**CMDA Aug 4, 2020 Meeting notes**

**Ann Kokish with CHCA update:**

* POC antigen machines are expected at: Mountain Vista Healthcare, Mountain Vista Estates, Center at Centennial, Life Care Center of Stonegate
* State lab is working on training for how to use the POC machines
* Criteria for getting POC machines appears to be:
	+ 3 or more new cases in the last week
	+ 1 new case of either patient or staff and previously negative for COVID-19
	+ Inadequate access to testing
	+ At least one resident death from COVID in the past week
* All nursing homes are required to submit data to EMResource and NHSN. There are efforts underway to combine the two data resources to reduce duplicative efforts.
* HHS is releasing another $5B to nursing homes, in order to be eligible for funding all facility staff needs to complete 23 modules of infection control training and CMS is working on development of the modules now
* Protective goggles/eyewear are required in all resident areas in nursing homes…
* Colorado is still at “safer at home” status
* Communal dining is not allowed yet
* Full PPE is required for all new admissions for 14 days regardless of their COVID-19 status

**Jo Tansey with CDPHE update:**

* Reminder that goggles or glasses with side shields are required in all resident areas. Primary reason is to keep people from touching their eyes which could lead to transmission or protect eyes from direct transmission if someone was to cough or sneeze in your face
* Outdoor visitation - Medical Director must approve of outdoor visitation plans. A reminder that the Medical Director MUST approve a plan and allow outdoor visitation because there is a public health order stating outdoor visitation is allowed. The Medical Director is not deciding whether or not to do outdoor visitation but rather approving a plan to make it as safe as possible.
* Surveys will continue weekly. CDPHE receives a weekly list of nursing homes to survey based on information provided by NHs on NHSN the week before. CPHE is finding that incorrect information is sometimes reported by the NH on NHSN resulting in unnecessary trips to the NHs for survey. A reminder to all NHs of the ramifications of submitting inaccurate data, so please be mindful of the accuracy of information reported on the NHSN report.
* CDPHE is working on getting surveyors tested for COVID-19 regularly
* Guidance for cleaning goggles/face shield - clean when soiled with alcohol pad
* As of this week 100% of NHs in CO are signed up and reporting in NHSN, reminder there is a fine from CMS for not reporting

**Medical Directors Panel on Novel Experiences on Coronavirus Outbreaks in CO - Chaired by Dr. Sing Palat**

*Panel Members: Dr. Joyce Mobley, Dr. Reza Esfahani, Dr. Rebecca Jackson, Dr. Karen Leible*

Lessons learned from Coronavirus Outbreaks:

