The Public Health Emergency Has Ended

Breaking Down the Guidance for Acute and Continuing Care Facilities

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1973-2023 50 years Quality Insights

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- Expiration for this enduring material is 06/28/2026

Objectives

At the conclusion of this webinar the attendee will be able to:

- Identify the changes that all providers across all healthcare environments must make with the ending of the public health emergency.
- Explain the policies and procedures that community mental health centers must implement at the end of the public health emergency.
- Describe the changes that ESRD facilities must adopt at the end of the public health emergency.
- State the many changes that hospital must make regarding patient rights, medical records, medical staff credentialing, discharge planning, and telemedicine services at the end of the public health emergency.

Ambulatory Surgical Centers and Licensed Independent Freestanding Emergency Departments (IFEDs)

- During PHE: Could enroll as hospitals and provide hospital services. CMS waived the requirement that medical staff privileges must be periodically reappraised, and the scope of procedures performed in the ASC must be periodically reviewed.
- After PHE: ASCs must decide either to meet the certification standards for hospitals or return to ASC status. IFEDs can no longer bill Medicare for services. Medical staff privileges must be periodically reappraised, and the scope of procedures performed in the ASC must be periodically reviewed.

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

3 Years and 100 Days Later…

As Covid Emergency Ends, U.S. Response Shifts to Peacetime Mode

The coronavirus public health emergency, declared by the Trump administration in 2020, will expire on Thursday. Interviews with senior health officials suggest the nation is not ready for a new pandemic.

Give this article 269

Stolberg, Sheryl Gay and Weiland, Noah. “As Covid Emergency Ends, US Response Shifts to Peacetime Mode.” New York Times. May 10, 2023.

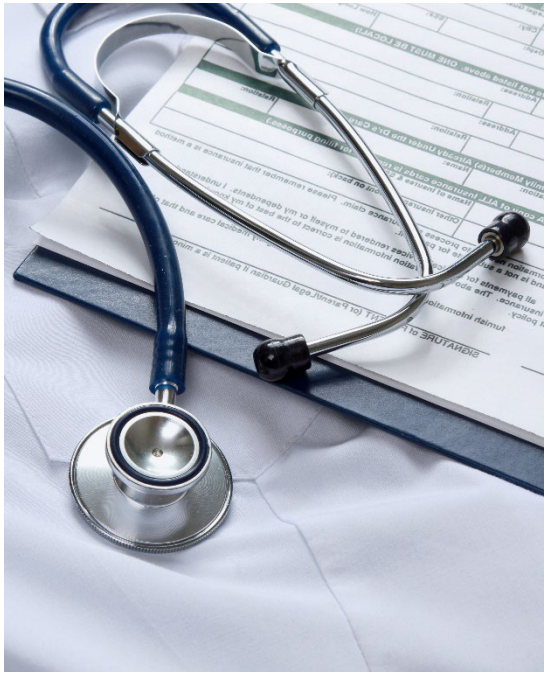
Public Health Emergency

- On January 31, 2020 the Secretary of the Department of Health and Human Services (HHS), Alex Azar, declared the 2019 Novel Coronavirus (2019-nCoV) outbreak a public health emergency.
- The Secretary of the Department of Health and Human Services (HHS) may, under section 319 of the Public Health Service (PHS) Act, determine that: a) a disease or disorder presents a public health emergency (PHE); or b) that a public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists.

https://aspr.hhs.gov/legal/PHE/Pages/Public-Health-Emergency-Declaration.aspx

Waivers and Regulations

- Some changes during the PHE involved more regulations (vaccine mandate)
- Most of the changes made as a result of the PHE resulted in a “relaxation” or temporary suspension of regulations required by CMS
- These waivers allowed providers and facilities to focus on issues surrounding the pandemic



