ALLIANT HEALTH SOLUTIONS

Georgia Department of Public Health:
Strike & Support Team GADPH Office Hours for NHs & SNFs
October 21, 2022

Meet the Team

Presenters:

Swati Gaur, MD, MBA, CMD, AGSF
Medical Director, Alliant Health Solutions

Erica Umeakunne, MSN, MPH, APRN, CIC
Infection Prevention Specialist
Alliant Health Solutions

Swati Gaur, MD, MBA, CMD, AGSF

MEDICAL DIRECTOR, POST-ACUTE CARE
NORTHEAST GEORGIA HEALTH SYSTEM

Dr. Swati Gaur is the medical director of New Horizons Nursing Facilities with the Northeast Georgia Health System. She is also the CEO of Care Advances Through Technology, a technology innovation company. In addition, she is on the electronic medical record (EMR) transition and implementation team for the health system, providing direction to EMR entity adaption to the long-term care (LTC) environment. She has also consulted with post-acute long-term care (PALTC) companies on optimizing medical services in PALTC facilities, integrating medical directors and clinicians into the QAPI framework, and creating frameworks of interdisciplinary work in the organization. She established the palliative care service line at the Northeast Georgia Health System.

She also is an attending physician in several nursing facilities. Dr. Gaur attended medical school in Bhopal, India, and started her residency in internal medicine at St. Luke's–Roosevelt Medical Center in New York. She completed her fellowship in geriatrics at the University of Pittsburgh Medical Center and is board certified in internal medicine, geriatrics, hospice, and palliative medicine. In addition, she earned a master's in business administration at the Georgia Institute of Technology with a concentration in technology management.

Erica Umeakunne, MSN, MPH, APRN, CIC

Erica Umeakunne is an adult-gerontology nurse practitioner and infection preventionist with experience in primary care, critical care, health care administration and public health.

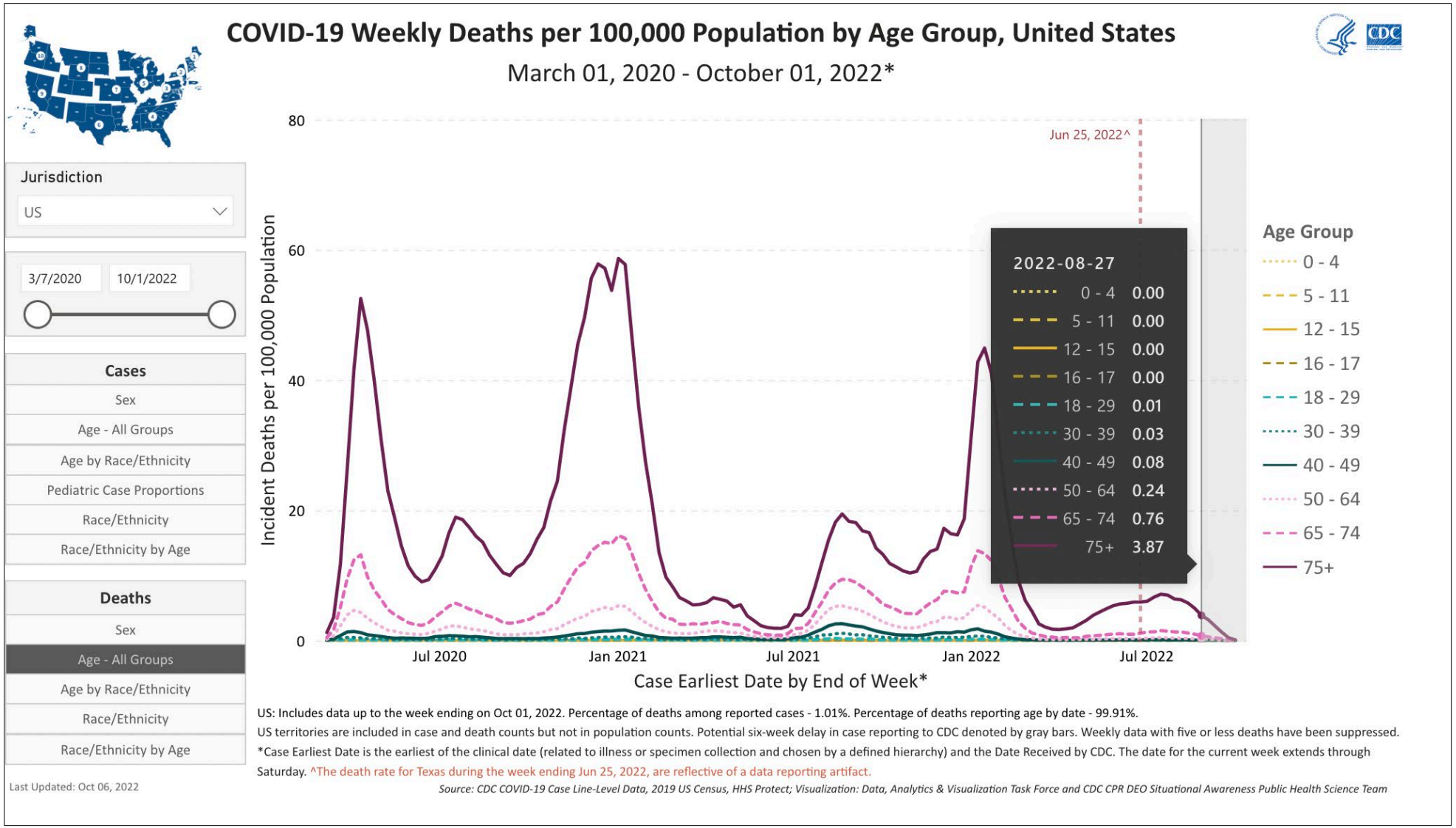
She previously served as the interim hospital epidemiology director for a large health care system in Atlanta and as a nurse consultant in the Centers for Disease Control and Prevention's (CDC) Division of Healthcare Quality Promotion. While at CDC, she served as an infection prevention and control (IPC) subject matter expert for domestic and international IPC initiatives and emergency responses, including Ebola outbreaks and, most recently, the COVID-19 pandemic.

Thank You to Our Partners

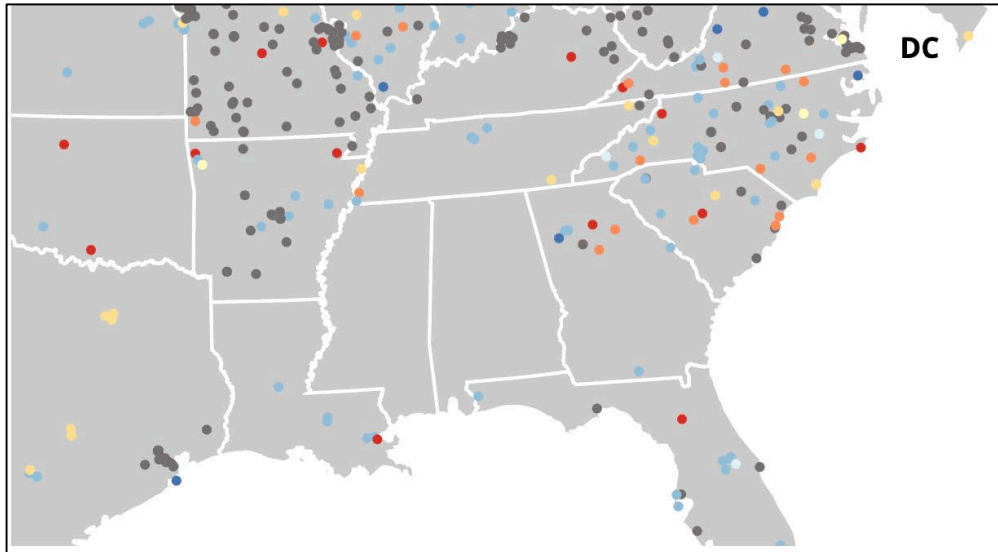
- Georgia Department of Public Health
- University of Georgia

Objectives

- Provide updates on the COVID-19 pandemic and vaccination recommendations
- Present updates to the CDC COVID-19 interim infection prevention and control (IPC) recommendations
- Highlight Center for Medicare & Medicaid Services (CMS) IPC-related guidance updates
- Share Alliant Health Solutions resources to support COVID-19 IPC activities


