



COVID-19 Chicago Long Term Care Roundtable

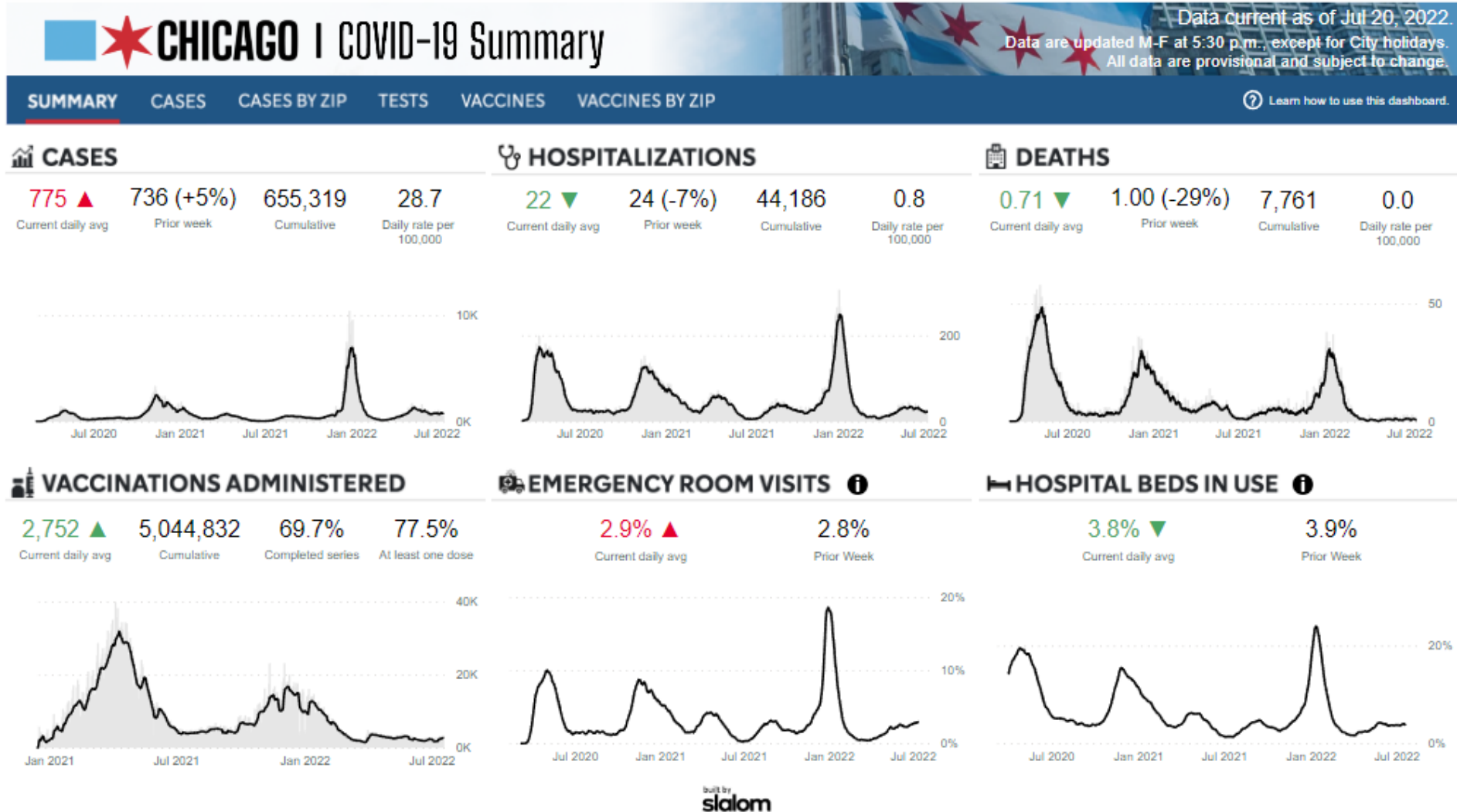
07-21-2022



Agenda

- COVID-19 Epidemiology
- COVID Reminders, Updates, and FAQs
- Enhanced Barrier Precautions
- Monkeypox Update
- Questions & Answers

