Boost Office Hours

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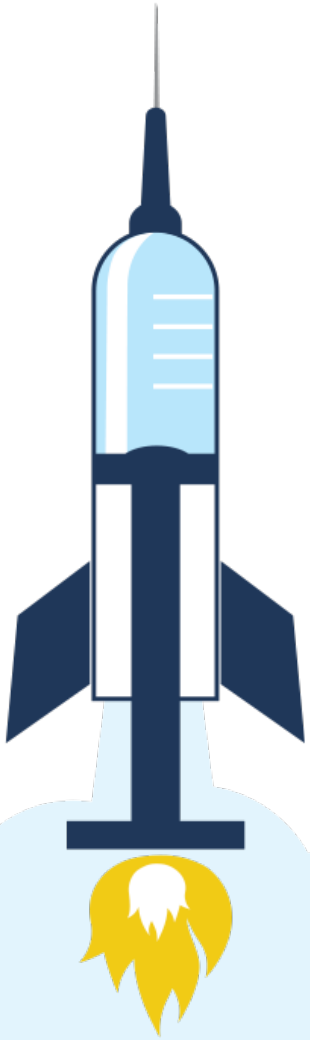

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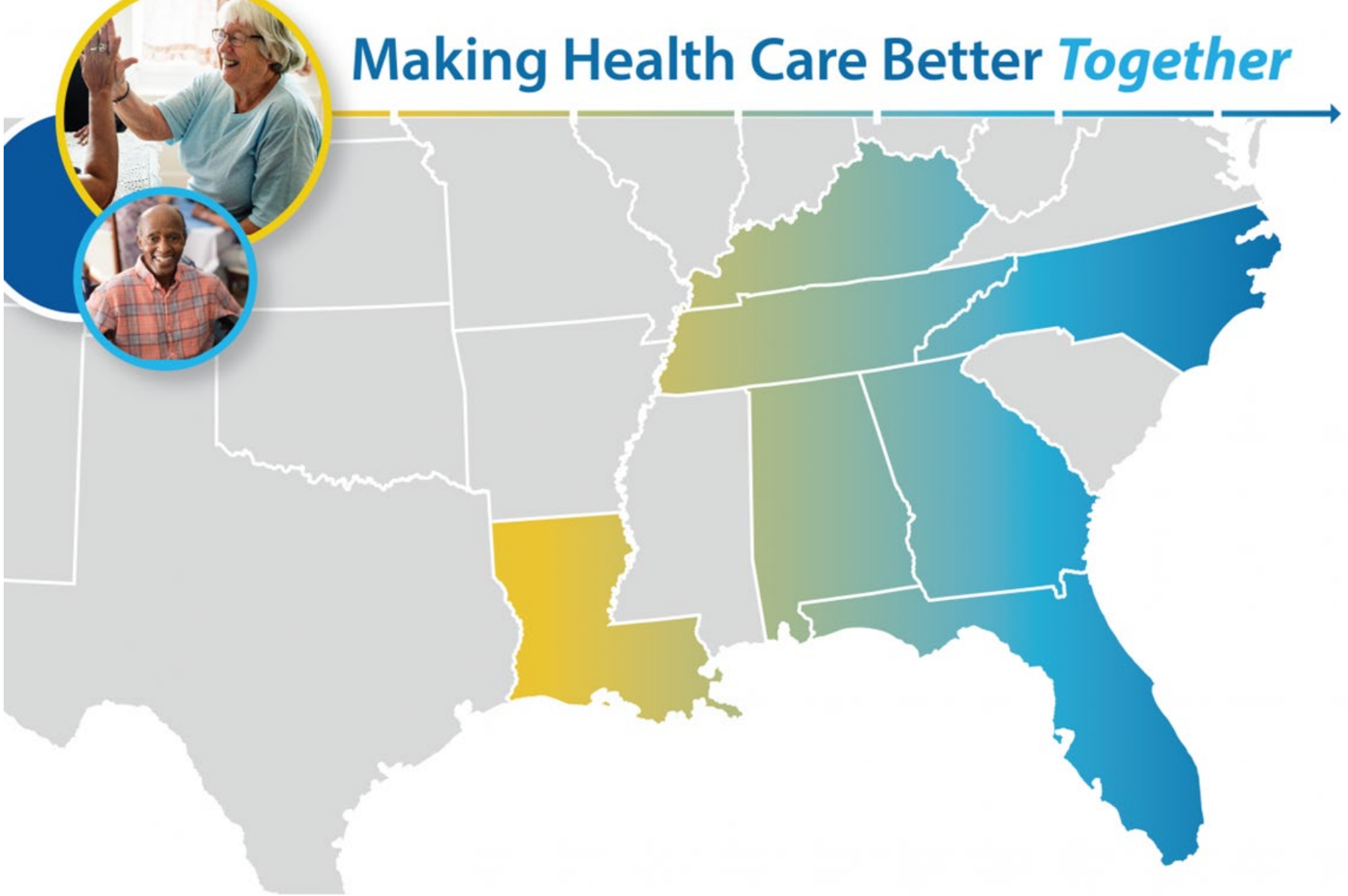
Continuing Education Information

Learning Outcome:
Following this activity, learners will share their intention to use the tools shared during the session to increase Influenza & Pneumococcal vaccination rates by 10%, COVID resident vaccination rates to 95% and achieve COVID staff vaccination rates of 100%.

Accreditation Council for Continuing Medical Education (ACCME)
Alliant Health Solutions is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

Alliant Health Solutions designates this other activity (live and recorded session) for a maximum of *.75 AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Expiration Date: 12/31/24
Bibliography: References are contained in the slides



About Alliant Health Solutions

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Swati Gaur, MD, MBA, CMD, AGSF

2022 Medical Director of the Year

ASSOCIATE CHIEF MEDICAL OFFICER, RAINMAKERS
SENIOR MEDICAL DIRECTOR, POST-ACUTE CARE,
NORTHEAST GEORGIA MEDICAL CENTER
MEDICAL DIRECTOR, ALLIANT HEALTH SOLUTIONS

- Past Infection Advisory Committee chair for COVID-19
- Created and issued guidance for COVID-19 task force
- Participated as a national and international speaker on infection prevention and control issues in nursing homes
- Board certified in internal medicine, geriatrics, hospice and palliative medicine
- Attained a Masters in Business Administration from Georgia Institute of Technology

Erica Umeakunne, MSN, MPH, APRN, CIC

INFECTION PREVENTION SPECIALIST

Erica 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 health care system in Atlanta and a nurse consultant in the Center for Disease Control and Prevention's (CDC) Division of Healthcare Quality Promotion. 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.

