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FOCUS POINT NEWSLETTER
MONTHLY FOCUS POINT and COVID-19 ALERT JULY 22, 2020

CDC UPDATES – *On July 17th,* The CDC updated their guidance on,

- Discontinuation of Transmission-Based Precautions of Residents with COVID-19 in Healthcare Setting – summary offered below click here for entire document.
- Revised Duration of Isolation and Precautions for Adults with COVID-19 – summary offered below click here for entire document.
- Revised Return to Work Criteria – summary offered below, click here for entire document

Discontinuation of Transmission-Based Precautions of Residents With COVID-19 In Healthcare Setting

- Except for rare situations, a test-based strategy is no longer recommended to determine when to discontinue Transmission-Based Precautions.
  - For residents with **severe to critical illness or who are severely immunocompromised**, the recommended duration for Transmission-Based Precautions was extended to 20 days after symptom onset (or, for asymptomatic severely immunocompromised1 patients, 20 days after their initial positive SARS-CoV-2 diagnostic test). CDC definitions include:
    - ***Severe Illness***: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
    - ***Critical Illness***: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
    - ***Severely Immunocompromised***: Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions.
    - Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions
      - Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.
- Other symptom-based criteria were modified as follows:
  - **Changed from "at least 72 hours" to "at least 24 hours"** have passed *since last* fever without the use of fever-reducing medications.
  - **Changed from "improvement in respiratory symptoms" to "improvement in symptoms"** to address expanding list of symptoms associated with COVID-19.

REVISED Guidance for Duration of Isolation and Precautions for Adults with COVID-19

- ***Symptom onset***- is defined as the date on which symptoms first began, including non-respiratory symptoms.
- ***PCR testing*** - is defined as the use of an RT-PCR assay to detect the presence of SARS-CoV-2 RNA.

1. **Duration of isolation and precautions**	▪ For most persons with COVID-19 illness, isolation and precautions can generally be discontinued 10 days *after symptom onset* and resolution of fever for at least 24 hours, without the use of fever-reducing medications, and with improvement of other symptoms. ▪ A limited number of persons with severe illness may produce replication-competent virus beyond 10 days that may warrant extending duration of isolation and precautions for up to 20 days after symptom onset; consider consultation with infection control experts.

	▪ For persons who never develop symptoms, isolation and other precautions can be discontinued 10 days *after the date of their first positive RT-PCR test for SARS-CoV-2 RNA.*
2. **Role of PCR testing to discontinue isolation or precautions**	▪ For persons who are severely immunocompromised, a test-based strategy could be considered in consultation with infectious diseases experts. ▪ For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the strategy outlined in Part 1, above.
3. **Role of PCR testing after discontinuation of isolation or precautions**	For persons previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset for the initial COVID-19 infection. In addition, quarantine is not recommended in the event of close contact with an infected person. For persons who develop new symptoms consistent with COVID-19 during the 3 months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant retesting; consultation with infectious disease or infection control experts is recommended. Quarantine may be considered during this evaluation based on consultation with an infection control expert, especially in the event symptoms develop within 14 days after close contact with an infected person. For persons who never developed symptoms, the date of first positive RT-PCR test for SARS-CoV-2 RNA should be used in place of the date of symptom onset.
4. **Role of serologic testing**	Serologic testing should **not** be used to establish the presence or absence of SARS-CoV-2 infection or reinfection.

