

Good afternoon. I'm Commander Ibad Khan And I'm representing the Clinician Outreach and Communication Activity, COCA with the Emergency Risk Communication Branch of the Centers for Disease Control and Prevention. I'd like to welcome you to today's COCA call Coronavirus Disease 2019 COVID-19 Update Information for Long-term Care Facilities.

For participants using the Zoom platform to access today's webinar. If you are unable to gain or maintain access, or if you experience technical difficulties, please access the livestream of the webinar on COCA's Facebook page at [www.facebook.com/cdcclinicianoutreachandcommunicationactivity](http://www.facebook.com/cdcclinicianoutreachandcommunicationactivity). Again, that web address is [www.facebook.com/cdcclinicianoutreachandcommunicationactivity](http://www.facebook.com/cdcclinicianoutreachandcommunicationactivity). The video recording of this COCA call will be available immediately following the live call on COCA's Facebook page at the above address. The video recording will also be posted on COCA's webpage at [emergency.cdc.gov/coca](http://emergency.cdc.gov/coca) a few hours after the call ends. Again, that web address is [emergency.cdc.gov/coca](http://emergency.cdc.gov/coca). Continuing education is not provided for this COCA call.

After the presentation, there will be a Q&A session. You may submit questions at any time during the presentation, through the Zoom webinar system by clicking the Q&A button at the bottom of your screen and then typing your question. If we are unable to ask the presenters your question, please visit CDC's COVID-19 website at [www.cdc.gov/covid-19](http://www.cdc.gov/covid-19) for more information. You may also email your question to [coca@cdc.gov](mailto:coca@cdc.gov). For those who have media questions, please contact CDC media relations at 404 639-3286 or send an email to [media@cdc.gov](mailto:media@cdc.gov). If you're a patient, please refer your questions to your healthcare provider. Also, please continue to visit [emergency.cdc.gov/coca](http://emergency.cdc.gov/coca) over the next several days as we intend to host COCA calls to keep you informed of the latest guidance and updates on COVID-19. In addition to our webpage, COCA call announcements for upcoming COCA calls will also be sent via email. So please subscribe to [coca@cdc.gov](mailto:coca@cdc.gov) to receive these notifications. Please share the invitations with your clinical colleagues. For instance, we intend to hold a COCA call this coming Monday, March 23 at 2 PM Eastern. where the topic will be COVID-19 and guidance on underlying medical conditions. Additional information will be shared via email call announcements and should be posted shortly on the COCA call webpage at [emergency.cdc.gov/coca](http://emergency.cdc.gov/coca).

I would now like to welcome our two presenters to today's COCA call. Our first presenter is Dr. Brendan Jackson, a medical epidemiologist from the COVID-19 response clinical team at CDC. Our second presenter is Lieutenant Commander Kara Jacobs Slifka, a medical officer from the COVID-19 response clinical team. Now, our first presenter, Dr. Jackson, please proceed.

Thank you and good afternoon. And thanks everyone for joining. So, over the next hour, we'd like to share what we know about preparing for and managing COVID-19 in long-term care settings. And as our country faces this unprecedented pandemic, we know that you're on the frontlines of protecting some of the most vulnerable people in society. So, our goal this afternoon is to summarize the best and most up-to-date information we have available to inform your decisions. I'm going to discuss clinical aspects of COVID-19, relevant to long-term care settings.

My colleague Dr. Jacobs Slifka will then discuss how facilities should be preparing, including actions to prevent spread. So, over the next 15 minutes I'm going to cover a brief update on COVID-19, provide an overview on COVID-19 clinical presentation and course, including mortality and risk factors, focusing specifically on long-term care. And discuss management and treatment. I should point out this next slide is my only slide, so please do not be concerned that the slides do not advance. So, if you could go to the next slide, that would be great. So, onto the brief update on COVID-19 in the US. As you all know, the

coronavirus is now spreading in communities in many states. To date, thousands of cases have been reported in the United States, including from nearly every state. Although we know that many cases are probably going undiagnosed. We expect many more cases to occur in the coming days and weeks.

Social distancing is now essential to reduce spread and save lives. For life example, the federal government now recommends that everyone avoid social gatherings in groups of more than 10 people and avoid discretionary travel. CDC has more guidance on community mitigation strategies and other topics including clinical management on the CDC website at [www.cdc.gov/covid19](http://www.cdc.gov/covid19). Please also consult your local and state health departments for more information.

All right, well our experiences with long-term care facilities in Seattle and elsewhere suggests that the virus can spread rapidly in long-term care facilities and have a relatively higher mortality than among the general population. So, first I'm going to talk about recognizing possible COVID-19 to help protect residents and staff. So, in the clinical presentation, most of our information about how it presents, and progresses is based on reports from Asia and the early US experiences.

So, first, how long does it take from someone coming in contact with the virus to getting symptoms, which is also known as incubation period. Typically, 4 to 5 days. But it can be as short as 2 days in some people and up to 14 in others. We don't yet know much spread happens from the asymptomatic people. But we do think that most transmission happens when people are having symptoms. All right.

