Guidance and responses were provided based on information known on 8/27/2020 and may become out of date.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 27, 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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# Robot for Nursing Home Tele-presence

**Natalie Manley, MD, MPH, CMD**
**University of Nebraska Medical Center**
**Division of Geriatrics, Gerontology and Palliative Medicine**

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# The Problem

Sometimes providers can't come to the facility due to possible COVID exposure, etc.

Staff don't have time to stand there holding a tablet

- And if they do take the time…you as a provider always have in your head that you are taking them from their other duties.

Patient privacy limited if staff has to stand there

If the staff member leaves the tablet for the resident…

- then a space has to be cleared on their bedside table, it might get knocked over, etc
- Also the resident might accidentally turn it off by touching the screen

Bill Warren, who lives in a Winter Springs memory-care facility, gets a virtual visit with his wife, Lisa. Holding the tablet is staff member Shan'a Mann. (Courtesy of Lisa Warren)

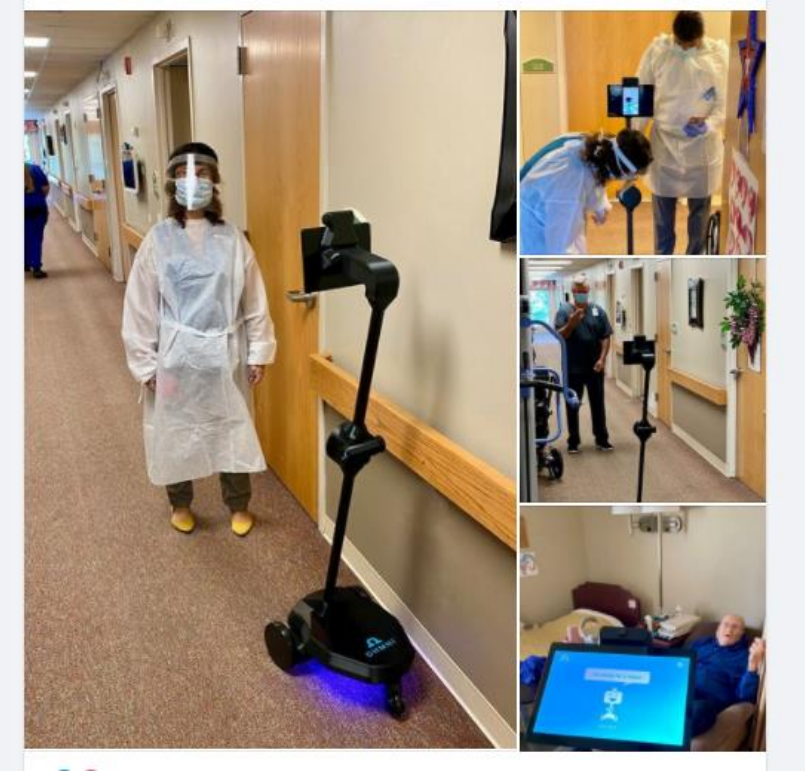
https://www.orlandosentinel.com/coronavirus/os-ne-coronavirus-florida-task-force-approves-nursing-home-visitors-20200826-wwht3fxgobhtzg2c7vhsgqybay-story.html

