office of the governor of the commonwealth of virginia

GOVERNOR'S COVID-19 LONG-TERM CARE TASK FORCE

Dr. Laurie Forlano, Deputy Commissioner of Population Health, VDH
Gena Berger, Chief Deputy Commissioner, DSS

July 9, 2020

Welcome and Housekeeping Items

- Please mute your phone (do NOT put us on hold) if you are not speaking
- We prefer to take questions/comments at the end of each agenda item
    - Feel free to utilize the chat box

Overview of Agenda

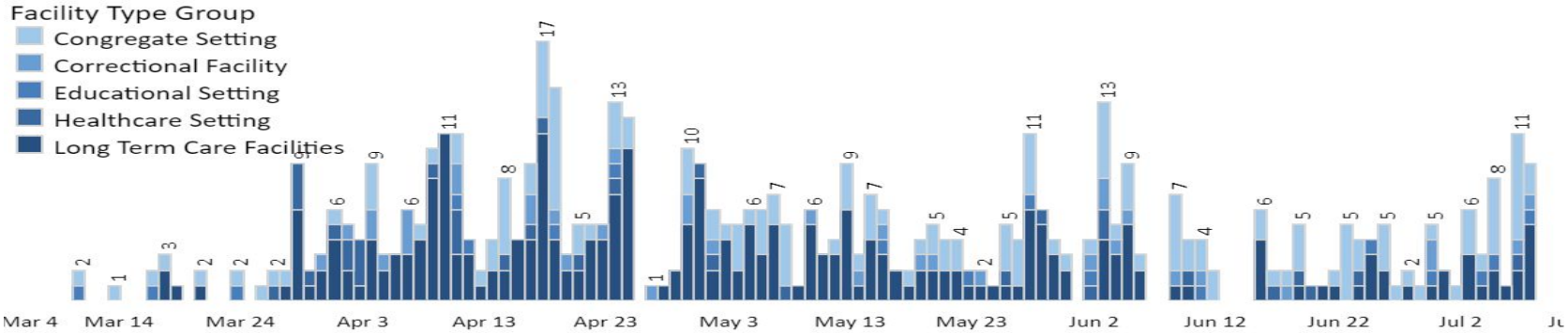
- Data Update
- Phased Reopening Guidance
- Testing Updates
- Infection Control
- Fit Testing Train the Trainer
- Financing
- Discussion
- Next Steps

COVID-19 Outbreaks in Virginia

Cases and Deaths by Outbreak Facility Type - State Totals

Long Term Care Facilities	Cases	7,089
	Deaths	1,149
Congregate Setting	Cases	2,453
	Deaths	34
Correctional Facility	Cases	1,988
	Deaths	11
Healthcare Setting	Cases	237
	Deaths	10
Educational Setting	Cases	87
	Deaths	0

Number and Facility Type of Outbreak by Date VDH Notified



Point Prevalence Surveys: Between 4/21 & 7/05

587 Requests Received:

7 On Hold
58 Received
123 Scheduled
12 Specimen Collection
37 Testing
29 Withdrawn
321 Closed

By Setting:

341 Long-Term Care Facility
37 Correctional Facility
9 Business Place/Other
1 Educational Setting
199 Community Testing

Phased Reopening: Nursing Homes

Additional documents posted:

- Nursing Home Reopening Guidance FAQs
- LTCF Playbook to Access Resources (updated July 6)

Nursing homes in Phase I:

- 43

Nursing homes in Phase II:

- 2

Reopening briefings completed

- VDH local health departments (x2)
- Regional healthcare coalitions
- LeadingAge Virginia (x2)
- VHCA/VCAL
- DARS (Ombudsman network)

Phase II and III Testing Recommendations

Test symptomatic staff and residents	
If testing identifies a **NH-onset case**	If testing identifies a case in a **staff**
Facility should regress to Phase I, including Phase I regression testing recommendations	**Test all staff and residents that are identified as close contacts.** In the event identifying close contacts is too labor intensive and will delay testing, testing could include staff in the same work unit as the index case and all residents on the same floor/unit/wing as the index case. ● Testing should continue weekly until there are no new cases among staff or nursing home-onset cases for the previous 14 days **If a NH-onset case is identified** ● Follow Phase I regression testing recommendations. **If *additional* staff cases or resident cases not classified as NH-onset are identified,** testing of all staff and all residents should be conducted ● Testing should continue weekly until there are no new cases among staff or nursing home-onset cases for the previous 14 days (at a minimum weekly testing should occur twice). Identification of a NH-onset case triggers regression to Phase I, including Phase I regression testing recommendations.

