COVID-19 Region 7 Webinar for Critical Access Hospitals and Outpatient Facilities

Presented by Nebraska Medicine and the University of Nebraska Medical Center in collaboration with the Centers for Disease Control (CDC) through NICS (National Infection Control Strengthening for Small and Rural Hospitals)

University of Nebraska Medical Center

Nebraska Medicine

Today's topic: Clinic Case Cluster

Guidance and responses were provided based on information known on 1/19/2021 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and jurisdictional guidance for updates.

Margaret Deacy, Moderator

Panelists:

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Karen Amsberry, MSN, RN	kamsberry@nebraskamed.com
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Acknowledgement:

Today's presentation is produced in cooperation with Nebraska ICAP (Infection Control Assessment and Promotion Program)

Clinic Case Cluster

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Associate Professor
Medical Director, Specialty Care Center
Associate Medical Director, Nebraska ICAP

University of Nebraska Medical Center

Nebraska Medicine

Harmony Clinic COVID-19 Outbreak Case

- On Wednesday October 7, a clinic employee (Debra) reported symptoms of cough, fever and fatigue
- Debra reported her husband got with a group of friends 5 days ago and one of the friends now tested positive for COVID-19
- The husband is asymptomatic, but both of them will get tested
- Debra was directed to self isolate until the test result is back and contact employee health
- October 8, Debra tested positive for COVID-19

Staff Exposures at the clinic

- Debra shares an office with another employee Tina and they sit> 6 feet apart, but don't wear masks most of the time
- On October 5 and 6, Debra was in the clinic, sitting in the work room 3 feet from Laila for >8 hours
  - Both employees worse masks most of the time, but were sipping on water and coffee occasionally
- Several other employees were in the workroom >6 feet apart and wore mask except for when drinking water
- The work room also serves as office space for 2 clinic staff
- Several other employees were in and out of the work room and briefly interacted with the sick employee

Patient Exposure

- The clinic has a strict mask policy for all patients entering clinic
- Patients who do not have a mask are handed a mask at the door
- Staff mask and eye protection when interacting with patients is strictly enforced
- Debra is a provider and saw several patients in clinic on Monday and a couple of patients on Tuesday, but all of them wore a mask and she had mask and googles on

Spread to staff

- October 10, Laila reported not feeling well, she worked from home and contacted employee health to get tested
- Her test result came back positive so she self isolated at home for 10 days
- October 19 days later Tina developed symptoms and tested positive for COVID-19
- A third employee who had a minimal interaction with Debra (but has recently travelled outside of the country) tested positive for COVID-19
- All these employees immediately self-isolated as soon as symptoms started

Colleague to Colleague Exposure (Status Update As of 10/29)

- Initial Positive on 10/8 - works closely with team in confined space and some team members removing masks periodically when working within the confined space.

- Tested 11 individuals between 10/11 and 10/13
  - 2 have developed symptoms
    - 1 tested positive on 10/10: Incubation period from last day of exposure would be through 10/23
    - 1 tested negative
  - 9 remain asymptomatic
    - All 9 have tested negative - instructed to continue monitoring for symptoms and contact EH if symptoms develop

- Additional positive on 10/19. Re-testing 16 employees between 10/21 and 10/23, will continue to monitor through 14-day incubation period from last exposure, which will be through 10/30
  - 15 tested negative
- 1 tested positive, but not related to work exposure

Mitigation Strategy

- Work room was dedicated to staff who use it as an office and separated by >6 feet
- Staff to work from their office and no longer to use workroom
- Staff who share offices to wear masks all the time
- Other desks in the workroom were blocked by a sign
- Strict mask enforcement for employees unless they are alone in their office
- Housekeeping staff were informed and the offices were disinfected
- Email communication with staff with regular updates
- Weekly huddle with update to staff
- Update on status of sick employees with their permission
- Attention to staff morale

