California Department of Public Health
Center for Health Care Quality
AFC Skilled Nursing Facilities IP Call
July 30, 2020, 12:00 pm

I: Introduction/Overview **Heidi Steinecker & Nate Gilmore**

None provided.

II: CALTCM **Dr. Mike Wasserman**

It's been five months since the first report of COVID-19 in Kirkland, Washington. As I've said on many occasions, the fact that the first outbreak occurred in a nursing home has probably saved many lives. It was an important warning that many nursing homes took to heart, first by closing to visitors, and then taking additional steps to protect their residents. We've learned a lot in five months. What do we know and how can we use that knowledge to continue to protect the vulnerable older adults who live in nursing homes.

First, the single most important thing that every nursing home must have an abundance of is PPE. Without PPE, this virus is particularly lethal in congregate living settings. As I've said on many occasions, not having PPE is not an option for a nursing home. If you're facility is in danger of running out of PPE, there should be nothing to keep you from getting PPE. There are no acceptable excuses or answers to questions that don't begin with the response "we'll have an abundance of PPE."

Second, in the early days of this pandemic, we didn't fully understand the fact that staff could be asymptomatic carriers who could transmit the virus to residents and other staff. We've known about this since the end of March, and now have the ability to test staff so as to minimize this potential transmission vector. We also know that staff can bring the virus from one facility to another, so knowing where local outbreaks are is critical for minimizing the spread of the virus. Hopefully, as we are better able to develop and utilize point of care, rapid turnaround time, testing, we can reduce the spread of the virus from staff and other visitors.

Finding a way to allow visitation from family must start influencing our plans. We cannot keep vulnerable older adults socially isolated for months and years at a time. We know that this will cause its own harm. I wish I had more specific advice today, but hopefully we'll have some guidance within the next few weeks. We've convened a panel of experts from the United States and Canada to help us navigate this challenge. It's also a reminder regarding something else that I've regularly recommended. Engage your medical director. The medical director for a 99 bed facility should typically spend 10-14 hours a month on administrative time. That's

during normal times. During the COVID-19 pandemic, that time could easily double. Medical directors should never be hired for the primary purpose of bringing admissions to a facility. During this pandemic, it is essential that medical directors be engaged in helping to make difficult clinical decisions about admissions and discharges.

The medical director should also be supporting the infection preventionist in their required fulltime role. The full-time IP should not be distracted by other duties. The medical director can be a support person to assure that this is happening. In addition to their full-time role, the IP should literally be deputizing other staff on all shifts and on all units to monitor hand hygiene and proper PPE use. Staff must practice stellar hand hygiene prior to donning PPE and after doffing PPE.

Finally, every nursing home leadership team should continue to operate under their emergency preparedness plan. The COVID-19 pandemic is an emergency unlike any seen in our lifetime and requires an incident command leadership approach. This approach dictates that staff can focus on the key tasks at hand every day.

The focus must be on PPE, testing and infection prevention. As always, I want to thank each one of you for the work you're doing. As we protect the residents, we also protect the staff. Too many health care workers have lost their lives already. Too many nursing home residents have lost their lives. If we focus on the task at hand, we will continue to make a difference. CALTCM continues to work to help support you in this endeavor. Please feel free to reach out to us at outreach@caltcm.org if you have any questions, or visit our website, www.caltcm.org, for the latest information. Thank you.

III: Healthcare-Associated Infections **Vicki Keller, RN, MSN, PHN, CIC**

None provided.

IV: Questions & Answers:

Q: We have a resident in a sub-acute room and tested positive for COVID. What are the recommendations for limiting the spread of COVID from this resident?
A: The most important recommendation is proper PPE use, including N95 masks. this is especially important in handling this patient for various actions. Any respiratory treatments should be done in collaboration with a respiratory therapist. In addition, minimize number of healthcare personnel in the room. If possible, utilize private rooms.

Q: We have a staff member that is immune compromise that also tested positive. Are they treated the same as residents that tested positive?
A: The guidance in place involves the time-based strategy (10-days) from CDC. For severely compromised individuals, the CDC guidance stipulates 20 days. Most will not fall into this severe category – very specific cases. For healthcare personnel who are asymptomatic and can work, they can continue to work in zones that only have positive residents.

Q: Question related to CDPH daily survey. Would CDPH consider a positive resident to be recorded for both asymptomatic and symptomatic?
A: For symptomatic individuals, the timeframe begins when symptoms are registered. For asymptomatic individuals, the timeframe begins when the specimen registered positive.

Q: If a resident refuses to retest after the 14-day period, what recommendations do you have prior to this individual being released?
A: First, explore all possible options to allow for retesting. Ff resident continues to refuse and is asymptomatic, the most conservative approach then would to assume the person becomes symptomatic. You would then apply the 10-day time period for observation. This is also a facility-based decision and is dependent upon multiple factors as well**.**

Q: Question related to AFL and readmission, as well as not having residents put under observation – what was the purpose of this decision?
A: The purpose of this guidance was to help facilitate the movement of patients and to logically apply the observation period.

Q: An individual was symptomatic and based on our facility's mitigation plan, they were sent upstairs and handled with PPE. In this scenario, should a time-based strategy be used?
A: Because this individual did not test positive and discovered this person had pneumonia, this would not need to be handled as a symptomatic, positive case.

Q: How should PPE be utilized in the yellow zone?
A: To clarify first, this zone is for residents/staff who were exposed to positive individuals but are not yet positive themselves. It is recommended that staff use full PPE as if the individuals were COVID-positive (eye protection and N95 masks). The PPE can be used in an extended fashion if conservation is needed at the facility.