



Program Directors' & Clinical Directors' Call: COVID-19 Updates

May 20, 2020



Agenda

1:00pm – 1:05pm	Welcome/Introductions	Beverly Miller
1:05pm – 1:10pm	IHS COVID-19 Surveillance Data	Christine Brennan
1:10pm – 1:20pm	Billing Updates - Telehealth	Toni Johnson
1:20pm – 1:30pm	Desert Sage COVID Updates	Justin Peglowski
1:30pm – 1:35pm	Behavioral Health Updates & Guidance	Carrie Greene
1:35pm – 1:40pm	Pharmacy Updates & Guidance	Carolyn Pumares
1:40pm – 1:45pm	CHR & PHN Updates & Guidance	Susan Ducore
1:45pm – 1:50pm	PPE & Medical Supplies Updates	Carolyn Garcia & Tim Shelhamer
1:50pm – 1:55pm	OEHE - M&I and Equipment COVID Funding Guidance	Jim White
1:55pm - 2:05pm	Dental Updates & Guidance for Re-Opening	Michael Donaleski
2:05pm - 2:15pm	Medical Updates & Guidance for Re-Opening	Charlie Magruder/Christine Brennan/Carolyn Pumares
2:15pm – 3:00pm	Open discussion/Sharing of Information on Re-opening of Health Programs/Dental	All



IHS COVID-19 Surveillance Data

Christine Brennan

IHS COVID-19 Surveillance – World Totals



World Map

NEW



U.S. Map



Critical Trends

COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)

Total Confirmed

4,881,619

Confirmed Cases by Country/Region/Sovereignty

- 1,525,367 US
- 299,941 Russia
- 271,628 Brazil
- 250,138 United Kingdom
- 232,037 Spain
- 226,699 Italy
- 180,933 France
- 177,778 Germany
- 151,615 Turkey
- 124,603 Iran
- 106,475 India
- 99,483 Peru



Cumulative Confirmed Cases | Active Cases | Incidence Rate | Case-Fatality Ratio | Testing Rate | Hospitalization Rate

Global Deaths

322,457

- 91,661 deaths US
- 35,422 deaths United Kingdom
- 32,169 deaths Italy
- 28,025 deaths France
- 27,778 deaths Spain
- 17,840 deaths Brazil

US State Level

Deaths, Recovered

- 28,558 deaths, 61,886 recovered New York US
- 10,587 deaths, 23,657 recovered New Jersey US
- 5,938 deaths, recovered Massachusetts US
- 5,017 deaths, 28,234 recovered Michigan US
- 4,628 deaths, recovered Pennsylvania US

Global Deaths

US Deaths, Recovered



Confirmed | Logarithmic | Daily Cases

Admin0 | Admin1 | Admin2

Last Updated at (M/D/YYYY)

5/19/2020, 3:32:35 PM

188

countries/regions

Lancet Inf Dis Article: [Here](#). Mobile Version: [Here](#).

Lead by JHU CSSE. Automation Support: [Esri Living Atlas team](#) and [JHU APL](#). [Contact US](#). [FAQ](#). Read more in this [blog](#).

Data sources: [WHO](#). [CDC](#). [ECDC](#). [NHC](#). [DXY](#). [1point3acres](#). [Worldometers.info](#). [the COVID Tracking Project](#) (testing)

COVID-19 Surveillance Data – U.S. Totals



World Map

NEW



U.S. Map



Critical Trends



COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)

Total Confirmed

1,525,367

Confirmed Cases by Province/State/Dependency

352,845 confirmed New York US

149,356 confirmed New Jersey US

98,030 confirmed Illinois US

87,925 confirmed Massachusetts US

81,904 confirmed California US

67,311 confirmed Pennsylvania US

52,350 confirmed Michigan US

50,134 confirmed Texas US

46,944 confirmed Florida US

Admin0 Admin1 Admin2

Last Updated at (M/D/YYYY)

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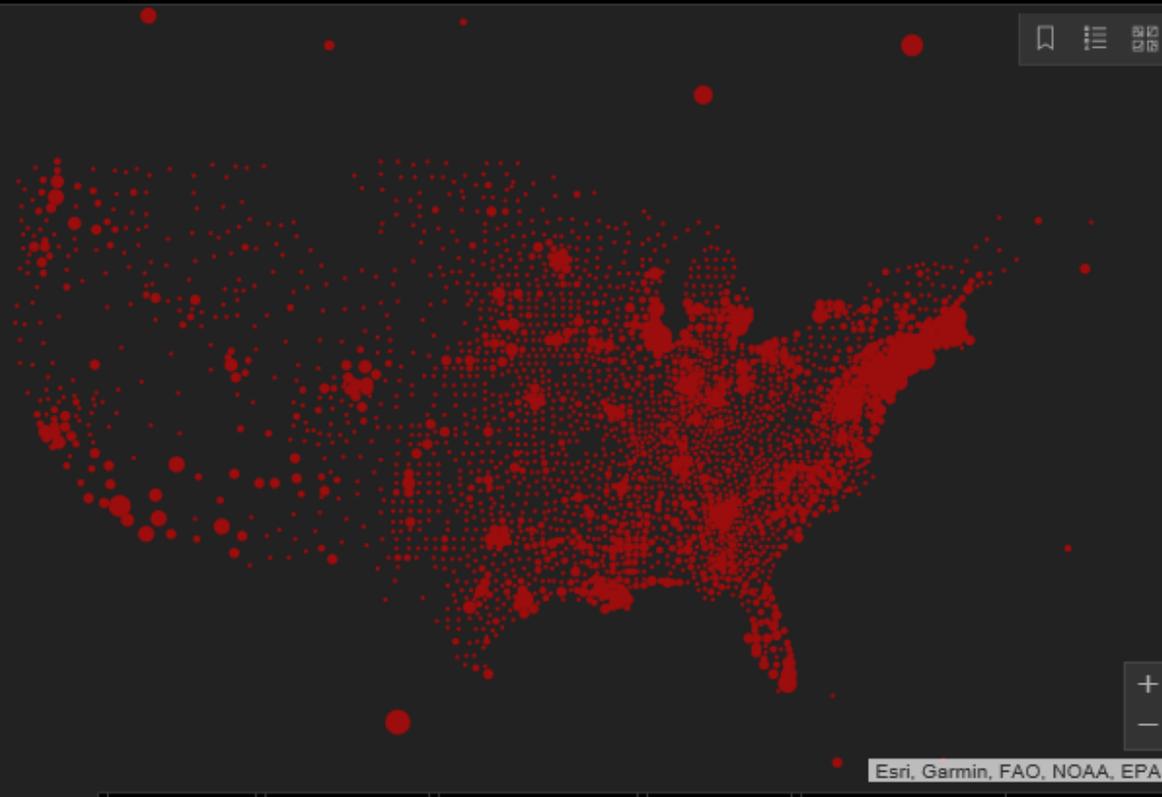
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Cumulative Confirmed Cases

Active Cases

Incidence Rate

Case-Fatality Ratio

Testing Rate

Hospitalization Rate

Esri, Garmin, FAO, NOAA, EPA

Global Deaths

91,730

91,730 deaths US

Global Deaths

US State Level

Deaths, Recovered

28,558 deaths, 61,886 recovered

New York US

10,587 deaths, 23,657 recovered

New Jersey US

5,938 deaths, recovered

Massachusetts US

5,017 deaths, 28,234 recovered

Michigan US

4,628 deaths, recovered

Pennsylvania US

US Deaths, Recovered



Confirmed

Logarithmic

Daily Cases

CDPH CA SURVEILLANCE DATA: Positive Cases

COVID-19 Last Updated on 5/18/2020

Statewide Case Statistics



Positive Cases by County

Sort by Positive Cases

Los Angeles	38,477
San Diego	5,948
Riverside	5,873
Orange	4,558
San Bernardino	3,558
Santa Clara	2,468
Alameda	2,442
San Francisco	2,183
San Mateo	1,701
Kern	1,566
Santa Barbara	1,501
Tulare	1,491
Fresno	1,244
Sacramento	1,233
Contra Costa	1,173
Ventura	850
Imperial	767
San Joaquin	697
Stanislaus	572
Solano	398
Sonoma	387

California Case Statistics

Positive Cases

81,795

+1,365

+1.7%

Deaths

3,334

+32

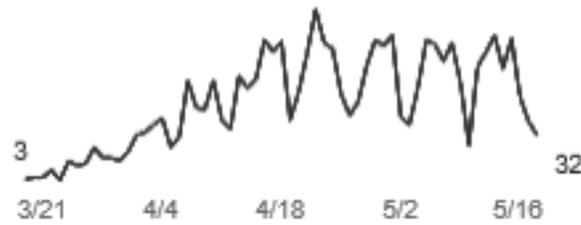
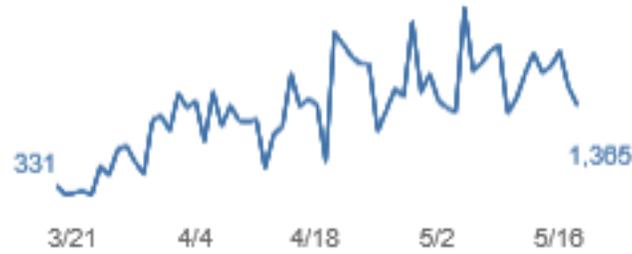
+1.0%

Lab Tests Reported Statewide

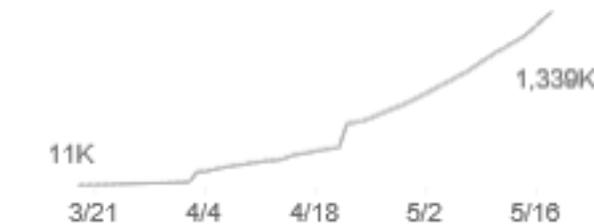
1,339,316

+46,644

+3.6%

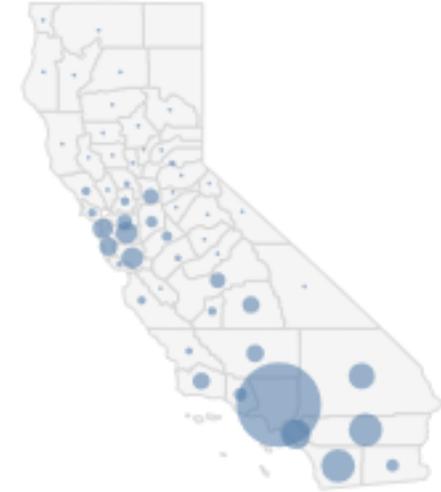


Note: Any instance of a negative number of cases or deaths reflects a correction to previous reporting.



