Chiles Healthcare Consulting LLC
1908 Maple Shade Lane, Richmond, Virginia 23227
mary@chileshealthcare.com 804-690-5824

FOCUS POINT NEWSLETTER
FOCUS POINT COVID ALERT – 7/16/2020

VDH Updated Nursing Home Guidance for Phased Re-Opening

On July 13, 2020, VDH issued Updated VDH Nursing Home Guidance for Phased Reopening . The complete document can be found here.

The summary and location of changes in the guidance is below:

Updated Definition of NH-onset Case (page 4)

A resident that previously tested positive and now retests positive, is not considered a NH-onset case. It is unknown at whether an individual can be re-infected. This guidance may be updated as we learn more information on viral persiste reinfection

- Removed testing recommendations from Section 4 (page7) and added a new section 5 for testing recommendations
- Updated Phase I testing recommendations to include testing surrounding identification of a resident case not classified as NH-onset case (page 9)
- Added Phase II and III testing recommendations) page 10-11)

Phase I Testing Recommendations

During or before Phase I, test all staff AND all residents weekly (**except those previously testing positive within the past 8 weeks).** Testing should continue weekly until there are no new cases among staff or nursing home (NH)-onset cases in residents for the previous 14 days (at a minimum weekly testing should occur twice). Symptomatic staff or residents should be tested immediately.

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

1.If testing identifies **a NH-onset case (see definition page 4) or a staff case:**

- Test all staff and all residents, except those previously testing positive within the past 8 weeks.
  a. If no additional NH-onset cases or staff cases are identified, repeat testing of all staff and all residents. Ideally, repeat testing would occur one week from the previous specimen collection date.
  b. If no NH-onset cases or staff cases are identified, no further weekly testing is recommended
  c. If additional NH-onset cases or staff cases are identified, repeat testing should continue weekly until there are no new cases among staff or nursing home-onset cases for the previous 14 days (or two consecutive rounds of testing with no additional NH-onset cases or staff cases).

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

- Test staff and residents identified as a close contact (see definition pages 11-12). 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.
  a. 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 (or two consecutive rounds of testing with no additional NH- onset cases or staff cases).

Testing Recommendations for Phase I Regression

Test all staff and all residents weekly, except those previously testing positive **within the past 8 weeks.** Symptomatic staff or residents should be tested immediately.

- Testing should continue weekly until there are no new cases among staff or NH-onset cases for the previous 14 days (or two consecutive rounds of testing with no additional NH-onset cases or staff cases).

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

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

- Test all staff and all residents, except those previously testing positive within the past 8 weeks.
  a. Testing should continue weekly until there are no new cases among staff or NH- onset cases for the previous 14 days (or two consecutive rounds of testing with no additional NH-onset cases or staff cases).

2.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.
  a. If no additional cases are detected, repeat testing is not recommended.
  b. 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 (or two consecutive rounds of testing with no additional NH- onset cases or staff cases).

Phase II and III Testing Recommendations

Test <u>symptomatic</u> staff and residents

1.If testing identifies a **NH-onset case (see definition page 4):**

- Facility should regress to Phase I, including Phase I regression testing recommendations.

2. If testing identifies a case in a **staff**:

- Test staff and residents that are identified as close contacts (see definition pages 11-12), except those previously testing positive within the past 8 weeks. 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.
  a. If no additional cases are identified, repeat testing of close contacts to ensure transmission has not occurred. Ideally, repeat testing would occur in one week.
  b. If no additional cases are identified, no further testing is recommended
  c. If a NH-onset case is identified, the facility should regress to Phase I and follow Phase I regression testing recommendations.
  d. 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 the past 8 weeks.
  e. Testing should continue weekly until there are no new cases among staff or NH-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.

3.If testing identifies a case in a resident that is not classified as NH-onset case (e.g., resident who tested positive within 14 days of admission):

- Test all staff and residents that are identified as close contacts, except those previously tested positive within the past 8 weeks. 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.
  a. If no additional cases are detected, repeat testing is not recommended. I
  b. If a NH-onset case is identified, the facility should regress to Phase I testing recommendations.
  c. 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 the past 8 weeks
  d. Testing should continue weekly until there are no new cases among staff or nursing home-onset cases for the previous 14 days. Identification of a NH-onset case triggers regression to Phase I, including Phase I regression testing recommendation