COVID-19 Weekly Deaths per 100,000 Population by Age Group, United States
March 01, 2020 - October 01, 2022*
Jurisdiction
US
3/7/2020
10/1/2022
Cases
Sex
Age - All Groups
Age by Race/Ethnicity
Pediatric Case Proportions
Race/Ethnicity
Race/Ethnicity by Age
Deaths
Sex
Age - All Groups
Age by Race/Ethnicity
Race/Ethnicity
Race/Ethnicity by Age
Last Updated: Oct 06, 2022
Incident Deaths per 100,000 Population
80
60
40
20
0
Jun 25, 2022^
2022-08-27
0 - 4 0.00
5 - 11 0.00
12 - 15 0.00
16 - 17 0.00
18 - 29 0.01
30 - 39 0.03
40 - 49 0.08
50 - 64 0.24
65 - 74 0.76
75+ 3.87
Age Group
0 - 4
5 - 11
12 - 15
16 - 17
18 - 29
30 - 39
40 - 49
50 - 64
65 - 74
75+
Jul 2020
Jan 2021
Jul 2021
Jan 2022
Jul 2022
Case Earliest Date by End of Week*
US: Includes data up to the week ending on Oct 01, 2022. Percentage of deaths among reported cases - 1.01%. Percentage of deaths reporting age by date - 99.91%.
US territories are included in case and death counts but not in population counts. Potential six-week delay in case reporting to CDC denoted by gray bars. Weekly data with five or less deaths have been suppressed.
*Case Earliest Date is the earliest of the clinical date (related to illness or specimen collection and chosen by a defined hierarchy) and the Date Received by CDC. The date for the current week extends through Saturday. ^The death rate for Texas during the week ending Jun 25, 2022, are reflective of a data reporting artifact.
Source: CDC COVID-19 Case Line-Level Data, 2019 US Census, HHS Protect; Visualization: Data, Analytics & Visualization Task Force and CDC CPR DEO Situational Awareness Public Health Science Team

Wastewater Surveillance



15-day % change category	Num. sites	% sites	Category change in last 7 days
– 100%	20	3	5%
– 99% to – 10%	345	48	– 33%
– 9% to 0%	33	5	6%
1% to 9%	23	3	– 15%
10% to 99%	84	12	– 36%
100% to 999%	123	17	14%
1000% or more	84	12	68%

Total sites with current data: 712

Total number of wastewater sampling sites: 1133

How is the 15-day percent change calculated?

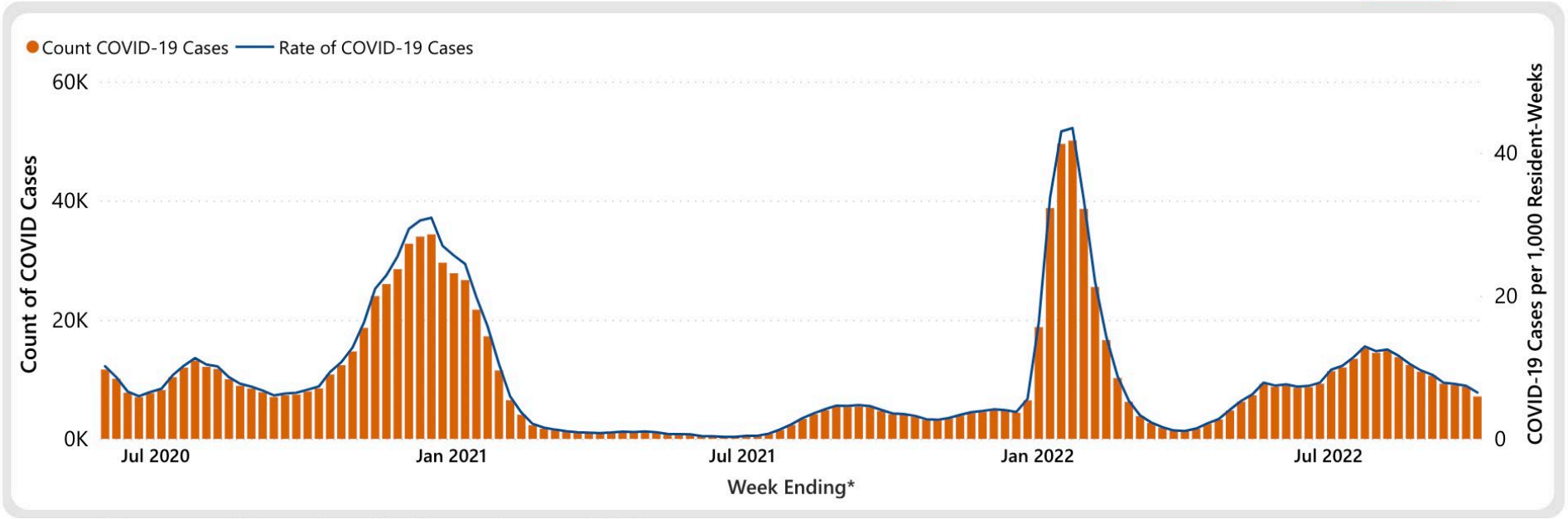
Confirmed COVID-19 Cases among Residents and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week—United States

NHSN NATIONAL HEALTHCARE SAFETY NETWORK

Display by State: All

Display by FEMA/HHS Region: All

Cases Deaths



* Data are likely accruing, all data can be modified from week-to-week by facilities

For the purpose of creating this time-series graph, data that fail certain quality checks or appear inconsistent with surveillance protocols are assigned a value based on their patterns for data-entry or excluded from analysis

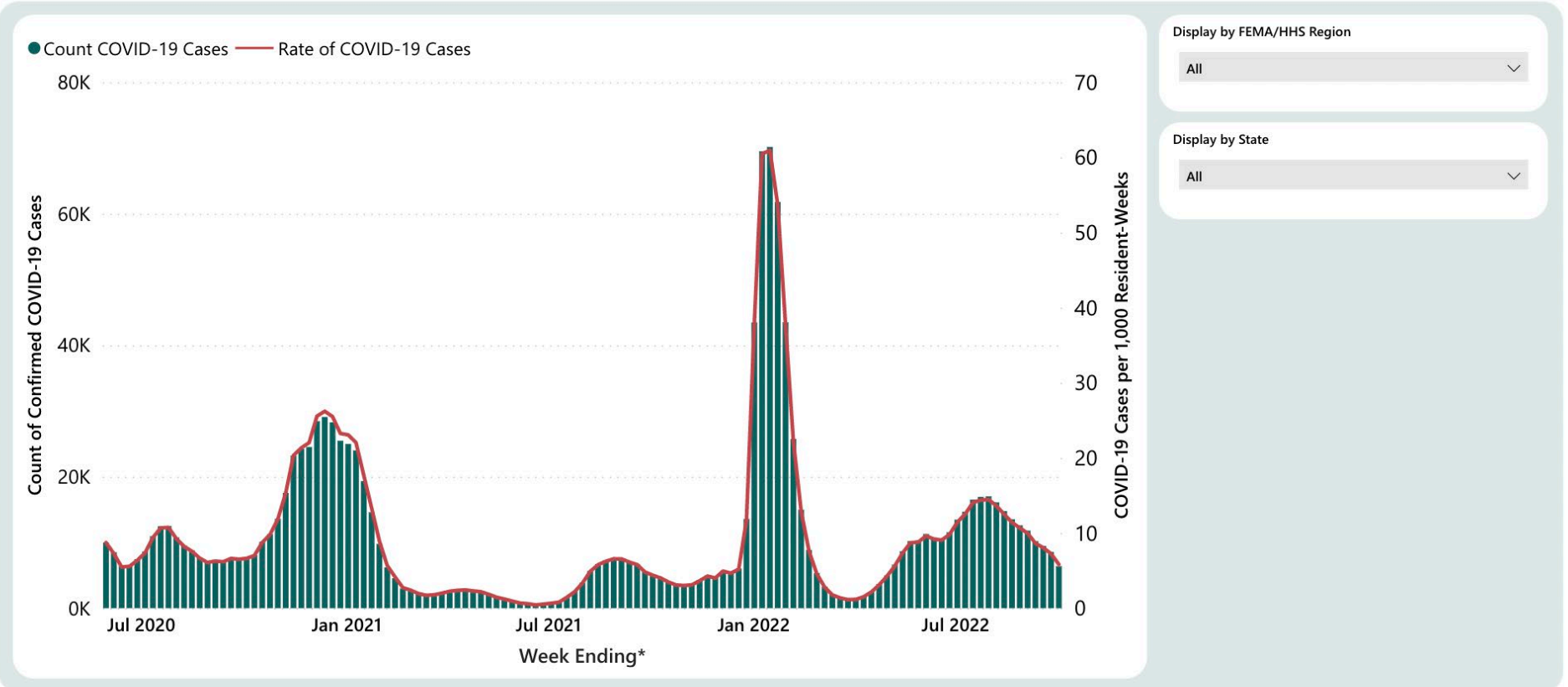
Data source: Centers for Disease Control and Prevention, National Healthcare Safety Network

For more information: https://www.cdc.gov/nhsn/ltc/covid19/index.html

Accessibility: [Right click on the graph area to show as table]

Data as of 10/3/2022 5:30 AM

Confirmed COVID-19 Cases among Staff and Rate per 1,000 Resident-Weeks in Nursing Homes, by Week — United States



* Data are likely accruing, all data can be modified from week-to-week by facilities

For the purpose of creating this time-series graph, data that fail certain quality checks or appear inconsistent with surveillance protocols are assigned a value based on their patterns for data-entry or excluded from analysis