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Amy Ward, MS, BSN, RN, CIC, FAPIC

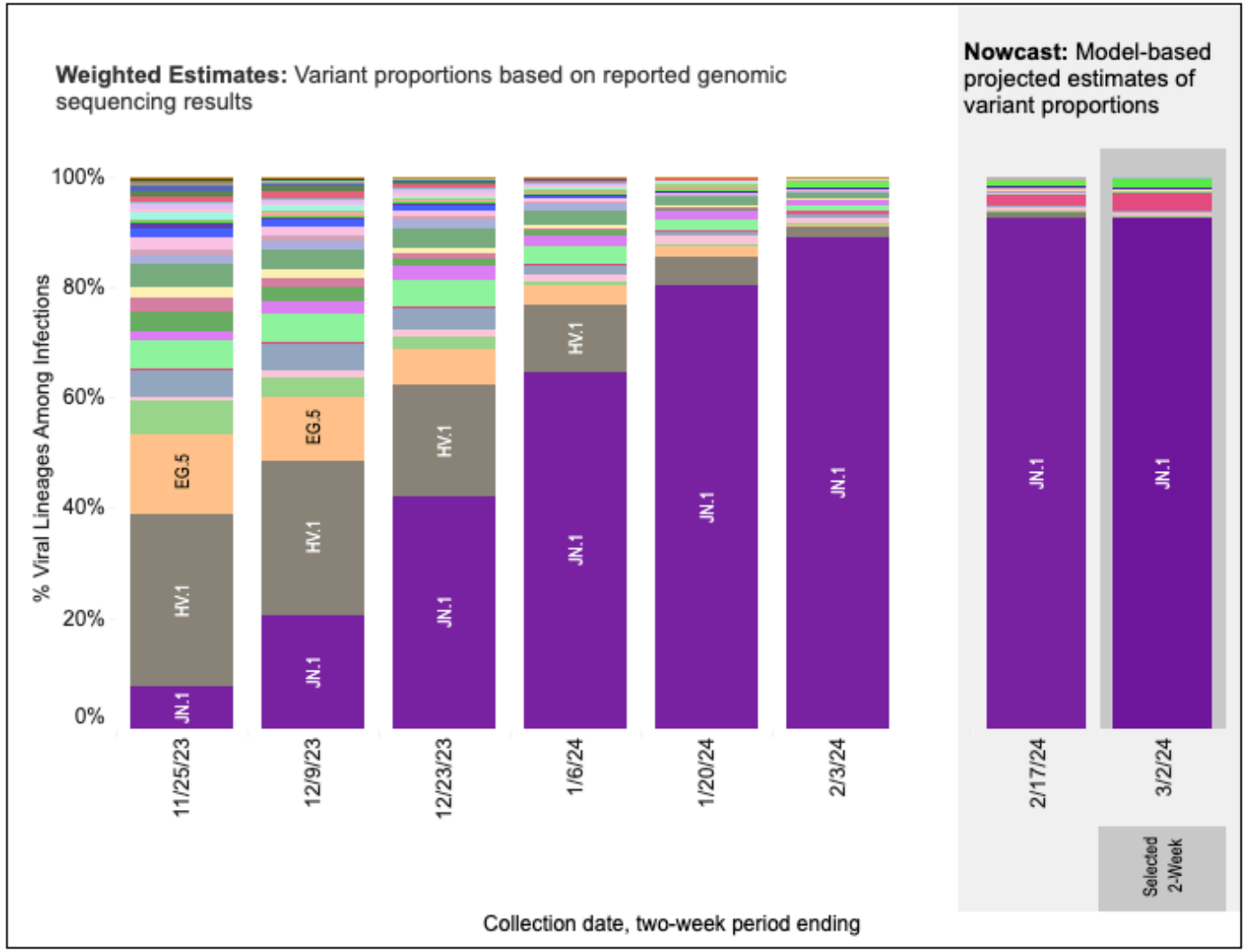
PATIENT SAFETY MANAGER

Amy is a registered nurse with a diverse background in acute care nursing, microbiology, epidemiology and infection control. She is passionate about leading and mentoring new and future infection preventionists in their career paths and assisting them in reducing healthcare-associated infections across the continuum of care.

Amy enjoys spending time with her family and doing outdoor activities.

Amy.Ward@AlliantHealth.org

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



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%

* Enumerated lineages are US VOC and lineages circulating above 1% nationally in at least one 2-week period. "Other" represents the aggregation of lineages which are circulating <1% nationally during all 2-week periods displayed.
\# While all lineages are tracked by CDC, those named lineages not enumerated in this graphic are aggregated with their parent lineages, based on Pango lineage definitions, described in more detail here: https://www.pango.network/the-pango-nomenclature-system/statement-of-nomenclature-rules/.

https://covid.cdc.gov/covid-data-tracker/#variants-genomic-surveillance

Wastewater Surveillance

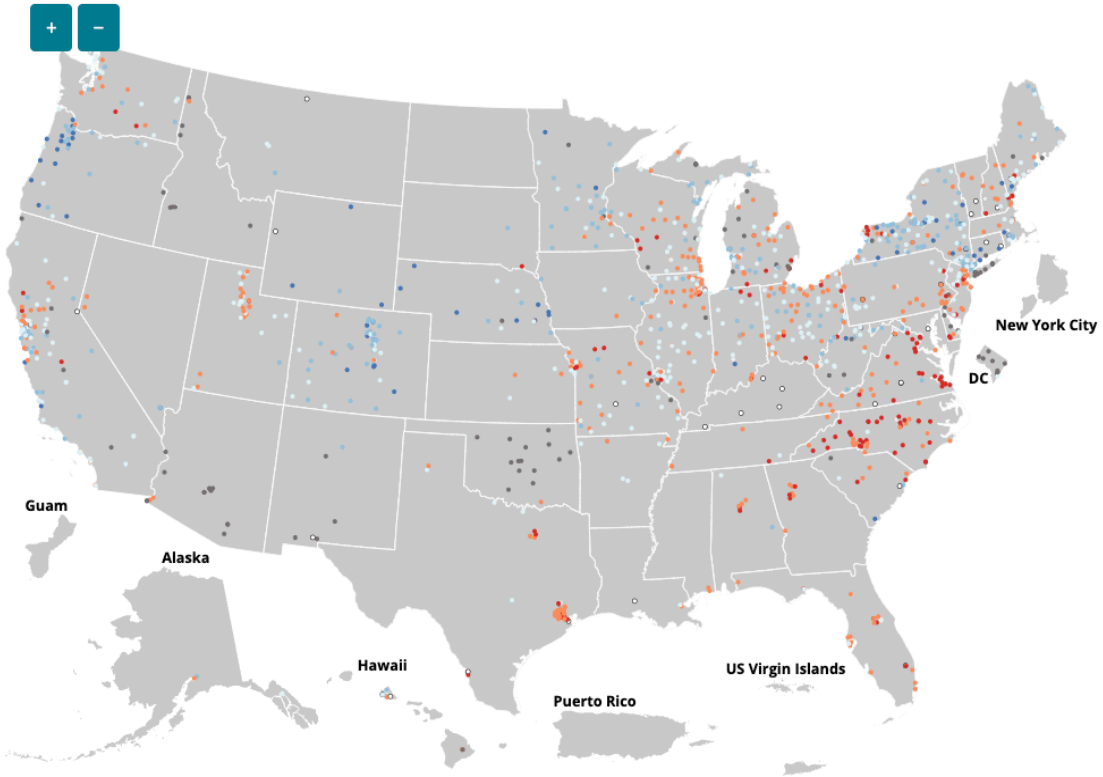
Metric:
- (•) Current virus levels in wastewater by site
- ( ) Percent change in the last 15 days
- ( ) Percent of wastewater samples with detectable virus

Show:
- [x] Sites with no recent data
- [x] 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.