So, what about signs and symptoms? Some people, we don't exactly know what proportion never get symptoms and are asymptomatic. Others might have nonspecific symptoms, just not feel quite right. But for those who develop symptoms, COVID-19 is often a flu-like illness with over 3/4 having fever, over 1/2 having cough, and a smaller proportion having things like muscle aches, fatigue, and sore throat. A small percentage of people have experienced GI symptoms. Things like diarrhea and nausea before getting fever and respiratory symptoms. Now, based on what we know so far, most, or about 80% of people have mild symptoms. It's important to know the COVID-19 seems to progress to severe disease much more often than seasonal influenza. One thing to note is that most adults do not get a runny nose, known as rhinorrhea. That said, people might have a runny nose if they have COVID if they also have an infection with a virus that causes something like the common cold.

Now for many, symptoms run their course in about a week, and then start getting better. But in others, things can get worse, leading to severe shortness of breath, pneumonia, and something called acute respiratory distress syndrome, known as ARDS, where the lungs fill with fluid. We want clinicians to know that people may not develop shortness of breath, until they've already been sick for several days. We've seen this on numerous occasions, where even into their second week of illness. In one report in China, the average patient wasn't hospitalized until day seven of their illness. And sometimes people may be fairly stable for about a week and more quickly develop respiratory failure. So be on the lookout for that. Now, people who have been in acute care hospitals, about 20 to 30% have required intensive care for respiratory support. Ranging from high-flow oxygen to noninvasive ventilation, like BiPAP, or even mechanical ventilation with a breathing tube. One thing to note is that noninvasive ventilation like BiPAP requires close monitoring, as some patients will eventually progress to needing mechanical ventilation or like intubation. So, moving onto mortality and risk factors, I think it's widely known that older people and those with serious chronic medical conditions are at a higher risk of death. Which is one of the reasons that long-term care facilities need to take COVID-19 so seriously.

Now, among hospitalized patients in China, about 1 in 500 people in their 30s died. Versus about 1 in 12 people in their 60s, and about 1 in 7 people in their 80s. So, you can see that change with age. We need more information on which conditions, chronic conditions place people at the highest risk. But the following conditions here probably increase that risk. Things like chronic lung disease, heart failure, diabetes, certain neurologic conditions, weakened immune systems like including from certain drugs with biologics or from chemotherapy, cirrhosis of the liver, kidney disease, requiring dialysis, and potentially extreme obesity or a body mass index of over 40. But we're still learning more about these things. People who die from COVID-19 often have respiratory failure from pneumonia, ARDS as I was talking about. We're also seeing that some patients in addition to that may develop septic shock and damage to the liver, kidney, heart, and other organs.

A few items on laboratory findings. There's nothing that's really clear early in the disease that says for sure whether this is COVID-19 or not. We do see that a low lymphocyte count is common in critically ill patients. But it might not always be present. Patients often, later in the illness, will have an elevated white blood cell count. But early on, they may be low, high, or normal. Again, later they might have things like elevated liver enzymes or lactate dehydrogenase, LDH. Those are maybe predictors of worse outcomes, but early on again, it's not as obvious. It's also important to know when it comes to laboratory testing that some studies have found that SARS-CoV2 infections, that's the virus that causes COVID-19 has been seen together with other respiratory viruses, including influenza. So, just because you have one doesn't mean you can't have another. Now, on imaging, patients often will have a normal chest x-ray early in their illness. If they're getting shortness of breath, they may develop other findings on x-ray like infiltrates, bilateral lung infiltrates, or even consolidation and ground-glass opacity on chest CT, although that's not universally seen.

Okay, now here's a few special considerations when it comes to long-term care. First both residents and older visitors have had mortality rates substantially higher than the general population, making infection prevention and control all the more important. Second, when it comes to signs and symptoms, please educate your staff on what those signs and symptoms are and their critical role in protecting residents. And I mean not everyone with COVID-19 will have a fever. We all know that older adults, especially those with severe medical conditions don't always display typical responses to infection. So that said, the early symptoms of COVID-19 in these patients may be a little bit vague. Things like confusion, or just general malaise and not feeling that well.

So, here's a couple of things that you can do. If the virus that causes COVID-19 is spreading in your community, consider checking on residents more frequently than you otherwise would. You can ask residents if they feel feverish or have symptoms of respiratory infection on admission. And then at least daily. In skilled nursing units, facilities could consider adding pulse oximetry to vital signs if they don't use it already. And even on long stay units, residents should be closely monitored. At least daily for signs and symptoms of illness. Including checking their vital signs and pulse oximetry. And the assisted living facilities should also increase their vigilance for symptoms among their residents and create a process for monitoring temperature and pulse oximetry, at least daily if possible. If a resident develops even mild temp, we suggest you monitor more frequently. Pay particular attention to increases in temperature, even if not being the true criteria for a fever. And in their heart rate, or declining oxygen levels by pulse oximetry. Now, if a case of COVID-19 is found in your facility, we recommend instituting at least twice daily vital signs and clinical evaluation. At a minimum being, temperature, heart rate, and pulse ox to see if there's anyone else who's getting sick.

