Transcript for Long Term Care Settings Webinar
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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 Tilson

It's 10 o'clock. Let's get started. Good morning everybody, hope you're having a great day. Thank you for participating in today's COVID-19 webinar for long term care providers.

This webinar is put on by the Department Health and Human Services it's supported by North Carolina AHEC to discuss recent updates to the state's COVID-19 response, and to provide a forum for you to ask questions of DHS leaders. As you can see, we've got a full agenda, lots of timely information for you today. My name is Hugh Tilson I'll be moderating today's forum. Before I turn over to Jennifer, thanks everybody for making time in your busy schedules to participate in today's webinar. Whether as a participant or panelist, we know how important your work is how busy you are. You'll get information today.

To make your work a little bit easier and make navigating these trying times a little bit easier as well.

After we hear from our presenters we'll turn to your questions. Next slide please. We've learned in past forums that the presenters will often address your questions during their presentations, we will have time to get to your questions and encourage you to wait till the presenters are through with their presentations. before submitting a question about what they're presenting. All participants will be muted, other than our presenters to submit a question, you need to use the q&a function on Black bar at the bottom of the screen. That q&a function on Black bar at the screen will send the questions and a recording of this as well these slides on the NC AHEC website and get those posted as soon as possible. Now let me turn it over to Jennifer. Thank you, Jennifer.

Jennifer MacFarquhar

Good morning everyone and thank you. Thanks everyone for joining the call today. As you already stated, we very much appreciate your taking time to be with us today. I also want to thank you for the tremendous amount of work that you're doing every day to care for residents in your facilities. We have several updates for you today. And as I already stated a very full agenda, I will actually began by

providing an epidemiology update, and also talking to you about the elements on the slide here. So as far as the epidemiology updates. We've actually continued to see an increase in numbers. Globally, the number of cases now exceeds 7 million, with th enumber of deaths over 400,000. Nationally according to CDC the number of cases is approaching 2 million with a number of deaths over 112,000. And then for the state perspective, the number of cases currently on the website this morning that number is over 38,000 was slightly more than 1000.

Next slide please.

So I want to touch to touch base on key infection prevention principles for caring for residents in your facilities. So these do include the use of cloth face coverings for residents and patients. As a reminder, residents and patients should wear a face covering or surgical mask if available when staff are present in the room again to minimize the potential for transmission to staff. Facemasks, surgical face masks are to be used for health care providers staff, cohorting, otherwise known as grouping of residents who are COVID positive, along with cohorting or grouping of staff also caring for those residents.

Just a quick reminder for staff and healthcare facilities, including long term care settings. Staff are to maintain social distancing, and appropriately, and often care for their PPE while in break rooms or or lounges, staff should continue to be careful to not touch potentially contaminated PPE and also staff and residents should appropriately use hand hygiene frequently, and staff particularly also in staff lounges and break rooms, as well. And other personal protective equipment as appropriate for the care of residents to this specific type of facility. So we do currently recommend testing for the virus that causes to COVID in the following scenarios, testing of symptomatic residents or staff in these environments, as well as testing the residents and staff, once a day. I'm sorry once a case is identified in a facility. If you have not already done so we do encourage you to identify resources in the event you need to conduct testing, and please do this in concert with your local health department. It is also important to note that testing is not a substitute for other control measures.

So, last week CDC actually updated guidance on the use of eye protection and N95 use located here. Next slide please. So actually, we will send out this link to where it's located. So it is now... Oh, sorry. So, for the care of residents with respiratory illness consistent with COVID. We do recommend in addition facemask to wear gowns gloves and also eye protection. Next slide. And so, so again last week CDC updated their guidance on the use of eye protection. It is now recommended for healthcare providers to wear eye protection, and a face mask for the care of all patients who are not wearing a face mask or face covering in an area with moderate to substantial community transmission. So again, this is a bit of a change than what we have seen before. And additionally, healthcare providers should also wear a N95 or higher level respirator for aerosol generating procedures for the care of all patients in the same areas, again for long term care settings we do not anticipate the need for aerosol generating procedures. But that is just mentioned here for your benefit.

So this edition is about limiting the high risk exposures. If healthcare providers encounter an asymptomatic or a pre symptomatic patient, again with the virus that causes COVID. As previously personal services open up again, and as described in CDC healthcare provider risk assessment guidance, the highest risk to health care providers likely occur when their eyes, nose and mouth are unprotected. So by implementing universal eye protection and face mask use in areas where health care providers are more likely to encounter a symptomatic or asymptomatic patient. The CDC has recommended this addition to minimize the risk to healthcare providers, and also the need for work and exclusion.