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?

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

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Wastewater Surveillance percent change

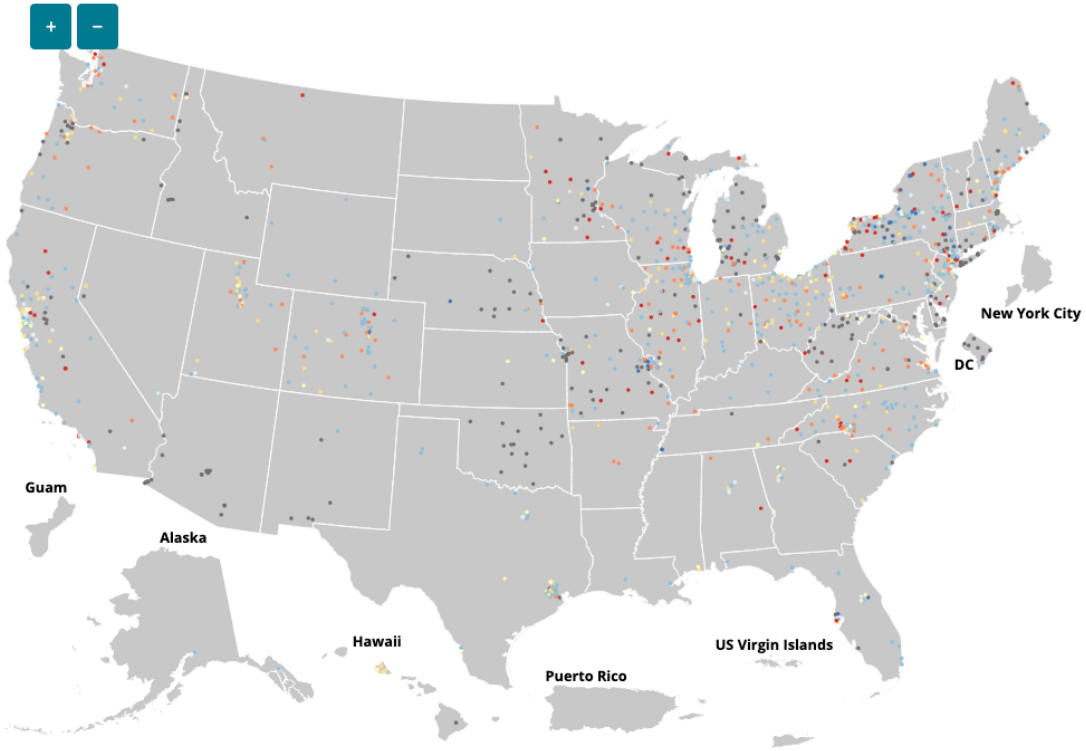
Metric:
- ○ Current virus levels in wastewater by site
- ◉ Percent change in the last 15 days
- ○ Percent of wastewater samples with detectable virus

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

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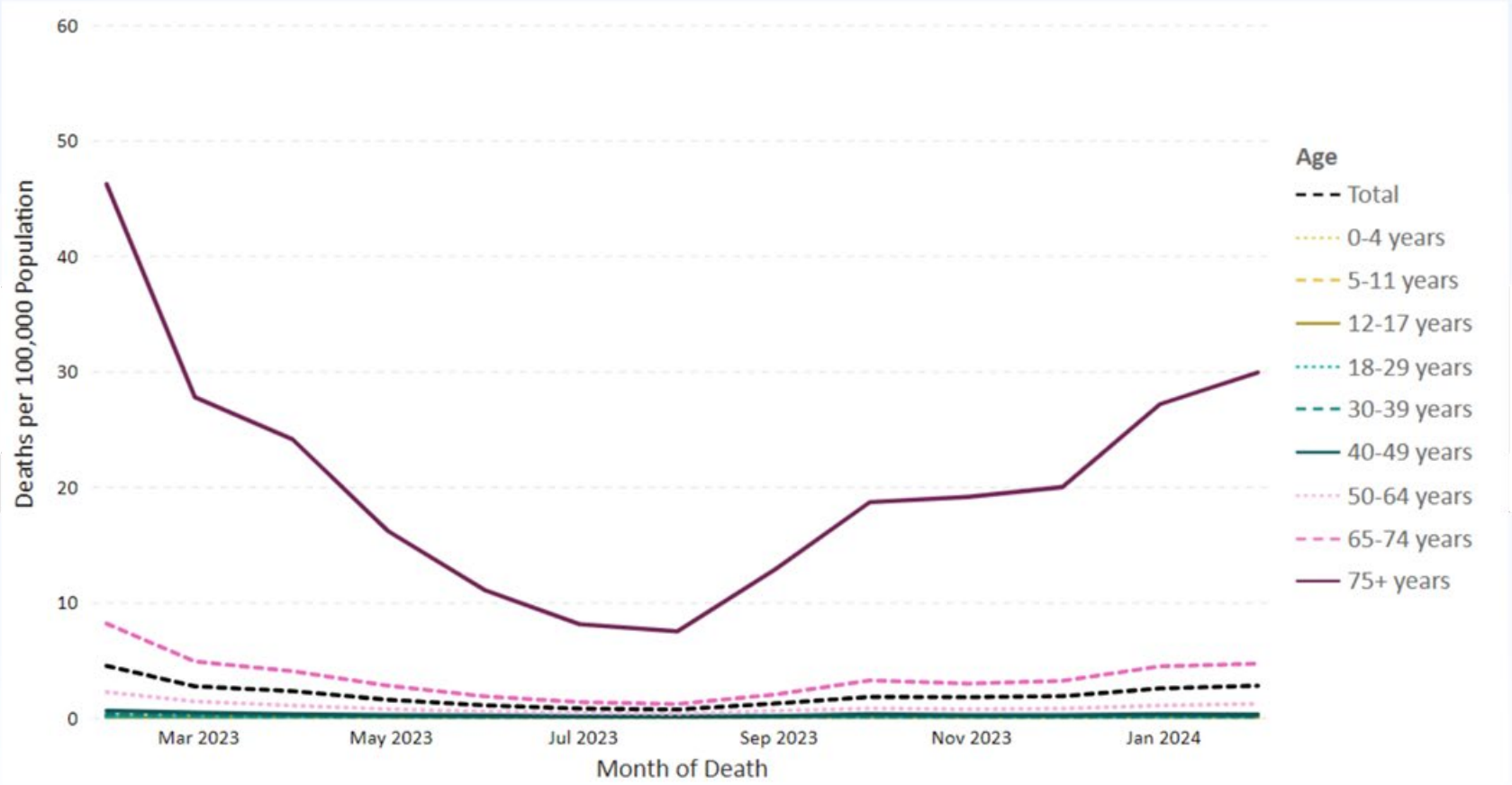
Why is this new recommendation made?

