

# Covid-19 Webinar for Critical Access Hospitals and Outpatient

Presented in collaboration with Nebraska ICAP,  
Nebraska DHHS HAI Team, Nebraska Medicine, and  
The University of Nebraska Medical Center

Presented by Kate Tyner  
Moderated by Mounica Soma

## Panelists:

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Guidance and responses were provided based on information known on 5/5/2020 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and jurisdictional guidance for updates.

# Questions and Answer Session

Use the QA box in the webinar platform to type a question. Questions will be read aloud by the moderator

If your question is not answered during the webinar, please either e-mail it to NE ICAP or call during our office hours to speak with one of our IPs

A transcript of the discussion will be made available on the ICAP website

<https://icap.nebraskamed.com/coronavirus/>  
<https://icap.nebraskamed.com/covid-19-webinars/>

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DEPT. OF HEALTH AND HUMAN SERVICES

# Important CDC Updates

# Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19

- Changed the name of the ‘non-test-based strategy’ to the ‘symptom-based strategy’ for those with symptoms and the ‘time-based strategy’ for those without symptoms, and updated these to extend the duration of exclusion from work to at least 10 days since symptoms first appeared. This update was made based on evidence suggesting a longer duration of viral shedding and will be revised as additional evidence becomes available.
- Based on this extension of the symptom-based and time-based strategies, language about the test-based strategy being preferred was removed.
- Removed specifying use of nasopharyngeal swab collection for the Test-Based Strategy and linked to the [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#), so that the most current specimen collection strategies are recommended.

# Return to Work Criteria for HCP with Suspected or Confirmed COVID-19

## **Symptomatic HCP with suspected or confirmed COVID-19**

(Either strategy is acceptable depending on local circumstances):

- ***Symptom-based strategy. Exclude from work until:***

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 10 days have passed *since symptoms first appeared*

- ***Test-based strategy. Exclude from work until:***

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens)[\[1\]](#). See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

# HCP with laboratory-confirmed COVID-19 who have not had any symptoms

- ***Time-based strategy. Exclude from work until:***
  - 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.
- ***Test-based strategy. Exclude from work until:***
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individual are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

# Return to Work Practices and Work Restrictions

- After returning to work, HCP should:
- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. **A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility.** After this time period, these HCP should revert to their facility policy regarding [universal source control](#) during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
  - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen



# What is an exhalation valve?

- The presence of an exhalation valve reduces exhalation resistance, which makes it easier to breathe (exhale). Some users feel that a respirator with an exhalation valve keeps the face cooler and reduces moisture build up inside the facepiece.
-  exhalation valve allows unfiltered exhaled air to escape into the environment
- An N95 respirator with an exhalation valve **does provide the same level of protection to the wearer** as one that does not have a valve.

# Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings

- **Symptomatic patients with COVID-19** should remain in Transmission-Based Precautions until **either**:
- *Symptom-based strategy*
  - At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - At least 10 days have passed *since symptoms first appeared*
- *Test-based strategy*
  - Resolution of fever without the use of fever-reducing medications **and**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens) [1]. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

# Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings

**Patients with laboratory-confirmed COVID-19 who have not had any symptoms** should remain in Transmission-Based Precautions until **either**:

- ***Time-based strategy***

- 10 days have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

- ***Test-based strategy***

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected  $\geq 24$  hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

# Symptom-Based Strategy to Discontinue Isolation for Persons with COVID-19

While this strategy can apply to most recovered persons, CDC recognizes there are circumstances under which there is an especially low tolerance for post-recovery SARS-CoV-2 shedding and risk of transmitting infection. In such circumstances, employers and local public health authorities may choose to apply more stringent recommendations, such as a test-based strategy, if feasible, or a requirement for a longer period of isolation after illness resolution. Entities enacting such policies should do so *explicitly*, with *clear justification*, and *in coordination with local public health authorities*.