I also wanted to clarify the use of N95 masks. We're receiving quite a few questions about the use of N95. If you are wearing a N95, and it's not fit tested, then it does not provide that level of protection, that it is intended to do. If you are conducting aerosol generating procedures, then you must wear and N95, and you must be fit tested and medically cleared and the facility must have a respiratory protection program. And also wanted to mention that at no time should two masks be worn simultaneously. So, a face mask should not cover a N95 mask for example.

So the last item that I wanted to address today is around easing of restrictions in congregate care settings. Currently, all restrictions, including visitor, dining, and communal activities do remain in place. There are exceptions to this and that does include compassionate care, and end of life circumstances. We've heard from many of you working in these settings, and we've also heard from families as well. And we understand the extreme hardship that some of these restrictions, specifically visitor restrictions have placed on everyone. And we have been actively engaged with partners and external stakeholders in developing guidance to ease restrictions in congregate care settings, we have divided our discussions and guidance into two segments. The first targeting smaller settings defined as six beds or fewer, and that would encompass behavioral health, IDD, intermediate care facilities and small group homes. And then, a larger study defined as seven beds or more, and that would encompass other adult care homes, nursing homes and other residential long term care settings.

We are working on an executive order to ease restrictions in these smaller residential settings, and hopefully those will be available in the very near future. For those larger settings we anticipate that the easing of these restrictions will not take place until phase three or later. So that concludes concludes my portion of the webinar, and I will now turn it over to Dr. Susan Kansagra and Scott Shone who are going to provide an update testing discussion.

Dr. Susan Kansagra

Good morning all thank you so much Jennifer and thank you again to everybody for joining the call, appreciate everything you are doing on the frontline. I am going to walk through first, just quickly our DHHS testing guidance, which was released, about two weeks ago, and you'll see it up on the slide now and there is a lot there but the one piece I wanted to emphasize is that our testing that anybody who

thinks they may have been exposed to COVID-19 regardless of symptoms should get tested and particularly anybody you'll see in this highlighted area that is in the high-risk settings such as long term care is eligible for testing, and this is an important point. And I've heard in a few cases where for example staff members might be going to the clinic, and in pregnancy, were being told that they were not systematic and therefore not eligible to get tested again this is to really emphasize this guidance going out to providers across our state that this is to emphasize that if you are seeking testing. You do not have symptoms, it does not matter you are in a high risk setting and therefore are able to get testing and with virtue tosecure this guidance as well with providers as we make it available. Next slide please.

Also in addition on our website. There is a testing site locater. ne of our goals as a department is to make sure we are increasing the number of access points in our communities again this is more relevant to staff or perhaps settings where individuals are able to go to testing sites, but this is available on our website, again every day. [Indiscernible] And lastly I wanted to just very quickly go through our CDC testing guidance, that has been put out. Again, where we [Indiscernible] be tested for all long term care facilities, not just nursing homes as you'll see on the slide for CDC but really for all long term care settings, is when there are one or more confirmed cases of COVID-19. When that does happen, obviously, you're working with your local health department at that point that they will be decided [Indiscernible]

Hugh Tilson

Susan. Susan your sound is going in and out. I wonder if we could maybe have you take a couple steps in a different direction perhaps or...

Scott Shone

[Indiscernible]

Unknown Speaker

Hey, how about this. How about now. Sorry about that. Otherwise, I will. Okay, let me, let me try to repeat this slide again and if I cut out again then I think we can go on to Scott and I'll try to make a change in my location and go back, but to emphasize this slide, which is CDC testing guidance and it's available on the CDC website, their guidance, again, specifically for nursing homes, but we as a state are also putting this guidance to all long term care facilities and that is really when there are one or more cases of confirmed COVID-19 in a facility our recommendation, through the local health department is to all residents staff when capacity is limited CDC suggests directing that testing to residents who staff on the same unit, or floor of a new confirmed case. In addition, CDC also recommended continuing to test all negative residents and staff weekly until [Indiscernible] after from the initial initial case. So again this guidance is happening in conjunction. Once you report to the local health department they will be advising on next steps and testing. In some cases the local health department is able to support

the actual testing, in some cases facilities may need to work with a private lab to conduct that testing if they don't have other community resources available so wanted to share that guidance I know one of the most, the more frequent questions we get is if we do not have a case. Should we be testing all residents and staff, and we are currently examining that recommendation and working to identify additional lab vendor capacity in our state, and we'll be issuing some guidelines on that in the next few weeks. Now let me turn it over to Scott Shone to talk a little bit more about testing for the State public health lab and other recommendations.

