Physician Advisory Group – 4-27-2020

MEETING MINUTES

I. PPE-Identified as a likely rate-limiting step for the Smart Restart
   a. **Propose that Medical Cache be reserved for essential facilities that primarily rely on cache for their PPE supplies…**
      i. Timing for business reopening tied to adequate amounts/sources of PPE
      ii. Medical cache supply/access- 600K N95s, 650-700K gowns
         1. Minimum 3 weeks from a decontamination procedure
         2. No verified receipt of PPE to cache as of yet
      iii. Institutional supply/access to PPE varies…
         1. Current supply and prospects for replacement/site-driven repurposing MUST be tied to facility's smart restart plan
         2. ACS/ASA recommends that elective surgery start decision based on PPE supplies that are adequate for 2nd wave of Covid 19.
         3. Per Dr. Sather's recommendation, Joan sent email to Tim Blasl to organize meeting for OR leads, surgical heads from each institution to discuss best practice strategies of safety/PPE conservation in the Smart REstart of Elective Surgery plans being developed at each institution (email sent out 4/27)
         4. **Based on limited supplies of PPE in cache and at institutions, PAG recommends aggressive rationing of PPE from medical cache (recommend against availability for nonemergent dental visits, optometrist visits etc)**

II. Dual (PCR/Serology) Testing Strategy
   i. **Agreed with Proposal from last week that involves surveillance testing ND corrections to determine baseline and follow for new infection/recurrent infection, as surveillance testing in correctional facilities in NC and OH showed that 2/3 of residents and staff in NC facilities and 78% in OH facilities were positive for COVID, but only 10% of these were symptomatic.** - (we do not know if positive serology infers immunity…and if so, for how long)
      1. Serology testing with high specificity kit at baseline and monthly thereafter (could test all to follow Ab nadir or only test negatives?)
      2. Should we require 2 positive tests due to FP rate?
   ii. PCR testing weekly, and at time of symptoms, to determine new cases.

iii. Once we have proven that antibodies are protective, we can begin using the antibody test for this reason (nonsurveillance- ie: putting positives on front lines…)

b. Additional Proposed Priority Sites for dual-type Surveillance testing described above- no consensus on what top priority is...
    i. LTCF Workers (direct pt contact>no pt contact)
    ii. LTCF patients
    iii. Hospital Workers (direct pt contact>no pt contact)
    iv. Essential businesses/Intermediate care facilities
    v. Communities with high/medium/low incidence

III. Proposed Expansion of PCR testing as available
    a. Asymptomatic Contacts (could couple this with serology test)
    b. One symptom

IV. Proposed Expansion of Serology Testing-ONCE POSITIVE SEROLOGY IS PROVEN PROTECTIVE- and some idea of duration of protection…
    a. All essential employees
    b. Teachers
    c. Elderly and other vulnerable
    d. General public

V. Proposal for Location of Care for LTCF + Covid Patient –
    a. DHS VP3 plans to hospitalize all Covid + LTCF patients, regardless of their criteria for hospitalization
        i. Much opposition to this
    b. Alternate Criteria that eliminates unnecessary hospitalization while protecting Covid – residents housed in same LTCF
    c. Tb-Meeting tomorrow at 130-big 6 with ceos and cmos and shelly peterson and maybe Wednesday. need to have at least 1 board-certified geriatrician.
    d. Alena suggests that we have planned for our leadership will need to move to hospital. Come up with place to cohort here. Almost always full. Primary concern is to make sure staff available. 8-10 pts each. PPE is good except gowns. Reusing when possible. ONly using n95s with testing and aerosolizing procedures. If we tfer 20 patients to hospital, spots can be held for pt for 15 days.
        i. 1 pt is taking 2 spots... Would prefer to keep patients in NH if asymptomatic... some deaths in flood due to psych trauma of being removed from home... Tfer by EMS, hospital area...
        ii. Within NH, can you cohort pts with internal devices ie: plastic devices etc...? Alena is working on the plastic sheeting in 5 room groups with outside entrance...
        iii. Dawn from Bethany has 2 positive- cohorting them... Dawn adds that the challenges with families- many would rather have the pts go to the hospital... Difficulty with staffing in that people do not want to work on Covid unit and Covid + HCW. last room at end of

hall and doing 1:2 staffing- in for whole 12 hours... People will be in room but staff does not want to be on unit...

iv. If Covid + pt in bldg, rest of pts/hcw have right to not be exposed to that.
v. Med Ctrs will restart the procedures soon so may crescendo
vi. Liz from Villa Maria/Rosewood with 10+/6+ residents and both staff. Have created Covid units. cohort into semiprivate rooms at VM with outside door. In env and have staff that volunt to work. 10 asx and 2 sx staff each place. Have been able to mntn staffing. Majority really mild sx. Did not do plastic separation because using doors or separate areas.
vii. Jane says that we should develop solution to develop education piece for preventing long term... I will put skeleton together-
viii. Indications for admission/Plan for cohorting positive patients/rural place needs to put in place
ix. Paul says this is crazy and hospitals will not accept. Would only work if does not – 80% of rural facilities will say this creates a different set of problems...
x. Faye- addl scenarios... need to discuss that they do not want stuff done, even if hypoxic... in the memory care units, this weekend the residents wander- DHS said pt could not be cohorted said that pt admitted to hospital so they are medically sedated... What do they want with care... had clear plan for them before test
xi. Rich Vetter says that we should keep residents safe... families and pressure... addl downsides- falls, catheters and infections,
xii. **Document created with these suggestions after the meeting, with plan for modification of that plan over the rest of 4/27, so it can be used on 4/28 by VP3 meeting attendees Rich Vetter, Paul Carson, David Field, Jeffrey Sather**