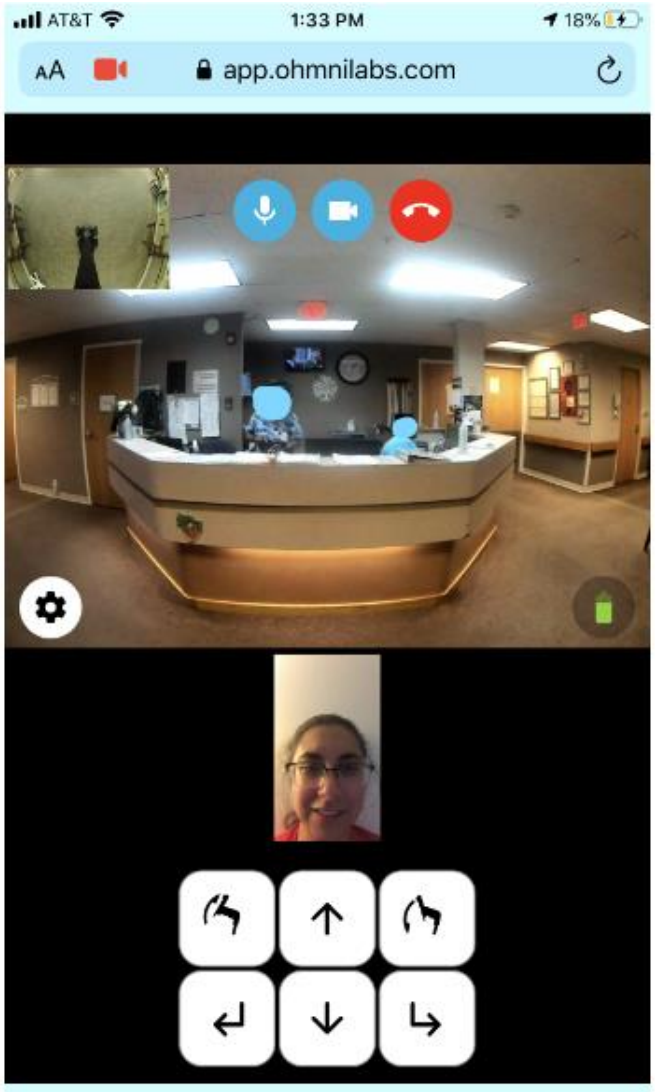
# One Possible Solution

## (there are other robots on the market)

https://ohmnilabs.com/

# Robot at Azria Health in Gretna

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18%
AA
app.ohmnilabs.com

# Cleaning protocol-disinfecting wipes are fine

| Green Rooms/zones | Yellow/Grey rooms/zones | Red zones |
|---|---|---|
| Wipe down a couple times a day or<br><br>If someone touches it<br><br>Or close enough to person for droplets | Wipe down before it leaves each resident's room | Wipe down a couple times a day or<br><br>If someone touches it/droplets or<br><br>if it leaves the red zone |

Avoid being in the room if aerosolizing procedures happening, if risk for Being sprayed then would be best to cover it with something like a trashbag

Recommend against sanitizing sprays

Be sure to use the wipe so that the wet time after wiping is long enough to disinfect

# Benefits with this Robot

All the staff member needs to do is push the on-button
Required less than 5 minutes of staff training
Something new and exciting/morale booster
Takes up little space
HIPAA approved
Easy to learn to drive
Invitations to drive can be shared with multiple providers

- E.g. nurse practitioners
- Specialty consultants
- Hospice providers
- Ultimately could be a way for families to visit with loved ones

Allows me to “walk” down the hall and say hi to people as I go by
Allows for involvement in multiple different activities…eg can stop by a meeting and then go see a patient and then go back to the nursing station to talk with the nurses and give recommendations.
Decreased PPE needs: Doesn’t require a staff member to have to don PPE to bring the tablet into the resident.

# Limitations with this Robot

Strong Wifi Connectivity needs—sometimes cuts out, usually comes back on after a few seconds.

Volume can sometimes be too quiet for the driver and the audience

Does not have a telescoping pole so limited to standing at one height

- Becomes an issue for visualizing skin concerns
- Has 3x zoom, but it does get pixalated with this

Requires someone to be present to wipe down

~ $2500

Could possibly get similar benefit by attaching a tablet to an AV cart wheeled into the residents room.

This is a nice supplement, but there is nothing as good as hands-on care

Calling is one-directional, ie…the resident/staff can't call out with it

# Before you buy

**Does your facility have wifi that will work with the robot requirements?**

Is your organization ok with it—it is HIPPAA approved.

It works on it's own hippaa approved telepresence website, not set up to work with Zoom, but can be done with some tinkering

Can work with multiple providers, possible to change the person in charge of the account

Doesn't seem to have a way for the facility to call you

The robot's tablet is an android device but the caller can be on any device with access to the web

# Influenza Vaccine Guidance

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# Influenza Vaccine Guidance

- CDC is recommending influenza vaccinations for:
  - **All persons age 6 months and older** including:
    - All essential workers
    - Persons at increased risk for COVID-19 severe illness
    - Persons at increased risk for influenza complications
- Vaccination should be administered to help reduce the burden on the healthcare system and healthcare resources during the COVID-19 pandemic

https://www.cdc.gov/vaccines/pandemic-guidance/index.html

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# Influenza Vaccine Guidance

- Vaccines should be administered by no later than the end of October
- Facilities should be aware of balancing the administration of the influenza vaccine with the peak of the flu season
- Appropriate PPE should be worn during administration of vaccines

https://www.cdc.gov/mmwr/volumes/69/rr/rr6908a1.htm

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# Nebraska Public Health Laboratory
# Point of Care Waived Testing for
# Long Term Care Facilities

