Transcript for Long Term Care Settings Webinar
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Presenters:
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Trish Barnum

Hi everyone and welcome to this, this week's session. We appreciate your joining my name is Trish Barnum and I'm part of the North Carolina Medicaid program, and pitch hitting as a moderator for today's conversation. We have a very full agenda for you today and we'll be doing some pitch hitting throughout the webinar as folks are on leave or otherwise have commitments during this session so thank you for your patience, and we're going to get started here in just a second. Nevin if you could go to the next slide. And just as a reminder, if you have questions you can submit your questions through the q&a chat box, related to this webinar questions that we are not able to access your questions that we are not able to process today we will certainly work with our AHEC colleagues to get that information, organized and distributed as quickly as possible. So with that, I believe I'm turning it over to Evelyn Cook from the NC SPICE program for the first set of slides, just to confirm. Dr Kansagra Are you back on yet again? I know, you were having to multitask. Okay, so Evelyn I think I am turning it over to you and thanks again everyone for joining today.

Evelyn Cook

Thanks Trish, good morning everyone. And I also want to thank you for taking the time out of your busy schedule today to join us on the call this morning. So I have a few updates. In addition to discussing or reviewing a few of the key infection prevention recommendations that are so essential in helping us try to interrupt transmission and decrease spread of COVID-19. And while these are not new recommendations we still receive a fair amount of questions about them so I thought it would be worth going over again today a little bit.

So I'll start by providing a little bit of an epidemiology update. According to the World Health Organization globally, the number of cases is just under 19 million. With a little over 700,000 deaths being recorded. And then, according to the CDC from a national perspective. In the United States, the number of cases is just over, 4.7 million, and a reported 159,000 deaths. And then locally in our state, North Carolina, our case numbers are just over 129,000 with a little over 2000 deaths being reported. So, clearly, we are still having issues with spread. So, as I mentioned, I want to review some of the key infection prevention principles. And the first one, relates to the management of new admission. I'm sorry, Nevin, could you go to the next slide please. The first recommendation that we want to review it

relates to new admission, or readmission addressing both those residents whose covid status is known, in addition to the residents whose covid status is unknown. So for newly admitted, or readmitted residents with confirmed COVID-19, who have not met the criteria for discontinuation of transmission based precautions when they're admitted to your facility they should go to your designated COVID-19 care unit. For those residents with COVID-19, who have met criteria for discontinuation of transmission based precautions. They can go to your regular unit. In the event there precautions have been discontinued that the resident remained symptomatic with some sort of persistent, or chronic symptom which is above their baseline. They can be housed on a regular unit that should remain in a private room until those symptoms resolve, or return to baseline.

So, for, so that's if they're status is known, if their status is unknown, their covid status and unknown options are to place in a single private room or in a separate observation, or quarantine unit or area. So the resident can be monitored for evidence of COVID-19. During their time on this unit, all recommended covid 19 PPE should be worn during the care of the residents under observation. And that recommended PPE include use of the N 95 if available and the staff has been fit tested, or a face mask if the respirator is not available, eye protection, which can be in the form of goggles, or a disposable face shield that covers the front and sides of the face. In addition to the gloves and gown. And while testing the resident upon admission could possibly identify those who may be infected and help with your health director placement on to your covid unit. A single negative test upon admission, does not mean that the resident was not exposed, or will not become infected. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission, regardless of testing, unless that test is positive, and cared for, using all recommended personal protective equipment. In addition, testing should not be required prior to transfer of a resident from an acute care facility to a nursing home.

So, the next infection prevention recommendation I wanted to mention his personal protective equipment. And just to remind everyone that CDC has categorized how we should think about optimizing our supplies of personal protective equipment, and the first strategy is the conventional capacity so if your supplies are adequate. And you're not having any issues or problems getting your personal protective equipment. You really should use those products, according to the product lightly, and to the manufacturer's instructions. I'm not sure if anybody is there yet where we are back to our normal supplies, but if you are that's the really the way we should be using our personal protective equipment. Then the next strategy is the contingency capacity. And that's really to be used when there's anticipated shortage of personal protective equipment, and some of the key strategies are to prioritize use of that personal protective equipment. For example, the face mask are used by healthcare personnel and not visitors or residents, they can use the cloth face covering. And then the second strategy under contingency is addressing extended use, which could include extended use of face mask, N 95 protection, and in a very specific scenario that may include extended use of gowns as well. And that would be on your covid positive unit with dedicated staff. And then the last strategy is the crisis capacity, which may need to be considered during unknown period of PPE shortage when we're not sure how long that's going to last. And under this is where we address limited reuse of personal protective

equipment, which may include face mask, N95, eye protection and cloth isolation gowns, not the disposable ones but the cloth that can be laundered between these.

