Transcript for LTC Settings Webinar
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10:00-11:00 am

Presenters:
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Kimberly Clements, Program Manager, Healthcare Preparedness Program
Susan Kansagra, NC DPH
Scott Shone, Director of State Public Health Laboratory
Trish Farnham, Senior Health Policy Analyst

Hugh Tilson

Well it's 10 o'clock so let's go ahead and get started. Good morning everyone and thank you for participating in today's COVID-19 webinar for long term care providers. This webinars put on by the North Carolina Department of Health and Human Services and supported by North Carolina to discuss recent updates to the state's COVID-19 response, and to provide a forum for you to ask questions of DHHS leaders. As you can see we've got a full agenda with lots of timely information for you today. My name is Hugh Tilson I'll be moderating today. I'm gonna turn it over to Evelyn in just a little bit before I do just want to thank everybody for making time in your busy schedules to participate in our webinar, that's both the presenters and the participants. We know how busy you are, and how important your work is and we hope the information that's provided today will help you in your important work and will help make navigating these trying times a little easier. You'll hear from our presenters that will turn to your questions. Next slide please. We've learned in the past that presenters will often address your questions during their presentations. We should have time to get to your questions so please wait until you hear from presenters before submitting a question. To submit a question just wanted you to know that all participants are going to be muted except for our presenters. So, if you want to submit a question use the q&a function on the black bar at the bottom of the screen. The q&a function on the black bar at the bottom of the screen, and we'll send all the questions to DHHS so they can respond to them, or include them in future webinar content as we move forward, we will record this webinar and the recording a transcript of it these slides will be available on the NC AHEC website tomorrow. Now, let me turn it over to Evelyn. Thank you.

Evelyn Cook

Thank you. Good morning everyone. I want to thank you again for being with us I know everybody's still really swamped and busy so we appreciate your taking some time out this morning to join the call. So we're going to begin as usual we're just providing a little bit of an epidemiology update. So from a global perspective according to the World Health Organization, the number of cases is just a little over 22 million currently with about 781,000 deaths being reported. According to the CDC here in the United States, our numbers are about 5.5 million for cases, and a reported a little bit over 170,000 deaths. Here at home in North Carolina, our cases are just under 148,000, with almost 2.5 thousand deaths being recorded. Next slide please.

So, here on the CDC updates this morning there's not a lot of new updates, but there were two that came out over the weekend I believe August the 16th that I just wanted to bring your attention to. The first one is, when to quarantine, and a quarantine is used to keep someone who might have been exposed to COVID-19 away from others. And it helps prevent the spread of disease that may occur before a person actually knows they are sick. This sometimes gets confused with the word, or the term isolation and I've also even heard them being used interchangeably, but they are not the same. Isolation is really used to separate those individuals who have the disease from others that do not. So, just to remember quarantine and isolation do have different meanings. People who have tested positive for COVID-19, do not need to quarantine or get tested again for up to three months, unless they develop symptoms again. And even if you test negative for COVID-19 and feel healthy, but have been around someone had contact with someone who was positive for COVID-19, you do need to still quarantine for at least 14 days after that last contact and web link is listed below. When you see these slides. If you have any additional questions about that update the web link is listed below as well. Next slide please.

The second update that I wanted to mention is also came out on August, the 16th is duration of isolation and precautions for adults with COVID-19. And we discussed this in some detail a few weeks ago. But just as a reminder for everyone. The test based strategy is no longer recommended to or recommended to be used primarily to discontinue precautions and precautions can be discontinued 10 days after the first symptom, and resolution of the fever for at least 24 hours and improvement in their symptoms. Asymptomatic individuals can have their precautions discontinued 10 days after the date of their first positive test. And that guidance is extended to 20 days for individuals with severe illness. And in their guidance document CDC provides a description of what severe to critical illness includes. And it also provides information about what constitutes being immunocompromised. So when you're thinking about that 10 to 20 days please reference that and make sure you're trying to follow that guidance.

And then again in this update, they make the point that persons previously diagnosed with symptomatic COVID-19, who remain asymptomatic after recovery retesting is not recommended within three months after the date of their initial symptom onset. So that's once that symptom onset has been identified retesting is not recommended within three months if they remain asymptomatic. If they are asymptomatic, to begin with, then we'll use their first positive path to kind of define that time period for three months. Individuals who develop new symptoms within that three month period may warrant retesting. If an alternative etiology cannot be identified that addresses their symptoms, if we cannot have a different diagnoses, then you may want to consider retesting in consultation with clinical your clinical provider. And again, that web link is on the slide. So if you want to review that to get more information about this. Next slide please.

