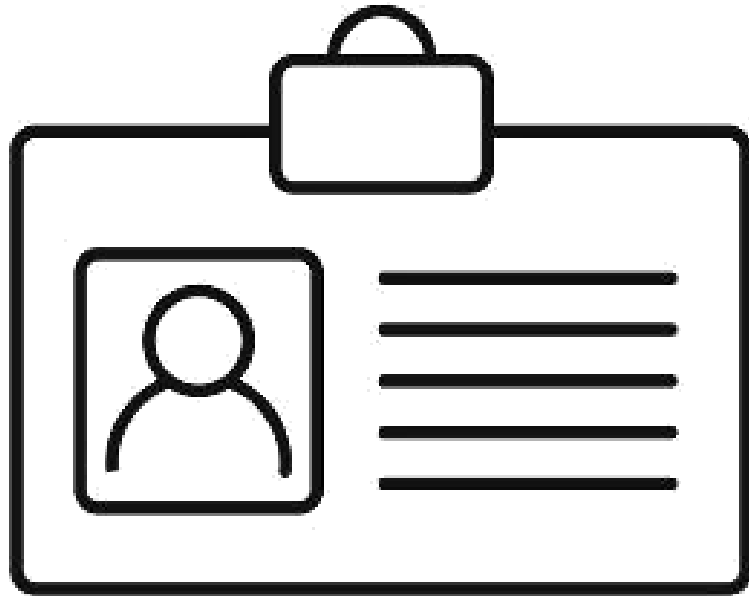




Georgia Department of Public Health: Strike & Support Team
Office Hours for SNFs & Medical Directors
March 15, 2024

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. 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, Dr. Gaur 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.

Dr. Gaur is an attending physician in several nursing facilities. She 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 with a concentration in technology management at the Georgia Institute of Technology.



Erica Umeakunne, MSN, MPH, APRN, CIC

Infection Prevention Specialist
Alliant Health Solutions

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 was previously the interim hospital epidemiology director for a large Atlanta health care system and a nurse consultant in the Centers for Disease Control and Prevention's (CDC) Division of Healthcare Quality Promotion. While at the 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.



Erica enjoys reading, traveling, family time, and outdoor activities.

Contact: Erica.Umeakunne@allianthealth.org



Thank You to Our Partners

- Georgia Department of Public Health
- University of Georgia



Objectives

- Provide updates on COVID-19 and other respiratory viral threats that nursing homes are facing
- Review CDC COVID-19 guidance updates
- Share GADPH and Alliant Health Solution Resources to support their infection prevention and control initiatives
- Address any questions or concerns from facilities



COVID-19 Update



CDC COVID Data Tracker

COVID-19 Update for the United States

Early Indicators

Test Positivity >

% Test Positivity

7.4%

(February 18 to February 24, 2024)

Trend in % Test Positivity

-0.9% in most recent week



Jan 6, 2024 Feb 24, 2024

Emergency Department Visits >

% Diagnosed as COVID-19

1.5%

(February 18 to February 24, 2024)

Trend in % Emergency Department Visits

-14.6% in most recent week



Jan 6, 2024 Feb 24, 2024

Severity Indicators

Hospitalizations >

Hospital Admissions

17,310

(February 18 to February 24, 2024)

Trend in Hospital Admissions

-10.3% in most recent week



Jan 6, 2024 Feb 24, 2024

Deaths >

% of All Deaths in U.S. Due to COVID-19

2.1%

(February 18 to February 24, 2024)

Trend in % COVID-19 Deaths

-8.7% in most recent week



Jan 6, 2024 Feb 24, 2024

These early indicators represent a portion of national COVID-19 tests and emergency department visits. [Wastewater](#) information also provides early indicators of spread.

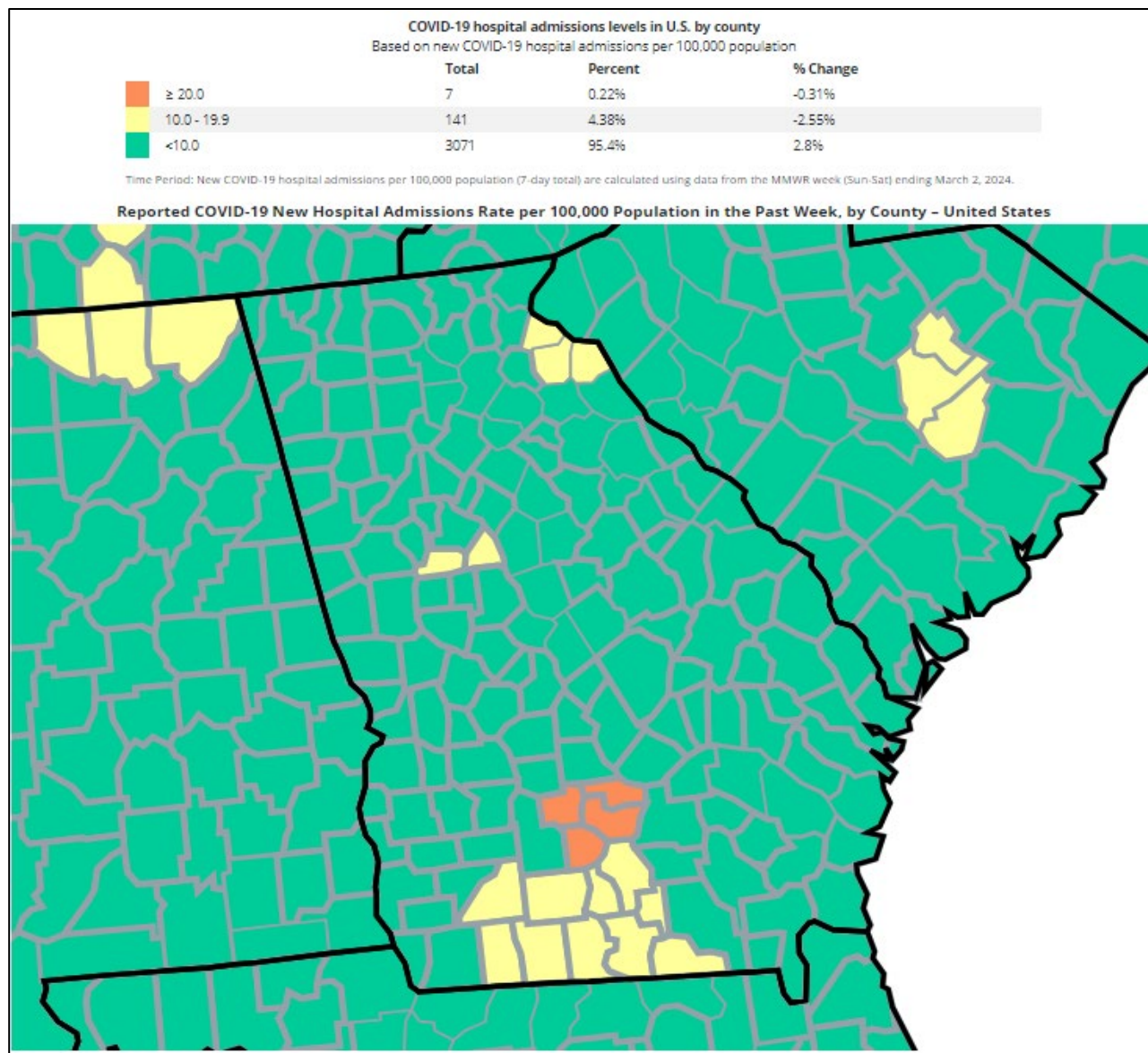
Total Hospitalizations

6,851,629

Total Deaths

1,181,607

CDC | Test Positivity data through: February 24, 2024; Emergency Department Visit data through: February 24, 2024; Hospitalization data through: February 24, 2024; Death data through: February 24, 2024.
Posted: March 4, 2024 3:15 PM ET

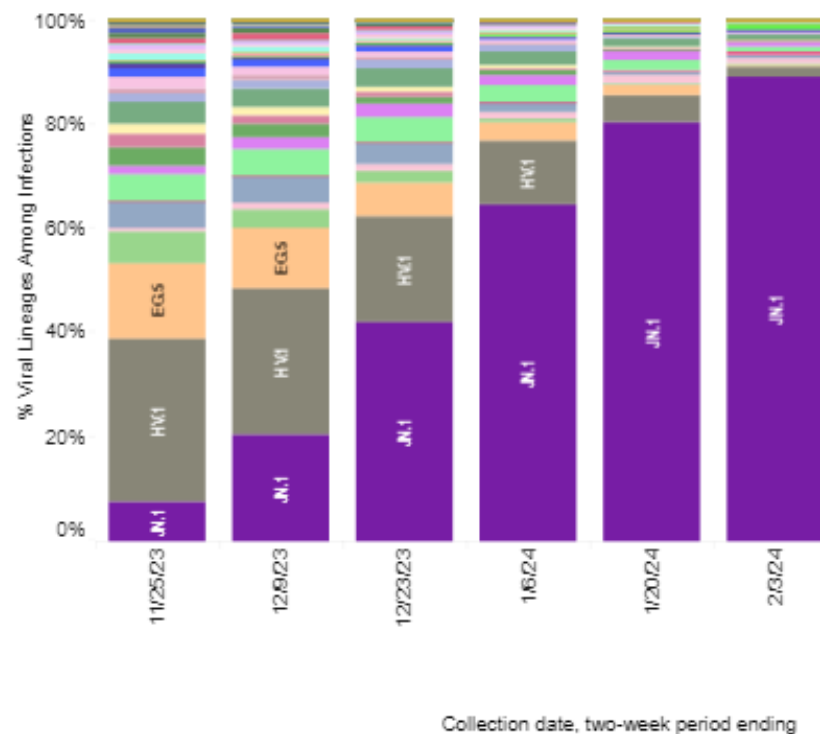


https://covid.cdc.gov/covid-data-tracker/#cases_new-admissions-rate-county

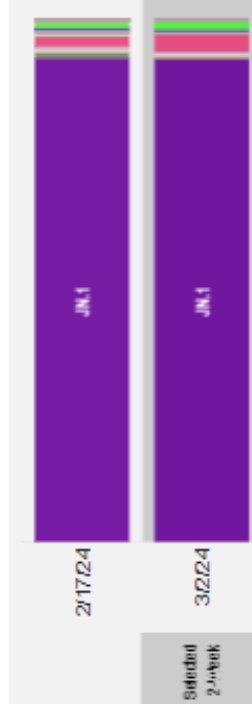
Weighted and Nowcast Estimates in United States for 2-Week Periods in 11/12/2023 – 3/2/2024

Hover over (or tap in mobile) any lineage of interest to see the amount of uncertainty in that lineage's estimate.