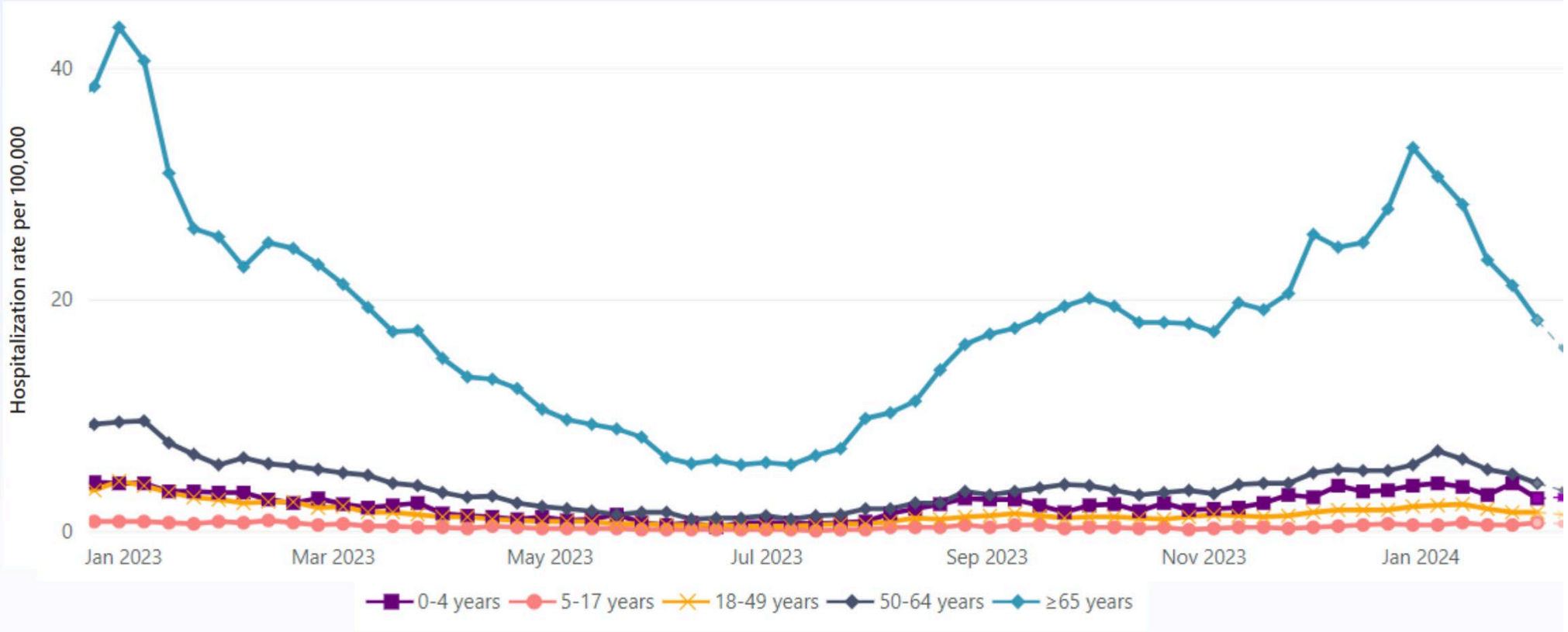
Monthly rates of provisional COVID-19 deaths by age group, United States, January 1, 2023 – January 31, 2024



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

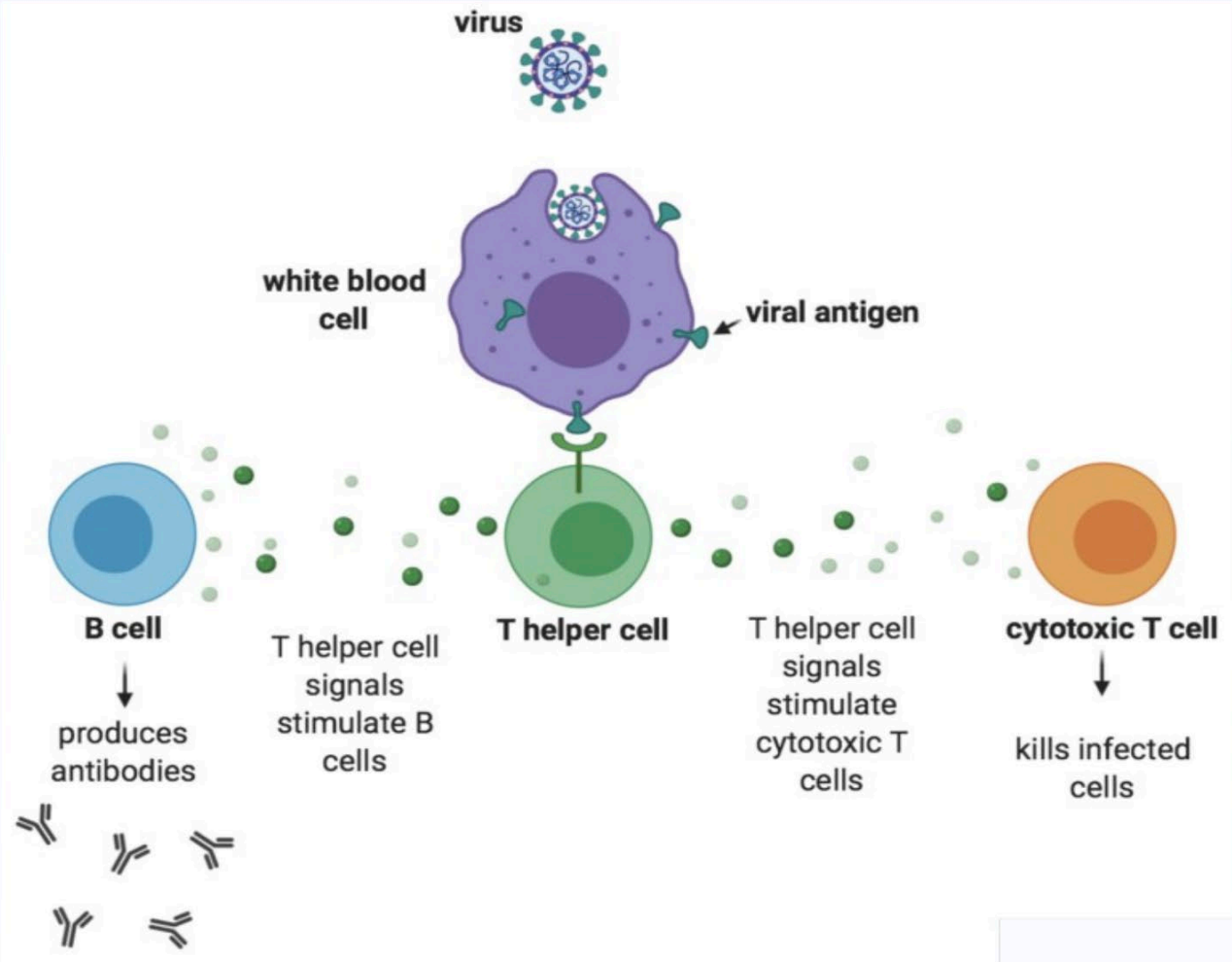
Weekly population-based rates of COVID-19-associated hospitalizations, by age group — COVID-NET, January 1, 2023 – February 24, 2024