And one of the things that can really help you decide which level your at is the CDC PPE burn rate calculator. If you've not used this tool it can be found on the CDC website. And it basically consists of an Excel spreadsheet based model that can help facilities plan and continue to optimize the use of their PPE. So with this particular calculator you just enter the number of full boxes of each type of PPE you have, the total number of patients at your facility, and the tool will actually calculate the average consumption rate. So you can make a determination about how long the remaining supply of PPE will last is very user friendly and it really does help kind of guide you and direct you with knowing how to use your personal protective equipment.

The other thing I do want to mention here that I mentioned a couple weeks ago but just as another reminder. It's really important to remember that gloves should should always be removed and discarded at the time of leaving the care unit or the care area for each resident and hand hygiene performed after glove removal. And then the last thing that I wanted to mention related to infection prevention recommendations is addressing healthcare personnel. Specifically, asymptomatic healthcare personnel, returning to work. And they should not return to work. Even if asymptomatic until all return to work criteria has been met those criteria were updated on July 17. And just to go over very quickly again. Those who are symptomatic may return to work when at least 10 days have passed since their first symptom. At least 24 hours have passed since their last fever, without the use of any fever, reducing medication, and their symptoms have improved healthcare personnel who are asymptomatic may return to work when it least 10 days have passed since the day of their first positive viral diagnostic testing.

In the event that you are in a staffing shortage. Please follow the CDC guidance for strategies that mitigate healthcare personnel staffing shortages. And one of the most important things that you can implement is to be in communication with your local Health Care Coalition, and public health partners to identify additional health care personnel that may could assist you when needed. That being may be retired individuals, volunteers and or students. And next slide please. And then as far as CDC updated guidance. Really the newest thing that might be of interest to this audience is the COVID-19 guidance for shared or congregate housing, which was updated on August 3. And it really was created to help owners, administrators, or operators of shared housing facilities, working together with residents, staff and public health officials to prevent the spread of covid 19. And one of the primary recommendations in this guidance is that all staff, and residents should wear a mask when in shared areas of the facility, and also maintain social distancing to slow the spread. Of course these recommendations are in addition to the May 29 ones, considerations for preventing spread COVID-19 in assisted living facility, as well as the CDC guidance updated. I believe the end of June for preparing for COVID-19 in nursing homes. So this concludes my portion of the webinar and I will now turn it over to Susan is she's been able to join us for an update on testing.

Dr. Susan Kansagra

Great, thank you so much Evelyn and I'm here, and wanted to cover two components around testing and then I will turn it over to my colleague, Scott Shone to talk a little bit more about this as well, but first is for skilled nursing facilities just as a reminder of the current guidance. Again, all facilities should be doing baseline testing of residents and staff. Right now we do have a partnership with CVS Omnicare who is has contacted every skilled nursing facility and has scheduled facilities for testing through CVS and that has been paid for by the state. We are starting to wrap that up, and we have over 250 facilities that have been scheduled for testing through that we have 150 facilities that have approximately identified on their own and have already completed that testing through other vendors. And then there's a handful of facilities we are still trying to get in touch with and put on the schedule. But that testing is wrapping up. And so wanted to provide an update on that. We'll be sharing more as we get test results back and to understand and use that data to further inform testing strategies for our state.

Second is, you know, as part of the recommendation of baseline testing all staff should be that they're tested afterwards, on a bi weekly basis every other week. And so that is a recommendation that we have shared with skilled nursing facilities, again as part of the PPS testing some of that guidance was also on our website and wanted to mention that we are currently working through some additional funding that would be able to go out to facilities to support that testing being done as well as some compliance and monitoring reporting guidelines, so we will be sharing more on that, probably in the next day or two. And so be on the lookout for that but I would encourage for skilled nursing facilities. If you haven't already thought about, you know, or don't have a partnership with a vendor around staff testing to start making those plans and that is a recommendation that the CDC and CMS have also put out there, and I wanted to note there that also the federal government has put out guidance that they will be mandating, perhaps even weekly testing for certain states. And so we are waiting to hear more on that but that that information has come out from the federal government I'll cover that in a second.