Weighted Estimates: Variant proportions based on reported genomic sequencing results



Nowcast: Model-based projected estimates of variant proportions



Nowcast Estimates in United States for 2/18/2024 – 3/2/2024

USA			
WHO label	Lineage #	%Total	95%PI
Omicron	JN.1	92.3%	90.5-93.8%
	JN.1.13	3.3%	1.8-5.7%
	JN.1.18	1.8%	1.1-2.9%
	HV.1	0.4%	0.3-0.5%
	BA.2.86	0.3%	0.2-0.5%
	JG.3	0.2%	0.1-0.2%
	BA.2	0.2%	0.0-0.7%
	JD.1.1	0.1%	0.1-0.2%
	HK.3	0.1%	0.0-0.1%
	EG.5	0.0%	0.0-0.0%
	XBB	0.0%	0.0-0.0%
	GE.1	0.0%	0.0-0.1%
	EG.5.1.8	0.0%	0.0-0.0%
	JF.1	0.0%	0.0-0.0%
	XBB.1.9.1	0.0%	0.0-0.0%
	FL.1.5.1	0.0%	0.0-0.0%
	XBB.1.16.15	0.0%	0.0-0.0%
	XBB.1.5.70	0.0%	0.0-0.0%
	XBB.2.3	0.0%	0.0-0.0%
	XBB.1.16.6	0.0%	0.0-0.0%
	XBB.1.16.11	0.0%	0.0-0.0%
	HF.1	0.0%	0.0-0.0%
	GK.1.1	0.0%	0.0-0.0%
	XBB.1.16	0.0%	0.0-0.0%
	GK.2	0.0%	0.0-0.0%
	XBB.1.9.2	0.0%	0.0-0.0%
	XBB.1.5	0.0%	0.0-0.0%
	XBB.1.42.2	0.0%	0.0-0.0%
	XBB.1.16.1	0.0%	0.0-0.0%
	EG.6.1	0.0%	0.0-0.0%
Other	Other*	1.1%	0.6-2.0%

COVID-19 Variant Surveillance CDC

<https://covid.cdc.gov/covid-data-tracker/#variant-proportions>

Metric:

- ☒ Current virus levels in wastewater by site
- ☐ Percent change in the last 15 days
- ☐ Percent of wastewater samples with detectable virus

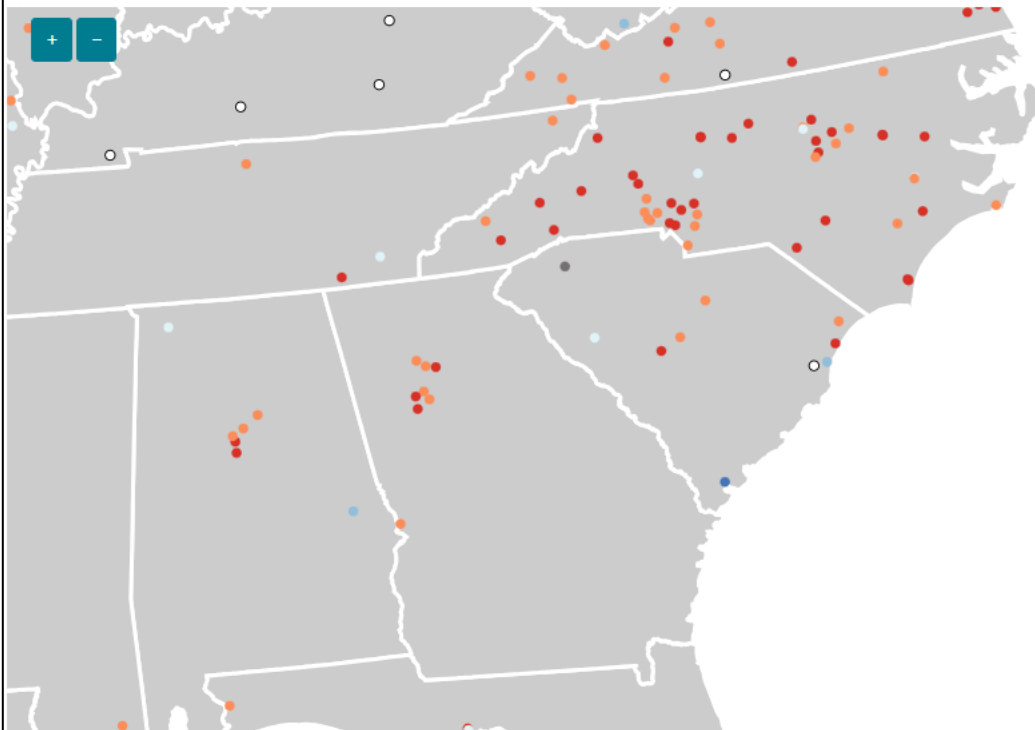
Show:

- ☒ Sites with no recent data
- ☒ Sites that started sampling after 12/1/21

Current virus levels in wastewater by site

This metric shows whether SARS-CoV-2 levels at a site are currently higher or lower than past historical levels at the same site. 0% means levels are the lowest they have been at the site; 100% means levels are the highest they have been at the site. Public health officials watch for increasing levels of the virus in wastewater over time and use these data to help make public health decisions.

⚠ Note: Sites began collecting data at different times. Sites that began reporting wastewater data after December 1, 2021 are not comparable to sites that started reporting data on or before December 1, 2021. The data history for these new sites is not long enough to reflect the same surges as the other sites.



Select legend categories to filter points on the map.

☐ New site ☒ 0% to 19% ☐ 20% to 39% ☐ 40% to 59% ☐ 60% to 79% ☐ 80% to 100% ☐ No recent data

Current SARS-CoV-2 virus levels by site, United States

Current virus levels category	Num. sites	% sites	Category change in last 7 days
New Site	33	3	6%
0% to 19%	72	6	18%
20% to 39%	241	19	- 1%
40% to 59%	399	32	- 4%
60% to 79%	368	30	- 12%
80% to 100%	130	10	- 4%

Total sites with current data: 1243

Total number of wastewater sampling sites: 1359

[How is the current SARS-CoV-2 level compared to past levels calculated?](#)

Wastewater Surveillance

<https://covid.cdc.gov/covid-data-tracker/#wastewater-surveillance>

Metric:

- ☐ Current virus levels in wastewater by site
- ☒ Percent change in the last 15 days
- ☐ Percent of wastewater samples with detectable virus

Show:

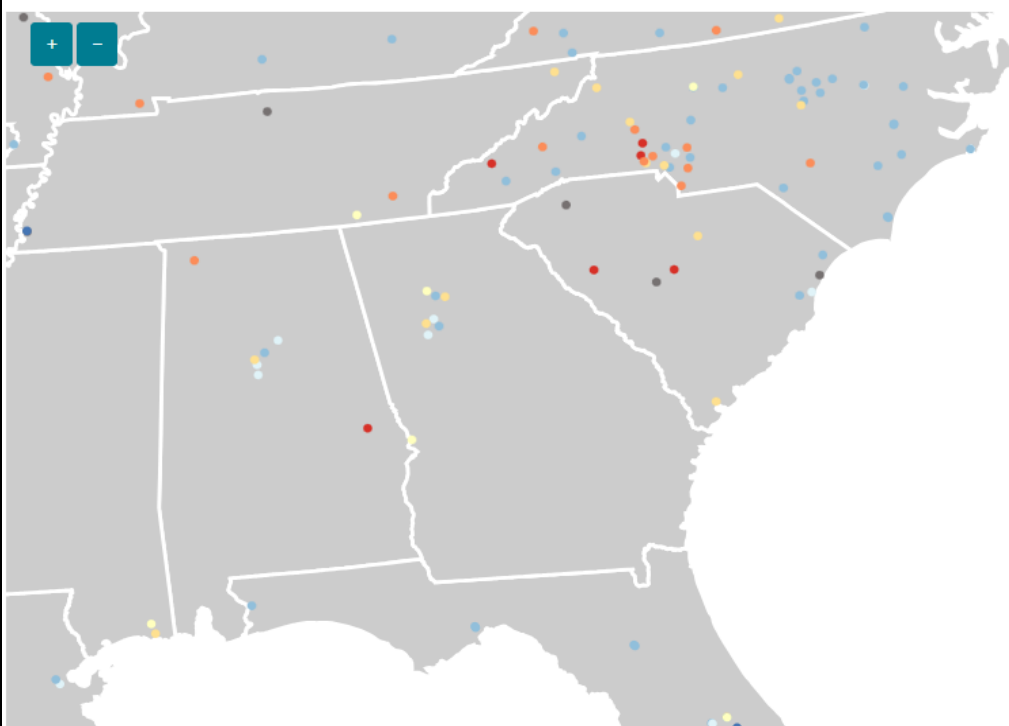
- ☒ Sites with no recent data

Percent change in the last 15 days

This metric shows whether virus levels have increased or decreased over the last 15 days. When levels of virus in wastewater are low, a modest increase in virus level can appear much larger when you look at the percent change. This metric may be affected by how often wastewater plants collect samples or by environmental factors (such as rainfall).

Wastewater data showing the percent change in virus levels should be used along with other data such as overall levels of the virus in wastewater, historical wastewater data for that location, geographical context, and clinical cases.

Note: This metric does **not** show overall levels of SARS-CoV-2 in wastewater.



Percent change of SARS-CoV-2 in the last 15 days by site, United States

15-day % change category	Num. sites	% sites	Category change in last 7 days
- 100%	35	3	9%
- 99% to - 10%	450	42	- 13%
- 9% to 0%	97	9	- 23%
1% to 9%	65	6	7%
10% to 99%	164	15	- 25%
100% to 999%	167	16	- 13%
1000% or more	93	9	6%

Total sites with current data: 1071

Total number of wastewater sampling sites: 1359

[How is the 15-day percent change calculated?](#)

Select legend categories to filter points on the map.