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

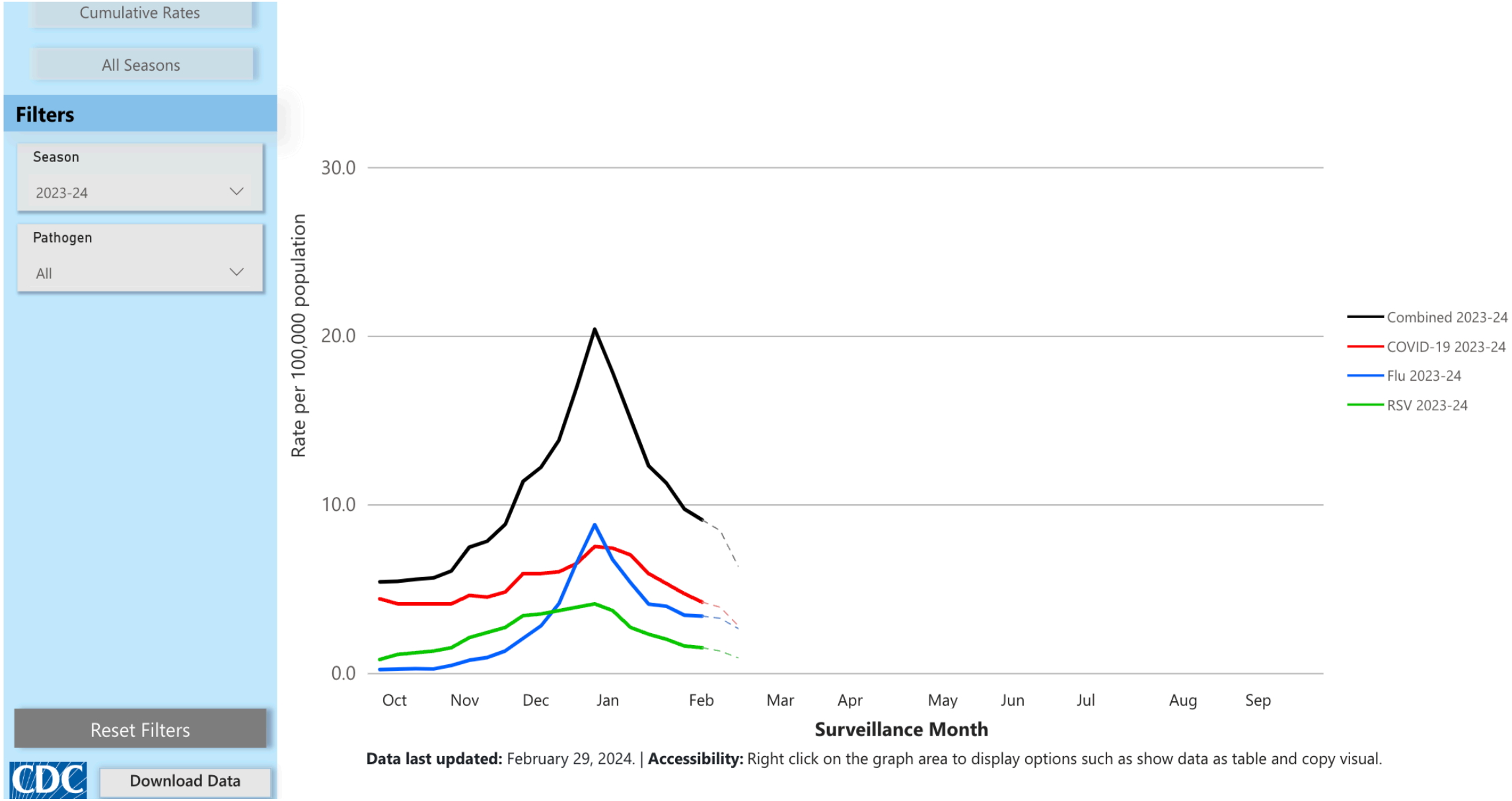
Adaptive immunity includes cellular and humoral responses



Insufficient pools of naïve T cells impacts ability to generate:

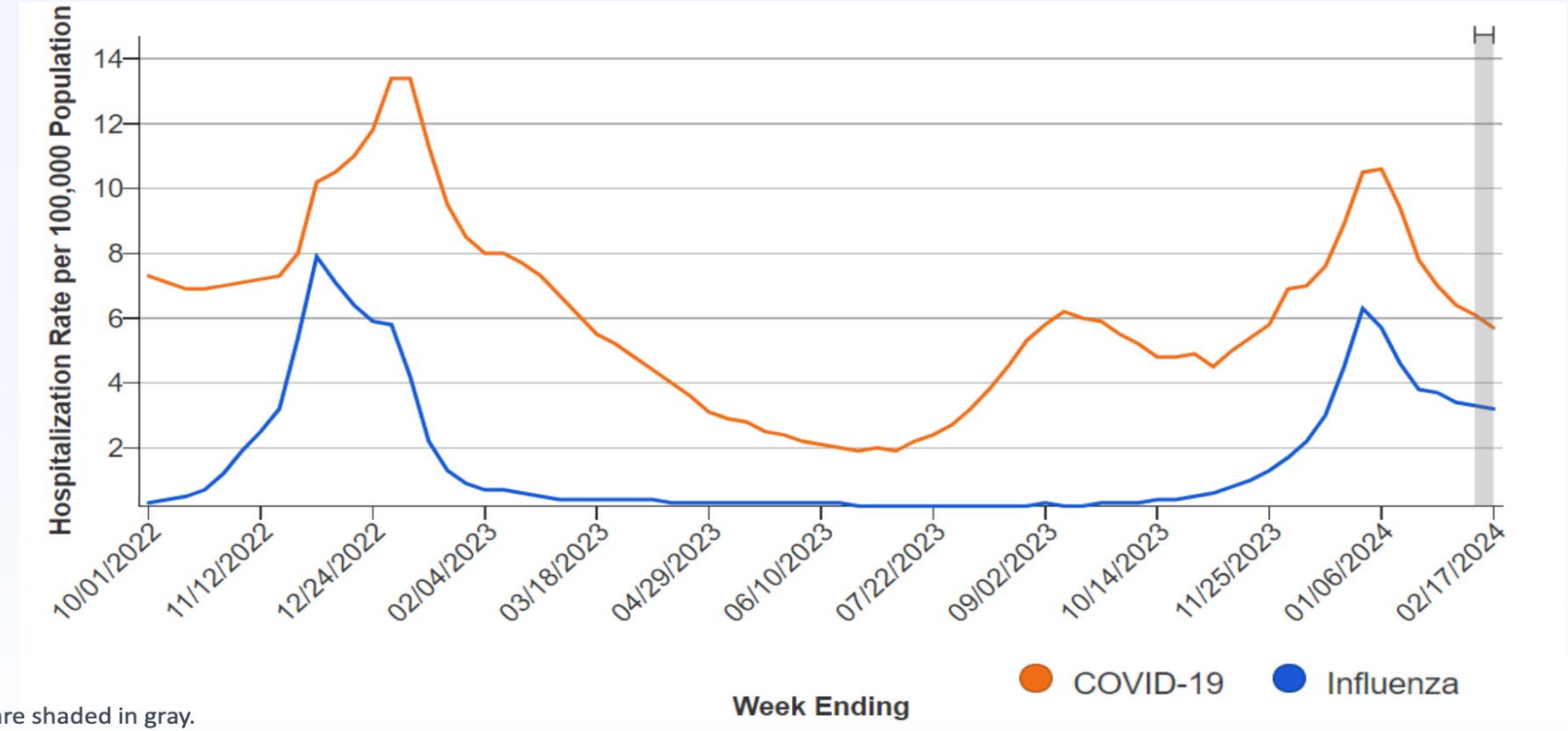
- Neutralizing antibody responses
- Cytotoxic T cells

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/



https://www.cdc.gov/surveillance/resp-net/dashboard.html

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



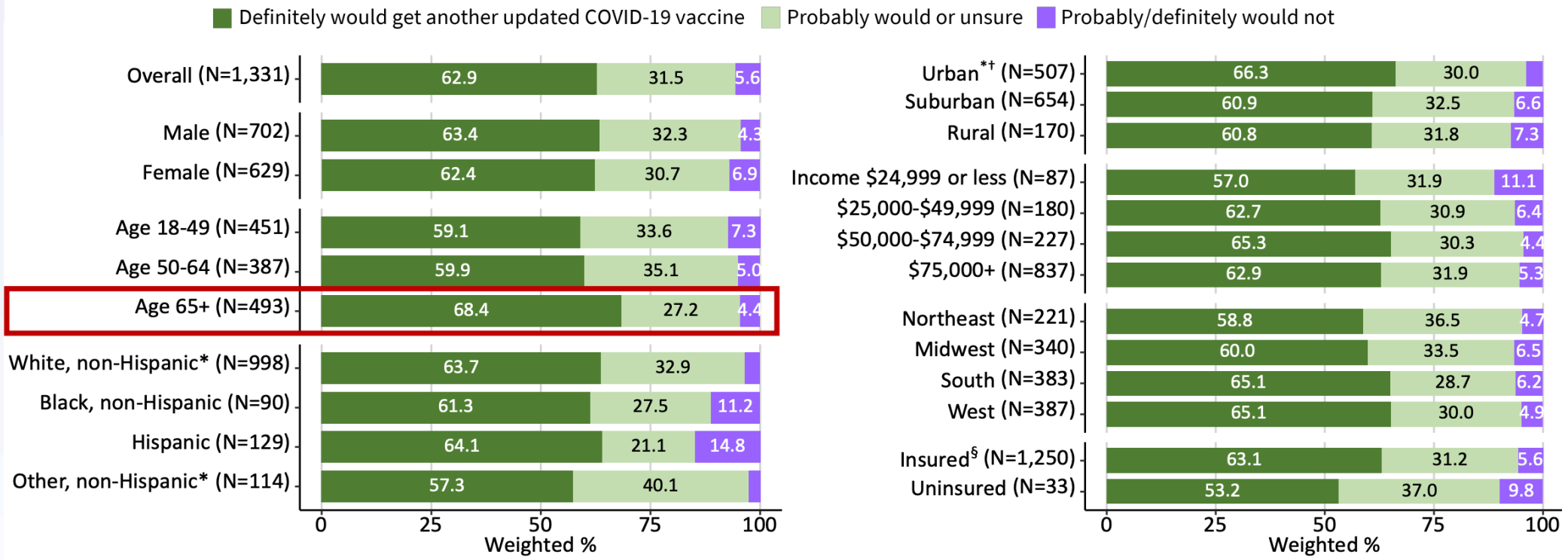
Preliminary data are shaded in gray.

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 additional COVID-19 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.

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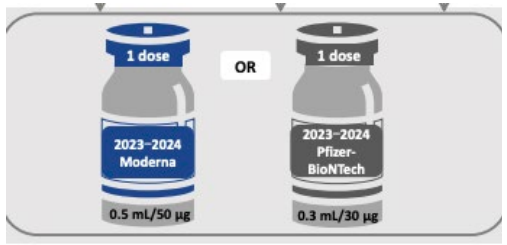
Are these shots dangerous?

