Guidance and responses were provided based on information known on 10/01/2020 and may become out of date.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

October 01, 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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Teri Fitzgerald, RN, BSN, CIC	TFitzgerald@nebraskamed.com
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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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Influenza Considerations During COVID-19 Pandemic

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2019-20 Flu Season Estimates

CDC estimates* that, from **October 1, 2019**, through **April 4, 2020**, there have been:

39,000,000 – 56,000,000
flu illnesses

18,000,000 – 26,000,000
flu medical visits

410,000 – 740,000
flu hospitalizations

24,000 – 62,000
flu deaths

https://www.cdc.gov/flu/about/burden/preliminary-in-season-estimates.htm

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COVID-19 vs. Influenza

COVID-19

- Loss of Taste
- Loss of Smell

Shared

- Fever/ Chills
- Cough
- Shortness of Breath
- Fatigue
- Runny/ Stuffy Nose
- Muscle Pain/ Body Aches
- Headache
- Vomiting/ Diarrhea

Influenza

- *All Influenza Symptoms could also be shared COVID-19 symptoms
- *Testing to confirm Influenza and COVID-19 status should be done

https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm

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COVID-19 vs. Influenza

- COVID-19
  - Symptoms usually develop 2-14 days after exposure
  - Contagious for up to 2 days before symptom onset and can remain contagious for up to 14 days
- Influenza
  - Symptoms usually develop 1-4 days after exposure
  - Contagious for about 1 day before symptom onset and can remain contagious for up to 7 days

https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm

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Influenza Vaccination

- CDC recommends that all healthcare personnel (and anyone over 6 months of age) receive the annual influenza vaccine to help prevent the transmission of influenza within the facility
- Even if residents are in the Yellow Zone or quarantine, proceed with vaccinations for residents that are asymptomatic
- Yellow Zones can last for a long time, you don't want to delay influenza vaccination
- General guidance for vaccination states they should be deferred for residents if they have confirmed COVID-19 positivity (Red Zone) until they meet the requirements for discontinuation of isolation

https://www.cdc.gov/flu/professionals/diagnosis/consider-influenza-testing.htm

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Proper Influenza Vaccination

- Best Practices for administering Influenza vaccinations
  - Modify vaccination process to account for zoning (if needed)
  - Social Distancing: Avoid congregating residents for vaccination, consider bedside administration
  - Proper PPE: COVID-19 transmission based precautions based on zoning within the facility
    - Green Zone: Change gloves/ hand hygiene for each resident care instance. Surgical masks (and eye protection, if applicable based on community transmission) may stay on between patients
    - Yellow Zone: Change gown and gloves/ hand hygiene for each resident care instance. Mask/ respirator and eye protection may stay on between patients

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Staff Education

- Staff education can play an important role in your facility
- Staff education can include;
    - New employees can take a course on the flu and why it's so important to be vaccinated when working with older adults
    - Develop a FAQ for the staff that dispels myths surrounding vaccination
    - Create a news article or blog abut the importance of the flu shot this year and add it to your employee information
    - Share status updates and data directly with leadership to help identify barriers

https://www.cdc.gov/flu/professionals/diagnosis/consider-influenza-testing.htm

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Additional Tools and Resources

- AMDA Best Practices on Influenza Vaccination for 2020-2021
  - https://paltc.org/sites/default/files/AMDA%20Best%20Practices%20on%20Influenza%20Vaccination%20for%202020_9_21_20.pdf
- Interim Guidance for Influenza Outbreak Management in Long-term Care and Post-Acute Care Facilities
  - https://www.cdc.gov/flu/professionals/infectioncontrol/ltc-facility-guidance.htm

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PPE Storage

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PPE Storage

- PPE may NOT be stored in any egress corridor/ window area
- Paper bags may NOT be hung on the wall as they are flammable
- These violate fire code

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PPE Storage

- PPE should be stored in areas away from exits and resident care areas (no resident access)
- Face Shields may be hung on the wall in rooms behind a fire –rated door

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Antigen Testing

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Examples of Scenarios Requiring Confirmatory PCR Tests

- A symptomatic resident or staff who tested negative
- An asymptomatic staff who is positive on routine weekly testing but denies having any recent exposures to COVID-19
- An asymptomatic resident in green zone (who is not considered to be exposed) is identified on facility-wide testing
- An asymptomatic resident in yellow zone who is antigen positive during outbreak testing may require PCR test on case-by-case basis before being moved into a COVID-unit.
    - Discuss with ICAP as decisions on moving to COVID-unit based on positive antigen test will depend on the probability of being exposed. In general, if there are several residents already identified on the unit confirmatory PCR will not be required.