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CDC
Centers for Disease Control and Prevention

NPHL
Nebraska Public Health Laboratory

DHHS
NEBRASKA

The College of American Pathologists (CAP) defines POCT as “testing that is performed near or at the site of a patient with the result leading to a possible change in the care of the patient.” POCT is usually performed by non-laboratory trained individuals such as nurses, physicians, nursing assistants, and anesthesia

# Clinical Laboratory Improvement Amendments of 1988 (CLIA)

Congress enacted the CLIA Act to ensure:

- accuracy and reliability of all laboratory testing.
- extended Federal regulation to all laboratories – hospital, independent, and physician office laboratories, etc.
- perform testing on human specimens for the purpose of diagnosing or treating a disease, illness, or assessment of the health of human beings.
- (CMS) has primary responsibility under CLIA for regulating laboratories

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# CLIA Certificates

- Many of the point-of-care testing procedures are identified by CLIA as waived while others are moderately complex.
- A site performing only waived tests must have a “Certificate of Waiver” license but will not be routinely inspected.
- They must however adhere to manufacturer’s instructions for performing the test.
- “Good Laboratory Practice” dictates appropriate quality testing practices
  - training of testing personnel,
  - competency evaluation and
  - performance of quality control.

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# Point-of-Care Versus Lab-Based Testing: Striking a Balance

**Advantages**

- portable, easy-to-operate devices
- return results quickly
- enabling immediate treatment or intervention
- speed and efficiency often greatly improves both patient outcomes and patient satisfaction.
- https://www.aacc.org/publications/cln/articles/2016/july/point-of-care-versus-lab-based-testing-striking-a-balance

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# Point-of-Care Versus Lab-Based Testing: Striking a Balance

**Disadvantages**

- not as precise and accurate as lab-based methods
- fall short of the sensitivity and specificity associated with laboratory analyzers.
- inability to detect interferences, such as hemolysis, icterus and lipemia in whole blood samples, can lead to inaccurate test results.
- Certain POCT methods are intended only for screening purposes and should not be utilized for diagnosis

- https://www.aacc.org/publications/cln/articles/2016/july/point-of-care-versus-lab-based-testing-striking-a-balance

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# What factors can affect POCT accuracy?

- Pre-analytical specimen collection errors
- Interfering substances including certain medications and over-the-counter supplements
- Altitude
- Temperature
- Humidity
- Failure to follow manufacturer instructions for calibration and quality control
- Failure to recognize and resolve instrument flags indicating an erroneous test result
- Improper instrument maintenance
- Inability to effectively troubleshoot failed instrument calibration, quality control, or error codes

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# POCT: Waived versus non-waived

- POCT may be waived or non-waived.
- Waived testing may be performed at the POC or in a centralized facility.
- POCT that is non-waived must follow all regulations for non-waived testing and have the appropriate CLIA certificate for compliance.
- Must follow manufacturer's instructions
- Not subject to routine inspections
- CoW Site Visits - Announced, designed to help educate on sound laboratory practices

