Guidance and responses were provided based on information known on 7/30/2020 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates.

COVID-19 and LTC

July 30, 2020

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ICAP
Infection Control Assessment and Promotion Program

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/

Panelists today are:

Dr. Salman Ashraf, MBBS	salman.ashraf@unmc.edu
Kate Tyner, RN, BSN, CIC	ltyner@nebraskamed.com
Margaret Drake, MT(ASCP),CIC	Margaret.Drake@Nebraska.gov
Teri Fitzgerald, RN, BSN, CIC	TFitzgerald@nebraskamed.com

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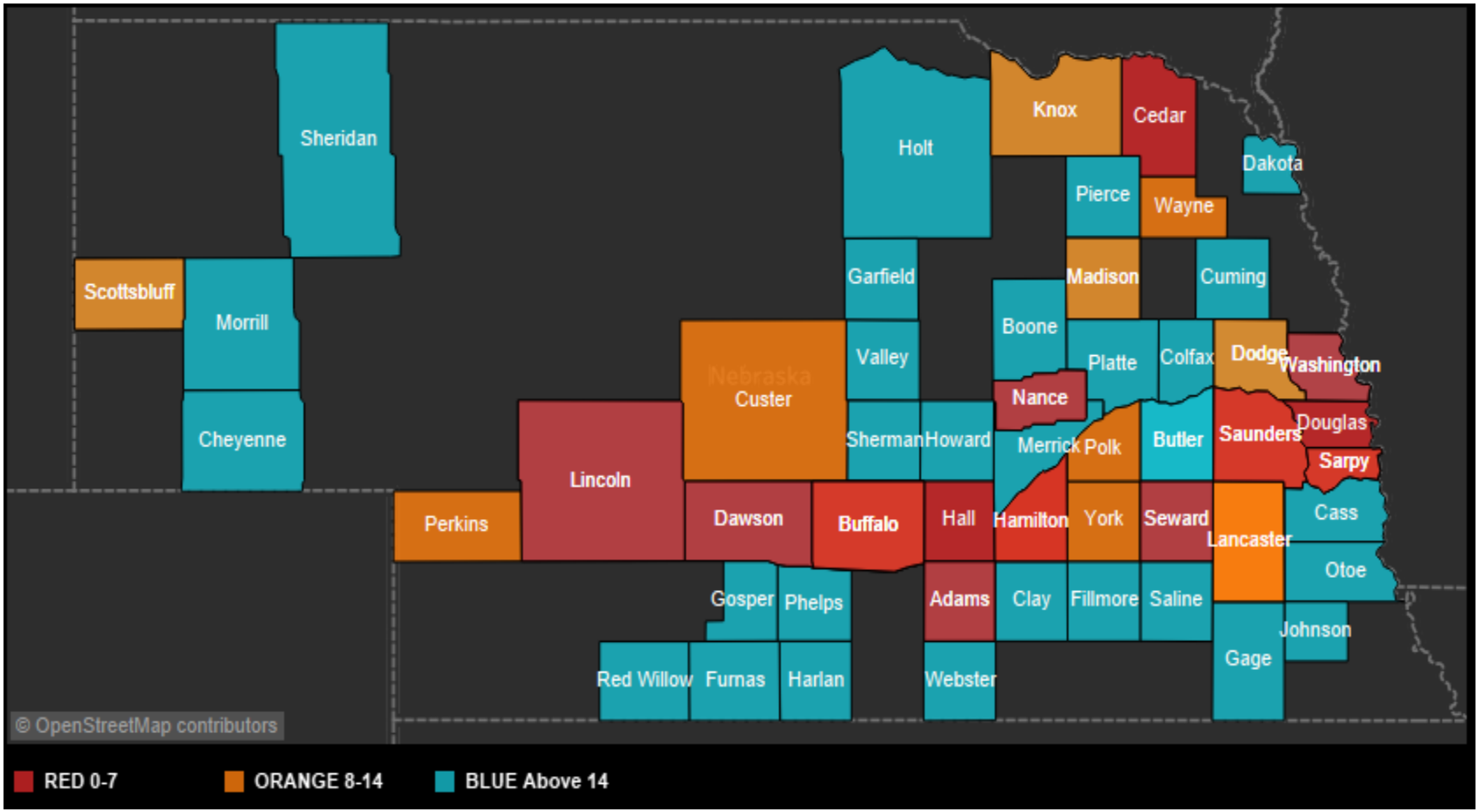
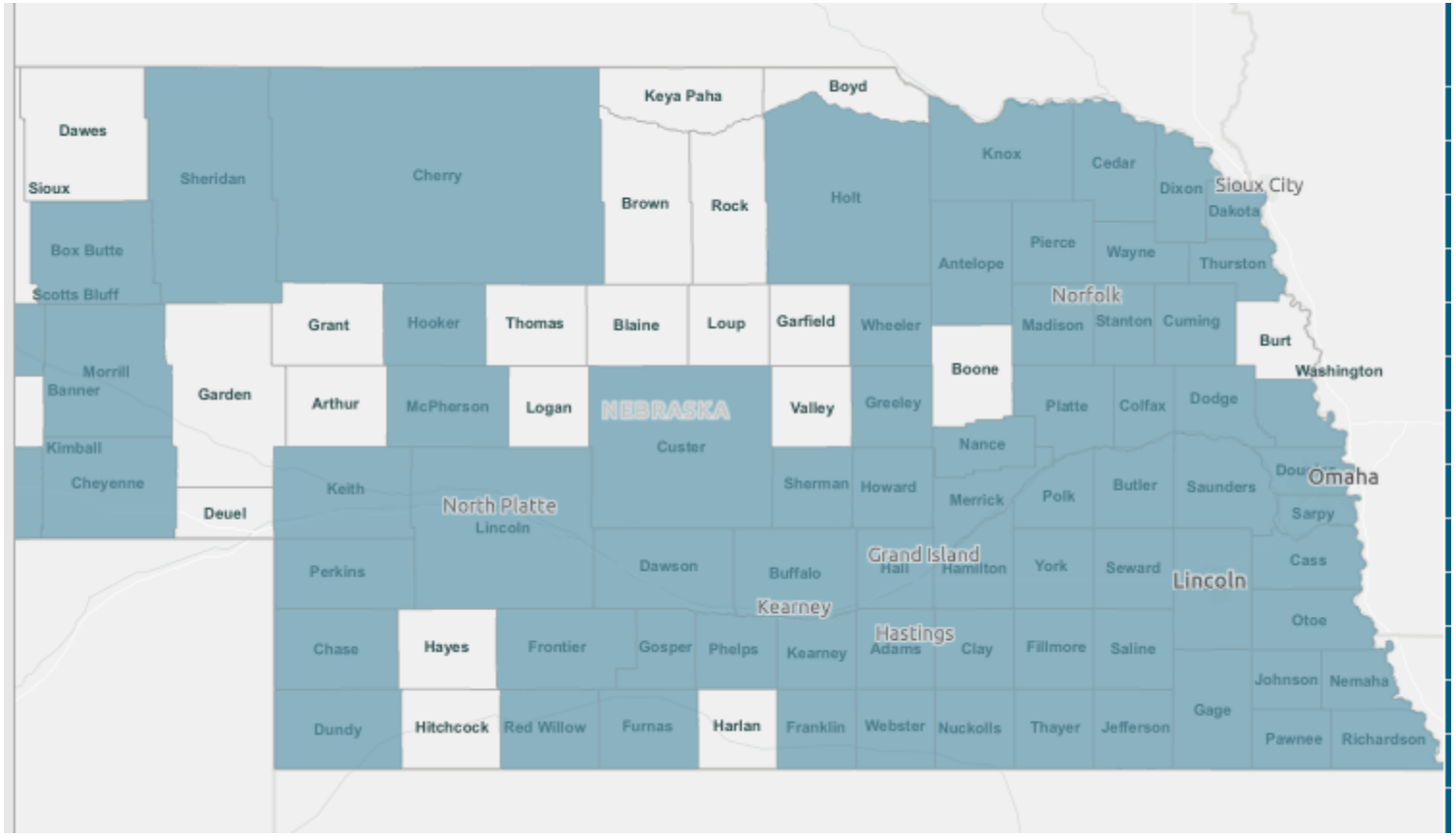
Map showing Counties Categorized by Days Last Tested Positive Cases



Updated: 7/30/2020 11 AM CST
Source: Unofficial Counts Compiled by Nebraska ICAP based on date reported by facilities; Actual Numbers may vary slightly

