Transcript for COVID-19 Update for Long Term Care Settings
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10am – 11am

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Hugh:
Good morning everybody, we will start in five minutes.

Our moderator will begin in about one minute.

It's 10:00. Let's go ahead and get started.

Good morning everybody, thank you for participating in today's COVID-19 webinar for long-term care providers. This forum is put on by the North Carolina Department of Health and Human Service and supported by North Carolina AHEC to discuss recent updates to the state's COVID-19 response and to provide a forum for you to ask questions of DHHS leaders. My name is Hugh Tilson, I will be moderating today's forum.

Before I turn it over to Dr. Kansagra, thanks everybody for making time in your busy schedules to participate in today's webinar. Your work is really important, and we hope the information provided today will help you do that important work a little better and make navigating these trying times a little bit easier.

After today's presenters provide their updates, we will turn to your questions. We've learned in past forums that the presenters will often address your questions during their presentations. We'll have time to get to your questions. I encourage you to wait until the presenters are through with their presentation before submitting a question. If you are participating through the webinar, please submit a question using the Q&A function on the black bar at the bottom of the screens - it's that Q&A function on the black bar at the bottom of the screen. If you are on the phone, your lines are muted and you cannot ask questions. So, we want to give you an opportunity to ask a question using a Gmail account, which is questionsCOVID19webinar@gmail.com. We anticipate being able to get to your questions. If for any reason we can't, we will forward all of those to DHHS so they can respond to you directly. Lastly, we'll record this webinar. We'll make that recording a written transcript and these slides available on the NC AHEC website as soon as possible, probably tomorrow.

Now, let me turn it over to you, Susan. Thank you so much.

Susan:

Thank you, Hugh, and, again let me echo on behalf of DHHS, thank you to everybody that is participating on this webinar. We so appreciate everything you all are doing to support the care of residents in our long-term care facilities, which we know are such a high priority population. The work you are doing is so important and we appreciate your continued collaboration and partnership as we work to combat this epidemic. So, thank you.

Today, we have guests with us from throughout the DHHS agency, including Medicaid, our division of public health, and the division of health services regulation who will each speak and then be available to answer any questions.

So, without further ado, I will turn it over first to Jennifer MacFarquhar, who is director of the SHARPPS Program in the division of public health to go through epidemiology updates as well as updates on new CDC guidance. So, thank you Jennifer.

Jennifer.
Good morning, everyone, and thank you for joining this call. Thank you too for the tremendous amount of work you are doing every day to care for the residents in your facilities.

I will provide a high-level overview for updates globally, nationally, and also in North Carolina. Globally, the number of cases currently exceeds 4 million, with the number of deaths approaching 290,000. Nationally, the number of cases is approaching 1.4 million with the number of deaths over 82,000. Here in North Carolina, the number of cases is almost 16,000 and approaching 600 deaths. Beginning this week, the North Carolina Department of Health and Human Services began to post estimates on the number of patients in North Carolina presumed to have recovered from COVID-19, and this information will be updated weekly.

Also wanted to mention briefly that we are aware that there are a number of companies that have developed antibody serology tests, and we are aware that they are becoming increasingly available. At this time, we are not requesting results from these tests, and we are not using them in our case definition for purposes at this time. The Food and Drug Administration is currently in the process of validating these tests, so hopefully sometime soon we will be able to be more comfortable with the characteristics of these tests and the interpretation of their results. So, there is still quite a bit of uncertainty around these tests and their interpretation.

So, for infection prevention and guidance for long-term care facilities, that really remains the same, and that does include the use of cloth face coverings for residents and patients, face masks for healthcare providers and staff, and other personal protective equipment as appropriate for the care of a resident based on the specific type of facility and the care that the resident needs. It also includes cohorting or grouping of residents who are COVID positive along with the cohorting or grouping of staff caring for these residents. Those restrictions on canceling of communal activities also remain in place.

So, for testing, we currently recommend testing for the virus that causes COVID in the following situations: testing of symptomatic residents or staff within these long-term care setting environments, testing of residents and staff once a case is identified in the facility. We know that federal guidance has come out encouraging states to consider point prevalence surveys in all nursing homes with some additional guidance on repeat testing. It is important to note that CDC guidance stresses, and we would agree, that testing is not a substitute for other infection prevention control measures. And, we are currently in discussions here at DHHS on how to implement testing of residents and staff in a way that is most meaningful and would protect this most vulnerable population, and we hope to have this guidance out in the relatively near future.