* When testing results are delayed a good lesson learned is to initiate protocols as if COVID-19 is active in the building with any suspicions of positive cases
* Without rapid testing the decisions on how to administer isolation protocols and use PPE effectively are more difficult. Widespread testing with rapid results would empower NHs to be more deliberate and effective with isolation protocols, PPE use, staffing, cohorting.
* The role of surveillance testing: can certainly be helpful but it takes a lot of time, resources and effort from staff to handle the logistics, additionally it is voluntary instead of mandatory. This is important because in order for the surveillance testing to be effective you need to reach at least 70% of the staff every 7 days. Therefore POC testing, if accurate, would be a game changer for making this more possible in NHs.
* It is more important than ever to work together with good communication and having a unified leadership. Interdisciplinary teams regularly discussing and planning for COVID is key to success in dealing with the pandemic.
* Frequent staff “huddles”, daily phone calls, weekly updates, were all very effective in managing COVID during an outbreak.
* PPE conservation strategies: one NH partnered with a company called ThermalStrike, gowns are running out so can transition to washable/wearable lab coats and gowns. Gowns can be worn from one COVID room to another with proper hand hygiene(use antibacterial gel on gloves)
* Given all the bad press NHs are getting, it is important for Medical Directors to try and be more visible and communicate with patients, family, staff, and even the media if needed. The increased visibility and communication provides a more helpful narrative and can help manage the fear associated with the pandemic. Often, all we need is more communication to help manage our fears.
* Trauma informed care has become a required but critically important part of our care in NHs. Providers also need to support each other to help manage the stress of the pandemic. Please reach out to colleagues or CMDA for added support.
* Check out the podcast from our own Dr. Lea Watson on supporting providers during the pandemic called “Behavioral Health Effects of COVID-19” from the AMDA on-the-go podcast series. Click here to access: <https://paltc.podbean.com/e/covid-19-effects-on-mental-health/>
* There has been some pressure not to report deaths related to COVID on death certificates. Regardless of political pressures, it is our job to report COD accurately on death certificates.
* Social isolation, isolation sickness, skin hunger have been devastating to our frail elderly residents. Some strategies for dealing with isolation:
	+ Hallway activities and exercises
	+ Approving a designated PT or OT to be assigned to a facility and do regular therapy sessions with residents
	+ Promote the outdoor visitations with families
	+ When providers are doing a visit, we can use something like facetime to bring in family members to be present during our visit. This improves communication as well as gives the patient and family members a better feeling that they know what is going on and is involved in their care.
	+ Consider making a schedule to remind residents to get out of their rooms, the schedule can encourage people to move around in shifts to limit the numbers out of their rooms at one time and can help encourage people that are severely depressed and not initiating a request to leave their room
* CDPHE communication with facilities has evolved and it is imperative for Medical Directors to reach out to CDPHE and use their resources to deal with the multitude of issues associated with COVID-19. Communication is a two way street.

**COVID-19 Strike Force Update from Dr. Leslie Eber and Dr. Greg Gahm**

* If you are interested in doing surveillance at your facility you can reach out to the strike force for support
* There are opportunities for providers to get weekly testing as a part of the surveillance testing
* There is no need for a test-for-cure for known positive COVID cases. We are using symptom based and time based strategies to determine when people can come off isolation. If someone has a fever within 90 days following a confirmed positive COVID case then look for other reasons for the fever as it is very unlikely the fever is related to COVID after they have recovered from their initial infection.
* Antigen testing is being rolled out to some facilities. This comes with some problems. The antigen testing has been tested on people with symptoms which raises the probability that the testing result accuracy is artificially inflated when compared to and used on people without symptoms. It is not a basic screening test and does not match PCR testing. Additionally, you will get 400 tests for free then the facility will need to pay for them. This is going to be very costly and may not be worth the cost.
* Antibody testing is not a great test until the prevalence in the community is higher. The antibody tests are effective when they are negative, meaning you can be relatively sure you don’t have the antibodies. When they are positive, there is about a 60% chance that it is actually positive. This means people could think they are protected when in fact they are not and engage in riskier behaviors.
* Schools reopening are likely to cause another wave of infections. Be aware that conspiracy theories are growing and try to educate people about the actual risks of getting infected as well as the benefits of mask wearing and social distancing.
* There are NO reliable evidence based treatments for COVID-19 in the nursing home population. Please do not use Hydroxychloroquine and Azithromycin or Doxycycline in nursing home patients. There is a large trial in New York going on right now looking at the combination of Hydroxychloroquine plus Azith/Doxy plus Zinc. The trial is a good double blind placebo RCT, so if the results are in favor of this triple combo then we may start using it. Until those results are in, we have good RCTs actually showing NO benefit using hydroxychloroquine plus Azith/Doxy.
* Remdesivir and Dexamethasone may have some place in treatment but typically not in nursing homes. These are reserved more for patients that have been hospitalized.
* If a patient chooses to leave the facility, when they return they must be in isolation for 14 days. If they are educated about this prior to leaving and that is well documented and they choose not to adhere to isolation precautions, then you can initiate an immediate discharge. We are responsible for ALL patients in a facility, so a potentially unsafe discharge for one patient in order to protect many others is reasonable.