5.21.20 WA DOH COVID-19 Q&A for Healthcare Providers

Question	Answer
1. **Website links to COVID-19 Q&A documents**	https://www.adultfamilyhomecouncil.org/covid-19-updates-best-resources/ https://www.leadingagewa.org/ill_pubs_articles/copy-resources-preparing-your-community-staff-residents-and-families-for-the-coronavirus/ https://www.whca.org/covid-19-resources/"
Reporting	
2. **We are currently having to report COVID information via RCS/ALTSA on-line reporting system (this is in addition to weekly CDC/NHSN reporting) - do we also have to continue to send the bi-weekly emails to DSHS/RCS surveyor?**	RCS/LTSA and DOH are working on combining into one portal, working towards a one stop for data entry. Nursing Facilities will still have to enroll with NHSN but will be able to input data into the RCS/DOH portal. DOH will then be able to upload the data to NHSN. A provider letter with more detail and instructions will be released shortly
3. **Hello, there is a COVID-19 "button" on the CRU website. Where does information entered here go? (ie. to DOH? to CRU?, to both)?**	This button does not lead to CRU it leads to the DOH/RCS reporting site for data gathering purposes not for mandated reporting purposes. The data is used to assess PPE shortages, outbreak areas, capability for facility to do their own testing, etc. The data collected from NH can also be used to upload into the NHSN reporting site allowing NHs to decrease the number of places they are required to report (see #4 above). Facilities still need to report to CRU and the LHJ if an outbreak occurs.
4. **Currently having to report COVID information via RCS/ALTSA on-line reporting system (this is in addition to weekly CDC/NHSN reporting) - do we also have to continue to send the bi-weekly emails to DSHS/RCS surveyor?**	See #2 above
COVID-19 units	
5. **Amy Abbott, what about fit testing? Does DSHS recommend/require COVID units to have respiratory protection programs with fit testing, training and medical clearance per OSHA guidance? Is this an assumption that these units will follow federal guidelines?**	The contract requires facilities to follow local, state, and federal guidelines. OSHA requires employers to develop a respiratory protection program.
6. **What do you do with agency staff? Are they dedicated to care for COVID units? Are they tested along with your staff? Does the agency provide any testing or background on workers who may have worked in facilities that have**	I'm not sure about which agency, but if this is referring to external or contracted staff, I would have them subjected to your routine symptoms screening process prior to entering the building like you do for the rest of your staff, also should wear all of the same PPE. This

outbreaks? How is this communicated? Yes agreed about the testing but how is the agency screening the staff? How can you confirm that the agency staff person might not be a source of exposure in your negative unit?	would NOT apply to EMS service staff though. Re required statewide testing in LTCFs and how this applies to external staff I would have to defer to Charissa, but in my mind it would make sense to have those individuals tested as well.
7. Are you taking Covid+ patients in all of the identified facilities? Or do they have to have had Covid, but then received a negative test?	There are COVID-19 patients in Richmond Beach and Transitional Care of Puget Sound. In order to be admitted to the COVID-19 units they must test positive for COVID.
8. How often are staff and residents screened for Covid? Which kit do you use to test?	Screening for signs and symptoms occurs daily with employees screened at the beginning and end of their shifts. Symptom-based guidance used to determine when to test residents. Swab tests.
9. Assuming there is space, are there any restrictions to an immediate placement of a COVID-19 positive resident from an adult family home or do transfers to these COVID recovery facilities have to have some levels of symptoms??	COVID-19 admissions are conducted in the same manner as regular: based on clinical appropriateness and staffing/resource availability. They need to test positive for COVID-19. There are not clnical criteria to meet aside form positive test.
10. When do you see expanding capacity, particularly at the Richmond Beach facility since Seattle is in need of more than 19 beds?	Once proper staffing is established we will increase the number of beds. This is James Lewis from King County, I would also add that facilities can have COVID units without a contract and can accept COVID patients to that until without the contract. Definitely agree we need more of these beds.
11. Do the agency staff then work in other facilities?	No
12. How are covid tests on employees being paid for by Avamere. Lots of LTC employee insurance plans offer minimal coverage with high deductibles, co-workers may test positive from community acquired virus, then co-employees would also need a test. How is this being paid?	We are currently discussing payment options for tests performed on staff. The goal is to minimize, eliminate any costs for staff.
13. What about when residents in the wing or unit become negative or asymptomatic? Do you move them to a different part of the building? What do you plan for these residents once they recover?	The primary goal is to discharge to their place of residence (ALF, AFH, home). Once a resident tests negative and have been monitored for resurgence of symptoms for a period of time they can be moved to other parts of the building. This is James Lewis from King County, based on current CDC guidance which does not have a preference between symptom and time based criteria versus test criteria (https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html) as well as emerging data further supporting that transmission is unlikely beyond the time based