Nebraska COVID-19 Cases DHHS



Last 14 day Positive Cases as of 7/29 6:20 pm

https://experience.arcgis.com/experience/ece0db09da4d4ca68252c3967aa1e9dd

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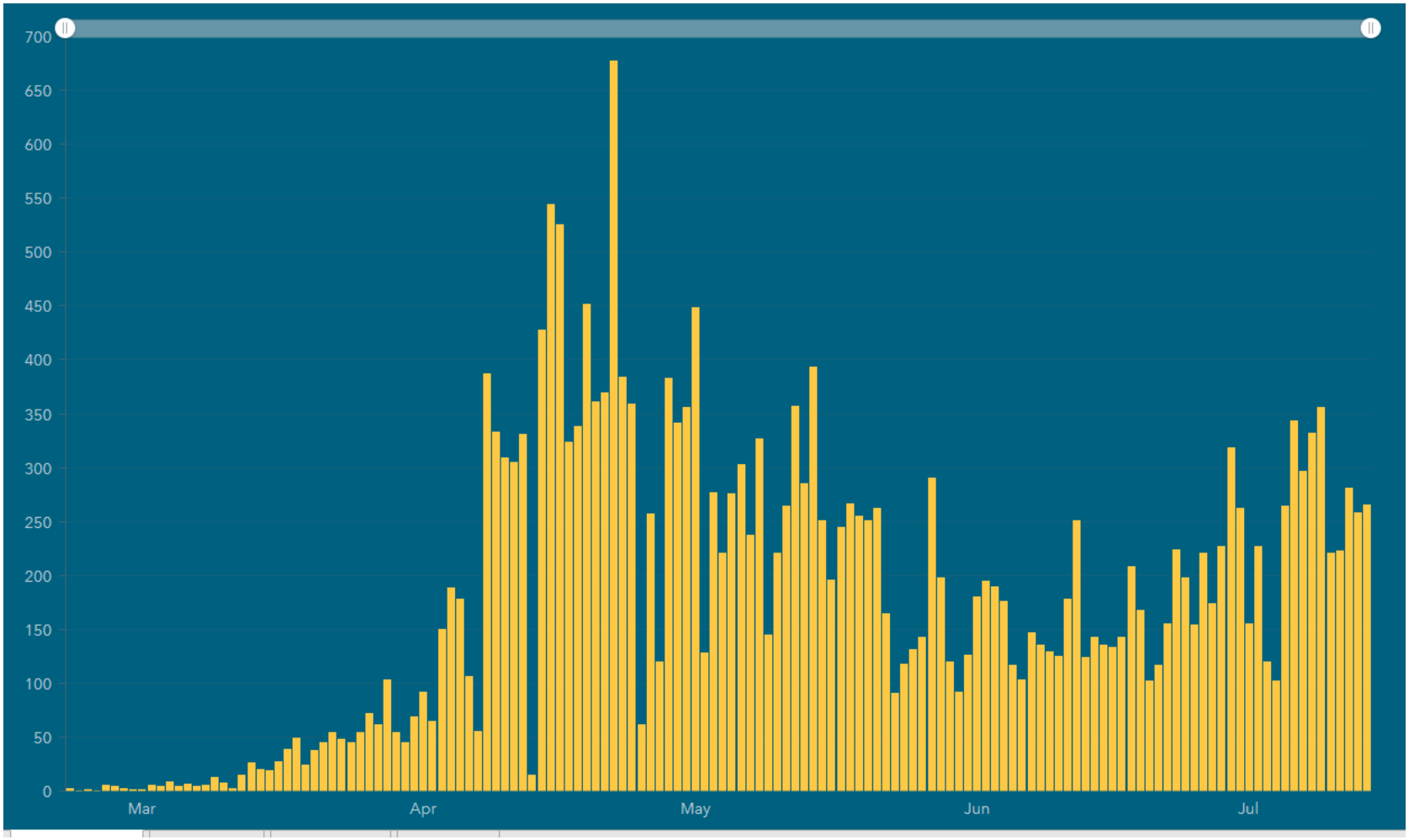
Nebraska COVID-19 Cases DHHS



New positive cases by date as of 7/29 6:20 pm

https://experience.arcgis.com/experience/ece0db09da4d4ca68252c3967aa1e9dd

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What's hot?