Scott Shone

Thank you Susan so I don't have any slides, I'm just going to share a couple quick updates from the state lab as well as some information about a RFQ that recently went out or rather an RFP that recently went out to identify vendors for a variety of tests, including testing. So, at the state laboratory of public health. We continue to participate in testing efforts in support of local health including responding to several outbreaks in long term care facilities. We have identified a fairly common practice that I wanted to share with, with all of you. That seems to be working in a lot of settings, and as Susan said, you know, guidance continually evolves and opportunities and we'll talk about the RP activists to sort of identify another opportunity that's coming down the road with, with what we're seeing in some, some facilities as residents, most residents have access to a form of insurance, either other third party, medicare, medicaid that a lot of facilities are looking to engage with a commercial resource, who will bill those insurance companies for the testing, and then utilize the state lab if necessary for employees who are either un- or under insured. And it's easier to to sort of bulk test and sort of cohort with having residents go to a commercial facility. And if the employees can also go to that commercial facility come to the state lab, we continue to evaluate that on a case by case basis for large volumes of testing only because the state lab capacity we want to assure that there's an understanding of turnaround times. And, and making sure that we these critical results are continue to get back to you in the 24 to 48 hours necessary after we get the samples here in the lab so that that has been a common practice and we walk through that with with local health departments as they respond to some of these efforts.

We are at the state lab building capacity. We are bringing on additional instrumentation and staff, over the next several weeks to assure that we have not only capacity for the summer, but increased capacity as we head into the later months of the year. To answer the question, what is your capacity we have been putting out about 400 results a day. We get anywhere between 300 and 800 samples a day. So obviously on the higher days, it might take us, you know, on the higher end to the 48 sometimes to the 72 hours to report results from when the specimen comes in. But we've been. We've been usually we have some lower volume days Sundays and Mondays and we tend to catch up. As we move through the week so that's been the process as far as the state lab, and how we're working to increase our capacity, but the state issued and days run together I apologize, I would, I want to say sometime last week, in the last 10 days in advance your may 29 okay so on May 29 the Department issued a request for qualifications RFP [Indiscernible] to apologize to identify a pool of vendors who can assist the state with testing. These would be state provided resources either high throughput sites that would be set up or innovated in communities that need to increase testing. Again, hundreds of tests collections per day, but also identify or directed total testing opportunities, to serve sort of immediate needs in terms of

responding, on a smaller scale whether the outbreaks towards smaller locations, and then also to provide the state lab with additional capacity, should we exceed. Should we get enough substantial volume of samples that would exceed our typical turnaround time we could defer to, to, to that lab as well. And so the RFQ closed on Tuesday, and after this call I will be spending an hour with our procurement team to review all the vendors and qualify vendors who meet the specifications of the RFQ. Subsequent to the identification of these vendors. Our team at DHHS will be developing task orders that will be issued, that those qualified vendors can then bid on. And some of those will be associated with facilitating testing at Long Term Care outbreaks or other other types of needs across the state. And then that will be funded by the state to provide additional resources so this is just another tool. In, in the box that the department can use to assist with responding to testing needs for COVID-19.

And so I'm gonna end there. There'll be more in terms of as we as we progress through the procurement process that we can share. But that's where we sit right now in terms of trying to add additional resources to these efforts. So, there's any questions, I'll be on the line. Thank you.

I'm sorry HughI don't know who's next because I don't have the agenda of me.

Kimberly Clement

I am, we want to get to the next slide. All right, so we just wanted to give a very quick update on the long term care personal protective equipment distribution, we have completed all regions at this point. And just wanted to give a quick roll up of the numbers of that we're actually distributed. Overall, we were able to reach over 3500 facilities across 92 counties. Some of the counties works with their DSS entities, or their emergency management entities to have them pick up all their PPE and take it to them. And in those counties you don't have a specific list of what facilities, so they may not be included in this but we are working to get that information so we can update that further. Next slide please. So, Again, these were the final regions that were picked up on this was a huge effort between North Carolina emergency management, North Carolina Department of Health and Human Services, Civil Air Patrol and the North Carolina National Guard. We've received a lot of questions over whether we will be doing this type of a distribution again. At this time we do not have this type of distribution planned, a couple different reasons for for that. We're looking at some more expedited ways to do some distribution, and hopefully in the next 7-10 days we will have a good update on how that would look. But in the meantime you can still go to our website and request from that website. Next slide please.

