Guidance and responses were provided based on information known on 8/6/2020 and may become out of date.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

August 6, 2020

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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:

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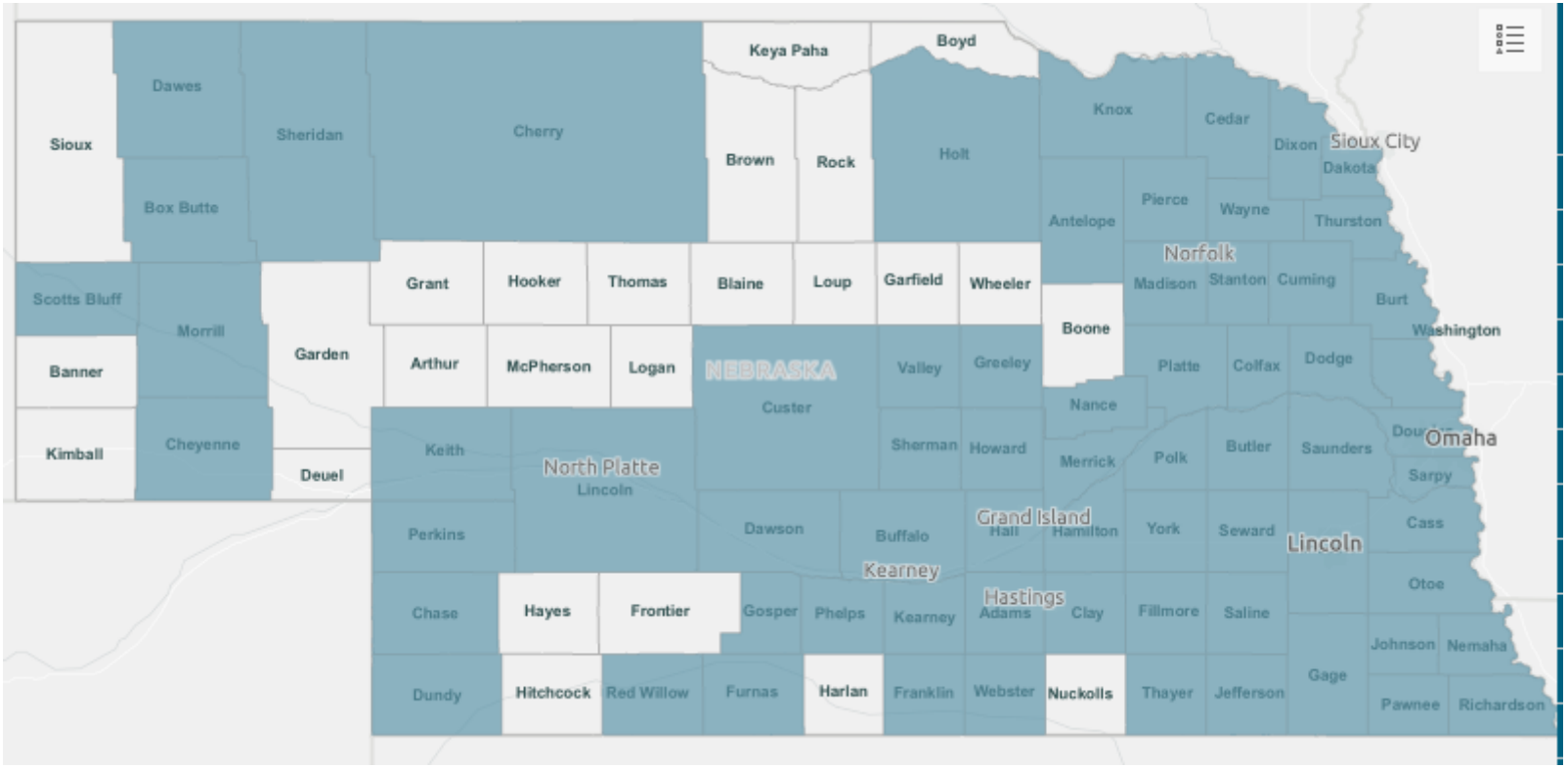
Nebraska COVID-19 Cases DHHS