Common questions heard at ICAP

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"Our facility can officially move into Phase III, but our county is hot and getting hotter. Do we have to reopen?"

Image: Pixabay

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Facilities can choose to be more restrictive than the phasing guidance suggests.

There are no mandates for automatic regression even if there are a lot of cases in your community/county

- Rather, regression is currently driven by cases of COVID-19 in staff or residents, not the surrounding community

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Nebraska Long-Term Care COVID-19 Phasing Guidance

"Each facility will need to pay close attention to current county/local community trends (e.g., outbreaks) and determine if movement through Phases is appropriate for that facility or if additional precautions are warranted (e.g., additional testing or expanded PPE precautions)."

http://dhhs.ne.gov/licensure/Documents/LTCCOVID19PhasingGuidance.pdf

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CDC gives some guidance on this

Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown.

Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19

Preparing for COVID-19 in Nursing Homes
https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

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What are some community criteria to consider?

- Number of positive tests in county in the last 14 days

  https://experience.arcgis.com/experience/ece0db09da4d4ca68252c3967aa1e9dd
- Is your referral hospital currently seeing/treating COVID-19 admissions?

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ICAP recommends attempting to balance resident psychosocial needs with safe re-opening

- Communal Dining
- Group Activities
- Visitation

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Communal Dining

- Socially distance
  - Plastic barriers don't replace distancing and mask necessity
  - 2 to a table/ 6 ft. apart, even with a barrier in place
- Residents remain masked until eating, don mask when finished eating (source control)
- Dine in shifts
  - have different "shifts" of eating to help accommodate as many residents as possible so that they can get out of their room to eat if they would like.
  - Cohort meals by neighborhood
- Consider placing conversation cards at all tables – this has worked well in starting 'happy' and engaging conversations
- remind staff of the focus for residents is achieving the highest practicable physical / mental / psychosocial wellbeing

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Group Activities

- Social distancing
- Source control: Mask use
- Do not share supplies
- Singing is avoided
- Cohort by neighborhoods
- While community numbers are high, decrease or eliminate outside volunteers
- Discourage food or fluids as part of activities, to reduce touching masks
- Emphasize hand hygiene for staff and residents, especially when exiting room and re-entering

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Group Activities (continued)

- Community group outings are not offered
- Discourage residents leaving for outings
- Maximize the most of technology, like online tours
  - Smithsonian Museum of Natural History, https://naturalhistory.si.edu/visit/virtual-tour [naturalhistory.si.edu]
  - The Louvre, https://www.louvre.fr/en/visites-en-ligne#tabs [louvre.fr]
- Spiritual / bible reading
- Acoustic stimuli
  - soundscape (both music and natural sounds such as wind chimes)

Visitation

- Social distancing
- Source control: Mask residents and visitors
- Screen visitors
- Use appointments to control flow and numbers
  - reduce number of visitation appointments when community cases are high
  - Do not allow children when community cases are high
- Use designated rooms, outdoor patios, or booths
- Communicate with residents and families if you are putting in more restrictions; should include the rationale and specifics
- If visitors do not or cannot comply with visitation guidance the facility has set forth, facility can re-educate family/visitor, and if that does not work, involve ombudsman, and consider other ways to resolve the issue.

Other reminders…

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Anticipate that baseline testing will identify COVID-19 cases

- Facility should have PPE on hand
  - At least enough to go 48-72 hours with entire facility in a yellow zone
- Incident command to address cases as results are reported
- Communication expectations and strategies with staff
- Data entry during the testing process
- Plan in Hand: Actions needed to be taken upon identification of a COVID-19 case at a facility https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

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ICAP Infection Control Assessment and Promotion Program

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Actions needed to be taken upon identification of a COVID-19 case at a facility

Notification:

- ☐ Inform Local Health Department of Positive COVID-19 case
- ☐ Inform Licensure (LTC-CMS Survey team)
- ☐ Notify facility leadership and activate Incident Command System if it has not already been activated.
- ☐ Identify a point person (IP, DON, ADON etc.) who will subsequently get in touch with Nebraska ICAP team for reviewing infection control measures on an ongoing basis in coming days.
  - ICAP will assist long-term care (including skilled nursing) and assisted living facilities with implementation of infection prevention strategies and may advise on testing, isolation, staff cohorting, PPE use and other infection control related issues
  - The introductory call will preferably include facility leadership, local health department and ICAP team, when possible and will be arranged by the local health department.