Note: The increase in number of tests conducted on 4/22 is due to the addition of data sources to reflect a more complete count of testing in California.

Positive Cases by County



Positive Cases Demographics

Gender	Age	Race/Ethnicity
Female 49%	0-17 4%	AIAN 0%
Male 50%	18-49 51%	Asian 11%
Unknown 1%	50-64 25%	Black 6%
	65+ 21%	Latino 54%
	Unknown 0%	NHPI 1%
		White 23%
		Multiracial 1%
		Other 5%

Note: Percentages may not add up to 100% due to rounding. Breakdown of deaths is a subset of total deaths as reported by law enforcement.

CDPH CA SURVEILLANCE DATA: Hospital Data

COVID-19 Last Updated on 5/18/2020

Hospital Data



Positive Patients by County

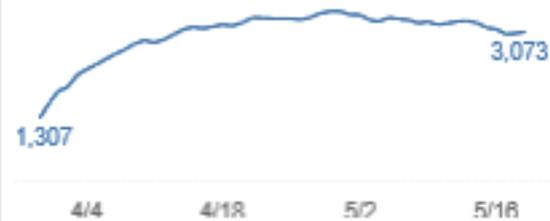
Sort by Positive Patients

Los Angeles	1,531
San Diego	329
Orange	263
Riverside	195
San Bernardino	140
Alameda	87
Imperial	73
Fresno	61
San Francisco	46
Santa Clara	46
San Mateo	41
Kern	36
Tulare	35
Ventura	33
Santa Barbara	25
Kings	21
Contra Costa	19
Stanislaus	18
Solano	16
Sacramento	13
San Joaquin	9
Monterey	8

California Patient Statistics

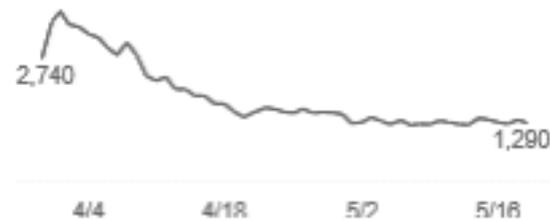
Positive COVID-19 Patients

3,073 +36
+1.2%



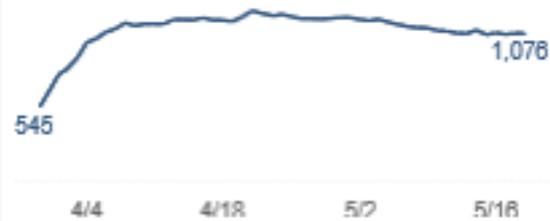
Suspected COVID-19 Patients

1,290 -64
-4.7%



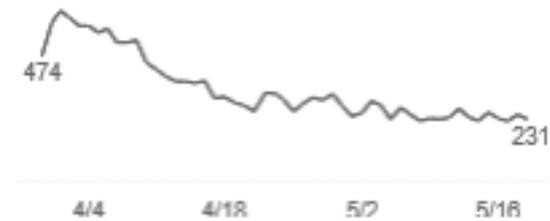
ICU Positive COVID-19 Patients

1,076 +0
+0.0%



ICU Suspected COVID-19 Patients

231 -18
-7.2%



Daily Survey Response Rates

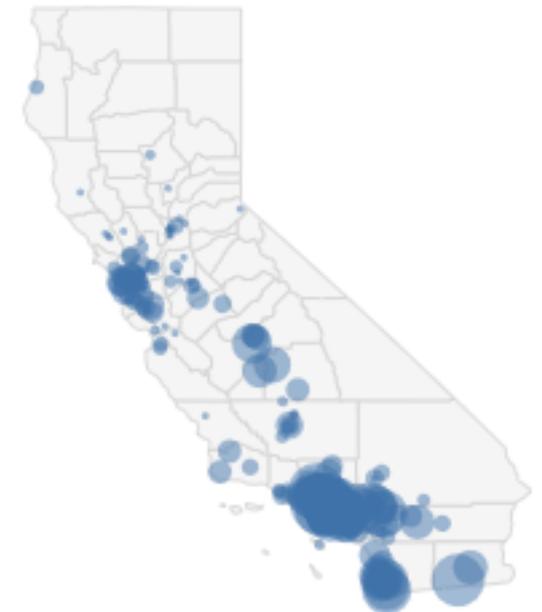
99% of facilities (388 of 393)

99% of licensed beds (73,106 of 73,867)

There are 418 licensed facilities (1 in suspense); one or more facilities can operate under the same license.

California Positive Patients

Note on map: may be difficult to see every number due to overlap of circles.



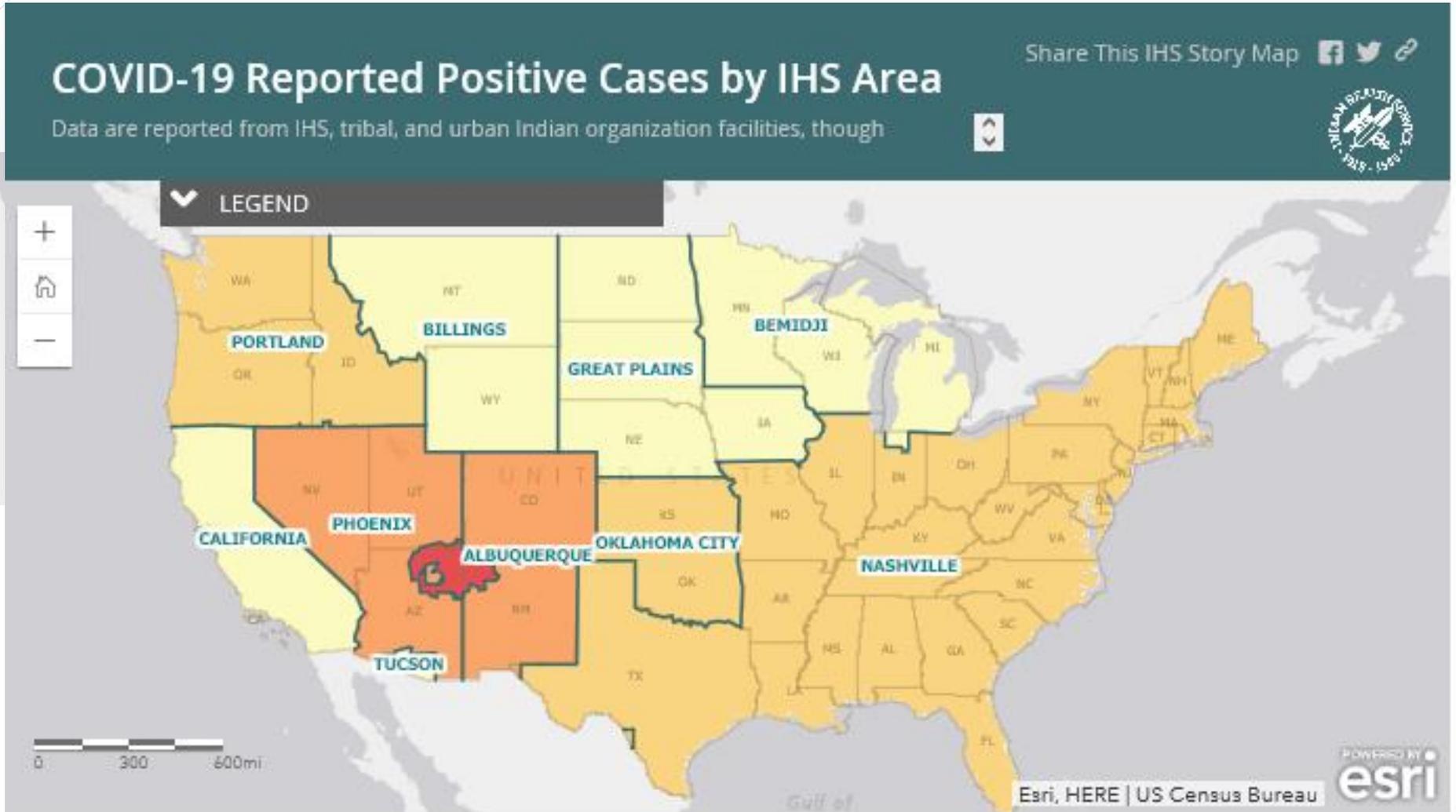
IHS COVID-19 Surveillance – Area Totals

COVID-19 Cases by IHS Area

Data are reported from IHS, tribal, and urban Indian organization facilities, though reporting by tribal and urban programs is voluntary. Data reflect cases reported to the IHS through 11:59 pm on May 17, 2020.

IHS Area	Tested	Positive	Negative
Alaska	13,021	24	10,523
Albuquerque	7,261	602	4,079
Bemidji	2,597	100	1,839
Billings	6,033	157	5,803
California	2,461	85	1,897
Great Plains	3,545	151	3,041
Nashville	3,731	397	3,174
Navajo	18,922	4,278	13,690
Oklahoma City	8,627	251	7,589
Phoenix	5,664	919	4,380
Portland	2,722	256	2,341
Tucson	878	24	760
TOTAL	75,462	7,244	59,116

IHS COVID-19 Surveillance – Area Totals





IHS COVID-19 Surveillance Data

- IHS encourages **all** California Tribal and Urban Indian Health programs to report COVID-19 testing data and results for their health programs
- Surveillance data reported from Indian health programs provides HQ with information needed to report the impact of COVID-19 on our health programs and communities and assists HQ with determining where the greatest needs are for any available resources
- If your site is not currently reporting but would like to participate, please email Christine Brennan (Christine.Brennan@ihs.gov) to request access to the portal for a staff member at your facility
 - If you do not have staff available to report, another option is to send surveillance data to Christine Brennan, identified by date test was collected, and date of results as well as positive or negative and the data can be entered for your facility



COVID-19 Billing Updates

Toni Johnson



Disclaimer

- ▶ The information enclosed was current at the time it was presented. Medicare and Medi-Cal policy changes frequently.
- ▶ Although every reasonable effort has been made to assure the accuracy of the information within this presentation, the ultimate responsibility for the correct submission of claims lies with the provider of services.