So this is actually something that we covered last week, and I'm not going to go through or two weeks ago when we had the webinars so we won't go through all of these things again today. What I do want to say there's really not any really new infection prevention recommendations, but I'm going to be on the call and during the q&a session, I am happy to answer any questions that anyone might have related

to infection prevention recommendation. And so this really concludes my portion of the webinar so we'll turn it over to, I believe Kimberly Clements is next on the agenda. Thank you.

Kimberly Clements

Good morning everybody just want to confirm this you can hear me okay.

Hugh Tilson

We can hear you. Thank you.

Kimberly Clements

Excellent, thanks so much sorry I had to join a few minutes late. So I just wanted to give a very quick update on some staffing initiatives we actually have put together a one pager which will be going out later today we're going to be sending it out through the various listservs that we use, but it will speak to a new initiative that we have been working to put in place the middle of July. So most of you know we've been doing some emergency staffing support through our medical volunteers. And we had a lot of initial requests and it was able to fill it about a 40 to 50% rate but at that rate decrease down. We made some adjustments to it and we have actually on boarded some full time staff and some temporary staff that are between 28 to 40, hours a week, that they are setting aside and dedicating to be able to do some staffing support. And we're referring to this as long term care outbreak strike teams. And the main reason we're using that term, not just saying it staffing support is we're providing some unique training and education opportunities to these individuals to help be able to come into facilities when they first start to experience an outbreak, or even potentially before it's officially been declared an outbreak but they're first starting to realize that there might be a concern for an outbreak. To start putting in place some good infection control procedures to work on helping with different standard operating protocols. Addressing staffing concerns early. And a lot of these individuals have been working in facilities across the state that have been an outbreak status and they have a lot of expertise and experience in this way. And we've set up a team. Through UNC SPICE through the ECU Doctoral nurse program Division of Public Health, and then also within our program with Healthcare Preparedness to pull this group together weekly to talk through issues and concern, look for educational opportunities that can come from that, both for our Strike Team individuals and then also for facilities, to be able to provide some of that ongoing support, and our main goal really is just to provide some extra level of support for each of you early on in that outbreak status or again even before potentially that outbreak status hit, to see what we can do to better support and decrease the number of days of facility status and outbreak status.

So we have a one pager that kind of speaks to that, it goes over all the potential staffing options to include the ECU temporary higher, and still our medical volunteers which we are continuing to deploy and utilize, but we've just added this new capability to the list, and we're continuing to build that

program and project. So, wanted to speak to it very quickly give that update and let you know to be looking for that one pager, that is all that I have. I'll turn it back to you for the next person. Thank you.

Dr. Susan Kansagra

Great, thanks Kimberly This is Susan. So, a few updates as we transition to testing wanted to provide updates around point of care testing. We know that the federal government is starting to release point of care testing machines to nursing homes that they have pre identified for certain criteria which are listed here. There is about 65 nursing homes that we know of in North Carolina that have been identified thus far to receive machines and that list is available on the CMS website and they contain update it. We also are hearing that they will be releasing additional rules in the next several days, that will tie frequency of staff testing to state and local metrics, and so we don't have further details on this yet but we are continuing to look out for that and would encourage those of you that are with skilled nursing facilities to look out for that. Also, you know if they do tie this to frequency of state and local metrics, we'll have a better understanding of what that specifically is, I didn't want to encourage folks so it's a good, good time to, if you haven't looked at our data dashboard to look at the information on there it has a lot of great data on state and county level metrics and so to start looking at that and getting familiar with the data but again as we find out more information we'll let you know. In the meantime, we know that there's been a lot of new guidance that has come out on point of care testing and I'm going to turn it over to Scott Shone our director for state public health lab to talk through point of care testing a little bit more and the new CDC guidance that was released this week. Next slide please.

Oh, and I'm sorry actually before we get to that, actually I'm going to turn it over to Trish to talk a little bit more about the secretarial order on biweekly testing that we have at a state level, and then Scott will talk a little bit more about the point of care testing.

Trish Farnham

Hi you all and Dr. Kansagra and I may tag team on this, just to confirm it somebody can hear me.

Hugh Tilson

Yep. Gotcha. Great.

Trish Farnham

So, as you all know secretarial order number two was released on August 7, and we have been in intense conversations and communications with our nursing home partners and launched a training initiative earlier this week, which we'll talk a little bit more about. We know that there are a lot of questions about not just the reporting but also the underlying public health requirements, and guidance on on testing in general. So, it was Dr. Kansagra wants to highlight any of these in particular I'm just

going to direct you to some of the questions we've received, and we wanted to just make sure that you had this, the answers in writing so that you all could make informed next steps on as we're as we're moving forward with reporting I'll talk a little bit more about our reporting effort later in this presentation but I just wanted to bring more public health facing questions and answers to your own attention. Thanks for coming.

