Transcript for LTC Settings

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Presenters:

Jennifer MacFarquhar, MPH, BSN, RN, CIC Director, SHARPPS Program

Susan Kansagra, MD, MBA NC Division of Public Health

Scott M. Shone, PhD, HCLD(ABB) Director, NC State Laboratory of Public Health

Kimberly Clement, MPH, Paramedic Program Manager, Healthcare Preparedness Program

Dave Richard, Deputy Secretary NC Medicaid

Hugh:

It's 10 o'clock. Let's get started. Good morning everybody. Thank you for participating today's COVID-19 webinar for long-term care providers. This forum is put on by the North Carolina Department of Health and Human Services and supported by NC AHEC to discuss recent updates to the state's COVID-19 response and to provide a forum for you to ask questions of DPH and DHS leaders. As you can see, we have a full agenda with lots of timely information for you today.

My name is Hugh Tilson and I will be monitoring today's forum. Before I turn it over to Jennifer, thanks everyone for making time in your busy schedules to participate in today's webinar. Your work is really important. We hope the information presented today will help you do that important work, and make navigating these trying trying times a little bit easier.

After today's presenters provide their updates, we will turn your questions. We have learned in past forums that presenters often address your questions during their presentation. We should have time to get to the questions, but I encourage you to wait until the presenters are through their presentations before submitting questions.

All participants will be muted other than our presenters. To submit a question, please use the committee function on the black bar on the bottom of the screen. That's the Q&A function on the black bar on the bottom of the screen. We send all the questions to DHHS whether we get them

or not on this webinar, so they can be answered. We also record the webinar and make the recording and have the slides available on the NC AHEC website as soon as possible, hopefully tomorrow morning.

Now let me turn it over to Jennifer. Jennifer, thank you.

Jennifer:

Good morning everyone. Thank you for joining the call. And we appreciate you taking the time to be with us today. Thank you also for the tremendous amount of work you're doing everyday to care for residents in your facilities. As Hugh said, we have a full agenda, with several updates for today. I will begin by providing an epidemiology update. Globally, the number of cases exceeds 5.5 million. With a number of deaths over 350,000.

Nationally, according to the CDC, the number of cases is approaching 1.7 million with the number of deaths over 99,000. And here locally in North Carolina, the number of cases is almost 25,000 with almost 800 deaths.

One of the updates for this week, North Carolina Department of Health and Human services is rolling out a new tool and tool kit for contact tracing. Identifying and tracing people exposed to coved-19 is a critical piece of the response. The local health departments are primarily responsible for conducting contact tracing, but since you have experience, they will reach out to you for assistance and input in this process.

Moving on to the key infection prevention recommendations. Infection prevention and guidance for long-term care settings remains the same. And these include: cloth face coverings for residents and patients. As a reminder, residents and patients should wear a cloth face covering or surgical mask as available, and possible, once staff are present in the room. Again, to minimize the potential of risk to transmission to staff.

Face masks are required for health care providers and staff for personal protective equipment. Other personal protective equipment is appropriate for the care of a resident and the specific type of facility.

Cohorting or grouping of residents who are COVID positive is also required. Along with cohorting or grouping of staff caring for these residents.

One quick reminder, for staff and healthcare facilities and this includes long-term care settings, staff are to maintain social distancing and appropriately care for their PPE while in break rooms

or lounges. Staff should continue to be careful to not touch potentially contaminated PPE, and to use hand hygiene while in these areas as well.

We currently do recommend testing for the virus that causes COVID, in the following scenarios. This includes testing of symptomatic residents or staff in these types of settings, and also testing residents and staff once a case is identified in the long-term care setting.

If you have not already done so, we do encourage you to identify resources in the event that you do need to conduct testing. And please do this in concert with your local health department.

Is also important to note that testing is not a substitute for other infection prevention control measures.

The last item I want to address today is the use of restrictions in long-term care settings. Currently all restrictions including visitors, dining, and communal activities remain in place. Visitors may be allowed in compassionate care and end of life circumstances. But please assure that visitors in these situations do adhere to infection prevention measures.

We have heard from many of you, working in the settings, and also from families of residents in the facilities. And we do understand and appreciate the extreme hardship that these restrictions have placed on everyone. Federal guidance regarding ease of restrictions has been disseminated over the past week to 10 days, and please be sure we are engaging stakeholders in these discussions as to how to safely lift some of these restrictions in the facilities while keeping this vulnerable population safe. We are looking at smaller residential facilities and larger more complex facilities differently. And while a definitive timeframe for easing of restrictions is not yet available, we envision that easing of restrictions for larger facilities will not occur until phase 3 or later of the governor's plan to reopen the state.