COVID-19 Medicare Telehealth – CMS Revises Distant Site Guidance for RHCs/FQHCs

- ▶ CMS revised MLN SE 20016 on April 30, 2020
 - ▶ Additional claims submission and processing instructions
 - ▶ Information on cost-sharing related to COVID-19 testing
 - ▶ Additional information on telehealth flexibilities
 - ▶ Information on provider-based RHCs exemption to the RHC payment limit
- ▶ All other information remains the same

The full version of the MLN Matters SE can be seen here:

<https://www.cms.gov/files/document/se20016.pdf>



Reimbursement for Telehealth Distant Site Services

- Services provided January 27 – June 30, 2020 – For FQHC qualifying visits, FQHC must report three HCPCS/CPT codes for the service:
 - PPS specific payment code (G0466, G0467, G0468, G0469 or G0470)
 - HCPCS/CPT code that describes the services furnished via telehealth with modifier 95 AND
 - G2025 with modifier 95
- Claims will be paid at the FQHC PPS rate until June 30 2020
- Hold claims for telehealth services that are not FQHC qualifying visits until July 1
- Beginning July 1, 2020 - FQHCs should only submit G2025
- Telehealth reimbursement of \$92.03 after July 1, 2020

Audio-only Visits Now Considered Telehealth Distant Site

- ▶ Audio only telephone evaluation and management (E/M) services
- ▶ At least 5 minutes of telephone E/M:
 - ▶ Physician or other qualified health care professional who may report E/M services
 - ▶ Provided to an established patient, parent or guardian
- ▶ Telephone E/Ms cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment
- ▶ HCPSC – G2025 no modifier
 - ▶ Telephone service codes include 99441-99443 (non-face-to-face physician telephone services)
- ▶ Reimbursement is \$92.03

COVID-19 Medi-Cal

- DHCS posted updated guidance for telehealth and virtual/telephonic communications on May 1, 2020
 - Expanded Frequently Asked Questions
 - Confusion on billing of “telehealth” and “audio only” visits
 - Request for conference call with DHCS to address billing questions
- Presumptive eligibility billing instructions posted on April 30, 2020 for FQHC/RHCs/IHS-MOAs
- CMS approves California SPA #20-0024 on May 13, 2020
 - Medicaid Disaster Relief for the COVID-19 National Emergency
- Medi-Cal Tribal and Designees of Indian Health Programs Meeting scheduled for May 28, 2020



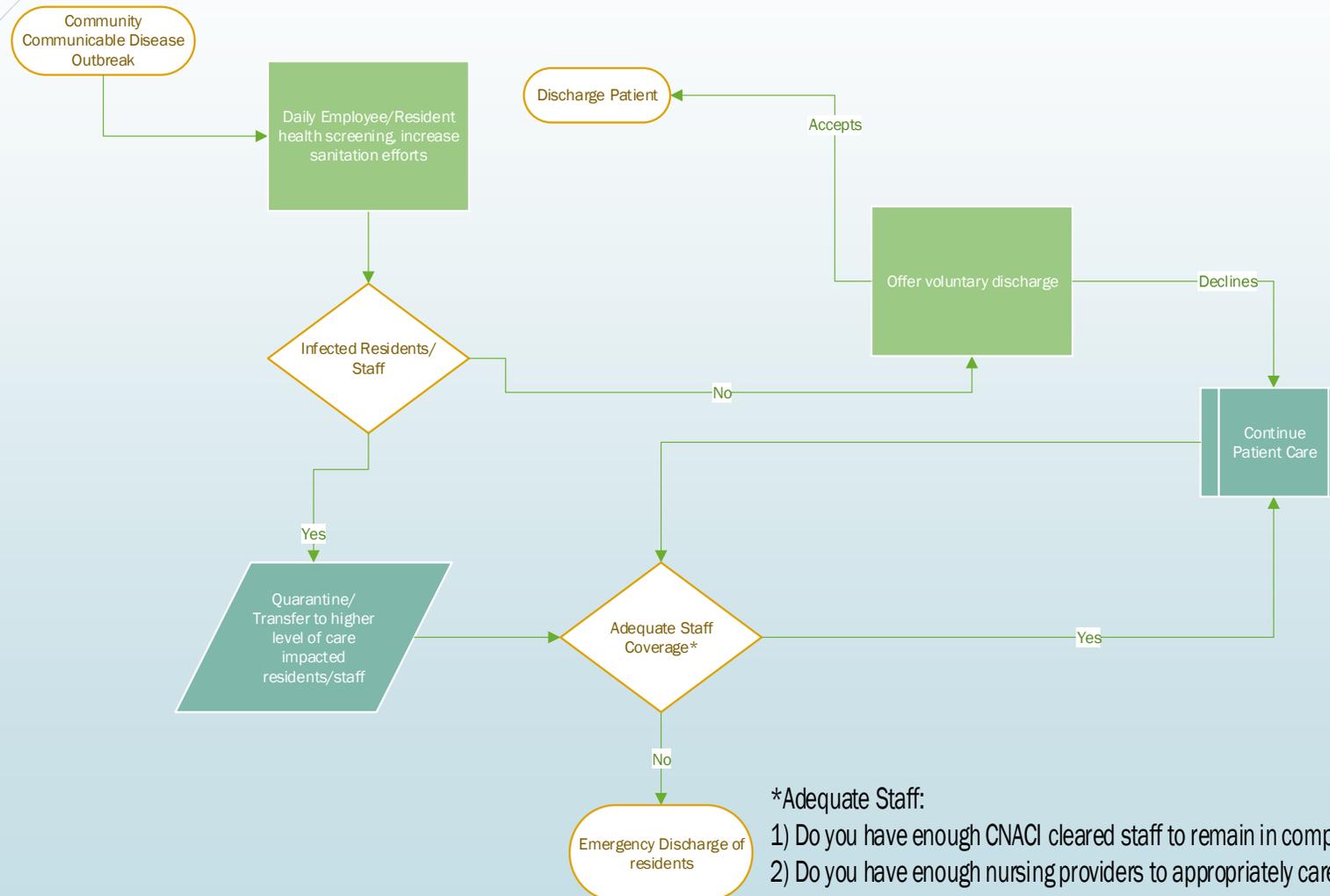
Desert Sage YRTC Updates

Justin Peglowski

Impact: Early March

- Staff are not quarantined, with each re-entry into the facility comes an increased risk of exposure for residents and staff
 - As of 3/20/2020 1030 Riverside County reports
 - 22 confirmed cases
 - 4 travel associated
 - 18 are locally acquired
 - 4 deaths
 - 23.6% of staff currently did not have CNACI clearance
 - 20% of staff were out due to symptoms of upper respiratory infection
 - 83% of staff out of work due to upper respiratory infection symptoms are CNACI cleared
 - Therefore, 69% of our staff are currently cleared and able to work
 - 4 PHS officers among those cleared with possibility to get ill or deploy further reducing the cleared staff
 - 21.4% of total positions remain vacant
 - 75% vacancy in RN level positions by 1 April 2020
 - 1 contract RN will be ending employment this month
 - 1 contract RN will remain
 - 1 pending backfill contract RN currently in Florida in a high risk COVID-19 situation and will need quarantine prior to reporting to YRTC
 - 25% vacancy in facilities/housekeeping positions currently
 - 2 team member out sick with respiratory symptoms, as a result vacancy 66%

Decision Tree



A dark grey arrow points to the right from the left edge of the slide. Several thin, curved lines in shades of blue and grey originate from the left side and sweep across the slide towards the right.

Decision

- ▶ Temporary treatment discharge pending stabilization
- ▶ Continued offering of care
- ▶ Expedited readmission upon stabilization

- ▶ Last youth returned home April 2, 2020



Interim Care

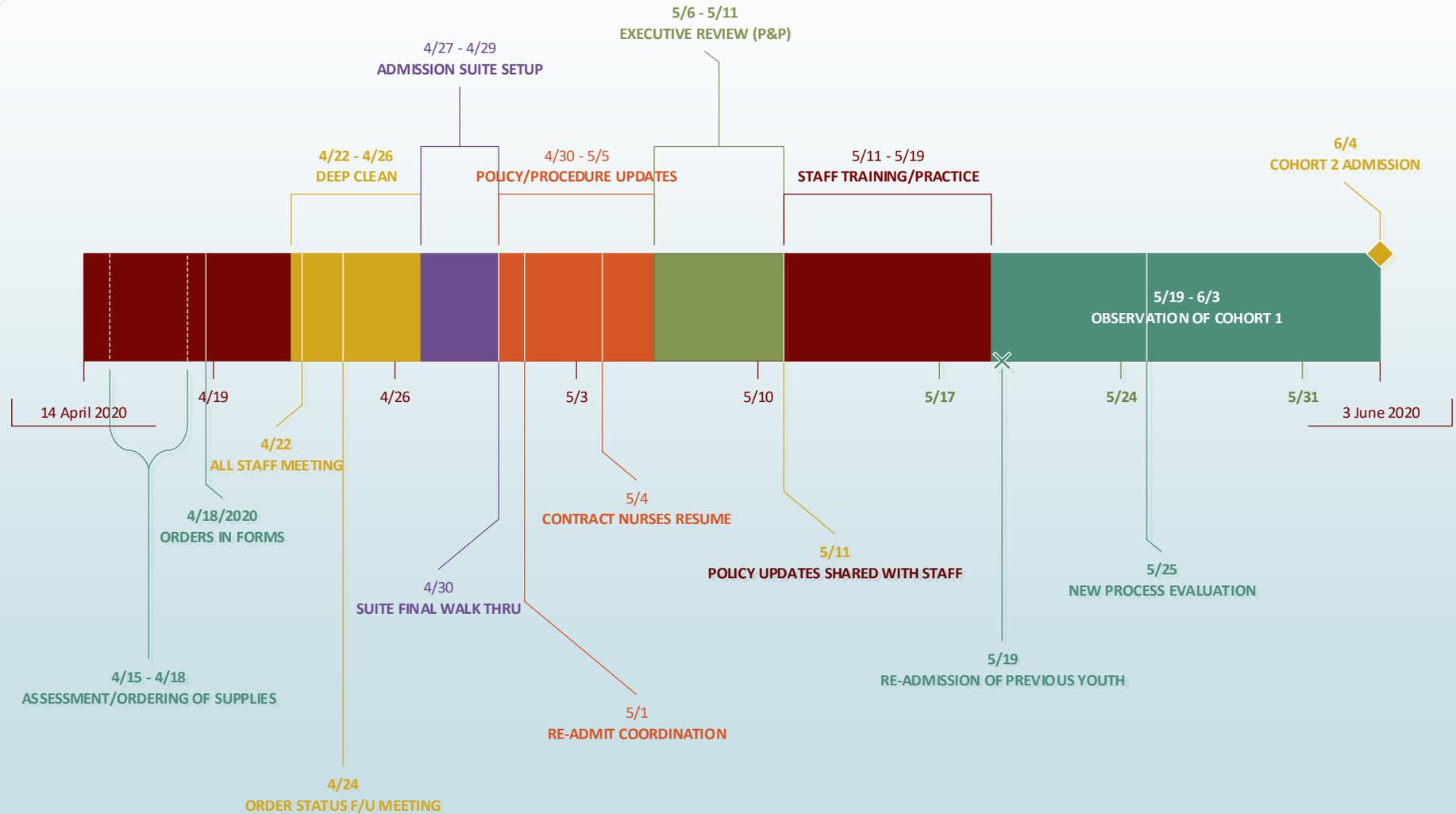
- ▶ Services offered to youth/family during treatment break included:
 - ▶ Weekly tele-health contact
 - ▶ Weekly group
 - ▶ Weekly meeting with outpatient therapist
 - ▶ Access to online education and teacher
- ▶ Treatment team continued to meet to review youth's progress and/or struggles
- ▶ Psychiatrist & Nurse Practitioner remained part of that care
- ▶ Allowance for level petition upon return from treatment break to resume care, as long as youth
 - ▶ Earned at least 1 credit in school
 - ▶ Completed their therapeutic workbooks
 - ▶ Had a negative urine screen upon readmission



