ODDS COVID-19 Policy Guide
ODDS responses to stakeholder Feedback 3/28/22

ODDS appreciates those who took the time and opportunity to review this proposal. We value your input in making our program better.
Comments that are similar may have been aggregated; others paraphrased. ODDS has made every effort to address all concepts noted in the comments. Grammar and formatting errors that were noted in comments are not addressed but are appreciated.

Comment: A lot of flipping back and forth through it to find what relates to our organization. It would be helpful if it was organized per type of facility type.
Response: ODDS acknowledges this is a lot of information meant for a variety of people and entities to use. The guide is grouped by service setting and some sections are broken down further by service type (such as the employment section). The table of contents is hyperlinked to make it easier to jump to the section needed within the guide.

Comment: The difference between "Face-to-Face contact" and "In-person contact" is a little bit confusing.
Response: Revised definitions to emphasize that face-to-face could be physically in-person or through telehealth but in-person could only be physically in-person, not through telehealth.

Comment: "2.3 Screening: When a CME employee, licensor, or other provider who does not live in the individual's home has an in-person visit, they must screen themselves for COVID-19 symptoms as outlined by their LPHA before conducting the visit."
Does this only pertain to in-home visits, or all in-person contacts outside the home as well (such as job coaching in the community)? And for all types of providers?
Response: The screening section of this guide was removed as a formal screening is no longer needed. It is recommended that all providers use professional judgement to determine if they or others are ill and should postpone or reschedule an in-person meeting.

Comment: 2.8 COVID-19 vaccinations: It does not include the current information about vaccine mandate for 24 hr. and foster home staff
Response: Revised guide to state requirements for 24-hour and AFH staff. Also added to the guide a link to the ODDS vaccination grid for other provider types to confirm their vaccination requirements.

Comment: Would ODDS consider allowing DSA site-based services to require participants to be vaccinated?
Response: At this time ODDS will not mandate vaccines for individuals. Individuals are encouraged to weigh the pros and cons of the vaccine to choose if it is right for them. Providers may not require vaccination for participation in services but may support individuals in making their own informed and independent decisions about the COVID-19 vaccine.

Comment: 2. Masks and Other Personal Protective Equipment 2.1 Masks *Please add PAs to the list of titled staff.
Response: Personal Agents and Service Coordinators added to the list, removed the term "case managers" from this section.

Comment: If mask requirements have been lifted for indoor and outdoor, mask wearing then why is it still a requirement to be wearing a mask in group settings like DSA and Employment?

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Response: The guide has been revised to remove the requirement for masks in an outdoor setting. At this time ODDS is maintaining the indoor mask requirements to ensure the health and safety of all individuals and staff who participate in congregate settings indoors. ODDS will continue to review the data on COVID-19 and will make updates as needed.

Comment: "Providers with a medical or religious exception that follows OHA guidelines are not required to wear a mask." Are there medical or religious exceptions for masks?
Response: Thank you for pointing this out as there are no current religious exemptions for masks. There is an exception under ADA if there is a medical reason a provider cannot wear a mask. Removed religious exception from this section as it only pertains to vaccinations. Added wording around medical exceptions. If the provider does not fall into the other categories for a mask exception, they should work with their employer to find the best type of mask for their needs.

Comment: When reviewing the ODDS Covid-19 Policy Guide it would be beneficial if it was clearer on page 7 where it states "Masks are required for Employment and DSA Services delivered in a group setting. If an accommodation is needed, it is a 1:1 individualized service.
Does that mean that individuals who are working 1:1 with their staff person (Direct Support Professional) do not need to wear a mask? I understand for group services, but if an individual attends a DSA 1:1, just the staff person is required is this correct? More clarification and information on this sentence would be helpful.
Response: If an individual cannot wear a mask, they can use 1:1 DSA as an accommodation so they do not have to wear a mask. If an individual does not need this type of accommodation, they must wear a mask but can still utilize 1:1 DSA services. Staff must continue to wear masks in this setting. Revised the guide for clarity. Also, of note this is for indoor DSA only. All outdoor DSA may occur without masks.