Return-to-Work Criteria - Summary of Recent Changes as of July 17, 2020

- Except for rare situations, a test-based strategy is no longer recommended to determine when to allow HCP to return to work.
  - For **HCP with severe to critical illness or who are severely immunocompromised**, the recommended duration for work exclusion **was extended to 20 days** after symptom onset (or, for asymptomatic severely immunocompromised HCP, 20 days after their initial positive SARS-CoV-2 diagnostic test).
- Other symptom-based criteria were modified as follows:
  - **Changed from "at least 72 hours" to "at least 24 hours"** have passed since last fever without the use of fever-reducing medications
  - **Changed from "improvement in respiratory symptoms" to "improvement in symptoms"** to address expanding list of symptoms associated with COVID-19
  - A summary of current evidence and rationale for these changes is described in a Decision Memo.
  - CDC guidance for SARS-CoV-2 infection may be adapted by state and local health departments to respond to rapidly changing local circumstances.
  - **Who this is for:** Occupational health programs and public health officials making decisions about return to work for healthcare personnel (HCP) with confirmed SARS-CoV-2 infection, or who have suspected SARS-CoV-2 infection (e.g., developed symptoms of COVID-19) but were never tested for SARS-CoV-2.
  - HCP with symptoms of COVID-19 should be prioritized for viral testing with approved nucleic acid or antigen detection assays. When a clinician decides that testing a person for SARS CoV-2 is indicated, negative results from at least one FDA Emergency Use Authorized COVID-19 molecular viral assay for detection of SARS-CoV-2 RNA indicates that the person most likely does not have an active SARS-CoV-2 infection at the time the sample was collected. A second test for SARS-CoV-2 RNA may be performed at the discretion of the evaluating healthcare provider, particularly when a higher level of clinical suspicion for SARS-CoV-2 infection exists. For HCP who were suspected of having COVID-19 and had it ruled out, either with at least one negative test or a clinical decision that COVID-19 is not suspected and testing is not indicated, then return to work decisions should be based on their other suspected or confirmed diagnoses.
  - Decisions about return to work for HCP with SARS-CoV-2 infection should be made in the context of local circumstances. In general, a symptom-based strategy should be used. The time period used depends on the HCP's severity of illness and if they are severely immunocompromised.
  - A test-based strategy is **no** longer recommended, except as noted because, in the majority of cases, it results in excluding from work HCP who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

CHC RESOURCES

The CHC team has compiled a listing of resources that have been developed over the last couple of years. The listing includes revisions to older resources as well as new resources that were developed in response to the Long Term Care regulations from 2016 and the Virginia Assisted Living Standards from 2019. CHC has also developed multiple resources and training tools related to COVID-19. The listing is divided into six different sections for easy identification and sorting of topics. There is no charge for the entire listing, should you like a copy, please contact Mary or any of the CHC associates.

The **NEW RESOURCES** developed in July include:

Independent Therapeutic Leave- package for assisted living and nursing facilities. This package includes a sample policy and screening tool for residents desiring to leaving your facility and go outside in the community without supervision / assistance of the facility team. The screening tool addresses the resident's safety from a variety of perspectives including cognition, behavior, functional, etc. and is designed to be completed by the interdisciplinary team with approval of the team's recommendation by the attending physician. Package cost is $75; if interested contact Mary at mary@chileshealthcare.com or your CHC associate.

DPoC Sample Template- a sample template for meeting the requirements of components of the Directed Plan of Correction. This template identifies the primary concern, the project team, conclusion of the root cause analysis [RCA], systemic changes and monitoring. The template also includes documentation of participation by the Infection Preventionist, QAPI Committee and governing body. Cost of the template is $50; contact Mary at mary@chileshealthcare.com if you are interested in the template or need help with your root cause analysis or Directed Plan of Action.

Anticoagulant Management Policy and Tracking Tool- Policy provides guidelines for managing administration of Warfarin and includes tracking tool for monitoring PT/INRs and Warfarin dose changes. Cost of package is $50, contact Mary at mary@chileshealthcare.com to purchase

Assisted Living Rounding Tool- Audit tool to guide the user on areas to inspect and review while rounding through the facility. Cost of resource is $50, contact Mary at mary@chileshealthcare.com to purchase.

Principles of Documentation Training Webinar- A 60 minutes PowerPoint presentation on the principles of documentation targeting all staff that document in resident's medical record. The Participants will:

- Explore why documentation is important
- Explore regulatory requirements of documentation in the residents medical record
- Explore the principles of documentation in a legal record
- Examine documentation Dos and Don'ts
- Examine the risks/consequences of poor documentation

Meal Tray/Food Delivery During COVID-19 Pandemic- Policy providing guidance on serving and delivering meals to residents with confirmed or suspected COVID-19 as well as to residents that are not suspected to have COVID-19 and may be participating in communal dining. Cost of resource is $50, contact Mary at mary@chileshealthcare.com to purchase.

