WELCOME!

CAHF OC Annual RAP Session

Agenda

12:30pm	Introduction and a word from our sponsor: **Golden Age Dental**
12:45pm	Breakout Networking
1:00pm	State of the Association, Craig Cornett, CEO, CAHF
1:30pm	SNF Updates on New Survey Process- Heidi Steinecker, CDPH
2:30pm	Dpt of Health Update, Dr. Helene Cavet, OC Public Health
3:00pm	Wrap-Up and Thank you

GOLDEN AGE
DENTAL CARE

We hope you find today's meeting helpful during these difficult times.

With extensive new precautions and exciting new technologies, we are ready to get back to serving SNF resident's safely when the time is right.

Click here to begin video

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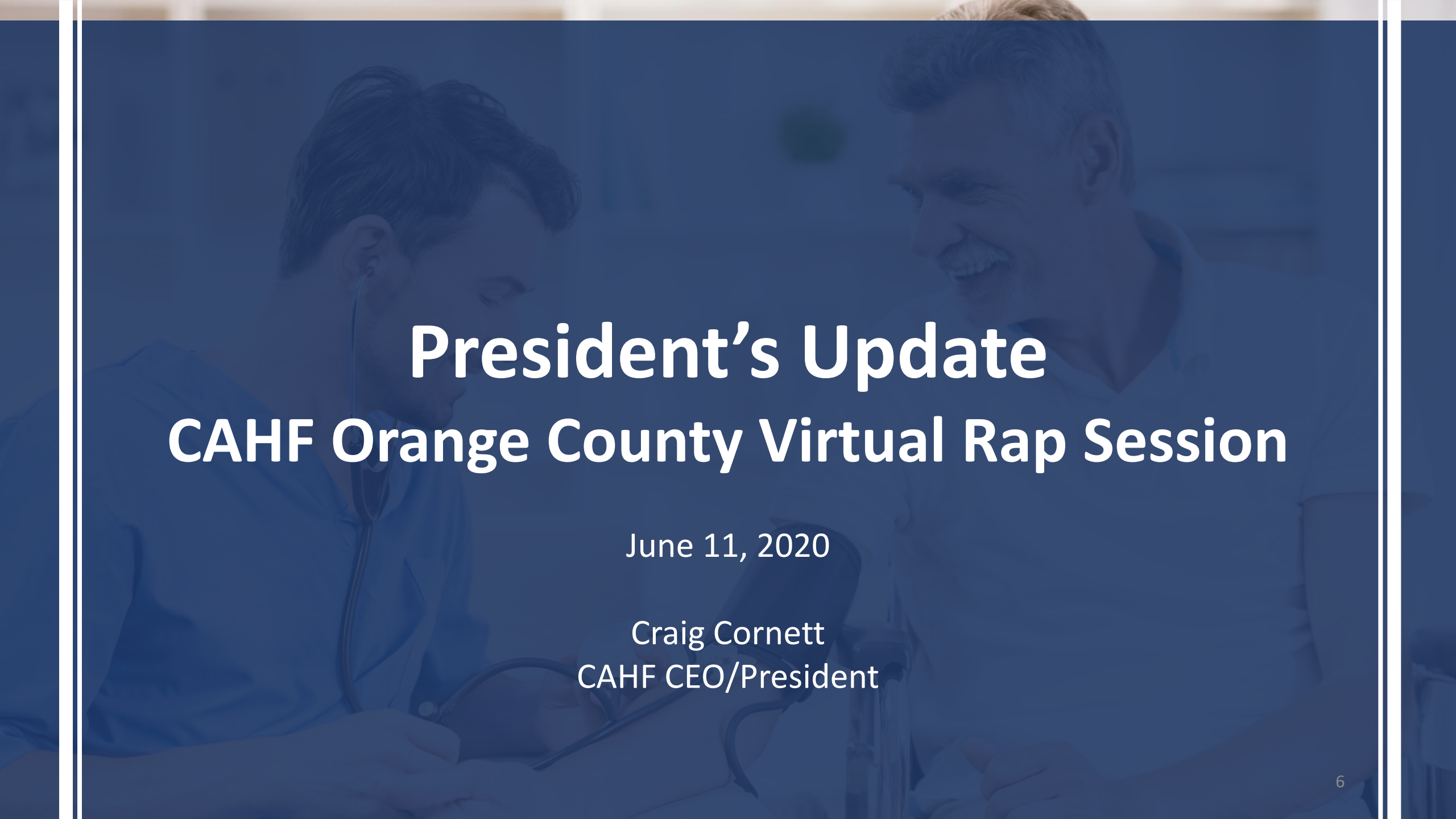
Networking Breakout

- Introduce yourself and your company!
- What has been my greatest achievement during COVID?



President's Update
CAHF Orange County Virtual Rap Session

June 11, 2020

Craig Cornett
CAHF CEO/President

AGENDA

- COVID 19: The Latest
- Mitigation Plans, Testing & Enforcement
- State Budget & 1629
- Liability
- Unique Local Issues
- Federal Actions
- “LTC at Home”
- AHCA Advertising Campaign
- What’s Next

COVID-19 : THE LATEST

Where we are in California

Latest Research

Our Challenges

MITIGATION PLANS & TESTING

- AFLs 20-52 [mitigation plans], 20-53 [testing recos.], and 20-55 [baseline testing deadline]
- Mitigation plans should be in—citations likely to start this week
- CDPH—message of "collaboration" on mitigation plans
- Regular state review of mitigation plans in foreseeable future
- "Baseline" testing: get it done by June 30!
- Follow-up testing, based on outbreaks
- "Surveillance" testing: every month

MITIGATION PLANS & TESTING *(continued)*

- Health plans must pay for staff testing—for both baseline and surveillance
- List of labs is updated regularly
- Related: Keep up your daily/weekly reporting to CDPH/CMS—avoid citations!

STATE BUDGET & 1629

- State fiscal situation is a mess—budget cuts proposed in every area…
- …but we are doing relatively well (but we're not bragging)
- CAHF success on 10% rate increase, retroactive to March 1, through end of federal emergency
  - $55 million per month to SNFs and ICFs
- Our 1629 extension is still moving in state budget process
  - Governor still supports
  - Legislature's budget deal includes it

STATE BUDGET & 1629 *(continued)*

- Budget “trailer bill” will need to be enacted
  - CAHF not happy about some provisions of trailer bill, but overall not bad
  - Needs to be done by July 31
- Stay tuned on budget issues—likely to stretch through the summer
- Please complete the minimum wage survey!