These are the regions we have been asked a lot of questions over which regions we hear. And this is just a roll out of those different regions and again we did one distribution point in each one of these and recognize that for some of you, it was difficult to reach the different locations, so again that's why we're looking at an alternate option for the future but we appreciate everyone who came out and picked up their PPE and hopefully you're finding it useful.

Next slide please. I also wanted to provide a quick update on our long term care outbreak response. So, since the beginning of this we have put together that response team that includes a lot of our state level partners to do some coordination and outreach and also works with our Regional Health Care Coalition. So at this point, we've done 129 outbreak coordination touchpoints. We have filled 347, or, sorry, we've received 347 requests, a lot of different personnel have been asked for we've been able to fill about 34% of the missions that have come in and have deployed over 117 different volunteers to your facilities. We've also worked with ECU as you guys know, and we've been doing a lot of referrals with that we're hearing a lot of positive feedback from those referrals. The facilities that have made contact with the individuals that were interested in working in several different cases were able to onboard eight to 10 additional personnel to help out with some of their staffing concerns. And one of the things we just wanted to reiterate, is that the more proactive you can be in looking to start getting some additional staffing if there are some concerns about staffing issues from potential outbreaks or something like that the better youll end up being. Our goal really is to only utilize those volunteers to fill missions for 72 to 96 hours. And the main reason for that is just we are receiving so many requests and long term requests. So the idea is that we're able to get you some immediate relief in that 72 to 96 hour time frame with the volunteers, but ECU has individuals that they're ready to send to you to for you to onboard and hire to help out with some of those longer term 2-3-4 weeks long mission requests. We do encourage that you reach out to your corporate parent companies first and foremost to have a conversation with them as we have received some feedback that they have different policies and procedures and so after setting up some missions we've, we've learned that should've have probably gone through a different pathway so we would really strongly encourage you to reach out to your corporate and parent entities as you're working through them.

Next slide please. This is just a look at the different counties where either the terms volunteers are the ECU staffing project has happened. And you can see as of right now we only have the one county that has an active mission and all the other counties have results at this time. And in most cases, the counties the facilities in these counties have gone for both the term volunteers and the ECU staffing project although we've had a handful that are just on that ECU backing projects and again we've heard great feedback from the facilities that did make those phone calls and engage those individual.

So, we can go to the next slide and I will turn it over to Dave I think.

Dave Richard

Perfect, thank you so much.

We'll just run through these real quickly and then we'll get some question answers and answers to questions and then we'll get to your questions pretty rapidly after that. So as a reminder of what we're trying to do inside of Medicaid and really is to support all the wonderful work that folks are doing in the community, make sure that we're supporting obviously the COVID positive residents, trying to reduce

transmission of disease and and really increase the service flexibility for provider networks as it moves forward.

Next slide please. And it's the slide we use every time we come up and just a reminder of what you're hearing today is that this is accross departmental effort. And, in conjunction with our provider community and I think that it's one of those things that is important that we learn from each other we continue to do that. And the fact that we, we do have this collaborative effort I think it is proven to be successful, I want to continue that effort. And then we'll go next slide, which we just jumped to the next one after because we don't need to talk about a question and answers show.

So, we've had several, several questions from folks that just wanted to put these out so people hear them when we're talking about how funding works that particular question about rate adjustments for group homes for for your group homes because a it is a wide broad definition for folks, but what we think is that for most of our... when we think about group homes, a lot of those fall under our LME/MCO system. So if you think about the innovations inTBI waiver group homes that would be under there, an ICF/DD facilities and LME/MCO. What we do mention that I want to make sure that if there are group homes or eligible for special assistance. That is a division of agent adult services, effort and there is some funding that has come from the General Assembly to support that effort. I also mentioned is that for group homes where personal care services are being provided, you can look at these bulletins 32 and 82, to make sure that understand how best to access those funds that come from personal care services.

