Batten down the hatches: coastal storm expected this weekend.
High wind gusts up to 55 mph, 1-3 inches of rain. Stay safe!

AHCA and DHCFA Honor Our Skilled Nursing Staff and Caregivers

"Skilled nursing caregivers and staff at all levels work hard every day to keep our most vulnerable population safe, healthy and socially engaged under incredible challenges," said Mark Parkinson, president and CEO of AHCA. "These individuals are the backbone of our communities. This week is a time to celebrate them by sharing our appreciation for all that they do for our loved ones."

FRIDAY ROUNDUP MAY 6, 2022

STATE UPDATE

Curative Testing Billing, Insurance Issues, and Testing Guidance

Your concerns about the Curative testing announcement have moved up the chain. The state is working on the details about insurance, the samples that were collected before the announcement, etc.

Until these issues are resolved, the state will supply a month's worth of rapid testing supplies to use for twice-a-week testing for employers in May and June. Access the test kit request form here: https://bit.ly/3FjeS5I

The following reporting information is part of the DPH Testing Guidance for long-term care:

> All providers or testing sites must report data and results for ALL COVID-19 diagnostic and screening testing completed. **This includes point-of-care molecular, antigen and antibody testing for each individual tested.** This data must be reported daily, within 24 hours of having received the test results, to NHSN or DPH. Additional information regarding reporting of tests sent to outside laboratories can be requested through Dhss_Dph_CSVreporting@delaware.gov Additional information regarding the reporting of point-of-care testing (including antigen testing), which includes a link to the point-of-care testing portal, can be requested through DHSS_DPH_RedCapAccess@delaware.gov
>
> **Complete testing guidance is here**

RedCap Reporting Website

All skilled and intermediate nursing care facilities, assisted living facilities and rest residential facilities must use the CMS guidance to govern visitation. The CMS guidance, which was updated March 10, 2022, can be found at: QSO-20-39-NH REVISED (cms.gov)
Dining with visitors: See FAQ #5

Kate Brookins has been re-assigned to her previous duties. Donna Doyle will be the new DPH contact. donna.doyle@delaware.gov

Lisandra Clarke, Division of Public Health Epidemiologist – Non-COVID: Lisandra.clarke@delaware.gov 302-744-4777

Interagency Transfer Form – Emergent: Microsoft Word - PILOT Delaware Interagency Patient Transfer Form - Emergent Aug5 2019.docx

A Day of Hope: COVID-19 Remembrance Ceremony

Pictured left: Board Member Lisa Sierer (Buena Vista), Stacion Gibbs (Complete Care at Silver Lake DON), Board President Vickie Cox (Complete Care at Silver Lake), Gov. Carney, DHCFA Executive Director Cheryl Heiks, and Kim Blunt (Buena Vista) at the ceremony.

Pictured right: (L to R) David Parkinson and a staff member from The Lorelton also attended, next to Stacion, Vickie, Lisa, Kim, and Cheryl.

A Day of Hope Commemoration Honors Those Lost, Battling With, or Affected by COVID-19

Governor Bethany Hall-Long, the Delaware Division of Public Health and advocates partnered with the Yellow Hearts Memorial and COVID Survivors for Change to keep their memories alive and to lift up those who are impacted by COVID-19 long-haul symptoms. The event also recognized all Delawareans who have been affected by COVID-19, including everyone in the long-term care community.

On May 3, Lt. Gov. Hall-Long led a commemoration ceremony at the Jesse Cooper Building in Dover that included Gov. Carney, Dr. Karyl Rattay, members of the Interfaith Council, and Rosie Davis of the Yellow Heart

Memorial. A tree on the building lawn is now designated at the COVID-19 memorial tree. Watch the recorded ceremony here.

Please contribute long-term care names COVID-19 Memorial here: https://ltgov.delaware.gov/covid-19-memorial/

- **In remembrance of someone who has passed away from COVID-19**
- **To recognize someone living with long-haul symptoms of COVID-19**
- **Lift up an individual for their service during COVID-19. This could be state employees, someone in health care, long-term care, education, essential services, or other front-line areas.**

DHCFA encourages you to bombard the site with not only those our community lost, but those who have worked so hard to keep our residents alive and safe.

DHSS

DHSS Update on Vaccines, J&J

Cases and hospitalizations are increasing the DPH staff have created the attached social media posts that you can use on your channels to share some prevention strategies.

Additionally, yesterday the FDA limited the authorized use of the J&J COVID-19 Vaccine:

In most situations, Pfizer-BioNTech or Moderna COVID-19 vaccines are preferred over the J&J/Janssen COVID-19 vaccine for primary and booster vaccination due to the risk of serious adverse events. The J&J/Janssen COVID-19 vaccine may be considered in some situations, including for persons who:

- Had a severe reaction after an mRNA vaccine dose or who have a severe allergy to an ingredient of Pfizer-BioNTech or Moderna (mRNA COVID-19 vaccines).
- Would otherwise remain unvaccinated for COVID-19 due to limited access to Pfizer-BioNTech or Moderna (mRNA COVID-19 vaccines).
- Wants to get the J&J/Janssen COVID-19 vaccine despite the safety concerns.
- For more information on J&J visit: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/janssen.htmlThe . Information on the revision to the authorized use of the vaccine and updated information on this risk of blood clots with low levels of blood platelets has been added to the Fact Sheet for Recipients and Caregivers.

Thank you to all of the incredible nurses who care for Delaware's long-term care residents. You are heroes!

May is Viral Hepatitis Day, May 19 Hepatitis Testing Day

DPH is announcing May as Viral Hepatitis Awareness Month and May 19 as Hepatitis Testing Day. There are several different viruses that can cause hepatitis. The most common type of viral hepatitis are hepatitis A, hepatitis B, and hepatitis C. Both hepatitis A and hepatitis B are preventable with vaccines and while there is no vaccine for hepatitis C, it is curable with proper treatment. Hepatitis B and C are the leading causes of liver cancer in the United States. The only way to know if you have a viral hepatitis is to get tested.

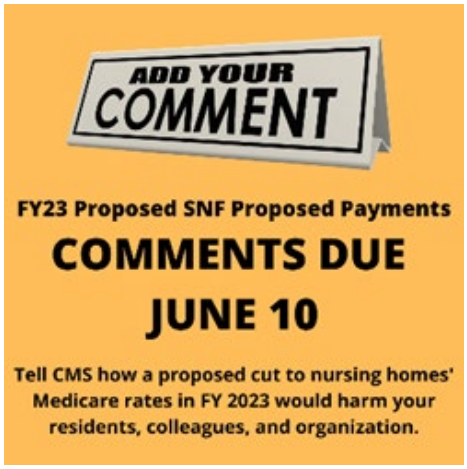
It is estimated that 2.4 million people in the United States are living with hepatitis C and between 880,000 and 1.89 million people are living with hepatitis B. Many are unaware that they are infected since symptoms usually are slow to present themselves. The Centers For Disease Control and Prevention (CDC) suggests everyone should get tested for viral hepatitis at least once in their lives. Some of the risk factors for contracting viral hepatitis include but are not limited to:

- Individuals born between 1945 and 1965
- IV drug users
- Unstable housing
- Travel to an area with endemic hepatitis A virus without being immunized
- Unprotected sex with multiple partners
- Job that exposes you to human blood

For more information, or to report a viral hepatitis case, call DPH's Viral Hepatitis program at 302-744-4990.

CMS NEWS

CMS 1135 Waiver Updates: Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers (cms.gov)



Due to CMS on FY 2023 SNF Proposed Payment Rule by June 10 at 5 pm.

The comment deadline is June 10, 2022, 5PM EST. Submitting your comment is easy, **CLICK HERE** to send your comment today!

On April 11, CMS released the proposed rule, FY 2023 Skilled Nursing Facility (SNFs) Prospective Payment System Rate Update and Quality Reporting Requirements (CMS-1765)**.** Due to the proposed parity adjustment, CMS estimates that the net market basket update would decrease Medicare SNF payments by approximately $320 million.

Questions? AHCA/NCAL hosted a member webinar on tips for drafting and submitting your comments on the FY 2023 SNF Proposed Payment Rule. Recording is now available.

Thank you for taking the time to send a comment letter to CMS. Together, we are making a difference in quality care!

DHCFA MEMBER ZOOM MONDAY, MAY 9, 3-4 pm

Link: https://us02web.zoom.us/j/6627149379 Meeting ID 662 714 9379
OR Phone: 646-558-8656

Slides from Monday's meeting with MaryAlice St. Claire at Halosil are attached.

SHOC CALLS NOW MONTHLY UNTIL FURTHER NOTICE

Tuesday, JUNE 7, 11 am -12 pm

This call is with Director of Health Care Quality and representatives of Division of Public Health.

Please send questions in advance to cheiks@dhcfa.org
Join from the meeting link
https://stateofdelaware.webex.com/stateofdelaware/j.php?MTID=mfad1bf60fcc3894055e6c65d64d698dd
Join by meeting number

- Meeting number (access code): 1738 94 4344
- Meeting password: vfA3Xizv69S

Join by phone: +1-202-860-2110 United States Toll (Washington D.C.)

RECORDING from the May 3 Call: Link: **DHCQ/SHOC-20220503 1502-1** Password: EbXMC8bF

AHCA NEWS

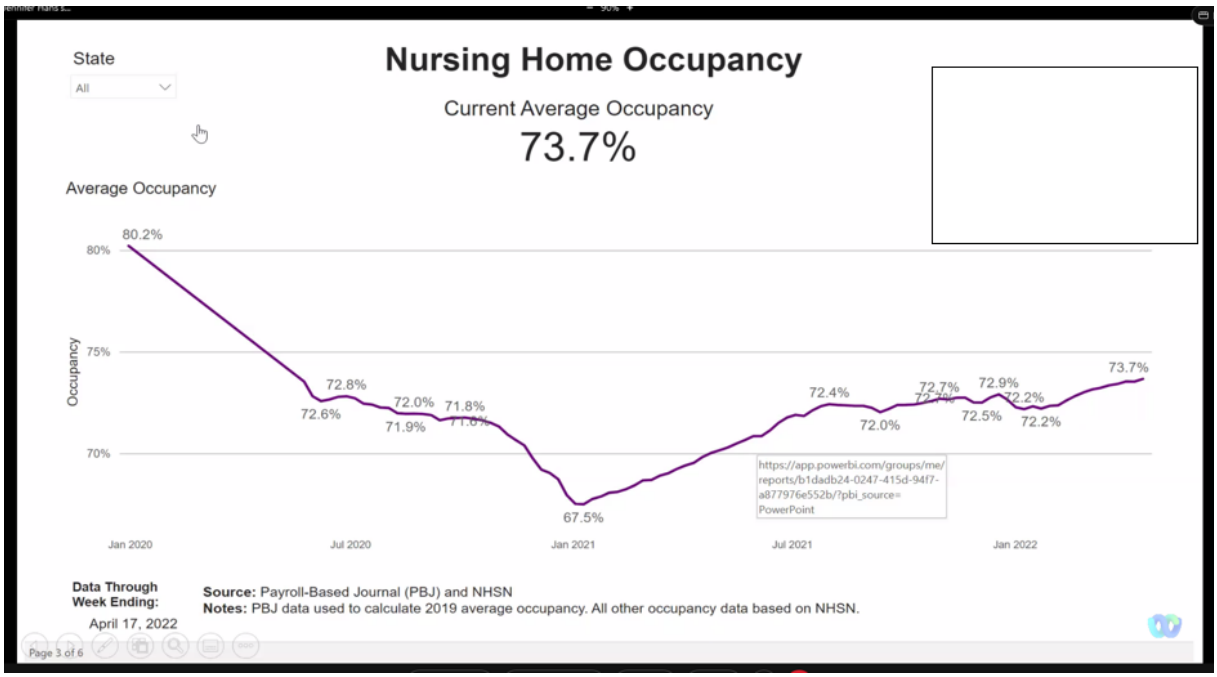
Marsh's Senior Living & LTC Industry Practice and Oliver Wyman's Actuarial Practice are conducting a 2022 update to and expansion of their General and Professional Liability Benchmark Report for Senior Living and Long-Term Care Providers. AHCA/NCAL has partnered again this year with Marsh and Oliver Wyman and other leading national trade organizations including the American Seniors Housing Association, Argentum, and LeadingAge. There is no cost to participate, and all participants will receive a copy of the report and an invitation to the presentation of the results. We only ask for your assistance in obtaining the necessary data.

The information presented in this study is critical information for industry stakeholders interested in understanding important trends, loss drivers and other factors impacting resident care and quality. **If you're interested in participating, please contact Oliver Wyman regarding the data collection process or with any additional questions at LTCBenchmark@oliverwyman.com.**

The information Marsh and Oliver Wyman are collecting includes:

- Individual claim listing (excluding Protected Health Information) in Excel-readable format including as much detail as possible, valued as 12/31/2021. Please include claim information for the last 10 calendar years, if available.
- Occupied unit equivalent exposure information for the past 10 calendar years, if available.

National Occupancy Rates



GERO Nurse Prep on Sale Through May 31!

Save $200 with code QUALITYRN22

The Gero Nurse Prep course is specifically designed for registered nurses working in long term care. This curriculum provides comprehensive online training that leads to board certification in gerontological nursing by the American Nurses Credentialing Center (ANCC) for RNs.

Watch this video or visit the website at geronurseprep.com to learn more about this online program designed to help RNs increase their geriatric nursing skills and to pass the ANCC exam. Don't forget to use the **QUALITYRN22** promo code when you register by May 31 to save $200 off the regular $790 Gero Nurse Prep registration fee.

Workforce

Links to Nationwide Compacts

Compact Nursing States List 2022 | Licensure Map (nurse.org)
APRN Compact | NCSBN
https://ptcompact.org/ptc-states

QLARANT Training/Office Hours for May and June

IPRO QIN-QIO Resource Library https://qi-library.ipro.org/

One-hour webinars, Thursday, 12-12:30 pm *Note: No CEs offered*

- Small Talks: Opiod Use Disorder & Related Behaviors: Supporting Patients & Each Other **Thursday, May 5** and **Thursday, May 11**

Check-in with the QIO – Office Hours, **May 19**, **June 23**, 12-12:30 PM
A monthly half-hour zoom session to follow up on recent Small Talks, explore new intervention(s), ask questions, and connect with peers. These 30-minute sessions do not require registration.