Isolation and quarantine:

If a resident is identified to have COVID-19:

- ☐ Isolate the resident (either in a designated isolation area if already established or in the resident own room if no isolation area is yet established)
- ☐ Identify any other ill residents or staff by evaluating them for presence of any symptoms for COVID-19. Isolate and test those with COVID-19 symptoms.
- ☐ Review the exposures and movements of COVID resident with COVID-19 illness in the past 14 days in order to establish how they may have been exposed to the infection.
- ☐ Determine who else (staff members and residents) in the building may have been exposed to COVID-19.

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-be-taken-upon-identification-of-a-COVID-19-case.pdf

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PPE Request Process Updates & Reminders

NE DHHS has implemented a process improvement initiative for the PPE allocation process

- Local health departments will have more input on facility requests as they are sent up to the State for fulfillment. With this change, requests for PPE through the NE DHHS Jotform need to be submitted by **Noon on Thursday** in order for a facility to receive PPE for the following week.
  - https://form.jotform.com/NebraskaDHHS/PPERequestForm
- Continue to utilize the normal supply allocation and vendor processes. The state PPE program is meant to supplement, not replace normal processes.
- This supplemental PPE program is meant to assist with current supply needs. It should not be used to stockpile PPE.

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Infection Prevention and Control Office Hours

Monday – Friday
7:30 AM – 9:30 AM Central Time
2:00 PM -4:00 PM Central Time
Call 402-552-2881

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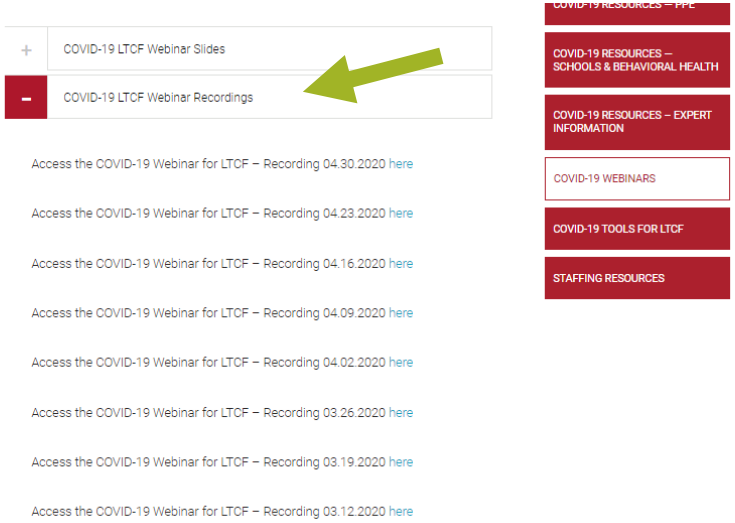
Moderated by Mounica Soma, MHA

Supported by Sue Beach



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

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Nebraska DHHS HAI-AR and Nebraska ICAP
Long-term Care Facility Webinar on COVID-19 7/30/2020

1. **Will you please provide example of verbiage to provide to both residents and employees as to why baseline testing is important prior to reopening/lessening restrictions for visitation within an assisted living facility?**
   The rationale for this, now that we have been doing baseline testing, we have evidence of why baseline testing is so helpful. COVID 19 is different from flu or tuberculosis because people can be incredibly contagious but not have a single symptom. Before we reopen, it is important to know where we are at with people having COVID and continuing to work. That's why we need to testing, so that if people are identified with COVID, we can take them out of service so that they don't continue to spread in the community. When we are opening up, we are opening up to a little more risk and people need to know where they are at before we do that. We have definitely found a handful of cases in a couple of facilities where we have to take a person out of service, do some isolation, and we've been able to contain situations so we have not had further spread in the building. It positions facilities so that we are not having COVID spread in a facility

