

FAQs for Long Term Care and Assisted Living Facilities

July 8, 2020

Today's Overview



NH Updates and Resources



Pre-submitted Questions



Follow up Q&A

Updated NH Resources

- ▶ ESU Supply Request - Gown and Surgical Mask
 - Submit your order by Friday, July 10th
 - Order from this link: https://prd.blogs.nh.gov/dos/hsem/?page_id=8673
 - Delivery within 3 weeks beginning on July 13
 - No cost to the facility
- ▶ Travel guidance: follow current Travel Guidance for LTCF

Hot Topic: Airborne Transmission

- ▶ Respiratory droplets are main driver SARS-CoV-2 transmission; however, 239 scientists from 32 countries challenging that in open letter to WHO
- ▶ Authors argue airborne transmission playing a larger role in pandemic
 - Droplet transmission risk mitigated via physical distancing and barriers like face shields and face masks
 - Airborne transmission suggests virus particles could linger in the air for prolonged periods of time and/or travel longer distances

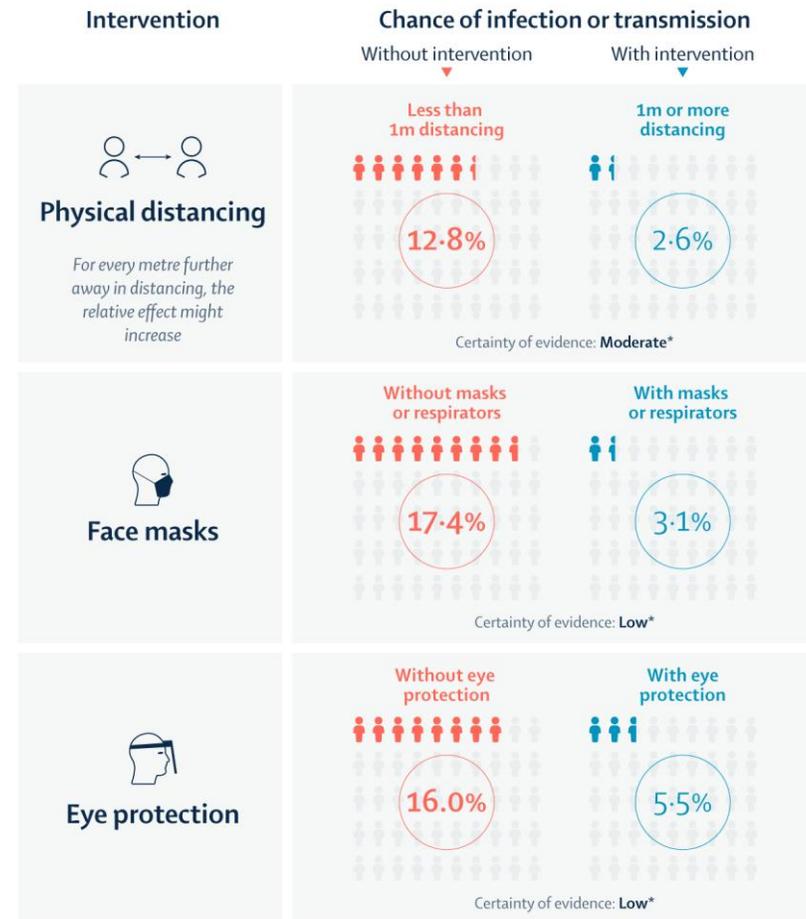
Public Health Authority Responses

- ▶ Definitive evidence of human-to-human transmission solely by microdroplets does not exist
- ▶ When droplet/contact precautions and PPE are available and used appropriately very few infections occur
- ▶ COVID-19 has been controlled in many countries without having to purchase, fit test, and train entire populations with N95 masks
- ▶ Possible limited role of certain types of indoor ventilation systems in viral spread under investigation
 - No transmission via HVAC systems has been documented, although SARS-CoV-2 RNA can be isolated from air handlers

Lancet PPE Review

- ▶ Studies done in health care settings re:SARS-CoV-1, -2, MERS
- ▶ Distancing >3ft reduces risk of transmission by 82%, compared with <3ft
 - Increased as distance lengthened
- ▶ Face mask use 85% reduction
 - Stronger associations with N95 or similar respirators compared to surgical masks
- ▶ Eye protection 78% less infection

What protects against COVID-19 infection or transmission?



