away and running out of medicine for critically ill people.
   - Always fact check with subject-matter experts. One incorrect message can cause harmful behaviors and may result in people losing trust in future messages.

3. **Be Credible:** Honesty, timeliness, and scientific evidence encourage the public to trust your information and guidance. Acknowledge when you do not have enough information to answer a question and then work with the appropriate experts to get an answer.
   - Do not make promises about anything that is not yet certain, such as distribution of vaccines or medications without confirmed availability.
   - Clinicians should be present at press or community events to answer medical questions.

4. **Express Empathy:** Disease outbreaks can cause fear and disrupt daily lives. Lesser-known or emerging diseases cause more uncertainty and anxiety. Acknowledging what people are feeling and their challenges shows that you are considering their perspectives when you give recommendations.
   - For example, during a telebriefing for the coronavirus disease 2019 response: “Being quarantined can be disruptive, frustrating, and feel scary. Especially when the reason for quarantine is exposure to a new disease for which there may be limited information.”

5. **Promote Action:** In an infectious disease outbreak, public understanding of and action on disease prevention is key to stopping the spread.
   - Keep action messages simple, short, and easy to remember, like “cover your cough.”
   - Promote action messages in different ways to make sure they reach those with disabilities, limited English proficiency, and varying access to information.

6. **Show Respect:** Respectful communication is particularly important when people feel vulnerable. Respectful communication promotes cooperation and rapport. Actively listen to the issues and solutions brought up by local communities and local leadership.
   - Acknowledge different cultural beliefs and practices about diseases, and work with communities to adapt behaviors and promote understanding.
   - Do not dismiss fears or concerns. Give people a chance to talk and ask questions.
Implementation of Mitigation Strategies for Communities with Local COVID-19 Transmission

Background

When a novel virus with pandemic potential emerges, nonpharmaceutical interventions, which will be called community mitigation strategies in this document, often are the most readily available interventions to help slow transmission of the virus in communities. Community mitigation is a set of actions that persons and communities can take to help slow the spread of respiratory virus infections. Community mitigation is especially important before a vaccine or drug becomes widely available.

The following is a framework for actions which local and state health departments can recommend in their community to both prepare for and mitigate community transmission of COVID-19 in the United States. Selection and implementation of these actions should be guided by the local characteristics of disease transmission, demographics, and public health and healthcare system capacity.

Goals

The goals for using mitigation strategies in communities with local COVID-19 transmission are to slow the transmission of disease and in particular to protect:

- Individuals at increased risk for severe illness, including older adults and persons of any age with underlying health conditions (See Appendix A)
- The healthcare and critical infrastructure workforces

These approaches are used to minimize morbidity and mortality and the social and economic impacts of COVID-19. Individuals, communities, businesses, and healthcare organizations are all part of a community mitigation strategy. These strategies should be implemented to prepare for and when there is evidence of community transmission. Signals of ongoing community transmission may include detection of confirmed cases of COVID-19 with no epidemiologic link to travelers or known cases, or more than three generations of transmission.

Implementation is based on:

- Emphasizing individual responsibility for implementing recommended personal-level actions
- Empowering businesses, schools, and community organizations to implement recommended actions, particularly in ways that protect persons at increased risk of severe illness
- Focusing on settings that provide critical infrastructure or services to individuals at increased risk of severe illness
- Minimizing disruptions to daily life to the extent possible

Guiding principles

- Each community is unique, and appropriate mitigation strategies will vary based on the level of community transmission, characteristics of the community and their populations, and the local capacity to implement strategies (Table 1).
- Consider all aspects of a community that might be impacted, including populations most vulnerable to severe illness and those that may be more impacted socially or economically, and select appropriate actions.
- Mitigation strategies can be scaled up or down depending on the evolving local situation.
- When developing mitigation plans, communities should identify ways to ensure the safety and social well-being of groups that may be especially impacted by mitigation strategies, including individuals at increased risk for severe illness.
- Activation of community emergency plans is critical for the implementation of mitigation strategies. These plans may provide additional authorities and coordination needed for interventions to be implemented (Table 2).
- Activities in Table 2 may be implemented at any time regardless of the level of community transmission based on guidance from local and state health officials.
- The level of activities implemented may vary across the settings described in Table 2 (e.g., they may be at a minimal/moderate level for one setting and at a substantial level for another setting in order to meet community response needs).
- Depending on the level of community spread, local and state public health departments may need to implement mitigation strategies for public health functions to identify cases and conduct contact tracing (Table 3). When applied, community mitigation efforts may help facilitate public health activities like contact tracing

For more information: www.cdc.gov/COVID19
Table 1. Local Factors to Consider for Determining Mitigation Strategies

<table>
<thead>
<tr>
<th>Factor</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiology</td>
<td>• Level of community transmission (see Table 3)</td>
</tr>
<tr>
<td></td>
<td>• Number and type of outbreaks (e.g., nursing homes, schools, etc.)</td>
</tr>
<tr>
<td></td>
<td>• Impact of the outbreaks on delivery of healthcare or other critical infrastructure or services</td>
</tr>
<tr>
<td></td>
<td>• Epidemiology in surrounding jurisdictions</td>
</tr>
<tr>
<td>Community Characteristics</td>
<td>• Size of community and population density</td>
</tr>
<tr>
<td></td>
<td>• Level of community engagement/support</td>
</tr>
<tr>
<td></td>
<td>• Size and characteristics of vulnerable populations</td>
</tr>
<tr>
<td></td>
<td>• Access to healthcare</td>
</tr>
<tr>
<td></td>
<td>• Transportation (e.g., public, walking)</td>
</tr>
<tr>
<td></td>
<td>• Planned large events</td>
</tr>
<tr>
<td></td>
<td>• Relationship of community to other communities (e.g., transportation hub, tourist destination, etc.)</td>
</tr>
<tr>
<td>Healthcare capacity</td>
<td>• Healthcare workforce</td>
</tr>
<tr>
<td></td>
<td>• Number of healthcare facilities (including ancillary healthcare facilities)</td>
</tr>
<tr>
<td></td>
<td>• Testing capacity</td>
</tr>
<tr>
<td></td>
<td>• Intensive care capacity</td>
</tr>
<tr>
<td></td>
<td>• Availability of personal protective equipment (PPE)</td>
</tr>
<tr>
<td>Public health capacity</td>
<td>• Public health workforce and availability of resources to implement strategies</td>
</tr>
<tr>
<td></td>
<td>• Available support from other state/local government agencies and partner organizations</td>
</tr>
</tbody>
</table>
Table 2. Community mitigation strategies by setting and by level of community transmission or impact of COVID-19