Assisted Living Administrative Manual Sections- In March CHC developed an entire administrative manual for Virginia based assisted living facilities. The separate sections of the manual include multiple policies and procedures are now available for purchase and include:

- Section 1 – Virginia ALF Administration – package price $175
- Section 2 – Resident Electronics and Paper Records – package price $135
- Section 3 – Personnel Policies – package price $135
- Section 4 – Uniform Assessments and Individual Service Plans – package price $100

- Section 5 – Resident Care and Services – package price $175
- Section 6 – Medications – package price $100
- Section 7 – Mental Health Services – package price $100
- Section 8 – Meal Service and Nutrition – package price $135
- Section 9 – Infection Control – package price $175
- Section 10- Resident Safety – package price $135
- Section 11- Emergency Procedures – package price $100
- Section 12- Incident Investigation and Reporting – package price $75
- Section 13- Special Needs Unit – package price $100
- Section 14- QAPI – package price $74

A Note from Judy Wilhide Brandt – ICD-10 Update and Training Opportunity

CMS has released the FY21 ICD-10 CM updated code sets and the Official Guidelines for Coding and Reporting. Judy is teaching a live webinar on **July 28th** on how to use an ICD-10 CM coding book for MDS coordinators who code for PDPM. Designed for MDS Coordinators who also assign ICD 10 CM codes for PDPM. This approximately 90 minutes to 2-hour live webinar will teach an MDS coordinator how to use an ICD 10 coding manual, following all general and chapter specific guidelines. During the webinar, Judy will use very common PDPM ICD 10 CM diagnosis codes to impart the coding rules. There will be live Q&A via chat box. Topics include: Where to find and how to use the General and Chapter Specific coding guidelines; What it means to "follow all notes and instructions." Judy, as always, developed this course and will teach it. She is a CPC and a current AHIMA approved ICD-10 trainer. Judy assisted in developing the AHCA/AHIMA ICD-10 Coding certification course. Register for the live webinar at: https://attendee.gototraining.com/r/7411199161782203138

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 are 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

CHC Facilitates Discussion on Documentation for Activity Professionals for VHCAVCAL.

Mary Chiles will be facilitating two webinars on documentation for activity professionals working in Virginia assisted living and nursing facilities. Session 1 is scheduled for August 19, 2020 at 2PM and will focus on the Principles of Documentation; Session 2 is scheduled for August 26, 2020 at 2PM and will focus on Documentation Regulations and Requirements. Watch the VHCA website for registration information.

Be Infection Control Survey Ready: Join HQIN's Office Hours Series

Join the Health Quality Innovation Network (HQIN) for an office hours series to support survey readiness and help you be responsive to identified opportunities, survey deficiencies and Centers for Medicare & Medicaid Services (CMS) enhanced enforcement actions. Each 30-minute session will demonstrate how to apply quality improvement principles to

your infection control and prevention program and provide you with turnkey resources and tools to address gaps and drive improvement in your facility. A panel of nurses, infection preventionists and quality improvement professionals will also be available to answer questions.

Infection Prevention Action Plans - July 28, 2020 | 2:00 p.m. ET/1:00 p.m. CT
Upon completion of the RCA process, the next step is to develop a plan of action. During this session, we will share our Infection Prevention Action Plan Templates that complement the Centers for Disease Control and Prevention's Infection Control Assessment tool. A template for the key categories of improvement, i.e., hand hygiene, surveillance, environmental hygiene, etc. will be available. To register for this session and subsequent sessions visit HQIN.org.

Nurse Scholarship Opportunity
Staffing has been a challenge in Virginia nursing homes and assisted living facilities for a long time and it is growing exponentially during the pandemic. The pandemic has not only impacted our work force availability but has also taken a significant financial and emotional toll on everyone. Each year VHCA-VCAL's Commonwealth Long Term Care Foundation awards $1,500 scholarships to employees in VHCA-VCAL member nursing centers and assisted living communities who want to become LPNs or RNs and continue their careers in long term care. Encourage your staff members who are interested in obtaining their LPN or RN degree to apply for the scholarship. CHC has been a supporter of the scholarship for years and we encourage you to reach out to your staff for their interest in this available resource. To apply click here for the scholarship brochure.

"It is really wonderful how much resilience there is in human nature. Let any obstructing cause, no matter what, be removed in any way, even by death, and we fly back to first principles of hope and enjoyment."
— Bram Stoker, Dracula