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

Presenters:
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Hugh Tilson:

Our moderator will begin in about one minute.
It's 10:00. Let's get started. Morning, everybody and thank you for participating in today's COVID-19 webinar for long-term care providers. This webinar is put on by the North Carolina Department of Health and Human Services and supported by NC AHEC to discuss recent updates to the states COVID-19 response and to provide a form for you to ask questions of DHHS 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 moderating today's forum. Before I turn it over to Jennifer, thanks to everyone for making time in your busy schedules to participate in today's webinar. Your work is really important we hope the information today will help you and help navigating these trying times a little easier.

After today's presenters provide their updates we will turn to your questions. We have learned in past forms of the presenters are often addressing your questions during their presentations. We should have time to get to your questions and I encourage you to wait till they are through before submitting a question. All participants will be muted other than our presenters. The only way you can submit a question is by using the Q&A function on the black bar at the bottom of the screen and it's the Q&A function on the black bar on the bottom of the screen. In the event we don't get to all of your questions today we will share these questions with DHHS, although each individual question may not be answered, your questions will be used to inform future guidance or add to the agenda for the next call. We will record the webinar and make that recording a written transcript and these slides available on the NC AHEC website as soon as possible, probably tomorrow morning. Let me turn it over to Jennifer.

Jennifer MacFarquhar:

Good morning, everyone. Thank you, Hugh and thanks everyone for joining the call. We appreciate you taking the time to be with us today and thank you for the tremendous amount of work that you are doing every day to care for residents in your facilities. We have several updates for you today and I will begin by providing an epidemiology update. In numbers, we do have some areas of increasing activity nationally and in some areas we've seen the largest increases over the past few days, particularly in the southeast, Midwest and also California. Globally the number of cases exceeds 9 million with the number of deaths over 478,000. Nationally, according to CDC, the number of cases is over 2.3 million with the number of deaths over 121,000. And again the state perspective, the number of cases is over 57,000 with almost 1,300 deaths. And again, here in North Carolina we have continued to see increases over the past several weeks and it does seem to be disproportionately affecting the African-American, Hispanic and Latinx communities. We do recognize the challenges and potential correlations with density and workplaces. Housing situations, and we are looking at determining what exactly additional measures are driving these increases. And

we are attempting to be very thoughtful in how we address this and care for this population but not stigmatize the population. We are also beginning to see clusters in other settings, so outside of healthcare facilities, long-term care settings but in other workplace settings as well. We do continue to refine the process of identifying any areas of interest and we are looking at pulling metrics and identifying counties where there are increasing trends. Next slide.

Some key infection prevention -- let's see -- measures that I wanted to touch base on again. I know we talked about it on the last session but again I think it's important to highlight these infection prevention principles and recommendations. These do include cloth face coverings for residents and patients, as a reminder residents and patients should wear a face covering or a surgical mask if available when staff are present in the rooms in order to minimize the potential of transmission to staff. Surgical face masks and other face masks for other healthcare provider should be used and again something I mentioned last time, we spoke on June 11th with CDC's updated guidance for staff healthcare providers to where eye protection in addition to face masks for the care of all patients. And in an area with moderate to substantial community transmission and again there's no clear definition for what that moderate to substantial community transmission does look like but if you are seeing areas of increased transmission, and outbreaks in your community, I would define that as moderate to substantial community transmission.

So the next infection prevention recommendation would be co-horting or grouping of residents who are COVID positive along with staff caring for these residents and again a quick reminder for staff in these healthcare settings including long-term care settings, staff are to maintain social distancing and appropriately take off and care for their PPE while in break rooms or lounges. They should still be careful to not touch the potentially contaminated PPE and use hand hygiene appropriately in these areas as well. Other personal protective equipment as appropriate for the care of resident in the specific type of facility should also be worn. One thing I did want to mention today, we received questions about shoe covers. Shoe covers -- it is not a recommendation to use shoe covers for the care of COVID patients. And for testing for screening we do still currently recommend testing for the virus that causes COVID. For symptomatic residence or staff, in these settings and also testing of residents or staff once a case is identified in a facility. If you have not already done so, please do identify resources in the event you need to conduct that testing and we recommend you do this in concert with your local health department. Last but not least, it's important to note that testing is not a substitute for other infection prevention and control measures that we've already talked about here. Next slide.