Last 14 day Positive Cases as of 8/4

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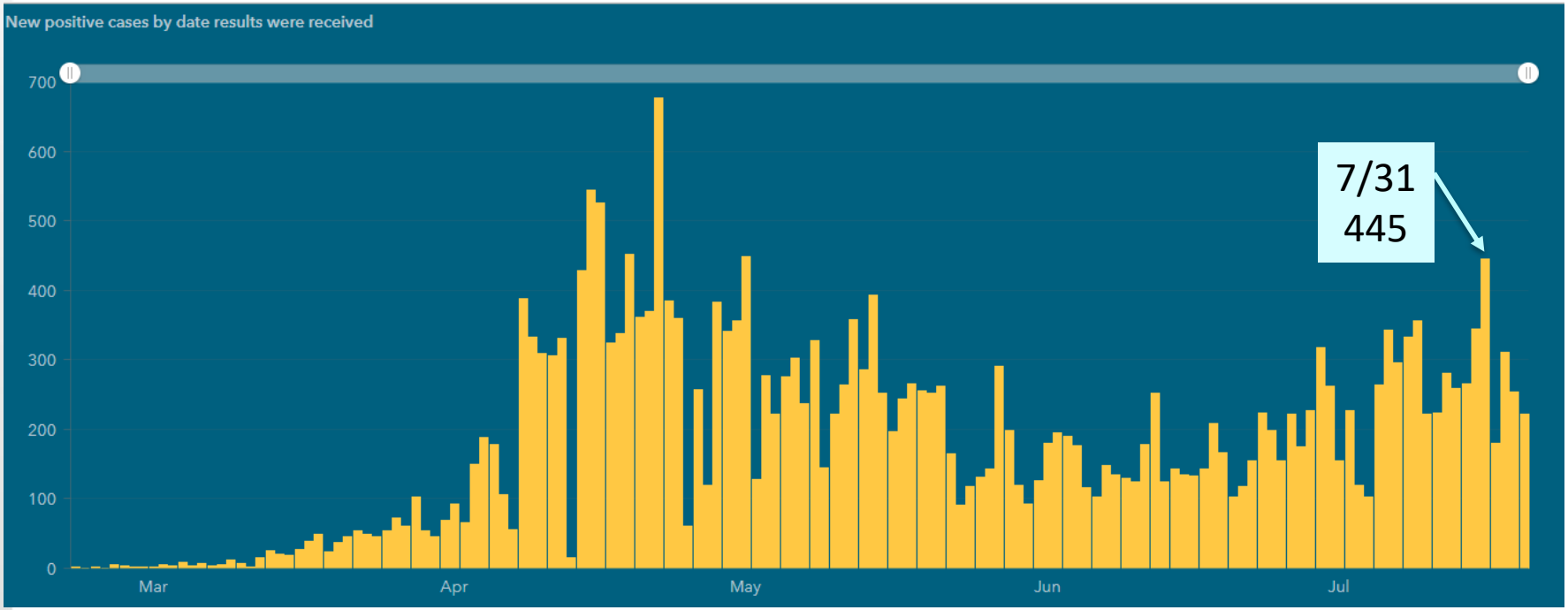
Nebraska COVID-19 Cases DHHS



New positive cases by date as of 8/4

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Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance)

Summary of Recent Changes as of July 17, 2020

- Except for rare situations, a test-based strategy is no longer recommended to determine when to allow HCP to return to work.
- For HCP with severe to critical illness or who are severely immunocompromised[1], the recommended duration for work exclusion was extended to 20 days after symptom onset (or, for asymptomatic severely immunocompromised[1] HCP, 20 days after their initial positive SARS-CoV-2 diagnostic test).
- Other symptom-based criteria were modified as follows:
  - Changed from "at least 72 hours" to "at least 24 hours" have passed *since last* fever without the use of fever-reducing medications
  - Changed from "improvement in respiratory symptoms" to "improvement in symptoms" to address expanding list of symptoms associated with COVID-19
- A summary of current evidence and rationale for these changes is described in a Decision Memo.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

Decision Memo https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

Symptom-based strategy for determining when HCP can return to work.

HCP with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
Decision Memo https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

HCP with severe to critical illness or who are severely immunocompromised

- At least 20 days have passed *since symptoms first appeared*
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
Decision Memo https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

Discontinuation of Isolation for residents COVID-19+

New guidance and data

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Summary of Changes to the Guidance

Below are changes to the guidance as of July 17, 2020:

- Except for rare situations, a test-based strategy is no longer recommended to determine when to discontinue Transmission-Based Precautions.
- For patients with severe to critical illness or who are severely immunocompromised[1], the recommended duration for Transmission-Based Precautions was extended to 20 days after symptom onset (or, for asymptomatic severely immunocompromised[1] patients, 20 days after their initial positive SARS-CoV-2 diagnostic test).
- Other symptom-based criteria were modified as follows:
  - Changed from "at least 72 hours" to "at least 24 hours" have passed *since last* fever without the use of fever-reducing medications.
  - Changed from "improvement in respiratory symptoms" to "improvement in symptoms" to address expanding list of symptoms associated with COVID-19.
- A summary of current evidence and rationale for these changes is described in a decision memo.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
Decision Memo https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

Why is a test-based strategy for discontinuation of iso no longer recommended?