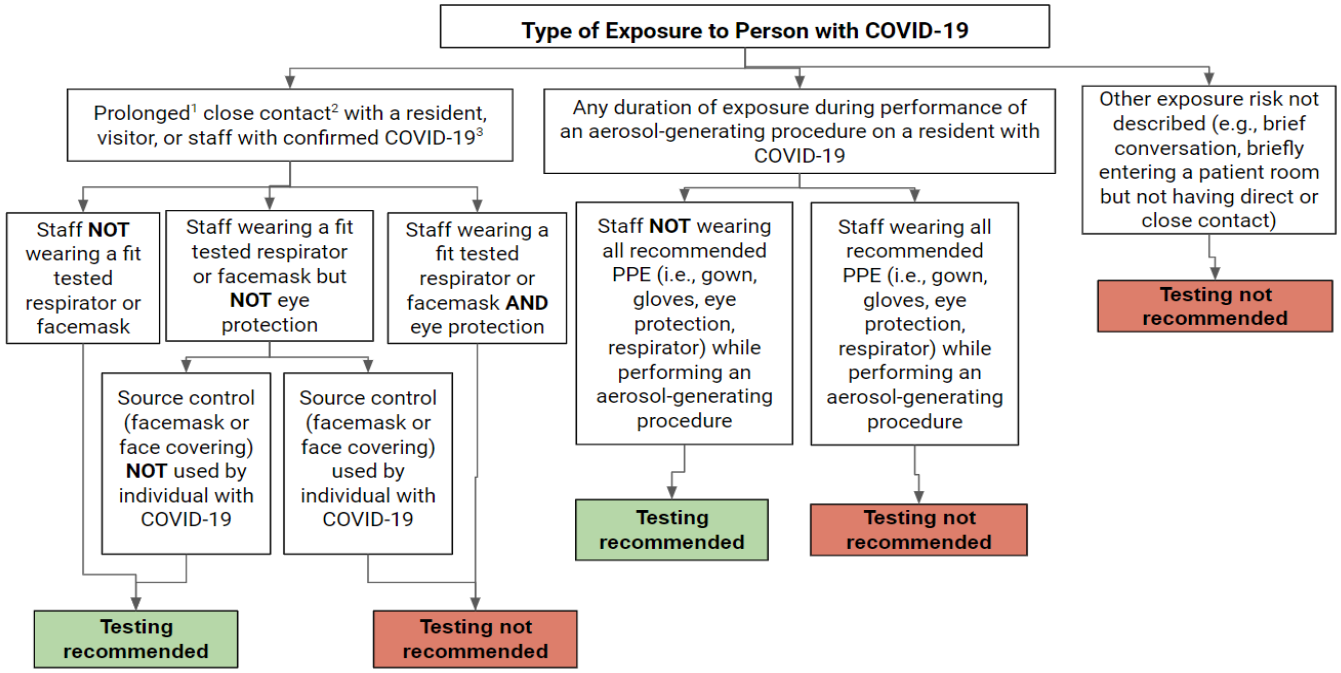
Retesting Previous Positives

When testing is indicated, asymptomatic individuals who previously tested positive greater than 8 weeks ago 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.

Identifying Close Contacts

Assessing Staff

Use the following algorithm to determine if testing is recommended. Below information is adapted from the VDH Guidance for Assessing and Managing Exposed, Asymptomatic Personnel.



1. CDC recommends considering 15 minutes or more as prolonged exposure.
2. CDC defines close contact as within 6 feet of a person with confirmed COVID-19 or having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19.
3. Determining the time period when the patient, visitor, or staff with confirmed COVID-19 would have been infectious: a) For symptomatic cases: 2 days prior to symptom onset through the time period when the individual meets the criteria for discontinuation of Transmission-Based Precautions. b) For asymptomatic cases: either 2 days after their exposure, if known, until they meet criteria for discontinuing Transmission- Based Precautions or 2 days prior to positive specimen collection through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions.

VDH Updates to Nursing Home Reopening Guidance Frequently Asked Questions

The updates found on the VDH website are not dated, however CHC found the following updates when reviewed on 7/16/2020 See updated FAQs here.

Testing	
Do staff or residents with a previous positive viral test who have recovered still need to be tested when indicated by the recommendations?	Answer reworded - When testing is indicated, asymptomatic individuals who have previously tested positive greater than 8 weeks ago should be re-tested. 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. 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 and placed back on the appropriate Transmission-Based Precautions (TBP) or excluded from work, respectively. See CDC guidance for more information.
New Question-Should a facility proceed with repeat testing if the results from the previous week aren't back yet?	VDH is aware of increased turnaround times causing delays in receiving and responding to testing results and planning additional testing. It is reasonable to wait for results, however, there are situations where waiting would not be recommended to conduct more testing. If a facility is testing in response to identification of one case and subsequent testing resulted in additional cases, the next round of weekly testing should not be delayed while waiting for results. For example, if a facility found positives on their first round of facility-wide testing, they will have to do at least two more rounds of testing (14 days of no new positives), so waiting for results from the second round of testing shouldn't delay the third round.
Infection Prevention and Control	
Where can I find more details regarding staff and resident screening for COVID-19 symptoms?	Answer Reworded The VDH Nursing Home Reopening Guidance is a supplement to other guidance documents that have been previously disseminated. An updated symptom list and details regarding screening can be found in the VDH Guidance for LTCFs.
New Question- A person who previously tested positive and clinically recovered from COVID-19 is later tested again. If that person again tests positive by PCR, should they be managed as potentially infectious to others, and should be isolated again for COVID-19.	The person should be managed as potentially infectious and isolated. 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 and placed back on the appropriate Transmission-Based Precautions or excluded from work, respectively. When a positive test occurs less than about 6 weeks after the person met criteria for discontinuation of isolation, it can be difficult to determine if the positive test represents a new infection or a persistently positive test associated with the previous infection. If the positive test occurs more than 6-8 weeks after the person has completed their most recent isolation, clinicians and public health authorities should consider the possibility of reinfection. Ultimately, the determination of whether a patient with a subsequently positive test is contagious to others should be made on a case-by-case basis, in consultation with infectious diseases specialists and public health authorities, after review of available information (e.g., medical history, time from initial positive test, RT-PCR Ct values, and presence of COVID-19 signs or symptoms). Persons who are