Chicago Dashboard

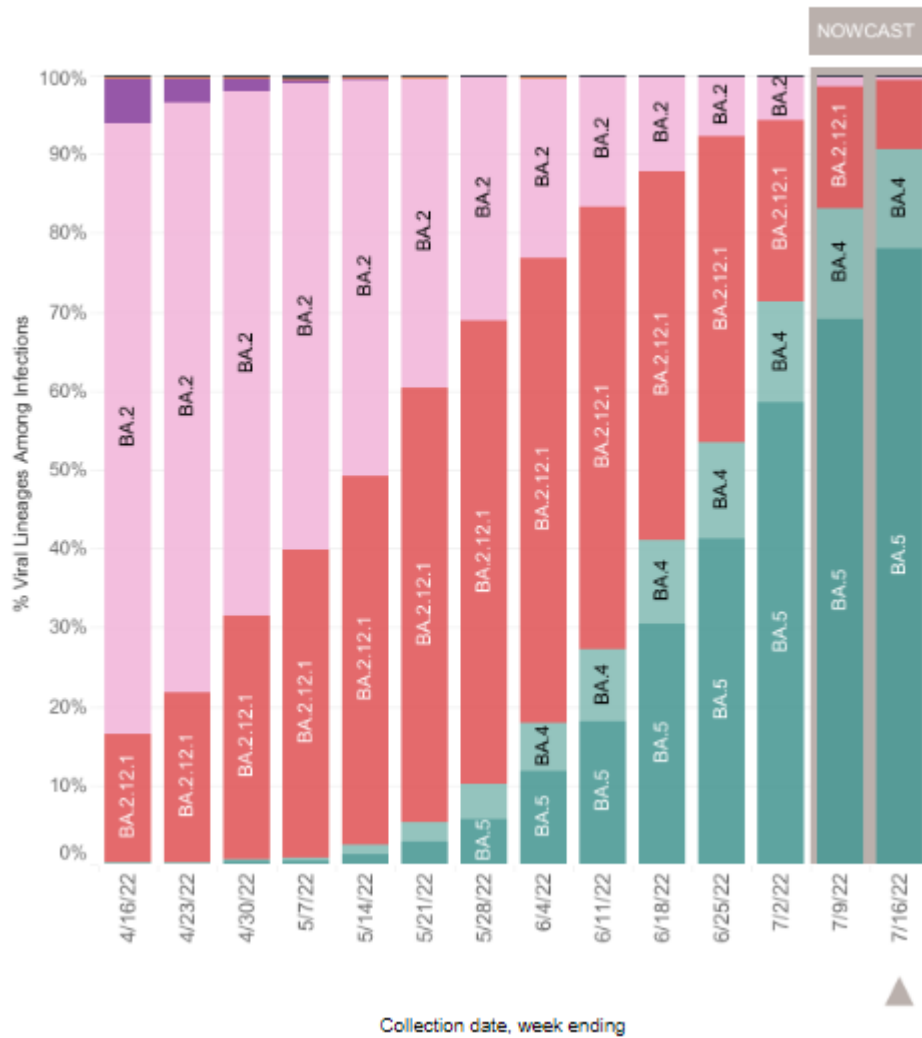


COVID-19 Variant Proportions



HHS Region 5: 4/10/2022 – 7/16/2022

HHS Region 5: 7/10/2022 – 7/16/2022 NOWCAST



Region 5 - Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

WHO label	Lineage #	US Class	%Total	95%PI
Omicron	BA.5	VOC	78.0%	75.7-80.2%
	BA.4	VOC	12.6%	10.4-15.1%
	BA.2.12.1	VOC	8.8%	7.6-10.2%
	BA.2	VOC	0.6%	0.5-0.7%
	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. For regional data, BA.1.1 and its sublineages are also aggregated with B.1.1.529, as they currently cannot be reliably called in each region. Except BA.2.12.1, BA.2 sublineages are aggregated with BA.2. Sublineages of BA.4 are aggregated to BA.4. Sublineages of BA.5 are aggregated to BA.5.

★ Reminder: CDC COVID Data Tracker

Indicator - If the two indicators suggest different transmission levels, the higher level is selected	Low Transmission Blue	Moderate Transmission Yellow	Substantial Transmission Orange	High Transmission Red
Total new cases per 100,000 persons in the past 7 days	0-9.99	10-49.99	50-99.99	≥100
Percentage of NAATs ¹ that are positive during the past 7 days	0-4.99%	5-7.99%	8-9.99%	≥10.0%

CDC COVID Data Tracker: Cook County



Cook County, Illinois

[State Health Department](#)

COVID-19 Community Level

● High

Recommended actions based on current level

Wear a mask indoors in public and on [public transportation](#). Stay [up to date](#) with COVID-19 vaccines. [Get tested](#) if you have symptoms. If you are at [high risk for severe illness](#), consider taking [additional precautions](#).

Weekly Metrics Used to Determine the COVID-19 Community Level

Case Rate per 100,000 population	255.85
New COVID-19 admissions per 100,000 population	12.6
% Staffed inpatient beds in use by patients with confirmed COVID-19	4.1%

[How are COVID-19 Community Levels calculated?](#)

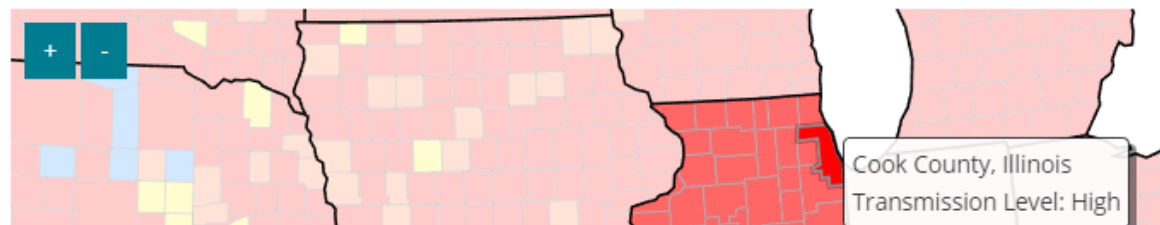
*Note: The COVID-19 Community Level and associated metrics presented above are updated weekly on **Thursday** and may differ from the values for the same metrics presented below, which are updated daily.*

Data Type:

Community Transmission

Map Metric:

Community Transmission



★ Recent Hospitalizations and Deaths Among Chicago SNF Residents & Staff

Hospitalizations and COVID-related deaths by role within the **last 28 days**

Data between 6/21/2022 – 7/19/2022

Role	# of total cases	# of total hospitalized (%)	# of COVID-related deaths	Change in hospitalizations and deaths since last report
Resident	192	18 (9%)	4	+1 death, +5 hospitalizations
Staff	221	0 (0%)	-	No change
Unknown	33	1 (3%)	1	No change



Reminder: Minimum Routine Staff Testing Frequency

Vaccination Status	Testing Frequency
Unvaccinated	2x a week*
Partially Vaccinated	2x a week*
Vaccinated but not up to date**	2x a week*
Up to date	No required routine testing

Based on Executive Order and related Emergency Rules

* Unless symptomatic, had a high-risk exposure, or your facility is in outbreak and performing broad-based testing.

** An individual has not received all COVID-19 vaccinations for which they are eligible, as outlined under “up to date”

★ Reminder: Minimum Routine Resident Testing Frequency

Vaccination Status	Routine Testing Frequency
Unvaccinated*	No required routine testing**
Partially vaccinated*	No required routine testing**
Vaccinated but not up to date*	No required routine testing**
Up to date*	No required routine testing**
New and readmissions, regardless of vaccination status, <i>when community transmission is low or moderate</i>	No required routine testing**
New and readmissions, regardless of vaccination status, <i>when community transmission is substantial or high</i>	Must be tested upon admission (unless tested within the 72 hours prior to admission) <i>and</i> at 5-7 days post-admission

*Excluding new/readmissions when community transmission is substantial or high

**Unless symptomatic, had a high-risk exposure, or your facility is in outbreak and performing broad-based testing.



Update: One-time Rapid Antigen Test (RAT) Offer from IDPH

- IDPH is offering free RATs in a one-time bulk shipment
 - Requirements:
 - Must be a LTCF
 - Must have a CLIA waiver
 - Must have a provider order for testing
 - Must be set up to report test results to the State of Illinois
 - To order, visit:
<https://redcap.dph.illinois.gov/surveys/?s=T78A4HAKFTPKWAA>
 - Tests will be delivered to the Chicago Department of Public Health and one of our colleagues will contact you to arrange for pick-up