Nebraska ICAP Acute Care Services and Support

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Nebraska ICAP Acute Care Support and Services

Infection Preventionists can be reached at **(402)552-2881**
During the hours of 8 AM – 10 AM and 2 PM- 4 PM, Monday – Friday
Infection Preventionists can also be reached via email at
nebraskaicap@nebraskamed.com

ICAP
Infection Control Assessment and Promotion Program

The Nebraska ICAP (Infection Control and Assessment Promotion) Program is a grant funded team that works through a CDC grant for Biopreparedness. The ICAP Team is proud to announce they have Infection Prevention and Control support for acute care facilities in Nebraska.

The Nebraska ICAP Team is composed of Infectious Disease Physicians and Infection Preventionists that have a background in the acute care setting. They are committed to helping facilities review and identify infection control needs and help to provide support and resources as needed to those facilities.

While Nebraska ICAP works closely with CDC, Nebraska DHHS and other State Agencies, they are not a regulatory reporting agency. Nebraska ICAP is meant to be a resource to assist facilities with their infection control and prevention questions and will keep any facility information confidential to the ICAP Team. Any information used for presentation of grant deliverables or other data will be de-identified before use.

General Infection Prevention and Control Office Hours

Call with questions regarding general Infection Prevention and Control

- PPE
- Hand Hygiene
- Sharps Safety
- Waterline Maintenance
- Environmental Cleaning
- Hazardous Waste Management
- Sterilization and Disinfection
- Respiratory Hygiene / Cough Etiquette

Prevention and Control Facility Review COVID-19 Infection

Call to schedule a time with an Infection Preventionist for a virtual infection control facility review and interview with your team. Plan 90 minutes for assessment and a separate 30 minute virtual meeting to discuss operationalizing the feedback.
Acute Care Infection Preventionists:
Karen Amsberry
kamsberry@nebraskamed.com
Jody Scebold
jscebold@nebraskamed.com

Limited availability
Due to COVID-19, this review will be completed through a phone or Zoom interview until further notice

COVID-19 Response

Call with specific questions regarding COVID-19 response in the dental setting

- COVID-19 safety for Staff and Patients
- Testing
- Contact tracing
- Isolation and Discontinuation of Isolation Guidelines

COVID-19 Infection Prevention and Control

Call with questions regarding COVID-19 specific Infection Prevention and Control

- PPE
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Nebraska ICAP Outpatient Care Services and Support

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Outpatient Infection Preventionists:
Lacey Pavlovsky
lpavlovsky@nebraskamed.com
Sarah Stream
stream@nebraskamed.com

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Nebraska ICAP Dental Support and Services

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COVID-19 Infection Prevention and Control Facility Review

Call to schedule a time with an Infection Preventionist for a virtual infection control facility review and interview with your team. Plan 90 minutes for assessment and a separate 30 minute virtual meeting to discuss operationalizing the feedback.
Dental Infection Preventionist
Sarah Stream
sstream@nebraskamed.com

Limited availability
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COVID-19 Response