	determined to be potentially infectious should undergo evaluation and remain isolated until they again meet criteria for discontinuation of isolation or of transmission-based precautions, depending on their circumstances. More information regarding patients with persistent or recurrent positive tests can be found in the CDC FAQ.
What is VDH guidance in regards to resuming onsite physical therapy in nursing homes during phased reopening?	This question is not on the most recent FAQ

CMS Enhanced Enforcement Action for Deficiency Citations at F-880 Infection Control

In our previous FOCUS POINTs, we have shared information about the CMS Enhanced Enforcement Actions related to deficiencies cited at F-880, which became effective 6/1/2020. We have included information on the potential actions including that some will require the nursing facility to complete a Root Cause Analysis [RCA], Directed Inservice Training specific to the citation, and develop and completed a Directed Plan of Correction [DPoC]. We have also included a series of Q&A from Virginia OLC regarding the RCA and DPoC.

- On 7/13/2020 – Kim Beazley from OLC requested "I wanted to reach out to you to see if you could remind the facilities of one important piece of information On of one your slides you have: The DPOC does not have a required format. The POC format can be used. The DPOC should not be documented on the 2567 form. The part that is highlighted above is the key point. OLC is receiving DPOC's on the 2567 form. This makes things very confusing. I just wanted to clarify and stress that the response for the DPOC should not be submitted on a 2567 form.

CHC RESOURCE -CHC has experience assisting clients with competing a Root Cause Analysis (RCA) and developing a corresponding Directed Plan of Correction (DPoC). A new training tool has been developed to provide education on the enhanced enforcement of deficient practices cited in F-880. Please contact Mary if CHC can be of support to you – mary@chileshealthcare.com. The Power Point presentation and follow up discussion will be facilitated by a CHC team member. The objectives for the participants of the training include:

- Exploring CMS regulatory guidance for enhanced enforcement for citations at F-880 Infection Control
- Exploring requirements for developing a DPoC
- Exploring Virginia OLC guidance on submitting and completing the DPoC

Telehealth Therapy Policy for SNFs and ALF/ILFs (billed as Rehab Agency)

Seagrove Rehab Partners has put together a shell of a Telehealth Therapy Policy for their clients and is making it available to other SNF and ALF/ILF therapy departments. Included with the policy are multiple considerations such as implementation, patient consent, billing, and documentation considerations. Many SNF providers may not initially think that telehealth therapy services is something that they need to consider. However, as the pandemic continues, more and more staff (including therapy staff) are actually or potentially exposed to COVID-19 and are required to quarantine for a period of time. If this happens in your facility, and you do not have any additional evaluating therapists, then losing this one therapist for a period of time could have a significant negative impact on the care your facility can provide to its residents. Having a telehealth policy in place could help bridge this gap if/when your facility is affected. If you would like a copy of our Telehealth Therapy policy, please e-mail Mark McDavid at mark@seagroverehab.com for more information

Well-being and Connection

During this time of physical distancing and isolation, to help slow the spread of COVID-19, social connection is more important than ever.

We know the measures that have been taken for the benefit of our residents has been challenging. Now, as restrictions are being lifted, it is essential to make sure that residents and families feel connected to a supportive facility that supports their well-being.

We know that creating and maintaining these relationships has been easy for some and hard for others. Re-uniting families and friends will create emotions that we should be prepared to handle.

Tips for keeping well-being:

1. *Maintain positive relationships*: Be open to collaboration, idea sharing, and emotional support. Take time to talk, listen, and be available.
2. *Create a sense of belonging and connections for residents and families*: A strong sense of connection is necessary to create positive social, emotional, and behavioral outcomes. Creating a sense of belonging meets the basic human needs of being cared for and building enhanced social bonds. Connecting with families can help channel any pent-up emotions in positive ways.
3. *Emphasize respect, safety, and community*: Share information and answer questions. We have all been in this COVID-19 pandemic together. In a time when much has been out of our control, we can control how we act and respond to others.