TESTING REQUIREMENTS

Attached: QSO-20-38 NH REVISED and QSO-20-39-NH REVISED

DPH updated its COVID-19 Testing Guidance based on CMS's revised guidance. The guidance is attached or you can download here: DPH-LTC-COVID-19-Testing-Guidance-3.8.22.pdf (delaware.gov)

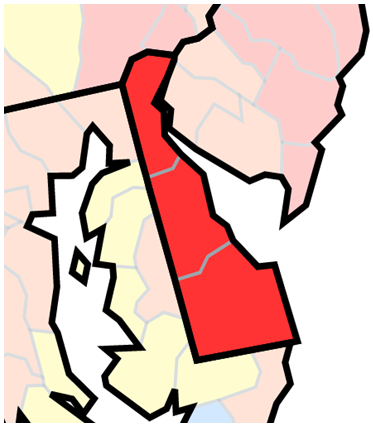
"Up to Date" means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible. Current recommendations can be found at: Stay Up to Date with Your Vaccines | CDC

Routine testing for staff who are up to date on all recommended COVID-19 vaccination doses is no longer required.

Using information posted on https://covid.cdc.gov/covid-data-tracker/#county-view, the Delaware counties' **level of community transmission** as of **April 25, 2022** are listed in the table below:

County	Current Level of Community Transmission based on CDC COVID-19 Integrated County View	Minimum Frequency of Routine Testing for **Staff Who Are Not Up To Date With All Recommended COVID-19 Vaccine Doses**
Kent County, DE	High	Twice a week
New Castle County, DE	High	Twice a week
Sussex County, DE	High	Twice a week

The metrics used for routine testing of staff who are not "up to date" on COVID-19 vaccination are based on **level of community transmission** in each county. This is not to be confused with the CDC's community level data which does not apply for LTC routine testing!



The UPDATED testing guidance for Delaware is posted here: https://coronavirus.delaware.gov/wp-content/uploads/sites/177/2022/03/DPH-LTC-COVID-19-Testing-Guidance-3.8.22.pdfwebsite

Facilities that wish to continue testing their staff at a higher frequency are permitted to do so using Curative tests up to once per week per staff, POC tests or their own testing resources.

SUGGESTIONS FOR SURVEY AWARENESS in BOTH SNF and ALF ENVIRONMENTS

COVID vaccination:

- Verification of education provided to staff who refused vaccine.
- For those staff who have medical or religious exemptions, a review of documentation to ensure it is in place and corresponds to reported numbers.
- Surveyors' significant review of vaccine data.
- Verification of screening of staff and visitors.
- Checking to see if someone was working during the time, they were positive.
- Checking to see if someone was working during the time, they were unvaccinated.
- Testing frequency as required by the state.
- Copies of vaccination cards
- Verification of offering vaccine to residents, and if needed declination forms

Other Vaccination requirements:

- Influenza and Pneumococcal records

Other:

- Proof of required dementia training.
- Documentation for use of psychotropic medication
- Review of ADL Care
- Boosters are given to residents.
- Requirements for TB and immunizations.
- All staff fit tested for N95 masks
- Bed Hold Policies and Return to Facility
- Observation of proper mask wearing (masks much cover nose and mouth).
- Completeness of resident service agreements.
- Observation of staff encouraging residents to wear masks appropriately
- PASSAR procedures and documentation
- Review of appropriate discharge procedures including notification and time limits
- Kitchen:
    - Cleanliness of screen over Stove
    - Fly traps
    - Accessibility of kitchen sink
    - Avoiding using any moisture trapping materials in food storage racks

Flu Update

Weekly Flu Report Week 17

Delaware (Widespread)
There have been 1,929 laboratory confirmed cases of influenza in Delaware so far this season.

Location	This Week	2021-2022 Season
Statewide	196	1,929
New Castle	90	908
Kent	57	428
Sussex	49	593
Hospitalizations	**3**	**119**
Deaths	**0**	**2**

Weekly Emerging Infectious Disease Report - attached

Of particular interest:

- Model predicts rise in U.S. COVID-related hospitalizations and deaths over the next month
- U.S. FDA official says that a second course of antivirals should not be used to treat relapsed COVID-19 infections

Community

Community Event Flyers Attached

- Understanding Relapse in Recovery
- Wellness Fair Event - Middletown

Delaware Nurses Association: DAISY Program Launch & Spring Membership Assembly Rescheduled for May 10 at 6 pm

The DAISY recognition program launch, featuring Donte DiVincenzo, Lt. Governor Hall-Long, Split Decision, Bonnie Barnes, and many more, will be held from **6:00-7:00 PM**. ALL are invited to attend this event to learn about how DNA is structuring the international DAISY recognition program so that all Delaware Nurses may be nominated, and potentially honored, either through their DAISY-partner employer or DNA. Immediately following, the DNA Spring Membership Assembly will be held from **7:00-8:00 PM**. Members, affiliates and student nurses are encouraged to attend and get a comprehensive picture of DNA, our leadership, and our programs. Information and registration here.

Upcoming DEMA Courses

https://dema.delaware.gov/training/dema/index.shtml?dc=demaTrainingCalendar

- **MGT-452 Physical and Cybersecurity for Critical Infrastructure, May 25**
- **Tornado Awareness, June 7 Details Here**
- **Hurricane Awareness, June 8 Details Here**
- **AWR-209V Working With the Media, Virtual, June 15-16 Details Here**

Hello,

Thank you for contacting Curative! We understand that you have questions about your site's billing.

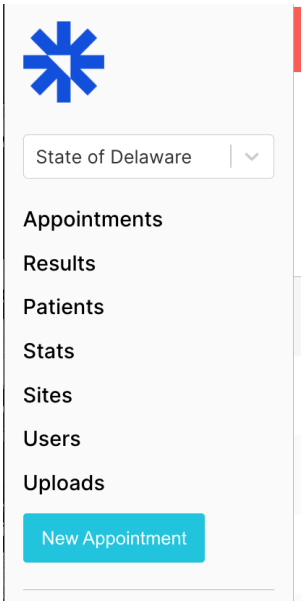
As of 5/2, the State of Delaware's testing is now set up with insurance billing. Please note that patient booking is seamless with an integrated insurance submission. Uninsured patients also receive testing at no cost. They will be required to upload photo identification cards during the appointment scheduling process.

Curative will never bill patients for COVID-19 test costs. Please visit this link to our website for more information: curative.com/legal/billing

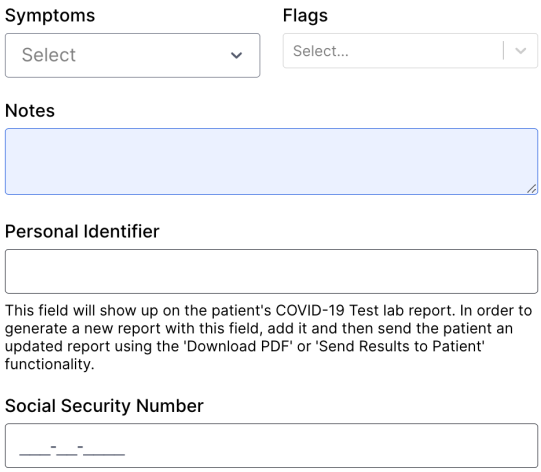
Please see the following pages for a step-by-step walkthrough of what the process looks like in your Drive Thru portal.

In order to complete insurance eligibility for your patients:

- Log into your Drive Thru portal
- Click on “New Appointment”



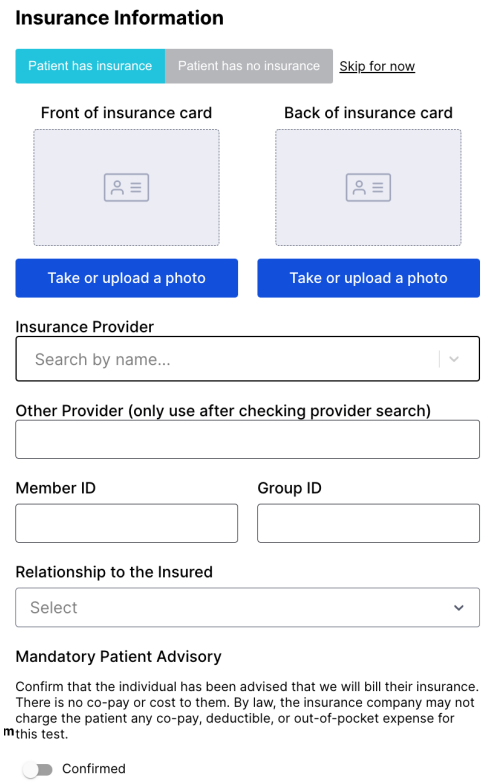
- After entering the patient contact and demographic information, you will see a section that asks for the patients social security number. **<u>This is NOT required.</u>**



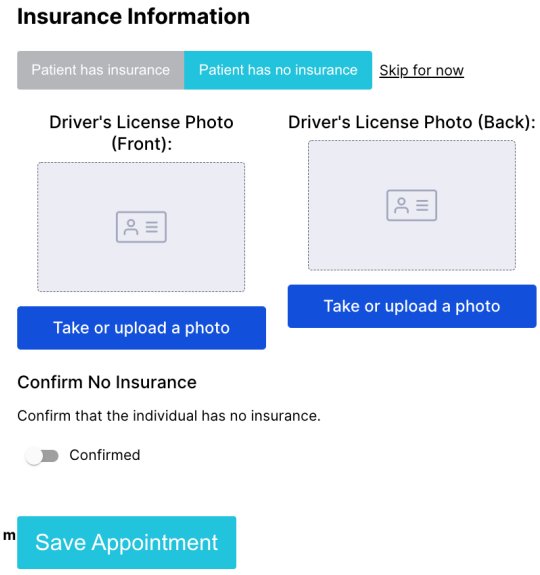
- On you have entered all applicable information, click “Save Patient/Appointment located at the bottom of the screen”

- Scroll down to the bottom of the screen

- If the patient has insurance, select “Patient has insurance” and upload insurance cards and fill out the information, click Save Insurance Information



- If the patient does not have insurance, select “Patient has no insurance”, upload their ID and click Save Appointment once again.



- At this point, it will prompt the patient to sign Legal Agreements. Alternatively, when you go back to the main appointments page, it will prompt you to sign the legal agreements at time of check in. Please assist the patient to electronically sign the agreements
- Alternatively, you can click Generate access code so a code and a link is sent to the patient for them to upload their information themselves and sign off on Legal Agreements
- Proceed with the check in process as normal.

When you are ready to test a *returning* patient:

- Click New Appointment
- Under Patient Information, select Use existing
- Type their first and last name completely
- *Verify their date of birth* to ensure you are selecting the correct patient
- Assist the patient in answering the screening questions to determine eligibility

As part of our ongoing effort to meet federal requirements, we have made screening questions mandatory in the appointment creation process for each COVID-19 test. These required screening questions help us identify the proper codes for billing purposes.

As the responses determine patient eligibility for testing, please note that if the patient's test is not deemed eligible based on the screening questions, they will not be able to move forward with the testing process.

If you have any questions or concerns, please let us know.

Thank you so much for your continued partnership.

Sales Support is available Monday through Friday from 6:00AM- 5:00PM PST, 9:00AM- 8:00 PM EST via phone at 888-702-9042 - select Option 3. You can also email us directly at salessupport@curative.com.

Best regards,

Curative Sales Support Team

curative

CMP Application for In-Person Visitation Aid Requests

Frequently Asked Questions (FAQs)

1. What is the application for in-person visitation aids?

The Centers for Medicare & Medicaid Services (CMS) has issued guidance for Nursing Home Visitation – COVID-19.[1] By following a person-centered approach and adhering to the core principles of COVID-19 infection prevention, visitation can occur safely based on this guidance. Recognizing that considerations allowing for visitation in each phase of re-opening may be difficult for residents and their families, CMS has developed this application template for requests for the use of Civil Money Penalty (CMP) Reinvestment funds to provide nursing homes with in-person visitation aids.

2. Will applications requesting CMP funds for in-person visitation aids be expedited?

State Agencies can approve applications that meet the defined CMS parameters without review by CMS. CMS anticipates that this process will reduce the amount of time needed to review and approve the use of funds for in-person visitation aids.

The purpose of this application is to provide a template to potential applicants so they provide all the required information for the State Agency to make a timely determination on the request for the use of funds.

3. When can states approve CMP applications without CMS review?

States must first retain 60% or $1M (whichever is lowest) of their available CMP funds for emergencies. If a state has questions or concerns about the maximum amount they may spend on in-person visitation aid projects, they should work with their LTC Branch.

4. What criteria must Applications meet?

Applications must meet ALL of the following criteria:

- Applications must be on the COVID-19 In-Person Visitation Aid Application Template.
    - If the application is for in-person visitation aids but is on the standard CMP Application template, the state may follow up with the applicant to request they resubmit on the correct template.
- Applicants must only include requests for funds to purchase in-person visitation aids (i.e., portable fans, portable air cleaners with high-efficiency particulate air (HEPA, H-13 or -14) filters to increase or improve air quality, tents or other shelter for outdoor visitation and/or clear dividers (e.g., Plexiglasor similar product)).
    - The application should not include requests for items identified as prohibited (Personal Protective Equipment, COVID-19 testing machines or supplies, etc.).

[1] https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

- Applicants must ensure:
    - Requests directly address the need to facilitate in-person visits for residents.
    - Appropriate Life Safety Code requirements found at 42 CFR 483.90 are met, unless waived under the PHE declaration.
    - Tent or other shelter allows for social distancing to be observed.
    - Core principles of infection prevention and control practices are followed. Surfaces must be cleaned and disinfected between resident use.
    - Work with state officials to determine the appropriate level of visitation
    - Nursing facilities should continue to consult with state and local health departments when outbreaks occur to determine when modifications to visitation policy would be appropriate. Facilities should document their discussions with the health department, and the actions they took to attempt to control the transmission of COVID-19.
- Facilities may use up to $3,000 for in-person visitation aids (e.g., tents or other shelter for outdoor visitation and/or clear dividers) including installation, installation materials, and shipping costs for the in-person visitation aids. All eligible expenses incurred on or after the release of Memorandum QSO 20-39-NH (September 17, 2020) are eligible for reimbursement.
- Facilities may use up to an additional $3,000 for in-person visitation aids (e.g., indoor portable fans, indoor portable air cleaners with high-efficiency particulate air (HEPA, H-13 or -14) filters to increase or improve air quality) and shipping costs for the in-person visitation aids.
- Expenses incurred on or after the release of Memorandum QSO-20-39-NH FAQ Revised, February 2, 2022 are eligible for reimbursement.

5. **Can states approve CMP Applications in excess of the $3,000 maximum for tents or other shelter for outdoor visitation and/or clear dividers costs, and/or $3,000 maximum for indoor portable fans and/or portable air cleaners** with high-efficiency particulate air (HEPA, H-13 or -14) filters to increase or improve air quality?

No, states cannot approve these requests.

6. **Can applicants use the standard CMP Application process to request additional in-person visitation aids?**
    - No, Applicants cannot use the standard CMP application process to supplement their visitation aids request to obtain additional in-person visitation aids in excess of the $3,000 maximum limit for in-person visitation aids (e.g., including installation, installation materials, and shipping costs for the in-person visitation aids).
    - No, Applicants cannot use the standard CMP application process to supplement their visitation aids to request to obtain in-person visitation aids in excess of the $3,000 for portable fans, portable air cleaners with high-efficiency particulate air (HEPA, H-13 or -14) filters to increase or improve air quality, and shipping costs for the in-person visitation aids.