Planning & Training

- ▶ Leadership created training plans for staff during the break in patient care
- ▶ Cultural trainings were planned and conducted on topics including:
 - ▶ California Native History
 - ▶ Historical Trauma
 - ▶ Cultural/Spiritual practices
 - ▶ White Bison
- ▶ Executive team assessed, planned, and implemented new policies and protocols to resume care in as safe a manner as possible

Implementation Timeline





Current Plans

- Readmission of youth starting 5/19-5/20
- Cohort model will be followed with universal screening & testing
 - Remain in admission area for 2 weeks of monitoring
 - If no positive tests or symptoms, youth will move to normal milieu environment
 - Admission area properly cleaned
- Admit additional youth to the admission area and repeat process above
 - Second cohort admission being planned currently for 6/4-6/5



Behavioral Health Updates & Guidance

Carrie Greene



Behavioral Health Guidelines

- Conduct as many visits via secure telehealth platforms whenever possible.
- Continue to use of phone, skype, FaceTime during this time if secure telehealth platform is not available.
- Follow medical guidelines established by your clinic for in-person.
- Consider virtual groups whenever possible.
- Follow physical distancing and cloth face covering guidelines.
- Limit group size to 10 or fewer.
- Consider adding cloth face coverings, hand washing/sanitizing to group norms.



Pharmacy Updates & Guidance

LCDR Carolyn Pumares



State of California - Department of Consumer Affairs Waiver

- ▶ Order waiving restrictions on Pharmacists Ordering and Collecting Specimens for COVID-19 tests
 - ▶ Governor's Executive Order N-39-20- pharmacists can order and physically obtain specimens necessary to perform COVID-19 tests.
 - ▶ It does not allow the pharmacist to analyze the results of the test.
 - ▶ All specimens must be processed at public health, commercial or clinic labs
 - ▶ Effective: 5/12/2020, Expiration: 7/12/2020
- ▶ No guidance yet on reimbursement

Source: https://www.dca.ca.gov/licensees/pharmacists_covid19_tests.pdf

CA Board of Pharmacy Law Waivers

- ▶ Licensees must submit a request for a waiver at the following;
 - ▶ Compounding.waiver@dca.ca.gov
 - ▶ Include the following info:
 - ▶ License number(s)
 - ▶ Brief statement regarding the extent of the waiver requested
 - ▶ Brief statement detailing how the declared emergency caused the need for the waiver
 - ▶ Relevant laws that the licensee is requesting to waived
 - ▶ Authorized contact person (E.g. owner, officer, pharmacist-in-charge, or other individual authorized to act on behalf of the licensee)
 - ▶ Board of pharmacy will respond to the request via email
 - ▶ Waivers last 30 days
- ▶ Note: Board of pharmacy can not act on waiver requests beyond Chapter 9, Division 2 of the Business and professions Code and Title 16, California Code of Regulations



CA Board of Pharmacy Waivers of interest

- **Certification in Basic Life Support** (Business and Professions Code section 4052.8(b)(2))
 - BLS certification that expired on or after march 15, 2020
 - Pharmacist can still administer immunizations
 - Effective: 4/6/2020, Expiration: 7/4/2020
- **Duty to Consult** (Title 16, California Cod of Regulations, section 1707.2(a))
 - Effective: 4/2/2020, Expiration: 7/1/2020
- **Prohibited Acts involving Dangerous Drugs or Devices** (BPC sections 4169(a)(1) and 4161(b))
 - CA pharmacies can receive drugs and devices from a pharmacy, wholesaler or third-party located in another state that is not licensed in California
 - Effective: 3/21/2020, Expiration: 7/24/2020 or emergency declaration is lifted
- **Staffing Ratio**
 - Pharmacist to Pharmacy Interns (BPC section 4114(b))
 - Pharmacist to pharmacy technicians (BPC 4115(f)(1) and 4127.15©(2); and Title 15 California Code of Regulations, section 1793.7)
 - Effective: 3/20/2020, Expiration: 6/24/2020 or emergency declaration is lifted



CA Board of Pharmacy Waivers of interest

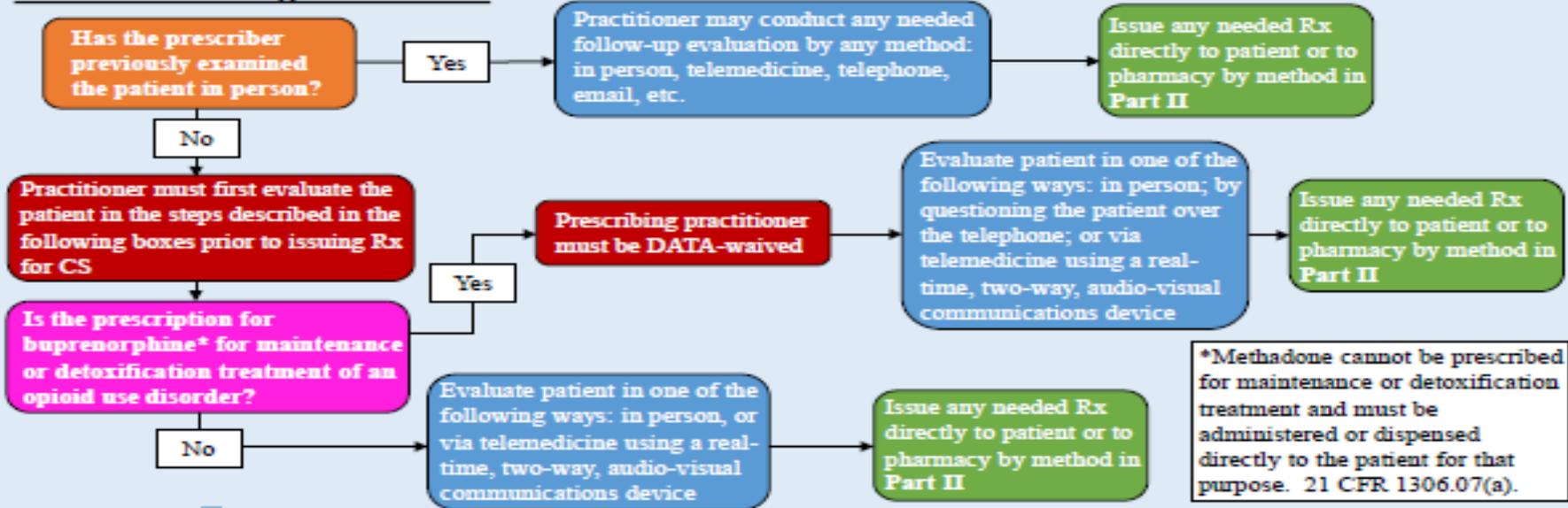
- ▶ **Signature Requirement for Receipt of Drug Delivery** (BPC section 4059.5)
 - ▶ Delivery personnel does not need to obtain pharmacist signature upon delivery daily medication delivery
 - ▶ Effective: 3/17/2020 Expiration: 6/24/2020 or until emergency declaration is lifted
- ▶ **Remote processing of prescriptions** (BPC Section 4071(a))
 - ▶ Effective: 3/18/2020 Expiration: 6/24/2020 or until emergency declaration is lifted
- ▶ **Inventory Reconciliation Report of Controlled Substances** (Title 16), California Code of Regulations, section 1715.65(c)
 - ▶ Inventory reconciliation can be complete once every 6 months instead of every 3 months
 - ▶ Effective: 3/24/2020 Expiration: 6/22/2020



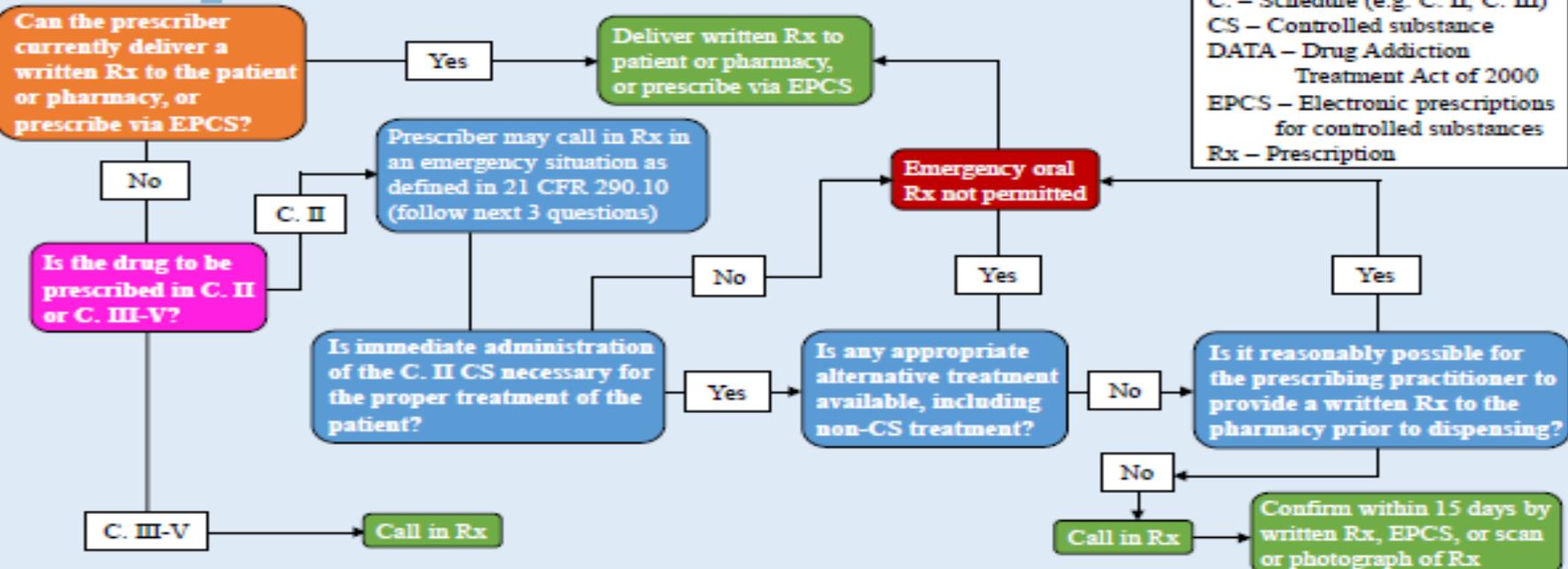
Drug Enforcement Agency (DEA)