# HOSPITAL TO POST-ACUTE CARE FACILITY TRANSFER COVID-19 ASSESSMENT





**HOSPITAL TO POST-ACUTE CARE FACILITY  
TRANSFER COVID-19 ASSESSMENT**

**INSTRUCTIONS: Hospitals are encouraged to use this form to document your assessment of the COVID-19 status of all hospitalized prior to transfer to a post-acute care facility. CHECK THE BOX FOR EACH CRITERIA APPROPRIATE TO THE PATIENT'S STATUS:**

Patient Name \_\_\_\_\_  
 Transferring Facility \_\_\_\_\_  
 Accepting Facility \_\_\_\_\_

**Has patient been laboratory tested for COVID-19?**

**YES**, Patient tested for COVID-19  
 Date of test(s) \_\_\_\_\_  
 What was the indication for testing? \_\_\_\_\_

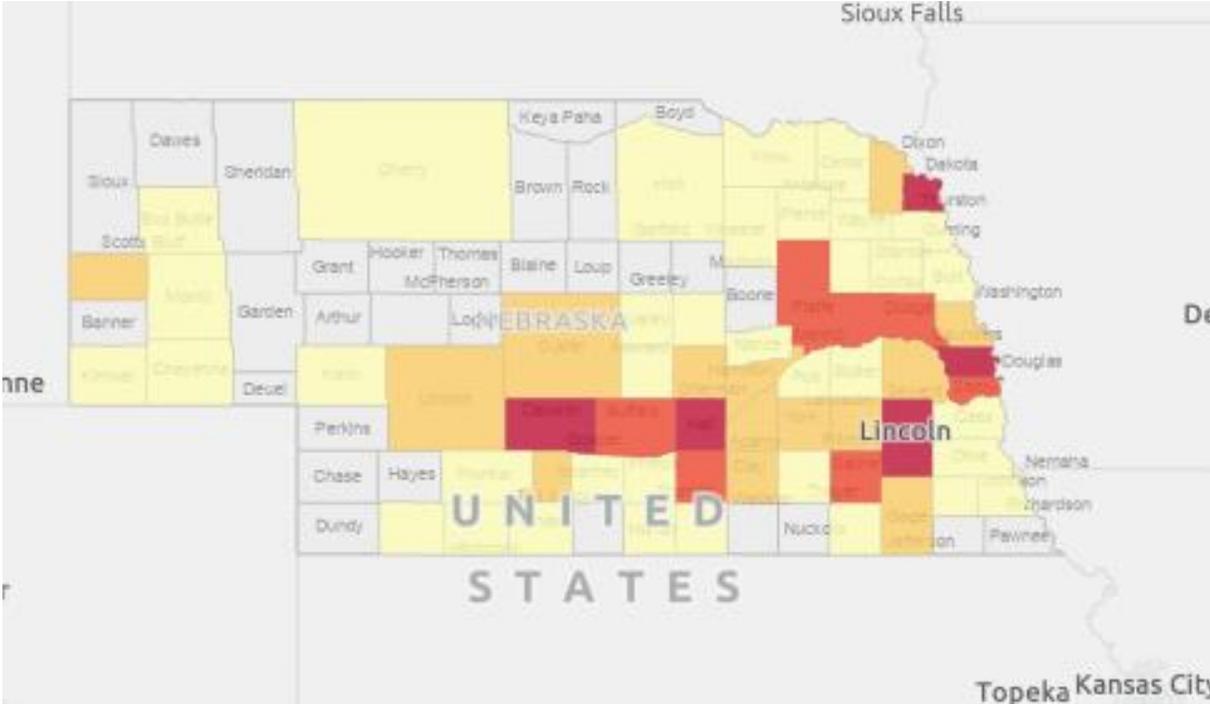
**NO**

<input type="checkbox"/> <b>Results Pending</b> Check if <u>any</u> results are pending	<input type="checkbox"/> <b>Negative Test</b> Check <u>only if all</u> results are negative	<input type="checkbox"/> <b>Positive Test</b> Check if <u>any one</u> test resulted positive
↓	↓	↓
<input type="checkbox"/> <b>Await Results MAY NOT TRANSFER</b>	<input type="checkbox"/> <b>Is another COVID-19 test planned/pending?</b> <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b> ↓ Any new signs/symptoms of	<b>Does the patient meet all 3 criteria:</b> 1. Resolution of fever without fever reducing medications, 2. improvement in respiratory symptoms AND 3. two negative COVID-19 test >24 hour apart <input type="checkbox"/> <b>YES</b> <input type="checkbox"/> <b>NO</b>