The last item, which I know will be of great interest to all of you, staff, families and residents alike -- is to discuss easing of restrictions in residential care settings. The current executive order which restricts visitor dining and communal activities will expire at 5 P.M. on Friday, June 26th. There is a new Executive Order in place which allows for some easing of restrictions and specific types of facilities. Guidance has been developed to correspond and outline how to safely implement some of those activities. First I will outline easing of restrictions for smaller residential care settings and those are defined as six beds or fewer, and the facility types that this does encompass includes family care home, behavioral health, IDD homes, and intermediate care facilities. Facilities should have plans in place to outline their policy on visitation, communal dining and group and outside the home activities and this does include employment, day programs, and home visits as well. Factors such as resident health status, the physical layout of the facility to accommodate visitation, staff availability and other procedures to conduct daily screening of resident and staff should be included in the plan. And specific guidance -- guidelines to allow for social distancing, adherence to hand hygiene and other prevention can be found in the guidance that is currently located on the DHHS website. Next slide.

Larger residential care settings are defined as seven beds or more and currently those types of facilities included would be adult care homes, behavioral health, IDD, intermediate care facilities and also psychiatric residential treatment facilities. Currently outdoor visitation is allowed after facilities meet specific requirements. Including not having an ongoing COVID outbreak, having a written testing plan for COVID and assuring appropriately [Indiscernible] for the outdoor visitation space and additional guidelines are available in the guidance which is on the DHHS website and this is to assure health and safety of all staff, visitors and residents. We do continue to be actively engaged with partners to further ease restrictions in these larger residential care settings and hopefully this additional guidance will be available in the next few days. At this time visitation and other activities remain restricted in skilled nursing facilities or nursing homes. Because of the continued increase in numbers across the state, we did want to pause though and mention that it's important to highlight that CMS guidance aligns with ours, which does maintain that visitation in skilled nursing and nursing homes should be allowed for compassionate care circumstances including but not limited to end-of-life reasons, and again so CMS and our guidance aligns in this respect. CMS has a good definition for compassionate care circumstances which I think is helpful to describe now. CMS states that the term compassionate care situations does not exclusively refer to end-of-life situations, for example, for a resident who is living with their family before recently being admitted to a nursing home, the change in environment and sudden lack of family can be a traumatic experience and thus allowing a family member to visit in this situation would be consistent with the intent of the term compassionate care situation. So again we've heard from many of you working in the settings and also families of residents and your facilities and we understand the extreme hardship that some of these restrictions, specifically visitor restrictions, place on everyone and we hope that with the new Executive Order and guidance documents that loved ones will be safely reunited. So that includes -- concludes my portion of the webinar and I will now turn it over to Dr. Susan Kansagra and Scott Shone who will update you on testing discussions.

Dr. Kansagra:

Thank you so much, Jennifer. I will cover a few updates related to testing and pass it over to Scott Shone, the state lab Director. First of all, and as discussed on the webinar two weeks ago, just a reminder that DHHS has issued new guidance for testing, this is geared towards providers and criteria for which they would consider who to test. Obviously anyone with symptoms of Covid-19 should get tested but in addition anyone that has a regular contact with high-risk settings, such as long-term care, are also eligible regardless of symptoms. This is important to remember should for example staff members be exposed outside of work as well that they should consider going to their provider and their provider should be testing them, they should mention their connection to long-term care to get that testing and the provider again should be testing them given that criteria. Next slide, please.

On our website you will see there is a testing site locator. Again this is more as a potentially useful resource for again staff in facilities. As well as those residents perhaps in smaller facilities that might be more mobile, but this testing site locator is available on our website and points specifically to community locations and every day there are new sites being added. Next slide, please. As a reminder, wanted to highlight a few key points regarding the CDC testing guidance on nursing homes. Right now CDC does recommend testing all residents and staff in a nursing home if there is a new or confirmed case of COVID-19. In our state this is happened in coordination with local health departments once they are notified of a case. When they provide additional guidance and input around infection prevention and control and other measures in the facility, they will also advise around testing and in most cases this should be testing of all residents and staff in the nursing home or other long-term care facilities. In addition, they do stipulate some additional suggestions if for any

reason testing capacity is limited, how to prioritize what staff members and residents should be tested. So that is listed also and you can see a link to that full testing guidance available on the CDC website. Next slide, please.