Phase II and III Testing Recommendations (cont)

Test symptomatic staff and residents
If testing identifies a case in a resident that is **not classified as NH-onset case**
Test all staff and residents that are identified as close contacts. In the event identifying close contacts is too labor intensive and will delay testing, testing could include all residents on the same floor/unit/wing as the index case and staff members working on the same floor/unit/wing as the index case. ● If no additional cases are detected, repeat testing is not recommended. ● If a NH-onset case is identified, the facility should follow Phase I regression testing recommendations. ● If *additional* staff cases or resident cases not classified as NH-onset are identified, testing of all staff and all residents should be conducted, except those previously tested positive within less than 8 weeks. ○ Testing should continue weekly until there are no new cases among staff or nursing home-onset cases for the previous 14 days.

Phase I Regression Testing Recommendations

Test all staff and all residents weekly. Testing should continue weekly until there are no new cases among staff or NH-onset cases for the previous 14 days.

Once the facility is no longer testing staff and residents weekly: Immediately test any resident or staff with symptoms.

If testing identifies a **NH-onset case or a staff case**:

- Test all staff and all residents weekly, except those previously testing positive within less than 8 weeks.
  - Testing should continue weekly until there are no new cases among staff or nursing home-onset cases for the previous 14 days (at a minimum weekly testing should occur twice).

If testing identifies a resident case that is **not classified as a NH-onset case**:

- Test all staff and residents identified as a close contact. In the event identifying close contacts is too labor intensive and will delay testing, testing could include all residents on the same floor/unit/wing as the index case and staff members working on the same floor/unit/wing as the index case.
  - If no additional cases are detected, repeat testing is not recommended.
  - If additional cases are detected, testing of all staff and all residents should continue weekly until there are no new cases among staff or NH-onset cases for the previous 14 days.

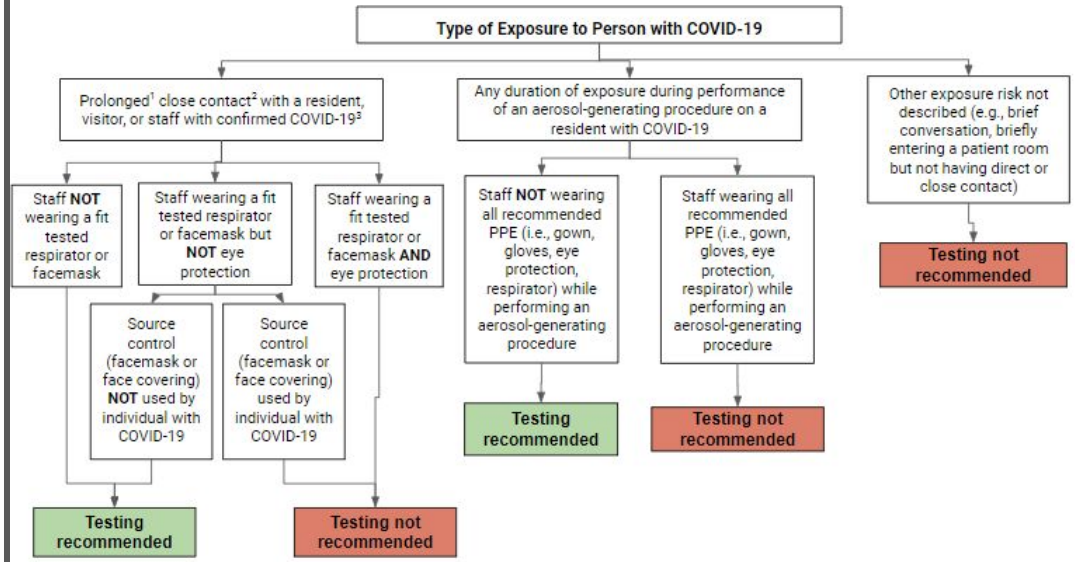
Additional Information

Re-testing Previous Positives
When testing is indicated, asymptomatic individuals who have previously tested positive greater than 8 weeks prior should be re-tested. Residents and staff who had a positive viral test at any time and become symptomatic after recovering from the initial illness should be re-tested. See CDC guidance for more information.