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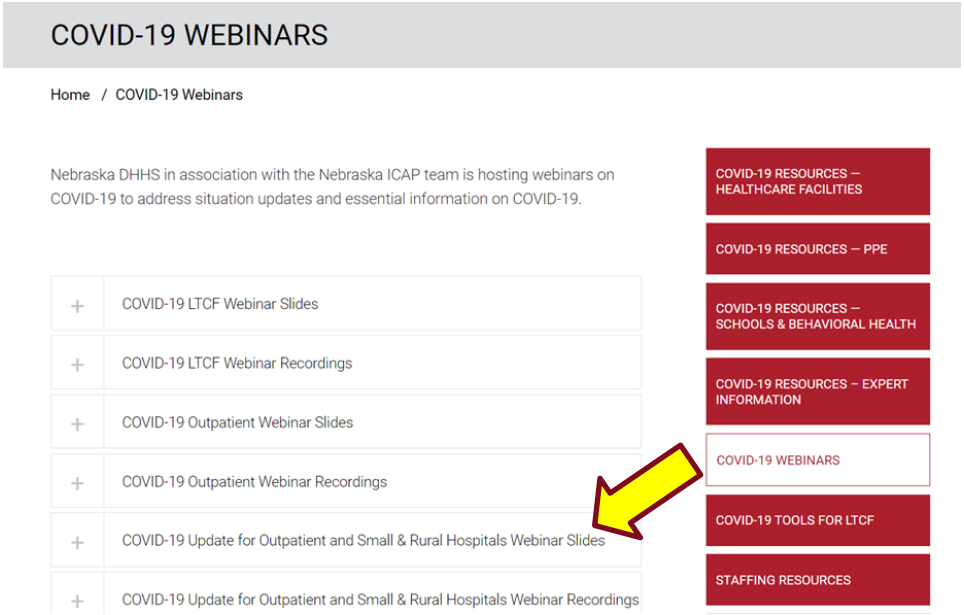
Question and Answer session

Use the QA box in the webinar platform to type a question. Questions will be read aloud by the moderator; in the order they are received. A transcript of the discussion will be made available on the ICAP website



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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NETEC – NICS/Nebraska DHHS HAI-AR/Nebraska ICAP
Small and Critical Access Hospitals-Outpatient Region VII Webinar on COVID-19 1/19/2021

1. **Do you know if the clinic involved in this COVID cluster assessed the airflow for the HVAC, such as the fresh air returns in the clinic during this time?**
   Dr. Fadul knows the clinic leadership was involved in this investigation, and that was one of the things that was pointed out to them by infection prevention because this is a very old building. She was unsure of the results of that investigation, whether changes were needed in the airflow or not. She knows that it was brought up as a concern, especially in the workroom. The staff had noticed, even before COVID, that the workroom had problems with airflow. That could have been mitigated before COVID; she does not know the results of that.

2. **What is your advice as a practicing clinician on PPE use? Do you correct colleagues on their PPE use? Do you find yourself ever having to that? Do you have a script or a way that you do that?**
   It is a very sensitive issue. I think we want to put in their mind that our goal in the end is patient safety and staff safety. If you approach it from that perspective, you find that people are very receptive to feedback. Dr. Fadul says, "that for your safety, you might want to do this a little differently. Your N95 doesn't seem to be fitting and tight. Do you want to check in and make sure that it is okay." Or, "you don't have your goggles on, make sure you do have your goggles, etc." If you give it from that perspective, that "for your own safety and for your patient's safety, you might want to check this." That's different that saying something in a punitive fashion like "you're doing this wrong, you need to do it right." One of the things Dr. Fadul did in her clinic, early on during COVID, was that they reached out to the staff that was doing PPE training, and rather than going to them, they asked the PPE training team and rather than sending the clinic staff out to be trained, they had the PPE team to come to the clinic and do the PPE training on the spot. The clinic staff was very responsive to that. A few months later, they saw they could improve PPE use while staff was under pressure, so they actually had one of their own staff become a PPE champion. In the HIV clinic, where Dr. Fadul works, they were not seeing very many COVID cases in the beginning, where they only saw a COVID case or suspected COVID case once a month, so it was very easy for people to forget how to put on their PPE correctly or how to swab somebody correctly, so they had to be sure they had refreshers for the staff from time to time.

3. **What would your recommendation be for wearing a mask full time if there is only one person who uses the room, such as an office where people are working by themselves? Would your recommendation be that the person wear a mask when they are by themselves, or that they don't?**
   If you are in a room by yourself, with the door closed, and it's not like people are coming and standing at the door and talking to you without a mask, then it is okay. In Dr. Fadul's personal situation, when she is in the clinic, she has her separate office and she doesn't have her mask on. But if somebody comes to the door, then she needs to put her mask on. Sometimes she has to remind them to wait before coming in so she can put her mask on before the guest comes in. That is very important. She finds that even with 6 feet of distance, it's still very important to be

in masks. Nobody is going to stop and measure the distance. It is easy to imagine how a 6 foot tall person is and try to keep that distance, but even with the distance, it's important to have masks on to avoid exposure to anybody else.