In the majority of cases, waiting for test-based clearance results in prolonged isolation of patients who continue to shed detectable SARS-CoV-2 RNA [i.e., COVID-19 virus] BUT ARE NO LONGER INFECTIOUS.

Recovered persons can continue to shed detectable SARS-CoV-2 RNA in upper respiratory specimens for up to 3 months after illness onset, albeit at concentrations considerably lower than during illness, in ranges where replication-competent virus has not been reliably recovered and infectiousness is unlikely. The etiology of this persistently detectable SARS-CoV-2 RNA has yet to be determined.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
Decision Memo https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

Symptom-Based Strategy for Discontinuing Transmission-Based Precautions

Patients with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and** symptoms (e.g., cough, shortness of breath) have improved

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What do they mean by “mild to moderate illness?”

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

Criticaland/or multiple organ dysfunction.

Illness: Individuals who have respiratory failure, septic shock,

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html#definitions

Symptom-based Strategy for Patients with severe to critical illness or who are severely immunocompromised

- At least 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

As described in the Decision Memo, an estimated 95% of severely or critically ill patients, including some with severe immunocompromise, no longer had replication-competent virus 15 days after onset of symptoms; no patients had replication-competent virus more than 20 days after onset of symptoms. Because of the risks for transmission and the number of patients in healthcare settings at risk for severe illness if infected with SARS-CoV-2, a conservative approach was taken when assigning duration of Transmission-Based Precautions.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
Decision Memo https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

ICAP Interpretation for long-term care facilities

Long-term care facilities can use the following guidance on making decisions on discontinuing isolation for the residents who are diagnosed with COVID-19.

In general, isolation should be discontinued for all residents (including those with severe and critical illness) who were diagnosed with (or had symptom onset) of COVID-19 twenty (20) days ago as long as they are afebrile for more than 24 hours and other symptoms have improved.

However, the duration of isolation may be longer or shorter in some specific cases as mentioned below:

- If a resident continues to have significant symptoms on day 20, then extend the duration for isolation until the resident is afebrile for more than 24 hours and other symptoms have improved.
- Facilities may consider to discontinue isolation earlier for those residents who are: (a) not severely immunocompromised and (b) clearly had mild to moderate illness or were completely asymptomatic all along. The isolation for those residents {who meet both criteria (a) and (b)} can be discontinued at day 10 after the diagnosis (if they were asymptomatic) or symptoms onset (if they had symptoms and has now been afebrile for >24 hours with all other symptoms improved).
- Facilities may consider using testing-based strategy for discontinuation of isolation if they are considering discontinuation of isolation earlier than what is recommended above.
- Test based strategy may also be considered for severely immunocompromised residents, if concern exist for them being infectious for more than 20 days.

Note: In order to be considered afebrile, the fever should be absent without the use of fever-reducing medications.

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/07/7.23.2020-DC-Isolation-for-LTC-Residents-with-COVID-19_updated.pdf

What's hot?

Common questions heard at ICAP

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A patient positive for COVID-19 is requesting admission to our LTC. Can we take them?

Image:Pixabay

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Yes, using the symptom based strategy, you could admit according to days since positive.

See slides 11-14 to review that guidance.

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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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Do we need to get a flu vaccine earlier this year (i.e. July/August)?

Image: Pixabay

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Do we need to get a flu vaccine earlier this year (i.e. July/August)?

While the Advisory Committee on Immunization Practices has not yet voted on the flu vaccine recommendations for 2020-2021, CDC does not anticipate a major change in the recommendation on timing of vaccination. Getting vaccinated in July or August is too early, especially for older people, because of the likelihood of reduced protection against flu infection later in the flu season. September and October are good times to get vaccinated. However, as long as flu viruses are circulating, vaccination should continue, even in January or later.

https://www.cdc.gov/flu/season/faq-flu-season-2020-2021.htm

If one of my staff members has a house-mate that is COVID-19 positive, can they work?