Also consider COVID-19 nesting and hospitalization for older adults with concerning changes, even if they lack typical fever or respiratory symptoms. So, enhanced monitoring can be critical because nursing homes have reported that residents have developed respiratory failure quickly after seeming pretty well during an initial mild illness. We don't know if this is because the disease came on suddenly in them, or whether illness had been present for a little while but it's hard to detect. It's also important for healthcare providers to have discussions with residents and families about their goals of care. This is true any time and including about the end of life. If a resident has expressed a desire to avoid hospitalization or intensive care, that information should be clearly reported.

So, now onto management and treatment. Currently, there's no licensed antiviral drugs for the treatment of patients with COVID-19. And so, management and care is, generally supportive. One thing to note in an older population or those with comorbidities is to use caution with intravenous fluids. If patients are having respiratory distress, since older patients are more susceptible to having volume overload and pulmonary edema or some of that fluid ending up in their lungs, which can worsen their breathing. Another note is that although secondary infection, you know infection on top of the COVID-19 like bacteria or fungus or something like that have not been seen that widely, they do happen in COVID-19.

So, be on the lookout for those, including for drug-resistant infections. Another management issue is that based on available data CDC, is recommending that corticosteroids be avoided unless indicated for other reasons. So, you know you might give it for instance if a patient is having a COPD exacerbation, or if they're in the hospital and having septic shock, under the guidelines for surviving sepsis. But the reason for avoiding corticosteroids in most people is the potential for prolonging viral replication, or how long the virus stays in the body. And this is been observed with MERS. With the MERS coronavirus.

So that's part of what's setting that recommendation. So, as you all know and you're probably reading online, there are a number of investigational therapies out there. Intravenous Remdesivir, it's a nucleotide analog is being studied in the United States for treatment of COVID-19. At this point, the efficacy of Remdesivir remains unknown. There are trials ongoing. Specifically, an adaptive NIH trial and two open-label investigational new drug trials of Remdesivir. It's also available on a limited basis from the manufacturer for compassionate use. For more information about these trials and compassionate use can be found online at [clinicaltrials.gov](https://clinicaltrials.gov), or CDC's clinical care guidance webpage.

Now, we're also aware that some physicians are using drugs like chloroquine, hydroxychloroquine, Lopinavir, Darunavir and other drugs for COVID-19. But we're not able to make a recommendation on those given limited data and no data from randomized controlled trials. Investigators are starting new studies and this situation is evolving very rapidly.

So, it's important to note that CDC does not recommend for or against the use of any of these investigational or off label therapies at this time. I should point out we've also been getting questions about the use of ACE inhibitors, angiotensin receptor blockers, and nonsteroidal inflammatory drugs, NSAIDs like ibuprofen. At this point, there's not enough data for us to make recommendations about these medications.

So, to summarize, I'd like to emphasize that our understanding of the nature of the clinical presentation and course of COVID-19 is still evolving, especially in this long-term care population. The CDC will continue to share additional information as we have it. Thanks, and I'll now pass it over to my colleague Dr. Jacobs Slifka.

Thank you. And as Dr. Jackson described, older adults and people who have severe underlying chronic medical conditions, things like heart or lung disease, diabetes, or obesity seem to be at higher risk for developing more serious complications from COVID-19 illness. And given their congregate nature, frail and older adults residing in nursing homes and assisted living facilities are at the highest risk from COVID-19. If infected with Sars-cov-2, the virus that causes COVID-19, this population is more likely to experience severe illness, require hospitalization, and is at increased risk of death. Ill visitors and healthcare personnel are the most likely sources of introduction of COVID-19 into the facility.

I want to share a little bit about our recent public health responses to COVID-19 outbreaks in nursing homes and assisted living facilities over the past few weeks as these have helped inform our current guidance for these settings. We've discovered clusters of symptomatic residents at not just one facility, but at multiple facilities in the same geographic area. And during those investigations have identified ill healthcare personnel as being among the earliest identified cases of COVID-19 in facilities. We've also seen visitors of long-term care facilities developing COVID-19 and have seen movement of both ill healthcare personnel who may work at more than one facility, and residents being associated with outbreaks. We have observed challenges with identifying residents at high risk for progression to severe illness and hospitalization. And seen those residents move very quickly from what appears to be a milder illness to a much more serious infection. COVID-19 is already circulating in many communities across the United States. We expect that COVID-19 will continue to be identified in more communities, including areas where cases have not yet been reported. To protect our vulnerable residents, nursing homes, assisted living, and other residential care facilities should assumed that COVID-19 is already in their community and take aggressive efforts to keep residents, visitors, and healthcare personnel healthy.

Over the next few minutes, I will be describing specific strategies that nursing homes, assisted living facilities, and other residential care facilities can use to decrease the risk that COVID-19 enters and spreads in the facility, inform and educate residents, staff, and visitors, and rapidly identify residents, ill residents, and healthcare personnel so that the appropriate infection prevention and control practices can be implemented. We will also talk about strategies for social distancing among residents and for preserving PPE supply. One of the most important things that you can do to prevent the entry of COVID-19 into you're your nursing home or assisted living facility is to restrict visitation.