Comment: "What specific requirements and/or guidelines would you recommend eliminating potential harm or disparities related to service equity?" Guests that are unable to wear a mask or read a lot of facial cues that are unable with mask mandates.
Response: ODDS understands that some of the precautions needed at this time may create difficulty for some people. The guide has been revised for clarity in the masks section. It states, "If wearing a mask negatively impacts the individual being served due to behavior or other concerns, specific providers may not be required to wear a mask." If an individual meets this criterion, their provider may be able to go without a mask but must be supported to adhere to safety precautions as much as possible per the guide. If an individual does not meet this criterion, they, their family, or their provider may be able to request or purchase a mask with a clear window through means outlined in this guide. ODDS will continue to monitor data regarding COVID-19 and will continue to revise its guidance as it is safe to do so.

Comment: Section 2.1 Masks: The last paragraph states masks with holes or permeable space are not permitted, but it does not specifically define "mask" or call out face shields, which we know can be a problem. Suggest adding definition of "mask" or specifying use of face shields. – this is addressed in OSHA rule linked in Section 2.9 but should be stated up front.
Response: The guide has been revised to outline which masks are permitted for use and that ODDS strongly recommends the use of N95 or KN95 masks. Wording was added to the guide to clarify the use of face coverings with holes is not permitted and does not meet the mask requirement. Also added the use of face shields alone does not meet the masking requirement.

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Comment: In section 2.1 Masking Requirements we thought it might be beneficial to add under the second bullet point to read, "Direct support professionals and Agency Staff" rather than only DSP's.
Response: Updated guide to state "direct support professionals and agency staff".

Comment: 2.4 COVID-19 Testing: Providers and case managers must support individuals to understand and access COVID-19 testing in their local area. *Suggestion to remove case managers here and replace with CME staff
Response: Removed "Case managers" and added "CME staff".

Comment: CME staff and PSWs should refer to Local Public Health Authority (LPHA) for guidance for reporting presumed or positive cases of COVID-19 for provider staff,
*Is this about CME staff? Who are the "provider staff" referred to here? Is this about CMEs reporting on PSW cases? PSWs wouldn't be contacting public health for guidance directly (?)
Response: Revised guide for clarity per reword suggestion: "CMEs should refer to Local Public Health Authority (LPHA) for guidance on reporting presumed or positive cases of COVID-19 for their staff or reported cases for PSWs collaborating with individuals served by the CME."

Comment: Section 2.5 COVID-19 Reporting: According to this section text, it is required that providers report individuals with presumed or confirmed cases of COVID to ODDS but is only recommended that they report to the CME. In following the links provided in this section it appears providers and agencies are required to report to the CME, but it is not stated directly in the worker guide, which leaves a lot of room for misinterpretation. Additionally, it is only recommended that staff and agency outbreaks be reported to the CME. Reporting outbreaks should be mandatory as the individuals in the home are then directly affected through illness, rights restrictions, and quarantine times.
Response: The guide has been updated to state it is required to align with the scenario guide in the link. Providers must report presumed or positive cases of individuals to ODDS through the reporting tool. There is no longer a requirement to report presumed or positive cases of staff or others to ODDS through the reporting tool. Providers, families, and individuals must report presumed or positive cases for staff or agencies to the CME for the continuation and coordination of services if the individual is impacted by the staff's presumed or positive case.

Comment: Feed back to the draft guide is in reference to the link to the scenarios tool within the guide that directs providers to give written notification to individuals and staff regarding any potential exposures from staff or individuals. Can this requirement be removed?
Response: At this time ODDS will continue to require that notification of exposure be provided. This is to help everyone who may have been exposed to continue to plan and coordinate for the continuation of services for individuals should their services be impacted due to these exposures. ODDS will continue to monitor data and make changes to these policies as it is safe to do so.

Comment: This Covid reporting form could be VERY confusing (page 8). It would be incredibly difficult to understand if English was not your first language and if you did not have a pretty good sense of DD/ODDS language. The guide should be in alternate languages. It might be helpful to provide instructions so the person understands how the form will proceed and some definitions.
Response: The COVID-19 reporting tool is primarily for provider and CME use. ODDS understands that though staff in both areas require proficiency in English there may be occasion where it could be

beneficial for someone to review information in their first or preferred language. ODDS is reviewing this recommendation and will have further discussion around the possibility of providing this tool and guide in other languages and how that might be implemented. Additionally, the guide introduction and definition sections were reviewed and updated to clarify how this guide is laid out and to further define some terms used throughout the guide.