Image: Pixabay

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- No, they should not work
- We suggest HCW try to quarantine away from the positive individual as soon as possible.
- The HCW must be off work for the 14 day period that would **start** with last exposure to the family member.
- If not separated, then the 14 days starts once the family member isolation is appropriate to end (at least 10 days illness + 14 day quarantine= minimum 24 days)

10+ 14=24

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The Nebraska Accommodation Project

The Nebraska Department of Health and Human Resources (NEDHHS) provides temporary accommodations to residents exposed to coronavirus disease (COVID-19) who need to quarantine or isolate.

http://dhhs.ne.gov/Documents/COVID-19-FirstRespondersAccommodationRequest-FAQ.pdf

http://dhhs.ne.gov/Documents/COVID-19-GeneralPublicAccommodationRequest-FAQ.pdf

There are facilities for first responders/HCW and general public. Here is a link to the request form.

https://cip-dhhs.ne.gov/redcap/surveys/?s=K97PH77LYL

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Do I have to call ICAP with all new positive cases?

Image: [Pixabay]

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If you can get started on your own, that is fine!

- If it is a staff member positive, contact trace the unit where staff works
- Implement a yellow zone

- If it is a resident positive, implement yellow zone where the resident lives
- Implement your red-zone procedure

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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.

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

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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Questions and Answer Session

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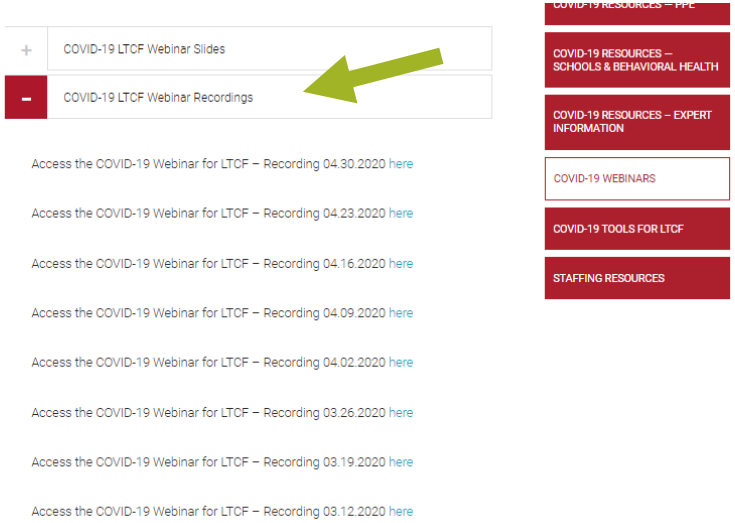
Panelists:
Dr. Salman Ashraf, MBBS
Kate Tyner, RN, BSN, CIC
Margaret Drake, MT(ASCP),CIC
Teri Fitzgerald, RN, BSN, CIC
Sarah Stream, MPH, CDA

Moderated by Mounica Soma, MHA

Supported by Sue Beach



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

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Responses were provided based on information known on 8/06/2020 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates.

Nebraska DHHS HAI-AR and Nebraska ICAP
Long-term Care Facility Webinar on COVID-19 8/06/2020

1. **We are currently taking temperatures of employee on entry and exit for their shift. CDC guidelines say temperatures on arrival. Do we need to temp staff when they leave?**
   The purpose of taking temperatures on arrival of staff is to determine if they are fit for duty. If they have a fever, you would not want them working inside the facility. Taking the temperature at the end of the day would not be useful. You want staff to be sure to self-monitor for signs and symptoms at the end of the day, letting leadership know that they need to go home if they begin feeling ill during the day. Taking them out of service right away when they feel ill should limit exposures. Dr. Ashraf agreed with Kate, that there needs to be reinforcement often to staff that they should let someone know just as soon as possible if they do not feel well during their shift so they are not present any longer than necessary if they start feeling ill.

   Dr. Ashraf stressed that temperature screening is just one thing out of many signs and symptoms. Screening should also be for headache, nausea, vomiting, sore throat, etc. There is a list of those symptoms from the CDC. The screening has to be for all these and not just rely on the temperature screening by itself. Kate added that if you have a staff member working who is mid-shift and comments that their body hurts all over, that is a person you want to take out of service. The value of this is any one of these symptoms that occur at the beginning of a shift, or mid-shift, we want to get those people out of service. Dr. Ashraf further clarified that screening mid-shift is not a requirement, but you want to set up good communication strategies so that staff knows they should communicate about any symptoms as soon as they happen. Having a pattern where you get to talk to people throughout the day can help with that.