<table>
<thead>
<tr>
<th>Factor</th>
<th>Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None (preparedness phase)</td>
</tr>
<tr>
<td></td>
<td>Minimal to moderate</td>
</tr>
<tr>
<td></td>
<td>Substantial</td>
</tr>
<tr>
<td><strong>Individuals and Families at Home</strong></td>
<td>“What you can do to prepare, if you or a family member gets ill, or if your community experiences spread of COVID-19”</td>
</tr>
<tr>
<td>• Know where to find local information on COVID-19 and local trends of COVID-19 cases.</td>
<td>• Continue to monitor local information about COVID-19 in your community.</td>
</tr>
<tr>
<td>• Know the signs and symptoms of COVID-19 and what to do if symptomatic:</td>
<td>• Continue to practice personal protective measures.</td>
</tr>
<tr>
<td>» Stay home when you are sick</td>
<td>• Continue to put household plan into action.</td>
</tr>
<tr>
<td>• Limit movement in the community</td>
<td>• Individuals at increased risk of severe illness should consider staying at home and avoiding gatherings or other situations of potential exposures, including travel.</td>
</tr>
<tr>
<td>• Limit visitors</td>
<td>• Continue to monitor local information.</td>
</tr>
<tr>
<td>• Know what additional measures those at high-risk and who are vulnerable should take.</td>
<td>• Continue to practice personal protective measures.</td>
</tr>
<tr>
<td>• Implement personal protective measures (e.g., stay home when sick, handwashing, respiratory etiquette, clean frequently touched surfaces daily).</td>
<td>• Continue to put household plan into place.</td>
</tr>
<tr>
<td>• Create a household plan of action in case of illness in the household or disruption of daily activities due to COVID-19 in the community.</td>
<td>• All individuals should limit community movement and adapt to disruptions in routine activities (e.g., school and/or work closures) according to guidance from local officials.</td>
</tr>
<tr>
<td>» Consider 2-week supply of prescription and over the counter medications, food and other essentials. Know how to get food delivered if possible.</td>
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<tr>
<td>• Establish ways to communicate with others (e.g., family, friends, co-workers).</td>
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<tr>
<td>• Establish plans to telework, what to do about childcare needs, how to adapt to cancellation of events.</td>
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</tr>
<tr>
<td>• Know about emergency operations plans for schools/workplaces of household members.</td>
<td></td>
</tr>
<tr>
<td>Factor</td>
<td>Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>None (preparedness phase)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Schools/childcare</td>
<td>“What childcare facilities, K-12 schools, and colleges and universities can do to prepare for COVID-19, if the school or facility has cases of COVID-19, or if the community is experiencing spread of COVID-19)”</td>
</tr>
<tr>
<td></td>
<td>• Know where to find local information on COVID-19 and local trends of COVID-19 cases.</td>
</tr>
<tr>
<td></td>
<td>• Know the signs and symptoms of COVID-19 and what to do if students or staff become symptomatic at school/childcare site.</td>
</tr>
<tr>
<td></td>
<td>• Review and update emergency operations plan (including implementation of social distancing measures, distance learning if feasible) or develop plan if one is not available.</td>
</tr>
<tr>
<td></td>
<td>• Evaluate whether there are students or staff who are at increased risk of severe illness and develop plans for them to continue to work or receive educational services if there is moderate levels of COVID-19 transmission or impact.</td>
</tr>
<tr>
<td></td>
<td>» Parents of children at increased risk for severe illness should discuss with their health care provider whether those students should stay home in case of school or community spread.</td>
</tr>
<tr>
<td></td>
<td>» Staff at increased risk for severe illness should have a plan to stay home if there are school-based cases or community spread.</td>
</tr>
<tr>
<td></td>
<td>• Encourage staff and students to stay home when sick and notify school administrators of illness (schools should provide non-punitive sick leave options to allow staff to stay home when ill).</td>
</tr>
<tr>
<td></td>
<td>• Encourage personal protective measures among staff/students (e.g., stay home when sick, handwashing, respiratory etiquette).</td>
</tr>
<tr>
<td></td>
<td>• Clean and disinfect frequently touched surfaces daily.</td>
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<tr>
<td></td>
<td>• Ensure hand hygiene supplies are readily available in buildings.</td>
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<table>
<thead>
<tr>
<th>Factor</th>
<th>Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None (preparedness phase)</td>
</tr>
<tr>
<td>Assisted living facilities, senior living facilities and adult day programs</td>
<td>• Know where to find local information on COVID-19.</td>
</tr>
<tr>
<td></td>
<td>• Know the signs and symptoms of COVID-19 and what to do if clients/residents or staff become symptomatic.</td>
</tr>
<tr>
<td></td>
<td>• Review and update emergency operations plan (including implementation of social distancing measures) or develop a plan if one is not available.</td>
</tr>
<tr>
<td></td>
<td>• Encourage personal protective measures among staff, residents and clients who live elsewhere (e.g., stay home or in residences when sick, handwashing, respiratory etiquette).</td>
</tr>
<tr>
<td></td>
<td>• Clean frequently touched surfaces daily.</td>
</tr>
<tr>
<td></td>
<td>• Ensure hand hygiene supplies are readily available in all buildings.</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Factor</td>
<td>None (preparedness phase)</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Workplace              | • Know where to find local information on COVID-19 and local trends of COVID-19 cases.  
• Know the signs and symptoms of COVID-19 and what to do if staff become symptomatic at the worksite.  
• Review, update, or develop workplace plans to include:  
  » Liberal leave and telework policies  
  » Consider 7-day leave policies for people with COVID-19 symptoms  
  » Consider alternate team approaches for work schedules.  
• Encourage employees to stay home and notify workplace administrators when sick (workplaces should provide non-punitive sick leave options to allow staff to stay home when ill).  
• Encourage personal protective measures among staff (e.g., stay home when sick, handwashing, respiratory etiquette).  
• Clean and disinfect frequently touched surfaces daily.  
• Ensure hand hygiene supplies are readily available in building. | • Encourage staff to telework (when feasible), particularly individuals at increased risk of severe illness.  
• Implement social distancing measures:  
  » Increasing physical space between workers at the worksite  
  » Staggering work schedules  
  » Decreasing social contacts in the workplace (e.g., limit in-person meetings, meeting for lunch in a break room, etc.)  
• Limit large work-related gatherings (e.g., staff meetings, after-work functions).  
• Limit non-essential work travel.  
• Consider regular health checks (e.g., temperature and respiratory symptom screening) of staff and visitors entering buildings (if feasible). | • Implement extended telework arrangements (when feasible).  
• Ensure flexible leave policies for staff who need to stay home due to school/childcare dismissals.  
• Cancel non-essential work travel.  
• Cancel work-sponsored conferences, tradeshows, etc. |
<table>
<thead>
<tr>
<th>Factor</th>
<th>Potential mitigation activities according to level of community transmission or impact of COVID-19 by setting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>None (preparedness phase)</td>
</tr>
<tr>
<td></td>
<td>Minimal to moderate</td>
</tr>
<tr>
<td></td>
<td>Substantial</td>
</tr>
<tr>
<td>Community and faith-based organizations</td>
<td>• Know where to find local information on COVID-19 and local trends of COVID-19 cases.</td>
</tr>
<tr>
<td></td>
<td>• Know the signs and symptoms of COVID-19 and what to do if organization members/staff become symptomatic.</td>
</tr>
<tr>
<td></td>
<td>• Identify safe ways to serve those that are at high risk or vulnerable (outreach, assistance, etc.).</td>
</tr>
<tr>
<td></td>
<td>• Review, update, or develop emergency plans for the organization, especially consideration for individuals at increased risk of severe illness.</td>
</tr>
<tr>
<td></td>
<td>• Encourage staff and members to stay home and notify organization administrators of illness when sick.</td>
</tr>
<tr>
<td></td>
<td>• Encourage personal protective measures among organization/members and staff (e.g., stay home when sick, handwashing, respiratory etiquette).</td>
</tr>
<tr>
<td></td>
<td>• Clean frequently touched surfaces at organization gathering points daily.</td>
</tr>
<tr>
<td></td>
<td>• Ensure hand hygiene supplies are readily available in building.</td>
</tr>
<tr>
<td></td>
<td>• Implement social distancing measures:</td>
</tr>
<tr>
<td></td>
<td>» Reduce activities (e.g., group congregation, religious services), especially for organizations with individuals at increased risk of severe illness.</td>
</tr>
<tr>
<td></td>
<td>» Consider offering video/audio of events.</td>
</tr>
<tr>
<td></td>
<td>• Determine ways to continue providing support services to individuals at increased risk of severe disease (services, meals, checking in) while limiting group settings and exposures.</td>
</tr>
<tr>
<td></td>
<td>• Cancel large gatherings (e.g., &gt;250 people, though threshold is at the discretion of the community) or move to smaller groupings.</td>
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<tr>
<td></td>
<td>• For organizations that serve high-risk populations, cancel gatherings of more than 10 people.</td>
</tr>
<tr>
<td></td>
<td>• Cancel community and faith-based gatherings of any size.</td>
</tr>
<tr>
<td>Factor</td>
<td>None (preparedness phase)</td>
</tr>
<tr>
<td>--------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Healthcare settings and healthcare provider (includes outpatient, nursing homes/long-term care facilities, inpatient, telehealth)</td>
<td>• Provide healthcare personnel ([HCP], including staff at nursing homes and long-term care facilities) and systems with tools and guidance needed to support their decisions to care for patients at home (or in nursing homes/long-term care facilities).&lt;br&gt;• Develop systems for phone triage and telemedicine to reduce unnecessary healthcare visits.&lt;br&gt;• Assess facility infection control programs; assess personal protective equipment (PPE) supplies and optimize PPE use.&lt;br&gt;• Assess plans for monitoring of HCP and plans for increasing numbers of HCP if needed.&lt;br&gt;• Assess visitor policies.&lt;br&gt;• Assess HCP sick leave policies (healthcare facilities should provide non-punitive sick leave options to allow HCP to stay home when ill).&lt;br&gt;• Encourage HCP to stay home and notify healthcare facility administrators when sick.&lt;br&gt;• In conjunction with local health department, identify exposed HCP, and implement recommended monitoring and work restrictions.&lt;br&gt;• Implement triage prior to entering facilities to rapidly identify and isolate patients with respiratory illness (e.g., phone triage before patient arrival, triage upon arrival).</td>
</tr>
</tbody>
</table>
Table 3. Potential mitigation strategies for public health functions

| Public health control activities by level of COVID-19 community transmission |
|--------------------------------------------------|------------------|------------------|
| Evidence of isolated cases or limited community transmission, case investigations underway, no evidence of exposure in large communal setting, e.g., healthcare facility, school, mass gathering. | Widespread and/or sustained transmission with high likelihood or confirmed exposure within communal settings with potential for rapid increase in suspected cases. | Large scale community transmission, healthcare staffing significantly impacted, multiple cases within communal settings like healthcare facilities, schools, mass gatherings etc. |
| • Continue contact tracing, monitor and observe contacts as advised in guidance to maximize containment around cases. | • May reduce contact tracing if resources dictate, prioritizing to those in high-risk settings (e.g., healthcare professionals or high-risk settings based on vulnerable populations or critical infrastructure). | • May reduce contact tracing if resources dictate, prioritizing to those in high-risk settings (e.g., healthcare professionals or high-risk settings based on vulnerable populations or critical infrastructure). |
| • Isolation of confirmed COVID-19 cases until no longer considered infectious according to guidance. | • Encourage HCP to more strictly implement phone triage and telemedicine practices. | • Encourage HCP to more strictly implement phone triage and telemedicine practices. |
| • For asymptomatic close contacts exposed to a confirmed COVID-19 case, consideration of movement restrictions based on risk level, social distancing. | • Continue COVID-19 testing of symptomatic persons; however, if testing capacity limited, prioritize testing of high-risk individuals. | • Continue COVID-19 testing of symptomatic persons; however, if testing capacity limited, prioritize testing of high-risk individuals. |
| • Monitoring close contacts should be done by jurisdictions to the extent feasible based on local priorities and resources. | | |
| • Encourage HCP to develop phone triage and telemedicine practices. | | |
| • Test individuals with signs and symptoms compatible with COVID-19. | | |
| • Determine methods to streamline contact tracing through simplified data collection and surge if needed (resources including staffing through colleges and other first responders, technology etc.). | | |


Appendix A: Underlying medical conditions that may increase the risk of serious COVID-19 for individuals of any age.

- **Blood disorders** (e.g., sickle cell disease or on blood thinners)
- **Chronic kidney disease** as defined by your doctor. Patient has been told to avoid or reduce the dose of medications because kidney disease, or is under treatment for kidney disease, including receiving dialysis
- **Chronic liver disease** as defined by your doctor. (e.g., cirrhosis, chronic hepatitis) Patient has been told to avoid or reduce the dose of medications because liver disease or is under treatment for liver disease.
- **Compromised immune system (immunosuppression)** (e.g., seeing a doctor for cancer and treatment such as chemotherapy or radiation, received an organ or bone marrow transplant, taking high doses of corticosteroids or other immunosuppressant medications, HIV or AIDS)
- **Current or recent pregnancy** in the last two weeks
- **Endocrine disorders** (e.g., diabetes mellitus)
- **Metabolic disorders** (such as inherited metabolic disorders and mitochondrial disorders)
- **Heart disease** (such as congenital heart disease, congestive heart failure and coronary artery disease)
- **Lung disease** including asthma or chronic obstructive pulmonary disease (chronic bronchitis or emphysema) or other chronic conditions associated with impaired lung function or that require home oxygen
- **Neurological and neurologic and neurodevelopment conditions** [including disorders of the brain, spinal cord, peripheral nerve, and muscle such as cerebral palsy, epilepsy (seizure disorders), stroke, intellectual disability, moderate to severe developmental delay, muscular dystrophy, or spinal cord injury].
CDC Protects and Prepares Communities

CDC is aggressively responding to the global outbreak of COVID-19 and preparing for the potential of community spread in the U.S.