And then lastly, of course, as many of you already know if there are one or more cases identified at that point, the recommendation is to test residents and staff, every week until 14 days out from the last positive case. And once you're past that then to resume that bi weekly staff testing. So wanted to cover those recommendations I know, I know this is, you know, incredibly hard it's not easy. It requires a lot of operational and logistical efforts to coordinate testing. I know we are all monitoring, you know turnaround times very closely. We know that getting results back to you quicker enables you to make those decisions and take those infection prevention protocols and processes in place faster and so this is something we are closely, looking at as well as we think through testing in our state and how to increase access and availability of that testing.

Next slide please. And so also to touch on, as I mentioned, the announcement from the federal government around skilled nursing facilities and point of care testing. So, so the information that you all have gotten is the information that we have received also from the federal announcement. They are

probably prioritizing certain nursing homes to receive a point of care testing device, based on the criteria that is mentioned on the slide, including being identified in hotspots based on certain metrics that also include things like the number of cases in that facility or the number of deaths due to COVID in the prior week. There is an Excel list of facilities that are receiving devices on the CMS website, thus far as of last week there were about 65 nursing homes on the list and that continues to expand the announcement mentioned that your facilities will be responsible for getting additional testing region and supplies directly to the manufacturer. So, I think, you know, we will be listening for your feedback on how that is working and if you're able to get those supplies and what you're hearing also since that is coming directly from the federal government. And then in addition we, as DHHS have looked at point of care testing overall and have created some guidance for providers around those that testing modality and I'm going to turn it over to Scott Shone to talk a little bit more about point of care testing overall. Thank you.

Dr. Scott Shone

Thank you Dr Kansagra. So, I'm gonna speak a little bit about antigen testing, and both its, its use appropriate use, as well as reporting guidance and so this, what I'm going to share. Over the next couple of slides, was released on Monday in a guidance document from Dr Zack Moore who is the state epidemiologist and me. It's available at the website at the bottom of the screen. And so antigen testing for covid is essentially identical to antigen testing for flu. It's ideal use is in situations where there's a high pretest probability of SARS CoV2, and I'll talk a little bit more about that but essentially, it's the same type of upper respiratory sample collection, a nasal pharyngeal or nasal swab depending upon which of the two methods are utilized there are two platforms the Becton Dickinson or BD Veritor as well as the Quidel Sofia, that have emergency use authorizations from the Food and Drug Administration, the swab is applied. And then this is really high level applied to a cartridge as you see here. And the cartridge itself looks for proteins and markers on the virus surface as opposed to laboratory based molecular methods which are looking for the viruses genetic material This is looking for proteins on the surface. Antigen testing by nature is less sensitive than the laboratory based methods, however, antigen testing does have a significant role as part of our testing algorithms in the state in our, and our ideal for those who are either symptomatic or who are in situations where there are known close contacts or in situations where other individuals are symptomatic.

It is very specific, so while it might have a higher rate of false negativity than the molecular laboratory based methods. It is just as specific in terms of only identifying SARS CoV2 the virus that causes COVID-19 that method takes about 15 minutes, and it's somewhat lower throughput because it's a one at a time assay. There are multi flow assays and then it and I'm not going to get into the details but the instructions for use, do, do, describe ways to try to increase throughput in testing multiple cartridges at the same time, but, But the assays is fairly low complexity in fact, it can be used in CLIA waived environments as has been previously stated So next slide please.

So I apologize for the text I prefer pictures but I wanted to be crystal clear on this is the exact text lifted from the DHHS guidance that we've distributed on Monday. And so populations or circumstances where imaging testing should be considered to include symptomatic individuals if COVID is suspected at a time and place of known high prevalence. So essentially if antigen testing is available and someone comes in with symptoms of covid it is perfectly reasonable, and it should be considered to perform an antigen test first. Likewise, for those individuals who are symptomatic or asymptomatic, but are in a correctional facilities long term care facilities, those are high risk congregate settings where there are active cases, or cases have been confirmed as part of an active outbreak investigation. So again, referring back to my comment earlier on a high pretest probability of positivity so you're likely going to find covid cases in this individual or in the area where this individual comes from. Next slide please.