In addition I know many have asked about the idea of point prevalence testing for nursing homes including testing in nursing homes that do not have one or more cases and so here DHHS is in the process of identifying a vendor to support initial point prevalence testing needs. There was a larger RFQ that was released a few days ago to support increasing testing capacity over all for our state for many different needs. That includes initial testing, in skilled nursing facilities, so that there will be more to come over the next week or two. In addition, nursing homes should continue to identify lab companies or community testing resources to support ongoing testing needs and this applies really to all long-term care facilities, not just skilled nursing facilities. Around pre-identification of lab support should you need that and should there be an outbreak for other testing needs. Next slide, please. There is one resource I wanted to highlight in community resources which are the Federally Qualified Health Centers located throughout North Carolina. Many of them are already working with long-term care facilities to conduct testing of staff and residents and some FQHCs are able to come on-site to support testing needs. The list of FQHCs is available at that website link that you see on the page. FQHC's serve all patients regardless of insurance status so this is an important resource so if you are a facility that has not thus far identified a vendor or are working with a vendor already to consider reaching out to your FQHCs to start the conversation and partnership for ongoing testing needs. With that I will turn it over to Dr. Scott Shone to give lab updates.

Dr. Scott Shone:

I don't have any slides but just a quick update from the State laboratory of public health. We are continuing to provide testing on a case-by-case basis to support the needs of the long term care facilities. As Dr. Kansagra mentioned, the RFQ process, we partnered on helping to develop that and work together to support those needs but in the interim we still continue to support testing whether it's directly with your facilities or local health departments. I want to remind everyone that even if you are not submitting to the state laboratory of public health there are collection supply resources available to you through the department website. If you go to the department's COVID-19 website and look at information for healthcare providers there is a link to request collection supplies. It is right next to the link to request PPE. So even in those devices can be used to submit to the commercial and private lab of your choice. It does not have to come back to the state laboratory. If you are submitting to the state laboratory, two things to note, one is next week is Independence Day holiday, UPS and FedEx are shut down on Saturday, July 4th. They will pick up samples on July 3rd but they are not delivering on the fourth and so anything shipped on the third will not make it to us until Monday, the sixth and therefore be unsatisfactory for testing so a memo will be going out shortly to alert everybody to this, that we are working, the state lab will be open and we will be testing samples all weekend but those would need to come in through a private courier or some other means other than you yes and FedEx.

With respect to the samples that have been coming in, I would ask for some support in assuring that the demographic forms, the request forms are filled out completely and accurately. Our team is unfortunately having to spend a lot of time pestering staff at the facilities for accurate and correct information. Which not only is a burden to you all but delays testing here at the state lab so if we could get those completed correctly the first time, it would make everyone's life a lot easier and more streamlined and I will -- and this is by far not a threat but I will say that for all other testing we do at the state lab, when a form is not completed correctly it is actually rejected for testing. We understand the criticality of COVID samples and we are trying to work with submitters and this is not something

isolated to long-term care facilities. We are having issues across the board as volumes increase but I'm asking all of our stakeholders to help us improve the system overall and work more efficiently together.

Other than that the state lab -- I will finalize with kudos to my team who are working to increase our capacity. I know I've been talking about this for the last few weeks. There was some unexpected and unfortunate delays in supplies on our end as well. This has been a supply chain whack a mole through the pandemic and we had an issue with one of our vendors, which caused us to do a little bit of a course correction on expanding our capacity but early in July we will have enhanced capacity and so I know some of you have said our normal 1 to 2 day turnaround time has gone to 2 to 3 days. I still applaud my staff for being able to maintain that but that has been -- that is why but as we increase our capacity we should see a more routine resumption of our 1 to 2 day turnaround time which I know is critical for you guys to respond to your facilities. I believe that's it on my side. If there's any questions, don't hesitate to reach out to me or the state lab on our website. There is an email address for general questions. If you have issues with supplies or results, please direct them there. That's it for me.

Thank you. I don't have the agenda.
I've got you, Scott.
Thanks, Kimberly.

Kimberly Clement:

Good morning, everybody. Kimberly Clement, healthcare preparedness. I just wanted to give a quick update on some of her healthcare request by provider type. This is really over the 10 day time frame from June 9th, to June 19. The majority of our healthcare requests continues to be from our long-term care partners, which we are very pleased about. Happy to continue supporting that area. We are looking at some strategic changes within the next couple of weeks can help us be a little bit more advanced thinking and ensuring you guys have the supplies ahead of time so stay tuned for some exciting announcements on that, likely in the next couple of weeks. I wanted to quickly highlight that you can see across the state a lot of different resources are being provided, some of the areas we don't see any provided, it's likely because this is again a snapshot in time from the June 9th to June 19th time frame. But as we would expect our population centers have the largest number of items requested and in that time frame we did have over 470,000 different items that were delivered during that time. All of this is driven by the request process which is on the DHHS website and we encourage you to continue utilizing that to help with your supply chain shortages. That is all for me and I will turn it over to Dave.