Again we're actively in conversations about this easing of restrictions.

So that concludes my portion of the webinar, and I will now turn it over to Dr. Susan Kansagra and Dr. Scott Shone who will provide an update on testing discussions.

Susan:

Great, thank you so much Jennifer. And as Jennifer mentioned, I wanted to provide an update on two new pieces of guidance that were released by the CDC over the last week and a half. And I know many of you have already heard about it, and that is the CDC testing guidance in nursing homes, as well as guidance related to performing facility wide testing. Now if you look at both of

these areas of guidance, it leaves a lot of flexibility back to states and local health departments in determining priority populations for the testing. And right now in North Carolina, where we are prioritizing facility wide testing, is for those facilities that have one or more cases. And as Jennifer mentioned, that is happening in conjunction with local health departments doing an initial outbreak investigation or providing initial advice when the first case is detected in the facility. They are then working to determine and facilitate that testing and provide testing resources to the facility to do further testing of staff and residents. There is some flexibility in the guidance by the CDC, for example if that initial case happens in a closed unit or wing with dedicated staff, certainly that wing can be prioritized. But generally, given that they have seen asymptomatic transmissions in facilities and rapid spread in facilities once a case is detected, they are generally recommended broader testing when that occurs.

In many places, questions have come in, are we thinking of testing broader than just facilities with one or more cases. And, we're looking at lessons learned from those other states and what is recommended in the federal guidance and we are in discussions right now to determine what the appropriate next steps are. And again with the prioritization of one or more cases. That really is something that many states are doing again because putting tests of resources to the facilities provides the most important benefit in preventing the future transmission. Especially when coupled with the infection prevention practices. So, that's our priority at this point in time. Obviously when you expand testing, we want to make sure the results are turned around quickly in a time that is useful for facilities. In some places where there is broader testing or a lack of prioritization, that makes it difficult to get those test results in a timeline that's feasible for facilities to act on. So we're looking at all those factors and looking at next steps. But right now, prioritizing for a facility wide testing is for facilities that have one or more cases.

And I will turn it over to Dr. Scott Shone who will talk more about broader testing strategy and plans for the state.

Scott:

So good morning and thank you everyone. So, overall the state is moving forward and I would say that if you look at the dashboard on the department's COVID website, we see that our expansion efforts for testing across the state are meeting with success so far as we look to inform

our reopening decisions and easing restrictions across the state with good data on number of cases and percent positivity-- and testing drives a lot of that.

To facilitate after the testing, and collection supplies have been a barrier thus far through the pandemic. The department has received allocations of collection supplies, swabs, and media from the federal government, and has also been able to procure supplies from commercial sources and have made those available through a request mechanism online similar to the mechanism that's been used thus far for PPE. If you go to the department's website and under information for health care providers, you can see a request for collection supplies that is now available to any provider in the state who needs to do collection in response to outbreaks or as part of routine testing.

We also continue, and I will deviate now to the state's lab for a moment. We have had some feedback from the nursing home community around ensuring access to results. Susan just mentioned this in her presentation. With submissions to the state lab, our turnaround time has been between 24 and 48 hrs, but we do know that there have been barriers to accessing results, so we will be working to make modifications to our information system that will allow online access for all facilities that are submitting under the national provider number, NPI number, to get access to those results separate from the pathways that are typically taken to get you through local health department.

And so I think I will end my comments there and ask questions as they come up. I don't know Susan if there's anything else you wanted me to address.

Susan:

Thank you, that's helpful. And we'll wait for the Q&A to address the questions at the end.

Now I believe next on the speaker list was Kimberly Clement to talk a little bit more about the PPE.

Kimberly:

Thank you, I appreciate it. So I just wanted to give a quick update. We have gotten through a little over 60% of all long-term care facilities at this point, providing that 10-14 day proactive supply of the various items of personal protective equipment. We do plan on finishing up the initial distribution on June 4. The next two days we will be in region J, in the Wake County area,

so a large number will be covered in the next two days. We received a lot of questions of what to do if long-term care facilities missed their pickup on their designated date. So what we would encourage you to do is go to the PPE request link that is on the DHHS website. And, in the justification, indicate the number of beds that your facility has and that you missed your pickup and we will route the PPE to your county emergency management receiving point. And you'll be able to pick up your PPE from that location. But it's really important that you indicate the number of beds and that you missed your pickup in that justification. That will allow us to cross-reference our list of facilities, and make sure we're able to give you the larger 14 day supply as opposed to a much shorter amount that we normally fill.

So that's the main update from us, and I want to say a lot of people have asked are we planning on doing this again, and a lot of that just depends on our supply chain and the ability to get those large numbers of items again. At this point, although they have been ordered, we have not received enough to start a second push. So just wanted to proactively answer that question.