   Dr. Ashraf added a simple explanation for family members is that right now, before the baseline testing, while we are not in Phase 3, we are closed to visitation and we have limited movement and activities and limited movement in the facility, it can be more easily contained. If there is a case or two in the facility that we don't know about, it might have less chance to spread right now, just because of all the restrictions that are in place. If we open it up, there is a chance that there was a case there we did not know about, it was not spreading because of all the restrictions in place. If we don't test before reopening, now we will have the chance to spread COVID because the barriers are not there. It is always good to do the baseline testing, to figure out, before reopening, if there are any asymptomatic cases in the facility. Before reopening, that asymptomatic case is probably contained because of the restrictions and we don't want to open it up having that person who is infectious, start spreading the infection, just because the restrictions have been taken away. It is important to prevent that asymptomatic person to stop spreading COVID right now. The baseline testing will give us a little idea that at this time, there is nothing in the facility and we can open it up and go forward. That is the concept, to identify the asymptomatic carrier who will spread COVID if restrictions taken away.

2. **What would be safer for our facility- to give our own flu shots this year or to allow an outside agency like the VNA in to give shots? We are in Phase 3 but our county is still having cases.**

   This is a facility-level discussion. If you are having someone from outside come in and do the vaccinations, you may want to check their protocols; make sure they have some protocols with safeguards in place. Talk to them, you can work it through and figure it out. If it appears that whatever agency is coming in or staff members who are coming in from outside and they are

following very strict protocols themselves, following strict infection control guidance, wherever they go, they don't take unnecessary risks, it is probably okay. When you are in Phase 3 (because Phase 3 does not have those restrictions, you have to be careful of anyone coming into your facility. You have to talk to them and make sure that those processes are in place for them, also, before you proceed. If you are comfortable enough that they have good processes in place and they are screening themselves and not entering into high risk situations without PPE, then it will probably be fine. Kate Tyner added that if you are not used to doing flu shots yourself, it is important to make sure people are trained on safe injection practices. She also cautioned that if you do COVID testing yourself, that you don't inadvertently delay flu shots. We know of a lot of facilities that get into staffing crunches quickly with COVID cases and Kate wouldn't want to slow the flu vaccine process because you are doing something you don't normally do. Staffing issues are the other side of the coin, and another consideration.

3. **Could you please clarify the guidelines for skilled communities for when a resident goes out for an appointment (not overnight; not hospital)? Specifically if they share a room with another resident. Plus, if they are in the green zone, can they return to the green zone?**

   Dr. Ashraf said this issue was discussed during the webinar. If you are in Phase 3, the state guidance does not require any kind of quarantine in Phase 3. However, the CDC does say that depending on the level of community prevalence, you may want to apply the quarantine/grey/transitional zone for 14 days. It all depends on the community that you are living in. If you are in Phase 3, the state guidance does not mandate a 14-day separate quarantine, but if you are a high risk community seeing a high number of cases, you may want to consider having a grey zone. Don't put the same person in a room with roommates. Take them to another, private room and observe them there in 14-day quarantine. It all depends on the risk. If this in an outpatient, the risk might be a little lower, then a new admission criteria. It also depends on the kind of outpatient appointments. It is different if it is a primary care kind of appointment, where others there might have acute respiratory conditions who are coming to see their family care provider, versus an appointment, for example, an eye exam, where people who are going there are not usually acutely sick. You have to do your risk and benefits assessment. Have heard there have been citations if they are going out and coming back they need 14 days quarantine. I think it is risk based and not a general room. Dr. Ashraf noted that there have been cases where facilities are getting citations for not having the 14-day quarantine, and we have heard that facilities tried to follow the recommendations he just gave and they are cited because the surveyor said it does not matter, that they are going out and coming back and need 14 days of quarantine. Dr. Ashraf personally thinks that for every general rule, the determination should still be made on the basis of risk. ICAP is trying to clarify that from the licensure division, to get an answer on what their expectation is. But as of this point, Dr. Ashraf's general, professional interpretation is that it depends on the risk of the appointment and the risk in the community. You are going to assess and decide if this person can go into the green zone and back again, or if this person needs to go into the grey zone first, and then 14 days later come into the green zone.