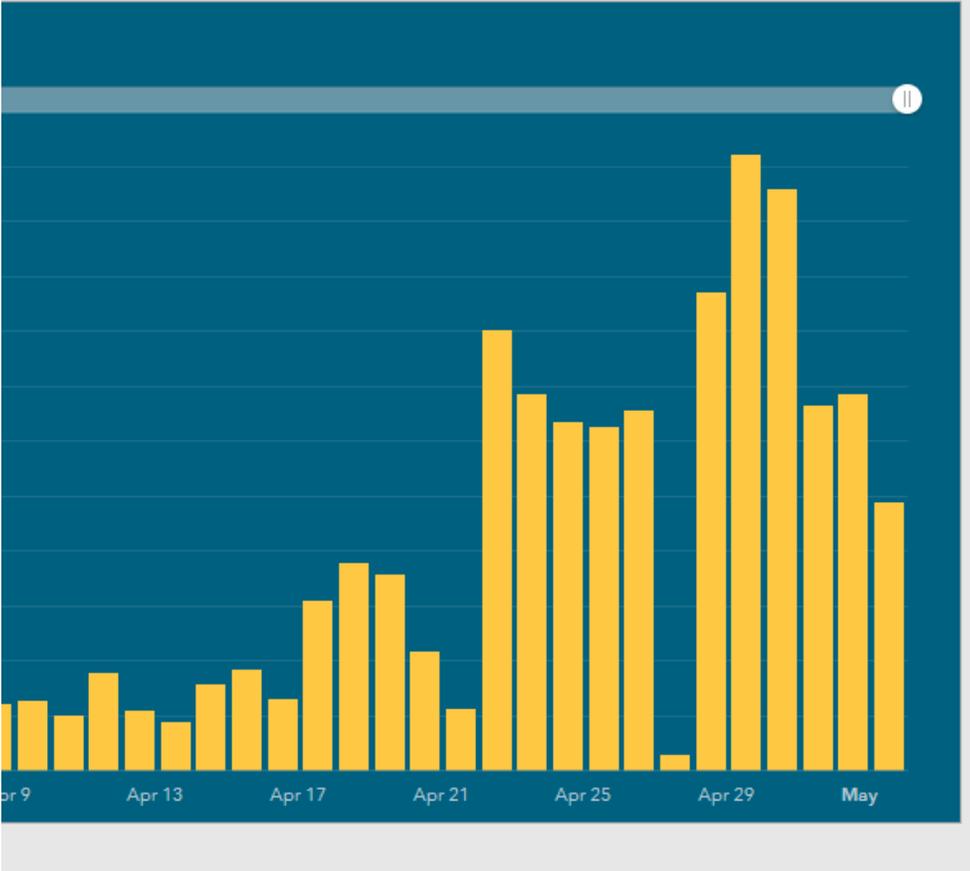
\*To accept transfer, receiving facility must have sufficient staff and supplies/equipment to provide the necessary care.

# Nebraska Case Update

## Coronavirus COVID-19 Nebraska Cases



## New positive cases by date results were received



<https://nebraska.maps.arcgis.com/apps/opsdashboard/index.html#/4213f719a45647bc873ffb58783ffef3>

# Gating Criteria

<https://www.whitehouse.gov/openingamerica/#criteria>

## SYMPTOMS

Downward trajectory of influenza-like illnesses (ILI) reported within a 14-day period

AND

Downward trajectory of covid-like syndromic cases reported within a 14-day period

## CASES

Downward trajectory of documented cases within a 14-day period

OR

Downward trajectory of positive tests as a percent of total tests within a 14-day period (flat or increasing volume of tests)

## HOSPITALS

Treat all patients without crisis care

AND

Robust testing program in place for at-risk healthcare workers, including emerging antibody testing

# OPENING UP AMERICA AGAIN

## CMS Recommendations Re-opening Facilities to Provide Non-emergent Non-COVID-19 Healthcare: Phase I

- General Considerations
- Personal Protective Equipment
- Workforce Availability
- Facility Considerations
- Sanitation Protocols
- Supplies
- Testing Capacity