Likewise, there. The converse of this is where are these tests, not necessarily appropriate and should not be considered. And that is testing of asymptomatic individuals who are not in those high risk settings so so we don't, we do not recommend asymptomatic screening of just populations drive through testing using antigens for wide scale asymptomatic populations is not advisable but the rate because of the sensitivity of the method, positive results in populations that are wholly asymptomatic are likely, or more likely on a, on a per probability standpoint to be false positives. And so we do not recommend asymptomatic screening, or screening of essential workers, healthcare workers emergency responders are essential personnel were that high degree of sensitivity is necessary to assure that their contacts are and that they are not affected to come in contact with those who are at risk, as well as population based surveillance studies so again those population based surveillance studies rely on on accuracy to understand who has been, who has been, who is infected.

So, next slide please talk about reporting. So, positive antigen tests are considered an indication of likely SARS CoV2 infection that's similar to laboratory tests and clinical management of patients with a positive antigen test or the same as a molecular test so if you're positive by antigen test. It's identical to being positive by a molecular PCR test and quarantine and the associated clinical management should follow. Negative results with an antigen test should be considered in the context of those patients recent exposure, their history as well as sign symptoms consistent with COVID. And so, if physicians, clinicians feel that this person does have continue to have symptoms and or is a known close contact and is negative by antigen testing. It is suggested that that patient be confirmed negative using an alternate FDA authorized molecular assay so another swab sent to a lab. I mean, I think we're all will have stories of individuals who historically might have flu like symptoms test negative on a rapid flu test, and then a swab is sent to the lab and it is positive for flu, we saw that early on in the pandemic when we were rolling out flu before testing people for covid. So, so if somebody does have symptoms, is a contact, as a known history, and is antigen negative. It is recommended that it be considered for a more sensitive laboratory based test. And her state health order all positive and negative antigen results must be reported as part of the required reporting of COVID-19 diagnostic test to the Department of Health. I believe that is my last slide. And I will be available for questions. Thank you.

Dave Richard

Great, thank you Scott This is Dave Richard. Sorry, I think it's my turn right. This is Dave Richard I was gonna jump in and Medicaid side and you've seen this slide before it is about what our what our goals are in the next slide please. Which is really just a slide that tells you, I'm going to say something more about about that. We, we wanted to make sure that we were ready to make the announcement today but we. One of the things that we've heard from a lot of folks is that, How long will Medicaid continue the rate increases that have been put in place for both just general rate increases for all long term care and then also for the outbreak rate increases that are in place for PCS and for nursing homes. So with the extension of the public health emergency at the federal level,it then allows us to know that we're going to continue to receive the enhanced federal participation in the Medicaid program at 6.2% for North Carolina. That allows us to say with 100% percent certainty that we will continue these through the end of September, or be clear what to say, continuing through the end of September doesn't mean that they will end at the end of September. But as, as I think we've discussed in the past, is that when the Senate passed that when the house and senate passed and the governor signed senate Bill 808, and during the last short session that included a Medicaid rebase which which anticipated that the health emergency would continue, since it has continued that allows us that certainly through September. What we'll be doing is through the month of August and early September is evaluating how the rate increases across the board that were done to Medicaid, not only for long term care but also for other organizations, determining what our budget looks like and what are what the budget numbers look like and are we able to continue beyond that, I think we will, I think that's something that we want to be able to go as far as we can but want to make sure that everybody knows and there is a Medicaid bulletin it should be out today. That will will say this, but just so everybody in the call knows that you, we will have no changes between now and the end of September, you will hear from us as we get to the end of August and early September about what our thinking is for additional months and Avenue. So if we go to the next slide, please.

So the other one that we wanted to make sure that everybody saw and had a chance to do this is that many of you know that CMS has announced changes to the provider Relief Fund for Medicaid providers. They have extended the deadline to apply to August 28 for Medicaid providers. Funding for this provider relief funds, what it does do is that I think you remember is that for many providers that have received funds from some other ways of particular Medicare sides are not eligible for this but we want to make sure that everybody sees this as a reminder, if you have a Medicaid provider, and you have not submitted to CMS to do this you should do so, so that you can get the funds from this provider relief fund. What we've heard from CMS and what we've seen from looking at applications is that there hasn't been as big of an uptake on this as we anticipated. So we want to make sure that everybody's aware of that really encourage people to apply for that and go on the line for this the bulletin and see where, where to make sure you can apply for that. And I think there's one other slide which is for us if you move that just reminds you of the bulletins that we have in order to make sure that you saw that and that's going to be as AHEC posts these that will continue to be up there and I believe that's all we have for Medicaid, and it may then mean that we turn to a question and answer so Trisha I'll turn it back to you.

