STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor

Susan Bysiewicz
Lt. Governor

HEALTHCARE QUALITY AND SAFETY BRANCH

BLAST FAX 2020-30

TO: All Nursing Homes and Assisted Living Service Agencies

FROM: Commissioner Renée D. Coleman-Mitchell, MPH

CC: Deputy Commissioner Heather Aaron, MPH, LNHA
Barbara Cass, RN., Branch Chief, Healthcare Quality and Safety Branch
Donna Ortelle, Section Chief, Facility Licensing and Investigations Section

DATE: April 6, 2020

SUBJECT: Infection Control Guidance and Containment Webinar for Long Term Care Facilities and Assisted Living Service Agencies

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This webinar is scheduled for Tuesday, April 7, 2020 at 3:00 PM. Registration Information:

https://attendee.gotowebinar.com/register/8858525897517116685

After registering, you will receive a confirmation email containing information about joining the webinar.

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ANSWERS TO QUESTIONS FROM APRIL 1, 2020
DPH CALL WITH LONG-TERM CARE FACILITY ADMINISTRATORS

These are written responses to questions typed into the chat room during the webinar. The questions have been edited and arranged by alphabetized topic. Some document the verbal responses given on the webinar, while others were not asked due to limited time and are responded to here.

Acute Care Hospital Capacity

Question: Is there a plan to move patients between hospitals, especially in Fairfield County, which is heavily impacted by the epidemic, to provide relief to overburdened hospitals?
Answer: There is not a current State plan to move patients between hospitals. The hospitals may opt to implement this if this is in their pandemic plan in order to meet the needs of the patients.

Aerosol-generating procedures

Question: Are nebulizer treatments, BiPAP, CPAP, and open suctioning aerosol generating procedures?
Answer: Yes, they are. According to CDC guidance,[1,2] respirators must be worn by healthcare providers (HCP) during such procedures. Contact precautions (face shields for eye protection, gowns and gloves) should also be worn when aerosol-generating procedures are performed on any patient suspected or documented to have COVID-19. Ideally, AGPs should take place only in an Airborne Infection Isolation Room (AIIR). If no AIIR is available in your facility, and AGPs must be done, limit the number of individuals in the room to the minimum necessary, keep the door closed, and clean the room afterward.

Question: Is the use of Narcan an aerosol risk?
Answer: CDC does not list delivery of Narcan as an aerosol-generating procedure.

Statement: Pharmacy notified us today that they are anticipating a shortage of metered dose inhalers (MDI).
Answer: Thank you for the information. NB: When using an MDI, all patients should be using a spacer.

Cohorting

Question: Is there a recommendation as to whether it is better to group residents with documented coronavirus SARS-CoV-2 (i.e., the cause of COVID-19) in a neighborhood or house or treat in place in private rooms?
Answer: Individual patients with documented COVID-19 should be cared for in individual rooms, or if need be, cohorted. Cohorting can mean more than one person in a room, a dedicated wing or floor, or a whole facility with only COVID-19 documented patients in it. There can also be cohorting of persons with negative COVID-19 status or with indeterminate COVID status. Persons under investigation (due to exposure or suggestive symptoms) and under observation for COVID-19 or with pending SARS-CoV-2 tests, should not cohort with persons with documented SARS-CoV-2 infection.

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Question: As we aim to keep SARS-CoV-2 out of the long term care facilities, and are creating special facilities for positive residents, why would we want to continue to care for a resident with SARS-CoV-2 in a non-COVID-dedicated SNF where it might spread from them to other residents?
Answer: While moving all COVID patients to a dedicated facility has certain advantages, such as permitting enhanced capacity for infection control and more adequate PPE, and less cross-contamination, there are disadvantages. As you know, moving medically fragile and aged residents is very disruptive to them physically and psychologically, and can have its own health and mental health dangers. As residents often consider their facility their home, it can be a very difficult to leave their familiar physical surroundings and emotional attachments with other residents and staff, leading to stress and possible feelings of isolation and abandonment.