So, around lifting of restrictions, we have heard from many of you working in these settings, and also families of residents in your facilities, and we understand the extreme hardship that some of these restrictions, specifically visiting restrictions, have placed on everyone. I think it's important to highlight that memos dated from March 13th, the federal guidance, has actually mandated restriction of visitation to some of these facilities. And so, you know we are working under those guidelines. But we are also actively engaging stakeholders in discussions as to how we can lift some of these restrictions in these facilities while again protecting this vulnerable population.

So, here at DHHS we've also been actively working to put together resources for our long-term care settings and also our local health departments. We have created a toolkit which is available on the DHHS website for long-term care facilities to aid in the implementation of infection control, prevention and other guidance documents. The toolkit contains an infection control assessment, infection staffing worksheet, infection prevention educational resources, in addition to other documents. This toolkit, again, is available on the DHHS website. In addition, a similar toolkit that provides additional guidance for local health departments, who are investigating outbreaks in long-term care settings, is also under final review.

So, the last piece I will talk about today relate specifically to infection prevention activities.

Nevin, if you would move to the next slide, please.

To support and enhance the infection prevention and management activities of providers serving beneficiaries at high risk of contracting COVID-19, we are partnering with CDC and the North Carolina statewide program for infection control and epidemiology, or NC SPICE, to conduct infection prevention and control consultation and technical assistance. We will be working with long-term care and home-health services to first conduct an infection control assessment and response self-assessment. And then to a subset of facilities we will offer a remote self-assessment and potentially an on-site assessment as well. These assessments will consist of an evaluation of infection prevention measures at your facility and support the key strategies of keeping COVID-19 out of the facility: identifying infections as early as possible, preventing the spread of COVID-19 in a facility, assessing and optimizing personal protective

equipment or PPE supplies, and identifying and managing severe illness in residents with COVID-19. Areas assessed in this ICAR visit will include, again, visitor restriction, education to both staff and residents about COVID-19 and associated prevention measures, and we also will encourage education to family as well. Compliance with screening of staff and residents. Again, assessing availability, knowledge and use of PPE and related supplies, and ensuring adherence to infection prevention practices and compliance with communication channels to local health department and other partners. We will be reviewing action plans based on gaps identified in these assessments and assure steps are taken to address these gaps. Last but not least, we will review included elements in the written infection prevention plans and provide technical assistance to assure aspects of the plan are appropriate. The assessment tool, action plan template, infection prevention program plan template, and other helpful resources are available on the SPICE website. That is SPICE.unc.edu.

So that concludes my portion of the webinar, and I will now turn it back over to Dr. Susan Kansagra.

Susan:
Great. Thank you so much, Jennifer, and I will go through the next piece of this, which is, I wanted to make folks aware that on the DHHS website there is a flowchart for long-term care facilities and hospitals when patients are being discharged from the hospital to a long-term care facility that outlines considerations to take in-place given the test results of the patient. For example, if the patient does have a positive COVID-19 test, how to consider facility placement and the guidance that should be followed as well is when a test is negative. In addition, if you look on the right-hand side of that flowsheet it also goes through what to do if the patient does not have a test. That is a question that I know has come up quite a few times and certainly if there is signs or symptoms of COVID-19 that patient should be tested. If there are not signs or symptoms, it is still reasonable to get a test, and CMS does state that testing can be considered if available. Now, that is not a requirement necessarily, because, sometimes, if there is a very brief admission from a nursing home to a hospital and back to a nursing home, that test result would not provide any additional information usually, given a patient could still be incubating the virus at that point. There is some flexibility there. And also, important to keep in mind that in either case when somebody is going into a long-term care facility, that the guidance is still to use 14 days of precaution regardless of the test result. So anyways, this flow chart is available on the DHHS website and I just wanted to point people to that and make everyone aware. So, thank you.

Now I will turn it back over to our next presenter, which I can't see the agenda on the screen, but I believe that is Kimberly Clement, to talk through PPE?

Kimberly:
Thanks Dr. Kansagra, I appreciate it.

So, a couple quick things I wanted to talk about before I jump into personal protective equipment. I want to make sure folks were aware one of the efforts that we have been working on with our healthcare preparedness

coalition is ensuring there is good coordination and discussion around potential assets or staffing needs or just any gaps or concerns as we are working with our long-term care facilities. Specifically, when we are notified of an outbreak or any kind of concerns or gaps related to staffing or equipment. And, that touch point really is just trying to make sure local emergency management, local public health, the facility, and our healthcare coalitions are connected and talking and we are able to fill and address any of those concerns or gaps that come up. So, I wanted to quickly make sure people were aware that that is an initiative and a really big push from us so we can make sure we are meeting the needs that are out there.