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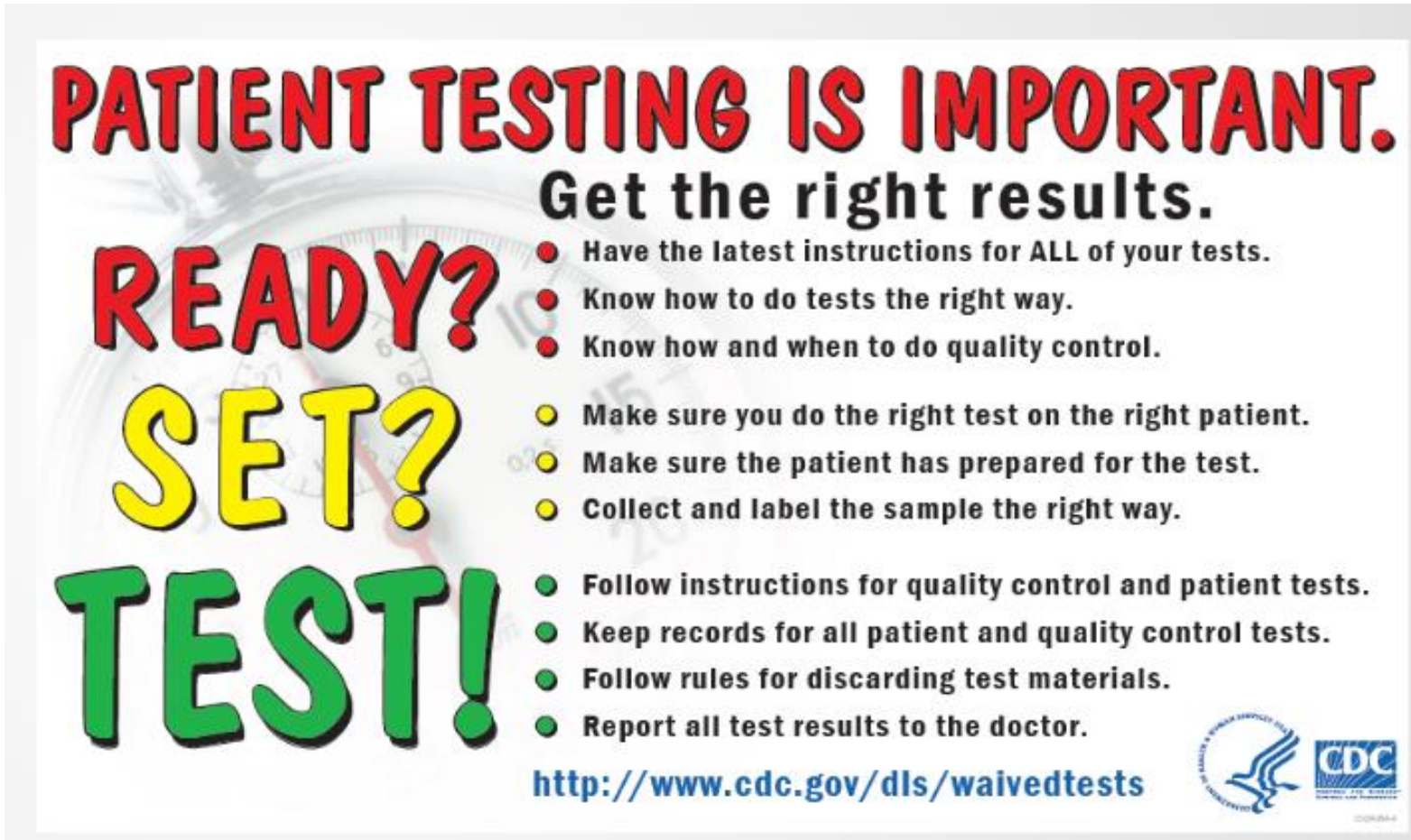
PATIENT TESTING IS IMPORTANT.
Get the right results.
READY?
Have the latest instructions for ALL of your tests.
Know how to do tests the right way.
Know how and when to do quality control.
SET?
Make sure you do the right test on the right patient.
Make sure the patient has prepared for the test.
Collect and label the sample the right way.
TEST!
Follow instructions for quality control and patient tests.
Keep records for all patient and quality control tests.
Follow rules for discarding test materials.
Report all test results to the doctor.
http://www.cdc.gov/dls/waivedtests
CDC

# Contact Tracing Resources

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# Contact Tracing Resources

- ICAP has developed Contact Tracing Worksheets for both Staff and Resident positive COVID-19 cases
- These worksheets are meant to help facilities work through the contact tracing process and document their findings
- These can be found on the ICAP Website along with the Contact Tracing Guidance document that was shared on last week's webinar

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/08/Staff-Contact-Tracing-Document.pdf

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/08/Resident-Contact-Tracing-Document.pdf

# Nursing Home Project ECHO

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# Nursing Home Project ECHO

- Project ECHO is a national program that is meant to give nursing homes (not assisted living facilities) access to subject experts and peers to expand their knowledge in infection control and quality improvement
- Project ECHO consists of 90-minutes weekly teleECHO meetings designed to bring you relevant training content and an opportunity to discuss your specific needs with subject matter experts
- 16 weeks of mandatory course content completes the program
- Nursing Homes will have option to participate in 60 minute optional weekly teleEHCO resource meetings for the remainder of the calendar year

# Nursing Home Project ECHO

- Project ECHO participants will have a chance to work with their cohort peers to develop best practices and discuss particular issues within their facilities
- The local Project ECHO HUB team will be available for questions and resources between the ECHO training sessions
- Funding will be made available to help LTCF facilitate participation in Project ECHO
- Each LTCF will nominate 3 to 4 healthcare workers to get trained (e.g. medical director, nurses or other staff interested in getting involved in quality improvement process)