4. **What do you think of other engineered barriers, such as Plexiglass? If people had a cubicle with Plexiglass in place, would you recommend a mask be worn at all times?**
   Kate Tyner said she personally works in a "cubicle farm" when she is working on campus and not remotely, and she is personally more comfortable in her cube if she is wearing a mask the whole time. Kate says that even if you are six feet apart, you are still in an office space together for minutes and minutes and hours and hours and so Kate would rather wear a mask full time in a cubicle. Dr. Fadul agreed with Kate. She said there is a lot of variability in the cubicles, and even with the Plexiglass, how tall the barrier is. There is a lot of variability with space, ventilation, etc. So Dr. Fadul highly recommends that people working in cubicles, even with Plexiglass barriers, that they wear their masks. A lot of cubicles have little hallways between them, so that would create the potential for exposure and cross-contamination. It's probably not ideal to take off masks when working unless it is inside a dedicated office.

5. **Are the recommendations still PCR tests for anyone who is asymptomatic and Rapid tests for anyone with symptoms?**
   Kate said the answer depends on where you are encountering a person with COVID. Clearly, we are much more "bullish" on testing and not letting go of someone who has symptoms in a congregate living situation, whether that is long-term care facilities, assisted living, a group home, or even a jail setting. In those places where people are living together, if people have symptoms and they test negative on a point of care test or an antigen test, for example, ICAP would say, "keep going…do the PCR test" because that's essentially a discordant result. You would expect to see someone with symptoms test positive. Anytime you have something like that, you move on to the next kind of test. You are going to keep going on this until you find a diagnosis. People ICAP would advise using the PCR test for are people who are potentially part of an outbreak, so we know they don't have symptoms, but they could be an exposure risk. You can start with an antigen test and go from there. She asked Dr. Fadul that clinically, when she sees that, is it any different?

   Dr. Fadul said that in general, in theory, it is not different, but in the UNMC clinic settings, there is easy access to PCR testing and the results come back pretty quickly, so they totally rely on that, using PCR testing for everyone. But depending on the setting, and the availability of testing, if you have access to these or antigen testing, you get quick results so you start with that. In your pre-test probability, if a person is symptomatic or you are expecting COVID, a negative test isn't' the end of it; you have to go down the algorithm.

   Kate added that we remain poised for influenza, and that a lot of the PCR tests right now are a panel, where you would be able to test for both influenza and COVID. ICAP wants the audience to remain poised to recognize influenza and to chase down that diagnosis if you run into people with respiratory symptoms.

6. **If contact tracing is done, and no close contact is identified, are the CDC recommendations absolutely followed, or is that an employer-specific policy?**
   Dr. Fadul said the CDC recommendations are changing rapidly. The last time she looked at this, is that if somebody is symptomatic, and has an exposure, or somebody has close contact, then

the recommendation is to test. So in the case of a clinic cluster or a clinic outbreak, if somebody is symptomatic, regardless of the nature of the contact, they probably should get tested. Even if that cannot be directly linked to the index case, you still want to test that person, so if they have gotten COVID from another source, you want to make sure they are not spreading to others. If they are symptomatic, test them. If they are close contact, the recommendation is to test them. If somebody is asymptomatic, and they were not in a close contact, then it's basically up to the employer in that case. Dr. Fadul thinks most employers would probably not test, but there's really no reason not to test, because we do know there are asymptomatic cases out there. Close contact is less than 6 feet of distance for a total of 15 minutes or more. Many times, working from memories, it's really hard to pinpoint if was truly 6 feet, whether it was less than 6 feet, whether it was a few minutes, whether it was less than 15 minutes. So if you are in doubt, for peace of mind of everyone, and your own peace of mind as an employer, you should test. You don't want to be dealing with any issues of staff morale, or even legal issues down the line. It's probably better to be on the safe side and test, rather than holding off on testing.

