POLSINELLI

The following Recommended Operational Protocols are the result of a collaborative effort among several of the leading providers in the home health and home care industries to help providers of all types and sizes respond to the COVID-19 crisis in a responsible way that protects the vulnerable patients and clients they serve and protects the fearless direct care workers who risk their own safety and the safety of their families to provide essential services. A list of those contributors is available at the end of this document. Each agency must make a decision about its best practices based on the information available to it and the circumstances it faces in its area. There is no obligation or expectation that any one agency will follow all of these Recommended Operational Protocols. Please note this document may evolve as new developments inform our understanding of this novel disease, governmental and non-governmental agencies provide additional guidance and information about how it spreads and the best ways to combat it. Please pay attention to the version date in the footer and independently review the source guidance. These protocols are not a substitute for experienced legal counsel. For use in practice, it is highly recommended that experienced counsel assist with development of protocols for your agency pursuant to the circumstances of each specific employer and factual situation. If you operate in California, Oregon or Virginia, you should also consult COVID-19 related regulations that may impact your operations.

RECOMMENDED OPERATIONAL PROTOCOLS

AGENCY MANAGEMENT ACTION STEPS

- Keep apprised of current guidance (the agency can sign up for automatic email updates from many governmental agencies)
    - Regularly visit the Centers for Disease Control and Prevention (CDC) website
    - Regularly visit the Occupational Safety and Health Administration (OSHA) website
    - Regularly visit the state and local health department websites
- Implement a COVID-19 Plan if OSHA's COVID-19 Emergency Temporary Standard (ETS) applies to the Agency (note under the ETS, the agency must seek the input and involvement of non-managerial employees and their representatives, if any, in the development and implementation of the COVID-19 plan)[1]
- Provide updates to staff as the situation changes
- Provide training to staff and document this activity on the topics of:
    - Hand hygiene
    - Infection prevention and control practices

[1] Federal OSHA's COVID-19 ETS became effective for the most part on July 6, 2021 and completely effective on July 21, 2021. In addition, several states have implemented their own version of an ETS. At the federal level, home health, hospice and non-medical home care workers are considered to be in-home healthcare workers providing healthcare service or healthcare support services. As such the ETS will apply in nearly all cases to in the home care providers.

- Use of personal protective equipment (PPE)
- Infectious or communicable diseases
- Vaccinations

- Encourage all clients or patients and those living in the home to become vaccinated
- Consider implementing a practice of weekly testing of unvaccinated employees who work or live in areas with high transmission levels
- Screen clients or patients **and other household members** for COVID-19-like illness
  - **Minimum:** in advance and by phone if possible
  - **Better:** by phone immediately before a visit (if community transmission is moderate or above in the county where the care is performed and the care is not 24 hours a day)
  - **Better:** communicate with the local health department where the client or patient resides within 24 hours prior to the start of service to determine if any prospective clients or patients are under mandatory quarantine or precautionary quarantine for possible COVID-19 infection before providing services to a new client or patient
- Maintain a written record of screening in patient or client files (remember to follow any privacy laws with regard to safeguarding this information)
- Develop plans for:
  - Minimizing the number of direct care workers who are assigned to one particular client
  - Maintaining PPE levels during crisis supply periods — strive for multiple supplier sources
  - Advising and referring direct care workers for medical attention when they exhibit signs or symptoms consistent with COVID-19, such as a fever or chills, cough, shortness of breath/difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and/or diarrhea
  - Continuing client or patient care should a large proportion of staff become sick or need to be absent for other COVID-19-related reasons, or there is an unexpected influx of clients due to COVID-19-related conditions
  - Encourage all direct care workers and other agency employees to become vaccinated[2]

[2] The agency should determine whether it operates in a jurisdiction that requires its employees to become vaccinated, such as in Denver. Similarly, the agency should determine if

- Addressing the emotional health of the agency's direct care workers
- Addressing hiring, orientation and training in a virtual environment

- Develop/update/maintain the following policies:
  - Addressing how the Agency will respond to an employee with a communicable disease (with reference to COVID-19, as well as others)
  - Care and management of a patient or client with a communicable disease
  - Emergency preparedness plan (and/or emergency management plan)
  - Infection prevention and control policies
  - Telecommuting policy for non-direct care staff
  - Paid sick leave, particularly if the agency qualifies for tax credits under the American Rescue Plan Act of 2021 and/or is covered by the ETS

AGENCY COMMUNICATIONS TO CLIENTS OR PATIENTS

- The agency cares about them and will be monitoring them and the direct care workers
- The agency encourages them to become vaccinated and will assist them in such efforts (consider a mandatory program if appropriate/required in the jurisdiction where the agency operates)
- The agency will be using enhanced infection control protocols (to the extent possible)
  - Highlight staff training
  - Discuss screening of direct care workers and patients or clients
- The agency is tracking the latest developments on COVID-19 to remain current with CDC and health department guidelines
  - Provide information from the CDC on prevention and social distancing
- Review the agency's emergency preparedness plan and reiterate that home is the safest place
- The agency will continue to communicate to the clients or patients and direct care workers as its plans or operations change

there are any laws that might prohibit it from requiring employees to become vaccinated, such as in Montana.