Question: We are hearing that some facilities are looking to provide care-in-place... knowing how difficult it is to maintain strict isolation in a SNF environment, will the Department be verifying the ability of these Facilities to provide the care in accordance with CDC guidelines?
Answer: The facility should be adhering to the CDC guidelines. The Department is monitoring the facilities daily and obtaining information to determine that the facilities have adequate supplies of PPE and are utilizing conservation strategies for PPE. DPH is also monitoring staffing, mitigation plans, and the status of COVID affected residents. FLIS conducts monitoring visits if necessary.

COVID-19 Dedicated Facilities
Question: At what point would a nursing home transfer a resident to a COVID-19 dedicated facility?
Answer: DPH and the State of Connecticut is exploring options to cohort nursing home residents across the state. At this time, there are no plans to transfer residents from their current nursing homes to another nursing home. The primary reason the COVID-dedicated facilities are being established is to allow hospitals to discharge patients with active or resolving SARS-CoV-2 infection to medically appropriate long-term care, as hospitals are having significant difficulty placing such patients in long term care facilities. This will likely be necessary to open space in the hospitals for the surge of patients that has begun and that will increase in the next several weeks. We will continue to evaluate if transfers need to occur between nursing homes for patient safety, however there are no current plans to do so.

Question: Which facilities will be COVID-dedicated, and when will they be open for admissions?
Answer: We cannot say exactly, planning is going very quickly, and an announcement of when the facilities will open will be made in the next few days.

Question: I am concerned about moving patients determined to not have COVID signs and symptoms to a different location when in fact they could be later identified as positive. Would we be testing everyone before they are moved? I am concerned about an ability to staff a "vacant space" option.
Answer: Depending on testing turnaround time, individuals could become infected after the test has been obtained and before transfer. A better approach would be to put the new patient in isolation for 14 days after transfer. This approach could be revisited if testing turnaround decreases significantly in the future, e.g., sufficiently accurate point of care rapid testing becomes widely available.

Question: There was a report in the news that suggested transfer of residents with documented COVID will be mandated, is this true?
Answer: Residents with COVID-19 can remain in their facility if that facility is able to care for them safely with correct infection control and PPE, or they may have to be relocated if a specific situation calls for it for their safety of the safety of the other residents.

Question: Are these beds (in a COVID facility) available to residents that currently reside in assisted living?
Answer: If the ALSA resident requires a higher level of care based on the resident's needs and the resident can be certified to meet the skilled nursing facility level of care, this can be an option, depending on bed availability in the COVID-dedicated facility.

Documentation

Question: Where will the FAQ document be located?
Answer: We will upload the Guidance and FAQ document on the LTC-MAP website for everyone.

DPH and other State of Connecticut Issues

Comment: That joint letter from DPH/Ombudsman is well intentioned but incomplete. We are hesitant to put this letter out to our families, only to cause alarm.
Answer: The letter that was sent to all nursing facilities was intended to inform long term care facilities and residents on what is happening in the state due to the COVID-19 pandemic, and how some of changes that may impact on where the residents reside, based on their COVID status. This information was provided so residents and families could have this information and be allowed time to ask questions as the plans were being developed with the resident's safety and well-being as a priority.

Question: What is DPH's position on CMS's just approved 8-hour CNA class?
Answer: The Department is currently reviewing and developing a training class for patient care assistants in order to increase the workforce to support nursing home staff. More information will be forthcoming as the program is developed.