UNMC ID Nursing Home Project ECHO

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Infection Control Assessment and Promotion Program

Nursing Home Project ECHO

- 90 minutes per week of educational content in group settings through Zoom
- 16 weeks of mandatory course (with certificate of completion)
- 32 weeks of 60 minute sessions optional after that
- 3 to 4 healthcare workers will participate in this training (e.g. medical director, nurses/ IPs, Administrator/QI Staff, or other staff [e.g. CNA] interested in getting involved in quality improvement process)
- LTCF will receive $6000 to compensate for the staff time spent on training

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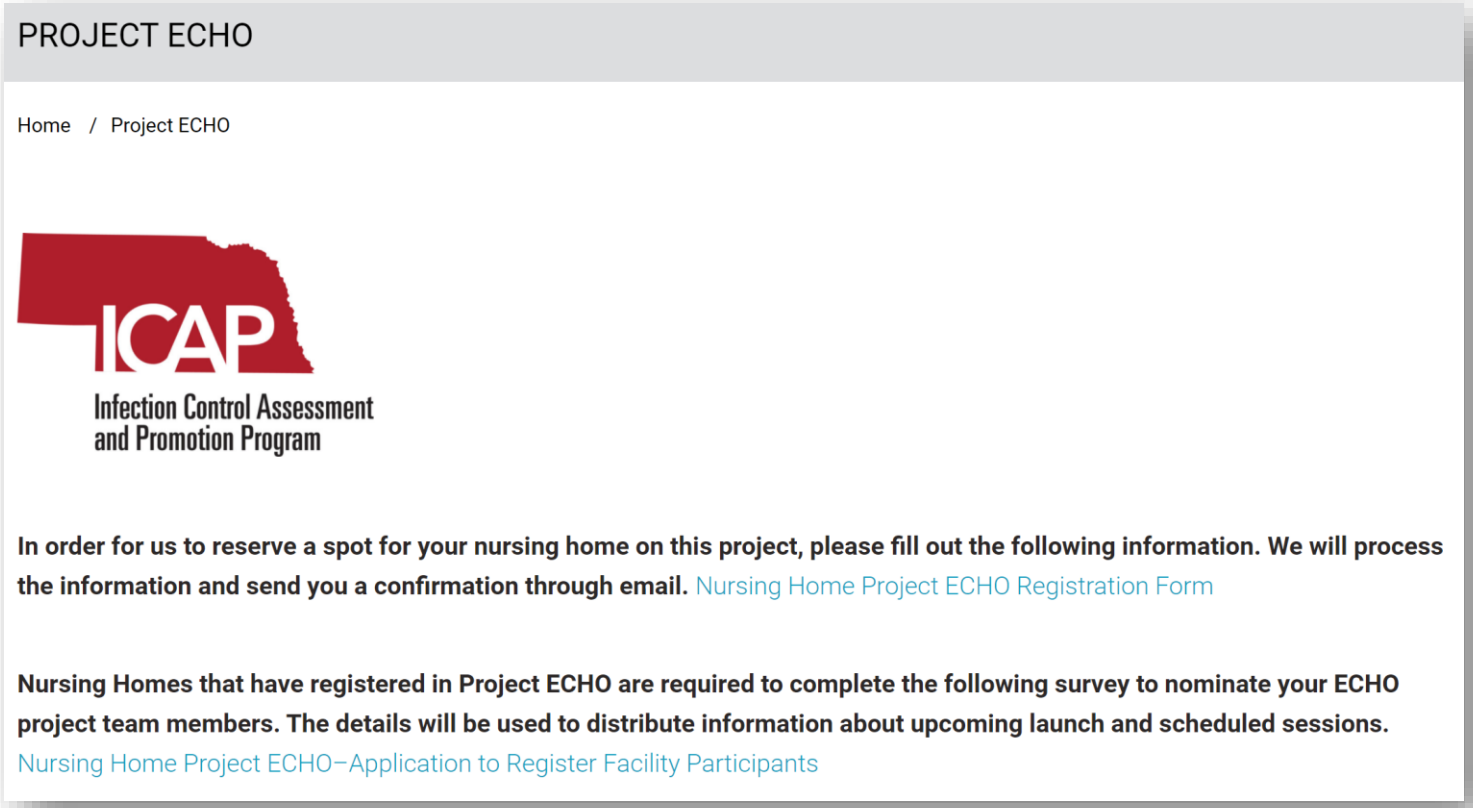
Nursing Home Project ECHO