☒ - 100%
 ☒ - 99% to - 10%
 ☒ - 9% to 0%
 ☒ 1% to 9%
 ☒ 10% to 99%
 ☒ 100% to 999%
 ☒ 1000% or more
 ☒ No recent data

Wastewater Surveillance

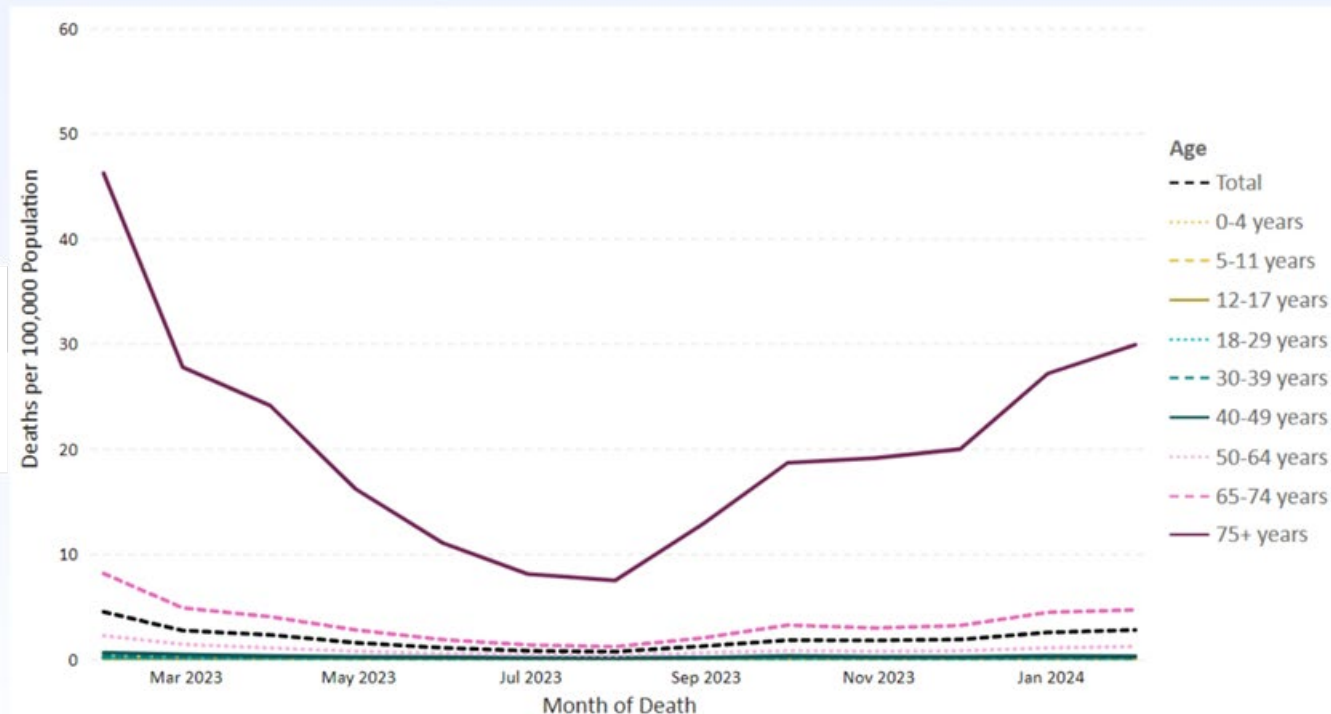
Percent Change

<https://covid.cdc.gov/covid-data-tracker/#wastewater-surveillance>

Why was the new COVID-19 vaccination recommendation made?



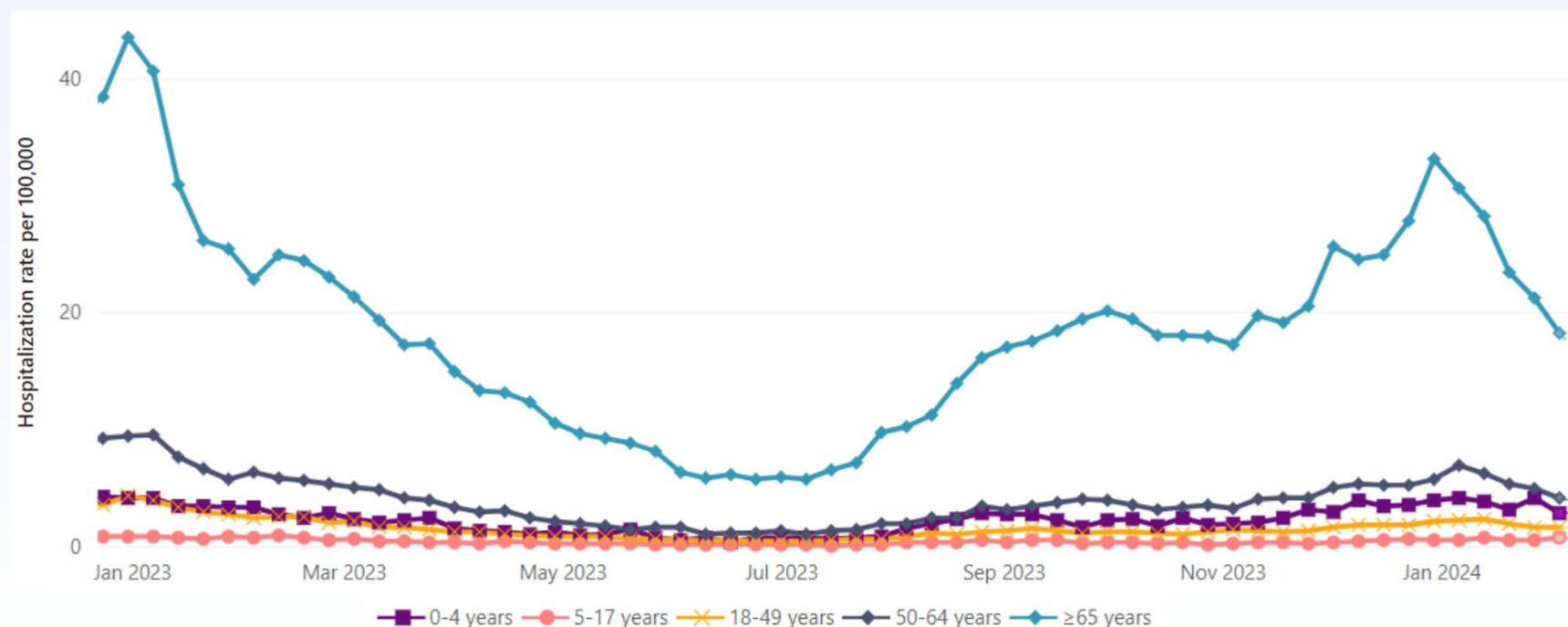
Monthly rates of provisional COVID-19 deaths by age group, United States, January 1, 2023 – January 31, 2024



Provisional data are non-final counts of deaths based on reported mortality data in NVSS. Deaths include those with COVID-19, coded as ICD-10 code U07.1, on the death certificate. Death data are displayed by date of death (event).

Source: Provisional data from the CDC's National Center for Health Statistics (NCHS) National Vital Statistic System (NVSS); CDC COVID Data Tracker. <https://covid.cdc.gov/covid-data-tracker/#demographicsovertime>. Accessed February 23, 2024

Weekly population-based rates of COVID-19-associated hospitalizations, by age group — COVID-NET, January 1, 2023 – February 24, 2024

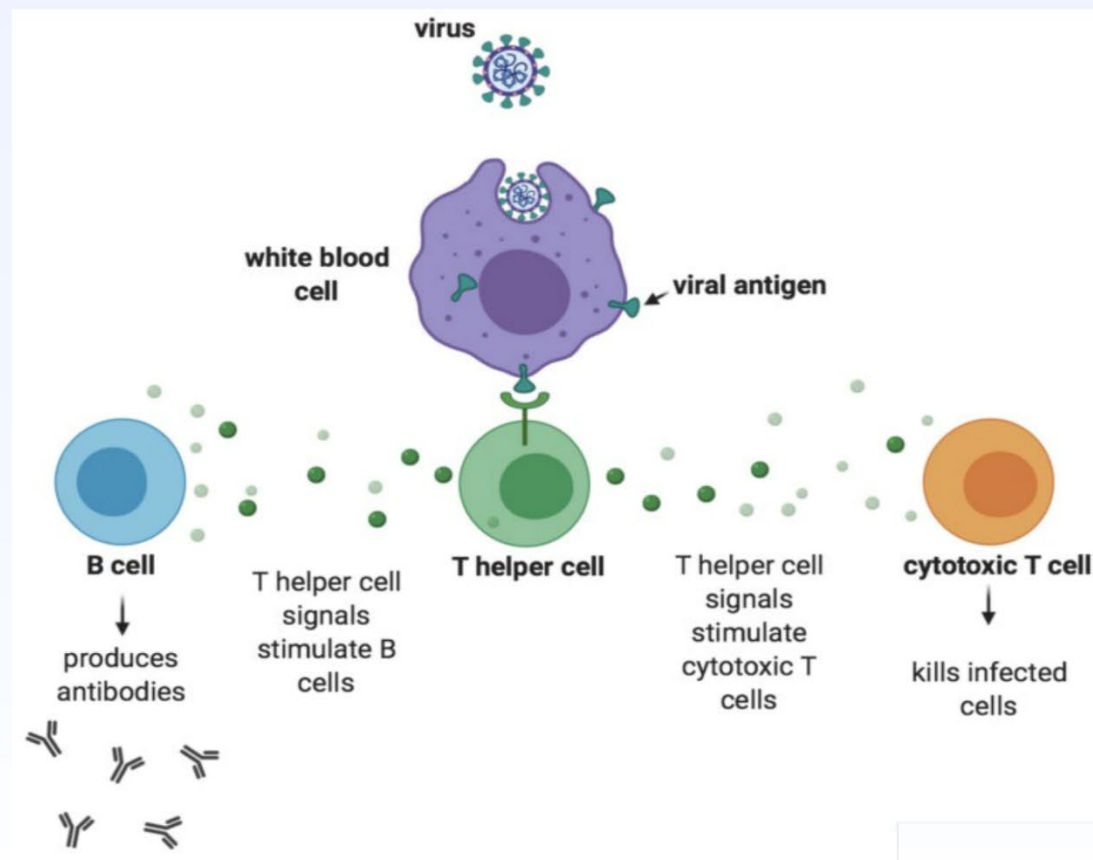


Dashed lines indicate potential reporting delays and interpretation of trends should exclude these weeks.