Both CDC and the Centers for Medicare and Medicaid Services, CMS, have issued strong recommendations to immediately restrict all visitation to nursing homes. There may be some exceptions for certain compassionate care situations, such as end-of-life. But no other visitors should be allowed entrance into these facilities at this time.

Absolutely no ill person should be allowed to enter the facility for the safety of the residents, visitors, and facility staff. We recognize the negative impact that social isolation can have on this population. But are recommending such extreme measures due to the risk of serious illness and mortality among older adults.

Communication at this time becomes essential in order to help residents and families understand the current situation and maintain connections with loved ones. CDC has created a template letter for nursing homes and assisted living facilities to share with residents and families that explains visitation restrictions, how healthcare personnel and residents will be monitored for symptoms of respiratory illness, the infection prevention and control practices that they can expect to see in the facility. Such as the use of personal protective equipment, or PPE. And the actions that residents can take, such as how residents may practice social distancing and clean their hands. We encourage you during this rapidly changing situation to incorporate alternative methods for communication into your routine in order to help ease the anxiety that your residents and their families may be experiencing due to COVID-19 and visitation restrictions. Some ideas for this including using methods such as phone, or video conferencing to allow residents and families to connect.

Maintaining contact information for family and friends of residents, as well as sharing the facility's preferred contact information with those individuals so that important messages can continue to be communicated. And doing things like posting reminder signage outside of the facility about visitation restrictions. And who the visitor can contact for further information is encouraged as well. In addition to restricting visitors, CDC is recommending that you restrict any nonessential healthcare personnel from entering the building. We recognize that this may not be an easy task. But the overall goal is to minimize potential exposure of nursing home and assisted living residents to individuals that may be able to spread COVID-19.

For those of you that do not yet have COVID-19 in your facility, now is the time to think about how you might do this. The first step may be to create a list of staff, visiting consultants, volunteers, and any other services that enter your facility. This will look different for every facility. But what you may consider doing is engaging each of those different services and providers in order to create a plan for how you may limit, or even stop visits. Consider looking at the services provided and creating a list of services that absolutely must continue for the necessary medical care of your residents, those that may be delayed, or those that could be stopped, even if temporarily. Ultimately, the decision about which personnel should be restricted will need to be determined locally, at the facility level. We do have numerous resources available on the CDC webpage with an abundance of information that can be used to education both facility-based, and consultant personnel on COVID-19. We encourage you to check it out, and also to create a communication chain with your staff so that you can rapidly disseminate any messages. Social distancing of residents is another challenge, but very important strategy for preventing the spread of COVID-19.

Although activities and socialization are so important for these adults, CDC is recommending that group activities are cancelled, and residents try to maintain a distance of at least 6 feet apart from one another. Since communal dining involves many residents and facility staff in the same place, at the same time, communal dining should be halted. However, residents must continue to be safely fed. So, resident needs may dictate exactly how your facility implements dining for the immediate future. We encourage you to find creative ways to continue to keep your residents active and engaged and share those ideas with one another. As I've mentioned, we have learned from current outbreaks that ill healthcare personnel are one of the ways that COVID-19 can enter a nursing home and assisted living facilities.

Actively monitoring both residents and healthcare personnel for fever and symptoms of respiratory infection is a vital component of preventing spread of COVID-19. By rapidly identifying illness so that appropriate infection prevention practices can be implemented. The well-being of your facility staff is essential to the continued care of your residents. In order to keep residents and healthcare personnel healthy, facilities staff must have the ability to stay home when they are ill. Staff should regularly monitor themselves, even when they're not working for fever or symptoms of respiratory infection. And when staff come to work at the start of their shift, they should have their temperature taken, along with symptoms screening. Ill staff who are identified throughout the workday should immediately stop what they're doing, put on a face mask, notify the facility and go home. All residents should be assessed at least daily for symptoms of respiratory infection, including sore throat, shortness of breath, new or changed cough. In addition to having their temperature checked. As soon as an ill resident is identified that resident should immediately be restricted to their room. If the facility has a respiratory protection program with fit tested staff and N95 or higher-level respirators, a respirator can be used. Otherwise, healthcare personnel should use gloves, gown, face mask, and eye protection for the care of any resident with an undiagnosed respiratory infection, which includes any resident with suspect, or confirmed COVID-19.

Healthcare personnel should perform frequent hand hygiene, clean and disinfect environmental surfaces, especially high touched surfaces and shared equipment. And the universal use of face masks should be considered. It is extremely important that nursing homes, assisted living, and other long-term care facilities notify the Health Department for residents with severe respiratory infection, or if they identify a cluster of residents and/or healthcare personnel with new onset respiratory systems. Should a resident require a higher level of care, such as needing to be transferred to an acute care hospital, the receiving facility, EMS, or transport service and the Health Department should be notified. We are currently facing serious PPE shortages across the country. Assess your inventory now, so that you have an idea of what PPE you currently have available.