LIABILITY PROTECTION

- Still seeking an Executive Order from Governor Newsom
  - State of CAHF conversations
- Potential State legislative route
- Potential at federal level
- Workers comp
- Let CAHF know about

LOCAL REGULATORY VARIATION

- Still great variation in approach by county health departments
- Cities have gotten into the act
- CAHF attempting to monitor local variation
- Los Angeles County “Inspector General”
- CAHF’s new lobbying presence in Southern California

FEDERAL ACTIONS

- AHCA success on funding: Almost $8 billion so far
  - California: About $225 million in first two tranches, $325 million in SNF-specific pot
- AHCA seeking piece of the remaining $97 billion HHS fund—for COVID+ buildings, testing, ICFs, etc.
- Congress still likely to pass another stimulus bill
  - Federal liability protection is priority for inclusion
- CAHF working on important issues surrounding accounting for federal funds; likely webinar series in future

“LTC AT HOME”

- DHCS planning potential new Medi-Cal benefit
- Targeted or hospital transfers, SNFs to home, or to prevent SNF stays
- Development in next few months, submit to CMS in Fall, and implement statewide in early 2021
- Master Plan on Aging Stakeholder Advisory Committee will be “sounding board”
- Start considering: How can I revamp to work with “LTC @ Home”?

AHCA'S NATIONAL ADVERTISING CAMPAIGN

- Designed to push for additional financial support, immunity protection, increase positive awareness, and defense
- Digital advertising, Cable TV in D.C. market, print coverage
- Designed to support sector with D.C. policy makers and increase positive awareness nationally
  - CAHF will be coordinating closely with AHCA
- $10 per bed dues assessment for 2020 and 2021
- Support this effort; pay the assessment when the dues bill arrives

WHAT'S NEXT

- Navigating reopening plans
- Responding to existential threats that remain
  - Financial/liability
  - Regulatory
  - Oversight, finger-pointing
- Focus on IP and clinical
  - CAHF Medical Providers Conference (web based, for MDs, NPs, PAs): July 30
  - CAHF Infection Prevention Virtual Conference: August 26
  - CAHF Infection Prevention Basics: coming soon
- OSHA focus on employee COVID exposure

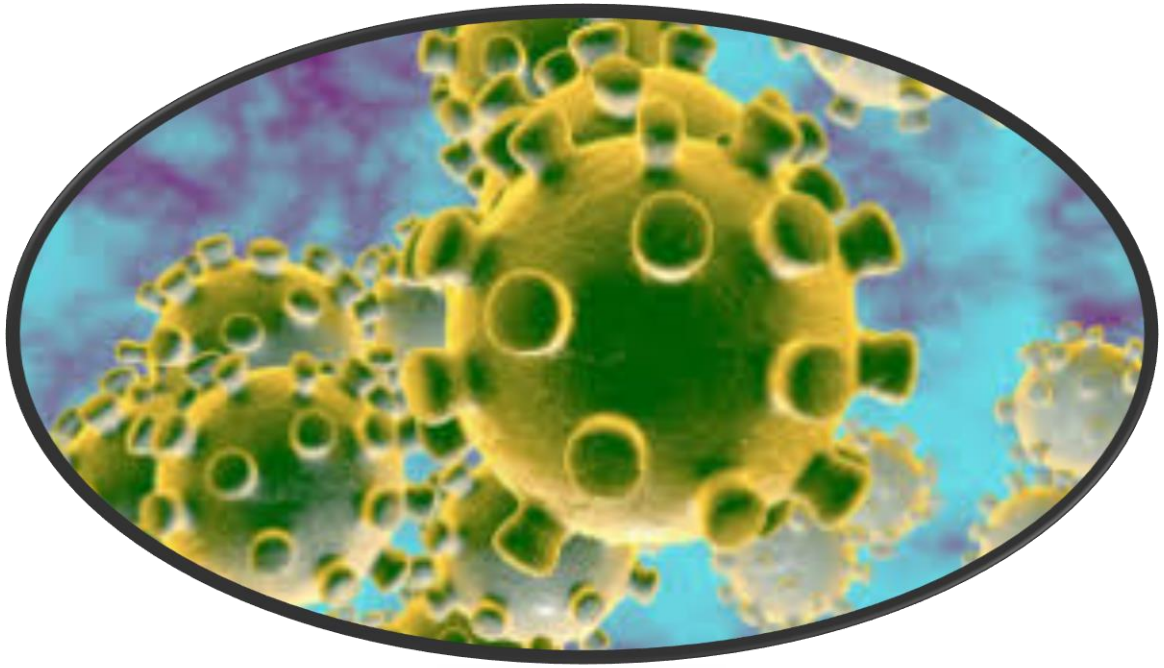
WHAT'S NEXT *(continued)*

- Vaccine—in production or use by end of the year?
- Preparing for pull-back of federal and state regulatory waivers
- CMS return to enforcement actions
- Getting people to feel comfortable returning to SNFs
- Building back census
- Documenting lessons learned
- Managing efforts on reforms
- Supporting or fighting new legislation (including non-COVID legislation)

WHAT'S NEXT *(continued)*

- Support CAHF members who are subjects of litigation
- Maintaining the focus on quality
- A future surge? The next pandemic? Adjusting to a "new normal"
- Upping the game for staff development—consider CAHF's Nursing Home Leader Academy
- Rethinking business models
- "Virtual" conferences/conventions
- Supporting associate members and business partners
- Solidifying important political relationships

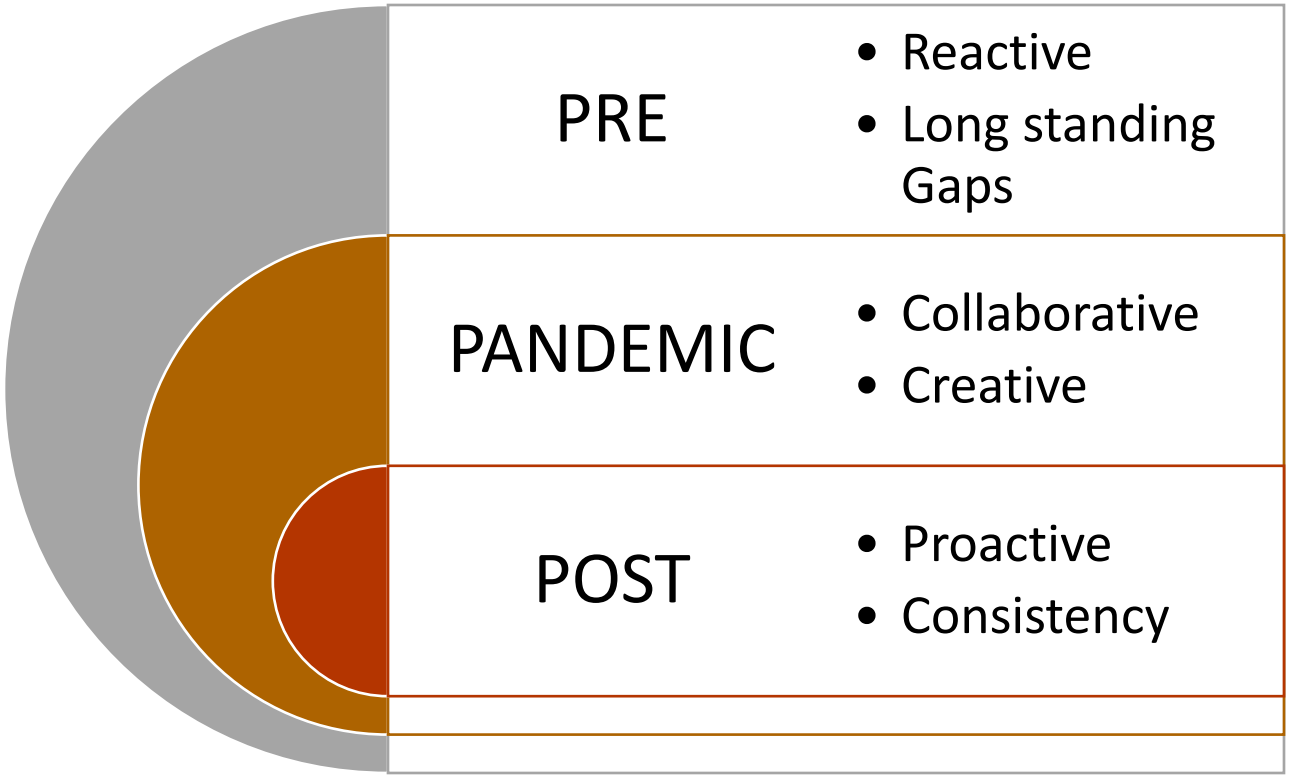
Questions?