# Joint Statement: Roadmap for Resuming Elective Surgery after COVID-19 Pandemic

American College of Surgeons

American Society of Anesthesiologists

Association of periOperative Registered Nurses

American Hospital Association

<https://www.aorn.org/guidelines/aorn-support/roadmap-for-resuming-elective-surgery-after-covid-19>

# Joint Statement Categories

- Timing for Reopening of Elective Surgery
- COVID-19 Testing with a Facility
- Personal Protective Equipment
- Case Prioritization and Scheduling
- Post-COVID-19 Issues for the 5 phases of surgical care
- Collection and management of data
- COVID-related safety and risk mitigation surrounding second wave
- Additional COVID-19 Related Issues

“Facilities in the state are safely able to treat all patients requiring hospitalization without resorting to crisis standards of care.”

# Information for Pediatric Healthcare Providers

Updated 5/3/2020

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html>

# Maintain Childhood Immunizations during COVID-19

- Use strategies to separate well visits from sick visits, such as scheduling well visits in the morning, and sick visits in the afternoon
- Separate patients spatially, such as by placing patients with sick visits in different areas of the clinic or another location from patients with well visits.
- Collaborate with providers in the community to identify separate locations for holding well visits for children.

**If a practice can provide only limited well child visits, healthcare providers are encouraged to prioritize newborn care and vaccination of infants and young children (through 24 months of age) when possible.**

# COVID-19 Among Children

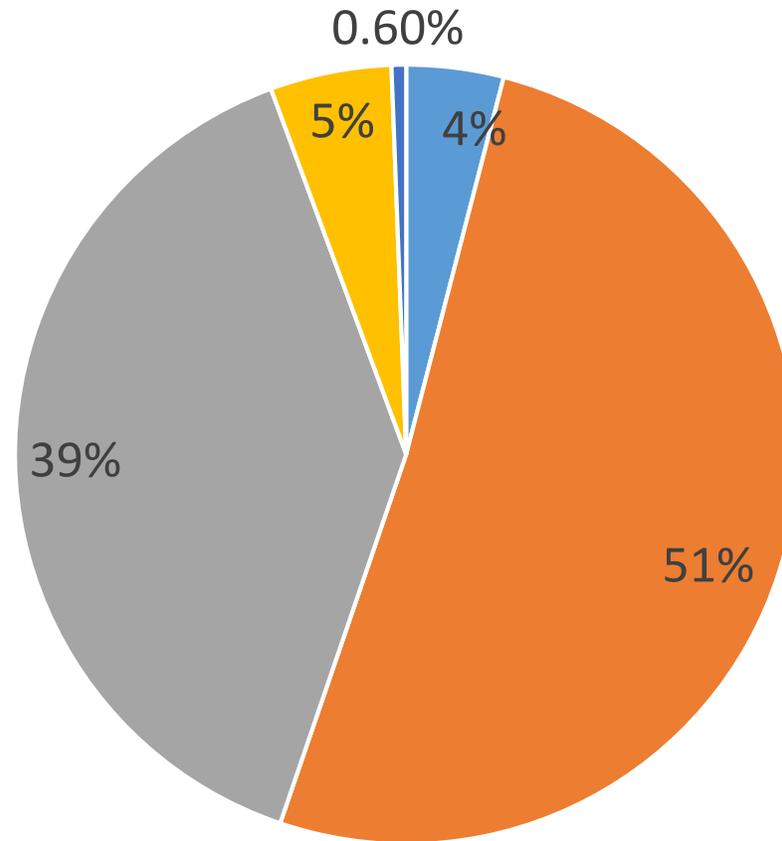
- In the United States, 2% of confirmed cases of COVID-19 were among persons aged <18 years.<sup>4</sup>
- In China, 2.2% of confirmed cases of COVID-19 were among persons aged <19 years old.<sup>1</sup>
- In Italy, 1.2% of COVID-19 cases were among children aged  $\leq 18$  years.<sup>2</sup>
- In Spain, 0.8% of confirmed cases of COVID-19 were among persons aged < 18 years