Know your Health Department and your Health Care Coalition contacts so that you're able to reach out about the availability of additional PPE as necessary. Now is not the time to be expanding your use of PPE. Now is the time to talk about and educate your staff on ways to preserve your PPE supply. More details will be available on the CDC website as we expect numerous additional resources to become available in the near future. But some strategies for preserving PPE supply include prioritizing gowns only for certain situations, such as aerosol generating procedures if they are performed at your facility, as well as care activities where splashes and spays are anticipated, and for things like high-contact resident care activities. And these high-contact resident care activities are the same activities that we have talked about with enhanced barrier precautions. And these are the activities that are at the highest risk of transmitting infectious pathogens, and include things like dressing, bathing or showering, transferring, providing hygiene, changing linens, assisting with toileting, device care or use of a device, and wound care. Another strategy is to start extended use of eye and face protection, which depending on your inventory may mean that healthcare personnel use the same face mask and eye protection for their entire shift and reprocess the eye protection for continued use. In order to do this, healthcare personnel would only change their gloves and their gown if it was used and perform hand hygiene in between providing care to different residents with confirmed COVID-19, while continuing to wear the same eye protection, and the same face mask.

In this situation, the healthcare personnel must not touch their eye protection or face mask. They would then remove the eye protection and face mask, only if they became damaged or soiled, or when leaving the unit, or at the end of their shift. And of course, perform hand hygiene before and after removal is required.

So, in conclusion, I want to thank you all for being on this call and for the COVID-19 preparedness efforts that you're all putting into place to protect your residents and facility staff. I want to stress the importance of restricting visitation to nursing homes and assisted living facilities and not allowing entrance to any ill person, including healthcare personnel. Actively monitoring residents and healthcare personnel will help identify respiratory illnesses as early as possible so that the appropriate infection prevention and control practices can be implemented immediately, decreasing the risk of COVID-19 spreading within the facility. Please closely monitor any ill residents as they have a high risk of developing serious illness. And notify the Health Department when you identify these residents or clusters of residents or healthcare personnel with respiratory illness. Please also refer to our website for additional guidance and resources, and to your state for local guidance.

Now, I think we are ready to take questions.

Presenters, thank you for providing our audience with such useful information on this rapidly evolving pandemic. We appreciate your time and value your clinical insights on this matter. We will now go into our Q&A session.

Please remember, you may submit questions through the webinar system by clicking the Q&A button at the bottom of your screen and then typing your question.

**Our first question is one we are seeing routinely from facilities and the question asks if our facility does not have an airborne infection isolation room, is there a need to transfer our residents who are COVID-19 positive?**

This is Kara, an airborne infection isolation room, or AIIR, is not required for the care of residents with suspect or confirmed COVID-19. The use of an AIIR, if available should be prioritized for aerosol generating procedures, although most long-term care facilities, we recognize, do not have AIIRs. Ideally, a resident with COVID-19 is placed in a single-person room with a private bathroom. But room sharing and cohorting may be necessary. We also recognize that many long-term care facilities have very limited single person rooms. So, transfer really should be considered only if a resident, clinically, is requiring a higher or different level of care.

**Thank you. Our next question is sort of a compilation of a common one we have seen, and that question is asking, what is your best recommendation for what we should do if you have a resident that we think might have COVID-19?**

This is Kara again. If you're suspecting that a resident may have COVID-19, you should move that resident to their room and close the door. The resident should stay in their room, although continue to be monitored with staff wearing gloves, gown, face mask, and eye protection. Notify the Health Department immediately. And if the resident must leave the room, they should wear a face mask and perform hand hygiene. And I just wanted to mention, just in terms of you know we also get asked, do

we need to send the person to the hospital if they've got COVID-19 and I just want to emphasize that the decision about whether to hospitalize someone should really be based on their clinical status. On a clinical assessment of their need for additional care and not really based on just whether they have a coronavirus infection alone. Because a lot of people are going to have fairly mild infection. Again, like we said before, keep in mind that there are some residents who have mild illness initially and seem fine, and then they actually will get worse over time. So, that's why we're talking that that monitoring is so important. Thanks.

**Thank you. Our next question is a frequently asked question. And the inquiries are asking how can they figure out how to get the test for COVID-19?**

Yeah, that's a great question. So, clinicians may be able to access testing through a network of state and public health labs. And you can direct those questions to your State Health Departments. We know that there's some shortages right now. An increasing number of clinical labs are receiving FDA authorization for testing under this emergency use authorization. And so, they are and are expected to roll out even more volume of testing for COVID-19. So, what facilities can do, and you may have done this already is contact your existing laboratory vendor, find out if they have that test available, or if there's a way to get it through them as well. Thanks.

**Thank you. We have multiple follow-up questions on the topic of testing. So, first question asks what clinical samples are best for testing for COVID-19?**

So, in terms of which clinical samples to collect. For initial testing, CDC recommends a single nasopharyngeal, so an NP swab up the nose, deep inside the nose for testing. Clinicians can also choose to swab both the nasopharynx, deep inside the nose, or the oropharynx, the back of the mouth. And combine those swabs in a single tube for testing. Although given limited supplies, it may just be better to just stick with the nose. For patients that develop a productive cough, sputum can be, in certain cases, submitted for testing immediate that maybe have higher sensitivity, it's not required. I want to mention though, and I don't know if long term care facilities would be doing this, but we don't recommend inducing sputum if people aren't producing it already. Because that can generate more aerosols and potentially increase risk of infection to others. For some you I know have ventilator units. If you have patients that are intubated, bronchoalveolar lavage, basically, you know putting down a tube and a wash down the windpipe, or tracheal aspirates can be collected for testing. And those may have a little bit of increased sensitivity in those populations. And I also want to point out that patients might have a negative test early on in illness, and that repeat testing, if that's available to you, after a day or two, if your symptoms continue to worsen, that might actually be a little more sensitive in picking up the virus that causes COVID-19.