### Travel
- Conducts outreach to travelers
- Issues travel notices

### Laboratories and diagnostics
- Develops diagnostic tests
- Confirms all positive test results submitted by states

### Business
- Provides business guidance including recommendations for sick leave policies and continuity of operations

### Schools
- Provides guidance for schools including school closures and online education options

### Community members
- Shares information on symptoms and prevention
- Provides information on home care
- Encourages social distancing

### Healthcare professionals
- Develops guidance for healthcare professionals
- Conducts clinical outreach and education

### Healthcare systems
- Develops preparedness checklists for health systems
- Provides guidance for PPE supply planning, healthcare system screening, and infection control
- Leverages existing telehealth tools to redirect persons to the right level of care

### Health departments
- Assesses state and local readiness to implement community mitigation measures
- Links public health agencies and healthcare systems

For more information: [www.cdc.gov/COVID19](http://www.cdc.gov/COVID19)
ADDITIONAL RESOURCES

• Employee Screening Tool
• Visitor Screening Tool
• DMAHS-Coping with The Emotional Impact of Public Health Emergencies (brochure)
• EPA’s Registered Antimicrobial Products for Use Against Novel Coronavirus-SARS-CoV-2 the cause of COVID-19
• PHENS LINCS preferred email Contact List by County
• Directory of Local Health Departments in New Jersey
• The Society for Post Acute and Long Term Care Medicine: COVID-19 in PALTC Settings
• Grainger Products available for purchase to provide potential solutions for converting single resident rooms or hallways into negative pressure isolation environments.
# Employee Screening tool

**Name of employee**: 

**Date of screening**: 

Have you travelled by plane or cruise ship within and/or outside the United States in last 14 days?

- Yes __  
- No __

If yes, please include details:

____________________________________________________________________________________

Have you had fever above 99.6 degrees F within the last 14 days?

- Yes __  
- No __

If yes, please indicate temperature and include details:

____________________________________________________________________________________

<table>
<thead>
<tr>
<th>Symptom</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sore Throat</td>
<td></td>
</tr>
<tr>
<td>Cough</td>
<td></td>
</tr>
<tr>
<td>Runny Nose</td>
<td></td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
</tr>
</tbody>
</table>

Exposure to individuals with cold or flu-like symptoms within the last 14 days?

- Yes __  
- No __

Education and/or materials provided?

- Printed Materials
- Hand Hygiene with return demonstration

Name of Screener ________________________________________________________________

Approved/Not approved to work __________________________________________________

Comments ________________________________________________________________
Visitor Screening tool

Name of Visitor_________________________________________ Date of visit____________________

Name of resident being visited______________________________________________________________

Have you travelled by plane or cruise ship within and/or outside the United States in last 14 days? Yes___ No___

If yes, please include details:

____________________________________________________________________________________

Fever above 99.6 degrees F within the last 14 days? Yes___ No___

If yes, please indicate temperature and include details:

____________________________________________________________________________________

Sore Throat Yes___ No___
Cough Yes___ No___
Runny Nose Yes___ No___
Shortness of Breath Yes___ No___
Diarrhea Yes___ No___

Exposure to individuals with cold or flu-like symptoms within the last 14 days? Yes___ No___

Education and/or materials provided? _____Printed Materials  _____Hand Hygiene with return demonstration

Name of Screener________________________________________________________

If you answered “yes” to any of the above questions, you may not enter the center at this time. Please feel free to call your loved one or call our staff and they will check on them until your symptoms have resolved. Thank you for your understanding and cooperation with keeping our residents, staff and community safe.
Stay Connected

The fear associated with a public health emergency can push people apart. People who are normally close to family and friends may avoid contact because they are afraid they might get sick or get someone else sick.

It is important to stay connected with others. Use the phone, e-mail, or other electronic means of communication. If you are anxious about a health risk, talk to someone who can help. This may be your doctor, a family member, friend, member of the clergy, teacher or mental health professional.

If you notice a big change in a loved one, friend or co-worker, reach out to them. Make some time to talk. Watching out for others shows you care. It can be comforting to both of you.

If you or someone you know is having a hard time managing their emotions, seek help from a medical or mental health professional.

If you notice that a loved one, friend or co-worker’s behavior has substantially changed, reach out and ask them how they are doing. Make some time to talk, when it is convenient for both of you, and follow up later on to see how they are doing. Watching out for each other demonstrates that you care and it can be comforting to both of you.

Get Reliable Information

When we face uncertainty about health risks, it is important to keep things in perspective. Get information during public health emergencies from:

- Your doctor or healthcare provider
- Your local health department
- The New Jersey Department of Health website at: http://nj.gov/health/ (800) 367-6543

The Centers for Disease Control and Prevention:

1-800-CDC-INFO (4636)
for assistance in English and Spanish
TTY: 1-888-232-6348
E-mail: cdcinfo@cdc.gov

This publication available on-line at www.disastermentalhealthnj.com.
Coping with Public Health Emergencies

The information in this brochure can help you cope with fears and anxiety related to public health emergencies. Such emergencies may include outbreaks of contagious disease, air or water contamination, or the effects of a natural disaster on individuals, families and communities.

It is natural to be upset when you think your health – or the health of your loved ones - is threatened. Pay attention to your own feelings and take care of your own emotional needs. By doing so, you can better help friends and family members handle their concerns.

Uncertainty

Anxiety can be related to fear of the unknown. It is normal to feel anxious and worried about a spreading disease, especially if there is no known cause or cure, or if the disease manifests as a frightening illness or includes injuries.

Everyone reacts differently to a public health risk.

These are normal reactions:

Physical
- headaches
- tiredness
- increased pulse
- high blood pressure
- changes in appetite
- unexplained aches or pains
- trouble sleeping
- stomach aches

Emotional
- panic
- anxiety
- distrust
- fear
- anger
- irritability
- sadness
- blame
- feeling overwhelmed
- increased stress

Mental
- troubling concentrating
- problems at work or school
- memory problems
- troubling thoughts
- concern about health issues

Behavioral
- avoiding others
- substance abuse
- excessive cleaning or washing
- being overly cautious

Here are some ways you can cope with stress and anxiety:

- Limit your exposure to graphic news stories
- Get accurate, timely information from reliable sources
- Educate yourself about the specific health hazard
- Maintain your normal daily routine, if possible
- Exercise, eat well and rest
- Stay active – physically and mentally
- Stay in touch with family and friends
- Find comfort in your spiritual and personal beliefs
- Keep a sense of humor
- Share your concerns with others
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<td><a href="mailto:ggaretano@essexregional.org">ggaretano@essexregional.org</a></td>
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<td>AnnMarie Ruiz</td>
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Directory of
LOCAL HEALTH DEPARTMENTS
in
New Jersey

March 10, 2020

Office of Local Public Health (OLPH)
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**Disclaimer:**
This directory represents a listing of Local Health Departments (LHDs) that is dynamic and as comprehensive as possible at this time. As coverage areas and contact information of LHDs change frequently, we encourage you to visit the OLPH website for the most current version of the directory at https://www.nj.gov/health/lh/documents/LocalHealthDirectory.pdf.
ATLANTIC

Atlantic City Department of Health & Human Services
Health Officer: Vacant
Health Officer Phone: 609-347-5671
Health Officer Email: N/A
Agency Website: www.cityofatlanticcity.org
Public Emergency Contact After Hours Number: 609-347-5780

Municipalities Served:

Atlantic County Division of Public Health
Health Officer: Patricia Diamond
Health Officer Phone: 609-645-7700 x 4373
Health Officer Email: diamond_patricia@aclink.org
Agency Website: www.aclink.org
Public Emergency Contact After Hours Number: 609-909-7200

Municipalities Served:

BERGEN

Bergen County Department of Health Services
Health Officer: Hansel Asmar
Health Officer Phone: 201-634-2601
Health Officer Email: hasmar@co.bergen.nj.us
Agency Website: www.co.bergen.nj.us
Public Emergency Contact After Hours Number: 201-785-8500

Municipalities Served:

OLPH 3-10-2020
Englewood Health Department
Health Officer: James Fedorko
Health Officer Phone: 201-871-6501
Health Officer Email: jfedorko@englewoodnjhealth.org
Agency Website: www.cityofenglewood.org
Public Emergency Contact After Hours Number: 201-871-6400

Municipalities Served:
ENGLEWOOD

Fair Lawn Health Department
Health Officer: Carol Wagner
Health Officer Phone: 201-794-5330
Health Officer Email: health@fairlawn.org
Agency Website: www.fairlawn.org/
Public Emergency Contact After Hours Number: 201-796-1400

Municipalities Served:
FAIR LAWN

Fort Lee Health Department
Health Officer: Jill Scarpa
Health Officer Phone: 201-592-3500 x 1105
Health Officer Email: j-scarpa@fortleenj.org
Agency Website: www.fortleenj.org
Public Emergency Contact After Hours Number: 201-592-3700

Municipalities Served:
FORT LEE

Hackensack Department of Health
Health Officer: Susan McVeigh
Health Officer Phone: 201-646-3960
Health Officer Email: smcveigh@hackensack.org
Agency Website: www.hackensack.org
Public Emergency Contact After Hours Number: 201-646-3965

Municipalities Served:
HACKENSACK
Mid-Bergen Regional Health Commission

Health Officer: Sam Yanovich
Health Officer Phone: 201-599-6290
Health Officer Email: sam.yanovich@njlincs.net
Agency Website: www.midbergen-regionalhealth.org
Public Emergency Contact After Hours Number: 201-785-8505

Municipalities Served:
BERGENFIELD                  GARFIELD                        RIDGEFIELD PARK
BOGOTA                        HASBROUCK HEIGHTS                   RIVER EDGE
CARLSTAD                      LEONIA                                       TENAFLY
CLOSTER                       NEW MILFORD                                WALLINGTON
ENGLEWOOD CLIFFS              RAMSEY

N.W. Bergen Regional Health Commission

Health Officer: Angela Musella
Health Officer Phone: 201-445-7217 x 0
Health Officer Email: amusella@nwbrhc.net
Agency Website: www.nwbrhc.org
Public Emergency Contact After Hours Number: 201-445-7217

Municipalities Served:
BOROUGH OF EMERSON            MIDLAND PARK                        SADDLE RIVER
HILLSDALE                     MONTVALE                               WALDWICK
HO-HO-KUS                     OLD TAPPAN                               WASHINGTON TWP (BERGEN CO.)
MAHWAH                        RIVER VALE                              WESTWOOD

Palisades Park Health Department

Health Officer: Branka Lulic
Health Officer Phone: 201-943-6062
Health Officer Email: blulic@ridgefieldboro.com
Agency Website: www.ridgefieldnj.gov
Public Emergency Contact After Hours Number: 201-943-5210