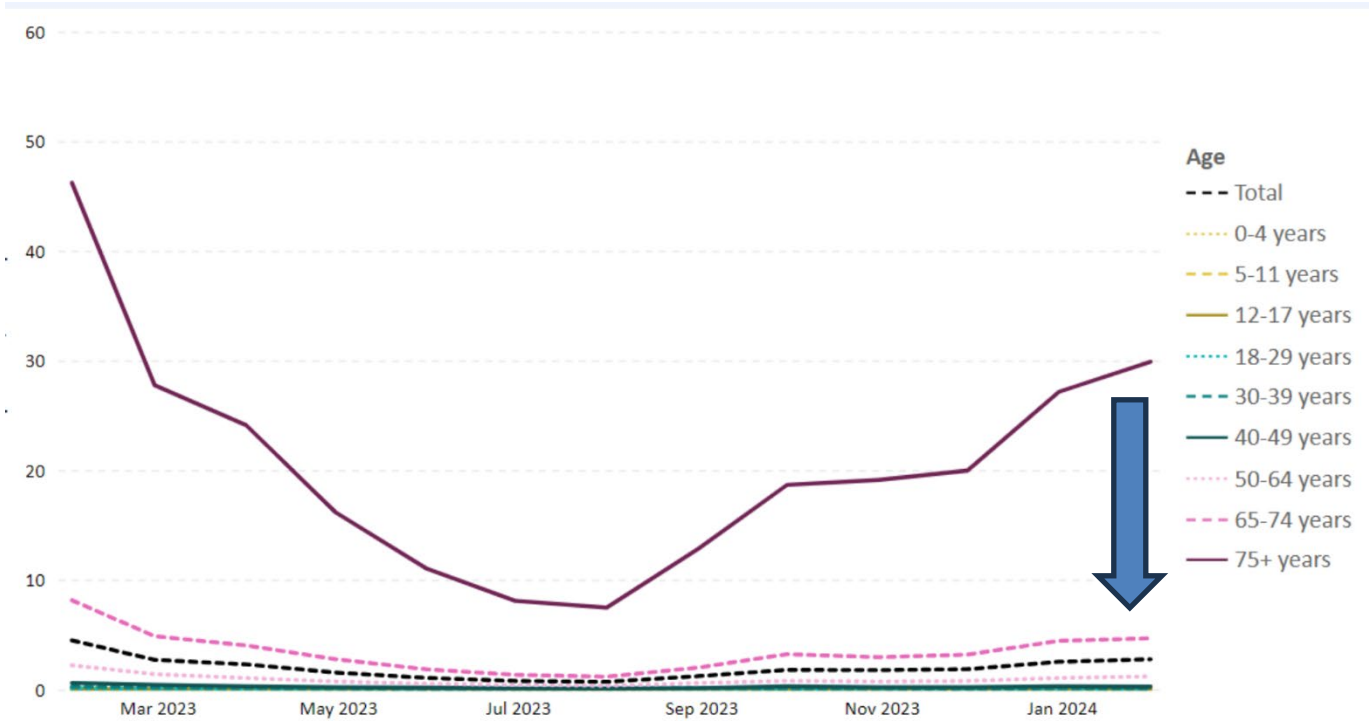
Summary
Benefits and Harms

- 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 recommendation?

ALL > 6 months SHOULD receive an Updated COVID-19 vaccine (existing recommendation)
Additional dose of Updated COVID-19 vaccine **SHOULD** be administered 4 months after the original updated vaccine (new additional recommendation)





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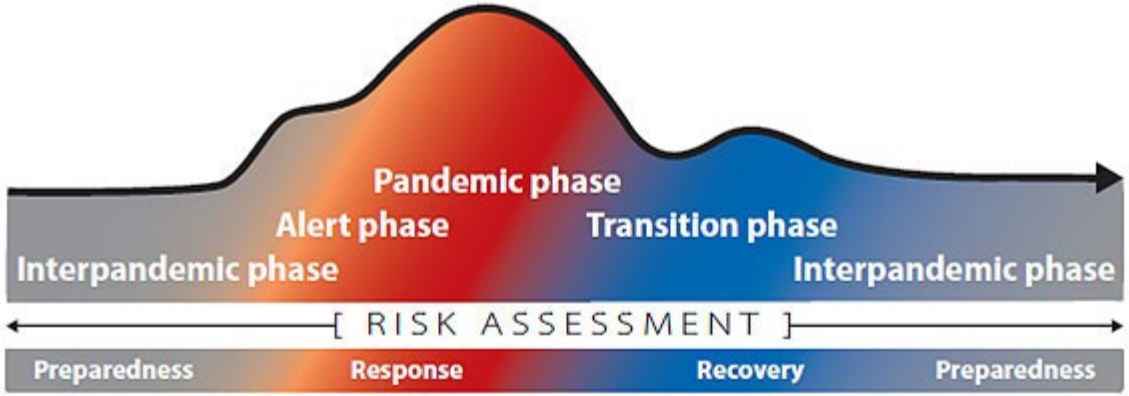
CDC Recommendations for COVID-19

Healthcare Settings

- No changes have been made to the CDC guidelines for healthcare settings. This guidance still applies to all settings where healthcare 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).



COVID-19 IPC Practices Continue

- Vaccination and treatments
- Source control, respiratory etiquette, hand hygiene
- Standard and transmission-based precautions
- Testing and response procedures
- Environmental cleaning and disinfection

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 QAPI committee regularly
- Identify barriers to compliance among staff

Testing Considerations

- Testing should be guided based on the severity of symptoms, the need for hospitalization, and local data regarding the circulation of respiratory viruses.
  - Clinical Guidance for Patients with Acute Respiratory Illness Not Being Hospitalized When SARS-CoV-2 and Influenza Viruses are Co-Circulating | CDC
    - Consider tests available to collect the necessary specimens for testing
    - SARS-CoV-2 Testing should be completed by PCR or antigen testing. If the antigen test is negative, PCR should be performed, or if unavailable, antigen testing repeated within 48 hours. If the second antigen test is negative, a third test could be considered if high clinical suspicion of COVID-19.
    - 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.
- COVID-19 testing
  - Prioritize testing for anyone even with mild symptoms 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 that remain asymptomatic and with negative test results

CDC Healthcare Personnel Recommendations

- After an exposure to COVID-19, restriction is not generally necessary for healthcare workers if they remain asymptomatic and do not test positive
- Return to work criteria
  - HCP with mild to moderate illness who are not moderately to severely immunocompromised may return when:
    - At least 7 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 5-7), 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 5 and again 48 hours later
  - HCP 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 7 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 5-7).
    - *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later
  - HCP 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

Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC

Resident Placement and Admissions

- **Admissions**
  - Admission testing performed at the discretion of the facility
    - Facility leadership should consider both risks to the resident population as well as the pros and cons of admission testing
  - Residents who are outside of the facility for more than 24 hours should be considered an admission

- **Resident placement**
  - Single room with private bathroom preferred for those with confirmed or suspected COVID-19
  - If co-horting is necessary, place residents with the same respiratory pathogen together.
    - MDRO colonization status and/or presence of other communicable disease should also be taken into consideration during the co-horting process.
  - If the above is not possible or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location

Transmission-Based Precautions

Duration of precautions – consider both severity of illness and immune status

- For mild to moderate illness for those who are not moderately to severely immunocompromised
  - At least 10 days have passed since symptom onset and at least 24 hours since last fever without use of fever-reducing medications
  - Symptoms have improved

- For those who were asymptomatic and who are not moderately to severely immunocompromised
  - At least 10 days have passed since first positive test

- For those with severe to critical illness and who are not moderately to severely immunocompromised
  - At least 10 days have passed since symptom onset and at least 24 hours since last fever without use of fever-reducing medications
  - Symptoms have improved
  - Test-based strategy can be used

- For those who are moderately to severely immunocompromised
  - Symptomatic
    - Fever resolved and symptoms improved in conjunction with test-based strategy
  - Asymptomatic
    - Test-based strategy – negative results from 2 consecutive respiratory specimens collected 48 hours apart using antigen or NAAT

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

Questions?