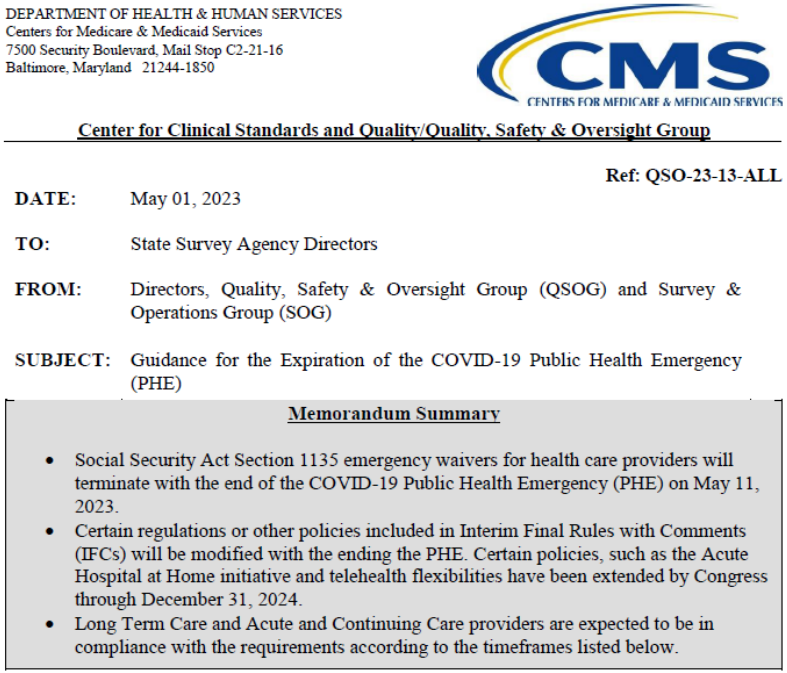
U.S. Federal Emergency Declarations in Response to COVID-19*

Declaration	Conditions of Authorization	COVID-19 Response Timeline	Primary Effect during COVID-19
Public health emergency declaration	Declared by the HHS secretary when a public health emergency exists as a result of "a disease or disorder," "significant outbreaks of infectious diseases," or "bioterrorist attacks" (42 U.S. Code § 247d)	Initially declared on January 31, 2020; renewed in 90-day increments, most recently on January 14, 2022; likely to be renewed again because the Biden administration announced at least 60 days' notice to governors before final expiration	HHS has waived certain regulatory and reporting requirements applicable to health care providers, private insurers, and state Medicaid and CHIP programs while the declaration is in effect.
Emergency use authorization declaration	Declared by the HHS secretary when there is a public health emergency (or significant potential for one) that affects national security or the health and security of U.S. citizens living abroad and that involves a biologic, chemical, radiologic, or nuclear agent (21 U.S. Code § 360bbb–3)	Initially declared on April 1, 2020; effective until the HHS secretary determines circumstances justifying emergency authorization have ceased	Medical countermeasures may be authorized by the FDA, sold, and administered without full approval under the declaration. On termination, products that have not received full FDA approval must be discarded.
Public Readiness and Emergency Preparedness Act declaration	Declared by the HHS secretary when a disease, other health condition, or other threat to health poses a credible risk of a public health emergency (42 U.S. Code § 247d–6d)	Initially declared on March 17, 2020; valid until October 1, 2024, unless rescinded	A federal liability shield and compensation program is in effect for injuries and deaths resulting from the manufacture, distribution, administration, or use of medical countermeasures covered by the declaration.
National emergency declaration	Declared by the president when determining there is a national emergency (50 U.S. Code § 1621)	Initially declared on March 18, 2020; renewed annually, most recently on February 23, 2022	Various federal agencies have waived certain regulatory requirements for the health care industry and other sectors.
Stafford Act emergency and disaster declarations	Declared by the president when state and local resources are insufficient to protect lives and property; additional federal support is authorized when the threat qualifies as a major disaster (42 U.S. Code § 5121–5207)	Series of state-specific declarations issued in March and April 2020	FEMA has provided financial support for governmental and private institutional response efforts.