And that is all from me.

Susan:

Great, thank you Kimberly. And next I will turn it over to Dave Richard to talk about the Medicaid update.

Dave:

Thank you so much. And let me start by saying we're just going to run through a couple of slides very quickly and then hit a couple of others for a little longer. But, first a reminder of what we're trying to do with Medicaid in terms of the facilities. We really want to make sure we're doing everything we can to support our facilities as we go through this. We know that it is a difficult time and very very difficult to manage this. What we attempt to do mostly is support with rate changes and support for the facilities that way, but much more flexibility to the providers impacted by the crisis.

And this is sort of just a reminder that this is not a Medicaid only thing. All of our teams work together and we really appreciate the support of public health and folks across the department as we're thinking about our work and the incredible work they're doing with the industry.

But this would be very helpful to see, is that what we wanted to know is how people were using the funds, the additional funds that were coming out with the outbreak in facilities. I think we knew this would happen, but it's great to see that as we've looked at the surveys, the vast majority of this is related to staff. And the need to increase base pay and hazard pay, but also overtime costs as people have dealt with outbreaks. And then again I'm excited to see the training that's working with the staff. And the PPE has been important for that. But I think that what we expected and what we are seeing is a real need to support people.

These incredible workers who are doing the work in our facilities. We need to recognize them as the real heroes that they are. So, glad to see that money going to the staff.

And the other thing we want to mention is we have done this, and we are working and have been working on developing a COVID discharge type of response facility. We established this under our special bulletin 82. We have had facilities that have indicated a willingness to accept these COVID positive patients as they are coming out of hospitals. Really important component of our strategy is to make sure that we have our hospitals available to serve people that need that. So we will receive enhanced rates for those Medicaid residents when they come in, and right now we have a network to identify facilities, but we may expand to others as post-acute resources. If you have an interest in that, please email the provider reimbursement at DHHS.nc.gov.

We also recognize that for many individuals in terms of congregate settings, the ability to actually have people at home and stay at home is really important. So we should be releasing very soon a special bulletin that shows the rate realignment increased our availability to support in-home personal assistance under our state PCS plan and our CAPDA and CAPC will serve COVID residents. Those reporting requirements will align closely for those with facility outbreaks. And again, you'll see that special bulletin coming soon. We have a technical assistance session scheduled for June 3 from 1 to 2 and we'll show on the slide a chance to register.

And we can turn the slide one more time, it might be my last one, and here we are, for the last slide we have. Just make sure you know how to get in touch with us if there's things that you need. We still have hardship payments for facilities and others that need those. So here's how you get to that website. And rate increases, you see that, and the reports of outbreaks so we can actually begin to support the additional rates. Make sure you get that information to us.

So thank you very much again for all of your doing to support our citizens and residents during this period of time. We know you're doing incredible work and I apologize, not sure who is next on the slides but I will stop here.

Susan:

Thank you so much. Actually you were the last one. As Dave mentioned in the closing thoughts, we appreciate all the hard work that everybody is doing. We know this is challenging and difficult and we appreciate anything that has been done. We will open it up for Q&A and I know there's already a lot of questions on there and I'll turn it back to Hugh.

Hugh:

Thank you Susan.

As a reminder, submit questions using the Q&A feature at the bottom of the screen. We've already got a number of them. **First question is as it pertains to easing the restrictions in nursing homes, will North Carolina follow the guidance from CMS issued on May 18? Specifically the guidance states that new nursing homes want that refers to COVID-19 cases that originated in the nursing home, and not cases where a nursing home admitted individuals from the hospital with a known COVID-19 positives status, or unknown COVID-19 status, but the resident came COVID-19 positive within 14 days of admission. Is that what North Carolina is going to do, use the phases of reopening?**

Jennifer:

This is Jennifer and I will take the first one. Yes, we are using the CMS guidance. As it relates to the easing of restrictions, so we would use that definition for facility onset and we will not penalize the facility, if you will, for serving as a COVID identified facility or if you have admitted patients from hospitals or other locations into your facility. So what we'd be looking for is transmission within the facility. And not accepting patients from other entities.

Kimberly:

And I think there's just one more clarification on that. Just to add, we're not saying that goes into effect now, but as Jennifer mentioned, we're looking at that and will be putting out additional guidance forward-looking around when that would occur.

Hugh:

Couple questions about **what's considered a larger facility related opening, and if there's any flexibility in the steps for reopening**?

Jennifer:

This is Jennifer again. I'll take a shot at that. I'm not the regulatory entity, but in discussions with the regulatory counterpart and also within work groups, we're considering the smaller facilities to be those family care homes and also behavioral health facilities and intermediate care facilities. So family care homes, having two to six beds with the larger facilities with more than seven beds.