2. **If the change is 10 days for those that have mild illness, why are we continuing to isolate residents in their room for 14-days (e.g. yellow zone even though no one staff or residents have symptoms) when an asymptomatic staff tested positive? The 14-day of isolation and full PPE do not seem to be in line with the 10 days. It seems like resident isolation is causing more harm than good as we continue to see the decline in resident's mood/spirits.**
   Kate said that 10-day period refers to times when there is an exact starting point of when the asymptomatic person is tested and positive for COVID. That is a different thing than a quarantine period for a known exposure. For a known exposure the incubation period can last up to 14 days, which is why the longer time is required; that is the length of time a facility needs a yellow zone for exposed residents. The 10 day period for positive, asymptomatic staff covers the time after the asymptomatic staff tests positive and could transmit the illness. That's really different than if you have an exposure and know about it, which is the time you want a yellow zone and use full PPE to protect the facility from spread. After exposure, the time to incubate can take up to 14 days. These are scientifically different things, and the isolation is done for different reasons. The duration out when ill at least 10 days; quarantine for a known exposure is 14 days. Margaret Drake compared the 14 day resident quarantine for known exposure to COVID to chicken pox incubation of 14-21 days. She said the 10 day period is the starting point

for when you know someone has the disease; now you are just watching for when the person gets better. The yellow zone is exposed, within those 14 days.

We know that quarantine and isolation is hard on residents. Kate suggests that we want to do everything we can do to limit exposure and the need to do those kind of quarantines for 14 days. We want to limit exposures so that in the long term we can keep residents active and engaged. Strategies we can think of are things like dining. If you have residents from all different neighborhoods going into the dining room together, if you have an exposure in any one neighborhood, now everyone in the dining room is now exposed. We could limit that, if people from one neighborhood continue to dine together, or maybe continue to do their group activities together. Now if one of their staff members, who is cohorted to that unit is ill, or one of those residents becomes ill, we isolate this one neighborhood. We don't have to necessarily isolate the whole building. We totally see that if we can limit how often we have to quarantine residents, that has everything to do with consistent staffing and trying to do communal activities in such a way that you limit the chance that people are exposed. If you have an exposure, this allows you to try to limit the group that is exposed.

3. **For a test result to be considered a 'false positive', what criteria must be met? Is it two negative tests, 24 hours apart?**
   ICAP is very reluctant to ever call anything a false positive. There is a rumor out there that there are a lot more of these than is actually true. Kate is not aware of any false positives that ICAP has directly worked with among the many cases ICAP has worked with since the start of the pandemic. Anytime you have a positive COVID test, we have to regard that result as positive. We have to do the work to do contact tracing, to put people into isolation, and to make decisions. The idea of false positive, Kate said, is becoming something of an urban legend. That would be a situation where if you are feeling that way, definitely do your contact tracing and definitely do isolation. You can involve ICAP at that point to help ask questions, to work with the lab, etc. This will be the very rare instance, certainly not the norm. We would want you to regard this as positive and work from there. In addition, if you have an employee or resident with symptoms, we treat those people as if they are positive. We have had instances where we will retest. We want everyone to have low threshold for COVID positivity and do all the work, all the isolation, etc., because once these are loose in a facility, it is nearly impossible to get them back. It pays to be aggressive up front and work back from there. Be aggressive about every single positive result and we can work it from there.

4. **Are you saying we cannot take a COVID positive resident before they are out of isolation status i.e. 10-20 days?**
   No, ICAP is not saying that. If your building is set up that you are prepared with PPE, with staffing, etc, absolutely you can take a COVID positive resident. We especially see this as pretty common in facilities where you have multiple COVID positive cases. Maybe somebody gets sent out to the hospital but then they are ready to come back and join a couple of other residents in a red zone, that is no problem. The rule is that we want to make sure that a long-term care facility is ready for that. We don't general admit COVID positive residents into a building that has no COVID cases. There is no rule that says that you cannot take a COVID positive resident.

But that is not the norm. Most facilities are just a little more hesitant to take a COVID positive resident back. That is some of the rationale you can use when bringing COVID positive people into the building.