- For more information on UNMC ID Project ECHO, go to our website https://icap.nebraskamed.com/project-echo/



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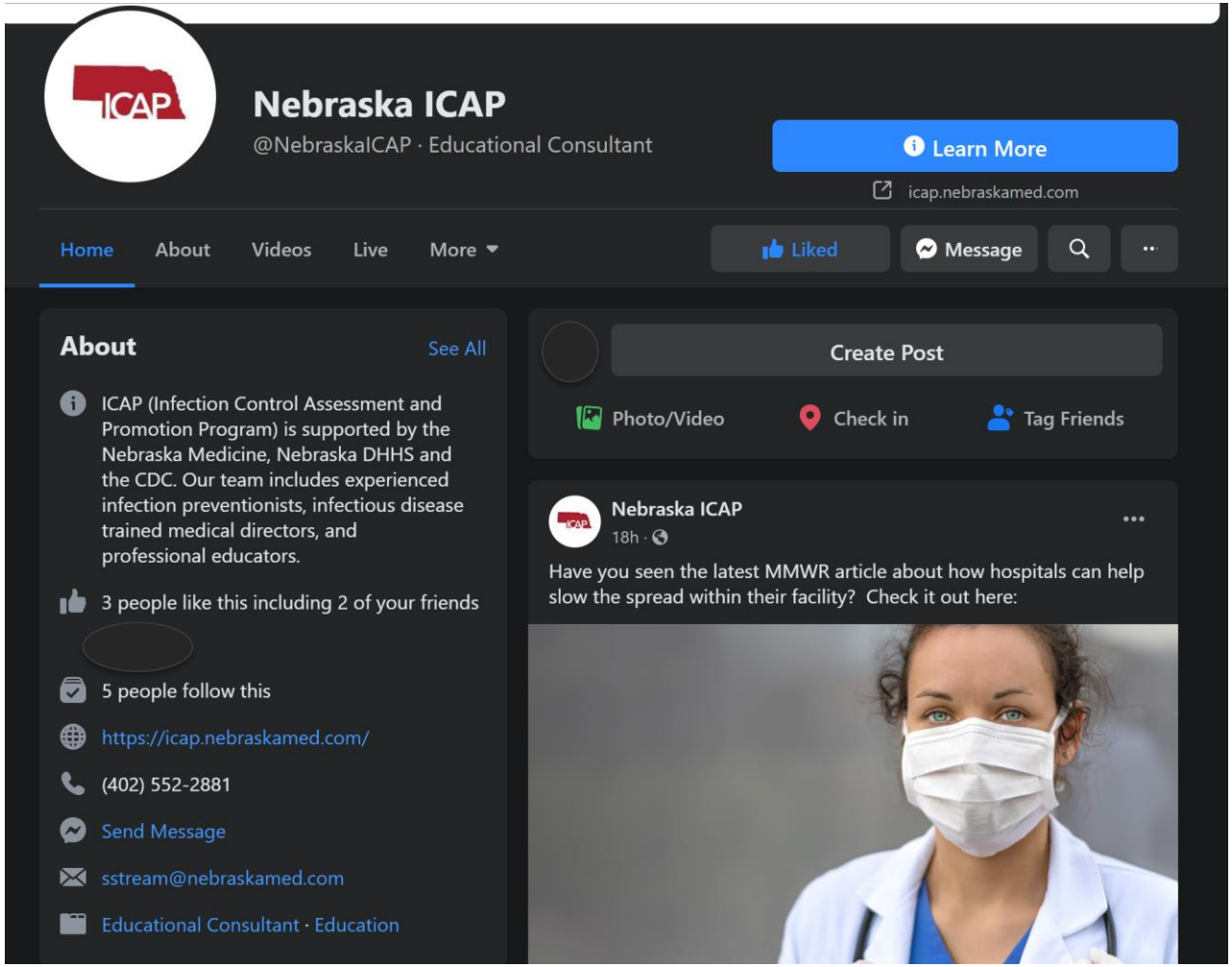
We are on Facebook!