7. **What if an applicant fails to use the CMP COVID-19 In-Person Visitation Aid Application Template?**

In-person visitation aid requests submitted via formats other than the CMP COVID-19 In-Person Visitation Aid Application Template can **NOT** be approved by the states. These applicants should be provided a copy of the correct template and advised to resubmit their

request.

8. What are types of visitation aids that promote in-person visits?

- tents or other shelter for outdoor visitation (purchase and/or rental);
- clear dividers (e.g., Plexiglas or similar product) to create a physical barrier to reduce therisk of transmission during in-person visits;
- indoor portable fans; and/or
- indoor portable air cleaners with high-efficiency particulate air (HEPA, H-13 or -14) filters.

9. What expenses are prohibited for in-person visitation aid requests?

These applications are strictly for in-person visitation aids only. Prohibited expenses include but are not limited to:

- Ventilation systems
- *Replacement filters*
- Personal Protective Equipment (PPE)
- Portable fire extinguishers of approved types
- Disinfectant and Cleaning Supplies (Disinfectant wipes, hand sanitizer, etc.)
- No-Smoking signage
- Administrative fees
    - i.e., payment of individuals to help administer the program
- Indirect Cost. For example: federally determined indirect (facilities and administrative-F&A or overhead) costs such as staff fringe benefits, facility maintenance, rent, or utilities.
- Travel expenses
- COVID-19 testing and testing equipment

10. How can a facility prevent the transmission of COVID-19 in the facility while using in-person visitation aids?

Facilities should ensure person-centered approaches and core principles for preventing COVID-19 transmission are followed while using in-person visitation aids. Core principles and best practices that reduce the risk of COVID-19 transmission include:

- "Visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or currently meet the criteria for quarantine, should not enter the facility. Facilities should screen all who enter for these visitation exclusions
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose)
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high frequency touched surfaces in the facility often,and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR 483.80(h) (https://www.cms.gov/files/document/qso-20-28-nh-revised.pdf).

11. What must be included in the application and application budget (application template Section 5)?

To be considered for funding, each application must include the following information:

- Name(s) of facility(ies) to receive visitation aids (and CMS Certification Numbers (CCNs)).
- Number of certified facility beds.
- Type(s) of visitation aids.
- Cost per visitation aid.
- Total number of visitation aids requested.
- Total funds requested.

Applicants must also provide a line-item budget for all visitation aids (i.e., tents or other shelter for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar product), indoor portable fans, and/or indoor portable air cleaners with high-efficiency particulate air (HEPA, H-13 or -14) filters to increase or improve air quality), broken down per facility for which CMP funding is requested.

12. How should funds be tracked by states?

In accordance with 42 CFR 488.433, states shall maintain a list of all nursing homes receiving CMP reinvestment funds for in-person visitation aids during the COVID-19 Public Health Emergency. This information should be entered into the Annual CMP Reinvestment Tracker completed by each state. The CMP-Info@cms.hhs.gov mailbox should be carbon-copied (cc) on all state approval and denial notifications.

Civil Money Penalty (CMP) Reinvestment Application Template
Coronavirus Disease 2019 (COVID-19)
In-Person Visitation Aids Request Instructions

On 2/2/2022, the Centers for Medicare & Medicaid Services issued a revised FAQ guidance for Nursing Home Visitation – COVID 19 (Refer to https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf).

CMS is clarifying that CMPs can be used to purchase any of the following strictly for the purposes of in-person visitation:

A facility *has a second opportunity to* request the use of Civil Money Penalty (CMP) Reinvestment funds to purchase portable fans and portable room air cleaners with high-efficiency particulate air (HEPA, H-13 or -14) filters to increase or improve air quality. *However, replacement filters cannot be purchased with these funds, as they are a prohibited expense.* A maximum use of $3,000 per facility, including shipping costs *and taxes*, may be requested *even if a nursing home received up to $3,000 for prior visitation aid purchases*. When utilizing these items for visitation purposes, facilities need to ensure appropriate life safety code requirements found at 42 CFR 483.90 are met, unless waived under the PHE declaration.

Expenses incurred on or after the release of Memorandum QSO-20-39-NH FAQ Revised February 2, 2022 are eligible for reimbursement. (Refer to https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf).

In addition to the above revised guidance, the following guidance remains in effect:

On September 17, 2020, the Centers for Medicare & Medicaid Services (CMS) issued guidance for Nursing Home Visitation – COVID-19. By following a person-centered approach and adhering to the core principles of COVID-19 infection prevention, visitation can occur safely based on this guidance. Recognizing that considerations allowing for visitation in each phase of re-opening may be difficult for residents and their families, CMS has developed this application template for requests for the use of Civil Money Penalty (CMP) Reinvestment funds to provide nursing homes with in-person visitation aids.

Applicants shall submit this CMP Reinvestment Application to the applicable state agency (SA). The SA shall make a determination on the potential of the project to benefit nursing home residents and improve their quality of care and quality of life. The applicant will be notified by the SA about a funding decision, and applicants may contact the applicable SA with questions about their CMP Reinvestment Application.

NOTE: This template can only be used for in-person visitation aids for nursing homes.

CMS is clarifying that CMPs can be used to purchase any of the following strictly for the purposes of in-person visitation:

- tents or other shelter for outdoor visitation (purchase and/or rental); and/or
- clear dividers (e.g., Plexiglas or similar product) to create a physical barrier to reduce the risk of transmission during in-person visits.

Funding is also limited to a maximum of $3,000 per facility which can include installation, installation materials, and shipping costs for allowable items mentioned above. When installing any items for visitation purposes, facilities need to ensure appropriate life safety code requirements found at 42 CFR 483.90 are met, unless waived under the PHE declaration.

Expenses incurred on or after the release of Memorandum QSO 20-39-NH (September 17, 2020) are eligible for reimbursement.

Prohibited expenses include but are not limited to:

- Ventilation systems
- *Replacement filters*
- Personal Protective Equipment (PPE)
- Portable fire extinguishers of approved types
- Disinfectant and Cleaning Supplies (Disinfectantwipes, hand sanitizer, etc.)
- COVID-19 testing and testing equipment
- No-Smoking signage
- Administrative fees
    - i.e., payment of individuals to help administer the program
- Indirect Cost. For example: federally determined indirect (facilities and administrative-F&A or overhead) costs suchas staff fringe benefits, facility maintenance,rent, or utilities.
- Travel expenses

1. **Project and Applicant Requirements to use the In-Person Visitation Aids Application Template.**

Projects must:

- Directly address the need to facilitate in-person visits for residents.
- Fall within the following parameters for use of funds:
    - Funds must only be used to purchase the types of visitation aids described above.
    - Tent or other shelter must allow for social distancing to be observed.
    - Maximum allowance of $3,000 per facility for tents or other shelter for outdoor visitation and/or clear dividers
    - Maximum allowance of $3,000 per facility for indoor portable fans and/or indoor portable air cleaners.
- Ensure appropriate LSC requirements found at 42 CFR 483.90 are met, unless waived under the PHE declaration.
- Ensure core principles of infection prevention and control practices. Surfaces must be cleaned and disinfected between resident use.
- *Follow the latest visitation guidance in Memorandum QSO 20-39-NH*

To be considered for funding, each application must include the following information:

- Name(s) of facility(ies) to receive visitation aids (and CMS Certification Numbers (CCNs)).
- Number of certified facility beds.
- Type(s) of visitation aids.
- Cost per visitation aid.
- Total number of visitation aids requested.
- Total funds requested.

2. **Eligibility Guidelines –** confirm this project meets criteria outlined in Section 1.

☐ Yes ☐ No

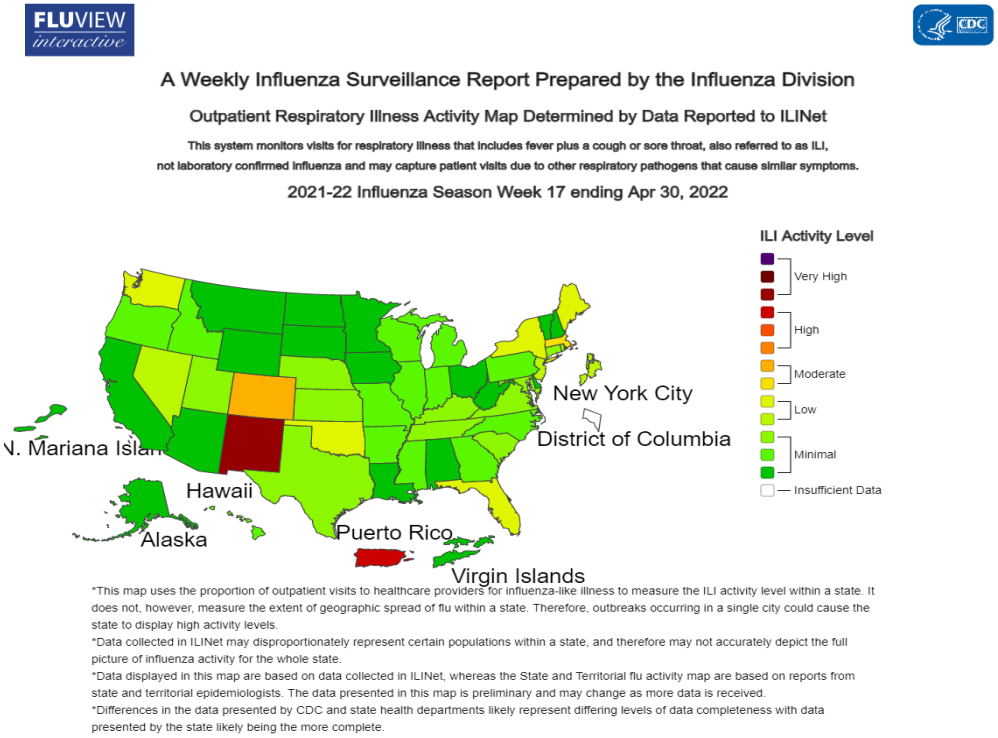
3. **Applicant Contact and Background Information**

Organization Contact Information	
Contact:	
Name:	
Phone:	
Email:	
Address:	
State:	

Delaware Weekly Influenza Report
MMWR Week 17 (April 24, 2022-April 30, 2022)
Delaware Division of Public Health

National Influenza Synopsis 2021-2022:

National influenza data is updated Friday of each week. Please visit https://www.cdc.gov/flu/weekly/ for the most current information. The percentage of national respiratory specimens testing positive was at **8.1%** this week. **One** new influenza-associated pediatric deaths were reported to the CDC this week. The total for the 2021-2022 season is **24** influenza associated pediatric deaths. This week, National Outpatient ILI data showed **two** jurisdiction experienced moderate influenza-like-illness activity and **two** jurisdictions experienced high or very high influenza-like-illness activity.



Summary of International Influenza Activity:

- The current influenza surveillance data should be interpreted with caution as the ongoing COVID-19 pandemic has influenced to varying extents health seeking behaviors, staffing/routines in sentinel sites, as well as testing priorities and capacities in Member States. Various hygiene and physical distancing measures implemented by Member States to reduce SARS-CoV-2 virus transmission have likely played a role in reducing influenza virus transmission.
- In the temperate zones of the northern hemisphere, influenza activity increased or remained stable, except in East Asia where detections decreased. Detections were mainly influenza A(H3N2) viruses and B/Victoria lineage viruses.
- In North America, influenza activity continued to increase in recent weeks but remained lower than pre-COVID-19 pandemic levels at this time of the year and was predominantly due to influenza A viruses, with A(H3N2) predominant among the subtyped viruses. Respiratory syncytial virus (RSV) activity remained low in the United States of America (USA) and Canada.
- In Europe, overall influenza activity has stabilized with influenza A(H3N2) predominant. Very little RSV activity was observed.
- In Central Asia, a single influenza B detection was reported in Kyrgyzstan.
- In East Asia, influenza activity with mainly influenza B/Victoria lineage detections appeared to decrease in China. ILI rate and pneumonia hospitalizations remained elevated in Mongolia. Elsewhere, influenza illness indicators and activity remained low.
- In Northern Africa, increasing detections of influenza A(H3N2) were reported in Tunisia.
- In Western Asia, influenza activity was low across reporting countries, with the exception of Georgia where increased detections of influenza A(H3N2) were reported.
- In the Caribbean and Central American countries, low influenza activity was reported with influenza A(H3N2) predominant.
- In tropical South America, low influenza activity was reported with influenza A(H3N2) predominant.
- In tropical Africa, influenza activity was reported mainly from Eastern Africa with influenza A(H3N2) predominating followed by influenza B/Victoria lineage viruses.
- In Southern Asia, influenza virus detections were at low levels with influenza A(H1N1)pdm09 and A(H3N2) viruses detected.
- In South-East Asia, influenza detections were at low levels except in Timor-Leste with influenza A(H3N2) predominant.
- In the temperate zones of the southern hemisphere, influenza activity remained low overall, although detections of influenza A viruses (with A(H3N2) predominant among the subtyped viruses) continued to be reported in some countries in temperate South America and South Africa.

Centers for Disease Control and Prevention (CDC) https://www.cdc.gov/flu/weekly/index.htm
WHO https://www.who.int/teams/global-influenza-programme/surveillance-and-monitoring/influenza-updates/current-influenza-update

Influenza Surveillance 2021-2022:

During MMWR week 17, there were **110** laboratory-confirmed cases of influenza reported among Delaware Residents. Reports of influenza-like-illness (ILI) received from participating providers, facilities, and institutions in Delaware show the ILI rate is at **0.88%** which is below Delaware's 2021-2022 baseline rate of 2.0%. Nationally, **2.2%** of visits to a healthcare provider were for ILI, which is below the 2021-2022 national baseline of 2.5%.

Past Influenza Surveillance from 2020-2021:

Last Season, during MMWR week 17, there was **0** laboratory confirmed cases of influenza among Delaware Residents. The ILI rate was at **0.29%** compared to Delaware's 2020-2021 baseline of 1.9%. The rate nationally for the 2020-2021 season, MMWR week 17, was **1.1%** of visits to a healthcare provider were for ILI compared to the 2020-2021 national baseline of 2.6%.

Past Influenza Surveillance from 2019-2020:

*Due to the 2020 Covid-19 Pandemic the end of the 2019-2020 influenza season was unable to be accurately tracked and therefor the data is unavailable for this period.