COVID-19…A WHOLE NEW WORLD

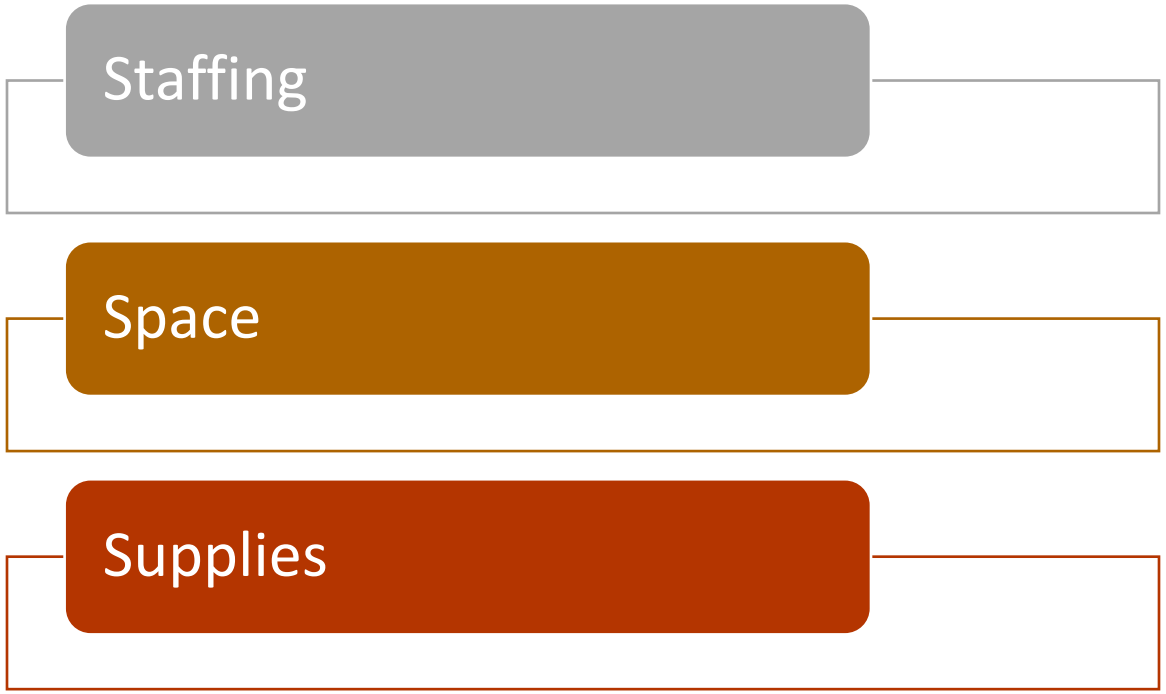
Heidi W. Steinecker
Deputy Director
Department of Public Health

THE TRANSFORMATION



CORE ISSUES TO SOLVE

Skilled Nursing Homes have unique nation-wide industry challenges that differ from hospitals and other health care facilities. In addition, they serve many end of life patients who are most vulnerable to communicable diseases. PPE and staffing are vital but they are not the simple solution to a complex problem.



Quality & Safety Oversight

Traditionally Licensing and Certification (L&C) surveyors have served solely as enforcers; pointing out the areas of non-compliance for citations and penalties. During the beginning of the pandemic, they broadened their role as educators providing technical assistance for infection control. Healthcare Acquired Infections (HAI) staff have always served in the role of consultant and preventionists but were only in hospitals prior to COVID.

Before COVID-19

- About 600 L&C staff conduct once a year state re-licensing/ CMS re-certification surveys
- HAI teams were funded for 9 staff to focus on hospitals and assisted with some emergencies
- Infection Prevention roles in SNFs are usually part-time or performing multiple duties in more than one location.

During/Post COVID-19

- L&C staff conduct onsite visits for Infection Control about every 4-6 weeks, daily calls until an online survey was developed, and daily monitor SNF Urgent Needs Dashboard to intervene quickly onsite. L&C also assist in weekly cite visits to Department of Social Services (DSS) facilities.
- HAI trained 20 L&C staff to serve as HAI strike teams and tripled their capacity. They focus on SNFs but have been deployed to other healthcare facilities and DSS facilities.
- All SNFs must have the equivalent of a fulltime infection preventionist onsite. This can be a trained MD or RN or shared role between two people.

6 SNF Strategies

In addition to creating systems for PPE, Staffing and Testing for SNFs, California must overhaul the Quality and Safety oversight process as well for both the state and federal CMS survey system.

Strategy	Overview
1. **Baseline, Surveillance, and Response Testing and Cohorting Plan**	Baseline test all SNF HCWs, surveillance test 25% of HCWs weekly and test everyone in a facility as soon as they have a single case to immediately cohort positive residents and staff. Require insurance to cover cost.
2. **Infection Prevention (IP) Workforce Resources**	Expand IP workforce and PPE resources within facilities and local health departments (LHDs).
3. **Infection Prevention (IP) Education**	Increase IP core competencies in facility staff, state RN staff, and with other local public health staff.
4. **Adopt a SNF Model**	Reform the quality and safety healthcare facility oversight process to include continuous presence in facilities to create a consistent compliance culture.
5. **Quality and Safety Oversight Mobile App**	Overhaul the healthcare facility oversight system from paper/manual processes to electronic, automated and mobile system to capture real-time data to track, trend and monitor facilities.
6. **Predictive Analytics**	Use data to target high risk facilities for early intervention; and use the data to shape the public narrative to reduce fear.