Next slide please. And then the question that we keep getting asked from folks and I think the really important question. Is that how long would these specific rate adjustments be in fact, most people realize that the General Assembly is in session right now, and so on, because we are coming up at the end of the fiscal year, we have a, we have to wait till the, whatever, whatever process finally plays out in the General Assembly in terms of how they will either add to rebase number or as we call it a Medicaid program or rebase which is to make sure that we can continue to provide services at the level that we apply in a previous year. If that process goes goes as we hope it does. Then we'll be able to continue those rate adjustments beyond, and we'll have to make sure that we'll, we'll continue to update you about that at that time. But we can't do it at this time commit past June 30, although I will tell you that our goal is that we will continue because obviously we haven't had, we haven't seen the need for COVID response so goal is continue to do that. We have optimism that we'll be able to do so but we really do have to wait for the General Assembly to make decisions about the budget before, we're able to make that final commitment for LME/MCOs if you have a rate adjustment for LME/MCOs actually are LME/MCO specific so we contact the LME/MCO if you, if you need that. And another question we have is you have to have an outbreak experience before drawing down Medicaid rate adjustments and again, it's displayed very well in the bulletins that we've put out to talk about those rate adjustments. And there are some, some funding increases occur without an outbreak. Obviously additional ones that occur with an outbreak. And next slide please. And then we have released this special bulletin that really talks about our PCS, CAPSCA programs for individuals who have COVID and those programs or services provided by those programs.

And please review that, that, that bulletin 93, because it indicates how how folks can fill and be supported as ever. And also know that Medicaid is hosting a, second of two training sessions this Friday, June 12 from 1130 to 1230, where you can register. And if you need more information the provider reimbursement email is up on the list. I think the last slide. If you could change to that just reminds you to where to get additional information around Medicaid. We'll close with is that I know that having a little bit of uncertainty this close to the end of the fiscal year is not optimum but what we don't want to do is to promise something that we can't fulfill our, our intention and goal is to continue providing the rate adjustments, beyond the fiscal year but we do have to wait for the general assembly process is finished. So I'll stop there and I think we go to questions and answers. Thank you

Hugh Tilson

I think we do. Thanks everybody. So I think what I'm going to do is, Jennifer I notice you've been answering a number of questions that have been submitted. There are a number of people who are on the phone, who can't see those answers. So since you've already kind of run through a number of those Can you accept those questions and then provide the answers so that the people that are on the phone can see the answers to those.

Jennifer MacFarquhar

Sure, questions about what cloth face masks in a building with new cases. And the response is that face masks are generally preferred over cloth face covering if available, but cloth face coverings can be used. It's important to keep in mind that these face coverings are not PPE. There were a couple of questions around the definition of moderate to substantial transmission, and that is a very good question. CDC I'm gonna see if I can actually pull up the website here. CDC has some definitions again it's very vague. And I'll just go with kind of the substantial definitions that they've given and it kind of encompasses different community characteristics, but it's basically controlled community transmission including in communal settings such as school and workplaces. And then the definition read under that is sustained transmission with high likelihood or prolonged exposure within communal settings potential for rapid increase in cases. So, again, not a one size fits all, can be challenging to interpret, I will say that right now in North Carolina. We are continuing to see an increase in cases. In many counties, specifically the larger counties, actually, are some smaller counties as well. So I think, for those of you who are in those counties you know that that is, you know, kind of moderate to sustained transmission. And I know I had a question yesterday, or day before yesterday on another call about, if we were actually going to put out on the state level for what we consider to meet this definition. And right now we are not planning to put out that discreet of guidance. But I do know that there's actually been additional data that's provided on the dhhs.gov website, and have access to that and you can actually look at some of your own numbers for your counties.

Let's see a couple of questions around wearing a face mask over an N95. And if you've been told that that's okay then that is incorrect. For a number of reasons. It actually does increase the risk of contamination. It's actually a waste of resources and can affect the filtration of the mass, the filtration efficiency of the mass, and also potentially impact the ability of an individual to breathe. Oh, and then I protection and weather glasses if personal glasses would count as eye protection, and no they do not. So it's recommended for individuals to wear eye protection, shield or goggles. But again, eyeglasses personal eyeglasses prescription glass do not count as eye protection. Oh, I think. I think that's it.

Hugh Tilson

Okay, well thanks I just since you've done all that I wanted to make sure that everybody had the benefit of those answers. Let's turn to testing for a little bit. Is there any way to test the caregiver before her shift. Fever is being downplayed as a symptom and I know the caregivers and families are not practicing good safety practices, outside of work.