Comment: 5.5 Training Requirements *Training requirement for who? DSPs? PAs? Please clarify what is required and for what positions
Response: Added "24-hour res and AFH providers" to section heading for clarity. Training requirements for other provider types such as CMEs and PSWs are under their respective sections of the guide.

Comment: 6.3 Needs Assessments: This appears to conflict with current guidance – it is our understanding that you can no longer "extend" ONAs and that, with exits happening again, all ONAs need to take place either virtually or in-person.
Response: Removed information from the guide regarding ONA extensions. Added verbiage stating that all ONAs have resumed to the process prior to the pandemic.

Comment: 6.6 Planning and Service Authorizations Timelines: An ISP end date may be extended once for up to an additional year. An ISP that had an end date extended once in the previous year must be renewed. No ISP can be authorized for a period longer than two years. The extension and the reason for it must be documented in a progress note. *Please clarify the purpose of this and provide examples of when/how this would be used – exits are permitted apart from the 300% qualified individuals.
Response: Revised guide to clarify purpose and provide examples. Added; An ISP may only be extended due COVID-19 (for example if an individual is hospitalized due to COVID-19 or there is a staffing issue at the individual's CME due to a COVID-19 outbreak) and must be agreed upon by the individual.

Comment: Section 6.6, ISP authorizations can be extended up to a maximum of 2 years, which means someone could have their rights restricted for quite some time before it is (maybe) brought to the CME's attention.
Response: Revised guide to clarify purpose and provide examples of why an ISP may be extended. Added; An ISP may only be extended due COVID-19 (for example if an individual is hospitalized due to COVID-19 or there is a staffing issue at the individual's CME due to a COVID-19 outbreak) and must be agreed upon by the individual. CMEs must continue to monitor individuals and their ISPs. CME staff and individuals can also assess when an in-person meeting is needed per the guide and do not have to wait for an ISP renewal.

Comment: Could the allowable cohort sizes be raised to 12?
Response: COVID-19 has been a stressful time for many people and businesses alike. The goal of the department to continue to support entities to provide services while remaining safe and reducing the risk of contracting or spreading COVID-19. Current cohort size per the guide is 8 individuals. At this time there are no plans to increase this cohort size, but ODDS will continue to review data and make changes as cases continue to decline and it becomes safe to do so.

Comment: We would like to see more clarity that we don't need visitor logs any more.
Response: Added to the guide for clarity: Visitor logs are no longer required.

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Comment: The CME is listed as a LPHA in the definition (pg. 5), but it is also recommended the CME refer to the LPHA. (pg. 15).
Response: Reviewed for clarity. On page 5 the CME is stated as an example of a local entity that the LPHA is providing guidance to. Page 15 refers the CME to LPHA for additional guidance.

Comment: Can ODDS standardize these responses instead of advising providers to refer to the LPHA in multiple scenarios?
Response: ODDS refers to LPHA for guidance throughout this guide to stay aligned with OHA changes in guidance. The intent is to have adaptability as the guidance changes with the increase or decrease in cases of COVID-19.

Comment: It is very important that all essential visitors be named in some way as having access to the homes.
Response: Revised guide to clarify that only nonessential visitation may be paused and only when there is a confirmed outbreak per LPHA. Also clarified who is considered an essential visitor; abuse investigators, legal guardians, licensors, CME staff, residential facility ombudsman, and that these visitors must be allowed entrance to the home during a pause.

Comment: Concerns about providers making justifications to impose restrictions based upon their interpretation of county guideline or for their own convenience. Or using quarantine dates to keep others out of the house, cover up staffing shortages, and not take people out.
Response: Under the visitation section the guide states that providers may not prohibit a resident from leaving or reentering their home. Added a sentence to also clarify that providers must support individuals to access their community per the individual's choice and ISP goals. Guide was also revised to state essential visitors may not be prohibited from entry to the home at any time and that nonessential visitors may only be declined entry when there is a positive COVID outbreak per LPHA.