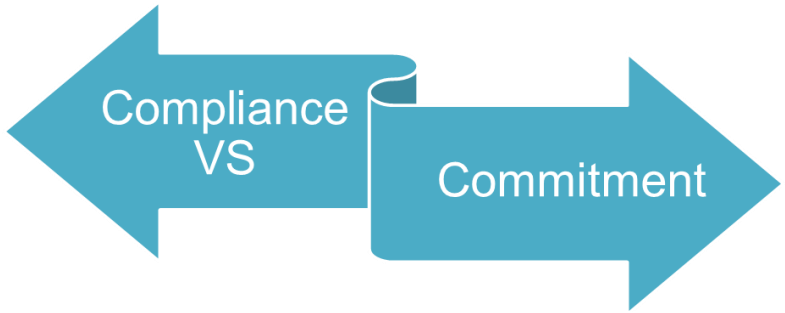
Constant Communication Pathways

The Center for Health Care Quality (CHCQ) within DPH has considerably increased the frequency of information, and focused the communication pathways directly to the SNF facilities rather than only through stakeholders.

Before COVID-19	During/Post COVID-19
Quarterly Long Term Care Stakeholder Meetings	Since January 28, 2020 Weekly All Facility Calls that consistently have between 1200-1750 participants
Frequent individual stakeholder meetings with patient advocates and facility advocates	SNF Infection Prevention Weekly Calls that average 1500 participants
Averaged 40 All Facility Letters a year, and two All Facility Calls a year	Published over 60 guidance documents in 4 months since January including All Facility Letters
Annual Stakeholder Engagement Survey and Stakeholder presentations	L&C District Office Regional Training, and HAI Infection Prevention Webinars for facilities

BEYOND COVID 19

There is a difference between Quality & Safety Compliance vs a creating a Culture that is Committed to Quality and Safety.



Instead of band-aids to the health care delivery system, we need sustainable transformations in how we provide enforcement and education for continuous quality improvement.

COVID-19 and SNFs in OC

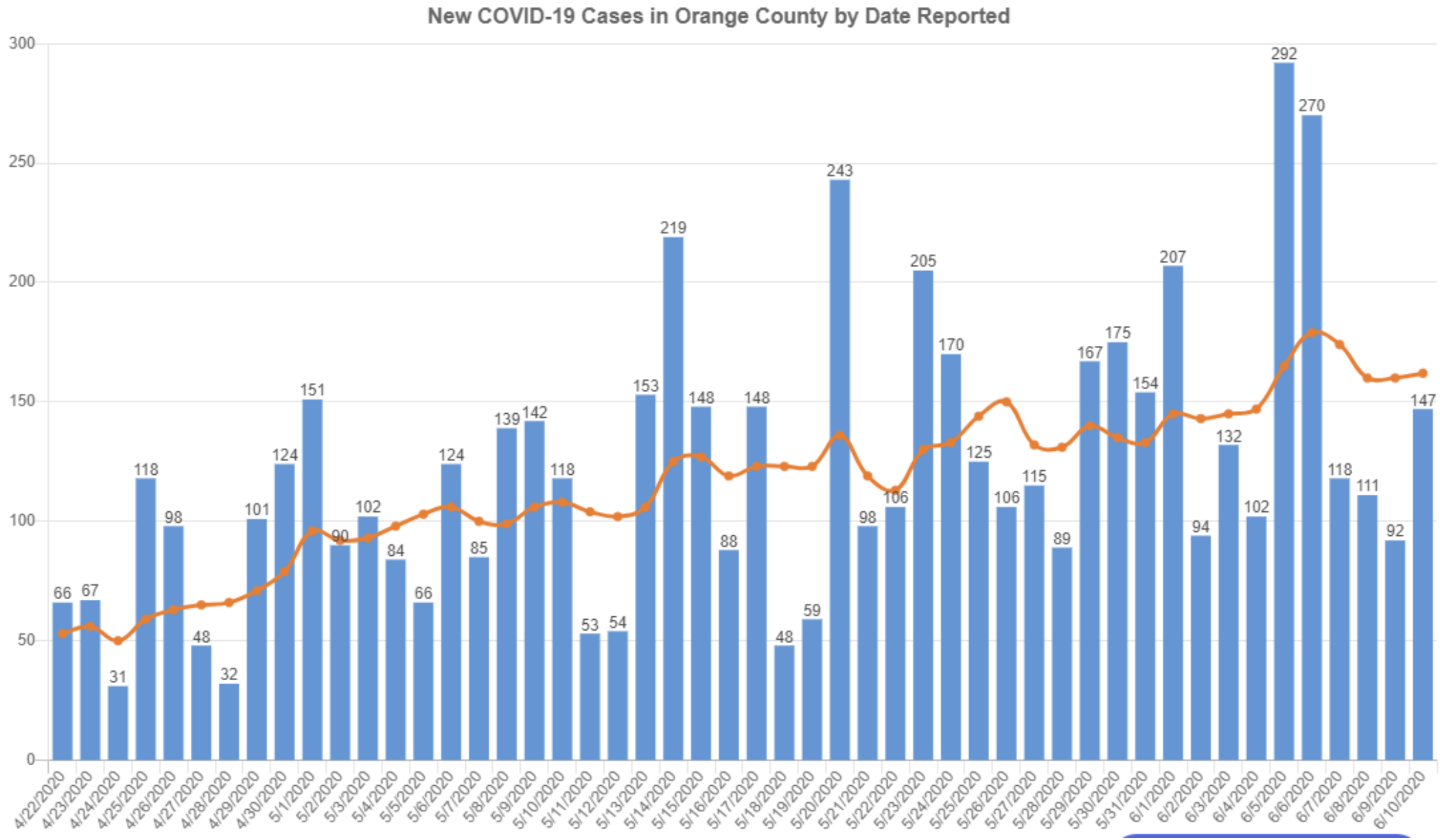
Helene M. Calvet, MD

Deputy Medical Director, Communicable Disease Control Division

Orange County Health Care Agency (OCHCA)