Another part of that is really trying to have increased access to personal protective equipment for our long-term care facilities. We really want to make sure that the items that are needed are out there and that you can have good confidence in doing a lot of the infection prevention items that Jennifer talked about. So, we are working on a coordinated effort to get into a closer area, into a regional - we are using the 16 regions for the division of aging and adult services across the state. Notifications are going out to facilities that they are able to go to a location and pick up a large quantity, we are looking at about a 14-day quantity of personal protective equipment. To include some face shields, and gloves - actually if we can go to the next slide that would be great - procedure masks, shoe covers. So, starting tomorrow, we will have that initial distribution and again the locations will be coming to you in an email. We are pushing out the information through multiple different avenues, to include the [Indiscernible], our healthcare preparedness coalition, and local emergency managers. A lot of that information should've already come to the two regions K and Q that will be filled starting tomorrow.

So, if we can advance the slide Nevin, that would be great. Perfect. And one more would be excellent. Okay, perfect.

So, you can see there where region Q and region K are. Those are the different counties and that information is going out to all of our state regulated long-term care facilities in those locations. And, just specific details on how to get that personal protective equipment, I know a lot of local emergency managers are also working with us to help with some of that. So, lots more will be coming to your inbox, but we wanted to make sure you guys were aware of that and the gloves, face shields, shoe covers, and procedure masks so we can really ensure that the infection prevention piece is able to happen.

Okay, and I will now turn it over to our next speaker, who I believe is Stephanie McGarrah.

Stephanie:
Thank you, Kimberly.

Next slide please.

As Kimberly discussed the process for workforce and going to the emergency managers in your local areas, I wanted to talk about how we are trying to address the workforce staffing needs that many long-term care facilities,

and others have had. DHHS has worked to reach out to healthcare workers who may want to take on additional shifts through professional associations and licensure boards. As a result of these efforts, we have gotten about 2600 people who have signed up and are interested in taking on additional shifts. These individuals, about 1500 of them are nurses or RNs, another 400 or so are CNA's, then we have several other categories, LPNs, physician assistants and others who have signed up and expressed an interest. These workers are in 94 counties across the state, and so what we are doing is we have a team of volunteers from ECU the college of nursing, they have clinical expertise. And after the request comes in through the emergency management channels that Kimberly discussed, the ECU team is reaching out to the facilities to talk with them about their specific needs. And then matching them with the workers that have indicated an interest in taking on additional shifts, and then linking those workers with the facilities. From there the facilities contact those individuals and are choosing to enter into an employment agreement with those people who are interested.

There has been a little confusion about ECU's role so I wanted to try and clear that up. These individuals and workers who are interested in picking up additional shifts are professionals who are licensed, and have an ability to start working right away. They are not students at ECU and they are located across the state. ECU has merely been willing to participate and volunteer their time and we are very appreciative of their clinical expertise, because it allows them to understand the needs of the facilities quite quickly and match them with workers who are interested and willing to take on additional shifts.

And I think I'm ready for the next presenter who is Dave Richard.

Hugh:
Dave, are you there?

Dave:
Can you hear me now?

Hugh:
Yep, we've got you.

Dave:
I was doing it on the phone rather than this way.

I want to thank everybody on the call for the work that you are doing. I think as we mentioned at the beginning of the call, we know this is difficult and that folks have been doing a great job and effort.

I wanted to talk briefly about Medicaid and what we think is the response here. We want to, obviously, effectively support the care of any COVID positive resident in our funding strategies and other methods in which we support residents there. We clearly wanted to accommodate the needs related to hospital discharge, so we don't want to have people that can move out of hospitals be in hospitals not allowing us to meet the needs of folks who have needs for those beds. We want to reduce the transmission through the effective infection management and prevention and then

obviously increase the service flexibility of the provider networks who were impacted by this crisis.

So, if we can do the next slide.

This is quick, I think you've heard from the conversation today is that the work we are doing is really all related across our departments of public health, the DHSR regulatory folks, Medicaid finance and policy folks, and it is clearly a team effort to try to work toward supporting long-term care in those efforts.

So, we will go to the next slide.