# Clinical Presentation in Children

- While data on the incubation period for COVID-19 in the pediatric population are limited, it is thought to extend to 14 days, similar to adult patients with COVID-19.
- Pediatric patients with COVID-19 may experience the following signs or symptoms over the course of the disease:

Fever	Shortness of breath
Cough	Diarrhea
Nasal Congestion or Rhinorrhea	Nausea or vomiting
Sore Throat	Fatigue
Headache	Myalgia
Poor feeding or poor appetite	

## Clinical Course and Complications in Children



■ asymtomatic ■ mild ■ moderate ■ severe ■ critical

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html>

# IP Office Hours

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Monday – Friday

7:30 AM – 9:30 AM Central Time

2:00 PM -4:00 PM Central Time

**Call 402-552-2881**



Infection Control Assessment  
and Promotion Program

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Moderated by Mounica Soma, MHA

COVID-19 WEBINARS

Home / COVID-19 Webinars

Nebraska DHHS in association with the Nebraska ICAP team is hosting webinars on COVID-19 to address situation updates and essential information on COVID-19.

+	COVID-19 LTCF Webinar Slides
+	COVID-19 LTCF Webinar Recordings
+	COVID-19 Outpatient Webinar Slides
+	COVID-19 Outpatient Webinar Recordings
-	COVID-19 Update for Small & Rural Hospitals Webinar Slides
	<a href="#">COVID-19 Update for Small &amp; Rural Hospitals Slides with Q&amp;A</a> 04.07.2020
+	COVID-19 Update for Small & Rural Hospitals Webinar Recordings

COVID-19 RESOURCES – HEALTHCARE FACILITIES

COVID-19 RESOURCES – PPE

COVID-19 RESOURCES – SCHOOLS

COVID-19 RESOURCES – EXPERT INFORMATION

COVID-19 WEBINARS

COVID-19 TOOLS FOR LTCF

<https://icap.nebraskamed.com/resources/>

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**NETEC – NICS/Nebraska DHHS HAI-AR/Nebraska ICAP**

**Small and Critical Access Hospitals-Outpatient Region VII Webinar on COVID-19 5/5/2020**

**1. Should we be concerned about menus or charge sheets hanging in the COVID positive room and then being taken out?**

Anytime you have an infectious process happening, facilities should work towards not having paper hanging in the room. Options include using cover sheets you can disinfect; move the papers out of the room completely; use disposable papers and get rid of them and not move it of the room.

**2. Should you use the two-test strategy to a healthcare professional to return to work in long-term care?**

Based on the latest CDC guidance, the chances for someone to transmit infection after 10 days is very low. If it has been 10 days since someone who was symptomatic tested positive, it should be okay, the chances may not be zero. We can extend the duration longer for someone working with a vulnerable population, going to the two-test strategy might be best. Either extend the duration of the break at least 14 days if you are not testing someone, or get the two negatives. There are different opinions, but the two-test strategy is preferred in a long-term care setting. The answer can be site-specific, too. If the facility already have COVID positive patients and have a COVID positive unit, and the healthcare worker who tested positive will be working in that area and is asymptomatic now, you could relax and use a symptom based strategy there in allowing the worker to return. It can be case-specific.

**3. Can a long-term care facility require a hospital to test a patient for COVID before the patient is transferred to them? Is that different for new patients vs. transfer back of one of their already established patients?**

The algorithm shown in the slides today goes through the situation well and shows what scenarios could allow a long-term care facility to require a hospital to test for COVID before accepting transfer. If a patient has a respiratory illness and is being transferred to a nursing home, the long-term care facility should require the testing before taking the patient back. Refer to the algorithm for guidance. In the case of a patient fall hospitalization, with no known community exposure and no symptoms of COVID, the nursing home should not be asking for testing for that patient. Instead, the long-term care center should admit the patient and place them in a Transitional (gray) zone, isolating the patient with COVID-level PPE for 14 days before putting them in the general nursing home population. If there is no transitional zone in the facility, then isolate in their own room for 14 days with COVID-level PPE for 14 days and then release them from isolation after 14 days if they are still asymptomatic

**4. Is there recommendation of what day of illness that we should test for our first negative on the patients going to the nursing homes?**

If your patient has been afebrile 72 hours and symptoms have improved, you can retest that patient to see if they are now negative. That probably averages about 10 days for the most part. If you test too early you will probably still get a positive result.