Level of Influenza Activity in Delaware, MMWR Week 17

Widespread
CDC Definitions: **No Activity:** No laboratory-confirmed cases[2] of influenza and no reported increase in the number of cases of ILI. **Sporadic:** Small numbers of laboratory-confirmed influenza cases or a single laboratory-confirmed influenza outbreak has been reported, but there is no increase in cases of ILI. **Local:** Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in a single region of the state. **Regional:** Outbreaks of influenza or increases in ILI and recent laboratory-confirmed influenza in at least two but less than half the regions of the state with recent laboratory evidence of influenza in those regions.[3] **Widespread:** Outbreaks of influenza or increases in ILI cases and recent laboratory-confirmed influenza in at least half the regions of the state with recent laboratory evidence of influenza in the state. *Influenza-like illness (ILI) is defined as patients presenting with fever of 100º F or greater, cough and/or sore throat.*

[2] Laboratory-confirmed case = case confirmed by viral culture or PCR.
[3] Region = population under surveillance in a defined geographical subdivision of a state. Regions typically include several counties. Regional does not apply to states with ≤ four counties.

Summary of Figures for the MMWR Week 17Report:

Table 1: Comparison the MMWR Week 17of the 2019-2020 Influenza Season, 2020-2021 Influenza Season, and current 2021-2022 Influenza Season Confirmed[1] Influenza Cases Reported Statewide by County

Confirmed Flu Cases by County	2019-2020 Influenza Season			2020-2021 Influenza Season			Current 2021-2022 Influenza Season[3]		
	Week 17	YTD[2]	YTD County Percentage (%)	Week 17	YTD[2]	YTD County Percentage (%)	Week 17	YTD[2]	YTD County Percentage (%)
STATEWIDE	-	7075	--	0	23	--	**110**	**2041**	--
New Castle County	-	3187	45.05%	0	5	21.73%	57	965	47.28%
Kent County	-	1810	25.58%	0	14	60.87%	28	458	22.44%
Sussex County	-	2078	29.37%	0	4	17.39%	25	618	30.28%

[1]Influenza Cases are confirmed via PCR testing

[2]YTD stands for "Year to Date" and represents the cumulative number of cases through the current MMWR Week being assessed for the 2020-21 and 2021-22 influenza seasons, respectively.

[3] There may be technical discrepancies of reporting numbers week to week due to retroactive reporting or reclassification of cases.

Table 2: Comparison of MMWR Week 17of the 2019-2020 Influenza Season, 2020-2021 Influenza Season, and current 2021-2022 Influenza Season Confirmed[1] Influenza Cases Reported Statewide by Age

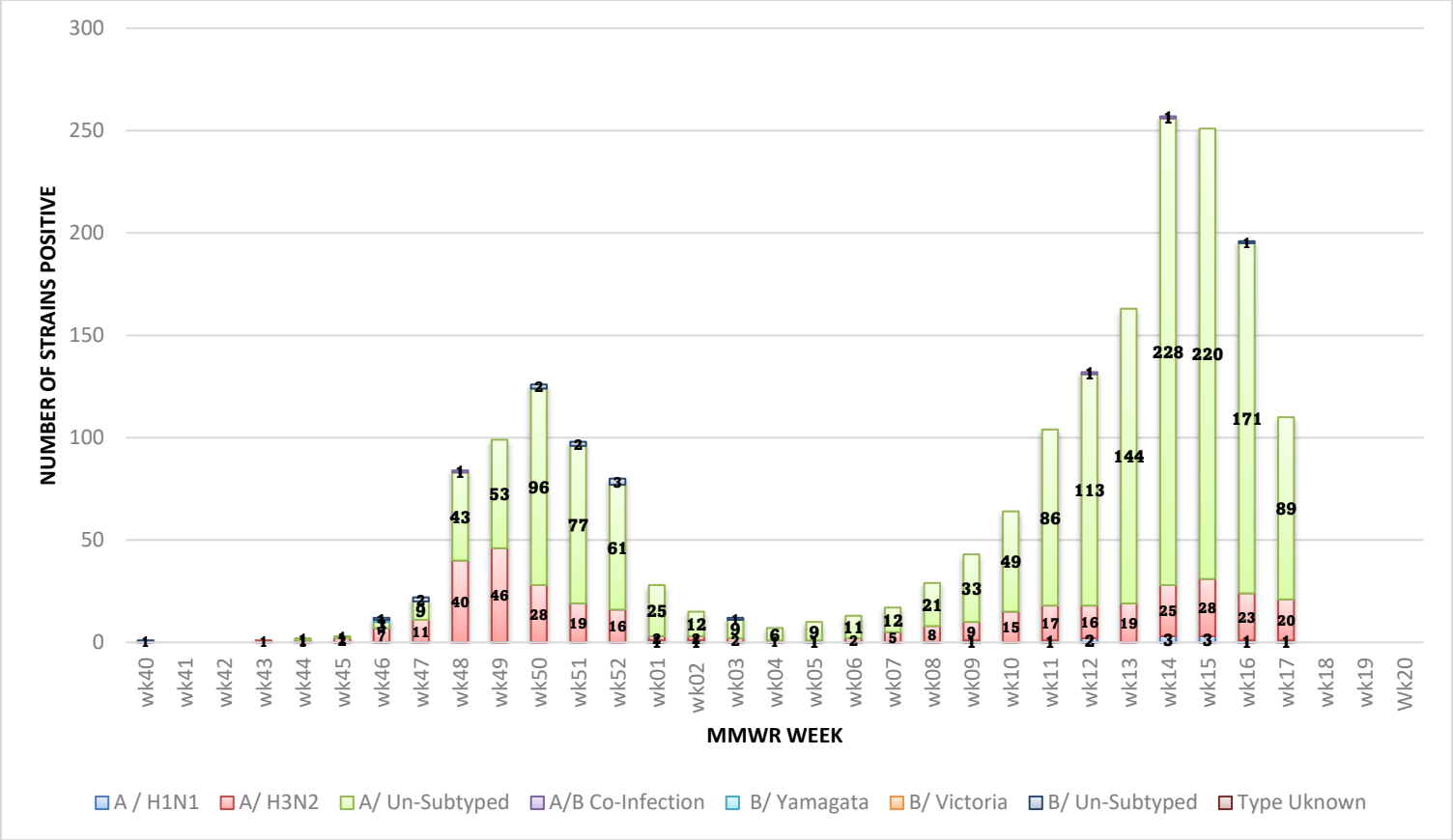
Confirmed Flu Cases by Age Group*		2019-2020 Influenza Season			2020-2021 Influenza Season			Current 2021-2022 Influenza Season		
		Week 17	Total Count	YTD[2]	Week 17	Total Count	YTD[2]	Week 17	Total Count	YTD[2]
STATEWIDE	0-4 years	-	-	7075	-	0	23	17	**110**	**2041**
	5-11 years	-			-			26		
	12-17 years	-			-			-		
	18-34 years	-			-			12		
	35-49 years	-			-			14		
	50-64 years	-			-			-		
	65+years	-			-			16		

[1]Influenza Cases are confirmed via PCR testing

[2]YTD stands for "Year to Date" and represents the cumulative number of cases through the current MMWR Week being assessed for the 2020-21 and 2021-22 influenza seasons, respectively.

*Cell counts with less than 10 cases are suppressed for smaller age groups. Due to suppression guidelines, stratification by age group, within each county, is not shown in the table above.

Figure 1: Confirmed Cases of Influenza by Type and Subtype/Lineage, Delaware 2021-2022 Influenza Season



During MMWR Week 17for the 2021-2022 Delaware Influenza season, there were **110** confirmed cases of Influenza. Currently in this season the predominate strain of influenza in Delaware is Influenza A (un-subtyped) followed by Influenza A(H3N2).

Table 3: Comparison of the 2019-2020 MMWR Week 17and the 2010-2022 MMWR Week 17Influenza-related Hospitalizations and Deaths Statewide

Hospitalizations and Deaths due to Influenza	2019-2020 Influenza Season				2020-2021 Influenza Season				Current 2021-2022 influenza Season			
	Week 17	YTD Totals[1]	Percentage of Confirmed Case (%)[2]	YTD Percentage of Confirmed Cases (%)[3]	Week 17	YTD Totals[1]	Percentage of Confirmed Case (%)[2]	YTD Percentage of Confirmed Cases (%)[3]	Week 17	YTD Totals[1]	Percentage of Confirmed Case (%)[2]	YTD Percentage of Confirmed Cases (%)[3]
Hospitalizations	-	362	0%	5.12%	0	1	0%	4.76%	1	120	0.91%	5.88%
Deaths	-	11	0%	.16%	0	1	0%	4.76%	0	2	0%	.10%

[1]YTD stands for "Year to Date" and represents the cumulative number of cases through the current MMWR Week that were hospitalized or died
[2]Percentage of cases confirmed during the single MMWR Week
[3]Percentage of cases for the cumulative count of confirmed cases through the influenza season to the current MMWR Week.

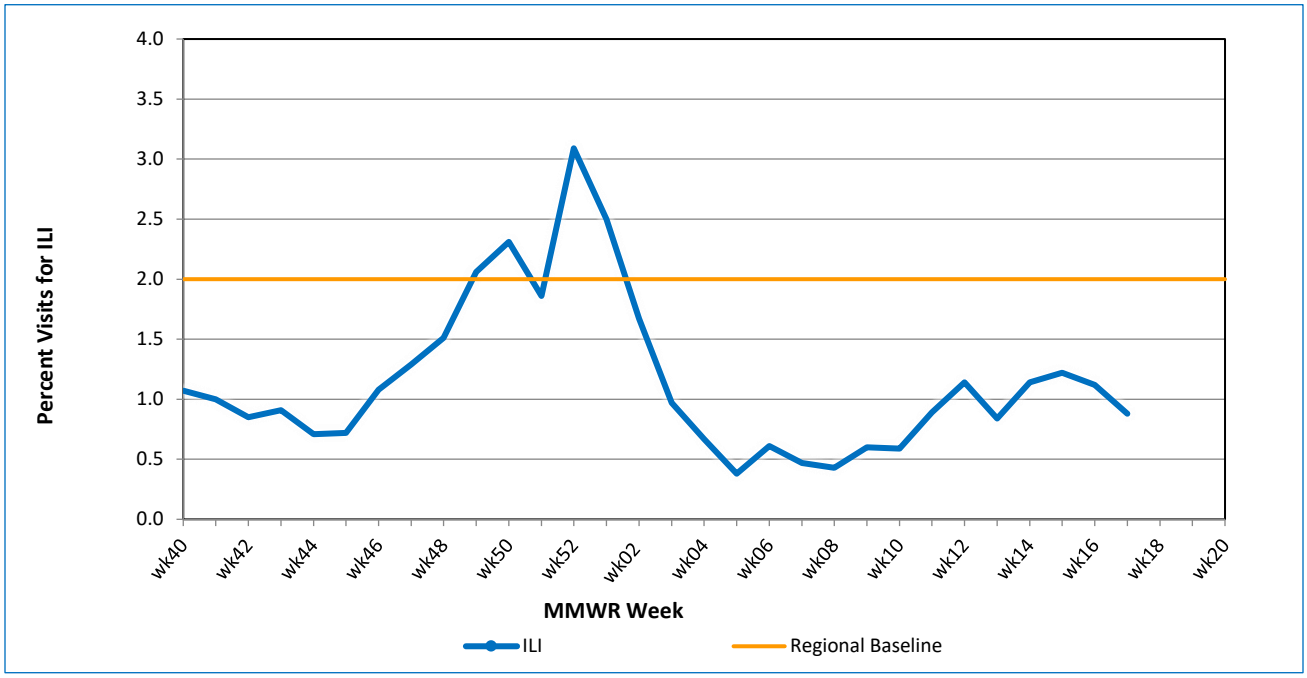
Table 4: Annual Number of Influenza Cases Reported by Flu Season, Delaware 2004-05 through 2021-22

Influenza Season	Total Annual Influenza Cases
2004 – 2005	995
2005 – 2006	541
2006 – 2007	508
2007 – 2008	1,401
2008 – 2009	738
2009 – 2010	2,247
2010 – 2011	1,479
2011 – 2012	267
2012 – 2013	1,781
2013 – 2014	1,843
2014 – 2015	2,390
2015 – 2016	1,843
2016 – 2017	4,590
2017 – 2018	9,050
2018 – 2019	6,387
2019 – 2020	7,075
2020-2021	26
2021-2022 (YTD)	**2041**

U.S. Outpatient Influenza-Like Illness Surveillance Network (ILINet) Sentinel Providers

An ILINet (sentinel) provider conducts surveillance for influenza-like illness (ILI) in collaboration with the Division of Public Health and the Centers for Disease Control and Prevention (CDC). Data reported by ILINet providers, in combination with other influenza surveillance data, provide a national and

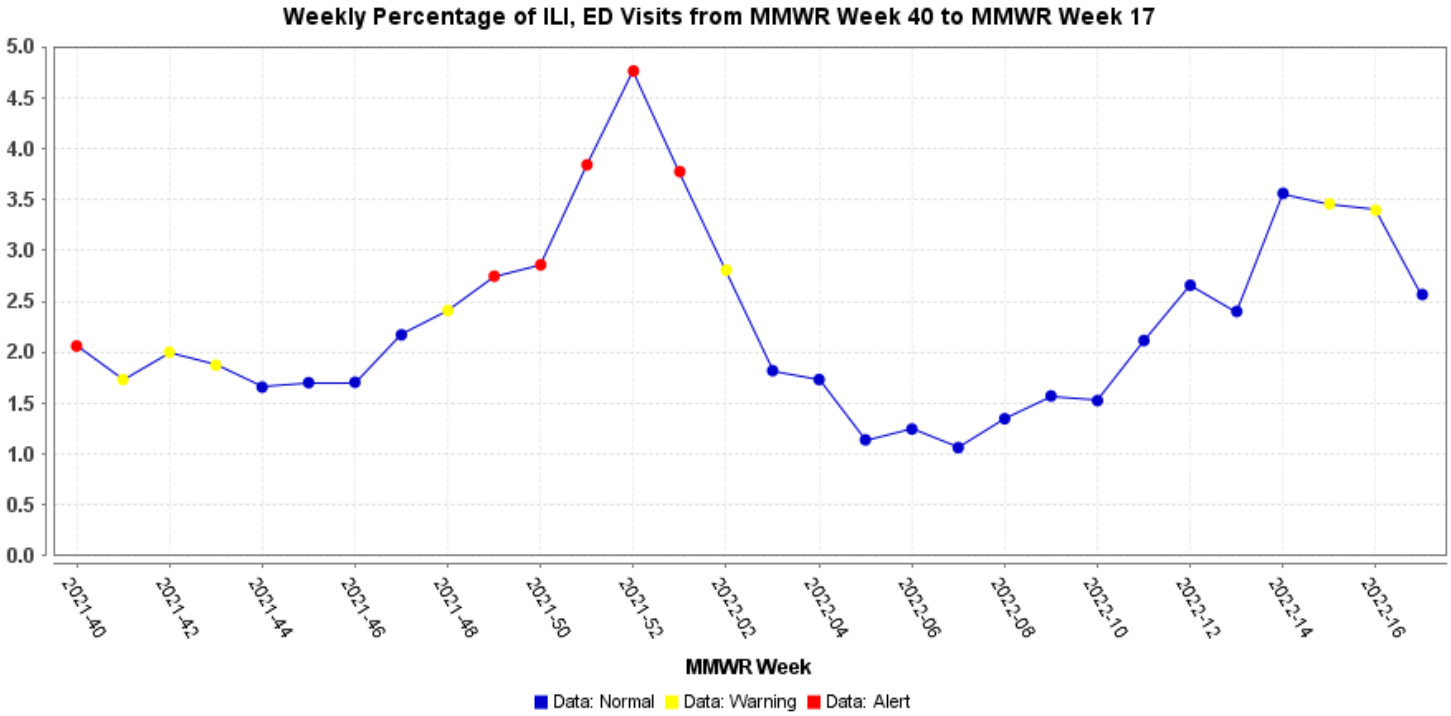
Figure 2: Percentage of Visits for Influenza-Like Illness Reported by Sentinel Providers[1] participating in the U.S. Outpatient ILI Surveillance Network (ILINet), Delaware 2021-2022



Delaware's regional baseline[1] for healthcare visits relating to ILI symptoms in the 2021-2022 Influenza Season is 2.0 % and the national baseline[2] is 2.5%. In MMWR Week 17, the amount of ILI related visits reported by sentinel providers in Delaware is at **0.88%** and is below regional and national baselines.