Dr. Susan Kansagra

Great, thanks. And I think as Trish mentioned, you know just clarifies it right if there are, you know, while the definition of a outbreak is two or more cases really the guidance for weekly testing begins when there is one identified case in the facility and that that even though the order of secretarial order applies to skilled nursing facilities and we can talk a little bit more about that. The, the outbreak guidance and testing is really for all long term care facilities. You know if there are cases and that site is required to follow the guidance of their local health department, but that guidance is to conduct weekly testing of both negative, staff, and residents and continue to do that till they are 14 days out from the last positive case. And then, as mentioned by Evelyn already staff or residents who previously tested positive when within the past three months, and are now asymptomatic do not need to be retested again as part of that staff testing that occurs. So I think those are the main points there let me flip to the next slide, and turn it over to Scott Shone who will talk a little bit more about point of care testing.

Dr. Scott Shone

Okay good morning everyone. So, this is a slide that I shared the last time I spoke to the group on antigen testing. And just a reminder. So, compared to what everybody is used to used to with respect to standard molecular in lab PCR testing, obviously antigen testing closely, the closest example we have is, is rapid flu testing where same type of upper respiratory sample for the two approved tests, you can use either an NP nasal pharyngeal swab or a nasal swab, which is a lot less invasive than an NP swab. That swab is applied directly to a cartridge, a rapid test and then either read by eye, or by a small instrument which obviously we just, it's been part of the discussion so just reminding everybody that the antigen tests are less sensitive than than other methods currently in use.

The two methods that have EUAS are specifically labeled for use for diagnostic testing and individuals in the first five days of symptoms, or those close contacts and I'll get into. I'll get into some nuance, on my next two slides. This test is highly specific though so we can. There has been some growing data looking at just how specific they are. And I'll just remind everybody about false positivity I know it is a continued discussion I have every day about what's your false positive rate, do we have false positives does one lab more have more false positives than another false positive reality of any lab test that's done not just COVID. The, the false positivity rate does depend on the test itself, and other pre analytic, you know collection issues as well as perhaps some analytic issues within the laboratory that said, you know, false positivity and we talked about antigen testing, where the false negative rate might be higher due to sensitivity, but if you use these tests in a broadly asymptomatic non exposed population, you actually do increase your risk of false positivity because there's a greater chance of within the population that

doesn't have exposure to the virus that the result would actually be a false positive so I think it's important to consider that balance of performance with the, with the population in which you're using. So antigen testing remains, at least the two current methods to Quidel and the BD are best used when there's a high pretest probability of SARS- CoV2 infection and I'll lead into my next slide.

So, CDC issued guidance earlier this week, specifically about antigen testing. And I will say right up front that there are pieces that seem contradictory, not only within the document itself but with what has been other messaging, both from federal testing partners, FDA. So HHS continues to pull together their messaging and my hope is over my next two slides to try to bring some clarity at least as our experts of the state, see it and realize that all of this is constantly evolving and we bring any updated interpretations or new guidance to you as soon as we have it. As soon as we can be clear and trust that we're sharing with you the best information to care for your populations. So, the CDC antigen testing guidance does permit the use of these devices and this technology in high risk settings such as nursing homes. The two rapid antigen tests that have received emergency use authorizations from FDA the BD and the Quidel are currently limited to diagnostic testing on symptomatic persons within the first five days of symptom onset and CDC clearly defines diagnostic testing is intended to identify current infection in individuals, and is performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has a recent known or suspected exposure to SARS-CoV2. So that is related to my comment earlier about the high pretest probability. So the person is either symptomatic or has a known exposure to someone with the virus.

Now, this is where that contradictory piece may come in and I know has caused some confusion, CDC does say that when used for screening testing and congregate settings test results for SARS-CoV2 should be considered presumptive that's both positive and negative, and confirmatory nucleic acid testing, so PCR following a positive antigen test may not be necessary when the pre pop pretest probability is high. So if you're doing screening in a, in an area with, or in a setting where there are known cases and known transmission. So again, especially if the person is symptomatic or has known exposure that might not that confirmatory testing might not be necessary. However, when the pretest probability is low, so no known cases, well established pattern of negativity in a population. Those people who receive a positive test should isolate and be confirmed by PCR. So again, that goes back to my earlier discussion of sensitivity and specificity sensitivity does, does vary based on the population in whom you're testing. So, and again, CDC defines screening is testing to identify infected persons who are asymptomatic or without any known exposure. So screening testing is performed to identify persons who may be contagious so that measures can be taken to prevent further transmission. So we've seen, and is still ongoing data collection on this, that PCR does tend to be more sensitive and specific in asymptomatic individuals and, and I'll just before I go on to the next slide reiterate that the two tests, currently authorized by FDA the Quidel and the BD are labeled for diagnostic testing. They're not labeled for screening. So next slide, please.