NH-onset Case
Positive result in a resident with an unknown COVID-19 status or negative status on admission after the resident has been admitted for at least 14 days • Note: A resident that previously tested positive and now retests positive, is not considered a NH-onset case. It is unknown at this time whether an individual can be re-infected. This guidance may be updated as we learn more information on viral persistence and risk for reinfection.

Identifying Close Contacts for Testing

Assessing Staff



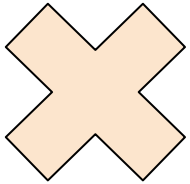
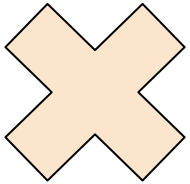
Adapted from the VDH Guidance for Assessing and Managing Exposed, Asymptomatic Healthcare Personnel.

Assessing Residents

Identify residents who were within 6 feet of an infected person for at least 15 minutes starting from 2 days prior to symptom onset (or, for asymptomatic individuals, 2 days before positive specimen collection) through the time period when the individual meets criteria for discontinuation of Transmission –Based Precautions.

Definition is based on CDC Contact Investigation Guidance.

Comparing VDH and CMS Recommendations

	CMS Recommendations	VDH Recommendations
Phase II	• Test all staff weekly. Test all residents upon identification of an individual with symptoms consistent with COVID-19, or if staff have tested positive for COVID-19. Weekly testing continues until all residents test negative.	
Phase III	• Test all staff weekly. Test all residents upon identification of an individual with symptoms consistent with COVID-19, or if staff have tested positive for COVID-19. Weekly testing continues until all residents test negative.	

https://www.cms.gov/files/document/qso-20-30-nh.pdf-0

Comparing VDH and CDC Recommendations

CDC Recommendations	VDH Recommendations
• At least daily, take the temperature of all residents and ask them if they have any COVID-19 symptoms. Perform viral testing of any resident who has signs or symptoms of COVID-19.	
• Perform expanded viral testing of **all** residents in the nursing home if there is an outbreak in the facility (i.e., a new SARS-CoV-2 infection in any HCP or any nursing home-onset SARS-CoV-2 infection in a resident). ◦ A single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected with SARS-CoV-2 who can continue to spread the infection, even if they are asymptomatic. Performing viral testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent SARS-CoV-2 transmission. ◦ When undertaking facility-wide viral testing, facility leadership should expect to identify multiple asymptomatic and pre-symptomatic residents with SARS-CoV-2 infection and be prepared to cohort residents. See Public Health Response to COVID-19 in Nursing Homes for more details. ◦ If viral testing capacity is limited, CDC suggests first directing testing to residents who are close contacts (e.g., on the same unit or floor of a new confirmed case or cared for by infected HCP). ◦ See Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes for additional details.	 

Comparing VDH and CDC Recommendations

CDC Recommendations	VDH Recommendations
• After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below. Repeat testing should be coordinated with the local, territorial, or state health department.	→ ✓
• Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission.	
○ If viral test capacity is limited, CDC suggests directing repeat rounds of testing to residents who leave and return to the facility (e.g., for outpatient dialysis) or have known exposure to a case (e.g., roommates of cases or those cared for by a HCP with confirmed SARS-CoV-2 infection). For large facilities with limited viral test capacity, testing only residents on affected units could be considered, especially if facility-wide repeat viral testing demonstrates no transmission beyond a limited number of units.	→ ✓

https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

Testing Recommendations

- Will be reviewed on a regular basis
  - Will be updated as more information is known

- Considerations
  - Testing capacity
  - Testing technology
  - Community transmission

Infection Prevention and Control Assessment (IPCA)

- HHS proposal for IPCA teams; fulfilled by the Veterans Administration

- Timeline & Schedule
  - IPCA teams began assessments June 24
  - 30 day deployment
  - 12 teams of 2 infection control nurses distributed by district
  - Each team visits one facility per day to conduct assessment and provide education/training
  - Voluntary, non-regulatory assessment
- Tool
  - CDC: Infection Prevention & Control Assessment Tool for Nursing Homes Preparing for COVID-19

- A facility can still sign up for an IPCA through July 24, 2020
  - Contact Angela Spleen at 804-239-2273 or angela.spleen@vdh.virginia.gov