This is a little bit busy of a slide, but I wanted to sort of show in particular about adult care, acute care discharge, how we see this and obviously on the left side as you are looking at your screen, we want to make sure we are working as you heard before with our provider community especially here in the skilled nursing facilities, to make sure that everyone has the technical assistance that they are needing on the support they need to do the kind of work that they are. And then for certain individuals we believe that going into a COVID competent response facility that is willing to accept COVID patients is an important collaboration that we've been working with the associations on, so we are trying to look through that. And now we are looking more around swing bed needs, so some of the other nontraditional swing bed efforts that are not traditional SNFs to do that work. We have a slide up here talking about the future and in terms of the Medicaid program, the COVID outbreak has clearly had us taking a look at all of our policies and thinking about what the long-term options are. We will be working with the industry to think about these as we go forward once we get past the most critical part of this outbreak, so that we can really think clearly about what we need to do in the long-term response to COVID.

Next slide please.

One of the things that is really important, and I will try to walk through and it might not all be on the slide, but talk about the funding that we have tried on the Medicaid space to put in place to support folks as they are going through COVID. I believe it was in early March we implemented a 5% rate increase across multiple areas, including our skilled nursing facilities and our adult care homes, as well as our community-based providers that are trying to make sure that people stay in their homes in the community. Just recently as you will see on bulletin 82 we really wanted to target adult care homes and nursing homes where there were outbreaks. So, they were very specific. I'm sorry it wasn't bulletin 82 it was previous to that, I will talk about 82 and a second, where outbreaks have existed. So, a significant rate increase for facilities that have an outbreak for all individuals at the facilities and secondly, for those individuals that are COVID positive in skilled nursing facilities, a significant increase for those individuals. So, to address the issues around staffing, the overtime, the prices and pay, equipment, infection control, we also have done the same thing in terms of our adult care homes. Which are different than the way we fund a nursing home, just because from the Medicaid side it is part of the PCS program that does

that work. So, we added for that program the same ability that if there is an outbreak we increase the rate significantly for those facilities. It is almost doubling the rate for the PCS number there. And then I want to add the last item that is happening is that we are implementing an additional 10% rate increase for our skilled nursing facilities as well as our adult care, and community-based facilities.

I believe that's on the next slide if we can move to that.

Yeah, this is really a recognition that doing more on the front end to try to help stop the outbreak. And in it what we are asking is that we coordinate across our agencies and facilities to complete the long-term care infection control assessment and response, the ICAR that was mentioned earlier. And prepare to participate in follow-up technical assistance as appropriate. Again, in partnership with the providers we want to make sure that we are doing everything we can to support providers in this effort. And I think most importantly if we can avoid outbreaks, that is where we want to be. So, we want to be aggressive on the front end of that effort.

Next slide please.

And then just to add, I won't read through all of these, but we have been working throughout the pandemic to create additional flexibility to use at the long-term services that make it easier for individuals to be served in this effort. We know so much is going on at this point, that the administrative burden is pretty high, and that we would like to reduce it as much as possible. So, you can see more of this and look at the special bulletins on the NC Medicaid website to see all of the changes that of been made to the flexibility.

Next slide please.

And then our next steps is that it's really important that we continue to work with providers to look at what are the other provider supports that may be needed? What are things coming from the federal government? How do we work together to make sure that we are supporting people in the best way possible? That also includes the continuous examination of potential flexibilities that the federal government would allow through the 1135 waiver and the SPA mechanisms. We also wanted to do evaluations of interventions, to make sure what we are doing is working. That is a really important part of how we are doing the work and we want to make sure that we are again listening to what the provider community says. Paying attention to what data drives us, and to make adjustments as needed as we go forward.

And then if we can go to the next slide please.

There are multiple places on our website, or things that you can look for to get more information about this. I really did not mention the hardship process, but that is part of our effort to make sure that although we are doing great changes, that if there is need for immediate cash for a provider to address these issues, that the cash will be paid back but we do hardship payments. You can go to that website there. Looking for the

COVID related rate increases specifically there. Then about reports and about COVID related flexibilities you see up there. And I believe that is the last light I have, so I will move to the next speaker who unfortunately I cannot remember who that is.

Hugh:
Actually, I think it is time for Q&A. So, I thank everybody for those great updates.

Dave:
So, return that back over to Hugh?

Hugh:
Yes, I'm speaking and taking questions. A couple of quick observations, number one is we have a number of questions, so keep them coming at the Q&A feature on the black bar at the bottom of your screen. If you are on the phone you can't do that, so go to questionsCOVID19webinar@gmail.com and we will try to field your questions there.

I've got a number of requests for the slides and I want you to know we posted those at the NCAHEC website. If you go to www.ncahec.net/COVID-19/webinar you can access the slides there.