*CHIP denotes Children's Health Insurance Program, FDA Food and Drug Administration, FEMA Federal Emergency Management Agency, and HHS health and human services.

Horwitz JR, Wiley LF. Not Ready for the End Game - Why Ending Federal Covid-19 Emergency Declarations Will Harm Access to Care. N Engl J Med. 2022 Apr 21;386(16):e40. doi: 10.1056/NEJMp2203468. Epub 2022 Apr 6. PMID: 35385629.

The PHE Ended May 11, 2023



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-23-13-ALL

DATE: May 01, 2023

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: Guidance for the Expiration of the COVID-19 Public Health Emergency (PHE)

Memorandum Summary

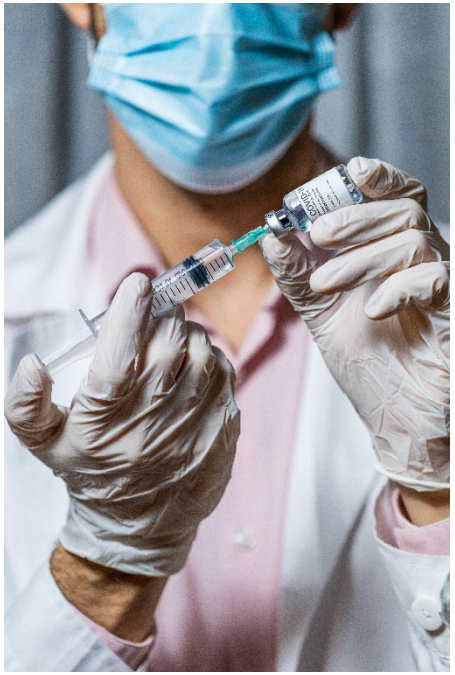
- Social Security Act Section 1135 emergency waivers for health care providers will terminate with the end of the COVID-19 Public Health Emergency (PHE) on May 11, 2023.
- Certain regulations or other policies included in Interim Final Rules with Comments (IFCs) will be modified with the ending the PHE. Certain policies, such as the Acute Hospital at Home initiative and telehealth flexibilities have been extended by Congress through December 31, 2024.
- Long Term Care and Acute and Continuing Care providers are expected to be in compliance with the requirements according to the timeframes listed below.

https://www.cms.gov/files/document/qso-23-13-all.pdf

Guidance for All Providers and Environments (1/2)

Vaccination requirements:

- On November 5, 2021, CMS issued an interim final rule requiring Medicare and Medicaid-certified providers and suppliers to ensure that their staff were fully vaccinated for COVID-19.
- CMS will “soon end this requirement”, but more details to come…(will “share more details regarding ending this requirement at the anticipated end of the public health emergency.”)



Guidance for All Providers and Environments (2/2)

Emergency Preparedness Training and Testing: during or after an actual emergency (PHE), the EP regulations allow for a one-year exemption from the requirement that the provider/supplier perform testing exercises.

- Inpatient providers and suppliers: must conduct a full-scale exercise within its annual cycle for 2023 and an exercise of choice
- Outpatient providers: must conduct either a full-scale exercise or an exercise of choice within its annual cycle for 2023, if scheduled to conduct the full-scale exercise within 2023. The provider/supplier must conduct the exercise of choice, if scheduled during the annual cycle for 2023 and resume the full-scale exercise requirement in 2024.

Testing Exercises

- Full-Scale Exercise (FSE): A full scale exercise is an operations-based exercise that typically involves multiple agencies, jurisdictions, and disciplines performing functional (for example, joint field office, emergency operation centers, etc.) and integration of operational elements involved in the response to a disaster event, i.e. "boots on the ground" response activities (for example, hospital staff treating mock patients).
- Exercise of Choice: Mock Disaster Drill, Table-top Exercise, Workshop

Ref: QSO-20-41-ALL-Revised, https://www.cms.gov/files/document/qso-20-41-all-revised-05262022.pdf