Update: HHS Rapid Antigen Test Orders

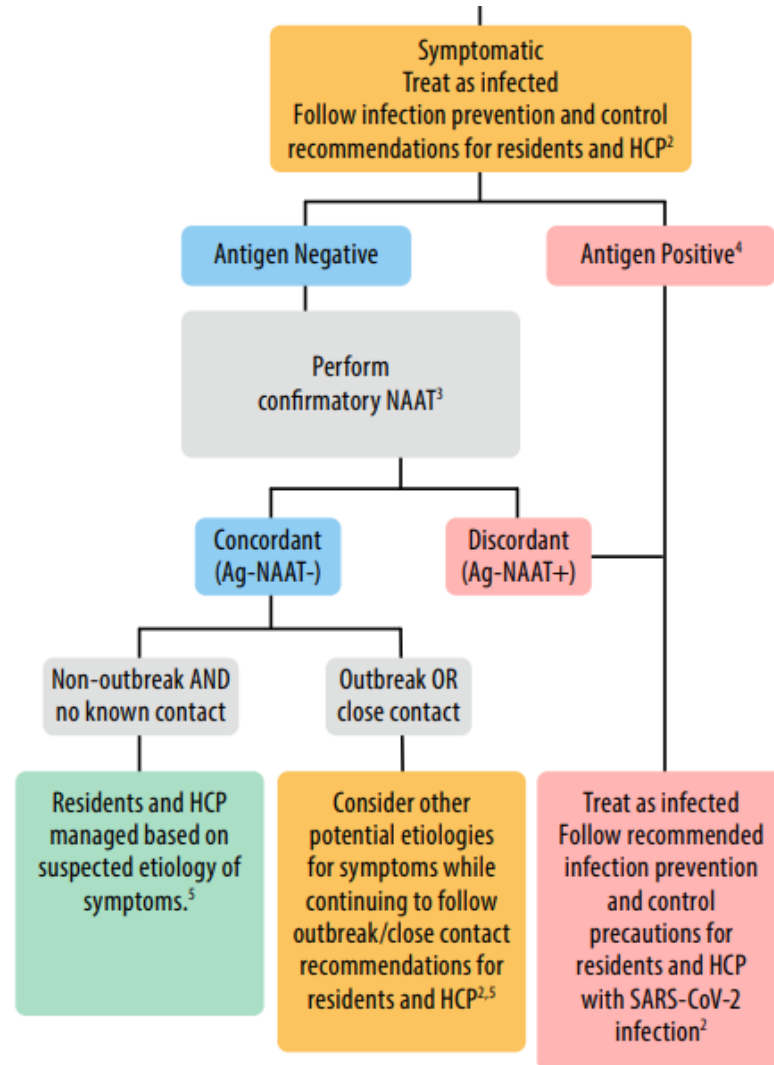
- Facilities can sign up for free direct shipments of BinaxNow RATs from the federal government
 - If interested, e-mail the HHS Binax Team at Binax.Team@hhs.com
 - Let them know you are a LTCF interested in receiving RATs and someone will assist you with next steps.



FAQ: I have a symptomatic resident who is rapid positive but was PCR negative the next day. Do we treat this as a false positive?

- No. If a resident is symptomatic and antigen positive, they should be treated as infected.

CDC Algorithm for Symptomatic Nursing Home Staff/Residents





Booster Focus Group/Interviews: Impact of the Pandemic

- Majority of staff felt scared, stressed, and exhausted at the height of the pandemic
- Staff were concerned about being able to provide the level of care their residents needed given staff shortages and constantly evolving guidelines
- Family and personal relationships were negatively impacted as staff were exhausted and worried about infecting their loved ones. When they were at home, it was harder to connect with friends and families

Pandemic Impact

“It felt like I was working in a crisis. Heavy workloads. Very sick dying patients was very heartbreaking. I cried a lot! I was overwhelmed and extremely exhausted.”

-Unboosted staff

“I felt scared to go home. I’d come home and go straight to the shower and put my clothes in the laundry before I’d see [my family].”

-Unboosted staff

“I had not left my room. The only time I [would] leave my room was to sometimes go shower. I didn’t even go outside on the patio when they finally opened the doors.”

-Unboosted resident

“It was really tough. We didn’t know what this was or how it came about. We lost people, both residents and staff. It was overwhelming due to staff getting sick and [we were] very short staff[ed]. It was scary and unknown.”

-Unboosted staff



Booster Focus Group/Interviews: COVID-19 Messengers

- For residents who have already decided to get the booster, family members were key influencers in that decision-making process
- Both residents and staff indicated that they trusted their own primary care providers. Staff indicated that their PCPs know their whole health history so they can provide the best advice
- Most respondents who don't trust anyone about boosters pointed to the fact that different institutions give different and/or conflicting guidance making it difficult to know what is accurate
- Vaccination leaders felt 1:1 conversations were the most effective at changing people's minds about getting vaccinated

★ COVID-19 Messengers

“[I trust] infection control because they do the most research, stay up to date with all the agencies, and offer us recommendations”
-Unboosted staff

“I just don’t trust anyone right now. There’s not enough information on long-term effects. They don’t even know how effective the vaccines are”
-Unboosted Physical Therapist

“I’m just following behind my cousin. He said he did it and told me no, don’t play with it, go on and take it”
-Unboosted resident

“It’s hard to trust anyone to be completely honest. Everyone says different things.”
- Unboosted CNA



Booster Focus Group/Interviews: Primary Series Perceptions/Experiences

- Staff reported more side effects than residents, although many staff said they did not have any side effects
- Majority of staff respondents reported feeling scared and anxious after receiving the primary series because they weren't ready to be vaccinated and/or were worried about side effects
- A few respondents felt relieved after being vaccinated. Many said that they felt selfless and proud of protecting their communities
- Some respondents mentioned that getting vaccinated caused conflict in their lives due to judgement from friends and family
- Residents said they got the primary series to protect themselves and to do the right thing

★ Primary Series Perceptions/Experiences

“I felt like I had accomplished something...if I wasn’t in this facility, I probably wouldn’t have even got a chance to take the vaccine...It felt like a shield of protection”

-Unboosted resident

“I was afraid because I felt the vaccine was rushed and might do more harm than good”

-Unboosted Staff

“I felt that my freedom and personal autonomy was taken from me”

- Unboosted Director of Rehab

“I overall think it was a good decision. As a person working in healthcare, you have to put others first. Being selfless is good to protect others.”