# Bringing Nursing Home Project ECHO to Nebraska

- ICAP team leaders are working with other colleagues at UNMC to establish Nursing Home Project Hub in Nebraska
- A multidisciplinary team will be established to assist our nursing home healthcare work force with their education

The goal is that **by the end of 16 week training**:

Each nursing home will have their own experts in COVID-19 prevention and mitigation

# Nursing Home Project Echo

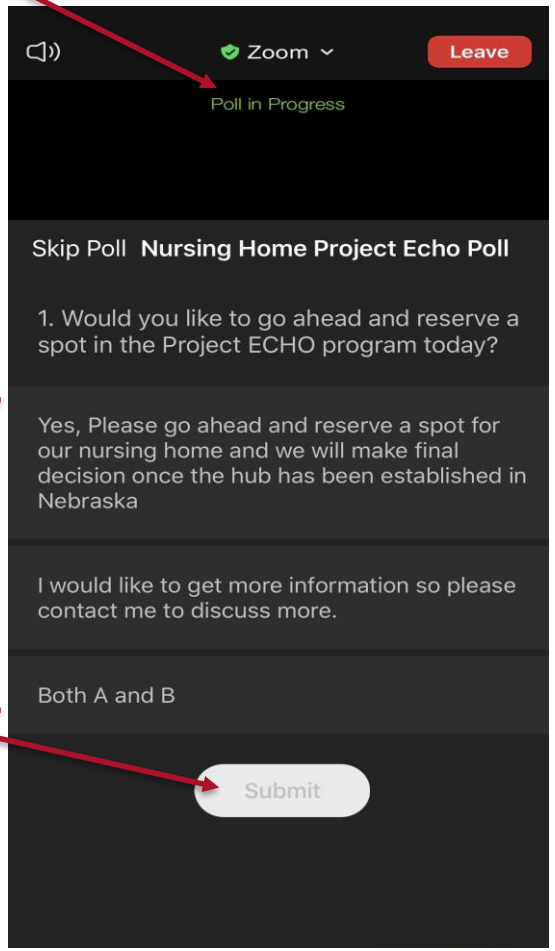
Poll Question:

Would you like to go ahead and reserve a spot in the Project ECHO program today?

A. Yes, Please go ahead and reserve a spot for our nursing home and we will make final decision once the hub has been established in Nebraska.

B. I would like to get more information so please contact me to discuss more.

C. Both A and B



# Infection Prevention and Control Office Hours

Monday – Friday
8:00 AM – 10:00 AM Central Time
2:00 PM -4:00 PM Central Time
Call 402-552-2881

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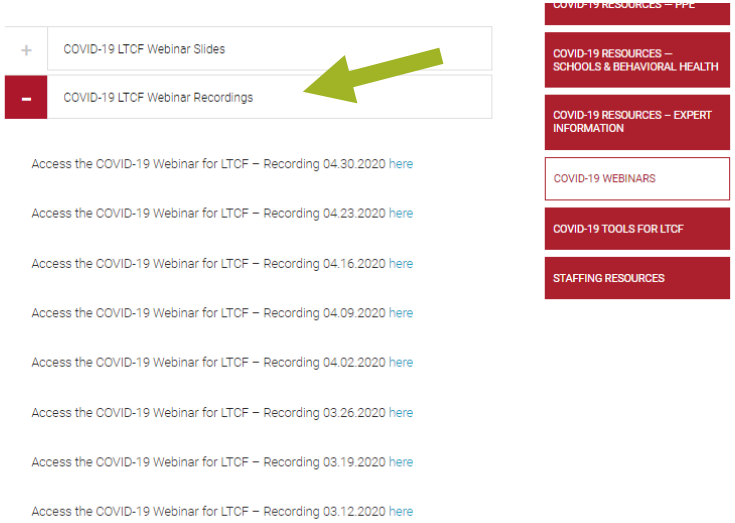


https://icap.nebraskamed.com/resources/

Moderated by Mounica Soma, MHA

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**Nebraska DHHS HAI-AR and Nebraska ICAP**
**Long-term Care Facility Webinar on COVID-19 8/27/2020**

1. **Related to POC testing, and identified problems, it would seem that at the present time the ability to get results quickly is very important, especially since the turnaround time is unduly long at times for the PCR tests. Are there tradeoffs identified to aid in the decisions to try more POC tests? Does this include saliva tests?**