Dave Richard:

Thank you so much, Kimberly, and we will move to the next slide and I'm going to go quickly through the first two and we have -- if you move on our goals that we remind everybody what we are trying to achieve, so we go to the next slide. Another reminder of this is -- as you've heard from people on the call across departmental effort we are all trying to work together and obviously work closely with you as our community of providers and beneficiaries to make sure we are doing the best we can to support people living in long-term care. The real meat of it is in the next slide that we want to talk about, so we have communicated in previous bulletins that the COVID rate adjustments, we couldn't commit to be on June 30th. I want to give a little bit of a background of what this is about. We obviously -- the fiscal year ends June 30th so we have to make sure we have the resources available in the next fiscal year to be able to continue these efforts. We believe we will. There's a lot

of work in a general assembly and places to do that but I want to convey today is that our goal is to continue the rate increases. We say through the projected current duration is December 20, it may adjust depending on the public health emergency. But we do require -- actually the funds to be able to go forward. But I want to be clear about with everyone on the phone call today is we are not -- even if something would happen and we do not have the resources appropriated in the General assembly to move forward, we are not planning to end anything on June 30th. We know people would have time to adjust. A goal and I think we will achieve this is we will work well through the summer and fall in the rates will stay in place and that we will be communicating with the associations and with our member groups about how we plan to continue that work and when we would have to reduce or go back to the other rates. There would be plenty of advanced notice for that so what I want to make sure that everybody hears on this call is that no one should expect that next week that there will be a reduction in the rates. Those will continue and again our belief is we will be able to continue those through the summer and fall and have the conversation with all of you about when they would be reduced.

The rate adjustment criteria is still in a special bulletin and you should follow that. I do want to make sure we mention, we had asked for certain things around infection control plans to be sent in to continue that enhanced rate, the additional enhanced rate. We are reviewing the compliance of that and we will make sure that we are reporting that out in the coming meetings. Really encourage people if you are receiving enhanced rates, please make sure you are following up on the compliance of that effort. We can go to the next slide, please.

This is -- I think it's an exciting slide and we really want to keep showing. Your response to us about how people are using the additional funds that have come through Medicaid. And I think the part that is most exciting to me is the recognition that this is being used to support our front-line staff which I continue to want to say how much we need -- we really need to raise them up as people that are doing incredible work because we know often in these positions, the salaries are not things that people get rich on. They are difficult and people are showing up every day doing that work. We know that. It's hard and it's obviously sometimes very difficult and scary work to do. But you as providers, the people that do this work, have used these increases to really support staff by increasing base rates or paying overtime as people need that. The training part of it, the additional specialized PPE is really important, but I think what gives us great comfort is that -- how these rates are being used as really being directly to impact the support of your residents to avoid COVID or if there are COVID operates to support people so I want to make sure we continue to share that information with you. Next slide, please.

I just want to remind people that you can go to the dedicated page and get all the guidance around how reimbursement is there, please refer to that, obviously there are places you can get questions and answers about this but I think all the guidance about how the rates are put in place are there. I think that may be the last slide but if we move forward -- just a reminder of the COVID knowledge center. It will soon be posted with all of the responses that we've had. There's also -- when they AHEC send out the slides we have a long list in our appendix of questions and answers that people have raised in the past. And hopefully you will be able to access that. Again I want to say, from a Medicaid standpoint, and I know from all of our colleagues how much we know how hard this work is and how hard people are working to make sure we get it right and we really do appreciate the partnership with DHHS and making this effort.

The last slide says we will go to questions. Maybe not. I was wrong. Sorry. I forgot this slide. Just a reminder that we are looking to continue to work on COVID response facilities. The most important part of this obviously is we want places for hospitals step down as we talked about earlier in the

things we are trying to achieve in this effort. The rate adjustment is comparable to an outbreak facility but if you want more information, please refer to the provider reimbursement at DHHS.gov and we have a couple others. The last one I think from us is a reminder -- if we go to the next slide, of all the special bulletins that have been published since the last webinar. We just want to make sure again that people are referring to those as you are looking at the reimbursements schedules and other things like the laboratory code for testing, that was the one most recently published and I think that's important for people to see. The last slide for Medicaid is a reminder about where you can get information on the Medicaid side if you have questions. Please send it to these email addresses, you are assured to get quick responses from the Medicaid team. Now I know we are going to the last slide which says question-and-answer so thank you for all you are doing and I will turn it back over to Hugh.