CDC COVID Data Tracker. <https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalization-network>. Accessed February 23, 2024

ACIP Meeting February 28, 2024

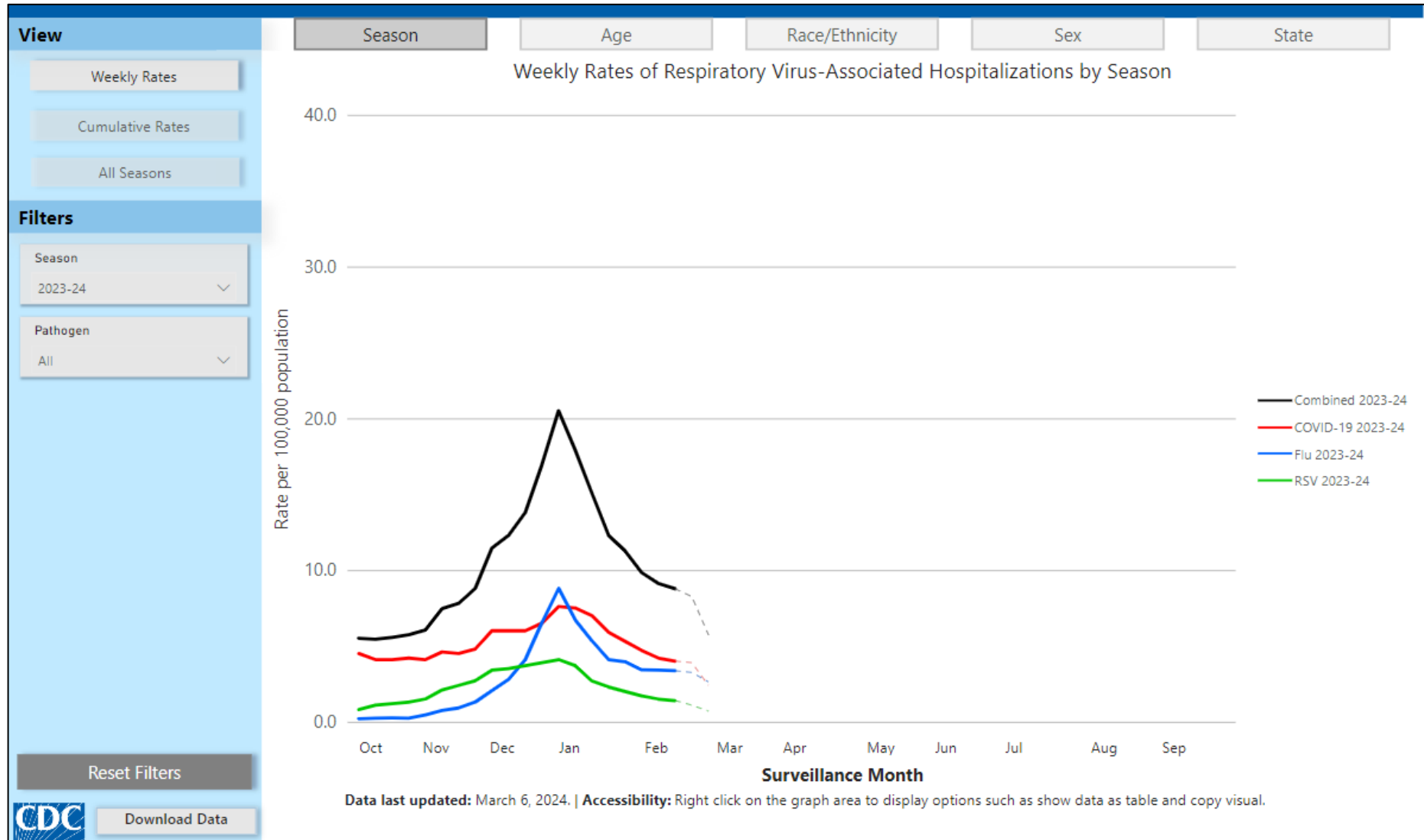
Adaptive immunity includes cellular and humoral responses



Insufficient pools of naïve T cells impacts ability to generate:

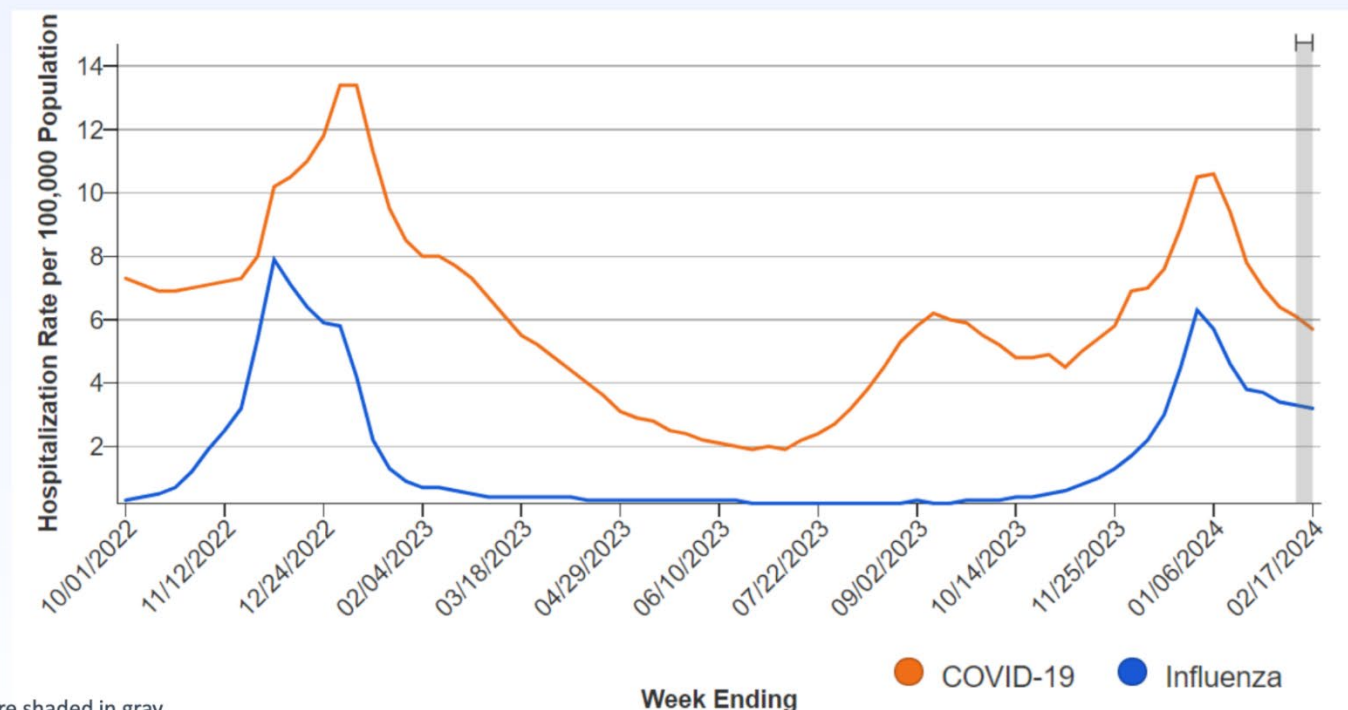
- Neutralizing antibody responses
- Cytotoxic T cells

Source: Rey, Gertrud. T Cell Responses to Coronavirus Infection are Complicated. <https://www.virology.ws/2020/11/05/t-cell-responses-to-coronavirus-infection-are-complicated/>



CDC RESPNET Dashboard

Weekly hospitalization rate per 100,000 population, United States, October 1, 2022 – February 17, 2024



Preliminary data are shaded in gray.

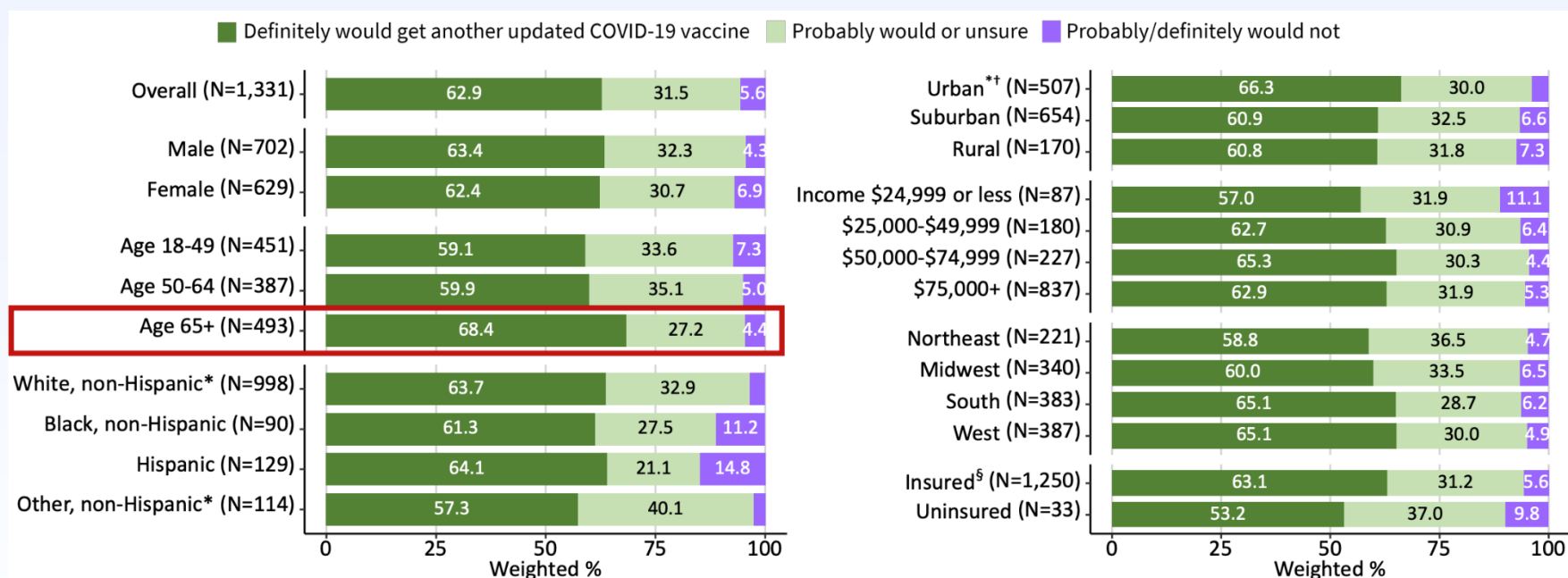
Dashed line represents the nadir for COVID-19 hospitalization rates.

CDC Respiratory Virus Activity Levels. National Healthcare Safety Network. <https://www.cdc.gov/respiratory-viruses/data-research/dashboard/illness-severity.html>. Accessed February 23, 2024

Are people over 65 likely to take an additional COVID shot?



Intent to receive *additional* COVID-19 vaccine dose among adults ≥18 years of age who received a dose since September 14, 2023, Omnibus Surveys, November 30, 2023-January 16, 2024 (N=1,331)



*Labels for estimates <4% not shown. **NORC and Ipsos base urbanicity on different, but comparable measures. NORC uses Census tract-based RUCA (Rural-Urban-Commuting Area) codes, whereas Ipsos uses Office of Management and Budget's CBSA (Core Based Statistical Area) classification. §Includes plans purchased through employer, insurance companies, marketplaces, military insurance, Medicare, Medicaid, VA, IHS, and "other."

Omnibus Surveys: Data for this analysis were collected through the Ipsos KnowledgePanel and NORC AmeriSpeak Omnibus Surveys, which use probability-based panels to survey a nationally representative sample of U.S. adults aged 18 years and older. CDC fields questions about vaccination status, intent, knowledge, attitudes, beliefs, and behaviors on each survey for 2 waves each month, for a combined sample size of ~4,000 respondents. These slides present results from January (N=4,287). Data were weighted to represent the non-institutionalized U.S. population and mitigate possible non-response bias. All responses are self-reported.

Are these COVID shots dangerous?