5. **So when a staff member calls in for the "stomach flu" do we have to test them before they come back to work? Or, what if they call in for diarrhea?**
   It makes sense to be aggressive up front. If this is not normal for your employee, they should get tested. Certainly, there are people who have nausea and vomiting or diarrhea and that is their only symptom. It makes sense to hold those people out, and get them tested. What you run into people who have a chronic condition, those are people who should probably be seen by a primary care physician to understand if they have alternative chronic diagnosis in place, and work through that. Work through your employee health, or the primary care provider for that employee. But a one off, an employee calling in with diarrhea or nausea and vomiting should be tested. If that is not normal for them, they should definitely have that checked out and have a COVID test.

6. **Can the same eye protection and facemask be used between zones if it is not soiled? Is it preferred to extend eye protection and face mask to reduce staff touching their face? Can the same mask and face shield be used between the gray, yellow and green zones if not soiled?**
   Teri Fitzgerald said she has heard Dr. Ashraf say in the past that it was appropriate. If you were caring for different zone due to your inability to dedicate staff to a particular zone, then you should keep on your N95 and Faceshield (your Faceshield s protecting your N95 from soilage) and disinfect your Faceshield when it becomes soiled. It is very difficult to be doffing your PPE for your grey zone/yellow zone and then put on a different mask when you have to go into a green zone. Therefore, wearing that same PPE (COVID-level face protection) is appropriate. Kate added that if it is possible to cohort staff so that you don't have staff moving between the grey and green zone, for example, or a yellow zone and a green zone, that is ideal. Margaret Drake said that you should think of your face shield and mask as your face. You don't change your face going between rooms. What you do change is your gown and gloves. Changing a gown and doing good hand hygiene between zones, if you have to that, is the best bet. As Kate said, the best thing is if you can have cohorted staff dedicated to each zone that is the very best way to do it.

7. **There is not enough staff in Nebraska to do this. Often it is the mother of a child who is positive. Do you have emergency staffing to help? Unemployment payments and COVID scare has exacerbated an already tough staffing market.**
   Kate said it is important to clarify on these points. If you go back to that CDC table that talks about healthcare worker exposure. If you have a team member who is exposed to a COVID positive person outside of work, if no one is wearing masks, that is a high risk exposure. If no one is wearing masks, then those people will have to automatically have to be furloughed for 14 days. That is a high-risk exposure with face-to-face contact which requires a 14-day furlough. If a staff member is not able to separate from them (such as a husband who is exposed to COVID or he is positive, you cannot just take a test and start my 14 day quarantine. But if the staff member continues to have exposure to the husband, quarantine period has to begin again every

single day. Every day they live together is a new exposure. The 14-day quarantine where the staff person could potentially have symptoms based on the exposure, begins again each day. It they can't separate, that is why you have to wait until the end of the illness period for the husband and then the quarantine period starts.
Dr. Ashraf clarified that if while the staff member and husband are living at home, if they can come up with some kind of arrangement where the husband has a separate room and a separate bathroom and he is isolating in that area (not coming into close contact with the wife), -- because the wife is staying in another room and using another bathroom – and they are not coming close together, then in that scenario, the last day of exposure can be the day they decided to live in separate rooms and places in the same house. For those people who can do that kind of quarantine within house, the day you start the arrangement becomes Day One of quarantine. Kate added that couples also need to remember not to share meals when they are living in that kind of distanced home quarantine. A well person would prepare a meal and leave a dish, and later on the positive person would come up and pick it up. If it is a basement, you deliver it to the entry of the basement, or wherever they are living separately in the same house.

8. **Has the guidance changed regarding taking residents on bus trips or rides?**
Kate referred this questioner back to the Nebraska DHHS phasing guidance. That would depend on your community prevalence, and the Phase that your building is in to decide if taking residents on bus trips or rides is appropriate. The two risks you are considering on a bus trip or ride are the residents being together in the bus (one type of exposure) but if you are in Phase 3 we are less worried about that. And if you are going out in to the community with residents, is it safe to do so? In Omaha right now, we are seeing a high enough prevalence of positive cases, that even though you might be considered Phase 3, that might be a time to choose to be a little more restrictive, because if you are taking people to a restaurant or something like that they may be encountering a lot of cases at that time. That guidance comes from Nebraska DHHS phasing guidance. If you have specific questions that, that is really more of a local public health and regulatory decision. It is the job of ICAP to steer you towards that resource. That document has not changed, there have been no updates to that document at this time. Dr. Ashraf added that even if you are in a low community prevalence setting, if you are Phase 3, then you probably are okay to get residents out on that kind of trip. You still have to follow universal masking in the bus for the residents all the time and the driver wears a mask also, basically just for social distancing and masking policy; that should continue to be followed.