Municipalities Served:
PALISADES PARK                RIDGEFIELD BORO

Paramus Board of Health

Health Officer: Judith Migliaccio
Health Officer Phone: 201-265-2100 x 2300
Health Officer Email: jmigliaccio@paramusborough.org
Agency Website: www.paramusborough.org
Public Emergency Contact After Hours Number: 201-674-0202

Municipalities Served:
PARAMUS
Teaneck Department of Health & Human Services  
Health Officer: Ken Katter  
Health Officer Phone: 201-837-1600 x 1502  
Health Officer Email: kkatter@teanecknj.gov  
Agency Website: www.teanecknj.gov  
Public Emergency Contact After Hours Number: 201-837-2600

Municipalities Served:  
TEANECK

Village of Ridgewood Health Department  
Health Officer: Dawn Cetrulo  
Health Officer Phone: 201-670-5500 x 245  
Health Officer Email: dcetrulo@ridgewoodnj.net  
Agency Website: http://www.ridgewoodnj.net  
Public Emergency Contact After Hours Number: 201-652-3900

Municipalities Served:  
VILLAGE OF RIDGEWOOD

BURLINGTON

Burlington County Health Department  
Health Officer: Holly Cucuzzella  
Health Officer Phone: 609-265-5548  
Health Officer Email: hfunkhouser@co.burlington.nj.us  
Agency Website: www.co.burlington.nj.us  
Public Emergency Contact After Hours Number: 609-267-8300

Municipalities Served:  
BASS RIVER TWP  
BEVERLY  
BORDENTOWN CITY  
BORDENTOWN TWP  
BURLINGTON CITY  
BURLINGTON TWP  
CHESTERFIELD TWP  
CINNAMINSON TWP  
DELANCO TWP  
DELRAN TWP  
EASTAMPTON  
EDGEWATER PK  
EVESHAM TWP  
FIELDSBORO  
FLORENCE  
HAINESPORT  
LUMBERTON  
MANSFIELD (BURLINGTON CO.)  
MAPLE SHADE  
MEDFORD LAKES  
MEDFORD TWP  
MOORESTOWN  
MT HOLLY  
MT LAUREL  
NEW HANOVER  
NORTH HANOVER  
PALMYRA  
PEMBERTON  
PEMBERTON TWP  
RIVERSIDE  
RIVERTON  
SHAMONG  
SOUTHAMPTON  
SPRINGFIELD TWP (BURLINGTON CO.)  
TABERNACLE  
WASHINGTON TWP (BURLINGTON CO.)  
WESTAMPTON  
WILLINGBORO  
WOODLAND  
WRIGHTSTOWN
CAMDEN

Camden County Department of Health & Human Services
Health Officer: Paschal Nwako
Health Officer Phone: 856-374-6037
Health Officer Email: paschal.nwako@camdencounty.com
Agency Website: www.camdencounty.com
Public Emergency Contact After Hours Number: 856-783-1333

Municipalities Served:
AUDUBON                  CLEMENTON                  LAWNSIDE                  SOMERDALE
AUDUBON PARK             COLLINGSWOOD               LINDENWOLD                STRATFORD
BARRINGTON              GIBBSBORO                  MAGNOLIA                  TAVISTOCK
BELLMAWR                 GLOUCESTER CITY            MERCHANTVILLE             VOORHEES TWP
BERLIN BORO              GLOUCESTER TWP              MT EPHRAIM                WATERFORD TWP
BERLIN TWP               HADDON HEIGHTS              OAKLYN                    WINSLOW TWP
BROOKLAWN                HADDON TWP                  PENNSAUKEN                WOODLYNNE
CAMDEN                   HADDONFIELD                PINE HILL                 
CHERRY HILL              HI-NELLA                    PINE VALLEY               
CHESILHURST              LAUREL SPRINGS              RUNNEMEDE                 

CAPE MAY

Cape May County Health Department
Health Officer: Kevin Thomas
Health Officer Phone: 609-465-1311
Health Officer Email: thomas@co.cape-may.nj.us
Agency Website: www.cmchealth.net
Public Emergency Contact After Hours Number: Office of Emergency Management 609-465-1190

Municipalities Served:
AVALON                    NORTH WILDWOOD            WEST WILDWOOD
CAPE MAY                  OCEAN CITY                WILDWOOD
CAPE MAY POINT            SEA ISLE                   WILDWOOD CREST
DENNIS TWP                STONE HARBOR              WOODBINE
LOWER TWP                 UPPER TWP                 
MIDDLE TWP                WEST CAPE MAY             

OLPH  3-10-2020
CUMBERLAND

Cumberland County Department of Health
Health Officer: Megan Sheppard
Health Officer Phone: 856-327-7602 x7109
Health Officer Email: msheppard@ccdoh.org
Agency Website: www.ccdoh.org
Public Emergency Contact After Hours Number: 856-455-8500

Municipalities Served:
BRIDGETON GREENWICH TWP (CUMBERLAND CO.) SHILOH
COMMERCIAL TWP HOPEWELL TWP (CUMBERLAND CO.) STOW CREEK
DEERFIELD LAWRENCE TWP (CUMBERLAND CO.) UPPER DEERFIELD
DOWNE TWP MAURICE RIVER
FAIRFIELD TWP (CUMBERLAND CO.) MILLVILLE

City of Vineland
Health Officer: Robert Dickinson
Health Officer Phone: 856-794-4131
Health Officer Email: rdickinson@vinelandcity.org
Agency Website: www.vldhealth.org
Public Emergency Contact After Hours Number: 856-691-4111

Municipalities Served:
VINELAND

ESSEX

Bloomfield Department of Health & Human Services
Health Officer: F Michael Fitzpatrick
Health Officer Phone: 973-680-4024
Health Officer Email: mfitzpatrick@bloomfieldtwpnj.com
Agency Website: www.bloomfieldtwpnj.com/health
Public Emergency Contact After Hours Number: 973-680-4141

Municipalities Served:
BLOOMFIELD CALDWELL GLEN RIDGE MOUNTAIN LAKES (MORRIS CO.)

East Orange Department of Heath
Health Officer: Victor Kuteyi
Health Officer Phone: 973-266-5480
Health Officer Email: victor.kuteyi@eastorange-nj.gov
Agency Website: www.eastorange-nj.gov/
Public Emergency Contact After Hours Number: 973-518-3969

Municipalities Served:
EAST ORANGE
Essex County Health Department
Health Officer: Maya Lordo
Health Officer Phone: 201-988-2528
Health Officer Email: mlordo@dchs.essexcountynj.org
Agency Website: www.essexcountynj.org
Public Emergency Contact After Hours Number: 201-988-2528ho

Municipalities Served:
No municipalities are covered

Essex Regional Health Commission
Health Officer: Carrie Nawrocki
Health Officer Phone: 973-251-2059
Health Officer Email: cnawrocki@hudsonregionalhealth.org
Agency Website: www.essexregional.org
Public Emergency Contact After Hours Number: 973-445-2454

Municipalities Served:
No municipalities are covered

Irvington Health Department
Health Officer: Christopher Hellwig
Health Officer Phone: 973-399-6724
Health Officer Email: ch10@njlincs.net
Agency Website: www.irvington.net
Public Emergency Contact After Hours Number: 973-399-6600

Municipalities Served:
IRVINGTON

Livingston Health Department / Millburn Health Department
Health Officer: Louis Anello
Health Officer Phone: 973-535-7961 x 233
Agency Website: www.livingstonnj.org
Health Officer Email: lanello@livingstonnj.org
Public Emergency Contact After Hours Numbers: 973-535-7961

Municipalities Served:
LIVINGSTON MILLBURN

Maplewood Health Department
Health Officer: Candice Davenport
Health Officer Phone: 973-762-8120 x 4400
Health Officer Email: cdavenport@twp.maplewood.nj.us
Agency Website: www.twp.maplewood.nj.us
Public Emergency Contact After Hours Number: 973-762-3400

Municipalities Served:
MAPLEWOOD
Montclair Health Department
Health Officer: Susan Portuese
Health Officer Phone: 973-509-4968
Health Officer Email: sportuese@montclairnjusa.org
Agency Website: www.montclairnjusa.org
Public Emergency Contact After Hours Number: 973-744-1234

Municipalities Served:
CEDAR GROVE MONTCLAIR NUTLEY VERONA

Newark Department of Health & Community Wellness
Health Officer: Vacant / Temporary: Marcia McGowan
Health Officer Phone: 973-733-7592
Health Officer Email: mcgowanm@ci.newark.nj.us
Agency Website: https://www.newarknj.gov/
Public Emergency Contact After Hours Number: 973-733-7600

Municipalities Served:
NEWARK

City of Orange Township
Health Officer: Vincent DeFilippo
Health Officer Phone: 973-266-4073
Health Officer Email: vdefilippo@ci.orange.nj.us
Agency Website: www.ci.orange.nj.us
Public Emergency Contact After Hours Number: 973-266-4111

Municipalities Served:
BELLEVILLE ORANGE

Township of South Orange
Health Officer: John Festa
Health Officer Phone: 973-378-7715 x 7710
Health Officer Email: jfesta@southorange.org
Agency Website: www.southorange.org
Public Emergency Contact After Hours Number: 973-763-3000

Municipalities Served:
SOUTH ORANGE

West Caldwell Health Department
Health Officer: William Wallace
Health Officer Phone: 973-226-2303
Health Officer Email: bwallace@westcaldwell.com
Agency Website: www.westcaldwell.com/
Public Emergency Contact After Hours Number: 973-226-2300

Municipalities Served:
FAIRFIELD (ESSEX CO.) NORTH CALDWELL WEST CALDWELL
West Orange Health Department
Health Officer: Theresa De Nova
Health Officer Phone: 973-325-4124
Health Officer Email: tdenova@westorange.org
Agency Website: www.westorange.org
Public Emergency Contact After Hours Number: 973-325-4000

**Municipalities Served:**
ESSEX FELLS
WEST ORANGE

GLOUCESTER

Gloucester County Department of Health & Senior Services
Health Officer: Annmarie Ruiz
Health Officer Phone: 856-218-4131
Health Officer Email: aruiz@co.gloucester.nj.us
Agency Website: www.gloucestercountynj.gov
Public Emergency Contact After Hours Number: 856-589-0911

**Municipalities Served:**
CLAYTON
DEPTFORD
EAST GREENWICH
ELK TWP
FRANKLIN TWP (GLOUCESTER CO.)
GLASSBORO
GREENWICH TWP (GLOUCESTER CO.)
HARRISON TWP (GLOUCESTER CO.)
LOGAN
MANTUA
MONROE TWP (GLOUCESTER CO.)
NATIONAL PARK
NEWFIELD
PAULSBORO
PITMAN
SOUTH HARRISON
SWEDESBORO
WASHINGTON TWP (GLOUCESTER CO.)
WENONAH
WEST DEPTFORD
WESTVILLE
WOODBURY
WOODBURY HEIGHTS
WOOLWICH

HUDSON

Bayonne Health Department
Health Officer: Vacant
Health Officer Phone: 201-858-6100
Health Officer Email: N/A
Agency Website: www.bayonnenj.org/
Public Emergency Contact After Hours Number: 201-858-6900

**Municipalities Served:**
BAYONNE CITY
Harrison Health Department
Health Officer: Janet Castro
Health Officer Phone: 201-392-2084
Health Officer Email: jcastro@northbergen.org
Agency Website: www.northbergen.org/Departments/health
Public Emergency Contact After Hours Number: 201-392-2100

Municipalities Served:
HARRISON (Hudson Co.)