Karen Amsberry added that this is a situation where it is very important that employers' contact tracing policies and procedures be very defined. They need to mark that out and then go by that process in close contact. You need to do that absolutely if there is any question, then testing is the ultimate recommendation. Your contact tracing process and procedure to identify what is considered a close contact; the amount of time of contact; the days that have lapsed are all very important when you are looking at these plans and these cases.

Dr. Fadul agreed with the importance of having policies and procedures. These things, she said, are not as straight forward as they are when they are written on paper. There are a lot of layers and complexities and a lot of issues in-between. And then if you have another case that pops up positive, that complicates things even more because you have to restart it. But whom do you restart with? What is the exposure to the first case? Are those okay? And then do you have to retest someone who was exposed to the first case because they might have been exposed to the second case? There are a lot of complexities within this process, so for facilities that don't have a defined or structured employee health team, or are part of a large corporation, she would encourage them to contact a large hospital with those questions. She said that is why the ICAP team is here, to do that and ensure that your contact tracing process and procedures are done well and correctly and insure that those who need to be tested are getting tested. If you are sure you are not waffling, that will avoid complications down the line.

7. **Do you know of any national statistical data on the likelihood that when people are identified and it leads to quarantine, how often those people end up infected in the 14-day period? Have you seen any data on that?**
   Dr. Fadul knows of a study early on in China that looked at household contacts from positive cases. What they found from that study is that the majority of transmissions, about 80 percent or so, happened within the first six days. The rest of them, 90 percent plus, happened within 10 days. It is very rare that transmission happens after 10 days of an exposure. Again, it was in a household, so there was the variability of whether that the 10 day period was truly the last exposure. Was that truly the last exposure, when you haven't seen the infected person again within the 10 days? That was very reassuring, because even with that household contact, 90 percent of the positive cases occurred no longer than 10 days after the exposure. It is probably unlikely that it happens much later than that. That's the reason behind why the CDC now has reduced the quarantine period from 14 days to 10 days. If you didn't develop symptoms or

contract COVID within those 10 days, it's really unlikely that you are going to get it from that index case you were exposed to. You might get it somewhere else, or from somebody else, but it's unlikely that you are going to get it from that specific exposure.

8. **In term of mitigation planning for the outpatient clinics, do you feel that frequent employee screening or temperature checks throughout the day would be beneficial? That would be same manner that ICAP advises long-term care to periodically or two or three times a day to check employees for symptoms?**
   Dr. Fadul said that is a very important point; she had not included in the slides today because the employer already had a screening app in place where employees go and report symptoms daily. But in the clinic COVID cluster, it was not actually followed all the time. They did have a temperature screening, which in this setting (outpatient) it hasn't been shown to be beneficial. For most outpatient clinics, it is not recommended to have temperature screening as a method of screening. Symptom screening is important and essential and people should enforce that. But there is a lot controversy about the importance of temperature screening and whether it is helpful in these settings or not. Many employers are actually now moving away from that. In the case study, they did have that in place but they were not enforcing it, making sure employees were actually doing their symptom screening daily before they come to work.

9. **Kate said that brings to mind the importance of "presenteeism", that people don't want to leave their colleague hanging. Kate thinks providers like Dr. Fadul have a patients they are meant to see. Kate asked how Dr. Fadul would coach colleagues and other staff about the importance of recognition of symptoms, early notification of management, and getting out of the clinic when they feel sick. Do you have any experience with that?**
   Dr. Fadul said that was a challenge for many providers early on, who were brought up in a culture of the mentality where you as an employee, or being in school, that unless you were absolutely sick, your mom didn't let you miss a day of school. Many times, Dr. Fadul remembered her mom sneaking in doses to her of a Tylenol-type product, so that she didn't have to miss school. We grew up in the mentality of being absent was looked upon as a negative thing, and somewhat shameful. That has to change dramatically during COVID, because the wrong thing to do is actually to go to work when you are sick. But it's hard to give up that guilt feeling that you are leaving your colleagues hanging.