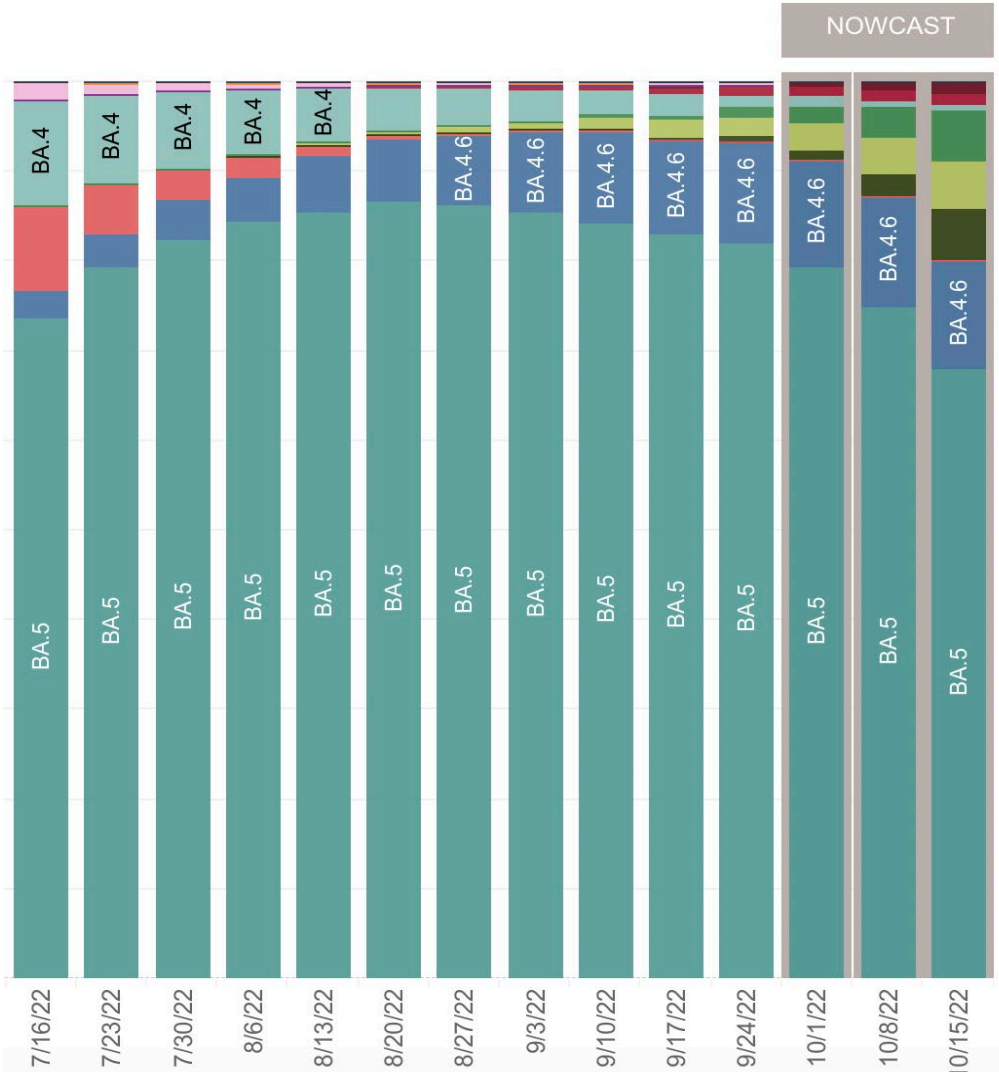
Data source: Centers for Disease Control and Prevention, National Healthcare Safety Network. **Accessibility**: [Right click on the graph area to show as table]

For more information: https://www.cdc.gov/nhsn/ltc/covid19/index.html

Data as of 10/3/2022 5:30 AM

75%

United States: 7/10/2022 – 10/15/2022



United States: 10/9/2022 – 10/15/2022 NOWCAST

USA

WHO label	Lineage #	US Class	%Total	95%PI
Omicron	BA.5	VOC	67.9%	64.1-71.4%
	BA.4.6	VOC	12.2%	11.1-13.4%
	BQ.1.1	VOC	5.7%	3.5-9.1%
	BQ.1	VOC	5.7%	3.5-8.9%
	BF.7	VOC	5.3%	4.6-6.1%
	BA.2.75.2	VOC	1.4%	0.9-2.2%
	BA.2.75	VOC	1.3%	1.0-1.6%
	BA.4	VOC	0.6%	0.5-0.6%
	BA.2.12.1	VOC	0.0%	0.0-0.0%
	BA.2	VOC	0.0%	0.0-0.0%
	BA.1.1	VOC	0.0%	0.0-0.0%
	B.1.1.529	VOC	0.0%	0.0-0.0%
Delta	B.1.617.2	VBM	0.0%	0.0-0.0%
Other	Other*		0.0%	0.0-0.0%

* Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all weeks displayed.
** These data include Nowcast estimates, which are modeled projections that may differ from weighted estimates generated at later dates
# AY.1-AY.133 and their sublineages are aggregated with B.1.617.2. BA.1, BA.3 and their sublineages (except BA.1.1 and its sublineages) are aggregated with B.1.1.529. Except BA.2.12.1, BA.2.75, BA.2.75.2 and their sublineages, BA.2 sublineages are aggregated with BA.2. Except BA.4.6, sublineages of BA.4 are aggregated to BA.4. Except BF.7, BQ.1 and BQ.1.1, sublineages of BA.5 are aggregated to BA.5. Sublineages of BA.1.1 and BA.2.75 (except BA.2.75.2 and its sublineages) are aggregated to the parental BA.1.1 and

Up to Date (NHSN)

The below information describes the updated surveillance definition and should be used for reporting up to date with COVID-19 vaccines which is to be applied for data reported to NHSN COVID-19 Vaccination Modules beginning **September 26, 2022.**

Up to date with COVID-19 vaccines

Individuals are considered up to date with their COVID-19 vaccines during the surveillance period of September 26, 2022 – December 25, 2022 for the purpose of NHSN surveillance if they meet (1) of the following criteria:

Received an **updated (bivalent)* booster dose**,

or

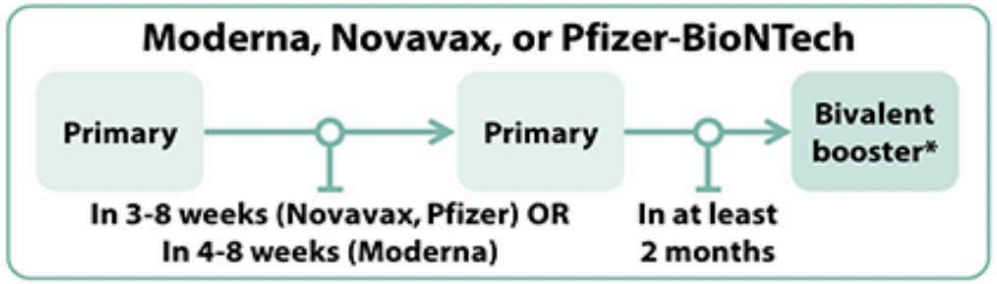
Received their **last booster** dose **less than 2 months ago**, or

Completed their **primary series less than 2 months ago**

CDC

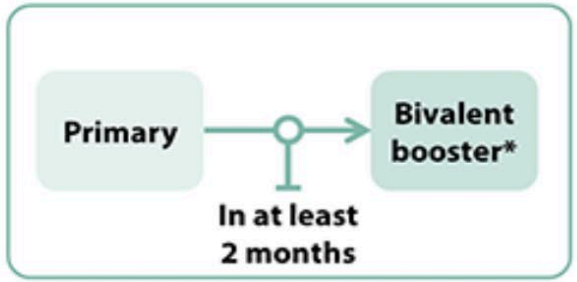
Up to date = completed a COVID-19 vaccine primary series **+** received UPDATED (Bivalent) booster dose

People ages 12 years and older



In very small subset Novavax can now be used as booster

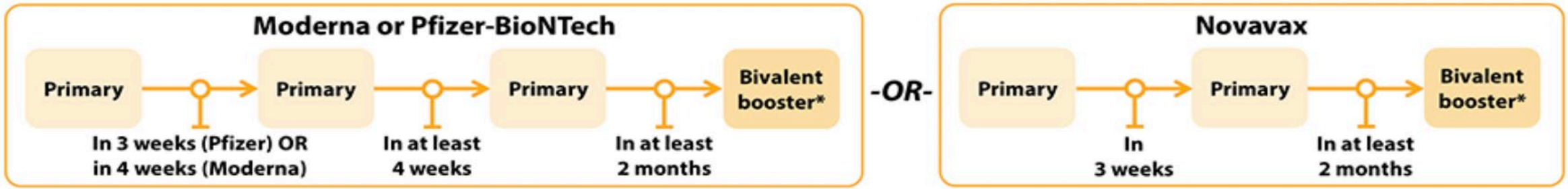
People ages 18 years and older who previously received Janssen primary series dose†



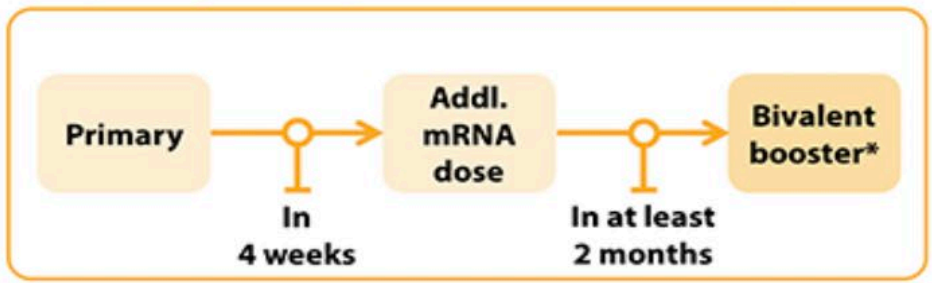
*The bivalent booster dose is administered at least 2 months after completion of the primary series. For people who previously received a monovalent booster dose(s), the bivalent booster dose is administered at least 2 months after the last monovalent booster dose.