   **Dr. Iwen:**
   The NPHL recognizes the importance of the TAT and tries to keep this as short as possible. We are trying our best to turn around results within 24 hours after receipt of the specimen in the laboratory, but some of this is out of the control of the laboratory i.e. transport and limitations in reagents. We do realize that POC tests are not as accurate as the PCR tests used in the laboratory but will provide positive results quickly. The goals now are to do more testing to be able to recognize more people who are infected with the idea that confirmation testing may be needed to identify those patients who may not be detected by the POC and the facility feels may be infected. Saliva tests are easy to collect but there are still limitations on who can perform these tests and information on the accuracy of these tests is still not known under clinical conditions.

   **Kate Tyner:**
   That was very helpful. Thank you, Dr. Iwen.

   **Dr. Iwen:**
   You're welcome and if there's any more questions on that topic, I'm happy to answer them. I would like to just make one comment here, and it's that the Nebraska Public Health Lab is really here and available for people to use for upright detections. We feel that our role in the state is to put out the fires when they start before they start to explode and we are available and we have career services. We have order entry with our new alert software to be able to get the samples collected, ordered and sent to us quickly and we will try to turn those around as fast as we can. Now the issue would be if all of a sudden every facility in Nebraska wanted us to send 10 samples. That would overwhelm our system. But we're there to get that original test quickly and get results back quickly to you to figure out what's going on. And hopefully, if you need confirmation testing on a negative point of care tests that you still feel that that person is infected, we'd be happy to get that sample as well and run a quick turnaround for that. So just to collect, you know we are here to help.

**Dr. Ashraf:**
Thank you, Doctor Iwen, I mean, I think it's great that that you have provided that information. You know, basically, the guidance for the nursing home through the State Health Department has changed over the last couple of months because we were having so many outbreaks that that the NPHL system was getting overwhelmed. So it is at one point of time, you know, it was decided by the State Health Department, and the guidance came out that all nursing home testing, including outbreak testing, has to go through Test Nebraska. So right now what the nursing homes are doing are sending it to the Test Nebraska based on the state guidance. But if there is an official change in that guidance, I think it will be good to have that circulated around. I just don't want to end up in a situation where you would start to get overwhelmed again because there are many outbreaks going on, even right now in the nursing homes as we speak. So that sometimes their tests in each facility are about 150-200 tests coming out of just one facility.

**Dr. Iwen:**
We can't we can't handle that. The bottom line is that if it's one sample, if it's a half dozen samples of close contacts, then yes, we can get a quick turnaround on that. We cannot do a complete facility surveillance of employees and residents. That's where Test Nebraska, really that is their goal to be able to deal with that type of volume. But, like I say, we can do the ones, twos, threes, whatever, to get you a very quick result. I'm realizing that Test Nebraska is doing a huge volume of tests, and it's difficult for them to turn those around quickly. Or if you're sending them to a reference lab, it's difficult to get those turned around quickly. So we want to help where we can to get a quick result. If that's something that would be needed for your facility.

**Dr. Ashraf:**
Thank you very much for the clarification.

2. **Any guidance to date on the use of POC testing to comply with CMS requirements to test staff?**

**Dr. Ashraf:**
I can let you know that the State Licensure department is actually working on coming up with some guidance that is going to come out soon, so I will leave it there right now because there is a state guidance that's going to come out. As far as I know, they're still working on it.

3. **What does ECHO stand for?**

ECHO=Extension for Community Healthcare Outcomes

**Dr. Ashraf:**
Project ECHO is basically, you know, I can I can find what ECHO stands for, but it is basically a tele educational service. It provides a platform like a zoom platform where people can come

together and discuss important, difficult, challenging scenarios and come up with an answer that they can go back and implement in their own clinical practice, in their own institution. So that is basically what product ECHO is for. It's for people to learn from the experts and become experts within their own institution. That has been the case, especially in rural settings, where there is a lack of expertise. Project ECHO has been utilized to develop local experts for many, many years now. And as I said, if you if you are interested, just answer to the poll that you are interested in that and we will reach out to you and give you more information.

**Kate Tyner:**
One of the themes with some of the questions is some of our friends from critical access facilities are saying they already participating Project ECHO. This is like a like a different work group?