AGENCY SCREENING OF CLIENTS

- When screening a client or patient, the agency should ask: "Does anyone in the residence currently, or who has been in the residence in the past seven (7) days, have new onset of fever or chills, cough, shortness of breath/difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea that either cannot be attributed to an underlying or previously recognized condition or a worsening of an underlying or previously recognized condition *(e.g.*, asthma, emphysema)?"
    - If NO — COVID-19 is not likely a risk
        - There is no need to cancel or postpone the visit
        - If client or patient reports other illness, manage as per the agency's usual protocols
        - Be aware of the risk for pre-symptomatic and asymptomatic transmission by the patient and others in the home
    - If YES — Someone in the residence may have COVID-19 and precautions should be taken as outlined in the below section titled: "Response to suspected COVID-19 in a patient/client home"
- If the answer to the above question is NO, the agency should also ask: "In the past 7 days, has anyone in the residence who is not fully vaccinated traveled either domestically or internationally?"[3]
    - If NO, then there is no need to cancel or postpone the visit
    - If YES, consider the precautions outlined in the below section titled: "Response to suspected COVID-19 in a patient/client home"

PATIENT/CLIENT TRAINING AND INSTRUCTION

- **Minimum:** Encourage clients and patients to become vaccinated and maintain good hygiene habits, including:
    - Frequent handwashing (as noted below) or use of an alcohol-based hand sanitizer
    - Covering coughs and sneezes with a tissue or sleeve (not hands)

[3] The CDC recommends that International travelers arriving in the United States receive a viral COVID-19 test 3-5 days after travel regardless of vaccination status. But vaccinated travelers do not need to self-quarantine following international travel.

        - If the client is suspected to have, or has been confirmed to have, COVID-19, use tissue when coughing or sneezing and place tissues immediately in a bag for disposal in regular trash and perform hand hygiene

    - Avoiding touching the eyes, nose and mouth with unwashed hands

    - Request the patient and others in the home wear a cloth face covering when within 6 feet of the caregiver

        - If the client or anyone living in the home is suspected to have, or has been confirmed to have, COVID-19, request that the client or patient or other person to wear a face mask, if available, or a cloth face covering, while the direct care worker is in the home.

- Share with the clients and patients the agency's COVID-19 protocols, including that visitors to the home should be screened

- **Better:** If available, the client or patient should be encouraged to provide (at client's or patient's expense) a portable High-Efficiency Particulate Air ("HEPA") filtration system for use in the client's or patient's room if someone with a possible or confirmed case of COVID-19 is in the home

- One-to-one ratio between direct care worker and the client or patient in the home should be maintained to the extent possible. When not possible:

    - Clients and patients should be encouraged to post a notice on their home's door asking that anyone entering do so only if:

        - They do not feel sick, and

        - They have not traveled (either domestically or internationally) in the past 7 days if they are unvaccinated, and

        - They have not been in close contact (within six feet for a total of 15 minutes or more) with anyone who is suspected to have, or has been diagnosed with, COVID-19

    - The notice also should encourage proper hand hygiene and require the wearing of a cloth face covering for anyone entering the home. They should also stay six feet away from the client or patient if possible

    - Request the patient and others in the home wear a face mask when within 6 feet of the caregiver.

    - If the client lives in an area with a high transmission level, encourage the limitation of visitors

DIRECT CARE WORKER COMMUNICATIONS/TRAINING

- Encourage all direct care workers to become vaccinated
    - Offer information about the vaccines (visit www.bewiseimmunize.com for helpful educational materials)
    - Speak to any myths about the vaccine that may be circulating
    - Show images of management and coworkers becoming vaccinated
    - Maintain a regular cadence of reminders about the benefits of becoming vaccinated
    - If covered by the ETS or otherwise required by applicable law, explain to employees that the agency will pay the time (up to a certain amount per dose) for employees to become vaccinated and the agency will pay for any missed work (again, up to a certain amount) to the extent side effects prevent the employee from working
- Notify direct care workers that they may not continue to work while symptomatic, because they risk causing the continued spread of COVID-19
- Train on areas required by the ETS (to the extent applicable), including:
    - How COVID-19 is transmitted
    - The importance of hand hygiene
    - Ways to reduce the risk of spreading COVID-19
    - The signs and symptoms of COVID-19
    - Risk factors for severe illness
    - When to seek medical attention
    - Policies and procedures on client and patient screening and management
    - Tasks and situations in the workplace that could result in COVID-19 infection
    - Policies and procedures to prevent the spread of COVID-19 that are applicable to the employee's duties (e.g., policies on Standard and Transmission-Based Precautions and physical distancing)
    - Multi-employer workplace agreements related to infection control policies and procedures, the use of common areas, and the use of shared equipment that affect employees at the workplace