For questions let's take them in order.

In a long-term supervised living program substance abuse, can residents have passes? Can residents have visitors? Anybody have an answer to that?

Jennifer:
So, this is Jennifer and I will take a stab at that and anyone else can jump in.

So, we recognize that there is a variety of facilities represented on this call. And so, I think these facilities should also follow public health recommendations which are to limit visitors to restrict visitors and also limit engagement outside of the home. And so, obviously, maintain appropriate social distancing. But limit group interaction as possible.

Hugh:
We operate four group homes for adults with IDD, one of the individuals place to go to South Carolina beach, should we expect them to be quarantine for 14 days before returning to the group home?

Jennifer:
So, this is Jennifer again. So, again, recognizing the variety of facilities represented on the call, for these entities, you know if it were specific long-term care setting, the recommendation is to quarantine that individual for 14 days upon return. So, the quarantine does not necessarily need to take place outside of the home, but we would recommend as much as possible that if that resident does return that they remain in their room as much as possible, and then when they do exit that room, again following the universal recommendation for cloth face coverings for residents. That the resident when they do exit the room where a cloth face covering, and of course maintain appropriate social distance, thanks.

Hugh:
Will North Carolina be doing full facility testing for independent living, senior living campuses?

Jennifer:
I'm sorry, Hugh, can you repeat the question?

Hugh:
Yeah, will North Carolina be doing testing for independent. Sorry.

Jennifer:
Independent living?

Hugh:
Yes. Campuses.

Jennifer
Right. So, again, we are in very active discussions around the testing recommendations, and so we will have a certain prioritization of facility types, and of course these types of facilities will also be considered within those testing recommendations.

Hugh:
Will surveys resume in December?

Mark:
So, good morning this is Mark Payne, thanks for the question and let me just add my thanks for all the work that the long-term care facilities have been doing, and your collaboration with our division of health services regulation staff.

So, with regard to surveys, it depends on the type of facility obviously. The legislation that was enact did by the General assembly does suspend routine surveys for a period of time, December being the outer limit, and of course that is subject to any CMS directives and there is still some investigations into infection control. Surveys ongoing particularly in the nursing home area, there is still some complaint investigations and other areas as well that are ongoing. But, you know, we will continue to assess resuming the survey activity as needed. But complaint investigations right now are limited to allegations of abuse and neglect and also infection control.

Hugh:
Thank you, Mark.

Will DHHS employees be tested prior to going into the field of facilities?

Mark:
So, as Susan has indicated that as part of the discussion that is underway. Our employees are being given PPE to use, and certainly we have reviewed with them the appropriate protocols in order to help ensure the

safety of the staff and residents in the facilities that we survey, as well as the safety of our surveyors.

Hugh:
How often is the congregant living setting ongoing outbreak list updated? I don't see two county LDC outbreaks recently listed.

Jennifer:
Yeah, this is Jennifer, and so that list is actually updated I believe daily. But if the facility has been 28 days without a new case, then that facility will roll off of that congregate care setting list.

Hugh:
We have a COVID positive nurse willing to care for our COVID positive residents. How do we reorient this nurse into our facility? Does she need the negative COVID test result? Does she need to stop working with them? I assume that means the COVID positive patients and residents.

Jennifer:
So, the recommendation of discontinuation of isolation for any individual who has tested positive for COVID is 10 days from date of symptom offset, with at least three days or more with improvement in those symptoms. But again, it is a minimum of kind of 10 days from date of symptom onset or date of specimen collection if that healthcare provider or the individual does not have symptoms. We recognize that there are staffing, severe staffing shortages. And, so, this is not a recommendation to be taken lightly, but we do recognize that CDC does have guidance available for crisis staffing shortages. Which kind of is a last resort, again, it would allow a healthcare provider who has tested positive, and who is improving, or who is not symptomatic, but improving in symptoms, to again wear appropriate PPE and care for patients who are COVID positive. So again, this is not a recommendation to be taken lightly, but as a last resort.

Hugh:
Should all staff and residents wear face coverings? At all times?

Jennifer:
So, when residents or patients are in their rooms it is not necessary to wear cloth face covering, but certainly whenever they leave their room they should, if at all possible, wear cloth face covering the residence. And staff within the facility it is actually universal guideline right now to wear a cloth face covering, but then appropriate PPE when caring for patients. So, a surgical facemask or something along those lines.

Hugh:
We have a couple iterations of this one, but the president has recommended that all nursing home residents and staff be tested. Will this happen in North Carolina and if so when?