- This platform will be used to distribute Infection Prevention and Control (IPC) Firstline Training to staff
- The staff will be able to receive training certificates for participating in the training programs



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Questions and Answer Session

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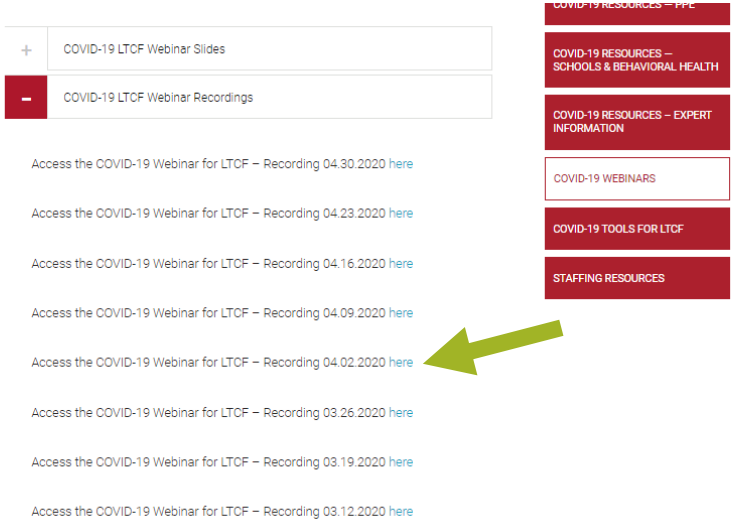
A transcript of the discussion will be made available on the ICAP website

Panelists:

- Dr. Salman Ashraf, MBBS
- Kate Tyner, RN, BSN, CIC
- Teri Fitzgerald, RN, BSN, CIC
- Sarah Stream, MPH, CDA
- Jody Scebold, Ed, MSN, RN

- Moderated by Mounica Soma, MHA
- Supported by Marissa Chaney and Margaret Deacy
- Slides Developed by Sarah Stream, MPH, CDA



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

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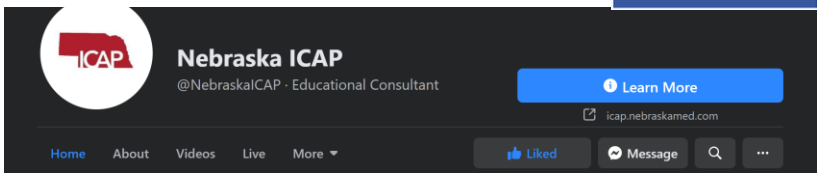

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Nebraska DHHS HAI-AR and Nebraska ICAP
Long-term Care Facility Webinar on COVID-19 10/01/2020

Question and Answer Session (time stamp 26:47)

1. Can you please clarify this? According to WHO, you do not need gloves to give an IM vaccination. Many people do not glove to give influenza vaccine, as it is not required. Hand hygiene should be done between residents.

Kate Tyner:

Yes, So I saw this question come into the chat, and I appreciate the clarification. So the rationale that we put into the slide set is really balancing COVID precautions with influence of vaccination. It's a very good clarifying point that gloves are not necessarily required to give IM vaccination, but we were really trying to frame this more and how do you do it in a COVID environment? So furthermore, you know, Teri and I, we have lots of experience giving flu vaccines, and I think, Teri, if you want to weigh in on this, we often wore gloves, or at least have them nearby in case of your patient or your resident starts to bleed. You want to have the equipment you need to stop bleeding and be able to don gloves quickly because there can be blood, so you may not have to wear gloves because they're in most cases is no blood. But when you do encounter blood, you want to be ready to, use your good blood borne pathogen control measures for that. So, Teri, do you want to add to that at all?

Teri Fitzgerald:

No, Kate, I think that was a great answer. Yeah, we always kept them nearby so we could don them quickly. That was in the, you know, congregate, a study of everybody lined up waiting for that scene at a busy facility. So I think going room to room would probably be a little bit more convenient, you know, to have them nearby for sure. If your resident does bleed. So I think you covered it.

2. Could someone advise on which flu vaccine to give: the regular dose or the high dose for seniors? Last year, a local doctor during a flu clinic gave regular dose, but not the high dose. He advised it only catches like another one person and does not give it.

Dr. Ashraf:

Basically, the CDC's recommendation does not prefer one over the other. However, the high dose vaccination does have increased benefit in terms of immunogenicity off those vaccines. There is no mandate from the CDC about the definitely using, high dose vaccine in the elderly, although if they have been shown to be a little bit more beneficial in terms of creating Immunogenicity from that immune response from that vaccine. So again, what we want is everybody to get a vaccination. If there are elderly, who may benefit from high dose vaccine and you can give them that is great. But the focus should be on getting everybody immunized.