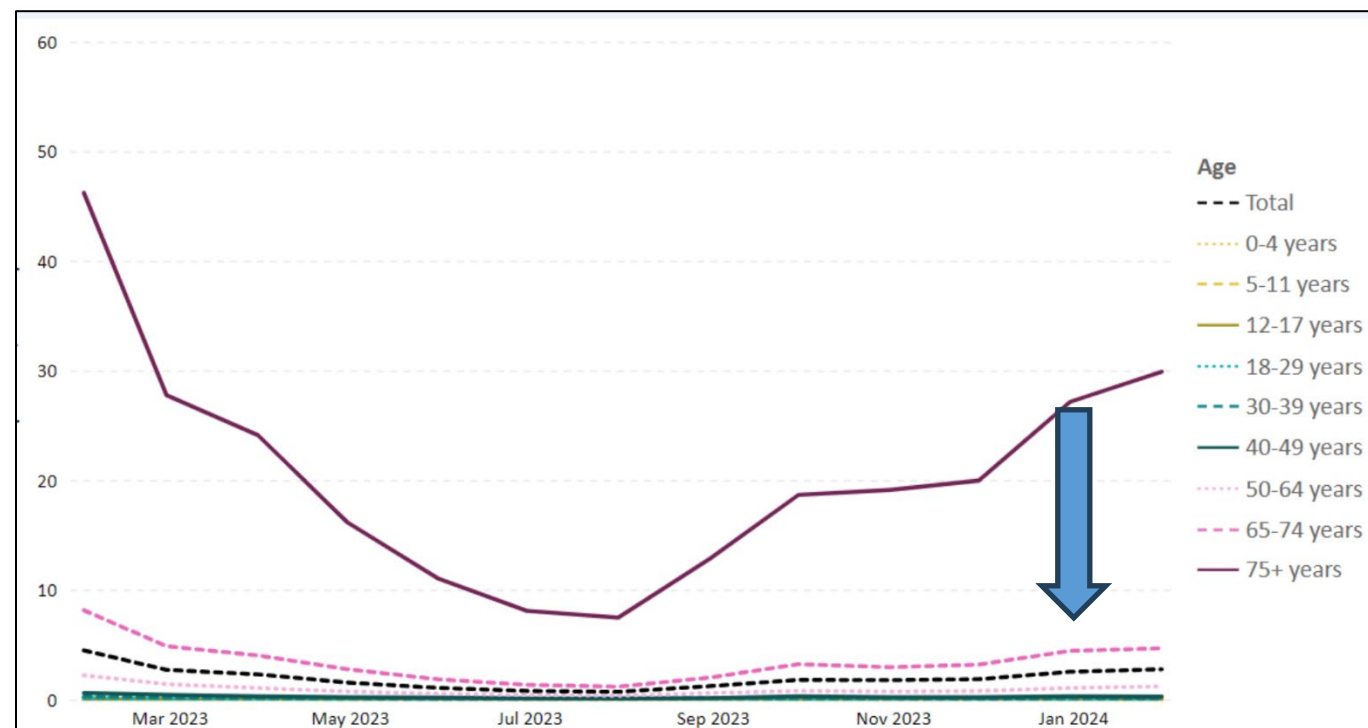
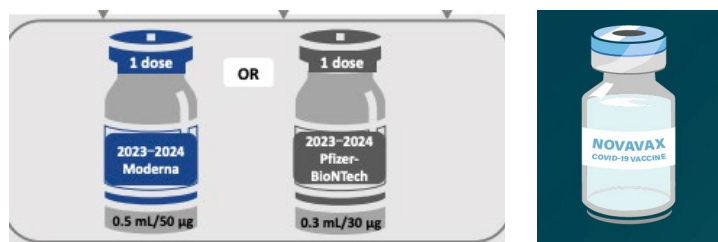
Summary

Benefits and Harms

- 2023-2024 Formula COVID-19 vaccination provided increased protection against symptomatic SARS-CoV-2 infection and COVID-19-associated ED/UC visits and hospitalizations compared to no updated vaccine dose.
 - COVID-19 vaccine effectiveness from previous vaccine formulations has waned over time but appears more durable against critical illness.
- An additional dose of 2023-2024 Formula may restore vaccine effectiveness which is expected to wane, providing additional protection until the next updated vaccine is available.
- COVID-19 vaccines have a favorable safety profile.
 - Local and systemic symptoms have been reported following receipt of COVID-19 vaccines; however, symptoms are less frequent and severe among older adults compared with adolescents and younger adults.
 - Available data do not provide clear and consistent evidence of a safety issue for ischemic stroke with bivalent mRNA COVID-19 vaccines either when given alone or given simultaneously with influenza vaccines.

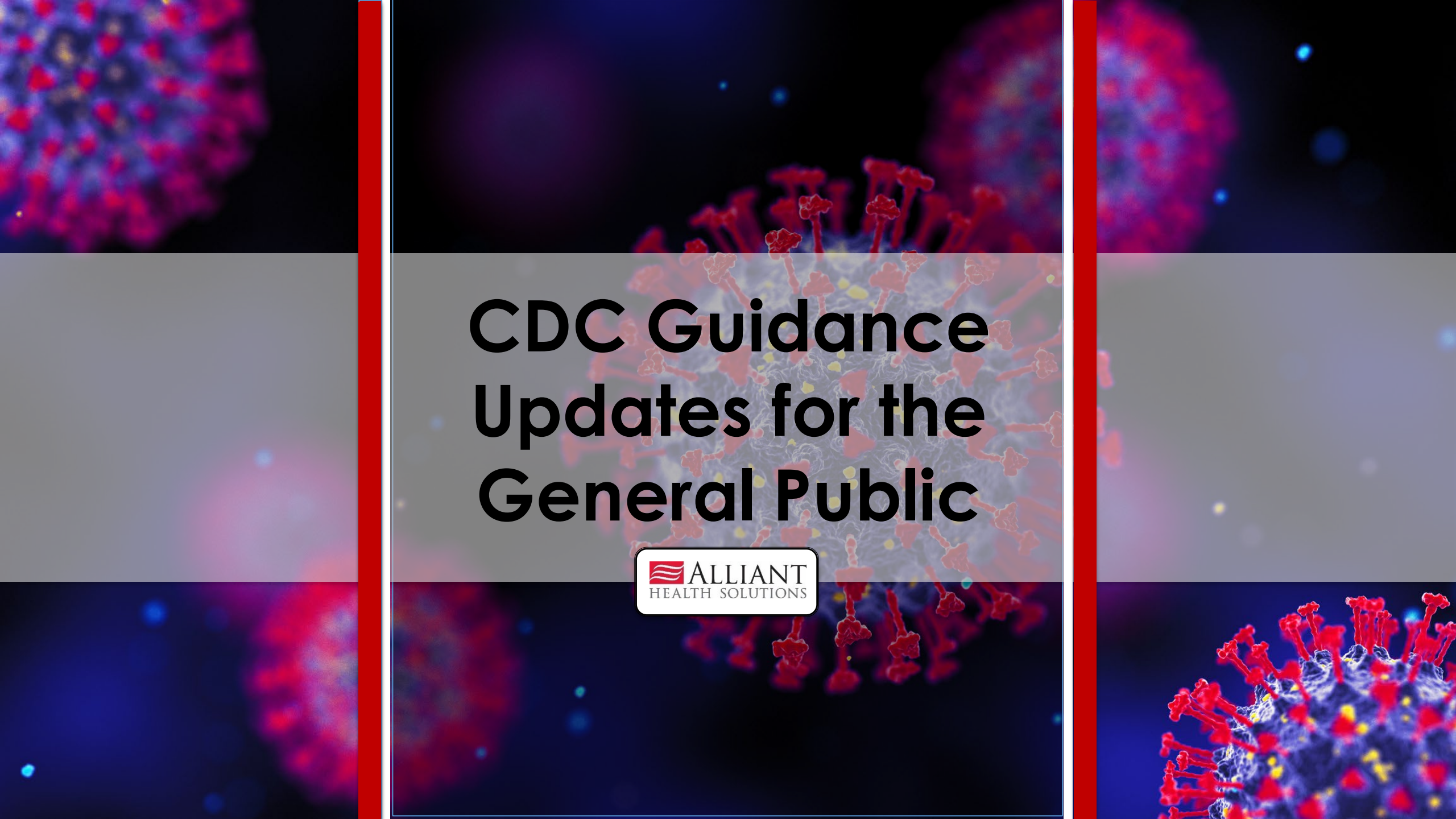
What Is the COVID-19 Vaccine Recommendation?

- ALL > six months SHOULD receive an Updated COVID-19 vaccine (existing recommendation)
- Additional dose of updated COVID-19 vaccine **SHOULD** be administered four months after the original updated vaccine for those ≥ 65 years old (new additional recommendation)



<https://www.cdc.gov/media/releases/2024/s-0228-covid.html>

<https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html>



CDC Guidance Updates for the General Public



CDC Recommendations for COVID-19

Health Care Settings

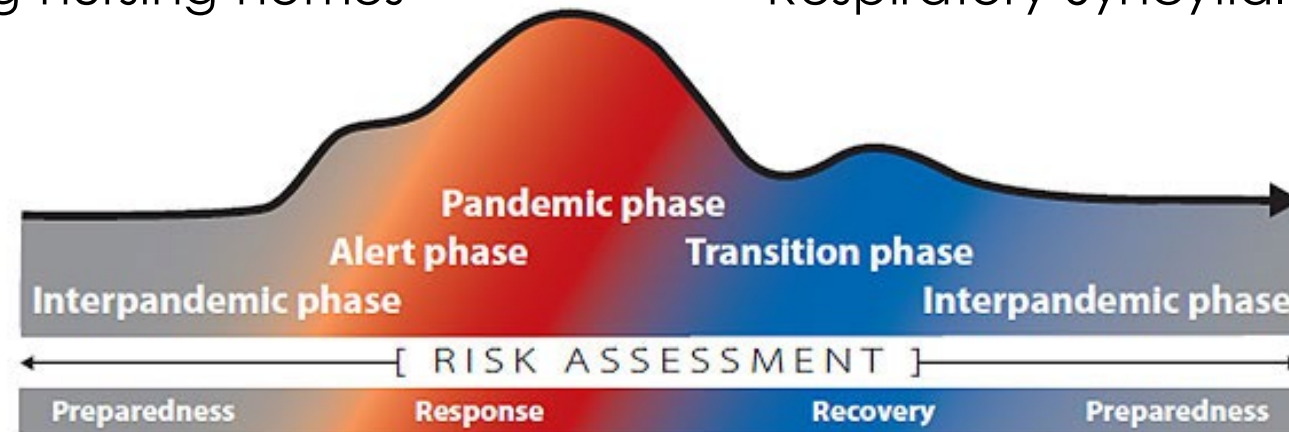
No changes were made to the [CDC IPC guidelines for health care settings](#)

- This guidance still applies to all settings where health care is delivered, including nursing homes and home health.