- Unboosted Social Worker



Booster Focus Group/Interviews: Primary Series Motivators

- The top motivator to get the primary series of the vaccine was that it was mandatory to stay employed at the long-term care facility
- The second most cited reason was that staff wanted to protect themselves, their loved ones, the residents at work, and their communities
- Most residents who were interviewed were already planning on getting boosters. They described wanting to protect themselves from severe illness and death
- Vaccination leaders remain hopeful that those who have medical and religious exemptions will decide to be vaccinated eventually

★ Primary Series Motivators

“I found out I was pregnant and wanted to protect myself and my family”

- Unboosted staff

“A lot of people got it just to keep their jobs.”
- Vaccination leader

“I was forced”

- Unboosted staff

“Well, I did a good thing and I won’t be sick.”

- Unboosted resident

“My family advised me to get it, to reduce the percentage of me getting someone else sick and protecting myself. It was necessary to travel and I love to travel.”

- Unboosted social worker

★ Stay Tuned: Boosted LTC Staff Posters



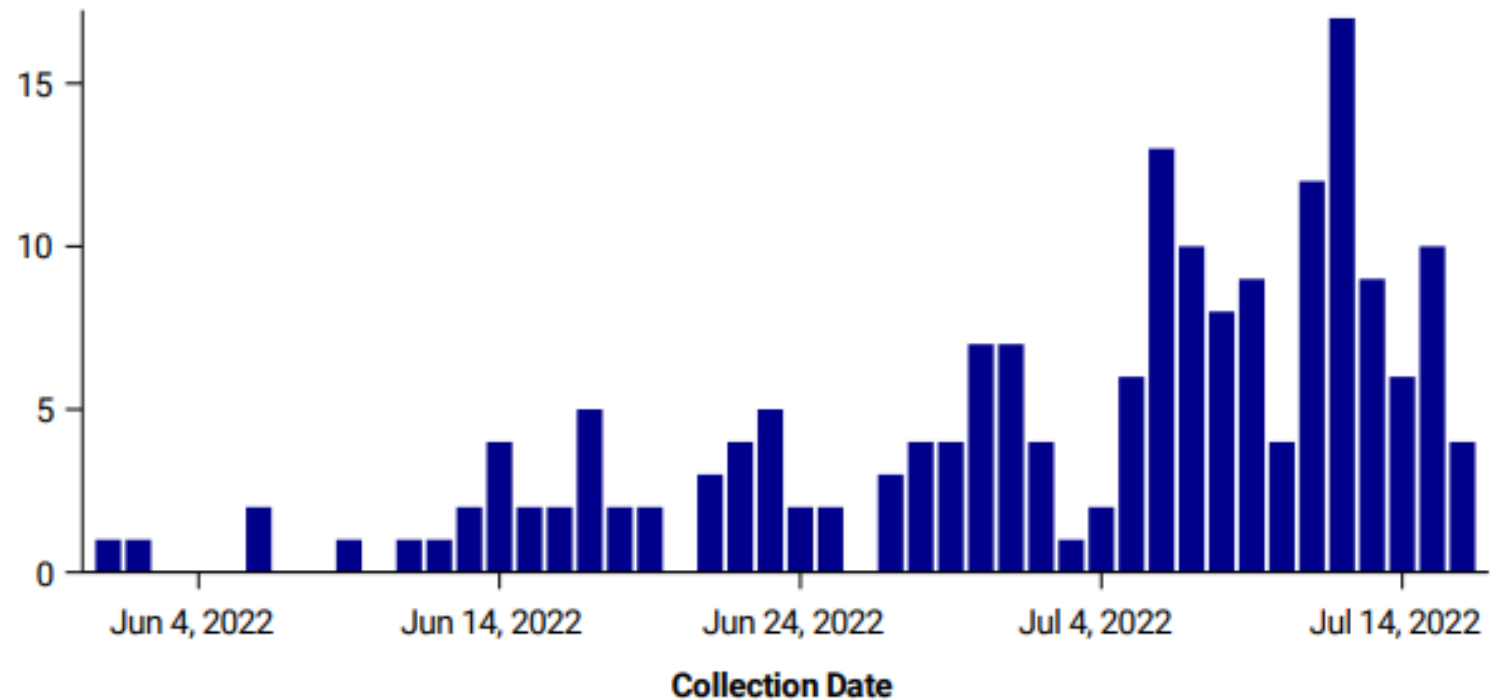


Monkeypox Outbreak

Situation Report as of July 20, 2022

Summary: As of July 20, 2022, there have been 182 Chicagoans who have tested positive for Monkeypox, 9 of which were known to be hospitalized for their symptoms. From these cases, 311 have been identified as close contacts - 190 were monitored by CDPH and 64 are still actively being monitored.

Daily Monkeypox Cases by Specimen Collection Date



MPV Symptoms

- Monkeypox is a rare disease caused by infection with the monkeypox virus. Monkeypox symptoms are similar to smallpox symptoms, but milder; and monkeypox is rarely fatal.
- Monkeypox is not related to chickenpox
- Symptoms of monkeypox can include:
 - Fever
 - Headache
 - Muscle aches and backache
 - Swollen lymph nodes
 - Chills
 - Exhaustion
- A rash that can look like pimples or blisters that appears on the face, inside the mouth, and on other parts of the body, like the hands, feet, chest, genitals, or anus.
- The rash goes through different stages before healing completely. The illness typically lasts 2-4 weeks. Sometimes, people get a rash first, followed by other symptoms. Others only experience a rash.



FAQ: What does a monkeypox lesion look like?



Treatment for MPV

- If you have symptoms of monkeypox, you should talk to your healthcare provider, even if you don't think you had contact with someone who has monkeypox.
- Antivirals, such as tecovirimat (TPOXX), may be recommended for people who are more likely to get severely ill, like patients with weakened immune systems.