[1]The regional baseline is calculated by the CDC using non-influenza weeks from the previous three influenza seasons. Delaware is in Region 3, which also includes DC, MD, PA, VA, and WV.
[2]The National baseline is calculated by the CDC using non-influenza weeks from the previous three influenza seasons.

Figure 3: Percentage of Emergency Care Visits Due to Influenza-Like Illness MMWR Week 40-MMWR Week 17, Delaware 2021-2022



Syndromic data collected from ESSENCE shows that from Week 40 through Week 17, the percentage of ED visits due to ILI symptoms has decreased from past weeks and is significantly higher than last year's season. The percentage of ED visits for ILI for Week 17 was highest Kent County in (**3.16%**), followed by Sussex County (**2.53%**), and New Castle County (**2.39%**).

Additional Respiratory Virus Surveillance

Table 5: Current 2021-2022 Respiratory syncytial virus (RSV) Season Confirmed[1] Influenza Cases Reported Statewide by County

Confirmed RSV Cases by County[3]	Current 2021-2022 Respiratory syncytial virus (RSV) Cases		
	Week 17	YTD[2]	YTD County Percentage (%)
STATEWIDE	**0**	**25**	-
New Castle County	0	2	8%
Kent County	0	22	88%
Sussex County	0	1	4%

[1]Respiratory syncytial virus, (RSV) Cases are confirmed via PCR testing

[2]YTD stands for "Year to Date" and represents the cumulative number of cases through the current MMWR Week being assessed for the 2020-21 and 2021-22 [1]Respiratory syncytial virus, respectively.

[3] There may be technical discrepancies of reporting numbers week to week due to retroactive reporting or reclassification of cases.

Table 6: Current 2021-2022 Respiratory syncytial virus (RSV) Confirmed[1] Influenza Cases Reported Statewide by Age

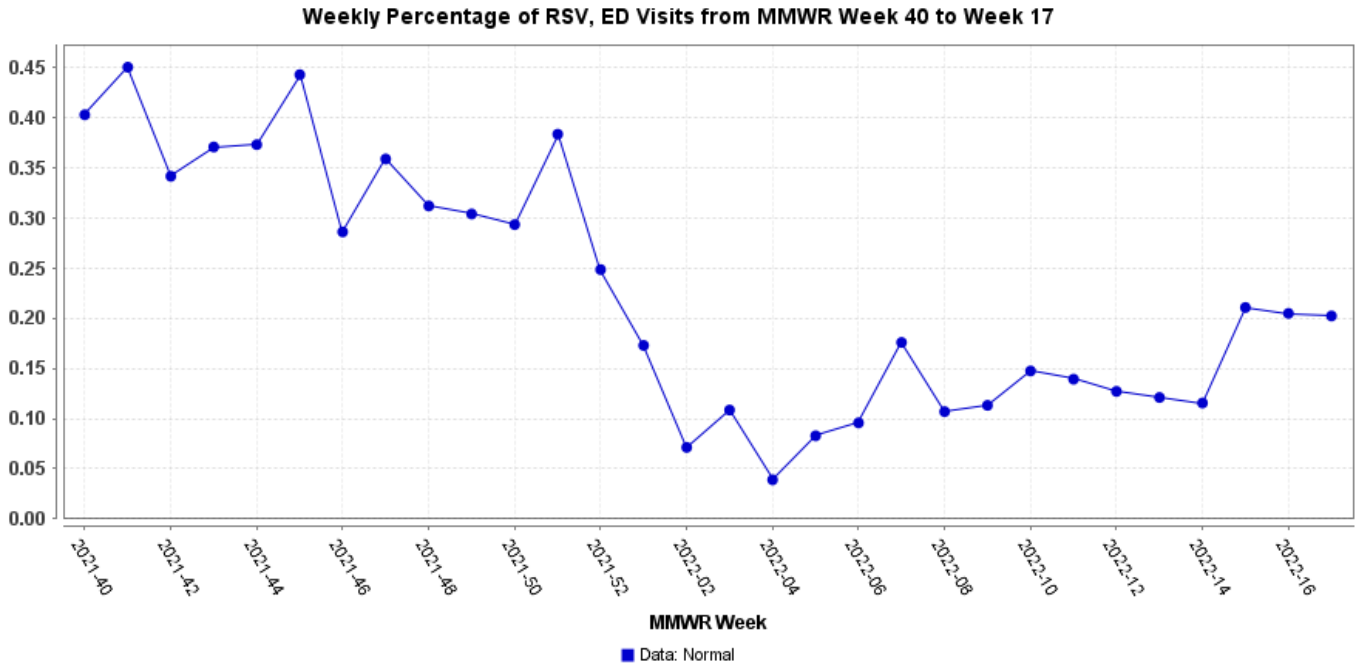
RSV Cases by Age Group*		Current 2021-2022 Respiratory syncytial virus (RSV) Cases		
		YTD by Age Group	Total Count Week 17	YTD[2]
STATEWIDE	0-4 years	16	**0**	**25**
	5-11 years	-		
	12-17 years	-		
	18-34 years	-		
	35-49 years	-		
	60-64 years	-		
	65+years	-		

[1]Respiratory syncytial virus, (RSV) Cases are confirmed via PCR testing

[2]YTD stands for "Year to Date" and represents the cumulative number of cases through the current MMWR Week being assessed for the 2020-21 and 2021-22 Respiratory syncytial virus seasons, respectively.

*Cell counts with less than 10 cases are suppressed. Due to suppression guidelines, stratification by age group, within each county, is not shown in the table above.

Figure 4: Percentage of Emergency Care Visits Due to Respiratory Syncytial Virus RSV MMWR Week 40- MMWR Week 17, Delaware 2021-2022



Syndromic data collected from ESSENCE shows that from Week 40 through Week 17, the percentage of ED visits due to RSV-related ED* visits has decreased from past weeks. The percentage of ED visits for RSV for Week 17was highest in New Castle County (**0.35%**), followed by Kent County (**0.39%**), and Sussex County (**0.05%**).

*The syndrome is defined a combination of chief complaints and discharge diagnoses

NOTE: Data provided do not reflect the total number of individuals who have been infected with the Influenza virus or Respiratory Syncytial virus in Delaware during the reporting period due to the following factors:

- Many people ill with influenza-like symptoms do not seek medical care.
- Many who do seek medical care are not tested for influenza.
- The Delaware Public Health Laboratory is limited by capacity to processing a maximum of three specimens per day from each reporting entity.

The Delaware Division of Public Health (DPH) is committed to serving you better by providing the most accurate, up-to-date influenza data available.

- For general information on influenza, visit flu.delaware.gov or http://dhss.delaware.gov/dhss/dph/dpc/immunize-flu.html.
- For more information on Respiratory syncytial virus (RSV) visit: https://www.cdc.gov/rsv/index.html
- For specific information on DPH flu clinics, visit http://dhss.delaware.gov/dhss/dph/fluclinics.html.
- For questions on Delaware's weekly flu report, call the DPH Office of Infectious Disease Epidemiology at 302-744-4990.
- For questions regarding influenza vaccination, please call 302-744-1060.

4. Total CMP Fund Request Amount

Note: this amount should match the total cost of the items in section 5 below, in addition to items in the addendum (section 7).

5. Budget

Applicants must provide a line-item budget for all items, broken down per facility, for which CMP funding is requested. All items must directly relate to in-person visitation aids.

Facility Name	CMS Certification Number (CCN)	Number of Certified Facility Beds	Type of Visitation Aids (e.g., tents, clear dividers,installation, installation materials, shipping costs, and/or indoor portable fans, indoor portable air cleaners, shipping costs)	Cost per Visitation Aid	Number of Visitation Aids	Total Cost per Facility
						0
						0
						0
						0
						0
						0
						0
TOTAL PROJECT COST						0

If the project includes more items than will fit in the table above or the addendum section below, please provide a complete record in an Appendix.

6. Attestation Statement

CMP funds have been provided for the express purpose of enhancing quality of care and quality of life in nursing homes certified to participate in Title 18 and Title 19 of the Social Security Act. **Applicants cannot use the standard CMP application process to supplement their visitation aid request to obtain additional in-person visitation aids in excess of the $3,000 maximum limit for tents and clear dividers, and/or $3,000 maximum limit for indoor portable fans and/or indoor portable air cleaners** with high-efficiency particulate air (HEPA, H-13 or -14) filters to increase or improve air quality**.** By signing below, you are confirming that everything stated in this application is truthful and you are aware and in compliance with the CMP project and applicant requirements.

Name of the Applicant (print):	
Date of Signature:	
Signature of the Applicant:	

7. Optional Addendum to Application Template Budget

Applicants must provide a line-item budget for all items, broken down per facility, for which CMP funding is requested. All items must directly relate to in-person visitation aids.

Facility Name	CMS Certification Number (CCN)	Number of Certified Facility Beds	Type of Visitation Aids (e.g., tents, clear dividers,installation, installation materials, shipping costs, and/or indoor portable fans, indoor portable air cleaners, shipping costs)	Cost per Visitation Aid	Number of Visitation Aids	Total Cost per Facility
						0
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						0
TOTAL PROJECT COST						0

SHOC COVID Testing Resource Request Form **Request Number:**

Return Form to: dhss06sg_shoc_operations@delaware.gov

Date Sent:	Time:	Priority: ☐ Low ☐ Routine ■ High

REQUESTOR INFORMATION

Person Making Request:		Title:
Requestor's Organization:		
DIRECT Phone #:	Mobile #:	Fax #:
Email Address:		

Type Organization:

State Agency	**Schools**	**Healthcare Provider**	**Congregate Setting**
☐ DPH	☐ K-12	☐ Private Provider	■ Long Term Care Facility
☐ DEMA	☐ Day Care	☐ Pharmacy	☐ Federally Funded
☐ DDDS	☐ Camps	☐ Hospital	☐ Department of Corrections
☐ _____	☐ IHE	☐ _____	☐ _____
	☐ _____		

FACILITY/PRACTICE INFORMATION

Population Served: ☐ K-12 ☐ Age >65 ■ Other:

Who are you testing? ☐ Staff ☐ Public ☐ Congregate Care Residents ■ Other:

Number of tests conducted **PER** week:

Other testing options tried? ☐ YES ■ NO If NO, explain:

REQUESTED RESOURCES Description of Requested Assistance/Resources Required

■ Rapid Antigen Test-**SEE BELOW** ■ BinaxNOW (40/box) ☐ BD Veritor ☐ Abbott ID	☐ PCR Who is processing PCR tests? ☐ Alinity (Curative) ☐ State Lab ☐ NP/OP (Kits) ☐ Curative ☐ NP/OP (Bulk - Assemble) ☐ Other:	**IN OUTBREAK?** ☐ YES ☐ NO

Quantity:	**Ea/Box**	**Detailed Resource Requested (include resource Type/Kind):**

***REQUIRED FOR RAPID ANTIGEN TEST KITS**

Does facility or practice hold a CLIA waiver or certificate? ■ YES ☐ NO

Practitioner Name:	Practitioner NPI:
Practitioner Phone Number:	Practitioner Email:

Does facility or practice have an analyzer? ☐ YES ■ NO If yes, model:

DELIVERY/PICKUP/POINT OF CONTACT INFORMATION

Delivery Address:

Delivery Site Point of Contact:	Phone #:

COMMENTS

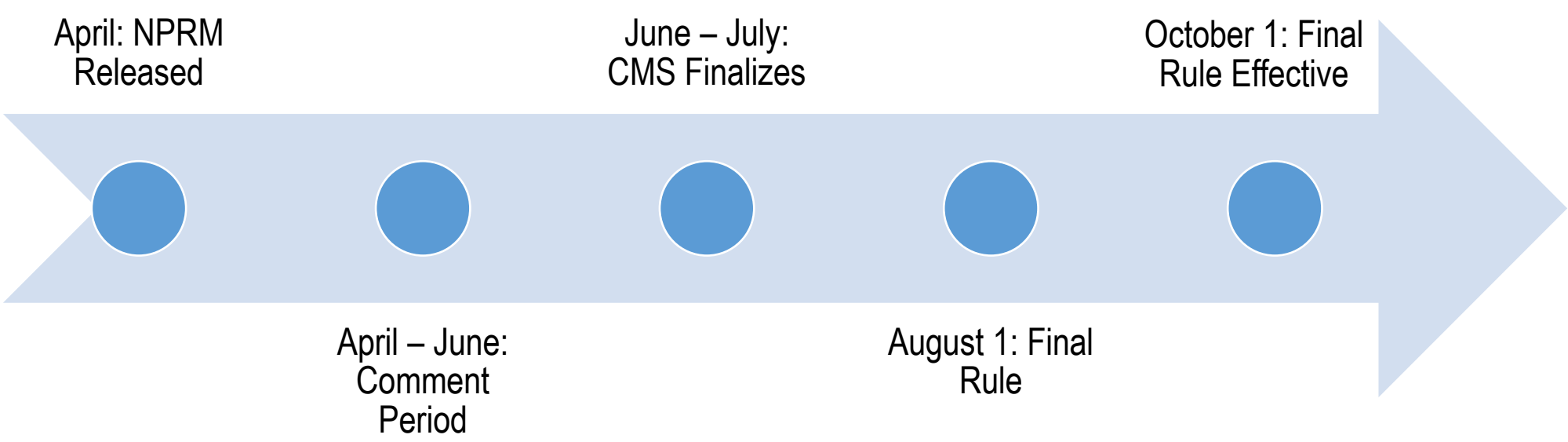
FY 2023 SNF Payment Rule: Submit Your Comments to CMS