- Policies and procedures for PPE worn to comply with the ETS (to the extent applicable)
- Policies and procedures for cleaning and disinfection
- Policies and procedures on health screening and medical management
- Available sick leave policies, any COVID-19-related benefits to which the employee may be entitled under applicable federal, state, or local laws, and other supportive policies and practices (e.g., telework, flexible hours)
- The identity of the safety coordinator(s) specified in the COVID-19 plan
- How the employee can obtain copies of the ETS, and policies and procedures developed under the ETS, including the COVID-19 plan (to the extent applicable)

- Each employee should receive training, in a language and literacy level the employee understands
- The training should be overseen or conducted by a person knowledgeable in the covered subject matter
- The training should include an opportunity for interactive questions and answers
- Additional training should occur when there are changes that affect the employee's risk of contracting COVID-19 at work (e.g., new job tasks), or when policies or procedures are changed or there is an indication that the employee has not retained the necessary understanding or skill
- Training on standard precautions should include but are not limited to hand hygiene, as follows:
    - Perform hand hygiene by washing the hands with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer (at least 60% alcohol), which should occur at a minimum:
        - When you arrive at a client's home
        - Before and after patient or client contact
        - Before and after handling food
        - After contact with the patient's or client's immediate environment
        - After contact with blood, bodily fluids and other potentially infectious materials, or contaminated surfaces
        - When soiled

        - Before and after putting on and taking off PPE, including, but not limited to, gloves and masks

    - Make hand sanitizer available for use

    - Cover coughs and sneezes with a tissue or sleeve (not your hands)

    - Avoid touching your eyes, nose and mouth with unwashed hands

- When training on cleaning and disinfection, explain when and how direct care workers should clean and disinfect equipment and supplies, including electronic equipment, high touch surfaces in the patient's or client's care area with a U.S. Environmental Protection Agency ("EPA") registered disinfectant with a label claim of effectiveness against human coronavirus or emerging viral pathogens for the EPA's recommended contact time or manufacturer's contact time, whichever is longer

    - High touch surfaces in the patient's immediate care area may include: television remotes, doorknobs, light switches, bathroom fixtures, phones, keyboards, remotes, tablets, and bedside tables

    - Wear gloves when required by the manufacturer when cleaning and disinfecting to prevent exposure to the chemicals in the disinfectant

    - Do not mix chemicals

    - Follow the product's label instructions. If the manufacturer's instructions are not specific, then any disinfectant listed on the EPA's website (in List N) can be used. If a product from List N is not available, a disinfectant may be used if the product label states that it is effective against coronaviruses. Chemicals can potentially damage the electronics being cleaned, but the risk is greater of not properly cleaning and disinfecting the device, particularly if it will be used by multiple clients or patients. Allow the surface to dry thoroughly.

    - For electronics, consider putting a wipeable cover on the item

- When training on proper donning and doffing PPE, include follow up demonstrations

- Review emergency preparedness plans (and/or emergency management plans) with all staff

DIRECT CARE WORKER ACTION STEPS

- Become vaccinated if medically able and consistent with the direct care worker's religious beliefs – agencies should visit www.bewiseimmunize.com for helpful educational materials that can be used to encourage vaccinations

- Monitor personal health daily for COVID-19 symptoms (e.g., new onset of fever or chills, cough, shortness of breath/difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and/or diarrhea)

- Temperature checks and self-assessment of COVID-19 symptoms:

    - **Minimum:** Self-assess for COVID-19 symptoms and check personal temperature before the workday begins, before entering the office or before seeing the first patient or client of the day, and after an exposure

    - **Better (and after an exposure):** Self-assess for COVID-19 symptoms and check personal temperatures twice a day **and** before the workday begins at either the office or before seeing the first patient or client of the day

    - Report any fever above 100.0° Fahrenheit or any other COVID-19-like symptoms directly to your agency immediately for further instructions[4]

- Certify at the beginning of each shift, **but before having contact with other employees or the client or patient,** that the worker is not currently experiencing COVID-19 signs or symptoms

    - Direct care worker should contact the agency daily to confirm compliance with this requirement, whether by speaking to someone directly, leaving a voicemail, text message or through an app

- Maintain a distance of six feet from all persons in the residence when possible, and wear a face mask when possible and/or when mandated by state or local government

    - Note, cloth face coverings are not PPE and should not be used when caring for someone suspected to have, diagnosed with, or under quarantine due to exposure to COVID-19. For the appropriate PPE in those circumstances, see the section titled: "Personal Protective Equipment if people with possible or confirmed COVID-19 are in the home (including clients/patients) — this includes those under quarantine"

- Use standard and transmission-based precautions when caring for **clients or patients with possible or confirmed COVID-19,** which include:

    - Hand hygiene

[4] According to the CDC's Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination, fully vaccinated Healthcare Personnel with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure. Asymptomatic HCP with a higher-risk exposure and patients or clients with prolonged close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately and 5–7 days after exposure. Healthcare Personnel should receive a viral test immediately, regardless of vaccination status if they develop symptoms of COVID-19.