   Dr. Fadul said that everything you do with medicine is weighing the risks and benefits. If you prescribe a blood pressure medicine to a patient, you go through the risks and benefits of taking blood pressure medicine. It has these side effects that might cause "this, or this, or this" but if we don't treat your blood pressure, "this could happen" so you have to weigh that when you make a decision. This is what we are doing now with vaccines. If you think about that scenario in term of risks and benefits, if you go to work when you are sick, even with a slight chance that you might have COVID, but it turns out that you do have COVID, think about the burden you put on that clinic. They might even have to shut down in some cases. They could have to screen multiple people to make sure they can operate sufficiently. But if you call out one day or two days, or three days while you wait for your test results, yes, you are adding burden to your staff, but it is much less of a burden of what you could have put the through if you had COVID and exposed them unnecessarily. By trying to be present or to be conscientious, about your coworkers, you could cause that. In terms of risks and benefits, there's not even a comparison in risk just because you are trying to be conscientious. For those people like Dr. Fadul, who has that guilt complex herself, that's what she uses to calm herself down and tell herself on days

that she did not feel well, "just don't go". If you can work from home, do it. Some days Dr. Fadul had to turn all her visits to telehealth. There was some inconvenience from having to call patients so she could do that from home rather than come to the office, but that's still a much lower risk than if she had gone, ended up with COVID and then what could she have done to her colleagues?

10. **Do you have any recommendations on a policy or protocol for staff members who did not receive the COVID vaccine? Only about 50 percent of the staff members in the particular facility (of the questioner) have taken the vaccine. Kate added another question; how do we start adjusting policies and procedures for people who are vaccinated? That includes quarantine rules, how to contact at work, things like that.**
Dr. Fadul asked to clarify why only 50 percent of the staff had taken the vaccine? She asked if it was because of availability, vaccine hesitancy, or what are the reasons behind that? The questioner replied that it was vaccine hesitancy among the staff. Dr. Fadul said she would love to encourage that staff. Kate reported that ICAP has an upcoming webinar with an obstetrician and gynecologist who is going to come on this same regional webinar at noon on Tuesday, Feb. 2. She will be addressing the myths about infertility and vaccination. She will also be addressing COVID vaccine hesitancy among lactating and pregnant women. Kate encourages people to return to this webinar on Feb. 2 to hear this great speaker. Kate invited facilities to have their staff join in on this next webinar if that would help. The questioner suggested creating a YouTube video of this next webinar that could be shared with staff. Dr. Fadul also encouraged listeners to encourage their staff to visit the ICAP website for more information. There are videos of Nebraska Medicine staff getting vaccinated, with their reviews of the vaccine. Dr. Fadul said the ICAP staff is happy to create any resources to target myths and misconceptions on getting the vaccine.

    Kate clarified for Dr. Fadul that she thinks the questioner was referencing any possible penalties or special PPE required for staff members who decline to take the COVID vaccine. Kate added that she does not know of penalties or special requirements yet, because we are still in the phase of trying to attract staff to taking the vaccine through education, rather than approach it with penalties for not getting the vaccine.

    Dr. Fadul said this scenario has already come up in a small group discussion among some members of IDSA (Infectious Disease Society of America) and they considered a question from someone in leadership in a hospital who asked a similar question. That particular leader was going to meet with his staff, which included a large number of minority workers (Hispanic, African American) who had a very high rate of vaccine hesitancy. That stemmed from a lot of other things those communities were going through, including mistrust of healthcare systems, etc., so only 40 percent of them actually expressed interest in getting vaccinated. Sixty percent were completely refusing vaccine. He asked for some "pearls of wisdom" on what to share when he meets with his staff. Some of the recommendations that were given to him included active listening, where the staff is asked face-to-face, "why are you not getting vaccinated?", with the understanding that we can't make them get vaccinated.