Nursing Home and Partnership for Community Health:
CMS 12th SOW GOALS

OPIOID UTILIZATION AND MISUSE

Promote opioid best practices

•

Reduce opioid adverse drug events in all settings

PATIENT SAFETY

Reduce hospitalizations due to c. diff

•

Reduce adverse drug events

•

Reduce facility acquired infections

CHRONIC DISEASE SELF-MANAGEMENT

Increase instances of adequately diagnosed and controlled hypertension

•

Increase use of cardiac rehabilitation programs

•

Reduce instances of uncontrolled diabetes

•

Identify patients at high-risk for kidney disease and improve outcomes

CARE COORDINATION

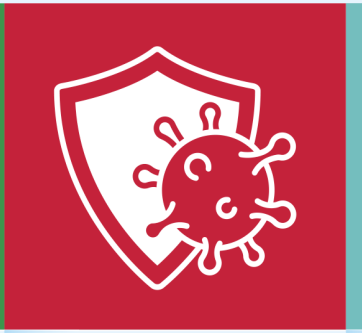
Convene community coalitions

•

Reduce avoidable readmissions, admissions to hospitals and preventable emergency department visits

•

Identify and promote optimal care for super utilizers



COVID-19

Support nursing homes by establishing a safe visitor policy and cohort plan

•

Provide virtual events to support infection control and prevention

•

Support nursing homes and community coalitions with emergency preparedness plans

IMMUNIZATION

Increase influenza, pneumococcal, and COVID-19 vaccination rates

TRAINING

Encourage completion of infection control and prevention trainings by front line clinical and management staff

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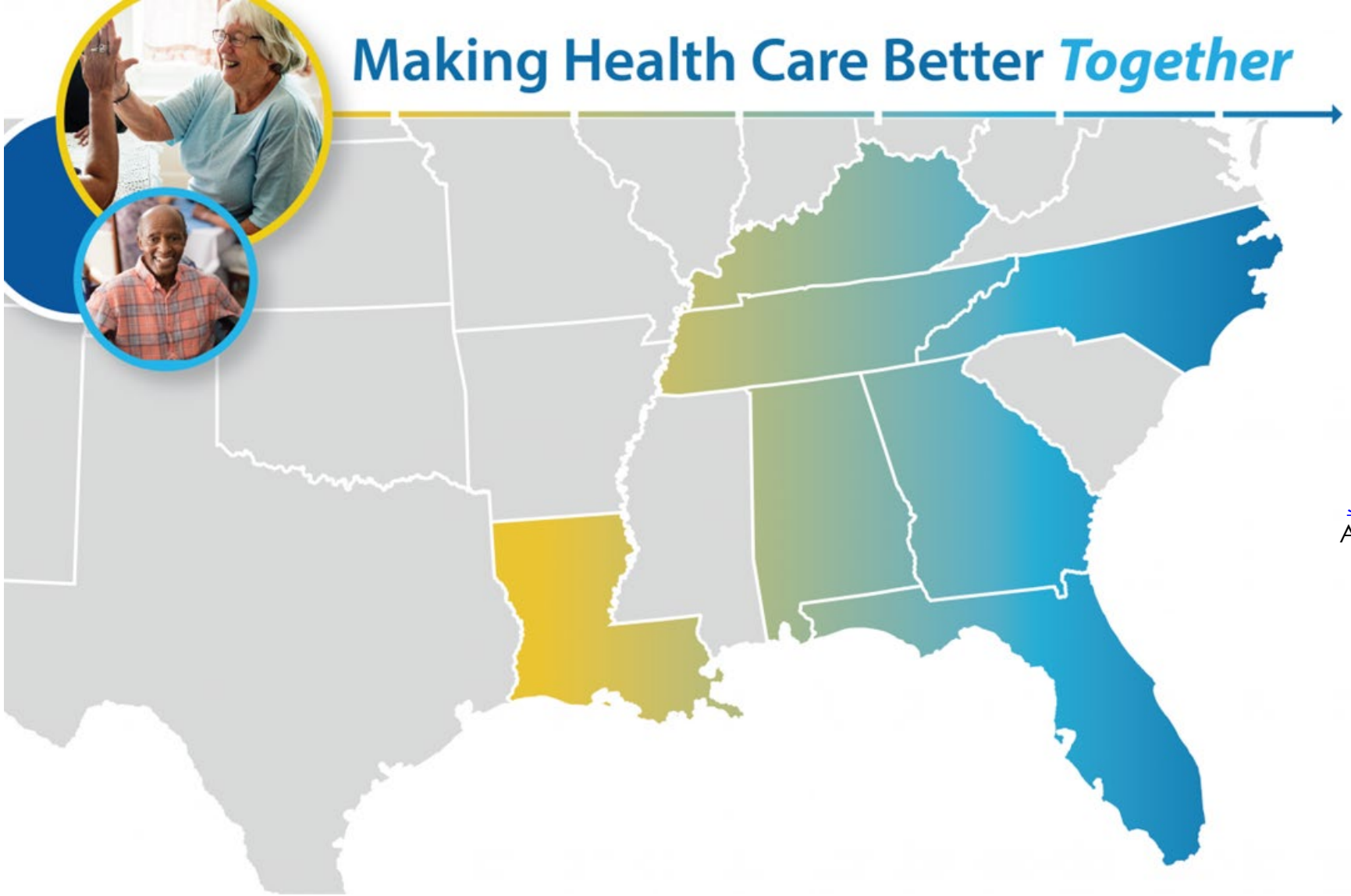

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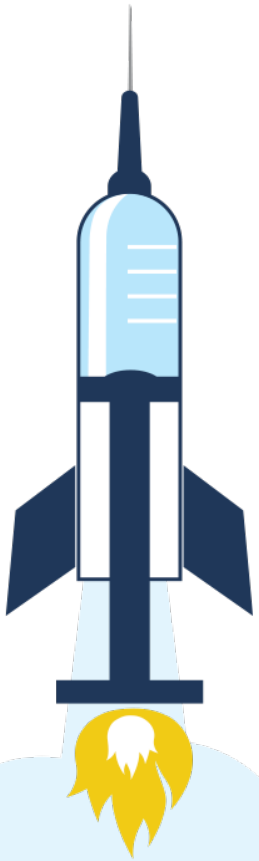

Thank you

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