- Wear appropriate PPE (see below)
- Follow respiratory hygiene and cough etiquette principles
- Properly clean and disinfect the immediate area where the client or patient is located
- Handle laundry carefully

- Contact the agency **immediately** if signs or symptoms develop
  - If signs or symptoms of a respiratory infection develop during the workday, cover your nose and mouth with a face mask, if one is available, or a cloth face covering, and **immediately cease visiting clients or patients**

- Stay home if sick
  - Direct care workers with symptoms of COVID-19 should undergo a viral test with approved nucleic acid or antigen detection assays (note that if governed by the ETS, the agency should require a PCR test). Negative results from at least one FDA Emergency Use Authorized COVID-19 molecular viral assay for detection of SARS-CoV-2 RNA indicates that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. A second test for SARS-CoV-2 RNA may be performed at the discretion of the evaluating healthcare provider, particularly when a higher level of clinical suspicion for SARS-CoV-2 infection exists. For direct care workers who were suspected of having COVID-19 and had it ruled out, then return to work decisions should be based on their other suspected or confirmed diagnoses
  - See the below section titled "Steps To Take If A Direct Care Worker Is Diagnosed With COVID-19" for additional information on returning to work

PERSONAL PROTECTIVE EQUIPMENT FOR NON-COVID-19 CLIENTS/PATIENTS

Note, this section discusses PPE to wear when caring for patients and clients who do NOT have and are NOT suspect to have COVID-19. The appropriate PPE to wear when caring for someone suspected to have, diagnosed with, or under quarantine due to exposure to COVID-19 is addressed in the section titled: "Personal Protective Equipment if people with possible or confirmed COVID-19 are in the home (including clients/patients) —this includes those under quarantine." Also, direct care workers should perform appropriate hand hygiene when donning and doffing PPE.

Minimum:

- Direct care worker wears a face mask when in the home of a client or patient.[5] Be aware that state or local regulations may require the use of a face mask

[5] When an employee is NOT caring for a COVID-19 patient or client *(i.e.*, someone who is suspected or confirmed to have COVID-19 or is under quarantine), an employee may voluntarily wear an N95 respirator. If covered by the ETS, the agency should follow the requirements provided in the mini-respiratory protection program

- Client or patient wears a cloth face covering when possible if direct care worker is within six feet, even when the direct care worker is wearing a face mask

- Gloves are used when there may be contact with blood, body fluids, other potentially infections materials, non-intact skin, or when state-regulated

- Eye protection should be worn when within 6 feet of a client or patient when the client or patient resides in a county with moderate, substantial or high rates of COVID-19 transmission

Better:

- Cloth face covering or face mask if possible for the client or patient and a face mask for the direct care worker

- Gloves

- Gown or outer covering — worn when client or patient care activity may include contact with blood, bodily fluids and respiratory excretions

- Eye protection

Facility Setting:

- Direct care workers in long-term care facilities or other communal living settings should follow facility protocol, which may include wearing gown, gloves, eye protection, N95 respirator or, if not available, a face mask for the care of all residents, regardless of the presence of symptoms

standard, 29 CFR 1910.504. Otherwise, before allowing an employee to wear an N95 respirator on a voluntary basis, the employer must: (1) make sure that wearing the mask is safe for that particular employee; and (2) have the employee complete and sign a one-page document, Appendix D of the OSHA standard, which is available online and at the end of this document. There are many ways to determine that wearing the mask is safe. One method would be to have the employee complete the medical evaluation that is part of the OSHA respiratory standard, which is available here. The employee would need to confirm that he or she has none of the underlying conditions or problems identified in Part A, Section 2, questions 1 through 9 of the form, and be told that if he or she experiences any problem breathing while wearing the mask that it should be removed until a medical evaluation can be completed, which can be done through on-line services with most follow-up consults being done by phone. A registered or licensed nurse employed by the employer may also be competent to handle the evaluation and certify that the worker can safely wear the mask, depending on state law. If the employer has any questions or would like assistance implementing a voluntary program, the employer should discuss this with a safety consultant, attorney knowledgeable in this area, or a physician or other licensed health care professional whose scope of practice covers these types of matters.