† Janssen COVID-19 Vaccine should only be used in certain limited situations. See: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us-appendix.html#appendix-a

People ages 12 years and older



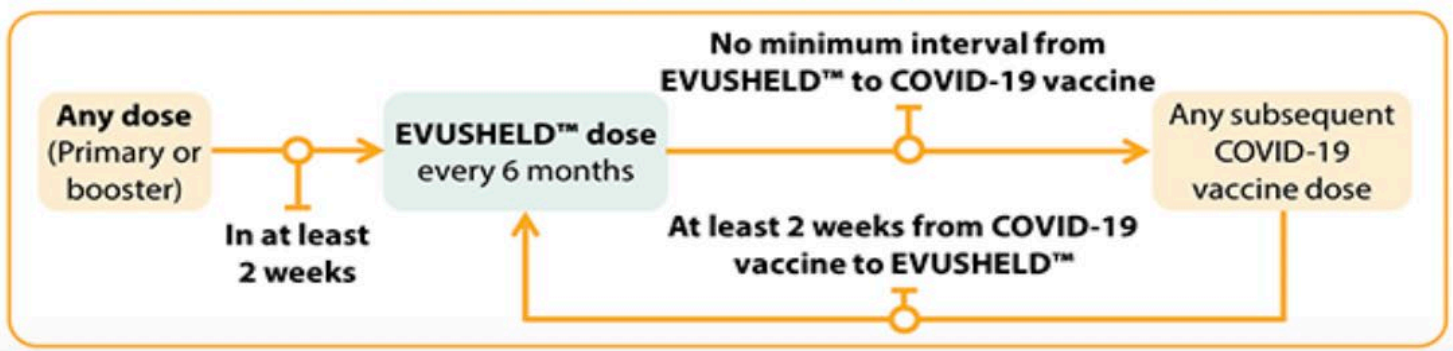
People ages 18 years and older who previously received Janssen primary series dose†



In very small subset Novavax can now be used as booster

Monoclonal antibodies (EVUSHELD™) for COVID-19 pre-exposure prophylaxis

People ages 12 years and older (must weigh at least 40kg)



*The bivalent booster dose is administered at least 2 months after completion of the primary series. For people who previously received a monovalent booster dose(s), the bivalent booster dose is administered at least 2 months after the last monovalent booster dose.

†Janssen COVID-19 Vaccine should only be used in certain limited situations. See: https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us-appendix.html#appendix-a

Who Is Immunocompromised?

Moderate and severe immunocompromising conditions and treatments include but are not limited to:

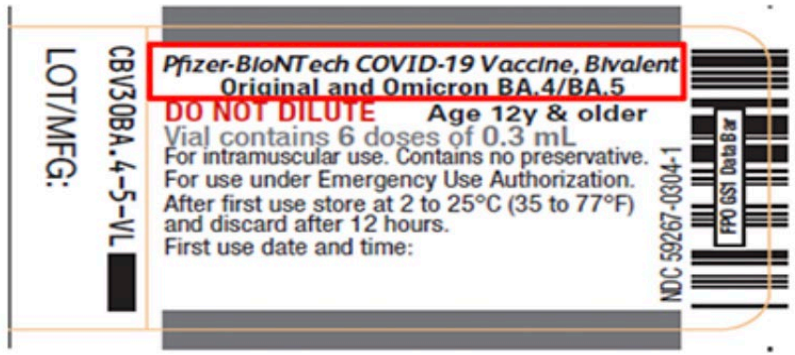
- Active treatment for solid tumor and hematologic malignancies
- Receipt of solid-organ transplant and taking immunosuppressive therapy
- Receipt of chimeric antigen receptor (CAR)-T-cell therapy or hematopoietic cell transplant (HCT) (within 2 years of transplantation or taking immunosuppressive therapy)
- Moderate or severe primary immunodeficiency (e.g., DiGeorge syndrome, Wiskott-Aldrich syndrome)
- Advanced HIV infection (people with HIV and CD4 cell counts less than 200/mm^3, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV) or untreated HIV infection
- Active treatment with high-dose corticosteroids (i.e., 20 mg or more of prednisone or equivalent per day when administered for 2 or more weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory

Booster

- No (old) monovalent vaccine
- J&J is NOT a booster

In very small subset Novavax can now be used as booster

Bivalent label
Booster dose only
Ages 12 years and older

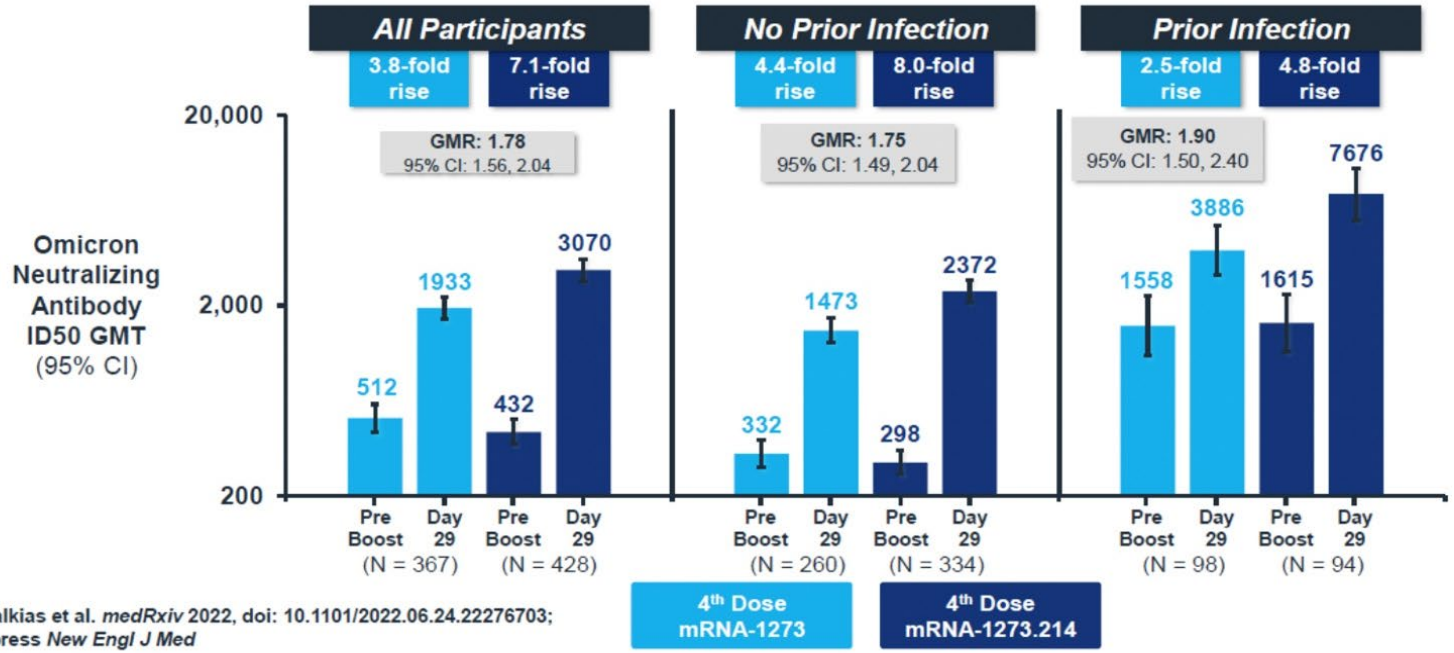


Pfizer LABEL

Bivalent label
Booster dose only
Ages 18 years and older

Moderna LABEL

Immunogenicity: Moderna bivalent booster



Chalkias et al. *medRxiv* 2022, doi: 10.1101/2022.06.24.22276703; in press *New Engl J Med*

- Met superiority criteria* in participants ≥18 years <u>with or without</u> evidence of infection on day 29

*Superiority criterion: the lower bound of the 95% CI for GMR is >1.0

https://www.medrxiv.org/content/10.1101/2022.06.24.22276703v1.full.pdf

https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2022-09-01/08-COVID-Oliver-508.pdf