Thank you. So, with respect to DHHS assessment of all of the guidance we've seen and we will work on our, Dr. Moore and I will work on the editing guidance that is currently out there to reflect a lot of the

this week new information that using point of care antigen testing to conduct testing under Secretary order number two is most appropriate for testing with symptoms, individuals with symptoms or asymptomatic with known exposure, such as working in a facility with an outbreak. If a nursing home has established a vendor based testing arrangement for its biweekly testing, that is continuing to provide timely results. We encourage you to maintain this practice, however antigen test as and so antigen testing devices are not advised for bi weekly testing, when there is no known positive cases, or suspected exposure. However, if your facility's lab based testing strategy is not producing timely results, you can consider point of care testing as a reasonable alternative, bearing in mind, the presumptive nature as described in the CDC guidance. I really hope that I brought some clarity to this somewhat muddy waters, and I'm happy to answer questions and whew, I know I said I had to drop off but my other call already ended so I can stay until the end for questions.

Hugh Tilson

Thanks. So does that mean you're done, we need to transition

Unknown Speaker

Yes, thanks.

Trish Farnham

Hi you all. So my name is Trish Farnham, and I'm a senior policy analyst who works for the North Carolina Medicaid program specifically under Dave Richards, who is not attending today and has ceded the floor to our reporting initiative so we always start with this slide just to kind of ground ourselves in everything that Medicaid is trying to do to support the larger department's efforts related to covid response specifically in long term care facilities so we can move to the next one. And we started, we alluded to secretarial order earlier in this presentation, but we wanted to, again, as we really launched so many of the activities related to reporting under secretarial order number two we did want to share and re communicate some of the slides that we've shared in earlier trainings this week with this broader group just so that everybody could have a foundational understanding of what what hte Secretarial order was about. So importantly secretarial order. And the last thing I want to say is that we've tried to prioritize those slides that will help clarify some of the questions we've received. So, just wanted to note that.

Importantly secretarial order number two, requires nursing homes regulated by the Division of Health Service Regulation to participate in required testing that's outlined in the executive order, and is also reinforced in the guidance that's also provided and that we've provided the link here. There's been questions about which facilities that actually covers, so it's important to know that if you are not a nursing home, you can tune out right now because it's important to know that that is the scope of the secretary order number two's universe at this point. So, but within the nursing home definition there

are obviously some nuances that need to be clarified. And we just wanted to make sure it was super clear to this group, which types of facilities were covered. So importantly it includes facilities that do not participate in the Medicaid and or Medicare programs so if you are a private pay facility. You are still covered by this order. It covers nursing homes that are combination facilities that have AHL or adult care home life beds within the same building. So it does cover those combination facilities. The third bullet, we're going to be providing some additional guidance on, related to the nuances within this statement, but it's important to know that there are hospital affiliated nursing homes, rehabilitation centers, and the intent is that they at least at least a component of that of that group will be included, but we're going to be providing additional guidance on that. And then finally, our state operated health facility neuro medical centers are also covered under this order.

Next slide. As folks hopefully know at this point, who were impacted by secretarial order number two. The activities underway really do have a couple of interrelated components that we just wanted again to kind of level set with folks who are impacted by the order. And just to orient folks who may not be impacted by the order directly just so everybody has a good foundational understanding of what's covered. So, under secretarial order number two. The focus is on staff testing and secretarial order number two, covers a requirement that nursing homes, like I mentioned earlier, conduct biweekly staff testing, and then weekly testing of staff and residents if an outbreak, or newly identified case is identified through testing. So it's important to know that this is this is a testing initiative, and in order to track the activities under this initiative we are working to develop a reporting platform that most of the folks on who are impacted by this order have gotten a little bit of a preview to but will get more of a preview to later this week. And they, the department has also worked to mechanize a process for leveraging CARES Act funding to cover the staff testing costs and methodology that we will be going through in our training tomorrow. Importantly, the CARES Act funding is not applicable or available for residents testing costs. We encourage facilities to examine a number of different resources that are available to cover that expense. Next slide.

A couple of things just as an update for those folks who attended Monday's session that hopefully is helpful. We are in the process of developing FAQs based on what you have submitted really thank you for those questions. We also wanted to acknowledge that if you needed to look at the secretarial order and the guidance that was released through our DHSR partners on Monday. Both are now posted on this link at the top of the page. And again more information will be posted in short order. Next slide.