Trish Barnum

Thank you, everybody. So we do have several questions in the inbox. Several we should be able to address today. And again, if we can't we will we will take them back. Evelyn we're going to start at the top here, based on a couple of questions that I think are addressed to you. Could you please repeat when asymptomatic and positives can return and when this can where this can be found I think they're talking about the staff.

Evelyn Cook

Certainly. Thanks Trish. So absolutely so if your healthcare personnel are positive for COVID but they're asymptomatic, they still need to find the guidance that was released on July, 17 by CDC and that guidance can be found if you just Google CDC return to work for healthcare personnel, it should pop right up for you I don't remember if I included the website link on the slide or not. We can certainly do that. But that guidance is basically they should not return to work until at least 10 days after their first positive diagnostic test. So 10 days, is the time frame.

Trish Barnum

Thank you. And then, this is perhaps just to point people in the general direction there was a comment that there was a lot of information shared during the presentation. Would you like to point people to specific places, either on the department's website or the SPICE website or on the CDC website.

Evelyn Cook

There, there was a lot of information. While it's not new information, it can still be very confusing at times, and, you know, we all have to go back and reread things several times but on the new admission or readmission discussion that can be found, both in the preparing for COVID and long term care facilities or nursing homes on the CDC website. And then there's another guidance document where it's actually not just preparing for COVID but dealing with COVID in nursing homes, and the readmission, new admission and readmission guidance can both be found there. And I can't maybe Teresa can can help me with this whether that language is also in the North Carolina guidance or part of the North Carolina Long Term Care toolkit, Teresa, are you on. Do you know if that guidance is in there as well.

Teresa Fisher

Hi this is Teresa, and I am on. Which specific guidance are you...

Evelyn Cook

The guidance about management of new admissions and readmissions to long term care facility, about the quarantine and the use of PPE.

Teresa Fisher

They I think they are all in our North Carolina guidance, but they're linked to the CDC website. Okay, but they would so if they search under the North Carolina guidance and the long term care and the and that toolkit when they're looking at those things that they will find it, but to be consistent we're trying to keep them linked.

Evelyn Cook

So that, that's two options just to go on the CDC website and Google there. The same thing truefor the return to work again that date was July the 17th that criteria was updated for returned to work with healthcare personnel in addition to criteria for releasing individuals from isolation. After either being symptomatic or testing positive for COVID-19.

Trish Barnum

Thank you all. The next couple of questions are related to the frequency or testing frequency. Is it a recommendation or a requirement to test staff bi weekly, and Dr. Kansagra I know you and Dave addressed this to some extent, who's responsible for the cost associated with this.

Dr. Susan Kansagra

Sure thanks Trish. And I see two costs right so this is again for skilled nursing facilities, and this is moving towards the mandates I would encourage every facility to start if not already doing this based on the recommendation to, to start doing this and making plans to do this again the federal government has put out an announcement that they will be moving towards mandating even perhaps weekly and that they will be going through a rulemaking process to do this and we as a state are also looking at reporting and compliance around this measure and we will be. We are also looking at additional funding to skilled nursing facilities to support this. So again, we're still working out some details around this, we'll have some information tomorrow or Monday early next week. To share back with facilities specifically skilled nursing facilities and so. So again I would consider this a very strong, strong indication that this would be moving towards a mandate, facilities should start doing it if they're not already based on the recommendation to do this.

Trish Barnum

And Dr. Kansagra, just to keep with that. The next question or comment may or may be reflected in what you're saying what you said. It was my understanding that as long as North Carolina is above 5% positivity rate that SNF is required to do weekly testing.

Dr. Susan Kansagra

So this is something to clarify that. Yes. This is the guidance announcement that the federal government has made, they have not provided additional details on which states that is, and they have said that they will be going through additional rulemaking for this so we haven't seen any further information will come out, but that is what they are saying that they will do and so that's really the federal government process right now we're waiting to hear more information from CMS.

Trish Barnum

Great. I think these next couple of questions are related to the point of care testing for Scott. The first question is, where would we record the POC testing to?

Dr. Scott Shone

So the mechanism for antigen reporting positive reporting is the same as current molecular testing and I do know that we are working on some predefined guidance to support that for reporting to support that. So that some more detail will be forthcoming, this is Zach Moore's wheelhouse and I should be better versed so I apologize for not being more articulate on that so how about I promise to get some more language on that we'll get that out to this group subsequent to this call.