Comment: In section 5.4 Notice to Exit: a provider may not issue a notice of exit to an individual due to challenges the provider is facing or the provider's decision to change operational practices, including the following situations: Provider has limited staffing resources.
Response: Revised guide to clarify when an exit may not occur: Providers are now permitted to issue a Notice of Exit in accordance with current Oregon Administrative Rule (OAR). A provider shall not provide a notice of exit to an individual based on the individual contracting a communicable disease, such as the COVID-19 virus. Also, a provider may not issue a notice of exit to an individual due to the provider's decision to change operational practices, such as for a desire to self-quarantine. In the event of a medical or behavior situation that meets the administrative rule condition for an exit notice, the provider must make reasonable efforts to explore alternatives to safely support the individual and allow for the maximum amount of time possible for notification and identification of another living situation for the individual.

Comment: 2.6 Background Checks
"The agency or certified/licensed provider may determine if working unsupervised is appropriate on a case-by-case basis." What constitutes "appropriate"?
Response: This was removed from the guide. Background checks and renewal variances were tied to the state of emergency and have resumed their regular process.

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Comment: Section 2.9 OSHA COVID-19 Regulations
Recommend removing the words if and may from the paragraph. The OSHA rule linked is very specific to healthcare settings, including licensed/certified settings and providers/agencies are required to follow OSHA rules. It appears this guidance is relying heavily on providers/agencies to do their own "due diligence", instead of stating up front what the requirements are. This leaves A LOT of room for confusion and misinterpretation, especially when OSHA updates their rules, or the embedded links become broken.
Response: This guide is intended for all provider types across all service settings. Part of the OSHA requirements may not pertain to all providers across all settings (an example could be a provider who works with on individual in their home) therefore "if" and "may" are used to indicate this variation. ODDS is not affiliated with OSHA and is not able to maintain a guide of their rules and regulations. It is the providers responsibility to know what rules pertain to them and it is recommended that they reach out to OSHA directly if they have questions or need assistance in understanding these rules. ODDS will maintain the links within this guide to the best of its ability.

Comment: Section 6.1 Resuming in-Person Contact with Precautions
The guidance (last sentence starting on pg. 14) states "In addition to site and home visits, all children, and adults whose ISPs renew on or after December 1, 2021, must have at least one in-person case management contact within the plan year. There are no exceptions to this requirement." The following paragraph then states "…For additional support please see Appendix A of this worker guide for questions to ask to assess the need for an in-person visit." These two statements contradict themselves. Is an in-person visit require by the CME or not?
Response: The CME must conduct an in-person contact with everyone enrolled with the CME at least once within the individual's plan year. The in-person contact may occur at any time within an individual's plan year. This is flexible to adapt to any outbreaks that may occur. CME staff can use their professional judgement to weigh the need of the individual and the risk (if there is a current outbreak, for example). The appendix is for those who may want additional support to assess if an in-person contact is needed now or if it can be planned for later in the individual's plan year. The guide has been revised in this section to clarify the above information.

Comment: Page 34, Appendix A The questionnaire appears to provide a lot of leeway as to whether an in-person visit should be conducted or not. After 2 years of limited or no in-person interaction, in-person visits should be mandatory and no less than annually.
Response: Revised to add an introduction to outline that the appendix can be used to assess when within an individual's plan year an in-person contact can be planned. Emphasized that it is a requirement that at least one in-person contact happen within the individual's plan year.

Comment: Page 16/17, Section 6.5 Individually Based Limitations
The suspension of the IBL requirements has resulted in unacceptable rights violations against individuals during the pandemic. Peoples' rights need to be fully reinstated as quickly as possible.
We do not understand why these limitations are still allowable without formal, or even informal, processes. If a restriction is imposed for whatever reason, the reason needs to be documented and reviewed with the CME immediately. That way the CME and/or ODDS can assist in finding appropriate resources and track ongoing issues. As it's written, the providers/agencies can just decide this is how it is or how it's going to be, without taking steps to address barriers.
Response: Exceptions to the IBL process have been removed from the guide. The guide now states the IBL process is to resume as it did prior to the pandemic.

Comment: Page 20, Section 10 touches on this subject as Choice Advising. However, it leaves it up to the CME during meetings/service planning to engage in conversations around COVID-19 topics and concerns.
Response: Revised to add that choice advising may occur any time there is contact with the individual. Service coordinators and personal agents are required to conduct choice advising. Choice advising may occur multiple times throughout the individual's plan year and often occurs during meetings, monitoring, and other service planning contacts with the individual, their family, and ISP team. It is required that service coordinators and personal agents include conversations around COVID-19 information during choice advising so that individuals may make informed decisions about their services and care as it pertains to COVID-19.