General Public

CDC updated guidelines for the public

- Standardized [recommendations for respiratory viruses](#), including but not limited to COVID-19, influenza and Respiratory Syncytial Virus (RSV).



Rationale for General Public Guidance Updates



Fewer hospitalizations and deaths due to COVID-19

Protective tools (i.e., vaccines, treatments)

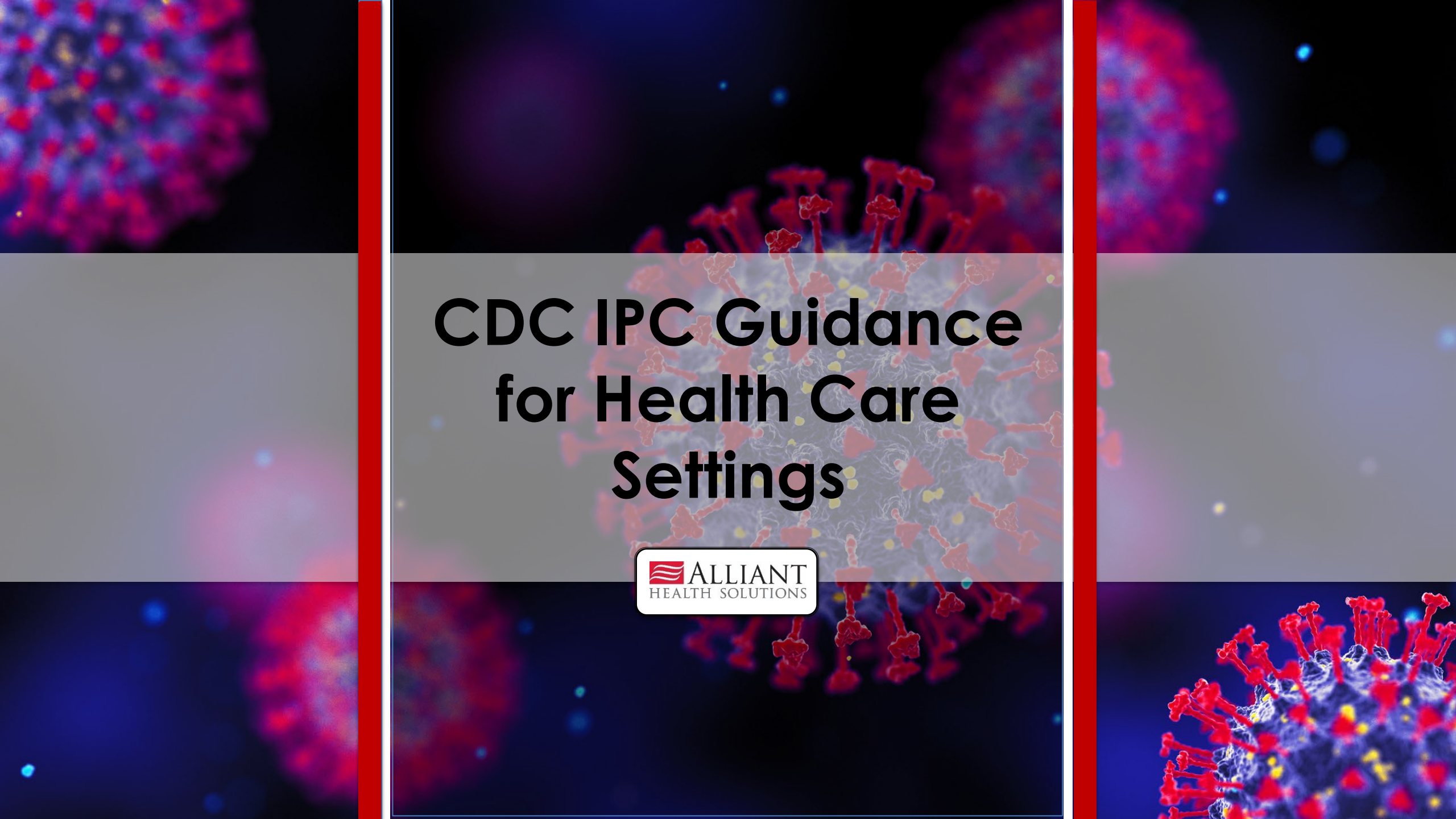
High degree of population immunity against COVID-19

<https://www.cdc.gov/respiratory-viruses/background/index.html>

Situations for Which the Respiratory Virus Guidance Does Not Apply

- **This guidance is not meant to apply to specialized situations, like health care or certain disease outbreaks, in which more detailed guidance specific to the pathogen may be warranted.**
- The Respiratory Virus Guidance covers most common respiratory viral illnesses but should not supplant specific guidance for pathogens that require special containment measures, such as measles.
 - The guidance may not apply in certain outbreak situations when more specific guidance may be needed.
- CDC offers separate, specific guidance for health care settings ([COVID-19](#), [flu](#), and [general infection prevention and control](#)).

<https://www.cdc.gov/respiratory-viruses/background/index.html>



CDC IPC Guidance for Health Care Settings



COVID-19 IPC Practices Continue

- Vaccination and treatments
- Source control, respiratory etiquette, hand hygiene
- Testing and response procedures
- Standard and transmission-based precautions
- Environmental cleaning and disinfection
- Health care worker exposure and COVID-19 illness procedures

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

Source Control, Respiratory Etiquette and Hand Hygiene

Source Control

- Utilize as an IPC intervention to reduce risk in certain situations
 - Can be implemented in specific areas of the facility or broadly when there is an increased risk of transmission within the local area or during active or ongoing outbreaks
 - Could be guided by facility policies, risk assessment, or public health authorities

Respiratory Etiquette

- Post [signage](#) at facility entrances
- Provide masks, tissues, hand sanitizer and trash receptacles along with signage

Hand Hygiene

- Regularly monitor compliance
- Set improvement goals and report data to the QAPI committee regularly
- Identify barriers to compliance among staff



Admissions Testing

- Admission testing performed at the discretion of the facility
 - Facility leadership should consider the risks to the resident population and the pros and cons of admission testing
 - Residents who are outside of the facility for more than 24 hours should be considered an admission
- Empiric use of transmission-based precautions is generally not necessary for admissions or for residents who leave the facility for less than 24 hours (e.g., for medical appointments or community outings) and do not meet criteria described in Section 2

Testing Considerations

- COVID-19 testing
 - Prioritize testing for anyone, even with mild symptoms and regardless of vaccination status, as soon as possible
 - Implement transmission-based precautions or work restrictions
 - Individuals who have had close contact with someone with COVID-19 should have a series of three tests completed at 0 hours, 48 hours, and 48 hours after the second negative test.
 - In most circumstances, source control is recommended for individuals in the testing period who remain asymptomatic and with negative test results
- Influenza testing should be considered if it will alter clinical management or infection control decisions (administration of antiviral therapy, guiding influenza outbreak protocols, admissions, and placements, etc.)
 - **Note:** Co-infection can occur and a positive test result for influenza without COVID-19 testing does not exclude COVID-19, and COVID-19 testing without influenza testing does not exclude influenza

Resident Placement

- Placement of resident with suspected or confirmed SARS-CoV-2 infection.
 - A single room with a private bathroom is preferred for those with confirmed or suspected COVID-19.
 - If cohorting is necessary, place residents with the same respiratory pathogen together.
 - MDRO colonization status and/or the presence of other communicable diseases should also be considered during the cohorting process.
- If the above is not possible or numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning COVID-19, residents should remain in their current location.

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

Transmission-Based Precautions

Patients with mild to moderate illness who are *not* moderately to severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared*, **and**
- At least 24 hours have passed *since the last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved.

Patients who were asymptomatic throughout their infection and are *not* moderately to severely immunocompromised:

- At least 10 days have passed since their first positive viral test.

Patients with severe to critical illness and who are *not* moderately to severely immunocompromised:

- At least 10 days and up to 20 days have passed *since symptoms first appeared*, **and**
- At least 24 hours have passed *since the last fever* without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved.
- The test-based strategy, as described for moderately to severely immunocompromised patients below, can inform the duration of isolation.

Patients who are moderately to severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

- Use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when Transmission-Based Precautions could be discontinued for these patients.



Transmission-Based Precautions

Criteria for the test-based strategy (to discontinue transmission-based precautions).

Patients who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved, **and**
- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

Patients who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

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



Environmental Cleaning and Disinfection

- Utilize dedicated medical equipment whenever possible
 - All non-dedicated/non-disposable must be cleaned and disinfected before use on another patient or resident
- Follow routine cleaning and disinfection procedures should be followed
 - Utilize disinfectants from [List N](#) on EPA website with efficacy against the virus that causes COVID-19
- Follow routine management processes for laundry, food service items, and waste

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



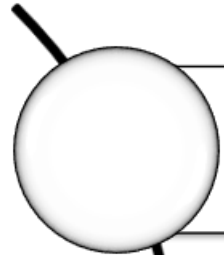
CDC Health Care Personnel Recommendations

After an exposure to COVID-19, restriction is not generally necessary for health care workers if they remain asymptomatic and do not test positive

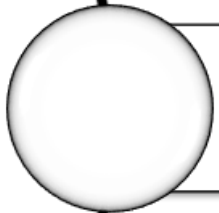
Return to work criteria

- HCPs with **mild to moderate illness** who are not moderately to severely immunocompromised may return when:
 - At least seven days have passed since symptom onset (negative viral test* is obtained within 48 hours before returning to work) or 10 days if testing is not performed or if a positive test at Day Five through Day Seven), and no fever within 24 hours without fever-reducing medications
 - Symptoms (e.g., cough, shortness of breath) have improved.
 - *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on Day Five and again 48 hours later
- HCPs who were **asymptomatic throughout their infection and are not moderately to severely immunocompromised** could return to work after the following criteria have been met:
 - At least seven days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours before returning to work (or 10 days if testing is not performed or if a positive test at Day Five through Day Seven).
 - *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on Day Five and again 48 hours later
- HCPs with **severe to critical illness** who are not moderately to severely immunocompromised could return to work after the following criteria have been met:
 - At least 10 days and up to 20 days since symptom onset, and no fever within 24 hours without fever-reducing medications
 - Symptoms have improved

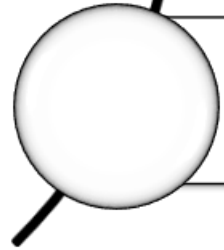
CDC COVID-19 Infection Prevention and Control Guidance Updates



[Interim IPC Recommendations for Healthcare Personnel](#)



[Interim Guidance for Managing Healthcare Personnel with Infection or Exposure](#)



[Strategies to Mitigate Healthcare Personnel Staffing Shortages](#)



Viral Respiratory Pathogens Toolkit



Viral Respiratory Pathogens Toolkit for Nursing Homes

Preparing for and responding to nursing home residents or healthcare personnel (HCP) who develop signs or symptoms of a respiratory viral infection

ACTION: PREPARE for respiratory viruses (e.g., SARS-CoV-2, influenza, RSV)

Vaccinate

Provide [recommended vaccines](#) to residents and HCP and provide information (e.g., posted materials, letters) to families and other visitors encouraging them to be vaccinated. Recommended vaccines help prevent infection and complications such as severe illness and death. Utilize pharmacy and public health partners to ensure access to indicated vaccines for residents and HCP.