So that's kind of the definition that I'm aware of. There may be others on this call who might have additional information.

Hugh:

Anybody else want to chime in?

All right**. Does the facility wide testing include residence on hospice with medicare only? I had one resident that the hospice would not cover testing and I was told it would not be approved.**

Susan:

This is Susan. I will take a stab at that. But the goal of the facility wide testing and the decisions that are made are really based on what is needed for that scenario and the patient and for cohorting patients, so that's really regardless of the payer type you shouldn't be looking at that, but once you make a decision around who to test and when to test, the idea of then looking back in determining where you may have coverage now for those facilities that have one or more cases, often time, insurers will cover that. I don't know the particular situation here, but oftentimes if you're working in conjunction with the health department, they may be able to point

you to the state resources or FQHC. Sometimes they're using on-site support resources to help facilitate the testing. Scott, do you have any thoughts on that?

Scott:
I agree with everything you just said in terms of the decision should not be based on the funding and payer, but what we have seen is a lot of facilities, once moving forward, do identify all of our commercial labs, our billing insurance directly. And as was mentioned, the FQHCs have been excellent partners in terms of facilitating with the local health departments as well. And, the state labs have done a good bit of testing, especially in support of uninsured, and we do a lot of staff testing as well. So it's sort of a hybrid of options, not the decision point, but after that there's a variety of ways to pursue based on what resources are in the correct direction.

Susan:
And also I mentioned, this just reminded me of one more thing when Dave mentioned the enhanced Medicaid rates for those facilities that have cases. That Medicaid enhanced rate really helps with increased cost that the facility will have in covering the cost of testing for those where insurance is not covered, or additional costs, PPE, or whatever it may be. And also, think about that funding that is coming and we also know there's a need for more funding, but some of that funding that's coming in comes from the federal government and from our Medicaid rate does also support the increased cost that a facility may have.

Hugh:
A couple other testing related questions. **What about testing before an outbreak given the broad instances of asymptomatic COVID cases?**

Susan:
Yes so right now we are recommending testing when there's one or more cases. Technically, the definition of an outbreak is two or more. So it is right when a first case is detected. That is our prioritization for where we're asking the local departments to work together with facilities to facilitate testing. Certainly, if the facility wanted to do testing at this point, doing testing before that on their own, they certainly can choose to do that. And w;ere working through options and

working on ways to facilitate that broader testing, but right now the main priority given that we are seeing rapid transmission, particularly when there's already an existing case, that is our priority for where we are focusing our local health department's resources and time.

Hugh:
A couple questions, **when we refer to the nursing homes, does this also apply to adult care homes and assisted living? And what guidance are they following?**

Susan:
I will try this one and Jennifer can add in. There is guidance federally from CDC and a lot of is geared toward nursing facilities, so it can be applicable to other settings. Many adult care homes could also look at that and implement different things based on those guidelines. We have more specific resources geared toward different types of facilities and that's available to you if you Google DHHS guidance COVID. Under the long-term care tab, there's guidance to specific facility types.

Hugh:
I will turn to PPE for a little bit. Number of questions about specific distribution, one about Lenoir Community College. One about Sampson County, questions about other particular counties. I'm trying to figure out the best way to do this**. Do you want to reply to specific ones or is there a place we can direct people so they can get information to the specific counties. And when pickup is going to be. Kimberly, how do you want to handle that?**

Kimberly:
Thanks, I appreciate that. A couple things about that. The flyers with all the details will be going out this afternoon. We were waiting on a few details. Some of this comes down to making sure we have good options for whether and those kinds of things, but I would just very quickly say June 1st, which is Monday, we will be in Caldwell County. June 2, which is Tuesday, we will be in, I'm not sure the county, but Morganton, North Carolina. Wednesday, June 3, we will be in Lenoir and Brunswick. And then on Thursday, we will be in Lumberton. For those flyers to those

counties and any regions associated with that, regions L, P, O, M, and N, will be coming up and again, those flyers will go out this afternoon.

Hugh:
And how can people access a map to figure out what region they're in?

Kimberly:
So we are using the regional Ombudsman map and that's on DHHS's website . I will have to look up the actual piece for that, but give me just a second and I will pull that up.

Hugh:
And then there was a question, will there be ongoing distribution of PPE or one-time supply? I think you answered this earlier.

Kimberly:
So as of right now we do not have enough in our supply cash to start another distribution, but we are working to source that. And so a decision on future distribution will be based on both receipt of those items and also some decision points for leadership. But we will continue to fill requests that will come in on the DHHS website.