- ▶ Emergency control prescription provided orally (21 CFR 1307.03)
 - ▶ DEA grants providers 15 days instead of 7 days to provide prescription to the pharmacy
 - ▶ Prescription can be provided via facsimile, photograph or scanned in place of paper script
 - ▶ Include statement “ Authorization for Emergency Dispensing”
 - ▶ Providers must maintain original prescription in patient's file
 - ▶ Effective: 3/16/2020, Expiration: duration of Public Health Emergency unless modified or withdrawn

Part I: Evaluating the Patient



Part II: Delivering the Rx to the Pharmacy





CMS Part D Patient Signature Requirement waiver

- ▶ Minimizes face-to-face contact for medication delivery or dispensing
- ▶ HHS not requiring and will not audit for patient signatures as proof of delivery for any medication including controlled substances
- ▶ Caveat: check with the plan as some may require pharmacies to document “COVID” on the signature box
- ▶ Effective: 3/20/2020, Expiration: duration of declaration of emergency
- ▶ Questions or additional info: CPI MedicarePartD_data@cms.hhs.gov

FDA guidance on compounding hand sanitizer

- ▶ Policy for temporary compounding of alcohol-based hand sanitizer products
 - ▶ Specific ingredients required
 - ▶ Ethanol (80% volume/volume) or Isopropyl alcohol (75% v/v)
 - ▶ Glycerol (1.45% v/v)
 - ▶ Hydrogen peroxide (0.125% v/v)
 - ▶ Sterile distilled water
 - ▶ NO addition of other active or inactive ingredients
 - ▶ United States Pharmacopoeia has specific formulations
 - ▶ <https://www.usp.org/sites/default/files/usp/document/about/public-policy/usp-covid19-handrub.pdf>
 - ▶ Preparation conditions is similar to that of compounding non-sterile drugs
 - ▶ Finished product: aqueous solution NOT gel, foam, or aerosol spray
 - ▶ Appropriate packaging to prevent alcohol evaporation
 - ▶ Appropriate labeling

Source: <https://www.fda.gov/media/136118/download>



COVID-19 Guidance/Program Updates: Public Health Nursing and CHRs

Susan Ducore, DNP, MSN, RN, PHN

CA Area Nurse Consultant

susan.ducore@ihs.gov



Public Health Nurses (PHNs)

- ▶ **2019 Novel Coronavirus Guidance for Home and Community Healthcare Workers** – IHS/HQ approved; distributed to Area PHNS and CHRs on March 20
 - ▶ Offers strategies to reduce transmission of SARS-CoV-2 Virus within IHS healthcare facilities
 - ▶ Includes links to various, recognized, sources for practice guidance – CDC and other
 - ▶ Offers protocols for practice in community health/outreach settings
- ▶ IHS/HQ sponsored session – “**PHN COVID 19-EHR Templates**” Adobe Session **for PHNs using RPMS for documentation**_ May 7 and 11 (repeat sessions)
- ▶ Area Nurse Consultant COVID-19 Activities:
 - ▶ **Communication** with Area nurses and other clinical staff, **sharing resources and providing technical support** with regard to COVID-19 guidance re the following areas:
 - ▶ practice protocols/guidance,
 - ▶ testing and contact tracing,
 - ▶ staffing,
 - ▶ telework,
 - ▶ EMR documentation, and
 - ▶ infection control
 - ▶ **Collaboration and advocacy**, working with various Area Office, Tribal, Federal, State and local partners to enhance resources for Area healthcare programs/staff.

Practice Guidance for PHNs and CHR Programs

Create **clear protocols, communicate them** to staff and supervisors and **implement them through practice:**

- PHN Programs should implement protocol to prioritize home visits to provide services to the greatest need, if resources become strained (refer to local Public Health Nursing Program Priority, Intensity and Timeliness of PHN Referrals).

- CHR Programs should consider protocol for home monitoring and outreach in coordination with local established policies and procedures (refer to local tribal guidelines).

- **Screening clients and household members** in advance and/or at the time of a home visit for

- Recent travel (i.e., within the past 14 days) from COVID-19-affected geographic areas or contact with a person diagnosed with COVID-19, AND
- Fever (subjective or confirmed, >100.4°F), cough, or shortness of breath.

- Suggested practice for **follow-up care** if individuals present with **COVID-19-like symptoms:**

- Postpone or reschedule visits for persons who do not require immediate care until their 14-day self-monitoring period has ended.
- Develop plans to manage clients whose medical needs cannot be postponed during the 14-day self-monitoring period.
- Contact the client's health care provider to report their patient's illness.

Community Health Representatives (CHRs)

- **IHS recommends consideration for utilization of CHRs**, consistent with training and community affiliation, in the following important roles:
 - to **educate** the population about a new disease,
 - to perform active **case finding**,
 - to **accompany** those who are ill to health facilities, and
 - to support those who are not ill but need to remain isolated at home through **targeted social support**.
- **IHS recommends, where appropriate**, a layered* approach to contact investigator recruitment and training efforts:
 - (1) a lay or para-professional contact tracer position (such as **CHRs or CHAPs**),
 - (2) **Public Health Nurse**, and
 - (3) a **healthcare provider** or other clinical, epidemiologist, or other specialist positions to support tiers 1 and 2.

*These layers **can** be adapted by IHS/tribal/or urban Indian organization (I/T/U) public health agencies based on their needs and specific circumstances, human resources systems, and available assets and resources.



CHR Guidance

IHS COVID-19 Interim Guidance for Community Health Representatives /Community Health Workers' Virtual Home Visits during the COVID-19 Pandemic - May 12, 2020.

- ▶ Distributed to Area CHRs, PHNs and Program Directors by e-mail on May 13; content is posted on the IHS Quality Portal (refer to resource slide)

Interim Guidance focus:

- ▶ Visit Content
- ▶ Personal information and privacy
 - ▶ e.g. patient name, contact information, consent, name address, acknowledgement of intent to document in EHR
- ▶ Information to be collected:
- ▶ Recording of information in electronic health record

COVID – 19-Associated Education/Training

Public Health Nurses (PHNs)/Clinic Nurses Webinars:

IHS/HQ PHN Hosted Training – April 30

- ▶ Case investigation,
- ▶ Contact tracing
- ▶ Case monitoring guidelines
- ▶ Recorded Session:
<https://ihs.cosocloud.com/p9ocqb9bls7v/>
- ▶ Division of Diabetes Treatment and Prevention:
Caring for Elders during the COVID-19 Pandemic
- May 12
- ▶ Recorded Session:
<https://www.ihs.gov/diabetes/>
- ▶ **Compassion Fatigue:** Additional Risks while Serving Vulnerable Populations During a Pandemic – May 20
- ▶ Supporting the **Mental Health of Healthcare Workers** during Covid-19 – May 28

Community Health Representatives

Webinars:

IHS/HQ CHR hosted Training Series: (4 virtual sessions)

Community Health Worker (CHR/HE/HPDP) Seminar Series – showcases **best practices for coronavirus outreach, education and prevention in tribal communities**

- ▶ May 7 - COVID-19 101
- ▶ May 14 - Home Visitation During Social Distancing
- ▶ May 21 – CHR COVID-19 Best Practices
- ▶ May 28 – Individual and Community Recovery

Practice Resources

- Framework to address the under-utilization of important medical services for patients with non-COVID-19-related urgent and emergent health needs during the COVID-19 pandemic: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/framework-non-COVID-care.html>
- COVID-19 Contact Tracing Training: Guidance, Resources and Sample Training Plan: <https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/index.html>
- Guidance on preventing the spread of Coronavirus Disease 2019 in homes and residential communities: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html>
- IHS COVID-19 Interim Guidance for Community Health Representatives/Community Health Workers Virtual Home Visits during the COVID-19 Pandemic: [2020 05 12- CHR-CHW Virtual Home Visit \(Final\).pdf](#) (located on IHS Quality Portal : <https://www.ihs.gov/office-of-quality-portal/resources>)
- CDPH Memo to VFC Providers on “Routine Childhood Immunizations during COVID-19 Pandemic”: <https://files.constantcontact.com/9d04821c001/8c834852-adc9-4b7d-a522-231b91dedd58.pdf>
- Maintaining Childhood Immunizations During COVID-19 Pandemic: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html>
- Interim Infection Control Guidance for Public Health Personnel Evaluating Persons Under Investigation (PUIs) and Asymptomatic Close Contacts of Confirmed Cases at Their Home or Non-Home Residential Settings: <https://www.cdc.gov/coronavirus/2019-ncov/php/guidance-evaluating-pui.html>
- IHS Recommendation for Home and Community Health Care Workers during COVID-19 Pandemic: *2019 Novel Coronavirus Guidance for Home Community Health Care Workers.pdf*