April 21, 2022

AHCA AMERICAN HEALTH CARE ASSOCIATION

NCAL NATIONAL CENTER FOR ASSISTED LIVING

Annual Timeframe



Understanding Parity Adjustment

- CMS Transitions from a Previous SNF Payment System to a New System in a **Budget Neutral** Manner
- **Budget Neutral** Means no More Medicare Dollars are Spent under the New System Than Spend Under the Old System
- **Parity Adjustment** is Payment Reduction Used When CMS Believes the Transition was not Budget Neutral

RUG Spending < PDPM Spending

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FY 2022 Final Rule Refresher

- CMS proposed a parity adjustment of 5%
- CMS paused parity adjustment due to commenter concern about data adequacy and continued PHE impacts
- Noted would be revisited in FY 2023

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Market Basket Higher Than Normal but Proposed Parity Offsets

Market Basket Term	Figure
Unadjusted Market Basket	2.8%
Forecast Error	1.5%
Total Productivity Factor*	(0.4%)
Adjusted Market Basket Before Proposed Parity Adjustment	**3.9%**
Proposed Parity Adjustment	4.6%
Possible Final Market Basket Update	**(0.7%)**

**Bureau of Labor Statistics (BLS) moved to "Total Productivity Adjustment Factor" from "Multifactor Productivity Adjustment" – change in name, only*

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Request For Information: Establishing Mandatory Minimum Staffing Levels

CMS is Seeking Input on…

- Which individuals should be considered direct care staff
- 17 specific questions as well as invite other aspects of staffing related considerations
- Comments from NH residents/caretakers, nursing staff, CNAs, physicians, NH admins, owners/operators, & researchers

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Suggestions for Your Comments

Proposed Outline for Your Comments

- Describe yourself and your operation
- Explain your commitment to quality
- Discuss how difficult the past two years were
- Explain the impact of a 4.6% reduction on your residents
- Discuss your workforce challenges

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Describe Yourself & Your Operation

- What you do and how long you have been in this line of work
- Why you work in long term care
- Location of your building
- Describe your building
  - Number of units
  - Profile of your residents
- Discuss how you and your team feel about your residents

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Explain Your Commitment to Quality

- If you are 3-Star or better let them know that
- Discuss any AHCA Quality Award or other award you have received
- Discuss any particular quality efforts underway
- Explain what your residents mean to you and your team

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Discuss How Difficult the Past Two Years Were

- Tell them about the sacrifices you and your team have made
- Give a specific example of a team member who has worked tirelessly
- Discuss the tragedy of the losses you have seen

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Explain Impact of 4.6% reduction

- Explain that a phased in reduction would be better
- Discuss how the pandemic is not over in our buildings
- Explain your loss in census and increased labor costs
- If you are worried about closing, let them know
  - Discuss the impact on your residents

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Discuss Your Workforce Challenges

- Let them know how many open positions you have
- Discuss your inability to fill shifts
- Discuss your use of agency staff and related costs
- Let them know how hard it is to recruit new hires
- Tell them that a staffing mandate will not create workers – the workers are not out there

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Comment Deadline is June 10

- Send through **Voter Voice**
  https://www.votervoice.net/AHCA/Campaigns/93978/Respond

- Or submit to Regulations.gov
  https://www.regulations.gov/document/CMS-2022-0069-0001
  - Subject: FY 2023 Skilled Nursing Facility (SNFs) Prospective Payment System Rate Update and Quality Reporting Requirements (CMS-1765)
  - Please send copy to ACHA at ahcaadvocacy@ahca.org

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Post your questions in the chat

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SHOC Resource Request Form	**Requesting Agency Contact Information**

Date:	Time:	Event:
Mission Priority: ☐ FLASH (immediate) ☐ High (<6 hr.) ☐ Medium (<12 hrs.) ☐ Low (24+ hrs.)		
Requestor's Name:		Title:
Requestor's Organization:		
Phone #:	Mobile #:	Fax #:
Email Address:		
Requested Resource(s):		
Normal supply chain exhausted: ☐ Yes ☐ No		Partner assistance available: ☐ Yes ☐ No
Description of Requested Assistance/Resources Required (*must include 1)what capability cannot be met and 2)additional resources that are required to meet the capability)*		

Quantity:	Detailed Resource Requested (include resource Type/Kind): *Provide details such as setup/transport, fuel, meals, operator(s), water, maintenance, lodging, power, etc:*	
	1)	
	2)	
	3)	

Delivery Site POC (*Point of Contact*):	Title:
Delivery Address *(include facility name, street, city, state and zip*):	

POC 24 hour Phone #:	POC Mobile #:	POC Fax #:
POC Email Address:		
Request sent to SHOC Operations: (by whom, date & time)		

Received in SHOC Operations: *(by whom, date & time)*	**SHOC Operations Assigned To:** ☐ Logistics ☐ Planning ☐ Finance and Admin ☐ Healthcare Services Branch ☐ Other *(define other)*
Received by:	Date and Time:
Augmenting Justification/Comments:	

Ability to fill request:				
☐ In entirety	☐ Partially	☐ Pending	☐ Redirected	☐ Other
Comments (*why partial pending, redirected or other*)				

Send to SHOC Operations for action	
Received by:	Date and Time:
SHOC Operations Chief Recommendation:	
SHOC Operations Chief Signature:	

SHOC Command Actions:	
SHOC Command Approval: ☐ Fill the request in entirety ☐ Partially fill request ☐ Request Denied ☐ Other	SHOC Command Signature:
SHOC Command Comments:	

Approved Request sent to:

☐ Logistics ☐ Planning ☐ Finance and Admin

☐ Healthcare Services Branch ☐ Other

Task Completed: *(signature, date & time)*

☐ Copy of form to Operations

☐ Copy of form to Finance and Admin

SHOC COVID Testing Resource Request Form **Request Number:**

Return Form to:

HCSB ACTION		
Received By:	Date:	Time:
☐ Filled request in entirety ☐ Partially filled ☐ Request denied ☐ Other:		
Justification:		
Signature:		
SHOC ACTION		
Received By:	Date:	Time:
☐ Attestation Form on file ☐ Conservation Letter on File	Previous Requests:	
Approved Request sent to: ☐ Logistics ☐ Planning ☐ Finance and Admin ☐ Other:		
Task Completed: *(signature, date & time)*		
☐ Copy of form to Operations	☐ Copy of form to Finance and Admin	

Click to Submit Form

COMMUNITY

OF WELLNESS FAIR

MAY 14 12 NOON – 3:00 PM

VENDORS

Mental Health Professionals, Local Businesses, Social Services, Churches, Elected Officials, Free Food (while supplies last).

ARTS & CRAFTS

There will be an Arts & Crafts Table as well as a Face Painter for the event.

MUSIC & ENTERTAINMENT

There will be a live DJ, Moon Bounces for the kids, A Gaming Truck and a Basketball Skills Challenge.

COME OUT FOR AN AMAZING FUN FILLED DAY AT 201 NEW STREET MIDDLETOWN DE

LOUIS L REDDING MIDDLE SCHOOL
201 NEW STREET
MIDDLETOWN, DE 19709

Appoquinimink School District
THE WORLD IS OUR CAMPUS

This a shine only event. If it rains, the event will be canceled! A district-wide message will be sent.

Understanding Relapse in the Recovery Process

Panelists:

Philip Thompson, LCSW
Manager Behavioral Health & Clinical Operations Liaison
Wilmington Psychiatric Services-Outpatient Practices

Charmaine Bishop, LCSW, CADC

Rev. Tyrone Johnson, Sr., Founding Director
Churches Take A Corner

Friday, May 13, 2022
6:30 – 8:30 P.M.
Virtual via Zoom

Register Here

https://www.eventbrite.com/e/understanding-relapse-in-the-recovery-process-tickets-292821375617

Event Sponsored by
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Alpha Alpha Mu Omega Chapter- Georgetown, DE
Mary C. Lomax, President

Weekly Emerging Infectious Diseases (EID) and Preparedness Report

Contents

Contact: Jamie Ahlers, DPH Infectious Disease Epidemiologist • (302) 744-4990 • Jamie.Ahlers@delaware.gov

Purpose

The purpose of this report is to inform medical providers and the Delaware medical & public health community about infectious disease outbreaks, as well as other health updates that are of concern, both nationally and globally.

Overview & Updates

Brief overview of content covered in report.

COVID-19

- According to the weekly ensemble forecast from the COVID-19 Forecast Hub, COVID-related hospitalizations and deaths in the U.S. are expected to increase over the next month. For the week ending 16 May, 1,300 to 6,300 hospital admissions secondary to COVID-19 are predicted. For the week ending 28 May, 1,600 to 4,600 new deaths are predicted.

Other EID & Preparedness Updates

- DPH announced May Is Viral Hepatitis Awareness Month; May 19 Hepatitis Testing Day
- Colorado and U.S. CDC confirm the first human detection of avian influenza A(H5) in the U.S.
- According to media quoting the WHO, as of 05 May, a third confirmed EVD case was reported in Mbandaka City in a 48-year-old male who was a high-risk contact of the first fatal case. Cumulatively, 3 confirmed cases (2 deaths) have been reported during this outbreak; 444 contacts of the confirmed cases have been identified, with health monitoring underway.

Contact: Jamie Ahlers, DPH Infectious Disease Epidemiologist • (302) 744-4990 • Jamie.Ahlers@delaware.gov

National Biosurveillance Integration Center (NBIC) Monitoring List

Part of Homeland Security Information Network (HSIN).

Reference: National Biosurveillance Integration Center (NBIC), 2022. Monitoring List 10 March 2022. Confidential Resource.

Highlight indicates change in status, addition to monitoring list, or removal from monitoring list.

COVID-19 – North America: UNDETERMINED

Many areas of the U.S. report decreasing cases, hospitalizations, and deaths. Several SARS-CoV-2 Omicron variant sublineages with potentially increased transmissibility and/or vaccine and antibody evasion capabilities are now prominent in the U.S., Canada, and Mexico. Younger adults account for higher percentages of cases and hospitalizations. Vaccinations began on 14 December 2020 in the U.S. **As of 04 May at 0600 ET, 729.6 million doses have been distributed and 577.3 million doses administered (79% utilization); 66.2% of the total U.S. population has been fully vaccinated, with 77.7% receiving at least one dose. In total, 76.1% of the U.S. adult population has been fully vaccinated, with 89.1% receiving at least one dose. As of 04 May at 1316 ET, the U.S. Centers for Disease Control and Prevention (CDC) reported 81,319,274 (+61,712) confirmed and presumptive positive cases, including 993,341 (+325) deaths, in all 50 U.S. states and the District of Columbia (DC), the U.S. Virgin Islands, Guam, Northern Mariana Islands, and Puerto Rico. As of 05 May at 1837 CEST, the World Health Organization (WHO) reported that Canada had 3,761,261 confirmed and probable cases and Mexico had 5,739,680 confirmed cases.**

Recent Developments:

- **According to the weekly ensemble forecast from the COVID-19 Forecast Hub, COVID-related hospitalizations and deaths in the U.S. are expected to increase over the next month. For the week ending 16 May, 1,300 to 6,300 hospital admissions secondary to COVID-19 are predicted. For the week ending 28 May, 1,600 to 4,600 new deaths are predicted.**
- **The director of the Office of Infectious diseases in the U.S. FDA's Center for Drug Evaluation and Research said that there is no evidence at this time to suggest that a repeat course of antiviral treatment for COVID-19 is warranted if symptoms return following completion of a first course. The FDA will continue to review data and will release new information when available.**
- **The Baker-Polito Administration of Massachusetts initiated a free telehealth program to increase access to treatments like Paxlovid for adults who test positive for COVID-19 and have mild to moderate symptoms. Through the program, Massachusetts residents can schedule a virtual consult with a healthcare provider who prescribes appropriate COVID-19 treatment, if indicated.**
- **A study using data from Mass General Brigham's COVID-19 Data Mart Enclave showed that after correcting for confounding factors such as public health strategy implementation and vaccination status, the Omicron variant appears to have morbidity and mortality rates just as high as earlier COVID-19 variants.**

COVID-19 – Global: IMPROVING

Contact: Jamie Ahlers, DPH Infectious Disease Epidemiologist • (302) 744-4990 • Jamie.Ahlers@delaware.gov

The World Health Organization (WHO) urges all countries to isolate, test, and treat every suspected case of COVID-19 in addition to tracing all contacts. **As of 05 May at 1837 CEST, the WHO reported 513,384,685 confirmed cases, including 6,246,828 deaths, worldwide.** Global cases of COVID-19 reported during the week of 25 April – 01 May decreased by 17% while deaths decreased by 3% compared to the previous week. The WHO Region of the Americas and the African Region reported an increase in new cases, while all other regions reported a decrease compared to the previous week. The WHO South-East Asia Region reported an increase in new deaths, while all other regions reported a decrease compared to the previous week. The increase in deaths reported in the South-East Asia Region is due to delayed reporting from India. The WHO highlighted that these trends should be interpreted with caution as several countries are progressively changing their COVID-19 testing strategies. Many countries continue to struggle with vaccine access, the spread of variants, and overburdened healthcare systems.