Trish Barnum

And Scott just to just to piggyback on this. I'm assuming these, these would these results would also be reflected in like you were noted the upcoming reporting requirements and expectations that we're going to be releasing. Yep. But to stay with you for just a second. The recommendations state that antigen testing is not appropriate for screening healthcare professionals. If we continue with our screening with temps with screening questions with healthcare professionals is it appropriate to use the antigen testing on all staff, rather than lab testing of all staff.

Dr. Scott Shone

So I can speak on the technical side I don't know if Susan or others can speak to the requirements side I don't want to misspeak on what's required versus versus technical in terms of what's recommended and how the FDA labels, these rapid antigen tests. And in terms of our guidance that we've released. They should be used in environments where, again, there's this high pretest probability, where there are case settings and I think that's where the federal government has prioritized distribution initially for these cases as Dr. Kansagra showed that the route, it is not ideal for routine screening in an environment where there are no cases. For this test it will give you really a false sense of security in my opinion I think that the symptom checks are one piece routine testing is another piece from, I would just say from a technical standpoint, the way that the antigen test works is that you're going to run the risk of really a false positive if you're just testing asymptomatic individuals with no other potential exposure etc so I

think that there's some new, I know that I'm trying to nuance the message, a little bit. It's ideal obviously molecular testing is ideal in those scenarios where the pretest probability is low, you know, hopefully we get to a scenario where we are far away from any outbreaks or positive cases in any of these congregate settings. And I think we're continuing to look at other rapid methods to help support the need for this testing, specifically with this antigen testing. It's best used and ideal for, for those scenarios where there are cases or outbreaks, etc. I hope that answers the question.

Dr. Susan Kansagra

if I can, if I can add a little bit more Scott to that, I would also add, right, I think the word screening there also. You're seeing it used in in two different ways. One is the recommendation to screen temperatures and screening questions for healthcare personnel should still continue and that is still a recommendation should still continue to screen staff members at the start of their shift. But as Scott mentioned for the test itself it's better used when there is indication and again if there's a you know an outbreak in the facility we're doing testing it's better used in that way rather than testing when there is no indication at all for that, you know, in a population that might not have as high of a probability for having COVID in the first place so I think that's the distinction there, you should still continue to screen, you know, with those screening questions and temperature checks as well for your healthcare personnel.

Trish Barnum

Staying on the thank you and staying on the testing topic, which is more appropriate, conduct a lab test and wait seven days for results or conduct antigen tests weekly and get results in 15 minutes I'm assuming this is on a weekly testing cadence.

Dr. Scott Shone

That was a bit of a backhanded comment about turnaround times I hear you. So, I, I would say that most labs right now have been able to reduce turnaround times to this pre surge level from several weeks ago, I am aware, at least, our major commercial labs LabCorp, Quest in North Carolina are back down to two, maybe at most three days but are typically around two days now. Our state lab has again returned to that two days with 95% of our results going out in two days and 99% in three days. So, I just want to defend some of the turnaround time issues, and and say that there is some normalcy returning there. It's a little bit of apples and oranges question though because, you know, as a sort of from a laboratory perspective is a, is a is false security, based on a potential false negative better than getting an accurate result in three to four days. I think the three to four days is better but it's not going to be situational again I fully trust these, these rapid tests when using the appropriate settings I would do it I've said, I would do it myself if I had symptoms that I could get access to an antigen test, I would do it first as opposed to taking away that molecular test. But I do think that that when not used in the, in the situations that we've discussed and that that are recommended, and included it even in the FDA kit in certain directions can potentially give a false sense of security, no matter how many anecdotes we hear

about that the test always matches in these scenarios in these settings the potential risk around a false negative is high, so I would, as Dr. Kansagra said the screening questions are critical. The routine testing, especially when we have cases and using this antigen test is completely appropriate, but again it's situational based and so and I'm happy to have an I can share my contact information that one off conversations around what's what from a technological standpoint is best case use, and also how can the stay lab support any of the needs that you guys have.

Dr. Susan Kansagra

This is where there's also an acknowledgment that there is so much emerging technology, and as these tests are used more I think there will be more data that will help answer some of these questions as well and obviously the technology is emerging as well. So, you know, ideally I wish there was a test that would have accurate results in a short period of time and be useful in a variety of scenarios but it looks like with any test use is that, again -- maybe as more clarity on new types of technology and also this disease as well as we go.