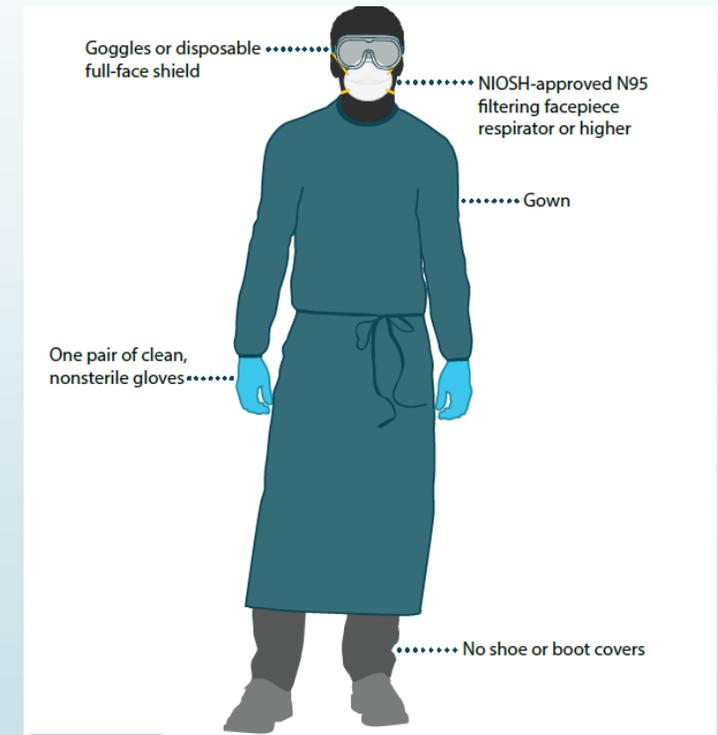


PPE & Medical Supply Updates

California Area EMPOCs: Carolyn Garcia & Tim Shelhamer

FEMA Region IX: Changes to PPE Request Process

- ▶ Beginning 5/14/2020, no justification is required by any T/U health program requesting PPE through FEMA.
 - ▶ PPE: Masks, gloves, gowns, face shields, goggles
- ▶ To request PPE:
 - ▶ Complete the OMB 1660 Request for Resources Form boxes 1-8.
 - ▶ Make sure include size/quantity information on the form for each item requested.
 - ▶ Complete only 1 form per request.
 - ▶ If all items you wish to request do not fit on the form, put additional items on a MSWord document.
 - ▶ Submit request to CAIHS EMPOC/Alt. EMPOC for processing and tracking.
 - ▶ carolyn.garcia2@ihs.gov
 - ▶ tim.shelhamer@ihs.gov



FEMA Region IX: Other Supply Requests



- ▶ For non-PPE requests, you will need to include a justification along with a completed OMB 1660 Form.
 - ▶ Justification: Specify what were the shortfalls/why unable to procure the item.
- ▶ Non-PPE defined as:
 - ▶ Hand sanitizer, cleaning supplies, cleaning wipes, air purifiers, medical equipment.

Cloth Face Masks

- ▶ T/U health programs should have received their shipment of cloth face masks, EXCEPT:

- ▶ **CAIHS has received 4500 cloth masks for T/U programs who requested a number that was significantly smaller than 1 case (500 masks).**

- ▶ **5/18/2020: CAIHS has begun repackaging cloth masks for distribution to 21 health programs.**

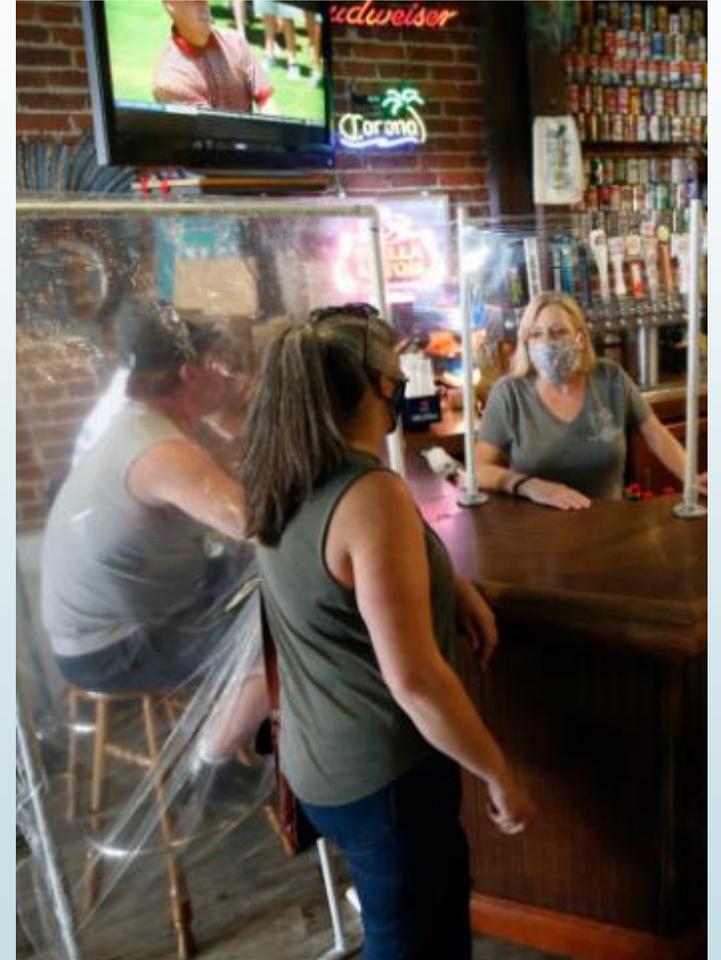
▶ Reminder: Cloth masks are not PPE

- ▶ Infection control measure to prevent the spread of COVID-19.
 - ▶ Protects others from possible exposure to the wearer (via aerosolized droplets released when talking, coughing, etc.)
 - ▶ Cloth masks received may only be reused 15 times each (as they are to be laundered after each use per guidance from CDPH).



Other COVID-19 Support Available

- ▶ DEHS staff are available to review and comment upon reopening plans for Tribal enterprises.
 - ▶ CAIHS DEHS is not a public health authority and cannot authorize the reopening of a facility.
 - ▶ Available to provide feedback on draft reopening plans for tribal enterprises based on guidelines issued by CDC, OSHA, CDPH, Cal OSHA and other regulatory authorities.
 - ▶ Available to review facility modifications to ensure they comply with applicable guidelines.
 - ▶ Available to provide assistance with finding references for use in developing a facility reopening plans.
 - ▶ Some assistance and referral to IHS SME regarding reopening specific health care operations such as dental and optometry.





OEHE – CARES ACT P.L. 116-136 Maintenance & Improvement and Medical Equipment Funding Guidance

Jim White

Indian Health Service FY 2020 COVID-19 CARES Act P.L. 116-136 **California** Facilities Allotment

- M&I Distribution = \$3,034,000 Med. Equipment Distribution = \$3,870,200
 - M&I Distribution completed using current M&I Distribution Methodology – « Modified University of Oklahoma Formula»
 - Med. Equipment Distribution completed using the current Methodology – «Medical Equipment Funds Allocation Methodology...»
- The funds are **one time** non-recurring and for COVID-19 response only.
- If the Tribe or Tribal Organization does not want to use the funds for their intended purpose they must be returned.
- Contract support costs (CSC) will be negotiated at a later date. (contact OEHE personnel to determine if CSC are eligible)
- These **X-year** funds are available for activities **to prevent, prepare for, and respond to COVID-19 within the period of this emergency.**
 - M&I funds– any activities that would typically be supported in the Facilities account to prevent, prepare for, and respond to COVID-19 within the period of this emergency.
 - Med. Equip - purchase any medical equipment to prevent, prepare for, and respond to COVID-19 within the period of this emergency.
- **Transparency and accountability** – Keep a record of all expenditures and purchases and be prepared to provide that information.



YES ANYTHING to prevent, prepare for, and respond to COVID-19 within the period of this emergency.

These include but are not limited to:

Alternate care site (ACS) - Rental costs, Modular buildings for on-site expansion for surge capacity, Consulting fees, Security, Staffing, Mobile Testing

Renovations to a facility - Adjusting patient entrance and patient flow, Upgrading or modifying HVAC systems, Adding or renovation of negative pressure rooms, Supplies to complete this work, Public Outreach and Information Materials

Medical equipment - COVID19 test equipment and supplies, Medical beds, Exam Tables, PPE, HEPA air filters, VHP Sterilizer, Medical supplies, Cleaning and disinfection supplies

And anything else you need to prevent, prepare for, and respond to COVID-19...



Dental Updates & Guidance for Re-opening

CDR Michael Donaleski, DMD

Area Dental Consultant



Re-opening Dental Facilities for Routine Care

- ▶ County and Tribal Health Authorities
- ▶ State of California Guidance
 - ▶ CDPH, CDA
- ▶ Federal Agency Guidance
 - ▶ OHSA, CDC, IHS, ADA



Local Guidelines

- Depending on the conditions in a community, a local health officer may issue or update current “stay-at-home” orders; orders that are more stringent than the state’s public health orders must be followed.
 - Some of our facilities operate in multiple counties that may issue different orders
- All practitioners should continually evaluate whether their region remains at a low risk of incidence and should be prepared to cease all but emergency procedures if there is a surge. The [California COVID-19 Statewide Case Statistics dashboard](#) has case information by county and should be accessed regularly by providers to stay current.
- Do you have a stand alone dental facility
 - Coordinate with administration staff for screening of patients and employees
- Is the dental clinic in the main health center or a separate building
 - Coordinate medical staff for screenings



State Guidance

- ▶ California Dental Association
 - ▶ Has been providing CDE on re-opening
 - ▶ <https://www.cda.org/Home/Practice/Back-to-Practice>
- ▶ California Department of Public Health
 - ▶ It is strongly recommended that dental practices have a minimum 2-week supply of PPE for dentists and staff. This includes N95 respirators, face shields, goggles, surgical masks, and other infection control equipment
 - ▶ Comply with the Cal/OSHA requirements under its Airborne Transmissible Diseases (ATD) standard
 - ▶ Developing a Respiratory Protection Program as required by [Cal/OSHA Section 5144](#)
 - ▶ Initial Fit testing of N95 Respirators is mandatory, yearly fit tests may be postponed



CDPH

- ▶ Have patient scheduling and flow protocols and infection control precautions in place to minimize exposure to and spread of COVID-19. Limit the number of patients in the office or clinic at any one time to maintain physical distancing of a minimum of six feet between patients. If physical distancing is not possible inside the waiting room, consider having patients wait outside.
- ▶ Ensure that all patients are wearing a face covering while in the office.
- ▶ Evaluate the necessity of the dental care based on urgency of dental problems. Clinicians should prioritize care that was previously postponed and for those conditions that are likely to lead to dental emergencies if treatment is not provided in a timely manner. As low community transmission rates and ample supplies of PPE and tests dictate, dentists can also begin to provide essential preventive care taking measures to minimize aerosol generation. Preventive services such as topical fluoride application, sealants, and scaling as well as minimally invasive restorative techniques may be considered.



Division of Oral Health 3 Phase Approach

- ▶ Phase I – Dental programs can begin the slow return to re-opening by providing Levels I and II (preventive) services to patients.
- ▶ Phase II – Dental programs can provide Levels, I, II, and III (basic oral health services). This includes most restorative/operative dentistry using a high-speed handpiece.
- ▶ Phase III – Dental programs can provide levels IV and V services as needed after successful implementation of levels I-III (basic) services.