Monkeypox (MPV) Employee Risk Assessment



Employee Exposure Guidance	
High Risk Exposure - Call CDPH	
Unprotected contact between a person's skin or mucous membranes and the skin, lesions, or bodily fluids from a patient (e.g., inadvertent splashes of patient saliva to the eyes or oral cavity of a person, ungloved contact with patient), or contaminated materials (e.g., linens, clothing).	Active surveillance for symptoms, which includes measurement of temperature for 21 days following the exposure. Healthcare workers should check symptoms prior to reporting to work. AND Post Exposure Prophylaxis (PEP) Recommended.
Being inside the patient's room or within 6 feet of a patient during any procedures that may create aerosols from oral secretions, skin lesions, or resuspension of dried exudates (e.g., shaking of soiled linens), without wearing an N95 or equivalent respirator (or higher) and eye protection.	
Intermediate Risk Exposure - Call CDPH	
Being within 6 feet for 3 hours or more of an unmasked patient without wearing, at a minimum, a surgical mask.	Active surveillance for symptoms, which includes measurement of temperature for 21 days following the exposure. Healthcare workers should check symptoms prior to reporting to work. AND Post Exposure Prophylaxis (PEP) - Informed clinical decision making recommended on an individual basis to determine whether benefits of PEP outweigh risks.
Activities resulting in contact between sleeves and other parts of an individual's clothing and the patient's skin lesions or bodily fluids, or their soiled linens or dressings (e.g., turning, bathing, or assisting with transfer) while wearing gloves but not wearing a gown.	
Low Risk Exposure	
Entered the patient room without wearing eye protection on one or more occasions, regardless of duration of exposure.	Symptom monitoring daily for 21 days following the exposure. Healthcare workers should self-check for symptoms prior to reporting to work.
During all entries in the patient care area or room (except for during procedures listed above in the high-risk category), wore gown, gloves, eye protection, and at minimum, a surgical mask.	
Being within 6 feet of an unmasked patient for less than 3 hours without wearing at minimum, a surgical mask.	

- PEP recommended
- Active monitoring (21 days)

- PEP based on individualized assessment
- Active monitoring (21 days)

- Monitor only (self-check)



MPV Risk Assessment: High Risk Exposure

- Unprotected contact between a person's skin or mucous membranes and the skin/lesions/body fluids from a patient or contaminated materials (e.g., linens, clothing)
- Being inside of a room during a procedure that may create aerosols from oral secretions, skin lesions, or resuspension of dried exudates (e.g., shaking soiled linens or clothing) without wearing a N95 respirator and eye protection
- **Contacts with a high-risk exposure:**
 - **Should undergo symptom monitoring for 21 days**
 - **May be indicated for post-exposure prophylaxis**



MPV Risk Assessment: Intermediate Risk Exposure

- Being within 6 feet for 3 hours or more of an unmasked patient without wearing, at a minimum, a surgical mask
- Activities resulting in contact between an individual's clothing and the patient's skin lesions or body fluids, or their soiled linens or dressings while wearing gloves but not a gown (could occur during turning, bathing, or assisting with transfer)
- **Contacts with an intermediate-risk exposure:**
 - **Should undergo symptom monitoring for 21 days**
 - **May be indicated for post-exposure prophylaxis**

★ MPV Risk Assessment: Low Risk Exposure

- Entered a patient's room without wearing eye protection, regardless of duration of exposure
- During all entries in the patient care area or room (except for any procedures listed in the high-risk category), wore gown, gloves, eye protection, and a surgical mask or higher
- Being within 6 feet of an unmasked patient for less than 3 hours without wearing a surgical mask
- **For low-risk exposures:**
 - **We may ask for residents with low-risk exposures to be monitored for symptoms (e.g., new onset rash)**
 - **Post-exposure prophylaxis is not indicated**



Suspect Cases and Post exposure prophylaxis (PEP)

- To request public health testing, please complete the CDPH suspect case report form: <https://redcap.link/reportmpx>.
- Monkeypox virus testing is also available at many commercial reference laboratories, including LabCorp & Quest. Specimen can be submitted directly to commercial laboratories without prior CDPH approval.
- Post exposure prophylaxis (PEP) with the Jynneos vaccine is available for individuals who have had “high” or “intermediate” close contact with a confirmed case of monkeypox (MPV). PEP should ideally be provided within 4 days from the date of last exposure to prevent onset of disease.
- To locate PEP for high risk close contacts and exposed healthcare workers can be arranged through CDPH by contacting monkeypoxPEP@cityofchicago.org.

MPV: Additional Notes

- No known transmission in this current outbreak from a case to a HCW
- No known transmission from a HCW to other staff or residents
- No known cases in Skilled Nursing Facility residents
- If you have any questions, contact your resources at CDPH. We are here to support you 😊

★ MPV: Additional Notes

- Staff diagnosed with MPV must be excluded from work from the time of symptom onset through the time that the rash has fully resolved, the scabs have fallen off, and a fresh layer of intact skin has formed
 - This process often takes 2-4 weeks
- Very important to maintain confidentiality
 - Only tell leadership staff that must be in the know (e.g., DON)
 - Based on a risk assessment, we can let you know if further notifications should be made (e.g., to intermediate or high-risk contacts)



Multi Drug Resistant Organisms (MDRO's)

- Multidrug-resistant organisms are bacteria or fungi that have become resistant to certain antimicrobials
- Examples of MDROs include:
 - ✓ Pan-resistant organisms
 - ✓ Carbapenemase-producing carbapenem-resistant Enterobacterales (CRE).
 - ✓ Carbapenemase-producing carbapenem-resistant Pseudomonas spp (CRPA).
 - ✓ Carbapenemase-producing carbapenem-resistant Acinetobacter baumannii (CRAB).
 - ✓ Candida auris (C.auris).
- Additional epidemiologically important MDROs may include, but are not limited to:
 - ✓ Methicillin-resistant Staphylococcus aureus (MRSA)
 - ✓ ESBL-producing Enterobacterales
 - ✓ Vancomycin-resistant Enterococci (VRE)
 - ✓ Drug-resistant Streptococcus pneumoniae