Community Mental Health Centers

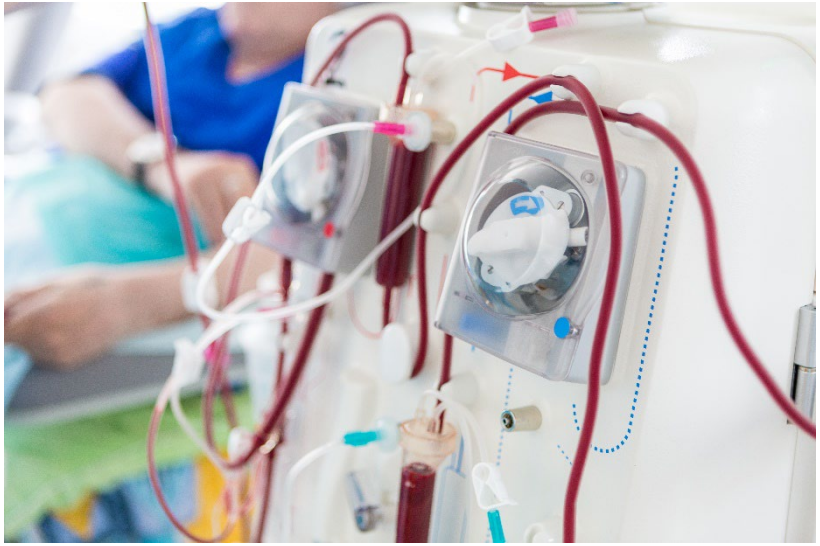
- During PHE: Modified QAPI allowed, can provide partial hospitalization services and other CMHC services in an individual's home, 40% rule waived.
- After PHE: Full QAPI process required, NO partial hospitalization services provided in an individual's home, CMHC must provide at least 40% of its items and services to individuals who are not eligible for Medicare benefits

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-J/section-485.917
https://www.federalregister.gov/d/2011-14673/p-159

ESRD Facilities

Training Programs and Audits/ Emergency Preparedness

- During PHE: CMS waived the requirements for on-time periodic audits for operators of the water/dialysate equipment and that patient care staff maintains current CPR certification
- After PHE: Facilities are required to demonstrate on-time periodic audits for operators of the water/dialysate equipment and that patient care staff maintains current CPR certification



https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-494/subpart-B/section-494.40#p-494.40(a)
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-494/subpart-B/section-494.62#p-494.62(d)(1)(iv)

Patient Assessments

- During PHE: CMS allowed some delay in conducting patient assessments
- After PHE:
  - An initial comprehensive assessment must be conducted on all new patients (that is, all admissions to a dialysis facility), within the latter of 30 calendar days or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session
  - A follow up comprehensive reassessment must occur within three months after the completion of the initial assessment to provide information to adjust the patient's plan of care

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-494/subpart-C/section-494.80#p-494.80(b)

Care Planning and Monthly Physician Visits

- During PHE: CMS modified requirements related to care planning and physician visits
- After PHE:
  - The dialysis facility is required to implement the initial plan of care within the latter of 30 calendar days after admission to the dialysis facility or 13 outpatient hemodialysis sessions beginning with the first outpatient dialysis session. It is also required for monthly or annual updates of the plan of care within 15 days of the completion of the additional patient assessments.
  - The dialysis facility is required to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-494/subpart-C/section-494.90#p-494.90(b)

Home Visits

- During PHE: Home visits not required
- After PHE: Home visits to assess adaptation and home dialysis machine designation is required to periodically monitor the patient's home adaptation, by facility personnel.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-494/subpart-C/section-494.100#p-494.100(c)(1)(i)

Dialysis Patient Care Technician (PCT) Certification

- During PHE: Certification requirement modified
- After PHE: Dialysis PCTs are required to obtain certification under a state certification program or a national commercially available certification program within 18 months of being hired as a dialysis PCT for newly employed patient care technicians.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-494/subpart-D/section-494.140#p-494.140(e)(4)