Allocate resources

Ensure that resource limitations (e.g., personal protective equipment (PPE), alcohol-based hand sanitizer (ABHS)) do not prevent HCP from adhering to recommended infection prevention and control (IPC) practices. Plan for situations (e.g., multiple symptomatic individuals) that may require increased supplies. Have a process for monitoring supplies availability and access.

Monitor and Mask

Be aware when levels of [respiratory virus spread](#) are increasing in the community. When levels in the community are higher, consider having visitors and HCP [wear a mask](#) at all times in the facility and at a minimum, consider having residents wear a mask when outside of their room.

Educate

Ensure everyone, including residents, visitors, and HCP, are aware of recommended [IPC practices in the facility](#), including when specific IPC actions are being implemented in response to new infections in the facility or increases in respiratory virus levels in the community. Encourage visitors with respiratory symptoms to delay non-urgent in-person visitation until they are no longer infectious. Following close contact with someone with SARS-CoV-2, [testing is recommended](#) and [visitors should wear](#) a mask while in the facility.

Ventilate

In consultation with facility engineers, explore options to improve ventilation delivery and indoor air quality in resident rooms and all shared spaces.

Test and Treat:

Develop plans to provide rapid clinical evaluation and intervention to ensure residents receive timely treatment and/or prophylaxis when indicated.

- Ensure access to respiratory viral testing with rapid results (i.e., onsite or send-out testing with results available within 24 hours). Testing results can inform recommended treatment and IPC actions.
- Establish pharmacy connections to enable the use of any available respiratory virus treatments or prophylaxis.

ACTION: RESPOND when a resident or HCP develops signs or symptoms of a respiratory viral infection

When an acute respiratory infection is identified in a resident or HCP, it is important to take rapid action to prevent the spread to others in the facility. While decisions about treatment, prophylaxis, and the recommended duration of isolation vary depending on the pathogen, IPC strategies, such as placement of the resident in a single-person room, use of a facemask for source control, and physical distancing, are the same regardless of the pathogen.

Prevent Spread

Residents apply appropriate Transmission-Based Precautions for symptomatic residents based on the suspected cause of their infection.

- When available, residents can be placed in a single-person room to minimize the risk of transmission to roommates. Moving residents to a single room is often not practical (e.g., limited rooms available), and in those situations, residents could remain in their current location. In shared rooms, consider ways to increase ventilation; the use of [in-room HEPA air cleaners](#) could also be considered. Use of facemasks at all times by both residents while in the room might also reduce the risk of transmission but is often impractical and not routinely recommended.
 - Symptomatic residents should not be placed in a room with a new roommate unless they have both been confirmed to have the same respiratory infection.
 - Roommates of symptomatic residents – who have already been potentially exposed – should not be placed with new roommates, if possible. They should be considered exposed and wear a facemask for source control around others.
 - Residents placed in Transmission-Based Precautions for acute respiratory infection should primarily remain in their rooms except for medically necessary purposes. If they must leave their room, they should practice physical distancing and wear a facemask for source control. The resident should be removed from Transmission-Based Precautions as soon as they are deemed no longer infectious to others.
 - HCP who enter the room of a resident with signs or symptoms of an unknown respiratory viral infection that is consistent with SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved* particulate respirator with N95* filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). This PPE can be adjusted once the cause of the infection is identified. Recommendations on PPE for respiratory viruses are available in [Appendix A of the 2007 Guideline for Isolation Precautions](#).
- Healthcare Personnel:** Develop sick leave policies for HCP that are non-punitive, flexible, and consistent with public health guidance to discourage presenteeism and allow HCP with respiratory infection to stay home for the [recommended duration of work restriction](#).

Test

Test anyone with respiratory illness signs or symptoms

- Selection of diagnostic tests will depend on the suspected cause of the infection (e.g., which respiratory viruses are circulating in the community or the facility, recent contact with someone confirmed to have a specific respiratory infection) and if the results will inform clinical management (e.g., treatment, duration of isolation). At a minimum, testing should include [SARS-CoV-2 and influenza viruses](#) with consideration for other causes (e.g., RSV).

Treatment and Prophylaxis

Provide recommended **treatment and prophylaxis** to infected and exposed residents when indicated.

- For Influenza:
 - [Provide antiviral treatment immediately](#) for all residents who have confirmed or suspected influenza.
 - Provide chemoprophylaxis to exposed residents on units or wards with influenza cases (currently impacted wards) as soon as an influenza outbreak is determined. See the [guidance](#) for additional chemoprophylaxis recommendations.
- For SARS-CoV-2 infection:
 - [Provide COVID-19 treatment](#) for eligible residents with [mild-to-moderate COVID-19](#) with one or more risk factors for severe COVID-19; be aware of potential drug interactions. Treatment must be started as soon as possible and within five days of symptom onset to be effective.

Investigate

Investigate for potential respiratory virus spread among residents and HCP.

- Perform active surveillance to identify any additional ill residents or HCP using symptom screening and evaluating potential exposures.
- For SARS-CoV-2 infection, [testing of exposed individuals](#) is recommended, even if they are asymptomatic.

PREPARE for Respiratory Viruses

Vaccinate

Allocate
resources

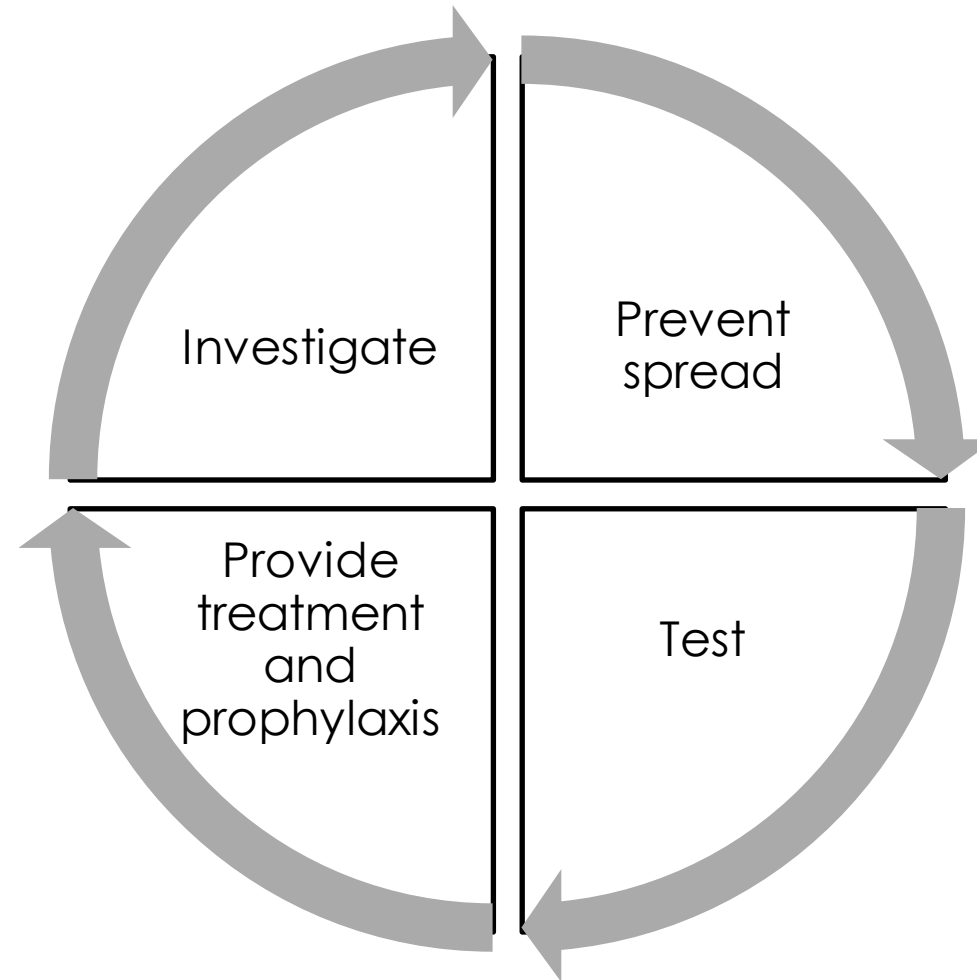
Monitor
and mask

Educate

Ventilate

Test and
treat

RESPOND When Symptoms Identified



CONTROL Respiratory Virus Spread

Follow CDC guidance

Implement universal masking for source control

Active surveillance to identify additional cases

Consult with local or state public health experts

Consider cohorting units

Limit group activities and communal dining



Resources







GEORGIA DEPARTMENT of
PUBLIC HEALTH

An official website of the State of Georgia.
 How you know

About DPH
 Health Topics
 COVID-19
 Vital Records
 Women and Children
 Immunizations
 Environmental Health
 Epidemiology

> Epidemiology

Epidemiology

Healthcare Associated Infections

Acute Disease Epidemiology

Emerging Infections Program (EIP)

Viral Hepatitis

Epidemiology Emergency Preparedness

Epidemiology

Epidemiology is the central science of public health. As such, epidemiology provides the scientific input that shapes public health policy, program directions, and activities. The Georgia Department of Public Health Epidemiology Section conducts surveillance for the occurrence of diseases and other health conditions that affect Georgians. By determining the who, what, where, when, how, and why related to these diseases and health conditions, appropriate interventions and control measures can be implemented to lessen their health impact. When an outbreak occurs, immediate action may be needed to prevent or control a situation. In the case of chronic diseases or injuries, more sustained activities may be required to prevent their occurrence or reduce their severity.

The Epidemiology Section carries out a number of activities to identify diseases and describe health conditions, assess the health of Georgians, and develop recommendations to control diseases and improve the overall health status in the state. These include:

://dph.georgia.gov

<https://dph.georgia.gov/epidemiology>

COVID-19 Vaccines

Schedule an Appointment

Vaccines are a safe and effective way to limit serious illnesses, hospitalizations, and death.

[LEARN MORE →](#)



Frequently Asked Questions

Frequently asked questions about COVID-19 vaccination.