3. What is your recommendation with gowns? We are receiving gowns from the health department that are ones you place over your head. Although we know we cannot do this since our face shield exteriors are dirty, are these acceptable?

Kate Tyner:

So that is a great question, and I want to remind people that we had presented on this topic during the summer, and I hope for the question and answer. Maybe we can put a link back to those slides. When you are allocated the gowns that do not tie, they are over the head. Remember that the ideal way to don those is actually to break the neck and to tie them behind your back. So, like as you are putting on the gown, you would literally tear the paper or the plastic so that it opens as if it is a tie gown. Then, you tie that onto your neck so that you do not have to go over your head. So they can be used, but you have to, you do not do a different process for donning those. Morgan Shrader had given some very good guidance about, you know, tying those in a bow so that they're easy to take off. And then it kind of even showed how you would tie those kind of closer to one shoulder so that it is easy to untie with one hand. And so the answer is yes. They are appropriate gowns, but you have to tear them in order to make it so they do not go over your head.

I am hoping for when we post the Q and A, we can put a link right into that. I will have to go and find that just reminding the viewers that those of us at UNMC and Nebraska Medicine we have had some computer issues, and so we will have to go in and find those links, but we will definitely put them into the posted Q and A document. The transcript.

4. Are you aware that outbreak Test Nebraska results are taking 4 to 6 days?

Kate Tyner:

So I was the one who kind of identified. I really wanted to address that question, so we know that Test Nebraska results are really slowing down again. I have been working with facilities that are going longer than 4 to 6 days, more like seven days again. And so what I want to put in front of people is remember that you are not required to use test Nebraska. Many facilities are learning now to use different services who can give you a faster turnaround time. The benefit with Test Nebraska is we can get you supplies through the local health department. Nobody pays for those you know, that does not cost the resident. It does not cost your facility, so that is the benefit of test Nebraska. But the cost is, sometimes those results are much slower. And so, if your facility really wants a faster turnaround than we would encourage you to continue to look for labs, who could give you that. In addition, in the rare instance that we really need a very rapid turnaround for a test to make decisions about clinical care, you can contact ICAP and we can work with you to send some specimens, and we are talking like, ah, handful, or less to the Nebraska Public Health Lab. But that is the rare instance that cannot be used for testing the whole facility that cannot be used for doing any surveillance testing. It is the rare instance where we need a very rapid decision so that we can make clinical decisions.

Dr. Ashraf:

I would like to add is that you know, we have brought that up to the state, uh, a team who is working with the Test Nebraska and informed them about these delays and have been told that they have been looking into even increasing the staff on the Test Nebraska and increasing the capacity and all those things. So they are hoping that they can get the numbers, the time turnaround time back down again. So we will see. They are aware of it, they are working on it and they think that they can bring it back down again. They were able to cut the time down before, but I think recently there have been some surge and they probably had some lags. Now they are probably if they are able to cover those lag things that they were lagging on, they probably can start turn around sooner than later. Sometimes we have seen that the community testing of Test Nebraska is a little bit faster than the long term care testing. And that is, we are asking them to look into that and maybe even prioritize the long term care time. So we will continue to, advocate for prioritizing the nursing home labs.

Kate Tyner:

Dr. Ashraf, you made a really important point that we did not stress on our slides. Like we sometimes do, is that in Nebraska were experiencing a pretty severe surge. Um, you know, it has been on the cover of

the World Herald in the last week, here in Omaha. But, you know, our acute care beds are really stretched. We are at the point, even with, you know, the number of beds that were required during the surge in May. So we are experiencing as serious, if not more serious COVID spread than we ever have before. And that is very clear. I think Dr Ashraf's point that the testing capacity is really stretched right now. It really, as health care workers who are really familiar with COVID wearing our masks in the community, really being cautious and vigilant about our contacts, things like that. You know, we stress that all the time. And I think it's just important that we, you know, put that in front of the viewers again, that the surge is really, really intense right now and we can't let down our guard.

Dr. Ashraf:

Yeah, in just the last two weeks, we have more than 70 facilities, more than 70 long term care facilities that have, been having ongoing cases of COVID 19. More than 70 facilities in the state is having ongoing cases in the last two weeks alone. So that is how much, our nursing homes are being getting involved because of the community surge I will say.