Hugh:
Is PPE only available for long-term care facilities? We are a nonprofit hospice agency with home care community patients as well. Will they get PPE as well?

Kimberly:
So you have the option of going on the website and filling out the form. Everyone in healthcare does. The proactive push with the 14 days of supply was only for long-term care facilities.

Hugh:
Question about gowns. **Do you have any updates on gowns?**

Kimberly:
Gowns continue to be one of the largest scarce items that we're dealing with, although we have started to see a little bit of a breakthrough, such as receiving 20,000 here and there. So the number of gowns in recent days has started to increase. We definitely don't have enough to fill all the orders that we are receiving for those. So we're still trying to be cautious with that and utilizing the scarce resource plan related to gowns. But the good news is we are starting to see that increase. We have increased the number gowns we are starting to source, and a lot of these are long-term contracts where they're agreeing to give us a certain number per week. So we are hoping to see some positive movements in the gown space in the next couple weeks.

Hugh:
What type of equipment are communities using their funding to purchase?
I'm not sure that I understand the question.

Kimberly:
I'm not sure how to answer the question or if I am even the right person to.

Hugh:
Well let's turn to Medicaid. **Any word about when the $1325 Medicaid per president will be sent to communities?**

Dave:
I think that refers to the legislative appropriation that is around special assistance and I know that it's in the works with the adult services division, but I don't have a date, so I'll try to get that out in the Q&A as soon as possible.

Hugh:
Will ICF IID residential facilities that directly bill medicaid through NC TRACS be receiving rate increases similar to the SNFs?

Dave:

We have, that's in progress because we weren't able to participate in the LME/MCO which is typically where the ICF rates go. So it won't be at the same level of the SNFS because that wasn't how it was handled at the LME/NCO level, but there will be a rate increase and I believe it's 5% back to March 1.

Hugh:

Regarding the 10% PCS increase over the already approved 5% increase, should we bill at the 15% increased rate, use the current 5% increased rate and anticipate the support that we'll be reimbursed at a later time? Calling medicaid and no one seems to know the answer.

Dave:

That's complicated. So let me assure you, I don't want to mislead anybody here and I think I understand the question. But, let me get our team to put something together that will clear that, because what will wind up happening is one of the people had already billed that 5% and now with the additional one, they're trying to figure out how to manage that. It's a great question, but let me get our team to put out something that is really clear about that.

Hugh:

Let me go back to testing. **If you don't mind, please repeat the information about testing for nursing facilities.**

Jennifer:

Yes. So again there are two new pieces of guidance on that, on the CDC website around testing. Right now when there are one or more cases in a skilled nursing facility, or really any congregate care facility, the local health department is working with the facility to engage in testing of all residents and staff. There's a little bit of flexibility in that, but really that's the main recommendation. There is flexibility in one particular unit or with the idea of prioritizing that first. But the health department will be quoted with the facility. And another piece I want to add is that I do recognize in our current state, the way we have our public health system, there are 83 different health departments, across the state, and they each function and have different resources

available to them, just due to historical reasons and just due to what they might be dealing with in the county. In some cases, the health department may be able to support sending staff in to help with swab collection and in some cases they may not. They may be referring you to, for example, another partner or a lab testing entity, but those decisions are made in accordance with the local health department.

And I would say also for any facility that doesn't want to think... This is true of any facility, to be prepared in the event that there is a case. To be prepared to do testing and start thinking in advance of your own labs, your left vendor that you are using and other lab resources in the county and start to make those relationships and understand where that is available to you.

Hugh:

We got a related question for long-term care. **Is the ability for community test processing by the state lab in the event that there are one or two residents or staff that end up having a positive test?**

Scott:

Can you say that one more time, I'm sorry.

Hugh:

One of the questions is can long-term care settings seek the state lab testing rather than going to commercial testing I guess is the point of the question?

Scott:

So the short answer is yes. As you said earlier, that when it comes to especially residents who have insurance coverage, we have suggested that the commercial options who do billing of those insurance carriers be sort of a first option. We have, and continue to support, both testing residents and staff at facilities when other options are not available. The state lab does not, and is not designed to have the capacity of these commercial labs that can test thousands, if not tens of thousands of samples a day. And so we are expanding, I will say, in our response, we are adding equipment and adding capacity to increase above what we can currently test so we can more easily facilitate responses. But part of the reason for some guidance around who or what, what

specimens are prioritized at the state lab, is to assure that our capacity is used for those individuals who don't necessarily have another avenue for being tested, for getting testing. So I don't know if that's the best answer to the question, but that's, the state lab is here and can provide testing, and I think when through local health and through our epi on-call, the decision made of how best to maneuver some of these. But I do agree with Dr. Kansagra in terms of identifying the resources in advance to help facilitate if and when these situations occur.