Trish Farnham

And just as a reminder, we do have the second of two webinars that are orienting impacted providers to the order and to related activities. So we just wanted to remind folks that our second session is tomorrow. And we will be providing additional detail related to the payment processing and related documentation. And then we're also going to do be doing a tour of the reporting tool. So, we, we have a screenshot here to give you kind of an insight about what the reporting tools can be looking like. But we'll be giving a tour of it. We, if you had not are excuse me if you have not otherwise registered and would like to attend the registration information is provided in the guidance document that I referenced on the earlier slide. And if you have already. If you've already registered for Monday's session, you are

already registered for tomorrow's session as well. Next slide. And finally we just wanted to reiterate that as you all are working through your processes for establishing your work through your processes under the secretary order number two. And as we begin implementing the reporting related activities. We just wanted to reassure that we will be hosting office hours on a regular basis for the next several Thursdays. Starting next Thursday. And we want to encourage people to register and helpful. Next slide.

And then as we always try to do on these calls or on these webinars we wanted to just feature, all of the COVID specific special bulletins that have been published since the last AHEC webinar. And just as a heads up, we will be also drafting a special bulletin and publishing a special bulletin related to the activities under Secretary order number two. And then the final slide, I believe, is just to know, as always, here are the contacts for if you have questions, we have added now a, an option for submitting reporting questions under secretarial order number two. Thank you so much for your patience we do try to turn those around as quickly as we can, but because a lot of questions coming in are more about public health guidance, more than the reporting specifically sometimes they need to be routed and processed by several people before we can release the answer. So we really appreciate your patience to do we do, we do work really hard to turn those questions around as quickly as we can so thank you for submitting them they certainly have helped and advised and informed the process. I think at this point I'm turning it back over to you.

Hugh Tilson

Great.

Dr. Susan Kansagra

Can you put out one more slide. Is there one more slide after this.

Trish Farnham

Oh, that's the mute immunisations slide, thank you so much Dr. K I'm sorry about that.

Dr. Susan Kansagra

And this is just a reminder, and certainly related to COVID, not COVID itself but just a reminder that there are immunization requirements in statute for influenza and pneumococcal disease for residents employees of adult care homes and nursing homes. And so, that requirement is listed there and this is just as a reminder, as we go into flu season that we are certainly thinking about how we continue to encourage and emphasize people to be vaccinated against influenza as well. Given, especially given obviously that this is very similar to covid disease with fever and cough. And so continuing to encourage that as well so for adult care as nursing homes and really for all long term care facilities, you know, start

thinking about how you will be, you know, looking at this information, and getting residents and employees vaccinated as well and encouraging that. Thank you. And now we can move on to the q&a.

Hugh Tilson

Thank you guys. Lots of questions about testing and all those things we've got. So let's handle some of the non testing questions first. So I think this one is for Kimberly, how is the staffing support requested and is a contract required. Is she still there or did we lose her. She might have signed off we'll have to loop back around on that. And then I thought I might be able to catch her. Trisha know that you had some follow up from last week you wanted to talk about as well.

Trish Farnham

Oh, thanks, thanks. I just wanted to acknowledge a line of questions that we did not explicitly address on last, or two weeks ago the call two weeks ago, and it related to the application of 42 CFR part two, and how 42 CFR Part Two impacts some of the communication and reporting requirements. They were great questions. We are still circulating those, there's entire legal team really thinking that through. So we wanted to just acknowledge that we received that question that we didn't overlook it or didn't ignore it. But we are circulating in additional guidance, and hope to have it answered as quickly as we can. Thanks so much.

Hugh Tilson

Got a question about, please review the continuing use of face shields in nursing facilities.

Evelyn Cook

Hey this is Evelyn i'll start with that question and then Wanda or, Dr. Kansagra can add if they have some. In addition, so it is continued to be recommended that healthcare personnel, continue to wear eye protection, in addition to their surgical facemask for the care of all residents, regardless of symptoms. And this is due to the fact that and it does specify that if you're in an area with moderate to substantial community transmission, which basically means if your facility certainly is in an outbreak setting or there are other congregate locations in your community that are in an outbreak or continued transmission session. Transmission condition then you would be included in that community level. And this is really about protecting your eyes and your mucous membrane. Because that our eyes, nose and mouth are really the areas that are most likely to be exposed and need to be protected from that exposure.

Hugh Tilson

Any other comments. Got a couple questions about how can we access or join the outbreak strike team if we need it.

Dr. Susan Kansagra

This is a question for Kimberly as well and as she mentioned she is putting together a one pager that will provide more information so we will make sure that that gets out to y'all. You know how that has happened, thus far is in coordination with their local emergency management as well as a facility in thinking about staffing needs especially after an outbreak, but again, since she's developing that one pager we will make sure that it goes out to all.

Hugh Tilson

While I've got you got some questions about the flu shots. Just something about what do you do if a resident refuses the flu shot.

Evelyn Cook

So this, this is Evelyn and I'll start with that one and then others can join and so you know the the requirement is that you provide education about the risk and the benefit to your residents and or their family member is needed. About influenza and providing that education, they do have a right to refuse the influence of immunization, all of that should be completely documented. But the most important thing is to make sure that you've provided that education in a manner that they understand what the risks and the benefits of influenza immunization are.