5. Having the paper bags, not by doors. How is this okay, since CMS and the state say you cannot enter the building beyond 6 feet without your mask or goggles. How are we supposed to be compliant?

Kate Tyner:

So that is a really great question. And I can give one response that has been suggested from our colleagues on the NETECH team. And that is, in instances where you don't have an appropriate kind of anti-room or like a double doors coming into your facility, that you can send your staff home with a surgical mask for the next day, so that they can put that on in their car. At Nebraska Medicine, the protocol is that we are accountable to wear cloth masks from the time that we leave our car into our appointed units or you know, parts of the building. So those are some things you can consider. With that, this challenge with, you know, compliance with fire precautions and PPE I would like to ask the audience if anybody has come up with some good creative solutions that we could share, you know, remember that these webinars aren't just, you know, for us to give information to you. We want these to be an opportunity for people to share information. And so, if you have come up with, like a creative hack for this or you have some advice, we would really love to see those pictures or hear your feedback. So, um, if you could email any one of us, um, those examples, I would love to share that on a future webinar. I think this is an important point. It is a difficult challenge and we want to kind of share best practices.

Dr. Ashraf:

Yeah, and you know that's exactly what I do Kate, is that when I come from home to the to the hospital, I am wearing my own cloth mask on when I go to you know, before I go to enter the clinic, I will get a surgical mask and then I will wear that and then enter the clinic. So basically, somewhere between my car until the patient care area. If there is a place, where you can get the surgical mask and in the meantime, be wearing the cloth mask. That is another way of doing it. And you know, the other part is also good. If somebody can take a mask home for next day, that is fine, too.

Kate Tyner:

The strategy with the taking home the mask that are neat colleagues had suggested that particularly for like the smaller assisted livings or memory care areas where the whole building is essentially becomes a red zone. Because you could have residents with cognitive challenges or dementia who could be out of their rooms. Um, you know, at that point everybody sharing airspace and in some of those buildings, we have defined the whole spaces red in those situations. That's where NETECH has really started

coaching some of those facilities, and that's it should be kind of a smaller niche of facilities, but that's where you might even send people home with an N 95 respirator for them to store at home. And that way, a soon as they enter the airspace of the building with those residents. They have an N 95 respirator on again. I think that is kind of the rare example. But that is one of those challenges where you might have to come up with kind of out of the box strategy.

6. If a staff member test positive and has two negative tests before their 14 day quarantine is done, are they allowed to come back to work or must they wait until they have been isolated for 10 days? They're not immuno compromised. Or is it for 14 days?

Okay, I am going over the question one more time. If a staff member tests positive and has two negative tests before the 14-day quarantine is done, are they allowed to come back to work? Must they wait until they have been isolated for 10 days or 14 days?

Dr. Ashraf:

Okay, so the isolation duration is not 14 days. Quarantine is 14 days, but those are quarantines for people who never had COVID 19, who were exposed to COVID 19 and are now waiting to develop COVID19. If they can wait up to 14 days and if they are still negative at day 14 then they can come on, come back to work. So basically, that is for people - the quarantine for 14 days for people who have never developed the disease but have been exposed have a significant exposure. So that is different. Now I think the question what is asking is that if somebody actually have COVID 19 so they need to isolate. They need to isolate, depending on how severe the COVID 19 disease is. For mostly mild disease or asymptomatic disease, the duration is 10 days for severely ill people or severely immunocompromised person; the isolation can be up to 20 days. The question is that if they have not gone through those 10 days, then they are not gone through the 20 days. Can they come back to work if they have to test negative, definitely to tell if they have to test negative and they are asymptomatic, Um, then they can return to work at that point of time. So let's say they got they got a test on day seven and they got a test on day eight, and both day seven and day eight test was negative. Then they do not have to wait an extra two days. I think they can come back to work on day number eight. That is perfectly fine. But remember, the two test negative is only pertinent when you have a positive test before. You cannot apply the two test negative logic to someone who never had a positive test. The two-test logic goes only for people who were positive at some point and then eventually turned negative. That is when two-test strategy can apply. I sometimes hear about or somebody was exposed and then we got two test negative on that person. Can that person come back? No, because that person was exposed, but we never had a positive test on that person. We cannot apply the two-test logic on that person. That person will need 14 days of quarantine regardless. It does not matter whether they have two test or not. But for this person, I think how that situation is being described, that person probably can come back to work. I do not know how many days have passed by now. But for most part, if you are doing a follow up as you probably not doing it before they seven anyhow. So I think it makes perfect sense.