- 5. For hospitals that have restricted visitors, are you giving any guidance as to when they can loosen these restrictions? My thought would be to continue with no visitors until we see what "opening up" brings. Does that seem appropriate?**

This will vary geographically. The CMS and national gating criteria are to see two weeks of fewer respiratory infections and fewer COVID cases and you are able to operate without crisis level care. No hospitals in the state probably could do that right now. Those should be the guiding force.

- 6. Should the test base also be used in the hospital for discontinuing isolation?**

The CDC is using both. Facilities should adopt a policy and follow that. Nebraska Medicine is using symptom-based strategy and requiring 14 days from the onset of symptom and off for healthcare professionals; being asymptomatic for five days and not asking for testing. In long-term care there are so many vulnerable patients in close proximity, we are being cautious because we have seen so much spread in so little time.

- 7. What are the recommendations for cleaning the OR between cases when not testing patients prior to surgery?**

We recommend cleaning the same as you do during flu season, since COVID spreads similarly to influenza. Clean your OR between cases in the same manner; standard room turnover procedure and worthwhile for Infection Preventionists to observe this cleaning to make sure all things (i.e. anesthesia cart) are being cleaned the way you would want the room cleaned. If there was extubation - intubation you might want to give a little more time for air exchanges between cases, but that doesn't relate to cleaning. It is important to let the air exchange in these cases before the environmental services staff comes in to do the cleaning.

- 8. Can you reuse an N95 for surgical cases after it has been decontaminated with UV light?**

Yes, we are doing UV to recycle it and use that to extend the use through all inpatient care areas including ORs. (Except for exhalation valves – unfiltered air - in surgery, can't reuse N95s) In Nebraska Medicine and the Omaha Healthcare Coalition there are no restrictions on reusing those decontaminated N95 masks in inpatient care.

- 9. Should all patients admitted to the hospital including those that screen negative for COVID signs and symptoms and are admitted with a diagnosis not related to COVID be wearing a source control mask when within 6 feet of caregivers?**

Yes, the universal masking guidance says everyone should be wearing in the community and hospitals including patients should be using this for source control. Patients don't need a surgical mask – those should be conserved for healthcare workers. Some patients can't tolerate the cloth masks and keep them on; i.e., dementia, but the masks provide additional source control.

**10. We are aware that many hospitals in our area are going ahead with resuming elective surgeries. It does not appear that we as a state are meeting the gating guidelines. How do we reconcile this with our hospital plans?**

One thing to consider is the definition of elective surgery. People have had necessary surgeries pushed back by the pandemic and in those cases the procedures still have to be scheduled. Nebraska Medicine has discussions going on and are setting up criteria to phase in surgeries, not to the normal levels. There are people who were not urgent at the time of restrictions who have been waiting for weeks. Such as biopsies can wait 3-4 weeks, but it can become more urgent and not elective anymore. Nebraska Medicine are prioritizing procedures that have to be done now. Leaders across the city and other hospitals are looking at it like a dimmer switch, and are classifying surgeries by urgency and time sensitive. If we creep into a census where staff is stretched and supply chains are stressed, we may dial it back down if the pandemic increases the same time as we increase outpatient procedures.

**11. How frequently are surgical N95 masks to be decontaminated by UV light?**

The frequency of N95s masks have been every time you remove an N95, it goes into a brown paper bag and then is disinfected the UV light before re-donning. In extended use coupled with reuse, you wear an N95 3-5 hours at a time before sending it out for disinfection. One pre-print study out of Montana study showed three different UVGI cycles that continued to have comparable function using quantitative fit-testing does not decrease after 4 uses. There was no degradation of the filters in excess of 12-14 UVGI cycles. Every time you take it off you should UV it before putting it back on if you have that ability. It depends on the end user completing the seal test to make sure it is still functioning after each UVGI cycle.