Hoboken Health Department
Health Officer: Nancy Tarantino
Health Officer Phone: 201-420-2000 x 5208
Health Officer Email: ntarantino@hobokennj.gov
Agency Website: www.hobokennj.org
Public Emergency Contact After Hours Number: 201-420-2100

Municipalities Served:
HOBOKEN

Hudson Regional Health Commission
Health Officer: Carrie Nawrocki
Health Officer Phone: 201-223-1133
Health Officer Email: cnawrocki@hudsonregionalhealth.org
Agency Website: www.hudsonregional.org/
Public Emergency Contact After Hours Numbers: 201-223-1133

Municipalities Served: No municipalities are covered

Jersey City Department of Health & Human Services
Health Officer: Shatrughan Bastola
Health Officer Phone: 201-547-5286
Health Officer Email: sbastola@jcnj.org
Agency Website: www.jerseycitynj.gov/
Public Emergency Contact After Hours Number: 856-469-1263

Municipalities Served:
JERSEY CITY

Kearny Department of Health
Health Officer: Kenneth Pincus
Health Officer Phone: 201-997-0600 x 3505
Health Officer Email: kpincus@kearnynj.org
Agency Website: www.kearnynj.org
Public Emergency Contact After Hours Number: 201-997-0600

Municipalities Served:
EAST NEWARK KEARNY
Township of North Bergen
Health Officer: Janet Castro
Health Officer Phone: 201-392-2084
Health Officer Email: jcastro@northbergen.org
Agency Website: www.northbergen.org/
Public Emergency Contact After Hours Number: 201-392-2100

Municipalities Served:
GUTTENBERG
NORTH BERGEN
SECAUCUS
WEST NEW YORK

Union City Health Department
Health Officer: Janet Castro
Health Officer Phone: 201-392-2084
Health Officer Email: jcastro@northbergen.org
Agency Website: http://www.ucnj.com/services/health/
Public Emergency Contact After Hours Number: 201-220-8048

Municipalities Served:
UNION CITY

Weehawken Health Department
Health Officer: Vacant
Health Officer Phone: 201-319-6054
Health Officer Email: N/A
Agency Website: www.kearnynj.org
Public Emergency Contact After Hours Number: 201-863-7800

Municipalities Served:
WEEHAWKEN

HUNTERDON

Hunterdon County Department of Health
Health Officer: Karen DeMarco
Health Officer Phone: 908-788-1351
Health Officer Email: kdemarco@co.hunterdon.nj.us
Agency Website: www.co.hunterdon.nj.us
Public Emergency Contact After Hours Number: 908-788-1351

Municipalities Served:
ALEXANDRIA TWP
BETHLEHEM TWP
BLOOMSBURY
CALIFON
CLINTON TOWN
CLINTON TWP
DELWARE TWP
EAST AMWELL TWP
FLEMINGTON
FRANKLIN TWP (HUNTERDON CO.)
FRENCHTOWN
GLEN GARDNER
HAMPTON BORO (HUNTERDON CO.)
HIGH BRIDGE
HOLLAND
KINGWOOD
LAMBERTVILLE
LEBANON TWP
LEBANON
MILFORD
RARITAN TWP
READINGTON TWP
STOCKTON
TEWKSBURY
UNION TWP
WEST AMWELL TWP
**MERCER**

**Hamilton Township Division of Health**  
Health Officer: **Vacant / Temporary: Kristin Reed**  
Health Officer Phone: **609-689-5562**  
Health Officer Email: **kreed@mercercounty.org**  
Agency Website: **www.hamiltonnj.com**  
*Public Emergency Contact After Hours Number*: 609-890-3820  

**Municipalities Served:**  
EAST WINDSOR TWP  
HAMILTON TWP (MERCER CO.)

**Hopewell Township Health Department**  
Health Officer: **Robert English**  
Health Officer Phone: **908-359-8211 x 245**  
Health Officer Email: **healthofficer@hopewelltwp.org**  
Agency Website: **www.hopewelltwp.org**  
*Public Emergency Contact After Hours Number*: 609-737-3100  

**Municipalities Served:**  
HOPEWELL TWP

**Lawrence Township Health Department**  
Health Officer: **Carol Chamberlain**  
Health Officer Phone: **609-844-7090**  
Health Officer Email: **cchamberlain@lawrencetwp.com**  
Agency Website: **www.lawrencetwp.com**  
*Public Emergency Contact After Hours Number*: 609-896-1111  

**Municipalities Served:**  
LAWRENCE TWP (MERCER CO.)

**Mercer County Division of Public Health**  
Health Officer: **Kristen Reed**  
Health Officer Phone: **609-689-5562**  
Health Officer Email: **publichealth@mercercounty.org**  
Agency Website: **www.mercercounty.org**  
*Public Emergency Contact After Hours Number*: 609-890-3820  

**Municipalities Served:**  
EWING TWP
Princeton Health Department
Health Officer: Jeffrey Grosser
Health Officer Phone: 609-497-7610
Health Officer Email: jgrosser@princetonnj.gov
Agency Website: www.princetonnj.gov
Public Emergency Contact After Hours Number: 609-921-2100

Municipalities Served:
PRINCETON

City of Trenton, Department of Health & Human Services
Health Officer: Yvette Graffie-Cooper
Health Officer Phone: 609-989-3242 x 171
Health Officer Email: ygraffie-cooper@trentonnj.org
Agency Website: www.trentonnj.org/
Public Emergency Contact After Hours Number: 609-789-7737

Municipalities Served:
TRENTON

West Windsor Health Department
Health Officer: Jill Swanson
Health Officer Phone: 609-936-8400 x 251
Health Officer Email: jswanson@westwindsortwp.com
Agency Website: www.westwindsornj.org
Public Emergency Contact After Hours Number: 609-799-1222

Municipalities Served:
HIGHSTOWN BORO ROBBINSVILLE TWP WEST WINDSOR TWP

MIDDLESEX

Edison Department of Health & Human Services
Health Officer: Lester Jones, Jr.
Health Officer Phone: 732-745-3121
Health Officer Email: les.jones@co.middlesex.nj.us
Agency Website: www.edisonnj.org/index.php
Public Emergency Contact After Hours Number: 732-248-0900

Municipalities Served:
EDISON
Middlesex County Office of Health Services
Health Officer: Lester Jones, Jr.
Health Officer Phone: 732-745-3121
Health Officer Email: les.jones@co.middlesex.nj.us
Agency Website: www.co.middlesex.nj.us/Pages/Main.aspx
Public Emergency Contact After Hours Number: 732-745-3271

<table>
<thead>
<tr>
<th>Municipalities Served:</th>
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<td>CARTERET</td>
<td>MIDDLESEX BORO</td>
<td>PLAINSBORO</td>
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<tr>
<td>CRANBURY</td>
<td>MILLTOWN</td>
<td>SAYREVILLE</td>
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<tr>
<td>DUNELLEN</td>
<td>MONROE TWP (MIDDLESEX CO.)</td>
<td>SOUTH AMBOY</td>
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<tr>
<td>EAST BRUNSWICK</td>
<td>NEW BRUNSWICK</td>
<td>SOUTH PLAINFIELD</td>
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<td>HELMETTA</td>
<td>NORTH BRUNSWICK</td>
<td>SOUTH RIVER</td>
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<td>HIGHLAND PARK</td>
<td>OLD BRIDGE</td>
<td>SPOTSWOOD</td>
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<td>JAMESBURG</td>
<td>PERTH AMBOY</td>
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<td>METUCHEN</td>
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</tbody>
</table>

South Brunswick Health Department
Health Officer: Lester Jones, Jr.
Health Officer Phone: 732-745-3121
Health Officer Email: les.jones@co.middlesex.nj.us
Agency Website: www.sbtnj.net
Public Emergency Contact After Hours Number: 732-329-4000

<table>
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<tr>
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<tbody>
<tr>
<td>SOUTH BRUNSWICK</td>
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</tbody>
</table>

Woodbridge Township Health & Human Services
Health Officer: Dennis Green
Health Officer Phone: 732-855-0600 x 5026
Health Officer Email: dennis.green@twp.woodbridge.nj.us
Agency Website: www.twp.woodbridge.nj.us
Public Emergency Contact After Hours Number: 732-634-4500

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<tbody>
<tr>
<td>WOODBRIDGE</td>
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</table>

MONMOUTH

Colts Neck Township Health Department
Health Officer: Thomas Frank
Health Officer Phone: 732-462-5470 x 109
Health Officer Email: tfrank@coltsneck.org
Agency Website: www.colts-neck.nj.us
Public Emergency Contact After Hours Number: 732-462-4343

<table>
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<th>Municipalities Served:</th>
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<tbody>
<tr>
<td>COLTS NECK</td>
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</tbody>
</table>
Freehold Health Department
Health Officer: Margaret Jahn
Health Officer Phone: 732-294-2060
Health Officer Email: mjahn@twp.freehold.nj.us
Agency Website: http://twp.freehold.nj.us/
Public Emergency Contact After Hours Numbers: 732-577-8700

Municipalities Served:
FREEHOLD BORO FREEHOLD TWP WALL TWP

Long Branch Department of Health
Health Officer: Sidney Johnson
Health Officer Phone: 732-571-5665
Health Officer Email: sjohnson@longbranch.org
Agency Website: www.visitlongbranch.com
Public Emergency Contact After Hours Number: 732-222-1000