Division of Oral Health- Dental Hygiene

- ▶ Dental hygienists have been listed by various sources as the profession that is at the highest risk for COVID-19. This is due in part to most dental hygienists working alone in patient care and using ultrasonic (Piezon, Cavitron, etc.) instrumentation. To reduce risk, the IHS DOH recommends two practices be immediately implemented in IHS dental service units:
- ▶ Assign a dental assistant to provide chairside assisting for all dental hygiene procedures, especially those using ultrasonics (the assistant would provide high-volume evacuation during the procedures);
- ▶ Require that dental hygienists wear face shields (not goggles) in addition to masks when using ultrasonic instrumentation or a handpiece.



Division of Oral Health

- ▶ The latest OSHA guidance has recommendations regarding engineering and administrative controls that may fall outside the subject matter expertise of many dental staff (i.e., directional air flow, airborne infection isolation rooms, etc.). For that reason, the IHS DOH encourages dental directors and other dental staff to work closely with environmental health officers to determine what additional controls can be implemented in the dental setting to reduce the risk of occupational exposure to dental staff and patients for COVID-19 in our dental departments.
 - ▶ Extra-Oral Vacuums
 - ▶ HEPA Filters



Division of Oral Health

- ▶ ***Disinfection of equipment/operator down time.***
- ▶ Unfortunately, not enough information is known still about how long aerosols remain in the air following dental aerosol-generating procedures (AGPs). Out of an abundance of caution, the IHS DOH recommends that dental units (operatories) and operator countertops and other environmental surfaces in operatories be disinfected immediately using routine [Guidelines for Infection Control in Dental health-Care Settings---2003](#), Consult with the clinic's/hospital's health facility engineers and environmental health officer to determine the operatories ([Airborne Contaminant Removal Efficiency](#).) Once the determined time has passed, the room must be disinfected and reprocessed per CDC guidelines before the next patient. If new information becomes available on this issue, we will issue clarifying guidance.

Air Changes/Hour

1. Airborne Contaminant Removal

Table B.1. Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency *

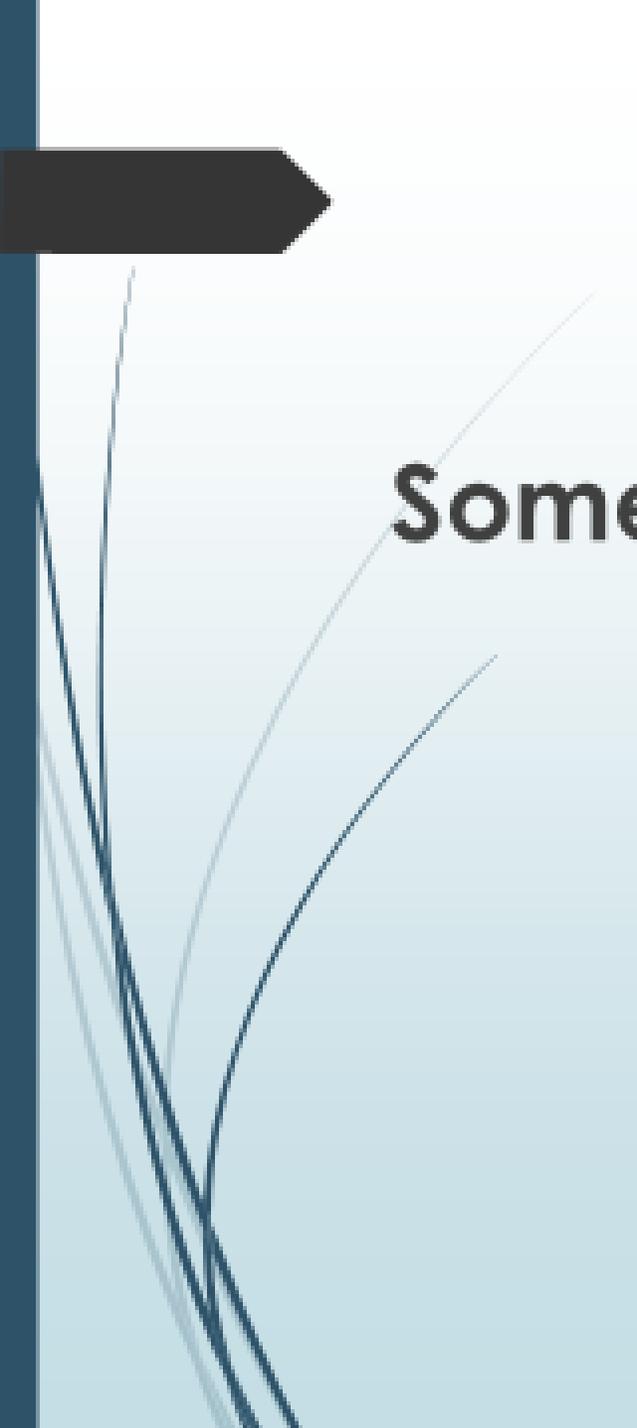
The number of air changes per hour and time and efficiency.

ACH § ¶	Time (mins.) required for removal 99% efficiency	Time (mins.) required for removal 99.9% efficiency
2	138	207
4	69	104
6 ⁺	46	69
8	35	52
10 ⁺	28	41
12 ⁺	23	35
15 ⁺	18	28
20	14	21
50	6	8



Medical Updates & Guidance for Re-opening

Charlie Magruder, Christine Brennan, Carolyn Pumares



Medical Updates

Some Relatively New Concepts Moving Forward

Leading Change

Building Coalitions



1. Leading Change – Quality of Care

Primary Prevention is a good, basic strategy to avoid serious health problems in the future

Addressing Heart disease is a good example

We have recently been working in this area with the American Heart Association who have rendered equipment and training to hone skills.

They can also assist in developing an overall strategic plan to further enhance Quality of Care



Recently we had an opportunity to assist in this regard with Indian Health Center of Santa Clara to begin developing a strategic plan for enhancing quality of care

2. Building Coalitions

Primary Foundation Established

AHA and CA Department of Public Health developed a partnership, including the CAO of the Indian Health Service and CRIHB.

Others involved:

- Numerous Universities
- All county health departments in CA
- Several not-for profits

This is where we can bring any current issues about Covoid 19.



Guidelines and Best Practices for Reopening Medical Practices

- ▶ American Medical Association and CA Medical Association:
 - ▶ <https://www.ama-assn.org/delivering-care/public-health/covid-19-physician-practice-guide-reopening>
 - ▶ <https://www.cmadoocs.org/Portals/CMA/files/public/CMA%20COVID-19%20Best%20Practices%20for%20Reopening.pdf>
- ▶ Centers for Medicaid and Medicare Services
 - ▶ <https://www.cms.gov/files/document/covid-flexibility-reopen-essential-non-covid-services.pdf>
- ▶ California Department of Public Health
 - ▶ <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/ResumingCalifornia%E2%80%99sDeferredandPreventiveHealthCare.aspx>
- ▶ American Academy of Pediatrics
 - ▶ <https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/guidance-on-providing-pediatric-well-care-during-covid-19/>



California Medical Association Best Practices for Reopening

- Consult local health department to determine current status of local stay-at-home orders for the county your clinic resides in
 - CMA recommends a phased approach to reopening based on factors such as: # of infections, by population, demographics of local population, trends in hospitalization, local health system capacity
 - Assess your health programs capacity to support potential future surges of COVID-19
 - Assess testing availability and capability in your region
- Construct a Financial and Staffing Plan
 1. Patient volume may return slowly, staffing levels may not need to be at 100% at the beginning of the reopening process
 2. Plan staffing levels and finances accordingly to account for this
- Develop safety protocols to help alleviate fear or apprehension staff and patients may have about returning to a medical clinic
- Assess your supply of PPE
 1. Ensure PPE supply is enough for staff and patients coming in for visits
 2. Ensure PPE supply is enough to prepare for a second wave of COVID-19 cases



California Medical Association Best Practices for Reopening

- ▶ Consider what role telehealth will play in your reopening plan
 - ▶ Practices who have not yet implemented telehealth may wish to consider how it can support safe patient care during reopening
 - ▶ Practices who have implemented telehealth can work on moving to a hybrid model, seeing patients both in-office and virtually
- ▶ Clearly communicate with patients about practice changes
 - ▶ Communicate new safety protocols to patients upfront so they are properly prepared when they arrive at your facility
- ▶ Be watchful of medication shortages



Financial Considerations

- ▶ Consider the financial needs of the health program and funding sources
 - ▶ Revenue and patient volume may be slow upon reopening. Health programs should consider capital needs for reopening and all funding sources both private (bank loans) and public (SBA loans and government grants)
 - ▶ See [CMA's Financial Toolkit for Medical Practices](#)
- ▶ Create a plan to meet existing obligations
- ▶ Develop a monthly budget
- ▶ Keep open lines of communication with vendors
 - ▶ Plan to meet existing obligations
 - ▶ Speak to vendors about possible reduced rates or deferred payments
- ▶ Tackle Accounts receivable slowly and analyze revenue streams
- ▶ Verify patient contact and insurance information



Universal Safety Precautions for Health Clinics

- ▶ Maintain physical distancing
 - ▶ Ask patients to check in for appointments via phone or text and wait in their vehicle until their exam room is ready
 - ▶ Only allow visitors to patient appointments for young children; teens and adults should be unaccompanied unless necessary
 - ▶ Schedule patients so that only a few are in the office at any one time; consider extending clinic hours into evenings and/or weekends and increasing the time between scheduled appointments
 - ▶ Remove any articles in the clinic that may be handled by multiple patients (magazines, toys, coffee maker)
 - ▶ Set aside clinic hours for vulnerable patients
 - ▶ Consider telehealth visits for those patients that don't require an in-office visit



Universal Safety Precautions for Health Clinics

- ▶ Require everyone entering the clinic to wear a cloth mask (staff and patients)
- ▶ Implement strict sterilization procedures
 - ▶ Follow [CDC Guidelines for Cleaning and Disinfecting of Community Facilities](#)
- ▶ Continue to use telehealth as appropriate
- ▶ Prescreen patients for COVID-19 symptoms
 - ▶ Patients should be screened on the phone when scheduling their appointment to determine if they have had common COVID symptoms (you can utilize the AMA's Pre-visit screen script template)
 - ▶ All patients should have their temperature checked prior to entering the office. If possible, any symptomatic patient should be tested prior to entering the clinic.
- ▶ All staff should be trained on the use and preservation of PPE. Health programs should follow CDC guidance on the extended use and reuse of PPE
- ▶ A quarantine policy should be in place to explain steps to take if an employee contracts COVID-19 or that shows symptoms, requiring a 14 day quarantine.