Local and Systemic Adverse Reactions

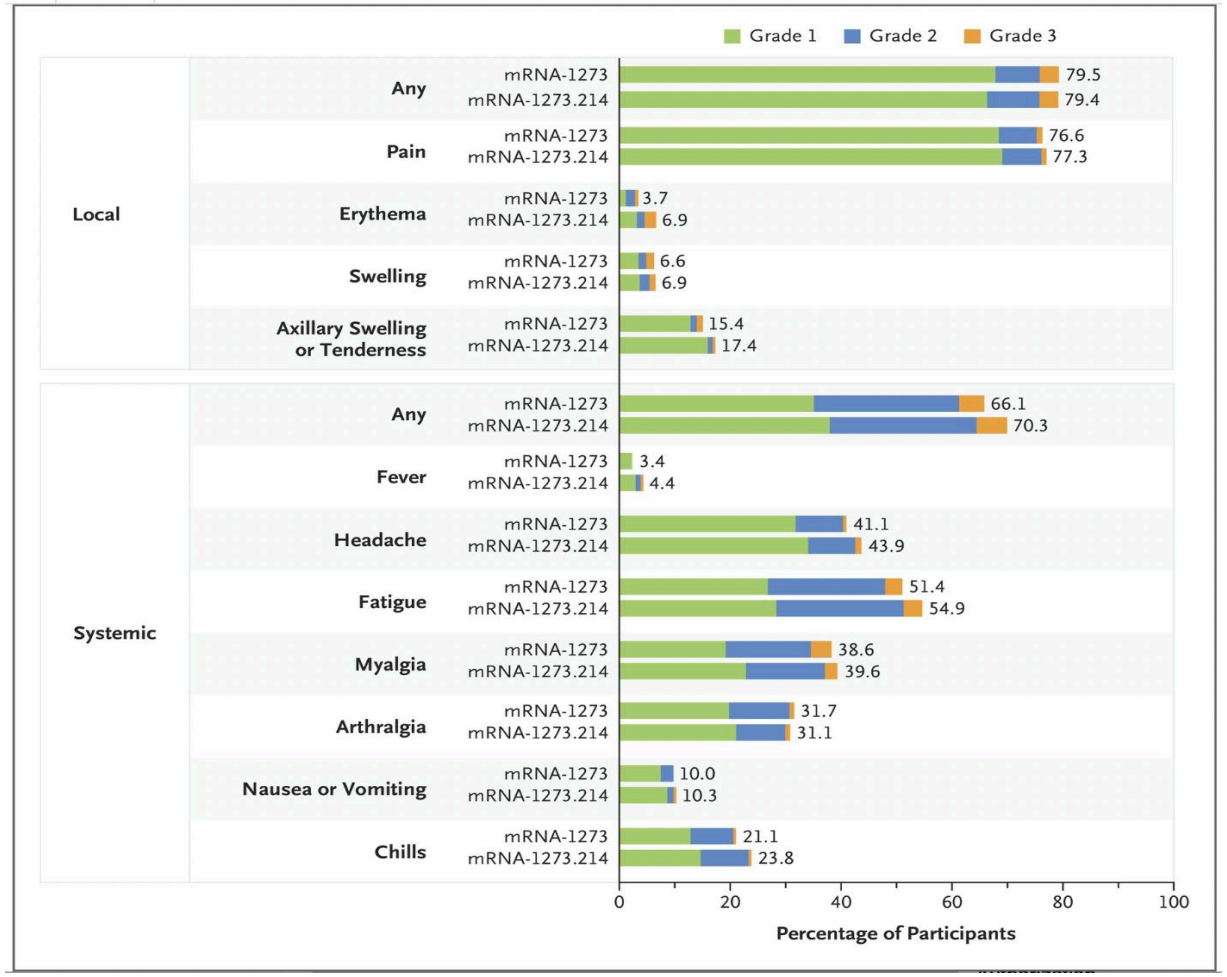
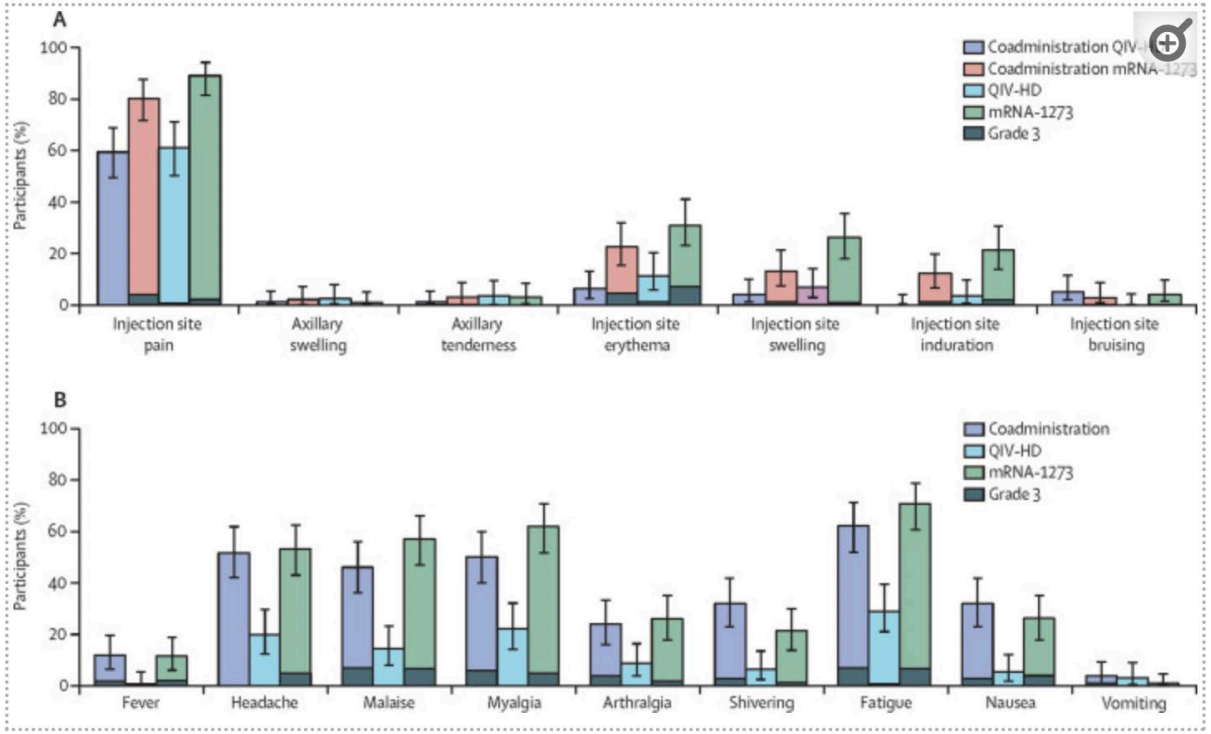


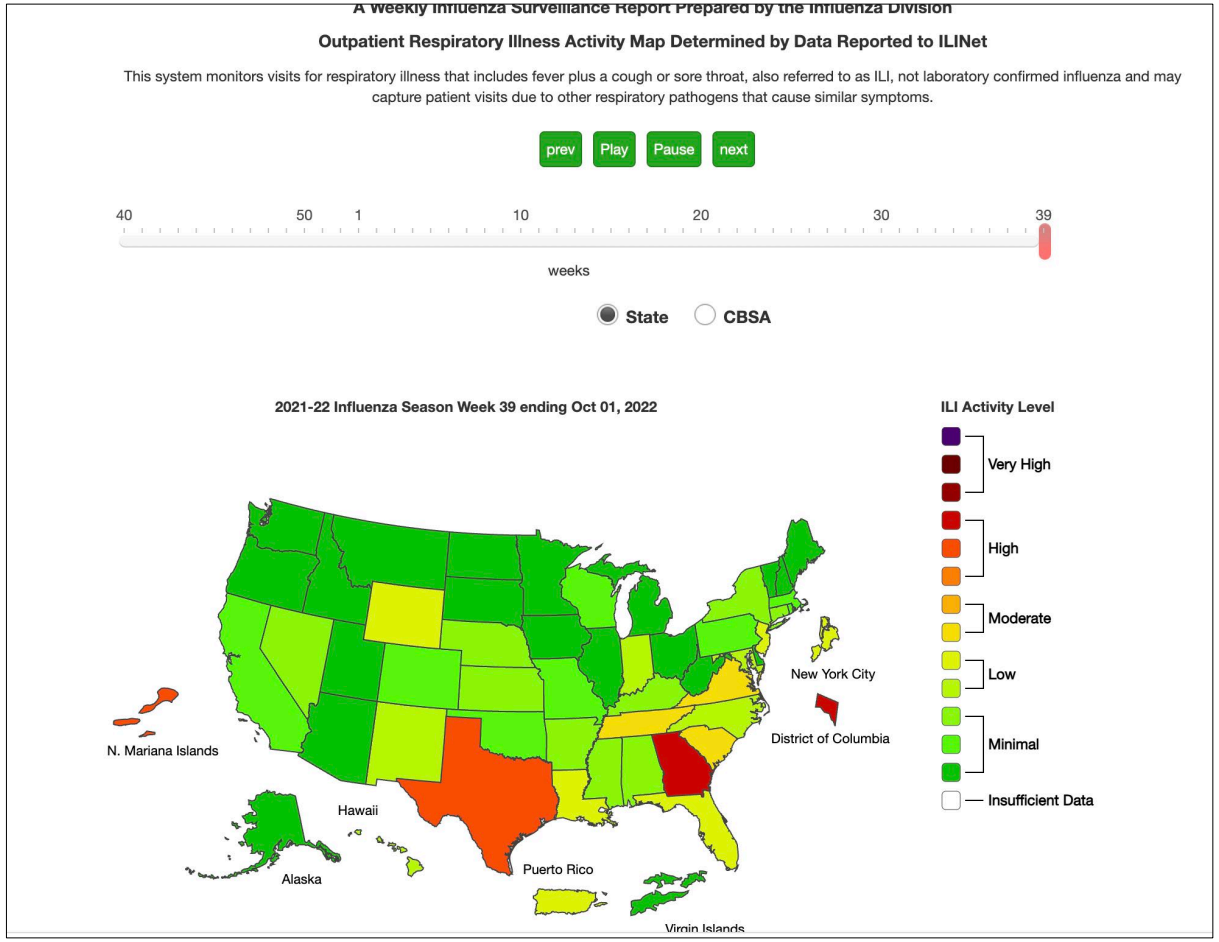
Figure 2



Solicited injection site reactions (A) and solicited systemic reactions (B) occurring up to 7 days after injection (immunogenicity analysis set)

Error bars show 95% CIs. Coadministration QIV-HD shows the solicited reactions observed in the QIV-HD-injected limb of participants in the coadministration group. Coadministration mRNA-1273 shows the solicited reactions observed in the mRNA-1273-injected limb of participants in the coadministration group. QIV-HD=high-dose quadrivalent influenza vaccine.