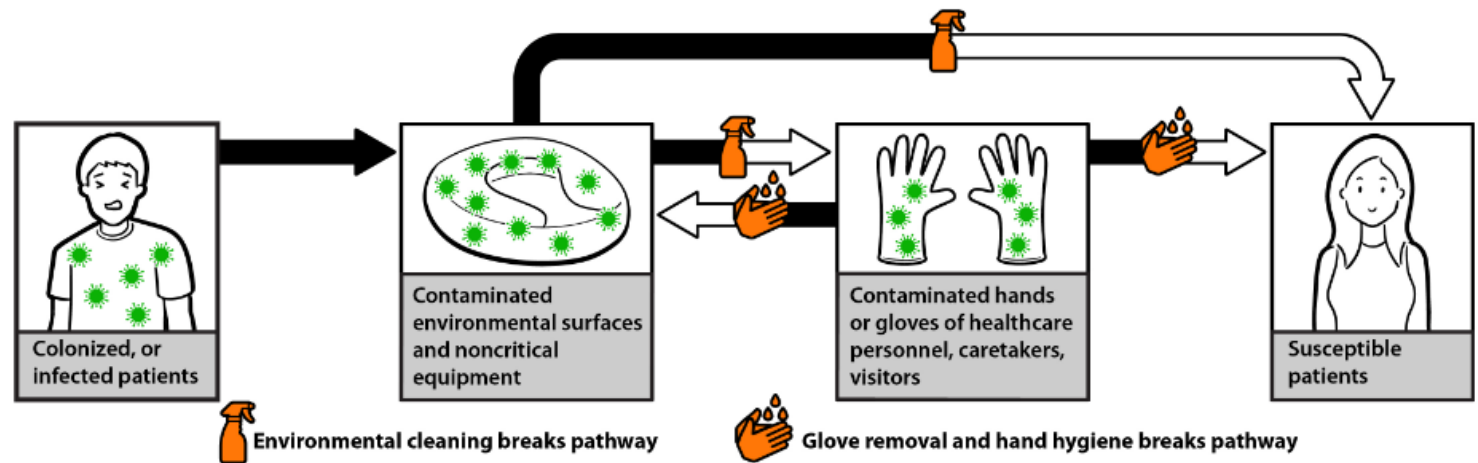
★ Transmission of MDRO's

- Clinical – detected from a specimen obtained from an individual over the course of clinical care (e.g., blood, respiratory, or wound)
 - Colonized: these germs are living on or in your body. You may not be sick with an infection, but you can spread the germs.
- Both clinical AND colonized individuals are potential sources of transmission
- Both clinical AND colonized individuals require transmission-based precautions



★ Transmission of MDRO's

- Many nursing home residents are unknowingly colonized with an MDRO and can remain colonized for long time periods, and spread MDROs to others
- Healthcare personnel can spread MDROs through contaminated hands and clothing
- Transmission based precautions throughout the duration of stay may be indicated to prevent MDRO transmission





COVID-19: U.S. Impact on Antimicrobial Resistance, Special Report 2022

6 of the 18 most alarming antimicrobial resistance threats cost the U.S. more than \$4.6 billion annually⁸

- Vancomycin-resistant *Enterococcus (VRE)*
- Carbapenem-resistant *Acinetobacter species*
- Methicillin-resistant *Staphylococcus aureus (MRSA)*
- Carbapenem-resistant Enterobacterales (CRE)
- Multidrug-resistant (MDR) *Pseudomonas aeruginosa*
- Extended-spectrum cephalosporin resistance in Enterobacterales suggestive of extended-spectrum β -lactamase (ESBL) production

⚠ Available data show an alarming increase in resistant infections starting during hospitalization, growing at least 15% from 2019 to 2020.

- Carbapenem-resistant *Acinetobacter* (+78%)
- Antifungal-resistant *Candida auris* (+60%)*
- Carbapenem-resistant Enterobacterales (+35%)
- Antifungal-resistant *Candida* (+26%)
- ESBL-producing Enterobacterales (+32%)
- Vancomycin-resistant *Enterococcus* (+14%)
- Multidrug-resistant *P. aeruginosa* (+32%)
- Methicillin-resistant *Staphylococcus aureus* (+13%)

**Candida auris* was not included in the hospital-onset rate calculation of 15%. See [Data Table](#) and [Methods](#) for more information on this pathogen.

Pandemic-related challenges hindered many infection prevention and control practices like hand hygiene, cleaning equipment, separating patients, and using personal protective equipment (PPE)—undoing some progress on combating antimicrobial resistance.



COVID-19: U.S. Impact on Antimicrobial Resistance, Special Report 2022

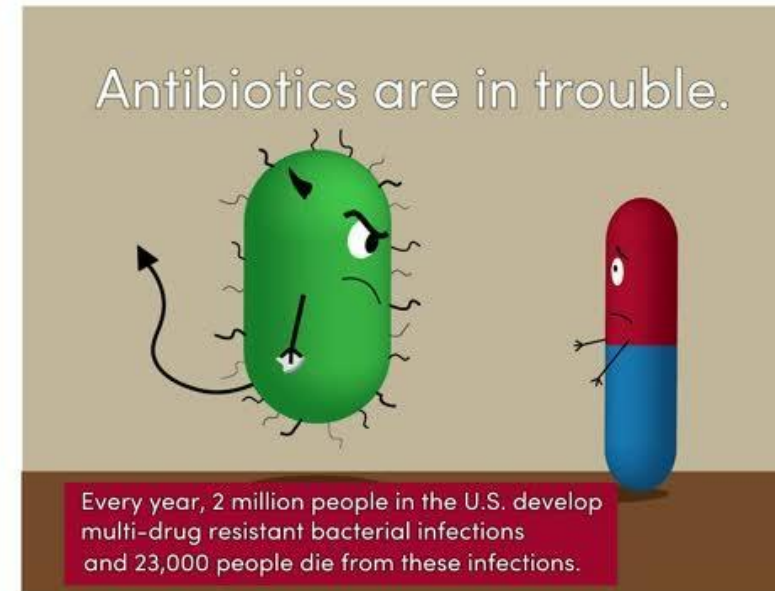
- During the COVID-19 pandemic, hospitals treated sicker patients who required more frequent and longer use of catheters and ventilators. Hospitals also experienced supply challenges, reduced staff, and longer visits during the pandemic.
- The pandemic also greatly impacted antibiotic prescribing.

COVID-19 Impacts on 18 Antimicrobial-Resistant Bacteria and Fungi Threat Estimates

The following table summarizes the latest national death and infection estimates for 18 antimicrobial-resistant bacteria and fungi. The pathogens are listed in three categories—urgent, serious, and concerning—based on level of concern to human health identified in 2019.