Hugh Tilson:

Trying to group some of these questions. But with restriction on group meal dining, is it a requirement to use disposable dining wear?

Jennifer:

So no, it's not a requirement to use disposable dining wear, its just that people who are retrieving the trays and cleaning those, the equipment that they need to take appropriate precautions, but no, it is not a requirement to use disposable dining wear.

Hugh Tilson:

With new admissions, what strategies have others implement to ensure families are still able to sign the needed forms with restrictions against entering the facility? Any advice about that?

Susan:

That's a good question. I don't know that anybody on the team here can answer that, but it would be interesting if others have thoughts on that maybe they could also, if others have come up with methods for that if they could consider putting that in the chatbox and maybe we could circulate some strategies. We might have to defer that to best practices of others.

Unknown:

I agree with you Susan, that would be very helpful.

Hugh Tilson:

When will hospice nurses be allowed in to care for residents across the board and to admit new patients?

Jennifer:
This is Jennifer and I will take a first stab at that. Of course, other can feel free to jump in. What we have recommended and what's been recommended on the federal level as well is to restrict the nonessential workers. So again I think there has to be some discussion on what's essential and so I think that is yet to be determined. I'm not sure that I'm quite qualified to answer the question.

Hugh Tilson:
Yeah, there was a related question about are independent consultants still considered essential so that's probably the same answer. **Did I hear the cloth faced coverings are recommended for all residents regardless of COVID status?**

Jennifer:
That's a good question. This is Jennifer again. So a cloth covering would be recommended for all patients and residents outside of their room. But for COVID positive patients in particular, we would request that COVID positive patients wear a cloth face covering or a surgical face mask when staff are present in the room. So there's a definitive difference there but if residents are healthy and not COVID, not affected by COVID, and they are allowed outside of the rooms in designated areas, then we would recommend that they wear a cloth face covering.

Hugh:
Will there be COVID positive rehab facilities established for those who test positive, but are either presymptomatic or asystematic and don't currently warrant hospitalization? Especially if they currently reside in an assisted living setting.

Susan:
I would take a stab at that. So right now what many skilled nursing facilities are doing is certain skilled nursing facilities are establishing themselves in creating COVID units or wings to accept

patients coming out of hospitals. So, the operators are thinking across the different facilities and again a designated one for acceptance. And all facilities should be prepared to have a COVID wing or unit, given that at any point you can have an outbreak, you could have a new resident, you should pre identify a place in your own facility, but again particularly for some skilled nursing facilities, they are doing that and CMS has waived certain rules related to the transfer of residents between facilities as well for the purposes of facilitating cohorting. Mark, do you want anything else to that?

Mark:
I do not.

Hugh:
Any idea when restrictions in six bed group homes will be reviewed and updated?

Jennifer:
This is Jennifer. And so yeah, I think as mentioned during the initial discussion, I see some additional questions that have come up about that. So we are actively engaging in discussions with the stakeholders both internally, internal to the DHHS, as well as external, as how to safely lift some of those restrictions in both the smaller facilities and the family care homes, the behavioral health facilities, as well as in the larger facilities, adult care homes, assisted living and nursing homes, so we are again working to try to meet the needs. The distinct needs in the smaller facilities versus larger facilities as well.

So we recognize that resident needs are different with different types of facilities. So, again we are in active discussions and hopefully we'll have something available over the next few weeks as far as what that will look like. We don't have a defined timeline.

Hugh:
Is it being recommended or mandated for skilled facilities test weekly even without cases?

Jennifer:

Right now the recommendation around testing weekly, that is a recommendation that they federally have provided. They are saying that the weekly testing should be considered a. When there are staff or residents that leave more frequently, and really again back to prioritizing which facility should be doing that. There is also weekly testing after there is an outbreak and the health department will be advising facilities on the next steps around what might be required around continued weekly testing with negative staff after an outbreak. So there's two different situations in an outbreak setting.

Hugh:
And a couple of questions of funding. **How do small family care homes get access to additional funding to service patients being released from COVID-19?**

Dave:
This is Dave. So could you repeat that one more time, I want to make sure I understood.

Hugh:
When people are released from COVID-19 and they go to small facilities, can they get extra resources for the additional costs? Is that being carried over to them?

Dave:
I think it depends on the type of facility. And the funding stream that comes in. So, and the service that is provided there.
What I am trying to think of the best way to make sure that the person gets the right answer. We will be working on guidance, they may want to call into or email into one of those emails with medicaid that we had on our slides with a very specific questions for the type of facility it was. And we'll make sure they get the answer.