Infection Prevention and Control Assessment (IPCA)

As of July 7, 2020:

- Conducted
  - 73 IPCAs
  - 1 LHD training on IPCAs
- Scheduled for July 8-24
  - 72 IPCAs
  - 6 LHD training on IPCAs

Infection Prevention and Control Assessment (IPCA)

Notable findings include:

- PPE shortages
  - Facilities struggling with prioritization, extended use /reuse of N95s, gowns
  - Fit-testing and respiratory protection education is needed; increased supply of respirators that match the fit test
- Lack of sound cohorting practices especially with large number of positive residents
- Incomplete implementation of containment measures including universal masking, social distancing, restrictions of visitation and communal dining
- Many facilities reported strong staff education activities, but lack competency checks including regular auditing/monitoring of IPC practices (HH and proper PPE donning and doffing)
- Environmental cleaning and disinfection education needed for appropriate product selection and dilution instruction
- Questions regarding safe communal dining, pet therapy, outdoor visitation, proper use of cooling fans

IPCA Findings Drive Change

- Results from the assessments will be used to identify IPC gaps
- Guide LTCF program activities including education and training activities
- Identify regional needs and target assistance resources

Planning for Influenza Season

- Vaccination of residents
- Vaccination of staff
- Order vaccination supplies

N95 Respiratory Fit Test Train the Trainer

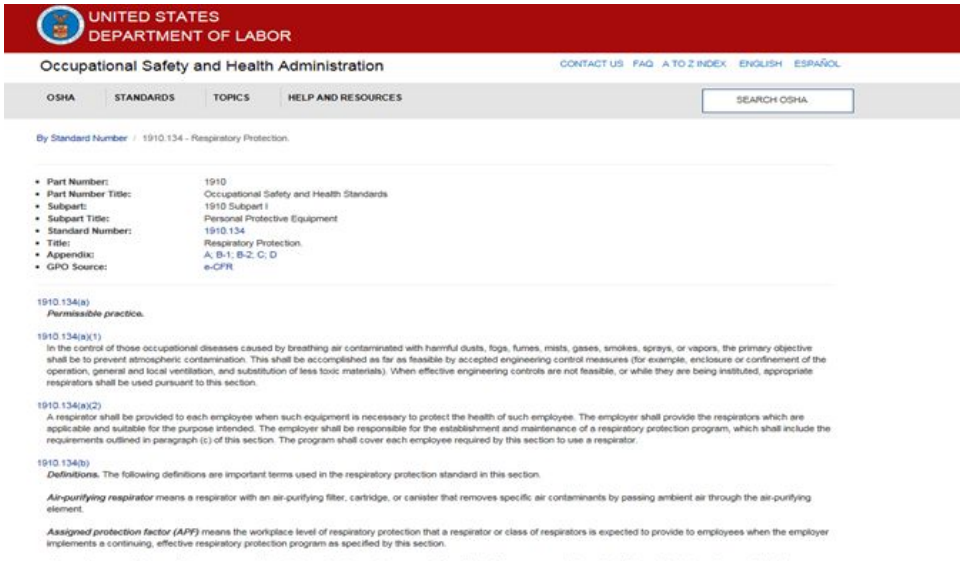
Suzi Silverstein

suzi.silverstein@vdh.virginia.gov

804-864-7538

OSHA Respirator Protection Standard (29 CFR 1910.134)

https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134



UNITED STATES
DEPARTMENT OF LABOR

Occupational Safety and Health Administration

CONTACT US FAQ A TO Z INDEX ENGLISH ESPAÑOL

OSHA | STANDARDS | TOPICS | HELP AND RESOURCES | SEARCH OSHA

By Standard Number / 1910.134 - Respiratory Protection.

- Part Number: 1910
- Part Number Title: Occupational Safety and Health Standards
- Subpart: 1910 Subpart I
- Subpart Title: Personal Protective Equipment
- Standard Number: 1910.134
- Title: Respiratory Protection.
- Appendix: A; B-1; B-2; C; D
- GPO Source: e-CFR

1910.134(a)
Permissible practice.