PERSONAL PROTECTIVE EQUIPMENT IF PEOPLE WITH POSSIBLE OR CONFIRMED COVID-19 ARE IN THE HOME (INCLUDING CLIENTS/PATIENTS) — THIS INCLUDES THOSE UNDER QUARANTINE

Direct care workers who are at higher risk for severe illness from COVID-19 should not be assigned to care for a client or patient who has possible or confirmed COVID-19, or if anyone in the home has possible or confirmed COVID-19. This includes situations where a client, patient or other person living in the home is under quarantine because they were in close contact with someone who has contracted COVID-19. The agency should consider designating those direct care workers who are fully vaccinated provide care for such clients or patients.

- Require the use of a fit tested respirator, such as an N95 or one offering the same or better respiratory protection
    - Note: an employer must have a respiratory program pursuant to OHSA's respiratory standard at 29 CFR 1910.134 to require an employee to wear an N95, which requires
        - A written respiratory program
        - A successful medical evaluation for each employee who will wear the respirator to ensure wearing the mask does not pose a hazard
        - Fit-testing to ensure the employee has a proper mask that will prevent the virus from entering around the mask; and
        - Training
    - Note: the CDC has also authorized use of non-National Institute for Occupational Safety and Health ("NIOSH") approved masks that meet other countries' standards for N95s, such as KN95, R95, P95, PFF2, PFF3, DS, DL2, P2 and P3 masks, when there is a crisis level of stock available
- Eye protection — preferably face shield that covers the entire front and sides of the face and that extends to the chin or below
- Gloves
- Gown
- Client or patient wears a face mask, if available, or a cloth face covering, when possible if direct care worker is in the home
- Client or patient wears a face mask (preferred) or cloth face covering when out of the patient's or client's isolation room and in the presence of others in the home

RESPONSE TO SUSPECTED COVID-19 PERSON IN A PATIENT/CLIENT HOME

- Ask if the person has been in contact with their health care provider or local health department

- Notify the client's or patient's medical provider and/or designated family member if that has not already happened and the agency is authorized to do so

- The client's or patient's medical provider may need to evaluate whether the client or patient can still safely receive home care or home health or should be transferred to a hospital or other healthcare facility

- Ask if the person has been diagnosed with, or is seeking a test for, COVID-19

- If possible, postpone the visit for a time when the person who is ill has had at least ten days after the symptoms started (if severely immunocompromised or the person has severe or critical illness, wait 20 days), and 24 hours after a fever has stopped without the use of fever-reducing drugs, such as Tylenol, and symptoms have improved (except for a loss of smell or taste)

- If postponing the visit is not possible, and if it is the client or patient who is sick, and the agency has decided that it can continue to provide care, prepare to manage the client or patient with the most appropriate PPE available (see above) and in accordance with the agency's COVID-19 protocols. See also the above section on client/patient training and instructions for additional steps

- If the client or patient is sick and needs immediate medical attention *(e.g.,* difficulty breathing persistent pain or pressure in the chest, new confusion or inability to arouse, bluish lips or face) call 911 for transport to a hospital

    - Inform 911 that the client or patient may have COVID-19 to ensure appropriate infection control practices are implemented

- Once the person has been diagnosed with COVID-19, the home should be cleaned and disinfected

    - **Minimum:** Clean and disinfect the high-touch surfaces in the patient's or client's immediate care area of the home with an EPA-registered disinfectant with a label claim of effectiveness against human coronavirus or emerging viral pathogens for the disinfectant's recommended contact time. This should also be done throughout the period the client or patient is in the home

    - **Better:** A professional cleaning service should thoroughly clean and disinfect the home once the person who has been diagnosed with COVID-19 is no longer shedding replication-competent virus (i.e., when no longer infectious). According to the CDC this is 10 days after symptom onset for persons with mild to moderate illness, and 20 days for persons with severe to critical illness or are severely immunocompromised

IF A CLIENT OR PATIENT HAS TESTED POSITIVE

- Notify direct care workers who cared for the client or patient following the local health department guidance. In the absence of such guidance, use a time frame of 48 hours before symptom onset (or 48 hours before a positive test result if the client or patient is asymptomatic)

- Notify the direct care workers of the last date they may have been in contact with the client or patient

- Do not disclose the client's or patient's name without permission

- For direct care workers who were in close contact of less than 6 feet of the client or patient with lab-confirmed COVID-19 for a total of 15 minutes or more in a 24-hour time frame within 48 hours of the client or patient's symptom onset (or within 48 hours of a positive test result in the case of an asymptomatic client or patient):

    - Remove the worker from the schedule if he/she cared for the client or patient without wearing at least a face mask or respirator and eye protection and instruct him/her to self-quarantine for 14 days following the exposure

    - Remove the worker from the schedule if the direct care worker performed an aerosol-generating procedure and was not wearing a gown, gloves, eye protection, and a respirator at the time the procedure was performed, and instruct him/her to self-quarantine for 14 days following the exposure