* See the paper below for full explanations of certainty and why these categories are used. Moderate certainty: we are moderately confident in the effect estimate; the true effect is probably close to the estimate, but it is possibly substantially different. Low certainty: our confidence in the effect estimate is limited; the true effect could be substantially different from the estimate of the effect.

Even when properly used and combined, none of these interventions offers complete protection and other basic protective measures (such as hand hygiene) are essential to reduce transmission

Chu DK, Akl EA, Duda S, et al. Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis. *Lancet* 2020. Published online June 1.

Next (and Usual/Intuitive) Steps

- ▶ WHO expert committees are going over evidence and plan to release updated recommendations in a few days
- ▶ Avoid the “three Cs”: closed spaces, crowds and close contact

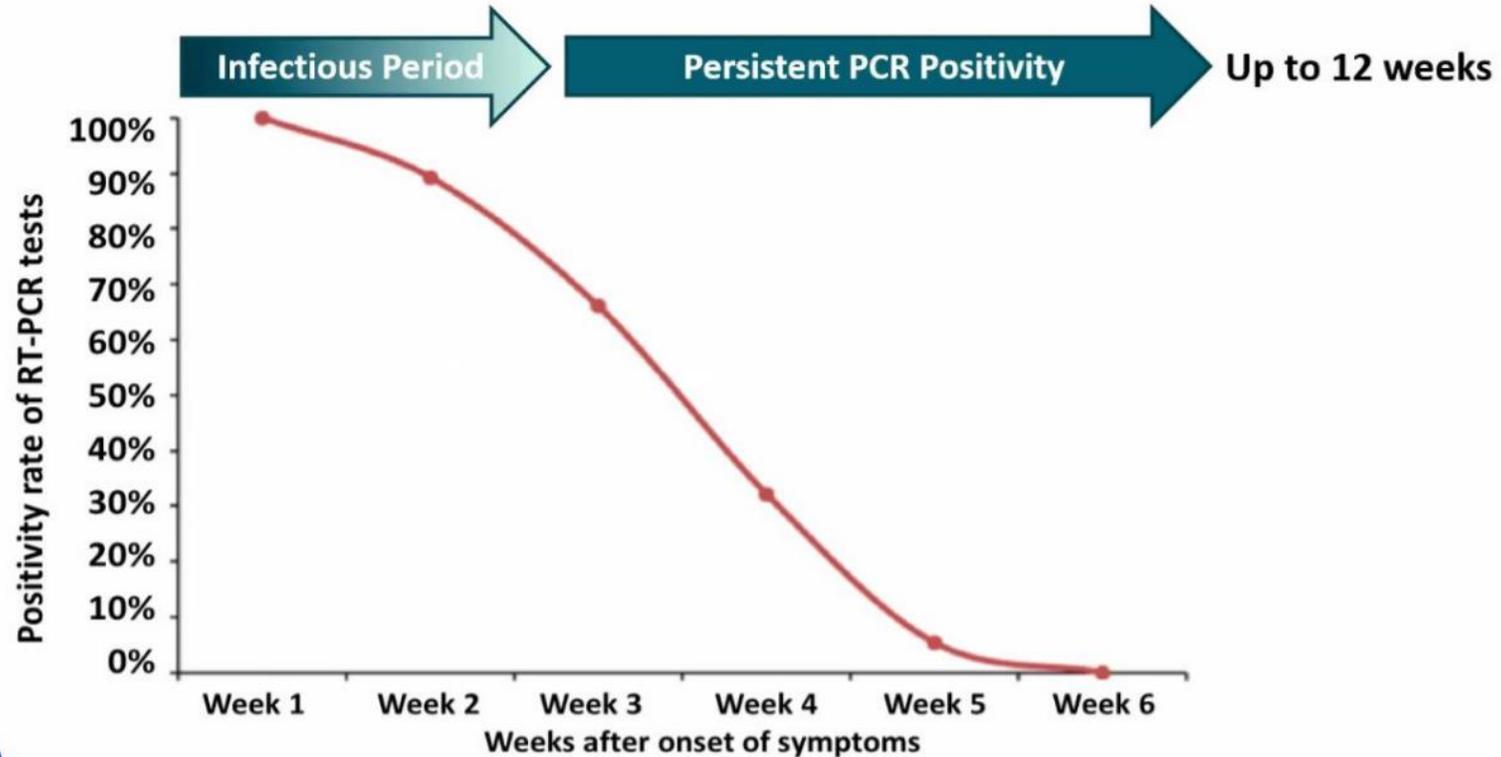
Pre-Submitted Questions

PCR Testing Strategies

- ▶ “CDC Guidance is to resume sentinel testing of past-positive staff and residents after 8 weeks following onset/initial positive test. Our HAI has indicated that NH does not yet have guidance for this and has recommended that we hold off on re-testing prior positives at this time. Is there an estimated timeline for NH guidance for resumption of testing for these individuals?”