    Right now there are no federal guidelines, from the CDC, any other entities, saying that this has to be enforced in healthcare settings for employees, so really they have the freedom to refuse vaccine. But life is going to be difficult on the community side because eventually travel documentation needs. In terms of their work, there's nothing to say they can't come to work, or

they have wear something, or they have to do something different, yet. But we may get some more information down the line. But the recommendation was basically to just listen to them, find out why they don't want to get vaccinated. What are the issues? Is it some of the barrage of the social media campaigns against vaccine, and how they were made, and what the mRNA technology is, and what is there put in there?

Even as a healthcare provider, these people outside can present their arguments in such a convincing way. Dr. Fadul was doing a Zoom webinar one time about the COVID vaccine with the community and somebody came on and presented all this false data about how the trials were done and without her familiarity with all the granularities about the Phase 3 studies and how they were done, she would have been speechless to come up with a counter argument. Sometimes it is just that misinformation that is out there, that's presented so well and in a scientific way, that can convey misinformation to people and lead to these misconceptions. It usually depends on what the cause of the misconception and you can address it afterwards, giving them the right information or education, it seems like there are those like Dr. Fadul who can help with that. Sometimes, it is just listening to your staff and using the "honey method" instead of the "punishment method", but if they don't get vaccinated, we still don't know what to do about it.

Dr. Fadul said we need to get to that 70-85 percent of herd immunity level for us to go back to normal. Anyone who is refusing to get vaccinated at this point is making COVID last longer, making transmission extend longer, making new patients happen. So it's basically a social responsibility at this point. You either get COVID and get immunity that way, or you get vaccinated and get immunity that way. These are the only two choices we have right now to get to that 85 percent herd immunity to make the globe go back to normal. If you take it as a personal responsibility, then maybe it will encourage people to do it for humanity, or maybe not.

Kate shared one more comment that was in the Q & A box that is about an encouraging method a facility is using. It touches on how they access the catastrophic leave versus the personal leave if they have an exposure or have to be isolated with positive COVID. Kate said that as a person with members of her own family who are very vaccine hesitant, she does not want to turn people off and make them not listen by having any penalties tied to not getting vaccinated. She encourages everyone in the community to speak plainly about this, to listen as Dr. Fadul said. Kate said there was a great article in the New York Times yesterday that talked about how we are kind of "underselling" the COVID vaccine when we say things like, "it is only 95 percent effective." This is one of the best vaccines we have ever seen in our lifetime. The fact is that this came to market and is saving peoples' lives right now. Public health and medical officials have an abundance of caution about the data that is available. It's possible we are underselling it a little bit right now and this is making people hesitant to get the vaccine. Have the access to the information and stress the importance of it and Kate really likes the "honey method" right now, and Kate really likes Dr. Fadul's message about active listening.

Dr. Fadul added that the flip side to people who don't get vaccinated is that we also have to consider the fact that people who do get vaccinated still don't know that they won't transmit COVID. So it's not recommended at this point to lower our guard. If everyone in the facility is vaccinated, staff may think it is now okay to share office space and not wear a mask. But what we know about the vaccine is that it prevents symptomatic COVID with 95 percent

effectiveness, and is one of the best vaccines ever made. You can compare that to the flu vaccine, which is 20-60 percent effective, and it does prevent symptomatic COVID. It does not completely prevent people from getting COVID and we don't know if it prevents people from getting asymptomatic COVID or prevents transmission. Those are the things that people have to keep in mind.

For facilities that have a high percentage of vaccination uptake, Dr. Fadul asks that people please do not lower your guard yet. We still have a few things that are not answered at this point.