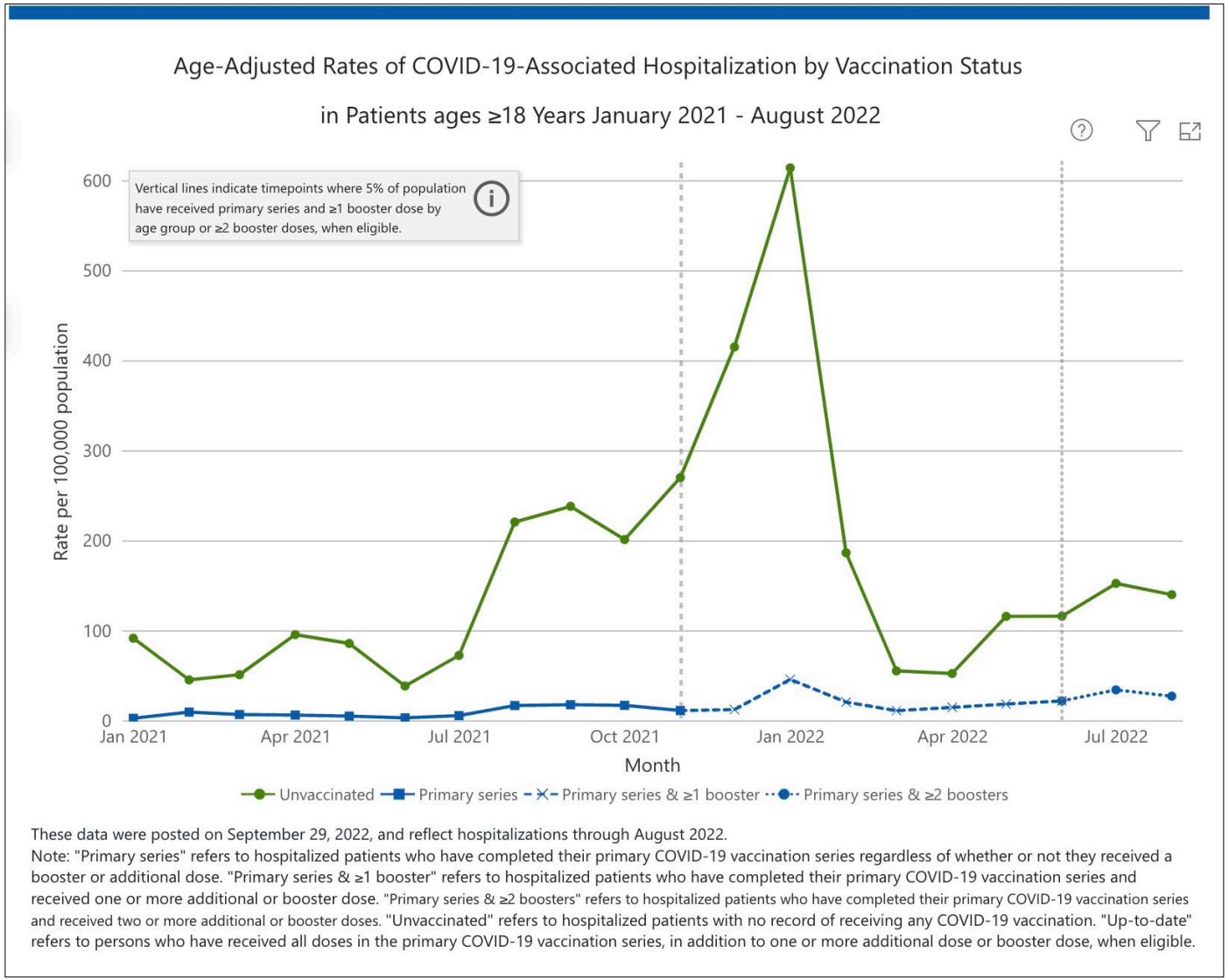
Flu Data (CDC)


A Weekly Influenza Surveillance Report Prepared by the Influenza Division
Outpatient Respiratory Illness Activity Map Determined by Data Reported to ILINet
This system monitors visits for respiratory illness that includes fever plus a cough or sore throat, also referred to as ILI, not laboratory confirmed influenza and may capture patient visits due to other respiratory pathogens that cause similar symptoms.
prev
Play
Pause
next
40
50
1
10
20
30
39
weeks
State
CBSA
2021-22 Influenza Season Week 39 ending Oct 01, 2022
ILI Activity Level
Very High
High
Moderate
Low
Minimal
Insufficient Data
New York City
District of Columbia
N. Mariana Islands
Hawaii
Alaska
Puerto Rico
Virgin Islands

Vaccine Strategy: Coadministration

- 2/3 of adults want it
- Side effects comparable
- Flu vaccine rates may go up with coadministration
- Nursing home resources
- Vaccine fatigue

Effectiveness of Vaccines on Hospitalizations



These data were posted on September 29, 2022, and reflect hospitalizations through August 2022.
Note: "Primary series" refers to hospitalized patients who have completed their primary COVID-19 vaccination series regardless of whether or not they received a booster or additional dose. "Primary series & ≥1 booster" refers to hospitalized patients who have completed their primary COVID-19 vaccination series and received one or more additional or booster dose. "Primary series & ≥2 boosters" refers to hospitalized patients who have completed their primary COVID-19 vaccination series and received two or more additional or booster doses. "Unvaccinated" refers to hospitalized patients with no record of receiving any COVID-19 vaccination. "Up-to-date" refers to persons who have received all doses in the primary COVID-19 vaccination series, in addition to one or more additional dose or booster dose, when eligible.

Effectiveness of Vaccines

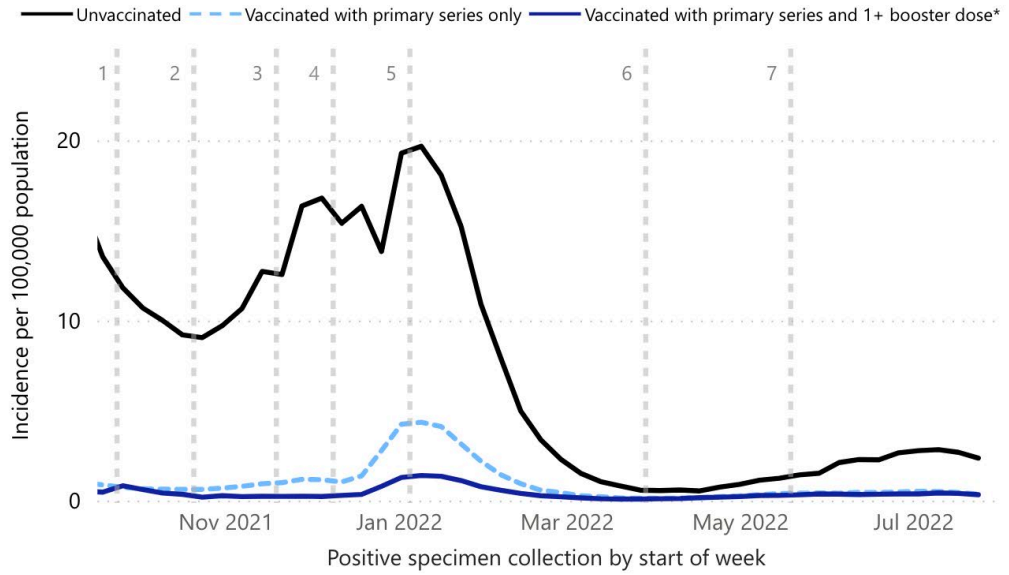
Overall | Age Group | Vaccine Product

Second Booster Dose

Rates of COVID-19 Deaths by Vaccination Status and 1+ Booster Dose* in Ages 5+ Years

September 19, 2021–July 30, 2022 (30 U.S. jurisdictions)

Select Outcome
- (●) Deaths
- ( ) Cases



Unvaccinated people aged 5 years and older had:

1.9X *Risk of Testing Positive for COVID-19*

AND

7X *Risk of Dying from COVID-19*

in July 2022, and

2.3X *Risk of Testing Positive for COVID-19*

in August 2022, compared to people vaccinated with a primary series and 1+ booster dose.*