June 11, 2020

OC health CARE AGENCY


New COVID-19 Cases in Orange County by Date Reported
300
250
200
150
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0
66 67 31 118 98 48 32 101 124 151 90 102 84 66 124 85 139 142 118 53 54 153 219 148 88 148 48 59 243 98 106 205 170 125 106 115 89 167 175 154 207 94 132 102 292 270 118 111 92 147
4/22/2020 4/23/2020 4/24/2020 4/25/2020 4/26/2020 4/27/2020 4/28/2020 4/29/2020 4/30/2020 5/1/2020 5/2/2020 5/3/2020 5/4/2020 5/5/2020 5/6/2020 5/7/2020 5/8/2020 5/9/2020 5/10/2020 5/11/2020 5/12/2020 5/13/2020 5/14/2020 5/15/2020 5/16/2020 5/17/2020 5/18/2020 5/19/2020 5/20/2020 5/21/2020 5/22/2020 5/23/2020 5/24/2020 5/25/2020 5/26/2020 5/27/2020 5/28/2020 5/29/2020 5/30/2020 5/31/2020 6/1/2020 6/2/2020 6/3/2020 6/4/2020 6/5/2020 6/6/2020 6/7/2020 6/8/2020 6/9/2020 6/10/2020

COVID and the State of SNFs in OC

- 73 facilities in Orange County
- For first 5 weeks of pandemic, only occasional cases in staff of SNFs
- April 14: two SNFs identified with outbreaks
- Response:
  - Site visit
  - Testing of all residents at facility done at Public Health Lab (PHL)
  - Advising on set up of COVID (red) and quarantine (yellow) units
  - Repeated weekly rounds of testing (most of these performed at the PHL) at each facility to detect and isolate new cases

Methods to Prevent Spread of COVID in Facilities

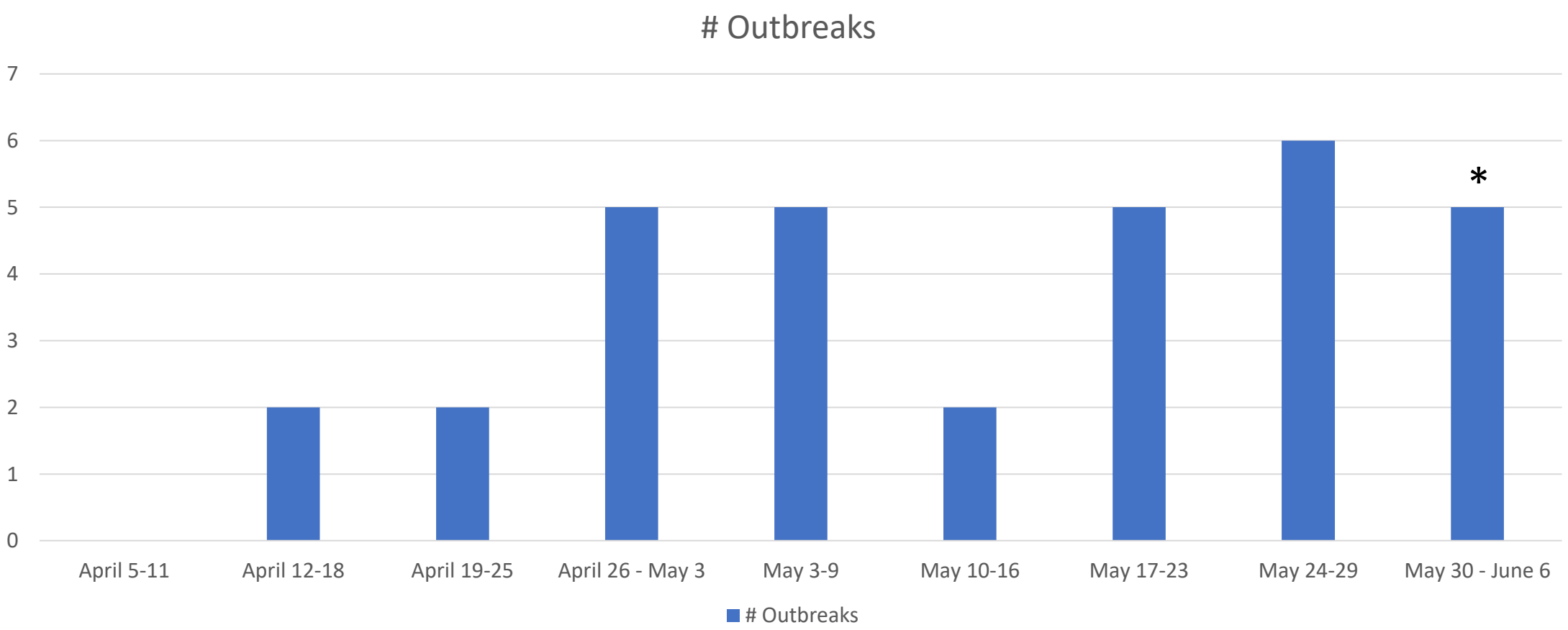
- Symptom screening (more on this next slide)
- Limitation of visitors
- Cancellation of group activities/congregate meals
- Social distancing (at last 6 feet away)
- Universal masking
- Cough/respiratory hygiene and hand hygiene

- Most facilities implemented all of these with good compliance since the beginning of March, but IT DIDN’T WORK!!!

Symptom Screening

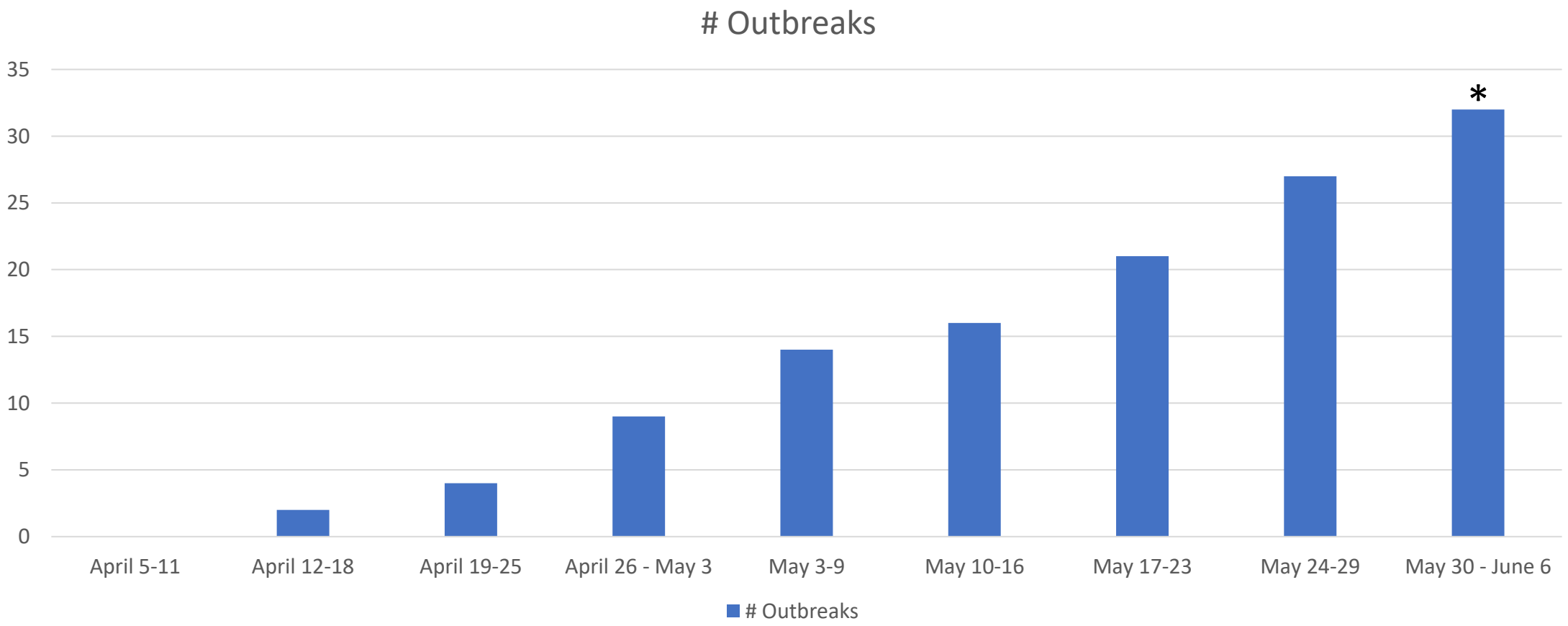
- All have been checking temperatures and screening for respiratory symptoms & oxygen saturation
- NOT GOOD ENOUGH!!!
  - Virus appears to be efficiently transmitted WITHOUT symptoms
  - Relatively small proportion of older adults with COVID-19 have classic symptoms of fever and cough; many patients present with less classic symptoms:
    - More mild elevation of temperature (99.2 – 99.3) or sore throat or body aches
    - Gastrointestinal symptoms: nausea, vomiting or diarrhea
    - Lack of appetite, weakness, falls
    - Loss of sense of taste or smell
    - Confusion, altered mental status, neurological signs
    - No symptoms at all!
  - Be vigilant for **any** change in status, and if change noted, test early and don't believe a single negative test
    - Sensitivity of test not 100%
    - Many occasions of initial test negative, then retest 3-7 days later positive