	Resistant Pathogen	2017 Threat Estimate	2018 Threat Estimate	2019 Threat Estimate	2017-2019 Change	2020 Threat Estimate and 2019-2020 Change
URGENT	Carbapenem-resistant <i>Acinetobacter</i>	8,500 cases 700 deaths	6,300 cases 500 deaths	6,000 cases 500 deaths	Stable*	7,500 cases 700 deaths Overall: 35% increase* Hospital-onset: 78% increase*
	Antifungal-resistant <i>Candida auris</i>	171 clinical cases†	329 clinical cases	466 clinical cases	Increase	754 cases Overall: 60% increase
	<i>Clostridioides difficile</i>	223,900 infections 12,800 deaths	221,200 infections 12,600 deaths	202,600 infections 11,500 deaths	Decrease	Data delayed due to COVID-19 pandemic
	Carbapenem-resistant Enterobacterales	13,100 cases 1,100 deaths	10,300 cases 900 deaths	11,900 cases 1,000 deaths	Decrease*	12,700 cases 1,100 deaths Overall: Stable* Hospital-onset: 35% increase*
	Drug-resistant <i>Neisseria gonorrhoeae</i>	550,000 infections	804,000 infections	942,000 infections	Increase	Data unavailable due to COVID-19 pandemic
SERIOUS	Drug-resistant <i>Campylobacter</i>	448,400 infections 70 deaths	630,810 infections	725,210 infections	Increase	Data delayed due to COVID-19 pandemic† 26% of infections were resistant, a 10% decrease
	Antifungal-resistant <i>Candida</i>	34,800 cases 1,700 deaths	27,000 cases 1,300 deaths	26,600 cases 1,300 deaths	Decrease*	28,100 cases 1,400 deaths Overall: 12% increase* Hospital-onset: 26% increase*
	ESBL-producing Enterobacterales	197,400 cases 9,100 deaths	174,100 cases 8,100 deaths	194,400 cases 9,000 deaths	Increase*	197,500 cases 9,300 deaths Overall: 10% increase* Hospital-onset: 32% increase*
	Vancomycin-resistant Enterococcus	54,500 cases 5,400 deaths	46,800 cases 4,700 deaths	47,000 cases 4,700 deaths	Stable*	50,300 cases 5,000 deaths Overall: 16% increase* Hospital-onset: 14% increase*

Implementation of Enhanced Barrier Precautions (EBP) in Long term care facilities to Prevent transmission of Multidrug-resistant Organisms





Who is at risk for an MDRO infection?

- Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs
- Vulnerable to colonization and infection include residents:
 - ✓ weakened immune system
 - ✓ recent surgery
 - ✓ indwelling medical devices (e.g., urinary catheters or endotracheal tubes)
 - ✓ Have had repeated or long stays in the hospital
 - ✓ Have open wounds or sores



The Large Burden of MDROs in Nursing Homes

Facility Type	Documented MDRO	Actual MDRO
Nursing Homes (n = 14)	17% 	58%
Ventilator-Capable Nursing Homes (n = 4)	20% 	76%

McKinnell JA et al, Clin Infect Dis. 2019; 69(9):1566-1573



★ Enhanced Barrier: Not a New Concept in Illinois

- ✓ IDPH's Feb 2016 publication on Enhanced Standard precautions
- ✓ Require the use of a gown and gloves for activities such as toileting, wound care and suctioning, but not for simply entering the resident room
- ✓ Independent residents may benefit from Enhanced Standard Precautions, rather than Contact Precautions, for routine care.



Prevention, Control, and Management of Carbapenem-Resistant Enterobacteriaceae in Long Term Care Facilities

Purpose

This document summarizes best practices for prevention and control of Carbapenem-Resistant Enterobacteriaceae (CRE) in long term care facilities. The document provides a brief description of CRE, guidance for surveillance and screening, proactive interventions to prevent CRE infections, as well as enhanced interventions to control transmission when cases are identified in a long term care facility. While not required under normal circumstances, some recommendations may become requirements in the event a cluster/outbreak is identified in a long term care facility.

There are two sections to this document. The first is formatted by intervention and includes a referenced narrative followed by recommendations. The second section (Appendix A) includes only the recommendations and is designed to be a stand-alone document that can be used as a ready reference.



Consideration for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities

- In 2019, CDC introduced a new approach to the use of personal protective equipment called Enhanced Barrier Precautions (EBP). This new approach recommends gown and glove use for certain residents during specific high-contact resident care activities associated with MDRO transmission

Enhanced Barrier Precautions can be applied (when Contact Precautions do not otherwise apply) to residents with any of the following:

- Wounds or indwelling medical devices, regardless of MDRO colonization status
- Infection or colonization with an MDRO

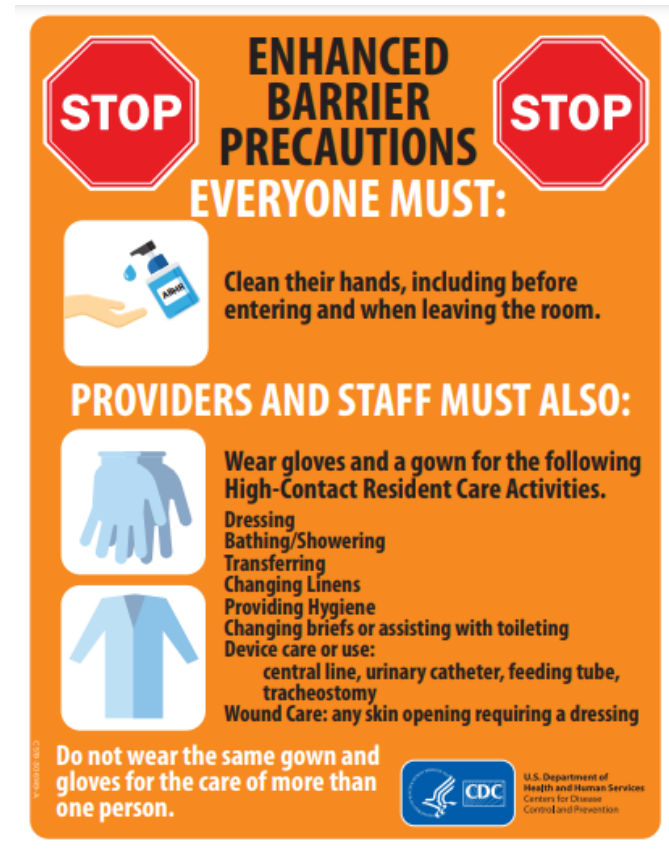


Updated Guidance: Enhanced Barrier Precautions

- Historically, interventions in nursing homes have focused only on residents who are actively infected with an MDRO
- Updated July 12, 2022:
 - ✓ rationale for the use of Enhanced Barrier Precautions (EBP) in nursing homes, including the high prevalence of MDRO colonization among residents in this setting.
 - ✓ Expanded residents for whom EBP applies to include any resident with an indwelling medical device or wound (regardless of MDRO colonization or infection status).
 - ✓ Expanded MDROs for which EBP applies.
 - ✓ Clarified that, in the majority of situations, EBP are to be continued for the duration of a resident's admission.