4. **We are hearing that Assisted Living will be surveyed regarding their Infection Control plans the same as LTC/SNF facilities. What do you suggest for "zoning" in Assisted Living?**

Zoning in assisted living has been difficult. Usually what we have said is that the room becomes part of the zone. So instead of a zone of a group of rooms in a hallway, for example, the individual rooms would become a yellow room, red room, a grey room or a green room. The room becomes your zone. In most assisted living facilities basically those are considered resident's home, so you are not going to be able to transfer one person from their home into another home. That just doesn't happen easily. ICAP teams have not been creating a separate zones where all the people in red or yellow residents will be cohorted. What ICAP has done in that is to assign rooms to become a "zone" – for example, this room becomes a red zone, or this room becomes a yellow zone and the have cohorted the staff members. What we have ended up doing is instead of having a different space, you dedicate staff to only take care of only red rooms, yellow rooms, or green rooms. Cohorting becomes more on the staff than the residents. You assign the rooms, red, yellow or green and then just have staff that takes care of the red rooms, or the yellow rooms or the green rooms. Dr. Ashraf does not think there national guidance on that, but so far it has worked very well. That is what ICAP has generally done with facilities dealing with outbreaks in the last three or four months. So far, it has worked very well. Kate Tyner added that is what we have been doing with facilities. Cohorting staff is very important. Further, with cohorting, ICAP suggests having care of higher risk residents last. This this is if you have crossover therapy like physical or occupational therapy, those residents would be the last rooms visited in that day. ICAP also suggests if you are using PPE in those assisted living environments, build in some hard-wired activities so that staff come out of that room, take off PPE appropriately, clean their hands and take a break so there is a hard stop when they come out of the room to ensure that they do the right practices. That is something that a lot of facilities are really working on, to be sure they have good compliance when they exit those rooms.

5. **After baseline tests have been completed in a facility, should new admissions and new employees have a COVID 19 test?**

   After the baseline admission is done, whether new employees should have a test or not, Dr. Ashraf has heard that the state health department is encouraging giving TestNebraska kits out for free for the new employees to get tested after the baseline testing. There is availability for testing. It is not a mandate, but it is something the is providing and encouraging. It is available for those kind of testing situations, so Dr. Ashraf recommends taking advantage of that. He does not think it is a mandate, but it something they are encouraging and providing, so he thinks facilities should utilize the resource and take advantage of it.

6. **Does the plastic barrier between residents at mealtime provide enough protection?**

   Dr. Ashraf said ICAP is getting a lot of questions on the Plexiglas barrier. Another question was if facilities could have visitors come in and sit on one side and the resident sit on the other side of the barrier, don't use a mask and share news and visits together Dr. Ashraf suggests care is needed in how these Plexiglas barriers are used. The barrier is adequate when you have two people on opposite side of the table, they are both seated, if the barrier is above their heads and people are eating. At that point of time, the barrier is working. Dr. Ashraf is concerned that if you start to use that barrier for other reasons socializing and talking and not people are not

wearing a mask, that is not adequate. That is because, if you are eating, that is a defined task, but when you are socializing behind the barrier, the size of the barrier is limited and people may be moving around behind them, sometimes standing and sometimes sit, there will be activity that is beyond your control during those visits. Plastic barriers will not be sufficient at that point in time. The plastic barrier is pretty okay when doing the act of dining. Dr. Ashraf usually recommends that people go into dining room with masks on, then they sit down, the food is served, they take masks off, after eating is done, put masks back on. The plastic barriers for the purpose of separating diners in the dining room is acceptable. Other than that, he would not use it for other socializing.

7. **On activities slides a lot of these don't work for memory care residents. What do you suggest?**

   Kate Tyner said that ICAP is looking for input on activities or memory care residents. She asked her colleagues listening to send in suggestions; these ideas will be offered during next week's presentation. Dr. Ashraf invited anyone listening who has found somethings that work that don't involve a lot of contact where residents don't have to do a lot of physical interactions or sharing equipment to send that information to ICAP so it can be shared.

8. **When a facility has health care and assisted living building connected what is some guidance on how to handle visitation between couples if they live in different areas. Can the spouse in assisted living wear a mask and gown and walk through health care area to get to the visitation zone to visit their spouse?**

   Dr. Ashraf said this sounds like a reasonable plan for someone who is in a facility that is in Phase 3. Kate Tyner cautioned with that ICAP is hearing a lot of good success with planning visits by appointment. She said we should still try to avoid carte blanche of people walking over anytime between facilities to visit. She said those visits should still be by appointment. It is safer to have visits on a safe room or patio or something like that. It's not okay not to let someone just walk over in a gown and glove. ICAP wouldn't recommend that for a visitor from the community, and she wouldn't suggest that for a spouse. There would be a question about their compliance with a gown and glove. Would they know when to take it off; where to dispose of it safely, or how to avoid contaminating themselves in the process of removing PPE? The visitors could contaminate themselves, the hallways, stop and talk to six people on the hallway. She said you don't want to have that happen without the supervision of some staff. She recommends you still have that spouse from a connected facility visit by appointment. She said that is her opinion on the question but invited listeners with more ideas on the process to email ICAP after the webinar with processes they have worked out.