Jennifer:
I actually spoke to that during my comments, so we do understand that there is federal guidance that do encourage states to consider testing of all residents and staff, and we know that CDC has also put out additional guidance on repeat testing and when that should occur. But again, we are

currently discussing how to implement testing of residents and staff in a way, that again is most meaningful to us. That is currently under discussion.

Susan:
One additional point - sorry to interrupt Hugh - one additional point on that is that if there is a case, if there is a positive patient or staff in a facility, then the local health department in those cases is recommending that all staff and residents are tested whether they are symptomatic or asymptomatic when a case is identified. Just to mention in those situations that will be happening.

Hugh:
What about anybody testing? I have a couple questions about those. What do you feel is the benefit for anybody testing and long-term care residences and stuff?

Susan:
This is Susan - go ahead Jennifer.

No, go ahead.

Jennifer:
So again, I think right now we know there are a number of companies that have developed antibody tests. But, at this time, we are not using those we are not implementing those or recommending those. There is a lot that we still don't know about the characteristics or performance of these tests or how to interpret the results so right now we are not recommending those.

Hugh:
Can you redefine point prevalence survey?

Jennifer:
Sure, so point prevalence survey is basically a screening or test of all residents and staff within a facility. So, it is a point in time. That is why it measures, you know the prevalence or the occurrence of a disease in a population at a point in time. So, again, it is just a screening of all residents and staff.

Hugh:
When and how will these ICAR visits be managed and who will reach out to facilities to offer them?

Jennifer:
So, this is Jennifer, I will start and anyone else can jump in.

So, this is kind of a tiered process, first I believe as Dave Richard mentioned, the ICAR self-assessment is tied to Medicaid reimbursement rate increase. And, so, the self-assessment should be occurring now, and facilities are submitting those data to SPICE. And based on some of those results what we are doing is reaching out to facilities just to touch base and provide additional consultation and follow-up. And we will have a second and third approach as far as reaching out to facilities that are

not receiving the rate reimbursement. And to again provide a similar service to them as well, but again it will be over a period of time. So with the self-assessment and follow-up occurring must immediately over the next few months, and then, you know, Tele ICAR visits and on-site visits will not occur until at the earliest beginning early 2021.

Hugh:
Is there any education being provided to hospitals by NC DHHS regarding the recommendation that people being discharged to skilled nursing facilities or other long-term care facilities be tested for COVID-19 prior to leaving the hospital even though patients are showing no symptoms?

Susan:
This is Susan and yes, this goes back to that flow chart that I mention and this is available on the DHHS website under long-term care guidance, there is a flowchart that hospitals discharging patients can use to determine next steps. And transferring patients to long-term care facilities, so I would encourage people to look at that.

Hugh:
How long is the incubation period, where a patient may have COVID but test negative and actually be positive?

Jennifer:
So, the incubation period for COVID-19 is actually 14 days, up to 14 days. And, so, at any point in time within that timeframe a person could be positive for COVID. It usually takes a few days for a person to if tested too early, in the illness phase. Then that person will not test positive, so it usually takes a few days, once exposure has occurred for the individual to develop an appropriate response. Or to become ill. I think the average timeframe is now five days I believe.

Hugh:
I had a couple questions about shoe covers and when they should be used. Is there guidance on that?

Jennifer:
Yeah, shoe covers are actually not a part of a recommended PPE to be used for COVID-19.

Hugh:
I've got a couple questions about supplemental workers, so where do we get the list of workers willing to pick up extra shifts?

Kimberly:
Hey so this is Kimberly and I'm happy to take that. So, what we would ask is that if you have a concern for staffing that you reach out to your local emergency manager, and you can also reach out to your healthcare coalition leads for some guidance on how to get involved in sort of the staffing piece of it. Really just to help us make sure that we are getting all the good information and have that good touch point a connection point. I would encourage starting with local emergency management and/or your healthcare coalition to get connect did there.

Hugh:
All right, I answered that one.

When will fingerprint checks be available again? Do we know that?

Kimberly
This is Kimberly - go ahead Mark.

Mark:
I'm sorry. Either one of us can take that but you know there is an executive order that allows for delay in fingerprinting in those areas where local law enforcement is not performing fingerprint checks. But otherwise, you know fingerprinting from what I'm understanding is available across much of the state.

Hugh:
A lot of residence in our assisted-living facilities are not going to primary care provider appointments due to being placed in quarantine for 14 days when coming back from their providers. Is this necessary when the residents are wearing masks?