1910.134(a)(1)
In the control of those occupational diseases caused by breathing air contaminated with harmful dusts, fogs, fumes, mists, gases, smokes, sprays, or vapors, the primary objective shall be to prevent atmospheric contamination. This shall be accomplished as far as feasible by accepted engineering control measures (for example, enclosure or confinement of the operation, general and local ventilation, and substitution of less toxic materials). When effective engineering controls are not feasible, or while they are being instituted, appropriate respirators shall be used pursuant to this section.

1910.134(a)(2)
A respirator shall be provided to each employee when such equipment is necessary to protect the health of such employee. The employer shall provide the respirators which are applicable and suitable for the purpose intended. The employer shall be responsible for the establishment and maintenance of a respiratory protection program, which shall include the requirements outlined in paragraph (c) of this section. The program shall cover each employee required by this section to use a respirator.

1910.134(b)
Definitions. The following definitions are important terms used in the respiratory protection standard in this section.

Air-purifying respirator means a respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through the air-purifying element.

Assigned protection factor (APF) means the workplace level of respiratory protection that a respirator or class of respirators is expected to provide to employees when the employer implements a continuing, effective respiratory protection program as specified by this section.

Training Course Content

- OSHA respiratory protection standards
  - Written Respiratory Protection Plan and Administrator
  - Medical evaluation prior to use of respirator
  - Documented annual training and fit testing
- Potential work –related respiratory hazards
- Function, capabilities and limitations of the selected respiratory protection
- How to inspect, don, and remove, check seals, and wear respirator properly
- Medical signs and symptoms that might limit or prevent effective use of respirators
- Hands on practice fit testing

Regional Sessions

• June 30-July 1	Fairfax	35 attendees
• July 2	Harrisonburg	52 attendees
• July 7	Richmond	43 attendees
• July 8	Newport News	41 attendees
• July 13	Richmond	
• July 16	Portsmouth	
• July 28	Wytheville	
• July 29	Roanoke	

Advanced Preparation

- Training is Free-registration is required
  - http://va.train.org Course ID 1046592
- OSHA Medical Questionnaire Form
  - https://va.train.org/DesktopModules/Documents/ViewDocument.aspx?LcmsItemID=766
- Signed Medical Recommendation Form
  - https://va.train.org/DesktopModules/Documents/ViewDocument.aspx?LcmsItemID=767

Fit Test Kit AND N95 mask

N95 Fit Test Kits

- Kit contains hood, collar assembly, nebulizers, solution
- Vendor list on VDH webpage
  - https://www.vdh.virginia.gov/emergency-preparedness/n95-respiratory-fit-testing-train-the-trainer/