Question: Please address the State's opinion of telehealth and permission to use.
Answer: We don't have an opinion, but executive orders 7F and 7G allow telehealth coverage.
https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=pb20_09.pdf&URI=Bulletins/pb20_09.pdf

Personal Protective Equipment (PPE)

Question: What is the current DPH recommendation about universal use of face masks in long term care facilities, even in facilities that do not yet have COVID-19 patents?
Answer: The Connecticut Department of Public Health is now recommending that all healthcare personnel (HCP) wear surgical masks while in healthcare facilities. This recommendation is based on growing evidence for pre-symptomatic shedding of SARS-CoV-2 (the virus that causes COVID-19), and the growing prevalence of COVID-19 in our state. Masking all HCP (also known as "universal masking") can help protect them, as well as prevent pre-symptomatic HCP from transmitting the virus to other HCP and patients. People who provide direct patient care should wear a medical-grade surgical mask all the time and follow CDC recommendations for re-use. Those who do not provide direct patient care can wear a medical-grade surgical mask if supplies allow, or cloth or homemade masks. Surgical masks should be carefully removed without touching the outer surface of the mask, and the mask should be folded (if foldable) with the outer surface facing inward, then stored in a clean sealable paper bag or breathable container facepiece facing down between uses. CDC guidance for extended use/reuse is available.[3]

Comment: Everyone is aware of the scarcity of PPE equipment. Some SNF's are requiring that First Responders be fully, gowned, gloved and masked regardless if the patient has COVID-19 symptoms.
Answer: Appropriate PPE depends both the patient's COVID status and the type of interaction. We are now recommending universal masking (see above). For other PPE (e.g., contact precautions, aerosolizing procedures) follow CDC/NIOSH guidance.[4,5]

Question: Is universal gowning, wearing one per shift, of any use to our HCP? DPH advises us to avoid burning through PPE, and to only wear masks if residents have respiratory symptoms.
Answer: Gowns for contact precautions should be used for contact with patients with signs and symptoms or with confirmed COVID-19. We are not recommending universal use of gowns for contact with ALL residents.[0]

Question: Regarding PPE utilization, if CDC, DPH and the facility Medical Director recommend different practices. To whose guidance should the facility adhere? Example: Some Medical Directors are recommending masking for all health care personnel. The LNHA and DNS historically follow their guidance.
Answer: The CDC is an authoritative source of guidance on infectious disease epidemiology and public health practice to prevent and mitigate infectious disease outbreaks. The National Institute of Occupational Safety and Health (NIOSH) develops authoritative scientific and science-based practice guidance that the Occupational Safety and Health Administration (OSHA) uses for its rulemaking and enforcement decisions. The Food and Drug Administration (FDA) promulgates standards, guidance and enforcement on medical devices, therapeutics, and diagnostics (e.g., laboratory tests). OSHA promulgates standards related to protection of workers from infectious disease. The DPH Infectious Diseases Section follows CDC guidance, but will develop guidance for Connecticut that supplements or interprets or applies the CDC guidance to Connecticut-specific situations. On rare occasions, DPH guidance may substantially differ from CDC guidance, but more often any differences are explained by DPH's role in interpretation, supplementation, and application of CDC guidance to our jurisdiction. DPH follows and complies with the standards, regulations, and enforcement findings of all the federal agencies in their areas of authority. Facility Medical Directors have authority and responsibility for the health and safety of their facility residents and staff and may use various sources of information to guide them, including CDC, NIOSH, FDA, DPH, and the medical literature. Regarding COVID, the situation is very rapidly changing, and guidance from any source may change as circumstances require and our understanding of SARS-CoV-2 advances.

PPE/Fit testing
Question: Can we use N95 even without a fit test?
Answer: In their emergency guidance of March 20, OSHA says that the annual fit test requirement is waived during the COVID emergency, but DOES NOT waive fit testing on the model the HCP will be wearing, and reminds workers and emphasize that fit checking for seal before each donning is still required. This means that if the worker is using an N95 make and model that they have been fit tested to before, even if they have missed their annual fit testing for 2020, they can still use that model with fit checking. IF it is a new model, in compliance with OSHA, they must be fit tested BERORE using that make and model of N95.[7] NIOSH, on the other hand, says that in extreme situations, N95s could be used without fit testing, but with fit checking.[5] Our recommendation is to please make every reasonable effort to avoid any use of N95s that have not been fit tested. If an employer and worker use an N95 that has not been fit tested, they should be prepared to justify this breach of protocol to OSHA. Also, when reusing N95s you still need to fit check before each use, which could contaminate the hands. Hands therefore need to be disinfected with alcohol-based hand sanitizer or soap and water after these fit checks.