Hugh Tilson:

Great. Thanks, Dave and everybody else. As a reminder please go to the Q&A function to submit a question. The slides will be available on the NCAHEC website. www.ncahec.net, there's a green bar across the top that has COVID resources on it and you click on that and the slides will be available and we are trying to get them out as soon as possible so that is where you can get those slides. Susan, it seems like you want to answer one of these questions live about the easing of restrictions? Let me -- **will the easing of constrictions conflict with the governor's rule to extend phase two? Shouldn't easing of visitation policies take place once we enter phase three?**

Dr. Kansagra:

Jennifer, let me turn it over to you to see if you want to answer first and then I can chime in.
I don't hear from Jennifer so let me take a stab at that. There is a new Executive Order that went into place yesterday. The new Executive Order continues to prohibit visitation in skilled nursing facilities except for compassionate care reasons which Jennifer outlined. But the current Executive Order that had been in place previously expires on Friday. So that means for non-skilled nursing facilities such as assisted living, smaller group homes, other long-term care facility types -- they are able to permit on a limited basis in accordance with the new guidance that we have posted on our website, outdoor visitation. And again if they are smaller than six beds, look at communal dining outdoor activities as well as visitation per the guidance that is posted on the website. That does not conflict. For skilled nursing facilities and will continue to remain in place except for compassionate care situations. But other facility types can consider according to guidance.

Hugh Tilson:

Thank you. Are we expected to have all protocols listed in the outdoor visitation guidance in place and operational by tomorrow at 5 P.M.?

Dr. Kansagra:

I will continue to answer and Jennifer can chime in but no. That means facilities can start tomorrow at five P.M. but they are not required to have it in place by 5pm and we recognize facilities will have to also do preparation and consider their facility layout and make other plans, do communication with families around scheduling those visits in advance which is recommended in the guidance. So that permits it to happen after Friday at 5 P.M. but it doesn't have to happen at that exact same time.

Hugh Tilson:
Should staff and consumers in other long-term care settings such as PRTF or congregate living centers test?

Dr. Kansagra:
The recommendations for those settings is if there are one or more known cases of COVID-19 then the recommendation is to test all residents and staff of that facility to identify further transmission. Right now the recommendation around point prevalence testing is really geared towards nursing homes. As we continue to get data in we are going to examine that and determine whether recommendations need to be broader than that but right now the requirement for those facilities around testing is in relation to identifying one or more cases.

Hugh Tilson:

Is there any guidance as to how long testing of employees will be required? I'm asking because if we have to test all staff weekly at $149 per employee for 200 employees we are talking about $30,000 per week which is not only not financially feasible for facilities who mostly funded by Medicaid.

Dr. Kansagra:

I think that is -- I going to say the $1 million question but in this case the $30,000 per week question you are asking. We recognize that there is a cost of testing. CDC has not specified an end date at this time and that is a recommendation but obviously we have worked on our end as Dave outlined to increase some support to facilities through Medicaid. I know federally they are increasing support specifically to skilled nursing facilities as well with additional funds. We are working to identify additional federal funding as well but that is a current recommendation at this time. There is some additional guidance on CDC website if testing capacity is limited, how to prioritize that testing.

Hugh Tilson:

I'm trying to see if there are other testing questions. Let me go to a Medicaid question. If the Medicaid rate increase is extended till December 31, do you anticipate MCOs will follow suit?

Dave Richard:

We are working with our LME-MCO's to make sure their capitation rate includes enough funding to be able to support people in rate changes. And as I think most people recognize, each LME-MCO has does might have had different rates put in place so that will be an individual decision but we are working with them to make sure our rate structure provides them the kind of support that they are able to continue what they've been doing and again I would emphasize, the slide said the goal between December 31st that we will continue to evaluate the timing of that to make sure we are communicating directly to you as providers and others about the time. The most important thing I want to remind folks is there's no intention to stop anything on June 30th.

Hugh Tilson:

Thank you. What update is available regarding state lab electronic access to test results?

Scott Shone:

Test results are currently available through our CELR system. If you go to our website, the state lab website, there is a link for our COVID page. On the COVID page -- and you know what, Hugh, I can put the link directly in the Q&A if that helps or we can -- I can give it to you and you can distribute it afterwards. To register for CELR with an account requires an EIN number. And then you can get your results online through the platform. There is a tutorial with a PDF -- a PowerPoint presentation we gave on how to use the CELR system a few months ago on our website as well.

Hugh Tilson:
If you could put that in the chat -- the Q&A that would be great and then Nevin and I can find a way to email that out as well.
Great.
Let's go to some Medicaid questions. When you refer to Medicaid are you referring to all Medicaid or SNF Medicaid?