7. We are in a yellow zone due to having a staff member testing positive for COVID. We have two roommates that are not getting along, and one resident wants to move to a different room to get a different roommate. Is it okay to move residents to a different room when you are in a yellow zone? How about admissions? Is it okay to accept new residents, but in the yellow zone.

Dr. Ashraf:

Okay, so I really hate moving people around when there are exposures in the unit. More movement can sometimes mean more transmission in that unit. Usually, if in those situations where we do have to separate people, I usually recommend that, go ahead and move the person out in the same unit to a private room. Not to, not with somebody else, but by themselves. That is the best strategy that I usually recommend now. If you do not have another room in that facility or in that unit. Then, you are kind of a,

at a loss. I guess you have to accommodate if two people are not getting along and you have to do that, you probably have to accommodate that and you will accommodate based on your best, thing that you can figure out for them. I just, I do not think that is the best idea. I do not know whether I can stop you from doing that. I do not think there is any regulation on not moving it with another resident, although I will be very suspicious off that move, and I will try not to do that kind of move. So that's number one. Number two about new residents. There is no regulatory requirement or that you stop admitting at that point of time, however, you know if you are having an outbreak and you are admitting someone, that person definitely may have a risk now after admission to be exposed to COVID 19. If it is going on in the building, that person have to understand the risk, and have to be ready to take that risk on. I usually try to recommend if you do not have enough staff - if you are having an outbreak, your situation in a facility situation is very, very unpredictable, also. Because it has not been uncommon for us to see that we actually close facilities down, in outbreaks, so sometimes it can become so bad that people actually will not be able to provide care. Facility will not be able to provide care off people who are already in the building. And then you are adding, adding more people on in that situation, you just have to be really careful when you do that kind of move. I cannot tell you that you cannot do that. I think you can. It is just that you just have to make sure you have enough resources and the people know on the residents who you are getting admitting knows what is going on. So, all of that? Yes.

8. Isn't it a conflict of interest when ICAP is to be a resource to the facilities and at the same time reporting to licensure, then licensure talking to ICAP about residents we are reaching out to you about? Is this not a HIPAA violation of discussing residents?

Dr. Ashraf:

It is not that that we are discussing residents. It is that we are discussing strategies with the licensure. Then the second thing is that what we are doing is mediating sometimes. Like we are providing expertise to the facilities were also providing expertise to the licensure. So we are acting as the state resource and expertise on infection control. So when we are reaching out to you were reaching out to you as infectious disease experts, Infection prevention control experts. When we are talking to the state, we are talking in the same capacities. Now, there are times where facilities do want to share the information with the state because they want to know why this, whether we should consider this, infection case or a reinfection case. Is this a new infection or it is an old infection. The only way to share that information is going to have a patient name and a date of birth and things like that, but that it does not happen without the consent of the facility without having the resident knowing about what is going on. So all of those things are happening with the consent involved in that. So there is no information that is going along that a facility is not already accepting, to pass along.

Kate Tyner:

Then I would add to your response Dr. Ashraf, that it's been on these calls, particularly where the audience is really compelled us to try to act in step with the CMS recommendations and compliance so that the recommendations that are coming out, you know, jive between the institutions. And so, we have taken that very seriously. And so we worked really hard with NETECH and with the licensure division so that we are all kind of acting in accord in respecting each other's guidance. We are trying to make that so that it is easier for the long term care facilities and that we are presented more of a united recommendation set. With that I think there's also this issue of, you know, we're in the midst of a pandemic and when we see things that are, you know, somehow unsafe or there's a way that by sharing you know, someone else's issue that we can help other facilities to be ahead of and be more compliant. We really want to do so. And so we could not be more pleased that we have such a collegial group of workforce, you know, between NETECH, licensure, ICAP and DHHS, and we are really acting in the best

interest of all the facilities that we work with. Therefore, you know, we really want you to know that that is not a conflict. We are doing that on your behalf.