Question: Where you can get fit test kits, we have been trying to get them for weeks?
Answer: You may consider asking a contact standalone occupational health facility, asking other long term care facilities, or asking a local acute hospitals or health care system if they have a testing kit that can be borrowed, or check with your local health department.

Question: Is there guidance that you can point us to for fit testing the N95 masks?
Answer: OSHA and NIOSH (the latter part of CDC) have authoritative guidance on fit testing and fit checking.[8,9] It should be noted the except for the waiver of annual fit testing, the other aspects of the OSHA respiratory protection standards still apply.[10]

Question: KN95 mask do not have fit guidelines. Some web sites say CDC does not approve the KN95 mask. But one site did O.K. them for use. They do not appear to need fit testing. Can we use them? Are they better than surgical masks?
Answer: NK95 masks are filtering facepiece respirators (FFRs) produced and certified in China. CDC offers guidance on use of non-US certified face filter respirators when there is a critical shortage of N95 respirators.[11] We recommend that any mask model that staff has not previously been fit tested for be just-in-time fit tested before any use. As always fit checks should always be performed before use. These masks should only be used in a crisis when there are no N95s. They would be expected to protect better than a face mask against aerosol if properly fit tested and checked. NIOSH has "trusted source" information that is very helpful to avoid problems, such as counterfeit masks.[12]

Comment: When considering the N95 just-in-time fit testing please consider the extremely limited supply facilities must use.
Answer: Consider using N95s that have exceeded the "beyond the manufacturer-designated shelf life" (also called "expired") for fit testing.[13]

Staff Return to Work
Question: What is the guidance on what defines health care provider (HCP) exposure to COVID-19?
Answer: CDC has published guidance on persons who have been exposed to other persons, whether in healthcare setting and defines close contact and degree of risk.[14] CDC notes that workers can also be exposed in the community to persons with known COVID-19. Community contact with known COVID patients should be addressed according to the CDC guidance as if it were a facility-based exposure. It is true that with community transmission, HCP may be unknowingly exposed, and that is why we advise screening of each HCP at start of each shift with an interview about symptoms and signs and a temperature check with a thermometer.

Testing
Question: According to Dr. Birx, White House Task Force Coronavirus Response Coordinator, there are millions of tests in the field from Thermo Fischer, Roche, Quest, Lab Corp, Abbott Labs (a 45-minute test). Dr. Birx has stated that many of these tests are not being employed and are available right now. what is the problem in accessing tests?
Answer: The roll-out of these tests is ongoing; the manufacturers are shipping them out in batches. However, even if the kits were available, it should be noted that there are other resources needed to make these or other additional test kits usable to expand our capability to actually do the testing: swabs, sample transport media, machines to extract test samples for the PCR test run, machines to run the kits, laboratory staff, and PPE for laboratory staff. DPH has been in communication with laboratories in Connecticut and there has been a steady increase in the number of labs using the tests that have quick turnaround times, mostly used by hospitals since they already had the specialized equipment to run the tests. The reagents and other necessary supplies to run these tests remain in short supply.

Question: On the previous long-term care facility call on March 26, a test backlog at the state laboratory was noted. How long does it now take to turn around a test for a result?
Answer: The aim is to turn SARS-CoV-2 tests in 24-48 hours, but due to supply constraints and the large number of submitted tests, we sometimes have a longer turnaround time of approximately four days. Facilities should first seek to use commercial labs if possible. The DPH laboratory tests hospitalized patients with signs and symptoms of COVID, healthcare workers with signs and symptoms, and residents of congregate settings with signs and symptoms, but not asymptomatic staff of long-term care facilities.