9. **If there is a red zone room on a yellow zone hallway, will the yellow zone hallway not be able to progress to green until the red room is no longer red?**
Dr. Ashraf said yes, it all depends on perspective and how the staffing is being, etc., but as a general rule you will try to separate it out as much as possible. The is staffing is the main issue here. How are you staffing these units? If that red zone person is being staffed by the same staffing nurse (and others interacting with residents, like dietary, social workers, whoever is going in the room) if they are the same people who are going into the other zone and then going in to the red zone room, Dr. Ashraf would probably be concerned about turning that area into a green zone. However, if there is a separate staff member on the red zone who is the only person

who is going in the room and everybody else has done their quarantine and is done, if you have a separate staff for them and the red zone room is always closed, the red zone person never comes out, Dr. Ashraf thinks you can make a case that it might be appropriate to turn the rest of the unit into a green zone. It is a case-by-case evaluation. Be careful on that part. If you have any doubts, you can always call ICAP.

10. **If a resident returns from a doctor appointment, ER visit, but is returning the same day, we are putting them into a grey zone room for 14 days. Should we still be using full PPE- mask, face shield/goggles, gown, shoe covers or can we wear limited PPE such as a mask/face shield/goggles and maintain appropriate hand hygiene. The resident has been asymptomatic from prior to and after their visit.**
If you have the reason to put a person into a grey zone for 14 days, the definition of that is to use full PPE. You can prioritize PPE for high-contact activities, if you don't have enough PPE. But if you are calling this zone a grey zone, or a transition zone, then by the definition of that, you would not be compliant with the way ICAP has written that guidance. You have used that guidance and redefined what grey zone would be. Essentially you are saying, "I'm using the grey zone (very much an ICAP word) but you are not using the appropriate PPE," that could get you in trouble. That is the difference. Shoe covers not part of the COVID PPE attire. The gown use of high contact care is definitely part of grey zone precautions, regardless of the length of time your resident was out of the building. If you're using grey zone, it includes a gown for high contact care. Margaret Drake agreed; if you are calling it a grey zone, you use it for 14 days and therefore you should be using the PPE that is set out for the grey zone. She cautions this is especially important if you have regulatory coming in, because if you say that person is in the grey zone, regulatory will use the definition that is set out for using PPE in that zone and if you don't use that PPE, they will cite you for it.

    Teri agreed and added that you need to monitor new admissions, especially if there is COVID prevalent in the community, for the full 14 days. That is something that the regulatory has said, that you must do that. But if you are talking about residents who go in and out for doctor's appointments, again in Phase 2 and Phase 3, the documentation does not say anything about using a grey zone. They say you must have a plan to monitor. Teri said that is difference; people are often trying to figure out whether they do need to put somebody in a grey zone. If they have been out with staff members, everybody was masked, they have not run into any crowds, they did not have to wait in a crowded waiting area, they were in and out and there is really no COVID in their area, people have some decisions to make when that person comes back if they even need a grey zone. Do they need that 14-day monitoring? If no exposure risks happened, because you don't have COVID, then you wouldn't need to be monitoring. Dr Ashraf agreed with Teri, wondering why a facility would need to put someone in a 14-day isolation if we don't even think they have been exposed or had the potential of getting exposed.

    If there is no COVID in your community, and you are in Phase 3, and you are sending someone out to an outpatient appointment in that community where there are no COVID cases going on, then why are we putting that person through a 14-day quarantine? Dr. Ashraf would probably not even consider that.

But if you are in a community where there are a significant number of cases of COVID 19 going on, and the appointment that someone went to was a primary care appointment, where everyone there was coughing and possibly had shortness of breath, then you may say that this is enough risk now that you want to put this person in a grey zone, even if you are in Phase 3. It is not required, but you may want to put them in a grey zone. If you are going to have them in a grey zone, then you need to use the complete PPE required by the grey zone, because you were concerned enough to put that person in a grey zone. If you were concerned enough to put them in a grey zone, you should be concerned enough to use all the PPE. It is either all or none. Either you are concerned or you are not concerned. If you don't put them in a grey zone, just continue to monitor them and take their temperatures twice a day at a minimum. That is all the guidance is requiring. It is the logic of if you are concerned or not concerned.