Dave Richard:

All Medicaid would be the right answer to that so we've made changes for both nursing homes and adult care homes and adult care home is the correct PCS rate change so yes, all medicaid

Hugh Tilson:

We've been told that IPRS and B2 money is being reduced rather significantly? How are we to support non-Medicaid recipients during this time of crisis?

Dave Richard:

I will try to answer that. It is really the folks in the division of Mental Health, that will help but at the LME-MCO level , right now we don't see a significant reductions in payment on a state dollar side to LME-MCO. There is a bill pending in the General assembly that would allocate additional $50 million to LME-MCOs that should be able to address any of the -- I wouldn't say any but I would say the concerns around any needs to reduce state funding in those areas. Stay tuned for that. Again pending the General Assembly, I think they are intending to leave town either today or tomorrow. So we should have an answer on that pretty quickly.

Hugh Tilson:

Under compassionate care visits would this also include a single visit from the family to meet with the resident prior to executing a MOST form with the physician?

Jennifer MacFarquhar:

This is Jennifer. I will take a first pass at that. I think, yes, under -- it would be good for the family to meet with the patient and the physician before signing that form. I think that would fit under the compassionate care circumstances.

Hugh Tilson:
For adult care homes if we have had positive cases, at what point can a facility to outdoor visitations?

I'm sorry, could you repeat that?
For adult care homes if we have had positive cases, at what point can a facility do outdoor visitations?

Jennifer MacFarquhar:
Yes, the requirement is actually that the facility not be listed on the DHHS website as having an active outbreak. So they would have to meet that requirement.

Hugh Tilson:

Since some restrictions are being relaxed, can a facility hire a hairdresser as a permanent employee and screen them as they would all other employees?

Jennifer MacFarquhar:

This is Jennifer. Susan, or anyone else feel free to chime in. At the moment we still have kind of the nonessential services exclusion criteria. And so you would have to look at it with that context in mind but also the fact that it's very close contact for that activity to take place. So I think we are really trying to balance easing up restrictions with what is of most value or -- to allow loved ones and family members to be reunited. So what essential services should occur along with that's why would hesitate to issue the go ahead for that.

Hugh Tilson:

Are outdoor window visits still permissible? The resident separated by a building and a window. Here is a related question, if there is a separate outdoor area that is not part of the existing building and it is modified, Plexiglas divider, sanitations station etc, does that require approval?

Jennifer MacFarquhar:

I think the language is actually pretty specific around any modifications that might be made and they actually have to be in compliance with life safety codes and so we would just want to make sure they are not blocking any fire exits and again would not -- would be in compliance with life safety code. And too, I want to make a comment about the Plexiglas. I know there has been some other states that have implemented the use of that and I think our concern here and actually other colleagues in other states share the concern, is the appropriate cleaning and disinfection of any type of barrier that might occur. Again because that can potentially serve as a motive -- mode of transmission if you touch that and then touch their eyes or face so just making sure does not a safety hazard but also that there is appropriate cleaning and disinfection protocols in place.

Hugh Tilson:

We have a follow-up question which is I guess a little more explicit. Based on the new guidance can facilities still prohibit outdoor visitation?

Jennifer MacFarquhar:

Others feel free to join in. As far as the executive order and we've issued guidance as well to assist facilities in making that determination. As far as how they can best and safely open to visitation.

Hugh Tilson:

If nursing homes cannot even consider visitors until possibly phase three, why would we start the testing for all staff and residents if we have no cases inside the facility to prepare for reopening? And waste all this money? Is the guidance that this is to start now or can we wait to do this when we are closer to reopening?

Jennifer MacFarquhar:

The guidance or recommendation as far as testing of staff has actually been in place for a period of time. So while some of the language might be different in the executive order and the guidance, that has always been in place and part of the reason for that -- actually the majority of the reason for the recommendation for testing of staff is to make sure that they are not bringing it into the residents because the staff members are exposed in the community and so they are at highest risk for acquiring it and then bringing it in to a closed environment to the vulnerable population and then if something happens then an outbreak could occur so that is the recommendation. The thought behind the recommendation for screening of staff.

Hugh Tilson:

I have a couple follow-up questions. If we don't want to allow outside visitation, can they prohibit it? I guess that was the specific question. Is there something in the guidance or the executive order says they can prohibit it?

Dr. Kansagra:

I can chime in there and Jennifer please feel free to add in but I think generally the recommendation is to consider that if the facility feels like they can safely do visitation and they had the staff in place and the appropriate layout and policies in place to be able to do that, ideally it would be the facilities -- they are able to work towards that and support that so and accommodate that to the extent possible if they absolutely cannot due to those factors, and certainly that is written and guidance that you should make sure you have the appropriate staffing and layout in place. And consider other factors in making that decision but that really should be more of a decision to not open to visitors.

