

## COVID-19 Module

### Dialysis Outpatient Facility

\*required to save as complete

\*\*conditionally required

<b>Facility Operational Information</b> <i>For the following questions, please collect data for the current reporting week. The reporting week is defined as Wednesday through Tuesday with reporting to occur on Wednesday by 3 PM ET. You should report on the same day each week, either close of business on Tuesday or Wednesday by the deadline. We advise you not to alternate reporting days.</i>	
_____	*Facility ID (OrgID)
_____	*CMS Certification Number (CCN)
_____	*Facility Name
_____	*Week of Data Collection
_____	*In-center Patient Census
_____	*Date last modified
_____	*Home Patient Census
_____	*Total Certified Stations
_____	*Isolation Stations Included in Total Certified Stations
<input type="checkbox"/> Yes <input type="checkbox"/> No	*Is your facility a designated COVID unit?
<input type="checkbox"/> Yes <input type="checkbox"/> No	*Does your facility have designated COVID shifts?
_____	*Total number of staff (physician, nurses, techs, environmental services, biomed, etc.) who worked at least 1 day during the current reporting week
_____	How many patients on the current in-center census reside in nursing homes?
_____	How many patients on the current home census reside in nursing homes?

For the following questions, report data during the current reporting week which is Wednesday through Tuesday each week. For questions requiring counts, include only **new data which has occurred during the current reporting week**. Data should not be cumulative.

<b>SARS-CoV-2 Positive (+) Patients and Staff</b>	
_____	*Number of newly confirmed in-center patients during the current reporting week
_____	*Number of newly confirmed in-center patients that reside in nursing homes during the current reporting week
_____	*Number of newly confirmed patients during the current reporting week that are home patients

_____	* Number of newly confirmed staff during the current reporting week
_____	* Number of SARS-CoV-2 patients who are currently admitted to the hospital during the current reporting week
_____	* Number of confirmed patients currently self-monitoring and continuing in-center therapy during the current reporting week
_____	* Number of confirmed patients currently self-monitoring and continuing home therapy during the current reporting week

<b>Suspected SARS-CoV-2 Infection</b>	
_____	* Number of new suspect patient cases during the current reporting week
_____	* Number of new suspect staff cases during the current reporting week

<b>Testing for SARS-CoV-2 Infection</b>	
_____	* Number of patients who were tested for SARS-CoV-2 during the current reporting week
_____	* Of those patients who were tested for SARS-CoV-2, how many had a negative SARS-CoV-2 test result during the current reporting week
_____	* Of those patients who were tested for SARS-CoV-2, how many had a positive SARS-CoV-2 test result during the current reporting week
_____	* Of those patients who were tested for SARS-CoV-2, how many had an unknown SARS-CoV-2 test result during the current reporting week

<b>COVID-19 Vaccination Status:</b> <i>For the patients who tested positive during the current reporting week, provide counts for the following categories.</i>	
_____	* Number of patients who have tested positive this current reporting week and have <b>not</b> received a COVID-19 vaccine or it has been 13 days or less after dose one.
<b>Pfizer-BioNTech</b>	
_____	* Number of patients who have been vaccinated with dose one of the Pfizer-BioNTech COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving the vaccine : Dose 1 _____
_____	* Number of patients who have been vaccinated with dose one and dose two of the Pfizer-BioNTech COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving dose two. Dose 2 _____
<b>Moderna</b>	
_____	* Number of patients who have been vaccinated with dose 1 of the Moderna COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving the COVID-19 vaccine: Dose 1 _____
_____	* Number of patients who have been vaccinated with dose 1 and dose 2 of the Moderna COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving

_____	the COVID-19 vaccine: Dose 2 _____
<b>Janssen</b>	
_____	* Number of patients who have been vaccinated with Janssen COVID-19 vaccine <b>and</b> have tested positive 14 days or more after receiving the COVID-19 vaccine Dose 1 _____
<b>Unspecified</b>	
_____	* Number of patients who have been vaccinated with dose 1 of an Unspecified COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving the COVID-19 vaccine:
_____	* Number of patients who have been vaccinated with dose 1 and dose 2 an Unspecified COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving the COVID-19 vaccine.