Jennifer:
Yeah this is Jennifer again, I will take the first pass at that. I don't know that it is a blanket recommendation to be placed in quarantine for 14 days when one individual comes back, but definitely that individual should be placed in a private room if at all possible. And yes, absolutely, to wear a face mask or cloth face covering any point when outside and monitoring the patient for signs and symptoms of illness.

Hugh:
Dave this might be a good idea to remind everybody of the opportunities to use telehealth for some of those services.

Will IDD group homes be eligible for the rate increase for personal care? Is this increase only for homes of positive residence?

Dave?

Dave:
Can you hear me now?

Hugh:
Yup.

Dave:
Okay great. I apologize.

So, the personal-care rate increase let me make some clarity of that. There was some confusion about what happened in terms of in-home personal care and so people have some of that confusion, please know we are correcting that on our website and pushing that out. But for personal care services, the 5% and 10% rate increases that we mentioned is that they will get those rate increases regardless of the setting. It is PCS dollars

so it will be in group homes as well and that definitely will come through.

Hugh:
If there is a positive case in a nursing home are we required to test every employee and every resident so, who will provide those tests?

Jennifer:
Yeah, this is Jennifer. It is a recommendation that if a case is identified in a facility that, if possible, all residents and staff are screened. And that again is to identify other potential unknown reservoir for the disease. Again, that is if possible, we recognize that there are many constraints upon resources, like the staffing, collection kits, laboratory capacity, and so again there is a way to prioritize those if unable to test all residents and staff at that time.

Hugh:
Will you be putting out any information specific to congregate living facilities that are not skilled nursing?

Jennifer:
This is Jennifer, and actually I'm not sure, that question is not clear to me.

Susan:
I can take it. There is guidance on the DHHS website that includes guidance for other settings, not just skilled nursing facilities, as well as some trainings available on that website.

Hugh:
A follow-up question I think to Mark. **Are we going to have additional surveys based on infection control?**

Mark:
So, certainly nursing homes. Per CMS guidance from late March, I believe it indicates that yes, nursing homes will have surveys related to infection control.

Hugh:
I want to make sure that I heard correctly, cloth face coverings are encouraged for all residents?

Jennifer:
Yes, this is Jennifer, so that was in the guidance and recommendations that have gone out, it is universal face coverings. So, again, cloth facemasks are most appropriate for individuals and residents.

Hugh:
Many vendors are pushing the use of pulse oximeters. Is there any evidence that pulse ox allows for the early detection of COVID-19, particularly in long-term care settings?

Jennifer:

So, there have actually been some articles, so some literature to support the use of pulse ox symmetry in these populations. So, again, some very limited data are available, but does support the use of pulse ox symmetry if available.

Hugh:
Questions about temperatures. **We have baselines with quite a range, how many degrees above an individual's average baseline is considered a temperature worth noting?**

Jennifer:
This is Jennifer, and I think, yeah, we have to recognize everyone's baseline temperature is a little different. I think CDC guidance is now stated anything over 100.0 Fahrenheit would be considered a temperature.

Hugh:
Is there any discussion yet about when visitor restrictions may begin to ease?

Jennifer:
Yeah, this is Jennifer, again I mentioned that as well, recognizing the many challenges that it places on families, residents, and also the healthcare staff. So, we are in the initial stages of engaging stakeholders and having those discussion so hopefully we will be able to have further guidance, but again it might be some time.

Hugh:
A couple of follow-ups on PPE. **Who we speak to about getting PPE and how will facilities be contacted about the PPE supplies being distributed? Who will receive that outreach?**

Kimberly:
Good morning this is Kimberly, so, several things in there I will try and hit all of them but grab me if I don't. So, we are sending out the notification on who will receive it through a variety of different methods. Our hope is that you actually receive it multiple different ways through healthcare coalitions, emergency management is receiving it, the ombudsmen are receiving it, lots of different people have that information and we are asking them to share it. We also, I think the question is who was receiving it? We are looking to provide it to all approximately 3800 facilities that are overseen, so mental health facilities, adult care homes, family care homes, skilled nursing, so it is all of those different groups. And I feel like there was something else but I'm not sure what that part of it was.

Hugh:
Who did they reach out to?

Kimberly:
So, if you want to ask for it separate from this PPE push, there is actually a link on the DHHS website. If you look up NC DHHS PPE you will find a webpage that gives a link for how you can request it. Which would be separate from this push we are doing. And we encourage you to do both, that is not an issue.

Hugh:
If a resident is sent to the hospital but not admitted, is quarantine required?