Hugh Tilson:

Do the guidance for settings with six or fewer beds apply to federally certified ICF IID homes?

Jennifer MacFarquhar:

As long as the facility is six beds or fewer, yes.

Hugh Tilson:
Following up on the barber/beauty. Cindy Deporter has said we could allow that as long as we put them in proper PPE, N95's since we are in phase two for the state and can we get a good answer for this?

Maybe that is a specific follow-up email. I will send you that email address.
That would be great, thanks.

Is the testing of staff and residents weakly required or just recommended at this point?

Dr. Kansagra:

That is a CDC recommendation at this point. Obviously we recognize there is testing capacity limitations. We would recommend facilities do that, and again for the reasons Jennifer outlined because there is concern around community transmission, staff bringing that into the facility unknowingly and certainly that could aid in detecting that transmission sooner.

Hugh Tilson:

When can we expect to allow small group activities again?

Jennifer MacFarquhar:

This is Jennifer. For the smaller residential settings, that guidance is now in place so when the new Executive Order goes into effect on Friday, facilities can begin to prepare for that. We are currently in discussion for the larger residential settings and hopefully we will have something out in the very near future for outdoor -- or for indoor activities for the larger residential settings.

Hugh Tilson:

Follow-up question on testing. So all staff would have to be tested before allowing outdoor visitations?

Jennifer MacFarquhar:

That is not a requirement. It's a recommendation.

Hugh Tilson:

If facilities are doing weekly testing for staff, how does this affect new admissions because as of now we have been told admissions must be put on hold pending resident or employee testing results?

Dr. Kansagra:
I think that's a question we can take off line. I don't know if that was a specific recommendation made by the local health department but right now the weekly staff testing is recommended in general. That is not linked to admissions in any way. But I think if there was some specific scenario or something we need to consider we can try to answer that off line.

Hugh Tilson:

Why is DHHS allowing visitation when North Carolina is experiencing increasing positive cases, hospitalizations and deaths and congregate living settings are open for visitation, please why the opening was put in place while we are still in phase two.

Dr. Kansagra:
I can help answer that and others please feel free to chime in but, one, there currently are quite a few restrictions in place around visitation. Again for skilled nursing facilities where we are seeing

outbreaks, visitation is currently prohibited except for compassionate care. For the other facilities it is limited to large facilities that are not skilled nursing, its limited to considering outdoor visits only. Which we think balances the need of residents and families to see each other with the risk of COVID-19 transmission. For the smaller facilities that are six beds or fewer, it allows them to set the policy based on the needs of their residents and family so that makes it more of an individual decision tailored to the needs of those residents . So again we recognize that there are I think arguments on both sides, certainly there is risk of COVID transmission at the same time there is many families and residents also experiencing other factors that have been made difficult through the lack of visitation so this is an attempt to strike the right balance.

Hugh Tilson:

Kind of specific question, we have a SNF on the second floor with ED and acute care on the first floor, what would we consider the facility in relation to testing of patients and staff if there were an outbreak?

Jennifer MacFarquhar:

This is Jennifer. That's a really good question. I would recommend the facility, particularly the SNF would be limited to the second floor with that but I would also put in the caveat that I would make sure that there are no shared staff among the floors, among the different entities and if there are shared staff then further recommendations for additional screening might be made.

Hugh Tilson:

As a family care home are we required to allow visitation at this time?

Jennifer MacFarquhar:

This is Jennifer and I think -- again I think as Susan just very eloquently stated, we are just putting out the guidance and the Executive Order that does allow for easing of restrictions and then some guidance around that. So that facilities can begin to implement those procedures and determine if they are equipped and ready to ease those restrictions. So there is some independence in that determination.

Hugh Tilson:

In six beds or less can we allow home visits and are there recommendations on length of time restrictions etc.?

Jennifer MacFarquhar:

Home visits are actually included within the easing of restriction guidance for this type of facility so we would recommend appropriate screening and monitoring of those individuals upon return again just to make sure they remain healthy.

Hugh Tilson:

Question on testing, the last I read NC is not required universal testing for adult care homes assisted living, but is it now required, in other words is it baseline testing of all residents and staff and after weekly testing is recommended for all staff?

Dr. Kansagra:

That is not a requirement. The guidance is really geared towards nursing homes at this time. Certainly if there were one or more cases identified then we would recommend full facility testing.

Hugh Tilson:

Does the weekly testing recommendation include ICF IID homes without any positive cases?

Dr. Kansagra:

Same as I just mentioned.