**COVID-19 Vaccination Status - ADDITIONAL DOSES:** For the patients who tested positive during the current reporting week, provide counts for the following. **Any patient who has received an additional or booster dose and has tested positive should also be reported in the above COVID-19 Vaccination Status section.**

<b>Pfizer-BioNTech</b>	
_____	* Number of patients who have received an additional dose or booster dose of the <b>Pfizer-BioNTech</b> COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving the additional dose or booster dose: Additional dose or booster _____
<b>Moderna</b>	
_____	* Number of patients who have received an additional dose or booster dose of the <b>Moderna</b> COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving the additional dose or booster dose. Additional dose _____
<b>Janssen</b>	
_____	* Number of patients who have received an additional dose or booster dose of the <b>Janssen</b> COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving the additional dose or booster dose. Additional dose _____
<b>Unspecified</b>	
_____	* Number of patients who have received an additional dose or booster dose of an <b>Unspecified</b> COVID-19 vaccine <b>and</b> have tested positive for COVID-19 14 days or more after receiving the additional dose or booster dose. Additional dose _____

**SARS-CoV-2 Positives (+) that have recovered**

_____	*Number of patients recovered during the current reporting week
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	* Number of staff recovered during the current reporting week
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Suspected or Confirmed SARS-CoV-2 deaths	
	* Number of patients with suspected or confirmed SARS-CoV-2 infection that have died during the current reporting week
	* Number of staff with suspected or confirmed SARS-CoV-2 infection that have died during the current reporting week

For the following questions, please collect data and report findings during the current reporting week

Staff and/or Personnel Impact	
Will your facility have a critical shortage of staff and/or personnel within the next week?	
Staffing Shortage?	Staff and Personnel Groups
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Nursing Staff:</b> registered nurse, licensed practical nurse, vocational nurse
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Clinical Staff:</b> physician, physician assistant, advanced practice nurse
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Tech:</b> dialysis technician
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Other staff or facility personnel,</b> regardless of clinical responsibility or patient contact not included in the categories above (for example, environmental services, biomed)

Supplies & Personal Protective Equipment (PPE)		
Supply Item	Do you currently have any supply?	Do you have enough for one week if using conventional strategies?
N95 masks	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Surgical masks or medical facemasks	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye protection, including face shields or goggles	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Single-use Isolation Gowns	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gloves	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol-based hand sanitizer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Laboratory Testing	
<input type="checkbox"/> Yes	Does your facility have the ability to collect

<input type="checkbox"/> No	specimens onsite for SARS-CoV-2 testing?
<input type="checkbox"/> Viral (PCR) <input type="checkbox"/> Antigen <input type="checkbox"/> Antibody	** If yes, what types of specimens are being collected?
<input type="checkbox"/> NP swab <input type="checkbox"/> Anterior Nares swab <input type="checkbox"/> Mid Turbinate swab <input type="checkbox"/> OP swab <input type="checkbox"/> Saliva	** If yes to viral (PCR) tests, what types of specimens are being collected?
<input type="checkbox"/> Lack of recommended personal protective equipment (PPE) for personnel to wear during specimen collection <input type="checkbox"/> Lack of supplies for specimen collection <input type="checkbox"/> Lack of access to a laboratory for submitting specimens <input type="checkbox"/> Lack of access to trained personnel to perform testing <input type="checkbox"/> Uncertainty about testing reimbursement <input type="checkbox"/> Other: Specify _____	** If no, indicate reasons why specimens are not being collected onsite for SARS-CoV-2 testing?
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, does your facility have an in-house point-of-care test machine (capability to perform SARS-CoV-2 testing within your facility)?