Recent Developments:

- **The WHO released new estimates showing that the total death toll associated directly or indirectly with the COVID-19 pandemic between January 2020 and December 2021 was approximately 14.9 million. Excess mortality includes deaths associated with COVID-19 due to the disease itself or due to the pandemic's impact on health systems and society. According to the report, 84% of excess deaths were concentrated in the WHO South-East Asia, European, and American regions.**
- **According to final results from the WHO's Solidarity randomized trial, COVID-19 patients already on ventilators do not benefit from remdesivir, but the antiviral treatment does offer a slight reduction in death or progression to ventilation among other hospitalized patients. The published findings were from an ongoing study of four antiviral medicines repurposed for treatment of COVID-19 in hospitalized patients.**
- **A published study monitoring wastewater in Israel showed that the Delta variant is still circulating, and researchers suggested that another wave of the variant is possible. After monitoring Omicron and Delta variant patterns, the researchers hypothesized that Omicron and its subvariants may disappear, and the Delta variant, which has proven resilient, could re-emerge. Researchers found that even when the Omicron variant was at its highest levels in wastewater, the Delta variant was still circulating.**
- **Novavax filed for the authorization of its COVID-19 vaccine among children ages 12 years and older in Britain. The two-dose vaccine, Nuvaxovid, is approved for use in adults in Britain. The vaccine showed 80% efficacy among adolescents in a late-stage trial when the Delta variant was dominant.**

Highly Pathogenic Avian Influenza H5N1 – North America: WORSENING

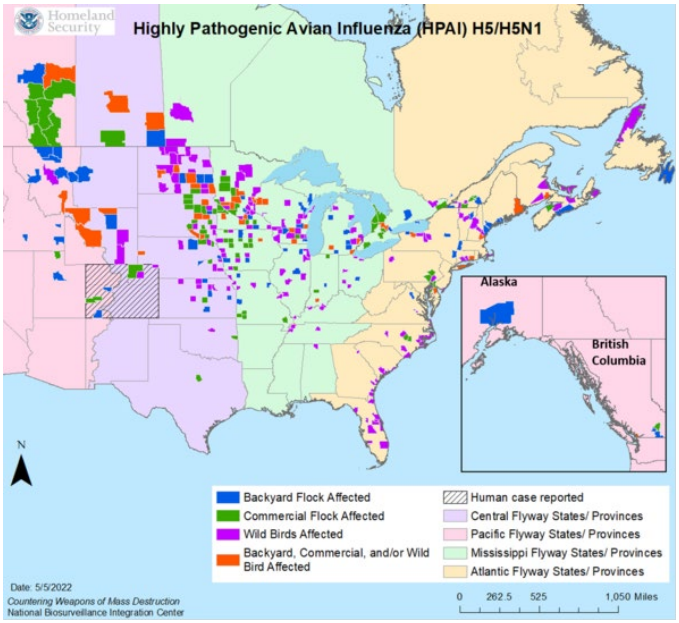
Added to NBIC Monitoring List 01/19/2022

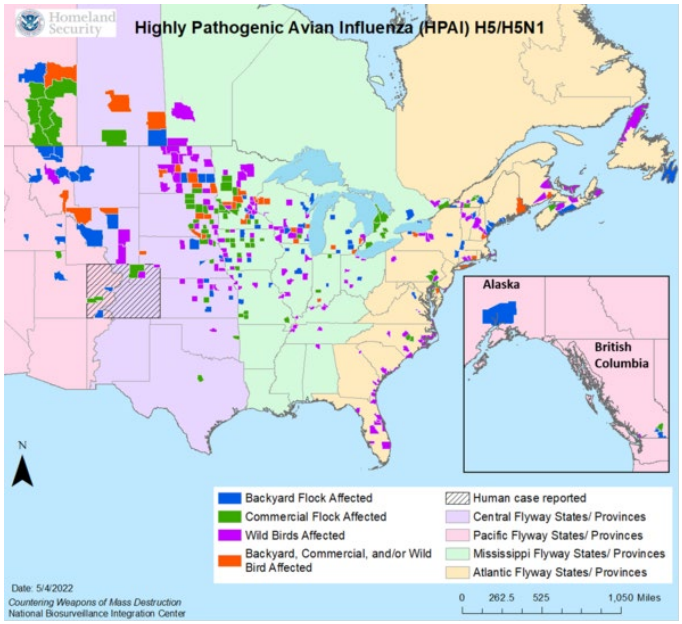
On 13 January 2022, the United States Department of Agriculture (USDA) Animal and Plant Health Inspection Service (APHIS) confirmed highly pathogenic avian influenza (HPAI) A H5 in a wild bird in South Carolina, marking the first detection of HPAI H5 in a wild bird in the U.S. since 2016. On 09 February, the first commercial poultry farm HPAI H5N1 outbreak was identified at a turkey farm in Dubois County, Indiana. On 11 February, USDA APHIS announced that wild bird surveillance for avian influenza would be expanded to include the Mississippi and Central Flyways. Prior to detection in the U.S., the City of St. John's in Newfoundland and Labrador, Canada, confirmed HPAI in a wild great black-backed gull on 04 November 2021. On 22 December 2021, Canada reported HPAI H5N1 at two poultry farms on the Avalon Peninsula of Newfoundland and Labrador. See Table 1 for additional information on HPAI H5/H5N1 in wild and domestic birds in North America, as reported by USDA APHIS, the World Organization for Animal Health (OIE) World Animal Health Information System (WAHIS), and other reporting authorities. In the case of wild birds, a confirmed

detection refers to an individual bird that tested positive for HPAI, while a suspected detection refers to untested birds found ill or deceased nearby the positive bird. In the case of commercial poultry and other flocks, each event is counted by outbreak, which refers to a flock of birds in which one or more tested positive for HPAI.

Why We Are Reporting on This Event

Novel and emerging avian influenza viruses remain a global priority due to their potential economic impact, effects on animal health, and the zoonotic risk for human populations. The UK and Europe reported HPAI H5N1 spreading among wild and domestic birds since October 2021. The 2014-2015 HPAI outbreak in the U.S. was a major national animal health emergency with significant economic impact. Recent detections of HPAI in Canada and the U.S. could potentially signal another resurgence of HPAI in the Americas. The risk of human infection from HPAI H5N1 is low, and no human infections with Eurasian H5 viruses have been reported in the U.S. No human infections are associated with this outbreak. The current situation is evaluated as worsening because of the increased number of detections in wild birds as well as the geographic distribution. While the source(s) of HPAI in the isolated poultry farms is unconfirmed, it is likely single introductions from wild birds to individual farms.





Location	# Confirmed Wild Bird Detections (# Suspected)	# Confirmed Commercial Detections	# Confirmed Backyard Detections
United States	**998 (7,572)**	**171**	**112**
Alabama	1	--	--
Alaska	--	--	1
Colorado	16	2	2
Connecticut	32	--	1
Delaware	9 (8)	3	--
Florida	75 (1,023)	--	--
Georgia	11 (3)	--	--
Idaho	--	--	4
Illinois	19 (382)	--	3
Indiana	1 (1)	9	1
Iowa	42 (89)	15	4
Kansas	21 (4,520)	1	5
Kentucky	14	2	--
Maine	10 (2)	--	12
Maryland	1	4	--
Massachusetts	13 (5)	--	1
Michigan	38 (26)	--	11
Minnesota	45 (54)	57	12
Missouri	33 (765)	6	3
Montana	3	--	8
Nebraska	10 (4)	4	4
New Hampshire	57 (47)	--	1
New Jersey	21	--	--
New York	21 (145)	1	7

Location	# Confirmed Wild Bird Detections (# Suspected)	# Confirmed Commercial Detections	# Confirmed Backyard Detections
North Carolina	144 (18)	9	--
North Dakota	167 (154)	4	10
Ohio	34 (38)	--	1
Oklahoma	1	1	--
Pennsylvania	11 (2)	9	--
South Carolina	28 (2)	--	--
South Dakota	53 (267)	36	3
Tennessee	8	--	--
Texas	--	1	--
Utah	--	1	1
Vermont	5	--	1
Virginia	4	--	1
Wisconsin	37 (14)	6	10
Wyoming	13	--	5
Canada	**98 (1)**	**49**	**23**
Alberta	--	19	4
British Columbia	1	1	4
Manitoba	2 (1)	1	--
New Brunswick	12	--	1
Newfoundland and Labrador	16	--	1
Nova Scotia	46	3	1
Ontario	4	17	6
Prince Edward Island	13	--	--
Quebec	3	4	3
Saskatchewan	1	4	3

Table: HPAI H5/H5N1 in wild and domestic birds in the U.S. and Canada from November 2021 through present, as reported by USDA APHIS and OIE WAHIS.

Contact: Jamie Ahlers, DPH Infectious Disease Epidemiologist • (302) 744-4990 • Jamie.Ahlers@delaware.gov

Recent Developments:

- **USDA APHIS confirmed HPAI in four backyard flocks in Bremer County, Iowa; Carver County, Minnesota; Day County, South Dakota; and Hamlin County, South Dakota. Additionally, through 29 April, USDA APHIS and USGS WHISPers confirmed 998 wild detections of HPAI from 34 states, of which 676 have been confirmed as H5N1.**
- **On 04 May, the Canadian Wildlife Health Cooperative reported the confirmation on H5N1 in two fox kits in Perth County, Ontario. One of the kits was found deceased and the second exhibited severe neurological signs and died shortly after being sent to a wildlife rehabilitation center.**
- **The Canadian Food Inspection Agency confirmed the detection of HPAI H5N1 in five backyard flocks in the City of Kelowna, British Columbia; the City of Richmond, British Columbia; Regional Municipality of Halton, Ontario; Wellington County, Ontario; and La Rivière-du-Nord, Quebec. Additionally, the agency confirmed HPAI H5N1 in a commercial farm in the Regional Municipality of York, Ontario.**

African Swine Fever – Dominican Republic and Haiti: UNDETERMINED

Added to NBIC Monitoring List 07/29/2021

On 28 July 2021, African swine fever (ASF) was confirmed in two locations in the Dominican Republic. As of 16 February 2022, the Dominican Republic had reported 224 outbreak sites throughout the country to the World Organisation for Animal Health (OIE). These are the first recorded cases for the Dominican Republic and the first cases of ASF in the Western Hemisphere in 40 years. On 18 September 2021, Haiti reported to the OIE that ASF had been detected in pigs from a backyard farm near the border with the Dominican Republic. As of 18 April 2022, 31 ASF outbreak sites had been identified in Haiti.

The risk of introduction to the U.S. via trade is considered negligible given safeguards already in place. The U.S. currently prohibits pigs and pork product imports from the Dominican Republic and Haiti due to the presence of classical swine fever (CSF). The primary risk to the U.S. is transmission through informal routes, such as airline passengers carrying undeclared animal products. U.S. Customs and Border Protection agricultural inspectors are working closely with U.S. Department of Agriculture's (USDA) Animal and Plant Health Inspection Service (APHIS) to address risks and prevent ASF from entering the U.S. Efforts include but are not limited to monitoring ports of entry for cargo and passengers, conducting bulk surveillance and outreach, using trained canine units, and raising awareness with non-commercial jets and small sea vessels traveling in affected areas. In addition, USDA APHIS has issued a Federal Order authorizing the movement of certain swine products from Puerto Rico and the U.S. Virgin Islands to the mainland U.S. under specified conditions. The USDA and other agencies have worked with the U.S. pork industry for years on prevention and mitigation efforts for ASF.

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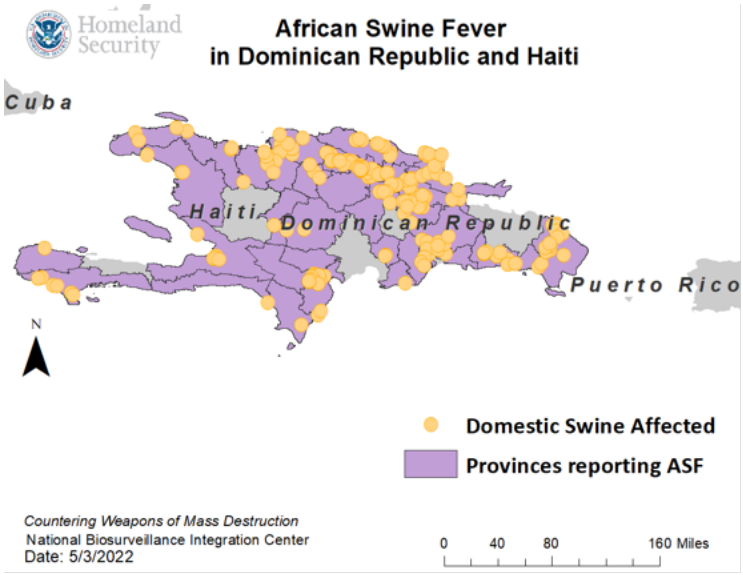

Figure 4: Geographic distribution of confirmed ASF cases in the Dominican Republic and Haiti.

Recent Developments:

- The S. National Pork Board is investing in vaccine research studies and recommends U.S. pork producers create an AgView account to assist in contact tracing in the event of an ASF outbreak in the U.S.
- USDA's Agriculture Research Service announced that a vaccine candidate for ASF passed an important step necessary for regulatory approval. The safety study results show that the vaccine candidate does not relapse to its original virulence after being injected into swine.
- Haiti reported 37 new cases of ASF to the OIE. The majority of these cases occurred in the Nord-Ouest Department, and three cases occurred in the L'Artibonite Department.

Acute Hepatitis of Unknown Origin- U.S., Europe, Middle East: UNDETERMINED

Added to NBIC Monitoring List 4/20/22

Since October 2021, children in Alabama have been diagnosed with hepatic injury (i.e., liver injury)/hepatitis (i.e., liver inflammation/disease) following symptoms of gastrointestinal illness with no predisposing health conditions. In the U.S., cases have since been reported in Alabama, California, Delaware, Georgia, Illinois, Louisiana, Minnesota, New York, North Carolina, **Ohio**, South Dakota, Tennessee, Texas, and Wisconsin. As of 27 April 2022, the Wisconsin Department of Health Services was investigating one fatality. Internationally, cases have been reported in the United Kingdom, Austria, Belgium, Canada, Cyprus, Denmark, France, Greece, Indonesia, Ireland, Israel, Italy, Japan, the Netherlands, Norway, **Portugal**, Romania, Singapore, and Spain. Medical treatment was typically required in these cases, while a few children needed liver transplants. The first international death associated with the disease was disclosed in a recent World Health Organization (WHO) report.

Adenovirus and SARS-CoV-2 have been identified in some cases, although the role of these viruses in the observed illness, if any, was unclear. At least 74 cases tested positive for adenovirus; of those with available data, 18 were adenovirus type 41. Because adenovirus type 41 is not known to cause severe disease in otherwise healthy children, other factors are being

investigated, including lower levels of adenovirus circulation during the COVID-19 pandemic, adenovirus and SARS-CoV-2 co-infection, and the possibility of a new adenovirus. Genomic sequencing is underway to identify any changes in the adenovirus genome that could cause increased disease severity. A World Health Organization (WHO) report published on 15 April noted that for 10 of 74 identified cases in the United Kingdom, hepatitis viruses A, B, C, E, and D were excluded through laboratory testing. According to the United Kingdom Health Security Agency and WHO, there is no association between the disease and the COVID-19 vaccine.

Why We Are Reporting on This Event

There has been an increase in acute hepatitis cases of unknown origin among children in the U.S. and Europe. Hepatitis sometimes occurs in children following viral infections, with non-infectious causes also possible. The reported cases are geographically dispersed, with most reporting no known history of contact. At this time, there is no clear indication that the events share a common cause or origin; however further investigation is warranted

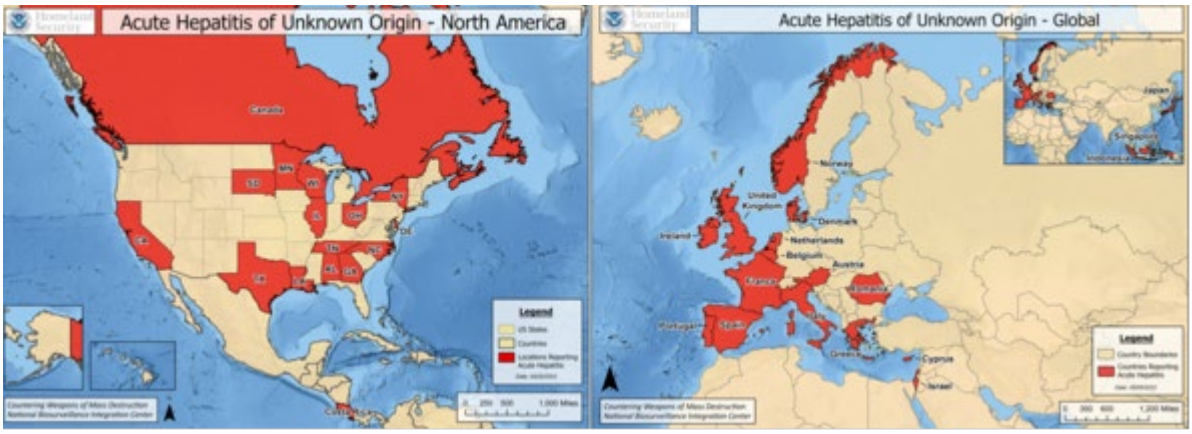

Figure 5: U.S. states and European and Middle Eastern countries reporting acute hepatitis cases of unknown origin in children.