[Learn more at CDC](#)

Stay Up to Date with COVID-19 Vaccines

What You Need to Know

- CDC recommends the 2023–2024 updated COVID-19 vaccines: Pfizer-BioNTech, Moderna, or Novavax, to protect against serious illness from COVID-19.
- Everyone aged 5 years and older [‡] should get **1 dose of an updated COVID-19 vaccine** to protect against serious illness from COVID-19.
- Children aged 6 months–4 years need multiple doses of COVID-19 vaccines to be up to date, including at least 1 dose of updated COVID-19 vaccine.
- People who are moderately or severely immunocompromised may get additional doses of updated COVID-19 vaccine.
- COVID-19 vaccine recommendations will be updated as needed.
- People who are up to date have lower risk of severe illness, hospitalization and death from COVID-19 than people who are unvaccinated or who have not completed the doses recommended for them by CDC.

[Find a COVID-19 or Flu Vax near you](#)

GA COVID-19 Hotline

This hotline is for questions about COVID-19 and COVID vaccine only, not for scheduling appointments for vaccination.

(888) 357-0169

<https://dph.georgia.gov/covid-19>



GADPH Public Health Districts and Contacts

<https://dph.georgia.gov/public-health-districts>

Consult With the DPH Team! We Are Here To Help!

State Region/Districts	Contact Information
North (Rome, Dalton, Gainesville, Athens) Districts 1-1, 1-2, 2, 10	<u>Sue.bunnell@dph.ga.gov</u> (404-967-0582)
Atlanta Metro (Cobb-Douglas, Fulton, Clayton, Lawrenceville, DeKalb, LaGrange) Districts 3-1, 3-2, 3-3, 3-4, 3-5, 4	<u>Teresa.Fox@dph.ga.gov</u> (256-293-9994) <u>Renee.Miller@dph.ga.gov</u> (678-357-4797)
Central (Dublin, Macon, Augusta, & Columbus) Districts 5-1, 5-2, 6, 7	<u>Theresa.Metro-Lewis@dph.ga.gov</u> (404-967-0589) <u>Karen.Williams13@dph.ga.gov</u> (404-596-1732)
Southwest (Albany, Valdosta) Districts 8-1, 8-2	<u>Connie.Stanfill1@dph.ga.gov</u> (404-596-1940)
Southeast (Savannah, Waycross) Districts 9-1, 9-2	<u>Lynn.Reynolds@dph.ga.gov</u> (804-514-8756)
Backup/Nights/Weekends	<u>Joanna.Wagner@dph.ga.gov</u> (404-430-6316)

Billing for Vaccines in Skilled Nursing Facilities: A Guide

Coding

The Centers for Medicare and Medicaid Services and the American Medical Association (AMA) have established codes for billing vaccines.

There are two components to billing any vaccine administered: the vaccine product/ingredients and its administration.

For the most up-to-date information on specific codes, visit the following websites:

Roster Billing:

Roster billing with your MAC:
www.cms.gov/medicare/payment/covid-19/definitions

Medicare Claims Processing Manual, Chapter 6 with consolidated billing guidance:
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c06.pdf

Medicare Claims Processing Manual, Chapter 18 with vaccine guidance:
www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c18.pdf

Specific Codes

Updated COVID-19 CPT codes:
www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes

List of CPT/HCPCS codes:
www.cms.gov/medicare/regulations-guidance/physician-self-referral/list-cpt-hcpcs-codes

In skilled nursing facilities, a vaccine may be billed by the facility or the long-term care pharmacy, depending both on whether a resident is in their Part A stay as well as what vaccine is being administered.

Staff

The LTC pharmacy can procure and bill for staff vaccination but it is typically considered out of network and not covered, leaving the facility or individual staff member to cover the bill.

The facility can choose to eat the cost of the vaccine or send staff elsewhere (eg, retail pharmacy or provider office that is a part of the insured staff person's network)

For COVID-19, uninsured staff can go to CVS/Walgreens, state they are uninsured, and use the Bridge Access Program. For other pharmacies who have applied to be Bridge Access Providers with eTrueNorth, an individual has to go online and get a QR code to prove they are uninsured.

For more information, please contact
movingneedles@paltc.org



Residents

Influenza, pneumococcal, and COVID-19 vaccines

Influenza, pneumococcal, and COVID-19 vaccines are billed as part of Medicare Part B. Hepatitis B vaccine is covered under Part B only if an individual is considered to be at high risk – residents of long term care are considered high risk.

Part A Stay Resident

FACILITY

Vaccine product and administration fee must be billed by facility using roster billing on a Part B claim

PHARMACY

The LTC pharmacy is not allowed to bill directly for Part B vaccines for residents in their Part A stay

Non-Part A/Long-term Stay Resident

FACILITY

Facility can use roster billing for both the vaccine cost and the administration fee on a Part B claim

PHARMACY

Pharmacy can bill directly for both the vaccine cost and the administration fee



If the facility staff administered the vaccine, they can ask the pharmacy to bill the administration fee and provide it back to the facility. This should be written into contracts between facilities and pharmacies.

Because vaccinations are not part of the Medicare hospice benefit, hospice claims (type of bill 81X or 82X) for vaccine services must be billed on a separate institutional claim and must only include charges for the vaccine and their administration.

COVID-19: For hospice patients under Part B only, include the GW modifier on COVID-19 vaccine administration claims if either of these apply:

1. The vaccine isn't related to the patient's terminal condition.
2. The attending physician administered the vaccine.

Tdap, shingles, and RSV vaccine

Tdap, shingles, and RSV are billed through Medicare Part D. Hepatitis B vaccine is covered under Part D if an individual is not at high risk.

Part A Stay Resident

PHARMACY

Pharmacies must provide and bill for the cost of the vaccine product and may bill for the administration fee

Non-Part A/Long-term Stay Resident

PHARMACY

Pharmacies must provide and bill for the cost of the vaccine product and may bill for the administration fee



If the facility staff administered the vaccine, they can ask the pharmacy to bill the administration fee and provide it back to the facility. This should be written into contracts between facilities and pharmacies.



Exceptions and special circumstances

When a vaccine such as Tdap (Part D) is administered therapeutically (i.e., post exposure) instead of preventively, it is included in the Part A global bundled payment for Part A stay residents.

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Alliant Health Solutions Resources



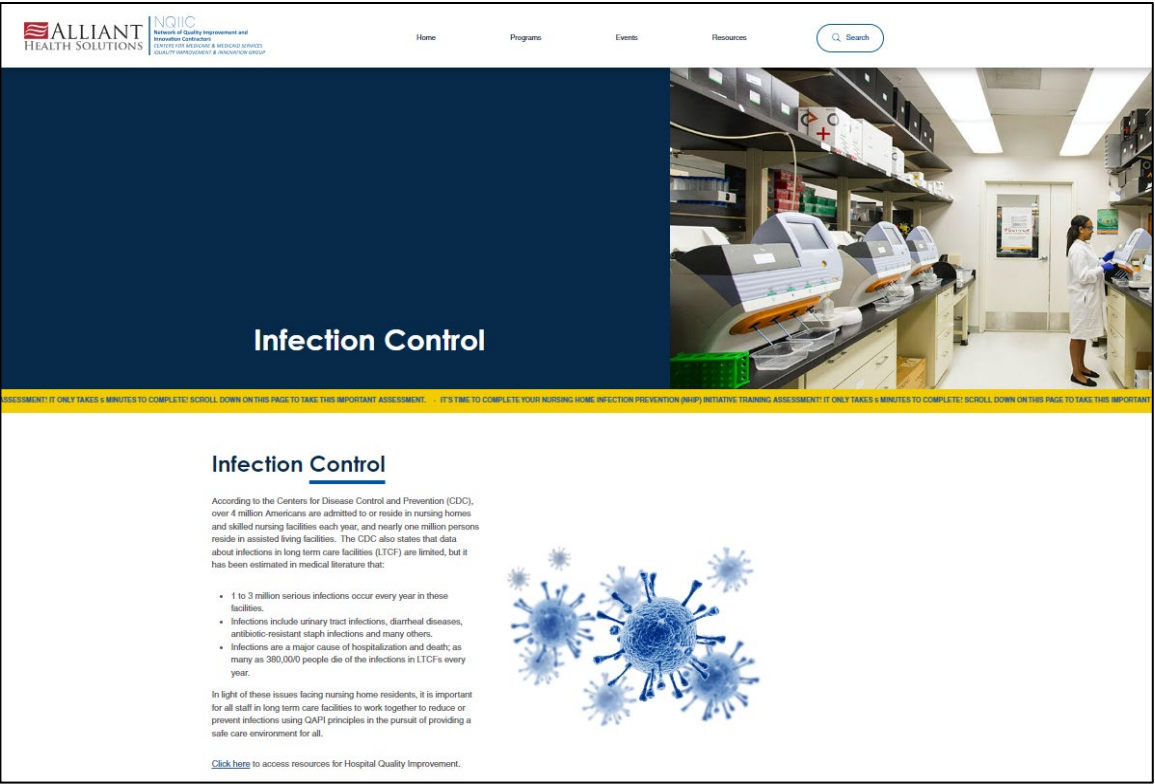
Georgia Department of Public Health

GA Strike & Support Team

Join us for the Georgia Department of Public Health Strike (& Support) Team Office Hours. These sessions will consist of a regularly scheduled monthly webinar for skilled nursing facilities (SNFs) as well as SNF medical directors. Office hours are your opportunity to come and learn, share, vent and more!

Each month we will have updates on infection prevention, clinical protocols and ideas for new tools and resources. This is your chance to access subject matter experts on infection control and clinical practice in long term care. Come prepared to pose your questions to subject matter experts and learn from your peers about their best practices and their barriers.

<https://quality.allianthealth.org/topic/georgia-department-of-public-health/>



Infection Control

Infection Control

According to the Centers for Disease Control and Prevention (CDC), over 4 million Americans are admitted to or reside in nursing homes and skilled nursing facilities each year, and nearly one million persons reside in assisted living facilities. The CDC also states that data about infections in long term care facilities (LTCF) are limited, but it has been estimated in medical literature that:

- 1 to 3 million serious infections occur every year in these facilities.
- Infections include urinary tract infections, diarrheal diseases, antibiotic-resistant staph infections and many others.
- Infections are a major cause of hospitalization and death; as many as 380,000 people die of the infections in LTCFs every year.

In light of these issues facing nursing home residents, it is important for all staff in long term care facilities to work together to reduce or prevent infections using QAPI principles in the pursuit of providing a safe care environment for all.

[Click here](#) to access resources for Hospital Quality Improvement.

<https://quality.allianthealth.org/topic/infection-control/>

Thank You for Your Time!
Contact the AHS Patient Safety Team
Patientsafety@allianthealth.org



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Thank you!

- Georgia Department of Public Health
- University of Georgia



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