Transferability of Physician Credentialing

- During PHE: CMS waived the requirement that required credentialing at each facility.
- After PHE: All medical staff appointments and credentialing must be in accordance with state law, including attending physicians, physician assistants, nurse practitioners, and clinical nurse specialists at EACH facility.

https://www.govinfo.gov/content/pkg/CFR-2008-title42-vol4/pdf/CFR-2008-title42-vol4-sec494-180.pdf

Special Purpose Dialysis Facilities/Furnishing Dialysis Services on the Main Premises

- During PHE: SPRDFs could be established without requiring normal determination regarding lack of access to care, dialysis facilities could provide services to its patients in nursing homes, long-term care facilities, assisted living facilities, and similar types of facilities.
- After PHE: SPRDFs can only be established with determination regarding lack of access to care and dialysis facilities can only provide services on the main premises. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-494/subpart-C/section-494.120#p-494.120(b)

Hospitals

Acute Hospital Care at Home

- During PHE: CMS established the acute hospital care at home initiative by waiving this Medicare Hospital Conditions of Participation, suspending the requirement for nursing services to be provided on premises 24 hours a day, 7 days a week, and for the immediate availability of a registered nurse for care of any patient.
- After PHE: Section 4141 of the Consolidated Appropriations Act,2023 included an extension of the waivers and flexibilities associated with the Acute Hospital at Home initiative to allow it to continue through December 31, 2024. Explicit criteria and data collection requirements were established as part of this extension.

Anesthesia Services

- During PHE: CMS waived requirements that a certified registered nurse anesthetist (CRNA) is under the supervision of a physician.
- After PHE: CRNAs must be under the supervision of a physician unless certain procedures are followed as approved by CMS (if the state in which the facility is located submits a letter to CMS signed by the Governor, following consultation with the State's Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs).

Emergency Medical Treatment & Labor Act

- During PHE: CMS allowed hospitals, psychiatric hospitals, and critical access hospitals (CAHs) to screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19, as long as it was consistent with a state's emergency preparedness or pandemic plan.
- After PHE: EMTALA enforced (section 1867(a) of the Act)

https://www.ssa.gov/OP_Home/ssact/title18/1867.htm

Verbal Orders

- During PHE: Read-back verification is required for verbal orders but authentication may occur later than 48 hours.
- After PHE: Read-back verification of verbal orders is required and authentication is required within 48 hours.

Reporting

- During PHE: Reporting of deaths associated with soft wrist restraints waived.
- After PHE: Hospitals are required to report patients in an intensive care unit whose death is caused by their disease, but who required soft wrist restraints to prevent pulling tubes/IVs, no later than the close of business on the next business day.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482#p-482.13(g)

Patient Rights

- During PHE: CMS waived requirements for hospitals that are considered to be impacted by a widespread outbreak of COVID-19 in a state that has widespread confirmed cases (i.e., 51 or more confirmed cases).
- After PHE: Hospitals must meet these requirements:
  - The patient has the right to access their medical records, including current medical records, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such medical records are maintained electronically); or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, and within a reasonable time frame.
  - A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation.
  - After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.

42 CFR § 482.13 https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R37SOMA.pdf

Discharge Planning

- During PHE: CMS waived the requirement of detailed discharge planning.
- After PHE: The hospital must have an effective discharge planning process that focuses on the patient's goals and treatment preferences and includes the patient and his or her caregivers/support person(s) as active partners in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to preventable hospital readmissions.

42 CFR §482.43 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.43

Medical Staff Credentialing

- During PHE: CMS waived regulations requiring periodic appraisals of medical staff.
- After PHE: The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital. The medical staff must periodically conduct appraisals of its members. The medical staff must examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment of these candidates in accordance with State law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations.

42 CFR §482.22 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.22

Medical Records/Advance Directives

- During PHE:CMS waived medical record requirements as well as requirements to provide advance directive policies to patients.
- After PHE: Medical record service requirements in full effect, hospitals must provide patients with information regarding their policies on advance directives (Patient Self-Determination Act).