**So, another follow-up question is so if a resident does test positive for another respiratory virus, does that exclude COVID-19 as a cause of illness? Can you elaborate on that please?**

Sure, it's a great question. And I know early on when testing was particularly limited, and it may still be going on in some places, people, they needed to sort of conserve the number of tests that were available. And so, if somebody had a positive test for another virus that would prompt them not to look for the COVID-19. What we're seeing from international data and a little bit now in the US data is that patients can have more than one virus at the same time, particularly if there's a large panel being

ordered. Or even have a co-infection between influenza and the virus that causes COVID-19. So, unfortunately, a positive test for another virus just can't by itself, rule out COVID-19.

**Thank you for your response. We have more questions more so on the idea of monitoring patients in these facilities. And the questions ask how do you decide which residents should have increased monitoring and if there is such a thing as that, then are you basing that on the individual signs and symptoms. Or is it a comprehensive sort of knowledge of what's going on in the community as far as spread is concerned?**

Yeah, that's a good question, it's good to draw down on that a little bit more. I think what we're concerned about at this point is that community spread maybe present nearly everywhere in the US, or it has the potential to be everywhere, we don't have a good handle on all of that. And so, given that it probably makes sense for facilities, as best they're possible to actively monitor all residents for these types of symptoms and check their vital signs on admission. So, when they arrive to a facility and at least daily. So, again, checking for fever, respiratory symptoms. You know, the skilled nursing units and long term stay units that would be great if they could measure vital signs as well as pulse oximetry daily after that. And that may be more of a challenge for assisted living facilities, but it would be good to create a process to check those vital signs and for symptoms daily as well. Now, if a resident has even mild symptoms, it would be good to monitor them at least twice daily, to make sure that any disease isn't getting worse. Now, we know there's all kinds of illnesses that can cause mild symptoms, a little bit of confusion, and a low-grade temperature. Not all that is of course, COVID-19. But it's wise given where we are right now, to monitor people more frequently. And then, certainly if there has been a case of COVID-19 in your facility, it would be good to monitor all residents at least twice daily. Thanks.

**Thank you for that. We're getting a lot of questions about personal protective equipment. And the first question asks you mentioned updating more supply and more opportunities for personal protective equipment, you hinted at some possible changes on the horizon. If a facility's running short on their supply of PPE, where can they obtain more supply. Can you give more information?**

This is Kara. PPE supply is running very low in the United States and so it's important to assess your inventory so that you have an idea of how much PPE you have, and if you are unable to obtain more PPE from your suppliers, or if you're part of a corporate group and you are unable to obtain additional PPE through that group, you should reach out and contact your Health Department and your Health Care Coalition as a next step. This is also why I was describing and encourage you to educate your staff about strategies for preserving the PPE that you do have.

**Thank you for that. Next question asks along with PPE and other such measures, how can I best prepare my facility for COVID-19.**

This is Kara, and I want to use this question to put a plug in for a preparedness checklist that we do have available online. It's on so, there is an abundance of information on the CDC website. But if you go in and navigate to the information for long-term care facilities, that I believe is under the healthcare facilities section. There will be a link to a checklist on the preparing for COVID-19 long term care facilities nursing home page. And that's that page that we provide specific guidance to long-term care settings. And there's a checklist that's available that you can print and walk through and will help you develop a preparedness plan which includes information about communication. There are places where you can fill in contact information for people that maybe useful for you to be able to reach quickly. There is

information about education, monitoring residents and healthcare personnel. Infection prevention, supplies, staffing shortages, and many other things that will help your facility to work on different pieces of that preparedness plan to get you as ready as possible.

**Thank you for that. Next question asks what do you suggest should be done for residents of these facilities if they test positive for COVID-19, do they need to be hospitalized?**

Yeah, no that's a good question. This is Brendan again. We were talking about that a bit earlier. I think that you know a recommendation is really, it's based on the clinical status, almost as you would for any other disease. Kara already touched on some of the infection prevention and control recommendations and interventions that need to go in place. Largely related to PPE. But you know it really comes down to a clinical assessment of whether that patient needs additional care that a hospital can provide. If the patient is clinically stable, has mild illness, at that point there's really no need for hospitalization, but increased monitoring is always a good idea.

**Thank you. We're getting more follow up questions on PPE and our inquirer wants to know can you please explain what you mean by preserving or optimizing PPE. Some strategies that you could share.**

Sure, this is Kara again. So, when we talk about preserving or optimizing PPE, we're referring to strategies to prolong the limited supply of PPE and so these strategies may differ depending on the type of PPE and on the situation. But they include things like extended use of PPE, selected use and reuse of PPE. And there will be more detail coming from CDC specifically on this and on different types of PPE and how we can optimize their use in the face of supply shortages. And I would expect to see this information soon coming from CDC and on our website. Sounds like it's going to be really important information, since this is going to be something new that any recommendation had been made before. Definitely. And once we have this information available, we will definitely be working on reaching out and sharing this information with partner groups and helping to disseminate this to all of you.