	criteria is unlikely (https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2765641 & https://www.cdc.go.kr/board/board.es?mid=a30402000000&bid=0030 for example) we would urge facilities to use time/symptom based criteria, once that criteria is met the individual can be transferred back to the regular floor or to their home facility.
14. Jessica what are the advantages to having a COVID 19 units?	Financial: enhanced reimbursement but note that facilities are often spending more money on other operational costs that may hinder the ROI. Also, an opportunity to serve the community, hospital capacity and patients in a critical time of need.
15. Do the staff who work in Covid-19 unit get some kind of incentive?	No
16. Do we need to have different break room for staff who work in Covid-19 versus non-Covid-19 unit?	Yes, including a separate entrance and COVID-19 employee only bathroom.
Testing	
17. Any update from State DOH regarding the plan for how facilities are to complete testing of all residents and staff in SNF's by 5/31/20?	The completion date is no longer May 31st. It will be 2 weeks from when a formal announcement about testing in LTCFs is made.
18. what are the rules about moving a new resident in the home? is there a need for two negative tests? what are the time limit from the testing time to the move in time?	No need for two tests, reasonable to ask for one prior to admission, then quarantine as per CDC recommendations: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html See section under heading "Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown." about 2/3 down the page
19. Is the antigen test approved to use for facility wide testing for staff/ residents (Sophia 2)	I am not entirely sure of the availability for the Antigen test, but certainly the sensitivity of Ag tests is much lower than PCR testing so this would not be recommended for facility wide testing or testing of asymptomatic people in general. Just like the rapid influenza antigen test it would be used when you highly suspect COVID based on clinical evaluation and if negative should likely be followed up with a PCR test, essentially Ag tests in general or most useful when positive but not so much when negative.

Question	Answer
20. What about staff who decline to test. I have seen that you would terminate? Is there a proclamation of some sort of legal mandate that will more specifically address so we can pass on to staff to make them understand it is a term of continued employment?	I do not think it would be appropriate to tie continued employment to testing, People should have the right to refuse, but it might be reasonable to limit duties based on willingness to test, i.e. perhaps require those individuals who refuse testing work on the COVID unit and not be able to work on the regular floor.
21. Last week it was no test-based strategies - now we are looking at weekly testing potentially for staff at least? Please help us determine - and again for the staff that declines to test..... which way do we turn?	This would likely be determined on a case by case basis, unlikely to have specific guidance in the near future. If really limited would likely focus on symptomatic individuals and have a very low threshold for symptoms meeting testing criteria.
22. Dr Lewis, why is there a shortage of test kits when private labs seem to have an abundance of them?	To my knowledge labs still have shortages and just yesterday I was speaking to a couple of facilities who are contracting with multiple labs because each lab will only provide a small number of test kits at a time (i.e. 8-10) which is not enough to have on hand for many facilities. Please let us know the labs you are referring to on the next call.
23. Has there actually been a DIRECTIVE from CMS or DOH to have all LTC facilities and staff tested before the end of May 2020? I've not seen anything in writing.	This was a recommendation by the White House (along with the date of completion). CMS has recommended testing prior to opening of facilities but has not specified a date the testing must be completed by). The Governor's Office in the state of Washington, along with an assigned group, is working on the testing process for LTC in our state
24. Some persons with COVID have lingering or intermittent symptoms such as muscle aches, fatigue, dry cough, even after 14 days. Do these count as symptoms in regards to releasing the person from isolation on a symptom based strategy?	The only symptom that must be completely resolved is fever, the only other symptoms included in the symptom-based strategy are respiratory symptoms which should be "improved" but not necessarily resolved. Please read the symptom-based strategy closely: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
25. How will SNF's address refusals by residents especially those with dementia? Will the test have to be naso-pharyngeal?	Residents have the right to refuse, each facility will need to develop an internal policy about how they deal with those, i.e. perhaps relocate to a "quarantine" unit. No, the swabs can be anterior nasal swabs rather than NP now.
26. If a SNF has not had a positive patient or employee are they required to test at this time.	They will be yes.