SNF Outbreaks per Week



*Another 3 facilities under investigation for outbreak

Cumulative SNF Outbreaks

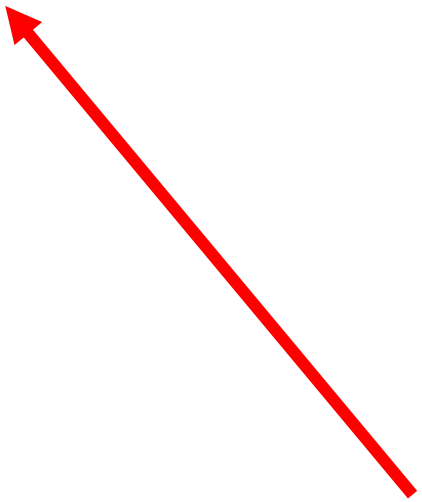


*Another 3 facilities under investigation for outbreak; 6 had resolved, but one just experienced second outbreak ☹

Outbreak Outcomes
(as of 6/9 at 5:00 PM)

OC SNF Outbreak Outcomes, 4/11 – 6/9

Total Residents	Infected Residents	Attack Rate (range)	Deaths	Case Fatality (range)
3169	926	29% (4% - 94%)	125	13% (0-40%)



Time Period	Total Residents	Total Positive Residents	Attack Rate	Deaths	Case Fatality
4/11-5/22	180	52	29%	6	12%
4/13-5/22	121	75	62%	11	15%
4/16-	113	67	59%	13	19%
4/20-	157	83	53%	15	18%
4/22-	153	94	61%	17	18%
4/22-	96	52	54%	6	12%
4/25-6/3	138	5	4%	2	40%
4/27-6/9	87	12	14%	0	0%
4/27-5/27	75	5	7%	0	0%
5/1-	188	90	48%	19	21%
5/4-	94	64	68%	6	9%
5/4-6/3	75	5	7%	0	0%
5/5-	111	66	59%	9	14%
5/6-	33	31	94%	1	3%
5/8-	117	9	8%	1	11%
5/13-	97	30	31%	2	7%
5/13-	66	37	56%	5	14%
5/14-	111	2	2%	0	0%
5/15-	136	45	33%	5	11%
5/19-	81	6	7%	0	0%
5/19-	74	3	4%	0	0%
5/20-	100	5	5%	0	0%
5/24-	179	44	25%	2	5%
5/28-	96	7	7%	2	29%
5/28-	76	21	28%	1	5%
5/28-	79	2	3%	1	50%
5/30-	85	3	4%	0	0%
6/3-	36	3	8%	0	0%
6/5-	147	2	1%	1	50%
6/5-	56	2	4%	0	0%
6/6-	12	4	33%	0	0%
Total	**3169**	**926**	**29%**	**125**	**13%**

Ramping Up Response

- After 3rd outbreak, created a team of Public Health Nurses (PHNs) to serve as liaisons to facilities
- Specimen collection teams have assisted with training on specimen collection
- Contracted with Expert Stewardship, a group of Infection Prevention (IP) specialists, to help outbreak facilities with IP issues/training
- Rapidity of new outbreaks (4 in one day) extremely challenging; had to expand team and Public Health Laboratory (PHL) capacity
- Very large volume of tests (1700 specimens received at PHL in just 3 days two weeks ago) due to number of facilities needing repeat screening
- Our approach to COVID in SNFs, as well as recommendations of state and national authorities, has evolved rapidly over the last 7 weeks

Testing After Detection of a COVID Case

- Initially, was recommended based on the situation
  - At first, a more focused approach (test patients/staff in the same area where a single COVID+ patient was), or test patients cared for by COVID+ staff
  - Now more liberal and recommending testing of all staff and all patients when one patient identified (if infected in the facility)
- Generally, multiple rounds of testing done, dictated by number of new cases found
- New recommendations:
  - CDPH guidance of 5-22 (AFL 20-53): test all residents and staff if case identified in either, and repeat weekly in both until two sequential negative rounds of testing.
  - If capacity for serial testing of HCW not sufficient, test all HCW on the unit with COVID+ resident or who are known to work at multiple facilities
  - Mandate or recommendation?
  - Surveillance testing, which starts after outbreak is over, to be discussed later

When Is Your Facility Closed to Admissions?

Resident Case(s)

- One resident case identified: closed at least until initial screening of all residents complete.
  - Can reopen after initial screening results completed if no additional cases are identified, **but…**
  - Recommend doing serial testing every 7 days until no new cases identified in two sequential rounds of testing (per AFL 20-53)
  - If any further cases identified on subsequent round(s) of testing (or in between rounds), facility is closed until reopening criteria met
  - Test all staff who had contact with infected resident as soon as possible, and all staff within 14 days
- Two or more residents within 14 days: closed until reopening criteria are met.

https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-53.aspx

When Is Your Facility Closed to Admissions?