Recent Developments:

- **Media reported that doctors at a Cincinnati Children's hospital in Ohio have treated at least six suspected cases of severe hepatitis of unknown origin. The children, ages 18 months to 10 years, were previously healthy; one required a liver transplant.**
- **Costa Rica's Ministry of Health reported an investigation into a suspected case of severe acute hepatitis of unknown origin in a child who has already been released from the hospital.**
- **Citing the Indonesian Health Ministry, local media reported additional suspected cases of acute hepatitis of unknown origin in children. The cases are still under investigation, with sequencing under way to rule out hepatitis viruses A through E.**
- **For the first time, media reported suspected hepatitis of unknown origin in Portugal. Four children ages 7 months to 8 years showed symptoms and were hospitalized in April. None of the children were reported in serious condition, and all have recovered. One of the patients reportedly tested positive for adenovirus.**
- **Media reported the first suspected case of severe acute hepatitis in Latin America in a child in Argentina.**

Ebola Virus Disease- Democratic Republic of the Congo: UNDETERMINED

Added to NBIC Monitoring List 4/25/22

On 23 April 2022, the World Health Organization (WHO) reported a resurgence Ebola virus disease (EVD) in the Democratic Republic of the Congo (DRC) following the confirmation of one case in Mbandaka City in northwestern Équateur Province. The DRC's Ministry of Health disclosed that a 31-year-old male patient experienced symptom onset on 05 April and sought treatment after more than a week of home care. On 21 April, the patient was admitted to an Ebola treatment center for intensive care but died later that day. According to the WHO, full genome sequencing results indicated that this outbreak represents a new spillover event from an animal population. The WHO noted that the source of the initial exposure is unknown, and understanding the extent of the outbreak requires further assessment.

The WHO reported that a second fatal case was identified as a 25-year-old woman who was a relative of the initial case. **A third confirmed case was reported on 05 May in Mbandaka in a 48-year-old male who was a high-risk contact of the first confirmed fatal case.** WHO experts are supporting national authorities in response efforts, including testing, contact tracing, and treatment. As of 01 May, provincial health officials reported that three vaccination sites were operational in Mbandaka, with 253 individuals vaccinated, including 50 high-risk contacts and 203 contacts of contacts.

Why We Are Reporting on This Event

EVD has a case fatality rate of 25% to 90% in the unvaccinated and is listed by the WHO as a top ten priority disease posing the greatest public health risk due to epidemic potential. This outbreak marks the third in the province since 2018 and the 14th outbreak the DRC has experienced since 1976. The current outbreak is the sixth since 2018, the most frequent occurrence in the country's history. Previous outbreaks in Équateur Province were in 2020 and 2018, with 130 and 54 recorded cases, respectively. It is not unusual for sporadic cases to occur following a major outbreak; however, there is currently insufficient information to conclude whether the new cases in Équateur are related to any previous outbreaks.

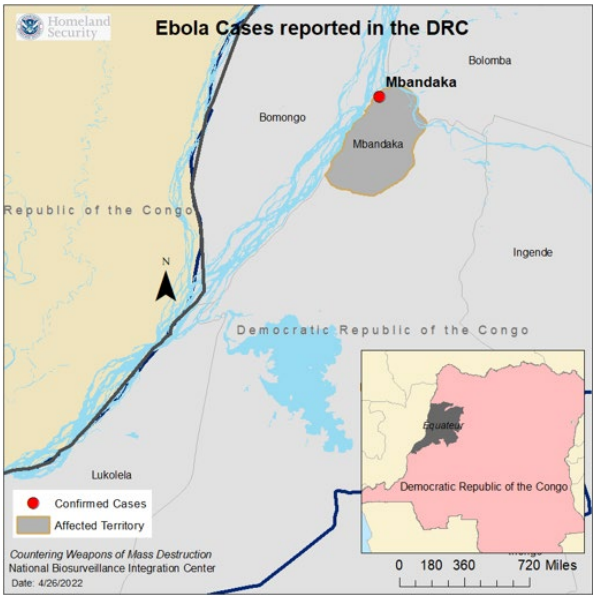

Figure 6: Geographic distribution of confirmed EVD cases in Mbandaka City, Équateur Province, DRC.

Recent Developments:

- **According to media quoting the WHO, as of 05 May, a third confirmed EVD case was reported in Mbandaka City in a 48-year-old male who was a high-risk contact of the first fatal case. Cumulatively, 3 confirmed cases (2 deaths) have been reported during this outbreak; 444 contacts of the confirmed cases have been identified, with health monitoring underway.**

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Additional (Re)Emerging Infectious Diseases of Interest

This section includes both current/present and recent/historical information.

Spotlight: Acute Hepatitis of Unknown Origin

- Since October 2021, a number of children in Alabama have been diagnosed with hepatic injury (i.e., liver injury)/hepatitis (i.e., liver inflammation/disease) following reported symptoms of gastrointestinal illness with no predisposing health conditions. In the U.S., cases have been reported in Alabama (9), Illinois (3), and North Carolina (2). As of 21 April 2022, at least 169 cases have been reported in the U.S., Europe, and the Middle East.
    - "**CDC is requesting notification from clinicians or state public health authorities** of children <10 years of age with elevated aspartate aminotransferase (AST) or alanine aminotransferase (ALT) (>500 U/L) who have an unknown etiology for their hepatitis (with or without any adenovirus testing results, independent of the results) since October 1, 2021."
      CDC recommendations:
        - Clinicians should consider adenovirus testing in pediatric patients with hepatitis of unknown etiology. NAAT (e.g. PCR) is preferable and may be done on respiratory specimens, stool or rectal swabs, or blood.
        - Anecdotal reports suggest that testing whole blood by PCR may be more sensitive than testing plasma by PCR; therefore, testing of whole blood could be considered in those without an etiology who tested negative for adenovirus in plasma samples

Delaware

- DPH announced May Is Viral Hepatitis Awareness Month; May 19 Hepatitis Testing Day
    - The Centers For Disease Control and Prevention (CDC) suggests everyone should get tested for viral hepatitis at least once in their lives. Some of the risk factors for contracting viral hepatitis include but are not limited to:
        - Individuals born between 1945 and 1965
        - IV drug users
        - Unstable housing
        - Travel to an area with endemic hepatitis A virus without being immunized
        - Unprotected sex with multiple partners
        - Job that exposes you to human blood

Regional

National

- On 4/28 CDC announced U.S. Case of Human Avian Influenza A(H5) Virus Reported

Global

- There is an outbreak of cholera in Cameroon's Centre, Littoral, South, Southwest, and North regions.

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- The World Health Organization (WHO) has been developing weekly updates on the current situation in Ukraine and refugee-receiving countries, priority public health concerns and WHO's actions to rapidly respond to the health emergency triggered by the conflict and to minimize disruptions to the delivery of critical health services. The latest report published on May 5th can be found here.

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COVID-19 Travel Recommendations by Destination

https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html
Last accessed 05/06/2022 9:00AM

Level 4: Special Circumstances/Do Not Travel

"Do not travel to these destinations. If you must travel to these destinations, make sure you are up to date with your COVID-19 vaccines before your trip

Level 3: COVID-19 High

"Make sure you are up to date with your COVID-19 vaccines before traveling to these destinations. If you are not up to date with your COVID-19 vaccines, avoid travel to these destinations.

- Albania
- Andorra
- Anguilla
- Argentina
- Aruba
- Australia
- Austria
- Bahrain
- Barbados
- Belarus
- Belgium
- Bermuda
- Bhutan
- Bonaire
- Bosnia and Herzegovina
- Brazil
- Brunei
- Bulgaria
- Canada
- Cayman Islands
- Central African Republic
- Chile
- Costa Rica
- Croatia
- Cuba
- Curaçao
- Cyprus
- Czech Republic
- Denmark
- Dominica
- Easter Island
- Ecuador
- Estonia
- Fiji
- Finland
- France
- French Polynesia
- Georgia
- Germany
- Gibraltar
- Greece
- Grenada
- Guadeloupe
- Guatemala
- Guernsey
- Honduras
- Hong Kong SAR
- Hungary
- Iceland
- Ireland
- Isle of Man
- Israel
- Italy
- Japan
- Jersey (U.K.)
- Jordan
- Kosovo
- Kuwait
- Laos
- Latvia
- Lebanon
- Liechtenstein
- Lithuania
- Luxembourg
- Malaysia
- Maldives
- Malta
- Martinique
- Mauritius
- Moldova
- Monaco
- Mongolia
- Montenegro
- Netherlands, The
- New Zealand
- North Macedonia
- Norway
- Panama
- Papua New Guinea
- Poland
- Portugal
- Qatar
- Réunion
- Romania
- Russia
- Saba
- Saint Barthelemy
- Saint Lucia
- Saint Martin
- Saint Pierre and Miquelon
- San Marino
- Serbia
- Seychelles
- Singapore
- Sint Eustatius
- Sint Maarten
- Slovakia
- Slovenia
- Somalia
- South Korea
- South Sudan
- Spain
- Suriname

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- Sweden
- Switzerland
- Thailand
- Trinidad and Tobago
- Tunisia
- Turkey
- United Kingdom
- Uruguay
- Vietnam

Level 2: COVID-19 Moderate

"Make sure you are up to date with your COVID-19 vaccines before traveling to these destinations."

- Antigua and Barbuda
- Belize
- Bolivia
- British Virgin Islands
- El Salvador
- Eswatini
- Iran
- Iraq
- Mexico
- Oman
- Peru
- South Africa
- Sri Lanka
- Taiwan
- Turks and Caicos Islands (U.K.)
- United Arab Emirates
- Zambia
- Zimbabwe

Level 1: COVID-19 Low

"Make sure you are up to date with your COVID-19 vaccines before traveling to these destinations."

- Angola
- Armenia
- Azerbaijan
- Bahamas, The
- Bangladesh
- Benin
- Botswana
- Burma (Myanmar)
- Cameroon
- Cape Verde
- Chad
- China
- Colombia
- Comoros
- Congo, Republic of the
- Cote d'Ivoire (Ivory Coast)
- Democratic Republic of the Congo
- Djibouti
- Dominican Republic
- Equatorial Guinea
- Ethiopia
- Gabon
- Ghana
- Guinea-Bissau
- Guyana
- Haiti
- India
- Indonesia
- Jamaica
- Kenya
- Kyrgyzstan
- Lesotho
- Liberia
- Libya
- Malawi
- Mali
- Mauritania
- Montserrat
- Morocco
- Mozambique
- Namibia
- Nepal
- Niger
- Nigeria
- Pakistan
- Philippines
- Rwanda
- Saint Kitts and Nevis
- Saint Vincent and the Grenadines
- São Tomé and Príncipe
- Saudi Arabia
- Senegal
- Sierra Leone
- Timor-Leste (East Timor)
- Togo
- Uganda

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Travel Health Notices (non-COVID)

https://wwwnc.cdc.gov/travel/notices
Last accessed 05/06/2022, 9:00AM

Warning Level 3, Avoid Nonessential Travel

- 09/30/2021: Health Infrastructure Breakdown in Venezuela

Alert Level 2, Practice Enhanced Precautions

- 03/21/2022: Polio in Asia and Eastern Europe
- 03/21/2022: Polio in Africa
- 12/14/2021: Yellow Fever in Ghana
- 09/30/2021: Yellow Fever in Nigeria

Watch Level 1, Practice Usual Precautions

- 05/03/2022: Cholera in Cameroon (NEW)
- 03/17/2022: Measles in Afghanistan
- 03/15/2022: Lassa Fever in Nigeria
- 03/04/2022: Measles in Africa
- 02/23/2022: Dengue in Asia and the Pacific Islands
- 12/30/2021: Dengue in the Americas
- 11/30/2021: Monkeypox in Nigeria
- 09/30/2021: Rabies in Haiti
- 09/30/2021: Leishmaniasis in Chad
- 09/30/2021: Dengue in Africa and the Middle East
- 09/30/2021: Monkeypox in the Democratic Republic of the Congo
- 09/30/2021: XDR Typhoid Fever in Pakistan
- 09/30/2021: Malaria in Burundi

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Resources

General

CDC Current Outbreaks: https://www.cdc.gov/outbreaks/index.html
CDC Health Alert Network (HAN): https://emergency.cdc.gov/han/index.asp
CDC Morbidity and Mortality Weekly Report (MMWR): https://www.cdc.gov/mmwr/index.html
CDC News Releases: https://www.cdc.gov/media/releases/2021/archives.html
Delaware Health Alert Network: https://www.dhss.delaware.gov/dhss/dph/php/alerts.html
Johns Hopkins Center for Health Security: https://www.centerforhealthsecurity.org/
My Healthy Community: https://myhealthycommunity.dhss.delaware.gov/locations/state
World Health Organization (WHO) Disease Outbreak News (DON): https://www.who.int/emergencies/disease-outbreak-news

COVID-19

CDC: https://www.cdc.gov/coronavirus/2019-ncov/index.html
CDC – COVID-19 Travel Recommendations by Destination: https://www.cdc.gov/coronavirus/2019-ncov/travelers/map-and-travel-notices.html
CDC – COVID vaccine: https://www.cdc.gov/vaccines/covid-19/index.html
CDC – Cruise Ship Color Status: https://www.cdc.gov/coronavirus/2019-ncov/travelers/crew-disembarkations-commercial-travel.html
CDC – Guidance for COVID-19 Prevention in K-12 Schools: https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-guidance.html
CDC – Interim Public Health Recommendations for Fully Vaccinated People: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html
CDC – Travel: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
CDC Variants: https://www.cdc.gov/coronavirus/2019-ncov/variants/variant-info.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fvariant-surveillance%2Fvariant-info.html
COVID Act Now: https://covidactnow.org/?s=2071991
Delaware: https://coronavirus.delaware.gov/
Delaware – COVID vaccine: https://coronavirus.delaware.gov/vaccine/
WHO Variants: https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/

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