9. **If an entire facility is yellow zone is communal dining allowed (all the residents are asymptomatic)?**

   Kate Tyner said you would want to avoid communal dining in that situation. A yellow zone is one where you want to separate people because some people may be positive and some may be negative. If you let people from a yellow zone get together, that is how you can have one or two positive cases spread COVID through the whole building. ICAP has discussed the possibility

of allowing communal dining of red zone residents because in theory they all have COVID already, but she cautioned that this idea has not been put to the regulatory team for their input. In the yellow zone, that is the number one situation to avoid. You don't want yellow zone residents to interact with each other so you can continue to limit the spread.

10. **Is there any type of risk assessment tool that has been developed to determine whether or not to keep in gray zone?**

    Dr. Ashraf and Kate agreed there is not risk assessment tool for this issue. Dr. Ashraf usually recommends looking at the community transmission where the person is coming in from and the local hospitalizations there. If there is ongoing community transmission and patient has been hospitalized in recent days, that indicates there is risk involved. The higher that transmission is, the greater the risk.

11. **Can you weigh in on the length of time it is taken to get the test results back. We had results 6 days after baseline completed which was 9 days from a staff test + ---this is way to late to try to be proactive**

    Dr. Ashraf completely agrees that test results should be back in 48 hours to be effective. The ideal time period would be 24 hours. Dr. Ashraf had been told that there was a delay in TestNebraska a couple of weeks ago because of some audits that had to be done and they were backlogged for a little while. We have been told recently that the backlog is resolved and they are back to getting results out in 48 hours. Dr. Gary Anthone, Nebraska's Chief Medical Officer, asked facilities last week that if facilities are not getting results within 72 hours of testing, that he should be emailed with specific examples so he can look into those particular situations. He offered that last week. If there are examples like that, please definitely contact Dr. Gary Anthone as he wants to be aware of that situation. (Gary.Anthone@nebraska.gov)

12. **What is the definition of a hospital-like setting: if a medical appointment is in a clinic, dentist office or even an x-ray? My definition if that this is not hospital-like so is there no need for isolation, even in Phase 2?**

    Dr. Ashraf would Agree if go by state guidance, that is right interpretation of how the guidance is set. Dr. Ashraf continue to say that community transmission (where your community is seeing over 10 percent positivity rate of testing), in that community even a dental appointment may be alarming. That would be if there is that high positivity rate in your community, even a dental appointment may be alarming. But, based on the guidance, you are not mandated to put that person in a 14-day quarantine, so therefore you should not be cited whether you decide to put them or not to put them in 14-day quarantine. Whatever your facility policy is, that is what you should follow. What Dr. Ashraf suggests is to have a policy based on a risk assessment and you can choose which level of risk to trigger a gray zone from outpatient visits. If you decide that if your community positivity rate is above 10 percent, that would trigger having anyone returning from an outpatient visit to go into a 14-day quarantine, you can set your policy that way. This is not a mandate but you can do an internal policy that says a number where you decide this is a high enough rate for us. Some other people may choose a positivity rate of 5 percent for their

trigger in their policy. Dr. Ashraf said he doesn't think there is a magic number. But definitely, the higher the positivity rate is, the more risk there is. The over 10 percent does indicate a higher rate of transmission in a community. That may be something you want to decide for yourself. Maybe for hospitalization you may want to have a lower threshold. That is something facilities will want to decide on their own and then follow their own policy. That is one of the ideas Dr. Ashraf is suggesting. Dr. Ashraf doesn't see in the state guidance anything in Phase 3 to require quarantine. Whatever you decide for your policy is what you need to follow. Dr. Ashraf cautioned that he wants listeners to know that they should be aware that facilities are getting citations and we are trying to clarify this.