    - If the direct care worker wore at least a face mask or respirator and eye protection, and the patient or client with COVID-19 was not wearing a cloth face covering or face mask, the worker may continue to work but should monitor their health as noted above, and wear a face mask. He/she should discontinue working, as noted above, if he/she becomes sick

- Note, the CDC has advised that asymptomatic Healthcare Personnel (which would include direct care workers) who are fully vaccinated and have a higher-risk exposure as described in this guidance (summarized in the following bullet points) do not need to be restricted from work. Such workers, however, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately and 5–7 days after exposure. Please note there are exceptions, and each case should be evaluated individually

- Asymptomatic HCP with a higher-risk exposure and patients or clients with prolonged close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately and 5–7 days after exposure

    - People with SARS-CoV-2 infection in the last 90 days do not need to be tested if they remain asymptomatic, including those with a known contact

- If possible, postpone the visit for a time when the client or patient has recovered

- If postponing is not possible, and the agency has decided that it can continue to provide care, prepare to manage the client or patient with the most appropriate PPE available (see above) and in accordance with the agency's COVID-19 protocols. See also the above section on client/patient training and instructions for additional steps

STEPS TO TAKE IF A DIRECT CARE WORKER FINDS, AFTER ENTERING THE RESIDENCE, THAT THERE IS SOMEONE (OTHER THAN THE CLIENT OR PATIENT) WHO HAS A COVID-19-LIKE ILLNESS

- Direct care worker should notify their supervisor

- Follow the agency's protocol as to whether the direct care worker should exit the residence or continue providing care

- The direct care worker should be wearing at least a face mask when making a visit (regardless of the patient's COVID-19 status), unless mandated otherwise. If the direct care worker is wearing a face mask, then the direct care worker should switch to a respirator (such as an N95), don a gown, gloves and eye protection, and perform hand hygiene prior to donning PPE

- If the agency still plans to care for a client or patient who lives in a home where a household member has possible or confirmed COVID-19, then:

    - Verify that a direct care worker is willing to care for the client or patient given someone in the household has tested positive or is exhibiting symptoms

    - The ill person who is not the client or patient should be isolated in a separate room from the client or patient. This room should have a private restroom for the ill person's use

    - The direct care worker should maintain a distance of six feet or more from the infected person and practice standard precautions as noted above

    - The direct care worker should wear a respirator, eye protection, gown and gloves whenever in the home

- Make sure the client's or patient's healthcare provider is aware that the client or patient lives in such an environment and develop a care plan that reflects the necessary safety precautions

STEPS TO TAKE IF A DIRECT CARE WORKER IS DIAGNOSED WITH COVID-19

- The direct care worker should call the agency immediately to report the diagnosis
- The direct care worker should **NOT** report the diagnosis directly to the client or patient. The agency should communicate that message
- The direct care worker should be taken off the schedule and reminded to follow the health department's guidance in regards to self-isolation and/or self-monitoring
    - If the agency is covered by the ETS, the agency should pay the direct care worker medical removal protection benefits while the direct care worker is not able to work. In such case:
        - For agencies with 500 or more employees, the agency must pay the direct care worker "the same regular pay the employee would have received had the employee not been absent from work, up to $1,400 per week, until the employee meets the return to work criteria specified in" the ETS
        - For agencies with fewer than 500 employees, the agency "must pay the employee up to the $1,400 per week cap but, beginning in the third week of an employee's removal, the amount can be reduced to two-thirds of the regular pay the employee would have received," with a maximum of $200 per day
        - This payment obligation can be "reduced by the amount of compensation that the employee receives from any other source, such as a publicly or employer-funded compensation program (e.g., paid sick leave, administrative leave)."
    - Regardless of whether the agency is covered by the ETS, the agency should determine if it is required to provide pay or benefits continuation while the direct care worker is unable to work
- Determining when a direct care worker may return to work, the CDC recommends employers use a "symptom-based method," which depends on the severity of the illness and the nature of the person's immune system:
    - Direct care workers who **are not** severely immunocompromised and remained **asymptomatic** throughout their infection may return to work after at least 10 days have passed since the date of the first positive viral diagnostic test
    - Direct care workers who **are not** severely immunocompromised, test positive and experience **mild** to **moderate** illness may return to work after:
        - At least 24 hours have passed since last fever without the use of fever-reducing medications; and
        - Improvement in symptoms (e.g., cough, shortness of breath); and

        - At least 10 days have passed since symptoms first appeared

- Direct care workers with **severe** to **critical** illness or who **are** severely immunocompromised may return to work after:

        - At least 24 hours have passed since last fever without the use of fever-reducing medications; and

        - Improvement in symptoms (e.g., cough, shortness of breath); and

        - At least 20 days have passed since symptoms first appeared

- Definitions for the above:

        - **Mild Illness:** Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging

        - **Moderate Illness:** Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) 94% on room air at sea level

        - **Severe Illness:** Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%

        - **Critical Illness:** Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction

        - **Severely Immunocompromised:** Determined by the individual's health care provider

- The CDC provides that in some instances, a test-based strategy could be considered to allow a health care worker to return to work earlier than if the symptom-based strategy described above were used. The CDC warns that many individuals will have prolonged viral shedding, limiting the utility of this approach. CDC criteria for the test-based strategy are:

    - Direct care workers who **are not** severely immunocompromised, test positive and experience **mild** to **moderate** illness may return to work after:

        - He/she no longer has a fever (without the use of medicine that reduces fevers), and

        - Improvement in symptoms (e.g., cough or shortness of breath), and

        - He/she received two negative results of an FDA Emergency Use Authorized, laboratory-based NAAT to detect SARS-CoV-2 RNA from at least two consecutive respiratory specimen tests in a row, collected at least 24 hours apart. All test results should be final before returning to work

    - Direct care workers who **are not** severely immunocompromised, and remained **asymptomatic** throughout their infection may return to work after receiving two negative results of an FDA Emergency Use Authorized, laboratory-based NAAT to detect SARS-CoV-2 RNA from at least two consecutive respiratory specimen tests in a row, collected at least 24 hours apart. All test results should be final before returning to work

    - Or, once released to return to work by their health care provider, provided the release is consistent with CDC guidelines in effect at the time of the release

    - When the direct care worker returns to work, he or she should:

        - Follow health department guidance

        - Wear a face mask at all times while on duty

        - Wear gloves, if state-mandated

        - Be restricted from contact with severely immunocompromised clients or patients until 14 days after illness onset

        - Adhere to hand hygiene, respiratory hygiene, and cough etiquette in CDC's interim infection control guidance (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)

        - Self-monitor for symptoms, and seek re-evaluation if fever returns or if respiratory symptoms recur or worsen

- The agency should ask the direct care worker for validation regarding the positive COVID-19 test result and confirm when the symptoms first began

- The agency also should ask the direct care worker for validation regarding the negative COVID-19 test results, when available

- The agency should notify all clients or patients for whom the direct care worker provided services during the 48 hours preceding symptom onset (or positive test in the case of a direct care worker who is asymptomatic)

    - The notice should not disclose the direct care worker's name

    - The notice should tell the client or patient the date the direct care worker last provided services to the client or patient

    - The notice should state that the direct care worker has been removed from the schedule
    - The client or patient should be reminded to self-quarantine and seek advice from their medical provider
    - The notice should indicate whether the agency will continue to provide care to the client or patient during the self-quarantine period
- Assign a new direct care worker when a new direct care worker was requested by the client or patient and the family will monitor the client or patient for signs or symptoms
- Ensure the new direct care worker continues to use standard precautions and infection control protocols to protect themselves and their clients or patients
- The client or patient should notify the agency immediately if they present symptoms
- Look to the direct care worker's healthcare professional confirming the direct care worker's diagnosis to report to the health department
- If the agency still plans to care for a client or patient while on self-quarantine, then the guidelines outlined in the section regarding care for a suspected or confirmed COVID-19 client or patient should be followed during the self-quarantine period (regardless of whether or not the client or patient is fully vaccinated)

CONTINGENCY PLAN CONSIDERATIONS FOR CONTINUING CLIENT OR PATIENT CARE SHOULD A LARGE PROPORTION OF STAFF BECOME SICK OR NEED TO BE ABSENT FOR COVID-19 RELATED REASONS

- Prioritize critical and non-essential services based on the client's or patient's health status, functional limitations, disabilities, and essential needs
- Use level of support as part of triaging clients:
    - Lives alone
    - Lives with family members
    - Lives in an assisted living or similar facility
- Identify minimum staffing needs based on the above triaging of clients or patients

OSHA RECORDING/REPORTING OBLIGATIONS

- Understand Occupational Health and Safety recording and reporting obligations based on applicable federal and/or state law (note, 22 states have their own OSH agency).

- If the agency is covered by the ETS, the agency should record any COVID-19 case involving an employee, regardless of whether there is a suspected workplace exposure

    - This log should be maintained in a confidential manner and shared only with employees who have a need to know. The agency should reference the ETS for additional information on storage and disclosure

- If the agency is covered by the ETS, the agency should report to OSHA any in-patient hospitalization of an employee (regardless of whether there is a suspected workplace exposure) within 24 hours of learning of the hospitalization

- If the agency is covered by the ETS, the agency should report to OSHA any employee fatality (regardless of whether there is a suspected workplace exposure) within 8 hours of learning of the fatality

- If the agency is NOT covered by the ETS (see footnote 1 above),

    - Record a COVID-19 case on the agency's OSHA 300 log if:

        - The employee tested-positive for COVID-19; and

        - The case is work-related (note, some states have enacted legislation regarding presumptions on this issue for Workers' Compensation purposes for healthcare workers); **and**

        - The case involves death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, loss of consciousness, and/or a significant injury or illness diagnosed by a physician or other licensed healthcare professional.