**Dr. Ashraf:**
Yes, as I said, Project ECHO has been going on for a very long time for different issues. And as you said, there are many critical access hospitals that are probably already working with Project ECHO for management of Hepatitis C or for something else. But this is a national funding that is coming out to develop leaders in the nursing home who are going to be their local experts for Covid-19 prevention and mitigation. So yes, there are Project ECHO's for many different things out there. But this is for training local, for each nursing home, a team that will be the expert in Covid-19 prevention and mitigation. So even if you are participating in some other Project ECHO, that doesn't mean that they will get a different team or Project ECHO that will be running this, so you will still have to enroll in this one separately. Critical access hospitals are not actually going to be participating in it. It is only for nursing homes.

**Mounica (Moderator):**
So, it doesn't include health departments, right?

**Dr. Ashraf:**
It doesn't include the health department. It is going to be the nursing homes.

4. **Staff have been instructed that they can remove their goggles when they chart and are not in a patient care area. What should staff do with their goggles when they sit at the desk to chart and take them off? Is it appropriate to put them on top of their head like glasses?**

**Dr. Ashraf:**
This this is a question I plan to answer tomorrow in a different session because we had a meeting set up today with our biocontainment experts to further discuss this particular issue because it has come up before. So I don't want to give an answer right now and then have to change it. I want to listen to every single person in our team and the biocontainment team, the NETEC team, before I make the decision. I think this is a gray area. There are arguments for and arguments against it. So before we make any recommendation, I think I want to hear every

voice and then make a recommendation based on the best possible evidence that we can find. So we will provide an answer. But just not today.

**Kate Tyner:**
What's that called tomorrow, Doctor Ashraf? Do you want to remind the group just so they know?

**Dr. Ashraf:**
Yes, the Leading Edge and Nebraska Healthy Association call that usually happens with Dr. Gary Anthone at 11 o'clock.

5. **We are receiving feedback from families of patients on hospice in our facility that we are denying the additional care hospice normally provides (like additional aide visits for more personal care). How can we move forward to reintegrate these services back into our facility?**

**Dr. Ashraf:**
Before I answer that question, I think we have to understand the situation at the facilities. If a facility is having an outbreak that is going to be different than a facility in Phase 3 without having any outbreak and in communities that are not having high community transmission. But I think those two places cannot be practicing the same thing. I also would like Dr. Manley to just comment on what she has been seeing. Dr. Manly, if I'm not wrong, you are actively involved in hospice and palliative care career. Correct?

**Dr. Manley:**
Yes, I am.

**Dr. Ashraf:**
Do you have some comments on it?

**Dr. Manley:**
I agree with you. I think it really needs to be very dependent on the situation of each particular facility and also the situation of each particular resident situation. This has been really, really difficult. And it's been frustrating, I think, on both sides. I think before I gave you any strong answer, I would probably need to talk to you offline.

**Dr. Ashraf:**
That's fine. What I was trying to figure out is have you had to manage some of these situations where a resident needed the service and how have you been able to kind of manage that?

**Dr. Manley:**
A lot of it's basically been on an individualized basis and a lot of talking with all of the different parties that are involved. I would be just as interested to hear what other people have come up with to make it work.

**Dr. Ashraf:**
Yes, I think a general rule in my mind is that if someone needs a service that is very important for their care, and a physician kind of deciding that has become an essential service for this person likely or held at that point of time that that kind of becomes an essential service and an essential health care worker who needs to be at the at the facility. So it is the determination of the physician sometimes that this is basically required and then become essential person can come in, you know, follow all the policies and protocols off all the essential health care worker and do that. So that's the general rule of thumb. You know, the limitations in those settings where they are having outbreaks and things like that are because of limiting traffic for essential services. Now at some point of time, it had been determined that this service cannot be delayed for another week or two weeks while we're controlling the outbreak, then that becomes an essential service in my mind. So, it has to be documented. It has to be verified from the physician, and it has to be clearly put down. That's my infection control kind of rule hat that I'm wearing. There may be some issues with regulation here, and we may be able to come to an agreement with regulation. So, this is something that I think we have a call today with our colleagues in the licensure. And we can definitely bring this up as a point of discussion also. So, Kate, if you can put it on an agenda. Thank you.

6. **At Skilled Nursing Facilities or nursing home, is it a MUST to have nurses do the COVID screening at the entrance or could it be CNAs and med aids? At our facility, the nurses are struggling with time management due to them having to answer the door all the time. It is a state regulation or a law to have nurses do these screenings/assessments?**

**Dr. Ashraf:**
Kate, I will let you answer that question, although I don't think that there is any significant personnel requirement there.