★ Enhanced Barrier Precautions

- Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing
- MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities
- Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs
- Facilities should define high risk contact activities in their policies and procedures and educate healthcare personnel to ensure consistent application of Enhanced Barrier Precautions



★ Enhanced Barrier Precautions

- Enhanced Barrier Precautions (EBP) reduce transmission of resistant organisms by employing targeted gown and glove use during high contact resident care activities.
- EBP are indicated for nursing home residents with any of the following:
 - ✓ Infection or colonization with an MDRO when Contact Precautions do not otherwise apply
 - ✓ Wounds and/or indwelling medical devices
- Additionally, Enhanced Barrier Precautions are indicated for any nursing home residents who have wounds and/or indwelling medical devices; as these are residents at increased risk of becoming colonized with an MDRO

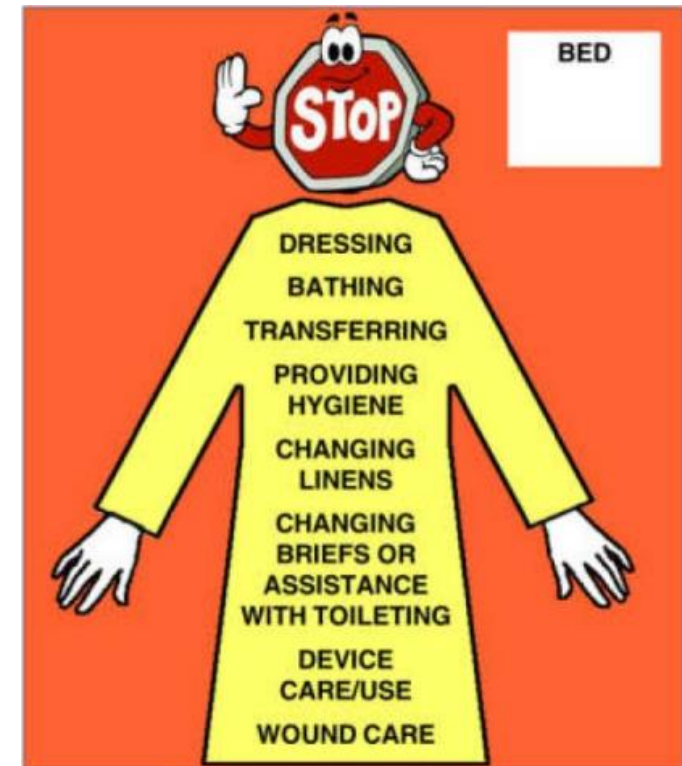


Image courtesy of Mary-Claire Roghmann



How is EBP different from Standard Precautions and Contact Precautions?

- Standard Precautions:
 - ✓ are a group of infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status.
 - ✓ Use of PPE is recommended based on the “anticipated exposure” to blood, body fluids, secretions, or excretions



Contact Precautions

- Indications:

- ✓ For residents infected or colonized with an MDRO

- ✓ Contact Precautions with room restrictions if:

- Acute diarrhea

- Draining wounds

- Secretions or excretions that are unable to be effectively or easily covered or contained which, in general, includes those who are fully-dependent on caregivers

- Use of gown and gloves on **every** entry into a resident's room, regardless of the level of care being provided to the resident. The resident is given dedicated equipment (e.g., stethoscope and blood pressure cuff) and is placed into a private room.



Implementing Enhanced Barrier Precautions

- Post clear signage on the door or wall outside of the resident room
- Make PPE, including gowns and gloves available immediately outside of the resident room
- Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room)
- Position a trash can inside the resident room and near the exit for discarding PPE after removal
- Conduct PPE and Hand hygiene audits
- Provide education to residents and visitors

Enhanced Barrier Precautions FAQs

Q: Is EBP a new standard of care--wearing gown and gloves for close care activities if resident at risk due to lines or wounds?

A: No, It is an updated recommendation for IPC standards. The initial EBP was published in 2019 and has been expanded based on further review. Residents with indwelling medical devices and wounds are at a much higher risk of contracting or already being infected or colonized with an MDRO. This is a method to help reduce transmission.

Enhanced Barrier Precautions FAQs

Q: Does EBP means no group activities and total isolation?

A: No. The updated recommendations for EBP do not require isolation, a private room, or being able to participate in group activities. Gowns and gloves are recommended for high-contact resident care activities and the resident may go to group activities.

Q: What if the resident who needs to be on EBP has dementia and travels around the facility?

A: This is okay. We do not require the resident to be isolated to his/her/their room. Gowns and gloves are recommended for high-contact resident care activities. The resident would still be able to participate in group activities and go to common areas

Enhanced Barrier Precautions FAQs

Q: If resident is placed on enhanced barrier precautions, but is a long stay resident, what is the guidance to remove EBP?

A: If a resident is placed on EBP for a wound or indwelling medical device and the wound heals or device is removed; that resident would no longer meet criteria for EBP so EBP can be removed.

Q: Our facility does not have any known MDROs, should are residents with an indwelling device or wound needs to be on EBP?

A: Yes, EBP are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized.

Enhanced Barrier Precautions FAQs

- **Q: Are Enhanced Barrier Precautions recommended for residents with Clostridioides difficile infection or scabies?**

No. Enhanced Barrier Precautions are intended for MDROs (other than Clostridioides difficile) and do not replace existing guidance regarding use of Contact Precautions for other pathogens (e.g., Clostridioides difficile, scabies, norovirus) and conditions in nursing homes.

★ Conclusion

- To reduce MDRO transmission, facility leadership must commit resources to educate staff on effective infection control practices:
 - ✓ Identify infections early.
 - ✓ Enhanced Barrier/Contact precautions
 - ✓ Conventional use of PPE.
 - ✓ Environmental cleaning and disinfection.
 - ✓ Improved hand hygiene.

XDRO
registry



Clean hands with alcohol-based hand rub or soap and water



Wear gloves when providing direct care



Wear gown when providing direct care





Questions & Answers

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**For additional resources and upcoming events,
please visit the CDPH LTCF HAN page at:**

<https://www.chicagohan.org/covid-19/LTCF>