    - Report a COVID-19 case to OSHA when:

        - An employee with a confirmed case of COVID-19 that is work-related dies within 30 days of the event that resulted in contracting COVID-19 *(i.e.*, exposure to COVID-19), or

        - An employee with a confirmed case of COVID-19 that is work-related is hospitalized on an in-patient basis within 24 hours of the event that resulted in contracting COVID-19 *(i.e.,* exposure to COVID-19).

- The Company may report COVID-19 fatalities and in-patient hospitalizations by:

- Calling the OSHA Area Office that is nearest to the site of the incident (see www.osha.gov/contactus/bystate)
- Calling the OSHA toll-free telephone number, 1-800-321-OSHA (1-800-321-6742); or
- Submitting information through OSHA's website at www.osha.gov

- When reporting a COVID-19 fatality or in-patient hospitalization, the Company should have the following information available:
  - The Company's business name
  - The name of the deceased or hospitalized employee
  - The time and location of the work-related incident (i.e., exposure) that led to the fatality or in-patient hospitalization, if known
  - The type of reportable event (i.e., fatality or in-patient hospitalization)
  - The number of employees who suffered a fatality or in-patient hospitalization (if applicable)
  - A brief description of the incident; and
  - The name and contact information of the Company's designated contact person

PREPARING TO RESPOND TO OSHA COMPLAINT

- The Agency should consider retaining counsel when responding to an OSHA complaint. Additionally, the Agency should consider taking some or all of the following steps:
  - Document the due date for a response
  - Catalogue all COVID-19 efforts (including review of Exposure Report Forms and Exposure Logs for relevant information)
  - Investigate the allegations
  - Consider program improvements
  - Draft a comprehensive response
  - Consider attaching documentation, such as written protocols for handling the outbreak, personal protective equipment ("PPE") requirements and protocols, procedures for reporting signs and symptoms of COVID-19, and photographic evidence of supplies of equipment

- And remember the cardinal rule: **do not retaliate.** The Agency will not be informed of the identity of the complainant. Even if the Agency believes it knows the identity of the complainant, that belief should not be divulged in the Agency's response. Furthermore, employees are protected from retaliation when exercising their rights under the Occupational Safety and Health Act of 1970, one of which is to raise safety and health complaints with OSHA. The anti-retaliation rule should apply regardless of whether the concern raised with OSHA was valid. Note, to the extent the ETS applies, there is a second anti-retaliation provision that protects workers.

WAYS TO COPE WITH THE EMOTIONAL REACTIONS TO STRESSFUL SITUATIONS, SUCH AS COVID-19

- Constant communication with direct care workers is critical during these stressful unprecedented times and be sure to give them the opportunity to discuss their concerns as often as possible

- Remind staff and clients or patients that feeling sad, anxious, overwhelmed, or having trouble sleeping or other symptoms of distress is normal

- If symptoms become worse, last longer than a month, or a person struggles to participate in their usual daily activities, encourage them to reach out for support and help

- The direct care worker is on the front lines and their health and well-being is critical to ensure the best outcomes for the care of our clients and patients

Contributors:

Supported by:

Appendix D to Sec. 1910.134 (Mandatory) Information for Employees Using Respirators When Not Required Under the Standard

Respirators are an effective method of protection against designated hazards when properly selected and worn. Respirator use is encouraged, even when exposures are below the exposure limit, to provide an additional level of comfort and protection for workers. However, if a respirator is used improperly or not kept clean, the respirator itself can become a hazard to the worker. Sometimes, workers may wear respirators to avoid exposures to hazards, even if the amount of hazardous substance does not exceed the limits set by OSHA standards. If your employer provides respirators for your voluntary use, or if you provide your own respirator, you need to take certain precautions to be sure that the respirator itself does not present a hazard.

You should do the following:

1. Read and heed all instructions provided by the manufacturer on use, maintenance, cleaning and care, and warnings regarding the respirators limitations.

2. Choose respirators certified for use to protect against the contaminant of concern. NIOSH, the National Institute for Occupational Safety and Health of the U.S. Department of Health and Human Services, certifies respirators. A label or statement of certification should appear on the respirator or respirator packaging. It will tell you what the respirator is designed for and how much it will protect you.

3. Do not wear your respirator into atmospheres containing contaminants for which your respirator is not designed to protect against. For example, a respirator designed to filter dust particles will not protect you against gases, vapors, or very small solid particles of fumes or smoke.

4. Keep track of your respirator so that you do not mistakenly use someone else's respirator.

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998]

Acknowledgment of Receipt:

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Employee Signature Date