Sterile Compounding Areas

During PHE: CMS waived requirements to allow used face masks to be removed and retained in the compounding area to be re-donned and reused during the same work shift in the compounding area only.

After PHE: Used face masks may not be reused in the compounding area.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.25#p-482.25(b)(1)
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F/section-485.635#p-485.635(a)(3)

Physical Environment

- During PHE: CMS waived certain physical environment requirements such as allowing for hospitals to utilize space that was not routinely used for patient care to be used for patient care or quarantine.
- After PHE: All of the requirement waivers regarding physical environments in hospitals have ended with the conclusion of the PHE.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.41
https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-485/subpart-F/section-485.623

Telemedicine

- During PHE: CMS waived the requirements for written agreements between those hospitals and CAHs using telemedicine services and the distant-site hospitals or distant-site telemedicine entities furnishing the services.
- After PHE: The waiver of the above requirements has ended, however, the Consolidated Appropriations Act (CAA), 2023, provides for an extension for some of these telehealth flexibilities for professional services under the Physician Fee Schedule as well as services furnished by rural health clinics and federally qualified health centers through December 31, 2024.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482#p-482.12(a)
https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency

Physician Services

- During PHE: CMS waived requirements for Medicare patients to be under the care of a physician.

- After PHE: Medicare patients must be under the care of a physician.

Utilization Review

- During PHE: CMS waived the entire utilization review condition of participation which requires that a hospital must have a UR plan with a UR committee that provides for a review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided.
- After PHE: The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs (as specified: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.30).

Emergency Preparedness Policies/QAPI

- During PHE: CMS waived requirements for the hospital and CAH to develop and implement emergency preparedness policies and procedures and waived requirements which provide details on the incorporation and setting of priorities for the program's performance improvement activities and integrated QAPI programs.
- After PHE: Emergency Preparedness Policies and Procedures, performance improvement activities, and QAPI programs are required per CMS regulations.

Nursing Services

- During PHE: CME waived requirements for nursing care plans and for hospitals to have policies outlining nursing staffing in outpatient departments.
- After PHE: Nurses are required to develop and keep a current care plan on each patient, hospitals must have policies and procedures in place establishing which outpatient departments, if any, are not required under hospital policy to have a registered nurse present.

Food and Dietetic Services

- During PHE: CMS waived requirements for therapeutic diet manuals.
- After PHE: Providers are required to have a current therapeutic diet manual approved by the dietitian and medical staff readily available to all medical, nursing, and food service personnel.

https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-C/section-482.28#p-482.28(b)(3)

Respiratory Services

- During PHE: CMS waived the requirement for hospitals to designate the personnel who are qualified to carry out certain respiratory services.
- After PHE: Hospitals must specify personnel qualified to perform specific respiratory procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing.

42 CFR §482.57(b)(1) https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-D/section-482.57

Hospitals Able to Provide Care in Temporary Expansion Sites

- During PHE: As part of the CMS Hospital Without Walls initiative during the PHE, hospitals could provide hospital services in other hospitals and sites that otherwise would not have been considered part of a healthcare facility, or could set up temporary expansion sites to help address the urgent need to increase capacity to care for patients. Surge sites were also allowed.
- After PHE: Hospitals are no longer allowed to provide services at temporary expansion sites.

Hospitals to Provide Swing Beds

- During PHE: CMS allowed hospitals to establish SNF swing beds payable under the SNF prospective payment system (PPS) to provide additional options for hospitals with patients who no longer required acute care but were unable to find placement in a SNF.
- After PHE: Hospitals must meet requirements at 42 CFR 482.58 if they would like to provide long-term care services to patients (https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-482/subpart-D/section-482.58).

Inpatient Psychiatric Unit Patients/ Inpatient Rehab Patients

- During PHE: CMS waived requirements and allowed Inpatient Psychiatric Unit Patients and Inpatient Rehabilitation Unit Patients to be cared for in acute care beds and units.
- After PHE: Hospitals cannot care for Inpatient Psychiatric Unit Patients and Inpatient Rehabilitation Unit Patients in acute care beds and units.