Staff Case(s)

- Single infected staff member:
  - Not closed to admissions, but ***should*** perform serial testing of all residents and staff every 7 days until no new cases identified in two sequential rounds of testing (per AFL 20-53)
  - At a minimum, test all patients cared for by and close staff contacts of COVID+ staff member at baseline and 14 days after last contact
- Facilities **may** be instructed to close if a cluster (2 or more within 7 -14 days) of infected staff identified, especially if those staff have significant patient contact.
  - This closure would continue until at least one round of testing of all residents is completed and no evidence of transmission to residents; also test close staff contacts
  - Second round of testing of all residents and close staff contacts at 14 days after last contact recommended

https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-53.aspx

Patient Cohorting in COVID Outbreaks

- Developed guidance for isolation and quarantine of patients early on; distributed in an advisory sent out 5/14, updated recently
- Three areas recommended:
  - Red Unit: for COVID+ (acute) patients; may be multiple per room.
    - Everything separate from main facility: entrance/exit, staff break room and bathroom, nursing station, dedicated staff
  - Yellow Unit: can accommodate 3 types of patients
    - Convalescing COVID+ (cohorted multiple per room): doors closed, droplet isolation
    - Close contacts of COVID+ patients (roommates): single room if possible; if not, two per room, beds far apart, privacy curtain closed, patients masked, door closed
    - PUIs: single room, door closed, droplet and contact isolation
  - Green Unit: COVID-negative non-exposed patients (“clean” unit)
- If all COVID+ patients are to be transferred out, can just have a yellow and green zone

Release From Transmission-Based Precautions

AKA, When to Stop Isolation in a SNF Patient

- For clearance from isolation, OCHCA **does NOT recommend** the test-based strategy
  - Can take 4-6 weeks to get two negatives
  - Positive PCR test in a convalescing patient does not necessarily indicate infectious virus; impossible to know the exact end of infectious period in older adults
- OCHCA **recommends a more conservative approach for release from isolation**:
  - **At least 14 days in COVID unit**; must have significantly improved symptoms and no fever for at least 3 days before transfer to yellow unit
  - **Stay in yellow unit (cohorted with other recovering COVID patients) for 2 additional weeks** (may shorten to one additional week if completely asymptomatic the whole time); during this time, doors closed and no wandering in halls
  - Green: when finally moved to green, ideally cohort with other recovered COVID patients
- Reasons for this conservative approach are:
  - Viral shedding thought to be more prolonged in older adults
  - Some with cognitive or physical impairments may not be able to practice respiratory hygiene
  - Have seen some asymptomatic COVID+ patients develop symptoms 17-19 days after positive test
  - High risk nature of population

Criteria for Reopening to Admissions

- At least three (baseline, 7 days and 14 days) or more rounds of weekly screening of all COVID-negative residents/patients in the facility have been completed, and last two rounds have identified no new cases.
- It has been at least two weeks since last resident/patient case was identified, and
- Staff have been advised in writing of OCHCA recommendation to be tested for COVID
  - Ideally, all or most staff have been tested (but this is not a criterium)

Surveillance Testing in Non-Outbreak Setting

- Recommended by both CMS (5/18) and CDPH (5/22)
- All agree on a one-time single baseline test of all residents and staff (seems to be mandatory)
- Then the differences:
  - CMS: continue to test all staff (including vendors and volunteers) weekly, but no resident testing on an ongoing basis (except PUIs)
  - CDPH: test 25% of staff weekly, with each staff member being tested at least monthly; test new residents on admission, then after 14 days prior to removing from quarantine
- What does OCHCA say?
  - **Agree with testing 25% of staff weekly,** but would focus more on staff with patient contact
  - **Agree with testing new admissions at baseline and after 14 days**
  - **In addition, would consider testing high risk residents (**such as those who are on dialysis or who leave the facility on a regular basis, and those who are particularly mobile/social), **on a regular basis** (e.g. every 2-4 weeks)
  - Had previously recommended testing of 25% of residents weekly, but we have rethought that since neither CMS or CDPH recommend ongoing resident testing (except new admits)

Testing Tips & Support

AFL 20-53 mandates testing without adding resources. To minimize administrative burden and cost consider the following…

- Contracting with a lab that:
  - Maximizes third-party (insurance) billing for patients and staff and bills the US Health Resources Service Administration (HRSA) for uninsured patients and staff. **A lab that has a comprehensive billing department will eliminate nearly all charges to the SNF.**
  - Utilizes CalREDIE for electronic reporting of results to Public Health.
  - Makes results available to you electronically in a manner that makes record keeping easy, such as with an Excel spreadsheet.
  - Ideally, has a turn-around time for results of no longer than 3 days, and generally within 48 hours.
- Conducting in-house testing of staff: reduces the burden to employees related to scheduling testing in the community, and to employers related to tracking testing and results.
  - Establish a relationship with a limited number of labs, ideally 1-2 that can process all tests for patients and/or employees.
  - Have the Medical Director create standing orders for patients and employees and have medical staff conduct/observe specimen collection (ideally utilizing nasal swabbing).
  - Follow a regular schedule of weekly testing with a limited number of lab pick-up (or shipping) times per week.

Community Testing Resources for Staff

CVS Minute Clinics	
Who Can Get Tested (Eligibility)	Free testing to California residents meeting California Department of Public Health (CDPH) priority criteria. Insurance will be utilized for people that have coverage, but no copayments are required.
Contact Information	To register, visit the website https://www.cvs.com/minuteclinic/covid-19-testing or call 1-866-389-2727.
Locations	Anaheim Costa Mesa Fullerton Huntington Beach Irvine La Habra Los Alamitos Seal Beach San Clemente Stanton Tustin Yorba Linda

OptumServe (State) Test Sites	
Who Can Get Tested (Eligibility)	Free testing to California residents meeting California Department of Public Health (CDPH) priority criteria. People without symptoms (asymptomatic) are prioritized. Insurance will be utilized for people that have coverage, but no copayments are required.
Contact Information	To register, visit the website https://lhi.care/covidtesting or call 1-888-634-1123.
Locations	Buena Park Orange Santa Ana San Juan Capistrano

Commercial Testing Resources* for Patients and Staff

Lab	Contact	Email & Phone	Details
Avellino Labs	Liz Puwal	Liz.puwal@avellino.com (832) 859-8666	Bills 3rd parties for patients and employees, including Kaiser and HRSA. Cash rate $100. Location: Menlo Park
Fulgent Genetics	Rachel Blake	rblake@fulgentgenetics.com (626) 350-0537	Bills 3rd parties for patients and employees, including Kaiser and HRSA. Cash rate $65. Location: City of Industry
HCCL (Healthy Care Clinical Labs)	Curt Canales	curt@hccllab.com (714) 356-7878	Bills 3rd parties for patients and employees, not Kaiser. Setting up HRSA billing and CalREDIE. Cash rate $75. Location: Montclair
Quest Diagnostics	Kate Ezra	kate.j.ezra@questdiagnostics.com (818) 737-6330	Bills 3rd parties for patients and employees including HRSA, not Kaiser. Cash rate $100. Location: Orange County
UCI Lab	Doug Grudt	dgrudt@hs.uci.edu (714) 981-4673	Bills 3rd party for patients and employees, including Kaiser and HRSA. Capacity limited but growing. Call for pricing. Location: Orange