Dr. Susan Kansagra

This is Susan. Yeah, the recommendation is not to test before a shift, obviously because that would be unsustainable but to screen before ships so there is a recommendation around asking, and checking temperature and asking about signs and systoms of COVID-19 as a part of a general screening. Jennifer Do you want to add anything else.

Hugh Tilson

Some facilities specificly nursing homes are reporting that the cost of continual testing is not sustainable. Is there any guidance or other options that are more financially friendly.

Dr. Susan Kansagra

Yeah, this is Susan, you know, I think this is a big issue nationally as well we know the guidance that has been put out by CDC and CMS do heavily rely on weekly testing of staff, we as a state are looking at other options to help support and sustain such testing. One thing that we're looking at is just last capacity overall as a state, Scott mentioned the RFQ that's going out. So we recognize that that this is a challenge I know also you know moneys have gone out directly to nursing homes to support additional costs from the federal government, we as a state have provided additional Medicaid rate increased to nursing homes to support the cost of various types of expenses, including testing so we recognize this is an ongoing challenge, there's no easy solutions there but the guidance [Indiscernible] is to the extent feasible, you know, we, especially if there are one or more cases do engage in that testing. If capacity is limited, for any reason then to consider prioritizing the floor and unit of that residence was on as a priority for testing.

Hugh Tilson

Test everyone weekly for how long is that until everyone is negative?

Dr. Susan Kansagra

Yes, if there is an outbreak in a facility their recommendation is to test weekly till 14 days have passed since the last positive case.

Hugh Tilson

Staff presented as asymptomatic but test positive multiple times over the course of 30 days, how long should they stay out of work before returning to work?

Dr. Susan Kansagra

Do you want to take that one.

Hugh Tilson

Yeah. The staff is asymptomatic but testing positive for 30 days, how long should they stay out of work.

Jennifer MacFarquhar

There's still ongoing research into length of time that peopl remain positive and if it's actually viable virus, everything that remains after two weeks. So, currently the recommendation is that the exclusion is for 14 days, and that if people do remain positive. Again we suspect that that viability is decreasing or non existent. And so, if the essential personnel can return to work as long as they follow the appropriate protection prevention measures. You know, they would have done wear a surgical face mask again for the care of all patients. And actually, wherever they are within the building.

Hugh Tilson

Small rural health departments, who do not have an overseeing physician on site, need standing orders to do testing.

Jennifer MacFarquhar

In most cases, there does need to be a physician order for testing for local health departments, oftentimes they have the ability to issue for example, if needed control measures to order testing, as well as usually, this helps to have access to a medical provider, even if it's not on staff to issue medical orders if needed for testing. So I think if you're at a local health department and that's a question that's coming up to raise it via your local health director.

Hugh Tilson:

Let's turn to PPE, is it still acceptable for a nursing homes to use N-95 's that are not made to be fit tested? They are not the same level that a true N95 is but it's the closest item nursing home can get access to during this pandemic. A nursing home would typically never require an N95 prior to this.

Jennifer MacFarquhar:

That is a question we are getting pretty frequently. A couple of things about N95s, if they are to be used as a respirator then again the individual must be fit tested and medically cleared and the facility should have a respiratory protection program in place. If the N-95 is used as a surgical facemask, so not intended to be used as a respirator, that is considered voluntary use and then fit testing is not required.

Hugh Tilson:

Can you repeat that guidance related to not wearing two masks to extend the use of N-95 or K N-95?

Jennifer MacFarquhar:

At no time are we recommending two masks be worn simultaneously so we would not recommend use of a surgical facemask over an N-95 or over another mask.

Hugh Tilson:

Can you clarify aerosolizing procedures, is a CPAP included, how do we protect staff at night when CPAPs are in use?

Jennifer MacFarquhar:

That's a great question. I had not considered a CPAP an aerosolizing procedure but I'm going to get clarity on that and I will get back with you all.

Hugh Tilson:

Can eye protection be cleaned and shared with other staff specifically for various shifts?

Jennifer Macfarquhar:

This is Jennifer, that would depend I think on the type of eye protection being used. I would say in general if it is being cleaned and disinfected appropriately it could be shared but again that would depend on the type of eye protection being used.

Hugh Tilson:

Follow up on eye protection, is it all staff in all facilities or just when there is a positive case?

Jennifer MacFarquhar:

This is Jennifer. If you are caring for an individual who would meet the definition of COVID you would where eye protection. For other instances if you're in a location where there is again that ongoing community transmission it would be recommended eye protection would be worn.