11. **Some facilities have been testing their staff every 7 days. Is this a CMS requirement?**
CDC has some guidance that you can test staff every 7 days. ICAP, when working with buildings that have had cases, is now using a strategy where they end up testing every 7 days, at least in that 14 day period. If you have a staff member who tested positive, ICAP will want to initially look at the residents and the close staff contact of the positive person. As soon as we know positivity has happened, we are testing at 5-7 days from the exposure for Test One We will want to test again at the end of the 14 day period to make sure that when we lift the yellow zone, we have done that and not left behind someone who is asymptomatically positive.

In that way, it is more common in Nebraska that facilities working with ICAP that have positive cases will have multiple testing phases and that recommendation is based on a CDC guideline and not a CMS requirement, to Kate's knowledge.

Dr. Ashraf said that we have to separate the two things out. Every 7 day requirement for staff testing is the CDC guideline. That is baseline testing and follow up testing. You do a baseline testing (every facility does a baseline testing, all across Nebraska). Some facilities are going after that baseline testing, every 7 days retesting for foreseeable future, and that is based on the CDC guidance. The CMS guidance does not mandate it but it refers to CDC guideline. CMS left it for the state to decide. Our state has not mandated it, either. What our state mandated was baseline testing, and after that they have not mandated every 7 days testing. So if you are not doing every 7 day testing for screening purposes (not outbreak),you are still okay in terms of compliance. However, if you are doing that based on CDC recommendation, you are not wrong doing that. Whatever you decide you are right (whether you do the 7 day testing after the baseline testing for additional screening for positive cases). If you don't do that, you are fine, too. However, in an outbreak situation, that is different. Once you have identified a positive case, and there is a potential exposure in the building, then it is a completely different scenario. Then the 7 day testing that is recommended by the CDC is being followed even in Nebraska where the state health department is providing test kits to do every 7 day testing to prevent/control the outbreak. But the facility does not have to secure testing outside of the state. For that testing, ICAP helps them with local health department to secure the testing. If you have no cases, you don't have to keep doing the every 7 day testing. It is up to you. If you

want to do that, it is not wrong because the CDC still recommends that. But if you have cases of COVID 19 right now in your facility, then you may have to do every 7 day testing, at least for a limited number of people who may have been exposed to contain the outbreak.

12. **Admitted resident that already have had COVID and admitted to nursing home can we take them out if isolation in 10 days instead of 14 days?**
    The rule for removing if already COVID, would come out of isolation, based on their disease and their symptoms ,and if they were immune suppressed or not, in 10 days or 20 days. We agree here that the 14 day grey zone quarantine period would not make as much sense. They are known to have COVID, they are going to stay in isolation for the duration of their COVID illness based on the 10-day or 20-day rule and the14 day rule is now ruled out. Teri Fitzgerald and Margaret Drake agreed. This is a situation ICAP has not run into it. Margaret Drake said that If already have COVID positive and know they are recovered there is no need for a 14-day quarantine. Dr. Ashraf added that we need to know how long ago the person was positive. Was a person positive and finishing their isolation duration is where you apply the 10 and 20 days. Dr. Ashraf said that if someone was positive three or four months ago and is now coming back as a new admission, coming for something else like rehab for a broken hip, they will still have to go through a grey zone for 14 days if they are in a high risk community and the cases are still going on in that community. They may still want to continue to have them in the grey zone, even though they were positive 4 months ago. Some people may even say after 6 weeks people could be positive again. We think immunity probably lasts at least 3 months, but we don't know for sure. We definitely don' t know how long the COVID immunity lasts, if someone being careful after 6 weeks and try to have a grey zone after 6 weeks, Dr. Ashraf would be okay with that, but definitely after 3 months the grey zone for admissions/readmissions is a must.

13. **What is thought about the re-infection of COVID? If you've had a positive resident who has recovered, if they go out to an appointment in a clinic in Douglas Co and are in a room with a resident who is also a recovered positive do they need to quarantine in the grey zone when they return for 14 days?**
    The definition being used for reinfection at ICAP is the three-months rule. Kate thinks that if a person has already been identified as positive and they are within the three-month time period it would make sense not for them to quarantine when they come back. Kate said the difficult thing is how do you put that in your policies and procedures? How do you identify residents who don't have to have a 14-day time period and how do you know they are at the end of their three-month period and return to using the 14 days again? The rationale is sound for this question, that this is a person who is not going to become sick again within three months, but the operationalization of this; how you communicate this, how to have that in a policy would be complicated. The rationale is sound but how to put it into policy and show yourself to be compliant with your own policies and procedures would be difficult.

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