- ▶ “If a COVID-recovered employee's family member (living in the same household) later tests positive (within 3 weeks of the employee's positive), must the employee still quarantine?”

Relapse vs Leftover RNA?

PCR Can Remain Positive for Weeks After Recovery



Xiao 2020, *Clin Infect Dis*; doi.org/10.1093/cid/ciaa460. Li 2020, *J Med Virol*; doi: 10.1002/jmv.25952.

Valid as of June 20, 2020

Reassuring Data

Korean “Re-positives After Discharge”: Cases Assessed as Not Infectious

Among 447 “re-positive” cases after discharge, investigated contacts of 285

- “Re-positive” cases identified 8-81 days after discharge (median 45 days)
- Monitored their 790 contacts for 14 days → **no attributable infections observed**

Among 108 “re-positives” tested, no positive cultures

- Ct values were captured for 68 persons → 11% Ct 25-30 and 89% Ct >30
- Times since illness onset for culture-negative range 8 to 81 days
- Viral culture protocol include serial passage (i.e., met CDC standard)

No longer requiring tests after being discharged from isolation

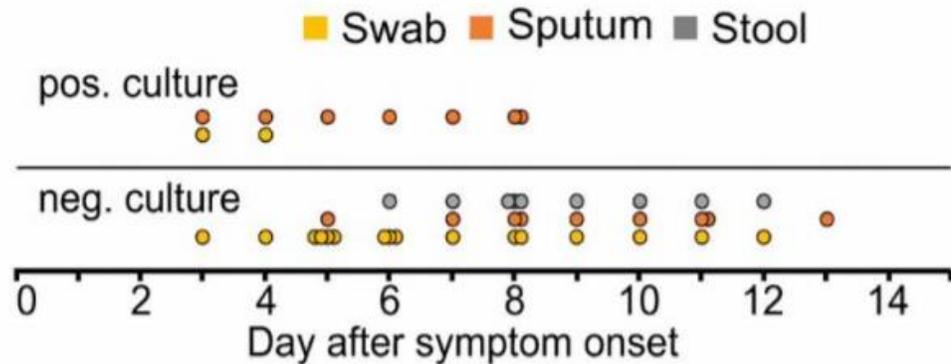
- “PCR re-detected after discharge from isolation”
- Discharge from isolation required two consecutive negative PCRs \geq 24 hours apart.



