Question	Answer
1. Our SNF currently has a quarantined unit for all residents admitted from the hospital. They are placed in 14-day quarantine. Can you please give specific guidance for PPE requirement for these residents during this time period? This has been discussed in our Leading Age webinars and everyone has a different take on what is best practice.	The official CDC guidance provided in the link to the right recommends full PPE/isolation for those in quarantine in LTCFs - about 2/3 of the way down the page under the section titled "Dedicate Space in the Facility to Monitor and Care for Residents with COVID-19". That being said given that we are in a situation where PPE is in short supply I think it is very reasonable to care for these patients while just wearing a mask +/- goggles, also if possible while care is being provided the resident could wear a mask. However, if the resident becomes symptomatic they should be assumed to have COVID and be placed on appropriate precautions, at least until test results return, if negative can use appropriate precautions for non-COVID illness. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
2. If our doctors see COVID-19 positive patients in other buildings, then, what PPE they should wear when entering our facility, which has no confirmed case.	They should wear at least a face mask (As other HCWs should do) they should be screened for symptoms as all other HCWs should be, adhere to standard precautions, good hand hygiene compliance, and consider using tele-visits wherever possible.
3. Are cloth masks okay to use in facilities without COVID cases to preserve PPE?	In all medical facilities, this includes all LTCFs, medical grade masks should be used when providing patient care. PPE requests can be made to your county health dept and more PPE is becoming available to fulfill these requests, facilities should also try to obtain PPE through their usual supply chain as well. If all options to obtain PPE are exhausted cloth masks can be used, btw this should be avoided if at all possible (this would be a crisis standard of care option)
4. We have staff who have been positive but are stating that they are still having a "headache" at the 14-day mark. Should they still return to work?	This is a difficult situation, but the guidance provided in the link to the right is relatively broad and does not use headache as a symptom for RTW. Fever must be resolved and resp symptoms "improved". In this case it sounds like it would be reasonable to have this individual return to work. https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/HealthCareWorkerReturnWork.pdf
5. Do you have a recommendation for a COVID positive assisted living resident whose symptoms is only failure to thrive – what are options for higher levels of care? the patient is not eating and drinking and would benefit from being in the skill facility with additional focus	This is a difficult question. Could contact DSHS about options but SNFs are also having a very difficult time right now so not sure they would be able to accommodate. That being said there are SNFs that are contracting to have COVID units this may be an option in the future, btw these beds will likely be prioritized for individuals who are needing discharge from the hospital and those who cannot safely isolate in their current facility.
6. In the event of a case with staff or resident, who should first be tested ? Staff? Residents?	Both should be tested. If prioritization is needed due to lack of testing supplies this would likely be determined on a case by case basis. Local public health will help prioritize

7. Question on cloth masks in facilities. Would you discourage the use of this in the AFH setting as well?	Yes, as above #4, AFHs are healthcare facilities.
8. We did a mass testing of all residents per our agency direction, of 90+ residents we had one positive result, resident was already in a private room, no visitors or outside appointments for a month, was asymptomatic, this test was collected on 4/22. No other residents are showing symptoms, we shut down the unit and isolated the patient. On 4/27 resident is still asymptomatic no other resident showing symptoms so we reran her test along with staff testing, her second test came back negative, we ran a third test on the resident 4/28 and that came back negative also. Of the staff tests we did have one come back positive and only about a quarter of tests not completed yet. Would it be safe to remove the resident out of precautions and lift the unit quarantine on Saturday based on her first test date and still no signs or symptoms of COVID. Saturday is day	Yes, this would be reasonable, but I would practice social distancing and have staff wear mask. Check in with your LHJ, if not in King County.
9. UW is going into some facilities and testing all residents and staff. Can you talk about how facilities qualify for this service and the geographic parameters - is this for any facility in the state? only King county?	UW chose the facilities they partnered with on this, mostly based on pre-existing relationships. King County is also working to perform this testing with other partners in the county. I know this is being done to varying degrees in other counties as well. Best to contact your LHJ for further information, btw UW is likely not an option if they have not already reached out to you.
10. Could a PCR lab test be a false positive.	This is a difficult question. It is very unlikely that this particular PCR would be a false positive. it is possible however that you test someone who was previously infected and now is only shedding RNA but is no longer infectious. Hope this helps.
11. If our facility's confirmed COVID-19 positive case (a staff was on 4/1), and we have NO other confirmed case until now, then are we considered as CLEAR now? Do we still need to keep reporting to King County Public Health and DOH?	If you have had no new cases or symptomatic individuals in >28 days you likely no longer have an outbreak. That said, it is very possible you could have another outbreak moving forward. I would recommend discussing this with the disease investigator assigned to your facility to come up with a plan moving forward, if they have any questions they will route them up through our team.
12. What place does serology have in our plan of care at this time? What is serology?	Serology is an antibody test, there are a number of varieties of antibody tests the most common are IgG and IgM. Generally, IgM indicates very recent or current infection, but has a relatively high rate of false positives/negatives. IgG determine if you have previously been infected and often requires at least two samples so that the titer (result) can be seen to

	go up indicating infection occurred. At this time serology does not have a role in management of disease in healthcare settings. In the future once the characteristics of the tests are better understood and duration of immunity to COVID-19 after infection is understood, it will likely play a role in return to work guidelines as well as HCW cohorting guidance, but this is not ready yet.
13. In regards to the gown comment - you mentioned in a prior session that DOH would be making recommendations on extended use for gowns. Are there any recommendations?	DOH and CDC has guidance for extending use of all PPE: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html and https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/ConservationStrat-PPE.pdf
14. Is there a list of skilled facilities that have Covid positive units?	Not yet statewide, but this may be coming. I know King County will make a list available soon. This will not include AFHs due to size and concerns for PHI breaches.
15. Curious about mention of extended use of gowns, is there a recommendation anywhere to download?	See above #13 for CDC an DOH links.
16. Is the self-test kit result accurate?	Yes, but only approved for use in symptomatic individuals at this time.
17. Do we have any greater understanding of build up of antibodies/immunity for those that have been positive and recovered?	Not yet but will hopefully get better in near future. See above #13
18. What precautions are you recommending for residents exposed to symptomatic staff that test COVID negative?	These people should be treated as quarantined see discussion above in #1 - per CDC full PPE/TBP, I think reasonable e to use mask and standard precautions, with resident masked during direct patient care. Test if symptoms develop, consider testing if available at the end of the 14 day quarantine period.
19. How contagious then should we assume a person is when they are testing positive for COVID-19 but have not had any symptoms?	Impossible to know, infectiousness is highest just before symptoms start (~48 hours) and during symptoms. The individual in question could be very contagious if they are about to develop symptoms, or they could have had asymptomatic disease and are at the tail end and not infectious at all at this point. no way to know unfortunately.
20. Is there precedence for withholding staff names from state agencies when they have tested positive?	No all cases should be reported to PH.