Pre-visit screening script template

Introduction: I would like to speak to [name of patient with scheduled visit]. I'm calling from [XYZ practice] with regard to your appointment scheduled for [date and time]. The safety of our patients and staff is of utmost importance to [XYZ practice]. Given the recent COVID-19 outbreak, I'm calling to ask a few questions in relation to your scheduled appointment. These are designed to help promote your safety, as well as the safety of our staff and other patients. We are asking the same questions to all practice patients to help ensure your safety. So that we can ensure that you receive care at the appropriate time and setting, please answer these questions truthfully and accurately. All of your responses will remain confidential. As appropriate, the information you provide will be reviewed by one of our practice's medical professionals who will provide additional guidance regarding whether any adjustments need to be made to your scheduled appointment.

Question	Yes/No	Details
Have you or a member of your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever, temperature at or greater than 100 degrees Fahrenheit? (If yes, obtain information about who had the symptoms, what the symptoms were, when the symptoms started, when the symptoms stopped.)		
Have you or a member of your household been tested for COVID-19? (If yes, obtain the date of test, results of the test, whether the person is currently in quarantine and the status of the person's symptoms.)		
Have you or a member of your household been advised to be tested for COVID-19 by government officials or healthcare providers? (If yes, obtain information about why the recommendation was made, when the recommendation was made, whether the testing occurred, when any symptoms started and stopped and the current health status of the person who was advised.)		
Were you or a member of your household advised to self-quarantine for COVID-19 by government officials or healthcare providers? (If yes, obtain information about why the recommendation was made, when the recommendation was made, whether the person quarantined, when any symptoms started and stopped and the current health status of the person who was advised.)		
Have you or a member of your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days? (If yes, obtain the facility name, location, reason for visit/treatment and dates.)		
Have you or a member of your household traveled outside the U.S. in the past 30 days? (If yes, obtain the city, country and dates.)		
Have you or a member of your household traveled elsewhere in the U.S. in the past 21 days? (If yes, obtain the city, state and dates.)		
Have you or a member of your household traveled on a cruise ship in the last 21 days? (If yes, determine the name of the ship, ports of call and dates.)		
Are you or a member of your household healthcare providers or emergency responders? (If yes, find out what type of work the person does and whether the person is still working. For example, ICU nurse actively working versus a furloughed firefighter.)		
Have you or a member of your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? (If yes, obtain the status of the person cared for, when the care occurred, what the care was.)		
Do you have any reason to believe you or a member of your household has been exposed to or acquired COVID-19? (If yes, obtain information about the believed source of the potential exposure and any signs that the person acquired the virus.)		
To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19? (If yes, obtain information about when the contact occurred, what the contact was, how long the people were in contact and when the diagnosis occurred.)		

Thank you.

<https://www.ama-assn.org/system/files/2020-05/physican-guide-reopening-practices-covid-19.pdf>



What role will telehealth play?

- ▶ Maximize use of telehealth modalities for care that can be provided virtually
 - ▶ Tele-triage program
 - ▶ Patients seeking in-person appointments may need more advanced care
 - ▶ Consider utilizing a uniform telephone screening for all in-person visits
 - ▶ Transition to a Hybrid model
 - ▶ Seeing patients both in-person and virtually
 - ▶ Consider providing educational and other services via telephone or videoconference communication
- ▶ Telehealth Implementation key considerations
 - ▶ State requirements
 - ▶ Patient consent and documentation
 - ▶ Reimbursement
 - ▶ Privacy and Security compliance
 - ▶ CMA recommends sites balance both short and long term goals when picking platforms
- ▶ COVID-19 Telehealth toolkit for medical practices
 - ▶ <https://www.cmadocs.org/Portals/CMA/files/public/CMA%20COVID-19%20Telehealth%20Overview.pdf>
 - ▶ <https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf>



Staffing Considerations

- ▶ Ensure workplace safety for clinicians and staff
 - ▶ Bring back provider and support staff in waves
 - ▶ Screen staff and keep screenings confidential
 - ▶ Keep results of employee screening in employment records – separate from personnel files
 - ▶ Minimize contact
 - ▶ Rearrange open work areas to increase distance
 - ▶ Consider dedicated workstations to decrease number of people touching same equipment
 - ▶ Cleaning schedules and protocols on shared spaces (e.g. kitchen)
- ▶ Consider hybrid telework model to allow certain team members to telework
 - ▶ Special considerations for remote workers
 - ▶ Applicable policies, employment contracts for hourly (non-exempt) and exempt employees
 - ▶ Meal breaks/rest periods compliance with state and federal laws for non-exempt employees
 - ▶ Consider reimbursement for expenses incurred while teleworking



Staffing Considerations

- ▶ Consider options for vulnerable staff
 - ▶ Staff over the age of 60 years and/or have pre-existing conditions
 - ▶ Evaluate potential hazards and existence of risk
 - ▶ Prepare internal policies for mitigating risk
 - ▶ Shift to telework if possible
 - ▶ Consider other duties with decreased patient contact if possible
- ▶ Give extra care and attention to the emotional and physical needs of staff
 - ▶ Signs of exhaustion, depression, stress
 - ▶ Resource: Care 4 Caregivers now
 - ▶ Connects front-line workers to trained peer coaches



Care 4 Caregivers Now

- ▶ Partnership with CA Med Association, Service Employees International Union and United Nurses Association of California
- ▶ Help address factors and cause of burnout
- ▶ Available to physicians, PAs, nurses, NPs, and respiratory therapists
- ▶ No cost remote coaching sessions for up to 30 days
- ▶ Application for coaching session link:
 - ▶ <https://cmawpca.org/hwapplication.aspx/>

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Communication with Patients

- ▶ Communicate clearly to patients your safety protocols
- ▶ Consider patient's perspective on how these changes affects they usual routines
- ▶ Informing patients upfront will help decrease confusion, allay concerns, and ensure they are properly prepared



Medication Shortages

- ▶ Stay alert to potential medication shortages
 - ▶ Compromised supply chains
 - ▶ Increased demand (e.g. hydroxychloroquine)
- ▶ Inform providers to consider medication alternatives
- ▶ Manage patient expectations by involving them in medication considerations



Prioritization of delayed care

- ▶ Prioritization of preventative care
 - ▶ Goal: identify serious health issues before they become severe
 - ▶ Management of patients with chronic conditions
 - ▶ Non-urgent screenings (e.g. mammograms, colonoscopies, etc)
- ▶ Consider Elective Surgery Guidelines
 - ▶ Published by surgical specialties with regional input from County Public Health Officers
 - ▶ Resource link: <https://www.asahq.org/about-asq/newsroom/news-releases/2020/04/joint-statement-on-elective-surgery-after-covid-19-pandemic>
- ▶ Reopening pediatric practices
 - ▶ Well-child visits
 - ▶ Recommended vaccinations for preventable diseases (e.g. measles)



COVID-19 Focused Immunization Guidance: Staying Safe & Getting Vaccinated During the Pandemic

As a consequence of the pandemic, under-utilization of important medical services for patients with non-COVID-19-related urgent and emergent health needs during the COVID-19 pandemic is of concern. The following are links to resources that may be useful as you re-focus clinic and outreach operations to address such non-COVID-19 related health needs:

- ▶ A framework for healthcare systems to deliver non-COVID-19 health care during the COVID-19 pandemic: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/framework-non-COVID-care.html>
- ▶ Maintaining Childhood Immunization Coverage During COVID-19 Pandemic: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html>
- ▶ CDPH Memo to VFC Providers on “Routine Childhood Immunizations during COVID-19 Pandemic”:
<https://files.constantcontact.com/9d04821c001/8c834852-adc9-4b7d-a522-231b91dedd58.pdf>

Staying Safe & Getting Vaccinated continued.....

In **California** and across the U.S. with the pandemic there have been “troubling” decreases in childhood vaccination. In a CDPH press release on May 18, 2020, Dr. Sonia Angell, Director of the California Department of Public Health and State Health Officer reminds us as to the vulnerability of our children:

"This pandemic has disrupted so much, including how we're seeking preventive health care services. During and after the pandemic, **unvaccinated infants and children will be more vulnerable to dangerous diseases like measles and whooping cough**. It's so important that parents make sure their children are up-to-date on their immunizations." <https://www.cdph.ca.gov/Programs/OPA/Pages/NR20-090.aspx>

- Many children are **unprotected** from vaccine preventable disease
- A “comparison of data from April 2019 to April 2020, indicates that the number of **vaccinations given to children 0 through 18 years old in California decreased by more than 40 percent**”. (Dr. Sonya Angell, May 18, 2020, CDPH Press Release)
- Continued **coordinated efforts** among and between local health care providers and public health officials at the local, state, and federal levels will be necessary to achieve rapid catch-up vaccination to reduce risk
- The Morbidity and Mortality Weekly Report (MMWR) recently released ["Effects of the COVID-19 Pandemic on Routine Pediatric Vaccine Ordering and Administration - United States, 2020."](https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm) This report reminds us that as social distancing requirements are relaxed, children who are not protected by vaccines will be more vulnerable to diseases such as measles. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e2.htm>



American Academy of Pediatrics (AAP) Guidance

- ▶ AAP strongly recommends the continued provision of health care for children during the pandemic
 - ▶ All well-child visits should occur in-person whenever possible; any portion of the well-child visit performed through telehealth should be followed up with a timely in-person visit
 - ▶ Health programs should identify all children who have missed well child visits and/or immunizations and contact them to schedule an in-person visit to get them up-to-date as soon as possible
 - ▶ Assure families of the procedures implemented at your health program to ensure the safety of the patients
- ▶ Best practices to ensure the safety of children and families during well child visits include:
 - ▶ Scheduling well visits and sick visits at different times of day
 - ▶ Separating patients there for sick visits and well visits in different areas of the clinic
 - ▶ Collaborate with other providers in the community to provide well-child visits in a location separate from the clinic



Open Discussion / Sharing of Information on Re-opening of Health Programs & Dental Clinics



Suggested topics for discussion

- ▶ What concerns does your clinic have with re-opening to provide full services again (medical or dental)?
- ▶ What resources or assistance would be helpful to your health program in implementing the re-opening process?
- ▶ Has anyone implemented new or innovative processes to provide health or dental care in a way to best protect staff and patients?