Hugh Tilson:

I'm getting a couple of questions about the easing of restrictions. Is there a timeline when the executive order easing of restrictions for smaller congregant facilities might be forthcoming?

Jennifer MacFarquhar:

We had hoped it would be available but we checked in this morning and we don't have a timeline for that.

Dr. Susan Kansagra:

That's right. We hope to have more information for next call and we would distribute that via our listserv as well.

Hugh Tilson:

Any guidelines for outside vendors or contractors working on campuses of long-term care facilities?

Jennifer MacFarquhar:

It depends on where they are on that campus. If they are external to the building there would not be any additional precautions. If they are entering the building obviously we would ask they not enter resident rooms unless necessary and they would need to don PPE to enter resident rooms. If they are just inside the building itself they would need to wear a cloth face covering.

Hugh Tilson:

What is the guidance for new admissions were a resident returning from a home visit in terms of length of isolation were sequence of negative tests?

Jennifer MacFarquhar:

There are a lot of factors at play. Again it would depend on the length of time that person was out and the type of facility itself. In general we would recommend 14 days when they are separated from other individuals.

Hugh Tilson:

For Medicaid related questions, is there a rate adjustment for assisted-living or additional funding for the assisted-living population?

Dave Richard:

The radius on assisted-living is related to personal care services and we have had the increase in those rates that are in place and in addition to that, if those rate increases for individuals that don't have a

COVID positive is in place but also if there is COVID positive there is an additional rate increase that are referenced on the slides on the Medicaid bulletins which is only related to the PCS service.

Hugh Tilson:

Are the one-time payments just for adult clients or also for others?

Dave Richard:

I'm going to have to get back to you. I think PCS is also for, let me get back to you on that. If we don't have it I will make sure we post it.

Hugh Tilson:

I'm seeing if there other Medicaid questions because I know you have to jump off in a little bit.

Mostly about masks. If there are others I will forward them to you.

Thank you. A bunch of questions coming in about eye PPE, is the state looking at distributing eye PPE for the new recommendation?

Kimberly?

Can you repeat the question?

Lots of questions about eye PPE, and whether this state is going to help provide to find eye PPE or distribute it.

Kimberly Clements:

It is available for request through the website. We are not proactively distributing it and that comes down to with eye protection it is not always disposable. There options for cleaning and reusing so it is a little more difficult to determine how to distribute it so we need to rely on the facilities to determine what they need and request it.

Hugh Tilson:

Since there is no way to know if a provider is located in a substantial ongoing transmission area should a cautious provider use eye protection all the time for all their workers?

Jennifer MacFarquhar:

This is Jennifer. I knew this would be a hot topic today. Again we would have to rely on the provider, the facility and working with the local health department to determine if they would fall into that classification as moderate to substantial community transmission.

Hugh Tilson:

Please address vacuuming in an outbreak of isolation typesetting within long-term care. No guidance has given to housekeeping when vacuuming or shampooing carpet with machines that blow air out.

Jennifer MacFarquhar:

This is Jennifer. That might be more of an environmental question. Right now that is not considered to be a risk but I can follow up and confirm that.

Hugh Tilson:

We have got some request you clarify the N-95 and fit test conversation again. When is fit testing required?

Jennifer MacFarquhar:

When an N-95 is worn as a respirator, if you wearing it to protect against respiratory pathogens and you are conducting aerosol generating procedures, that is when an N-95 or higher respirator should be used. Those respirators would need to be fit tested and again it is important individuals wearing those can be that fit tested and medically cleared because some individuals with respiratory conditions are not able to appropriately wear an N-95 it impacts their breathing, so it is important they have medical clearance as well. If facilities do conduct aerosol generating procedures again, N-95 's should be worn and the facility must have a respiratory protection program.

Hugh Tilson:

A question about PPE that wasn't the full allocation they expected. With whom should they follow up or will there be additional provided and who should they follow up with?

Kimberly Clement:

You can request on our website, the easiest way is to just Google NC DHHS and PPE and it will take you to the website to put in a request. In the justification you can put in you did not receive your allocation and we will work to get what is needed to you. At this time we do not have additional plans. We are working on a more streamlined and coordinated option to get PPE out to people.

Hugh Tilson:

The PPE pack included mostly food-service gloves, will future distribution include gloves approved for healthcare workers?

Kimberly Clement:

I will have to look into that. It was my understanding they were providing healthcare level gloves so feel free to reach out to us and request healthcare level gloves.