Hugh Tilson

Can employees refuse the flu shot.

Evelyn Cook

Yes. Again, you need to make sure that you've got evidence that you've educated them. You know there are some facilities that have to facility specific procedures and processes in place that include influenza immunization as a quote condition of employment but their employees certainly have a right to refuse taking influenza immunization if they if they choose to.

Hugh Tilson

Thank you. Got a number of questions now about testing and related issues, quarantining and try to figure out which one to start with. If a facility had an outbreak but it's outside of their 28 day window

with no new positive cases but they're still listed on the biweekly listing of facilities with an outbreak. Do they continue weekly testing until they're removed from that list are they good to stop since they're outside of their outbreak, period.

Evelyn Cook

This is Evelyn I'll just start with that with my comments which Susan you feel free to correct me or, you know, chime in there. It would be my understanding if they're outside of that, that period that they would go back to their bi weekly they're every two weeks testing for their staff if they're completely out of that outbreak rotation that 28 days has passed, but I'm happy to report to somebody on the public health side to correct me if I'm wrong without that.

Dr. Susan Kansagra

You're correct on that Evelyn, and the communicable disease team if they're on might want to weigh into but but the requirement for testing for outbreaks is 14 days after the last positive. The, the outbreak you continue to stay on the outbreak list for 28 days and then the report that's on our website is only updated twice a week so sometimes that takes also a few additional days to catch up but their requirement for doing the weekly testing is 14 days until 14 days after your, you know, last positive case, you know, so you would have two additional cycles where you did not detect any positives. And then phase out of that testing and if you were a skilled nursing facility than would just go back to the bi weekly step testing.

Hugh Tilson

There's a question about is it one, the case or two one positive test or two or is it, lots of some questions about that.

Dr. Susan Kansagra

Yes, the recommendation around the weekly testing is after there is one or more positive cases.

Hugh Tilson

All right. Questions about the testing machines if we have an outbreak we could use the machine but if we're just doing testing to meet DHHS requirements we cannot. Does that question makes sense.

Dr. Scott Shone

So Scott so I would, I'll defer guiding the questions to my other colleagues on the phone. But from a from a straight up instrumentation and performance. Again, it's going to depend on the you know the ground truth in the situation so if you're actively responding to an outbreak or have cases, then the antigen testing instruments are within current CDC guidance as well as the guidance that I shared. If you're outside of that, if you're not having active cases or responding to an outbreak, that's where the slide I showed related to using your contract lab or your or your at your molecular lab resources should be primary just because of accuracy and sensitivity issues.

Dr. Susan Kansagra

Also Scott, right, I think, then the additional CDC guidance there, which again is really hard but but if that molecular test is not able, if you're not able to do that in a timely way you could fall back on the point of care test but really the first preference is to continue to use PCR molecular based testing, if, if it's only done for the purposes of that biweekly testing and offer an outbreak or follow up for exposure.

Hugh Tilson

Getting some follow up questions about is the requirement for weekly testing with identified positive cases applicable to ACHs or only nursing homes.

Dr. Susan Kansagra

The weekly test for one or more cases is for all types of long term care facilities, and somebody might have been chiming in on that so feel free if you want to add additional info.

Wanda

Hi this is Wanda, can you hear me. Yep. Okay, so the long term care testing guidelines, the one the CDC guidance that says testing guidelines for nursing homes. I agree with what Susan said and it is clear in this guidance where it says, while this guidance focuses on testing and nursing home, several of the recommendations such as testing residents with signs or symptoms of covid and testing asymptomatic close contacts should also be applied to other long term care facilities, they list assisted living, intermediate care for individuals with intellectual disabilities, institutions for mental disease and psychiatric residential treatment facilities as examples.

Hugh Tilson

There's a question that says, when will there be more clarity for assisted living testing guidelines? County, state does not give same messaging. Are you saying that's where they should go to get that or will there be more.

Wanda

So this guy that does mention assisted living as part of the testing recommendation. And I'll defer to anyone else for additional comments.

Evelyn Cook

One I agree with what you said and there's also a complete guidance document, specific to assisted living facilities that CDC has on their website as well. So I guess the bottom line is that if you have a case, then the recommendations are for all those other settings to test weekly.

Hugh Tilson

Got a couple questions about do we need to test EMTs, vendors, assisted living staff or hospice staff coming into the building. Are they included in the order.

Evelyn Cook

And I'll let you comment on that as well but but it's, you know, it really, it's not so much the discipline its, its your current situation. So individuals that are in your facility and remember, you know, to really look at who is coming into your facility. Now, you know, and it is not someone who really is essential and should be there, just kind of in nursing homes there's certainly still a restriction for that they're not quite as strict for adult care homes and, but you need to really reduce who's coming into your facility. But it's my understanding the recommendations for testing are related to identification of new cases, either in residents or staff within those congregate care setting.