Question	Answer
27. Once testing is done for all residents and staff in SNF - is the plan to continue doing weekly for staff after that? Does DOH have a plan for this yet?	At this point in time the consideration for SNFs is to test every 2 weeks. DOH will continue to work with DSHS to support SNFs in this effort.
28. In regards to testing all staff/res in SNFs/Memory care units. If a staff or resident tested positive prior to April 1st, would they also be retested?	In point prevalence survey testing generally you would not re-test persons who previously tested positive as per CDC guidance here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html . But I would defer to DoH if the governors order would differ from this.
29. Will there be recommendations or requirements for ongoing testing?	Not at this time, as it relates to SNFs or other LTCFs.
30. How frequently would we test residents then?	I don't believe there is any info on this from the governor's mandate but there is CDC recommendations around this for facilities that have cases: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html . Here is an pertinent quotation from that page: "Continue repeat testing of all previously negative residents (e.g., once a week) until the testing identifies no new cases of COVID-19 among residents or HCP over at least 14 days since the most recent positive result."
31. Are SNFs going to be paying for their staff testing or is the State making provisions for this? For the ongoing testing, how is that going to be paid for?	Discussions regarding who will pay for both the point prevalence survey and ongoing testing are ongoing.
32. Is these testing requirements for all counties in the state.	Yes
33. Who will perform the tests in an AFH setting who are without an RN on staff?	Working on this, nurse delegator may assist in identifying resources.
34. What if the insurance plans don't pay for data gathering charges for testing in the absence of symptoms?	Discussions are currently underway with the HealthCare Authority, State AGs office, the OIC and insurance companies about payment responsibilities for tests.
35. What is the guidance when residents refuse testing? What about staff who refuse, especially after the base line test?	See answers 20 and 25
36. Is the staff testing every two weeks a recommendation or is that what is going to be the requirement?	It is currently being discussed as a requirement.
37. Is there a plan to test essential workers who frequently come in contact with facilities who are not employed by the	Workers who are contracted and/or volunteer to provide services will be required to get tested. It is not clear at this time if State staff, local health officials or APS are to be tested before entering the facility.

facility like PT/OT, state staff like RCS or APS, local health officials?	
38. Does a facility have to wait until testing is completed before allowing for guests	The testing requirement has no bearing on visitation, at this time visitation is still not recommended and that won't change after testing is complete to my knowledge.
39. If a staff test positive in a SNF, will it be recommended for them to self-isolate for 14 days? If so, will there be hazard pay, certainly if the staff is going to retested . Many of these staffs have a limited sick time.	Any staff that test positive should not continue to work if at all possible. In crisis standards of care as discussed on those CDC page for mitigation of staffing shortages https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html asymptomatic workers who test positive could continue to work but only with COVID + residents. This should be avoided if at all possible. I would defer the hazard pay to state and individual organizations.
40. Can this group provide clear instructions for employee and resident testing for Covid-19 in SNFs (in a written format)? Who is paying? Who do facilities contact? All aspects. Thank you	I assume this is in reference ot the state mandate but if in general there is written testing guidance form CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html re payment I would have to defer to state colleagues.
41. I received an email this week from Emergency Management asking me what testing kits I needed. I don't know the difference in the test kits. Also I have tried to research the Abbott tests (I have been told the initial Abbott tests were not reliable- missing approximately 67% of COVID-19 positive patients) What is the difference in the test?	Different laboratories at this time have some differences in the types of kits they will accept, you should determine what lab you are working with and then speak to that laboratory and ask what types of kits/specimens they accept for testing. The Abbott rapid PCR test does seem to have worse sensitivity that the other PCR tests and this requires you to have an Abbott machine on site so if you do not have one those kits would not apply to you.
Other topics	
42. If we have to put a unit on precautions, due to exposure from a positive staff member. are we required to let the residents know if that staff member worked with them.?	Yes, we need to develop visiting guidelines.
43. Are there any plans to revisit visitor restrictions in long-term care facilities?	Yes, we need to develop visiting guidelines.
44. There's been a lot of talk about how fever is not a good indicator of Covi-19 infection. Many healthcare facilities are moving away from taking temperatures and just having staff agree they are not disqualified to work (self-screen) when they electronically sign in to work at each shift. Are we	I do not believe temp checks and symptoms screens are going anywhere.

going to see the temperature checks go away? I'm hearing that intervention is not data driven, but fear based. What are DOH thoughts on this?	