Hugh Tilson:

What is the guidance for starting or stopping new admissions to a center considered an outbreak facility?

Dr. Susan Kansagra:

I can try taking that one. If a facility does have an outbreak the decision in stopping admission would be made in conjunction with the local health department, the facility, the division of health services regulation and is based on factors such as, is there enough staffing support and PPE and other facility

level factors that might play into that decision so that would be the factor on stopping admissions and also resuming admissions if that decision was made.

Hugh Tilson:

Any guidance for facilities with residents or staff who refused to take testing for COVID-19 when testing is required or recommended?

Dr. Susan Kansagra:

I know for residents you have to use your best clinical judgment with thinking about what that means for that resident and whether they need to be isolated or cohorted or monitored for symptoms. For staff it is trickier and I think each facility will have to determine their own policies with HR and legal counsel.

Hugh Tilson:

We are mental health facility, residents have their own apartments and 20 beds at each site, which of the guidelines would fall under for easing visitation restrictions, how do they know if they are deemed a large or small facility?

Jennifer MacFarquhar:

This is Jennifer. I'm not sure I'm quite the best person to address that, how large was the facility again?

20 beds at each site.

I think that would fall to the licensing determination. We will probably need to check on that unless somebody on the call knows.

Hugh Tilson:

Any idea when gowns will be distributed?

Are there any training flexibilities for essay providers and will they be extended if so?

Dr. Susan Kansagra:

I don't know if Mark Payne would know the answer to the question, there are some flexibilities around particularly nursing related positions. I don't know what we mean by essay providers.

Hugh Tilson:

We will forward these questions and get specific responses.

Can you address the wearing of masks outdoors in groups when it is hot and humid. We are concerned about potential heat exhaustion or heat related medical issues.

Jennifer MacFarquhar:

This is Jennifer. Again, the recommendation is to wear a cloth face covering and adhere to social distancing even went outside. We recognize there are challenges particularly in the heat of summer with

the humidity levels increasing. It can make it challenging for the wearers and particularly the elderly population. You would have to take that into account when interacting with residents outside.

Hugh Tilson:

Concerned about moving a resident to memory care assisted living without knowing COVID status. It is difficult to manage COVID positive in memory care. What is the availability of rapid testing and how accurate is rapid testing so they can be more informed about moving people into memory care units?

Scott Shone:

I don't see that question on the screen, rapid testing, maybe antigen testing? I will answer the question broadly and if there is a follow-up you can send it to me.

There are a couple rapid tests on the market right now. The two that come to mind in terms of what I would define as rapid which is return results in minutes are the Abbott ID now instrument which has had large notoriety for its use at the White House and the federal government. There was some news two or three weeks ago about a higher than expected false-negative rate on these tests. And the FDA issued new guidance that any negative result on the Abbott ID now should be considered presumptive negative and if a decision will be made for infection control or patient care and management then a molecular test should be performed, a robust molecular test. Likewise with the available rapid antigen test the same caveat holds the published false-negative rate on these rapid antigen tests is 20%. So negative results are presumptive and again for infection control or for patient management a follow-up molecular test would need to be performed and is in the instructions for use for that testing. We continue to work with our testing search workgroup and the scientific study counsel to develop guidance and there's more coming out from the federal government on this rapid test but you sacrifice sensitivity for speed and unlikely to be ideal for a lot of the purposes of what we talked about and talked about today as well as previously.

Hugh Tilson:

We are almost out of time but our nebulizers considered aerosolizing procedures?

Jennifer MacFarquhar:

This is Jennifer. The traditional form of nebulizer treatments, yes, we would consider this to be aerosol generating procedures. The multi-dose inhalers are not but the nebulizer treatments are.

Hugh Tilson:

It is 11 o'clock so let me say we will forward the questions over that we didn't get to and to thank everybody for participating. Susan and your team thank you for this tremendous information and all you do every day for the people of North Carolina. Susan, let me turn it to you for final comments.

Dr. Susan Kansagra:

Thank you for hosting this call. We are always appreciative of what you're doing on the front lines. I was told next week is national career nursing assistance day. For those of you on the front line we appreciate all you are doing and thank you for your work and we look forward to supporting and informing you in any way possible and in two weeks we will have this again so we look forward to talking to you then.

Hugh Tilson:

In the meantime these slides are available on the NCAHEC website . Thank you.

[Event Concluded]