**Kate Tyner:**
So the thing is, by your nursing license you're allowed to assess. That's like a high functioning licensure allowance. So I think you can have a less skilled person, a non-licensed person oversee the screening. And then maybe if somebody screens out with a symptom or has a question, that assessment would have to be a nurse, and I'm answering that from the basis of what I know about my nursing license. This is very much a regulatory question, and so I would recommend that this person reach out to regulatory. But that's my sense, you can't have a Certified Nursing Assistant (CNA) or your Administrator assess your staff members. They could help with the screening in the oversight and talking people through it. But if somebody screens out, if this person has some questions or we need to look further, that's when you would have to bring the nurse in.

**Dr. Ashraf:**
I think it makes perfect sense. If the job is to hand out a paper that has all the symptoms listed and say, 'yes, no, yes, no, yes, no', and if everything has been written no and a person hands

over that paper to let's say a CNA and there's nothing in there besides 'no, no, no, no, no', and everything checks out fine, then it's probably okay for that person to say, 'okay, fine'. Now, if there is a question or something comes up, then it has to be assessed by a nurse. Correct? That's what I'm understanding.

**Kate Tyner:**
That's the way I understand it, Dr Ashraf and I think furthermore, one of our colleagues has texted a couple of times during the webinar, if you have staff who are doing the temperature check or are passing out the papers, for example, you would want to reflect that somehow you had trained those people to do that task, and that there's a protocol in the background that if this happens, I'm going to ask a nurse. So the documentation of what the expectation would be in documentation of the training is really important, and we could lend that same need for documentation to the wonderful points that our public health friends brought to us from the laboratory. When you're training your staff to run these pointed care tests, that all has to be documented, right? So if you have five employees lined up around your new machine and you're watching the video together, that has to be documented that those people went through that training. So I think this answer about who can do what is important. But I think you also have to document how the facility made those choices and how they train people to do those special tasks.

**Mounica:**
Thank you, Kate. I don't think we will be able to get through all the questions online today. Is there anything else that you would like to touch base on before we sign off?

**Kate Tyner:**

There are a couple of questions coming through that are important because our ICAP team had the same questions today. In the new CMS, the testing memo that came out overnight, they talk about county rates of positivity, and Dr. Ashraf has let us know that the leadership team at the state level is looking at that and is helping to guide decisions about what positivity rates should long term care places should use. So we see the questions here, and I just want to comfort the audience that that conversation has taken place a little higher up and guidance will be coming on that. We really think our lovely guests for being here today.

**Dr. Ashraf:**
Thank you, everyone.

**Mounica:**
Thank you, everyone. If you have any other questions, or you need one on one support, you can always reach out to our ICAP team either via email or through our office hours. They are Monday through Friday, 8 to 10 a.m. and 2:30-4:30 p.m. at (402) 552-2881. The slides with the Q & A transcript and the recording will be posted on our ICAP website as soon as possible. Thank you so much for joining our call today.

## Other questions:

- **I understand that the Quidel machine has 97% sensitivity, is this true? If so would this not be as good a PCR testing and adequate for diagnosing?**

**Dr. Iwen:**
This sensitivity is listed by the manufacturer in the Instructions for Use based on evaluating 30 positive specimens. Unless this test has been evaluated under clinical conditions and peer-reviewed testing, I would not believe what is being reported by the manufacturer as what might be expected under clinical conditions.

- **Are there studies currently on the sensitivity of POC testing to determine what the true sensitivity rates are if the manufacturer information is not accurate as you indicated?**

**Dr. Iwen:**
Accuracy of testing is done by comparing among tests to determine by consensus true positive from true negatives and then presenting this data in a peer-review paper. I am not aware of any papers peer-reviewing the two POCs that we are talking about. Ideally it would be optimal to compare the test against culture which is not optimized for COVID-19 testing so comparison testing is really the only way to determine the accuracy.

- **Can we get something in writing from NPHL and Test Nebraska that they will not be able to guarantee a 48 hour turn-a-round for the required facility testing of all nursing home staff in a county?**

**Dr. Iwen:**
No lab can guarantee the TAT. There are too many variables involved in testing that are out of the control of the laboratory such as the preanalytical process to include collection and transport as well as the analytical processes when limitations in reagents and possible QC issues in testing that might occur.

- **Are Assisted Living Communities able to participate in Project ECHO?**

**Dr. Ashraf:**

No, it applies only for nursing homes as of now.