Municipalities Served:
LONG BRANCH

Manalapan Township Health Department
Health Officer: Keith Levine
Health Officer Phone: 732-446-8349
Health Officer Email: health@twp.manalapan.nj.us
Agency Website: www.twp.manalapan.nj.us
Public Emergency Contact After Hours Number: 732-446-4300

Municipalities Served:
MANALAPAN

Monmouth County Board of Health
Health Officer: Christopher Merkel
Health Officer Phone: 732-431-7456 x 2157
Health Officer Email: christopher.merkel@co.monmouth.nj.us
Agency Website: www.visitmonmouth.com/health
Public Emergency Contact After Hours Number: 732-431-7456

Municipalities Served:
ABERDEEN HAZLET MILLSTONE TWP
ALLENTOWN BORO HIGHLANDS NEPTUNE CITY
ASBURY PARK CITY HOLMDEL NEPTUNE TWP
ATLANTIC HIGHLANDS BORO HOWELL TWP OCEANPORT
AVON-BY-THE-SEA BORO KEANSBURG ROOSEVELT BORO
BELMAR BORO KEYPORT SHREWSBURY TWP
BRADLEY BEACH BORO LAKE COMO BORO UNION BEACH
EATONTOWN MANASQUAN
ENGLISHTOWN BORO MARLBORO TWP
FARMINGDALE BORO MATAWAN
Monmouth County Regional Health Commission # 1
Health Officer: David Henry
Health Officer Phone: 732-493-9520
Health Officer Email: dhenry@mcrhc.org
Agency Website: www.mcrhc.org
Public Emergency Contact After Hours Number: 732-493-9520

Municipalities Served:
ALLENHURST MIDDLETOWN SHREWSBURY BORO
BRIELLE MONMOUTH BEACH SPRING LAKE BORO
DEAL OCEAN TWP (MONMOUTH CO.) SPRING LAKE HEIGHTS
FAIR HAVEN RED BANK TINTON FALLS
INTERLAKEN RUMSON WEST LONG BRANCH
LITTLE SILVER SEA BRIGHT
LOCH ARBOUR VILLAGE SEA GIRT BORO

MORRIS

East Hanover Health Department
Health Officer: Carlo DiLizia
Health Officer Phone: 973-888-6035
Health Officer Email: health.dept@easthanovertownship.com
Agency Website: www.easthanovertownship.com/index.htm
Public Emergency Contact After Hours Number: 973-887-0432

Municipalities Served:
EAST HANOVER TWP PARSIPPANY-TROY HILLS ROSELAND BORO (ESSEX CO.)

Lincoln Park Health Department
Health Officer: Kathleen Skrobala
Health Officer Phone: 973-270-2036
Health Officer Email: kathys@bolp.org
Agency Website: www.lincolnpark.org/
Public Emergency Contact After Hours Number: 973-270-2040

Municipalities Served:
LINCOLN PARK

Madison Health Department
Health Officer: F Michael Fitzpatrick
Health Officer Phone: 973-593-3079 x 1
Health Officer Email: mfitzpatrick@bloomfieldtwpnj.com
Agency Website: www.rosenet.org/216/Health-Department
Public Emergency Contact After Hours Number: 973-593-3000

Municipalities Served:
CHATHAM TWP CRANFORD MADISON BORO SPRINGFIELD TWP (UNION CO.)
Montville Township Health Department
Health Officer: Aimee Puluso
Health Officer Phone: 973-331-3316
Health Officer Email: apuluso@montvillenj.org
Agency Website: www.montvillenj.org/index.php
Public Emergency Contact After Hours Number: 973-257-4300

Municipalities Served:
MONTVILLE

Morris County Office of Health Management
Health Officer: Carlos Perez, Jr.
Health Officer Phone: 973-631-5485
Health Officer Email: cperez@co.morris.nj.us
Agency Website: https://health.morriscountynj.gov/
Public Emergency Contact After Hours Number: 973-285-2900

Municipalities Served:
BOONTON TWP  HARDING TWP  MORRISTOWN
DENVILLE  MENDHAM TWP (MORRIS CO.)
HANOVER TWP  MORRIS PLAINS BORO

Township of Morris Health Department
Health Officer: Kevin Breen
Health Officer Phone: 973-326-7390 x 7391
Health Officer Email: kbreen@morristwp.com
Agency Website: www.morristwp.com
Public Emergency Contact After Hours Number: 973-539-0777

Municipalities Served:
MORRIS TWP

Mount Olive Township Health Department
Health Officer: Trevor Weigle
Health Officer Phone: 973-691-0900 x 7314
Health Officer Email: tweigle@mtolivetwp.org
Agency Website: www.mtolivehealth.org
Public Emergency Contact After Hours Number: 973-691-0850

Municipalities Served:
DOVER  MT ARLINGTON BORO  NETCONG TWP
MINE HILL  MT OLIVE  WHARTON BORO
Pequannock Township Health Department
Health Officer: Peter Correale
Health Officer Phone: 973-835-5700 x 128
Health Officer Email: peterc@peqtpwp.org
Agency Website: www.peqtwp.org
Public Emergency Contact After Hours Number: 973-835-1700

Municipalities Served:
BLOOMINGDALE (PASSAIC CO.)  KINNELON  RIVERDALE
FLORHAM PARK BORO  PEQUANNOCK

Randolph Township Health Department
Health Officer: Mark Caputo
Health Officer Phone: 973-989-7050
Health Officer Email: mcaputo@randolphnj.org
Agency Website: www.randolphnj.org
Public Emergency Contact After Hours Number: 973-795-0931

Municipalities Served:
RANDOLPH  ROCKAWAY BORO  ROXBURY TWP

Rockaway Township Health Department
Health Officer: Peter Tabbot
Health Officer Phone: 973-983-2848
Health Officer Email: pt1@njlincs.net
Agency Website: www.rockawaytownship.org
Public Emergency Contact After Hours Number: 973-625-4000

Municipalities Served:
BOROUGH OF BUTLER  ROCKAWAY TWP  VICTORY GARDENS BORO
JEFFERSON TWP  TOWN OF BOONTON

Washington Township Health Department
Health Officer: Cristianna Cooke-Gibbs
Health Officer Phone: 908-876-3650 x 1240
Health Officer Email: ccooke-gibbs@wtmorris.net
Agency Website: www.wtmorris.org
Public Emergency Contact After Hours Number: 908-876-3232

Municipalities Served:
CHESTER TWP  WASHINGTON TWP (MORRIS CO.)
OCEAN

Long Beach Island Health Department
Health Officer: Daniel Krupinski
Health Officer Phone: 609-492-1212 x 5002
Health Officer Email: dkrupinski@lbihealth.com
Agency Website: www.lbihealth.com
Public Emergency Contact After Hours Number: 609-494-3322

Municipalities Served:
BARNEGAT LIGHT HARVEY CEDARS SHIP BOTTOM
BEACH HAVEN LONG BEACH SURF CITY

Ocean County Health Department
Health Officer: Daniel Regenye
Health Officer Phone: 732-341-9700 x 7201
Health Officer Email: dregenye@ochd.org
Agency Website: www.ochd.org
Public Emergency Contact After Hours Number: 732-341-9700

Municipalities Served:
BARNEGAT TWP LAKEHURST PLUMSTEAD
BAY HEAD LAKEWOOD POINT PLEASANT
BEACHWOOD LAVALLETTE POINT PLEASANT BEACH
BERKELEY TWP LITTLE EGG HARBOR TWP SEASIDE HEIGHTS
BRICK TWP MANCHESTER SEASIDE PARK
EAGLESWOOD TWP MANTOLOKING SOUTH TOMS RIVER
ISLAND HEIGHTS OCEAN GATE STAFFORD
JACKSON TWP OCEAN TWP (OCEAN CO.) TOMS RIVER TWP
LACEY TWP PINE BEACH TUCKERTON

PASSAIC

Clifton Health Department
Health Officer: John Biegel, Ill
Health Officer Phone: 973-470-5760
Health Officer Email: jbiegel@cliftonnj.org
Agency Website: www.cliftonnj.org
Public Emergency Contact After Hours Number: 973-470-5911

Municipalities Served:
CLIFTON LITTLE FALLS TWP PASSAIC
City of Passaic - Health Services
Health Officer: John Biegel, III
Health Officer Phone: 973-365-5603 x 5606
Health Officer Email: jbiegel@cliftonnj.org
Agency Website: www.cityofpassaic.com/health
Public Emergency Contact After Hours Number: 973-365-5603

Municipalities Served:
PASSAIC

Passaic County Department of Health
Health Officer: Charlene Gungil
Health Officer Phone: 973-881-4396
Health Officer Email: charleneg@passaiccountynj.org
Agency Website: www.passaiccountynj.org
Public Emergency Contact After Hours Number: 973-725-2491

Municipalities Served:
HALEDON WANAQUE WOODLAND PARK

City of Paterson, Division of Health
Health Officer: Paul Persaud
Health Officer Phone: 973-321-1277
Health Officer Email: ppersaud@patersonnj.gov
Agency Website: www.patersonnj.gov
Public Emergency Contact After Hours Number: 973-321-1277

Municipalities Served:
HAITHORNE PATERSON TOTOWA
NORTH HALEDON PROSPECT PARK

Ringwood Health Department
Health Officer: Kathy Skrobala
Health Officer Phone: 973-962-7079
Health Officer Email: kathys@bolp.org
Agency Website: www.ringwoodnj.net
Public Emergency Contact After Hours Number: 973-962-7079

Municipalities Served:
RINGWOOD

Wayne Health Department
Health Officer: Maryann Orapello
Health Officer Phone: 973-694-1800 x 3243
Health Officer Email: orapellom@waynetownship.com
Agency Website: www.waynetownship.com
Public Emergency Contact After Hours Number: 973-694-0600

Municipalities Served:
POMPTON LAKES WAYNE
Township of West Milford Department of Health
Health Officer: Charlene Gungil
Health Officer Phone: 973-881-4396
Health Officer Email: charleneg@passaiccountynj.org
Agency Website: http://www.westmilford.org/
Public Emergency Contact After Hours Number: 973-728-2720