Hugh Tilson:

Just thought I would throw that out since it was a follow-up. I think those were all the questions that we've gotten. I will say that you got a couple of thank yous, which I think I will reiterate. You all are doing just incredible work and it's noted and appreciated and you've got a couple specific thank yous but let me reiterate it on behalf of everyone else. We have a couple of more minutes so please you can still submit questions using the Q&A feature. **We just got another question, with the way day treatment providers have decided to give services, I can see those providers attempting to now bring their services to a residential treatment settings due to the easing of restrictions. How can level 3 providers not be expected to carry that responsibility?**

Dave Richard:

This is Dave. I think that is one we want to respond back in writing.

Hugh Tilson:

Okay. Will these questions and answers be in the link? No, they will not. But this will be recorded so you can hear the recording of this once we get it posted. And I did get a comment from somebody that they were having a hard time accessing the recordings and they were timing out so we will look into that as well. As a reminder this will be available on the NC AHEC website, click on the green bar at the top with COVID resources and you can access the slides and recording there. **Is their contact permission to pose questions off line? I know there are for Medicaid, are other that we want to get to?**

Dr. Kansagra:

You, would you mind if we did give -- I know you all have an email inbox for questions. We haven't been posting it routinely just because sometimes the volume -- we try to scan it and address it for the next webinar but certainly if there is a specific scenario, we could suggest submitting it there.

Hugh Tilson:

Please feel free to send an email to questionsCOVID19webinar@gmail.com and I will type it in the Q&A.

Can we -- prohibit staff from working multiple jobs?

Jennifer MacFarquhar:

This is Jennifer and I don't know that we can prohibit staff from working multiple jobs. I think with these high risk settings it certainly discouraged, but no, we cannot prohibit that from occurring.

Hugh Tilson:

Can an employer do that? I know you guys can't but can an employer say you can only work here? Do you know the answer to that? I think that was the question.

Jennifer MacFarquhar:

I personally do not know the answer to that. Others on the call might.

Dave Richards:

I don't think we should be able -- I don't think we can give that advice. I think that is probably a employment law question that they should talk to their attorneys about. I don't think we can weigh in on that.

Hugh Tilson:

Do ICFs with 30 beds or more supporting people with medical issues fall under the new guidelines for visitation?

Jennifer MacFarquhar:

This is Jennifer. Yes, this particular group would fall under that outdoor visitation guidance.

Hugh Tilson:

For clients that live in adult care homes and have employment in the community, what are the recommendations for them returning to work as restrictions ease?

Jennifer MacFarquhar:

I think it would be following those recommendations that are actually in the guidance. Which again is monitoring their own health and making sure that they can safely interact with the community and social distance as much as possible. And also wear a cloth face covering. Those are kind of the recommendations for going out especially if they have a public facing employment and again when they return to the facility, just self monitor and also the staff should monitor them as well.

Hugh Tilson:

Great, Dave, I know you have to jump off. Anything you want to say before we go? We may have already lost you. All right. I think we lost him. **For PPE, our staff and facilities with no positive cases expected to work full eye protection in addition to masks or is the eye protection only for the care of those suspected or positive?**

Jennifer MacFarquhar:

This is Jennifer and that would actually -- guidance that was new two weeks ago and I did speak to again today so that was the CDC guidance for the care of all residents and locations in counties with moderate to substantial disease transmission. So part of that depends on where you are physically located in the state and county and what's going on in the community around you. But it would be for the care of everyone.

Hugh Tilson:

I think those are all the questions that we've gotten. Can you repeat the statement regarding home visits please? There were lots of them.

Jennifer MacFarquhar:

So home visits are allowed for those residents that fit into the smaller residential setting category. But again as much as possible maintain appropriate social distancing again as much as possible. Monitor and when they return to the facility they should self monitor and also have staff responsible for monitoring those individuals.

Hugh Tilson:

We are just about out of time. A couple quick reminders. If you have specific questions, please send them to questionsCOVID19webinar @gmail.com. We will post these slides and a recording of the webinar at the NC AHEC website as soon as possible. Certainly tomorrow morning at the latest. And let me now turn it back over to Jennifer, Susan and others for final comments.

Dr. Kansagra:

Thank you so much, Hugh and team for hosting and thanks to all again for joining the webinar. We appreciate everything you are doing on the front lines and we will continue to host these on a biweekly basis, and we will review questions received and Taylor our presentation as needed for next time. So thank you.

Hugh Tilson:

Susan and your team, thanks so much for all you are doing. We really appreciate it. You all take care. [Event Concluded]