Hugh:
And as a reminder, we will post the slides as well as the recording of this on the NC AHEC website probably tomorrow at the latest. **How long will increased rates be in effect for residential facilities?**

Dave:

To be in the facilities, we are right now, I think this is one, we want to be clear, that we are evaluating, they are currently in place to the end of the fiscal year. Because that's how we have to manage that. I don't want to imply that that means they'll end at the end of this fiscal year. But we do have to work through the budget process to make sure the ways it will carry on further. So right now, through the end of June. But stay tuned for more information based upon the budget process.

Hugh:

Could long-term care providers ICF receive matching support for funds if they were present to prevent the need to admit a member if the loss of life occurs due to COVID-19 at the facility?

Dave:

I think for the ICF and with that issue, that is that that is a question of working with the LME/MCO from where the resident resides. And, what was seen I think has been really good responsiveness from the LME/MCOs in terms of their ability to support providers on that, but it is unique to that region for how they respond. I think the best advice is to make sure that they are talking to the LME/MCO and where the people they serve are from.

Hugh:

Got a request to revisit and **repeat the loosening of restrictions for family visitors, if there's a timeframe when that may occur?**

Jennifer:

Hello, this is Jennifer. Again. So we are again in active discussions both internally at DHHS, as well as with external partners and stakeholders around how and when to safely ease some of these restrictions, again looking at the various populations and recognizing the differences among them. And so we would love to have a definitive timeline, but we do not at the moment. But hopefully we will have something in place over the next few weeks.

Hugh:

Who is responsible for paying for the testing?

Dave:

So Susan may jump in. I think what I would say is the testing, we are as a state, continuing to work on the funding streams and how that works. But for residents often they have a funding stream, and we want to make sure that the testing is paid for by that insurance, whether it's Medicare, Medicaid, or some private insurance. The same thing will be looking for staff, is that if there are funding sources that would be able to fund that, they should go there. But we as a state are working through the process of the broader testing strategy and how funding will be provided for those if there aren't other apparent sources.

Susan:

Thank you, and I will add on the back end that we are looking at mechanisms on how to, and labs as well, into how to draw down federal funding to support testing for uninsured, for example HRSA funding is one example.

Hugh:

Trying to look through these questions. **If a worker has a virus while working, will residents be able to receive the increased rate in the facility in the family care home setting?**

I'm not sure that makes sense.

Jennifer:

Hey, this is Jennifer. Could you repeat that?

Hugh:

I will move on to another one, I'm not sure I understand the question.

If a resident refuses to wear a cloth mask outside their room, do they still have the right to refuse? If the resident doesn't wear the cloth mask, what can the facility do?

Jennifer:
This is Jennifer again from the infection prevention standpoint, again others feel free to jump in. So again, it is a recommendation, it really depends on the circumstances within the facility, what type of facility it is, and the individual needs of the patient.
If that patient is a potential risk of transmission, or serves a potential reservoir of transmission to other residents and staff members, so it really is kind of a case-by-case basis.

Hugh:
Are masks required by staff at all times in the facility, or only when in direct contact with residents or other staff?

Jennifer:
So for staff, that is actually one of the recommendations that staff at all times while present in the facility have a surgical facemask or a cloth face covering.

Hugh:
Is initial N 95 fit testing waived or just an annual fit testing?

Jennifer:
So currently it's just that annual fit testing. I'm not sure exactly how long that will be in place. But all persons must have an initial fit testing and they must be medically cleared to wear the N95 mask. Again, because if they are not medically cleared, that's actually a liability for the facility if something happens. The facility must also have a respiratory protection program in place.

Hugh:
Is there a listing of labs in the state that are offering COVID testing that we can provide to facilities?

Scott:

This is Scott. I'll take that. Our team has been working on the list. We have one just about done. I would actually say it's growing, so Susan, we just need to decide terms of sharing that, a little effort getting that out sooner than later. My team at the state lab has been calling a variety of diagnostic labs in the state and around the country to identify basically just to see what they can offer. And still be incumbent on the facility to make the outreach and assess the capacity. I just said earlier, making sure you understand turnaround times, that doesn't do any good if it takes two weeks to get a result back obviously. But and we have not done that in that capacity changes, everyone is seeking out these resources.

So I believe that we have a document now that has about 20 or more different labs that have told us yes, they have capacity to do testing but it ranges from a handful to over 100 a day that they have the capacity to do, so we will get that together and get that out. That is on my plate and we will make sure we get that quickly.

Hugh Tilson:

An adult care community has no active COVID, can residents begin to live more normally within the confines of their home? As long as infection controlled social distancing practices are followed?