Municipalities Served:
WEST MILFORD

SALEM

Salem County Department of Health
Health Officer: Robert Dickinson
Health Officer Phone: 856-935-7510 x 8609
Health Officer Email: robert.dickinson@salemcountynj.org
Agency Website: https://health.salemcountynj.gov/
Public Emergency Contact After Hours Number: 856-769-1955

Municipalities Served:
ALLOWAY MANNINGTON PITTSGROVE
CARNEYS POINT OLDMANS QUINTON
ELMER PENNS GROVE SALEM
ELSINBORO TWP PENNSVILLE UPPER PITTSGROVE
LOWER ALLOWAYS PILESGROVE WOODSTOWN

SOMERSET

Bernards Township Health Department
Health Officer: Lucy Forgione
Health Officer Phone: 908-204-3067
Health Officer Email: lforgione@bernards.org
Agency Website: www.bernardshealth.org/
Public Emergency Contact After Hours Number: 908-766-1122

Municipalities Served:
BERNARDS TWP CHESTER BORO (MORRIS CO.) MENDHAM BORO (MORRIS CO.)
BERNARDSVILLE BORO LONG HILL TWP (MORRIS CO.) PEAPACK-Gladstone BORO

Branchburg Health Department
Health Officer: Vanessa Freire
Health Officer Phone: 908-526-1300 x 181
Health Officer Email: vanessa.freire@branchburg.nj.us
Agency Website: www.branchburg.nj.us
Public Emergency Contact After Hours Number: 908-526-3830

Municipalities Served:
BRANCHBURG
Bridgewater Township Health Department
Health Officer: **Vacant**
Health Officer Phone: **908-725-6300**
Health Officer Email: **Vacant**
Agency Website: [www.bridgewaternj.gov](http://www.bridgewaternj.gov)
Public Emergency Contact After Hours Number: 908-725-5750

Municipalities Served:
BRIDGEWATER

Hillsborough Township Health Department
Health Officer: **Siobhan Spano**
Health Officer Phone: **908-369-5652**
Health Officer Email: [sspano@hillsborough-nj.org](mailto:sspano@hillsborough-nj.org)
Agency Website: [www.hillsborough-nj.org/](http://www.hillsborough-nj.org/)
Public Emergency Contact After Hours Number: 908-369-4323

Municipalities Served:
HILLSBOROUGH          MILLSTONE BORO

Middle-Brook Regional Health Commission
Health Officer: **Kevin Sumner**
Health Officer Phone: **732-968-5151 x 1**
Health Officer Email: [ksumner@middlebrookhealth.org](mailto:ksumner@middlebrookhealth.org)
Agency Website: [www.middlebrookhealth.org](http://www.middlebrookhealth.org)
Public Emergency Contact After Hours Number: 908-753-1000

Municipalities Served:
BOUND BROOK          SOUTH BOUND          WARREN TWP
GREEN BROOK TWP      BROOK              WATCHUNG

Montgomery Township Health Department
Health Officer: **Stephanie Carey**
Health Officer Phone: **908-359-8211 x 245**
Health Officer Email: [scarey@twp.montgomery.nj.us](mailto:scarey@twp.montgomery.nj.us)
Agency Website: [www.twp.montgomery.nj.us/](http://www.twp.montgomery.nj.us/)
Public Emergency Contact After Hours Number: 908-359-3222

Municipalities Served:
HOPEWELL BORO (MERCER CO.)          PENNINGTON BORO (MERCER CO.)
MONTGOMERY                      ROCKY HILL (SOMERSET CO.)
Somerset County Department of Health
Health Officer: Namitha Reddy
Health Officer Phone: 908-231-7155
Health Officer Email: nreddy@co.somerset.nj.us
Agency Website: www.co.somerset.nj.us/health
Public Emergency Contact After Hours Number: 908-526-2500

Municipalities Served:
BEDMINSTER       MANVILLE       SOMERVILLE
FAR HILLS         NORTH PLAINFIELD
FRANKLIN TWP (SOMERSET CO.) RARITAN

SUSSEX

Sussex County Department of Health and Human Services,
Division of Health
Health Officer: James McDonald, III
Health Officer Phone: 973-579-0370
Health Officer Email: jmcdonald@sussex.nj.us
Agency Website: www.sussex.nj.us
Public Emergency Contact After Hours Number: 973-940-5500

Municipalities Served:
ANDOVER BORO       FREDON        LAFAYETTE        STANHOPE
ANDOVER TWP        GREEN TWP    MONTAGUE        STILLWATER
BRANCHVILLE        HAMBURG       NEWTON        SUSSEX
BYRAM              HAMPTON TWP    OGDENSBURG        VERNON
FRANKFORD          HARDYSTOWN    SANDYSTON        WALPACK
FRANKLIN BORO      HOPATCONG     SPARTA          WANTAGE

UNION

Clark Health Department
Health Officer: Nancy Raymond
Health Officer Phone: 732-428-8405
Health Officer Email: no1@njlics.net
Agency Website: www.ourclark.com
Public Emergency Contact After Hours Number: 732-388-3434

Municipalities Served:
CLARK
City of Elizabeth, Department of Health & Human Services
Health Officer: Mark Colicchio
Health Officer Phone: 908-820-4089
Health Officer Email: mcolicchio@elizabethNJ.org
Agency Website: www.elizabethnj.org/
Public Emergency Contact After Hours Number: 908-558-2111

Municipalities Served:
ELIZABETH

Linden Board of Health
Health Officer: Nancy Koblis
Health Officer Phone: 908-474-8408
Health Officer Email: health@linden-nj.org
Agency Website: www.linden-nj.org
Public Emergency Contact After Hours Number: 908-474-8500

Municipalities Served:
LINDEN

City of Plainfield Health Department
Health Officer: Atif Nazir
Health Officer Phone: 908-753-3092
Health Officer Email: atif.nazir@plainfieldnj.gov
Agency Website: http://www.plainfieldnj.gov/
Public Emergency Contact After Hours Number: 908-753-3131

Municipalities Served:
PLAINFIELD

Rahway Health Department
Health Officer: Dennis Green
Health Officer Phone: 732-827-2085
Health Officer Email: dennis.green@twp.woodbridge.nj.us
Agency Website: http://www.cityofrahway.org/
Public Emergency Contact After Hours Number: 732-827-2200

Municipalities Served:
RAHWAY SCOTCH PLAINS WINFIELD TWP
Borough of Roselle
Health Officer: Charles Glagola, Jr.
Health Officer Phone: 908-259-3031
Health Officer Email: cg3@njlincs.net
Agency Website: www.boroughofroselle.com/
Public Emergency Contact After Hours Number: 908-245-2000

Municipalities Served:
ROSELLE

Union County Office of Health Management
Health Officer: Annarelly McNair
Health Officer Phone: 908-518-5625
Health Officer Email: amcnair@ucnj.org
Agency Website: www.ucnj.org
Public Emergency Contact After Hours Number: 908-518-5620

Municipalities Served:
BERKELEY HEIGHTS
HILLSIDE

Union Township Health Department
Health Officer: Marconi Gapas
Health Officer Phone: 908-851-8507
Health Officer Email: mgapas@uniontownship.com
Agency Website: www.uniontownship.com
Public Emergency Contact After Hours Number: 908-851-5000

Municipalities Served:
KENILWORTH
UNION

Westfield Regional Health Department
Health Officer: Megan Avallone
Health Officer Phone: 908-789-4000
Health Officer Email: mavallone@westfieldnj.gov
Agency Website: www.westfieldnj.gov/health
Public Emergency Contact After Hours Number: 908-789-4070

Municipalities Served:
CHATHAM BORO
FANWOOD
GARWOOD
MOUNTAINSIDE
NEW PROVIDENCE
ROSELLE PARK
SUMMIT
WESTFIELD
WARREN

Warren County Health Department
Health Officer: Pete Summers
Health Officer Phone: 908-475-7960
Health Officer Email: psummers@co.warren.nj.us
Agency Website: www.co.warren.nj.us/healthdept
Public Emergency Contact After Hours Number: 908-475-7960

Municipalities Served:
ALLAMUCHY HARMONY OXFORD
ALPHA HARMONY PHILLPSBURG
BELVIDERE HOPE POHATCONG
BLAIRSTOWN INDEPENDENCE WASHINGTON BORO (WARREN CO.)
FRANKLIN TWP (WARREN CO.) KNOWLTON WASHINGTON TWP (WARREN CO.)
FREYLINGHUYSEN LIBERTY WHITE TWP
GREENWICH TWP (WARREN CO.) LOPATCONG
HACKETTSTOWN MANSFIELD (WARREN CO.)
List N: EPA’s Registered Antimicrobial Products for Use Against Novel Coronavirus SARS-CoV-2, the Cause of COVID-19

Date: 03/03/2020

An individual pesticide product may be marketed and sold under a variety of names. If you are seeking additional information about a pesticide product, refer to the EPA Registration Number (EPA Reg. No.), found on the product label, not the brand name. When purchasing a product for use against a specific pathogen, check the EPA Reg. No. versus the products included on this list.

All EPA-registered pesticides must have an EPA Registration Number. Alternative brand names have the same EPA Reg. No. as the primary product. The EPA Reg. No. of a primary product consists of two set of numbers separated by a hyphen, for example EPA Reg. No. 12345-12. The first set of numbers refers to the company identification number, and the second set of numbers following the hyphen represents the product number.

In addition to primary products, distributors may also sell products with identical formulations and identical efficacy as the primary products. Although distributor products frequently use different brand names, you can identify them by their three-part EPA Reg. No. The first two parts of the EPA Reg. No. match the primary product, plus a third set of numbers that represents the Distributor ID number. For example, EPA Reg. No. 12345-12-2567 is a distributor product with an identical formulation and efficacy to the primary product with the EPA Reg. No. 12345-12.

Information about listed products is current as indicated by the dates on this list. If you would like to review the product label information for any of these products, please visit our product label system. Inclusion on this list does not constitute an endorsement by EPA.

RTU- Ready-to-Use
<table>
<thead>
<tr>
<th>Registration Number</th>
<th>Product Name</th>
<th>Company</th>
<th>Formulation Type</th>
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<tr>
<td>1677-129</td>
<td>COSA OXONIA ACTIVE</td>
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<td>VIRASEPT</td>
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<td>Stepan Spray Disinfectant Concentrate</td>
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<td>Clorox Multi Surface Cleaner + Bleach</td>
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COVID-19 in PALTC settings  02/28/2020

BACKGROUND

COVID-19 is the abbreviated name for novel Coronavirus Disease 2019 that first emerged in Wuhan, Hubei Province, China. Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person.