**Thank you for that. We have more questions about monitoring, but this time the focus seems to be on the actual healthcare personnel at the facility. Can you explain what you mean when you say actively monitor healthcare personnel? And what are some ways that a facility can do that?**

Yes, this is Kara again. When we say that we want you to perform active monitoring of healthcare personnel, in addition to healthcare personnel monitoring their own symptoms, throughout the day, whether they're at home or at work, we want them to check their temperature each day at the start of their shift, and report any symptoms of respiratory infection. This is something that can be worked out at your facility in terms of how you will go about doing this, but we do actually have some resources online, again that you can access through the long-term care information. We have surveillance tools that you can use for both healthcare personnel as well as residents that would allow you to check and ensure that each healthcare provider has checked their temperature and has checked their symptoms each day when they are coming in for their shift.

**Now, I just mentioned, because we've been getting questions from other companies, businesses about whether they should be monitoring their employees. And the general recommendation is no, but I think the reason for long term care settings is because they're caring for such a vulnerable population, is that right?**

Yes. Yes. Exactly. We know that this population of older adults in nursing homes assisted living, other residential settings are at very high risk of developing infection and developing severe illness. And we also know from the outbreaks that we have seen, so far, that healthcare personnel are one of the ways that COVID-19 may find its way into facilities. And we want to prevent that as well as detect any of those illnesses as soon as possible so that we can decrease the risk of them spreading in the facility and decrease the risk of these vulnerable residents becoming ill.

**Thank you so much for the clarification. We have some questions that have come in about treatment of COVID-19 and they essentially boil down to the use of empiric antibiotics. Can you speak to the use of empiric antibiotics for patients suspected of having COVID-19?**

Sure. Yeah. You know when you have a patient with a fever and respiratory symptoms and they've got an infiltrate or you know some white stuff on chest x-ray suggestive of pneumonia, it may be reasonable to treat with antibiotics, right? You don't know right away whether they have COVID or something else. I think it's important to know though that COVID-19 can cause a pneumonia that looks just like a bacterial pneumonia on chest x-ray. So, when you're making those decisions about whether to start antibiotics, you just have to keep in mind your clinical suspicion, and the overall illness severity. I'll just point out that you know, in like for instance in influenza, secondary bacterial infections happen fairly routinely, when people have severe illness. We have not seen that as much yet with COVID-19, but it's certainly a possibility to keep in mind.

**Thank you for that response. We have facilities asking generally, how do you evaluate your cleaning agent, if it will work against the virus that causes COVID-19.**

This is Kara, I'll comment on that. So, I think first of all you should be using an EPA registered hospital grade disinfectant. And there is additional information online in a couple of different sections within our infection prevention and control guidance. As well as within some of the checklists and the long term care guidance that we have available that refers you to the EPA website for the EPA registered disinfectants that have qualified under the EPA's emerging viral pathogens program for use against the SARS-CoV-2. I also want to comment on the use of cleaning and disinfecting, both of high touch surfaces throughout your facility, and ensuring that this is frequently being done, as well as cleaning shared resident equipment. And I'm talking about things like blood pressure cuffs. And things like Hoyer lift. Any kind of equipment that might be moved from resident to resident, or possibly in different locations within your facility. Those things should be cleaned immediately after they're used with a resident, and before they are used on another resident. So, making sure that you have appropriate cleaning agents, but also that staff and housekeeping have access to them, that they are able to use them frequently.

Yeah, I just want to add to that for a second if I could. Which, this is Brendan. If you know we've been talking about this more active monitoring of patients with doing vital signs, and you know if you're going from patient to patient with the pulse ox, and the blood pressure cuff, and otherwise, you know you don't want to be actually potentially spreading something while you're doing that. So, I think what you said is so important about making sure that mobile equipment gets cleaned. Because you don't want this monitoring program to actually be more of a problem than it solves.

**Thank you for the response. We have more questions about personal protective equipment. And our question asks, should our facility be using N95 respirators or facemasks?**

This is Kara. So, if your facility has a respiratory protection program, fit tested healthcare personnel, and N95 or higher-level respirators then if you have them, you should use them. However, most nursing homes and other long-term care facilities do not. And given supply shortages that we are currently facing, face masks are an acceptable alternative. And as we've discussed, already on this call, you should also be thinking about how to preserve the PPE you have. Whether it is face masks, or N95 respirators, eye protection, and other PPE, start thinking about how you may preserve the supply that you have.

**Thank you for that. And a follow up question on that is can you further elaborate and give more information about how to extend the use of face masks?**

Sure, this is Kara again. So, there will be additional material available through CDC and on our website. But one strategy for extending the use of face masks is to keep that face mask, to use that same face mask possibly for an entire shift. And for the care of multiple residents. Provided that that healthcare personnel is able to avoid touching the face mask, and the face mask isn't getting damp or soiled. Eye protection should also be worn with the face mask. And whenever the face mask and eye protection are removed, the healthcare personnel should ensure that they are performing hand hygiene before removing it and then again afterwards. And to further extend the use of eye protection, that eye protection can be reprocessed and used again.