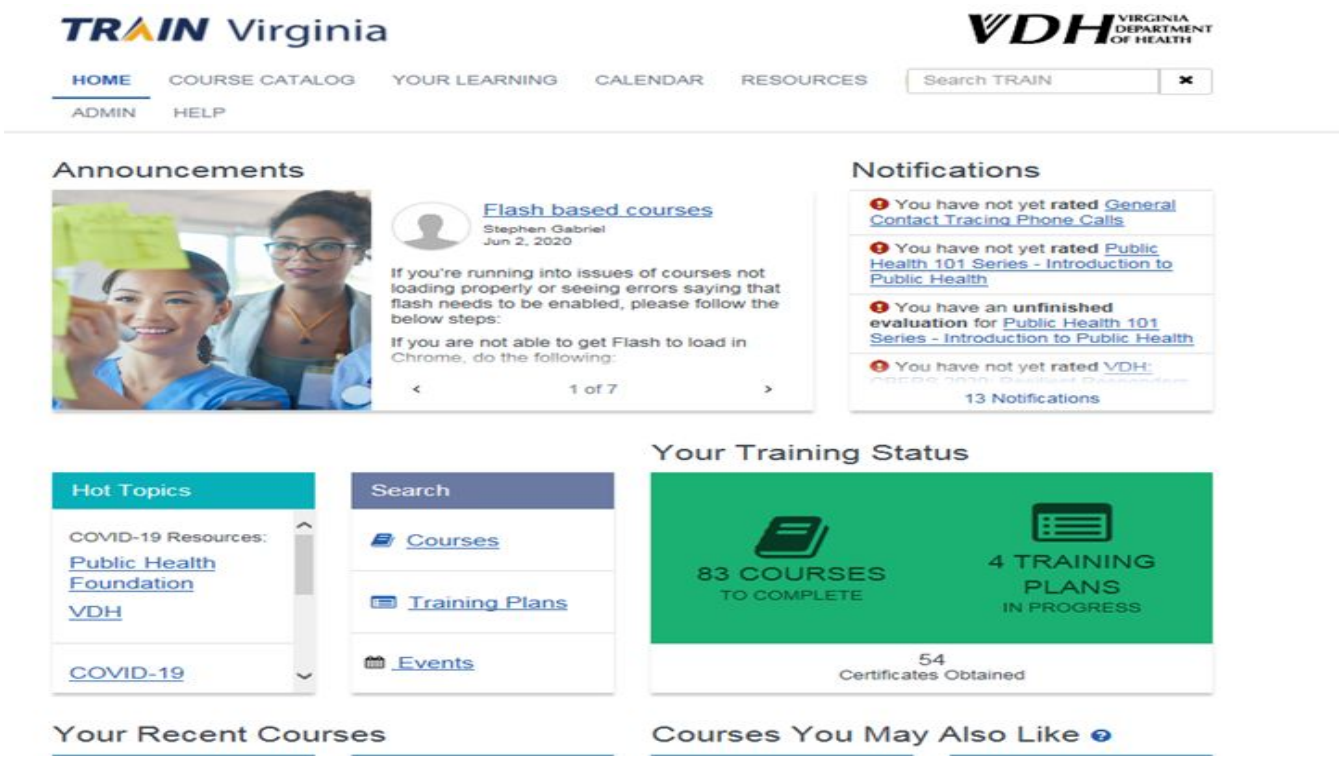
Course Material

- N95 Fit Test Train-the-Trainer Training
  - https://www.vdh.virginia.gov/emergency-preparedness/training-education/
- Powerpoint
- Videos
- OSHA Standard
- Forms
- Steps to Fit Test Job Aid
- Respirator Fit Test Record

Airborne Pathogens Course

- Online module
- http://va.train.org Course ID 1087669
- High level overview of airborne pathogens: what it is, how it is spread and how to protect yourself
- Objectives:
  - describe the airborne pathogen risk in your role
  - Identify when respiratory protection needs to be used
  - Recognize various airborne pathogens and the nature of these communicable diseases

http://va.train.org



Accessing CARES Act Funding

- Payments will be based on expenses have to be related to Covid-19 and those expenses must be documented.
- Any eligible expenses will be offset by other sources of funding (primarily the Provider Relief Fund and the existing $20 per diem DMAS pays under the Budget language approved during the reconvene).
- Total eligible expenses per facility will vary based on whether they are having an outbreak (for NFs), how many residents they have, and if they have auxiliary grant recipients (for ALFs).

Proposed Funding Schedule (Subject to Change):

- **July 1, 2020 - Eligible costs begin date**. Nursing facilities and assisted living facilities should make sure they are documenting their COVID-19 related costs for future invoicing.
- **Week of July 13th - DMAS awards administrative support contract.** DMAS will contract with an external vendor to support communication with recipients, receipt of invoices, and review and audit of submissions.
- **Week of July 27 - DMAS or Admin Vendor will send communications** to nursing facilities and assisted living facilities outlining the process for submission and necessary documentation, with enrollment, invoice and cost reporting/reconciliation forms.
- **Week of August 3 - Invoices Start Being Accepted / Facilities Enroll for Payment.** Facilities can submit invoices and necessary support documentation for costs incurred during July, 2020. Facilities will also have to document funds received from the Provider Relief Fund and DMAS's $20 per diem increase to calculate allowable expenses. Facilities will also have to submit required documentation for enrollment to be paid under this program. Please note, even if a nursing facility is already enrolled as a Medicaid provider, they will have to enroll separately to be paid under this CRF-funded program.
- **Week of August 27th - DMAS begins making payments**. DMAS will process payments on a rolling basis every two weeks following the initial submissions as they are processed by the support vendor.
- **October 31, 2020 - Eligible costs end date**. Facilities should submit no costs incurred after October 31 for reimbursement. DMAS and vendor will not accept documentation for costs incurred after this date.
- **December 1 - Final documentation due.**
- **December 25 - DMAS makes final payments.**
- **December 30 - All CARES Act Funding must have been expended.**
- **March 31, 2021 - Audits/reviews of funds are completed** and DMAS sends out any recovery notices. These funds will be returned to the Federal Government consistent with CARES Act Guidance.

Discussion

Next steps