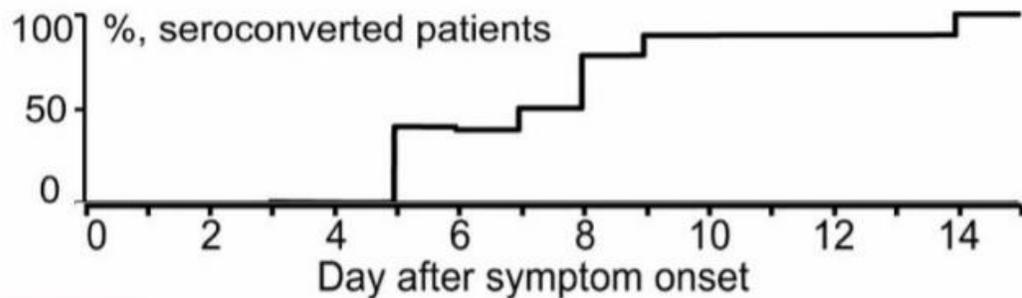
https://www.cdc.go.kr/board/board.es?mid=a30402000000&bid=0030&act=view&list_no=367267&nPage=1

Valid as of June 20, 2020

Ability to Culture Virus from Specimens Declines as Serologic Response to Infection Grows



- After 8-10 days, replication-competent virus can no longer be recovered from respiratory tract specimens, in otherwise healthy persons with mild to moderate illness.
- In severely ill and immunocompromised persons, shedding of culturable virus may persist up to 20 days



- Within days after symptom onset, patients begin to develop serologic response to infection that includes IgM, IgG, and IgA.
- IgG response includes neutralizing antibodies.



Wölfel 2020, *Nature*; doi.org/10.1038/s41586-020-2196-x. van Kampen 2020, *medRxiv*; doi.org/10.1101/2020.06.08.20125310

Valid as of June 20, 2020

Last Week's FAQ Follow-up

“Can students resume clinical rotations?”

- ▶ No, students would not be allowed under CMS guidance to “restrict non-essential personnel”
- ▶ However, if a facility is experiencing staffing shortages, it may be appropriate to allow students to work to provide adequate care to residents

First PPE Question

- ▶ “In DPHS guidance dated June 16th under compassionate visits, the visitor was required to wear full PPE; then in June 30th guidelines, under the questions and answers for handling of family member visits for hospice residents, it says "provide asymptomatic visitors a face mask"; so can we get clarification on proper PPE for end of life/compassionate care visitors, if facility is Covid free.”

“What PPE is required for new-admission/quarantine units?”

- ▶ For residents on observation/quarantine, staff should wear full PPE whenever in the resident room (see [CDC guidance](#))
 - Surgical mask is sufficient
 - No need for an N95 unless aerosol generating procedure

“How to optimize gown use on new-admission/quarantine units?”

- ▶ In the event of PPE shortages, reference CDC’s [crisis strategies](#)
- ▶ PPE optimization strategies are based on your local situation, PPE supplies, and assessment of risk
 - Some suggestions from the Cluster Investigation unit:
 - Bundle care being done (LNA delivers meal tray and also does ADL care, or nurse brings in tray with meds/vitals/assessment care)
 - In a shortage of gowns, CDC states that gowns can be prioritized for care where splashes/sprays/high-contact is anticipated
 - Utilize reusable gowns
 - Extended use of gowns for meal delivery
 - Use one gown to deliver meals to residents in a single cohort
 - No direct contact with the resident
 - Change gowns if the resident coughs or sneezes or if contact occurs

Other Follow-up Questions

- ▶ Can you confirm that a hairdresser exclusively works for one facility, no outside clients, is screened prior to each shift, is trained on PPE and is tested each week, is able to provide hair services (excluding blow drying and hair dryer). (Essentially, this person is an employee)
 - *If this hairdresser is an currently an employee, than yes. Do not bring in additional staff at this time. Non-essential personnel are still restricted*
- ▶ Do COVID + employees, that have recovered and back to work, have to be part of the testing surveillance program?
 - *No, currently employees that have recovered from COVID-19 are excluded from the sentinel surveillance program*

Additional Q&A?