Jennifer:
So, this is Jennifer, and so, again, I think if it is a quick visit and they are not admitted for a period of time, the recommendation would be to place them in a private room and again continue to just monitor them as you normally would for signs and symptoms of illness.

Hugh:
A couple of follow-ups on PPE, is there a timetable for the PPE to be distributed in each of the areas after K and Q?

Kimberly:
Our goal is to get all of the regents distributed in the next 2-3 weeks. We will have a final plan on each of those regions by end of day tomorrow and we will be able to share the exact dates and times based on those regions.

Hugh:
And then, clarification of the allocation of distribution of PPE, for all skilled nursing facilities, assisted living, and adult care homes and substance abuse disorder treatment and residential programs and others? Kind of a broader question about who will be able to get them?

Kimberly:
Let me send you that information that spells out the exact groups that get it so I make sure I speak to that correctly.

Hugh:
Great.

Can family care homes restrict residents from working outside the home, for example at the grocery store? Are there precautions to keep staff and residents safe?

Jennifer:
Yeah, so this is Jennifer, and I think again, acknowledging that group homes may be a little different, I don't want to compare settings. You know, it is recommended that group homes follow public health guidelines about social distancing and limiting group interaction. So, I think you would have to take into consideration that individual resident. So, again, we would limit the outside interaction, because again recognizing that that community engagement can lead that individual to bring COVID back to the facility in place others at risk.

Hugh:
Is independent living considered congregate care? Or are IDD groups considered congregate care?

Jennifer:

This is Jennifer again, so those are two different entities. So, independent living, it depends on the type of facility that the independent living is. If it is like an apartment style, then we would not consider that to be congregate living. If it is more along the lines of a nursing home, or you know, or a facility where folks are within one building and just have a room within that building, we would consider that congregate care. And behavioral health home, I think we probably would consider that to be congregate care. But, again, we could hold further discussion on that and others are welcome to chime in if they have different thoughts.

Mark:
You are correct Jennifer, it would be considered congregate care.

Hugh:
I've got a question about EMS providers in rural hospitals refusing to pick up residence from outbreak facilities from adult care facilities with outbreaks. Is that on your radar and anything you are doing to help with that?

Kimberly:
This is Kimberly, and I think that's another one that we probably will need to take them respond back to after the webinar.

Hugh:
Got you.

I've got a couple about can you please reiterate how to integrate staff from a COVID positive wing? So, about staff reintegration?

Jennifer:
This is Jennifer, so, just to clarify, so if a healthcare provider is positive, then it would be, again, discontinuation of isolation is 10 days. And if they are improving in their symptoms and, so symptom improvement, or you know if they were asymptomatic, and again it's not a general recommendation, but this would be one that could be implemented as kind of a crisis staffing strategy. Then that healthcare provider could care for patients that are COVID positive, but again they would need to wear appropriate PPE to serve that population.

Hugh:
Families are asking if they can do an outdoor visit if they wear a mask and the resident wears a mask, and they remain six feet apart from each other. Is that acceptable?

Jennifer:
So, social distancing is that six feet, so again it is a resident and what other entity?

Hugh:
Family.

Jennifer:

Oh, family. So, again, this is the visitor restrictions and currently we are recommending pretty strict visitor restrictions. But again, you know, the six feet apart definitely needs to be maintained and appropriate face coverings as well and no contact, thanks.

Hugh:
We have a number of questions that are coming in, but I think we are just about out of time. So, I will remind everybody that the slides are currently available on the NCAHEC website. We will post a recording of this and transcript of this as soon as possible, probably tomorrow again on the NCAHEC website. All the questions we have received we will forward to DHHS so they can respond specifically to them. That is true both for the Gmail account as for those of you on the phone as well as the Q&A.

I want to thank everybody for making the time to be on this and for the really, really important work that you are doing every day. And then, Susan and your team thank you so much for all that you all do all day every day. This webinar has been incredibly helpful. And provided great information. So, on behalf of everybody let me thank you for that. Let me turn it over to you for any final comments from you and from your team.

Susan:
Great, thank you so much Hugh for hosting and all that you are doing as well. Thank you all for participating, we will take a look at the questions and try to get that back to the NCAHEC team for posting. We appreciate the continued dialogue and encourage everybody to check out the DHHS long-term care facility guidance tab which has a lot of what we've talked about on that as well. So, for future reference and we will make sure to get the slide deck posted as well. Again, thank you everybody for all you are doing and we appreciate the continued partnership and collaboration, thanks.

[Event Concluded]