The situation with this outbreak is evolving rapidly with new information being learned daily. The CDC is monitoring the outbreak and working closely with federal, state, and local health departments. Because of this, healthcare personnel working in post-acute and long-term care (PALTC) settings should refer to the CDC website for the latest updates:  https://www.cdc.gov/coronavirus/2019-ncov/index.html

Illness: COVID-19 illness may be mild to severe. Symptoms may appear as soon as 2 days and as long as 14 days after exposure. Symptoms include fever, dry cough, and shortness of breath. Other symptoms include nasal congestion, runny nose, sore throat or diarrhea. These symptoms are usually mild and begin gradually. Some people who are infected may remain asymptomatic. Up to 80% of infected people recover without any need to seek care. Some will develop severe illness (typically in the second week of illness) and at present it is estimated that around 2% will die. Just as with influenza and other viral infections, older adults and patients with comorbid conditions are at increased risk for more severe illness.

Transmission: COVID-19 is spread from person-to-person by respiratory droplets between people who are in close contact with one another (about 6 feet). While there is not yet evidence for spread from surfaces or objects (fomites), this may also be a possible mechanism of transmission. At present, COVID-19 is not felt to be spread through airborne transmission such as seen with tuberculosis or measles.

INTERIM RECOMMENDATIONS FOR POST-ACUTE & LONG-TERM CARE FACILITIES

Who Should Be Evaluated As A Suspected Case: Currently, people returning from sites where there is ongoing person-to-person transmission of COVID-19, or who have been in close contact with individuals known to be infected with COVID-19 are at greatest risk for COVID-19. Such individuals have been part of the CDC’s case definition used to determine when to evaluate individuals for COVID-19. On February 26, 2020, the CDC updated its guidance to also consider COVID-19 in individuals with fever and severe lower respiratory failure requiring hospitalization without an alternative diagnosis.  https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html. The CDC may further expand guidance on who to test and under what circumstances.
COVID-19 in PALTC Settings

- We recommend healthcare personnel use the CDC definitions to guide whether an individual should be evaluated for COVID-19.
- We recommend healthcare personnel regularly monitor the CDC website for updates to the case definition.

How Should Post-Acute & Long-Term Care Facilities Manage Individuals with Suspected COVID-19: At present, given the rare presence of COVID-19 in the community, healthcare personnel suspecting a case of COVID-19 should contact their local and/or state public health department for guidance on management.

- At present and under an abundance of caution, the CDC is recommending that healthcare facilities use Standard Precautions, Contact Precautions, Airborne Precautions, and Eye Protection. This means wearing a gown, gloves, facemask, and goggles or a face shield.
- We also recommend frequent hand hygiene with alcohol-based hand rub or soap and water, washing for at least 20 seconds.

Most PALTC facilities will not have airborne isolation rooms (often called negative pressure rooms).

- If an individual meets the CDC case definition of a suspected case and an airborne isolation room is not immediately available, we recommend facilities place the individual in a single room with a closed door pending consultation with their local health department.

Reducing The Risk Of Introducing COVID-19 In Your Post-Acute & Long-Term Care Facility:

**Surveillance:** Active monitoring and surveillance are important to early detection and recognition of potential outbreaks of all infectious illnesses in long-term care settings.* Facilities should already have an active surveillance program in place capable of identifying cases, clusters and outbreaks of disease.

- We recommend facilities, at the present time, reassess their surveillance program and take any necessary steps to optimize its performance.

**Employees:** Because healthcare personnel reside in the community and work in facilities, they have the potential to introduce infections into PALTC populations. As with all situations, healthcare personnel who are ill should stay home and seek healthcare advice through their regular provider. Those with mild symptoms are encouraged to call, rather than going in person, for medical advice.

- We strongly recommend healthcare providers avoid working while ill.
- We strongly recommend healthcare facilities develop staff policies to allow and account for potential absenteeism during community-wide outbreaks.
COVID-19 in PALTC Settings

- If there is evidence of community-wide COVID-19 illness, we recommend facilities screen staff at entry into the facility for respiratory signs and symptoms and fever.

Visitors: Like healthcare personnel, visitors may also inadvertently foster spread of infections in the PALTC setting. Given the unique nature of the PALTC setting, it will not likely be possible to prohibit all visitors in the event of community-wide COVID-19 illness. For example, individuals on hospice should be able to visit with family members who are not ill.

- Consistent with good routine practice, we recommend posting signs requesting that people with acute respiratory illness to refrain from entering the PALTC facility. This applies whether or not there is COVID-19 activity in the community.
- We recommend individuals (regardless of illness presence) who have a known exposure to someone with a COVID-19, or who have recently traveled to areas with COVID-19 transmission, refrain from entering the nursing home.
- If there is community-wide transmission of COVID-19, we recommend facilities consider screening visitors at entry to the facility.

Planning: As part of a facility’s regular risk assessment, PALTC facilities should develop plans to prepare for and respond to potential outbreaks and/or pandemics. Plans developed for pandemic influenza are reasonable models to use in addressing the prevention and management of COVID-19.**

Key measures for this include:

- Call your State and/or Local Health Department (for testing and guidance)
- Social distancing, including suspending group activities including dining and other social events
- Consistent staff, in which staff are assigned to the same unit or hallway on a consistent basis
- Daily temperature checks and symptom monitoring for residents and staff
- Furlough for staff with respiratory symptoms
- Having a plan to bring in temporary staff, perhaps through an agency, when there is insufficient staffing due to illness or increased burden of care

Admitting New Residents with COVID-19: Current recommendations for the care of individuals with severe illness caused by COVID-19 includes Standard Precautions, Contact Precautions, Airborne Precautions and using eye protection. They also call for placing the person in an airborne infection isolation room (commonly termed a negative pressure room). As noted, few nursing homes have a negative pressure room. Settings without a negative pressure room may consider placing an individual with COVID-19 in a single room with a closed door. Such decisions should be made in consultation with the local public health department.

The length of time during which infected individuals shed virus is not yet known. As symptoms improve, the amount of virus shed by infected individuals should decrease. Based on
COVID-19 in PALTC Settings

Experience with similar viruses, people with severe illness will shed more virus and for a longer period of time than those with mild COVID-19 infection. People with severe illness may continue to shed virus even 12 days after symptom onset. The decision of when people no longer require isolation precautions should be made on a case-by-case basis and in consultation with public health officials. Such a decision will need to take into account the severity of the illness, comorbid conditions, resolution of fever, and clinical status of the individual.

- **We recommend that nursing homes accept patients recovering from COVID-19 only after consultation with the local and/or state health department and referring facility.**
- **If limited resources make this impracticable, we recommend that nursing homes should accept residents with a known COVID-19 infection when that individual can be placed in a single room with a closed door and when there is sufficient and adequately trained staff to care for that individual.**
- **We recommend that facilities be familiar with current CDC recommendations regarding cessation of transmission based precautions for individuals with COVID-19.**
- **We recommend facilities re-educate all staff, clinical and non-clinical on proper use of personal protective equipment (PPE).** [https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf](https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf)

COVID-19 is an evolving situation. Clinicians should use their judgment and consult with public health authorities. Please check websites from the CDC and State/Local Health Departments frequently for updated information.

*Long Term Care Respiratory Surveillance Line List (accessed 2/28/20)
Parent site for the above pdf: [https://www.cdc.gov/longtermcare/training.html](https://www.cdc.gov/longtermcare/training.html)

**Pandemic Influenza Planning Checklist for Long-Term Care and Other Residential Facilities (accessed 2/28/20)
HCANJ/LANJDE has secured pricing on potential solutions for converting single resident rooms or hallways into negative pressure isolation environments. Please see attached and below. I also have also attached the Grainger Part Numbers. The items that state "sourced" in red would be quoted at the time when you want to order by how many you will need. If you have any questions or have a need for this solution please contact the Grainger contact at the end of this alert.

The ECU4 can be deployed as an initial response, converting single resident rooms into negative pressure isolation rooms. With accessories and modular design, it can be configured into multiple options providing a scalable isolation area as more cases present themselves and the surge response needs to escalate.

The Grainger SKU are listed below, the first section is for the Anteroom configuration, the second for a corridor application that allows them to put a non-ambulatory controlled egress across a hallway and target a larger response as the need grows.

Please be advised - current Lead Time is roughly 3 to 4 weeks from time of order.

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<thead>
<tr>
<th>Single Anteroom at threshold</th>
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<table>
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<th>Bundle Configuration for corridors</th>
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<td>ECU4-MODCUF</td>
<td>QTY 1-Sourced, custom production5-Foot Cuff, Installed between 2 ECU4</td>
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Dri Eaze 500 HEPA NAM units in stock, our SKU for Sourcing is PAB500.

The ECU4 -our new 4th generation release-can help your facility meet its preparedness needs by: Provides you the ability to plan for multiple contingency scenarios for isolation as cases increase Temporarily increasing the number of available isolation-capable rooms Allowing isolation rooms to be set up wherever and whenever necessary Ability to scale your response for isolation to a hallway or even and entire floor/wing can be converted at any time Use of the ECU corridor flange seals the entryway of a hallway or ward and the ECU4 operates as a large negatively pressured anteroom, preventing direct air exchange between the target isolated area and general population space.
Utilizing the ECU anteroom for controlling safe ingress/egress of staff and equipment, accommodating all ambulatory and non-ambulatory needs Surge/Scalable Response

https://www.youtube.com/watch?v=xQ9sNsKThiQ&t=255s
https://www.youtube.com/watch?v=LOUu2UHnc

ESS Shield System

https://www.youtube.com/watch?v=_zHT0GyX8bo

ANTEROOM Example

A/R Example-ICO room generation-similar to your AR units-ECU that you have cached

https://www.youtube.com/watch?v=pEuubKNcFCU&t=25s

https://files.constantcontact.com/e1419ee3001/2b0ccadb-44bc-453f-afeb-c73847840208.pdf

https://files.constantcontact.com/e1419ee3001/77e27151-f888-4427-97d4-a319c993202b.pdf

ORDERING IS DIRECT TO GRAINGER with notification to source HCANJ/LANJDE account for ordering. Facilities will conduct payment to Grainger direct. ALL QUESTIONS RELATED TO THIS RESOURCE shall be directed to:

Mark Thompson | Healthcare Account Manager | W.W. Grainger, Inc.
Emergency 24 hrs / 7 days (800) 225-5994 | www.grainger.com/healthcare