Source: CDC COVID-19 Response, Epidemiology Task Force, Surveillance & Analytics Team, Vaccine Breakthrough Unit

Updated CDC Guidance Rests on Up-to-Date Vaccine Status for Staff and Residents

- Up-to-date vaccinate
- PPE and Infection Control
- Testing

CDC COVID-19 Infection Prevention and Control Guidance Updates

- Interim IPC Recommendations for Healthcare Personnel
- Interim Guidance for Managing Healthcare Personnel with Infection or Exposure
- Strategies to Mitigate Healthcare Personnel Staffing Shortages

Interim Infection Prevention and Control Recommendations for Health Care Personnel During the COVID-19 Pandemic: Key Updates

- Source Control
- Universal personal protective equipment (PPE)
- COVID-19 screening & testing
- Transmission-based precautions (for asymptomatic residents)
- Setting-specific

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Interim Infection Prevention and Control Recommendations for Health Care Personnel During the COVID-19 Pandemic: Key Updates

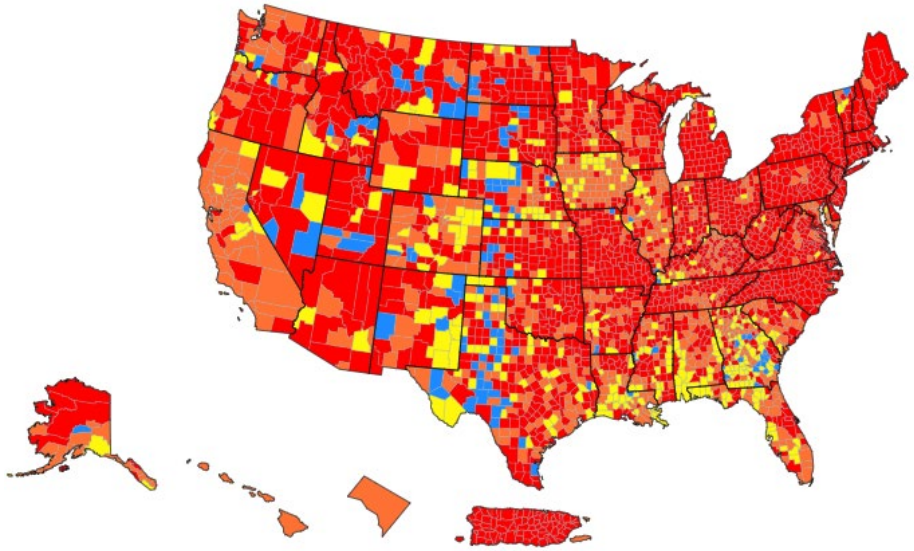
- Vaccination status is no longer used to inform source control, screening testing or post-exposure recommendations
- Source control recommendations based on community transmission levels
- Universal PPE use based on community transmission levels
- Asymptomatic patients/residents no longer require empiric use of transmission-based precautions following close contact with someone with SARS-CoV-2 infection
- Increased testing frequency to detect the potential for variants with shorter incubation periods
  - Address the risk for false negative antigen tests in people without symptoms
- Archived the Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes
  - Special considerations for nursing homes added under setting-specific considerations
  - Updated screening testing recommendations for nursing home admissions

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Transmission Levels

This metric uses two indicators:

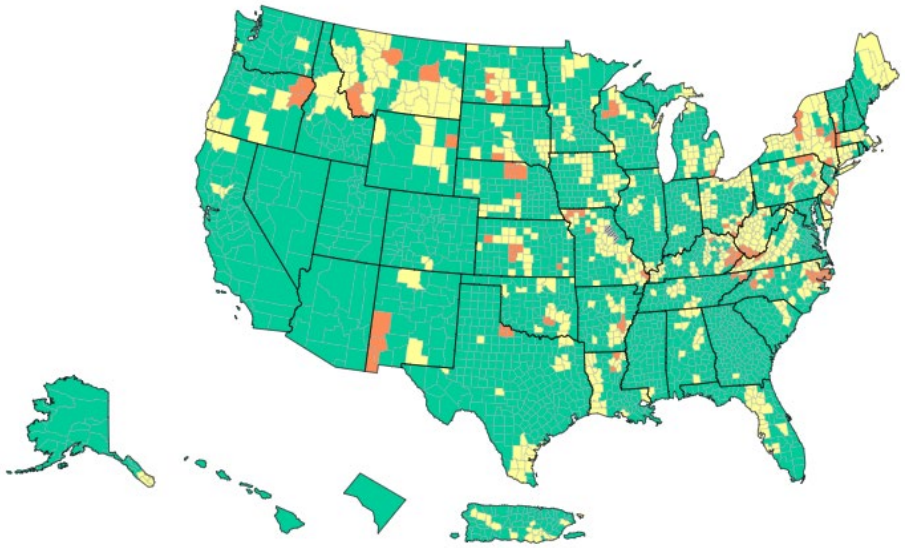
1. Total number of new cases per 100,000 persons within the last seven days.
2. Percentage of positive diagnostic and screening nucleic acid amplification tests (NAAT) during the last seven days.



COVID-19 Community Levels

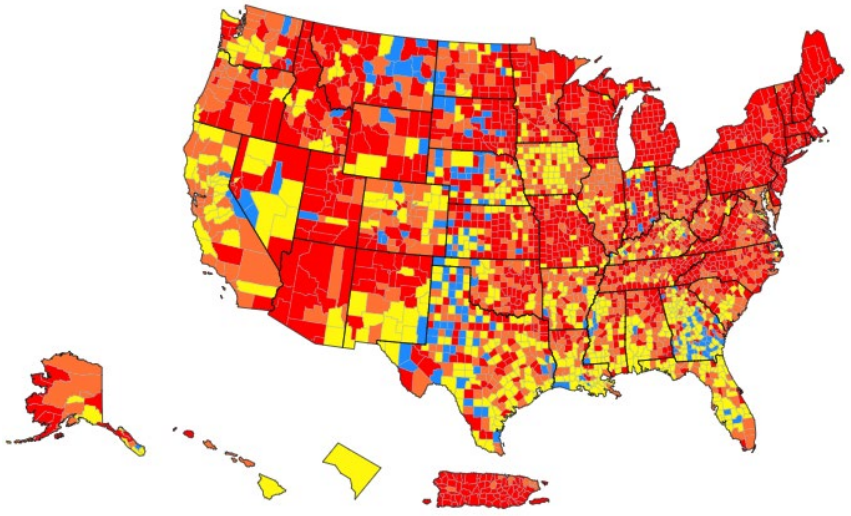
This metric uses three indicators:

1. New COVID-19 cases per 100,000 population in the last seven days.
2. New COVID-19 hospital admissions per 100,000 population in the last seven days.
3. Percent of staffed inpatient beds occupied by patients with confirmed COVID-19 (seven-day average).



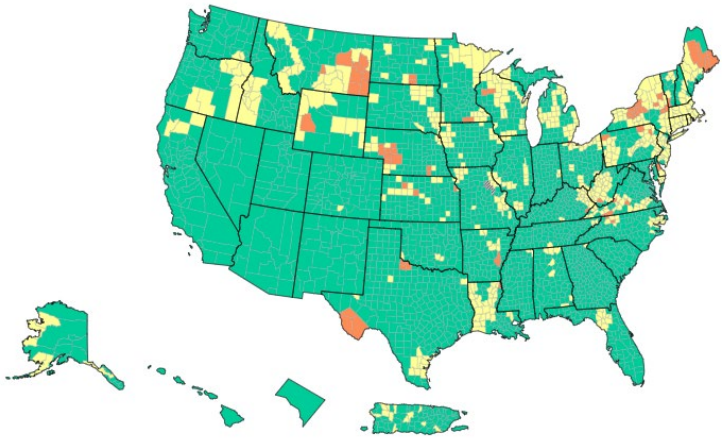
Transmission Levels

- **Healthcare settings**
- Used on a weekly basis to guide select infection prevention & control actions in healthcare setting
- Allows for earlier intervention
- Better protects individuals seeking medical care



COVID-19 Community Levels

- **Non-healthcare settings (assisted living facilities, group homes, retirement communities, congregate settings)**
- Help individuals and communities decide which prevention actions to take based on the latest information
- Informs individual- and household-level prevention behaviors and community-level prevention strategies for low, medium and high COVID-19 community levels



Interim Infection Prevention and Control Recommendations for Health Care Personnel During the COVID-19 Pandemic: Source Control Updates

- When transmission levels * are high:
  - Source control is recommended for everyone in areas where they could encounter patients.
    - HCP could choose not to wear source control in areas restricted from patient access (if community levels aren't also high and don't meet the criteria below).
- When transmission levels are not high:
  - Source control is recommended for individuals who:
    - Have suspected or confirmed respiratory infection
    - Had close contact with someone with COVID-19 for 10 days after contact
    - Reside or work in an area of the facility experiencing a COVID-19 outbreak
    - Have otherwise had source control recommended by public health
- Even if not otherwise required by the facility, individuals should always be allowed to wear source control based on personal preference.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Interim Infection Prevention and Control Recommendations for Health Care Personnel During the COVID-19 Pandemic: Universal PPE Updates

- When transmission levels * levels are high:
  - Consider implementing broader use of respirators and eye protection by HCP during patient care encounters.
  - NIOSH-approved particulate respirators with N95 filters or higher are used for:
    - All aerosol-generating procedures
    - All surgical procedures that might pose a higher risk for transmission if the patient has SARS-CoV-2 infection (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, and respiratory tract)
    - The patient is unable to use source control
    - The area is poorly ventilated
    - Specific units or areas of the facility at higher risk for SARS-CoV-2 transmission
  - Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) during all patient care encounters.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Interim Infection Prevention and Control Recommendations for Health Care Personnel During the COVID-19 Pandemic: Testing Updates

- Asymptomatic patients/residents with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection.
  - Testing is recommended immediately (but not earlier than 24 hours after the exposure), and:
    - If negative again 48 hours after the first negative test
      - If negative again 48 hours after the second negative test
      - This will typically be on day 1 (where the day of exposure is day 0), day 3, and day 5
- Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the last 30 days.
  - It should be considered for those who have recovered in the last 31-90 days; however, an antigen test is recommended instead of a nucleic acid amplification test (NAAT).