Trish Barnum

One other follow up question. A couple more about testing and then we'll move on, is if the provider is conducting one day, and five day testing for all new admissions and readmissions. Can the antigen testing be used instead of lab testing. And that may not have enough detail to answer it precisely.

Dr. Scott Shone

I don't, I don't know if that if that is intended for me I'm not sure the, no I don't, I don't know the reference to the one and five day. And then the timing of that job maybe perhaps offline or if somebody else on the call understands their relationship to that or somebody wants to reach out to me directly with some more clarity I'm happy to have that conversation.

Trish Barnum

We're going to segue a bit here as well. One other question about the staff testing is that if a staff person travels and this is probably to Dr. Kansagra and to Evelyn. If a staff person travels out of state for a funeral or other extended family gathering should they be tested before they return to work.

Dr. Susan Kansagra

And actually Evelyn maybe you can chime in. I'm not aware of any guidance that they need to be tested before they return to work.

Evelyn Cook

I'm not, I'm not either. So I think it's really important to make sure they're screened appropriately as you are all staff, you know, related to temperature and symptoms but I'm not aware of any recommendation that they be tested.

Dr. Susan Kansagra

And I think this is a good reminder one additional point that we're seeing in our data, and we're seeing now almost 20% of our outbreaks involve staff only cases which, you know, in some ways, it's good in the sense of that is not being spread to residents and we know since staff may be going in and out of the facility obviously there is that risk of picking up disease and not knowing it, bringing it back into the facility, asymptomatically and so, continuing to emphasize those basic measures, outside of, you know, outside of work, to those three W's on wearing a face covering you know washing hands and social distancing I think are really important outside of work especially, especially for all of us that might be going back into healthcare settings.

Trish Barnum

All right. One of the questions in this, I think, a couple of related questions related to the application of some of the testing expectations. And so I think this is going to Dr. Kansagra. Why are skilled nursing facilities the only, only required for resident and staff testing and not only not other long term care facilities such as ICF residential facility and ICF for intermediate care facilities.

Dr. Susan Kansagra

So for other types of facilities the recommendation around, full facility testing is related to when there is one or more cases. The requirement around the you know that we're seeing come down from the federal government and again some of the funding that we may be putting out is more tied to the skilled nursing facility but other facilities there is that requirement when one or more cases are identified. And that's something we continue to evaluate our surveillance strategy when we look at our outbreaks we are seeing a much higher rate of outbreaks among nursing homes and you see among other residential facility types. And so, that is some of the data that that we are seeing that lead to more emphasis around the nursing home, and federally as well. Again, we're relying on guidance there which is really emphasized for the nursing home, but if there is certainly for those facilities as well there should be screening every day on staff members, vigilance for signs and symptoms of disease and if that is detected then rapid testing, including testing of all staff and residents. If there is a case detected on a weekly basis.

Trish Barnum

Thank you. There is a question about some of the upcoming training modules that will be available through CMS. And the question is, CMS in partnership with the CDC is rolling out an online self paced on demand nursing home, COVID-19 training focused on infection control and best practices. When I think the training, being offered has 23 educational models, when will it be available and that question go to several of you.

Evelyn Cook

So, the traditional, I'll take the first stab at that and Teresa may be aware of something else or someone else on her call but you know I know that CMS and CDC partnered. Some time ago, before covid actually and then the question specifically relates to a covid training module that they also partnered some time ago and developed a 23 module online training course designed to orient and educate individuals who are going to be responsible for infection prevention and long term care settings. I know that course is self paced, online and currently available. I am not familiar with when a specific COVID-19 training module similar to that will be available they, there are a series of webinars that the QIO, or quality improvement organization are sponsoring and that is a collaboration between CMS and CDC are nursing called covid-19 training. And that is, in a series of webinars and those webinars, I believe, actually, may start today. There are weekly webinars on Thursdays at 5pm. So, but I'm not, I'm not familiar with when a 23 module online training course will be available and I'm not sure if someone else has had more information on that.

Dr. Susan Kansagra

I think that's part of the White House announcement, around the point of care machines and additional measures that you're putting into place and so, you know, that would be based on further information that we received from the federal government.

Evelyn Cook

I would just add Trish that if you're interested in those webinar training sessions which are usually very informative, you can find on just Google QIO programs, nursing home training, you should be able to find information about that but as I said I think the first one is going to be today at five o'clock eastern time.