Dr. Ashraf:

Yeah. And I think it is important to kind of facilities to know you know, what kind of information is being discussed so that the information that we discuss with the facility if a facility ask us a question or something like that and we answer that question; if you discuss a problem and we answer that problem to you, that information is not being shared with the licensor team at all. The information that is being shared is only, the one that you have asked us to go on, find solution, and find answer, whether it takes licensure or whether it takes somebody else to get that information out. There are many times a facility have called me and said, “This is what the situation is going on. You know, what should I do in this situation?” And I say to them that this is probably something that licenser should answer. Now, if you want me to go ahead and talk to the licensure about, I can do so on your behalf. Or you can go ahead and talk to them yourself. Because there are so many things that being discussed that is not related to infection control. It has to be discussed with the licensure, because they have the right information. So I think sometimes we just act as a mediator between the facility and the licensure. We do not have to, but sometimes it makes better sense for the facilities that we do that for them and we do that and same thing with the licensure, sometimes licensure get question that they cannot answer, and they then asked us to provide that answer and we do that. So I think it is like a network that we have developed collegially. And, I do not think so that there is any conflict of interest in that. But I will be very, very open if somebody had an example where they feel like that. That is not right. I will be very, very open to look into that. Because we do want to keep it the way that you guys want. Because you are the one that we want to work for. So if you see that there is a problem anywhere, reach out to me. You know. We will solve that problem right away and change the procedures. But I really need to know where the problem is. Thank you.

9. If we have an asymptomatic individual test positive on the antigen test and who subsequently test negative on a PCR, do we need to report that individual is positive to a local health department and to the CDC?

Dr. Ashraf:

So, all antigen test are supposed to be reported, so if you have a positive antigen test that is supposed to be reported. What you also have to do is you report the follow up PCR also to the state. So, you know, reporting. Actually, if you know, the PCR is going to get reported anyhow through the lab. But you can also on your spreadsheet, if you're sending a spreadsheet, you can also on that spreadsheet mention, the PCR result and the antigen result and that way they will know that there was a follow up PCR done. That was negative. So they can make an inference from that. That is probably what the false positive antigen. But yes, you still have to report both. And I think that's a very good example. Right there, right here. You know that this was not an infection control question. It was mostly regulatory question, but because we worked with them, we talk to them all the time. We have meetings. I know the answer to that. And I was able to give you the answer.

10. With a staff POC testing, if someone has had COVID positive in August, we do not have to test him for three months. Unless signs and symptoms closer to the three months. If COVID can last in your body for six months, how do we know they are truly positive again or carrying it yet?

Dr. Ashraf:

Okay, so here's the thing. If somebody has symptoms that are consistent with COVID and we test, we basically even in the 90 days’ time frame, we will have to test them, as you just describe, so we will test them and let's say they come back positive. Okay, so the question is very valid. Is that is it really COVID from this time a new one or is it previous? How will we know? So first of all, you know, how we know is

that, that person should be reevaluated by the physician for other causes off illness. If you can find a really good cause for what is causing the symptom, then it is probably that and not COVID, number one. But if we cannot, and that is the only thing that is coming back positive, then it will make the chances of a reinfection pretty high. The second thing that we usually do in those situations is you know, sometimes we look at this value called CT value, a cycle threshold value. What it tells us is that you know how well this virus is replicating so if the CT value is very high, sometimes it tells us that this probably is an older infection or a very ugly infection. Either, it can go either way, but in this situation, it might even mean a very old infection. So we try to look at the CT value. Then another way to look at it is if that person previous test was done let us say at NPHL and we have the sample at NPHL already from the previous test. What they can do is to look at this time virus, and they can try to compare the virus that was seen, three months ago to the virus that is being seen now and try to see whether they look the same or they are different viruses based on genetic sequencing. There are different ways to figure that out. It is a long process. This is one of those processes where you will contact us and say, This is the problem that is going on and you will probably than have to talk to that staff member, get their consent to discuss the information with us, send the lab test results and things like that in their date of birth. And when they did get tested, and we will then share it with state to go and do some investigation on this. So, that's where you will be providing us some information of about that stuff that we will then be providing to the state or you can directly reach out to state. I think. Either way, it is perfectly fine. It just happens that we know the process of people reach out to us. And then we will try to connect them to the right to the right people. And there is an investigation team at the state that will look into those cases.

Kate Tyner:

So, Dr Ashraf, I know we are coming up against time, but I think it would be also good, Doctor Nada Fadul is going to give, you know, an overview of you know what we know about reinfection during our Tuesday webinar at noon. That is usually a webinar we really distribute mainly for hospital infection preventionists. Um, but if there's people on this call that would want to learn more about kind of like the science that's been currently put out on reinfection, that would be another good webinar to join. And that information is on our website, as is the long term care webinar invitation.