Comment: Today Quest lab refused to draw labs on a patient that we also suspected COVID-19 but we were trying to rule out other etiologies of fever.
Answer: If your laboratory contractor cannot draw labs on a resident, any facility staff that has been trained and competent (MD, APRN, or RN) to perform phlebotomy can draw the lab specimens. You can obtain the blood tubes and supplies from the lab (e.g. Quest) and follow policies and procedures for patient identification, labelling of specimen,

storage and transportation. Staff should wear the appropriate PPE when drawing the samples. We have elevated the issue with Quest to CDC.

Testing workers

Question: Can we give Healthcare Providers (HCP) priority in lab tests and receiving results for SARS-CoV-2 test?
Answer: Hospital HCP with signs and symptoms are a priority group for state laboratory testing. HCP without symptoms are not. We are continually assessing our lab capacity, backlog, and testing capacity of other laboratories to re-evaluate our state laboratory testing criteria. If a HCP has signs and symptoms, commercial laboratories may be an option, via drive-through test sites. If a HCP who has been exposed to a family member or community contact with symptoms, the family/community member may need to be tested. If the contact cannot be tested, and staffing is critically low, then you could consider having the staff member work masked while avoiding immunosuppressed and other especially high-risk residents.

Question: While we are being told health care employees can be tested by their primary physician, primary physicians are frequently refusing to order testing if the employee is under 60 years old or not high risk despite being a health care worker with symptoms and a suspected exposure. Suggestions?
Answer: Consider asking your Medical Directors to order the test. Testing could be done through a commercial laboratory (and collected at drive-through testing).

Virology/testing

Comment: Testing all residents at the acute care hospital, prior to discharge to a SNF would preclude us burning through our PPE inventories. That's the best practice we need to embrace to protect our residents and employees. It seems that some of the SNF's are making decisions individually about their processes. Not following CDC guidelines, i.e., two negative tests for patients that are not under investigation for COVID-19.
Answer: CDC recommends two possible approaches, one with testing and one without testing.[15] If we test patients who do not have signs or symptoms consistent with COVID-19, we risk having inaccurate or uninterpretable results.

Question: Is there any guidance to the immunity for a person who has been positive and had two negative tests?
Answer: We do not know of any data indicating the degree long term immunity after a cleared SARS-CoV-2 infection.

Question: Can APRN draw blood from positive residents for labs to pick up for testing?
Answer: We are assuming that you mean blood for other tests, as the currently available test for SARS-CoV-2 is via nasal swab (though that may change with a serological test comes available). If proper contact and respiratory precautions (with surgical mask) are employed, yes, blood can be drawn by any person able to perform phlebotomy.

Therapies

Question: Any thoughts on Plaquenil (hydroxychloroquine) therapy in the nursing home setting?
Answer: This drug is in clinical trials and has recently been given an Emergency Use Authorization (EUA) by the FDA for compassionate use. It can only be used to treat hospitalized with COVID-19, for whom a clinical trial is not available, or participation is not feasible. There is little peer-reviewed scientifically validated information available on the efficacy and safety of this drug in the context of COVID care. The drug is available through the Strategic National Stockpile and must be requested through the state health department.[16,17]

Worker assignment

Question: Are there guidelines for staff that work at several facilities, especially if one of their facilities test positive, if they should not work at the facility that has no positive cases?
Answer: We strongly recommend to not have staff work in different facilities or floors, but we understand that staffing constraints may make this impossible.

Question: Should facilities avoid using department heads for all hands-on deck on the units?
Answer: Based on the facility's assessment of the facility's needs, staff who are trained and competent to perform different duties are okay to do them (i.e. social worker to pass meal trays).

Visitation

Question: Can the department offer a guideline for visits for "other end of life care" as some COVID- positive patients may become near death without the time to adopt hospice services.
Answer: DPH Commissioner Renée Coleman-Mitchell issued an order to nursing homes and long term care facilities that provides exceptions to the visitor restrictions for "family members, domestic partners, or other persons designated by a patient only when the facility's medical director, a licensed physician or advance practice registered nurse has determined such patient to be at the end stage of life with death being imminent."[18]

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