Trish Barnum

Thank you and he's just wanted to confirm Dave Are you still on the phone. Yeah. Okay, just wanted to make sure you were still on before proposing these next couple to you. So, this is, this may be a question that we may want to redirect folks to some of the Federal guidance. But if an ICF IDD received an increase, I guess the question is from the cares fund, would that make ineligible for the relief fund. And perhaps encouraging folks to go back to special bulletin 118 that's just getting posted for the criteria.

Dr. Scott Shone

Yeah, I think, I think that's the right answer is to go back to the bulletin as it's posted on air. I think they're very specific very specific rules around that and I'll be honest, I'm not sure if that's going to prohibit because it wasn't -- work on it and again say I'm not sure about this because I think mainly what they were referring to is that if you received funds directly from CMS through CARES, this money actually came to the state and the state delivered the CARES money so two things look at that bulletin let us also go back and research to make sure that I've got that right. And then we'll send out something to make sure that we get to the ICF providers.

Trish Barnum

And then one more question this is not related to the testing. But is there any update on the therapeutic leave increase.

Dr. Scott Shone

Nope, no update today. We'll go back and look at but I don't have an additional update to that.

Trish Barnum

And just to note on the q&a there are both questions about the disclosure of information about test positivity of folks who may be in SUD facilities, and have additional privacy protections under 42 CFR part two. I wanted to invite any of my colleagues to to address that but I flagged that for follow up to give a more organized response, given the complexity of the question. Okay, well, we'll take that there's a couple of questions related, and we'll take those back. We also received some questions about where we can access the materials, and AHEC does a great job of posting the material very quickly on their website so where the registration link is also housed on their website. They also post the materials, and the recording. So all the materials for all of these sessions are posted very quickly on the website after the session is completed. Just one quick review. Okay. This is another question related to testing and testing technology so i think it's it's a joint question and answer. Do you have any information on the vaccine, or the testing technology using paper step test strips with saliva specimens.

Dr. Scott Shone

I don't have any additional information on vaccines saliva is a tricky topic. So right now the only authorized methods using saliva require saliva collection in a tube with basically the participant as the spit into the tube. And that all the UI, I had to review this actually on Tuesday, the EUA methods that I reviewed all say that saliva can only be used in symptomatic patients because that the sensitivity in the, in saliva is actually quite low that the amount of virus that is found in the specimen so this isn't a test specific issues or like antigen is less sensitive. But the actual amount of virus detected in saliva is lower

than an oral swab or a nasal swab. So FDA still labeling it for symptomatic use. And a lot of home collection. I've heard about labs who are collecting using like some sort of spongy swab in the cheek, sort of just to sort of absorb saliva, had some recent discussions with FDA and they're looking into that and its validity. The FDA was sort of very hands off in terms of approving some of these and so I think they're going back and looking at some of these methods that are being used. So I think it's very critical. If it sounds odd it probably is. But as Dr Kansagra said, there's a huge push to identify new methods that are highly accurate and as rapid as possible with different sample types. And so, saliva is definitely on the trajectory and on the path, but I have not heard about saliva on a filter paper being being an authorized method. But I would guarantee somebody looking at trying to develop one for that platform.

Trish Barnum

Just wanted to confirm there any additional questions that we have another eyes enters and we've we've matched some of the similar questions so hopefully everybody has gotten their information. Okay. We are not seeing any additional questions come in at this point so I think we are closing Dr. Kansagra any final words?

Actually, I'll just address one I see there's one comment around long turnaround times, particularly with the Omnicare. And so I will mention there we're seeing turnaround times of about four days on average you know that that includes the time to courier the sample over, and then reporting it back and so for that facility I'd recommend getting back in touch with your CVS account manager or us, because if it's longer than that, you know, there can be other reasons maybe there was an indeterminate result or could be other issues so to definitely fly that back for us if you're seeing that because that's definitely not typical of what we're seeing in our other results. And just to wrap up. Trish thanks for moderating. Thank you all for everything you're doing I know everyone is working incredibly hard. You know we are in the thick of it so appreciate all that you were doing, you know we're continue to be here to answer any questions. And certainly, as you see needs or other things that need clarified or support. We want to be responsive for that so please continue to raise those both through these webinars and other channels and again just appreciate so much what everybody is doing. So thank you all. Have a good rest of the week.