Dr. Susan Kansagra

Yeah, and to to add to what Evelyn is saying and Trish can chime in, but the bi weekly secretarial order for skilled nursing facility staff testing, that is applicable to skilled nursing facility staff, contractors and volunteers could be considered in that. If there are, others coming in that are not staff or contractors, the regulatory requirement through that order does not necessarily apply to them certainly I think you can, you know, should still be encouraged but what we are measuring compliance says what is under your control which is your staff, your contractors and your volunteers that are coming into the facility. And if those volunteers are considered essential personnel, yeah obviously they're not they shouldn't be coming into the facility anyway. But that is what the biweekly testing requirement applies to.

Trish Farnham

And just to just to jump in on just one final point is that, that's one of the key questions that has been raised and there's the subject matter team really working to refine the guidance in a way that it can be easily shared on tomorrow's session so just know that that is going to be more formally answered tomorrow as well.

Hugh Tilson

A facilities large and has had one positive case can they divide their staff and resident testing into portions of the facility and not have to do the whole facility or does it apply to the whole facility.

Dr. Susan Kansagra

So, so there you know if a facility doesn't have a case and they're just doing bi weekly staff testing, then they're, you know, they could choose to approach it that way where they do half every other week or, you know, another method. When there's one positive case that's a little bit trickier because obviously if there's one positive case the reason you're doing that follow up testing is to determine if there is spread and waiting a full week might not make sense in that case. So there I think the answer is a little bit different, obviously, you'd want to try to test as many people as quick as possible to detect if it spread but if you're doing it for the purposes of bi weekly staff testing when there's no no cases of the facility then right you could choose to break it up that way to spread out the testing.

Hugh Tilson

If a facility uses point of care testing, do they have to report it as a lab.

Dr. Scott Shone

So, I'm not sure what they're doing to report it at the lab, but all that we are asking or requiring all test tests to be reported to the department. And I can share that guys I'm totally drawing a blank at the moment on the requirements but we have, we've issued recent messaging on this so Hugh, I'll look that up real quick and then, and can either share that or send that to you to share. Okay. The answer is yes, we need to have reporting.

Hugh Tilson

If an employee who was previously positive with symptoms four weeks ago calls out for similar symptoms now should they be set for retesting or refer them to their healthcare provider and go by the providers recommendations for retesting or length of time out of work.

Evelyn Cook

So, this one I'll start with that one if I understand the question correctly. So an employee is symptomatic with covid like symptoms, has been quarantined for their 14 days, and then developed symptoms, again, is that is that the question. Okay, so, in that particular case. I think there does need to be some clinical involvement and clinical assessment of that individual. First of all, to make sure there's not something else that might be going on. If the individual was not tested with the first onset of those symptoms, then certainly testing might want to be considered. But I think in that particular scenario you really need to involve a clinician to to assess that individual, both from a symptomology standpoint as well as the need to a need to test.

Hugh Tilson

Related question, kind of, what if a staff member test positive was away from work and has gone back to work, knows the source which is not the facility, would the facilities to have to count that as a case.

Evelyn Cook

Susan, well I think that's considered to be a community exposure but I mean you would, but I'm not sure about those definitions so if employees getting assigned to the their employment facility versus a community exposure.

Dr. Susan Kansagra

Yeah, I'll defer to Teresa or Wanda if they have additional info, I know the local health departments, when they come in to do the initial outbreak investigation or do that assessment, you know they are making you know they might be asking additional questions and there may be some determination there but but I think we have to follow up on that unless Teresa or Wanda you have additional info.

Teresa Fisher

Oh, that's okay, I would, I would agree with Susan, we have when we have a case in a facility we really have to look at it, we have made a few notes on the outbreak but usually when there's two or more, we have to take that into consideration. So yes, it definitely needs to be followed up. And you can contact us and we will look through that but it probably would be considered.

Hugh Tilson

Got a question about employees that have tested negative and feel healthy but have been exposed CDC recommends 14 day quarantine anyway, how does this apply to essential workers are there any best practices that can help minimize potential employee laying out using the quarantine requirement. Any thoughts about that.

Evelyn Cook

So I saw, again, this is Evelyn and I'll start with that. So CDC does have guidance for mitigating staffing shortages, it isn't an essential worker and you're in a staffing shortage pattern. You know certainly reaching out to your coalition and to watch your -- doing is really vital to that, that whole process as well. But you really do need to walk through those steps, because that individual should be quarantined, if at all possible, and in those steps of mitigation should be addressed before other considerations are put into play.

Hugh Tilson

There's a similar question if we have a positive test results with antigen testing in a setting with no known or suspected cases, do we isolate while waiting for PCR results or do we wait for the PCR test results first.