**Thank you. Our next question asks about the hand sanitizer. If our facility is running out of alcohol-based hand sanitizer, should we be switching to soap and water?**

This is Kara, we have definitely heard about shortages of alcohol-based hand sanitizer. We've heard reports of this running low in some parts of the question. So, if you have it, we definitely recommend that you use it. However, make sure that you have soap at your sinks. That you have paper towels at your sinks, and that you have a trash can or garbage nearby so that staff are able to continue to perform hand hygiene before and after resident care, using soap and water.

**Thank you. Question asks that you had briefly mentioned the use of investigational therapies. Can you please talk a little bit more about investigational therapies and what other therapies are being tested right now?**

Sure. Yeah. So, I mentioned that investigational drug Remdesivir. Like I said, there is an adaptive NIH trial that's underway. There's a couple open label trials, they're not blinded trials going on as well. And it's also available for compassionate use on a limited basis. There are trials outside of the US studying things like the HIV medicine lopinavir/ritonavir. I think others are looking at other HIV medications. Some are looking at drugs that are inhibiting part of the immune system in hopes that that would work. One would be certolizumab an IL 6 inhibitor. And another is looking at hydroxychloroquine and the way that it may just modulate the immune system and make it harder for the virus to enter. However, I think the issue is, at this point we don't have solid data on any of these and so this is why CDC is not able to make a recommendation one way or the other on their use.

**Thank you. We have a question asking if my facility should be performing COVID testing.**

This is Kara, I know Dr. Jackson has commented a little bit on testing already, but I wanted to step in and mention that although the approach may change by state and local area, currently if you suspect that a resident in your facility has COVID-19, or if you are identifying severe respiratory illnesses, or clusters of respiratory illness in staff or healthcare personnel. Our recommendation is that you immediately contact

your Health Department for further guidance. And testing will be among the many things that they discuss with you.

**Thank you that and we have time for one last question, and this is sort of a common question that we are seeing. That if we have residents in our facility that are on hospice and have requested the presence of their family members, how do you recommend we handle those family member visits.**

This is Kara. And I first want to comment that we understand how difficult a visitation restriction is for all who are involved. And have thought and talked with different facilities about how this may be implemented. For individuals who are at end-of-life, this is something that should be handled on a case by case basis with a facility. But should a visitor be granted permission, or considered permission for access to the building during an end-of-life situation? The visitor should first be screened for fever and symptoms of respiratory infection. Because we really do not want anyone who is ill to be coming into long term care facilities. However, if a visitor is entering the building, they should be provided a face mask. They should be instructed to frequently perform hand hygiene. And their visits should be limited to a specific location in the building. That may be the resident's room, or it may be another location that's designated by the facility. But this is something, this is the general guidance that we are providing. But we encourage facilities to think about this and talk about this with their residents and family members.

Thank you so much. On behalf of COCA, I would like to thank everyone for joining us today with a special thank you to our presenters Dr. Jackson and Lieutenant Commander Jacobs Slifka.

Video recording of this COCA call will be available immediately following the live call on COCA's Facebook page at [www.facebook.com/cdcclinicianoutreachandcommunicationactivity](http://www.facebook.com/cdcclinicianoutreachandcommunicationactivity). Again, that web address is [www.facebook.com/cdcclinicianoutreachandcommunicationactivity](http://www.facebook.com/cdcclinicianoutreachandcommunicationactivity). The video recording will also be posted on COCA's webpage at [emergency.cdc.gov/coca](http://emergency.cdc.gov/coca) a few hours after the call ends. Again, the web address is [emergency.cdc.gov/coca](http://emergency.cdc.gov/coca). Please continue to visit [emergency.cdc.gov/coca](http://emergency.cdc.gov/coca) over the next several days as we intend to host COCA calls to keep you informed of the latest guidance and updates from COVID-19. In addition our webpage COCA call announcements for upcoming COCA calls will also be sent via email, so please subscribe to [coca@cdc.gov](mailto:coca@cdc.gov) to receive these notifications. Please share the invitations with your clinical colleagues.

As stated earlier, we intend to hold a COCA called this coming Monday, March 23 at 2 PM Eastern time where the topic will be COVID-19, and guidance on underlying medical conditions. Additional information will be shared shortly via email call announcements and should be posted shortly on the COCA call webpage at [emergency.cdc.gov/coca](http://emergency.cdc.gov/coca). To receive information on upcoming COCA calls or other COCA products and services, join the COCA mailing list by visiting the COCA webpage at [emergency.cdc.gov/coca](http://emergency.cdc.gov/coca) and click on the join the COCA mailing list link. To stay connected to the latest news from COCA be sure to like and follow us on Facebook at [facebook.com/cdcclinicianoutreachandcommunicationactivity](http://facebook.com/cdcclinicianoutreachandcommunicationactivity).

Again, thank you for joining us for today's call and have a great day.