Jennifer:

So again this is Jennifer again I will take that. Again, the current restrictions do remain in place. So again I think we have to follow those guidelines that are currently in place.

Hugh Tilson:

Just got this. Can you repeat the requirement for a N95 mask use, we do not have anyone trained to do the testing and have not used in the past. And then, is the N95 testing for skilled nursing, adult care homes as well as have a policy place.

Jennifer:

This is Jennifer. So yeah. So regardless of the type of facility, if there is a desire and need, actually I will say a need, to use the N95 mask. And again N95's are required for aerosol generating procedures. So again, individuals must be fit tested initially and medically cleared to

wear a N95 mask and the facility must have a respiratory protection program in place and we recognize that not all facilities are set up to have that. And so there are entities out there that can come and assist with fit testing, and assisting with establishing the respiratory protection program and if there are questions they can also ask their local health department and they may or may not have resources available. But it's a good place to start.

Hugh Tilson:

And a couple questions about residents returning to their day programs or resident jobs are beginning to open back up, are they allowed to begin working again. For adult care homes or family care settings.

Jennifer:

Hey this is Jennifer and again I will take first pass at that. So again the current restrictions do remain in place. We recognize that facilities and programs are beginning to open up, and I believe that, I believe that the state program guidance was just posted to the website recently so I know that again they are looking at reopening. But current guidelines remain in place. And we are very actively engaged in discussions and hopefully will have additional guidance out soon.

Hugh Tilson:

What can the facility for a resident who refuses to remain in Quarantine as ordered by a doctor. Can we discharge for endangering other residents and staff due to noncompliance?

Jennifer:

So this is Jennifer and I'm not quite sure that I am the appropriate person to answer that, so not sure. If Mark or anyone else can answer that?

Mark:

Do you mind repeating the question? I'm sorry.

Hugh Tilson

What can the facility do if the resident refuses to remain quarantined?

Mark:
That's a real broad question, it depends on the facts. I would suggest the person who submitted the question contact the appropriate licensing section to discuss that with them.

Hugh Tilson:
Got a follow-up question about facilities, why testing in nursing homes and weekly testing of staff in nursing homes to clarify this is currently required, weekly testing is required even if no positive cases are found. Is that correct?

Susan:
Yes so it's currently not required. There is a recommendation, but we as a state are prioritizing, after that initial testing for one or more cases, then prioritizing weekly testing as needed to follow up and ensure that further transmission is detected if it is occuring, that's really for those facilities that have one or more cases and that decision and guidance is provided in combination with the local health department, now we are looking more broadly has got mentioned, broader strategies around testing and how we expand testing capacity. More broadly. So if there is opportunity to support additional weekly testing, we as the state can help provide resources, for example labs and other places have capacity to do it. Right now the recommendation is really prioritized for those facilities that have one more cases. After you do that initial point prevalence test, then to consider weekly testing of negative staff and that can't be done, to consider weekly testing of sorry, I said negative staff, negative residents or staff. And then to consider if that can't be done. Prioritization of those staff, or residents that might be leaving the facility for periodic testing. Again that's for facilities that have one more cases. And that's usually done until no more transmission is detected in the facility, there's no new positive cases identified.

Hugh Tilson:
Couple of questions about returning to community jobs. Number one is, where can the guidelines be located? If somebody wanted to find the guidelines, that were posted I think you said maybe today, Jennifer?

Jennifer:
Hello. Yes so all the guidance documents that are available are on the ncdhhs.gov website. If you click on guidance, you should be up to find that.

Hugh TilsoN:
I'm looking at all these questions to find ones we haven't answered.

Susan:
I will mention at the end. Some ideas did come in around that question with some really great ways to assist families in signing forms.

Hugh Tilson:
And we are just about of time. I will observe that I will forward all these questions to Susan, to you and your team so you can follow up specifically. I think we answered a lot of them generally. If not specifically. So since we are almost of time, let me just thank you and your team for making the time to present this really helpful timely information and for all you do all day everyday for the people in the state of North Carolina. I know you are working very hard. We all really, we all really appreciate it. And for those of you who participated in this webinar, really hope that information was helpful. And recognize the important work that you do thank you so much for that.
Susan, let me turn back over to you for final remarks or comments.

Susan:
Great, no, thank you. Thank you for moderating and thank you for all of you for everything you're doing. We know the job isn't easy. But we appreciate all the hard work and everything you are doing to protect our citizens and trying our best to support you the those efforts. So thanks for the continued dialogue, hopefully we can continue to do this.

Hugh Tilson:
Sounds great, we look forward to supporting those and as a reminder, the slides and webinar will be on the NCAHEC website starting tomorrow. Thank you everybody. Take care.