Evelyn Cook

I'll start with that from an infection prevention perspective and then Scott can chime in or Susan that my, my thoughts would be you would, if you have a positive antigen testing and you're going to do a follow up PCR. My thoughts would be that you should go ahead and implement precautions until you get those confirmatory results.

Dr. Scott Shone

This is Scott, I agree 100%.

Hugh Tilson

Got a follow up question, please clarify, are we testing our residents bi weekly as well, or just staff. We're a negative building and I'm assuming this is a nursing home.

Dr. Susan Kansagra

Just staff.

Hugh Tilson

Clarify a previous question on POC testing guidances if you use testing equipment, we are considered a lab, requirements for reporting as a lab are cumbersome. Do we have to report testing as a lab would? I think you're working on that Scott.

Dr. Scott Shone

Yeah. So in order to, I mean if you have a, if you're if you're doing testing you have a CLIA waiver. So you are defined by CLIA as a wave you know laboratory. And the, the state health director order does require reporting of all providers and laboratories doing testing. And so there are mechanisms being developed as well as current, to help facilitate reporting antigen testing results. We understand that the point of care tests presents unique challenges to collecting these data resources and we have a whole work stream at the department pursuing streamline methods for getting this data in.

Hugh Tilson

Got another follow up question I'm still not clear on assisted living staff testing if the nursing facility is a CCRC. Still not, can you clarify that again.

Dr. Susan Kansagra

So the requirement and Tricia help me with this, but the requirement for the bi weekly skilled nursing facility testing applies to skilled nursing facility staff. Now if you are sharing staff across the adult care home and new staff are also working in the skilled nursing facility, then yes they would apply under the order. If you have staff that you know you let's say your buildings are completely separate and you have staff that are only in the adult care facility and don't ever go to the skilled person side, then no, they are not technically considered in the order you can certainly, you know, consider testing but they're not technically considered under the secretarial order which applies to skilled nursing facilities, Trish you want to add anything else.

Trish Farnham

Yeah, no that's that's very clear and CCRC contacts specifically again the scope of the order like Dr K said is specific to the nursing home component of the community. And so that would be true, not only for the testing requirement but how you calculate your census and other things like that. And we, again, that's one of those areas that we're fine tuning the publicly facing guidance. Thanks for the question.

Hugh Tilson

How does this apply to psychiatric residential treatment facilities and what about in acute psych hospitals?

Trish Farnham

If the question is in the context of secretarial order number two, if those those two types of facilities are not covered under the scope of the order. The testing best practice may be similar and that would be a public health question but as far as the required reporting requirements, and the availability of CARES Act funding, those types of facilities are outside the scope of the order.

Hugh Tilson

If you have a positive test from the point of care and you send a sample to the lab that is negative, is the first test of false positive and is there a formal definition for a false positive.

Dr. Scott Shone

So, the, the, well the answer to a false positive is that if, and I get asked this question all the time is that you know routinely for for clinical laboratory tests, a false positive would be if a test is positive and then there's the absence of any other indications of the disorder and further the tests are negative, from an epidemiologic standpoint and I'm not an epidemiologist or infection control practitioner but typically they, not even typically, the instructions have been that positive as a positive and you should follow it up that way, that the scenario here the unfortunate scenario with the guidance has come out and the use of these antigen tests, is that in certain scenarios. And this low pretest probability so completely asymptomatic population with no known cases, no known exposures, testing positive on an on an antigen test requires confirmation. But absent that if an imaging test is positive, in a scenario where the pretest probability is relatively high, that's, that is it, regardless of what a subsequent test is, that positive test holds and should be treated as such. So, you know, there are there are a variety of issues a variety of reasons why a test on a different day we'll come up with a different answer. I mean that's the case with, with most laboratory tests, not just covid and so we're seeing with viral dynamics and shedding can change and different tests have different sensitivities. So, if you, if you're using this antigen test in your facility where you have cases or have ongoing transmission and somebody comes up positive, that, that, that is positive should be treated as positive and even if a nasal swab comes up negative the next day or two days later, that person should the guidance on a positive case should be followed.

Hugh Tilson

Thanks, Scott. Thanks everybody. Very informative discussion we're at a time, though we didn't get to all the questions, we will forward all the questions, so that they can help to inform subsequent webinars. So Susan or Evelyn or anybody else any final comments before we say goodbye for a couple weeks

Evelyn Cook

Yeah. Thank you guys for, for, for joining the call and we we do recognize that you know that there are no easy answers sometimes and we do understand that and we'll just try to answer any questions that we didn't have a chance to get to today.

Dr. Susan Kansagra

Great. I think that's it thank you all.

Hugh Tilson

Thanks everybody. Take care.