Critical Access Hospitals

After the PHE, CAHs must:

- Follow federal personnel requirements for clinical nurse specialists, nurse practitioners, and physician assistants
- Have staff who are licensed, certified, or registered in accordance with applicable Federal, State, and local laws and regulations.
- Be located in a rural area
- Limit number of beds to 25 and length of stay to 96 hours
- Have a doctor of medicine or osteopathy be physically present to provide medical direction, consultation, and supervision for the services provided in the CAH
- Not operate in temporary expansion sites
- Comply with EMTALA

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)

After the PHE, ICFs must:

- Allow clients to have the opportunity to participate in social, religious, and community group activities
- Provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently

42 CFR §483.430(e)(1) https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-I/section-483.430

Rural Health Clinics/Federally Qualified Health Clinics (RHCs/FQHCs)

After the PHE, RHCs/FQHCs must:

- Have a nurse practitioner, physician assistant, or certified nurse-midwife be available to furnish patient care services at least 50% of the time the RHC and FQHC operates
- Not operate at temporary expansion locations

Compliance Timelines Beyond May 12

July 11, 2023

- Hospices and HHAs are required to have a registered nurse, or in the case of an HHA a registered nurse or other appropriate skilled professional (physical therapist/occupational therapist, speech language pathologist), make an annual onsite supervisory visit (direct observation) for each aide that provides services on behalf of the agency.
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) are required to ensure that each client receives a continuous active treatment program, which includes consistent implementation of a program of specialized and generic training, treatment, health services and related services.

September 30, 2023

A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.

42 CFR §418.100(g)(3) https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-418/subpart-D/section-418.100

December 31, 2023

- Home health agencies and hospices must assure that each aide receives 12 hours of in-service training in a 12-month period.
- Hospices must use volunteers (at least 5% of total patient care hours of all paid hospice employees).
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) must provide sufficient Direct Support Staff (DSS) so that Direct Care Staff (DCS) are not required to perform support services that Interfere with direct client care.
- RHCs/FQHCs are required to ensure that physicians provide medical direction for the clinics or centers health care activities and consultation for, and medical supervision of, the health care staff, only with respect to medical supervision of nurse practitioners.

Acute and Continuing Care Reporting

- Beginning at the conclusion of the COVID–19 PHE and continuing until April 30, 2024 (unless the Secretary determines an earlier end date) hospitals and CAHs are required to report data for COVID-19 and seasonal influenza in a standardized format and frequency as specified by the Secretary.
- ICFs/IID are encouraged to report COVID-19 vaccine and therapeutics treatment information to the CDC's NHSN.

Resources

- CMS: https://www.cms.gov/files/document/qso-23-13-all.pdf
- CMS FAQs: https://www.cms.gov/files/document/frequently-asked-questions-cms-waivers-flexibilities-and-end-covid-19-public-health-emergency.pdf
- HHS: https://www.hhs.gov/about/news/2023/05/09/fact-sheet-end-of-the-covid-19-public-health-emergency.html#:~:text=Based%20on%20current%20COVID%2D19,day%20on%20May%2011%2C%202023
- CDC: https://www.cdc.gov/coronavirus/2019-ncov/your-health/end-of-phe.html
- White House: https://www.whitehouse.gov/briefing-room/statements-releases/2023/05/09/fact-sheet-actions-taken-by-the-biden-harris-administration-to-ensure-continued-covid-19-protections-and-surge-preparedness-after-public-health-emergency-transition/

Evaluation and Post-Knowledge Check

- **Evaluation: https://tinyurl.com/endofpheaacc**

QR Code
Activate the camera on your smart phone and scan this QR code to link to the **evaluation**

Thank You!

50 years 1973-2023 Quality Insights

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iQUALITY IMPROVEMENT & INNOVATION GROUP

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