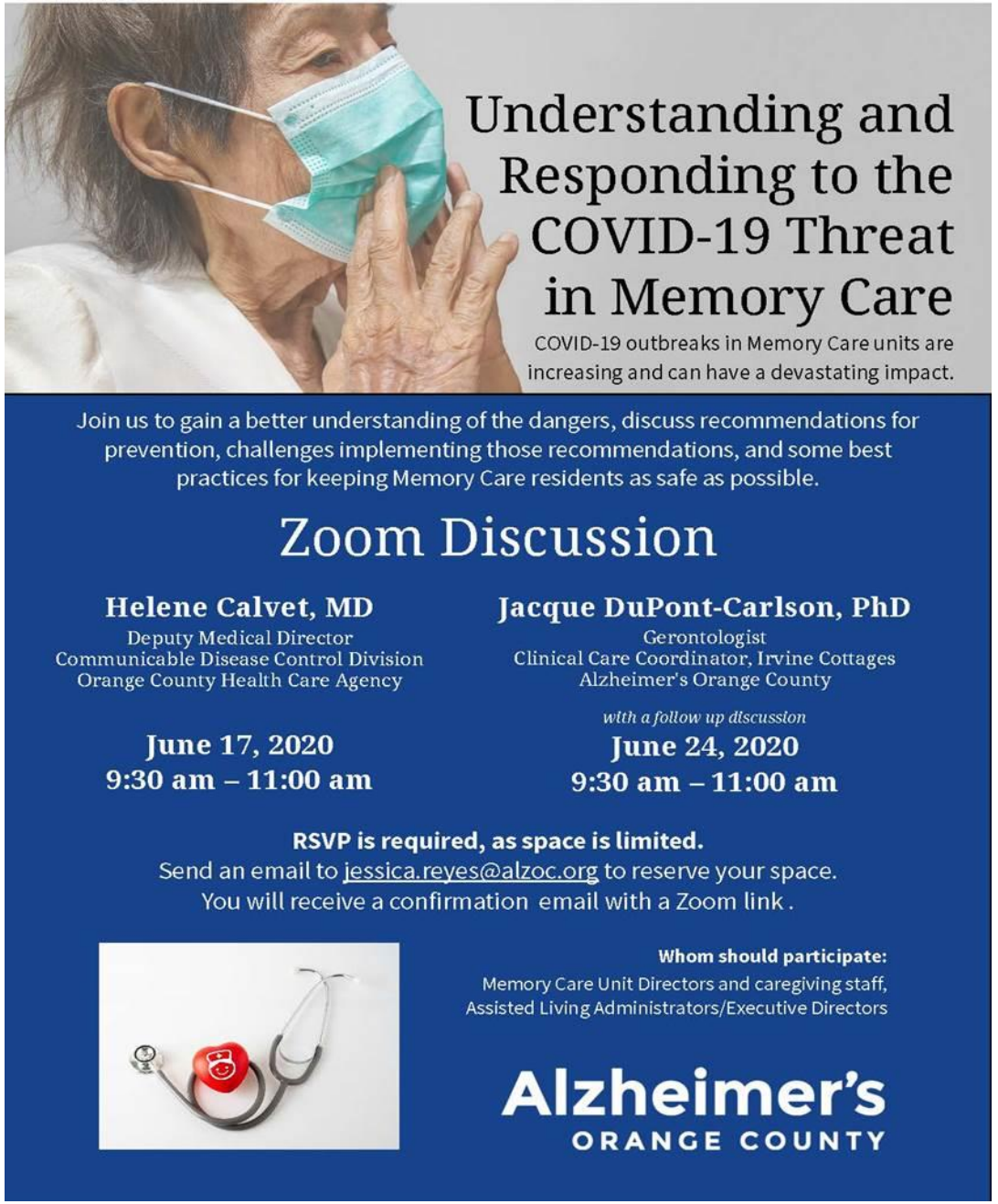
*This list is not exhaustive, nor does it imply an endorsement by the County of Orange

How Will OCHCA Help SNFs Going Forward?

- Assistance/advice in setting up commercial lab contracts
  - Contact Donna Fleming, dfleming@ochca.com or 714-824-9017
- Continue to help with outbreak response/advice, but will not be able to handle all of the testing at PHL
  - One to two rounds of resident testing may be offered if needed
- PHL will always be available to test PUIs (residents or staff) using Gene Xpert rapid PCR test
  - Call 714-834-8180 to schedule testing of symptomatic staff or for specimen pick up from symptomatic residents
- Expert Stewardship Infection Prevention (IP) consultants available for questions, advice, observation, evaluation and training
  - Facilities with active outbreaks will be prioritized for in-person services
  - Questions via hotline 714-545-6113 or e-mail ochca@expertstewardship.com welcome from all

When Can Facilities Restart Activities and Reopen to Visitors ?

- Certainly would not advise it yet
  - Community transmission likely to increase because businesses, etc., reopening
  - Most facilities have not been able to operationalize surveillance testing for staff
  - Facilities with group activities had very high rates of transmission (>90%)
  - Substantial attacks rates (about 30%) and case fatality rates (about 13% average, but up to 20%) seen in outbreaks in OC SNFs so far
- Timing is unclear at this point…stay tuned!



If you work in a Memory Care unit, or in a 6 bed Board & Care RCFE which cares for residents with dementia, please

SAVE THESE DATES! Join us for Zoom discussions to hear how the COVID 19 Threat is impacting Memory Care, how you can implement strategies for prevention, and learn best practices for meeting these new challenges. The faculty will include Dr. Helene Calvet, Deputy Medical Director, OCHCA Communicable Disease Control Division, and Dr. Jacque DuPont-Carlson, Clinical Care Coordinator, Irvine Cottages, AlzOC, as well as members of the AlzOC Education team.

June 17, with a follow-up discussion on **June 24**
9:30 am - 11 am
RSVP is required as space is limited.

Please e-mail jessica.reyes@alzoc.org to reserve your spot, and you will be sent the Zoom link.

Thanks for your attention!
Questions?

Stay up to date with future OC CAHF Events!

@OCCAHF @OC_CAHF

Thank you for joining us!

Ideas about future events?

Email: ocahfboard2@gmail.com

GOLDEN AGE
DENTAL CARE