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Interim Infection Prevention and Control Recommendations for Health Care Personnel During the COVID-19 Pandemic: Transmission-Based Precautions Updates

- Asymptomatic patients/residents do not require empiric use of transmission-based precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection.
  - These patients/residents should still wear source control, and those who have not recovered from SARS-CoV-2 infection in the prior 30 days should be tested as described in the testing section.
  - Examples of when empiric transmission-based precautions following close contact may be considered for patients/residents include:
    - Unable to be tested or wear source control as recommended for the 10 days following their exposure.
    - Moderately to severely immunocompromised.
    - Residing in a unit with others who are moderately to severely immunocompromised.
    - Residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.
- Empiric use of transmission-based precautions is unnecessary for admissions or residents who leave the facility for less than 24 hours (e.g., for medical appointments or community outings) and do not meet the above criteria.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Interim Infection Prevention and Control Recommendations for Health Care Personnel During the COVID-19 Pandemic: Screening Testing Updates

- Screening testing of asymptomatic HCP is at the discretion of the health care facility.
  - Screening testing for identifying asymptomatic infection might be useful in some situations to inform the type of infection control precautions used (e.g., room assignment/cohorting or PPE used) and prevent unprotected exposures like:
    - Performing higher-risk procedures
    - For HCPs caring for patients who are moderately to severely immunocompromised
- If a screening testing program is implemented, testing decisions should NOT be based on the vaccination status of the individual being screened.
  - If using an antigen test instead of a NAAT, facilities should use three tests, spaced 48 hours apart, in line with FDA recommendations.
  - Performance of expanded screening testing of asymptomatic HCP without known exposures is at the discretion of the facility.
- Screening upon admission is recommended for facilities in counties where transmission levels are high.
  - Admission testing at lower levels of community transmission is at the discretion of the facility.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Interim Infection Prevention and Control Recommendations for Health Care Personnel During the COVID-19 Pandemic: Setting-specific Updates

- Visiting or shared HCP who enter the setting to provide health care to one or more residents (e.g., physical therapy, wound care, intravenous injections or catheter care provided by home health agency nurses) should follow the health care IPC recommendations in this guidance.
- Long-term care settings (excluding nursing homes) whose staff provide non-skilled personal care* similar to that provided by family members in the home (e.g., many assisted living and group homes) should follow community prevention strategies based on COVID-19 Community Levels similar to independent living, retirement communities or other non-healthcare congregate settings.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Interim Guidance for Managing Health Care Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2: Key Updates

- In general, asymptomatic HCP who have a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2.
  - Examples of when work restrictions may be considered include:
    - HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure.
    - HCP is moderately to severely immunocompromised.
    - HCP cares for or works on a unit with moderately to severely immunocompromised patients.
    - HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

- Increased testing frequency to detect the potential for variants with shorter incubation periods and risk for false negative antigen tests in people without symptoms:
  - Testing is recommended immediately (but not earlier than 24 hours after the exposure).
    - If negative again 48 hours after the first negative test.
    - If negative again 48 hours after the second negative test.
    - This will typically be on day 1 (where the day of exposure is day 0), day 3, and day 5.
  - Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days; should be considered for those who have recovered in the prior 31-90 days.
  - An antigen test instead of NAAT is recommended.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Strategies to Mitigate Health Care Personnel Shortages: Key Updates

- Conventional strategies are updated to advise that asymptomatic HCP with higher-risk exposures do not require work restrictions, regardless of their vaccination status.
  - Contingency and crisis strategies for earlier return to work for this HCP were removed.

- Other key points to re-emphasize:

  - Maintaining appropriate staffing in facilities is essential to providing a safe work environment for HCP and safe patient care.

  - Maximizing interventions to protect HCP, patients and visitors are critical at all times, including when considering strategies to address staffing shortages.

  - Contingency strategies followed by crisis strategies are provided to augment conventional strategies. They are meant to be considered and implemented sequentially (i.e., implementing conventional strategies followed by contingency strategies followed by crisis strategies).

https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

Centers for Medicare and Medicaid Services (CMS) Guidance

- Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements (9/23/2022)

Table 1: Testing Summary

Testing Trigger	Staff	Residents
Symptomatic individual identified	Staff, regardless of vaccination status, with signs or symptoms must be tested.	Residents, regardless of vaccination status, with signs or symptoms must be tested.
Newly identified COVID-19 positive staff or resident in a facility that can identify close contacts	Test all staff, regardless of vaccination status, that had a higher-risk exposure with a COVID-19 positive individual.	Test all residents, regardless of vaccination status, that had close contact with a COVID-19 positive individual.
Newly identified COVID-19 positive staff or resident in a facility that is unable to identify close contacts	Test all staff, regardless of vaccination status, facility-wide or at a group level if staff are assigned to a specific location where the new case occurred (e.g., unit, floor, or other specific area(s) of the facility).	Test all residents, regardless of vaccination status, facility-wide or at a group level (e.g., unit, floor, or other specific area(s) of the facility).
Routine testing	*Not generally recommended*	Not generally recommended

Centers for Medicare and Medicaid Services (CMS) Guidance

- Nursing Home Visitation - COVID-19 (REVISED) (9/23/2022)
  - Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19 or had close contact with someone with COVID-19.
    - Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation.
    - Visitors who had close contact with someone with COVID-19 infection should defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).
  - Hand hygiene (use of alcohol-based hand rub is preferred)
  - Face covering or mask (covering mouth and nose) in accordance with CDC guidance

Thank You for Your Time!
Contact the AHS Patient Safety Team

Amy Ward, MS, BSN, RN, CIC
Patient Safety Manager
Amy.Ward@AlliantHealth.org
678.527.3653

Paula St. Hill, MPH, A-IPC
Technical Advisor, Infection Prevention
Paula.StHill@AlliantHealth.org
678.527.3619

Donald Chitanda, MPH, CIC
Technical Advisor, Infection Prevention
Donald.Chitanda@AlliantHealth.org
678.527.3651

Erica Umeakunne, MSN, MPH, APRN, CIC
Infection Prevention Specialist
Erica.Umeakunne@AlliantHealth.org

Questions?

Georgia Department of Public Health HAI Team Contacts

State Region/Districts	Contact Information
North (Rome, Dalton, Gainesville, Athens) Districts 1-1, 1-2, 2, 10	Sue.bunnell@dph.ga.gov (404-967-0582) Mary.Whitaker@dph.ga.gov (404-967-0578)
Atlanta Metro (Cobb-Douglas, Fulton, Clayton, Lawrenceville, DeKalb, LaGrange) Districts 3-1, 3-2, 3-3, 3-4, 3-5, 4	Teresa.Fox@dph.ga.gov (404-596-1910) Renee.Miller@dph.ga.gov (678-357-4797)
Central (Dublin, Macon, Augusta) Districts 5-1, 5-2, 6, 7	Theresa.Metro-Lewis@dph.ga.gov (404-967-0589) Karen.Williams13@dph.ga.gov (404-596-1732)
Southeast (Columbia, Albany) Districts 8-1, 8-2	Connie.Stanfill1@dph.ga.gov (404-596-1940)
Southwest (Valdosta, Savannah, Waycross) Districts 9-1, 9-2	Regina.Howard@dph.ga.gov (404 967-0574)
Backup/Nights/Weekends	Jeanne.Negley@dph.ga.gov (404-657-2593) Joanna.Wagner@dph.ga.gov (404-430-6316)

Save the Date

SNF and Medical Directors Office Hours:

November 18, 2022 | 11 a.m. ET

ALF and PCH

November 18, 2022 | 1 p.m. ET

Thanks Again…

- Georgia Department of Public Health
- University of Georgia

Making Health Care Better

ALLIANT HEALTH SOLUTIONS

@AlliantQIO

Alliant Health Solutions

@AlliantQIO

AlliantQIO

This material was prepared by Alliant Health Solutions, under contract with the Georgia Department of Public Health as made possible through the American Rescue Plan Act of 2021.

quality.allianthealth.org